# Suicide Prevention: National Mental Health Forum Report
# November 2019

## Summary

### Process involved in producing this report

- Suicide prevention chosen as a topic at our forum meeting in September 2018
- An initial report was written and presented at our forum meeting held in March 2019. At this meeting, views of forum members were collected via individual questionnaires and a group discussion (see appendices)
- There has since been ongoing feedback, comments and additions to this report and the final version has been compiled to reflect (as far as possible) everyone's views

### Key Themes

Service users and carers can offer a *unique perspective* on the subject of suicide prevention. This unique perspective from those with lived experience can enhance understanding of people providing services and also the general public.

Themes emerging from questionnaire completion, discussion and ongoing feedback are:

**The importance of:**

- *Not feeling judged*
- *Feeling valued and cared for*
- *Compassion and kindness*
- *Being listened to and believed*
- *Feeling understood*
- *Acknowledgment of pain and distress*
- *Taking action and intervening earlier*

**The need for:**

- *More openness*
- *Better understanding of individuals, the public, organisations and service providers*
- *Changing Attitudes and Challenging Myths*

- *Compassion, respect and kindness from all service providers*

**The view of forum members is that progress in suicide prevention requires:**

- Better engagement of those with lived experience
- Involvement of service users and carers in all training design and delivery
- Collection of stories from those who have made a suicide attempt and survived, and these stories to be used in both training and policy making
- Mandatory training for primary care staff, ED staff
- People with lived experience to be part of a suicide prevention programme in schools
- Proper funding for a good quality service and involvement of service users and carers in in discussions on how best to use this funding and any existing resources
- More use of SMART objectives to focus attention, plan services, gain feedback and learn

**Question to LPBs**

- In relation to what we (as service users and carers) have identified in our report, what resources have you committed to preventing suicide in your local area and how do you know if it is making a difference?

# National forum report: Suicide Prevention

## Introduction

A national forum subgroup discussed suicide prevention before going back to forum to report back and gather more views from other service users and carers

## Discussion points from forum subgroup meeting

**Themes:**

- **Unique perspective and contribution of service users and carers**
- **Importance of knowledge / understanding / education of the public and service providers**
- **Timely access to help and advice**
- **Coordination of preventative actions**

## Unique perspective and contribution of service users and carers

- How can we (as service users / carers) add value to current strategy
    - Important to have knowledge of what has already been included in reports and strategies so that we can add something meaningful / relevant from a service user and carer unique perspective
    - We need to focus on what is missing from reports
- Importance of suicide being 'Everybody's business' (some reports appear to have been written with very little input from those with lived experience, i.e. 'everybody's business' but ours)
- What is happening to £500,000? – service users need to have more say in this
- Importance of including peers / family / friends in any strategy (as 'first responders')
- Need stories from those who have attempted suicide and also friends / family of those who have attempted suicide /completed suicide (importance of 'lived experience' accounts). Existing reports have lots of stories from family/friends, and none from those who have attempted suicide themselves
- Recap on Suicide and self-harm strategy groups:

- National Advisory Group
- Three regional groups (North, South West and Mid, South East)
- There is a ‘service user’ on the National Advisory Group. Discussed need for more service user presence on National Advisory Group. Also would be good if the NAG service user could also come to the forum so that they would be more ‘representative’.

**Importance of knowledge / understanding / education of the public and service providers**

- Need evidence of what is effective in reducing suicide rates
- Need to undertake a training ‘audit’ for public / relevant staff
- Register for people with ASSIST training
- ‘Stay Alive’ app : content pack Grassroots
- Information campaigns, training campaigns
- Corporate marketing important – people have got to know about it – e.g. pens with phone numbers, beer mats with information. Needs to be much more awareness of what is going on / what help is available
- Need to discuss suicide prevention and self-harm prevention as two separate issues

**Timely access to help and advice**

- Need more focus on peer support
- Need for Safe place / Safe house / ‘Virtual’ safe house / person to ‘sit with’ those who are at crisis point (need to identify what is meant by ‘Place of Safety’)
- High risk of suicide first 3 days after discharge from hospital
- Helplines should not be expensive
- Numbers to call in a crisis should be memorable

**Coordination of preventative actions**

- Need for Action – not just theory, discussion, reports
- Problem identified re: lack of resources (finances) – money pledged appears to be going towards help for those people bereaved by suicide

- We would like to see local coordinators as opposed to regional coordinators. A network of coordinators (I per health board) plus resources could more effectively influence actions
- Should focus be ‘All’ or ‘High Risk Groups’? (as identified by strategy)

