Evaluation

Report

Shetland Lifeline

24/7 confidential response to people in crisis

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In July 2008, funding was confirmed from the Fairer Scotland Fund, giving the go-ahead for local charity Shetland Link Up to put into action a proposal for a 24/7 Crisis Support service, to be called "Lifeline".

After recruiting and training a team of staff, the service commenced operation on October 1st 2008 and, having secured further funding for 2009-10, continued until March 31st 2010.

Lifeline was fully operational for 18 months.

Shetland Link Up's Annual Report for 2009 stated:

"Although the Pilot phase of the Lifeline service has so far delivered everything it set out to, it was never expected that it could continue in its present form. The pilot was principally concerned to test the feasibility of an on-call crisis service provided by the voluntary sector.

The key questions we need to answer are:

- Is it **possible** to create, staff and provide a 24/7 service in this way?
- Is it **robust**: will it be delivered reliably and consistently up to the required standards?
- Is such a service **effective**: does it meet its aims and objectives?
- Is it **safe**: people who contact a crisis service are often at a high level of risk – does the service reliably address, manage and reduce that risk?
- Is it **sustainable**: is the cost of the service affordable? Are the conditions of service and demands placed upon staff reasonable? Will it be possible to recruit and retain staff on an ongoing basis?"

The pilot phase of the project having now concluded, we are ready to present an evaluation and offer some answers to the above questions.

The collected responses to questionnaires, and comments from service users, carers, referrers and Lifeline employees are included as Appendix 1.

For the benefit of readers who do not already know about the Lifeline project, this report also outlines the Policy Context of the Lifeline project, and summarises its history and methods of working, etc.

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Contents

A. Introduction

1. What is “Lifeline”?

Lifeline is the name of a service provided by local charity Shetland Link Up to Adults (aged 16+) anywhere in Shetland who are in acute distress and whose usual network of support and personal coping strategies are failing. The name was chosen to suggest that this is a service that offers a rapid response to anyone in crisis, with safety and the relief of distress as its main objectives, and that the service is short-term. This impression is reinforced by the Lifeline logo which shows a hand reaching to grasp a lifeline against a background of darkness.

Lifeline is available 24 hours a day, seven days a week, every day of the year. Two Crisis Support Workers, one male and one female, are on call at any one time. Access is via a freephone (0800) number which connects callers directly to a worker on-call, who (if appropriate) is ready to set out (usually with their co-worker) to see the person where they are or in a place where they feel safe, within 30 minutes of concluding the phone call, plus travel time (and subject to ferry times).

No formal referral is necessary; the service is intended to be contacted directly by the person in crisis or by someone on their behalf.

Lifeline also provides an option to anyone needing urgent help for someone thinking of suicide. All people being trained in ASIST (Applied Suicide Intervention Skills Training) and SafeTALK (Suicide Alertness For Everyone) in Shetland are provided with Lifeline’s leaflet and wallet card for this purpose.

Lifeline is a unique service in the UK. It is offered immediately and directly to people without gate-keeping, referral or prior assessment, where they are, at any time, irrespective of their psychiatric diagnosis (or the absence of one), and regardless of whether there are drug or alcohol or domestic abuse issues.

The challenges to providing such a 24/7 crisis service posed by our small, scattered 'remote and rural' communities, together with the fact that most crisis services elsewhere are provided by the statutory sector, has until now made such a development seem hopelessly inefficient and expensive in the Shetland context. It was Lifeline’s aim to meet the expressed needs of the people who would use such a service, address the remote and rural issue creatively and make the fullest and most efficient use of existing services, with the least possible outlay.

2. Policy Context

2.1 Delivering for Mental Health (December 2006)

This document confirms the expectation that local agencies and partners work together to deliver crisis services and responses in line with the standards set out in the **National Standards for Crisis Services (November 2006)** by the end of December 2009.

The National Standards for Crisis Services (page 7) lists twelve minimum functions for Mental Health Crisis Services. All of these have been met by Lifeline; mainly as a stand-alone service, otherwise in cooperation with other, existing services (A&E and the CMHT).

Pages 8-20 describe eight minimum Standards, Delivery Objectives and Operational Criteria. These cover the following issues:

1. Access and Availability
2. Planning and Delivering Support
3. Promoting Equality and Respecting Diversity
4. Resolution and Discharge
5. Service User Involvement
6. Supporting and Involving Carers
7. Training/workforce Development
8. Working with Communities

Advice and guidance for their implementation has been provided in the more recent document **National Standards for Crisis Service, Crisis Services Practice Toolkit (December 2008).** The vast majority of the requirements have been met by Lifeline.

Lifeline on its own could not meet all the Scottish Government's requirements for a crisis service, as it could not offer medical treatment or arrange admission to hospital. However, in its 18 months of operation, there were no cases where this lack proved to be an issue. Lifeline's contract with its clients did not include medical assessment or treatment, and its workers were always able (e.g. by taking clients to the A&E) to ensure that they promptly received any medical help they asked for or needed.

Some issues are properly the domain of the NHS (e.g. medication prescribing, administration and monitoring), and the rest, Lifeline believes, could be addressed satisfactorily by the further development of joint working and cooperation with the statutory agencies.

2.2 Shetland Mental Health Strategy, October 2007

A growing demand locally for a crisis service had been acknowledged, and the need to develop one is mentioned on 16 pages of the Strategy. Support to develop and implement the Lifeline project is specifically pledged on p65. A working party was devolved from the Mental Health Partnership to examine and refine the proposal, which was then endorsed by the full Shetland Mental Health Partnership. Since implementation commenced, the Partnership has been kept informed with regular reports on progress.

2.3 The Fairer Scotland Fund

Lifeline shares the Fairer Scotland Fund's general emphasis on "early interventions for vulnerable individuals, families and disadvantaged communities" and contributes to meeting the following Strategic Priorities:

- **Healthier:** prompt and early intervention reduces the risk of suicide and can prevent (a) the need for hospital admission and/or (b) acute problems becoming chronic ones. Clients use emergency (999 Ambulance and A&E) services less and are enabled to use other supports (e.g. GPs, CMHT, CADSS, Voluntary Organisations, and family, friends & neighbours) more effectively.
- **Wealthier and Fairer:** Where crises have been caused, in part, by debt or low income, Lifeline has enabled uptake of CAB help with debt counselling and/or benefit review and applications. Some clients were not able to work, or their jobs were at risk because of their crisis. Employment has been maintained, resumed or pursued as a result of Lifeline intervention.
- **Stronger (Transport & Community):** "Everyone should be able to access the… services… that they need… " Few of our clients were able to 'come to us' when in crisis. Lifeline was as accessible as it could be: the contact number was 'freephone' and we were ready to go to our clients, 24/7. Where possible, we aimed to resolve crises by helping people to take responsibility and more effective control of their personal, relationship, occupational & social needs: i.e. by increasing people's resilience to life's stresses and strengthening their informal support networks.

Lifeline was committed to the principles of equality and equal opportunity and to overcoming some of the inequalities that exist within Shetland because of:

1. Geographic location
2. Non-possession of a vehicle or the means to pay for taxi fares
3. Psychiatric diagnosis, or the lack of one
4. Other social factors that lead to disadvantage (such as drug/alcohol issues, domestic abuse)

Although anyone in our communities may find themselves in crisis because of traumatic life events, much of Lifeline's work was done among those who are living with multiple disadvantages of various types and are 'on the margins' of society: poverty, homelessness, mental ill health, unemployment (or precarious employment) and social isolation were common issues for the clients of our service.

3. History and Roots of the Project

The idea to create this service was inspired and shaped through consultation with service users at Shetland Link Up's drop-in centre in January and February 2006. In general, people expressed a deep dissatisfaction with the way they had been treated when in crisis, and so we organised a workshop for them to express their views about the help *they would have liked to receive.*

The main aspirations for a crisis response service may be summarised as follows:

3.1 Accessibility, Availability, Immediate Response

- To help avert the onset of an 'acute episode' or 'relapse' by earlier response to distress.
- To be available and easily accessible 24/7 by a freephone number.
- The person you call must be able to activate a service immediately and not just take your details and refer you to someone else or make an appointment.
- There should be a person (or two people: one male, one female) on-call at all times who could set off to see you straight away. A visit could be requested by a friend, a neighbour, a family member, anyone in fact, but only with the knowledge and agreement of the person themselves.

3.2 What should Crisis Support Workers do?

- "Someone I know and trust to 'be there' for me, be alongside me, and not be distracted by other duties; able to give me their full and undivided attention. Someone with a caring nature, experienced personally (an 'expert by experience'), who knows about people in crisis. A good listener, quiet, gentle, someone who is strong and capable – So you can lean on them and they won't buckle. A shoulder to cry on."

  They will be able…

- To help people formulate and start to implement plans to resolve their state of crisis and find better ways to stay well.
- To allow and encourage people to retain and recover as much independence and responsibility for themselves as possible.
- To offer a flexible and creative response to individuals' needs and circumstances, giving priority to their perspectives, hopes and fears.
- To facilitate access to and uptake of other support services within Shetland.

3.3 Who should run the service?

- Respondents were clear that they thought the voluntary sector to be best placed to provide a crisis response service. A number of reasons were given:
- A crisis is not an illness or a diagnosis, but if people already have a mental health problem they sometimes fear that a doctor will immediately see their problems as signalling an acute episode of illness, requiring medical, perhaps in-patient treatment.
- Some were afraid to seek help from statutory agencies because of the power they have to take control over their lives (If I say how I am really feeling, will my children be taken away? My medication changed? Will I be sent to Cornhill?).

- Some respondents' experience of the statutory services is that there is too much red tape; too much emphasis on forms and organisational procedures and a reluctance or inability to adapt to unusual circumstances. The voluntary sector is better at being informal and 'homely'. It is also easier for the voluntary sector to respond quickly to changing needs and operate services that are more user-led.
- Whilst there was an acknowledgement of the role of the medical and social work services, it was felt that these are better provided as at present by existing agencies, rather than in-house by a statutory sector crisis service.

3.4 What about a 'safe house'?

- The consultation also indicated the expectation of a need for a staffed 'safe house' for people to use when in crisis. It was not seen as possible to provide this in the pilot stage of this project, but the need for it was to be kept under review through the course of the pilot project.

The development of the Lifeline service took careful account of the views expressed to us. We quickly became convinced that the design of a crisis service must be user-led in order to be acceptable and accessible to those who will use it, and that we must meet from time to time with a consultative group of service users to ensure that the original vision of the project was not lost as the practical details were worked out.

The initial proposals were modified through discussions later in 2006 with professionals from relevant agencies and further amended during the process of making applications for funding. At each stage, a consultative group of service users was convened, and the proposed changes discussed and agreed.

Funding for the first nine-months of a pilot project was secured from the *Fairer Scotland Fund* in July 2008, and the service commenced on 1st October 2008.

In December 2008, at the request of the Shetland Islands Council, consultant Chris Fieldhouse visited with a brief to report and advise on the issue of Crisis Resolution and Home Treatment in Shetland, with particular reference to the Lifeline Project. His informative and helpful report enabled the SIC to see a way to allay their concerns about the safety of the service through using a Service Level Agreement (SLA).

Funding for the year commencing 1st April 2009 was secured on 6th March 2009, subject to a Service Level Agreement - a detailed document placing a range of expectations on Lifeline to meet quality and safety standards. It also required the preparation of an Operational Manual for the project. This was submitted on 13th July and approved on 11th September 2009. Although the SLA was received on 24th April, it was only agreed and signed off on 17th July.

This process led to a funding gap of four months from April 1st until 31st July during which the project was funded by money loaned by an employee.

In September 2009, a paper was presented to the Mental Health Partnership, requesting consideration of local funding to launch a 'full' (as opposed to 'pilot') service and advising that the project would otherwise close on 31st March 2010. Despite the goodwill and efforts of Partnership members, it was mid-March before an actual amount was even suggested: far too late to take the necessary actions (including recruiting and training staff) to accomplish this. It was therefore decided to conclude and evaluate the pilot phase of the project with a view (should the relevant agencies agree to fund it) to re-launching as a full, ongoing service.

4. Definition of Crisis, Principles and Values

The Lifeline service was offered in response to people who are "in crisis". A crisis is not a diagnosis, or even a medical term, so what do we mean by the word?

