Appendix 2

Report – City of Wolverhampton Suicide Prevention Stakeholders Forum written for the purpose of the Health and Wellbeing Together Scrutiny Panel to be hosted on the 8th July 2020

Report written by Independent Chair- Clare Dickens

Suicide is a historical and global phenomenon that is viewed morally, pathologically and existentially across differing milieus. Each year close to one million people die worldwide by suicide, and each one of those leave behind a ripple effect of exposure. This exposure spans across contexts of closeness to the deceased and exposure to the death. Since 1999, World Health Organisation (WHO) has been steadfast in highlighting suicide as a complex problem for which no single cause or reason exists. In 2009, the economic "burden" of suicide in the UK was estimated to be in the region of £1.67m for each suicide (McDaid and Kennelly, 2009) comprising years of productive life lost for the deceased, production losses for those directly impacted by each death, as well as other costs such as legal and public service associated with coronial response.

No suicide death should be considered inevitable, and nor should we be tempted to conceive that suicide is a phenomenon that is the preserve of mental health services to solve alone. Suicidal thoughts are indications of distress, very often in response to intolerable physical and emotional pain that an individual cannot perceive solution or hope for; and are rarely attributable to one trigger or issue. To offer a summation of this point, one does not have to experience or meet a diagnostic category of mental illness to experience a suicidal thought; they can commence more saliently and passively where no plans or desire to die exist, and we should avoid the temptation to try and collapse the complexity of the topic in to one single aspect. It is imperative we shift the narrative and thinking around this subject, which remains the biggest killer of men under the age of 49 in the UK, and the biggest killer of 5-19 year olds in England, to one where we consider a democratised approach across our community where everyone has a role to play. Our forum therefore, has to be adaptable, and able to conceive differing paradigms and priorities.

The remainder of this report will focus more succinctly on Wolverhampton and the challenges posed with in the field of suicide prevention prior to and since COVID-19.

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Data-

In 2018 the legal bar to determine suicide was lowered and pulled from its criminal anchor- previous to this a coroner had to be assured that beyond reasonable doubt the evidence pointed to suicide being the cause of death. Understandably this has caused concern for many years about under reporting of such deaths and the accuracy of the data sets, and since the 2018 shift, now an increase that does not align necessarily to an increase per se; more so an easier verdict to reach providing the trigger for this correlation. However, in 2018-2019 Wolverhampton saw a 40% reduction in suicide verdicts, it is a point worthy to note, that fortunately numbers are not excessive and any percentage should be viewed with this tenant in mind- however, one death is a death too many. Nevertheless the issue of data remains a barrier in the lack of real time surveillance. It remains, that to gain an accurate picture of possible trends, clusters and areas of concern, we have to await a three year aggregated figure from the Office of National Statistics (ONS), and at best have to await ONS data each year. This data is also not furnished with some of the demographic details public health would be interested in, in order to affect any real and timely preventative response to mitigate any further risk, nor to target resources where they are necessarily needed.

For example, there remains an indefensible omission in not reporting the ethnicity of the deceased. This is something the suicide prevention stakeholders forum have tried to affect and change locally, in collaborating with other Black Country Partners to galvanise support from our coroner, in allowing us access to his office in order to capture such intricacies and in a timelier manner than we have had previously. This has been a significant area of progress for the forum, whereby we now have a means of receiving quarterly data sets for Wolverhampton, in the hope we can continue to work toward the goal of real time data surveillance. It is worth noting that no country in the world has a reliable real time surveillance system, however some examples of good practice do exist with in the UK and we continue to work on a Black Country Wide footing in order to achieve this and we remain committed to driving this important priority forward.

Wolverhampton does have data from November 2019 – January 2020, and due to low numbers and the possibility of identification through discussion, we will not include the details for the purpose of this report; it does however give us some basis to work from in

considering the need to gain further and in depth context that is indigenous to Wolverhampton.

Because of this lack of Real Time Surveillance it is impossible to surmise that there has been an increase in suicide since COVID-19, it would possibly be unwise to fall in to the temptation to predict this either. We do however, given the intricacies mentioned in the opening chapters, know that people are struggling and we need to maintain close attention to some of the known evidence based red flag warning signs and known triggers for suicide; which will have increased since the COVID-19 situation. This report will focus attention on some of these and do form the basis of some of our targeted work as a forum so far and in the future.

