Nottingham and Nottinghamshire Suicide Prevention Team:

Suicide Prevention Listening Project 2024-2025

Exec Summary with recommendations

Opinion Research Services
January 2025

Opinion Research Services

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This study was conducted in accordance with ISO 20252:2019, ISO 9001:2015, and ISO 27001:2013

Contents

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Welfare statement

We know that suicide can be a sensitive subject to hear about, talk about and read about. It is important above all else that you take care of your emotional wellbeing. If you find the content of this report to be upsetting, we would strongly encourage you to talk about it, be that with a trusted friend or family member, or with a professional (some services are listed below). If you or someone you know are experiencing suicidal thoughts, you can also contact the following services for support:

- *Text SHOUT to 85258,*
- *Dial 111, and select option 2*
  - *Samaritans - call **116 123**, or visit **www.samaritans.org***
  - *Harmless – call the referral line on **0115 880 0280**, or email **info@harmless.org.uk***
  - *The Tomorrow Project – call the referral line on **0115 880 0280**, or email **info@tomorrowproject.org.uk***

SHOUT and the Samaritans are available 24 hours a day, seven days a week.

The Tomorrow Project and Harmless provide support for those experiencing suicidality and self, harm, and also support those who have been bereaved by suicide.

1. Executive summary

Summary of main findings

Background to the study

1.1 Opinion Research Services (ORS) was commissioned by the Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group (SPSSG) to undertake a listening project to identify the needs and preferences of people with suicidality in higher risk groups.

1.2 The following risk groups were identified as being the priority for engagement in the listening project:

- Males
- Financially vulnerable, unemployed, and gambling
- People with neurodevelopmental conditions (e.g. autism, ADHD, intellectual disabilities)
- Young people/young adults at risk of self-harm/suicide.

1.3 The fifth priority area was suicide bereavement, informed by local discussions about developing joint communication materials/resources, shared providers, and cross-border incidents.

1.4 The key findings below are a summary of the strongest themes which were identified from a series of interviews and focus groups held with practitioners, people who have been bereaved by suicide, and people who have lived experience of suicidality, all of which were held between February and July 2024.

Detailed information about the commission, methodology and participant demographics can be found in chapter 2, the Project Overview.

Key findings

Listening to Practitioners

1.5 Interviews were conducted with practitioners working in men's mental health, support for suicide bereavement, young people's groups and services, autism support services, gambling support services, and organisations supporting people facing unemployment and financial challenges, from across Nottingham and Nottinghamshire. The insight provided by practitioners covered the challenges or barriers they face in supporting people who are experiencing suicidality or bereavement by suicide (or in some instances both), observations about the needs of those they support, gaps in provision, and suggestions to improve services and outcomes in the future.

1.6 In determining the stage a person is at when they seek support (e.g. pre-crisis, crisis), some found no pattern, whereas others found it easier to identify, with practitioners from autism support services tending to see people seeking support in the pre-crisis stage. Referrals via health or education settings are common for young people; whereas the police are a key referrer for people who are bereaved by suicide. Others often initially seek support for a different concern (which subsequently leads to the identification of suicidal thoughts or ideation) or are encouraged to do so by friends and family.

1.7 Practitioners found that people are prompted to seek support or speak to others when they feel overwhelmed by their thoughts and feelings, the catalyst for which can simply be someone asking them how they are. Practitioners agreed that stigma is one of the main barriers to people talking about their suicidality and seeking support, especially with friends and family, and the importance of directly and explicitly asking about suicidal thoughts was emphasised. Peer support models were also recommended

as providing relatability, compassion, and empathy, all of which can lessen perceptions of judgement and stigma.

1.8 Inclusion or exclusion criteria can reduce the accessibility of services, but some offer provisions for those who do not meet their criteria, including assessments of need, 'waiting well' packages, and signposting to other relevant services. Some practitioners commented that a lack of joined up working between statutory and support services can limit the reach of services, and a few noted a lack of information sharing across the board, which impacts upon support pathways. Engagement was also noted as a challenge by some practitioners, and certain groups such as ex-offenders or gamblers can struggle to access or engage with services specific to their needs.

1.9 Of the risk groups included in the project, long-term term support was thought to be most needed by people bereaved by suicide and young people; and more pro-active early intervention would benefit recently unemployed people, people with a gambling problem, and autistic young people.

