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Leicestershire Partnership NHS Trust

Trust Board 26th July 2022

Response to Healthwatch paper: Male Suicide - Turning the Tide: raising awareness to reduce death by suicide (February 2022)

Purpose of the report

To provide a brief overview of the Healthwatch paper that was published in February 2022 and the Trust key areas for response and action. To receive a response to each of the recommendations described in the paper.

Introduction

Male Suicide - Turning the Tide: raising awareness to reduce death by suicide was published in February 2022 by Healthwatch. Healthwatch Leicester and Healthwatch Leicestershire is the independent voice of the public in health and social care services. They collect feedback from the public about their experiences of using health and social care services and use that feedback to work with service providers and commissioners to find ways to improve services. One of the ways that they collect feedback is by carrying out focused projects as part of their annual workplan. The male suicide report is a 37-page document with 13 recommendations.

This report pulls some key messages from the Report, outlines a brief Trust response against each of the recommendations – the responses are part of work already in progress and illustrate an ongoing commitment to our system-wide approach to suicide prevention. LPT is an active partner in the Leicester, Leicestershire and Rutland (LLR) Suicide and Audit Prevention Group and provided initial support and sector knowledge to the project.

Healthwatch reviewed a range of national research evidence and spoke with local organisations, individuals and carers who have accessed the whole range of services with an interest in suicide prevention. The Report largely concentrates on the voices of men interviewed and some of those have been quoted in this paper. The recommendations are consistent with transformation plans to strengthen pathways between services, develop ongoing support in primary care/mental health interface following self-harm and suicide attempts and to target priority groups to access specific support for mental health before a crisis.

Further resources in support of the wider national context of men and suicide is contained in detail in a specific 'men and suicide' section within the new LPT Staff Resource for Self-Harm and Suicide Prevention.

Suicide in Men in Leicester, Leicestershire and Rutland

The aims and objectives of the project Healthwatch reported on were:

- To understand the purpose of the LLR Suicide Awareness and Prevention Group and its role in the prevention of suicide across Leicester and Leicestershire, identifying any gaps in the prevention pathway
- To identify and contact suicide prevention services across the city and county and identify any gaps in service provision
- Give a voice to people who have used or attempted to use services to tell us of their experiences
- Identify any potential barriers that prevent men from coming forward to access services
- Explore ways to raise awareness of services and suggest appropriate tools to promote services

455 deaths have been recorded since January 2015 and 353 of these were males. This represents 75.1% of all deaths and nationally, 45–49-year-old men have the highest age-specific suicide rate, but the risk for LLR is nearly equal from 25 years through to 54 years.

Since the first version of the Healthwatch Report, we have also become aware through local intelligence that Melton has the second highest incidence of male suicide per % of population in the country – work is proceeding to verify, clarify and explore that through Leicestershire Police who lead the surveillance for LLR.

Key Findings Relevant to LPT **(Pages 18-23 of the Healthwatch Report)**

Men who had no diagnosed mental health condition or any long-term mental health issues were the ones who were more likely to fall through the net. There was a distinct lack of knowledge amongst participants on what help was available or where they could go for help. They were also the ones who were reluctant to access formal services not wanting to be seen as a 'patient' receiving counselling or psychiatric care.

Page 18 specifically related to the urgent care pathway: *It was not possible to get figures prior to meeting of the number of people who had attended ED subsequently having taken their own life. It is known however that 40% of male suicides in Leicester and Leicestershire over the past 5 years were known to mental health services. It has not been possible however to find out how many of these were in touch with mental health services at the time of their suicide, or whether they had been previously in touch or had been assessed for support from the mental health team but had not met the criteria for a service.*

The Report highlights the need for better access to services for individuals from diverse communities - with a recurring theme that people do not find existing services relatable or safe.

The report particularly highlighted the lack of ED and mental health team support for men who had presented to UHL with self-harm:

> *"I have attended A&E countless times from the age of 18 until the last time at Christmas 2020. I have taken around 17 overdoses and cut my wrists countless times. I have been dealt with in A&E and discharged but never had any follow up"*

There is limited evidence however of how ED link into the broader suicide prevention strategy. There is no sharing of information protocol in terms of the numbers of people attending ED who have attempted suicide or self-harmed so there is no opportunity to consider who may be at high risk who could be targeted for community-based prevention services. This we were told is being developed currently. We received feedback from both mental health service users and bereaved relatives of people who have died by suicide and most of this feedback indicated negative experiences and gaps in services. We interviewed eight men who were long term mental health service users many of whom were or had been regular attenders at ED for self-harming behaviours[1]