The textbook we used in preparing for crisis support was *Crisis and Trauma, Developmental-Ecological Intervention by BG and TM Collins, Lahaska Press, 2005*.

On page 4 they offer two basic definitions of crisis:

> A temporary state of upset and disorganization, characterised chiefly by an individual's inability to cope with a particular situation using customary methods of problem-solving, and by the potential for a radically positive or negative outcome. *Slaikeu (1990)*
>
> A perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. *James and Gilliland (2001)*

A definition we tested with our clients and used in our leaflet expresses in a simple way the experience of the person in crisis. It comes from The Mental Health Foundation's *Crisis Project Workbook* (May 2003, p28)

- being overwhelmed by bad feelings such as fear or despair
- losing your usual ability to cope with life
- finding the world very confusing, not sure what is real and what is not real
- people around you becoming very worried and saying you must get help

Why is it important to respond quickly to people in crisis?

A crisis can be a brief window of opportunity for a person to choose a different way to live. If the moment is not seized, people are likely, at best, to return to habitual, often dysfunctional ways of coping.

Without help, people in crisis do what they can to cope, but can quickly be driven to actions that make their situation worse.

> "The point of crisis, where someone recognises that things are going awry, and that they need help, may not (yet) constitute a relapse or acute episode of illness, and if the person seeks help from medical services they may be turned away because they are not "ill enough". By the time the conventional services accept that help is needed, the person may no longer want it, may resist it, and may in consequence be compelled to accept treatment."
>
> (From Shona Neil's introductory speech to the SAMH Crisis Conference on 15th June 2005)

Statement of Lifeline's Ethical Principles

- **Beneficence:** We will promote the client's well-being
- **Non-Maleficence:** We will avoid doing harm to the client
- **Fidelity:** We will honour the trust placed in us
- **Justice:** We will treat all clients fairly and impartially
- **Integrity:** We are committed to honesty and truthfulness
- **Respect for Clients' Rights and Dignity:** We respect the dignity and worth of our clients, and their rights to privacy, confidentiality, and self-determination
- **Self Respect:** We are committed to care for ourselves and each other as crisis support workers, to foster self-knowledge and improve our professional competence

(Based on The American Psychological Association's Ethical Principles and Code of Conduct)

B. Method of Working

1. Goals and Steps of Crisis Intervention

The worker answering a call to Lifeline assessed how best to respond. A crisis is not necessarily an emergency, and an immediate visit may not have been required or appropriate. Options ranged from signposting to a more appropriate agency, telephone support, arranging an appointment at a time/place to suit the client, through to agreeing to meet at a particular place as quickly as the worker could get there, given travel times, ferries, etc. The worker also considered and decided whether a second member of staff was needed or if they needed to report to them where they were going, etc for reasons of personal safety. On occasion, the other on-call worker was asked to make the visit because of their gender or previous contact with the client.

Lifeline staff were autonomous and decided how to proceed on the basis of what they learned when they spoke to the client. At their discretion, they consulted with their on-call colleague, the coordinator and other agencies.

Put simply and in summary, the goals and steps of the first crisis interview were as follows (adapted from *Crisis and Trauma*, op cit, pp46-56):

	Goals
1	Client is safe and risk of suicide is reduced
2	Client is psychologically stable and has attained short-term mastery of self and situation
3	Client is connected with appropriate formal and informal supports/resources
4	Follow-up opportunity offered

	Steps
1	Supportively and empathically join with client
2	Create safety, stabilise, de-escalate, address immediate needs
3	Explore and assess dimensions of crisis EVENT and crisis REACTION, encouraging ventilation
4	Anticipate the future and arrange follow up

	ABCDE Assessment Model
A	**A**ffect – Primary feelings in response to crisis
B	**B**ehaviour – Action/lack of action in response
C	**C**ognition – Thoughts, beliefs, explanations
D	**D**evelopment – Stage of life needs affected by crisis
E	**E**cosystem – Culture/Ethnicity factors, availability of support resources, preparedness to receive help, perceived barriers.

The above table was carried in the form of a laminated card by all staff on call. These cards provided a useful reminder of what we were there to do and how - without them we could easily have lost our focus or become drawn into issues and actions that were beyond our remit.

In training, and our reviews of cases, our goals and steps were often referred to in order to show how universally applicable they are, and to help make our use of them natural and automatic.

Achieving these goals may have taken a few minutes or several hours. However long it took, the worker did not conclude their contact with a client until he or she was satisfied that it was safe to do so, and sought the support of a colleague or other agencies if needed.

Part of the worker's brief was to help the client begin to make and implement plans for the future. This often involved other agencies and/or mobilising the support of family or friends. The client decided, together with the worker, the best way to move forward with this, and the worker was ready to make referrals on the client's behalf, and perhaps attend a first meeting with another agency to help the client express their needs, or to mediate with a family member.

In these and other ways, it was intended to avoid dependency on the crisis service and to strengthen clients' individual coping strategies and community support networks.

Where there were assessed to be unmanageable risks associated, for example, with a client's -

- Lack of insight
- Mental instability
- Delusions or
- Firmness of resolve to seriously harm themselves or another,

or if a child protection issue emerged during the course of the intervention, then the worker was expected to inform the relevant statutory agencies without delay and irrespective of the client's wishes (see also s4, below p14).

Follow-up was offered as appropriate, but the aim of this service was not to provide long or even medium-term support, only to help the client to -

1. express their worries and fears
2. recover a feeling of safety and control
3. begin to make and implement plans for the future

- at that point, the intervention from Lifeline normally ceased.

The worker/s involved then briefed the team of crisis support workers at the next (fortnightly) team meeting (or sooner, when appropriate). This ensured a continuity and consistency of approach if there were further referrals with regard to the same client.

2. Publicity, Communications and Systems

2.1 Leaflets & Publicity

A leaflet and detachable wallet-card was designed with the aim of describing the service, who it is for, how to contact it, and what to expect from it. This leaflet was seen as Lifeline's contract with its service users and referrers. Initially, in order to manage demand and ensure that the service was only used by people likely to need it, supplies of the leaflet were distributed to key referrers - GPs, GBH A&E & Ward 3, Community Mental Health Team, SIC Housing, Social Workers and certain voluntary organisations (including CAB and CADSS). Lifeline planned to advertise its existence openly and fully 'launch' the project on 1st February 2009, but at the request of the SIC this was delayed, and by the time we could go ahead (mid September), the project was nearing the end of its funding period, its future was uncertain, and it was felt that a full launch was no longer feasible. Nevertheless, over six hundred leaflets were distributed to people thought to be close to crisis, at risk of suicide, or as part of a planned support package agreed with a professional, and it is likely that the majority of people expected to need this kind of support did know about it. The Lifeline team much regretted not being able to 'launch' as planned, as there will always be unexpected crises and anyone at all could suddenly find themselves in need of such help. Although none of the people who used Lifeline completed suicide, as a team we wondered whether we could have helped some of those who did not even know about us, and died.

2.2 Telephone System

Lifeline's freephone number connected the caller to a virtual switchboard, which we programmed through the internet. The switchboard was updated twice a day, to prepare for the next shift.

The person calling Lifeline dialled 0800 7565 118. They then heard a recorded message informing them that they were through to Shetland Lifeline and that they would shortly be connected with a duty worker. The virtual switchboard phoned the on-call staff in the order programmed. When a worker received a call, their caller-recognition told them that it was from Lifeline, so they were able to answer in an appropriate way. The usual sequence was: Worker One landline & mobile (5 rings) then Worker Two landline & mobile (5 rings), then the Gilbert Bain Hospital switchboard (10 rings). Only two calls ever got as far as the GBH, all others were answered personally by on-call staff whatever the time of day or night.

The service offered by the GBH switchboard was to pick up calls not received by the on-call staff (the switchboard operators were all personally briefed by the coordinator and given written instructions). They were to explain to callers that the Lifeline staff were unable to pick up their call, take a name and telephone number, and page Lifeline workers (in a particular sequence), who would then ring the GBH Switchboard, get the details and phone the client. This system was based on one that had worked well in the past for the out-of-hours social work service. The GBH switchboard staff also agreed to provide a point for reporting out and in for lone workers. How this worked was detailed in Lifeline's "Safety at Work Policy and Procedures". NHS Shetland kindly did not charge us for this facility.

"Pay As You Go" mobile phones and Vodafone SIM cards were carried by all team members, though most had poor or non-existent mobile phone reception at home.

2.3 Pagers

The use of pagers to supplement other means of communication was employed for the following reasons:

1. Mobile phone coverage over Shetland is patchy and pager coverage is significantly better, though still incomplete.
2. Pagers cannot be 'engaged' so calls should always get through.
3. Simple messages can be sent to pagers: we restricted these to a list of codes instructing the recipient to phone a particular team member on their landline or mobile or to phone the GBH switchboard.

The "Page One" company was recommended by technical staff at the GBH, and basic pagers were rented for all eight team members.

2.4 Rota

In consultation with team members, it was decided that there should be two on-call shifts to cover each 24-hour day: a Day shift, 5am-7pm (14 hours) and a Night shift, 7pm-5am (10 hours). 5am was chosen as the latest time someone on a night shift could attend to a call-out and still be at work by 9am; 7pm gave people time to conclude their day's work, get home, have a meal and be ready to be on-call.

The coordinator emailed a blank rota for each month to all staff who filled-in whatever day or night shifts they were able to work, and then emailed it back to the coordinator who put all the information together and filled in any spaces with himself (male) or the team leader (female) and emailed it out to all the team. This method worked satisfactorily, but relied too heavily on the flexibility of the coordinator and team leader, and would therefore not be sustainable in the longer-term.

Research was undertaken with regard to the *European Working Time Directive* and its implications for Lifeline. The UK Government's current guidelines with regard both to hours worked and minimum wage requirements are under review and a change to stricter definitions, as some in the EU propose, could have serious consequences for on-call services. Specifically, if on-call time is regarded as hours-at-work, then legislation defining the minimum wage per hour and the maximum number of hours to be worked will start to apply: Lifeline's system would become uneconomic or illegal.

2.5 Policies and Procedures

Identity cards and a range of policy and procedure documents and forms were developed or adapted by Lifeline, and staff trained in their use. Key documents (e.g. Child Protection procedures, Worker Safety procedures, etc) were carried by crisis support workers for reference purposes when on-call. All of these documents were included in the Operational Manual and approved by the Chief Social Work Officer.

3. Staff Support, Supervision and Training

There was a 2½ or 3 hour meeting for group support/supervision/training and case review, held on alternate Tuesday evenings at Link Up. Individual debriefing and support was provided by staff on-call to each other and by the coordinator and team leader as required or requested.

If more specialist support was needed as a result of workers being traumatised through their work, this was available promptly from Wilma Stewart (Art Psychotherapist & Counsellor).

The fortnightly team meeting aimed to:

- provide group supervision and support
- build & maintain the culture and consistency of approach of the organisation
- accumulate a knowledge of the client base and keep it up-to-date
- share, discuss and learn from experiences of helpful and less helpful strategies

Most of our training was provided in-house, mainly by the team leader in consultation with the coordinator.

At the start of the project, on 5th, 6th & 7th September 2008, all prospective team members who had passed the interviews on 20th August, attended a residential workshop (at the Bridge End Outdoor Centre in Burra) with three aims:

a) To more deeply explore candidates' suitability for, understanding of and commitment to the new project,
b) To undertake training in the basic concepts and methods of crisis support, and
c) To build a team of people able to accept, support and be supported by each other through emotionally difficult and harrowing work.

This approach was agreed to be a great success and in just a few days we forged a team characterised by mutual respect, ease and personal liking. Members showed that they were highly motivated to do this kind of work and were prepared to take personal risks (e.g. with self-disclosure, a high level of which was expected and given) and make sacrifices of time, convenience and comfort for the cause. Team spirit and morale has proved resilient and enduring.

Many of the fortnightly team meetings incorporated 60 to 90 minutes for training. Visiting speakers featured from time to time to complement the training, including: the specialist CPN for children and young people, a representative from Women's Aid, a woman with personal experience of learning to cope with Post Traumatic Stress Disorder, Chris Fieldhouse (consultant in crisis work), a Housing Manager (homelessness and outreach support), a CADSS (Community Alcohol and Drugs Services Shetland) trainer and a bereavement counsellor. Other training has focused on Child Protection, Adult Support & Protection, Worker Safety, Suicide Intervention, Confidentiality, Motivational Interviewing, etc. As specific issues arose, we devised or arranged training according to our needs.