Access to timely support- the narrative around suicide and mental health distress tells us as a population we need to talk and seek help. We know that this is one area of focus that we can increase the efficacy of in trying to open up the inroads across our communities; whereby people are both receptive and competent at their community level to listen and sign post effectively and proportionately, when people do indeed talk and seek help. This is a way of shifting the gaze to the social construct and focus of responsibility, and not merely on the individual who is already possibly struggling and feeling burdened. This can in part be achieved with suicide awareness and mitigation training. In Wolverhampton, our university for example has been pioneering in its approach to make a commitment to train all staff since 2015, and furthermore offer both awareness and advanced levels of training for allied health care professional students such as nurses and paramedics. It remains that such training is not a compulsory component of any allied health professionals curriculum in the UK, and yet suicide is a preventable cause of death that most allied health professionals will be exposed to within their careers. This tenant is being met locally, and given the nature of our university it is likely the benefits of such competence, awareness and compassion will be felt and realised locally, given the vast majority of their students go on to work with in the West Midlands.

In our MH trust which has recently merged to create a Black Country Wide approach, training for all staff is also being made available, in the same delivery of approach as above which increases the likelihood of sharing the same language and level of understanding so that everyone who expresses distress, suicidal plans or ideation, is taken seriously and met

with empathy and understanding on every single occasion. Has a thorough review of their distress triggers with adequate and bespoke signposting, access to safety planning; with the underpinning knowledge and absolute belief that suicide is preventable, and such distress does pass. One gap that remains is our focus **on primary care**. For a long time it has been felt that there has been a disconnect between primary care and MH services, and though efforts to knead MH provision in to this arena have been made (employing MH nurses in primary care) this does risk posing another bolt on and a means of negating the GP's role in actually considering suicide risk for every patient they may see. We know due to multifaceted nature of suicide for example, that physical ill health and chronic pain are on par with a relapse in a known MH issue, in their status evidentially to contribute towards suicide, as are relationship break downs, bereavement and job loss.

As a forum we have gained access to a large number of **GP's** in Wolverhampton in managing to gain a slot at their by-monthly training events, this was in order to highlight this area of work that needs to be developed. It was well received and well evaluated and what we know is that any training delivered to GP's has to-

- engage all primary care staff not just GPs
- Be applicable to the 10 minute consultation
- Move beyond awareness alone, and give them tools to use
- Build upon and increase GP and other primary care staff's competencies in relation to suicide prevention
- needs to reflect the holistic needs of those patients contemplating suicide i.e. finances, relationships, employment, substance misuse, move their thinking beyond wider considerations than depression/MH
- Derbyshire and Staffs have successfully delivered training to primary care staff with high level engagement and positive feedback
- In Wolverhampton we want to achieve this, but conceive an evaluation beyond training satisfaction.
- We have identified a pilot site of three GP surgeries across Wolverhampton to commence work with, funding is pending. This is with the view to create a "champion" primary care example for whom we can turn up the volume and share their experiences.

We also need to consider that what we do know on a national level is that those with suicidal thoughts or who are self-harming aren't necessarily attending A&E or their GP. This is not necessarily because they fear the risk getting coronavirus, but because they don't want to be a burden and/or fear they won't get the help they need (i.e. because of stigma or unkind responses from staff). These key tenants tie in many of the points set out above, and a need to conceive increased access to all manner of help across our communities to include self-help also.

Self-help and culturally competent design- As well as the considerations of formal help seeking via both voluntary and statutory services, as a city and a forum we have to concede that however easy the inroad or available the help- some members of our community would remain blocked out or take a preferred option of self-help; and this may depend on the cultural intricacies of the person to which we need to be attuned. In many Eastern cultures for example, depression and other forms of mental illness are possibly viewed as a sign of personal weakness that brings shame to the family (Tzeng and Lipson, 2004). South Asian communities tend to discourage the open expression of emotions and emphasize shyness, restraint and sub-ordinance, (Marecek, 2006). In summarising Klimes-Dougan, Klingbeil and Meller, the approaches used to seek assistance for ailments are embedded in one's cultural perceptions associated with the origins of the problem and beliefs about remedies. Some depend on self-reliance and solitary coping mechanisms, such as drinking alcohol or meditating; some turn to their families for emotional support, while some seek help from formal services (Klimes-Dougan, Klingbeil and Meller, 2013). We should not therefore demand assimilation by the design of the provision we offer as we may in avertedly be omitting to consider the diversity of our cities population and the further distress this may invite, in Meyer, (1995), terms add to minority stress. More so we should get to know the members of our community with a commitment to creating truly inclusive and competent support that embraces every ontological world view of distress and its origins. In November 2019, our Mayor Claire Darke and forum Chair Clare Dickens were invited to Gulshan radio in the city whereby they discussed suicide prevention and the more salient stigma surrounding it, to include means of support and help- this was translated to Punjabi live to audiences listening in the city and received a warm response. In the same month, the university and chair Clare Dickens joined with Wolverhampton City council and Interfaith Wolverhampton to host a city wide conference discussing suicide prevention. Representation from all faith groups spoke and opened up conversations and future collaborative working in tackling the issue as members of one community.

