Calderdale Suicide Prevention Network

Notes of meetings: Autumn 2024

Tuesday 22 October 2024, 2 – 4pm at Calderdale Music
And **Wednesday 23 October 2024,** 6 – 7.30pm, online via Zoom
Total attendance: 26

Contact: engagement@healthymindscalderdale.co.uk

What happened

Georgia welcomed members and briefed the groups on the confidentiality agreement and collective care.

In groups of approximately 8 people, members were given time to discuss issues that mattered to them relating to suicide prevention. This followed feedback from our first meeting in June that people wanted more time and space to discuss and dig deeper into the issues.

Some of the topics raised at our first meeting in June were available as prompts for further exploration:

- Aftercare: after attempts
- Aftercare: for people bereaved
- Experience of mental health services: primary & secondary care
- Help-seeking, Help-signalling & Help-offering
- Suicide prevention skills and where they are needed
- Safe spaces & crisis lines
- BAME involvement & representation
- Prevention from an earlier age: education & intervention for children and young people
- Creating a stigma-free culture

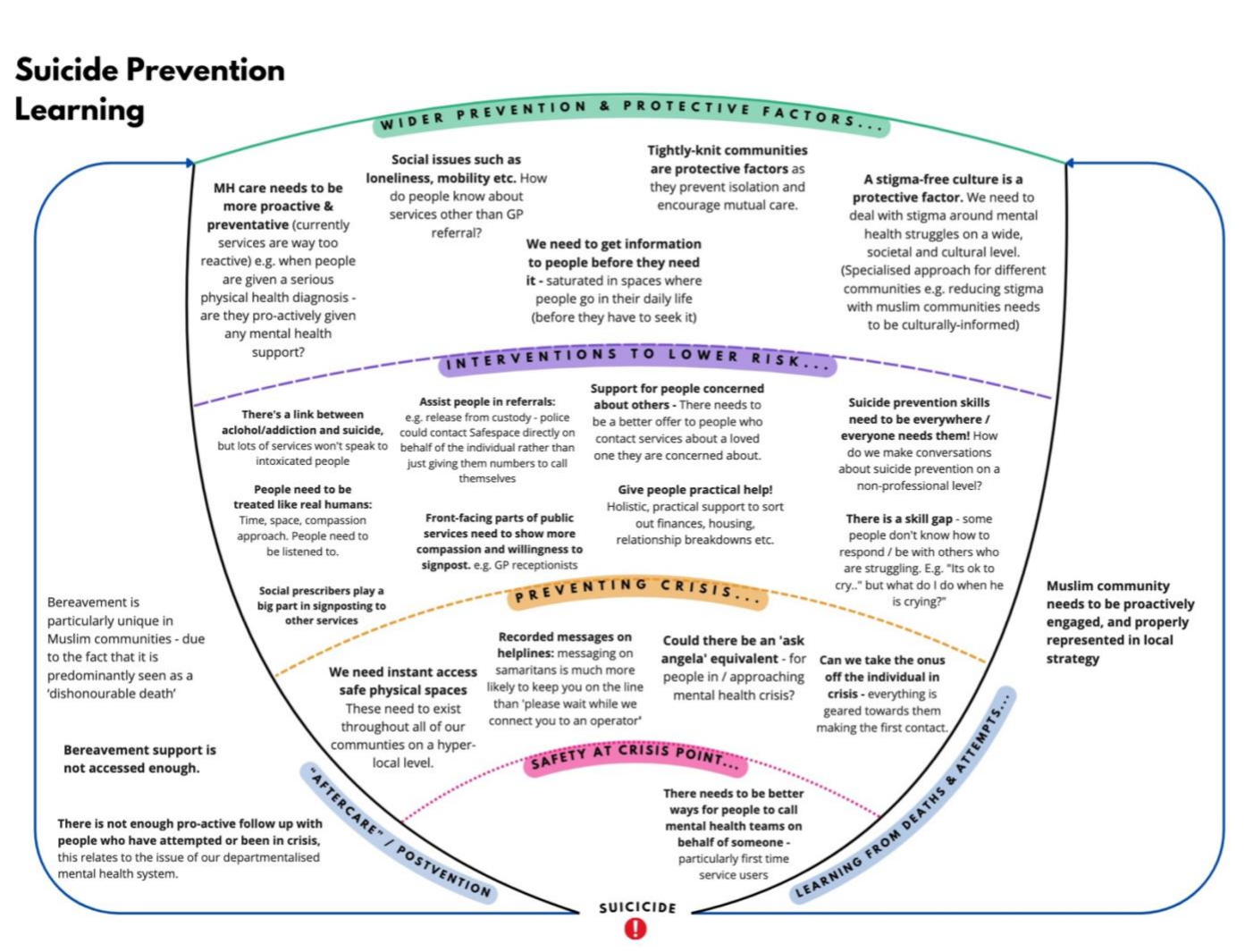
Members were prompted to consider:

- *What are your experiences of things that have helped with prevention?*
- *What hasn't helped / needs to be different?*
- *What are the missed opportunities?*
- *Where and how can the trajectory be changed earlier on?*

At the in-person meeting, we came together as a whole group towards the end of the session to try and map the discussion outputs onto a diagram (see image below) which represents the different 'layers of prevention' which included: wider prevention & protective factors; interventions to lower risk; preventing crisis; safety at crisis; 'aftercare' / postvention for those bereaved & who have attempted; and 'learning from deaths & attempts'. Outcomes of the discussions demonstrated a fair distribution

across all of these layers, indicating that members are bringing a diversity of perspectives and ideas to the table

Further mapping will help to identify where these issues might lie in the Calderdale Suicide Prevention Strategy, which has been noted as a next step.



^Diagram with some of the learnings from the 22/10/24 meeting mapped onto 'layers of prevention'

Key learnings, as well as some practical ideas that emerged from across the two meetings (three discussion groups) have been combined into a set of themes in the notes below.

Themes, Issues & Needs

1. The structure of the mental health system prevents holistic care

Services are not integrated with one another:

- Members discussed how our mental health services are highly compartmentalised, resulting in experiences of people being turned away because the service says 'we don't do/deal with that'. This often results in a lack of holistic, person-centred care.
- Mental health teams often appear limited to what they can do for people – there might be reasons for these limitations, but the resulting impact on the patient/client is still important.
- There feels to be a highly hierarchical, top-down decision-making structure within the NHS which negatively impacts on patient voice / concerns.

Navigation:

- Navigating the system continues to be a problem – if you don't understand the complexity of the system and how to advocate for yourself within that system, you are at a disadvantage.
- Interestingly, it was discussed how emerging roles such as the workers for the 'Stepping Stones' pathway partly need to be there to help advocate for the person they are supporting to be able to navigate the mental health system, perhaps this indicates the kind of issues around the ease of accessing different services, and the common experience of being 'chucked around' from one service to the next.
- Members identified that when someone (e.g. a service, family, friends, etc.) cannot call IHBTT to raise a concern about someone else unless they have directly consented – E.g. a person might have serious concerns about someone they know but IHBTT will not act on that unless the person is there or they have a record of consent.

Communication:

- Members expressed examples of where patients are not being listened to, with cases of patients repeatedly trying to raise concerns but nobody within the system being willing to deal with it or respond to the issue.
- There have also been cases of communication being poor – with the ability to email the person you want to speak to being limited (again, there might be reasons for this, but the underlying issue of this limited communication remains).

- A need was expressed for better systems around 'trusted contacts' and the potential for these to be used by service users to enhance their care from a person-centred approach.

Privatisation:

- Members were concerned about how a target-driven culture within the NHS is damaging the health outcomes of patients.
- There are strong concerns that the NHS is (at best) vulnerable to privatisation (at worst, it is being set up for privatisation by design). Privatisation of NHS services, including mental health services, directly conflicts the protective factor of having equal access to high-quality healthcare for all – a key element for suicide prevention across the board.

