Opinion Research Services

# Nottingham and Nottinghamshire Suicide Prevention Team:

# Suicide Prevention Listening Project 2024-2025

## Report of findings

Opinion Research Services
January 2025

Suicide
It's ok to talk about it

NHS
Nottingham and Nottinghamshire

Nottinghamshire County Council

Nottingham City Council

Opinion Research Services

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

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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.

## Theme Lists

1.25 To aid navigation, the headlined themes which feature in each chapter of the report are shown in the lists below, with page references:

### Listening to Practitioners

### Listening to people bereaved by suicide

- Participants suggested several ways to better support those bereaved by suicide… **p. 52**
- Several participants had experienced suicidality themselves… **P. 53**

## Listening to Lived experience

- Participants' experiences were evenly split between those who had experienced ideation, and those who had reached a stage of acute active ideation, planning, and crisis… **p. 56**
- Most participants felt that their experiences were long-term, with intermittent short-term crises triggered by specific (often multiple) factors… **p. 57**
- Participants described a broad range of things which have helped them cope and manage their situation over the years… **p. 60**
- Participants identified several things that would have helped them, but were not accessible at the point at which they were struggling with ideation or crisis… **p. 64**
- Barriers to seeking help and support are varied, but mainly based around stigma and fear of the consequences of admitting to suicidal thoughts… **p. 65**
- Privacy and confidentiality were a particular concern for many participants… **p. 66**
- Experiences of seeking 'informal support' were mostly positive and were often a catalyst for seeking formal support… **p. 67**
- Most participants who had experienced ideation or crisis sought formal support, and had accessed a variety of services… **p. 69**
    - GP services… **p. 70**
    - Mental health services (crisis team and mental health nurse)… **p. 70**
    - CAMHS… **p. 71**
    - Counselling/talking therapy… **p. 72**
    - Harmless/Tomorrow Project… **p. 72**
    - Peer support worker/peer support groups… **p. 73**
- Participants talked about their own future needs and what should be done better to support those experiencing suicidality going forwards in general… **p. 75**
    - Raising awareness… **p. 76**
    - Faster access to support… **p. 76**
    - Open access, non-clinical support options, or peer-based support… **p. 77**
    - Longer-term support… **p. 78**
    - Practical support… **p. 78**
    - Other suggestions **p. 78**

## Targeted Communication campaigns

- Raising awareness of suicidality… **p. 81**
    - People should know they are not alone and that speaking to others could help… **p. 81**
    - Promoting other types of support besides talking, and take a person-centred approach… **p. 82**
    - Increasing education on suicidality and self-harm… **p. 82**
    - Using specific language when raising awareness among autistic people…**p. 83**
- Addressing stigma… **p. 83**
    - Increasing education and awareness of mental health and the prevalence of suicidality… **p. 83**
    - Changing the way we speak about suicidality… **p. 84**
    - Reducing shame and fear by reinforcing that 'You are not alone' and 'You are not weak'… **p. 84**
    - Using public figures in suicide prevention campaigns… **p. 85**
    - Stopping the blame in bereavement to reduce stigma… **p. 85**
    - Addressing stigma among young people… **p. 85**
- Ways to increase help seeking behaviour… **p. 85**
    - Advertising and informing about available support… **p. 85**
    - Ensuring people know they will not be punished for seeking support… **p. 86**
    - Ensuring people know there is nothing to lose from talking before acting… **p. 87**

# 2. Project Overview

## Project context and methodology

### Background to the study

2.1 In 2021, the Office for National Statistics reported a total of 5,583 deaths by suicide in England and Wales at a rate of 10.7 per 100,000 population. The average suicide rate between 2018 and 2020 per 100,000 population was 11.5 in Nottingham and 8.6 in Nottinghamshire, compared with the England average of 10.1. For Nottinghamshire only, this related to 188 deaths by suicide (2018-2020). Data from OHID Fingertips shows that rates of suicide in 2021 in Nottingham were 11.1 per 100,000 population and 10.6 per 100,000 for Nottinghamshire compared to the England & Wales rates of 10.7 per 100,000 population.

2.2 The Nottingham and Nottinghamshire Suicide Prevention Strategy (2019-2023), which at the time of this project was being refreshed, set out a local strategic ambition to, 'Reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population mental health and wellbeing, and by responding to known risks for suicide in the population.' The five priorities within the Strategy focus on at-risk groups, the use of data, training and bereavement support, staff training, and media.

2.3 In addition, the Nottingham and Nottinghamshire Integrated Care Board (ICB) had been allocated Wave 4 suicide prevention transformation funding by NHS England. The Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group were responsible for overseeing the plans for this funding as part of the wider Suicide Prevention Strategy and Action Plan. The Wave 4 programme is underpinned by the engagement, co-production and participation of people with lived experience, as well as multi-agency collaboration with partner organisations and community groups.

### The project

2.4 Opinion Research Services (ORS) was commissioned by the Nottingham and Nottinghamshire Public Health teams to undertake a listening project to identify the needs and preferences of people with suicidality in higher risk groups. Understanding the perspectives of people with lived experience of suicidality in relation to services, support and themes (e.g. social connection) will help to identify improvements that can be implemented across sectors and communities locally.

2.5 To identify target groups, the Real Time Surveillance Working Group (RTSS) reviewed the themes in the data for the 18-month period from August 2020 to January-June 2022, as well as other data and intelligence. Based on this, the following risk groups were identified as the focus for 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.

2.6 It should be noted that for the purposes of the listening project, it was decided to focus on Autism at the recruitment stage, rather than broader neurodiversity.

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

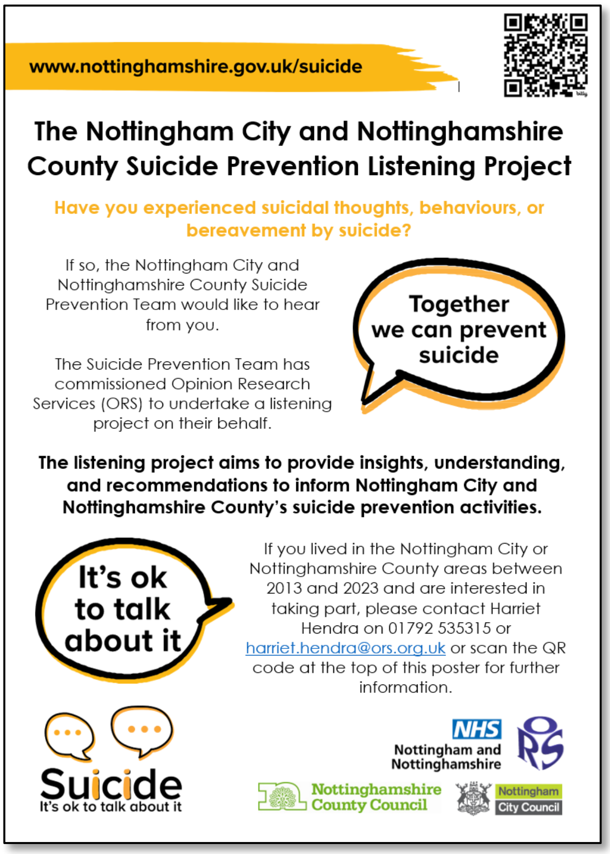
2.8 The insights, understanding, and recommendations from this project will directly inform suicide prevention work locally, and be used to:

- Shape the development of future suicide prevention work
- Contribute to the implementation of the new Nottingham/Nottinghamshire Suicide Prevention Strategy and action plan
- Inform future commissioning decisions
- Complement the implementation of a local suicide prevention charter or statement
- Support the further shaping of the suicide prevention stakeholder network
- Support the development of targeted communication campaigns to contribute to the reduction in stigma and increase in help seeking behaviour.

## Methodology

### Overview

2.9 The listening project involved a mixture of one-to-one interviews and group conversations with a range of practitioners and with people with lived experience of either suicidality, or bereavement by suicide. These were advertised through flyers, which were circulated via e-mail to over 80 practitioners and organisations working with the target risk groups, and also via circulation through the Nottingham and Nottinghamshire Suicide Prevention Stakeholder Network. The interviews and groups were all conducted between February and July 2024.



www.nottinghamshire.gov.uk/suicide

**The Nottingham City and Nottinghamshire County Suicide Prevention Listening Project**

**Have you experienced suicidal thoughts, behaviours, or bereavement by suicide?**

If so, the Nottingham City and Nottinghamshire County Suicide Prevention Team would like to hear from you.

The Suicide Prevention Team has commissioned Opinion Research Services (ORS) to undertake a listening project on their behalf.

**Together we can prevent suicide**

**The listening project aims to provide insights, understanding, and recommendations to inform Nottingham City and Nottinghamshire County's suicide prevention activities.**

**It's ok to talk about it**

If you lived in the Nottingham City or Nottinghamshire County areas between 2013 and 2023 and are interested in taking part, please contact Harriet Hendra on 01792 535315 or harriet.hendra@ors.org.uk or scan the QR code at the top of this poster for further information.

Suicide
It's ok to talk about it

NHS Nottingham and Nottinghamshire
Nottinghamshire County Council
Nottingham City Council

2.10 Thirteen interviews were conducted with a total of 19 practitioners from a range of fields, and organisations across Nottingham and Nottinghamshire. These included 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.

2.11 Eleven people who had been bereaved by suicide took part in interviews and 23 people who had experienced suicidal ideation, or crisis, took part in a mixture of interviews and group sessions. All had experienced suicidality, or bereavement by suicide at some point between 2013 and 2023. Three group sessions were held in person, in Worksop, Nottingham, and Newark, and two group sessions and one interview were undertaken online with young people from the MH2K mental health consultation panel. (A demographic breakdown of participants can be found below).

## Support and safeguarding

2.12 ORS and the Nottingham and Nottinghamshire Public Health Teams were aware that taking part in an interview of this nature could potentially be re-traumatising and/or triggering for participants. Therefore, to protect and support them as much as possible, the following measures were put in place for the lived experience and bereavement interviews and groups:

- Each interviewee would be able to involve a family member, friend or support worker in the interview in a supportive capacity, either to sit in (while not contributing unless explicitly asked to by the interviewee) or provide post-interview support
- Participants were offered regular breaks, reminded that they could withdraw at any point, and reassured that they did not have to answer any questions they did not feel comfortable with throughout the interview
- Follow-up, post-interview support was arranged, via the participant’s support worker and in the form of contact details for relevant support organisations.

## Participant profiles

2.13 The following tables provide a profile of the participants in the listening project.

### Practitioners

**Table 1: Practitioner profiles**

| Geographical remit | Working with men | Working with bereavement by suicide | Working with young people | Working with people with autism | Working with people who are facing financial challenges, unemployed or gambling |
|---|---|---|---|---|---|
| City | | | >5 | | >5 |
| County (Mid/North and South Notts) | | >5 | >5 | | >5 |
| Both City and County | >5 | >5 | | >5 | |
| Regional / National organisation | | >5 | | | 5 |
| **TOTAL** | **>5** | **>5** | **>5** | **>5** | **7** |

## People with lived experience of suicidality, and bereavement by suicide

**Table 2: Profiles participants by risk group**

| Risk group | Number of participants |
|---|---|
| Bereaved by suicide | 11 |
| Men | 7 |
| Young people | 14 |
| People with Autism | 5 |
| Facing financial challenges / unemployed | <5 |

2.14 Participants were categorised based on the main themes of their experiences, and how they self-identified. It should be noted that some participants fell into more than one category (see footnotes); several of those bereaved by suicide had also experienced suicidality (as covered in the chapter on bereavement), and some were autistic and also facing financial challenges, or male, or under 25. Those with multiple risk factors were taken fully into consideration in the analysis and report writing process.

2.15 It should be noted that no participants identified as having issues with gambling.

**Table 3: Profiles of participants with lived experience of suicidality or bereavement by suicide**

| | | Bereaved by suicide (11) | Lived experience of suicidality (23) | All lived experience participants (34) |
|---|---|---|---|---|
| Gender | Male | <5 | 11 | 15 |
| | Female | 6 | 10 | 16 |
| | Transgender/ non-binary | <5 | <5 | <5 |
| Location | Mid/ North Notts | 5 | 11 | 16 |
| | City | <5 | 6 | 8 |
| | South Notts | <5 | 6 | 10 |
| Age | 14-24 year | <5 | 14 | 14 |
| | 25-34 years | <5 | <5 | 5 |
| | 35-44 years | <5 | <5 | <5 |
| | 45-54 years | <5 | 5 | 6 |
| | 55 or more | 5 | <5 | 6 |

2.16 In terms of ethnicity, 25 identified as ‘White British’, and nine identified otherwise. Fewer than five participants identified as each of the following; ‘British-Other’, ‘White-Other’, ‘Mixed European’ background, ’Asian’, ‘British-Asian’, ‘Black-African’ and ‘African-European’.

2.17 The intention of this project was to gather qualitative insight into the experiences of local people. Due to the relatively small sample size, the findings should not be seen as statistically representative.

## The report

2.18 This is an independent report of the 13 practitioner interviews, the 11 bereavement interviews, and the data from 23 participants with lived experience of suicidality who took part in a mixture of one-to-one interviews and focus groups, complete with a short overall summary of the main issues raised and conclusions. The interviews and groups were all between 90 minutes and two hours in length.

2.19 The interviews and focus groups considered a wide range of important issues that are reported fully in the following chapters of this report. The views of different participant types (practitioners, people bereaved by suicide, and people with lived experience of suicidality) have been reported separately to enable us to draw out important differences, as have participants’ views on potential targeted communication campaigns.

2.20 The views expressed by participants may or may not be supported by available evidence; that is, they may or may not be fully accurate accounts of the facts. ORS cannot arbitrate on the correctness or otherwise of people's views in reporting them, and this should be borne in mind when considering the findings. Where possible, any such issues are noted in the report.

2.21 Verbatim quotations are used, in indented italics, not because we agree or disagree with them, but for their vividness in capturing recurrent points of views. ORS does not endorse the opinions in question but seeks only to portray them accurately and clearly. While quotations are used, the report is not a verbatim transcript of the sessions, but an interpretative summary of the issues raised by participants in free-ranging discussions.

2.22 ORS researchers used qualitative thematic analysis to identify themes and findings based upon transcripts of the interviews and focus groups conducted during the listening project.

## Acknowledgements

2.23 First and foremost, we would like to offer our heartfelt thanks to all of the listening project participants for giving their time, and for sharing their experiences so openly and candidly.

2.24 We would also like to thank the support service gateway agencies for their invaluable help with sharing the information about the project, and for supporting participants on our behalf and providing safeguarding measures.

2.25 ORS also thanks the Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group for commissioning this important project, and we hope the findings will prove useful in understanding and improving the experiences of those who are bereaved by suicide and with lived experience of suicidality. We are particularly grateful to Steph Knowles, Jane O'Brien, and Serena Coultress (Public Health and Commissioning Managers for Nottinghamshire County Council and Nottingham City Council) for their assistance in developing and managing the project.

## Glossary

2.26 The table below offers a plain word definition for the acronyms and other terminology used throughout the report.

**Table 4: Terms and acronyms**

| Term / Acronym | Full Name/ Definition |
|---|---|
| **Suicidality** | Experiences of suicidal thoughts and feelings, ideation and crisis |
| **Suicidal ideation** | Suicidal ideation is the broad term that describes a preoccupation with death, suicide, or self-harm.<br>There are two types of suicidal ideation: |
| **Passive ideation** | Specific thoughts of suicide, of “not wanting to be alive,” or “not wanting to wake up in the morning” but doesn’t intend or plan to carry out the action |
| **Active ideation** | Active ideation is when someone is actively thinking, planning, or preparing to end their own life |
| **Suicidal crisis** | A person in “suicidal crisis” is someone with significant acute suicidal ideation where there are significant concerns that the person may follow through, for example where there may be evidence of active planning or a previous suicide attempt. |
| **Informal support** | Support from friends, family, or other existing social networks |
| **Formal support** | Some form of professional help and support- for example a GP, a mental health service, or a charity or other organisation |
| **CAMHS** | Child and Adolescent Mental Health Services |
| **SoBS** | Survivors of Bereavement by Suicide (a national charity for those bereaved by suicide) |
| **CBT / MCBT** | Cognitive behavioural therapy / Mindful cognitive behavioural therapy |
| **EUPD** | Emotionally unstable personality disorder (treatment) |

# 3. Listening to practitioners

## Findings from conversations with practitioners

### Summary of evidence and insights

Practitioners reported difficulties in determining the stage a person is at when they seek support. 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.

For young people, referrals via health or education settings are common; 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 they are encouraged to do so by friends and family.

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, or directly asking about suicidal thoughts. Some highlighted prompts to seeking help which were specific to the groups they support.

Most services have inclusion or exclusion criteria, which can reduce their accessibility. In mitigation, some offer provisions for those who do not meet their criteria, including needs assessments, ‘waiting well’ packages, and signposting to other relevant services.

Peer support was noted as beneficial; relatability, compassion, and empathy are key strengths of the peer support model and sharing feelings with those who have experienced similar circumstances can lessen perceptions of judgement and stigma.

In terms of potential improvements, some said that a lack of joined up working between statutory and support services can limit the reach of services, and a few practitioners noted a lack of information sharing across the board, with an impact on support pathways. Engagement was also noted as a challenge by some practitioners; certain groups, such as ex-offenders or gamblers, can struggle to access or engage with services specific to their needs.

Practitioners identified some gaps in services: 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. Bereavement practitioners also identified gaps and expressed that that there is insufficient bereavement support available to reach everyone in need.

Practitioners agreed that stigma is one of the main barriers to people talking about their suicidality and seeking support, especially with friends and family.

A lack of awareness of support service provision among statutory services (like GPs, the police, ambulance services, and the coroner’s office) was thought to result in no or incorrect referrals: a key barrier to accessing the right support.

Practitioners suggested different types of support to improve outcomes for the people they work with, including 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 recognised the benefits of community support in reducing isolation and reaching people before crisis point, and the importance of multi-agency working in improving outcomes.

# Full overview of findings

## Practitioners working with the five different risk groups across Nottingham and Nottinghamshire contributed to the listening project

3.1 As part of the listening project, we conducted a series of interviews with practitioners supporting the following groups across Nottingham City and Nottinghamshire:

- Males
- People bereaved by suicide
- Financially vulnerable or unemployed people, including people with a gambling problem
- Autistic people
- Young people.

3.2 Some practitioners we spoke to were from statutory, or state-funded organisations, but most were from charitable or third sector organisations and groups. Further information about practitioner participants can be found in the methodology section.

3.3 The practitioners from groups or organisations for men that we spoke to offered peer support, talking opportunities, and psychology-based support. Both these charities used interest-based groups, such as sports, or motorcycling, to engage with men around mental health and suicidality. Support offers are primarily needs-based, offering support for the amount and duration that suits the individual. There is a mix of in-person support (one-to-one sessions or events) and virtual support (Facebook groups and a lived-experience podcast). One participant was an academic, who has conducted research with firefighters and with men in the criminal justice system.

3.4 The practitioners from bereavement charities that we spoke to offer emotional and practical support to anyone who has been bereaved by suicide. One service offers group peer support through volunteers with lived experience. Another provides a broad offer of support from practical elements like funeral arrangements, to emotional support, via one-to-one talking sessions with a practitioner.

3.5 Support for financially vulnerable people varied across the three different services interviewed: one offers financial advice and support to people on low-income or Personal Independent Payments (PIP); one supports people with gambling problems, and the other supports unemployed people. All take a holistic approach to improving a person’s wellbeing, initially addressing their financial concerns while also supporting any issues around mental health or suicidality.

3.6 Practitioners supporting autistic people that we spoke to provide services to support people on their assessment pathway, also addressing any impacts that may have on their mental health or suicidality. Within this, pre and post diagnostic support is offered, aiming for early intervention for people on the pathway. Practitioners also work with autistic people to form a crisis response, or a safety plan.

3.7 Finally, the practitioners working with young people (including, but not exclusively 18–25-year-olds) to provide a broad range of support around suicidality, including early prevention programmes, online support materials, a podcast, wellbeing support sessions and help with safety plans. Support for this group can be in-person or online, as services try to cater to their target audience. Some practitioners also support the parents of young people with suicidal thoughts or ideation.

## It can often be difficult to determine the stage a person is at when they make the decision to seek support

3.8 Some services, particularly those supporting men and people struggling with a financial or gambling issue, found no pattern in the way certain groups seek support, with the former noting the open and casual nature of their services as a possible reason for this. One men’s service noted its efforts to create a space to support the varying needs and circumstances people present with when seeking support.

> *"There's no pattern, it's just a wide plethora of men that have got completely unique circumstances with different time frames. What we've tried to do in the last six to eight months… is to say, 'What provisions can we do that are relatable for men… so different men can access it to get that support?' So they've got that environment no matter where they're at… We do that every fortnight. It's a kick about, dead laid back, we have a laugh. But then there's a half an hour peer support group chat afterwards. It's not mandatory, but we're just blown away because everyone comes." (Practitioner - Men)*

3.9 Other services found it easier to identify the stage at which people seek support. For some, people tend to do so in the pre-crisis stage. The extent of suicidal thoughts or ideation within this stage varies and can depend on the purpose or remit of the service: for example, if a service offers broad social support, the extent and type of help required can vary significantly.