And men who do not make contact with services:

> *"I didn't want to worry my family and friends and didn't want them getting all upset and phoning the doctor and people like that. Once you are in the system that's it for life. You will be labelled mentally ill and I didn't want that."*

Healthwatch Recommendations and LPT Responses

Healthwatch Recommendations		Suggested LPT Response[2]
1.	A review and strengthening of Pathways between NHS Trusts, GP's, ED and SAPG to improve coordination of services for those who self-harm or attempt suicide and present to GPs or ED. There is an important role in prevention particularly for primary care, ED, and mental health services. SAPG should focus on how these services can improve the recognition of risk and respond to men's needs, and how services might work better together.	Alignment with NICE Consultation due July 2022 Align with findings of NCISH Annual Report 2021 Ongoing work across the Urgent Care Pathway to develop and include aligned processes and skills for effective alcohol and substance misuse services
2.	ED and mental health services to develop a system to follow up people admitted or assessed by mental health services following a suicide attempt and to ensure they have information about ongoing support	Ensure that clinical practices are supported to deliver and support effective personal safety planning and follow-up calls.

[1] Page 23 incorrectly states: *The Mental Health team will carry out a rapid review led by the Medical Director and consider any immediate learning from an incident.* Rapid Clinical Reviews – a process introduced by the Lead Nurse Suicide Prevention is now facilitated by the Deputy Head of Nursing for Urgent Care.

[2] It has not been possible to get any feedback about ongoing discussions to inform these suggested responses – hence the recommendation.

	services. ED and mental health services to develop a system to follow up people admitted or assessed by mental health services following a suicide attempt and to ensure they have information about ongoing support services.	Align also with improved provision of sign-posting, managed referrals and specific & supportive follow-up
3.	Mental health services to provide information about ongoing support when discharging patients and hand over care following a suicide attempt or self-harm so that people have options for support should this be required.	Need to develop pathway outlining informed criteria for referral into secondary services Develop interface with new MHPs and PCNs. Would that be a useful part of the prevention and follow-up pathway.
4.	Information on where men can get help quickly and easily to be made available in an accessible way on the internet with a media campaign on how this can be accessed. Also consider information packs to be available in key places such as Libraries and Job Centres etc	Need to consider how to actively contribute to this via the Mental Health Facilitators and GHiN?
5.	A campaign to raise awareness of men's mental health and suicide prevention targeted at men who do not access mental health services either through choice or who don't meet the criteria for mental health support. This should be in partnership with organisations and businesses whose demographic is largely men such as sporting activities, pubs and clubs, where men can receive information on help available discreetly. (A campaign is planned to take place in January in partnership with Everards's brewery and Leicester United sporting clubs to raise awareness amongst men but there may be other opportunities to be explored with other business, community organisations in Leicester and Leicestershire.) Get the Ball Rolling	To consider active involvement in this campaign and others – also ensuring that any work is diverse and inclusive, built on a range of private and public social spaces that men across the life span inhabit. Also need to target older men as per NCISH data through covid at higher risk >65
6.	Information to be available to GP's, ED and mental health services that can be given to men who present with self-harm or suicide ideation but who do not need admission or mental health input so that men are not discharged without access to ongoing support.	Need to link across to current NICE consultation Self harm: assessment, management and preventing recurrence In development [GID-NG10148] as there are fuller details about the role

		of GPS/ED – although the evidence base is low Need to continue promoting info@harmless.org.uk, 01158 800280. A referral can be made via self-referral or professional referral and the online referral form is available at: harmless.org.uk/referring-partners-self-harm-form-leicestershire/ We have disseminated information for Mensoar – Men's Peer Support Groups via DMH S-H & SPG www.mensoar.co.uk/
7.	Development of a poster giving information to men on how they can access help either through use of a QR code or something discreet that is available in public place that men are likely to access including places like job centres.	Need to consider a response as system partner – likely to be a specific piece of Public Health work
8.	Consideration of more awareness raising activities targeted at younger men in schools, colleges, youth clubs etc, providing information on where men can go to access help or information and raising the profile of #StartAConverstation.	Need to consider a response as system partner – likely to be a specific piece of Public Health work
9.	Evidence of access to suicide prevention and support by the BAME and LGBT community is that the numbers are low. Consideration to be given by commissioners to allocating a specific budget to specialist providers of services to BAME groups and LGBT communities to develop these services to ensure that these groups have equal access to support to services that are relevant to their needs.	Needs a specific LPT programme of work to be considered at the Trust Suicide Prevention Group
10.	Further work to be considered looking at the myths and realities of the perceived low uptake of engagement of BAME and LGBT communities in suicide prevention initiatives.	Need to consider a response as system partner – recommended to be a specific piece of Public Health work.
11.	Information sharing protocols around ED attendances and admissions should be	Part of the work in support of Recommendation 1, 2, 3 & 6