4. Specific Areas of Risk

Because access to Lifeline was open directly to the public, we needed to be alert and ready to respond appropriately to a wide range of issues.

Our generic assessment and intervention method (described above in section B1) was an ideal starting point; however in the course of using it, and as a result of information we received or observations we made, we may have needed to focus on a specific area of risk that would require us to:

- Apply a more specialised technique, e.g. ASIST[1]
- Persuade or assist the client to seek a medical assessment[2]
- Refer to or seek the advice of a statutory agency[3]
- Contact an emergency (999) service[4]

[1] Applied Suicide Intervention Skills Training. We developed a 'Suicide Intervention Flowchart' which shows the process we followed to ensure, as far as possible, that people at risk of suicide were kept safe and put in touch with the appropriate agencies for medium and longer-term support.

[2] There could be many reasons that indicate a need for a client to be seen and assessed by a medical practitioner, either their GP or at the A&E (depending on severity, urgency, etc). Some examples are:

- The client has not been drinking fluids, eating or able to sleep for several days.
- He or she has suddenly reduced or stopped taking a drug (particularly alcohol or a benzodiazepine) to which they may be physically addicted.
- An accident, a violent incident or their self-harm (e.g. cutting or self-poisoning), may require medical treatment.
- An assault (including rape) has taken place and the person agrees to have a medical examination for evidence purposes in case they should later decide to inform the police (though may not wish to at the time).
- The client reports symptoms of illness - e.g. fever, acute pains, double-vision, severe headaches, etc.

[3] Where there was evidence that a child may have been or was being abused in any way, or an adult may have been at risk; Lifeline developed or adapted policies and procedures to ensure staff made the appropriate referrals promptly and effectively.

[4]Emergency services may need to be contacted for a range of reasons, including:

- Life-saving medical support is urgently required (e.g. overdose, serious blood loss due to self-harm).
- A person seems to have a mental disorder and they are in immediate danger of serious harm or of causing serious harm to another.
- A person needs urgent and robust protection from someone.
- Someone is at high risk of suicide and a firearm needs to be removed as part of their safeplan.

C. Financial Implications

1. Pilot Project Year One (July 2008 - March 2009)

INCOME	**£**
Fairer Scotland Fund	31,000
Total Resources	**31,000**
EXPENDITURE	
On-call Fees	2,601
Wages	10,233
Secondment Cover	7,275
Communications	923
Travel Expenses	542
Other Overheads (including Recruitment, Training Costs, Insurance, and Stationery/Printing)	5,136
Total Expenditure	**26,710**
Carried forward	4,290

2. Pilot Project Year Two (April 2009 - March 2010)

INCOME	**£**
Brought Forward	4,290
Fairer Scotland Fund	34,500
Total Resources	**38,790**
EXPENDITURE	
On-call Fees	8,489
Wages	15,839
Secondment Cover	7,538
Communications	1,520
Travel Expenses	985
Other Overheads (including Recruitment, Training Costs, Insurance and Stationery/Printing)	2,194
Total Expenditure	**36,565**
Refunded to Fairer Scotland Fund	**2,225**
Balance of Resources	0

3. Designing a Full Service

Chris Fieldhouse, in his December 2008 report to the SIC (pages 15-16) made the following observation about Lifeline's finances:

"The current funding is only sufficient because of the passion and commitment to deliver the service; this drives a willingness to work outside of a normal working shift pattern and for the service leaders to offer inordinate amounts of support to its staff. It is highly unlikely that this is sustainable. This is an openly acknowledged issue within Lifeline. The service commenced knowing this position and adopted the strategy of utilising the passion to prove that the Shetland Lifeline approach was valuable and could work for the people of the Isles. There was always an acceptance that this was not sustainable and it could only continue with more robust funding agreements."

The design of an economical staffing structure for a service that has two staff available on demand 24/7 plus an ability to undertake some planned work and provide a stand-alone service, presented considerable challenges which were overcome in the pilot phase by using secondments, and by some staff being prepared to forgo leave and be on-call for over 100 hours a week on average.

A particular difficulty Lifeline encountered was in recruiting staff who were already in other employment but could be available to work flexibly during the day Monday to Friday on an on-call basis, i.e. able to turn from anything they were doing to respond immediately to a crisis call as their first priority. In the case of the project coordinator, this was achieved during the pilot phase by using a seconded worker to cover his time-constrained duties. In the proposed staffing structure for a sustainable service run by Link Up, the secondment cover is turned into a permanent part-time post, (employed by Link Up rather than Lifeline), and a proportionate contribution made to the project coordinator post. A team leader would be employed who would be paid a living wage to work nearly full-time (28 contracted hours), but whose routine duties would not involve any specific time allocation. There would then be a minimum of two staff in this position, able to share daytime shifts, pick up follow-up work from client contacts the previous night, and cover each other's leave, in addition to sharing out-of-hours shifts with the rest of the team.

It is encouraging to note that only 2/9 employees said that the number of on-call shifts they were working would not be sustainable, and the new proposals would certainly improve the situation for the staff who had worked the most shifts. However the recruitment and retention of suitable staff for this work would remain a challenge.

The new staffing structure would lead to a modest increase in capacity, which would be needed in order to meet additional demand (both for crisis support and liaison with other services) arising from becoming better known, both among agencies and the general public. There would be an associated increase in travel and communications expenses, which are also anticipated in the costings.

The Pilot Project had no office base (the Link Up premises are only available Wednesdays, Sundays and out-of-hours), so an allocation for premises (based on Market House prices) is included.

Together with on-call fees, and other running costs, we arrive at an estimated total annual cost of £89,800 (at 2009-10 prices).

4. Full Service, Cost Estimates

Manager	21,944
Team Leader	24,958
Additional Crisis Support Hours	19,000
On Call Fees	9,198
Recruitment	1,000
Training Costs	1,000
Travel Expenses	2,500
Communications	2,000
Premises Costs	6,000
Publicity	1,000
Other Overheads	1,200
Total Expenditure	89,800

D. Evaluation and Conclusions

1. Evaluation

1.1 Questionnaire Data

Questionnaires were posted to:

- Individuals who had used the Lifeline Service as clients
- Referrers
- Employees of the service

A total of 67 Clients used the service between 1st October 2008 and 31st March 2010. Of these, 24 could no longer be contacted for various reasons: some never disclosed their address and had contacted us from public telephones; others (some of whom had been in temporary accommodation) have since moved (several have left Shetland) and we have been unable to trace them; others contacted us from mobile phones whose numbers are no longer in use. Questionnaires were posted to the remaining 43 plus 9 carers who had also used the service. 52 were posted and 20 (three from carers) were returned - a 38.5% response rate.

A total of 114 questionnaires were posted to referrers - i.e. people who had actually contacted us to make referrals, or to whom we had posted information about Lifeline (e.g. GPs, CMHT, Social Workers) at the start of the project. Of these, 42 were returned - a 37% response rate.

The same questionnaire was sent to Service Users, Carers and Referrers, and contained a request to answer ONLY the questions that applied to them. Almost all respondents appeared to follow this. Thus, only those referrers who had actually phoned Lifeline answered Question 2 (which was about contacting the service), and only service users who had also referred others to the service answered question 6 (which was about suggesting Lifeline to others). Occasionally, however, respondents ticked the 'neutral' box but indicated in a comment that they had not actually experienced this aspect of the service.

A different questionnaire was designed for employees.

The decision to use 'leading statements', with which respondents were invited to agree or disagree, was inspired by the recent NHS questionnaire survey of patients of GP practices in Shetland. This method enabled us to focus respondents on specific issues, and has led to a very clear picture of their views. The opportunity to make detailed comments was offered throughout the questionnaire at the end of each section and in a final, open-ended question.

For the sake of simplicity and brevity, in compiling the data from respondents, the author has deleted questions and sections of questionnaires which no respondents in that group had answered.

Throughout, the numbers listed record the actual number of people in each group who ticked that box. This was felt to be preferable to giving percentages,

which can be misleading. This also applies to Appendix 2 which collects un-interpreted data about Lifeline's work, broken down into quarters.

As the evaluation of the Lifeline Pilot Project was undertaken by the service coordinator (i.e. not independently), in the interest of objectivity, the full results and comments from all questionnaires have been collected and are presented in an Appendix to this report for readers to interpret for themselves. The use of leading statements has meant that, as far as possible, the data really does "speak for itself".

Readers' attention however, is drawn to the following points:

a) The vast majority, in all three sets of respondents (users/carers, referrers and employees), presented a consistently positive view of the Lifeline service in every category tested. All but one of the respondents in the service-users group appeared to have had a very beneficial experience of using Lifeline. Unfortunately, this one respondent did not write any comments to explain his or her dissatisfaction.

b) 63/64 respondents across all groups agreed (55 strongly agreed) that "A 24/7 Crisis Service like Lifeline freely available to anyone in Shetland is essential and should be provided on a permanent basis" (the 64th respondent was 'neutral').

c) There were two questions that asked respondents whether a crisis service would be better or preferred if run by the statutory agencies; 38/69 disagreed, 23/69 were neutral, and 8/69 agreed. Views were more divided on this issue than any other, but it was still clear that the majority (55%) of people who had used the service in some way thought it was *better* provided by the voluntary sector. If one includes those who were happy either way, over 88% would have been content to see it run by the voluntary sector. Fewer than 12% would have *preferred* a crisis service to be run by the NHS/SIC. Should this be the option chosen by the NHS/SIC, we hope that the views and comments expressed by respondents will be taken into account in the design of their service (see, for example, (d) below).

d) 55/58 respondents agreed (41 strongly) that "The Lifeline Project has shown that their approach, methods and organisation are effective" (of the other 3, two were neutral, one disagreed).

e) 15/16 Service users agreed (13 strongly agreed) that "Knowing Lifeline will help if I call, helps me feel safe", and 31/31 referrers agreed (25 strongly) that "I felt relieved that this service was available 24/7."

f) 29/30 referrers agreed (20 strongly) that "I had increasing confidence in suggesting Lifeline to people" (the 30th respondent was 'neutral'), giving the impression that despite understandable caution about this service when it first began, experience of using it allayed rather than confirmed their concerns.

1.2 Data drawn from Service Records

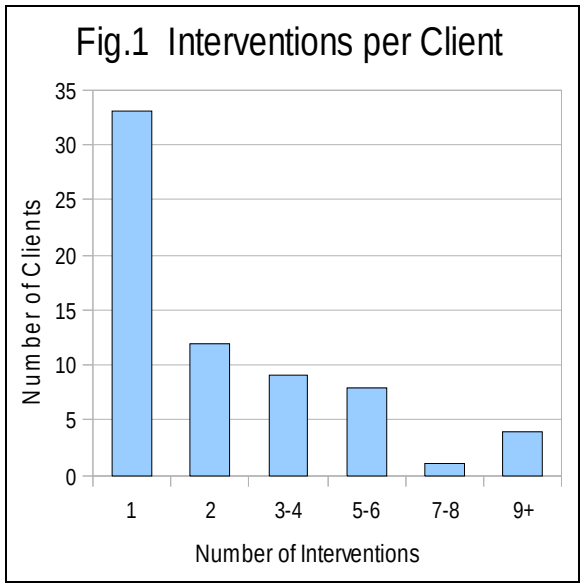
a) Numbers of Clients who used the Service, Calls and Interventions

Fig.1 shows that about half of the 67 clients who used Lifeline did so only once, and over two-thirds used it only once or twice in the 18 months it was operational.

There were, however, a relatively large number of interventions (9 or more) for a small number of clients (four, or 6%). The actual numbers of interventions being 17, 24, 29 and 45. Thus 6% of the clients received 45% of the interventions.

(NB below pp23-25, 1.4 (a), (h) & (k)).

The total number of Interventions was 256 - Approx 170 a year, on average.