2. Mental health care needs to be more proactive

- Members felt that our health care system has become forced to deal with mental health issues in a very reactive way – only responding when something presents a serious problem, rather than in a proactive way by pre-empting the potential for worsening health and being proactive about this (essentially this is a prevention approach). E.g. if someone is given a serious or life-changing physical diagnosis, are they always provided with the proper mental health support for them to cope with this news? (It was pointed out that this is an issue that happen often in cancer care).
- A more proactive approach is needed to change the way we classify mental health care and suicide prevention– e.g. viewing debt advice as potentially providing 'suicide prevention care'. This would also help to raise awareness of where and how suicide prevention can happen, and who's business it is (often many people would not see themselves or their work as having a suicide prevention aspect).
- An example was pointed out around the link between alcohol/drugs and suicide – but that lots of services won't speak to / engage with intoxicated people.
- Strategies for suicide prevention need to engage with a practical and social approach – cutting across priorities for housing, social care, and combatting inequality.

3. Suicide prevention skills & where they are needed

- Members feel that suicide prevention skills (e.g. the ability to identify signs of someone who may be experiencing suicidal ideation and to then initiate a conversation with this person and provide the appropriate support) are needed

everywhere. We need to equip *everyone* with 'soft skills' such as listening, social skills, caring for others, providing emotional support, empathy & compassion. These skills need to be nurtured throughout our lives – an emphasis on this early in life (through our families and education) would further help with long-term prevention.

- Having a better skilled population that can help care for other people in our lives and relationships at an informal level could address many missed early-opportunities where trajectories towards suicide could be prevented.
- There is a sense that within the skills gap issue is the problem that many people feel they need to try and 'fix' whatever is wrong, through directive advice. Generally, there needs to be a focus on developing people's listening and empathy skills, as these are effective ways of helping someone who may be experiencing / potentially going to experience suicidal ideation.
- Members who also work in mental health shared that suicide prevention training is often only accessible / you are made aware of it if you are in a professional role. E.g. the zero suicide alliance training /suicide prevention champions is an initiative that already exists but needs promoting more – only a handful of professionals and the public know about it and have a belief it is worthwhile.
- It is widely felt that Suicide Prevention skills and awareness should be embedded within all public-facing roles – e.g. negative experiences of talking over the phone with GP receptionists was raised. Interactions with GPs were also highlighted as crucial points for suicide prevention – but generally it is felt that GPs are under-skilled in this area.
- The importance and complexity of 'lived experience' workers was also discussed. It was expressed that having mental health workers who had also 'been there' is often positive and important, but there is also concern around ensuring these workers are equipped with the right skills and are 'ready' for this kind of work.

4. Help-seeking vs Help-offering (we need a culture-shift)

Shifting the sense of responsibility:

- The responsibility is still put too much on the individual to 'reach out for help' when they need it – in reality this is often not practical, especially when in crisis. People sometimes don't seek support. Should we be shifting the focus from encouraging 'help-seeking' to increasing *'help-offering'* within our populations?
- Further upstream, we need help-offering to be second-nature behaviour throughout society, within public services as well as wider culture: in family/friendship relationships and neighbourhoods.

- Initiatives such as ‘check in with your mate’ already exist, but how do we combat the scale of the ‘private individual’ ideology that pervades our culture, politics and economy?

Skill gap prevents help-offering:

- A problem was identified around the ‘skill gap’ when it comes to people feeling empowered to look after one another. There is a sense that although progress has been made to encourage people to de-stigmatise mental health needs, people still don’t necessarily feel they have the confidence to initiate or hold conversations to support others. E.g. The ‘its ok to cry’ messaging for men/within male friendships may have changed attitudes, but there is a remaining sense of ‘what do I do when he is crying?’.
- At times there is a knee-jerk response to quickly ‘refer them to the professionals’ e.g. tell them to go to the GP or self-refer to mental health services, which can at times reinforce the idea that distress should be medicalised and avoids a peer-support approach (possibly due to the lack of confidence and skills base previously mentioned).

