healthwatch Leicester

healthwatch Leicestershire

Male Suicide

Turning the Tide: Raising awareness to reduce death by suicide

February 2022

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Disclaimer

This report relates to our findings. Our report does not represent the experiences of all people but only those who contributed at the time.

Executive Summary

Healthwatch Leicester and Healthwatch Leicestershire are an independent voice for the people of Leicester and Leicestershire. Our role is to listen to the voice of the public and represent their views with commissioners and providers of services to influence service improvement, and hold to account where appropriate. We work with all communities and use feedback to help shape services and drive-up quality and improvement.

The context for this study was the increasing number of suicides in males year on year since 2013. Nationally the death by suicide figures reached a peak in 2019 with a death rate of 5,691 equating to 11 deaths per 100,000 population . The suicide rate for men is three times higher than that of women and this has been a consistent trend going back to the mid 90's. The figures for suicides in Leicester and Leicestershire are consistent with the national picture and the gender split of 75% male to 25% female also mirrors national statistics.

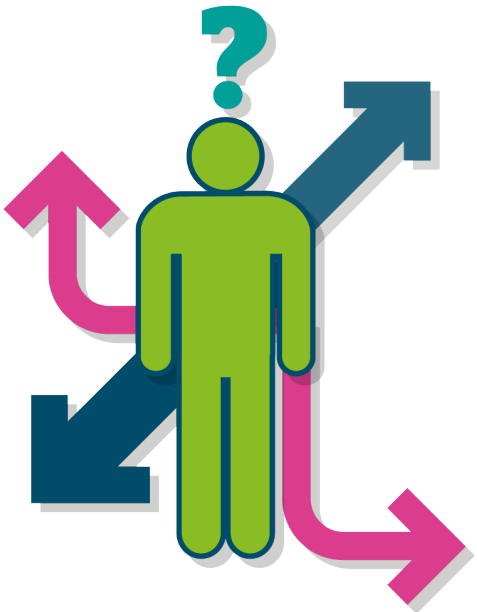
Our rationale for undertaking this study was informed by insights received through our involvement with Suicide Audit and Prevention Group (SAPG) and other strategic meetings which highlighted the significant number of men who take their own lives often without warning. By focusing on this area we were seeking to add value to the work already being done within the city and county through the Suicide Prevention Strategy. The focus of our study was to look at the prevention services available, specifically:

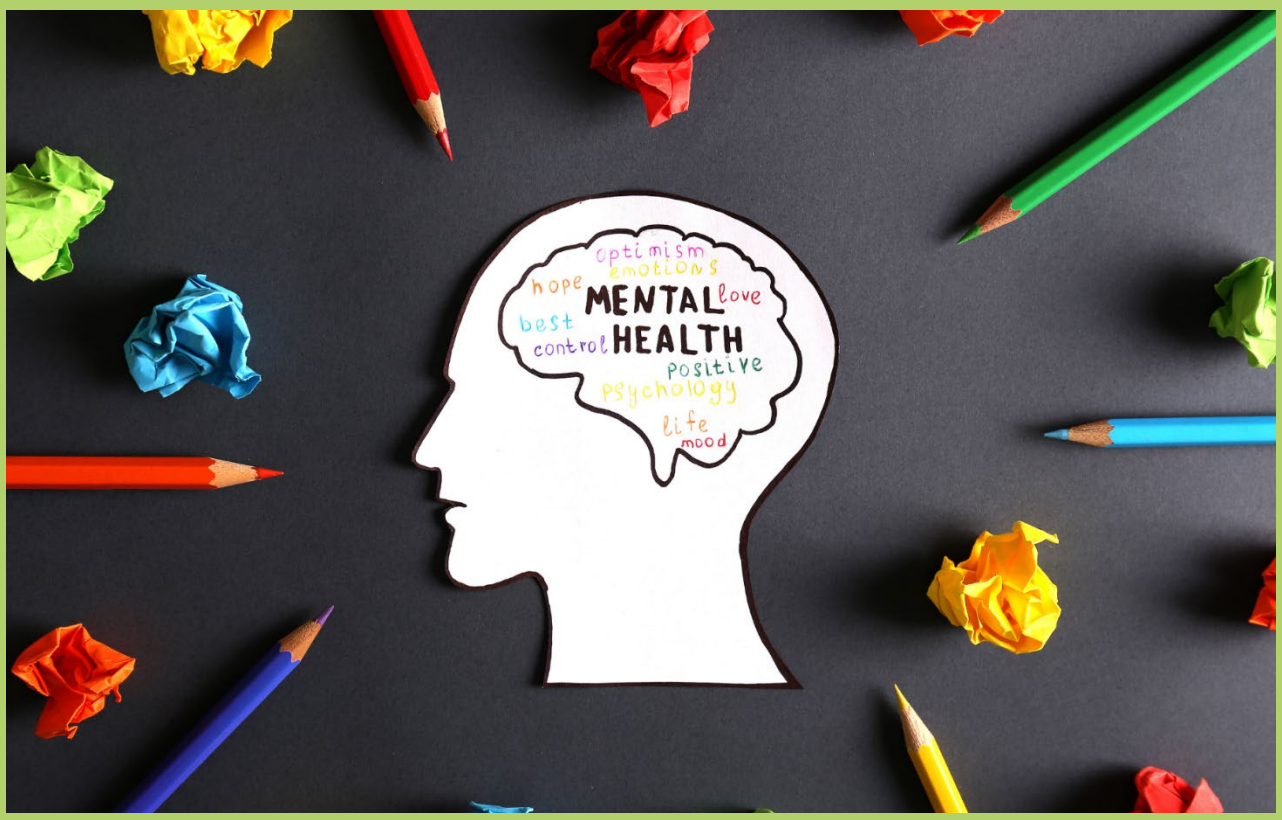
- How accessible they are to those who identify as male
- Identify any barriers to access and gaps in services
- Suggest ways in which to raise the profile of services to make them more accessible to men in Leicester and Leicestershire.
- Give a voice to people who have used or attempted to use services to tell us of their experiences.

What we did

A key component of this work was to seek out and represent the experience and voice of men who have been affected by suicidal thoughts or actions for which they may or may not have sought help.

Throughout our study we contacted organisations both statutory and voluntary across Leicester and Leicestershire who are commissioned to provide suicide prevention services. We also contacted organisations who are not commissioned to provide services but who in the course of their work encountered men who have attempted or contemplated suicide due to mental health issues.





Main Findings

Through our contact with services, we found a real passion, commitment, motivation and some excellent services delivered through the framework of the Suicide Prevention Strategy and coordinated through the Suicide Audit and Prevention Group.

There were however gaps identified in the pathways particularly in data sharing, and knowledge of services to refer to. This was an issue for people providing services in the community in as much as potential opportunities to support people who were recently bereaved or people who had sought help via emergency services or their doctor with suicide ideation or self-harm.
Gaps were also identified in access to services for people in the Black and Minority and Ethnic (BAME) and Lesbian, Gay, Bisexual and Transgender (LGBT) communities. Whether these barriers were real or perceived, uptake of services by these communities were generally low.

As part of this study we made contact with and held meetings with **20** organisations working in suicide prevention across the city and county. We also attended **6** peer support groups attended by **29** people including **3** groups of **8** men, one of **3** and one of **2** and conducted individual in depth interviews with 8 men talking about their experiences. These were mostly white males but reflected the demographic accessing services. We found that those who were currently receiving services valued them and found them helpful in managing their mental health. Peer support was valued highly in combating feelings of loneliness and isolation and making friendships.