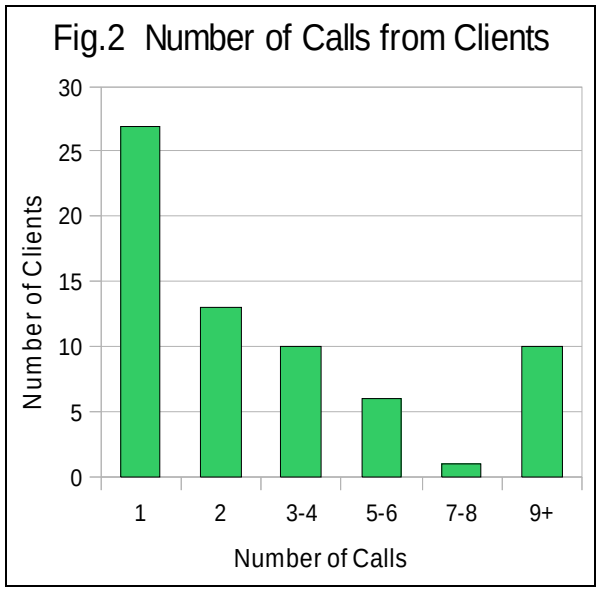


Fig.2 charts the number of calls made to Lifeline by clients. Although the same basic pattern as above is evident, it should be noted that 292 calls (nearly 70% of the calls made by clients) were made by the ten clients in the '9+ calls' category. The actual numbers of calls being 9, 10, 13, 17, 18, 30, 32, 33, 65 and 65. For some of these clients, there were a large number of calls in one intervention; the most extreme example being one who made 65 calls for 6 interventions (this client and two others in this group were using the service inappropriately and were persuaded to stop making calls).

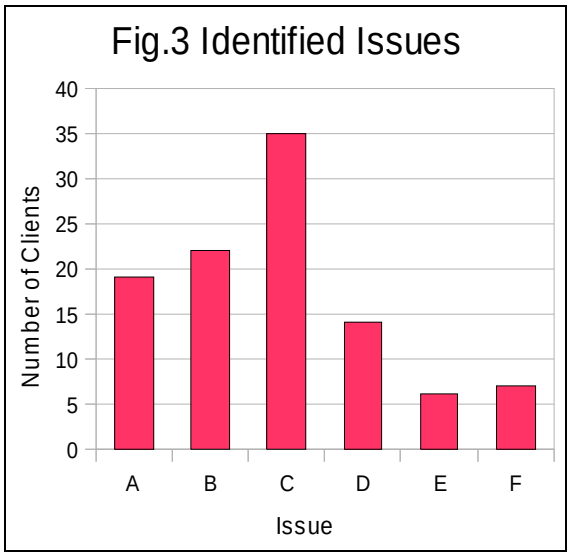
The total number of Lifeline calls made by clients was 421. A further 55 were made by others - 31 by referrers, 15 by carers, 9 by Lifeline staff, giving a total of 476 calls.

b) Weekend and other Out-of-Hours Work

Lifeline was a 24/7 service, i.e. both 'in-hours' and 'out-of-hours'. Normal 'office hours' actually constitute only about a fifth of the 168 hours in a full week. 67% of Lifeline interventions required out-of-hours work (i.e. before 9am, or after 5pm on weekdays or at weekends). 25% of interventions actually began with a call received on a Saturday or Sunday.

c) Issues involved in Clients' Circumstances

There was often a range of issues contributing to a client's crisis. Lifeline workers came to see a state of crisis as indicating that a threshold had been exceeded: the client's *usual coping mechanisms* may have been enabling them to manage their (often multiple) issues reasonably well, but recent events had exacerbated their situation in such a way as to take them above their 'crisis threshold'. Once in crisis, their *usual coping mechanisms* became ineffective (see *Definition of Crisis*, above p8). In our view, it was neither necessary nor helpful for workers to seek solutions to the list of problems clients often presented. By following our four *Steps* (p9 above), we found that clients were able to start recovering mastery of themselves and their situations; by attending to their immediate needs and priorities, in most cases, hope re-entered an apparently hopeless situation. The result was that the client was able to cope again, and pursue specialist help with their priority issues.



KEY

A = SUBSTANCE USE

B = MENTAL ILLNESS

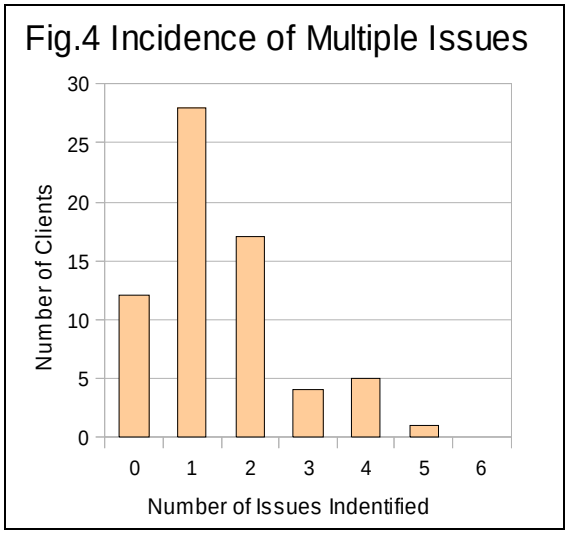
C = SIGNIFICANT SUICIDE RISK

D = RECEIVING INTENSIVE SUPPORT FROM STATUTORY SERVICES

E = HOMELESSNESS ISSUES

F = SELF HARM

Reviewing Lifeline's interventions and picking out the six issues listed in the KEY (above, right), produced the data represented in Fig.3 and Fig.4. It should be noted that in writing our records, we were not seeking to collect this data or working through any checklist of issues, and workers did not record information that seemed inessential to the matter-in-hand, so the data here presented should not be regarded as either complete or definitive. Interestingly, perhaps, of the 35 clients presenting a significant (medium to high) risk of suicide*, 20 also presented one or more of the other 5 key issues, but in 15 cases none are recorded. Only 9 of these 35 were receiving intensive support from a statutory agency at the time.



*We used the ASIST criteria in *Suicide Intervention Handbook*, LivingWorks (2004 Edition), pp 48-64

d) Lifeline's Criteria for Success

These are most clearly expressed in the report above on page 9 (a successful intervention being one where our *Goals* were met). It is, however, worth adding that the four goals listed in Lifeline's *Goals and Steps of Crisis Intervention* have a dual aspect: in order to be satisfied that each has been successfully met, the worker would be looking for evidences that both they and the client are in agreement. It is not, for example, a satisfactory (successful) outcome for *Goal 1* if the client says he is fine and safe and is ready to conclude the contact if the worker feels that there has not been significant psychological contact between them or a genuine rapport, and the client's statement that he is 'fine' seems incongruous. Also having informed the client about an appropriate specialist service does not mean they are 'connected' with it; the worker would be looking for a credible plan of contact, or a request for a referral, or agreement for the worker to accompany them to a first meeting. As a matter of principle, Lifeline interventions should *always* be successful, as the worker would not conclude a contact until the four *Goals* have been met. In practice, however, there were two telephone contacts in which the client terminated the call before this point had been reached, and two calls from referrers about people who would not speak to us. On no occasion did a face-to-face visit end 'unsuccessfully'. However, on one occasion, at the end of a continuous five-hour contact, the worker was still not confident that the client was safe, and persuaded him to go to A&E with the worker and seek admission. On another, a client was taken to see the Psychiatrist and admission to Cornhill requested (and arranged). In every other case, the worker was satisfied that the four *Goals* had successfully been met and that the intervention could be concluded (though clients were invited to call Lifeline again if they needed to in the future).

Additional, informal goals of Lifeline were that clients would be enabled to make use of other services that could help them with specific problems (so reducing their base level of stressors), that their work/occupations would be continued or resumed, that supportive relationships would be strengthened, and that clients would become more resilient and less likely to need 'external' help in future; but that if they did, it would be sought at an early stage, instead of when coping mechanisms and supportive relationships had already broken down (see also below p24, 1.4(c)).

Examples of successes under these criteria can be found in case examples, but a statistical analysis is beyond the scope of this report.

1.3 Other Relevant Information

At the Shetland Mental Health Partnership meeting of 17th September 2009, the consultant psychiatrist spoke strongly in support of the continued funding of Lifeline, saying that -

- Since Lifeline started there has been "a dramatic reduction" in the number of times he had been called to the A&E to see patients in crisis.
- He was "amazed" at how flexible Lifeline is prepared to be.
- If Shetland wishes to keep a psychiatrist for any length of time, it needs to have a service like this: although it is intended primarily to help the people of Shetland, "it also helps me!"
- He concluded that this would be money well spent and it would be "the worst decision you could make" to not fund it.

A letter printed in the Shetland Times of 28th May from a woman who has over ten years' experience as a user of Mental Health and Emergency Services in Shetland expressed a number of very relevant observations. As well as taking the risk of publicly describing some of her personal experiences and highlighting some of the strengths and limitations of the statutory services, she wrote:

"There was a service running called 'Lifeline'. It was a charity so was not affiliated to any government run organisations. This made it safe for people who were frightened of 'government intervention'. It didn't matter who you were, or what your circumstances were, they were there to help. That has been closed down due to funding issues, despite the fact that it was a very cost-efficient service... Shetland had an excellent 24/7 crisis service, so why have they decided to stop funding it? The only reason I can think of is that it was not controlled by the NHS but was run as a charity."

In response to the above letter, a professional (again with well over ten years' experience of Mental Health and Emergency Services in Shetland remarked (by email) -

"I'm dismayed. I just can't believe there isn't continuous funding for Lifeline. To my mind, this service is the most significant provision in the mental health field for many years, and is vital to so many people up here."

1.4 Reflections by the Service Coordinator on Lessons Learned

a) In the vast majority of cases, it proved possible to engage with clients, facilitate their articulation of the issues/events/feelings that were troubling them; reduce any risk of suicide, help them recover a sense of safety, control and hope, and take first steps towards resolving their crisis. This is what the service aimed to do and was designed to do, and it did it well. Most clients spontaneously expressed thanks for our help.

b) Our research when designing this project indicated that many people in crisis are afraid of Medical and/or Social Work intervention because once involved, statutory services will take control away from them. Specific concerns voiced were that their children will be taken into care, that they will be given a mental illness diagnosis, given powerful drugs and sent away from local support networks to Cornhill Psychiatric hospital on the mainland.

These fears may be rational or groundless, but either way they are powerful and can prevent people from seeking help when they most need it. Other worries (that people will find out, shame, stigma, etc) play a part too. The experience of running the project and reading responses to the evaluation questionnaires confirmed that these are indeed very significant issues and that using Lifeline opened the door to help for many people who would otherwise have tried, and perhaps failed, to do without help.

c) Lifeline saw it as part of its role to help people get the best out of the NHS and Social Work services by enabling them to present their needs in such a way that they could (wherever possible) recover and retain control of their situation and not lose it. We encountered some situations where service users, because of unhelpful experiences in the past, avoided the very services that were best placed to help them, and we were able to facilitate their successful and appropriate use of (e.g.) their local GP or the A&E, usually through attending with them as an advocate or by helping them to keep calm and articulate their needs effectively. This led to these clients being able to go on to access such services for themselves in a more appropriate way.

d) We were aware of one clear case (there may have been more) where a patient at high-risk of suicide was discharged from the GBH Ward 3 because the consultant psychiatrist had confidence that he would use Lifeline if in distress. This patient had recently been in Cornhill Psychiatric Hospital, had a bad experience there, and was refusing informal admission. He was not psychotic and so could not be admitted compulsorily.

e) In two cases, clients were very reluctant to use the A&E despite needing urgent medical attention for severe self-harm. We were able to ensure that they did receive the needed medical help.

f) Several clients had become accustomed to using health resources (particularly prescribed medication such as Diazepam) as a first resort in order to cope with practical problems-in-living. We were able to help them resolve some of the practical issues (e.g. debts, relationship problems) and so begin to find more functional and successful ways of managing their lives.

g) Our early response to clients' distress will have meant (to some extent) that they may not have needed to resort to extreme measures to cope (especially self-harm and overdosing), so reducing their use of A&E and ambulance services, and possibly avoiding the need for admission to Cornhill Hospital in Aberdeen. Sometimes, however, the use of these services is entirely appropriate and necessary: on several occasions we have escorted clients to A&E (helping to ensure a smooth and satisfactory outcome), and on one occasion we played a major role in ensuring that a person (whose high risk of suicide could not be reduced) was admitted to Cornhill under section 44 of the Mental Health Act. Importantly, our intervention made this admission less stressful for her than it might otherwise have been. On three occasions, Lifeline initiated 999 calls on behalf of clients who, we believe, would otherwise have died.

h) Lifeline's approach seemed best suited to 'early intervention' clients who were not already long-term users of mental health services. In such cases we tended to see rapid, significant and enduring change: our intervention had led to crisis resolution, and not only crisis support. Sometimes, with regard to clients who were long-term users of mental health services, although our interventions were supportive, we felt doubtful that they had produced any lasting change. However, we were able to soothe situations that could otherwise have led to a 999 call.

i) As we gained more experience in crisis intervention, our team continually reviewed our understanding of "what works", and we were confident that Lifeline would have carried on to develop new and creative solutions to what are sometimes seen as intractable problems.

j) Consultant Chris Fieldhouse, in his December 2008 report to the SIC, drew attention to the distinction between 'Crisis Resolution and Home Treatment' (CRHT) and 'Crisis Response' services:

- **Crisis Resolution and Home Treatment** services were originally designed for a client group defined very much by a psychiatric understanding of adult acute mental illness (an illness model/philosophy); i.e. those considered to be suffering with a diagnosed psychiatric disorder, the severity of which would traditionally have required an admission to hospital.
- **Crisis Response** services tend to have a much broader remit than CRHT services and tend to operate outside of traditional illness models and respond to those with levels of mental distress that are having an immediate impact on their ability to function.