**Some examples of good practice**

- Voluntary sector scheme working with young farmers
- Pilot for community MH team nurse going into schools working with counsellors and vulnerable children identifying pathways for children (involving CAMHS)
- Campaign about importance of opening up – SOS – Stop, Open up, Signal for Help. Posters, leaflets on back of public toilet doors, above urinals. Within the leaflet is information about what you can do to access help or to help yourself
- Some good websites (iawn)
- ‘Chatbot’ algorithm
- Samaritans running groups for people bereaved by suicide
- Papyrus

**Presentation to March 2019 Forum**

- Jane introduced session and give a brief outline of some key discussion points from our meeting
- Penny gave an overview of current reports and funding
- Maggie talked about the importance of Peer Support
- John talked about the need for Actions (and more funding)
- Jane explained questionnaire, workshop group questions and support available for forum members

## Existing policies, documents and structures (current reports and funding) - Penny

### Talk to Me 2

Welsh Strategy for the prevention of suicide and self-harm

This strategy goes from 2015-2020

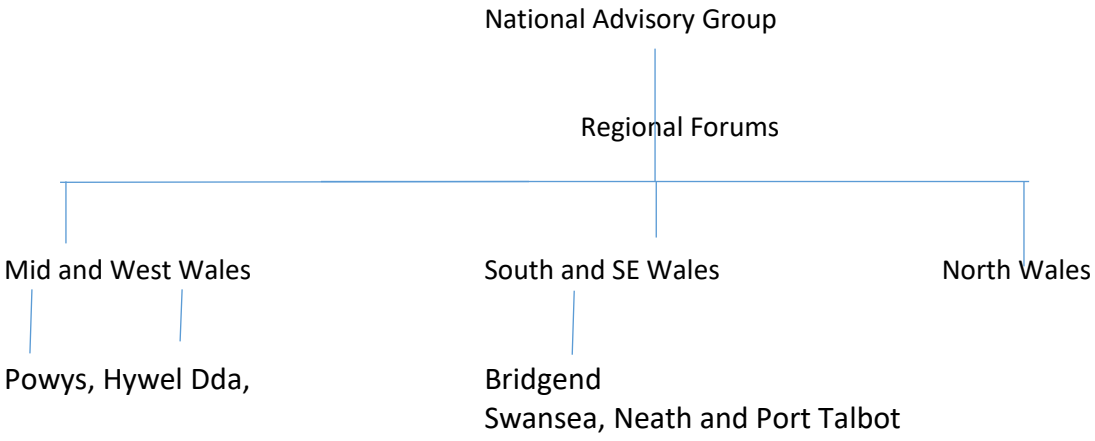
Its overall aims are to:-

- reduce suicide and self-harm in the general population of Wales
- Promote coordinate and support plans and programmes for the prevention of suicidal behaviours and self-harm at national regional and local levels

***It has 6 objectives***

1) Improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self-harm and professionals in Wales
2) To deliver appropriate responses to personal crises, early intervention and management of suicidal behaviours and self-harm.
3) Information and support for those bereaved or affected by suicide and self-harm
4) Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
5) Reduce access to the means of suicide
6) Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

***Structures for implementation***




Each aim to have local area plans

***Priority People***

The strategy recognises a wide range of at risk groups but picks 6 as priority.
These are:-

- Men in mid-life
- Older people over 65 with depression and co-morbid physical illness
- Adult prisoners
- Children and young people with a background of vulnerability
- People in the care of mental health services including in-patients
- People with a history of self-harm

***Services and priority care providers.***

The strategy recognises the contribution of many different services and professionals who regularly have contact with people at risk of suicide and self-harm.

They pick out a few priority professionals groups

- Police, fire fighters and Welsh Ambulance staff
- Primary care staff
- Emergency department staff

They also emphasise the need for all these services to be available through the Welsh language.

***Priority Places***

The strategy recognises a number of places where suicide prevention should be focussed, and picks 4 priority places.

- Rural areas
- Work-places
- Schools, further and higher education establishments
- Prisons and Police custody Suites

## ‘Everybody’s Business – A report on suicide prevention in Wales’ Health, Social care and Sport Committee of the National Assembly for Wales

There are 31 recommendations

The report was based on 55 responses to a request for views and evidence, and oral evidence from a number of people which does not seem to have included anyone who had made and survived at least one suicide attempt.

There is no information on how many people, who had made and survived any suicide attempts, sent in written evidence. I know I did, however their story is not reflected at all in the report. The report is heavily influenced by a very strong lobby from people bereaved by suicide, and shows a significant bias in this direction as a result.