Help needs to be offered earlier on (before people need to use it):

- Some members described the ‘mindset’ of suicide for some people being over a period of time, (not just in an impulsive moment) with it being described how people can be thinking about it for several weeks / months before attempting.
- Members discussed the need to get people information about support out there at points before things get worse, raising awareness sooner of what help is available.
- The role of social-prescribers was mentioned, and how these roles play a big part in signposting to other services. This can be really positive, but without the services / activities / provision available in the community, there a lack of places to signpost people to.
- Members expressed that directories of support were still needed, and that people with lived experience need to be better included in the development of these.

5. More safe spaces & better automatic messaging on crisis lines

- Members shared that there is huge value in ensuring that intervention happens in those ‘fragile moments’ – when someone is very close to taking their own life. Distraction (and even shock) were highlighted as important in preventing a suicide in these moments.

- Members expressed the need (ideally) for a dedicated, instant, 24/7 & simple-access physical space (or spaces) for anyone to go to (or be brought to e.g. by a friend or neighbour) if they want support or to just feel safe (e.g. a 'crisis-café' type environment). Members felt that face-to-face, drop-in style support which provides 'hands on comfort' are important, and that this kind of space should not feel like an institution (e.g. it shouldn't feel like going into a hospital). The idea of a crisis-café-type physical space does still rely somewhat on self-intervention, which we know often isn't a possibility.
- It was discussed that these kinds of spaces would work best if they were amongst communities on a hyper-local level to minimise travel and maximise awareness.
- The actual local presence of physical safe spaces/crisis cafés could potentially also help to normalise help-seeking and help-offering culture.
- Experiences of using crisis support lines were shared – including the observation that different lines have different kinds of messaging on the phone as it is ringing, some are more successful at keeping you on the phone for longer before being connected to a real person.

6. Better support is needed after leaving secondary care

- Members expressed that there is not enough intensive, follow-up support for people leaving secure settings: "What about when people go home and end up in the same negative cycle / environment / influences. People then end up having to come back into hospital."
- People can also end up leaving the ward with other problems that they didn't have when they went in.

7. Reducing male suicide needs a nuanced approach

- Members shared the experience of hearing the 'deep sense of shame' that men in particular can carry (particularly when leaving secondary care) which can lead to more potential self-harm or suicide.
- There is an emphasis in Calderdale on creative activities in hospital, but can we broaden this out? Can we seek to have a wider diversity of creative provision that will have a broader appeal (E.g. not to stereotype men, but activities like mechanics, cookery, sports can encourage creative health beyond the arts – which don't appeal to everyone).

- Can we better utilise more male spaces e.g. sports clubs, working men's clubs to disseminate messaging about suicide prevention and how to talk about life's struggles.
- It was pointed out that are mainly women working in mental health and creative wellbeing, highlighting a need for better representation of men in these kinds of roles which could have a positive influence on mental health outcomes for men.
- Members recognised the generational issue of stigma within men's mental health, but also shared concerns about a growing problem within young men (incel culture, Andrew Tate etc), which feeds on male insecurities and discourages vulnerability: "Not sure what the solution is but there is a need for good male role models, interventions that hear the issues of those young men before they get too stuck in all that"

8. We still need more compassion within mental health support

- Members discussed the importance that compassion and 'hands on comfort' has made to them, or perhaps would have made to them, in times of distress. A sense of 'human-ness' and humanity are important within these kinds of interactions, both within relationships with professionals as well as in personal or community relationships. This resonates with the 'Time, Space, Compassion' principles described and adopted by the Scottish Govt.
- Issues around physical contact were discussed – e.g. expressing the positive difference that a literal 'hand on the shoulder' can make, but perhaps policies around physical contact (often for good reason) can prevent this kind of interaction from happening in professional vs patient relationships.

9. There's a gap in engagement with BAME groups & communities

- Members continued to express the desire to know: where is the involvement and representation of local South Asian and/or Muslim communities within strategy? There are passionate people within these communities who are willing and able to explore the unique needs and stigma that needs to be addressed, but they are not being asked to be involved at a strategic level. More pro-active engagement with Muslim people & communities is needed. Particularly, to examine some of the issue of how suicide is seen as a 'dishonourable death' and the impact this can have on bereaved families – e.g. the cause of death will be covered up and resulting trauma can be suppressed.
- Members asked: How accessible are services to people who are from a variety of cultural backgrounds? In particular, people of African and Caribbean background or descent? The issue of suicide being a very taboo subject within

some of these groups was discussed, e.g. the damaging idea that if you are ‘religious enough’ you shouldn’t feel depressed / be suicidal.
- The affect on BAME people who are bereaved by suicide can be particularly complex and unique when accompanied by certain cultural beliefs.
- Members would welcome efforts for specific engagement with local BAME people.