He recognised that Lifeline offers its services to ***the full range*** of people in distress: including individuals that would elsewhere in the UK receive a statutory Crisis Resolution and Home Treatment service. We would suggest that this makes for an extremely efficient use of resources, and also helps to reduce the stigma of having services targeted only on people with a diagnosed psychiatric disorder. Anyone can be in crisis - Lifeline was available to all.

k) We had a small number of clients who had a history of childhood trauma resulting in long-term contact with psychiatric services, and who presented in crisis on a frequent or regular basis, 'usually out-of-hours'. In these cases, with the agreement of the client, we kept in close liaison with their Community Psychiatric Nurse: advising them promptly of the contacts they made with us, the issues presented, actions taken and outcomes. This arrangement worked well. It helped Lifeline to clarify its role, keep within appropriate boundaries for the individuals concerned, and take an approach consistent with, and complementary to, that of the other professionals involved.

l) None of the people who used Lifeline completed suicide, but we wondered whether we could have helped those who did not know about us, and died.
One of the carers who responded to our questionnaire wrote:

> "There is no doubt in my mind that Lifeline has done an outstanding service to the local community and has saved not only lives but a huge amount of terror and anguish to many clients."

One can easily overlook the fact that some people in our community are at risk of falling into a downward spiral of despair. Most of this is unseen, and easy to miss, dismiss or avoid. Shetland's efforts at suicide prevention were greatly strengthened by people trained to be suicide intervention helpers being able to call for assistance at any time from Lifeline staff.

m) Lifeline could be contacted at a time, any time on any day, chosen by the client, i.e. when they felt the need to contact us and were ready to speak. There may only be a brief period when a person in crisis is ready to speak of things they have not shared before, or is at a point where they are seriously considering making a major change in their lives. That window of opportunity is likely to be missed by a helping agency that is only able to offer an appointment, perhaps several days in the future, in office hours. Our willingness to visit straight away also demonstrated our acceptance of the authenticity and importance of our clients' distress, thus providing a good foundation on which to build a helping relationship.

n) The Lifeline Operational Manual (Page 4 of section 2) states:

"If counselling support is needed as a result of workers being traumatised though their work, this is available promptly from Wilma Stewart (Art Psychotherapist & Counsellor)."

This was seen by the service coordinator and Lifeline team (9/9 agreed, 7 strongly agreed) as an important part of the support they needed to do this work. With the closure of the Art Psychotherapy & Counselling (AP&C) service, this source of support no longer exists.

Furthermore, Lifeline, if it was re-launched, would not now have *any* direct referral pathway available to it for clients requiring the prompt attention of an experienced and versatile psychotherapist. In four high-risk cases, referrals to AP&C led to appointments within days and very good outcomes for service users. Although referral pathways *to* Lifeline were wide open and immediate, the need for priority referral pathways *from* any future crisis service to other services, must be addressed.

o) The issue of a 'safe house' (see above A.3.4, p7) was kept in mind as the Pilot Project ran its course. Our 2006 consultation had suggested that this would be a significant and recurring need, however, this proved not to be the case.

We found that a small number of service users tend to see moving house as the way to solve their problems-in-living, and if Lifeline had had accommodation available to it, it would no doubt have been under pressure to use it - leading to challenges regarding gatekeeping, admission criteria, lengths of stay, staffing, supervision… etc. Costs could easily have escalated, with doubtful benefit to the client.

In practice, alternative accommodation provided by existing agencies (SIC emergency/homelessness services, Annsbrae's respite flat and Women's Aid's refuge) met all the needs of our service users, and if such accommodation was not easily secured, this just served to emphasise the need to address the problematic issues, rather than seek to escape from them.

There might be some occasions where a safe house would be a very important provision indeed, but in 18 months of crisis intervention, we did not draw this conclusion with regard to any users of our service.

p) Despite being given the assurance of a Fairer Scotland Grant, in the middle of the project, Lifeline had to borrow money from an employee for three months to pay staff wages before the grant was actually received. Despite giving six months' notice of the need for further funding should the SIC/NHS wish the service to continue, only an informal offer was made (and then only for part of what was required), and that was mid-way through the final month of operation, by which time all employees had been served redundancy notices.

Even the brief history of Lifeline shows how precarious is the financial position of a small voluntary organisation. If such an organisation were to be commissioned to provide an ongoing crisis service, with the need to recruit, train and retain suitable staff, it must be possible to offer a reasonable level of job-security. We would therefore suggest there would need to be a commitment to a minimum of three-years' funding from the sponsoring agencies.

2. Conclusions

The ideas embodied in the Lifeline approach, its structure, organisation and the methods it used were put to the test in the 18 months of service operation and the evaluation questionnaires.

Lifeline was very well received by clients, carers, referrers and employees, who were almost universal in their strong support of the service in every aspect.

The opening page of this report quoted Shetland Link Up's Annual Report for 2009, which stated:

"Although the Pilot phase of the Lifeline service has so far delivered everything it set out to, it was never expected that it could continue in its present form. The pilot was principally concerned to test the feasibility of an on-call crisis service provided by the voluntary sector.

The key questions we need to answer are:

- Is it **possible** to create, staff and provide a 24/7 service in this way?
- Is it **robust**: will it be delivered reliably and consistently up to the required standards?
- Is such a service **effective**: does it meet its aims and objectives?
- Is it **safe**: people who contact a crisis service are often at a high level of risk – does the service reliably address, manage and reduce that risk?
- Is it **sustainable**: is the cost of the service affordable? Are the conditions of service and demands placed upon staff reasonable? Will it be possible to recruit and retain staff on an ongoing basis?"

We now feel able to claim with confidence, both from our own experience as the designers & providers of Lifeline, and with the support of those who used the service during the last 18 months, that it is indeed possible, robust, effective and safe to provide a 24/7 crisis service in this way. In terms of the conditions of service and demands placed upon staff, it is also sustainable.

If Shetland wishes to meet the challenge of providing a 24/7 crisis service, Lifeline has shown a way it can be done. If any gaps remain (see page 4, A.2.1 above), we believe they would be best addressed though cooperation between voluntary and statutory services.

We would suggest that should Shetland Link Up be commissioned to provide a full service, as described above, as a charity it could be funded in part by the statutory authorities (NHS Shetland and the SIC), whose responsibility it is to provide a crisis service, and in part by the Shetland Charitable Trust, as the service would go beyond that stipulated by the Scottish Government, which would only require that it is available to people with a mental illness diagnosis, rather than the whole population.

E. Summary

Lifeline is the name of a crisis response service which was provided from October 2008 to March 2010 by local charity Shetland Link Up, to Adults (aged 16+) anywhere in Shetland who were in acute distress and whose usual network of support and personal coping strategies were failing. The name was chosen to suggest a service that offers a rapid response to anyone in crisis, with safety and relief of distress as its main objectives, and that the service is short-term. This impression was reinforced by the logo of a hand reaching to grasp a lifeline against a background of darkness.

The Lifeline service was unique in the UK. Its innovative design was inspired and shaped by consultation with people who would use it. It was offered immediately and directly, without gate-keeping, referral or prior assessment, to people wherever they were, irrespective of their psychiatric diagnosis (or the absence of one), and regardless of whether there were drug or alcohol or domestic abuse issues: i.e. to *the full range of people in distress* - including individuals that would elsewhere in the UK receive a statutory Crisis Resolution and Home Treatment service.

Two Crisis Support Workers, one male and one female, were on call at any one time. Access was via a freephone (0800) number which connected callers directly to a worker on-call, who (if appropriate) was ready to set out (usually with their co-worker) to see the person where they were or in a place where they felt safe, within 30 minutes of concluding the phone call, plus travel time (and subject to ferry times).

Lifeline also provided an option to anyone needing urgent help for someone thinking of suicide. All people being trained in ASIST (Applied Suicide Intervention Skills Training) and SafeTALK (Suicide Alertness For Everyone) in Shetland were provided with Lifeline's leaflet and wallet card for this purpose.

It was Lifeline's aim to meet the expressed needs of the people who would use such a service, address the "remote and rural" issue creatively and make the fullest and most efficient use of existing services, with the least possible outlay.

The pilot project employed 8 crisis support workers, including a coordinator and team leader, at an average annual cost of £31,600. A full, sustainable, ongoing service would cost approximately £89,900.

Lifeline's Policies & Procedures and Methods were documented in detail, and were examined and approved by the Chief Social Work Officer. A Service Level Agreement with the SIC stipulated a range of quality and safety standards.

Research among the people who have had experience of Lifeline whether as clients, carers, referrers or employees showed clearly that the service has been very well received with good outcomes. Strong support for the service in every aspect, was almost universal.

If Shetland wishes to meet, and even exceed Government requirements to provide a 24/7 crisis service, Lifeline has shown a way it can be done.

Appendix 1(a) - Questionnaire Data: Clients

1 - The Lifeline Leaflet	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The leaflet contained all the information I needed	6	8		1	
I found the leaflet easy to read and understand	9	5	1		
The leaflet described how I was feeling - I could relate to it	6	6	1	1	
The leaflet helped me to take the step of phoning for help	7	6	1		

COMMENTS

"The leaflet raised awareness, but my phoning for help was based on my trust in the team running Lifeline."

"The leaflet was an invitation of support."

"The leaflet was my first step forward. It was different - a service that offered to be there WHEN YOU NEEDED IT!"

2 - Contacting Lifeline	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I found the recorded message easy to understand	9	5	1		
I was connected to a Lifeline worker quickly	9	5		1	
Getting connected to a worker was as easy as it could be	12	2		1	

COMMENTS

"The first contact is always the hardest, but the voice on the recording and the initial contact was fabulous - reassuring, unpressurised and personal to me."

Appendix 1(a) - Questionnaire Data: Clients

3 - The Service	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I was helped to talk through my worries and fears	8	6			
The worker helped me recover a sense of safety & control	7	6	1	1	
I was given all the time I needed, when I needed it	11	4		1	
I was helped to make plans and put them into action	3	7	1	1	
If I needed a visit, this was arranged without delay	10	3	1		

COMMENTS

"The support at the time was very helpful even though I was not really in a receptive frame of mind. The ongoing knowledge of its presence changed all that for the better."

"I didn't get the usual patronising rehearsed opening speech. What I did get were genuine, caring folk."

4 - The Service (continued)	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The worker put my needs first and accepted my priorities	10	5		1	
I felt confident in the skills and methods of Lifeline workers	11	4		1	
I felt supported and kept safe by Lifeline	11	4	1		
My need for privacy and confidentiality was respected	11	4	1		
I liked the fact that Lifeline is independent from SIC & NHS	10	2	1	1	
As a voluntary organisation, Lifeline is less stigmatising and I felt more able to ask for the help I needed	10		4	1	
I would have preferred the service to be provided by health and social work services	1	1	4	2	8

Appendix 1(a) - Questionnaire Data: Clients

COMMENTS

"I am and always have been dubious about health and social work intervention in my or anyone else's life."