The above is not withstanding that there is a possibility that when people have sought help from formal services, they may spend some considerable time on a waiting list, this is not posited as a criticism but a stark reality of the demand that would be negligent not to consider. The Improving Access to Psychological Therapies (IAPT) service for example was introduced during the financial crisis over a decade ago, in an attempt to meet the challenge of high levels of unmet needs. It appeared to be one of the NHS's answers to improve outcomes in the 'treatment' of common and "low-level' mental health difficulties. In 2018-19 the IAPTS received 1.6 million GP and self-referrals nationwide. No doubt many people found the intervention and support both enlightening and useful; however, despite evidence to support the efficacy of the model and the truly committed professionals behind it, it would be fair to suggest that many of these referrals possibly did not improve availability of treatment or even come to treatment fruition- it is therefore imperative that any funding made available for suicide prevention is not confused with an increase in this provision alone.

The scope of the forum whilst supporting access to any formal service provision for those who it is indicted, moves beyond that and considers the menu of choice and optionality with in our community beyond this paradigm. It is also explicit and clear, aligning more to principles of wellbeing and social capital, than it does to formal treatment options alone. There are plans to launch a campaign at petrol pumps and via on line means to advertise the access to a tool www.stayingsafe.net . The forum has already made plans to design (with the support of our university students), fund and evaluate the campaign in the hope more members of our community visit the resource and benefit from it. It is our hope that everyone conceives a need to have a safety plan for if ever suicidal thoughts occur; it remains folly to conceive trying to find out where to access support and navigate potential barriers when distress and hopelessness is already heightened.

The Hope walk took place on 22nd October 2019 from 12.30pm to 1.50pm led and organised by Papyrus, and began from St Peter's Square outside the Civic Centre and followed a circular 2 and a half mile route around the city centre. Walkers carried leaflets about the help and support available in Wolverhampton to give out to members of the public that were co-produced by forum members, and the walk visited the premises of some of the Wolverhampton Suicide Prevention Stakeholder Forum members to raise awareness of the help and support they provide. They also delivered resources to pass on to local people who use their services.

In November 2019 a support life exhibition was hosted at the cities Chubb building and was coordinated and led by local artist Alex Vann. Alex galvanised the support and contributions of local artists to include the local university Alumni, focusing on the issue of suicide prevention and mental health. Art work was available for general sale and 50% of the proceeds were donated to the mayor's charitable causes.

MH Patients in our community- Those issues in relation to those with existing MH difficulties and who are in receipt of services, that have increased since the COVID-19 situation and does still place them with in a heightened risk group include.

- Increasing isolation
- Lack of continuity of care – e.g. as staff redirected away from community services to inpatient care etc.
- Lack of contact with people who make them feel safe- e.g. SW/CPN/GP/family etc.
- Less F2F /new ways of working
- New service delivery models e.g. changes to crisis services/ more reliance on third sector organisations e.g. MIND

However on a national level there have been some observed differences and possible opportunities that have arose from the COVID-19 situation, to include;

- Fewer referrals to IAPT, Liaison Psychiatry (Reduction of 40%)
- Improved relationships with primary care, secondary care, voluntary sector
- Increased use of remote working
- New 24/7 crisis services in place

Prior to COVID-19 our MH trust stakeholder, who form part of the forum, have fed back in setting out their zero suicide ambition. Picking up on the 10 ways to improve safety report published by the National Confidential Inquiry at Manchester University, they have set out their plans against each factor which have been presented after reviewing 20 years' worth of evidence, research and a review of tragedies nationally. Such priorities include; out of area admissions being avoided, safer wards, personalised risk assessment. The chair of the forum has also supported the trusts quality improvement summits in presenting features of risk management and mitigation with in a clinical context based on her expertise and experience.

