

## National Suicide Prevention Plan Conversation Toolkit – Response Template

This response template sits alongside the National Suicide Prevention Plan Conversation Toolkit. The Conversation Toolkit has been developed to encourage people to consider, within their organisations and networks, and through the lens of their personal expertise or their sector-specific expertise, what more we can be doing to prevent suicide and self-harm. The feedback that we receive will help to inform the development of the new National Suicide Prevention Plan.

You can use this template to share responses to the questions that are set out in the Toolkit, following your discussions within your organisations and networks. You do not need to answer every question – any feedback, however small, is welcome.

Please submit your feedback and responses to the questions to the DHSC Suicide Prevention Plan mailbox using this template by **7th July 2022**:

[SuicidePreventionPlan@dhsc.gov.uk](mailto:SuicidePreventionPlan@dhsc.gov.uk)

### General Information

<b>Name and organisation:</b>	<b>Nina Huszarik, Policy Manager, Sue Ryder</b>
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<b>Information on the engagement that has contributed to the response (i.e. which sectors, organisations or networks were involved)</b>	Consulted Sue Ryder's Head of Bereavement Informed by new Sue Ryder research on access to and impact of bereavement support. The research comprised of a national survey of 8,555 people who had experienced bereavement in the last five years, as well as interviews with 10 GPs from across the UK.

### About Sue Ryder

Sue Ryder supports people through the most difficult times of their lives. For over 65 years our doctors, nurses and carers have given people the compassion and expert care they need to help them live the best life they possibly can.

We take the time to understand what's important to people and give them choice and control over their care. This might be providing care for someone at the end of their life, in our hospices or at home. Or helping someone manage their grief when they've lost a loved one. Or providing specialist care, rehabilitation or support to someone with a neurological condition.

We want to provide more care for more people when it really matters. We see a future where our palliative and neurological care reaches more communities; where we can help more people begin to cope with bereavement; and where everyone can access the quality of care they deserve.

## **Section 1: What can we all do to support suicide prevention and tackle drivers of suicide?**

**What are the 3 most important things we should address in order to prevent suicide?**

**Which drivers or risk factors do you think are the most important ones to focus on and why?**

There is a clear link between grief and suicidality. Research has indicated a substantially heightened risk of suicidality when people experience complex or prolonged grief disorder<sup>1</sup>, and highlighted grief as a predictor of long-term risk of suicidality.<sup>2</sup> Another study found that 65% of people reported wanting to be reunited with the deceased following the death of someone, with 9% of those individuals attempting suicide and 29% engaging in suicidal behaviour.<sup>3</sup>

We have identified grief as a risk factor for suicide through our own services. Sue Ryder provides online bereavement counselling, offering up to six sessions of free counselling via video chat with qualified counsellors. In 2021 we randomly sampled 186 clients in order to assess the effectiveness of the model and explore how people experience grief when coming into the service. Suicidal ideation was identified in 16% of sampled clients prior to counselling.

Bereavement support must be central to the National Suicide Prevention Plan. We know that, currently, bereavement support is not always available when it is needed and in the form it is wanted. Sue Ryder's new research, ***A better route through grief: support for people facing grief across the UK***, found that 70% of people who had experienced a close bereavement could not access the support they would have liked.<sup>4</sup> The findings also showed significant disparity in access to bereavement support across the UK and that certain demographics found it harder to access support than others. This level of unmet need and variation in access must be addressed.

**Do you have ideas for how employers can support and protect the mental health of their employees, and to support those at risk of suicide or self-harm?**

**What actions do you think should be taken to help address these risk factors?  
What role do different parts of society have to tackle this?**

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<sup>1</sup> Latham A & Prigerson H (2004), Suicidality and Bereavement: Complicated Grief as Psychiatric Disorder Presenting Greatest Risk for Suicidality. <https://psycnet.apa.org/record/2004-22504-003>

<sup>2</sup> Sandler et al (2021), Grief as a predictor of long-term risk for suicidal ideation and attempts of parentally bereaved children and adolescents. <https://onlinelibrary.wiley.com/doi/full/10.1002/jts.22759>

<sup>3</sup> Szanto et al (2006)

<sup>4</sup> Sue Ryder (2022), A better route through grief: support for people facing grief across the UK.

Bereavement support can play a vital role in helping people to cope with grief. Our research found that 85% of people who received formal support after a close bereavement said it led to an improvement in how they felt.<sup>5</sup> The positive impact of support is further evidenced by our services. Random sampling of Sue Ryder's online bereavement counselling clients revealed a 69% reduction in people with suicidal ideation after attending counselling.

It is therefore crucial that any actions taken to address grief as a risk factor for suicide aim to improve access to bereavement support. For this goal to be realised, different parts of society have distinct roles to play:

### **Government and health decision-makers**

- Commit to developing a bereavement specific pathway that adopts a public health approach. The pathway should be informed by evidence of clinical and non-clinical interventions and should establish formal referral partnerships and feedback loops. It should draw on the expertise of organisations who support people through bereavement and be co-created with people with lived experience.
- Lead a public health campaign supported by the bereavement sector to promote awareness of grief and the support available.
- Integrated Care Systems (ICSs) should further establish the adequacy of local bereavement support provision by identifying and mapping services in their area, including reach and capacity. This information should be shared with healthcare professionals to support their use of the pathway and any gaps identified should inform future commissioning decisions.