Recommendations include the following

- A training framework and requirement for GP’s and their staff to be better trained in suicide prevention
- Promote existing suicide prevention material and messages
- Suicide prevention training for assembly members
- Evaluate Samaritan’s campaign, and maybe roll out
- GPs to know GMC guidelines on sharing information. (This supports them to let families know when someone is suicidal)
- Parity between physical and mental health services
- Urgent referral route for GPs to be evaluated and maybe rolled out.
- A triage system by CPNs in police control rooms. Crisis teams to train other front line services e.g. A&E. transparency and accountability regarding follow up after discharge. Single points of contact. 24/7 crisis services.

- Check if discharged patients are receiving follow up care within target (see 3 day recommendation in Confidential Inquiry Report)
- Target for follow-up should be changed from 5 days to 48 hours
- Waiting time targets for talking therapies
- Implement a Wales wide postvention pathway. (Postvention is follow up and support of people after bereavement by suicide).
- National and regional Talk to Me 2 groups to listen to people who have had suicidal thoughts and behaviour, as well as those bereaved.
- Staff who have worked with people who have attempted or died by suicide to get support
- Male suicide a national priority. Reduce stigma to encourage men to talk and seek help
- NICE guidance on self-harm to be implemented
- Loneliness and isolation a priority when considering budgets
- Student Mental Health charters to be introduced in all colleges/universities
- Training for Welsh Government staff working with Farmers, to be more compassionate and understanding, especially of their increased suicide risk, e.g. by deferring farm inspections.
- Review process for assessing and managing prisoner suicide risk
- Guidance to schools on talking about suicide, especially in those schools where a suicide has happened. Basic mental health training becomes a part of teachers' initial training
- Prevent new structures being a means of suicide
- Signage to encourage help seeking in locations often used for suicide
- Formal arrangements to ensure media report suicide responsibly
- Explore how guidelines for responsible reporting of suicides can be included in journalists' training
- Ensure action is taken to protect children and young people on line. Use potential of social media to improve people's well-being.
- Regional forum membership needs to be more consistent, and forum effectiveness to be monitored
- WG and other public bodies, e.g. LHBs and LAs, make specific funding available.

Following the launch of the report Vaughan Gething announced funding of £500,000 for suicide prevention. Currently this appears to be likely to be mostly used for the postvention pathway, with little left for funding local posts to drive the work necessary to make better suicide prevention a reality.

**National Confidential Inquiry into Suicide and safety in Mental Health**

This is a report produced annually to look at deaths in the mental health services such as suicides, sudden unexpected deaths and homicides.

The clinical messages this year were that:

- The '10 ways to improve safety' reduce patient suicides these are:
    - Safer ward
    - Earlier follow up on discharge
    - No out of area admissions
    - 24 hour crisis resolution/home treatment teams
    - Family involvement
    - Guidance on depression
    - Outreach teams
    - Low staff turnover
    - Reducing drug and alcohol misuse

- A renewed emphasis on reducing suicide by in-patients is needed, in particular by
  (1) Improving the physical safety of wards, with the removal of potential ligature points

(2) Care plans at the time of agreed leave
(3) Development of nursing observation as a skilled intervention.

- The evidence in this year's report also emphasises key measures that services should take to reduce patient suicide risk:
  - Follow up within 2-3 days after hospital discharge
  - Safe prescribing of opiates and psychotropic drugs
  - Reducing alcohol and drug misuse

- Female patients who die by suicide have a unique risk profile and require a particular focus on:
  - Treatment of depression, following NICE guidance
  - Developing services that meet quality standards for self-harm care
  - Improving services for people with a diagnosis of personality disorder, in line with our recent report

- Recent self-harm is increasingly common as an antecedent of suicide in mental health patients but may not be given sufficient weight at assessment. Protocols for managing self-harm patients who are under mental health care should highlight the short term risk.

- Suicide in people under 20 is rising. A broad range of stressors appear to play a part, reflecting the lives of young people in general. Therefore, a wide range of professionals have a role in prevention including those working in self-harm, mental health, social care, primary care, youth justice and the voluntary sector.

- Preventing suicide in students requires specific measures, including:
  - Prevention, through promotion of mental health on campus
  - Awareness of risk, including the fact that conventional risk factors, e.g. alcohol or drug misuse, may be absent
  - Availability of support especially at times of risk, e.g. exam months
  - Strengthened links to NHS services, including mental health care