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. This is the group that should be targeted to raise awareness of support available. These are likely to be men who access community leisure activities such as sports clubs, gyms and pubs.

What should happen next - key messages

- Strengthening of Pathways between NHS Trusts, GPs, Emergency Departments (ED) and the Suicide Audit and Prevention Group (SAPG) to improve coordination of services for those who self-harm or attempt suicide and present at GPs or ED.
- Mental health services to provide information about ongoing support when discharging patients from the service following a suicide attempt or self-harm so that people have options for support should this be required following discharge.
- 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.
- A campaign to raise issues 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.
- Consideration to be given by commissioners to allocating a specific budget to specialist providers of services to BAME groups and LGBT communities.

Introduction

Healthwatch Leicester and Healthwatch Leicestershire is the independent voice of the public in health and social care services. We 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 we collect feedback is by carrying out focused projects as part of our annual workplan.

Death by suicide in males across England and Wales have increased year on year and in 2019 the suicide rates for men in England and Wales was the highest for two decades at 5,691. This equates to 11 deaths per 100,000 per population. In 2020 suicide rates were significantly lower at 5,224, equating to 10 deaths per 100,000. According to the Office of National Statistics (ONS) the decrease is likely to be driven by 2 factors, a decrease in the number of male deaths at the start of the covid-19 pandemic and delays in death registrations because of the pandemic. Despite this around 75.1% of suicide deaths were men, which follows a consistent trend back to the mid 90's. Furthermore, it is reported that of those males who died by suicide, over half had not sought help prior to the event.

A national confidential enquiry carried out by Manchester University and Health Quality Improvement Partnership (HQUIP) into suicide and safety in mental health looked at suicide in middle aged men and found that men aged between 40-54 had the highest rates of suicide in the UK and were less likely to be in contact with health or other support services, talk about or report mental health problems and were likely to perceive more barriers to accessing services than women.

Figures from the Mental Health Foundation show that the cost to the UK economy of mental health problems is between £70-£100 billion which represents 4.5% of Gross Domestic Product (GDP). The average cost of suicide to public services is £1.7 million and £70 million days are lost from work because of mental health issues.

We undertook this study to understand the impact of suicide on the male population in the city and county. Having communicated through the Mental Health workstream and the Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group (LLR SAPG), it was felt that this was a project that could add value to the current work. We wanted to look at the prevention services available, how accessible they are to the male community as a whole, identify any barriers to access and gaps in services and suggest ways in which to raise the profile of services to make them more accessible to males in Leicester and Leicestershire.

A key component of this work was to seek out and represent the experience and voice of men who have been affected by suicidal thoughts or actions for which they may or may not have sought help. The study did not focus solely on men in any particular age category though the majority of men we engaged with were 40-54 years old.

AIMS AND OBJECTIVES

The aims and objectives of this project were:

- To understand the purpose of the LLR SAPG 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.

Methodology

To meet our objectives, we employed several methods to gather information and data. Healthwatch is a participant of the LLR SAPG, a multi-agency group made up of local authorities, public health, the police, universities, primary and secondary health care agencies and service providers. The group meets weekly to receive reports on deaths by suicide, and to join forces to develop cross cutting approaches to enhance communication, improve signposting and support to maximise the effectiveness of services. All partners were contacted and several responded and engaged in conversations and interviews about the work that they do, their role, and that of their organisation, in suicide prevention. Those we spoke to from the LLR SAPG included:

- Police service lead for suicide prevention
- Lead Nurse Suicide Prevention - Leicestershire Partnership NHS Trust
- Leicester Samaritans
- Armed Forces Lead for Leicestershire Partnership NHS Trust
- CEO - Loughborough Well Being Centre
- Project Lead for the Tomorrow Project
- Richmond Fellowship Leicester and Leicestershire Lifelinks
- Harmless project
- Rural Community Council
- Survivors of Bereavement by Suicide (SOBS)
- Lead ED consultant, Lead Nurse for urgent care and Mental Health Team Coordinator at University Hospitals of Leicester (UHL)
- Public Health Leads in Leicester City and Leicestershire County councils

We also contacted organisations active in the community who are not members of the SAPG but work with people who have mental health issues or provide community based services which includes services to people who may be deemed ‘at risk’ These groups include:

- The Adhar Project, Leicester
- Leicester LGBT Centre
- Project Development Manager for Andy’s Man Club (National)
- Health and Well Being Centre of Leicester City Football Club
- Marketing Manager for Everards Brewery Leicester
- Project Officer for Equality Action
- CEO - Inini Initiative
- Mensoar, the peer support network for men in Leicestershire

We attended **5** peer support groups **1** drop in games group at the Wellbeing café in Loughborough and the ‘Mensoar’ group online via zoom. These were attended by **29** people of mixed gender but majority were male attendees and from this we held one to one follow up interviews with eight men. We also spoke to a further three men who contacted us through social media.

Additionally, we spoke to three mothers whose sons had died by suicide and the project coordinator of the Tomorrow Project who work with people bereaved or affected by a death by suicide.

To give context we also looked at research undertaken on the subject including:

- Engaging Men Earlier - Samaritans
- Out of sight, out of mind handbook for men's wellbeing services - Samaritans
- Adaptation of evidence-based suicide prevention strategies during and after the COVID-19 pandemic - Wasserman, Losue, Wuestefeld, Carli
- Suicide by Middle Aged Men National Confidential Inquiry 2021 - The University of Manchester and HQIP
- LGBT in Britain Health report - Stonewall organisation and YouGov
- Mental Health Foundation – BAME and Mental Health
- Mental ill health BAME and LGBT communities - Mental Health First Aid (MHFA)
- From Grief to Hope: The Collective Voice of those Bereaved or Affected by Suicide in the UK - University of Manchester. November 2020.
- Self-harm and suicide in adults. Final report of the patient safety group - Royal College of Psychiatrists.

Main Findings

The Figures

The model used by Leicester, Leicestershire and Rutland is known as 'Real Time Suicide Surveillance in Leicester, Leicestershire and Rutland'. The model is known as the LOSST LIFFE model. This is a practical model for suicide response and suicide prevention based on the real-time surveillance guidance of Public Health England. It was created and implemented by the Suicide Prevention Lead at Leicestershire Police with support and assistance from the University of Leicester. This model was designed for the operationalisation of national objectives by focusing on how one primary agency (the police) work with other local agencies to collate data, initiate support processes and meet wider objectives around suicide prevention. LLR have adopted the ONS definition of suicide, a death categorised by the coroner's office caused by:

- Intentional self-harm
- Injury/ poisoning of undetermined intent
- Sequelae of intentional self-harm/ injury/ poisoning of undetermined intent

Suicide figures in Leicester, Leicestershire and Rutland are:

- 455 deaths have been recorded since January 2015
- 353 of these were males
- This represents 75.1% of all deaths
- This follows a consistent trend back to the mid 90's
- Of these two were males in Transition
- Seven were identified as being from a BAME background

Year	Male deaths per year
2015	35
2016	53
2017	44
2018	49
2019	62
2020	63
2021*	43

*NB 2021 deaths are up to 30th June 2021

It is of note from the breakdown of the figures that only two males included in these figures were from the LGBT community. These figures are surprising given that the LGBT in Britain health report 2018 reported some key findings as follows;

- Half of LGBT people (52 per cent) said they've experienced depression in the last year.
- One in eight LGBT people aged 18-24 (13 per cent) said they've attempted to take their own life in the last year.
- Almost half of trans people (46 per cent) have thought about taking their own life in the last year, 31 per cent of LGBT Men people who aren't trans said the same.
- Forty-one per cent of non-binary people said they harmed themselves in the last year compared to 20 per cent of LGBT women and 12 per cent of LGBT men.
- One in six LGBT people (16 per cent) said they drank alcohol almost every day over the last year.
- One in eight LGBT people aged 18-24 (13 per cent) took drugs at least once a month.