3.10 Specifically, practitioners from the autism support services that we spoke to tend to see people seeking support in the pre-crisis stage, while they are dealing with the adjustments of being on the neurodevelopmental pathway.

> *"We have a dynamic support register in place now; we're able to identify those people that have got autism who are rated as perhaps being amber or red. So those who are at crisis point or are bubbling on the surface and have got the potential of reaching crisis point. That is around behaviours increasing, because mental health might be deteriorating or there might be sensory needs that aren't being met, and that distress is being demonstrated through these challenging behaviours." (Practitioner – Autism)*

3.11 Another key group that tends to seek support pre-crisis is people who have been bereaved by suicide. Bereaved individuals tend to need help dealing with the unique nature of their bereavement, the repercussions of which can involve suicidal ideation, but they are often not at crisis point themselves. One bereavement practitioner highlighted a change in this respect, noting that more people seem to be reaching crisis and approaching support services sooner after their loss than they used to.

> *"Many people in the early days of their bereavement will experience suicidal ideation... A lot of our volunteers are ASIST trained, so that they can intervene…" (Practitioner – Bereavement)*
>
> *"It's getting earlier, that is for sure. Probably within the first few weeks. That's probably a combination of people being aware of us, and how generally society seeks help a lot quicker." (Practitioner – Bereavement)*

3.12 Some practitioners shared experiences of people seeking support either at crisis point, or post-crisis. For certain services, it is within the nature of their support that the person has already reached crisis point.

## People are prompted to seek support in many different ways

3.13 For young people, it was said that referrals via health or education settings are common; whereas the police are a key referrer for people who are bereaved by suicide. More widely, practitioners highlighted the strength of family and friends' recommendations when it comes to people seeking support.

> *"Sometimes other people have pointed it out to them, so a parent, carer, family, friend… 'You're maybe not as well connected as you could be, and you need that extra support'." (Practitioner – Young People)*

3.14 It was also said that people often seek support for a different concern (usually around housing or finances) which subsequently leads to the identification of suicidal thoughts or ideation.

> *"Something will be an issue and when they start talking to the person, it can then lead to a conversation about being suicidal… Rather than being like Samaritans where as soon as you pick up the call it could be someone trying to take their life..." (Practitioner – Autism)*

3.15 Practitioners said that people with multiple issues impacting their mental health tend to seek more than one type of support. This, they said, has been easier in recent years due to the availability of more targeted support services.

> *"We do have a lot more options now than we used to have before, and some of those options are specific to people's circumstances." (Practitioner – Unemployed)*

3.16 Furthermore, 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 directly how they are. Some practitioners mentioned the importance of specifically asking about suicidal thoughts.

> *"I think the main reason people tell you is because you ask. That's not groundbreaking." (Practitioner - Men)*
>
> *"They've dug themselves such a big hole they don't know what else to do." (Practitioner – Gambling)*

3.17 Branding, visibility, and relatability can play a role in prompting someone to seek support from a particular service: those that have strong branding and both an online and in-person presence within communities tend to see a higher rate of self-referral for example.

3.18 The integration of activities and mental health support can also positively impact on people seeking help, and the relatability of this type of support can again be demonstrated and promoted well through effective branding.

> *"We go out and about a lot… I've been to major colleges, we're at both universities a lot, we go to a lot of different events where we can come in contact with young people and people who work with young people. If they've not seen us online, it's probably because they've seen us in person." (Practitioner – Young People)*
>
> *"The logo is really clever… because it screams out mental health... Then the word 'motorbike' is very curious for a lot of people, and they'll say, 'I identify as a biker, I'm very interested now. Mental health and motorbike, that's me'. That's what will prompt them to come in and try to suss out what this information means, what the offer is." (Practitioner - Men)*

3.19 One early intervention practitioner alluded to the challenges of receiving referrals too complex for the nature of the service, whereas other services that mainly attract self-referrals have had to make significant efforts to embed themselves as a known entity, in order to extend their referral pathways.

> *"What we are trying to do is make sure we embed ourselves within other partnerships and other services within the NHS, so it is part of a referral process that evolves over time. So, people may be struggling with other mental health issues [where] a secondary problem is gambling… Then we can begin to take referrals from… crisis teams, from early intervention teams, from other mental health teams, so it's recognised." (Practitioner – Gambling)*

3.20 Practitioners highlighted some prompts specific to the groups they support. Bereavement services tend to see people seek support because the stigma around suicide makes them feel misunderstood in their grief: they therefore pursue a safe space to discuss their complex feelings without judgement.

> *"Nobody understands them. They're so devastated. A lot of people that come are a little bit older… Perhaps in their 60s, lost their 40-year-old son and don't know where to turn. They've suffered bereavement themselves… but this loss feels so much different. They try and access services and it doesn't really fit what they feel they need because nobody understands them, and they don't feel they can talk to other people who haven't been bereaved by suicide because of the stigma that's attached to it." (Practitioner – Bereavement)*

3.21 Gambling support services recognised shame as a key prompt for seeking support. Positively, it was said that while there has been little support for this issue until recently, debt support services have now adopted a referral pathway for people struggling with gambling addiction and any associated suicidal ideation.

> *"There hasn't, until recently, been anywhere people can go to get help. There has often been a lot of shame there and people get so stuck and feel ashamed and don't know what else to do." (Practitioner – Gambling)*

3.22 One practitioner who works with unemployed people highlighted isolation and vulnerability as reasons why their mental health may decline, prompting them to seek 'formal' support, as their 'informal' support network may have diminished.

> *"[Unemployment] is very negative when it comes to mental health long-term. People lose their drive and motivation, they're more susceptible to anxiety and depression and mental health issues. They lose their confidence. Their world view becomes very limited. They lose their social circle, so the people they used to be there for them when they were in work obviously move on so their support network tends to diminish. What you tend to find is they become much more vulnerable." (Practitioner – Unemployed)*

3.23 Finally, in terms of motivations for seeking support, the autism pathway can be difficult both pre and post diagnosis, which is a significant prompt for people to seek emotional support.

> *"They know something is not quite right… and they're deteriorating. So when people do seek support… they normally are really anxious and mental health is an issue at that point… When people are fine, they won't access a service, but as soon as people aren't well and they struggle… professionals or whoever will tell them to go and use that service or self-refer." (Practitioner – Autism)*

## Most services and groups have some sort of inclusion or exclusion criteria, which can reduce accessibility

3.24 Practitioners acknowledged the general demographic criteria required to access their services: gender, age, and location tend to be the key qualifiers. In terms of the former, one men's support practitioner spoke candidly about the evolving nature of gender identification and the lack of training in place to support a transgender person within their service.

> *"We had a female transitioning person... We've referred them to the specialist LGBTQ+ services because we felt we couldn't offer specialist support around transitioning." (Practitioner - Men)*

3.25 Another practitioner highlighted limited building access for disabled people as an unintended exclusion criterion, which they address by holding events at more accessible locations where possible.

> *"There are lots of stairs, no accessible toilets, no lifts. One of my big priorities is to get an accessible space. Whenever we do groups out in the community, I always try and make sure they are at accessible venues." (Practitioner – Young People)*

3.26 Certain services have particular inclusion criteria: for example, one requires an autism diagnosis to access its support group. This type of criteria also applies to support aimed at certain professions like firefighters.

3.27 The general exclusion criteria for some support services relate to anti-social behaviour: one service exercises caution in supporting those with a history of violence or those who are under the influence of drugs or alcohol, while another has zero tolerance for rude or abusive behaviour toward staff.

> *"If they come in and they have a history of violence… We need to look at how to keep our staff safe. We would still support them, but it would be remote, they wouldn't be able to come in for face-to-face sessions if we felt our staff would be at risk." (Practitioner – Bereavement)*

3.28 Some practitioners noted timing as a key criterion for support: if a person has other issues impacting their mental health or are not prepared to receive the specific type of support on offer, they aim to ensure that person is correctly signposted to a more suitable service.

> *"It would be the discussion with them or with the person referring them as to whether we would be right for now, or whether we're better off further down the line…" (Practitioner – Young People)*
>
> *"It may be that 'This big issue needs to be addressed first'. There are a few people who we've had where we've said, 'This isn't the right placement for them, they're in a mainstream school, there's bullying, this is what's triggering the suicidal ideation or attempt'. They get to move schools, find a provision which fits their needs better..." (Practitioner – Autism)*

3.29 One bereavement charity specifies that anyone who accesses their group support must have been bereaved or impacted by a suicide. This is to ensure people are receiving bereavement support specific to suicide, and that others in the group are assured of that peer support element. This can prove challenging in cases of attempted suicide, where a person has survived and is on life support as a result. Their families are still impacted by this, but the fact that the person is still alive can cause a complication with access to bereavement services.

> *"For us it's those whose loved ones are on life support, because there is nowhere for them to go. We tend to ask the group how they feel, but a lot of survivors feel, 'They've still got their loved one, they're not going through what we're going through' and perhaps the family will dispute that because for all intents and purposes they've lost their loved one." (Practitioner – Bereavement)*

3.30 Practitioners offered assurance that provisions are in place for those who do not meet their criteria, including assessments of needs, 'waiting well' packages, signposting to other services, and transport links to services in the event of physical barriers. It was said that good working relationships with other services locally enables better signposting pathways.

> *"If a child isn't suitable for our service, say they are in that crisis and too complex, we offer a safety call within a certain amount of time with that child or young person. We'll try and contact them as soon as we can for the safety call and the harm minimisation. If we identify they're not right for our service… we do something called a 'waiting well' package… We'll signpost them to the most relevant areas..." (Practitioner - Young People)*

## Lived experience representation and peer support were noted by most practitioners as being beneficial to the people they support

3.31 It was said that relatability, compassion, and empathy are key strengths within the peer support model and that sharing feelings with those who have experienced similar circumstances can lessen perceptions of judgement and stigma.

> *"Hearing other people's experiences helps them feel less alone with it. You also get people that are at different stages of the recovery, and… it gives people hope that things can be different… When people are coming to our service, they are holding a lot of hope and that helps people to feel less suicidal because they have a sense that there's something that can be done here." (Practitioner – Gambling)*

3.32 The benefits of peer support (either from staff with lived experience or others accessing a service) were noted as a significant strength by bereavement support practitioners. It was said that people can have different experiences of suicide bereavement, but that having the opportunity to share those experiences freely and without judgement with others in similar positions can be a comfort.

> *"It's the peer support and breaking the stigma. Knowing they can talk about their suicide loss and the emotions they feel without the risking of offending or shocking somebody, or being judged… Some people won't tell other people how the other person has died… They'll say a road traffic accident or heart attack or something like that." (Practitioner – Bereavement)*

3.33 Practitioners also discussed other types of emotional support that work well within their services, suggesting that people value the opportunity discuss their thoughts and feelings with someone other than their friends and family. This can be done within a group or workshop or in a one-to-one session with a practitioner; and is made possible through positive relationships between practitioners and the people they support.

3.34 Some practitioners credited the ability to correctly and robustly assess people's needs, influencing factors, and risks as the main strength of their service. This, it was said, can help determine the best safety plan for an individual, whether through support from their service or referral to a better suited one. Practitioners' knowledge and understanding of the different groups they support enables better assessments and support for individuals.

> *"I think having that flexibility and knowledge of autism and then linking it up with the knowledge around supporting someone on the suicide prevention pathway is probably what works best. Quite often the young people will be supported by CAMHS, but not a specialist CAMHS service. It's finding that balance between recognising their needs as a young person with autism and their needs as a young person experiencing suicidality and finding something that works to meet both sides of it." (Practitioner – Autism)*

3.35 Practitioners also highlighted the sheer existence of their service and availability of trained, specialist staff as key assets in supporting individuals. In particular, services specifically for men were said to be of great benefit, and more prevalent now that they have been in the past. Adequate and consistent funding was considered a key enabler for this.

> *"I think the biggest impact is just being the presence there. It's just existing. We're getting DMs* [direct messages via social media] *from all over the place because they see us through Google ads, Facebook, or word of mouth." (Practitioner - Men)*

## Partnership buy-in and multidisciplinary working across Nottingham and Nottinghamshire are key areas for improvement

3.36 Some said that a lack of joined up working between statutory and non-statutory services can limit their ability to reach people in need of help.

> *"A limitation is some schools, not working with us… For example, if we get a referral from a school and they say, 'This is high-risk, it needs to be sorted,' then we arrange it as, 'OK, can we come into the school and see this young person?' 'No, you can't take them out for an hour a week in our school time'. It's like, 'OK, but we've got this referral which said it's high-risk, this client has presented with this and you're not working with or alongside us'…" (Practitioner – Young People)*

3.37 Moreover, a few practitioners noted a lack of information sharing across the board, and the impact this has on support pathways. One example of this related to men who are on probation.

> *"One of the other challenges is information sharing… Again, there is very little, what I would call true multidisciplinary working when it comes to managing people on probation..." (Practitioner - Men)*

3.38 Some bereavement practitioners felt there is insufficient police buy-in and suggested that a lack of recognition for support services and a perceived reluctance to refer families after a suspected suicide can prove challenging. One practitioner felt that general awareness and attitudes toward suicide within the police is an area for improvement going forward.

3.39 Some practitioners have found it difficult to fully establish and promote their service locally, limiting their reach within the community. One attributed this to a lack of support and advice from relevant umbrella organisations.

> *"Where is the support out there to set up groups and to do things right, to do it legally, do it by the book? We've had to go on this journey, and do it as we go along…" (Practitioner - Men)*

## Engagement with the people they seek to support was noted as a challenge by some practitioners

3.40 Despite their best efforts, services said they struggle to engage with certain groups depending on geography and demographics like age, gender, ethnicity, and deprivation. Stigma around suicide was thought to be a factor in this lack of engagement.

> *"We do struggle with some young people who won't want to talk to us. It's difficult to do that safety plan with mum or dad… Yes, it can be done but they don't know that young person as [well] as they know themselves." (Practitioner – Young People)*
>
> *"The Asian community is traditionally very hard to connect with. We did have a Punjabi speaking women's group… but there wasn't the need for it and that is largely to do with the cultural aspects around suicide." (Practitioner – Bereavement)*
>
> *"The attendance of one local group has always been very poor… but we're not really sure why that is. Where you have poorer areas, you get more suicides. Deprivation and suicide are absolutely linked." (Practitioner – Bereavement)*

3.41 Some practitioners found that certain groups, such as ex-offenders or gamblers, can struggle to access or engage with services specific to their needs. One practitioner supporting people with a gambling problem noted long waiting lists for community mental health teams as a reason for this. Furthermore, ex-offenders can be reluctant to access NHS-based suicide prevention services, as they may have had negative experiences of the statutory support provided within the criminal justice system.

## Peer support was said to make a positive difference to people and their families

3.42 This type of support works especially well when offered to bereaved people and parents of young people, providing them the opportunity to share experiences with others in similar situations.

> *"The majority of the feedback we get is it's been amazing to have somebody to talk to, somebody to listen, somebody who understands rather than someone who is just telling them what they need to be doing." (Practitioner – Bereavement)*
>
> *"Parents can drop in, ask questions where they might be struggling… It generally eases a lot of worries and concerns, just to be heard…" (Practitioner – Young People)*

3.43 Similarly, practitioners highlighted the impact of lived experience peer support on men, as it provides a sense of hope for those who have experienced suicidality.

> *"The difference we're making is we're showing those people… we've overcome and they're overcoming as well. You can't undermine that. We are living proof that you can do it. 'We've done it, and we're nothing special, we can do it so can you.'" (Practitioner - Men)*

3.44 People tend to seek peer support from 'formal' support services, preferring to speak to people they do not know due to the stigma and shame they feel when discussing suicide with family and friends, and the lack of understanding they often encounter.

> *"A lot of people seem to have a good support network and they're helpful to a certain extent. But they don't quite understand suicide bereavement... Further down the line, people want to seek more group support maybe, so something like Survivors of Bereavement Suicide, SoBS… A peer support group where they can instantly relate to some of these people." (Practitioner - Bereavement)*

3.45 Another positive impact for people and their families is improved quality of life through learning to build and maintain social skills and wellbeing; and to recognise and verbalise their feelings and ask for help when they need it. This was considered especially important for autistic service users.

> *"It's about improving their quality of life, providing the support, knowledge and tools in order for them to be able to have a good quality of life and remain at home in the community. A lot of autistic people, if they don't have that support and are not given the tools they will struggle." (Practitioner – Autism)*

## Services were said to increase the confidence of those supported, and to have wider impacts upon societal attitudes towards suicidality

3.46 Certain services have also seen improved confidence in the people they support and their families.

> *"I think we actually increase confidence, and you can see that through outcome measures... It's not just about supporting that young person to change things and make things better, it's also about increasing the confidence of the people around them to support them in the way they need." (Practitioner – Autism)*

3.47 Positive impacts on people's quality of life and confidence have consequent positive impacts on their mental health and, in some instances, have reduced the risk of crisis. Practitioners said this is most evident when they see a physical change in people's happiness levels; but it can also be demonstrated via improved 'impact of events' (IES-R) scores[1].

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[1] The IES-R is a 22-item self-report measure that assesses subjective distress caused by traumatic events https://www.ptsd.va.gov/professional/assessment/adult-sr/ies-r.asp

> *"I know from conversations… that have been had in the office, we have prevented people taking their own lives. That, for us, is a huge step forward. We all know that statistically you're 60% more likely to take your own life if you know somebody who has taken theirs. We have turned people's lives around, that is for sure." (Practitioner - Bereavement)*

3.48 Furthermore, support services were said to have had wider impacts on attitudes toward suicidality, particularly among men.

> *"It's helping get rid of that stigma of men can't talk about their feelings, they can't open up. I was always brought up to think a man shouldn't cry, and it's getting rid of that." (Practitioner - Men)*

## Practitioners identified several gaps in services for people who have experienced suicidality

3.49 Some practitioners alluded to gaps in both early intervention and long-term support for people experiencing suicidality. Long-term term support was thought to be most needed by people bereaved by suicide and young people; and practitioners identified three groups that would benefit from proactive early intervention: recently unemployed people, people with a gambling problem, and autistic young people.

> *"I'd like to get in there earlier with people and not have to wait until crisis… Working with schools to identify those really early signs as well; schools get to know young people really well." (Practitioner – Gambling)*
>
> *"When people first come into the job centre, they're fairly certain they're going to get another job. Their confidence is fairly… Then, when they get to know the system more and they have to jump through all of these hoops and they look at all the bureaucracy that's involved in everything, things tend to go down a little bit." (Practitioner – Unemployed)*

3.50 One practitioner noted that some (non- suicide/self-harm specific) services can be reluctant to support children and young people with their suicidality, and that there tends to be a great deal of wariness and a lack of confidence around providing this type of support to young people whose needs they consider to be '*too complex*'. Support for autistic people with mental ill-health was also said to be lacking both in general, and especially for those in crisis.

> *"[The referral] flags up that this child or young person has suicidal ideation or self-harm behaviours. When we see that, sometimes practitioners say, 'Oh, well I don't feel comfortable working with that'. They're a bit wary… I think that's where we're lacking in services, when some services see that young person and they worry, they panic and think they won't be able to help them, so they pass them onto someone else." (Practitioner – Young People)*

> *"Obviously you can have a mental health condition and neurodiverse condition, and it is much more difficult to find support in that area. It tends to be more mainstream. There are a number of charities and organisations locally that people can tap into, if they are neurodiverse, that will offer a degree of support. But for crisis groups, you always tend to go for neurotypical groups rather than neurodiverse because that's the service that's offered." (Practitioner – Unemployed)*

3.51 More specifically, one practitioner identified gaps in support for current and ex-offenders who are risk of suicidality, domestic violence perpetrators and perpetrators of other violence in particular.

> *"There's a couple of groups that I think sometimes miss out a little… The first of which is domestic violence perpetrators… The emerging evidence is very strong [that] they're higher risk than victims of domestic violence… What can happen is that… people who are violent can struggle to have access to services because of the risk of that they might pose to others. So, they may be expressing suicidality and are not believed..." (Practitioner – Men)*

3.52 A couple of practitioners highlighted some inconsistencies that are causing gaps in services and support. According to one bereavement practitioner, death by suicide records are incomplete in terms of demographics, which impacts the way services target support and messaging. Another observed that there is inconsistent support for suicidality locally particularly highlighting the difference between service provision for men in Derbyshire and Nottinghamshire/Nottingham.

