Suicide Prevention:

Stakeholder engagement

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West Sussex County Council

Authors:
Laura Asher
Public Health Registrar, Public Health

Verity Pinkney
Public Health Data Analyst, Public Health and Social Research Unit

Project team:
Ann Corkery
Consultant in Public Health

David Brindley
Public Health Lead

Helen Butcher
Consultation and Engagement Officer

Libby Hill
Project Support officer

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2.1 Summary and methods

As part of the development of the West Sussex suicide prevention strategy, a stakeholder consultation was undertaken. The specific objectives of the consultation were:

- to determine frontline workers' confidence in approaching/ signposting people contemplating suicide and people bereaved by suicide
- to estimate availability and uptake of suicide prevention training, and barriers to accessing training
- to understand barriers to frontline workers supporting people at risk of suicide
- to gather views on what resources, processes and services would help to reduce suicide in West Sussex

Local frontline workers were invited to take part in an online survey conducted via the "Have Your Say" online portal. The survey was available for completion between 6th March and 28th April 2017.

The consultation intended to gather the opinions of staff from a wide range of organisations and sectors, such as the voluntary sector, local community organisations, emergency services, housing and social care, primary care, and health and wellbeing services (e.g. wellbeing hubs, leisure services) among others. The consultation did not include; acute mental health trusts, NHS suicide prevention/support services and NHS mental health commissioners.

2.2 Demographics

There were 202 responses to the consultation. Around two-thirds (67.8%) were from people aged 40-59, with fewer aged under 30 (5.4%), or 70+ (1.5%). Three-quarters of respondents were female (N = 151).

Many different sectors were represented including the voluntary sector (e.g. Samaritans), primary care (e.g. GPs), education (e.g. safeguarding/pastoral leads) and housing (e.g. housing officers; see Table 1). The majority of respondents (n=158) have daily contact with members of the public, whilst 26 have weekly contact. Most respondents were in paid roles (92.6%).

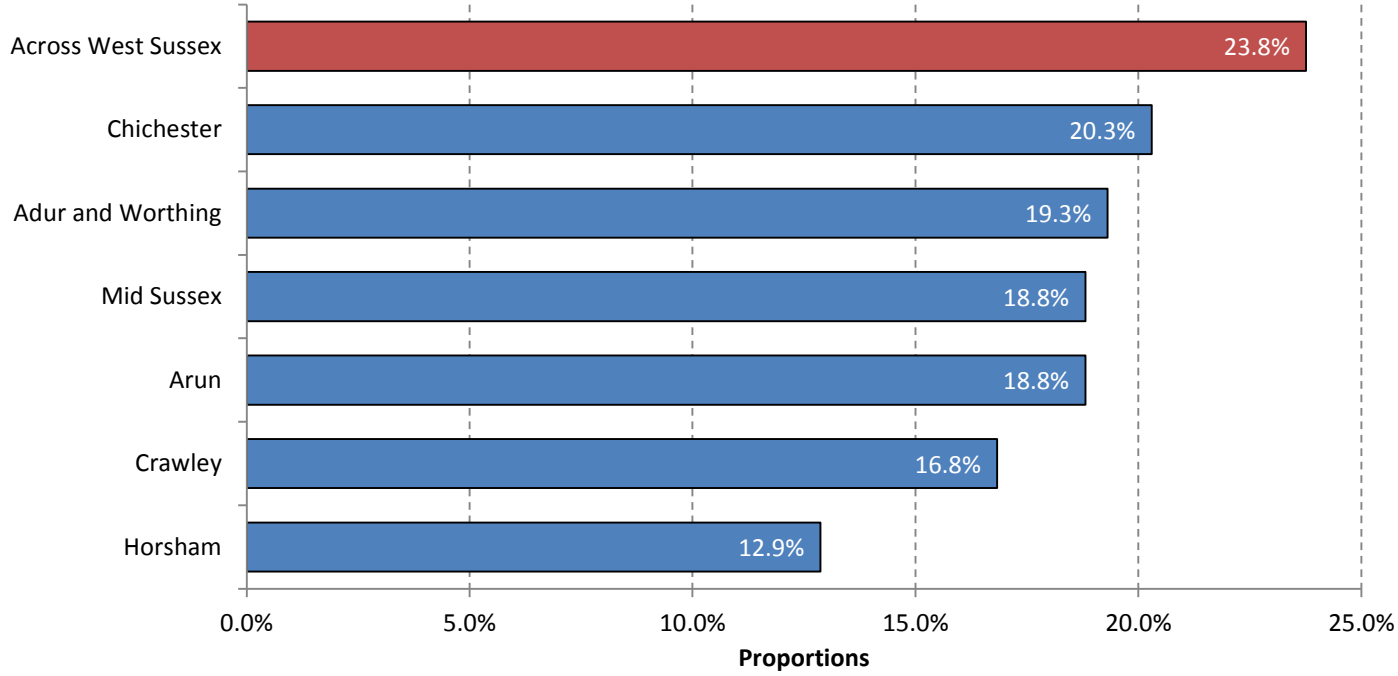
Table 1: Number of respondents to the consultation by sector and broad area of work

Sector	Number of respondents
Private	22
Housing	17
Other	3
Mental health services	2
Statutory	150
Library	31
Education	26
Housing	20
Children, YP, social and community services	19
Community health and wellbeing	16
Other	10
Emergency services	8
GP	7
Substance misuse	7
Mental health services	6
Third sector	30
Third sector counselling/ support	21
Housing	8
Other	1
Grand Total	202

Note. Those falling within the category "other", tended to be roles that were less clearly defined (e.g. "manager")

The consultation reached frontline workers covering all geographical areas of the county. 129 people worked solely within one local authority in West Sussex, whilst the remaining 75 worked in more than one local authority (N = 34) or across the entirety of West Sussex (N = 39).