**BMJ report on Best Practice suicide risk management**

- Compassion, safeguarding and safety planning
- Higher rate of suicide in men may be due to their use of more lethal methods than women.
- The rate of life time self-harm episodes in women is higher than in men
- Risk scales provide false reassurance, suicide cannot be predicted, and a risk based approach fails both patients and clinicians. Immediate risk of suicide was judged to be low or not present at the last contact with a clinician in 89% of 681 people who died by suicide
- The absence of risk factors does not mean the absence of risk of suicide.
- Use of screening questions asking about suicidal ideation does not increase the risk of suicide but reduces it.
- Look for informed consent from people who have already attempted suicide to involve their family if they become suicidal again, so clinicians and family can contact each other if there is a concern.
- Enhanced ED interventions plus on-going follow-up until out-patient mental health appointment gave decreased suicide risk in patients with no baseline of depression
- 60% of people who died by suicide had denied having suicidal thoughts when asked by a psychiatrist or primary care clinician
- Emotional abuse in childhood carries a particularly high risk of self-harm later in life
- There is uncertainty about the safety and effectiveness of no harm contracts between patients and clinicians

- Discontinuation of MH treatment increases suicide risk,  eliminating or reducing the degree of illness due to mental disorders reduces suicide rates

**Questionnaire completed by individuals –** What's your experience of suicide or suicide prevention? *What helped? What did not help? What would have helped?* (See App 1)

**Discussion group question** - What do you think would make the biggest difference to suicide prevention?

***Summary of responses to questionnaire (See Appendix 1 for full transcript)***

| What Helped? | What Did Not Help? | What Would Have Helped? |
|---|---|---|
| Not being judged | Feeling judged<br>Myths *(e.g. 'People who say they are going to take their own life are just attention seeking and shouldn't be taken seriously.')* | Clinical notes that were not judgemental and/or abusive.<br>People accepting that suicide is a tragedy, and not a crime.<br>The many myths about suicide need to be busted (See App 3).<br>More openness towards the subject.<br>Some kind of de-brief and investigation after a suicide attempt to help staff /family understand what happened and why, to learn for future occasions. It would have made me feel that people actually cared rather than just judging me. |
| Feeling valued<br>Compassion and kindness | Not feeling valued<br>Negative attitude of professionals | People caring for and about me<br>See the PERSON not the 'public health risk' or the 'category/demographic group' or the 'strategic priority group'. Everybody's life is worth saving. |
| Feeling listened to and believed<br>Being known / feeling understood | Not being believed<br>Feeling dismissed | Being believed<br>Better communication between staff about what I had told them.<br>Staff better understand the experience of feeling suicidal.<br>Understanding of the fundamental difference between self-harm as a coping mechanism and suicidal behaviour intended to end life. |

| | | |
|---|---|---|
| Recognition of pain and distress | Lack of understanding about how hard it is to ask for help or admit feeling suicidal<br>Staff expressing feelings of helplessness<br>Power dynamic | Don't be angry. Need a lot of campaigning to help to reduce the stigma and public anger.<br>Need people to understand more about what people go through and the heroic struggle required not to commit suicide when in extreme distress.<br>Staff must know how to help, so that they do not feel helpless. |
| | Family and friends of those who have taken their own lives (or attempted to) can be left with little or no support | More psychological support<br>I wonder if it would help those bereaved by suicide to meet those who have tried to end their lives and survived, to increase mutual understanding and reduce anger and distress. |
| Talking<br>Just being with other people<br>Friends and family | No one to talk to<br>Isolation | More support + just being there.<br>More advice and support. |
| Appropriate hospital admission and correct medication<br>Activity on the ward<br>Being creative | Being placed on a medical ward<br>Just being given pills and told to take them<br>No preventative changes / adjustments to medication<br>Being discharged from hospital too soon | Being on an appropriate ward, not an adult one at the age of 17.<br>At my worst, hospitalisation.<br>Being offered counselling / therapy instead of first pills. |

| | | |
|---|---|---|
| Taking action early | Waiting lists for counselling<br>Running away from help | An individualised suicide prevention plan with the crisis team, before I became suicidal would have helped.<br>Don't ask me to give up the means of suicide if the situation isn't first addressed to give me some hope, I'll just use something else. |
| Self-management training (by service users with lived experience)<br>Having insight | | |

**What Would Have Helped? (At strategic and policy level)**

- More man-power and higher priority given to suicide prevention.
- Parity of esteem - acceptance of assisted suicide for those in physical distress / pain, but not for people with mental distress / pain.
- True parity between mental and physical health requires acknowledging that suicide is the business of emergency services.
- There needs to be at least two representatives of those who have attempted suicide on the National Advisory Group in order to facilitate opportunities for local service users / carers voices to be heard.
- Training
    - Suicide prevention training should have parity with first aid training.
    - Mandatory training for Primary care and ED staff (including WAST and 999 call centre staff) to understand their role in suicide prevention.
    - Suicide prevention training must include trainees having a meaningful dialogue with people who have attempted suicide about their experiences. There should be payment and/or royalties for stories.
    - Approval of training should refer to competencies taught rather than off the shelf packages in order to promote healthy competition and affordability.