> *"We need to be able to support everybody. Especially where we're talking about same sex relationships, it's a massive problem in the LGBTQ+ [community]. Transgender people have very high suicide rates. Supposedly, this would be anecdotal because it's not recorded, the same with sexuality, not recorded. Status as a veteran is also not recorded on the death certificate so ONS don't collect the data." (Practitioner - Bereavement)*
>
> *"I think there's a real issue with the postcode lottery. Some services and areas are much better than others. For example, I think in Derbyshire there are some really good groups where people are getting support..." (Practitioner - Men)*

3.53 Concerns around capacity, waiting times, and limited funding were also highlighted by most practitioners as contributing to gaps in support services. Across all service types, these three factors were said to prevent people from accessing the support they need.

> *"[Services] are suffering with a lot of waiting lists… I suspect they don't have enough staff, which probably means they don't have enough money…" (Practitioner - Bereavement)*
>
> *"We have a lot of services out there… to deal with mental health crisis, but they're either very difficult to access or their services are so overused that they're almost impossible to get through to... Massively oversubscribed." (Practitioner – Unemployed)*

3.54 Related to this, a specific gap was said to exist around training and support for practitioners, particularly in ensuring they are equipped to support autistic people with their suicidality to the same level and quality as anyone else. It was also said that practitioners would benefit from trauma informed therapy training to better support people generally, and bereaved people especially. Furthermore, training opportunities are only effective when staff want to engage, which is apparently not always the case.

> *"For the majority of clients, what they've just experienced impacts them quite heavily. We really feel they would benefit from trauma therapy afterwards. Some of our team are qualified to deliver that already. It's having the funding to do so." (Practitioner - Bereavement)*

3.55 This gap was not thought to be limited to support service practitioners; some felt that the emergency services should also be trained in suicide bereavement support.

> *"Other support services need educating better in how to support people in these circumstances. Police for a start, they're usually the first call, or the ambulance service. But to make it cold and clinical; 'I'll take the body down'… it's that sort of approach which needs to change, and that's why there needs to be better education." (Practitioner - Bereavement)*

3.56 National economic and capacity concerns could be partly to blame for some of the gaps listed by practitioners. Indeed, it was said that limited capacity and reliance on volunteers can impact a service's ability to offer quality support to all that need it, and that further investment into key services could relieve capacity concerns and allow more people to access essential services. One practitioner stressed the importance of this in relation to changes in post-diagnosis services for autistic people.

> *"The post-diagnostic support offer for autism is lacking, and that's just because they're having to focus all their resource and efforts on… getting people assessed. That's the only element of the service I would say is not working well, and I think that is going to require some big changes and additional investment into the services and the pathway to be able to provide that, because they just can't cope with the amount of activity that is coming through." (Practitioner – Men)*

## Practitioners also identified gaps in services for people who have been bereaved by suicide

3.57 Practitioners were of the view that suicide bereavement is a big risk, suggesting that the impacts are underestimated, and that there is insufficient support available to reach everyone involved.

> *"135 people are affected by each and every suicide. Have a guess at how many people are actually referred per suicide? Two… There's a real issue. If you also look at the facts and figures… 6% of people who have been bereaved by suicide… will go on to try and take their own life. From every suicide death, you get around about 10 more attempted suicides if you don't get something in place to support these people. We're supporting two out of 135 maybe." (Practitioner - Bereavement)*

3.58 Practitioners described a particular gap in bereavement support for young people, who can sometimes experience an element of bullying that is unique to them in this context.

> *"I've heard young people say their dad or the mum might have taken their life and they go into school and they're being bullied for it. 'Even your dad doesn't want to be around you', those kinds of things… I think the space to actually hold that community is so needed, but not there." (Practitioner - Young People)*

3.59 One practitioner also alluded to a sense of 'othering' from services for young people bereavement support.

> *"I think there needs to be better joint working. Quite often it's 'who's carrying the risk here?', and a lot of services are happy to park the risk in the other services and say that that's their responsibility." (Practitioner – Gambling)*

3.60 Some specialist practitioners highlighted gaps in service provision for autistic people who have been bereaved by suicide. It was said that services need to ensure services are equipped to work with autistic people; and also to support the bereaved families of autistic people, who have often spent many years caring for the deceased.

> *"I think the approaches for people with autism are really important… Particularly for people with autism who have a very different take on life and circumstances. Our volunteers have difficulty supporting people with autism." (Practitioner - Bereavement)*

## Stigma acts as one of the main barriers to people talking about their suicidality and seeking support

3.61 Practitioners discussed the barriers to seeking support experienced by those they work with and were in agreement that stigma is the main barrier for many people. Due to stigma, people do not want their family and friends to know that they are having suicidal thoughts. There is also stigma around certain contributing factors within people's suicidality. For example, one practitioner mentioned male domestic abuse victims and the stigma that is attached to this when speaking out.

> *"Stigma, and family not knowing. We do have a bit on our referral form where we say, 'If this needs to be kept private… tick this box' so that flag comes up that they don't want it shared with anyone." (Practitioner – Young People)*
>
> *"The biggest one I've got is the domestic violence side of mental health. We have quite a lot of men who won't come forward and speak about mental health because of domestic violence." (Practitioner - Men)*

3.62 Young people tend to seek external support through teachers or online support platforms (like Headspace on YouTube), as they want to conceal their suicidality from their parents for fear of upsetting them or getting into trouble.

> *"I find a lot of young people prefer to turn to teachers... nine out of ten of the safety calls I do with young people, when I ask them 'who are your top three support networks?', sometimes mum or dad won't even be in there, it will be teachers, because it's external. I think with parents it is the instant turn to anger when they talk about having those feelings, instead of the compassion that should be shown or the understanding." (Practitioner – Young People)*

3.63 Another key barrier to accessing support relates to trust in services, as well as stigma around accessing services. This was said to be most prevalent for people with a gambling problem, men, and young people. Turbulent experiences of accessing support as a child were said to particularly impact a person's trust in services as they enter young adulthood, or the stigma they perceived around receiving services.

3.64 It was also said that societal stigma has created some misconceptions around suicidality and seeking support. For example, there are some myths around what it means to have suicidal ideation that can impact an individual's perception of whether they have it. One practitioner also noted the common misconception that in order for someone to be suicidal, they must have depression. Similarly, there is a lack of awareness around degree of intent and other aspects of suicidality that can impede people's self-awareness.

> *"One of the other big barriers is around myths that people have. If you've asked them if they're suicidal and they say no even though there are flags… Somebody is clearly in a very bad space. It opens the door if they say yes but doesn't close the door if they say no… Giving them a depression questionnaire, like that's somehow akin to being suicidal. You don't have to be depressed… Or if they say they haven't got a plan, so it's not imminent. There are all these myths about how you respond to these things." (Practitioner - Men)*

3.65 Furthermore, some people have misconceptions around eligibility and what support services can offer. For example, support for bereavement by suicide is often thought to only be available to direct relations of the deceased.

> *"Sometimes they feel like they can't access the support because they're not a direct relation to the person that has died, they're a work colleague or something like that. There may be disfranchised grief almost where they believe their grief isn't as important as the family of the person who has died." (Practitioner - Bereavement)*

3.66 A lack of awareness of support service provision among statutory services (like GPs, the police, ambulance services, and the coroner's office) was thought to result in no or incorrect referrals: a key barrier to accessing the right support. Practitioners considered it a risk that those who are referred into the 'wrong' service are deterred by poor experiences from accessing other types of support in future.

> *"There are a lot of people that report being in the wrong service and being told they now can't access that service until they deal with another service... The system is quite poor… at managing that because there isn't a clear pathway around suicidality, it's not very clear what you do with somebody so they can stay where they are and get additional support. It doesn't quite work like that." (Practitioner - Men)*

3.67 Practitioners also reported being told by service users that GP's often seem "*disinterested*' in supporting a patient's mental health, or "*absolutely useless in listening to them*."

3.68 Practitioners also noted barriers around access and engagement with services. Timing can be important to people when seeking support, and the lengthy and complex application process for some services can act as a deterrent. Conversely, it can be difficult for services to engage with certain groups. Practitioners found that young people, autistic people, and men tend to especially struggle when discussing their experiences of suicidality.

> *"Our organisation has done research into men and how they access support. I think it's pretty much a national issue with men accessing services." (Practitioner - Bereavement)*

> *"Sometimes the young person really doesn't want to engage with us, so that can be a little bit difficult. We've found that since COVID, that's been a really big issue and engagement with young people in general has gone down." (Practitioner – Autism)*

3.69 It was also said that despite practitioners' best efforts, not every person is ready or able to benefit from the support that is offered to them, particularly when it comes to bereavement.

> *"You don't want to disappoint people... We'd love to be able to support everyone exactly how they need to be supported and everyone improves spectacularly all the time, but it just doesn't work that way sometimes." (Practitioner – Bereavement)*

3.70 Some bereavement specialists found that support for autistic people can be more fractured if communication involves a carer or family member. It was also said that services should avoid making assumptions around an autistic persons' needs when assessing support.

> *"The main thing we hear about is services seeing that somebody is autistic and then automatically assuming they need to go to a specialist service for support, and they can't accept and provide the support required to them." (Practitioner – Autism)*

3.71 Finally, there are some physical barriers that can prevent people accessing the support they need, such as transport, finances, and a lack of IT infrastructure meaning they cannot attend virtual meetings. The latter is a particular issue in rural areas with poor broadband connections.

## Practitioners suggested different types of support that would further improve outcomes for the people they work with

3.72 In order to overcome access barriers, practitioners felt there should be more open access support for people in need, and more information around how to access available support services, preferably via a single point of contact. Quicker access to the right support was also considered key.

> *"Definitely more immediate support... If I'm in mental health crisis and my GP says, 'I'm going to put you on a waiting list for CBT and I believe that this will really help you' but the waiting list is 12 months long, that's not helping me." (Practitioner – Unemployed)*

3.73 The complexity of suicide bereavement was said to impact a persons' suicidality over time. It was thus suggested that bereavement support should reflect this journey and offer follow-ups by checking on a person's wellbeing over time.

> *"After the funeral, it's like this void... People feel a real loss after that hustle and bustle of arranging a funeral, and the million jobs that come from losing somebody. They almost need some follow-up, or picking up with these people a few weeks, few months, the year afterwards. What has changed? What support?" (Practitioner - Men)*

3.74 Some practitioners recognised the benefits of community support in helping to reduce isolation and reach people before crisis point. Indeed, building support through family, friends, social groups and activities can create a reliable network around an individual to supplement more formal support services. A few practitioners suggested crisis cafés as a good way to offer more community support.

> *"It's literally finding something that person can link into… Finding that one thing that allows that man or woman to open up in the first place. It could be the football club or the rugby club if it's got a social gathering… That's what we're finding; by training people in mental health, they're looking at ways they can use that in different environments. It's just more awareness of how you can support somebody." (Practitioner - Men)*
>
> *"The idea of crisis cafes and community groups, opening for set amounts each evening… Where you can go and have a hot drink and some toast and just speak to a support worker and it's open in the community." (Practitioner - Men)*

3.75 Training and education around suicidality were considered key to improving available support. Practitioners suggested more and better mental health training for workplaces, and more public education around suicide prevention and *"early warning signs"* (Practitioner – Autism).

> *"What we find now it's more of a tick box in the workplace, but what actually is happening with that mental health first aid? What are they doing with it? Is it working? Is it being analysed so it works? If it doesn't, what are they doing about that?" (Practitioner - Men)*

3.76 Under the wider theme of education was discussion around language relating to suicidality. A couple of practitioners felt that more open and honest discussions could reduce stigma and increase help seeking behaviour. It was also said that young people's services should aim to use more specific language that resonates with younger generations.

> *"We need to talk about suicidal ideation, suicide as a whole, almost saying the word to take that stigma away… It needs to be explored properly." (Practitioner – Young people)*

3.77 Practitioners recognised the importance of multi-agency working to improve outcomes, suggesting that there should be a shared responsibility for suicide prevention and support across services to reduce the 'othering' that is currently impacting their ability to provide the best support. Once again, it was suggested that a single point of contact would be beneficial in this respect. Also, while some practitioners work closely with other support services to signpost and refer where appropriate, a few practitioners felt that there could be more awareness of other charities and services and potentially more tandem working across services in the region.

> *"A multi-agency service that could co-ordinate police, GP, mental health crisis, all of that… Because quite often it comes down to the individual to do that. If there was something… where there would be a point of contact we would be able to get in touch with, we express our concerns, tell them what we know, pass over all the details. Something or someone that would co-ordinate it all." (Practitioner – Unemployed)*
>
> *"We don't really know about them [local support services]. We should know more about them, but we don't. I would say they say the same thing about us... I don't think we know as much as we should do about what else is out there." (Practitioner – Autism)*

# 4. Listening to people bereaved by suicide

## Findings from interviews with people bereaved by suicide

### Summary of evidence and insights

The main contributing factors to, or influences on, the suicidality of participants' loved ones were physical health issues and medication, past trauma, and relationship issues.

Most had sought support, commonly from healthcare providers like GPs and hospital-based mental health services. Key concerns were around premature hospital discharges, and healthcare providers not taking sufficient account of patients' medical histories.

The main barriers to people seeking support were not wanting or 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 is the key requirement of those who reach out for support.

Practically, there is a need for long-term therapy; information and education (for example around available support, and the risks of medication); more expert mental health support within primary care; peer support; safety plans for all who need them; and tailored support for neurodiverse people. Practitioners also need to pay more attention of the views and experience of the patient's family, friends, and others that are closest to them.

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 participants 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 more mixed around interactions with, for example, local healthcare trusts and schools.

Most participants had sought or accessed some form of support, 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 to seeking or 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.

# Full overview of findings

## Most participants were aware that their loved one was struggling prior to their death

4.1 Some participants' loved ones had experienced mental health issues and suicidal ideation for many years prior to their death, explicitly and repeatedly expressing a desire or intent to take their own lives. A few had previously attempted to do so, more than once in a couple of cases.

4.2 Others had undergone what were described as behavioural or personality changes: they were simply 'different.' However, in these instances, the changes were mild enough, initially at least, to not cause significant concern.

> *"… [They were] generally quite buoyant, bubbly and relatively laid back… After uni, we noticed [they were] different… much more serious and intense about life. [They were] also occasionally, in a way we hadn't seen before, quite deeply emotional… It wasn't overwhelmingly worrying at the time; it was just a bit odd… We didn't think [they were] unwell…" (Bereaved by suicide)*

4.3 One participant described how their child had begun to self-harm in the months leading up to their death. The participant had not been too concerned about this, as they perceived it as somewhat 'normal' behaviour amongst teenagers. Indeed, having discussed the issue with fellow parents, they had concluded that it was a widespread issue and not one to be overly worried about given *"they just all seem to be self-harming and no one else had taken their own life."* With the benefit of hindsight, they wished they had better understood the links between self-harm and suicide.

4.4 A common theme among several participants was that in the weeks or months leading up to their loved one's death, their mental health seemed to improve. This gave participants hope and exacerbated their disbelief when their loved one died by suicide.

> *"I felt that things were really coming together… [They were] happy, on a good path, talking about plans... I thought 'Great, [they'll] get there, [they're] alright'… And [they] always said [they were] fine…" (Bereaved by Suicide)*

4.5 In all circumstances, and no matter how aware participants were of their loved ones' distress and previous suicide attempts, their death came as an enormous shock. Several said that in hindsight they wished they had better recognised the signs of what was to come.

> *"Those little things… Nowadays I would think, 'Right, this is a cry for help'… But [they] hadn't voiced anything about suicide…" (Bereaved by suicide)*

## There are several common contributing factors to, or influences on, suicidality

4.6 Health issues were considered one of the most common triggers for suicidality. Participants described how their loved ones had variously suffered long-term chronic pain, memory loss (leading them to fear they were developing dementia), hormonal imbalances leading to very painful periods and extreme mood swings, autoimmune conditions, and the after-effects of recent surgeries or medical procedures. A feeling of '*not wanting to be a burden'* was thought to have arisen as a result for several of them.

4.7 For a few participants, their loved ones' mental health issues had been exacerbated by the medication they had been prescribed to treat their physical conditions. In one instance, a participant felt that their child had been given a combination of treatments that had significantly worsened their mental health.

They were also surprised and concerned that the doctor had not talked them through the possible side-effects of the medication and what they could do to mitigate against them.

> *"Pretty much as soon as [they] started them [they] got [bad side effects] … Things definitely weren't right… My feeling is that putting [them] on those two things at once with no support, no information, me not aware… [They] reacted to that medicine hugely…" (Bereaved by suicide)*

4.8 Another participant felt they should have been better informed about the potential side effects of the pain medication their parent had been prescribed; and a third described how their child, who was prescribed depression and psychosis medication, had become a *"different person"* while taking it, seemingly completely disassociated from their feelings. However, when their medication was eventually reduced and these feelings returned, so too did their suicidal thoughts.

> *"I just thought [they] might feel a bit more tired or a bit low. I didn't know you could get all these side effects... Stupidly from my point of view, I should have whipped [them] into the GP straight away... I didn't know it could increase suicidal thoughts." (Bereaved by suicide)*

4.9 Past trauma was also considered an important and frequent factor in suicidality. Participants described homelessness, alcoholism, childhood abuse, and severe past bullying as having had a long-lasting and significant impact on their loved ones' mental health.

> *"[They'd] been bullied as a child… There was that traumatic stress thing that was probably never addressed, and that was still there underneath which gave [them] a feeling of insecurity and that people were against [them]…" (Bereaved by suicide)*

4.10 A couple of participants also highlighted that their loved ones' own parents had either attempted or completed suicide, the trauma of which had never gone and had likely contributed to their own suicidality.

4.11 Several participants highlighted marital issues and traumatic break-ups as a catalyst for their loved one's mental health issues. Moreover, one participant had struggled with suicidal ideation themselves for many years and felt that this had triggered their partner's own mental health issues and eventual death by suicide.

4.12 Other less frequent (but still commonly stated) contributing factors and triggers were family bereavement, substance use (alcohol or drugs), and financial troubles.

> *"… [They were] a functioning alcoholic… Alcohol was [their] worst enemy… They then ended up going into one of the lowest paid jobs… Got in so much debt …" (Bereaved by suicide)*

4.13 It was also said that some of those who had completed suicide hid their pain behind a mask of joviality, which led to the internalisation of that pain and an inability to talk to anyone about it. This, it was felt, had contributed to their suicide.

> *"… [They] lit up the room… People loved [them]... That was probably part of the problem, people didn't realise where [they were] inside… That surface humour and everything was part of [their]downfall… because it masked too much from everyone else." (Bereaved by suicide)*

4.14 Finally, those who had died by suicide during the Covid-19 pandemic had, it was felt, been considerably impacted by lockdown. Some had been adversely affected by the enforced isolation from friends and family, while for others that isolation had enabled them to withdraw into themselves even further.

> *"Contact with other people, apart from us, was minimal… [They were] withdrawing from everyone so [they] didn't really reach out to make contact..." (Bereaved by Suicide)*

## Participants' loved ones sought support from several sources

4.15 Most participants' loved ones had sought support prior to their death, most commonly from healthcare providers like GPs and mental health services (i.e., mental health teams).

4.16 In a few instances, participants felt that their loved ones had been incorrectly discharged from hospital because they knew how to 'play the game' and healthcare providers had not sufficiently examined their history or taken heed of the family's views. For example:

» One participant's parent had been admitted to hospital several times and was *"… able to answer the questions in the way [they] knew they wanted…"* On one occasion they were very poorly in hospital following an overdose, and the participant explicitly asked staff to consider their medical history and not discharge them. They did so two days later, recommending ways to proactively find mental health support. The participant was of the view that her parent would not have died by suicide had there been a holistic needs assessment done, and a care plan including psychological support put in place

> *"… [They] needed professional help, and they needed to look at [their] history, not [their] frame of mind. It was just, 'Right, you need to attend such and such group,' or 'You need to put this in place' but then that was all down to my [parent] to access this stuff… Their thing was, 'It's got to be down to that individual to want to get the help', but I'm thinking, 'Would you not say that [they're] crying for help every time [they've] gone into hospital and attempted to do these things?" (Bereaved by suicide)*

» One participant had helped their loved one access support from the mental health team at their local hospital who, despite being explicitly told by the patient that they wanted to die, discharged them as no risk. The participant then rang social services and other potential sources of support, and again received little help or advice other than to *"Get my paperwork in order so that I wasn't liable when [they] did it."* Shortly after, their loved one died by suicide.

» Another participant's concern for their spouse led them to call their local mental health crisis team after they had left the house with a significant amount of alcohol and medication. They were eventually found and detained at a local mental health unit for assessment, whereby the participant asked the assessor to ring them due to her spouse's history of manipulative behaviour and the tactics they might use to be released. This call was never made, they were released without the participant being informed, and died by suicide the next day.