"It was useful that Lifeline was independent from the NHS, particularly as at the time the NHS said I was 'negative in my outlook' (I was recovering from an overdose and depression) so I felt that the NHS as a source of support was being taken away from me. Lifeline stood by me and didn't judge, and that enabled me to regain a more balanced outlook."

"I was very worried about the hospital in January and was given very sound advice about it which helped me to avoid it."

"Instead of being a health worker, a nurse, there were real people who LISTENED, yet were quick enough to respond and see past the barriers of "I am okay (not) - please help me". Their responses were genuine and should be more widely adopted."

5 - The Outcome	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I was helped to use other services I needed (if any)	3	5	2	1	
Using Lifeline led to changes for the better for me	6	6	1		
Knowing Lifeline will help if I call, helps me feel safe	13	2	1		
I think I have become more able to cope without extra help	6	4	4		

COMMENTS

"Since contacting Lifeline, and ongoing informal support I no longer face a series of crises and no longer need regular CPN support."

"I haven't yet been able to cope because the cause hasn't been resolved, but apart from that, the outcome was increased positivity. I am gutted that the NHS can't see past its barriers and install this service."

Appendix 1(a) - Questionnaire Data: Clients

6 - Suggesting Lifeline to Others	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I found it easy to offer people a leaflet	4	1	3		
People responded well to the offer of this service	2	5	2		
I felt relieved that this service was freely available 24/7	15	3			
Feedback from people (if any) about Lifeline was good	7	3	1	1	
I observed that people who used Lifeline had benefited	7	5	1	1	
Liaison with Lifeline (if agreed) was satisfactory	5	2	1		
I had increasing confidence in suggesting Lifeline to people	8	3	2		
Lifeline's independence and informality is a strength	13	2			
As a voluntary organisation, Lifeline is less stigmatising and people are more likely to ask for the help they need	13		3		
I would have preferred the service to be provided by health and social work services	2	1	4	2	6

COMMENTS

"As a voluntary service you didn't feel that everything you said was being written down to be used against you - even though information was relayed, it was positive."

"Some feedback was not positive, due to individuals not getting *exactly* what they *wanted,* as opposed to what they *needed*."

Appendix 1(a) - Questionnaire Data: Clients

7 - In Conclusion	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
A 24/7 Crisis Service freely available to anyone in Shetland is essential and should be provided on a permanent basis	18		1		
A service like Lifeline is needed as part of Shetland's policy to reduce the number of suicides here	17	1	1		
The Lifeline pilot project has shown that their approach, methods and organisation are effective	17	1		1	
Early intervention in this way can often prevent the development of longer-term support needs	15	3	1		
I still have serious doubts that Lifeline is a significant part of the answer to Shetland's need for a crisis service		2	1	2	14

COMMENTS

"I believe Lifeline is an essential part of an ongoing crisis service in Shetland, especially because it is not tethered by Health and Social Work policy, bureaucracy and agendas."

"A crisis service like Lifeline is vital in Shetland. Being purely reliant on A&E is not an option as when in crisis, unable to drive, etc meant that not only was it hard to physically access A&E but, having made it to A&E, the service was patchy at best, and at worst unsafe. Lifeline's strength is that you can contact from anywhere in Shetland 24/7 and the service can come to you at any point."

"Shetland Lifeline is sorely needed here in Shetland where immediate profound help is needed. In my experience backup was seriously lacking in mental health services before Lifeline came into being (carer)."

"This should be permanent. Mental health problems, worry, stress, anxiety, depression and suicidal thoughts do not work 9-5."

"Many problems intensify out of hours, often during sleepless nights so a 24-hour service is extremely useful."

8 - Other Information

HAVE YOU ANY OTHER COMMENTS YOU WOULD LIKE TO MAKE ABOUT LIFELINE OR CRISIS SERVICES IN SHETLAND?

"I only phoned Lifeline once. It was 4am and a worker came immediately and stayed a long time. Thank you."

"I only used this service once and after difficulties in speaking to someone I found them polite and very quick to respond. A home visit was made by a member of staff who I found to be polite and friendly but was of no practical help to me. I feel unable to comment further to be fair to your organisation based on one short experience."

"Having used Lifeline before, I know and believe it to be effective and necessary and I think it is a good idea to continue it."

"I felt comfort in the knowledge that I could phone Shetland Lifeline when unable to cope with my daughter in a crisis situation. I also greatly appreciated the follow-up call. Because my daughter knows the Lifeline workers the service was far better for her than, say, phoning NHS24. My thanks for the help we have had and I sincerely hope that the service is re-launched."

"A service like Lifeline is vital in Shetland. I found it invaluable and it helped me through an extremely hard time. It helped me regain a balanced outlook and move on. My contact with the NHS, although vital, was much more difficult. Lifeline did liaise with the NHS on my behalf and its strength was that I didn't feel judged about how I was feeling and about the overdose."

"It will be important for the pilot to be evaluated and that this important service continues after March and is an ongoing service for the benefit of Shetland people experiencing a crisis in mental health."

"There is no doubt in my mind that Lifeline has done an outstanding service to the local community and has saved not only lives but a huge amount of terror and anguish to many clients. I sincerely wish the service had been on the go when my family was in crisis with a schizophrenic member - we got no help at all."

"We are the carers/support of last resort for someone who used this service. This makes things difficult as the crisis is well advanced by the time it comes to us. As we are emotionally involved it can be exceedingly wearing. We found that the service supplied a much needed relief when we had got too worn and stressed to cope with much more."

/continued

8 - Other Information (continued)

HAVE YOU ANY OTHER COMMENTS YOU WOULD LIKE TO MAKE ABOUT LIFELINE OR CRISIS SERVICES IN SHETLAND?

"Lifeline is an essential service that could be used to help and support a lot of very vulnerable people during difficult periods of their lives. Because it is not a part of "the system" it feels more confidential and safer to contact. Less stigmatising. I know others too who have felt abandoned and very upset and alone at the loss of this service. The fact that the service did home visits put it above and beyond other services of its kind (e.g. Samaritans), and also people could get to know the Lifeline staff so don't have to explain their situation and problems every time they call for help and support. Early intervention can reduce the strain on other services; so removing a very good, supportive, early intervention network is a very bad error in judgement."

"When I first rang Lifeline I was shocked at how easily I was able to speak to the worker. (The worker) arranged a home visit with me within a couple of hours and I truly believe is one of the angels who have helped me through the hardest of times in my life. I do not know how I would have coped without (the worker). His understanding and input put everything into perspective and took a huge weight from my shoulders. Having (the worker) to talk to and his good advice gave me strength I didn't know I had, so I could take control of a life that was shattered. Thank you."

"I found Lifeline to be rapid and supportive. Very beneficial in my time of need."

"At present the crisis service on these islands, disregarding Lifeline, is appalling. Victorian in its approach.
(1) You can't have a crisis unless you are registered with Mental Health. So when you need someone, there's no one there.
(2) When you ring Samaritans a) you can't understand them and b) they are patronising and superb at put-downs.
(3) Lifeline is there 24/7 when you need someone - at 1am or 3pm or the next day and the next until you can resolve the crisis. Problems are not between 9-4.

Problems do not need a GP referral they need time, patience and a genuine ability to help: all of which Lifeline provides. The GPs don't, Samaritans don't, Mental Health can't. NHS24 - useless - keep them. One success is better than one statistic DEAD."

Appendix 1(b) - Questionnaire Data: Referrers

1 - The Lifeline Leaflet	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The leaflet contained all the information I needed	13	10			
I found the leaflet easy to read and understand	12	8			
The leaflet helped me to take the step of phoning for help	1	2			

COMMENTS

"I used the service following a call to Social Work's out-of-hours service (Social Worker)."

"I'm a GP. I have given folk leaflets on several occasions. Had feedback from two folk who both found it helpful."

"As a GP I found the leaflet self-explanatory and when I gave it to patients I thought it was easy for them to understand/use."

"As someone who used the leaflets for information and signposting people, I found them very useful."

2 - Contacting Lifeline	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I found the recorded message easy to understand	3	1			
I was connected to a Lifeline worker quickly	3	4			
Getting connected to a worker was as easy as it could be	4	4			

COMMENTS

"Contacting a worker was easy. I explained the situation and they agreed to take over the contact with the service-user (Social Worker)"

4 - The Service (continued)	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I felt confident in the skills and methods of Lifeline workers	3				
I liked the fact that Lifeline is independent from SIC & NHS	3	2			
I would have preferred the service to be provided by health and social work services	1				1

COMMENTS

Appendix 1(b) - Questionnaire Data: Referrers

6 - Suggesting Lifeline to Others	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I found it easy to offer people a leaflet	23	7	1	1	
People responded well to the offer of this service	15	15			
I felt relieved that this service was freely available 24/7	25	6			
Feedback from people (if any) about Lifeline was good	18	12			
I observed that people who used Lifeline had benefited	16	11	1		
Liaison with Lifeline (if agreed) was satisfactory	15	8			
I had increasing confidence in suggesting Lifeline to people	20	9	1		
Lifeline's independence and informality is a strength	17	9	5		
As a voluntary organisation, Lifeline is less stigmatising and people are more likely to ask for the help they need	17	8	10		
I would have preferred the service to be provided by health and social work services	1	1	12	6	7

COMMENTS

"I hope Lifeline continues so I can pass on leaflets to others I know that might benefit."

"This is a valuable, independent service that can still consult and coordinate with others - but a brilliant alternative to NHS/SIC. They let the people accessing the service decide what they want, or their family."

"I had feedback from two people. On both occasions they had no home address that would be constant, so your organisation seemed an ideal choice to suggest to them. Also quick and giving immediate access rather than waiting for an appointment (GP)"

"As a GP I found this to be a tremendous resource. It was very reassuring for my patients to know such a personal service was available to them locally 24/7."

"I work permanent nights in A&E so it would be a great help to patients and staff if an on-call mental health service was available."

"Lifeline was the first service suggested in training (not stated, but presumably ASIST or SafeTalk) for people in crisis - this will be sorely missed."

Appendix 1(b) - Questionnaire Data: Referrers

7 - In Conclusion	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
A 24/7 Crisis Service freely available to anyone in Shetland is essential and should be provided on a permanent basis	29	7			
A service like Lifeline is needed as part of Shetland's policy to reduce the number of suicides here	23	10	1		
The Lifeline pilot project has shown that their approach, methods and organisation are effective	16	12	2		
Early intervention in this way can often prevent the development of longer-term support needs	21	11	3		
I still have serious doubts that Lifeline is a significant part of the answer to Shetland's need for a crisis service			4	14	10

COMMENTS

"I have been struck by the discretion and professionalism of Lifeline workers (GP)"

"Lifeline has, in my personal experience, helped avert major disasters, and is a very necessary service here!"

"I have concerns about the bigger organisations in Shetland not taking Lifeline seriously."

"A 24 hour CPN service would be ideal, but I doubt if funding will ever be made available for this."

"I don't know how effective or otherwise the Lifeline service has been generally. The client of mine that used the service was very appreciative of it. I don't know if there needs to be a dedicated crisis service or whether existing services can be utilised to support people in this way."

"This should be provided by statutory agencies but also excellent to have a service provided by a voluntary agency as some patients prefer that."

Appendix 1(b) - Questionnaire Data: Referrers

8 - Other Information

HAVE YOU ANY OTHER COMMENTS YOU WOULD LIKE TO MAKE ABOUT LIFELINE OR CRISIS SERVICES IN SHETLAND?

"As a professional, I note how hard it is for many members of the community to access mental welfare services because of stigma and the fear of revelation of intensely private material. Lifeline makes a discreet and effective supportive alternative to formal services and I would like to see it continue." (GP)

"Providing support to people through the out-of-hours social work service, we can not always devote enough time to individual callers who are simply needing someone to talk with. It is an emergency service with one worker covering all areas of Shetland. Lifeline is an ideal service to offer callers when appropriate, knowing they will get the help they need 'short-term' until they can be referred to other appropriate services i.e. GP or CMHT. Keep up the good work." (Social Worker)

"I have valued this service highly and was relieved it started. However because you are not health or social work orientated, I have sometimes worried that the patients/clients I have referred - while they need your help - could be putting your workers at risk either physically or in other ways." (GP) (This respondent also noted that he/she had observed positive outcomes for patients)

"Service users who I have had contact with and advised of the Lifeline service seemed relieved that there was help available 24 hours a day. The fact that the service is based locally appealed to service users. Communication with Lifeline has been useful - both in Lifeline contacting Social Work about people who have come to them (with person's consent), and also Lifeline coming back to Social Work with information after SW advised someone to use Lifeline in a crisis. Feedback from service users is that they found the service really helpful. It was reassuring as a professional to know that here was a service available 24 hours a day that vulnerable service users who had reached crisis point could contact for advice and reassurance." (Social Worker)

"I feel that knowing a worker can visit or meet up with the person is reassuring, making this project seem more personal than phone-based services such as Samaritans."