1.10 Bereavement practitioners expressed that that there is insufficient bereavement support available to reach everyone in need. Furthermore, a lack of awareness of support services among statutory services (like GPs, the police, ambulance services, and the coroner's office) was thought to result in incorrect referrals, or a failure to refer at all.

1.11 Practitioners argued for more open-access support for people in need and more information around how to access services; quicker access to the right support was considered key. Practitioners also highlighted the importance of community support in reducing isolation, reaching people before crisis point and multi-agency working to improve outcomes.

Listening to people bereaved by suicide

1.12 Interviews were conducted with people who had been bereaved by suicide between 2013 and 2023, some of whom had also experienced suicidality themselves, and usually in direct relation to their bereavement. Participants discussed the contributing factors to their loved ones' suicidality, and where relevant they also discussed their loved ones' experiences of seeking support. Key concerns were around premature hospital discharges, and healthcare providers not taking sufficient account of patients' medical histories.

1.13 The main barriers their loved ones had experienced to seeking support were not feeling they needed it, the stigma around mental health and suicidality, not wanting to be seen as weak or a failure, poor past experiences, and not knowing where to go. Being and feeling listened to was felt to be the key requirement of those who reach out for support. Bereaved participants felt that their loved ones would have benefitted from a range of services; long-term therapy; information and education around available support and the risks of medication; more expert mental health support within primary care; peer support; safety plans; and tailored support for neurodiverse people. It was also said that practitioners need to pay more attention to the views and experience of the patient's family, friends, and others that are closest to them.

1.14 Bereaved participants emphasised that suicide bereavement is complex and very different to other types of bereavement, not least as its grief consists of so many different emotions including anger, resentment, guilt, and regret. Most had contact with several services or agencies after their bereavement, such as the police, the mortuary, and the coroner's office. These interactions were difficult, but staff were praised for their sensitivity, compassion, understanding, and empathy. Views were mixed however around interactions with local healthcare trusts and schools.

1.15 Most of the participants who were bereaved by suicide had sought or accessed some form of support for themselves, either informally via family and friends or more formally via their GP, private therapy, or bereavement support services like Harmless, SoBS (Survivors of Bereavement by Suicide), and Citizens' Advice. The main barriers they identified to accessing bereavement support were not feeling ready to do so, the stigma associated with suicide, a lack of knowledge about what was available, and long waiting times for anything other than private therapy. Key suggestions for improving support for those bereaved

by suicide were more and longer-term counselling and therapy; a range of support to cater for different preferences; proactively ensuring people know what support exists and that they can access it when ready; more peer support; and more support for the wider circle of family members and friends of those who die by suicide.

Listening to people with lived experience of suicidality

1.16 People who had experienced suicidality between 2013 and 2023, took part in a mixture of one-to-one interviews and focus groups. Their experiences were fairly evenly split between those who had experienced ideation, and those for whom it had reached a stage of acute active ideation and crisis. For those who had experienced ideation without reaching crisis point, it was their recurring and intrusive thoughts that had prompted them to seek support. Those who had experienced active ideation or crisis at least once talked about being "overwhelmed" or "catastrophising" ordinary situations and reaching a point where they could no longer escape or control their intrusive thoughts.

1.17 Participants discussed the nature and duration of their experiences; most described them as long-term (often resulting from traumatic childhood, teen or adult experiences), with intermittent short-term crises being triggered by specific, often multiple, factors. These included physical or mental health diagnoses; relationship issues; job pressures and redundancy; familial estrangement; and financial issues; and, for young people social media, puberty and social and academic pressure were all triggers. They also described the things that help them cope with their feelings and thoughts; animals, nature, music, and creative pursuits have helped participants cope with and manage their situations. Finding safe, non-judgemental spaces to have conversations about mental health, and not avoiding the subject of suicide was also important, especially for men. Recovery stories were also considered valuable in offering hope, and as a reminder that the feelings experienced during crisis are temporary.