10. Invest in creative health provision

- Members shared the positive impact that creative and cultural opportunities have on preventing & reducing the impact of suicide.
- There is a desire for this to not be lost as a priority – local cultural and creative programmes ought to be mapped onto suicide prevention strategy (and vice-versa).
- Adult Learning could be better utilised – currently Adult Learning provision is being pushed to be all about employability, but these programmes could also be a big asset for suicide prevention if they are better utilised for this purpose.

11. Better awareness of social media harm

- Members discussed how aspects of social media and the internet can be harmful, particularly in terms of how social media can be seen as an 'unhelpful coping strategy', with people ending up in dark ‘conspiracy theory’ spaces on the internet. This relates to social isolation - people have lost / don't have the social connection outside of their online community. This online community then becomes a space for freedom to explore dark thoughts - otherwise not ‘allowed’ in real life spaces.
- Members were particularly concerned about these issues in relation to young people / younger adults. It was raised what published guidance/resources existed already and if this can be better utilised in suicide prevention resourcing and promotional work. E.g. Internet safety week – how can we support social media hygiene education, relationship with online bulling etc?
- It was also pointed out that social media can also be utilised to combat some of the problems it causes – begging the question: is social media being used as a tool in this way at a strategic level locally?

Ideas for Action

A few specific ideas that have the potential to be actioned emerged from the discussions. These were sometimes also influenced by who was in the room and the professional capacity they were attending in.

Police could proactively make referrals to Safespace

There was a lot of positivity around the idea that the local police force could embed a simple question into their procedure for releasing people from custody: asking the person being released if they would like the police to contact Safespace (Healthy Minds service) on their behalf. Safespace would then get in contact with the person a week or so after the referral to pro-actively check in with them and offer support. This would:

- Possibly offer more meaningful and proactive signposting (as opposed to just 'handing them some leaflets').
- Shift the responsibility of the individual to contact Safespace themselves directly for support (which can be a daunting thing to do).
- Also raise awareness within the police force of the importance of helping people access mental health support.

Ask for a change to the automatic messaging on the WY 24hr helpline

When you call the WY 24hr helpline, the response on the line is the dial tone, interjected with 'please wait while we connect you with an operator', on repeat. Comparing this to calling the Samaritans, which intermittently shares reassuring messages such as "We listen to you and help you talk through your concerns, worries and troubles" and will indicate how long you have been waiting "we are aware you have been waiting for 7 minutes".

On the whole, the experience of calling the Samaritans tends to keep you on the line for longer. A minute feels like a long time when you are in distress, so being connected to a real person as quickly as possible is important, but when people have to wait to be connected, it is at least helpful to listen to reassuring messaging.

'Ask for Angela' equivalent for people in distress

The 'Ask for Angela' scheme creates a way for people feeling vulnerable in spaces like bars / pubs to ask for help discretely. Members wondered whether an equivalent kind of initiative could exist for people struggling with mental health issues in different public spaces. This is a large-scale idea that would need a lot of further discussion.

Member Representative Nominations

Members were informed about the ‘Member Rep’ role, and the need to decide who will attend the Calderdale Suicide Prevention Strategic Group on behalf of the Network.

The Member Rep will advocate for the voice of the Network, share our learnings, and feedback any responses that are communicated back from the Strategic Group.

Nominations were taken at and after the meetings, and the wider membership will be given the opportunity to have their say on who will represent the Network and how this will happen, e.g. it is possible for it to be a shared role with a rotating responsibility between different members to take turns to attend the Strategic Group.

It was also suggested that we encourage the members of the Strategic Group to attend our Network meetings (perhaps on a rotating basis) to create more two-way communication and representation between these two bodies.