> *"I was furious … I think the opportunity to save [them] was lost… They were released because [they said] it was all fine: 'I'm not suicidal. I'm planning for the future. I've got a safety plan. Let me out', and they did, without really assessing [them] properly. They basically took [it] at face value without the background because they didn't speak to me… I just don't think they explored enough beneath what they were hearing..."*
> *(Bereaved by suicide)*

4.17 Similarly, one participant recounted their child's experience with their GP, who they felt had not probed enough into their experiences, which would have revealed a history of self-harm and suicidality and contributory factors like poor physical health, relationship issues, and a traumatic family bereavement. A holistic consideration of needs could, the participant felt, have led to recommendations for appropriate support; instead, their child was quickly diagnosed with depression, prescribed medication, and *"… sent away with no information… No knowledge of side effects and risks, or what they should be doing or looking out for...".*

4.18 A couple of participants' loved ones had attended Accident & Emergency (A&E), which was not considered appropriate for those with mental health issues, and especially those in crisis, due to a lack of specialist mental health knowledge among staff. Moreover, one participant's loved one was autistic and struggled with sensory overload in the A&E environment, which was addressed by staff.

> *"We were able to go in a private room while waiting for A&E because he was not coping with the lights and the noises and other people. I think when you make something accessible especially for people with neurodivergences, it becomes more accessible for everybody." (Bereaved by suicide)*

4.19 Other sources of support accessed by participants' loved ones were family and friends, organisations like Mind, and private therapists and counsellors. This was sometimes engaged with participants' knowledge, but sometimes not; and similarly, some said their loved ones had disengaged with support without their knowledge in the period leading to their death.

> *"When [they] said to me that [they] had attempted suicide, I said, 'Have you spoken to your therapist about it', and [they] said [they] hadn't had a session in a while… I had no idea at the time that had stopped..." (Bereaved by suicide)*

## There are many barriers to seeking support with suicidality

4.20 A few participants' loved ones had not sought any support prior to their death, and the most common barrier to doing so was that they simply did not want it or feel that they needed it. This was especially the case for older people who may have been raised to not talk about mental health issues, and for 'larger than life' personalities who felt the need to hide their personal sadness to protect their public persona.

> *"What wasn't helpful for [them] was everybody treating [them] like [they were] the life and soul of the party. When you're that person, you can't have problems…" (Bereaved by suicide)*

4.21 Related to this is the issue of stigma around mental health and suicidality. Several participants said that their loved ones had been deterred from seeking support for fear of being stigmatised, and/or seen as weak or a failure.

> *"It was a stigma; [they] had a terrible shame about being labelled mentally ill... [They] didn't want anybody to know. [They] said if we had told [their] grandparents… [They] wouldn't be able to go and see them…" (Bereaved by suicide)*

4.22 Poor past experiences (with 'life' in general and with support services) also served as a deterrent to some participants' loved ones. One person in particular had agreed they needed help but did not believe they would receive it from any source. This, the participant felt, was largely due to living a largely isolated life and having *"no association between other people, and that being good...".*

4.23 Another important barrier is not knowing where to go for support, especially if it is not proactively offered or signposted to by, say, GPs or the police. Furthermore, there was said to still be worry among those who disclose feelings of suicidality that they will be taken away by the police and 'locked away.'

## Participants made several suggestions around the support their loved one needed

4.24 At a fundamental level, being and feeling listened to was thought to be the key requirement of those who reached out for support prior to their death.

> *"I think not feeling heard was a really big one, because [they] straight up said before we went to hospital, 'I'll come for you, but they don't care'... Just a dismissive attitude... From [their] point of view, [they're] like, 'I've gone in, I've told them explicitly that I want to die, and they've told me to go home again. So that's the decision, that I should go home and die.'" (Bereaved by Suicide)*

4.25 On a practical level, participants variously described a need for:

» Therapy, especially on a long-term basis, to help their loved ones work through past traumas and the ongoing factors contributing to their mental health issues and suicidal ideation.

> *"Six or eight sessions of talking to someone is not enough for someone who's got a lifetime of stuff to get off their chest..." (Bereaved by suicide)*

» More information and education around, for example, the support available locally and beyond (including waiting times and what could be put in place in the meantime); the risks and side-effects of medication; and, for friends and family, the signs to look out for in relation to self-harm and suicidal ideation.

> *"… Their friends could have spotted the signs… Also, if schools offered parent meetings on self-harm and suicidal ideation… It's like giving the wider community the knowledge and the information, and it not being stigmatized and hidden… People could spot those that are struggling more and are more vulnerable." (Bereaved by suicide)*

» More expert mental health support within primary care. Positively, one participant was aware of mental health occupational therapists based within some GP surgeries offering longer 30-minute appointments to those wishing to discuss their mental health, which they considered an important development.

» Peer support, so that those who are feeling suicidal can talk openly and without fear of judgement to someone with lived experience of surviving what they are experiencing, offering hope for recovery.

> *“It's about being able to say to somebody the things that you want to say about suicide… that they will get because they have been you, they have lived through that... It won’t be judgmental, because it’s lived experience… You know you can say anything at all.” (Bereaved by suicide)*

- A ‘befriending’ service, similar to one provided by a participant in their role as a community leader.

> *“I had [someone] ring yesterday... [A family member] had just died [by suicide]. [They] needed someone to talk to. I knew full well that there's nowhere that [they] can get that immediately… So we talked for an hour…” (Bereaved by suicide)*

- A safety plan for all of those found to be self-harming or experiencing suicidal ideation.

4.26 The participant whose child suffered significant side-effects from medication prescribed by their GP (paragraph 4.7) was strongly of the view that they should have been given a range of treatment/support options and time to think about which would be most appropriate, or at least some age-appropriate information about the risks and side-effects of anti-depressant medication. Such information would, it was felt, have not only have benefited their child, but could in future benefit all young adults who are prescribed medication for their mental health issues.

4.27 For one participant, whose loved one was autistic, there was a strong need for tailored support for neurodiverse people. Autism-informed inpatient care was said to be lacking, with autistic patients being placed in *“loud and intrusive”* places that are inappropriate to their needs (the Soteria Network[2] was proposed as an alternative). Alternatively, they are apparently told that because there are no appropriate inpatient settings available, they are ‘*better off at home’* – which is rarely the case when inpatient admission is being considered.

4.28 When asked about the help their loved one needed, several participants reflected on what they themselves could have done to better support them with the benefit of hindsight. This included not taking at face value that they were ‘fine’ when they said they were, and simply just being there for them more.

> *“I think if I was a bit more forceful, just as in being there more even if it was in silence. If [they] felt a bit down, [they] didn’t want you there. It was, ‘I’m a bit tired now, can you go?’ I think now I’d be like, ‘No I’m alright, I’ll just watch a movie’ and just sit there... I was very much if [they] said for me to go, I’d just go...” (Bereaved by suicide)*

4.29 There was also a strong sense 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, especially if the patient is at risk of harm to themselves. Indeed, there was some sense that practitioners often ‘*hide behind’* confidentiality despite the fact that Mental Health Act guidance permits them to speak to a patient’s family when necessary. One participant described how their loved one had always been happy for their family to consulted, but that despite knowing and understanding this, those involved in their care had never initiated contact.

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[2] A network that promotes the development of drug-free and minimum medication therapeutic environments for people experiencing ‘psychosis’ or extreme states.

> *"The initiative always came from me to talk to the home treatment team, to talk to the specialist. They would listen to me but would never initiate it and approach me and say, 'Let's work together on this'…" (Bereaved by suicide)*

4.30 The same participant noted a system at a hospital in another part of the country, whereby a week after inpatient admission of a mental health patient, a family liaison officer contacts the patient's family to see whether they want to discuss or highlight anything in relation to their condition or care. This, they felt, should be common practice.

## The bereavement journey is long-lasting and complex

4.31 When asked how their bereavement affected them in the days after their loss, most participants described feelings of shock, disbelief, denial, and confusion.

> *"... It was very much 'It's a mistake'… I thought [they] had been in a car accident or something... I slowly asked questions and found out that [they] had done it on purpose. The shock, it's like it's physical… Like someone is stabbing you with a knife and they're just twisting it and twisting it the more you find out…" (Bereaved by suicide)*

4.32 Once the shock wore off, participants tended to feel numb for a considerable period, going through the motions of life while feeling nothing.

> *"I suppose it was just really very numb. The feeling of nothingness… You just float around doing nothing. Time is just passing. You're forever making cups of tea, but it just goes cold on the side... I didn't want to see anyone, I couldn't look at anyone, I didn't want to talk to anyone." (Bereaved by suicide)*

4.33 The exception to this was those whose role within their family meant they felt the need to be strong for others, and to take the lead in organising the funeral for example. This, they said, led to them not processing their own grief for a long time.

4.34 For some, numbness was followed by anxiety and depression, and in a couple of cases panic attacks and flashbacks as they had built up an image of the suicide in their minds. One participant described the protracted nature of their flashbacks as a result of having to attend the inquest 12 months after the suicide.

> *"I had to read the reports, I had to look at the drawings, I had to look at the timelines. I built a video of it in my head… even though I wasn't there. I had a lot of panic attacks and flashbacks and stuff... I couldn't sit alone with my thoughts for long, because that video that I invented would just start playing again. I didn't really know how to cope with it…" (Bereaved by suicide)*

4.35 A couple of participants said they experienced a degree of relief among the myriad of other emotions, one due to the extreme unhappiness they had felt in their relationship with the deceased in the lead up to their death; and the other because their loved one had suffered with mental ill-health and suicidal ideation for so long and was no longer in pain.

4.36 Another couple of participants said they were unsure as to how they should feel given their relationship with their loved one. The first was the deceased's support worker, but also the person who was closest to them in the period leading up to their death. They highlighted that while there is bereavement support available to relatives and friends; "*There's no information on how impacted I was supposed to be about a work client…"*. The second was an ex-partner of the deceased, but still in close contact with them on a regular basis and was thus uncertain as to how they should feel and what they were entitled to in terms of support.

> *"I was never quite sure of my rights in any of this, all because of a label and, 'Was I in a relationship with him or not?' That really defines what you're entitled to and what you're not..." (Bereaved by suicide)*

4.37 With time, some said they drew strength from their experience, which ignited in them a strong desire to support other people through similar situations. They described this as a positive type of grief, and one that continues to help them navigate their way through their bereavement journey.

> *"What's been therapeutic for me has been helping other people … I try to think there's got to be something good that comes out of it for somebody..." (Bereaved by suicide)*

## Bereavement from suicide different is different to other types of bereavement

4.38 Participants universally agreed that suicide bereavement is complex and very different to other types of bereavement, not least as its grief consists of so many different emotions.

> *"…Anger crept in … Mixed up with sadness, pain, and feeling sorry for [them], and wishing I could've been there for [them], missing [them]... It went in circles. It was like a constant supply of numbness, where I felt nothing… Then would come sadness, then would come anger. Then would come regret, and guilt. It would just swirl. It just changed all the time." (Bereaved by suicide)*

4.39 As the quotation above suggests, the grief of those bereaved by suicide is often tinged with anger and resentment toward the deceased. Guilt and regret are other prevalent feelings described by participants, fuelled by a sense of 'what ifs?' and a feeling that they had somehow failed their loved one by not being able to save them.

> *"Grieving from suicide is so different because we look for someone to blame… When someone dies of cancer, cancer is to blame. But because it's so unexpected and it feels so out of the order of things and it feels like this person should still be here, people look for a reason and that reason often is the person…" (Bereaved by suicide)*
>
> *"You play over and over and over in your head, what could you have done differently? What should you have spotted? ... What was in [their] head for [them] to feel that low? [They] couldn't wait a couple of hours to talk to me?" (Bereaved by suicide)*

4.40 Related to guilt and regret is the constant searching for answers as to why the individual chose to end their life, as well as having to come to terms with that decision. Indeed, not being able to find those answers was said to mean many of people bereaved by suicide never find complete closure or resolution.

> *"It is such a shock, and it's so bewildering. You can't believe this person is not there and that they've done this thing… With an accident it's not their fault, they haven't chosen it. But when they've chosen to do that, it's hard to get your head around it..." (Bereaved by suicide)*

4.41 Other people's reaction to death by suicide was thought to be different to their reaction to other types of death. Participants felt that stigma still exists around suicide and described others' reactions as either '*not knowing what to say*' or inappropriate in calling their loved ones '*selfish*' and, in a religious context, '*damned*.' Moreover, a few participants said that they themselves were initially reluctant to discuss the way in which their loved one had died for fear of how people would react, and because they felt a sense of shame that that they had chosen to leave them.

> *"I didn't want to tell anybody that's what had happened. If anyone said, 'We're sorry about [your] loss,' I wouldn't say that it was suicide,' because… I felt embarrassed that the person that's meant to be in your life and love you forever had chosen to leave me…' (Bereaved by suicide)*

4.42 Other notable differences between suicide bereavement and bereavement through illness (for example) is the inability to be with and comfort the person as they pass; and the prolonged nature of the grieving process through having to wait often many months for an inquest.

> *"You've got an inquest to go to however many months or years down the road and that is not normal. Normally when the funeral is done, it's a line. But when you have a suicide and you know there's an inquest coming down the road, there's always that waiting." (Bereaved by suicide)*

## Most participants had contact with several services or agencies after their bereavement

### The police

4.43 Most commonly, participants had contact with the police in the immediate aftermath of their loved one's suicide. The officers they dealt with were generally praised for their sensitivity and empathy.

> *"… I was very impressed… With the way they spoke, and the way they considered us. They gave us their card, so we could personally get in touch with them." (Bereaved by suicide)*

### The mortuary

4.44 Following their initial interaction with the police, several participants then had to attend the mortuary to identify their loved one's body. Again, despite it being a traumatic experience, mortuary staff were praised for their compassion and understanding.

> *"They were extremely good… I went every day for three weeks... It was never too much trouble if I wanted to go in… And the same with the funeral directors... They were brilliant in letting me come in and sit with [them]." (Bereaved by suicide)*

4.45 Another participant, though, was prevented from entering the room where their loved one was, which they found difficult as they had anticipated being able to hug them and say goodbye. Whilst this had been in the participant's best interests this was something that they had found very difficult, and which had an impact on their grieving process.

### The coroner's office

4.46 The other agency with which participants had most contact was the coroner's office. The information and support provided by both the office and the coroner themselves was typically praised.

> *"I was very impressed with the coroner's officer... Every time I've spoken to [them] I thought [they were] very good in the way of being considerate, courteous, understanding. At the same time, [they were] efficient… [They were] also very open to us to asking questions... We had lots of communication over the coming months." (Bereaved by suicide)*

4.47 The inquest itself, however, was a universally difficult process for participants, and especially so for those who had raised concerns about their loved ones' care and treatment prior to their death. While the way in which the coroners managed the inquest was typically praised, participants described the extreme upset they and their family felt at:

» Hearing difficult details about their loved ones' death.

> *"The inquest and report affected my sister mentally... She almost came out a different person. Even if I mention it now, she cannot talk about it..." (Bereaved by suicide)*

» Having to discuss often very intimate and difficult information in front of both strangers and other members of the deceased's family.

> *"The coroner asked if I'd be willing to give evidence as part of the inquest... Some of the information that came out from my recounting… [the deceased's] background history, the fact… [they were] manipulative as a person, saying this in front of [their] family… It really caused a rupture… So I found it very, very difficult because of that..." (Bereaved by suicide)*

» Seeing those they blamed (to some extent, at least) for their loved ones' death *"trying to justify their actions"* and, for a few, having to be cross-examined themselves.

> *"... I found it very difficult to see the people that had discharged [them]… and they had no justification for their actions. I just felt so angry at them... I really wanted to blame them. I really wanted there to be consequences for them… I felt very questioned and scrutinised and it wasn't pleasant... Very distressing." (Bereaved by suicide)*

4.48 In terms of mitigating against this to some extent, it was suggested that the coroner's office could contact the bereaved to offer a post-inquest check-in because, *"It's that sense of 12 months down the road everyone's moving on with their lives, but it takes you back to day one."*

4.49 One participant had felt *"insulted"* at the fact that the only 'official' representative that attended the inquest in person was their police liaison officer; all other parties attended remotely, despite Covid-19 restrictions having been lifted at the time. They also accused those involved of not having prepared adequately for the inquest, and key people involved in their loved one's care of having sent another member of staff in their stead. This, the participant felt, gave the impression that they *"couldn't be bothered"* and hadn't afforded their loved one the priority or importance they deserved.

### The local health trust

4.50 A few participants' loved ones had been under the care of the mental health services of their local healthcare trust in the lead up to their death, and so there had been some contact with these organisations in the aftermath. These experiences were varied; some participants felt that Trust employees managed the situation exceptionally, showing an interest in the participant and their loved one, and trying their best to repair relationships, whereas others were disappointed and felt that insufficient effort had been put into internal enquiries and inquest reports.

### Schools

4.51 One participant described the importance to them of the support offered by their children's schools following the loss of their spouse (also the children's father). Both schools were described by the participants as *"brilliant, really fantastic."* One child transitioned into junior school soon after, and continued to receive excellent and helpful support there, including sessions with an Emotional Literacy Support Assistant. The other however, had transitioned from junior to senior school and subsequently struggled with:

- Going from having one teacher who knew the detail of their situation, to many who at most were only aware that they had been bereaved by suicide
- The unkind comments made by some of their peers
- Difficult discussions in lessons and assemblies around, for example, men's mental health and suicide and 'what makes a good dad?'
- Inappropriate language used by both teachers and pupils when discussing mental health issues and suicidal ideation.

4.52 Conversations with all the schools concerned, around their children's support needs and the fact they may be at greater risk of mental health issues, self-harm, and suicidal ideation themselves following their parent's suicide had helped to resolve some of the issues highlighted above, however concern was expressed for parents who are less able to advocate for their children.

### Other organisations

4.53 One participant had called the birth, deaths, and marriages department at their local council to register their loved one's death and said that the staff member they spoke to had not understood the inquest process and the fact they had an interim certificate of fact of death rather than a full death certificate. Moreover, the NHS prescription service was said to have been *"really, really difficult"* about needing proof of death, sending a threatening letter in response to a cancelled payment plan. Though upsetting, the participant felt that they had the strength to deal with these situations, but worried for those who may not.

> *"For someone who isn't okay, how horrendous it must be to have to do it all on your own and tell everybody about what happened." (Bereaved by suicide)*

4.54 Another participant had experienced issues with their insurance company, who delayed their loved one's life insurance payout because they had died by suicide. They eventually received the money after much to-ing and fro-ing, and while they had returned to work and were earning a good wage in the meantime, they felt that such a delay could prove very stressful for a person or family that is dependent on the money to financially survive.

## Most participants had sought or accessed some form of support

### GP

4.55 Several participants had sought support from their GP, with mixed results. Some had been treated with compassion and understanding by their doctor, who scheduled regular check-ups and made appropriate referrals to other professionals.

> *"My GP… he's been brilliant… I went in to see him on a three-weekly basis. He referred me to a mental health trauma therapist..." (Bereaved by suicide)*

4.56 Others, though, complained of a lack of empathy and compassion; a lack of follow-up care; a lack of recognition of the impact of the bereavement; and (as also highlighted earlier) being offered medication without a proper risk assessment.

> *"… [My wife] and I were getting no sleep… I phoned the doctor one day, and I said to her what had happened and she said, 'Well you know there's no cure, don't you?' I just lost my [child], I was asking for support." (Bereaved by suicide)*
>
> *"At no point did anyone check in on my mental wellbeing in terms of the fact that I was now the sole carer for two vulnerable children…" (Bereaved by suicide)*

### Private therapy/counselling

4.57 Accessing private therapy and/or counselling had been of great benefit to several participants. Some had accessed it relatively soon after their loved one's death, while others had done so sometimes a few years into their bereavement journey. All said it had helped them come to terms with what had happened and their grief, at least to some extent.

> *"He was helping me make up my mind as to why I think [they] did it, and how to deal with the overwhelming grief… He helped me organise it all and deal with it and pop it away... If I want to revisit that box, I can. If I don't, it's ok... It took a long time, but I found it really helpful… I always say 'I'd recommend speaking to somebody…. If it costs you money and you can afford it, it's worth every penny'" (Bereaved by suicide)*

4.58 However, the cost of private therapy was acknowledged as significant and potentially prohibitive for some, especially given that people typically need it on a long-term basis before they see any real benefit. Moreover, most participants had proactively researched and sourced the therapy themselves, which others may not have the strength or knowledge to do.

> *"It was an expensive time for us… We had to use money we didn't expect because counselling isn't cheap and we had it for quite a long time, both of us. We had to go out ourselves and be proactive, and we also had to find money to support that. I just thought several times, 'There are lots of people who just could not do what we did.' Either they wouldn't have the inner resources to be proactive, or the financial resources." (Bereaved by suicide)*

### Bereavement support services

4.59 Several participants had been offered a referral and/or accessed Harmless' Tomorrow Project. Those who had accessed the organisation were pleased with the emotional and practical support it offered but commented that six sessions were not really enough.

4.60 A few participants also referenced the long waiting lists for the service, acknowledging that the demand for it far exceeds its capacity. Indeed, by the time they reached the top of the waiting list, some people had already sourced their own support elsewhere.