General considerations for our population: the following issues are **increasing** during COVID 19, which we know that if left unaddressed can increase the numbers of tragedies and loss to suicide.

- Health Anxiety
- Isolation
- Disruption of MH care
- Financial difficulties
- Use of alcohol
- Domestic abuse
- CYPs- worries about their future
- Trauma esp. key workers
- Bereavement issues

A recent report that has been shared by our forum member *Kooth*, indicates that in children and young people for example, there are increased reports of the following issues with in week 10 of lock down compared to their data set last year.

- Abuse-Highest in East of England Up 69% from last year
- Sadness- highest in East of England Up 153% from last year
- Eating issues- Highest in South East Up 56% from last year
- Sleep issues- highest in North East Up 141% from last year
- Loneliness- Highest in London Up 43% from last year
- School/college worries – highest in the East of England Up 166% from last year
- **Suicidal Thoughts- highest in the Midlands Up 18% from last year**

With the theme of children and young people, we need to also consider the impact on their mental health and the continuation of lock down. The lockdown exacerbates key risk factors known to increase the risk of self-harmful thoughts and feelings to include defeat, entrapment, loneliness/social isolation, hopelessness and anger- it is therefore a possibly dangerous omission that the expert and scientific input on SAGE covering young people's mental health and education, is absent.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7223269/

- https://www.nottingham.ac.uk/vision/child-adolescent-mental-health-post-lockdown
- (https://www.ifs.org.uk/publications/14848).

The forum has membership from the University of Wolverhampton, Wolverhampton College and educational psychology that serves the city and the above will be a focus of discussion and planning within near future agendas.

Bereavement- Exposure to suicide death is well known to have significant impacts on those left behind, including increased morbidity and mortality directly associated with the suicide death for both kin (Pitman, Osborn, King, & Erlangsen, 2014) and non-kin (Maple, Cerel, Sanford, Pearce, & Jordan, 2017). Feeling rejected, shame and fear of being blamed that are all noted as a direct result of the taboo associated with a death by suicide, leading to engaging in self-stigmatising behaviour after suicide loss by suffering their loss in silence and within what has been described as complicated grief (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). It is not uncommon for people to feel and express sorrow for the person who has died by suicide, and they may also be overwhelmed by feelings of guilt, anger, abandonment and rejection towards the deceased (McIntosh, 2011). In summary suicide is generally considered to be a traumatic loss, which may have a long lasting effect on those bereaved by the death (Gutin et al, 2011).

With the above considered, in the city of Wolverhampton we have worked in partnership with our local police safeguarding team (and forum member) in order to increase the amount of awareness of their staff, and the need for access to timely support for those bereaved. Many of those bereaved who we have the humble experience of meeting, would argue that in the initial weeks their support needs veer more towards practical considerations in navigating language and arrangements they have never had to consider or deal with before. Therefore our officers have access to the Public Health Resource “help is at hand” which covers many aspects of suicide bereavement to include the aforementioned. We are also fortunate to have kaleidoscope Group on board with in our forum that we can signpost people to in order to gain specific bereavement support, with bespoke considerations around suicide bereavement. Each facilitator of such support has also received suicide awareness and

mitigation training in the hope that any distress that veers toward risk of suicide, can be recognised and responded to promptly in that space.

Targeted heightened risk groups –

The dichotomy of high and low risk is possibly a way of thinking that should be treated with caution, given that some members of our community may not meet any " high risk " threshold based on the demographic intelligence we have, but will be incredibly distressed and at risk of dying by suicide nonetheless. However, there is a need also to not ignore and to pro-actively conceive a need to target resource and support towards those "groups" who we can see and not deny are dying in increased numbers. Men are one such group, both nationally and within a Wolverhampton based context. Work with in the forum so far has included work place wellbeing principles of such employers with in construction for example who typically have a larger proportion of male colleagues. Wolves Foundation Trust have run their provision that has been offered for men only and offers an easy access to a six week programme for men in the city, hosted at the stadium. Activities include sports and talking based principles, as well as building communities of support amongst the attendees that can last beyond the six week sessions.