Figure 1: Proportion of responses by area covered



Note. This was a multiple choice question, therefore the same individual may work in more than one area in West Sussex. 264 fields were selected by 202 respondents. The number of people who said they work in each area is shown as a proportion of the total number of respondents (202).

2.3 Experiences of supporting people who are suicidal

More than ¾ of respondents reported that they had spoken with customers, clients or patients who are experiencing suicidal thoughts. Workers from mental health, primary care, substance misuse and third sector counselling/support services were the most likely to have spoken to individuals experiencing suicidal thoughts (Table 2). However, some respondents from **all sectors** represented in the consultation reported that this was something that they had experienced as part of their role. For example, 38.7% of respondents from library services and 84.4% of respondents who work in housing reported that they had spoken with someone who is suicidal.

Note that small numbers of respondents from some areas of work will affect the reliability of the proportions shown in Table 2.

Table 2: The number and proportion of respondents who reported that they had spoken with customers/clients/patients about suicidal thoughts they are experiencing by job role

	Total respondents	Spoken to individuals about suicidal thoughts	% spoken to individuals about suicidal thoughts
Mental health services	8	8	100.0%
Substance misuse	7	7	100.0%
GP	7	7	100.0%
Third sector counselling/ support	21	20	95.2%
Housing	45	38	84.4%
Children, YP, social and community services	19	16	84.2%
Community health and wellbeing	16	13	81.3%
Education	26	20	76.9%

Emergency services	8	6	75.0%
Other	14	8	57.1%
Library	31	12	38.7%
	202	155	76.7%

Of those respondents who reported contact with suicidal individuals, nearly 50% stated that these conversations occurred rarely (74 of 155 respondents, 47.7%). A further 43.2% reported that they had these conversations monthly (20.6%) or weekly (22.6%) and a minority (7.1%) reported that these conversations occur on a daily basis[1].

2.4 Confidence speaking with people who are suicidal, or bereaved by suicide

Around 40% of all respondents felt that they would be somewhat unconfident or not at all confident approaching or talking to someone who was feeling suicidal (41.1% unconfident). Similar numbers were not confident about approaching someone bereaved by suicide (42.6%).

Levels of confidence vary by job role (Table 3). GPs and mental health staff were most likely to say that they felt confident approaching or speaking to someone who is suicidal, whereas staff from the library services were the least likely to feel confident in fulfilling this role.

Table 3: Levels of confidence approaching or speaking to someone who is suicidal by job role

	Total respondents	Confident		Unconfident	
		Count	%	Count	%
Mental health services	8	8	100.0%	0	0.0%
GP	7	7	100.0%	0	0.0%
Third sector counselling/ support	21	17	81.0%	4	19.0%
Children, YP, social and community services	19	14	73.7%	5	26.3%
Substance misuse	7	5	71.4%	2	28.6%
Education	26	18	69.2%	8	30.8%
Housing	45	29	64.4%	16	35.6%
Community health and wellbeing	16	8	50.0%	8	50.0%
Emergency services	8	4	50.0%	4	50.0%
Other	14	4	28.6%	10	71.4%
Library	31	5	16.1%	26	83.9%
Total	202	119	58.9%	83	41.1%

Note. Small numbers of respondents in some sectors will affect the reliability of the proportions shown.

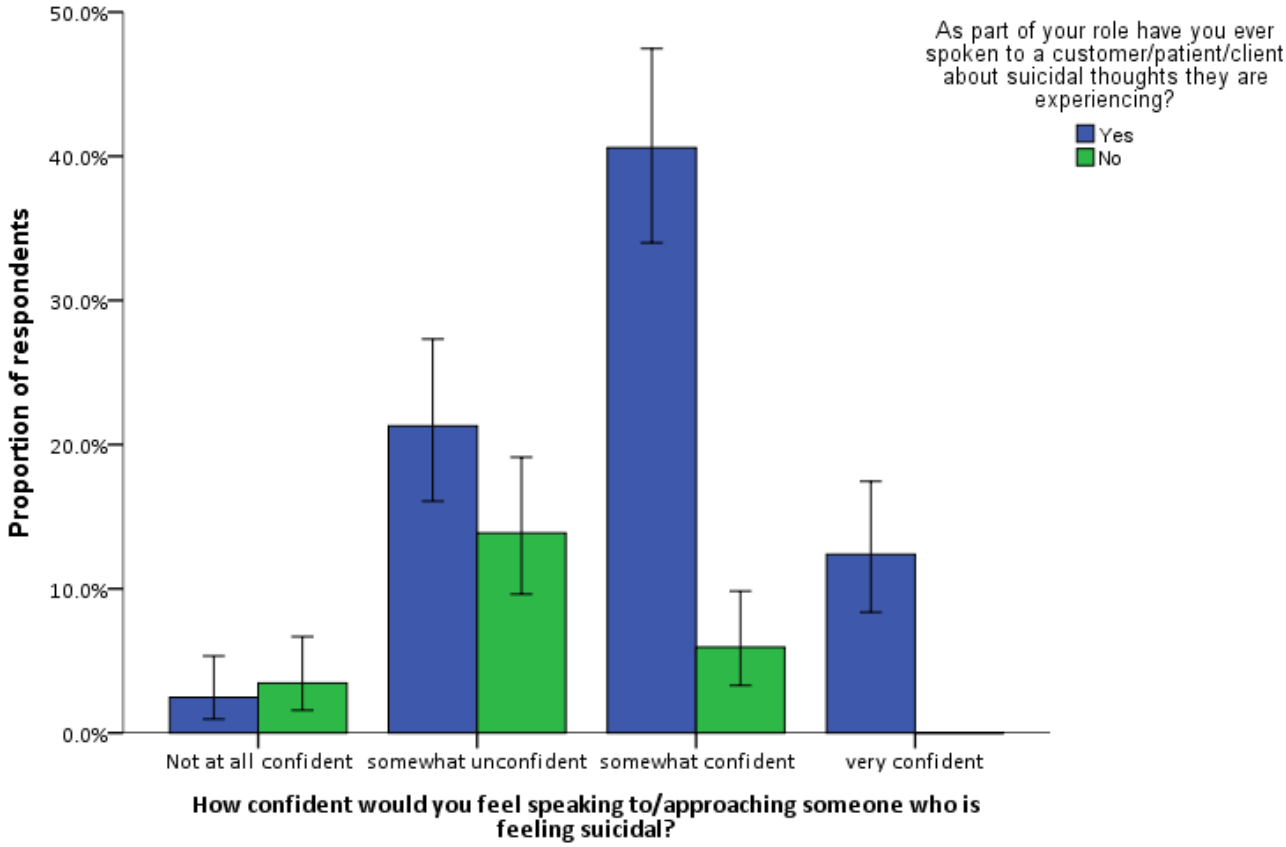
Levels of confidence approaching people who are feeling suicidal also vary with experience. Nearly 70% of respondents who have experience of talking to suicidal individuals felt that they would be very or somewhat confident doing so again. This compares to just over a quarter of respondents who have never spoken to someone who is experiencing suicidal thoughts as part of their role.