- One in eight LGBT people (13 per cent) have experienced some form of unequal treatment from healthcare staff because they're LGBT.
- Almost one in four LGBT people (23 per cent) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In the last year alone, six per cent of LGBT people – including 20 per cent of trans people – have witnessed these remarks.
- One in twenty LGBT people (five per cent) have been pressured to access services to question or change their sexual orientation when accessing healthcare services.
- One in five LGBT people (19 per cent) aren't out to any healthcare professional about their sexual orientation when seeking general medical care. This number rises to 40 per cent of bi men and 29 per cent of bi women.
- One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT.

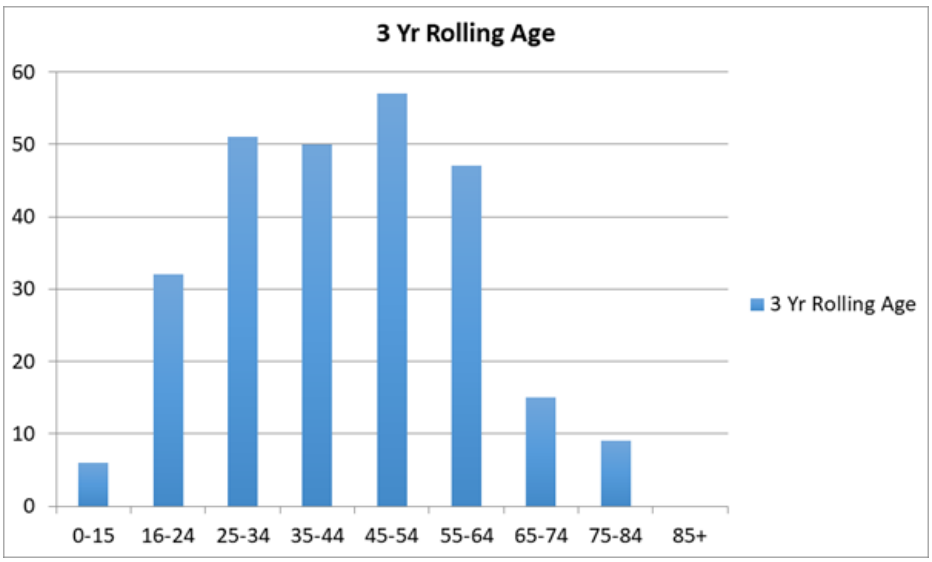
We contacted the Leicester LGBT centre who have supported the LGBT communities of Leicester, Leicestershire and Rutland for over 40 years. The centre runs on grants and pots of money for specific projects, providing a range of support groups and a counselling service. It also has a training and consultancy service which it provides to schools, colleges and other organisations involved with the LGBT community.

We were informed that anyone who identifies as LGBT can be referred to the centre, and often are by other organisations who are funded to provide suicide prevention whether appropriate or not. No specific funding is provided to the LGBT Centre to undertake work around mental health or suicide prevention.

We were informed by an LGBT counsellor that suicide ideation is very prevalent among this community, and it is never a shock when people express these thoughts that are not confined to a younger age group. Dysphoria was described as a key theme that is expressed, a feeling of not fitting into their body and not fitting into life. Waiting for treatment has a significant impact upon mental health and the increased waiting times for this has impacted on people's wellbeing.

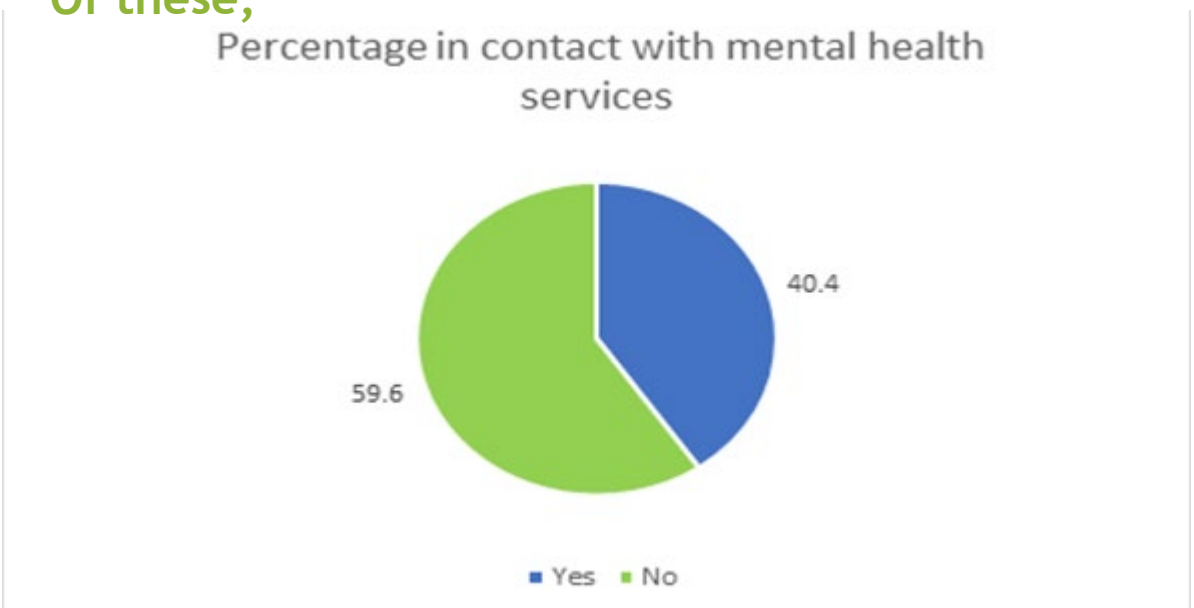
Barriers to accessing services were described as 'not feeling heard or understood', use of language and having to challenge prejudice, discrimination and fear about going into a service that was not LGBT safe. Training for people providing services was seen as key to overcoming these barriers as well as a consideration of funding for organisations providing services for specific diverse communities.