Substance misuse- our local addiction service Recovery Near You have reignited their forum attendance in recent months, and have expressed their commitment to work with us to conceive how the intricacy of their client groups increased risk of suicide can be best mitigated and considered.

The role of the media

The forum acts as a shaper and influencer, as well as a deliverer on actions; and is philosophically aligned to a principle as already mentioned, that seeks to democratise suicide prevention, viewing that everyone has a role to play in preventing suicide with in our city. This consideration includes our media colleagues with in local reports surrounding suicide. A black country wide action was taken forward by Clare Dickens (chair of Wolverhampton's stakeholder forum) to make contact with the editor from the Express and Star. The first aim of this contact was to invite the express and star to work closely with the forum as a valuable stakeholder in the city.

The second was to discuss a priority in considering our support of the media in safely reporting on suicide deaths in our local area. We firmly believe that deaths need to be reported, we cannot agree that suicide is an issue that needs to be prevented if it is not at the forefront of our collective conscience when it happens. However there are clear guidelines on how to do so in a safe and considered way.

A considerable body of research evidence shows that media portrayals of suicide, including information published by newspapers, can influence suicidal behaviour and lead to imitative acts. The research shows that overly detailed reporting does not just influence the choice of method of a suicide, but can lead to additional deaths which would otherwise not have occurred. In summary we cannot plant suicidal thoughts in to someone's thinking, by reporting suicide alone, however if someone is reading a press release or article, and are already considering that their life is not worth living; un safe reporting can tip this this distress to riskier territory; and it is not enough to merely tag the Samaritans help line number at the end of an article to mitigate this.

We included in the email the media guideline link developed by the Samaritans

https://www.samaritans.org/about-samaritans/media-guidelines/

as well as further details listed in the Independent Press Standards Organisation guidance

https://www.ipso.co.uk/member-publishers/join-ipso/

This email was intended to seek a collaborative relationship with the Express and Star in order to ensure the consistency, quality and safety of reporting. It also enclosed two fairly recent examples of articles published by the Express and Star where it is clear the principles of safe reporting have unfortunately not been embraced. This of course may be due to lack of awareness or experience of the reporters, and we are far from a forum that highlights problems without offering solution and support to remedy them if we can. To that end we extended an offer to provide free training to any of their staff or free-lance journalists; training can include principles of safe reporting but also around suicide awareness and community response, self-harm awareness and community response as well as emotional resilience and resourcefulness for self. This offer was extended to the editor also, and with the request to seek his support as editor to pledge that any report published detailing a death by suicide, is checked against the principles of safe reporting first, before it goes to print.

https://www.expressandstar.com/news/local-hubs/wolverhampton/2020/02/28/wolverhampton-firefighter-committed-suicide-inquest-hears/

https://www.expressandstar.com/news/local-hubs/dudley/stourbridge/2019/05/11/work-related-stress-linked-to-stourbridge-mans-death/

We have had a positive response, and a meeting is currently being arranged with the Chief Editor .

Forum Charity status- there is a need for the forum to conceive and continue to not merely evaluate trends and recognise higher risk groups, meet once every quarter and discuss them. But to also do and deliver outputs continually that have meaning and impact based on these insights. In December 2019, the forum chair and lead public health representative Parpinder Singh, along with forum member and consort Paul Darke- led on a consultation to consider presenting options to the forum in becoming a registered charity. Already with in her term our mayor Cllr Claire Darke appointed the forum as one of her chosen focuses for fundraising. This status would provide the forum with possibly many more opportunities to gain grants that can be spent on targeted suicide prevention work, evaluate them independently with the support of our university and re invest the money locally in supporting targeted work with third sector providers. After a democratic discussion, the decision to progress with registering has been made and will be led by Paul Darke.

This report has offered a summation of the Suicide Prevention Stakeholders Forum activities in the city of Wolverhampton with in the last twelve months, and since the last scrutiny panel met and heard evidence. It is by no means fully representative or exhaustive of all the

collective efforts of members across the city, to do so would be a difficult task. It has presented both ongoing and heightened factors, prior to and since the COVID-19 pandemic took hold in the UK. It has also aimed to provide an overview of some of the context, evidence and efforts to contribute to saving lives in our city for what remains a complex and mutli-faceted cause of death, which should both never be collapsed in to one single aspect, nor be perceived as inevitable.

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