Confidence also varied by the frequency with which these conversations take place. 93.5% of respondents who speak to suicidal individuals on a daily or weekly basis reported feeling somewhat or very confident in having these conversations. This compares to 57.5% of respondents who have less frequent[2] contact with suicidal individuals.

Figure 2: Levels of confidence speaking to or approaching someone who is feeling suicidal by previous experience

[1] Proportions do not sum to 100%. 1.9% of respondents who reported that they had spoken to someone who is experiencing suicidal thoughts did not answer this question.

[2] Rarely, or on a monthly basis



2.5 Awareness of services

Only 12 respondents (5.9%) had no knowledge of where to refer someone who was feeling suicidal, whereas 46 respondents (22.8%) would not know where to refer someone bereaved by suicide.

GPs and staff from mental health services or substance misuse services were the most likely to say they had knowledge of where to signpost and individual who was feeling suicidal (more than 70% of respondents said "Yes"). Those working in library services (9.7%), education (34.6%), housing (35.6%) or other (0.0%) roles were less likely to say that they had knowledge of services/support for individuals who are feeling suicidal. Note however, that the vast majority of respondents had at least some knowledge of where to signpost (94.1%).

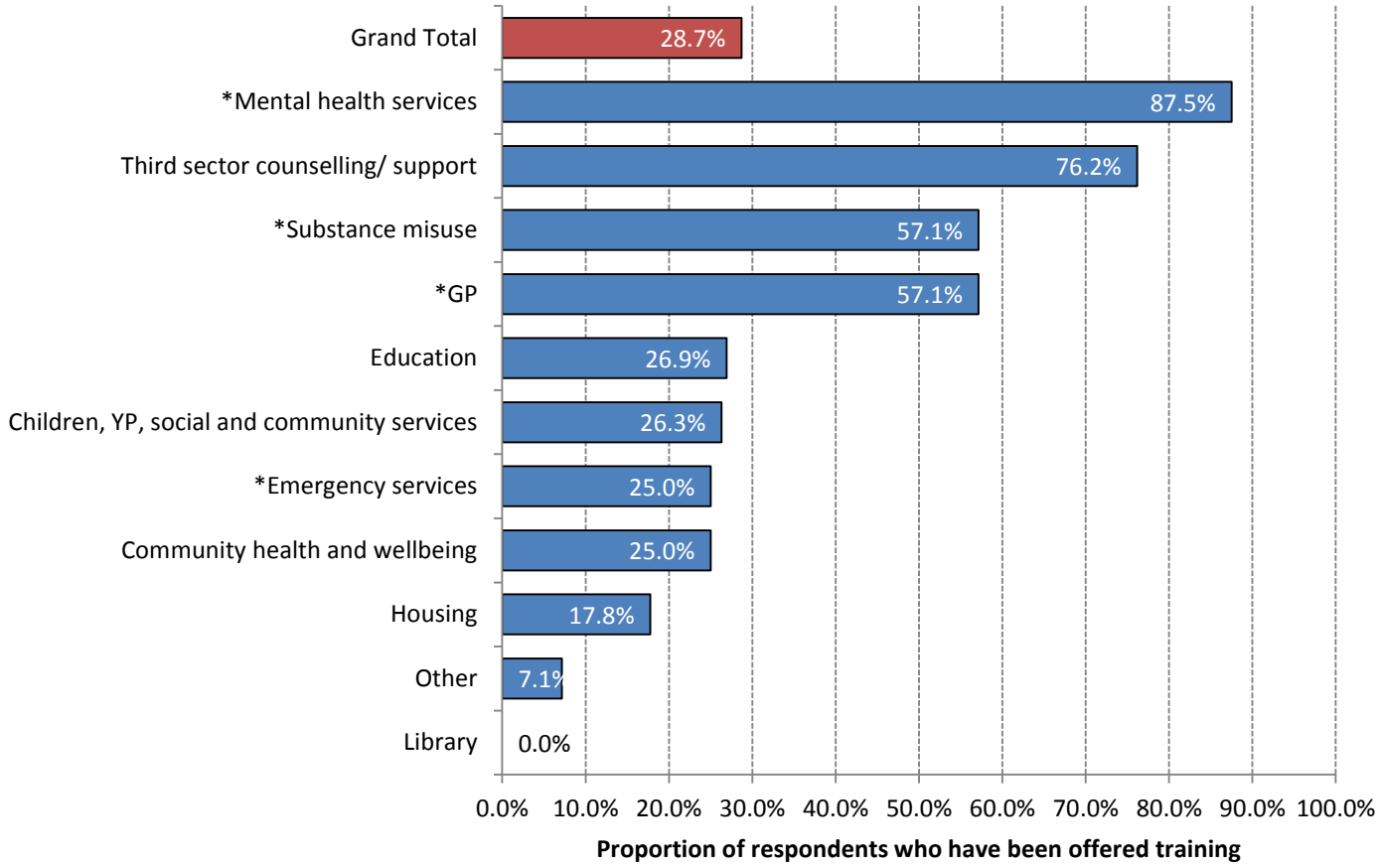
Respondents were generally aware of a wide range of services to signpost someone who is suicidal. The services that were most likely to be signposted to if someone presents as suicidal were the Samaritans and GPs. The same was the case for signposting those bereaved or affected by suicide.