Age Profile



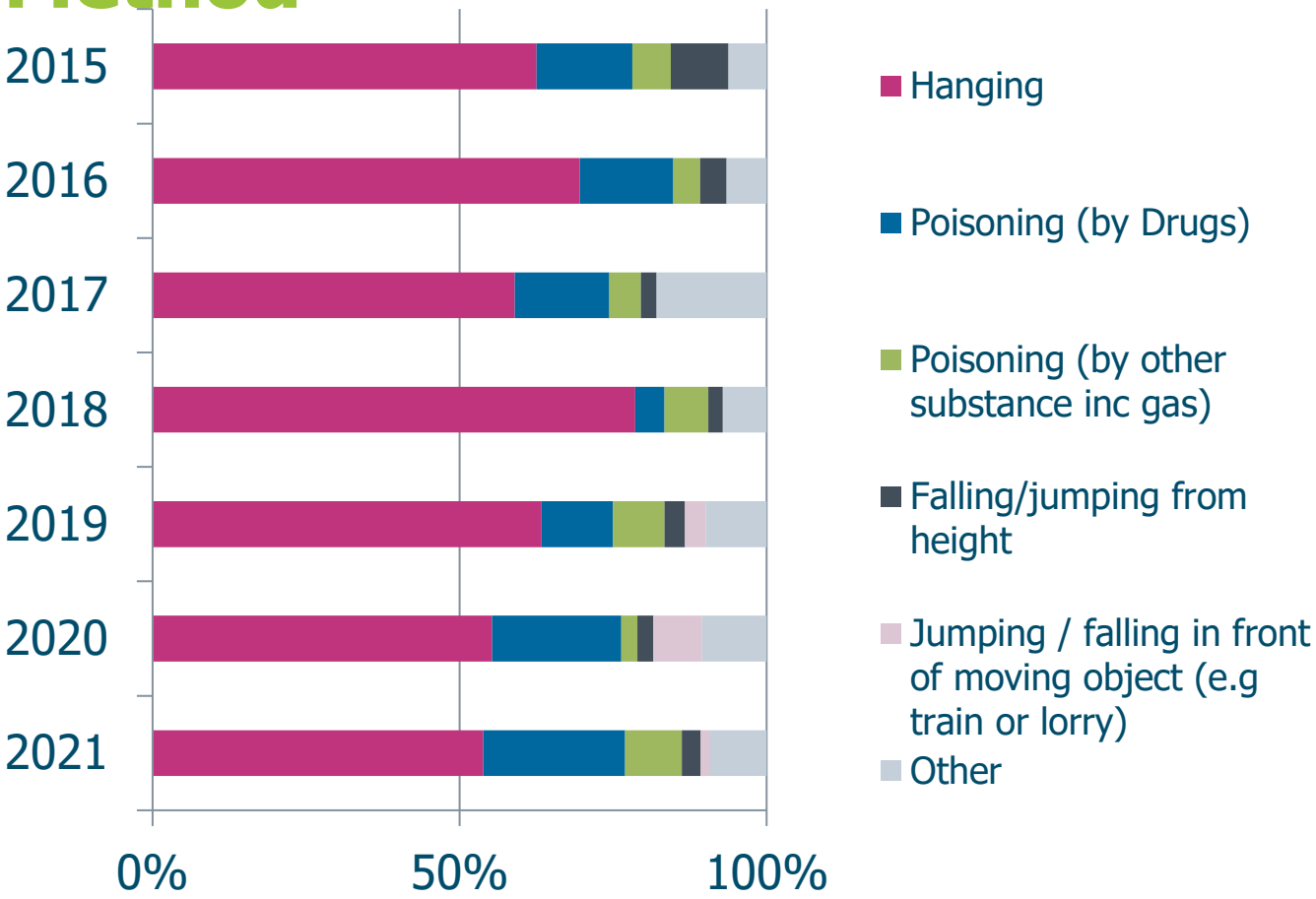
Nationally, 45-49 year old men have the highest age-specific suicide rate, but if we look at all of them (due to having RTS) we can see that risk for LLR is nearly equal from 25 years all the way through to 54 years.

Of these,



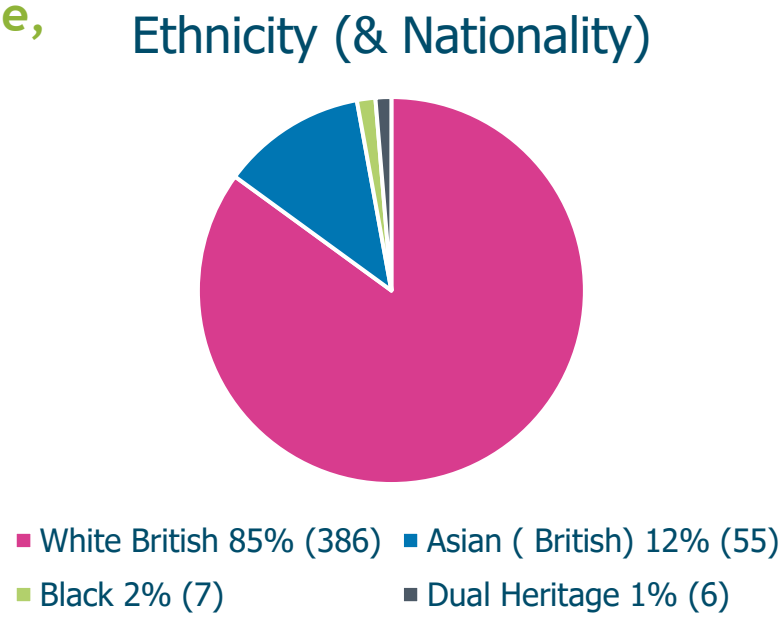
It has not been possible to ascertain how many men were involved with Mental Health services, or whether Mental Health services had been contacted prior to the event. Further, we don't know whether they had received an assessment by mental health services and not met the eligibility criteria, or whether they had been discharged from services in a period up to 3 months before the event.

Method



These figures largely mirror national figures with hanging being the most common method of suicide at over 50% of the total.

Of these,



Ethnicity

The figure shows small numbers of men from BAME communities who have taken their own lives compared to that of their White British counterpart. This is despite evidence that men are overrepresented within mental health services, and according to the Mental Health Foundation are four times more likely to be detained under the Mental Health Act.

We spoke to three organisations who work with people from BAME communities, asylum seekers and refugees. There is a belief that these figures may reflect an under-representation of the number of men who take their own lives. There is a view based upon experience of many years of working with BAME communities that men who have attempted suicide has gone under-reported or reported differently.

The Adhar project is a Leicester based Mental Health Charity for BAME communities. They work with people with a range of mental health conditions and though not specifically funded for suicide prevention or postvention work, they regularly support people who have attempted suicide or have suicidal ideation.

We witnessed first-hand, during our visit, a male in distress who attempted to throw himself from a first floor window. The man was attended by and supported by staff at the centre. We were informed that this, and other incidents such as drug overdose and severe alcohol abuse were common, but when deaths occur through such actions they are not treated as suicide, even though people who died through in this way have expressed suicidal thoughts over a period of time and spoke of these actions as a method of intent.

We were informed of an incident of a BAME service user attending ED having self-harmed and being told by the mental health crisis team "you look alright to me" and being discharged with no further information. We were told that people from BAME communities can have very different experiences of the mental health system and are less satisfied with their experience of the NHS, GP and hospital services than the rest of the population. This leads to a lack of trust in mainstream services.

Some of the barriers faced by BAME are described by Rethink as:

- Cultural barriers where mental health issues aren't seen as important.
- Language barriers.
- Professionals having a lack of knowledge about issues that are important to people from a BAME background, or their experiences.
- Professionals not from a BAME background not fully understanding what racism and discrimination is like.
- Stereotyping, for example, an assumption that black people with mental health issues will get angry or aggressive (conscious or unconscious bias).

There is a belief among organisations working in BAME communities that because of stigma and family shame around suicide, people will sometimes go abroad to take their lives or disguise it in some way and suicide will be covered up to avoid the stigma that can stay with families for years, even to the point of affecting other family members marriage prospects.

It is important to note that the data collected by real time suicide surveillance do include drug overdoses in line with the ONS definition(undetermined intent) This would be for a death in the community.