**What do you think would make the biggest difference to suicide prevention?**

***Summary: Some key points from National Forum discussion (See Appendix 2 for full transcript)***

**Better Knowledge and Understanding of individuals, the public, organisations and service providers**

- Consciousness raising.
- General public and individuals with better understanding of relevant issues.
- Appreciation that everyone is different and will need a different approach.
- Need to increase understanding of who is at risk.
- Education in schools.
- More understanding and support offered to those in further or higher education.
- Health professionals and team that understands.

**Changing Attitudes and Challenging Myths**

- Breaking down stigma
- Need culture change
- Challenge myths around suicide
- Changing attitudes of GPs
- Getting more men to seek help – changing values – 'its takes balls to talk'
- Lack of honesty, need to feel safe

**Interventions (Including Help and Advice)**

- A mix of strategies needed
- In Schools:
    - Building Resilience
    - Anti-bullying policies
    - Qualified counsellors
    - Mandatory MH education

    - People trained for suicide prevention programmes in schools should come from a background of lived experience. People with lived experience could be part of this programme and could narrate their stories

- From Service Providers:
    - Being treated like a person / not a child
    - Respect and Kindness
    - Crisis cafes
    - Rota of alternative professionals and peers to support someone in crisis
    - Safe spaces – confidential, non-judgmental
    - Better access to talking therapies
    - Self-management / emotional coping skills
    - Mandatory training for GPs on how to talk to vulnerable people
    - Consistency and Better follow up
- In the Community:
    - Increase community resilience
    - Making use of community workers
    - Easier access to support groups (including peer support)
    - Signposting to help groups / organisations
    - More support for people 20 – 40
    - Grassroots *The Stay Alive app is a suicide prevention resource for the UK, packed full of useful information and tools to help you stay safe in crisis. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide.*

**Recommendations**

- Treat all people who are suicidal with compassion and a collaborative approach
- Don't go straight to the safety plan, deal with distress tolerance and problem solving first, as far as possible, to help motivate people to want to safety plan
- Stop using risk assessment tools, especially those based on demographic characteristics and common triggers for suicide. Suicide cannot be predicted
- Every suicidal person is a life worth saving
- Train GP's, WAST and ED staff in suicide prevention
- Tackle the myths and deal with the anger against those who are suicidal

- Collect stories from those who have made a suicide attempt and survived, and use them in both training and policy making.
- Involve service users and carers in all training design and delivery
- *There needs to be at least 2 representatives of those who have attempted suicide and survived on the National Advisory Group. Anyone 'representing' service users and carers on the National Advisory Group should also be, or become a member of the Mental Health Forum Nationally, and engage with forum members in localities, in creating opportunities for local service users and carers to be heard, so that they can be truly 'representative' in this important role, as this is the best way of increasing the number of people's voices that can be heard on this important topic*

***Appendix 1***

**Results of short questionnaire: Suicide prevention (completed at national forum meeting)**

***What is your experience of suicide or suicide prevention?***

*Many attempts at suicide, mainly stockpiling medication. Thoughts of other methods of committing suicide. Self-harm.*

*Loneliness / despair.*

*Feeling suicidal when I was in hospital when I was 17.*

*I have lost too many friends from suicide. Because they were afraid to talk due to stigma. I suffer with depression and completely understand why people feel the way they do. I have never considered suicide but can see why.*

*Attempted suicide.*

*I have tried to take my life many times. I have been left to cope alone. Been in general hospital as a result.*

*My grandfather took his own life → lead to bullying among peers + shame of my depression → lead to drinking and mild substance abuse. Father's infidelity → led to university drug and alcohol abuse – led to depression and then bipolar diagnosis; suicide ideation and fixation.*

*I experience aggressive voices, which, in the past have compelled me to self-harm, or to take my own life. I have attempted suicide on 4-5 occasions, using increasingly extreme methods on each occasion. On many other occasions I suffered severe suicidal compulsions but made no attempt, because I got help in time.*

*The causes were complex and included the voices and the service staff not believing me about them and hence not helping me with them; hopelessness about recovery; lack of meaning and purpose due to lack of access to paid employment, or support to progress towards it; staff attitudes and behaviour towards me; Not being believed about my voices or my suicidal compulsions.*

*Three attempts were preceded by very harsh letters from psychotherapists.*

*In each case the battle against taking suicidal action was long term – at least 2-3 months and on some occasions much more, so exhaustion was a significant contributor.*

*These experiences were profoundly traumatic and have left severe mental scars. I thought I was 'doing the right thing' by asking for help. But frequently felt either punished for doing so, or invisible given the lack of response.*

*Like many women who self-harm or attempt suicide it was presumed I must have a Personality Disorder without any further history taking or evidence of other symptoms.*