> *"The Tomorrow Project phoned me out of the blue about 12 months after… saying, 'You're still on our list. Do you still want some help?' I said, 'No, I found some'. It was too late by then. I can't blame them for that, it was just the situation." (Bereaved by suicide)*

4.61 One participant, who had proactively contacted the Tomorrow Project themselves in the immediate aftermath of their loved one's death, was placed on a 12- to 18-month waiting list for a bereavement support worker but was helpfully able to access Keep in Touch (KiT) clinics in the meantime, whereby they could discuss their progress along their bereavement journey.

> *"…The' Keep in Touch' was probably the part of the service that benefitted me the most… because at least you have got that opportunity to talk to somebody. When you hear you're on a waiting list, you just think, 'How on earth am I going to do this? I need someone now that's going to understand this situation.' So when they offered the Keep in Touch, it was brilliant…" (Bereaved by suicide)*

4.62 A couple of people had attended group sessions held by SoBS (one had found them online, another in the Help is at Hand booklet, and another had encouraged to attend by a support worker), the 'lived experience' aspect of which had given them hope for the future. Simply being in a room with people who had been bereaved in a similar way was important to participants, for they felt able to speak openly in a way they could not with friends and family and were able to reflect on others' experiences and use them to make sense of their own feelings.

> *"Somebody said to me 'two weeks will go by, which will be a rough two weeks.' Then a month will go by and you'll think about them all the time, but it will get a little bit less. Then six months will go by, and it'll get that little bit less. Then eventually you might only think of them six times a day'. I remember thinking, 'That won't happen, it's consuming'. But… [they were] right. I just held on to that really." (Bereaved by suicide)*

4.63 One person had attended two separate SoBS groups and highlighted the complimentary differences between them. One was more of a 'round table' whereby each person was given an opportunity to tell the group how they were feeling. This, they felt, was good in terms of hearing many different stories and experiences. In the other group, there was opportunity for more in-depth discussions in pairs and small groups of people with similar experiences, which was beneficial in talking about more sensitive issues that may not be appropriate for a group setting.

4.64 One participant had contacted Citizens' Advice for practical help with employment and finances and was referred to a recovery worker offered as part of its service. They received the first of six sessions with the recovery worker within two weeks of their loved one's death, which they considered beneficial in helping them begin to process their grief at a very early stage. This was echoed by another participant who had received support from the Tomorrow Project in the early stages of their bereavement.

> *"With a lot of the bereavement support they say you need to be bereaved for three or six months before the services can support you. So to have that intervention with someone you can engage with as soon as possible after someone has died, that's probably the point where you're completely clueless about what's coming up, what's going to happen..." (Bereaved by suicide)*

4.65 Other support was accessed through:

- NHS Improving Access to Psychological Therapies (IAPT): One participant had accessed IAPT and did not consider it to be appropriate to their needs given it *"it's counselling and not proper therapy."* Also, the waiting list for this support was again too long for some people.

> *"I think it would be very beneficial for people that didn't have friends who were validating their feelings, but I already had that... I needed somebody like [my therapist] to tell me specific things about grief and be very blunt..." (Bereaved by suicide)*

- Suicide & Co: a participant had accessed one-to-one bereavement support in the run up to their loved one's inquest *"when I was trying to talk through things like my fears of what might come out of the inquest..."* They found the one-support aspect of the support useful in being able to say things they did not feel comfortable expressing at groups they also attended.
- Care for the Family: a participant and their spouse accessed a befriending service whereby they were paired with another couple who had experienced a similar bereavement. They have also attended events where they were able to take part in discussion groups with others whose loved ones had died by suicide.

### Peer support

4.66 A few participants had accessed some form of peer support, which they found enormously beneficial.

> *"Being able to be with somebody who knows you get it; they don't have to explain. They're probably not going to say something insensitive or stupid. All those barriers are not there, and you're able to be very open and honest... I think that is an irreplaceable element of the grief process..." (Bereaved by suicide)*

### Family and friends

4.67 More informally, participants had turned to friends and family for support. This, they said, had helped them reason through the situation as much as they could and eventually remember happier times.

## Few had been offered support without seeking or asking for it

4.68 A few people had been offered a referral to the Tomorrow Project and/or given the Help is at Hand booklet by the police in the immediate aftermath of their loved one's suicide. For those who had received it, Help is at Hand was considered a useful resource.

> *"I think one of the things that was really beneficial, like with Help is at Hand, was everything was in one place..." (Bereaved by suicide)*

4.69 Others said they had not been, or at least could not remember being, proactively offered support. Their experience was that while there was support available, it took time and energy to find what was relevant.

> *"I went to a suicide prevention talk last year, and they mentioned all these things and how you get support after. I was sitting there going, 'I didn't get any of that…' I didn't get any brochures… I don't think I would have accepted it at the time because I needed to do it my own time. But I don't know where it would have come from" (Bereaved by suicide)*

4.70 The fact that some participants could not recall whether or not they had been offered support in the early stages of their bereavement led some to suggest that they should receive some sort of follow-up at regular intervals over the next, say, 12 months to see whether they feel ready to access anything and if so, what they would prefer.

## There are several barriers to seeking or accessing support with suicide bereavement

4.71 The main stated barrier to seeking support, especially in the early stages of bereavement, was not feeling ready to do so. Furthermore, the stigma associated with suicide was again referenced as a barrier to seeking both formal support from organisations, and informal support from family and friends.

4.72 In terms of accessing support, a lack of knowledge about what was available was a key issue, as was availability. Indeed, waiting times for anything other than private therapy (which, as noted earlier, can be cost prohibitive for many people) were said to be so lengthy as to render many support offers meaningless.

> *"The waiting times just for anything in Nottinghamshire is ridiculous, and people need help... You're waiting years to actually get the help that you need." (Bereaved by suicide)*

4.73 One participant again highlighted the lack of help available for their teenage child (whose parent died by suicide), with an apparent two-year wait for age-appropriate support at their local bereavement centre. They were of the view that *"if it gets to that point where I'm concerned about [them]… I am going to have to fight tooth and nail to get [them] something; or pay for it."* (Bereaved by suicide)

## Participants suggested several ways to better support those bereaved by suicide

4.74 Although they recognised current capacity constraints within the sector, longer-term support was considered essential for people bereaved by suicide, especially given the aforementioned length and complexity of the bereavement journey.

> *"With suicide bereavement there are so many stages and so much you go through and different ways of looking at things, and anger and all sorts of things… It's so complicated and it throws so many things up in your mind and what you could have done and couldn't have done. It needs to be a more long-term and that isn't available really." (Bereaved by suicide)*

4.75 Offering a range of support was also frequently suggested, given some people will prefer one-to-one provision, and some will prefer to take part in group sessions. The need to proactively ensure that people know this range of support exists was stressed, as was the need to inform them that they can access it when they are ready.

> *"Don't expect the person to reach out. There's so much going on logistically… just negotiating all of that is so hard… There needs to be that outreach…" (Bereaved by suicide)*

4.76 Consistency of support was highlighted as an issue by one participant, who hosts group support sessions at the local community centre they run. They described the running of these groups as *"hit and miss,"* which they attributed to counsellor availability and running costs. To mitigate against this (and the lack of support service availability generally), they suggested a 'mental health awareness programme' whereby *"communities, churches, synagogues train themselves… to one level below mental health first aid."*

4.77 The provision of more peer support was considered essential in offering kinship borne from shared experience. Discussions between those with lived experience were said to be more open and honest as that fear of judgement is removed, and speaking to those who have travelled a similar path and emerged at the other side was said to offer hope for the future to those who have lost a loved one more recently.

> *"There are things [people] want to say that they would not say to a medical professional or a family member or friend… This stuff you keep in because you know if you say it out loud, you will feel ashamed. But when you are doing it with somebody who has that same lived experience, you know you're not being judged… You've got that person who you trust, and you can say anything to and not feel judged or ashamed... You also talk about different strategies... together you can come up with something new, just by bouncing off each other…" (Bereaved by suicide)*

4.78 A few participants mentioned the fact that while there is support available to the close family of those who die by suicide, there is little available for the deceased's wider circle of family members, friends, and colleagues.

> *"…[Their] extended family, but immediate family for [them], was very affected and weren't really given any support... [Their] friends; the Tomorrow Project did put in place some group sessions at school... But those that weren't at school, because some were at different colleges or work, got no support. My colleagues at work, [they were] hugely affected and didn't get offered any support. I understand there's no support to really offer. But I know they were all hugely affected…" (Bereaved by suicide)*

4.79 Other specific suggestions were to provide:

- More training for statutory agencies in dealing with a bereavement by suicide
- A dedicated 'navigator' to help those bereaved by suicide with their bereavement journey
- Information and education on 'what to say' to someone who has experienced bereavement by suicide.

> *"... Maybe teaching other people around you how to deal with you. I found that really tricky… They'd just say the wrong thing because they don't know what to say. Maybe some guidance on how other people can cope with other people in a suicidal situation..." (Bereaved by suicide)*

4.80 Finally, in terms of specific support or activity they had found useful and considered potentially beneficial to others, participants being directed to reading material and podcasts about dealing with bereavement from suicide; and creative therapy such as writing, art, and flower pressing.

## Several participants had experienced suicidality themselves

4.81 Around half of those who had been bereaved by suicide had also experienced suicidality themselves. This was a long-term issue that existed before the bereavement for a few, triggered by periods of depression, relationship issues, and substance misuse. For a couple of others, it arose following their bereavement by suicide.

4.82 All had sought some form of support with their suicidal ideation, be it formal or informal. Speaking to family members and friends had helped a few people, as had engaging with new and existing hobbies.

4.83 In terms of formal support, a few had approached their GP, praising the help they received with, for example, referrals to appropriate support services. Again though, they highlighted a lack of follow-up to check on their wellbeing and how they were coping with their grief.

> *"I just went in and I said what happened, and I just said, 'I'm really struggling through grief'… The GP was really good. The GP told me about Samaritans, and they said about counselling..."*
> *(Bereaved by suicide)*

4.84 One participant, whose mental health was rapidly deteriorating, rang their local mental health crisis team, who visited them at home and provided support and medication for the next few weeks. This intervention was described as *"brilliant,"* as was the subsequent care they received from the Early Intervention Team.

4.85 Private therapy was the avenue chosen by a couple of individuals, who appreciated being able to be open and honest with their therapist about their feelings of suicidality.

> *"With the therapist, I could tell him anything and he didn't blink. He wasn't shocked, but then he'd come up with things to help me process that… I could say anything to him... If you tell your family who you love and they love you, they panic." (Bereaved by suicide)*

4.86 A couple of participants had called the Samaritans but had not felt that the person they spoke to was equipped to respond to their experiences.

# 5. Listening to lived experience

## Findings from interviews and focus groups with people with lived experience of suicidality

### Summary of evidence and insights

Participants' 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.

Most participants felt that their experiences were 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.

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 considered valuable in offering hope, and as a reminder that the feelings experienced during crisis are temporary. Several participants also described 'grounding' techniques and other coping strategies they had learned through therapy or counselling.

In terms of would have helped but was not accessible at the point at which they were struggling with ideation or crisis, participants highlighted 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. For some participants, especially those with a diagnosis of autism and young people, access to online or text-based support was particularly important given the element of discretion they offer.

Barriers to seeking help and support are mainly based around stigma and fear of the consequences of admitting to suicidal thoughts. Privacy and confidentiality are also a concern; as is a fear of being dismissed or disappointed by services, based upon prior experience of long waiting lists or indifferent responses.

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 trying to talk about their feelings.

Most participants who had experienced ideation or crisis sought formal support from, for example, GP services, mental health services/CAMHS, counselling or talking therapy, peer-support groups, support workers, and charities like Harmless. Several had received medication in relation to their suicidality, or their broader mental health.

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.

Most 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 said they would visit their GP, but several would seek alternatives to NHS support due to waiting times and challenging access.

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.

## Full overview of findings

### Participants' experiences were evenly split between those who had experienced ideation, and those who had reached a stage of acute active ideation, planning, and crisis

5.1 A few of the young people we spoke to (in a group setting) said that they did not have personal lived experience, but that they had supported friends through ideation, crisis, or self-harm. One participant's experience related to their spouse's suicidal ideation and crisis, and their experiences of seeking support together. Of the participants with lived experience of suicidality, there was a fairly even split between those who had experienced ideation to varying degrees, and those for whom it had reached a stage of acute active ideation, planning, and crisis.

5.2 Those who described their experiences as being mostly passive ideation talked about increasingly recurring and intrusive thoughts, sometimes involving graphic visualisation, or a more general desire to 'find a way out' of their situation or escape their feelings.

> *"I'd just retreat into my head… thinking, 'I feel really sad, they'd be better off without me.' All the drivel you put through your head. It started off as the odd thought then suddenly it became that often I was thinking about that being a reality. I knew it was a problem, because it was following me…" (Lived experience of suicidality)*

5.3 Often, suicidal thoughts also brought feelings of shame and guilt, exacerbating the situation. But for all those who had experienced ideation without reaching crisis point, the recurring and intrusive thoughts had prompted them to seek the help and support that had ultimately prevented active ideation, or crisis.

> *"I didn't do anything about them, and then the thoughts started to become more of a reality. But I nipped it in the bud, so it never went as far as having a plan in place. It was more about the intrusive thoughts." (Lived experience of suicidality)*

5.4 Those who had experienced active ideation, or who had reached crisis-point 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 around, say, family members dying.

> *"It's when I lose all hope, when I can't find any answers to the problem and I feel there's absolutely no way out. Situations are slightly different. But it's that thought process." (Lived experience of suicidality)*

## Most participants felt that their experiences were long-term, with intermittent short-term crises triggered by specific (often multiple) factors

5.5 Participants were asked if they felt their experiences could be best described as long-term or short term, and whether those experiences are ongoing, or triggered by specific events.

5.6 A few participants described their experiences as short-term, and something they have been able to move on from. However, even those who considered themselves to be in recovery acknowledged that those feelings might return in the future, or that they are still part of who they are. So, the phrase 'ongoing' was used both by those who felt they are still struggling, and those who are in recovery and consider themselves to be '*in a better place*'.

> *"I don't think my mental health concerns are something that I'll get past, its who I am. I've had therapy around it which makes me understand it more, but the problems are not there to be fixed because nothing is broken; it's just who I am." (Lived experience of suicidality)*

5.7 Most participants described their experiences as longer-term, having experienced passive ideation for many years (sometimes since childhood), but they characterised their crises as short-term.

> *"I think the passive ideation was quite long-term. Whereas I've had a few attempts… where it has been a crisis. I'd say long-term but the major risk is short term..." (Lived experience of suicidality)*

5.8 Participants described a broad range of (often multiple) triggers or contributing factors to both their longer-term experiences of passive ideation and their shorter-term experiences of crisis.

5.9 Several thought the inception of their suicidal thoughts and ideation stemmed from traumatic childhood or teenage experiences. These included bullying, sexual or physical abuse, suppressed sexuality, early bereavement, or the breakdown of their parents' relationship. Indeed, difficult parental relationships or the early loss of a parent to either death or divorce were common among participants, with one even acknowledging that they have triggers they are not aware of, having blanked some traumatic parts of their childhood out completely.

> *"I had no love, because both my parents were abusive. My dad's idea of teaching me anything was assaulting me all the time. 'You got that wrong' and bang. All I understood was violence. I could never understand if you love somebody how you could hit them and cause them that much pain." (Lived experience of suicidality)*
>
> *"When my parents split up it was quite a shock. I just got brought downstairs and told 'your dad is leaving.' … I just remember finding myself upstairs and being incredibly sad. The only form of control I had was thinking, 'I could show him if I did this'. It just became a coping mechanism...." (Lived experience of suicidality)*

5.10 Adult trauma was also mentioned as a contributary factor, be that because of bereavement or trauma from an abusive relationship (which led to PTSD for one participant) or extreme workplace bullying. Moreover, several adult male participants had served in the armed forces and had suffered from PTSD both during and after their active service. They described specific events that had caused this, but also alluded to the lack of a conducive environment for discussing mental health issues during their military service (something that is apparently changing for the better).

> *"It is a changing space; they're talking about it more now. It's definitely changed since I was in the military… You had your mates and could banter with them, but it wasn't really a forum to open up about stuff." (Lived experience of suicidality)*

5.11 Relationship issues or break-ups were among the most common contributary factors. In several instances where participants described experiencing long-term passive ideation, they felt that issues within their intimate relationships had triggered an escalation into active ideation, and crisis.

> *"… Something happens, say a relationship breakdown, then everything gets dragged back up... You feel like you're back there, right back there, that's how bad it is." (Lived experience of suicidality)*

5.12 Similarly, several participants described reaching crisis point due to a combination of several factors, triggers, or situations, which in isolation might not have had the same impact, but which in combination were enough to 'tip the balance' for participants' mental health and resilience.

> *"It's the situation I'm in with the inability to deal with the stress of it. I don't seem to be that resilient to it. I don't get one problem, sort it and go onto the next. They all seem to snowball and hit me at one time, and I can't cope…" (Lived experience of suicidality)*

5.13 For some, the main trigger for their suicidality related to other physical or mental health diagnoses and conditions; both receiving (and in some cases struggling to accept) the diagnosis, and the impact of the condition itself.

> *"Mine is quite long-term triggered by problems with physical health, that's what contributed to the deterioration of my mental health; the implication that had on who I was and what I could do… I'm in a much better place with my mental health now, but it can fluctuate if I have problems with my physical health. They go hand in hand." (Lived experience of suicidality)*
>
> *"Originally it was depression, then it changed to ongoing depression, then it was borderline personality disorder, now it's that and bipolar… My emotions are all over the place so it can change just like that… [It] can lead to, 'I don't want to be here anymore' quite quickly." (Lived experience of suicidality)*

5.14 One participant who was dealing with chronic pain described opening up to a clinician about their suicidal thoughts, but felt that their disclosure was dismissed, which had triggered them further.

> *"I was very open and honest with her and expected something to come of that… she just said, 'Sorry to hear that, we'll see you in a month'." (Lived experience of suicidality)*

5.15 A few participants with a diagnosis of autism described both the diagnosis and the label as isolating and felt that it had been a trigger for their suicidal ideation.

> *"I hadn't expected to get [the diagnosis] and the process had been quite long and traumatic. I told my parents, and they weren't very supportive, so that was quite isolating. A lot of it sounds very silly, saying to people 'When I go outside, trying to talk to people is very scary'…" (Lived experience of suicidality)*

5.16 For the young people we spoke to, social media was one of the most cited triggers, both in terms of triggering content and social pressure. In relation to the latter, while they understood that social media often presents a skewed reality (whereby people present only the positive aspects of their lives), but that awareness in itself did not appear to ameliorate the culture and impacts of constantly comparing oneself with other people.

> *"You can find yourself in a bubble of other people, where everyone's kind of feeling bad and not really getting the help that they need. That can become triggering content..." (Lived experience of suicidality)*
>
> *"Social media and the ease of comparing yourself to other people from across the world. And not always reminding yourself of the fact that… on social media their life might be looking perfect, and we might be thinking, 'Oh why is my life not like that?' but they're just showing the good parts." (Lived experience of suicidality)*

5.17 Other common contributary factors for young people included puberty and hormones, academic pressure (both from parents and self-imposed) and negotiating their social life and friendships. Moreover, one young person described the isolating impact of having an eating disorder as a trigger, and factors such as body image, self-disgust, bulimia and excessive exercise were also mentioned by some of adult participants.

> *"One of the things I've pretty much always been miserable about is body image. I was a pretty fat kid as a teenager, so comparing myself to the good-looking teenage boys I always felt disgusting. What it for sure contributed to and always has is the idea of life is not worth living and I don't want to live with this disgusting physical body I have." (Lived experience of suicidality)*

5.18 Other contributory factors mentioned by participants included job pressures and redundancy, familial estrangement, financial issues (including fuel poverty). One participant described having life insurance as a significant factor for them: when they were at their lowest point, they felt that their family would "*be better off with the money,"* and it was described as making suicide feel like a *"valid option*."

5.19 Alcohol, drugs, and other substances (including steroids) were mentioned by a few participants as having been both a trigger and an exacerbating factor.

> *"I was drinking a lot [at the time of the first crisis], that would make things a lot worse. I don't drink anymore." (Lived experience of suicidality)*

5.20 Finally, a couple of participants described the Covid-19 pandemic as having been a factor for them, as it had compounded their feelings of isolation, impacted their education, or had put their pre-existing relationship issues *"under the microscope."*

## Participants described a broad range of things which have helped them cope and manage their situation over the years

5.21 Participants were asked what, if anything, has helped them cope with their suicidal ideation, and to manage their situation in either the long- or short-term. With the exception of a few themes, these were on the whole bespoke to each participant.

5.22 Several participants described their pets as being an important safety factor in terms of the responsibility, being something *"to get up for"* every day, and animals being a source of unconditional love and happy distraction.

