healthwatch Brent

Understanding Barriers to Accessing Suicide Prevention Support in Brent

February 2020

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Introduction

Nationally, suicide numbers were declining since the 1980s, however numbers have been increasing within the last decade. 5,965 individuals took their lives in 2016 in the UK[1] which means that over 16 people take their lives each day. Nationwide, the rate of deaths registered as suicide is on the increase, with a rise of 11.8% between 2017 and 2018. Last year, the Office for National Statistics recorded 6,507 deaths with suicide as the cause.

The risk of suicide is escalating; particularly among middle-aged men, to the extent that suicide is now the leading cause of death for this group. The proportion of middle-aged men who thought about suicide in the past year nearly tripled from 1.9% in 2007 to 5.3% in 2014[2].

According to the Office for National Statistics (2019), 128 deaths by suicide were registered in Brent between 2012 and 2017. The Brent suicide audit 2017 found that there were between 7 and 9 suicide cases per 100,000 people in Brent, which is slightly below the national average of 9.9 cases/100,00 people.[3]

The 2017 suicide audit revealed several consistent findings among the 6 confirmed cases of suicide over that year:

- All the cases were men. This picture is consistent with the national trend where mental health, mental wellbeing, suicidal thoughts and risk of suicide are worsening among middle-aged men.
- Five were born outside the UK (1 in Africa and 4 in Eastern Europe).
- One was known to be in contact or previously had contact with mental health services, which indicates that many individuals may not seek the support available in the borough
- The most common age for suicide in Brent in 2016 was people aged 20-35 (4), followed by those aged over 60 (2).

The most common cause of death was hanging/strangulation (4/6), followed by self-poisoning (2/6). This mirrors the national picture.

In 2017, there were 170 emergency hospital admissions for intentional self-harm in Brent. This figure is likely to be an underestimate of the levels of self-harm as national research shows that people do not always seek help or if they do present to services they may not be admitted. This could be for a variety of reasons including stigma and barriers to access support.

The British Medical Journal (2016) reported that there was a consistent underestimation of presentations for self-harm recorded by Hospital Episode Statics (HES) emergency department data, and fluctuations in year-on-year figures. HES admission data appeared more reliable but missed non-admitted episodes. Routinely collected data may also miss

[1] Annual Population Survey (2017)
[2] IBID
[3] Public Health Outcomes Framework (2017)

important trends in self-harm and cannot be used in isolation as the basis for a robust national indicator of self-harm[4].

As part of increasing understanding about suicidality in Brent, the CCG undertook some focused engagement work with members of the borough's diverse communities in January 2019. Emerging themes included:

- Perception that medical staff do not understand the cultural differences and struggles faced by men from Islamic beliefs and cultural values in relation to suicidal thoughts.
- Some men expressed concerned about the isolation and loneliness they would face as they got older especially if they became immobile.
- Concern was expressed about the cultural sensitivity and knowledge about suicide and attitudes towards suicide amongst Brent's diverse communities
- There was a lack of knowledge of local community resources and support available to people experiencing suicidal thoughts
- People felt there was little support or after-care available to those who had attempted to commit suicide

Based on this and the growing awareness about the importance of suicide prevention, Healthwatch Brent wanted to better understand the picture in Brent.

The objectives of this project were:

- To identify what support is available for residents of faith, and Central and Eastern European and wider communities at risk of committing suicide
- To understand how these needs are being met and identifying any barriers preventing residents to access support.
- To identify community groups or resources that could support in preventing suicide.

Methodology

Healthwatch Brent team gathered information from several sources. Firstly, the team spoke to the Samaritans, which is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland, often through their telephone helpline. The team also sought the views on the Men's Forum, a registered charity whose mission is to improve the health of men and boys in England, Wales and Scotland, to find out whether they had worked with faith groups or the community groups that had been identified as high risk from the findings of the Brent suicide audit.

Secondly, the team carried out a desktop research to find out whether there were resources available in the UK to support these groups in suicide prevention.