	agreed as a priority in order to accurately identify high risk groups and ensure resources are targeted at these groups and appropriate follow up support provided.	
12.	Public health to collect demographic data on the number of self-harm cases in order to assist with targeting of services and to analyse any demographic connection between those that self-harm and those that go on to take their own lives. This will assist with identifying and targeting those at high risk of suicide.	There is no consistent LLR robust process for collecting actual numbers, theming and developing This is being followed up for investment in data analysis across the system at the LLR group.
13.	Ensure that men identified as being at risk of suicide have access to Improving Access to Psychological Therapies (IAPT) where appropriate.	Development of an option to manage a referral process rather than rely on individuals seen in MHCUH/ED/CMHTs to self-refer?

1. Recommendations for the Trust Suicide Prevention Group

Establish a sub-group or use the DMH Self-Harm & Suicide Prevention Group to bring specific focus to support clinical and service developments, with an action plan, with the following considerations:

- Recommendations 1, 2, 3, 6, 9, 10, 11 and 13 all relate to the development of a revised clinical pathway between ED and LPT
- Use the feedback from local men interviewed to inform all services – involve Experts by Experience in the design & leadership of the work
- Align suicide prevention activities with the interface between MHPs, PCNs and SPAG to make the most of the strategic objective to support primary care
- Improve LPT data management to focus service design and partnership work especially with key groups e.g., LGBT, BAME communities and all other protected groups; and that LPT ensures that diverse communities ***inform*** service redesign and support provision of specialist services
- Ensure that the Trust suicide prevention group informs service design and priority actions are additionally informed by NCISH as outlined in **Appendix One** and **Two**
- Maintain the focus and resource requirements for veterans, who are predominantly men and as previously reported the east midlands has a higher % of regiments who were active in Afghanistan and Iraq tours – also note the very recent Office for

Veteran's Affairs Veterans Strategy Action Plan 2022-2024 with particular regard to a new method for recording and reporting veteran suicide, reporting from 2023. In the interim a 10-year lookback on veteran deaths through suicide, alcohol misuse and drug abuse is due to be reported in 2022.

- Not a specific recommendation – the Report highlights the lack of consistent sign-posting and referral from services to the Tomorrow Project for suicide bereavement support.

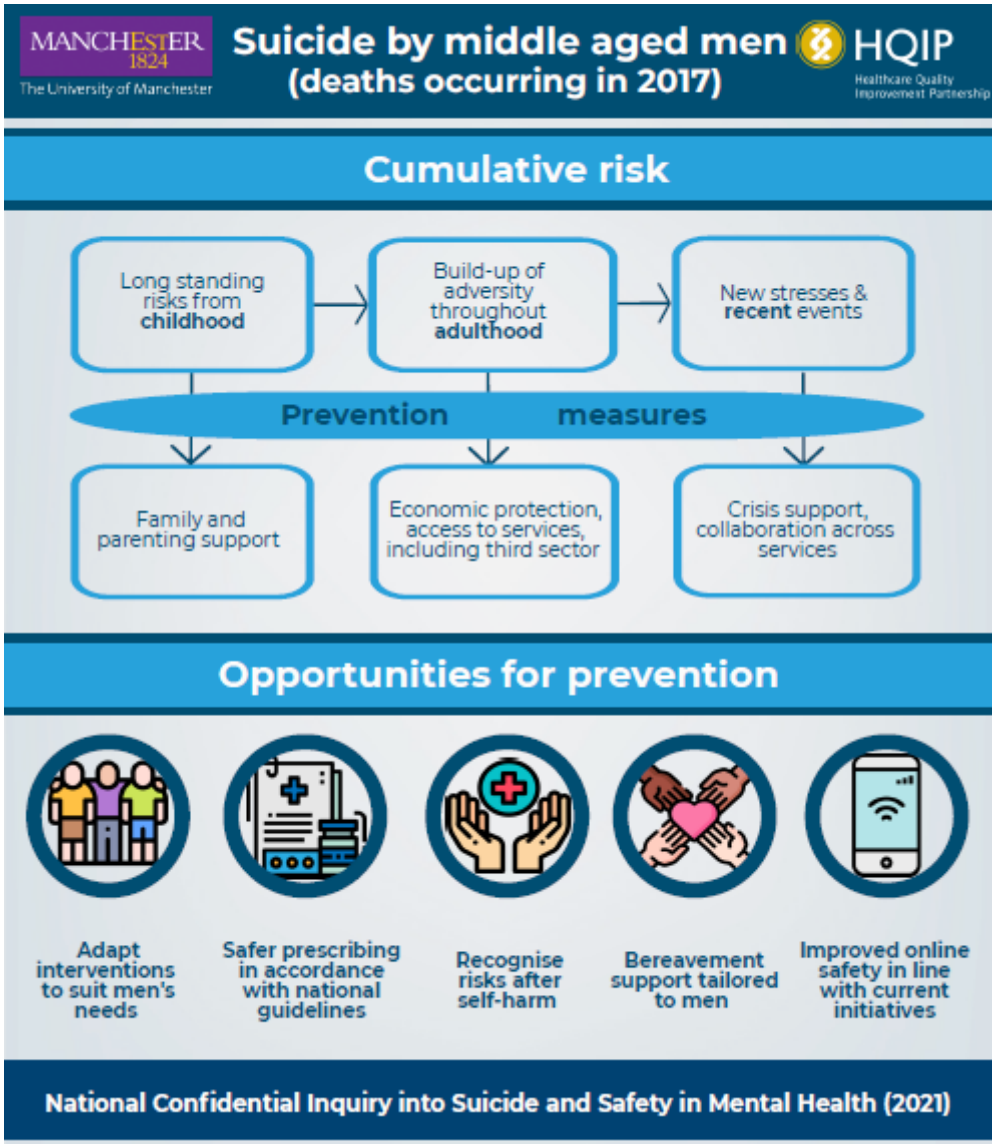
- Not a specific recommendation – develop a focus on different services to be available for males across age ranges, particularly as in LLR we have a lower age group vulnerable to suicide and NCISH have recently reported the increased risks post-covid for older men over the age of 65