> *"It gives you a reason to go outside of the house... And puppies are constantly happy… They are just a constant source of joy and something to do. And you feel like you have a purpose because you have something to look after." (Lived experience of suicidality)*

5.23 Several participants mentioned the therapeutic benefits of connecting with nature, and of listening to music.

> *"Connecting with nature, going for walks and things like that is a big one. I've always been nature orientated... Going through forests is really good for my mental health." (Lived experience of suicidality)*
>
> *"I found music really helped me. I have social anxiety, so whenever I have to go out… I just put music on with my headphones… It's really calming. Even when I'm overstimulated by my own feelings, I just have to listen to music and I feel better..." (Lived experience of suicidality)*

5.24 Creative pursuits were also popular as coping mechanisms for several participants, who described using a variety of arts and crafts to help them manage their thoughts and feelings. Some examples were diary and script writing, playing instruments, baking, DIY, puzzles, and crafting activity (like painting, pottery, jewellery making, and model making).

5.25 Several participants described the benefits of talking to others or getting out of the house and meeting friends. Indeed, some felt strongly that having a support network of family and friends was the main factor for them in avoiding suicidal crisis. For one participant who had experienced agoraphobia, travelling for social activities is now an important part of *"taking control of my brain*."

> *"The things that keep me going are trying to do the things that this feeling [agoraphobia] stopped me from doing... Travel is a big one, just seeing different places... I don't want to stand in my own way. Adding social stuff in where I can…. I see taking control of my brain as a full-time job, so I'm always looking to add in things that will help with that." (Lived experience of suicidality)*

5.26 Related to this, finding safe, non-judgemental spaces to have conversations about mental health, and not avoiding the subject of suicide, was important to several people. Men were thought to particularly benefit from these spaces given the social stigma many still feel in discussing mental health issues.

> *"Coming here [a men's space] has been an eye opener. You've got every mix of Jelly Baby in one room… No-one is telling me what to do, they're supporting me. I thought, 'I'm not on my own, there are other people like me who have had difficulties...'" (Lived experience of suicidality)*

> *"I go to the meeting on a Thursday... A lot of the lads there obviously still suffer with it [PTSD]. But we all get together and help each other. It's a friendship group. We're there to support veterans... It just basically takes your mind off it." (Lived experience of suicidality)*

5.27 In this respect, it was considered much more difficult for someone to actively reach out for help than to accept an offer of help. As such, they had found explicit messaging around self-harm and suicide to be essential in *"creating that opportunity for people to reach out to you. Rather than it being the other way around."*

> *"If someone tells you that, 'Hey, we know people struggle with these thoughts, with these problems, and if you know someone who is or you yourself are experiencing this, you can come talk to us.' And if that is written or said to you somewhere in school or wherever, or in a youth group, in church or mosque or something like that that…" (Lived experience of suicidality)*

5.28 Recovery stories were considered incredibly valuable by several participants in offering hope, and as a reminder that the feelings experienced during crisis are temporary. They were also thought to be empowering and to provide encouragement (or even permission) for participants to relate their own experiences. Recovery stories "*from the horse's mouth"* were also considered to be an important factor in the popularity of peer-based support models, as discussed later in this chapter.

> *"Somebody telling you from experience that it's a temporary thing. It might not feel like it, but you can literally leave it behind at some stage. But you can't hear that unless you hear the words, and somebody with experience of it is standing there telling you about it... It seems like the biggest hole to climb out of but actually, it is literally a moment in time and it's gone." (Lived experience of suicidality)*

5.29 In a similar vein, a young participant spoke eloquently about the importance of learning and knowing that their suicidal thoughts and feelings will pass, using the powerful analogy of a panic attack to illustrate their point.

> *"The main thing I always remember as someone who has always had suicidal ideation and very low points is that they pass. You get to a certain point where you realise "I've had so many and I'm still here." I think it's like a panic attack. When you have a panic attack you feel like you're about to die… Then you calm down and you're breathing fine again… It's the same thing of knowing this moment is extremely hard and it feels like the worst thing ever and like there's no other solution but you've been in this situation so many other times." (Lived experience of suicidality)*

5.30 Several participants described calming or 'grounding' techniques and other coping strategies or tools they had learned through therapy or counselling, and which they had subsequently utilised successfully. These included:

» Physical relaxation techniques like running body parts under cold water or having a hot bath

» Levelling up' (i.e., using 'blocking thoughts' to balance intrusive thoughts and *"get that thought away before [it] starts to manifest itself"*) and other types of self-motivation

> *"If I get a suicidal thought now, I just say to myself, 'There's too much in life to live for', and it just gets rid of it all. It does really help." (Lived experience of suicidality)*

» Actively taking control of intrusive mental images

> *"If I get a negative thought, I'll put a weight on it and I'll put that weight in the water and just let that thought sink. Or I'll put the thought into a balloon and watch it float away. Another one he suggested was just to imagine all the feelings I've got like water flowing out, but just let it run away..." (Lived experience of suicidality)*

» Sayings or mantras

> *"'There's too much to live for' is a key one that specifically blocks the suicidality. Another one I use is 'The f**k it bucket.' Just throw it in the f**k it bucket and forget about it because that's where it needs to stay." (Lived experience of suicidality)*

» Preventative visualisation (i.e., thinking about loved ones)

> *"It's quite grim, but I always think about two things… Think about at your funeral how sad your friends are going to be… and how it will impact them. And think about how if you survive, how annoying and hard and difficult it will have to be to explain yourself to every person." (Lived experience of suicidality)*

5.31 However, one participant said that such techniques are not always applicable, as they are not something they can use in the workplace, for example.

> *"The therapist had this relaxation technique. You look up and squeeze your hands and it's a physical relaxation technique. It works great, it absolutely works magic but… It's all well and good when I'm at home, but when I'm at work (where I spend most of my time) it's not practical to use it. What do I do then?" (Lived experience of suicidality)*

5.32 One young participant talked about receiving a 'Hope Box'[3] from CAMHS, which is a personalised box containing items, words, and activities aimed at calming the mind, or to prompt a focus on loved ones and other safety factors. The young person described how reading encouraging messages from friends helped to put their suicidal thoughts into perspective.

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

> *"It was basically all these things you could use to help yourself, like when you feel overwhelmed or really suicidal or anything. They have this letter shredded up like little pick-me-up lines like 'You're so amazing', and 'You're going to get through this'. So going through them and going through birthday wishes, messages from my friends, that really helps me when I feel like I don't want to be here anymore. Suicide is such a final decision, and in the moment you often feel worthless. Reading how people feel about you and reading encouraging things can really put into perspective what people really think of you and remind you that it would really hurt them if you weren't in their life anymore." (Lived experience of suicidality)*

5.33 The same participant had also received a list of emergency crisis contacts which they found reassuring to have available because *"whenever I feel like I have no one or like I can't talk to my friends because I don't want to, I'm always reminded I still have these numbers I can contact..."* (Lived experience of suicidality)

5.34 Other less frequently mentioned coping techniques, or things that have helped participants manage their feelings are included in the table overleaf.

| | |
|---|---|
| Volunteering/helping others | • *"Helping other people is one of my biggest coping mechanisms. Knowing I can support other people on their journey to becoming the best version of themselves…" (Lived experience of suicidality)* |
| Meditation | • *"I've been doing meditation. Like healing, visualisations and spiritual meditations that take me off somewhere else... I'm floating in the clouds or on a beach." (Lived experience of suicidality)* |
| Creating a 'sanctuary space' | • *"It's to get away from the world. In my room, different lighting, a waterfall thing, wind sounds..." (Lived experience of suicidality)* |
| Medication | • *"I do feel the meds have had a massive impact on me... I'll never go off them now. I don't get dips now..." (Lived experience of suicidality)* |
| Exercise (sometimes to an 'unhealthy' level) | • *"... Throwing myself into exercise. Maybe sometimes to an unhealthy level... I was using exercise as a coping mechanism, but not in a healthy way." (Lived experience of suicidality)* |
| Religion/spiritual belief | • *"I did an 'Alpha course' ... It's like an introduction to Christianity. I'd been going to church for a while, but it really helped me reconnect with it and actually see it as something I could lean on." (Lived experience of suicidality)* |
| Being proactive about seeking information | • *"Googling and hearing that term [ideation] helped me see it was a thing. I thought 'Oh right, that's not just my brain'. It is a known coping mechanism... I did a lot of Googling and searching myself." (Lived experience of suicidality)* |

## Participants identified several things that would have helped them, but were not accessible at the point at which they were struggling with ideation or crisis

5.35 Participants were asked if there was anything they felt would have helped them, but which had not been available at the time they needed it. Suggestions were made for a range of services, including more 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 which can be accessed outside working hours were also mentioned.

5.36 Some participants simply wanted more availability within peer support and counselling services or wanted their allocation of sessions to continue for longer than had been available. Another expressed frustration at the limited offer of Cognitive Behavioural Therapy (CBT) which, as someone with a diagnosis of ADHD, they felt would not have worked for them.

> *"Long-term, one-to-one therapy. When you go through talking therapies, they have to assess you on the phone, and they'd only give me CBT… which, according to recent studies might not work on people with ADHD anyway…" (Lived experience of suicidality)*

5.37 Several participants talked about wanting to be able to access services without having to go through their GP or CAMHS, either because of long waiting times, or because of a lack of anonymity. Young and older participants did not want to have their suicidality recorded in their medical records, for fear of implications for their future career or public lives. Furthermore, for young people there was a worry that their parents would automatically be informed against their will if they made a disclosure to a doctor, or indeed a teacher.

> *"So, I remember going to CAMHS and they would say, 'I have to let you know that if you say that you are experiencing suicidal thoughts or self-harm, we have to tell someone about it.' I think that can be a barrier for people... I always had a feeling from that that if I did want to share something like that, it would be 'all or nothing.'" (Lived experience of suicidality)*
>
> *"When I was younger, not wanting my parents to know was a big thing... In school, I couldn't speak to people… They would ring your parents if you disclosed…" (Lived experience of suicidality)*
>
> *"For a lot of young people, the first time they access support for mental health is when they're over 18, or over 16 if they're very lucky. Their mindset is 'Please don't tell my parents', because they don't want to take those problems home. If there is something traumatic happening a lot of people don't want their parents knowing, I think services should be aware of that. If there was a way to get support for young people in school, that would take the pressure off adult services when they're older." (Lived experience of suicidality)*

5.38 For some participants, especially those with a diagnosis of autism, access to online or text-based support was particularly important given the element of discretion it offers. Young people especially said they would not feel inclined to use a telephone-based helpline and did not feel they had enough opportunities to access support in privacy without being overheard.

> *"I couldn't really talk on the phone at the time… so more stuff you can access online would have been good for me. Even if it was a chat room or whatever. With the autism I was really stressed about talking on the phone… so I just didn't call any of the help numbers you'd usually call." (Lived experience of suicidality)*

5.39 Some felt that their local area was lacking in early intervention provision, due to under-funding; and one participant, whose first language is not English, wanted access to services in other languages, or via a translation service.

## Barriers to seeking help and support are varied, but mainly based around stigma and fear of the consequences of admitting to suicidal thoughts

5.40 Participants were asked whether there had been anything that had stopped them from seeking help at any point. Most of the given reasons for not seeking support were seated in stigma, pride and/or fear.

5.41 Several participants mentioned stigma around suicide as having stopped them from seeking support. This often dovetailed directly with feelings of pride or embarrassment.

> *"The main things that stopped me reaching out for help are stigmas. Not wanting to talk about it and let people know I'm feeling that way. There's a lot of stigma with it, and it's embarrassing… I don't know so much if it was fear of the response. It is just a sense of pride and embarrassment." (Lived experience of suicidality)*

5.42 One participant described a generational male culture of not talking about feelings, especially in more remote, or ex-industrial communities. Another (also male) similarly discussed growing up in a culture where they felt unable to express their feelings, or to cry.

> *"Stigma. I live in a former mining village. Your grandad didn't speak about his feelings, your dad didn't speak about his feelings, so you don't. If you do you're seen as being a 'soft lad'. It's always been a thing, and still is a thing. We have guys coming to the group and for some, it's their first time speaking about their feelings and they're in their 50s and 60s." (Lived experience of suicidality)*

5.43 One young person talked about how scary it can be to confide in a stranger about personal issues or mental health for the first time, but starkly compared that fear with the greater risks of not talking about suicidality or self-harm.

> *"… It's like 'I'm sharing the deepest parts of my life with a stranger' and that's very, very scary. For me, I think of it more as risk not to though, because it's either your life or you confiding in someone..." (Lived experience of suicidality)*

### Privacy and confidentiality were a particular concern for many participants.

5.44 Echoing the point at 5.40 above, privacy and confidentiality concerns were raised as a significant barrier to accessing services by several participants, due to fears around career impacts, social services involvement, and losing access to their children.

> *"One of the things that put me off seeking more NHS support was having that on my medical record. As soon as it's on there, there's a label to say it's a problem. I'm very fortunate that my work is supportive, but if I were to find another job to do with health and that came up, it could be a barrier... After my attempt I never went to a GP or to seek any medical attention. It was such a barrier and still is to stop me seeking support when I need it..." (Lived experience of suicidality)*
>
> *"Even when I went to the doctor… I just couldn't tell him the full story, there was something holding me back... I was still thinking I'm going to get sectioned and not see my son again..." (Lived experience of suicidality)*

5.45 Several young people feared receiving negative, dismissive, or even angry reactions from friends and family, and in some cases this was based on previous experience. A fear of being judged or labelled was also a barrier for some.

> *“Young people are just scared of feeling judged in general or being called over-dramatic... One thing that a parent has said to one of my friends is ‘You're so young; you're not experiencing real life problems yet’. And that's really not the way that you should be trying to discuss such a sensitive topic with someone.” (Lived experience of suicidality)*

5.46 Similarly, several participants feared being dismissed, or disappointed by services. They cited prior experience of long waiting lists or dismissive responses from clinicians as having informed those concerns. More than one participant alluded to the feeling that unless someone is ‘at crisis point’, they have to wait for some time to get any meaningful support, and this was considered a significant discouragement to seeking help.

> *“I would have to agree about the waiting lists. Often it’s really rubbish and unless things are really severe, things won’t get done quickly. Having ideation is just as important, and it makes you feel a bit dismissed…” (Lived experience of suicidality)*
>
> *“The first person I told about my mental health was probably the wrong person. It felt like almost a tick-box exercise for her because she asked, I told her, then that was it. I get they’re there for my physical health, but surely there should have been some sort of signposting as opposed to taking the information and sending me off... I didn’t know where to go. I was left on my own.” (Lived experience of suicidality)*

5.47 For a few participants, practical issues such as geographical location, distance to services, or a lack of transport were barriers to accessing services. For example, one participant, who lives just across the border in Derbyshire but is registered to a Nottinghamshire GP, described “*falling in the cracks”* when trying to access support services.

5.48 One participant felt strongly that being in work is a barrier to accessing services. This related to accessibility in terms of the timing and location of services, but also to a perceived difference in what is offered to working people. Indeed, they felt strongly that offers of support vary dramatically depending on whether the person seeking support is in work or not, suggesting that clinicians may feel that a person is at less risk if they remain in work, an assumption they challenged.

## Experiences of seeking ‘informal support’ were mostly positive and were often a catalyst for seeking formal support

5.49 Participants were asked about their experiences of seeking ‘informal support’, which was defined as support from friends, family, or other existing social networks.

5.50 Approximately half of the participants who had experienced suicidality described reaching out to partners, friends, family members and work colleagues. One participant had also reached out to a ‘mentor’ from their church. Experiences of seeking informal support were varied; participants described both positive and negative experiences.

5.51 Some said that not knowing how the people close to them would respond was enough to keep them from trying to talk about their feelings; or that they would talk about the life-stresses and triggers/root causes of their suicidality, but not specifically about the suicidal thoughts. So, even when participants felt able to reach out informally, they would often self-censor to some extent, or withhold elements of what they were going though.

> *"We ended up talking about what helps in this kind of situation [relationship breakdown]. I never actually told [them] I was thinking about suicide or anything like that." (Lived experience of suicidality)*

5.52 One participant said that they specifically chose someone who was not especially close to them to talk to, so that if the response they received was unsupportive, it would be less of a blow.

> *"[My colleague] has, in general, that demeanour of someone who is helpful, kind, simple, and direct. And we're not close; if he said, 'Eff off' I'd be fine." (Lived experience of suicidality)*

5.53 Experiences of seeking informal support were mostly positive and often a catalyst for seeking formal support. In a few instances, the help provided by friends and family was enough to carry participants through their darkest times without needing to access formal avenues.

> *"The support system I built with my family and friends. After I opened up to them, after keeping it in for some time, I have been able to discuss the thoughts I've been having with my family and then at school as well. I've been very fortunate to be able to create that kind of support system around me." (Lived experience of suicidality)*

5.54 In terms of specific experiences:

- One young person explained that while they could talk to friends about some of their experiences, they were more likely to turn to a supportive family member in some situations, as they felt that they would better understand the context for their feelings and would never use the situation against them (which they felt was a possibility with friends). However, while highlighting the importance of the support received from this family member, they were also reticent to over-rely on them, and always in a 'negative' context
- Another participant expressed gratitude for the support they received from their spouse, but also felt guilty for the impact of their suicidality on their spouse
- One participant talked about a family member assisting them in practical ways, such as with financial help and accommodation. Having what felt like a champion *"in my corner*" was invaluable in helping them to navigate their way out of an abusive relationship and make a new start
- One participant had found a great deal of support and solace in talking with their church 'mentor', who had also experienced suicidality. For this person, a faith-based approach had proved beneficial, offering them a different approach to managing their thoughts and feelings
- The same participant said that the support from a faith-based peer mentor had helped them gain control of their intrusive thoughts and given them more self-awareness. Furthermore, they felt able to go back to their mentor if at any point they felt they were struggling, but that with their increase in self-awareness and control it was becoming decreasingly necessary to do so

> *"... I go to my mentor, and I say I have had a couple of low points, and he says, 'Yeah but you're so much quicker now at snapping out of it, you're so much better of recognising it'… I think I've got so much more control over it now... I thought recently maybe I should go and see a counsellor, but mentoring is doing enough at the moment..." (Lived experience of suicidality)*

» One participant described mixed experiences of talking to friends about their mental health and emphasised the importance of 'choosing the right people to talk to'

> *"I've had good and bad experiences... When my anxiety started, I disclosed to two friends… They bought me a pint and didn't know what to say because they've got no experience and they didn't want to say the wrong thing. The positive thing is I've got another friend who has been through it himself… He knew exactly what to say. I think it's choosing the right people." (Lived experience of suicidality)*

5.55 Some participants' experiences of seeking informal support were less positive, and included dismissal and rejection from partners and spouses, and inappropriate or unhelpful responses from co-workers.

> *"[My husband] is one of those ones that wants to fix you. He says, 'You should do this, you shouldn't think like that, oh I think like this sometimes.' It wasn't meaningful and it would make it worse sometimes. I told a friend once, but she just buggered off. It was the heightened emotion of not wanting to be here… I did share it and it was dismissed..." (Lived experience of suicidality)*

5.56 Where participants got negative or unhelpful responses to their disclosures, it tended to put them off seeking further help from informal sources and increased their feelings of isolation. For some though it prompted them decide to seek formal help instead.

> *"It got me realising I've got to be external from everyone else…" (Lived experience of suicidality)*

## Most participants who had experienced ideation or crisis sought formal support, and had accessed a variety of services

5.57 The most common services accessed by participants were GPs, adult mental health services (including the crisis team), CAMHS, talking therapies/counselling, Harmless/the Tomorrow Project, and peer support workers/peer-based support groups. One participant explicitly said that in general they found it quicker and easier to approach charitable or third sector services than those offered via the NHS, though they recognised that this was pre-pandemic and that the situation may have changed.

5.58 As aforementioned, participants were often prompted to seek support by the family and friends they had opened up to informally. For one young person, it had taken some time for the people close to them to convince them to seek help, because they did not accept that there was anything 'wrong'.

5.59 For others, it was the severity or intensity of their ideation and its impact on their work or school life that prompted them to seek help.

> *"It just wasn't getting any better over the weeks where I had left it; it got worse and worse to a stage where I was thinking, 'This is no good, I need to do something about it'. It was starting to affect my sleep and my day-to-day activities." (Lived experience of suicidality)*

5.60 For several participants, thinking of their loved ones was the main preventative factor which prompted them to seek help.

> *"I know… I need to get some help before I end up taking my life… At the end of the day, you shouldn't feel like this... You know it's not right, so you think to yourself, 'I've got kids, I can't do it because how are they going to cope?' I think that's one thing that has stopped me recently." (Lived experience of suicidality)*

### GP services

5.61 For most participants, the GP was their first port of call. A few had prior diagnoses of depression or anxiety, and some had already been on anti-depressant medication for some time before reaching out to their GP specifically about suicidality. Those who were experiencing active ideation and crisis at the point they sought help from their GP tended to receive a referral to the crisis team or other mental health services, whereas participants who sought help at an earlier stage were more likely to be prescribed medication or referred for counselling.

5.62 Experiences of seeking support from a GP were varied. Several participants praised their GP for being genuinely caring and supportive, and said that talking to them had resulted in swift referrals to mental health services or third sector support. Nonetheless, the options available to GPs were said to be limited given they are only a referring service.