We spoke to two organisations who worked with asylum seekers and refugees. We were told that suicidal ideation is a very common in these groups and emanate not only from the trauma of fleeing their own country or travelling across many other countries to reach the UK, but from the reality of life having reached the UK and the ongoing trauma of trying to navigate the asylum system and achieve settled status so that they can get on with their lives.

There was a view that mainstream preventative services for this group of people would not be appropriate and that their experience of trying to access either formal mental health services or suicide prevention services have not proved either successful or helpful. What tends to work best is peer support amongst people who are experiencing similar issues and people who work with them day to day helping them through the system.

Strategic Approach to Suicide Prevention

Suicide prevention services in Leicester, Leicestershire and Rutland are underpinned by a strategic framework which outlines a strategic approach to suicide prevention 2020-2023. The strategy recognises that suicide prevention requires work across different settings. The vehicle for delivery of the strategy is through a campaign called #StartAConversation, led by Leicestershire County Council working in partnership with a number of organisations and delivered through the LLR SAPG. The SAPG draws on expertise and resources from the public, private and voluntary sectors. It works as a formal multi-agency group and as a wider network. Its purpose is to prevent suicide by:

- Supporting people who are at risk of suicide.
- Supporting people who have been bereaved by suicide.
- Developing community interest in suicide prevention.
- Supporting collective action towards their aims and objectives.
- Working with wider organisations to provide insights and expertise regarding high risk groups.
- Working with East Midlands regional suicide prevention networks to share knowledge

The group has a core membership which includes:

- Voluntary sector organisations with an interest in mental health, supporting people at risk of suicide and those bereaved by suicide e.g., Samaritans, Rural Community Council, Harmless, Tomorrow Project, Turning Point, Richmond Fellowship and Loughborough Wellbeing Café .
- Public Health, (Leicester City Council, Leicestershire County Council, Rutland County Council, Public Health England).
- Clinical Commissioning Groups for Leicester City, East Leicestershire, Rutland, West Leicestershire.
- Local Authority commissioners (Adult Social Care).
- Safeguarding experts (Local Safeguarding Boards, Safeguarding Manager CCG).
- Primary and secondary care.
- Military and Veterans representatives.
- Mental Health Providers (Leicestershire Partnership NHS Trust).
- Criminal Justice System, including Leicestershire Police and Probation.
- Emergency services (East Midlands Ambulance Service).
- Universities (University of Leicester, De Montfort University, Loughborough University).
- Crisis Care Concordat Network.
- Healthwatch Leicester and Healthwatch Leicestershire.

The aim of the campaign is to make it OK to start a conversation about suicide in order to:

- Remove the stigma and myths that surround suicide.
- Make sure people in distress have access to help, advice and support they need.
- Provide help, advice and support to those who have been affected by suicide.
- Provide information and advice on ways to improve mental health and wellbeing.
- Raise awareness of suicide across Leicester, Leicestershire and Rutland.

The strategic approach brands the slogan “suicide is everybody’s business” and is a focus for all partners of #StartAConversation and SAPG to address the following priorities:

- Targeting support to high-risk groups.
- Protecting people with a history of self-harm.
- Prevent death by suicide in public places.
- Supporting primary care to prevent suicide.
- Strengthen partnerships with the corporate sector to tackle suicide.
- Provide enhanced suicide awareness training.
- Better use of media to manage messages about suicide.
- Raise awareness with better data and better use of data.
- Supporting individuals experiencing suicide ideation during Covid-19.

The weekly meetings are well supported by the key organisations and provide a platform for sharing information, initiatives for suicide prevention, new service developments, planned events and provides opportunities to develop cross cutting and coordinated approaches to improve communication and support to maximise the effectiveness of services. The group also discusses the number of suicides in the preceding week, the circumstances as known and whether the person was known to mental health or other services prior to the event.

There is evident passion, commitment and motivation by participants of this group to work collaboratively, through the sharing of information, planning and supporting of events and the sharing of experience that can give immediate help to people who are seeking to support people in crisis. This may be because these are local groups and interested people involved in the development of the strategy which may be why it is such a big partnership with a lot of ownership. It is a mutually supporting group and seen as a powerful element in the prevention toolbox, being highly valued by its participants.

As a strategic prevention and audit group, there are opportunities that could potentially be exploited to better use the data available to target support to areas indicated by the emerging trends in suicide deaths and also self-harm.

There appears to be no link on the group to primary care services directly and it is difficult to see how information is shared and any learning from suicide cases is disseminated, or how it impacts upon strategic planning going forward.

However, we were told that links with primary care are via the Clinical Commissioning Groups and GPs are encouraged to review cases under the serious untoward incident process. As suicide prevention is everybody's business, a joining up, or better coordination/communication between primary, secondary and community services would be of benefit to all of the organisations involved in the prevention of suicide in terms of training, determining those as 'high risk' and active engagement of preventative services earlier.

The Role of University Hospitals of Leicester and Mental Health Services

We met with the ED Consultant, Urgent Care Manager and the Mental Health Team Leader based at the University Hospitals of Leicester (UHL). We were informed that only recently was an ED consultant with a remit for suicide appointed. Prior to this there was no lead person at the hospital responsible for suicide prevention because there was no funding within the budget for this area of work.

Consequently, there were large gaps in data sharing, coordination of services and this was an issue for people providing services in the community. The meeting was arranged by Healthwatch based on both feedback received from patients and bereaved relatives, but also links with the SAPG and the prevention agenda in general.

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

We requested Hospital Episodes Statistics (HES) from UHL on the number of people who attended ED including those who were admitted because of self-harm. These figures were not available from official HES data but were provided from UHL who ran an internal report. We were informed that it is not possible to get a completely accurate picture as self-harm is seen as a secondary diagnosis to the injury being treated. Therefore, self-harm may be missed off the figures and not recorded in the report. The figures provided by UHL however. Still make interesting reading.

HES Statistics for Self-Harm January 2020 - September 2021

Date	Male	Female	Age 0-17	Age 18-64	Age 65+	Died in hospital
Jan 20-Sept 21	838	1405	17 Male 212 Female	758 Male 1106 Female	63 Male 72 Female	7 Male 4 Female

It is of note that whilst the evidence points to the number of men who take their own lives being three times that of women, far more women attend ED as a result of self-harming, around 60% female to 40% male but more men have died in hospital as a result of self-harm. This reinforces the evidence that the pattern of self-harm is lower in men, and that men are less likely to seek help than women.

ED is represented at the SAPG as is the Mental Health liaison service and urgent care. 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 behaviors. One long term mental health user told us,

"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"

Another told us:

"Over a 10 year period I have attended A&E around 50 times having self-harmed. I was only ever treated with what was presented and discharged. I was finally diagnosed with anxiety and depression and am now receiving treatment and support and have not had any recurrence for over 5 years. I took up hours of time for the wrong thing and feel bad about that, but the right questions were not being asked".

We spoke to two parents, who had both lost sons to suicide, and to staff who facilitate groups and individual sessions at the Tomorrow Project, whose relatives' experience with ED were not always positive. They told us of their experience.