1.18 Participants highlighted a need for better access to peer support and counselling, long-term therapy, and non-NHS open-access services. Access to online support, early intervention, support for people whose first language is not English, and services that can be accessed outside working hours were also mentioned. Several participants talked about wanting to access services without having to go through the NHS, either because of long waiting times, or because of a perceived lack of anonymity, and for some access to online or text-based support was particularly important given the element of discretion they offer. Again, stigma was considered the main barrier to seeking help and support. Privacy and confidentiality were also a key concern; as is a fear of being dismissed or disappointed by services, based upon prior experience of long waiting lists or indifferent responses.

1.19 Experiences of seeking 'informal support' were mostly positive and were often a catalyst for seeking formal support, although some participants said that not knowing how the people close to them would respond was enough to keep them from talking about their feelings at all. When asked what formal support had been especially helpful, participants mentioned person-centred counselling, regular contact with a support worker, and services that address the contributing factors to suicidality. On the whole, participants said that in future they would either turn to their informal support networks and peer support, or to a range of services they have already used and found to be beneficial. A few would visit their GP, but several would seek alternatives to NHS support due to waiting times and perceived barriers to access (e.g. 5.37-5.39 and 5.47-5.48).

1.20 Suggestions about how to better support those experiencing suicidality going forward included raising awareness of services and sources of support in settings like schools and colleges; proactive offers of support; and swift or immediate access to open-access, confidential services, without long waiting lists, restrictive criteria, or time limited provision. Person-centred support, having safety plans in place, and access to out of hours provision (even a telephone or text-based helpline) were also considered essential.

Targeted communication campaigns – Key messages

1.21 The key suggestions around **raising awareness** were:

Ensuring people know they '*are not alone*' and that '*it's good to talk'*; encouraging people to '*seek help'* and reinforcing the message that there are people out there who can provide that help; promoting other types of support besides talking, such as self-help YouTube videos; increasing education on suicidality and self-harm; and co-producing materials with specific risk groups (autistic people in particular) to ensure any messaging resonates with them.

1.22 The key suggestions around **addressing stigma** were:

Increasing education and awareness of suicidality as a mental illness that does not discriminate, and the prevalence of mental ill-health and illness more generally; *c*hanging the way society speaks about suicidality; and having open and direct conversations about it to reduce shame and secrecy and encourage people to speak out. Reducing shame and fear by reiterating that '*You are not alone*' and '*You are not weak*,' and emphasising that it takes enormous strength to share experiences and seek support; using the influence of public figures sharing their lived experience to promote talking and reduce stigma; discouraging bereaved people from blaming themselves for the deceased's death and overthinking anything they could have done to prevent it; and ensuring communications aiming to address stigma among young people aim to view it from the perspective of those young people.

1.23 The key suggestions around **increasing help seeking behaviour** were:

More information and advertisement to encourage people to seek the support that is available; tailoring advertisements to inform bereaved people that the support offered is specifically for their type of bereavement; and ensuring people are aware of less formal settings and support models given the waiting lists for specialist services. Telling people that '*You won't be punished for seeking support' and 'You're in control…*' to reach those who fear a loss of agency over their life and decisions; aiming to change mindsets by telling people that 'There's nothing to lose from talking before acting.'; and coupling the phrase '*You are not alone*' with lived experience testimonies and recovery stories to foster hope. Wider messaging around people taking the initiative to directly ask family, friends, colleagues etc. about their mental health, and improving help seeking behaviours in men through using the 'right' language, people knowing there are appropriate spaces available for them, and overcoming gender stereotypes like '*Men don't cry*.'

1.24 The best ways to **communicate these messages** were thought to be:

Online, including via social media; displaying slogans and messaging on products like beer mats, 'business cards' and t-shirts or via posters on public transport and the back of toilet doors in pubs and clubs; and targeting people in the workplace and on their commute, or young people in educational settings, through strategically-placed messaging. Reaching people through hobbies and community activities and taking advantage of all available communication methods or platforms, given that no single approach will work for everyone.

2. Recommendations

Overall conclusions and recommendations

2.1 Based on the findings of the listening project (as detailed in the above chapters) this report points to a number of recommendations around the needs of those who are bereaved by suicide or experiencing suicidality themselves. These are presented thematically below.

Recommendations by themes

Recommendation 1: Early intervention

2.2 Ensure accessibility to and awareness of early intervention support, particularly for recently unemployed people, people experiencing gambling related harm, and autistic young people.