2.6 Training for frontline workers

Just over a quarter of respondents had been offered specific suicide prevention training, the majority of which participated in the training. Reasons for non-participation include; already knowledgeable about suicide prevention, inconvenience of time/date, and because it was not perceived as relevant.

Some respondents from most sectors had been offered training. Mental health services (87.5% of respondents) and third sector counselling/support services (76.2% of respondents) were the most likely to report that they had been offered suicide prevention training, whereas people working in the library service (0.0% of respondents) were least likely to have been offered training. Only a quarter of people from the emergency services, and fewer than 60% of GPs that took part in the survey reported that they had been offered specific suicide prevention training. However, these figures are based on small counts and should be taken with caution – those based on fewer than 10 counts can be identified with *.

Figure 3: Proportion of respondents who have been offered training by job role (* indicate fewer than 10 respondents within that role)



Of the 155 respondents who reported they had ever spoken to someone who is feeling suicidal, 57 (36.8%) had been offered training. Again, those working in mental health services and third sector counselling/support services were most likely to have been offered training (≥ 75.0%). None of the 12 library staff who have spoken with someone who is suicidal had been offered training. Similarly, 30 of the 38 housing services staff who have spoken with someone who is suicidal were either not sure, or had not been offered training.

For those who had participated in suicide prevention training, the majority (98.1%) agreed that it had been helpful, or extremely helpful in learning skills to approach/talk to someone experiencing suicidal thoughts. This aligns with evidence that respondents who had been offered suicide prevention training were significantly more confident at speaking with someone who was experiencing suicidal thoughts than those who had not been offered training ($p <$ .001)[3]. A smaller proportion (76.9%) found the training they had received to be helpful or extremely helpful in learning where to signpost someone who is experiencing suicidal thoughts.

2.7 Barriers to supporting those at risk of suicide

Respondents were asked what barriers they feel exist in supporting people at risk of suicide. A predefined list of potential barriers and an opportunity to provide free text were given. Each respondent could select multiple

[3] Responses to the question "How confident would you feel approaching or talking to a person who was feeling suicidal?" were coded 1 = "Not at all confident" through to 4 = "Very confident". An independent samples t test was conducted to examine levels of confidence in approaching or talking to someone who was experiencing suicidal thoughts by whether suicide prevention training had been offered. There was a significant difference in levels of confidence between the two groups with those who had been offered training reporting significantly greater levels of confidence (M = 3.2, SD = 0.6) than those who had not been offered training (M = 2.4, SD = 0.7; t(187) = 7.46, ($p <$ .001).

responses, therefore each of the given barriers in Table 4 are shown as a proportion of all possible respondents to that question (N = 202), not total responses. Thirty-six individuals described or expanded on barriers to supporting people at risk of suicide.

Table 4: Number and proportion of respondents who identified the following barriers to supporting people at risk of suicide

Barriers	Count	%
I have not received relevant training	115	56.9%
I'm not confident on how to approach or talk to a person who is distressed or appears suicidal	57	28.2%
I would be worried that asking a person about suicidal thoughts would make them more likely to attempt suicide	53	26.2%
I don't know how to recognize if a person is likely to be suicidal	51	25.2%
I do not know where to signpost people at risk of suicide	45	22.3%
I don't have the time to give support to individuals	40	19.8%
It's not part of my role to support people at risk of suicide	31	15.3%
I don't have the time to liaise with other services	23	11.4%
I would find it distressing to talk to someone who is suicidal	22	10.9%
Approaching or supporting people at risk of suicide is discouraged by my organisation	1	0.5%

2.7.1 Lack of training

Respondents identified a lack of relevant training as the most common barrier to supporting people at risk of suicide (Table 4). This was strongly emphasised by respondents who provided further descriptions of barriers, such as: *"Training would take away the fear of addressing feelings of suicide"* (- Housing); *"We have a great deal of people come in with a variety of mental health issues, as we lack training it's hard to support them"* (- Library Services).