"After a client had contacted Lifeline, their follow-up work in contacting appropriate services/agencies for each of the client's issues seemed to work well. Also clients who I told about the service appreciated that there was someone to call out of hours who was independent. I feel this service is needed on a permanent basis - it really is a 'lifeline' for those we work with."
(CAB Money Advisor)

Appendix 1(b) - Questionnaire Data: Referrers

"I am aware that colleagues from adult services have found Lifeline to be of great benefit, and I get the impression it's been reassuring to folk to have it there." (CPN, CAMHS)

"I work for the NHS and have used Shetland Lifeline on numerous occasions; including the service as part of a crisis plan with mental health patients. I have found the service extremely supportive to people in crisis. I have had positive feedback from mental health service users being supported by Lifeline staff. I am convinced that this service has helped to prevent patients being admitted to the Royal Cornhill Hospital, preventing disruption to the patient and their family and expense to NHS Shetland."

"It was a pleasure to make those joint efforts at helping Shetlanders in crisis." (Psychiatrist)

"As a professional, this service is beneficial not only for service users, but also for us. It enables us to speak to people who have a knowledge and understanding of a client's individual circumstances."

"I thought it is a great idea. I did forget it was there initially, but did recommend my patients use it, and put it on our website. I'm not sure if people did use it. Maybe it could have been better publicised with leaflets, posters, etc. and more publicity and reminders for GPs." (GP)

"I am sorry; I did not suggest it to any patients or hear about anyone using it. I'm sure the concept is excellent - the question is whether people in crisis will be familiar enough with the availability of the service to make use of it when needed." (GP)

"I have had to contact Lifeline on behalf of a friend in severe crisis, and was extremely grateful for their speedy intervention - a major crisis was averted. The volunteers arrived quickly, keeping me informed of their travel and ETA - reassuring, knowing someone is coming! As well as supporting my friend, the volunteers made sure I was supported and doing okay."

"I think this service is of the utmost importance - there is nobody else to turn to outwith office hours when you need help dealing with someone in danger of harming themselves. Sometimes a telephone help-line is just not enough: you need people to be available for physical one-to-one contact; especially when there's the risk of self-harm. I am very grateful to the Lifeline volunteers for all their help and support."

"A useful extra resource, especially for those who need support quickly and cannot wait for counselling, etc." (GP)

Appendix 1(b) - Questionnaire Data: Referrers

"I know people who have been in crisis and Lifeline seriously helped. This strand of a service should not end, as I believe this would be of detriment to the community of Shetland and vulnerable people. Who, except the police, offers a 24/7 service? - certainly not Mental Health. DO NOT END THIS SERVICE."

"I feel that all health and care services (including voluntary) should be more responsive to contacts made by people in crisis. There should be an agreed response that every service takes when someone expresses this kind of life-threatening crisis. The money might be better spent to train all services in how to respond in this instance, rather than rely on a small dedicated service."

"I feel that Lifeline is a fantastic service and if continued should be marketed in such a way that it would reach all the people who need it most. I have given the Lifeline card to two of my clients in distress. One used the service and one didn't need to in the end. I currently have contact with someone who I would love to be able to give the details of this service but now can't. I feel it is very positive that this service was independent of the SIC & NHS as people are afraid sometimes to contact these places in fear of over-reaction (e.g. being sectioned) when really all that is needed is a support person to help see them through that moment in time. Also it's more discreet - there isn't a doctor-marked car or ambulance outside or uniformed individuals visible for others to see. I really do hope this service can secure funding to start again and grow into a valuable part of the Shetland support network for people in crisis."

"I am vexed to hear that the pilot is over and that it will not be available again until a possible re-launch in the future. I hope the time between now and possible re-launch is not too far away. What's great about this service is that there is a response right away and folk can see someone to help them become safe in the immediate. I can't think of another service that offers this. I really hope re-launch funding can be obtained and for a sustainable period of time."

"Clients have told me of their involvement with Lifeline and each experience, though fairly varied, has been positive. For some of the clients, it is the only agency contact they are able to sustain because of their personal social situation. A responsive 24/7 service available independently to clients is a vital part of service provision. For this service to be no longer available is a retrograde step and I hope the process towards re-launch is a short one." (CAB Adviser)

"Valuable services delivered to patients on Ward 3 by Lifeline staff. They certainly fill a gap nursing staff on the ward struggle to cover."

Appendix 1(b) - Questionnaire Data: Referrers

"As a GP I have been hugely impressed by this service:
Firstly, the covering letter and leaflets gave me all the info I needed.
Secondly, I observed first-hand how relieved patients were to know that if they hit crisis point, someone would be available to speak with and visit them.
Thirdly, In the 18 months patients have reported finding the service useful.
Fourthly, There have been no inappropriate referrals made back to me from the Lifeline team, and none from the Lifeline team to the hospital that I am aware of - i.e. there is nothing to indicate that involving Lifeline has escalated a problem due to poor skills. The opposite is true. I think probably some situations have been very much soothed and settled by the Lifeline team's involvement.
My gratitude to all the team. Thanks for providing such a professional voluntary service" (GP).

"I am very sorry that this has come to an end. As well as through work, I have friends who have used this service and it has probably prevented their suicide." (Nurse, A&E).

"This is an essential service which is necessary and relevant for all. With the closure of Art Therapy there is a need for urgent counselling-type service."

"Please keep running!"

"I have accessed Lifeline from the hospital here and been very impressed with the response and support they have offered. For the few people admitted in crisis, I am sure there are many more in the community. The approach shown is more appropriate, for some people, than a formal mental health referral."

Appendix 1(c) - Questionniare Data - Staff

1- Recruitment and Training	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The recruitment presentation gave me a good initial understanding of the project and encouraged me to apply	2	3			
The residential Weekend Workshop clarified Lifeline's service approach and my role as a crisis support worker	5	1			
The Workshop fulfilled an effective team-building function	5		1		
Any emerging training needs have been identified and met	3	4			
Ongoing training has been clear and easy to understand	5	3			
Lifeline's training has adequately prepared me for my role	4	4	1		
I think there were significant gaps in the training provided			2	4	2

COMMENTS

Training met the needs identified by the employer and employees; often based on 'regular' clients with a specific need/needs. The nature of the job was that the unexpected and unknown could happen. Training was there to enhance staff's experience and knowledge. In my opinion, staff were selected because of their experience and ability to take on the job competently.

I feel that the importance of ongoing training was recognised and added to my skills and confidence as a worker.

The residential weekend workshop was a great way to initiate trust and understanding. Further training has been well presented and easily understood. Good input from other services in the in-house training.

The use of fortnightly team meetings to address emerging training needs was a great idea. The team was fortunate to have a skilled trainer in the team.

The residential weekend was an excellent team building exercise.

I think the recruitment and training was excellent right from the start.

2 – Service Approach	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I found the Goals & Steps and ABCDE Assessment model easy to understand and remember	6	3			
I was able to apply them from the start	6	2	1		
The Goals & Steps card helped me focus on my task	6	3			
My confidence in this model grew stronger with usage	4	4			
I think there are some ways it could be improved (how?)			6	2	

COMMENTS

I felt this model was an effective and practical system and could quickly be reviewed when needed.

Interesting training and good team bonding helped greatly towards our service approach. We encouraged each other and spoke a lot about 'goals and steps' in the initial weeks so we had a good understanding of our approach.

There is probably some room for improvement, but brevity and simplicity are also very important.

The tools given to do the job were more than adequate.

Appendix 1(c) - Questionniare Data - Staff

3 – Roles and Responsibilities	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I was given sufficient time to develop my skills	5	4			
I understood my role and that of the other team members	5	4			
I was consulted in all matters relating to my role	7	2			
I now feel well prepared for my role and its responsibilities	7	2			
The level of autonomy in my role is too high			2	6	1
The expectations put on this role were too high for me				7	2
Being a crisis support worker is not something I could keep doing for more than a couple of years			3	4	2

COMMENTS

Had funding continued and my hours (and personal life) not changed, I feel I could have continued for much longer. However staff working at a higher level of involvement may require more formal support and a regular structure to the rota.

I feel the issues and concerns around 'responsibility' were well aired and discussed amongst the team. I understood my role and this deepened with experience.

The role, level of autonomy and expectations are onerous and a challenge, but with team support and goodwill from other services, I could carry on.

I think that taking a break from being a crisis support worker would be advisable - for all staff.

Having another job at the same time as being a crisis support worker can be difficult to manage at times.

I was always able to choose how many shifts I worked each month, which was really beneficial to my own 'well-being' as I could make sure my shifts fitted in with my other commitments in life.

I felt listened to and well supported in every part of my responsibilities during my time with Lifeline. I also felt that I was trusted and allowed a level of autonomy which I was equipped to deal with.

4 – Support and Supervision	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The right priority was given to my safety and support	6	3			
I felt supported by my colleagues	7	2			
I felt supported by my team leaders	8	1			
I felt confident that I could have more support if I needed it	9				
When I needed to seek advice or consult with a team leader this was quickly and easily available	8	1			
Knowing there would be prompt access to an experienced counsellor if required for my support was important for me	7	2			
I found my team leaders unsupportive and unapproachable				1	8

Appendix 1(c) - Questionniare Data - Staff

COMMENTS

I found the team leaders to be available at all times to provide support to me as an individual and to discuss and explore issues regarding clients. I can honestly say I have never had such appropriate support from an employer while allowing me appropriate autonomy. The team leader was always ready to listen and take suitable action on any comments (even criticisms) that arose.

I felt the right supports were in place to do this challenging work.

Excellent support provided.

This is an important issue. From my point of view, Lifeline has got it right.

Team leaders and other crisis support workers were always supportive and approachable.

I knew that any time I needed to get in touch with any of my colleagues or my team leaders that I could phone them and receive the support I needed - and every time I did, I felt supported and encouraged by them all.

The teamwork was fantastic in my time with Lifeline; we were all supportive of each other and aware of the needs of all members of the team.

5 – Rota and On call	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The method used to create the monthly rota suited me well	4	5			
It was easy to change Lifeline shifts, when necessary	6	3			
The complexities of the Lifeline administration did not intrude on my role as a crisis support worker	3	6			
My other employers were understanding and accepting of my role with Lifeline	4	4	1		
Although onerous, the 14/10 hour on-call shifts were a satisfactory and practical way to spilt up the day	1	5	3		
I adapted satisfactorily to the demands of being on call	1	7	1		
Being on call adversely affected my other work			3	3	3
Being on call caused problems in my family		1	2	3	3
The number of on-call shifts I work would not be sustainable for me for more than a couple of years	2		2	4	1
The hourly rate of pay set for being on-call was satisfactory	1	3	3	1	1
The level of pay set for hours worked was satisfactory	2	3	3		

Appendix 1(c) - Questionniare Data - Staff

COMMENTS

Being on-call worked well for me because of the level of support and understanding from my family and employer.

It did take me a while to get used to being on call and if I got tired I would sometimes forget to carry my phone at all times (e.g. going into the garden).

I think you have to really believe in a project like this to give so much free time towards it. I wanted to be part of the team regardless. I think it has been extremely worthwhile, challenging at times, but I would still be keen to take part in the work of Lifeline if the chance arises in the future. I am a true believer that this is a really important service which shall be sorely missed.

Being on-call is not easy and is bound to affect other aspects of one's life. But it is worth it.

As I work shifts in my main job, there were times when I had to change from 1st person on call to 2nd - this was easily done. I found it difficult at times being 1st person on call when I had my family at home as I had to stop them using or answering the phone.

Having not done on-call work before, I found it at times very restrictive especially as a result of having a poor mobile signal in the area where I live.