Finally, the team interviewed a broad range of the community groups that serves the population in Brent to better understand whether they encounter people at risk from

[4] https://bmjopen.bmj.com/content/6/2/e009749

suicide in their communities and how they would help prevent suicide. Twenty-six faith and community groups, including Central and Eastern European groups, were interviewed during July and August 2019. We spoke to approximately 40 people. See list in Annex 1 . Semi structured questionnaires were used to guide telephone and face-to-face conversations with a mixture of faith leaders, representatives, staff and volunteers. A list of interviewed faith and community groups together with a map showing their location is presented at Annex 1. An outline of semi structured questionnaire used is given in Annex 2.

Findings

1) Organisations

The Samaritans in Brent told us that they have a dedicated team that delivers communication training across the UK to give staff the tools, knowledge and confidence to engage with vulnerable people sensitivity and professionally.

As neither organisation had worked with faith groups or the specific community groups that cover the demographics of Brent, we carried out a desktop research to find out if there are resources already available in the UK to support these groups in suicide prevention.

We hoped to ascertain the demographic details such as the age range, gender and ethnic makeup of the 170 cases of self-harm quoted in the 2017 data to help inform where and perhaps what type of resources needs to be considered in any future strategy on suicide prevention. Brent Council did not have access to patient level data to identify who these 170 people were. A Freedom of Information request was also made to the NHS Trust and they were unable to provide further information on these cases.

Hospital Episode statistics (HES) does collect the data for England for intentional self-harm, see Annex 3. Although, HES data does have demographic data, it does not provide specific reasons for the attendance and demographic information in the published data. It would be difficult from the list of codes to distinguish between accidental self-harm and intentional self-harm.

2) Desk top research

The desktop research found that there was very little on the role of faith communities in suicide prevention guidance or support in the UK. However, there was a report of a study in Highland, Scotland conducted in 2005[5] which explored the role of the church as a

[5] . H. Mowat, J. Swinton, C. Stark, and D. Mowat (2005) "Religion and Suicide: exploring the role of the church in deaths by suicide in Highland, Scotland."

voluntary organisation, in deaths by Suicide in Highland. The study was explorative and consisted of interviewing ministers from the Christian Churches of different denominations in Highland about their own experiences as ministers of the Church, of death by suicide and what they understood to be the key aspects of their experiences that might contribute to thinking about how the Church could offer protection and solace. Two findings were highlighted in this report: the importance of multidisciplinary education involving church ministers and the potential of parish nursing as a mechanism for connectedness.

In the USA this issue had been addressed by the Suicide Prevention Resource Centre (SPRC) based in Washington DC.[6] The SPRC had published a resource "The Role of Faith Community Leaders in Preventing Suicide"[7] in December 2012. This sheet uses the term faith community leader to refer to the leader of any religious or spiritual group (e.g., minister, rabbi, priest, or imam). The information in this sheet is intended for all groups regardless of their teachings about suicide. The premise is faith communities are a natural setting for suicide prevention. Spiritual beliefs and practices tend to help people experience greater hope and meaning in their lives. Faith communities can also provide opportunities for developing positive relationships with others and can be an important source of support during difficult times.

"The Role of Faith Communities in Preventing Suicide" [8]A Report of an Interfaith Suicide Prevention Dialogue held in March 2008 in Rockville, Maryland. Its findings were that although faith communities appear to have limited resources relevant to the complex issues of
suicide, participants noted that a great deal of their normal work of creating, affirming, and
nurturing connections among people is directly and powerfully related to the continuing life of
those who may consider hurting themselves. It was stated that while faith communities take on many difficult issues such as poverty and hunger, suicide prevention is a natural part of their life as a connected people. Therefore, faith groups can enhance the effect of their naturally relevant activities by focusing on those suicide prevention initiatives likely to have the most benefit.