Confidence identifying and approaching someone who is distressed or appears suicidal were identified as barriers by more than a quarter of respondents. Some respondents described the challenges they face in identifying someone as at risk of suicide: *"the difficulty lies in the difference between those that say it to our department fairly regularly … as opposed to someone in the middle of an acute crisis of tragedy or despair which may not be immediately recognisable"* (- Housing).

2.7.2 Lack of resources

A number of frontline workers also acknowledged a lack of resources as a barrier. This tended to focus around insufficient time to provide support, long waiting lists, and a lack of funding or knowledge. For example; *"the wait time at GP services … and CAMHS are too long and young people are left waiting"* (Education); *"It's not that I don't have the time. I don't have enough time to offer the support they need"* (- Children, YP, Social and Community Services); *"Perhaps as an organisation some people may think they don't have the time or knowledge"* (- Housing)

2.7.3 Difficulties referring to and accessing other services

In addition, a few respondents gave examples of difficulties they have encountered when referring to and accessing other services. This tended to focus on problems accessing support out of hours, and a lack of communication between different services. *"It is particularly difficult either day or night to find accessible support – e.g. 24 hours"* (- Mental Health Services); *"I have had cases where GP have said its CMHT's role to assess in crises and CMHT said it is GP to send assessment request"* (- Housing).

2.8 Actions, inputs and resources helpful to your organisation to support people at risk of suicide

Respondents were asked what actions, inputs and resources would help enable their organisation to better support people at risk of suicide[4].

Table 5: Number and proportion of respondents who thought the following actions would be helpful to support people at risk of suicide

	% helpful	% not helpful	% don't know
Information on where to signpost people with suicidal thoughts	97.5%	0.5%	2.0%
Clear communication/referral routes between your organisation and support organisations	93.1%	1.0%	5.9%
General training for staff on mental health or emotional wellbeing	92.1%	2.0%	5.9%
Specific training for staff in your organisation on how to approach or talk to a person who has suicidal thoughts	92.1%	0.5%	7.4%
Information on which groups are at risk of suicide in your local area	83.7%	5.0%	11.4%
Guidance on confidentiality and sharing information on suicide risk with families and friends	82.7%	6.9%	10.4%
Physical resources e.g. leaflets or posters on sources of support	82.2%	5.4%	12.4%
Clear local leadership on suicide prevention	74.8%	6.9%	18.3%
A local web/social media presence relating to suicide prevention	72.8%	9.4%	17.8%
Being part of a wider network of organisations working towards suicide prevention in West Sussex	66.8%	10.9%	22.3%
Information on local suicide hotspots (i.e. locations at which there is a concentration of suicides or suicide attempts)	61.4%	18.8%	19.8%
Having a suicide prevention champion within your organisation	47.5%	19.3%	33.2%
You or your organisation making a pledge to help reduce suicides locally	46.5%	18.3%	35.1%

Note. 202 respondents overall

2.8.1 Awareness of where to signpost

Information on where to signpost people with suicidal thoughts was almost universally felt to be useful (97.5% - see Table 5). Respondents raised the desire for a database or centrally held list of support groups/organisations that details who they are, what they do and how they can be contacted. This could be in the form of a website, a helpline, or leaflets; "*a "one stop" access point of services and times available"* (- Emergency Services). In addition 82.2% specifically endorsed having leaflets or posters available. Respondents also felt having a named contact with whom they could speak to would be helpful. The role of this contact would be to provide advice and further support; "*designated lead for this area with responsibility for cross service communications and support*" (- Education). This could be fulfilled by a Suicide Prevention Champion, or similar role.

There was a general feeling that workers want to know what the resources of other services are like. This will help to manage the expectations of clients, ease burden (where possible), and refer appropriately; "*better understanding or resource pressures, impacting different organisations and how we can work with our current resources to gain the most effective outcome for client and organisations concerned*" (- Housing).

2.8.2 Clear referral pathways

Having clear communication and referral routes between organisations was endorsed as helpful by the vast majority of respondents (93.1%); *"clear referral routes between your organisation and support organisations – this one is absolutely key*" (- Education). It was felt that training, particularly across organisations, could be a good way to create links between organisations and suicide prevention support services. This was felt to help raise awareness of

[4] Multiple choices could be selected, therefore proportions are based on the total number of respondents (N = 202), not total responses.

the support services available and to clarify referral pathways; *"training/talks direct to staff on the support services and what they do/offer"* (- Housing).

2.8.3 Training for frontline workers

The majority of respondents (92.1%) agreed that receiving general training on mental health and more specific training on how to speak with someone experiencing suicidal thoughts would help them better support people at risk of suicide. This concurs with the feeling that a lack of training is a barrier to supporting people at risk of suicide.

Some respondents specified that training school staff, social workers, youth workers and carers, would be important. It was suggested that training should cover the signs of suicidal thoughts, what to say, how to listen, and what services they can signpost to. Guidance on confidentiality and sharing information with families and friends was also felt to be useful by the majority of respondents (82.7%). *"Training could be rolled out to service providers so that support workers can also be aware of and have increased knowledge of what to do/how to respond to a customer who is expressing suicidal thoughts."* (- Children, YP, Social and Community Services).

2.8.4 More accessible support

A powerful message across all types of respondents was the need for easily accessible support for people at risk of suicide. Several key features of accessible support were identified from the responses:

- **Timely:** including extended opening hours, and being available immediately or with a short waiting time
- **Local or community based**
- **Non-judgemental and safe**
- **Ongoing:** for example with support available after the initial suicide risk is dealt with, or ongoing progress checks at home
- **Free**
- **Joined up:** the importance of easily linking to other services was highlighted.