"Our son, who had just started university, he was admitted to hospital having tried to take his life by hanging whilst we were on holiday. He was assessed by the mental health crisis team in A&E and was discharged with a leaflet which he left in A&E. We were completely new to this sort of thing but believed that as the hospital had discharged him, he must be okay. We tried to get help but didn't really know where to go. We tried the Samaritans, but they would only talk to him. Similarly, the GP could not really make any suggestions. 10 days later he took his life by hanging. We really believe the hospital and mental health service missed an opportunity to save our son by not following up to see if he was okay or could have been referred to a service that could have helped him". ***(Mother's experience of son's suicide)***

"My son aged 21 had been experiencing deteriorating mental health for some months and had tried to end his life a few times and ended up in A&E each time. He was seen by a mental health nurse who assessed him as not being ill enough for the mental health service. On the last occasion he was asked how are you feeling now? Good, okay off you go and was put in a taxi. The following day my son killed himself by hanging. I believe he was very let down by services as he wasn't taken seriously, there should be more communication with families who know the person". ***(Mother's experience of son's suicide)***

Both parents attend different bereavement support groups and felt that by listening to other people's experiences of bereavement by suicide, that there was little evidence that either ED or Mental Health crisis services have learnt lessons from these cases or have acted on Coroner's recommendations. One parent described it as "paying lip service". This view is echoed by other bereaved relatives who have attended the bereavement support service run by the Tomorrow project who described similar experiences. We also came across several people who had not been referred to the Tomorrow project by ED or Mental Health services meaning that relatives bereaved by a suicide in UHL might well fall through the net of support that they would get if the suicide had been elsewhere.

We did speak to one parent who told us of her very positive experience.

"My 19 year old son was seriously suicidal. I was so concerned I phoned the GP and was told to take him to A&E so that he could be assessed by the crisis team. Once there, we were taken to a quieter area and was offered tea. After a while my son was seen by the crisis team and though he was discharged home, he was followed up the following day and had a very good service from the mental health team".

Whilst this was a positive experience, she told us that she feels her son has been 'cast adrift' now that he is no longer receiving a mental health service. He was not referred to any other service for ongoing support. He has been unable to hold down a job for more than one day due to anxiety and depression and neither he nor his mother know where to turn to help him having not been made aware of any other support available following discharge. As a result of undertaking this study, we were able to provide information and links to service that may offer on-going support.

Our discussions with the ED consultant and Mental Health team sought to understand the process and procedure for people attending ED resulting from an attempted suicide or an episode of self-harm. We also looked to address some of the issues raised as outlined in reported experiences to gain an understanding of how the system does or should work according to the policy and procedures in place.

We were informed that people who arrive at ED either through walk in or by ambulance will have their immediate physical needs dealt with first to make them safe. All patients with mental health problems are assessed for this when initially assessed, which includes looking at the reasons for mental health presentation and details of this and risk stratification from a mental health point of view. When seen by the Mental Health Liaison team, patients have a full psychosocial assessment and treatment guided by this, or patients have a brief triage assessment by them and are sent to the mental health hub at the Bradgate unit for this assessment by the team there.

Following this assessment, some patients, depending on need may be provided with information on who to contact in a crisis as part of safety planning. Good practice guidance by the Royal College of Psychiatrists suggests that each person should have a personal safety plan and we were informed that there is a lot of work going on to support this development. Once a person is discharged, a GP notification is sent straight away. Referral may also be made to the Richmond Fellowship Life Links project or the Harmless project. Anyone needing further mental health support will be referred to the appropriate mental health service.

We were told that alcohol and drug abuse were major factors in self harm and attempted suicide attendance, and this is borne out by Turning Point who have also reported a big increase in the correlation between substance abuse and self-harm.

In terms of trying to determine the level of risk of repeat self-harm or suicidal behaviors, we were told that as no firm evidence base for suicide exists it can be extremely difficult to assess who is most at risk, even if mental health issues are present. This makes high quality evidence for suicide prevention very difficult to obtain.

According to a report by the Royal College of Psychiatrists 'Self Harm and Suicide in Adults' (final report on patient safety 2020) there are currently between **81** and **91** deaths by suicide in NHS in-patient services in England each year. The report looks at the relationship between suicide and self-harm and acknowledges increased recognition of the link between self-harm and subsequent death by suicide. Previously, non-suicidal self-injury was not recognised as a risk factor for later dying by suicide; now, active support for people who present with self-harm is recognised as essential in preventing suicide. The report highlights secondary care interventions that have some limited evidence of effectiveness in preventing suicide and suggests that "follow up following a suicide attempt, provides clear evidence of a link between self-harm and subsequent suicide" (Zalsman et al. 2016, While et al. 2012).

Similarly, the study carried out by Manchester University and HQIP found that around half of the men who died were known to have self-harmed. This highlights the importance of finding a reliable tool in which to assess potential for further self-harm of people attending ED.

Discussion with UHL and the Mental Health Liaison team highlighted evidence of links to some of the suicide prevention services available but it was also evident that there is a gap in knowledge about the full range of services that can be accessed across Leicester and Leicestershire and that patients could be referred to following an attendance at ED and an assessment by the Mental Health Liaison team.

Therefore, it seems inevitable that some people will fall through the gap and not receive support that is available which could prevent further incidences of self-harm. An online directory of services may be helpful in these circumstances if provided in a timely manner

When asked about the process for dealing with deaths by suicide in hospital or where a person had attended ED and had been seen by the mental health team, we were informed that at UHL all deaths by suicide or from serious mental illness are screened by the medical examiner to determine whether a structured review is required. There is also the Dr Foster mortality system which would also look at every case, via a serious incident analysis, that had been through ED.

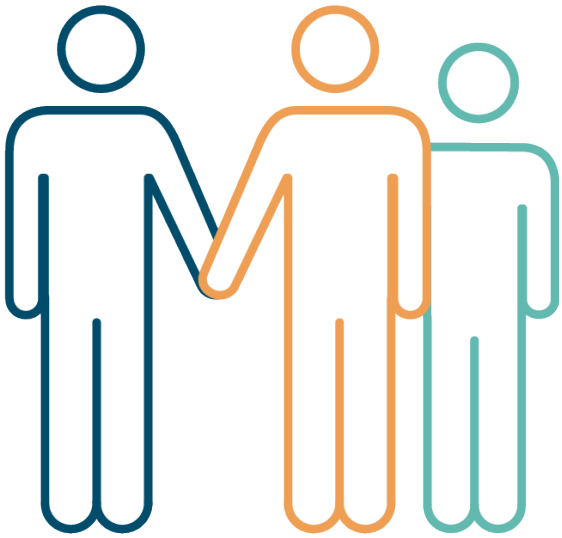
The Mental Health team will carry out a rapid review led by the Medical Director and consider any immediate learning from an incident. There would also be an incident review and a managers incident review meeting. This would determine what needs to be done regarding the investigation and how this will inform learning, including how this will be embedded into practice.

There was an acknowledgement that in the past, processes have not always been as robust as they should have been, and the case studies presented bear testament to this. However, we were informed that the process has changed considerably, and this should lead to improvements. There is now representation and regular attendance from UHL and the Mental Health team on the SAPG, and a commitment to embed learning into practice through processes and systems. We were also told that communication with families is built into the process and that the feedback Healthwatch received to the contrary should be a thing of the past.

*Suicide Prevention Services

Leicester and Leicestershire have a range of prevention services, both statutory and provided by the voluntary and community sector, and these are represented as key partners on the LLR SAPG In undertaking this study, we came across services that are not widely known by all the professionals involved, so it is important to keep the website updated regularly.