The Samaritans report "Men and suicide: Why it's a social issue", was a five-year partnership with Network Rail to reduce suicides (2012)[9] on the railways. The Samaritans identified that men, from disadvantaged backgrounds, in their 30s, 40s, and 50s, were at the highest risk of dying by suicide. These men were often not known to health or social care services, and so, in 2010 they developed a targeted campaign, across the UK and the Republic of Ireland, to encourage these men to seek help and raise awareness of the risk of suicide amongst their peers.

[6] : http://www.sprc.org

[7] https://www.sprc.org/settings/faith-communities

[8] http://www.sprc.org/sites/default/files/migrate/library/faith_dialogue.pdf

[9] Men and suicide: Why it's a social issue, Samaritans (2012) https://www.nspa.org.uk/wp-content/uploads/2018/05/Samaritans_Men_and_Suicide_Report_web.pdf

However, there were still many unanswered questions about the high risk of suicide among disadvantaged men in their mid-years. Such as, why they take their own lives. Samaritans, attempted to answer this important question in their next report, suicide in disadvantaged men in their middle years is a health and social inequality issue[10]. In this report, Samaritans made several recommendations. Among them was the recommendation that suicide prevention policy and practice must take account of men's beliefs, concerns and context – their views of what it is to 'be a man'. Recognised that for men in mid-life, loneliness was a very significant cause of their high risk of suicide and enabling men to strengthen their social relationships would help.

The "Dying from inequality" [11]report in 2017, Samaritans highlighted that areas of higher socioeconomic deprivation tend to have higher rates of suicide. Men are more vulnerable to the adverse effects of economic recession, including suicide risk, than women. People who are unemployed are two to three times more likely to die by suicide than those in employment.
However, in the six suicide cases from 2017 in Brent this was not the case.

While it is recognised that an increase in suicide rates are linked to economic recessions and the greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour. In addition, for men in mid-life, loneliness was a very significant cause of their high risk of suicide and enabling men to strengthen their social relationships would help.

3) Findings from interviews of faith and community groups in Brent.

This last section of findings presents the knowledge gathered from the interviews with faith and community groups in Brent. The information is divided in four subsections (i) Experience of encountering those at risk of suicide; (ii) Treatment in the community; (iii) Training needs; (iv) Barriers to support. Healthwatch Brent spoke with 26 Brent-based faith and community organisations reflecting Brent's diverse communities consisting of around 40 individuals. We spoke mainly to the community leaders and if possible some of the members of the community that were present at the time. Most of the leaders are men.

i. Experience of encountering those at risk of suicide

Most of these organisations had little recent experience of encountering those at risk of suicide in Brent. Some people interviewed did have some experience of knowing people

[10] "https://www.samaritans.org/about-samaritans/research-policy/middle-aged-men-suicide/

[11] Dying from inequality SUMMARY REPORT 2017 https://www.samaritans.org/about-samaritans/research-policy/inequality-suicide/

at risk of committing suicide, but it was gained mainly outside the borough. The responses below are typical of most of the organisations that we spoke to:

> *"This is not one of the things that has been high on our agenda - because it happens so rarely"*

> *"They might not want to tell their compatriots. It is a status issue and they might prefer not to go to their own faith organisation"*

> *"There is a problem with stress in middle-aged men and the stigma around mental health"*

Many organisations said that people are unlikely to come and simply say that they are going to commit suicide.

> *"[In our community]... not a lot of people talk about it… No-one's going to come to you and tell them they are going to kill themselves"*

> *"It takes a long time for them to open up"*

Of course, faith groups attend to the spiritual needs of those that they identify as needing pastoral support, but they recognise that people may need medical attention and practical support.

> *"As faith leaders we should be identifying signs that would lead towards suicidal thoughts... That might be through dialog or through their behaviour and then giving them support"*

> *"Guide them to the right people to experts to give them that support but as a faith organisation we believe that having a closeness to God is the cause of someone to be happy in this life...They need to be around the right people, and we provide social events and activities"*

> *"It helps when there is a community, a place where people come, where there can be a kind of healing. It takes the pain away...In the scripture it says one should not ever commit suicide, whatever the circumstances"*

> *"We try to pray for them, we counsel them, we give financial help, but some people need medical attention and, in some cases, where we do not see improvement, we realise that they need medical attention. We advise them to see their GP"*

ii. Treatment in the community

We should note that most interviewees would follow NHS advice and encourage anyone they felt was at risk of suicide to go to their GP.