Many respondents recommended **non-face to face services** including helplines, online support or live chat rooms, text or email support, or using apps and social media. The importance of using professionals to monitor online activity was occasionally raised. Having different means of accessing support was highlighted as important to address differing needs of individuals. *"Having a texting service to a helpline number rather than just a phone line initially I think would help. Depressed people often find it difficult to talk but can write what they feel"* (- Mental Health Services).

Suggested improvements to **primary care** included having young person or mental health focused GPs, or having psychiatric nurses based in GP practices. One respondent proposed that GPs should identify carers and offer tangible support other than simply signposting to Carers UK.

Some respondents suggested ways in which **mental health services** could be improved, including better direct access to crisis care and more proactive follow up for non-attenders *"Better follow up of people who are referred to specialist mental health services. There seem to be insufficient staff to follow up this high risk group. Also, patients who have been referred should not be discharged because they do not attend appointments. Their failure to attend is often a result of their underlying mental illness"* (– GP).

Several respondents indicated that there were numerous opportunities for suicide prevention in **non- health service settings.** *"Suicide prevention should be everybody's responsibility, not just the health services. Teachers, support workers, friends and family - everyone should have the basic awareness"* (– GP). Staff from the fire and rescue service, education, Find it Out, housing and library services suggested ways in which they could contribute. Suggestions included enquiring how vulnerable individuals were coping (e.g. as part of a home fire/gas safety check), listening to problems, and signposting to support services.

Several respondents suggested a **community-based "drop in"** service would be helpful, particularly if it was informal. ***"****Promoting access to "chat points" within the community so that they know there is always someone to talk to****"*** (– Other). Some suggested organised support groups, which could be focused around specific activities such as gardening.

2.8.5 Awareness raising to reduce stigma and publicise support available

A large number of respondents suggested that publicity around what services and support are available would be important. There was also strong support across all types of respondent for awareness-raising to decrease shame and stigma associated with mental health problems. Many spoke specifically of the need for openness around suicide or suicidal thoughts, including messages such as suicidal thoughts are common, and that those seeking help will be taken seriously. Two respondents proposed using people with lived experience of suicidal thoughts to raise awareness. *"Suicide should not be a taboo subject. People's attitudes need changing through education"* (- Children, YP, social and community services).

Respondents had many ideas for where publicity and awareness raising could be carried out. A popular suggestion was posters and leaflets in locations such as GP surgeries, libraries, toilets, bus stops, railway stations, schools, supermarkets, car parks, beauty spots, social security offices, district and county council buildings. Several respondents suggested school talks or assemblies. Some respondents emphasised the need for online information. Having a local web/social media presence relating to suicide prevention was endorsed as useful by around three quarters of respondents (72.8%).

2.8.6 Development of networks and leadership

Clear local leadership on suicide prevention was felt to be helpful by 74.8% respondents. Some respondents specified that this could come from their own management or the Health and Wellbeing board. It was felt this could raise the profile of suicide prevention and improve links between different organisations. This could be achieved through development of a local strategy that spans across all organisations; "*Leadership from the Health and Wellbeing Board, a clear strategy and commitment and a manageable action plan that involves all organisations, not just the 'usual' suspects"* (- Mental Health Services). Making a pledge to help reduce suicides locally was felt to be useful by less than half of participants (46.5%).

Around two thirds (66.8%) of respondents felt that it would be helpful to be part of a wider network of organisations working towards suicide prevention in West Sussex. Regular attendance at meetings was seen as an effective way to improve communication between organisations, and to help understand what local groups and services are able to provide ; *"I suggest regular meetings – once a quarter perhaps – where we can update each other on trends and helpful information which would prove useful in reducing suicide*"(- Children, YP, social and community services).

Some respondents commented that a conference or suicide prevention day would be a helpful way to build links with suicide prevention support services. This could provide networking opportunities and help raise awareness of services and training they may provide through stands or talks; *"network opportunities like an open day in a locality area where relevant organisations could display their service"* (- Children, YP, social and community services).

Overall, only 47.5% respondents felt that having a suicide prevention champion within their organisation would be helpful. However, the fact that 33.2% said they did not know suggests that the role of a suicide champion was unclear to many participants. Amongst those who were supportive of this proposal, most felt that a champion could act as a direct point of contact between organisations in order to feedback on any changes to services, provide examples of good practice, be knowledgeable on local trends/data, and direct others towards appropriate training and resources. *"It would be good if we had a suicide (prevention) champion who could attend relevant discussions and perhaps team meetings of other organisations and cascade relevant information/training to practitioners"* (- Children, YP, social and community services).

3 Qualitative analyses

3.1 What is already working well in West Sussex to support people at risk of suicide?

There were four main themes in relation to what is already working well in West Sussex: existing statutory and third sector services; training and skills of front line workers; links between organisations; and support within organisations. Thirty three respondents stated that they did not know, and a further 93 respondents left no response to this question.

3.1.1 Statutory and third sector services

The Samaritans were the single most frequently mentioned service across all types of respondent. Some respondents stated the Samaritans were the only suicide prevention service they were aware of. One Samaritans listening volunteer commented, *"Samaritans as a confidential help-line offering non-judgemental listening service and helping people determine choices for themselves helps overcome loneliness, isolation and distress*" (- third sector counselling/support). Other third sector services mentioned included MIND and CRUSE.

Some respondents reported that statutory mental health services were working well to prevent suicides, in particular crisis teams, the mental health triage service delivered in conjunction with the police, the use of approved mental health practitioners and the Time to Talk service. Fewer respondents mentioned other statutory services that were helpful, such as Wellbeing Hubs and the Youth Emotional Support service. However, respondents also pointed to the fact these services were under resourced and sometimes difficult to access: *"Crisis teams do a brilliant job and work hard but are probably under resourced"* (- Mental Health Services).