Recommendations For Trust Board

LPT Trust Board are asked to:

- note the findings and to be taken forward at the Trust Suicide Prevention Group.
- Support the actions being undertaken in response to the recommendations

Appendix One



Appendix Two

Key messages

1. Middle-aged men are the group at highest risk of dying by suicide; the reasons for this are complex, and include a combination of longstanding and recent risks. We should avoid attributing these suicide deaths to single causes, as this will make prevention less effective;

2. Rates of contact with services among middle-aged men were higher than expected; almost all had been in contact with a front-line service or agency at some time. It is therefore too simplistic to say that men do not seek help;

3. There is a vital role in prevention particularly for primary care, A&E, the justice system, and mental health services. We should focus on how these services can improve the recognition of risk and respond to men's needs, and how services might work better together;

4. We have confirmed that economic adversity, alcohol and drug misuse, and relationship stresses are common antecedents of suicide in men in mid-life. Prevention requires a range of public health, clinical and socio-economic interventions;

5. More than half of the middle-aged men who died had a physical health condition; over a third of those who were prescribed medication for their physical health were prescribed opiates. Physical ill-health is an important factor in suicide risk and help-seeking for physical health problems may be an opportunity for prevention. Opiate analgesics appear to add to risk, particularly in individuals with physical ill-health, and safe prescribing is vital and in accordance with national guidelines on the management of chronic pain;

6. Middle-aged men who seek help for their mental health sometimes remain untreated. In particular, psychological therapies suited to their needs should be offered;

7. Around half of the men who died were known to have self-harmed. Recognition of risk by services after self-harm is vital, as further self-harm may involve a method of greater lethality such as hanging;

Key messages (continued)

8. Many of the men in our study appear to have been affected by bereavement. There is a need to ensure bereavement support is available in a way that addresses the needs of men;

9. We found information on suicide methods was often obtained via the internet: online safety should be part of any prevention plan for men at risk of suicide. The current online harms initiative by the Law Commission is an opportunity to consider this aspect of suicide risk;

10. There is also a small group of suicidal men who appear to be out of contact with any supports. There are several examples of local and national third sector initiatives aiming to reach this group and these should be supported and adopted more widely.

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Fiona Myers, Director of Mental Health Services	
Paper authored by:	Michelle Churchard-Smith, Interim Deputy Director of Nursing/ Jackson, Suicide Prevention Lead DMH.C/LD	
Date submitted:	19.07.22	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	DMH Quality and Safety DMT, DMH Suicide Prevention Group Trust Suicide Awareness and Prevention Suicide Group.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	This is a one off report.	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes

	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	Yes
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	N/A	
Positive confirmation that the content does not risk the safety of patients or the public	This supports the safety of the patients and public	
Equality considerations:		