> *"Talk to them, pray for them...these people would know that they can approach their GP. I have suggested a medical professional where appropriate."*

> *"In terms of preserving life, I would make a medical referral. Get them talking to a professional and get them the medication they need."*

Some with experience of working with those they identified as needing support said that they dealt with the practical issues, for example, housing where they would refer people to the housing department.

> *"There is a practical side to it. One person had a problem with housing and we went to the Council for help. And after exploring the practical side, you try to help people with their spiritual journey"*

> *"There are other social and relationship issues that people deal with, we can help with the practical problem like providing a meal or finding a place to live"*

Some interviewees identified complex needs and recognised that people might already have been to see medical professionals.

> *"You ask questions. You ask if they are on medication. You ask if they have taken their medication"*

> *"I've seen people with disabilities who say 'I would rather be dead'. It can be very daunting. Very sad. I let them say what they want to say then we look for services and support - their GP, Brent counselling services, talking therapies… and Islamic counselling services"*

Only one organisation said that suicide is an issue in the community - but this was referring to self-harm among young people rather that the middle-aged men currently at risk in Brent.

Many found it difficult to identify those at risk of suicide among cases of poor mental health, depression and other medical complications.

> *"If someone is going to kill themselves, they will. When people are self-harming, abusing drugs, abusing alcohol, they are the borderline people"*

Some organisations keep treatment (including mental health issues) in the community where possible by referring to professional members of the community for medical support (including private Islamic Counselling Services).

> *"Always be positive. Don't allow the person to reach that point where they think that is the end…Care from members of the community...Psychiatry from within the community"*

However, we should note that not all have easy access to GPs.

"Many of our guests won't go to GPs, don't have GPs and wouldn't even go to a walk-in clinic"

It is interesting to note that the mention of the Samaritans was rare and not used by any organisation as the first point of referral. Some organisations mentioned that often the members of their community find the language a barrier and do not always know where to go for help.

iii. Training needs

Interviewees discussed complications and emotional needs of those who have feelings of inadequacy and those who believe they are stigmatised through social circumstance, societal prejudice or medical conditions such as mental health issues and HIV.

"Sometimes, they keep something back….Sometimes they don't see other options"

"A lot of suicides among men are around sexuality…. they might still be scared by notions of 'homosexuality is a crime, is a sin and you will go to hell'. We find a lot of that"

It was also suggested that those in employment have more opportunity (i.e. locations) to commit suicide as well as the resources to succeed.

One advice worker said that in all his years of working in the community, he had never come across anyone who said they wanted to commit suicide and it might be that, rather than turning to a faith or community group, they turn to family and friends around them.

"Maybe family members, maybe they are more able to see the deterioration of behaviour. They are the ones who should be very careful. If they see anything going wrong they should talk to the doctor"

Some of those who follow the NHS guidance still thought that mental health awareness training and/or a list of referral points for use when speaking to an at-risk person would be useful.

"We work with NHS services...We provide information, we provide direction. If you can tell us more, maybe we can start to do something"

"It would be nice if you could have a workshop on depression and how to cope with it"

iv. Barriers to support

Some barriers to supporting people at risk of suicide were identified.