**full details of services can be found in appendix A.*



Men's Experience of Accessing Services and the Perceived Barriers Encountered

Healthwatch spoke to **34** men and **3** Parents as part of this study. There were three groups of eight men and eight individual interviews with men who responded via social media. These were a mixture of ages between 25- 58 years and were from across Leicester and Leicestershire. However, the age group we interacted with reflected those receiving a service at the time. Only two of the men were from the BAME community, with the remainder white British. None were from the LGBT community. We also spoke to **2** men who attended the Wellbeing café in Loughborough .

There were no younger men identified to take part in this study, although feedback from two parents bereaved by suicide related to men under 25.

The men who attended the groups facilitated by The Richmond Fellowship Life Links project were generally known to Mental health services and some had a long history of mental health issues including several suicide attempts or attendances at ED through self-harming. In the main these men spoke positively about the services they had received and were receiving. Referral into Life Links had generally come via the mental health team and psychiatrist.

We attended three peer group support meetings: the creative group, the men's group and the depression and anxiety group.

In response to a question about how easy it was to access the support they needed most of the men responded positively saying that they were referred by their mental health social worker, nurse or psychiatrist and hadn't had to wait to receive a service. All the men also said that attending the groups really helped them and that it was good because they were attended by people who had similar problems to themselves and that they didn't feel so alone. In addition to the staff facilitator who could offer professional support and advice, men found the peer support aspect of the groups very helpful and because of their attendance, friendships had been formed.

"It's really helped me. Feeling depressed and suicidal is a lonely experience and you can't always talk to people about it. I found attending the group really helped me because I found other people felt the same at times and we are able to support each other when one of us is really struggling even outside of the group, I have some personal contacts that I can turn to if I am really struggling." ***(attendee at men's group)***

"I found it easier to talk to others in the group than my mental health nurse (MHN) because they are going through the same sort of thing and understand whereas my MHN listens but if they haven't had the experience they don't always understand." ***(attendee at men's group)***

Whilst most people found the groups provided a positive experience some expressed a hope that this was a steppingstone to other things.

"I enjoy being involved in the creative group but I would like eventually to have access to more 'normal' activities, but transport is a problem living in Oadby." ***(Attendee at Creative group)***

"My ambition is to join an art group locally in Market Harborough, but I'm not sure if or when I would ever be ready to take that step and here is it safe because we all have similar problems of anxiety and depression, so you are not judged." ***(attendee at anxiety and depression group)***

We spoke to **2** men who attended the Wellbeing café in Loughborough which offers a drop in for people struggling with their mental health. We attended the 'games group' where men and women have the opportunity to meet with other people and provide peer support whilst playing a variety of games. We spoke with 2 men who told us of the support this offers them to help their mental health. One spoke of it as a lifeline seeing him through some very dark times. Another spoke of how much he valued the support in a non threatening environment and valued the balance of peer support and the support and help offered by staff and volunteers.

We spoke to men who had not had contact with mental health services but contacted us through our social media and through other organisations. All eight men had had experience of feeling suicidal at some point due to circumstances in their lives at the time that had led to feelings of isolation, anxiety, depression and on some occasions despair. None of the men interviewed had heard of #StartAConverstion or any of the services out there. Four of the men had contacted Samaritans and had found the experience helpful in the immediate time when they had seriously contemplated taking their own lives.

Three of the men had not contacted any service and gave the following reasons:

"I didn't want anyone to know, I felt weak and hopeless and that I would be told to get a grip"

"I didn't know where to go to get help other than my GP but didn't want to bother him during the pandemic"

"I felt stupid and didn't want to worry my friends or family. I hoped it would pass but, in the end, I had to go to the GP because I wasn't getting any better. I was given anti-depressants and eventually started to feel better"

All the men were asked what barriers had or would prevent them from seeking help, and said:

"I didn't want to go to my GP for help as I felt that it would then be on record and didn't want anyone to find out. I also didn't want to go onto tablets in case I couldn't go to work and function normally. I was scared of getting the sack or experiencing negative consequences from colleagues."

"Was worried about becoming a mental health patient and being in that system."

"I felt like a complete failure, I knew I needed help but didn't want to speak to doctors about it because I thought I would be confirmed as the failure I believed I was."

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."

"It's difficult to know who to contact when you are feeling at your worst. There isn't an obvious number that you can call at 3am and even when you call your GP there is a waiting list to be seen by mental health services so it's not much use when you reach that tipping point where suicide is at the forefront of your thinking."

"It was about April/ May, I felt really low and down following a relationship breakdown. I am an introverted person by nature, so it was really hard for me to seek help. I looked online for some help but couldn't find anything so finally plucked up courage to phone the GP surgery. It was awful. I had to tell the receptionist why I was ringing, and she made me feel like I was a real nuisance because they were so busy. I finally got to talk to the GP, and he referred me to an online anxiety course which was okay but what I really needed was to talk to someone. I would have liked to have found access to something online myself rather than go to a GP but if there is anything it didn't jump out at me. I would have liked to access help that didn't mean going through the GP or any formal route."

This type of response was common in as much as what men saw as a barrier was having to 'be referred' to a service, being labeled as weak, and the stigma attached to seeking help especially with male friends and in the workplace. What men thought would be helpful was something 'discreet' that they could contact directly that is not part of formal mental health services. Speaking to people in a similar situation or who had been through something similar themselves and had come through it, (Peer support) was seen as preferable to sitting down and talking formally to a doctor.

Many of the men also mentioned the need for fast access to a service at a time of crisis as having to wait to speak to someone when they felt 'very down' was one of the things that put them off from seeking help once the moment had passed.

Studies undertaken by the Samaritans. report similar findings. Their study, 'Engaging Men Earlier' is supported by our findings that men can be reluctant to talk about and seek help for their problems and are less informed about mental health with more negative attitudes about mental health services. They report that men may not want to access conventional services but would prefer a more 'social' type of support such as activity groups etc., using a more indirect approach such as talking to other men under the guise of an activity. Their work on 'engaging and supporting men before they reach crisis' outlined a number of ways in which men can be successfully engaged through purposeful activities and meaningful connections. This work can be very helpful when looking at ways to engage with men in a purposeful way.

We contacted a national organisation called 'Andy's man club', which runs along the lines of being a "semi self-help group" but without the feel of counselling or psychological input. The organisation was set up by relatives of a 23-year-old man who took his own life unexpectedly. It was set up to try to prevent other men from taking their own lives and now has 72 clubs nationwide and has around 1000 men per week attending with over 80,000 Facebook followers. Their Facebook page contains several videos of men telling their stories and it is the being in a 'safe' space, where men come together to talk and support each other through a medium of sport, activities events, or just sitting and having a chat, that men really value. Whilst this model will not be suitable for everyone, and some men will need more formal mental health support, it is a model that would perhaps fit with the men we spoke to who do not feel comfortable with seeking help through a formal mental health route.

Conclusion

The risk of suicide is escalating, particularly amongst men aged 30 to 59. The impetus for this study undertaken by Healthwatch Leicester and Healthwatch Leicestershire was the high rates of suicides in males across the country which is mirrored in Leicester and Leicestershire. In addition, the suicide figures for the area reflect an increase in suicides overall. In 2020 the rate of suicides in Leicester and Leicestershire increased by 20% and, so far this year, the figures are already higher than this. The split of male to female is consistent with national figures and previous local figures so overall the suicide rate in males continues to increase. It is difficult to say whether this is related to the Covid-19 pandemic, but this makes it more important to look at and understand the barriers that prevent men from seeking help and to look at measures that can be taken to address this reluctance and engage more men to take up the prevention support that is available.