Some respondents highlighted aspects of service delivery that are important, including frontline staff being known and trusted by service users, picking up issues early, and addressing wider issues such as homelessness and lack of money. One respondent pinpointed the provision of naloxone to service users as effective in preventing overdose.

3.1.2 Training and skills of frontline workers

Some respondents reported that good training was available and that this had tangibly changed their approach: "*SAFEtalk training has made it more likely for me to ask the question directly and I have passed this advice on to other people and parents"* (- Education). A member of staff at Change Grow Live mentioned a suicide toolkit. A range of respondents, including schools, wellbeing hub staff and social workers, described general approaches, which they felt could reduce the risk of suicide, such as asking directly about suicidal thoughts and encouraging people to talk openly about their feelings. Having a dedicated mental health worker within the team was felt to be important for the youth offending service. "*We have a dedicated primary mental health worker and will shortly have a psychologist on a part time basis. This alleviates the stress on practitioners of what to do"* (- Children, YP, social and community services).

3.1.3 Links between organisations

Several respondents, including a district council housing officer and a GP, felt referrals between organisations were working well. "*We have very good support links with Crawley Open House who have workers within their organisation who deal with those who have mental health issues and can sign post to other services if people are feeling suicidal"* (- Housing).

Another housing officer described improvements in communication and information sharing between the district council and inpatient psychiatric facilities. Several other respondents talked about signposting to relevant services, sometimes using leaflets. One GP described the follow up she provides following an A&E visit for mental health issues "*I have started writing to patients who have been to A & E and referred directly to MH services - to let them know we are aware and can offer support and give info on resources"* (- GP).

3.1.4 Support within organisations

A handful of respondents felt that support within their organisations worked well, including a confidential counselling service at the Council and support for stressful incidents experienced by the Fire and Rescue Service.

3.2 Some people who experience suicidal feelings do not access support services, such as their GP. What more could be done to prevent suicide in these people? And Is there anything else that we haven't considered that might support people at risk of suicide?

There were six key themes in relation to what can be done to prevent suicide in West Sussex: challenges in accessing support; groups who need support; how to make support accessible; specific services that could be provided or adjusted; the need for awareness raising; and the need for training of frontline workers.

3.2.1 Challenges in accessing support

Several barriers were identified to people at risk of suicide engaging in services. Some respondents felt that shame and stigma around mental health problems, or a concern they wouldn't be taken seriously, prevented people from seeking support. Several respondents highlighted the difficulties getting a GP appointment, GPs having insufficient time, or long waiting lists to access mental health services. Other respondents said that people who are depressed may find it difficult to speak on the phone or find the motivation to attend the GP, whilst another pointed out that online services may exclude those with poor internet access. "*If you have a mental health condition and are reluctant to go, having to go through the stressful rigmarole of talking to a receptionist, potentially disclosing your condition, then waiting for a GP to call you back at an unknown time to then maybe get an appointment, again at an unknown time, it's no wonder people don't go"* (- Library services). Some respondents felt that whilst it was relatively easy to access initial support, ongoing support was more difficult to maintain.

3.2.2 Groups who need support

Most respondents didn't specify who most needed support and this wasn't specifically asked about. When it was mentioned, the groups most commonly specified as needing support were:

- young people, including both teenagers and those living away from home for the first time. The need to improve self-esteem in this group was highlighted several times by staff from education and youth services.
- People with dual diagnosis, including the need for more joined up work between substance misuse and mental health services
- Less frequently mentioned groups were Middle aged men, People with long term conditions, People bereaved by suicide

3.2.3 Specific services that could be provided or adjusted

Many respondents recommended **non-face to face services** including helplines, online support or live chat rooms, text or email support, or using apps and social media. The importance of using professionals to monitor online activity was occasionally raised. Having different means of accessing support was highlighted as important to address differing needs of individuals. *"Having a texting service to a helpline number rather than just a phone line initially I think would help. Depressed people often find it difficult to talk but can write what they feel"* (- Mental Health Services)

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Some respondents suggested ways in which **mental health services** could be improved, including better direct access to crisis care and more proactive follow up for non-attenders *"Better follow up of people who are referred to specialist mental health services. There seem to be insufficient staff to follow up this high risk group. Also, patients*

who have been referred should not be discharged because they do not attend appointments. Their failure to attend is often a result of their underlying mental illness" (- GP).

Several respondents indicated that there were numerous opportunities for suicide prevention in **non- health service settings.** *"Suicide prevention should be every bodies responsibility, not just the health services. Teachers, support workers, friends and family - everyone should have the basic awareness"* (-GP). Staff from the fire and rescue service, education, Find it Out, housing and library services suggested ways in which they could contribute. Suggestions included enquiring how vulnerable individuals were coping (e.g. as part of a home fire/gas safety check), listening to problems, and signposting to support services. *"It would be good for these people to be listened to and directed to the right support if they came in to the library"* (- library services).

Several respondents suggested a **community-based "drop in"** service would be helpful, particularly if it was informal. **"***Promoting access to "chat points" within the community so that they know there is always someone to talk to"*(– Other). Some suggested organised support groups, which could be focused around specific activities such as gardening.