Promote and encourage early help seeking for people experiencing suicidal thoughts and feelings.

Recommendation 2: Peer support

2.3 Support existing, and where appropriate expand peer support options and promote development of peer support.

Work with people with lived experience to develop 'recovery stories' that promote hope and a reminder that recovery is possible.

Recommendation 3: Long term support offers without time limits

2.4 Consider options for providing longer term support, particularly for people bereaved by suicide (recognising the length and complexity of the bereavement journey) and for children and young people.

Consider the ability for people to re-engage with support when needed and periodic wellbeing 'check-ins' following exit from services.

Recommendation 4: Alternative crisis support spaces

2.5 Consider local provision of alternative crisis support spaces such as the Nottingham Crisis Sanctuaries and allocated quiet spaces within A & E. This was noted particularly in relation to autistic/neurodivergent people experiencing suicidality.

Recommendation 5: Quicker access to the right services

2.6 Continue to work towards reduced waiting times and consider how to provide '*immediate support that is less clinical and more supportive*'.

Recommendation 6: Open-access services

2.7 Review availability of 'open-access' support options (without requirement of a referral from Primary Care, CAMHS or other healthcare setting). Ensure people have easy access to information about how to access available support services.

Provide safe and non-judgemental spaces for conversations about mental health which do not avoid the subject of suicide, particularly for men.

Recommendation 7: Family liaison

2.8 Review access to family liaison following a mental health inpatient admission relating to suicidality (where patient consent is provided). Promote and encourage routine family liaison within the first few days following admission, unless consent to do so is withheld.

Recommendation 8: Crisis support

2.9 Ensure that safety plans remain a standard offer within crisis provision and maintain flexibility of offering home visits to those who need them.

Recommendation 9: Out of hours access

2.10 Review out of hours provision for both crisis support and ongoing support to maximise accessibility for different groups.

Recommendation 10: Person-centred services

Support services for bereavement and suicidality should adopt a person-centred approach[1]. Services should be adaptive to peoples' accessibility needs (including transport, online access, out of hours provision and translation services).

Recommendation 11: Training

2.11 Ensure 'adequate and secure funding' to meet a range of training needs for staff in statutory and voluntary sector services.

Training provision should also include supporting men experiencing suicidality and bereavement, trauma informed practice to support people bereaved by suicide and people experiencing suicidality who have past experience of trauma, and skills and knowledge to work with autistic people. Support the recruitment and development of people with lived experience as important assets in the local workforce.

Recommendation 12: Information sharing and multi-agency working

2.12 Ensure good information sharing to support multi-agency working across both statutory and voluntary sector services.

Develop a culture of shared responsibility for suicide prevention and reduce the exclusion of people from services because they are already accessing support elsewhere. Develop multi-agency approaches and share information to support people through transitions, e.g. primary to secondary, a change of college or university, or the transition from CAMHS to Adult MH.

Recommendation 13: Support for GPs and other clinicians, as well as other statutory bodies and organisations, around responding to disclosures of suicidality, or to bereavement by suicide

2.13 Increase awareness of bereavement support across all statutory services and the voluntary sector and provide training and information to support empathetic and compassionate conversations.

[1] i.e. approaches which fit the needs of the participant as much as possible, and which are based on conversations with the participant to understand what works best for them (e.g. do they prefer 1:1 / group / peer support), and which also understands that those needs might change. This also relates to their practical needs, i.e. can they travel, or do they need to access community based support, and it also relates to recommendation 21, and a need to address the root causes of suicidality, not just the presentation/ symptoms.

Consider options to support staff in Primary Care in responding to suicidality and bereavement by suicide.

Raise awareness of the link between chronic pain and disability and mental and emotional resilience.

Work with prescribers to ensure that patients have sufficient and age-appropriate information about their medication.

Consider options to support employers in supporting employees who are bereaved by suicide or experiencing suicidality.

Recommendation 14: Providing proof of death

2.14 Support a broad range of organisations to review and improve staff awareness around death certification and how to communicate sensitively with people who contact them following a bereavement. Work to identify training needs, and changes to administrative protocols, which could also be applicable to a range of services.