5.63 For others the experience was disappointing, or entirely negative. Several participants felt that their GP's first (or only) resort was to medication, which for some was due to a lack of training around mental health for GPs and other primary care staff. Better guidance around prescribed medication would also have been welcomed.

> *"I did go to my GP, and they gave me medication, nothing else. They didn't warn me that when you start medication, you dip, so I dipped. No one talked me through that process. That would have been helpful." (Lived experience of suicidality)*

5.64 One participant had visited a GP to report feelings of suicidality, only to be told that their case was too complex to be dealt with in primary care. They did however find another GP to speak to, who was more supportive. Another participant who had mixed experiences described it as being "*like a roundabout*" of trying different treatments in a seemingly ad hoc manner.

> *"It's not one size fits all, but it's treated like it is by the doctors a lot of the time. It's like a roundabout, like 'We tried this and it didn't work so we'll try this, and this doesn't work so we'll go back to that'." (Lived experience of suicidality)*

### Mental health services (crisis team and mental health nurse)

5.65 Those who had contact with a mental health crisis team were largely critical of those experiences and expressed frustration that encounters with the team or with medical staff in A&E (which was a commonly challenging or stressful environment for participants) would often feel like they had come to nothing, especially if they did not result in being ‘taken on’ by the crisis team.

> *“When I’ve been in crisis with the crisis team, or when I’ve been at A&E… You go and see the doctor or whoever after a long wait. They say, ‘I might do a referral to this and this’, but then you go home and nothing has really changed… Unless they take you on, you’re back to nothing.” (Lived experience of suicidality)*

5.66 One participant described the phone call their spouse received from the crisis team following a referral from their GP as “*probably the most useless phone call you could ever have*.” They described it as seeming like a ‘tick box’ exercise that reached no resolution, with the patient opting for self-referral counselling instead. The same participant felt strongly that there should have been a follow-up to that phone call, as it had not reached a constructive conclusion.

> *“Whether it was the same person or somebody else, whether you gave it an hour and called back or even called back the next day… If the crisis team are phoning somebody because of the situation they’re in and they hang up on them… That’s probably a cause for concern. It wasn’t… a positive end to the conversation. In my eyes, it should have been passed to somebody else as failed and ‘Let’s see if we can contact them again’.” (Lived experience of suicidality)*

5.67 One of the participants who talked negatively about the crisis team was the same person who felt that being in work was a barrier to accessing available services, partly due to accessibility out of work hours, but also because the medications prescribed by the team were not compatible with their job.

> *“I went to the GP, then he referred me to… the crisis team… When I was out of work they were brilliant... When I was in work, shocking. Basically if you come off work you get seen faster and you get more care. It’s always, ‘Try these new drugs, try this one, try this strength’. But you can’t do what I do and be on them. You can’t work on them, not my job no way…” (Lived experience of suicidality)*

5.68 The same participant did however praise the crisis team for providing regular home visits at one point when they were at their very worst.

5.69 One of the young people spoke highly of the support they receive from a mental health nurse, who acts as an effective advocate for them, sometimes during their interactions with the crisis team. The young person especially appreciated their knowledge, and the feeling they have someone “*in their corner*.”

> *“I’ve seen the crisis team before, and [the mental health nurse] turned around and said ‘No, they can’t say that to you… you can’t do that…’ Especially when I feel so bad, I don’t have that fight in me. I don’t have that energy to go and say ‘No, I need this.’ I don’t have the knowledge to do that whereas they do.” (Lived experience of suicidality)*

### CAMHS

5.70 A few of the young people had been with CAMHS before they turned 18, and some had found a regular support worker to be beneficial, especially because they felt they had gone above and beyond in their approach.

> *"When I was in CAMHS, my worker was really good... I felt really connected to her... She was sort of like a mentor; she did a lot and probably outside of what the typical thing for CAMHS would be…" (Lived experience of suicidality)*
>
> *"Seeing my CAMHS support worker every week, having that routine, it helps to stabilise me to help me know where I'm at when I've got that once a week." (Lived experience of suicidality)*

## Counselling/talking therapy

5.71 Over half of the participants who had experienced ideation and crises had accessed talking therapy or counselling at some point. Some were referred to it by their GP, some were able to access it through work, whereas others had self-referred or had paid for the service privately. Often participants had seen several different counsellors or therapists.

> *"Speaking to the counsellors at work has been a really good support because they don't have a limit, they work out of hours, and all I've got to do it tap a button at my SharePoint at work and I could book an appointment. Its fully open access…" (Lived experience of suicidality)*

5.72 Where participants had found counselling or talking therapy to be beneficial, it was because they felt it had been '*kind and caring'* and person-centred, or because they had found a therapist or counsellor with whom they had '*clicked.'* A few participants had especially appreciated being given coping techniques like distraction and visualisation, although the latter was less useful for one autistic participant, as they struggle to visualise at all.

> *"When it started it was me not being able to cope with the thoughts because I had no strategies to do that. We'd talk about it in counselling, it was really wicked the way he put things and it tuned into my way of thinking. He was giving me the strategies I could take away each week, to use and then come back and give him examples. That was good." (Lived experience of suicidality*
>
> *"I don't visualise. For me, it's verbal… With the self-help, to manifest you have to visualise. I can't visualise, so what am I meant to do?" (Lived experience of suicidality)*

5.73 Those who were less satisfied with their experiences of counselling or therapy complained that it never went beyond the referral stage, and that they did not feel listened to. Others did not think it had achieved much beyond a degree of understanding as to why they felt the way they did, with no guidance given on how to deal with what they had learned.

> *"I had the counselling over Zoom call, but again that amounted to nothing. I did the 12 sessions, that's the NHS protocol then it is 'There we go sunshine, get on with your life'." (Lived experience of suicidality)*

## Harmless/Tomorrow Project

5.74 A few participants specifically mentioned Harmless/The Tomorrow Project, most often in a positive context (only one participant explicitly described it as *"unhelpful"* but could not recall why they felt that way). Staff members were typically praised, and using the service had made people feel less isolated and helped them to understand the root causes of their feelings and behaviour.

> *"The Tomorrow Project was lovely. Out of all the people I spoke to, [name] was one of the best people I've ever spoken to. She was absolutely magic. It was all phone calls; she'd send me links on email any numbers I needed to ring if I was getting bad. It felt there was somebody there, put it that way..." (Lived experience of suicidality)*

### Peer support worker/peer support groups

5.75 Peer support was mentioned in a very positive light by a few participants. One participant has a peer-support worker, and others talked about attending peer support groups. In both types of environment, participants said they can discuss their feelings and issues in a supportive, non-judgemental environment.

> *"We all have different experiences… It's all about that support for one another. Just to know it's a confidential space with predominantly likeminded people." (Lived experience of suicidality)*
>
> *"It's great having someone that's been through it. She's got the experience, and you can talk so freely without judgement. It's much better than having a clinical support worker because it feels they're judging you and want to get rid of you." (Lived experience of suicidality)*

5.76 Other formal therapies or interventions mentioned included the following:

| | |
|---|---|
| CBT (including MBCT or mindfulness-based cognitive therapy) | • *"My CBT therapist was lovely, and she understood who I was, but I don't think what we did was massively helpful... Worksheets and homework that I didn't feel up to doing so I would pretend I was fine so she'd think I was making progress." (Lived experience of suicidality)* |
| Occupational therapy (OT) | • *"The OT was really good… I thought she was listening to me and wanted to make a positive change… She was explaining why I felt anxious and overwhelmed... And there wasn't a limit on how long I could see her..." (Lived experience of suicidailty)* |
| Emotionally unstable personality disorder (EUPD) treatment | • *"The trauma therapy was good… I'd forgotten a lot of things to do with trauma, so it made me recognise those and why it was making me act certain ways that I wasn't understanding." (Lived experience of suicidailty)* |
| Recovery College | • *"I went to a Recovery College... A year with different courses... like Living with Depression, Living with Anxiety. Then you get a certificate at the end." ..." (Lived experience of suicidality)* |
| Hypnotherapy | • *"I tried hypnotherapy... I only had two or three sessions because they were £70 a pop, but they were just so powerful. I've never tapped into my subconscious self like I did with that..." (Lived experience of suicidality)* |
| Kooth (online mental health platform for children and young people) | • *"Trying to get on the Kooth database took about two years. I didn't ever see them though, they were extremely slow." (Lived experience of suicidality)* |
| Samaritans | • *"I've rung Samaritans before and they're really good, can't fault them one bit." (Lived experience of suicidality)* |

5.77 When asked what formal support had been especially helpful, participants mentioned person-centred counselling; having regular contact with a support worker (or similar professional/practitioner) who can encourage a person to leave the house, talk, and believe in the future; and services that address some of the contributing factors to suicidality.

> *"There's a root problem, and unless you sort the root problem you won't be able to fix the other problems. I really needed something to tackle the root problem as well as the secondary effects of it. I think that has really helped ..." (Lived experience of suicidality)*

## Participants talked about their own future needs and what should be done better to support those experiencing suicidality going forwards in general

5.78 Participants were asked what they would do if they found themselves nearing crisis point, or at crisis point, again in the future.

5.79 Responses varied, but most participants said 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 (Mind and Harmless were both mentioned). Although a few said they would visit their GP, several specifically said they would seek alternatives to NHS support due to waiting times and challenging access.

> *"Unfortunately for me, things that the NHS provide would be the last port of call. I think there's some real good in those areas but there are also big areas for improvement. A lot of it comes down to lack of funding which means access and criteria comes tighter. It's not the services' fault, but they end up getting the brunt of it." (Lived experience of suicidality)*

5.80 A couple of participants acknowledged that they might struggle to reach out at all if they had already reached crisis due to their own state of mind and their perception of there being no immediate support available.

> *"If I'm left on my own and I get to a crisis, I wouldn't contact anyone... it's all waiting now. I think there's nowhere to go to get immediate help..." (Lived experience of suicidality)*

5.81 Others were confident that they are now in a place of recovery and thought it unlikely that they would need to seek help in the future.

> *"My current state of mind is I feel like I have turned a corner. I can see it's a temporary thing; I can see when I'm looking inward and not really thinking logically… I've definitely got coping mechanisms and ways of snapping out of thinking like that now." (Lived experience of suicidality)*

5.82 When asked if they could foresee any barriers to seeking help in the future, a few participants restated some they had already mentioned, such as concerns about confidentiality or an impact on their work or career.

> *"It's such a barrier for so many workplaces. Things like the army, the police. How do you not recognise that someone acknowledging or processing what they've been through and working through that to become a better version of themselves as a massive positive, as opposed to someone who thinks speaking to someone will prevent them from accessing their chosen career?" (Lived experience of suicidality)*

5.83 Others expressed disillusionment with GP services and/or felt that available offers of support were limited to medication or short-term counselling, which they do not consider to be effective. Some expressed frustration at having to repeat their stories and having to seek help repeatedly from the same individuals, which can be off-putting.

5.84 When asked what could be done better to support those experiencing suicidality going forwards, participants suggested a range of considerations which again largely echoed previous comments and themes. These 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.

### Raising awareness

5.85 Raising awareness around mental health and suicidality was considered important, as was raising awareness of the services and support options available to people.

> *"I know the biggest thing with me was not reaching out soon enough and talking about it... Having more awareness around aspects of mental health, because I had no experience of it. I had no understanding of what it actually was." (Lived experience of suicidality)*

5.86 Participants suggested posters and leaflets in, for example, schools, workplaces, and GP and dental surgeries; and events such as Papyrus talks and awareness raising for university and college students.

> *"I think the talks. A lot of my information has come from Papyrus, but the parents who say 'I know they were sad, but the next minute they weren't there' type of thing. I just think more awareness is key. More awareness, breaking down the fact people don't like to talk about it makes it taboo because it's uncomfortable to talk about it. But there can be a state where it's not uncomfortable to talk about it." (Lived experience of suicidality)*

5.87 One participant described an awareness raising effort they had initiated at their college, whereby they developed classroom posters outlining the mental health support available to students, including *"pictures of the faces so [students] knew 'I recognize that person, I can talk to them.'"* Another referred to the 'Nott Alone' website, which they had been involved in developing, alongside other MH:2K[4] members.

> *"Nott Alone… is a great resource where you can either find out information [on] how you can help others [and] how you can help yourself through different topics. And I think there's… a helpline there as well in case you want to talk to someone." (Lived experience of suicidality)*

### Faster access to support

5.88 Several participants expressed a need for more 'swift' or 'immediate' responses to suicidal ideation and crisis, shorter waiting lists, and pro-active offers of person-centred support (i.e., ones that do not rely on self-referral).

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[4] MH:2K is a panel of young people from Nottinghamshire who take part in activities and consultations on topics relating to mental health MH:2K – Leaders Unlocked (leaders-unlocked.org)

> *"Immediate support that is less clinical and more supportive. I think the best approach would be up to the person, and I think the person needs to be seeing not necessarily a mental health professional but someone very kind and understanding. And not going, 'You're not that bad'. Instead, validate them and hear them..." (Lived experience of suicidality)*

5.89 Proactive, regular follow-up checks were also considered important.

> *"… Ringing up regularly, checking on that person... I can assure you more people will say it's beneficial if it's 'You ring me, rather than I ring you' because you won't ring them..." (Lived experience of suicidality)*

### Open access, non-clinical support options, or peer-based support

5.90 Open access, non-clinical support options were frequently suggested, especially in enabling early intervention. These, it was felt, should be accessible in a range of locations and formats: in-person, over the telephone, by text message or WhatsApp, and online.

> *"I think there should be one stop shop places where you can go to. It would give you someone to talk to and talk about your feelings. It could be a professional running… but it could be peer support. Someone you can go see on your own if you're having a crisis, not just a group." (Lived experience of suicidality)*
>
> *"I think there needs to be something that is regularly available to people, on an open access basis, where they're not expecting men to fill in all their details and what's wrong with them and everything… It needs to be an informal setting." (Lived experience of suicidality)*

5.91 Once again, peer support was considered crucial in offering opportunities for those with lived experience to support each other within safe, non-judgemental spaces.

> *"What has helped me a lot is speaking to someone who has got it themselves, because you know what they're going through and they know what you're going through. I think you feel more secure… No-one judges anybody. You can talk to them more than your wife, friends or whatever because they've been in the same situation." (Lived experience of suicidality)*

5.92 A couple of participants mentioned Nottinghamshire Crisis Sanctuaries[5] as a positive alternative to clinical support for people in crisis. In particular, offering an option other than A&E was thought to be important given the inappropriateness of the environment in dealing with mental health issues.

> *"Maybe having an alternative like that to A&E, because A&E is awful. It's so clinical. It's not very mental health focussed at all. It is just for physical health; you shouldn't be there." (Lived experience of suicidality)*

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[5] Follow this link to visit the Nottinghamshire crisis sanctuaries website

5.93 In this context, one participant also suggested a room in A&E “Where you can go and you can have a cup of tea and there’s just someone there you can speak to, even someone not trained.”

> *“Even if it’s just someone sat in the corner of the library that you can have a discreet chat to, it is having someone that is freely available for people that need support.” (Lived experience of suicidality)*

### Longer-term support

5.94 Sustained, or longer-term support was felt to be needed too. One participant said that “*The initial help was bloody fantastic and I can’t knock that, [but] the follow up has just been lacklustre*.” Time limited offers of counselling and CBT or being given medication without supplementary support were not felt to always be beneficial; participants were left feeling ‘*dropped*’ and still in need of support afterwards.

> *“Anybody going through something like this knows 12 sessions isn’t going to scratch anything. Come on, let’s be real here. Stop cutting people off and leaving them in limbo. You give the lifeline, then you cut the lifeline. It’s stupid.” (Lived experience of suicidality)*
>
> *“I thought I would have someone with me for a while to make sure I wouldn’t do anything again. I needed support regularly. It would disappear after so long if you’re on your medication. They tell you you’re ok even though you know you’re not. The last place I went to, the psychiatric nurse said, ‘No, you don’t need us. You said you were going to go swimming.’ I didn’t want to go swimming. She discharged me.” (Lived experience of suicidality)*

### Practical support

5.95 Some emphasised the importance of services that can provide practical support to address the root causes of suicidality, like financial and relationship problems, academic challenges, or bereavement. Indeed, it was said that without addressing the factors causing it, it is impossible to address the suicidality itself.

> *“Looking back at when I was struggling, it wasn’t just one thing [and] that’s a really important thing to consider when looking at services. They need to support you in every avenue you’re struggling with… When you’ve had the ideation where it’s like, ‘My life doesn’t matter anymore’ “You need someone to fix all those areas. It needs to be in one place.” (Lived experience of suicidality)*

### Other suggestions

5.96 Other suggestions for future support were as overleaf.

| | |
|---|---|
| Improvements to crisis provision (criteria, accessibility, and out-of-hours provision) | • *“When you call crisis services… because they’re so busy, if you’ve got a plan for a few days away… you’re not recognised as being at crisis so you won’t be accepted… They only do working hours and if you call them they’ll say ‘Ok, we can be there the next day.’” (Lived experience of suicidality)* |
| More safe spaces specifically for men | • *“… I went to a group session, and I didn’t find it very helpful. Straight away she was like, ‘Ooh, we have men in here’. There were three of us in there but they turned around and made us feel alien straight away… Like men aren’t allowed to get mental health [issues]? …” (Lived experience of suicidality)* |
| Crisis/safety plans for those experiencing suicide ideation | • *“… Having that plan… ‘In case of this, this is what you can do. Your friends are really important, talking about it, the support that’s available… There’s self-care…’ [Something that] provides that package of support which makes a difference. I think it’s made a definite difference for me…” (Lived experience of suicidality)* |
| More trauma-informed provision | • *“There needs to be more trauma informed and lived experience professionals, and the funding to give training to those who want to do it...” (Lived experience of suicidality)* |
| More advocacy services | • *“… Can we have advocates that are on our side? ... Someone who is on your team who will call and shout down the phone if needed.” (Lived experience of suicidality)* |
| Alternative support models (i.e., gym memberships | • *“They should listen to you and say, because everyone is different, ‘What would be more beneficial?’ Whether it be a free gym membership or something like that... Whatever they come up with, whatever they think would help.” (Lived experience of suicidality)* |
| Pre-crisis helpline (for people experiencing ideation but not at crisis point) | • *“It almost seems like the only options that are out there are the crisis point options, not for the build-up where people are starting to feel like they’re ideating... There’s no 111 for mental health... Just something less than a 999-phone number.” (Lived experience of suicidality)* |

# 6. Targeted communication campaigns

## Participants' views on targeted messaging and communications

### Summary of evidence and insights

Participants were asked to suggest key messages around raising awareness, addressing stigma, and increasing help seeking behaviours.

The key suggestions around <u>raising awareness</u> 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 want to and can provide that help

Promoting other types of support besides talking, such as self-help YouTube videos

Increasing education on suicidality and self-harm

Co-producing materials with particular groups (autistic people in particular) to ensure any messaging resonates with them

The key suggestions around <u>addressing stigma</u> 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

Changing 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.

Ensuring communications aiming to address stigma among young people aim to view it from the perspective of those young people.

The key suggestions around <u>increasing help seeking behaviour</u> 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, which can be complex

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.’
- 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
- 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.’

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; and via posters on, say, public transport and the back of toilet doors in pubs and clubs
- Targeting people in the workplace and on their commute through strategically placed messaging
- Targeting young people in schools and other education settings
- Reaching people through hobbies and community activities
- To take advantage of all available communication methods or platforms, given that no single approach will work for everyone.

# Full overview of findings

## Raising awareness of suicidality

### People should know they are not alone and that speaking to others could help

6.1 All participant types agreed that the message ‘*You are not alone*’ is important when raising awareness of suicidality. Participants highlighted the sense of comfort people feel when told that others share similar thoughts and feelings and felt that this statement can normalise a person’s experience of suicidality.

> *“… I want people to think what they're going through is important; that people care about their experience and just that they're not alone.” (Bereaved by suicide)*

6.2 Some practitioners found that promoting talking, particularly with peers with lived experience, can help raise awareness and prevent escalating suicidality.

> *“Something like, ‘It’s good to talk’ or ‘Just talk to someone’… It’s much better now, since Covid we’re all talking about mental health problems. It’s much better, still not brilliant…” (Practitioner – Bereavement)*

6.3 Moreover, acknowledging the challenges around capacity within ‘formal’ services, they felt that people should be encouraged to speak more informally with a trusted person. On the other hand, it was also considered important to reinforce the message that even if services cannot offer immediate support, they do want to help, and that some persistence may be needed.

> *"Seek help, because there are people there that care, and they do want to support you. They do want to help you on your recovery journey. If there's a number that doesn't answer, ring again." (Bereaved by suicide)*

## Promoting other types of support besides talking, and take a person-centred approach

6.4 Despite the perceived importance of talking, some participants acknowledged that not all people experiencing suicidality will benefit from doing so. Recommending other coping mechanisms could help reach those people.