*I felt that my life did not matter to the professionals. I felt invisible, or worse, that they were seeing a monster, instead of the terrified and tortured person that I was.*

*I was confused when I saw that other people with similar experiences were getting help, but I was not. The majority of those who got help were men. I heard of other women like me attempting suicide whilst under the 'care' of the crisis team, being discharged and then killing themselves. My hopelessness was increased by my lack of trust and faith in a service that would stand by and let this happen to other women.*

*There were times when I felt abused by staff, but could not escape. I could not get any help from safe-guarding at that time. It seemed that they assumed that abuse could not be happening within the health service and would not investigate. After that I did not feel safe to seek help or complain. I felt that the staff would always close ranks and hurt me even more. I asked if there was any policy to prevent abuse and who I should go to and was told that the 'professional abuse policy' was not public facing. When I read it, it still did not feel very trustworthy. I would never be able to prove what happened behind closed doors. I saw my clinical records and was very upset about the abusive things they said about me, and that I could never get those things removed. There is no justice in clinical records.*

*Some people assume that 'people who attempt or commit suicide' do not think about the consequences for those they leave behind. This is unfair. I did think very hard about the people I would leave behind which was why I made such an effort to find help. I did everything I possibly could, but failed. I could not live with my pain and torment any more, I could not get the help I sought. I could see the toll my illness was having on those I loved, and I had suffered bereavement and knew it was nowhere as bad as what I was living with. I wished this were not the case. I tried to write letters that would help but it was too hard. I could not talk to my family for fear of anger or of putting more on them than they could deal with.*

*It is now 6 years since I was seriously suicidal. I have a very good care coordinator and Dr. My diagnosis has been changed and now makes sense. My questions are*

*answered, and the current team believe me. The medication as a result is now keeping me stable. My care plan is now mine. No more big review meetings with so many scary professionals. I even have hope that I might get some kind of job, and don't have to fight for support to do so. My records have accessible lists of what does and doesn't help, guidance on how to communicate with me, my story/history about my life and my experiences. Fortunately the written records are so long that no-one is going to have time to find the abusive comments made in the past. No one is pressurising or coercing me. I feel safe. I feel hopeful. I am happy.*

***What helped?***

*Becoming a full time carer. Controlling medication. Being aware before crisis point is reached.*

*Talking / listening / a feeling within of being valued.*

*Having leave to see family so I could be from the ward. Having activities to do on the ward to take my mind off things for a little while.*

*People not being judged for their thoughts. Speaking openly about suicide and its implications. Support for family, friends and victims. Social media.*

*Friends and my mother. Afterwards, also, the stomach pump was so horrendous, it temporarily put me off attempting again.*

*Someone listening, being straight with me, getting a diagnosis and correct treatment. Recover your life.com – world-wide self-harm support.*

*Creativity – writing songs, poetry, short stories + lyrics. Playing guitar, joining a band + meeting new people – developing proper friendships – positive impact. Studying psychology at A level + talking to my auntie who has bipolar + learning from her experience, my service user engagement group. Supportive family + open about my feelings. Medication – anti depressants, lithium, olanzapine + lamotrigine (mood stabiliser).*

*Being with other people without the need to communicate directly with them. (I.e. not being alone).*

*Not being at home*

*The right medication at the right dose.*

*People talking to me and taking action early on in the situation before it had become overwhelming.*

*Medical rest – sedation for 4 days - providing a rest from voices and suicidal thinking.*

*Hospitalisation, with supportive staff who spend time trying to get to know, understand and help me.*

*People knowing me and helping me to use techniques that have proven to help me in the past*

*Support and compassion.*

*Recognition of the extent of my pain and distress, and the effort required to not attempt suicide.*

*Learning techniques, such as Emotional Coping Skills.*

*Kindness, non-judgemental approach, holding onto hope when I can't.*

*Cheer-leading, so long as it didn't come across as not recognising the battle I was dealing with.*

*Peer support from Bipolar group and Hearing voices group.*

*Self-management training from Bipolar group. (I didn't do so well with the Mental Health Foundation version as it was too 'show and tell' for me – I prefer interactive, and opportunity to hear from other sufferers.) I also prefer self-management led by service users with personal experience relevant to my own.*

***What did not help?***

*Admission to hospital and being put on a medical ward. Nurses talking and other patients becoming aware.*

*Running away from possibilities of help.*

*Being the only person around my age on the ward. Just being given pills and told I'd need to take them every day for the rest of my life.*

*Social media. Being judged. Waiting lists for counselling.*

*Not being able to cope with my life circumstances. Isolation and not being able to talk to friends before.*