There were no younger men (under 25) who took part in this study, this may have been because younger men find it more difficult to access services or find them less relevant to their needs. Alternatively, they may have access to different support systems through peer group friendships. It is perhaps worth considering whether younger men find current service provision relevant to them or whether it is appropriate to look at what men in this age group would find helpful.

In Leicester and Leicestershire there is a robust Suicide Prevention Strategy that has clear objectives and a delivery plan. The strategy was developed in conjunction with local groups and interested organisations and hence has a very active and well attended suicide prevention group which meets weekly. The SAPG draws on expertise and resources from the public, private and voluntary sectors. It works as a formal multi-agency group and as a wider network and is a valuable resource for sharing information, learning, and coordinating effort to target high risk groups. Attached to the strategy is an action plan to deliver its priorities and these are discussed and monitored in the weekly meetings.

There are a range of prevention services available across the city and county that are aimed at supporting men (and women) through crisis periods which are both formal and informal, (not requiring referral). There is also support services for relatives and friends bereaved by suicide and services for people who self-harm. There are robust training programmes for staff, groups, and individuals working with people at risk of suicide and there are regular training initiatives that people can access to help people recognise the signs of someone at risk of suicide and respond appropriately.

There was however a perceived gap in the information available on services that can be accessed in the community, particularly via primary and secondary care. It was evident from what men told us that people do not always get referred or made aware of what help might be available or how they can access on-going support, social or emotional. Closer links and information sharing protocols between organisations may help bridge that gap and strengthen access to the support available as well as enable primary and secondary care to be better informed about what is out there. This would be in line with the recommendations made by the Royal College of Psychiatrists who conclude:

"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".

Evidence suggests that a significant number of men who take their own lives, or contemplate doing so, do not have a diagnosed mental health condition or any long-term mental health issues that would require referral to mental health services, but who experience a crisis, possibly following an event such as relationship breakdown, unemployment etc. that lead them to feel that taking their lives is the best way of dealing with the problem, either for themselves or others. This is the group who are more likely to fall through the net of services and one that should perhaps be targeted to raise awareness of support available. These are likely to be men who access community leisure activities such as sports clubs, gyms, pubs etc. A campaign targeted at this population could greatly enhance awareness of help and support available. There was a distinct lack of knowledge amongst participants on what help was available so any awareness raising campaign should link into the services that are out there currently. Evidence suggests that there is poor uptake of current suicide prevention initiatives within the BAME and LGBT Communities. Services we spoke to acknowledge the difficulties in reaching these groups. There may be assumptions made that this is because suicide is less prevalent in these communities, and this is borne out in the figures in Leicester and Leicestershire.

Providers who work with these groups in the community, have a different experience and say that suicidal expression is very common amongst the people they work with and that the real problem is that people don't relate to or feel safe accessing services that currently exist. Challenges for service providers include, people feeling discriminated against and stigmatised. Cultural and language barriers were all cited by providers as to why men do not access the service. There is similar expression from people working with and supporting refugees and asylum seekers who do not feel that they are able to access mainstream services. A potential solution to this is to commission services specifically for people from diverse communities with those specialist service providers who work with these communities every day and understand the needs of people who need to access them.

Recommendations

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.

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 services.

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.

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

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 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.)

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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.

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.

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.

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.

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.

Information sharing protocols around ED attendances and admissions should be 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.

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.

Ensure that men identified as being at risk of suicide have access to Improving Access to Psychological Therapies (IAPT) where appropriate.

Appendix A

List of suicide prevention services

Name of group/organisation	Description	Contact details
Start a conversation	Start a Conversation is a **suicide prevention campaign** that aims to build a community that is committed to the mental health and wellbeing of its residents in Leicester, Leicestershire and Rutland. Stop Suicide	www.startaconversation.co.uk
Leicester. Leicestershire and Rutland Samaritans	Free any time, from any phone. Open 24 hours a day, 365 days a year	Jo@samaritans.org www.samaritans.org Freephone: 116 123
Turning point	Confidential Mental Health support, Well Being cloud	Helpline@turning-point.co.uk www.turning-point.co.uk
Papyrus-hopeline	For children and young people who are worried about how they're feeling and for anyone concerned about a young person	0800 0684141 Pat@papyrus-uk.org www.papyrus-uk.org
Universities Nightline for university students	A student-run, listening, support and information service	01509 227 650 www.loughborough.nightline.ac.uk www.leicester.nightline.ac.uk
CALM: Campaign against living miserably	A charity dedicated to preventing male suicide	0800 585858 www.thecalmzone.net
Childline /childline-coping with suicidal thoughts	A charity dedicated to supporting children and young people under the age of 19 in the UK with any issue they are facing	0800 11 11 www.childline.org.uk

Appendix A

Name of group/organisation	Description	Contact details
Tomorrow project	Suicide prevention counselling project	07895 753027 Info@harmless.org.uk
Leicester LGBT Centre	A support and counselling service for LGBT people in Leicester/shire support service for the LGBT community in Leicester	0116 254 7412 Info@leicesterlgbtcentre.org
Galop	LGBT domestic violence helpline	www.galop.org www.violence-helpline.org.uk
Richmond Fellowship Lifelinks	Mental Health and Well Being recovery support, provides a wellness recovery service tailored to meet your needs	0800 023 4575 www.rflifelinks.co.uk Leicestershirelifelinks@RivhmondFellowship.org.uk
Mermaids	Supports gender diverse children and YP until the age of 20 including families and professionals	0808 801 0400 Info@mermaids.org.uk
Trade	Sexual health service for LGBT community	Info@tradesexualhealth.com 0116 254 1747
Leicester lifelinks Mens group	Peer support group for men recovering from mental health issues	0800 023 4575
Adhar Project	A Leicester based mental health charity for BAME groups. Adhar provides a range of low level preventative, community-based support opportunities for people with mental health needs and their carers	0116 220 0070 **admin.box@adharproject.org.**
Loughborough Well Being Café Project	Provides a safe and welcoming meeting place for people (aged 18 plus) who are experiencing or recovering from mental health difficulties. We are suitable for people looking for fun activities and somewhere to rediscover their self-confidence and be socially active again	www.thewellbeingcafe.org

Appendix A

Name of group/organisation	Description	Contact details
Buddy to Buddy Veterans Café	Café style virtual drop ins run by and for ex service personnel. Informal sessions run by and for ex-service personnel and supported by the NHS.	LPTArmedForces@leicspart.nhs.uk
Mensoar	**The Peer Support Network for Men in Leicestershire** Mensoar is there to assist you on this journey towards gaining confidence when talking about your mental health. We're dedicated to supporting men and, through working together, creating a positive mental health environment for you, your friends and your family to thrive	www.mensoar.co.uk
Survivors of Bereavement by Suicide	We exist to meet the needs and break the isolation experienced by those bereaved by suicide. We are a self-help organisation, and we aim to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. We also strive to improve public awareness and maintain contacts with many other statutory and voluntary organisations	Contact Sarah: 07535 285973 leicester@uksobs.org
Rural Community Council LLR	We deliver simple but effective training sessions to raise awareness and break down the stigma of suicide	www.ruralcc.org.uk/awareness/

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