> *"Part of it is you don't necessarily have to talk to anybody… In my experience most people will come out with it after the event, but at the time they didn't tell anybody. They self-managed their way through that. We need some stuff that is less about 'You have to talk about it' but also about how you can help sort yourself out. 'Here are some films or YouTube videos,' whatever it may be…" (Practitioner – Men)*

6.5 A few participants felt that more discussion around other types of support is needed to raise awareness of how suicidality or bereavement impacts people differently, and what might be most beneficial to a particular individual (one-to-one versus group sessions for example). One practitioner highlighted parents of autistic children as a key demographic for this, as they can be particularly unaware of what is available.

> *"I think it would be mostly about signposting, making sure people are getting to the right place to get that support. I think probably one of the biggest frustrations parents have… is they've been asking for support but haven't been in the right place or haven't been heard." (Practitioner – Autism)*

## Increasing education on suicidality and self-harm

6.6 Participants with lived experience highlighted gaps in recognising suicidality among those experiencing it and the people around them. It was said that more education and messaging around the realities of suicidality could help people realise their own ideation, while also helping others to understand and support them with it.

> *"For me, it was the first time I sat and googled that ideation was a thing… It was raising awareness of it…" (Lived experience of suicidality)*
>
> *"I also think it's important to recognise that a lot of people hide It. When you see messaging for suicide awareness it's often someone that appears very sad whereas when I was at my worst I was going to work and making jokes and dressed in bright colours, when actually, I was quitting my job, moving out and not speaking to my parents." (Lived experience of suicidality)*

6.7 Similarly, more awareness and messaging around self-harm and the support available for it could, it was felt, raise awareness of suicidality overall.

6.8 One practitioner noted the use of statistics as key in educating and raising awareness around suicidality.

> *"… I'd probably say a statistic. How many people actually think about it, how many people have a fleeting thought or how many have been bereaved by suicide, someone with ideations. I think it always sticks out when you see a statistic… That normalises it for some people. It recognises the shock of it, but it normalises it." (Practitioner – Young People)*

### Using specific language when raising awareness among autistic people

6.9 A few practitioners noted the importance of language when raising awareness among autistic people: it was said that accessibility is key to reaching this audience and should be considered for any communication campaigns. There are also apparently some misconceptions around language and the autistic community, with people often assuming that the accessibility needs of autistic people and people with learning disabilities are the same. Practitioners advised co-producing materials with autistic people, to ensure messaging resonates when raising awareness of suicidality.

> *"… Identify first language, so they are autistic rather than somebody with autism, that is hugely important to them… They also don't like the assumption that autism equals learning disability, and therefore communications should be in an easy read format and using lots of symbols and pictures. They like things that are simple and easy on the eye and nicely presented, but they don't like the use of the symbols and what we would do to make something accessible to someone with a learning disability… I think it would be good to speak to the autistic community." (Practitioner – Autism)*

6.10 Practitioners also felt that communication campaigns should be produced in multiple reading formats to reflect the various types of autism and accessibility needs, and that anything produced for autistic people must be clear and direct about what support is on offer and *"what's in it for them."* (Lived experience of suicidality).

## Addressing stigma

### Increasing education and awareness of mental health and the prevalence of suicidality

6.11 Participants agreed that there should be more awareness of what suicidality means, suggesting that there should be more messaging explaining that it is a mental illness, which does not discriminate. Participants hoped that increasing awareness of the numbers of people impacted by mental ill-health and illness would eventually lead to a corresponding decrease in the shame and stigma attached to it.

> *"It's about getting the idea out to people that you don't need to be so ashamed about it. It's the reverse of stigma. People will be sympathetic… People are more understanding than you actually think… If his shame wasn't so big, [name] might have been more ready to accept that he was mentally ill. He just couldn't accept [it]… So to get across the idea [that] it is an illness… Some sort of education around that." (Bereaved by suicide)*

6.12 Conversely, one practitioner expressed the view that suicide is not exclusively a health concern, and that there are other cultural factors that resonate more with certain people. For example, some people have negative experiences or perceptions of accessing health services, and therefore struggle to identify with conversations around health. Stigma could be reduced for those people if suicide was discussed outside that sphere.

> *"A lot of people… very much align mental health with health services, and there's a whole other stigma attached to that. Suicide prevention sits within a health sphere, but most people will never go near a mental health practitioner, even though they are suicidal... There's something about disentangling suicide and suicide prevention from it being about mental health... We need to talk about suicide, but we also need to talk about suicide as not being only a health issue." (Practitioner – Men)*

## Changing the way we speak about suicidality

6.13 Bereavement practitioners noted the importance of language and how people speak about suicide in reducing stigma. For example, it was said that there should be less use of criminalising language like '*commit*' or '*committed*' to reduce stigma around the historical illegality of suicide. Furthermore, practitioners felt that people would benefit from more open and direct conversations about suicidality, reducing shame and secrecy around the topic and encouraging people to speak out.

> *"If we never mention suicide and suspected suicide, it's never going to reduce the stigma… People need to acknowledge it does happen and it happens anywhere to anybody." (Practitioner – Bereavement)*

## Reducing shame and fear by reinforcing that '*You are not alone*' and '*You are not weak*'

6.14 Participants from all groups (and particularly men with lived experience) reinforced the importance of '*You are not alone*' when addressing stigma around suicide prevention. They recognised shame, fear, and embarrassment as key feelings associated with suicidality stigma; and said that if *'You are not alone'* could be pushed across all messaging, these feelings could be mitigated for some people. Sharing lived experience and peer support could further cement this message.

> *"You're not on your own, it's way more common than you think… Don't feel like you're on your own and get stuck in that loop of just looking inwards and at yourself." (Lived experienced of suicidality)*
>
> *"I think that lived experience, the words from people that have been there, is really important, and I think hearing real life stories is really important." (Practitioner – Gambling)*

6.15 Similarly, stating that '*You are not weak*' when talking about suicidality and seeking help could, it was felt, reduce stigma. In fact, emphasising the very reverse – that it takes enormous strength to share experiences and seek support – was suggested, especially for men.

> *"I think we all experience negativity and bad thoughts… don't be afraid, it's not a weakness by any means. I think it's a strength coming out and saying, 'I know I need somebody to talk to because I know I'm just not feeling the best at the minute'..." (Lived experience of suicidality)*
>
> *"I'd just say it's not a weakness showing that you're vulnerable. That is a strength in itself. I think that's the first step to getting better." (Lived experience of suicidality)*

### Using public figures in suicide prevention campaigns

6.16 It was suggested that the influence and reach of public figures could be used to promote talking and reduce stigma around suicidality. As with peer support, people were said to find comfort in hearing others (particularly people they look up to) talk openly about how suicidality has impacted them and where to seek support. It was also suggested that this would be a welcome change to the source of information for those who have lost trust in public bodies like the government or NHS.

> *"You often find that when a celebrity comes out about their physical or mental health it becomes headline news and suddenly people start to access services. That breaks down that stigma." (Lived experience of suicidality)*
>
> *"… I sat with a lot of young men at the time and all of them were coming in going, 'I've been listening to Tyson Fury, and this is why I'm reaching out'…" (Practitioner – Men)*

### Stopping the blame in bereavement to reduce stigma

6.17 As mentioned earlier in this report, many people who are bereaved by suicide feel they are in some way to blame for the deceased taking their own life. Messaging should thus focus on the fact that it is not the fault of the person or people left behind even if they did or said something they regret, for *"it's up to the other person what they do with that."* (Bereaved by suicide)

> *"One of the messages I really don't like is this zero-suicide message. The narrative of 'all suicides are preventable'… Because if they're all preventable that means someone's failed to prevent them. And therefore, who's to blame? I think that's something that will help in terms of stigma, getting rid of some of those messages because sometimes it just happens and sometimes no one could have stopped it." (Bereaved by suicide)*

### Addressing stigma among young people

6.18 Practitioners commented on generational variations in how people recognise stigma. It was thus said that any communications aiming to address stigma among young people should aim to view it from their perspective (through co-production again). This can also be true of autistic young people: one practitioner explained that this group may not recognise stigma at all, so may not benefit from messaging around this issue.

> *"… the young people we work with, I'm not sure they see it as stigma particularly when people get to the point where they're coming here. Things are so bad for them it's not about what other people are seeing..." (Practitioner – Autism)*

## Ways to increase help seeking behaviour

### Advertising and informing about available support

6.19 Participants across all risk groups recognised that there are services that support people in their situation; but felt there should be more information and advertisement to encourage people to seek that support.

6.20 Bereaved people said they can feel like there is nowhere to turn, and that the unique nature of their bereavement can feel challenging. As such, it was said that services should tailor their advertisements to inform people that their support is specifically for this type of bereavement, while remaining sensitive to the topic of suicide.

> *"I think people need to hear that those services are designed for them. They're not general grief or bereavement services, and there will be no judgment… I think you need to know you don't need to censor, no one's going to be shocked." (Bereaved by suicide)*

6.21 Again, the message that there are people out there that want to support could increase help seeking behaviour for some. It was also said that waiting lists and access to specialist services can be a key barrier to seeking support, and that people need be made aware of less formal settings that can support them when they need it most.

> *"… Send that message out that there's a safe place to come and to talk about any problems, and any issues… A confidential, non-judgmental, place where you can get help and support straight away and not be turned away… Almost like a safety net, because services are so stretched. If someone needs help, they need it now… We might not all be expert counsellors, we might not have all the qualifications, but we understand. So at least that's there and we listen..." (Bereaved by suicide)*

6.22 Some participants highlighted that not everyone benefits from 'aggressive' advertisement and information, and that there should be space for 'gentle' signposting and optional support when accessing other services. For young people especially, not being too directive about what they might need and stressing the flexibility of available support was considered essential.

> *"… So, we get some young people who would potentially utilise behaviours that might not be so great like vaping, because it's a coping strategy we've managed to build down to from having been self-harming. Sometimes I think services are like, 'We're going to change all of that' … I think some of our young people do get really annoyed…" (Practitioner – Young People)*

6.23 For those with protected characteristics, knowing that they could receive support from someone from a similar background can be beneficial. One young person shared their positive experience of speaking to a professional of the same race for example, as they had a shared understanding of cultural issues.

> *"… The experiences I had with mental health support were very good, but I feel like the most impactful was when I had a black woman as my counsellor r because it felt like she shared my experience. Also, when you're talking about suicidal thoughts, why you feel suicidal, why you're self-harming and everything, a lot of cultural things might come out of it as well." (Lived experience of suicidality)*

### Ensuring people know they will not be punished for seeking support

6.24 Another main barrier preventing people from seeking support is the fear of possible consequences or loss of control over their life and decisions. Reinforcing that '*You are in control*' and '*You will not be punished'* could thus increase help seeking tendencies for some.

> *"… Some sort of message to say that you have more control over this than you think you do. And that you can, and you should take control in whatever way you can to try and make it better... That it is possible to seek help and find help on your terms. I think [recognising that you have] that agency is the main thing." (Lived experience of suicidality)*

## Ensuring people know there is nothing to lose from talking before acting

6.25 Participants felt that messaging like '*You have nothing to lose*' could be impactful for people (particularly those with active suicidality), as speaking to someone before acting upon any ideation could change their mindset in a positive way.

> *"People just need to know it's good to talk, which is the oldest one. If you're going to do it, you're going to do it. But before you do it, talk to somebody first. What have you got to lose? You've got nothing to lose if you're going to do it anyway, just put it off and talk to somebody professional, or peer. Somebody, anybody." (Bereaved by suicide)*
>
> *"I'd probably say something like, 'Have a go, you never know.' I would emphasise the mysterious aspect of you never know what might happen as a result of [talking to someone] …" (Lived experienced of suicidality)*

## The importance of lived experience and peer support in demonstrating effective help seeking behaviours

6.26 As mentioned earlier, the statement '*You are not alone*' can have significant impact on a person's outlook when seeking help with their suicidality. In order to portray this message authentically and offer hope, many participants suggested lived experience testimonies and recovery stories from peers.

> *"I know it's really trivial but, 'You are not alone'. It's what I see young people realising when they come to peer support sessions like 'I am not alone with this, it's ok. These people are like me and that's ok'. It makes them more comfortable to talk about or reach out for that support because they understand." (Practitioner – Young People)*

## Asking people about their suicidality to increase their help seeking behaviours

6.27 The sensitive nature of suicidality can often prevent people from talking directly about it. Some participants advocated messaging for society more generally around direct and open approaches to addressing someone's mental health issues to promote help seeking behaviour.

> *"It's about opening up the conversation. Don't be frightened to open up the conversation. Take the initiative, talk about it..." (Practitioner – Bereavement)*
>
> *"… I think just making ok that it's a conversation to be had at some point, especially if you feel like you see some signs in a close friend or a family member that that really could help." (Lived experience of suicidality)*

6.28 This could be especially effective for people who are not fully aware of their own suicidality, as having that discussion could prompt them to look internally and identify that they do have issues that need addressing.

> *"For a lot of people, they don't identify as at crisis point or suicidality, they just think life is too much and they can't do it anymore. If it's more practical elements or drivers to their stress they'll just think, 'This is my way out'. I think it's a way to relate to them in the messaging..." (Lived experience of suicidality)*

### Improving help seeking behaviours in men

6.29 Men were highlighted as a key group that struggle to seek help and support for their suicidality. Participants felt that there should be more focus on using the 'right' language, people knowing there are appropriate spaces available for them, and overcoming gender stereotypes like '*Men don't cry*' to encourage help seeking.

> *"… Most health professionals are women, so we are women writing messages for men. I think we need to get the people involved who are going to be reading the messages." (Bereaved by suicide)*
>
> *"Men are told from a very early age, 'Don't cry, man up, you'll be ok, stiff upper lip' and all the rest of it… I think it makes people become prideful, then they don't like to ask for help. So, men often are embarrassed to ask for help. They don't want to look vulnerable to people or look like they're somehow less because they've had to ask for help." (Lived experience of suicidality)*

## Communicating the messages

### Online/social media

6.30 Most participants felt that key messages should be communicated via online and social media platforms, as these have the biggest reach in modern society. Online forums (e.g., Enlighten the Shadows), work portals (e.g., Connect for NHS staff), and social media (e.g., Facebook, TikTok, and YouTube) were all considered ideal tools for this purpose.

> *"Social media, marketing, getting influencers, celebrities to talk about it… I think it's having every single channel at your disposal, because all of us have different preferences... I think hitting every one of them is effective." (Lived experience of suicidality)*

### Displaying key messages on tangible products and in key locations

6.31 Practitioners and those with experience supporting people with suicidality suggested displaying slogans and messaging on tangible products like beer mats,' business cards', and t-shirts; and via posters on, say, public transport and the back of toilet doors in pubs and clubs. It was said that this method of dissemination can reach targeted groups while remaining discreet.

> *“Being able to look down and see that [beer mat], its discreet. I was at an event handing out wallet sized cards and another lad was handing out flyers; I handed out around 200, the other lad must have given out around 40. Having that accessibility of small pieces of literature is key…” (Lived experience of suicidality)*
>
> *“… I do think the back of toilet doors is a good one, because a lot of people go in the toilet to have a moment to themselves, like a breather. If you do that, you’re likely to have your bag on you, with your phone so you can take a photo of it. Whereas if it’s on a wall somewhere and you’re with your friends, you might not want to take a photo of it.” (Lived experience of suicidality)*

## Providing information in the workplace and on commute journeys

6.32 Targeting people in the workplace and on their commute was suggested. For example, one men’s mental health practitioner described a successful visit to a local fire station whereby attendees fully opened up about mental health issues, some for the first time; and a person with lived experience pf suicidality proposed using advertising billboards to display messaging could prove effective, providing that messaging is compelling enough.

> *“… Places that people will see on the way to work. Work was the main thing I’d go out and do… If there was something on something like those big billboard type things on the streets in Notts city centre that you don’t want to look at but can’t miss… if there was something compelling enough on those that would break someone out of that fog.” (Lived experience of suicidality)*

## Targeting young people in schools and other education settings

6.33 Participants advocated more support in schools, colleges and universities to educate young people on emotional literacy, how to regulate emotions, and where to seek support. This, it was felt, could improve future outcomes for young people, as they take those teachings into adulthood.

> *“People have suicidal thoughts just because things are tough and they don’t know how to cope... It goes a lot further back. I think you need to start in schools, emotional literacy, emotional education with students, helping young people learn how to regulate emotion and to be okay and to let emotion in… So that when you're an adult and then you get those big feelings and you might be not wanting to be here, you can understand them. You've got language for emotional regulation to make sense of them.” (Bereaved by suicide)*

## Reaching people through hobbies and community activities

6.34 Spreading key messages through hobbies and community activities was thought to be a positive way of reaching people who would not usually engage with suicide prevention services. This could apply to all of the identified risk groups, though men and young people were identified as the key. Support services could, it was felt, form partnerships with suitable groups or clubs to build a rapport with those in need of help.

> *"Partnerships, we've got loads. The biggest thing is with 'No Shame[6]'. We've got a boxing gym, football club, Men's Health." (Practitioner – Men)*
>
> *"… They always put ads on before the cinema, before the football games. Occasionally we all gather in the middle of the city square to do something…" (Bereaved by suicide)*

## The most effective way of communicating key messages is by utilising multiple methods and platforms

6.35 Participants largely agreed that the most effective way to reach people in need is to take advantage of all available communication methods or platforms, given that no single approach will work for everyone. Essentially, variety is key to engaging with the different risk groups.

> *"I think a good variety is important… You want the younger people to see it, maybe on TikTok but you also want the people who are maybe in their 50s to see it as well, but they won't see it on TikTok..." (Lived experience of suicidality)*

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[6] 'No Shame' is a brand of sports clothing.

# 7. Recommendations

## Overall conclusions and recommendations

7.1 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 (NB see 3.11, 3.49, 5.37, 5.41, 5.90 and 5.92)

7.2 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 (NB see 3.29,3.31, 3.32, 3.42, 3.43, 4.25, 4.66, 4.77, 5.30, 5.37, 5.38, 5.77, 5.92, 5.93, 6.2, 6.14 and 6.26)

7.3 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 (NB see 3.49, 4.25, 4.58, 4.70, 4.74, 5.37, 5.38 and 5.96)

7.4 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 (NB see 4.27, 5.94, 5.95)

7.5 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 (NB see 3.72, 5.48, 5.86 and 5.90, 5.92)

7.6 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 (NB see 3.20, 3.72, 3.74, 5.28, 5.37, 5.86, 5.92, 5.93 and 6.21)

7.7 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 (NB see 4.16, 4.29 and 4.30)

7.8 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 (NB see 4.25, 4.84, 5.70 and 5.86)

7.9 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 (NB see 5.37 and 5.98)

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

### Recommendation 10: Person-centred services (NB see 5.74, 5.79, 5.86, 5.90 and 6.4)

Support services for bereavement and suicidality should adopt a person-centred approach[7]. Services should be adaptive to peoples' accessibility needs (including transport, online access, out of hours provision and translation services).

### Recommendation 11: Training (NB see 3.54, 3.55, 3.75, 4.79 and 5.65)

7.11 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 (NB see 3.36, 3.37 and 3.77)

7.12 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.

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[7] 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.

### 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 (NB see 3.66, 3.67, 3.72, 3.75, 4.6, 4.17, 4.18, 4.23, 4.56, 4.64, 4.65, 5.16, 5.66, 5.85, 5.88 and 6.32)

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

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 (NB see 4.53 and 4.54)

7.14 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 (NB see 5.34)

7.15 The use of 'Hope boxes[8]' 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 (NB see 3.64, 3.75, 4.3, 4.25, 5.57, 5.86, 5.87, 5.88, 5.89, 6.1, 6.6, 6.7, 6.9, 6.10, and 6.29)

7.16 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 (NB see 3.17, 3.62, 3.74, 5.37, 5.40, 5.92, 6.30 and 6.34)

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

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

### Recommendation 18: Services for men (NB see 3.8, 3.16, 3.35, 3.52, 5.37, 5.98, 6.14, 6.15, 6.29, 6.32 and 6.34)

7.18 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 (NB see 3.18, 3.49, 3.50, 3.58, 3.59, 3.62, 3.63, 3.68, 3.76, 4.51, 4.52, 5.18, 5.19, 5.39, 5.40, 5.46, 5.47, 5.71, 5.72, 5.92, 6.33 and 6.34)

7.19 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.

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 (NB see 3.10, 3.23, 3.34, 3.45, 3.49, 3.50, 3.54, 3.56, 3.60, 3.68, 3.70, 4.18, 4.27, 5.17, 5.40, 6.5, 6.9, 6.10 and 6.18)

7.20 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 (NB see 3.22, 3.49, 5.53, 5.76, 5.79 and 5.97)

7.21 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 (NB see 3.29, 3.32, 3.38, 3.40, 3.42, 3.49, 3.52, 3.53, 3.54, 3.55, 3.37, 3.58, 3.59, 3.69, 3.70, all of chapter 4, 6.17, 6.20 and 6.21)

7.22 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** (NB see chapter 6)

7.23 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)

# Appendix 2 : Table of figures