"When we tried to help someone, we found that the emergency contact was not available - help is not available 24 hours each day"

"The main barrier is economic. On an emergency basis, that's not an issue. - but for people who don't have the means for ongoing care or don't have the insurance, that's a real barrier"

"Someone can get close to the edge and go over very quickly...And the NHS can be very slow"

"My experience in another part of London is, when the suicide happened, we didn't expect it...When I am counselling, I have options to speak to family and get help, but in confession, my hands are tied. I can then only speak to that person and ask permission to speak to others"

Conclusions

1) Community groups in Brent have limited skills and knowledge of the opportunities to be able to reduce the incidence of suicide. In general, it appears that those at risk of suicide are not turning to either their faith or community groups for support. Or it could be that the needs of these community groups in addressing people at risk of suicide only partially met as they do not understand how to identify when they encounter individuals with suicidal thoughts.

2) Responses from Eastern European groups were consistent with those from other faith and community groups in their lack of confidence and lack of insight as to why Eastern European men were over-represented in the Brent suicide data.

3) A high number of community groups commented that they are unaware of the Samaritans, particularly Romanian groups.

4) The barriers to providing support are access to mental health services (including financial limitations), specific practical issues (e.g. housing), communications with landlords (in the public or private sector) and access to appropriate specialist advice to deal with such practical issues.

5) Some community organisations who do not provide care services may not have protocols in place for suicide prevention or providing support. Many of the smaller organisations rely on volunteers and lack the confidence to ask them to agree to attend training in suicide prevention or to provide support after suicide.

6) Some interviewees asked if they could have a list of suitable referral contacts and guidance would provide a useful resource, possibly supplemented by training on coping with mental health issues. This has since been produced by Public Health which could be circulated as an information resource.

7) Faith organisations and community groups shared their concern that they might, unintentionally, discourage those 'at risk' from self-identifying and approaching them through, for example, a focus on homeless men that might discourage other isolated men from seeking support or a focus on 'the family' that might discourage single men from seeking support. Some of these concerns could be due to lack of confidence and the anxiety of causing distress to people already feeling vulnerable at risk of self-harm.

8) Several community groups indicated that providing additional support was difficult to deliver within their current budget envelopes as activities were aligned to funding criteria. However, they would welcome the opportunity to explore additional funding for suicide prevention–activities which would help to support their communities and mental health awareness training would be useful and resources in their languages would be helpful.

Recommendations

For consideration by Brent CCG and Primary care

1. To provide discreet information about available suicide prevention support

2. Provide guidance and a list of contacts to which faith and community groups can refer those at risk (in addition to referral to their GP/A&E). This should include the standard NHS guidance for those identified as at risk of suicide, advice on supporting someone with suicidal thoughts (Rethink/ Samaritans / Mind) and crisis lines for those currently registered for Mental Health Services in Brent.

3. Refresh suicide prevention and support after suicide training to primary care staff.

4. Brent CCG and local health trusts capture demographic data on the number of self-harm cases as it would be useful in any future planning to see if there is any demographic correlation between those that self-harm and the completed suicides in the borough.

For Brent Council to include into the Suicide Prevention Action Plan

5. Encourage faith organisations and community groups to disseminate suicide awareness literature to their membership. For example, Hestia launched a Suicide Prevention Toolkit to mark World Mental Health Day on 10 October 2019[12] in partnership with The Listening Place. This is an online toolkit on suicide prevention aimed at staff who support people who may be feeling suicidal, contains practical tips on how to start the conversation on suicide as well as maintaining staff wellbeing when they do so. The toolkit stresses the importance of giving your full attention when talking to

[12] https://www.hestia.org/Handlers/Download.ashx?IDMF=23d7e6ae-82d1-47d8-9b66-c83adbe10ebf

someone who you think is suicidal, but also of showing self-compassion after supporting individuals who may be in distress..

6. Brent Council had promoted free online training in suicide prevention by zero alliance.com[13] to help make Brent a zero-suicide borough in October 2019. This could be promoted more widely to the community and faith groups. For example, provide support for Brent multi-faith forum as they would be willing to promote these initiatives. Provide the information in several languages, this would be especially helpful to the Eastern European communities. In addition, it may be useful to also include information about providing support to families and groups after suicide.