*Mum not talking me to hospital after OD for fear of me being sectioned. Psychiatrists calling me a stupid child, one psychiatrist grabbed my arm.*

*N/A*

*People not realising just how hard it was to ask for help or to admit that I felt suicidal. Negative and dismissive responses made asking for help even more difficult.*

*I really worry now about staff breaking my confidentiality, because my husband's angry reaction makes things much, much worse.*

*Being told off. Not being believed. Being judged, as if I was being manipulative or attention seeking. Highly critical and blaming attitude from others*

*Being told 'if I was really suicidal I would be dead by now, or I would not have asked for help', and after an attempt, that my survival meant I didn't really mean it and people saying suicide was selfish, or the 'easy way out'.*

*Being asked what would help me, then being told what I asked for was not possible. I felt set up to fail.*

*The power dynamic between professionals and service users is unhelpful.*

*It often felt like my life didn't matter because I wasn't a young man. The current Talk to me 2 and 'Everybody's business' focus on men in midlife, exacerbates this.*

*A crisis nurse saying – 'just don't do it', and an angry policemen telling my husband I was 'throwing myself around threatening suicide.'*

*A psychotherapist withholding information about my suicidal compulsions from other professionals in the mental health team, even when I asked him to pass it on.*

*No preventive changes in medication.*

*Being discharged from hospital when still suicidal without help in the community, despite promises that help would be there.*

*Being given the opportunity to talk, but with no solutions offered, and no notes of what was said.*

*Staff expressing feelings of helplessness.*

***What would have helped?***

*More advice and support. Someone dedicated to suicide prevention.*

*De-stress*

*Being on an appropriate ward, not an adult one at the age of 17. Being offered counselling / therapy instead of first pills.*

*More openness towards the subject.*

*I was so distressed I'm not sure anything would have helped then.*

*At my worst, hospitalisation. More support + just being there.*

*Education in school, more anti-bullying: online and real life. Education should be about 'facilitating' not imparting information - interactive + drama therapy – learning and acting – Shakespeare. Including not dividing in facilitation method. 'Kindness is exciting' – violence is exciting – peer pressure. 'Emotional intelligence' and building resilience. 'Not just what we teach but why'*

*Being believed*

*People caring for and about me*

*Some kind of de-brief and investigation after a suicide attempt to help staff /family understand what happened and why, to learn for future occasions. It would have made me feel that people actually cared rather than just judging me.*

*Better communication between staff about what I had told them.*

*Clinical notes that were not judgemental and/or abusive.*

*Staff better understand the experience of feeling suicidal.*

*The many myths about suicide need to be busted.*

*See the person not the public health risk category/demographic group or the strategic priority group. Everybody's life is worth saving.*

*Staff must know how to help, so that they do not feel helpless.*

*People accept that suicide is a tragedy, and not a crime.*

*An individualised suicide prevention plan with the crisis team, before I became suicidal would have helped.*

*Don't ask me to give up the means of suicide if the situation isn't first addressed to give me some hope, I'll just use something else.*

*Don't be angry. Need a lot of campaigning to help to reduce the stigma and public anger. Need people to understand more about what people go through and the heroic struggle required not to commit suicide when in extreme distress.*

*Understanding of the fundamental difference between self-harm as a coping mechanism and suicidal behaviour intended to end life.*

*I wonder if it would help those bereaved by suicide to meet those who have tried to end their lives and survived, to increase mutual understanding and reduce anger and distress.*

***At strategic and policy level***

*On a larger scale work to improve suicide prevention is severely hampered by a lack of man-power and priority. Even where there is a willingness to invest, the complications of managing a post as a partner are very real. The more posts hosted by smaller partnerships the better. It would seem most profitable to have one post per health board area, even if this were part time, to make it more practical.*

*I feel that training for Primary care and ED staff, including WAST and 999 call centre staff, to understand their own role in suicide prevention, and react compassionately and effectively should be mandatory. Some of the 'frequent user' management processes make things worse by both reinforcing the view that mental health/suicidality are not ED business, and by responding to those needing help as if they were committing a crime (over-using services), or even simply referring them to other staff and organisations not equipped to help them.*

*It makes no sense to me that there can be an acceptance of assisted suicide for those in physical disability and pain, but that this is looked on as wrong if the people have a mental health problem or mental distress/pain.*

*We need to recognise that mental health problems can be both fatal, and/or disabling, including leading to physical disability following self-harm or suicide attempts. True parity between mental and physical health requires acknowledging that suicide is the business of emergency services, and that ED can be the right place where nothing better is available, which is the case for most people at risk currently.*

*Suicide prevention training must include people who have attempted suicide conversing with trainees about their experiences and what helps and what does not. These people must be paid. Just using films is appropriation of service user stories in order to make a profit. It also deprives trainees of meaningful dialogue for exploring that experience. People should be paid for their stories, and get royalties for each showing if a film is used.*