The on call rota was issued each month and I felt able to put down whatever shifts I was able to do without feeling under any pressure to do more than I could, however this often meant that some workers were doing lots more on call duty than others due to their responsibilities or work patterns. This would indicate a need for more team members to avoid this problem.

6 – Systems and Organisation	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
The virtual switchboard system worked well for me	3	5	1		
The pager system was unnecessarily complicated			6	2	1
I knew when and how to page other team members and how to respond if I was paged	2	5	1	1	
I felt the log sheets were well-designed and easy to use	4	5			
Communication by email was quick and effective	7	2			
I was confident with the role I was expected to play regarding liaison with other agencies	4	5			
I was kept informed and involved in any decisions about Lifeline's development and future	7	2			
The fortnightly team meeting successfully -					
(a) Updated all team members with what was happening with the clients we were currently working with, so if I was called by a client, I felt well prepared	7	2			
(b) Enabled us to maintain a consistent culture and corporate 'style' - which was useful for clients who may speak to a different worker each time they phone	7	2			
(c) Gave all workers the opportunity to share when things were difficult, or went well, so we learned from our experiences	7	2			
(d) Gave team members an opportunity to say if they were struggling in any way - emotionally or otherwise - with the work, so they could be supported	7	2			

Appendix 1(c) - Questionniare Data - Staff

(e) Provided a forum for discussion about whether a change of approach or referral to another agency might be appropriate	8	1			
(f) Highlighted if anyone was misusing the service in any way so an appropriate course of action could be agreed	8	1			
I was informed and consulted on all policies & procedures	5	4			
Lifeline's policies & procedures were relevant, easy to understand, remember and apply	6	3			
There were significant gaps in the policies and procedures			1	6	2

COMMENTS

Regular meetings created a special bond with team members and afforded staff the opportunity to reach a deeper understanding - very necessary and useful when called out to the more difficult cases.

Because I hardly used the pager, I did not feel confident that I would always remember what to do. Team meetings were vital and kept us fully informed.

Well organised by our supervisor, excellent communication and team spirit.

The pager system was not used much and this could mean that team members forget how to use them. Coverage is not 100% which is problematic - also mobile phone coverage is patchy and erratic.

Team meetings were essential and lively discussions.

The communication systems in place were obviously well thought out and easy to understand and use. The policies and procedures were I believe equal to or better than some organisations I have worked for in the past.

Working with other agencies gradually developed over the time we were able to operate as a service.

7 - Personal Development	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
Working with Lifeline has strengthened my existing skills and confidence in working with people in distress	8	1			
My work with Lifeline has helped me become more confident and effective in my other work	6	3			
Working with Lifeline has adversely affected my family life		2	1	2	4
Working with Lifeline demands a very high level of commitment: I could not keep this up for more than two years		1	3	3	2
I am proud to have been a member of the Lifeline team and of the contribution I have made	8	1			

Appendix 1(c) - Questionniare Data - Staff

COMMENTS

Not only does this job require a high level of commitment, it necessitates a high level of investment of 'self'.

Because of the large number of daytime shifts I needed to do to cover the rota, it would not be sustainable for me in the long term. However, fewer shifts would enable me to be involved.

Without doubt there are personal sacrifices as well as gains.

I would become an active crisis support worker again if it was made 'public' and could be a career choice - e.g. contracted hours - full or part time.

Working as a crisis intervention worker with Lifeline has taught me so much about people with mental health issues and how they are affected by these issues. This has been extremely valuable to me in my full time job as a Substance Misuse Worker. My family have accepted me doing this and have no issues with me continuing to do so in the future if given the opportunity. I am extremely proud to have been a member of the Lifeline team and other people have told me (both users of the service and other professionals) what a valuable service it has been to the people of Shetland.

8 – In Conclusion	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
A 24/7 Crisis Service freely available to anyone in Shetland is essential and should be provided on a permanent basis	8	1			
A service like Lifeline is needed as part of Shetland's policy to reduce the number of suicides here	9				
The Lifeline pilot project has shown that its approach, methods and organisation are effective	8	1			
Early intervention in this way can often prevent the development of longer-term support needs	8	1			
I still have serious doubts that Lifeline is a significant part of the answer to Shetland's need for a crisis service			1	1	7
Lifeline's way of working is not sustainable for its workers			3	5	1
Lifeline is not sufficiently supported by NHS/SIC agencies	5	1	3		
I feel that a crisis service would be better if run by the statutory agencies (NHS/SIC)			3	3	3

COMMENTS

Lifeline, I strongly believe, has saved lives. Lifeline and how it was set up is sustainable for its workers, but needs stability of finances, a high level of personal commitment, and a high level of support from team colleagues and supervisors. They must have a keen understanding and insight of employees' needs and a solid base of theory and an ability to interpret this to workers when appropriate. This is the kind of support I experienced when working with Lifeline.

The response to the Lifeline service has proved to me that it is effective and valuable and should be available to the people of Shetland.

At a practitioner level we have experienced much goodwill from the NHS and SIC.

I feel that there is a need for Lifeline and it should be available to everybody in Shetland.

I think it is absolutely essential that the Lifeline service is continued. It is not particularly important which agency is responsible for running it, the only important thing is that it continues. I believe the last 18 months have proved the need for a service such as this in Shetland and it should be continued in the same or a similar way for the future.

9 - Other Information

HAVE YOU ANY OTHER COMMENTS YOU WOULD LIKE TO MAKE ABOUT LIFELINE OR CRISIS SERVICES IN SHETLAND?

I strongly support the re-launch of Lifeline, or a similarly robust and effective crisis intervention service in Shetland. From personal experience and verbal feedback, I know it was invaluable to many and has now left a huge gap. Confidentiality was so important and dealt with appropriately and sensitively. On occasions, an issue about boundaries would arise, and I felt comfortable to explore this either with the team as a whole, or with a team leader. As a Lifeline employee; I felt valued and respected by my employer and colleagues. Lifeline had a significant and critical role in meeting the needs of our community and local/national strategies. I experienced Lifeline promoting strong partnership working, putting individual clients at the centre. Lifeline employed highly skilled and experienced staff to meet the needs of service users in a professional and ethical way. Working for Lifeline meant a lot to me - the experience is something I value and have gained much from. I have broadened my knowledge and skills in ways I couldn't have in any other job. I would want to work for Lifeline again if the opportunity arises.

I think the need for services like Lifeline will increase rather than decrease. We have seen substantial and lasting improvements in client's resilience, even among people who have had long-term mental health problems. Some have used the service intensively for a while, but are now (at the time of writing) coping well without it. None of our clients have completed suicide, and in 18 months only one was admitted to Cornhill (on a section of the MH Act, initiated and assisted by Lifeline).

In the time I worked as a CSW, the people we helped were very needy and grateful for a face-to-face service. I know that had we not been available as a service 24/7 there would have been more demand put on other agencies.

I really feel that Shetland needs to have a crisis service such as Lifeline, as people cannot always get help from the other services straight away, especially out-of-hours and at weekends, and having a 24/7 service where anyone can phone in and then receive a visit if necessary is a very valuable asset to have. I also believe that the Lifeline service that has been running since October 2008 has indeed helped to save lives in Shetland and that without Lifeline's involvement with some of its callers/clients, these people would no longer be here!!

I was a volunteer with Samaritans both in Chester and then in Shetland from 2002-2008. This was work which brought me into contact with people who were often at their lowest time and had no one else to turn to. When the Lifeline service was recruiting I realised that it was, in many ways, an extension of what was offered by Samaritans. This opinion has been confirmed in my 18 months as a Lifeline worker.
I understand how difficult it is for people to cope with the issues which we were often presented with at Lifeline and to have the support of someone who is not going to judge or criticise you and not tell you what to do is I think the best support we can give to someone in distress and possibly at risk of taking their life or self-harming in some way. This is certainly borne out by the people I have visited and spoken to in my 18 months as a Lifeline worker. We have been able to give people who called Lifeline a "safe place" to talk about their fears and worries. I have spoken to many people who felt that suicide was the only option available to them because of the way they were feeling at that time. By exploring other options which they may not have been able to consider because of how low they were feeling we have been able to encourage them to think in a different, more beneficial and safer way.

Every person I have spoken to on the phone or visited at their home through the Lifeline service, without exception, has thanked me for being there to listen to them and talk about how they were feeling. We were also able to offer practical help if that was appropriate. When people ring Lifeline they are allowing us into their private world and that is a privilege we never take lightly.

As a Lifeline worker I have advised people to seek help from The Shetland Drugs and Alcohol service and as a Substance Misuse worker I have also advised people to ring Lifeline when other services are not available out of hours. I know that my colleagues in my full time employment have also referred many of their clients to Lifeline if they feel the need to talk to someone when they are struggling to cope with their lives and feelings. GPs in Shetland and members of the Mental Health service have also advised people to use Lifeline when other services are not available e.g. in the middle of the night and weekends.
I really hope that the Lifeline service is able to continue so it may carry on being of real valid benefit to the people of Shetland.

Appendix 2

Lifeline Statistical Data

QUARTER	1	2	3	4	5	6
DATES	01/10/08-31/12/08	01/01/09-31/03/09	01/04/09-30/06/09	01/07/09-30/09/09	01/10/09-31/12/09	01/01/10-31/03/10
TOTAL CALLS TO LIFELINE	113	120	45	65	95	143
COMPLETED INTERVENTIONS	34	27	33	41	43	70
FIRST CALL MONDAY	9	3	5	10	6	8
FIRST CALL TUESDAY	3	4	3	9	10	15
FIRST CALL WEDNESDAY	5	4	6	6	5	11
FIRST CALL THURSDAY	2	3	6	3	7	11
FIRST CALL FRIDAY	6	5	4	5	3	9
FIRST CALL SATURDAY	6	3	5	5	5	11
FIRST CALL SUNDAY	3	5	3	3	7	5
NEEDING OUT-OF-HOURS WORK	22	21	21	24	34	45
CLIENT'S LOCATION:						
NORTH MAINLAND	5	6	3	9	4	9
SOUTH MAINLAND	7	3	5	2	4	9
WEST MAINLAND	5	4	0	0	7	8
CENTRAL MAINLAND	15	11	21	22	28	41
ISLANDS	2	3	3	7	0	2
CLIENT'S GENDER – MALE	27	9	17	9	10	28
CLIENT'S GENDER – FEMALE	10	18	16	32	33	43
NEEDING A VISIT	21	12	15	19	22	30
TELEPHONE SUPPORT SUFFICIENT	13	15	18	22	21	40
TOTAL TIME SPENT (HOURS)	111	90	107	112	136	180
TOTAL MILES	852	610	432	459	641	717
NEEDING TWO WORKERS	6	7	10	5	7	10
FIRST CALL MADE BY:						
CLIENT	25	20	21	35	38	67
FRIEND/RELATIVE	4	6	14	1	1	2
PROFESSIONAL	1	1	2	5	4	1
LIFELINE FIRST SUGGESTED BY:						
NOT KNOWN/OTHER	2	4	2	2	0	7
LINK UP	13	9	13	22	6	18
GP	2	3	3	1	5	11
CMHT	6	7	9	15	19	25
GBH	2	4	5	0	6	4
SOCIAL WORK	2	0	0	1	6	1
SIC HOUSING	1	0	1	0	1	1
CAB	2	0	0	1	0	1
ANNSBRAE	4	1	0	0	0	0
SUICIDE RISK						
NONE IDENTIFIED	17	7	12	21	25	39
LOW	9	11	9	7	5	20
MEDIUM	4	7	4	9	5	9
HIGH	4	2	8	4	8	2
ADULTS AT RISK ISSUES INVOLVED	0	1	0	1	0	1
CHILD PROTECTION ISSUES INVOLVED	0	1	0	1	0	0
HIGH RISK DUE TO MENTAL DISORDER	0	3	0	1	2	0
OUTCOME CATEGORY A	0	0	0	1	2	0
OUTCOME CATEGORY B	20	20	24	25	24	36
OUTCOME CATEGORY C	14	7	9	15	17	30
OUTCOME CATEGORY D	0	0	0	0	0	0

KEY TO OUTCOME CATEGORIES

A = DISCONTINUE CONTACT WITH REASONS
B = SUPPORT THE SERVICE USER
C = B PLUS SEEK STATUTORY SUPPORT
D = REFER DIRECTLY TO STATUTORY SERVICE (DO NOT OFFER LIFELINE SUPPORT)