7. As areas of higher socioeconomic deprivation tend to have higher rates of suicide[14]. The greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour. Also, men are more vulnerable to the adverse effects of economic recession, including suicide risk, than women. We would suggest that the Council target the areas of Brent that have socio-economic inequalities as part of the Brent Suicide strategy.

Brent Council, Public Health Response

Recommendation 5
Encourage faith organisations and community groups to disseminate suicide awareness literature to their membership.

We are happy to include this in the action plan.

Recommendation 6
Brent Council had promoted free online training in suicide prevention by zero alliance.com to help make Brent a zero-suicide borough in October 2019. This could be promoted more widely to the community and faith groups.

Again, we are happy to do this. We will not be able to translate this into other languages as it's not our on-line training tool.

Recommendation 7
Our two priorities this year are 1. Targeting men and 2. young people

[13] Zero alliance https://www.relias.co.uk/hubfs/ZSACourse3/story_html5.html?utm_source=Relias&utm_campaign=Training-Landing-Page&lms=1

[14] Socioeconomic disadvantage and suicidal behaviour "Dying from inequality" summary report 2017

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About Healthwatch

Healthwatch Brent is part of a national network led by Healthwatch England, which was established through the Health and Social Care Act in 2012, to give service users of health and social care services a powerful voice both locally and nationally. We are the independent voice for people's views on Brent services, both good and bad. We listen to local people and feedback patient experience and liaise with local commissioners and decision makers, in order to improve services.

Appendix

1 List of Faith and Community groups Interviewed

A	Afghan Islamic Cultural Centre
B	Al-Khoei Foundation London
C	Association of Muslims with disabilities
D	Bethel Romanian Evangelical Church
E	Bosnia and Herzegovina Community Advice Centre
F	Brent Indian Association
G	Brent Punjabi Association
H	Brent Somali Community Centre
I	Church of God of Prophecy Wembley
J	Francis of Assisi Church/Our Lady of Mercy
K	Harlesden Methodist Church
L	Health and Happiness for All
M	Islamic Cultural Centre (ICC) Wembley
N	London Inter Faith Centre
O	Mosaic Liberal Synagogue
	Mosaic Reform Synagogue
Q	My Romania Community
R	Pakistan Community Centre
S	Patidar House
T	Romanian Cultural Charitable Trust (RCCT)
U	Sattavis Patidar Centre
V	St Erconwalds RC Church
W	St Laurence's Larder
X	St-Panteleimon
Y	Swaminaryan Mission
Z	Tamil Association of Brent

2 An outline of the semi- structured questionnaire used with the faith and community groups

1. Is suicide an issue that has arisen in your community?

2. How would you deal with someone who has thoughts of suicide?

    - What type of support do you have to deal with this situation?

3. What support do you need to deal with such a situation?

    - Are you aware of other organisations / community groups that could help individuals?

4. Do you face any barriers in accessing support?

    - What barriers?

5. What support would help you address this issue?

3 Hospital Episode Statistics (HES) in England coding for 2017-18

Cause Code: 3 character code and description	
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X65	Intentional self-poisoning by and exposure to alcohol
X66	Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
X67	Intentional self-poisoning by and exposure to other gases and vapours
X68	Intentional self-poisoning by and exposure to pesticides
X69	Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances
X70	Intentional self-harm by hanging, strangulation and suffocation
X71	Intentional self-harm by drowning and submersion
X72	Intentional self-harm by handgun discharge
X73	Intentional self-harm by rifle, shotgun and larger firearm discharge
X74	Intentional self-harm by other and unspecified firearm discharge
X75	Intentional self-harm by explosive material
X76	Intentional self-harm by smoke, fire and flames
X77	Intentional self-harm by steam, hot vapours and hot objects
X78	Intentional self-harm by sharp object
X79	Intentional self-harm by blunt object
X80	Intentional self-harm by jumping from a high place
X81	Intentional self-harm by jumping or lying before moving object
X82	Intentional self-harm by crashing of motor vehicle
X83	Intentional self-harm by other specified means
X84	Intentional self-harm by unspecified means