3.2.4 How to make support accessible

A powerful message across all types of respondents was the need for easily accessible support. Several key features of accessible support were identified from the responses:

- **Timely:** including extended opening hours, and being available immediately or with a short waiting time *"Services that are available beyond traditional office hours; evenings and weekends"* (- mental health services)
- **Community-based.**
- **Non-judgemental and safe: "***What about a shelter where they can come, have a cup of tea, just sit with others in safety without being judged or interacted with unless they want to"* (- mental health services)
- **Ongoing:** for example with support available after the initial suicide risk is dealt with, or ongoing progress checks at home
- **Free:** *"free and in-formal drop-in opportunities advertised so that people will know there is support in the community at times of crisis"* (-library services)
- **Joined up:** the importance of easily linking to other services was highlighted.

3.2.5 The need for awareness raising

A large number of respondents suggested that publicity around what services and support are available would be important. There was also strong support across all types of respondent for awareness-raising to decrease shame and stigma associated with mental health problems. Many spoke specifically of the need for openness around suicide or suicidal thoughts, including messages such as suicidal thoughts are common, and that those seeking help will be taken seriously. "*Increased awareness amongst the population, there is no shame in feeling suicidal and it is ok to share your feelings with others"* (-GP). *"Suicide should not be a taboo subject. People's attitudes need changing through education"* (-Children, YP, social and community services).

Respondents had many ideas for where publicity and awareness raising could be carried out. A popular suggestion was posters and leaflets in locations such as GP surgeries, libraries, toilets, bus stops, railway stations, schools, supermarkets, car parks, beauty spots, social security offices, district and county council buildings. Several respondents suggested school talks or assemblies. Some respondents emphasised the need for online information. Two respondents proposed using people with lived experience of suicidal thoughts. One person mentioned suicide awareness week.

3.2.6 The need for training of frontline workers

Some respondents suggested that training frontline workers, including school staff, social workers, youth workers and carers, would be important. It was suggested that training should cover the signs of suicidal thoughts, what to say, how to listen, and what services they can signpost to.

"Training could be rolled out to service providers so that support workers can also be aware of and have increased knowledge of what to do/how to respond to a customer who is expressing suicidal thoughts" (-Children, YP, social and community services).

3.3 What is the best way to create links between your organisation and suicide prevention support services?

There were 6 key themes in relation to what is the best way to create links between organisations and suicide prevention support services: improved communication, a suicide prevention champion, a suicide prevention day, knowledge of where to signpost and what resources are like, clearer referral pathways, and strong leadership.

3.3.1 Improved communication between organisations and suicide prevention support services

The need for better communication between organisations and suicide prevention support groups was emphasised, although there were some contrasting opinions about how best to achieve this. Email and face-to-face support were often put forward as suggestions. Some individuals felt that face-to-face contact was far more effective that via email and vice versa.

"Actual conversations with the person/s and family and support services" (- mental health services); "*Email is effective and immediate so creating groups online but also attending mental health forums"* (- third sector counselling/support).

3.3.2 A suicide prevention champion

Many respondents felt that appointing a Suicide Prevention Champion, whether within their organisation or across organisations, would be beneficial. Most felt that the role of the champion would be to act as a direct point of contact between organisations in order to feedback on any changes to services and provision that may affect others. In addition, it was generally felt the champion could provide examples of good practice, be knowledgeable on local trends/data, and direct others towards appropriate training and resources.

"It would be good if we had a suicide (prevention) champion who could attend relevant discussions and perhaps team meetings of other organisations and cascade relevant information/training to practitioners" (- Children, YP, social and community services).

In addition to, or as part of the role of a Suicide Prevention Champion, respondents clearly want to establish better links with key organisations via regular attendance at meetings. This was seen as an effective way to improve communication between organisations, and to help understand what local groups and services are able to provide.

"I suggest regular meetings – once a quarter perhaps – where we can update each other on trends and helpful information which would prove useful in reducing suicide" (- Children, YP, social and community services).

3.3.3 Suicide prevention day

Some respondents commented that a conference or suicide prevention day would be a helpful way to build links with suicide prevention support services. This could provide networking opportunities and help raise awareness of services and training they may provide through stands or talks.

"Network opportunities like an open day in a locality area where relevant organisations could display their service" (- Children, YP, social and community services).

3.3.4 Knowledge of where to signpost and what resources are like

Respondents also raised the desire for a database or centrally held list of support groups/organisations that details who they are, what they do and how they can be contacted. This could be in the form of a website, a helpline, or leaflets; "*a "one stop" access point of services and times available"* (- emergency services). In addition, respondents felt having a named contact with whom they could speak to would be helpful. The role of this contact would be to provide advice and further support.

"*Designated lead for this area with responsibility for cross service communications and support*" (- Education).

There was a general feeling that workers want to know what the resources of other services are like. This will help to manage the expectations of clients, ease burden (where possible), and refer appropriately.

"*Better understanding or resource pressures, impacting different organisations and how we can work with our current resources to gain the most effective outcome for client and organisations concerned*" (– Housing)

3.3.5 Clearer referral pathways

A few respondents stated that clearer referrals pathways between organisations would be helpful; *"clear referral routes between your organisation and support organisations – this one is absolutely key*" (- Education), and that training, particularly across organisations, could be a good way to create links between organisations and suicide prevention support services. This was felt to help raise awareness of the support services available and to clarify referral pathways.

"Training/talks direct to staff on the support services and what they do/offer" (- Housing).

3.3.6 Strong leadership

Finally, respondents identified that having strong leadership from management or the Health and Wellbeing board would help raise the profile of suicide prevention, and could improve links between different organisations. This could be achieved through development of a local strategy that spans across all organisations.

"*Leadership from the Health and Wellbeing Boar, a clear strategy and commitment and a manageable action plan that involves all organisations, not just the 'usual' suspects"* (- mental health services).