*There needs to be at least 2 representatives of those who have attempted suicide and survived on the National Advisory Group. Anyone 'representing' service users and carers on the National Advisory Group should also be or become a member of the Mental Health Forum Nationally, and engage with forum members in their locality, in creating opportunities for local service users and carers to be heard, so that they can be truly 'representative' in this important role, as this is the best way of increasing the number of people's voices that can be heard on this important topic.*

*Suicide prevention training should have parity with first aid training. It should be covered by the same legislation, with similar workplace requirements, and training for first-aiders should be a similar price and length to that for suicide prevention training.*

*It is important not to approve training if doing so gives it a market advantage that makes high charges practical. Approval of training should refer to competencies taught rather than off the shelf packages in order to promote healthy competition and affordable offers.*

## Appendix 2

## Notes from National Forum Discussion:

## What do you think would make the biggest difference to suicide prevention?

### Better Knowledge and Understanding of individuals, the public, organisations and service providers

Consciousness raising.

General public and individuals with better understanding of relevant issues.

Appreciation that everyone is different and will need a different approach.

Need to increase knowledge and understanding of who is at risk (e.g. people who are isolated, lonely, rural areas farmers); triggers; signs of suicidal ideation.

Education in schools.

More understanding and support offered to those in further or higher education.

Health professionals and team that understands

Anger from family – means won't talk to family.

### Changing Attitudes and Challenging Myths

Breaking down stigma

Treatment with empathy helps to overcome stigma

Need culture change

Challenge myths around suicide

Changing attitudes of GPs

Getting more men to seek help – changing values – 'its takes balls to talk'

Importance of how people react / respond

Must not feel belittled

Cover ups, lack of honesty, need to feel safe, and cannot say to those suicidal that they will get appropriate help

**Interventions (Including Help and Advice)**

A mix of strategies needed

**In Schools:**

Building Resilience

Anti-bullying policies

Qualified counsellors in schools / colleges who can deal with complex issues e.g. trauma

Mandatory MH education to children of school age

**From Service Providers:**

Being treated like a person / not a child

Respect and Kindness

Crisis cafes

Rota of alternative professionals and peers to support someone in crisis, suicidal

Safe spaces – confidential, non-judgmental, Samaritans

Better access to talking therapies – very long waiting lists. Discuss how to deal with waiting lists, Self-management / emotional coping skills during waiting lists

Mandatory training for GPs on how to talk to vulnerable people (mental health, substance misuse, co-morbidity) who to refer to / how they can help / person centred

Consistency, Same professional, regular meetings

Relationships and trust

DBT and diagnosis

Better follow up

Training in prisons

**In the Community:**

Increase community resilience

Making use of community workers – postmen, barbers, taxis, and tattoo artists – places where people are willing to talk

People to talk to (‘I wish I could have talked to someone’)

Easier access to support groups - especially self-harm support

Signposting to help groups / organisations

Peer support groups – autonomy and support

More support for people 20 – 40 (there is no adequate support for people of this age)

Men’s sheds

Help to get into work – peer support

Music

Friends helped me, Being there – person centred / sharing

Grassroots *The Stay Alive app is a suicide prevention resource for the UK, packed full of useful information and tools to help you stay safe in crisis. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide.*

## Appendix 3: Myths

### Popular myths

- People who attempt suicide are just selfish or weak
- People who talk about or attempt suicide are just trying to get attention
- People who talk about suicide do not kill themselves
- People who attempt suicide are crazy
- People who talk about suicide are trying to manipulate others
- When people become suicidal they will always be suicidal
- Most suicides occur without warning
- You should never ask a suicidal person if they are thinking about suicide because just talking about it will give them the idea
- It can't really be that hard to kill yourself
- The only genuine suicide attempt is the successful one
- Suicide is a cowardly act…taking the easy way out
- People are grateful (relieved) when they survive a suicide attempt
- Suicide is a youth problem
- Suicide is immoral or sinful
- Depression is the major cause of suicide

### Professional myths

- Suicide is an impulsive act
- Suicide is a violent act
- We must teach our kids that suicide is not an option
- Suicide is a gendered issue
- Suicidal behaviours justifies involuntary medical treatment
  (From David Webb 2010 – Thinking about suicide, PCCS Books, ISBN – 978 1 906254 28 5)

Whilst some of these myths may be true to some extent for some people they are sweeping generalisations that are certainly not true for all, and therefore need to be busted. I wonder if it would help those bereaved by suicide to meet those who have

tried to end their lives and survived, to increase mutual understanding and reduce anger and distress.