Recommendation 15: Hope boxes

2.15 The use of 'Hope boxes[2]' were considered beneficial by young people who had received them from CAMHS and this is something that could potentially be used or adapted for use with other (adult) risk groups too.

Recommendation 16: Awareness raising

2.16 Use awareness raising campaigns to:

- Challenge myths about how suicidality and ideation are likely to present
- Raise awareness of 'early warning signs'
- Raise awareness of links between self-harm and suicide
- Support people in responding appropriately to people who had been bereaved by suicide or experiencing suicidality

Recommendation 17: Having a presence both in communities and online

2.17 Review service models to ensure online and community-based offers to maximise accessibility and reduce barriers.

Recommendation 18: Services for men

2.18 Support and create 'safe' spaces for men to interact and reduce stigma around talking about feelings and expressing vulnerability. Community or interest-based groups with an element of activity are recommended. Ensure accessibility outside of working hours.

Recommendation 19: Services for young people

2.19 Privacy and confidentiality were very important to children and young people. Ensure clear messaging around availability of confidential support and ensure that where telephone-based support is offered privacy is considered.

For young people bereaved by suicide, ensure that this is considered in transition between schools.

2 A description of a 'hope box' can be found on the Papyrus website: Hope-box.pdf (papyrus-uk.org)

Review capacity for provision of regular, direct, face-to-face support from an appropriate professional for children and young people, including in transition to adult mental health services.

Recommendation 20: Services for autistic people

2.20 Ensure services avoid making assumptions around an autistic person's needs when assessing support.

Address the issue that support for autistic people can be more fractured if communication involves a carer or family member, by seeking to communicate directly with the individual in the first instance, and especially where this is the stated preference of the individual concerned, provided there are no material or ethical reasons to do otherwise.

Several participants with a diagnosis of autism expressed that they would prefer to access online or text-based support, as opposed to support over the phone or in person. Neurodiverse – friendly crisis spaces (where staff understand that people with Autism may present quite differently in crisis to neurotypical people) are also strongly recommended (see also recommendation 3 above).

Recommendation 21: Services for people facing financial challenges or unemployment

2.21 Ensure and increase awareness of practical support to address the root causes of suicidality, particularly for those facing financial challenges or unemployment.

Recommendation 22: Services for those bereaved by suicide

2.22 Promote availability of suicide bereavement support to friends, colleagues, care givers and others who may be impacted by support.

As with recommendation 2, Consider options for providing longer term support, ability for people to re-engage with support when needed and periodic wellbeing 'check-ins' following exit from services.

Continue to provide specialist bereavement services that support the immediate bereavement needs and practicalities and the inquest process.

Support development of peer support options for people who have been bereaved by suicide.

Recommendation 23: Targeted communications and co-production

2.23 Chapter 6 of this report details a large number of suggestions made by participants around targeted communications.

Key themes included :

- Messages of hope and reassurance; that 'it is OK to talk' and that 'you're not alone'
- Education and awareness raising around suicidality and self-harm
- Encouraging people to have direct conversations, and to use specific language to support suicide prevention
- The importance of co-production to develop targeted messaging
- Utilising a broad range of communication formats and locations

It is recommended that practitioners involved in the development and delivery of such campaigns in the future look at the full findings in chapter 6 to inform their work.

Furthermore, there is already some very good co-production work in place, especially with young people (e.g. MH2K and 'Nott Alone') and it is recommended that co-production approaches with relevant risk groups continue to be applied going forwards, to inform branding, visibility, relatability, and messaging.

Appendix 1: List of participating organisations

The following organisations were actively involved in the listening project. To those who took part in interviews, helped with recruiting people with lived experience of suicidality and bereavement by suicide, helped to host groups and events, and supported participants to take part we would like to offer a sincere 'Thank You'. Many others also forwarded on information during the recruitment process, for which we are also grateful.

Autism Strategy Group at Nottinghamshire County Council

Autistic Nottingham

Be U Notts

East Midlands Gambling service

Enlighten the Shadows

Harmless/ The Tomorrow Project

In Sam's Name

Men on the Edge (Oasis community centre)

Mental Health Motorbike

MH2K

Positive Behaviour Consultancy Ltd

SoBS (Survivors of Bereavement by Suicide)

St Anne's Advice Group

The Wolfpack Project

DWP (Jobcentre staff)