### **Charities and service providers**

- In partnership with communities, charities and service providers should continue to conduct and commission research to improve bereavement support. An initial area of focus should include building a better understanding of diverse cultural beliefs around death and grief, as well as the barriers that exist for certain groups. These insights should inform service design at both a local and national level.

### **Society**

- Acknowledge the role we can all play in supporting others through their unique grief journey by being aware of support services and available to direct people to them, as well as encouraging others to have conversations around grief.

There must also be greater support for those who face delays in accessing services as a result of waiting lists. Research and GP polling by Sue Ryder found that prescription drugs are used to provide short-term relief for people awaiting bereavement support.<sup>6</sup> However, further interventions from healthcare professionals are needed, including:

- **Proactive engagement.** Raising awareness of and signposting people to services and groups they could access in the interim. Holistic alternatives should be considered as part of this, widening the support offer available and supporting early non-clinical interventions that improve overall well being. Examples of this can be

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<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

seen in the German healthcare system where positive inputs are provided to prevent deterioration, which in turn helps overcome long waiting lists for formal therapies. In order for this to happen, the NHS would need to be better linked into available community groups/support.

- **Regular monitoring and assessment of need.** To identify changes in need or signs of prolonged grief disorder, so that any necessary changes in approach can be planned and implemented promptly.

Grief can remain a risk factor for those who are receiving bereavement support. It is therefore imperative that bereavement support service providers have the appropriate processes and training programmes in place for both staff and volunteers. This should include a safeguarding escalation pathway and mandatory suicide awareness training. The [Zero Suicide Alliance](#), of which Sue Ryder is a member, offer free and easily accessible training. Such measures will support staff and volunteers to quickly identify the early signs of deterioration and enable them to signpost at pace when concerns arise.

Any actions to address grief as a risk factor for suicide must also consider people who have been bereaved and are not actively seeking support (including those who have previously accessed bereavement services).

For example, healthcare professionals inviting people to respond to questions about their mental health as part of routine appointments for other health concerns. This would support early identification and signposting of those in need of bereavement services. We know that GPs are pivotal in identifying the needs of those facing grief. GPs interviewed for our bereavement support research<sup>7</sup> explained that they were mainly approached by concerns broader than bereavement, and that these interactions enabled them to signpost people to clinical and non-clinical services.

The long-term needs of those who have previously accessed bereavement support should be reflected within the bereavement pathway that Sue Ryder is calling for. Grief is not linear. The pathway should be flexible enough so as to allow people to go back a step if needed, rather than starting from the beginning on a new waiting list.

Finally, focusing on bereavement support alone does not go far enough. Mental health recovery does not happen in isolation but includes full integration and participation in all aspects of community life. People with mental ill health are often in need of stable factors to reduce variables affecting their mental health like living, working, education, finance, spiritual, and social issues and goals.

## **Section 2: What can we all do to help to support prevention of self-harm?**

**What are the 3 most important things we should address in order to prevent self-harm?**

**What actions do you think should be taken to ensure those who are self-harming receive the best support possible?**

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<sup>7</sup> Ibid.

## Section 3: What can we all do to support specific groups at risk of suicide and self-harm?

### Are there any particular groups you think should be highlighted specifically in the new Plan? If so, why have you highlighted these groups in particular?

Whilst the Plan must seek to improve bereavement support provision for everyone, there should be a specific focus on groups who face greater barriers in accessing support and those who are at higher risk of suicide. These groups include (but are not limited to):

- **People who have been bereaved by suicide.** Research indicates that those who have been bereaved by suicide are at greater risk of suicide themselves. A UCL study demonstrated the significantly heightened risk amongst young adults, with those bereaved by suicide 65% more likely to attempt suicide than if the deceased had died suddenly of natural causes.<sup>8</sup>
- **People from Black, Asian and minority backgrounds.** Research by Sue Ryder<sup>9</sup> has found that the most common barriers to accessing formal bereavement support are a lack of culturally-relevant services and services not being provided in the recipient's language. Further, the report shows that people from Black Caribbean and Black African backgrounds have a higher than average access rate to prescription drugs after a bereavement (89% compared to 64%). This reflects broader research which suggests that people from Black, Asian and minority ethnic communities are more likely to be prescribed antidepressants than White patients in place of other forms of mental health support.
- **Men.** Sue Ryder research<sup>10</sup> has found that 80% of men feel alone in their grief. Respondents cited 'wanting to appear strong, fear of exclusion and not wanting to make others uncomfortable' as reasons why they did not open up about their feelings. The research goes on to show that, in place of talking about their grief, men can turn to unhealthy coping mechanisms such as self-medication. 41% of respondents said they would not have been able to get through their bereavement without alcohol or drugs. Although the initial use of either substance may help someone to escape their grief in the short-term, the long-term impact can be devastating. 15% of men surveyed never resumed normal alcohol or drug habits and 30% reported that these unhealthy coping mechanisms actually heightened their grief.
- **Carers.** Research has shown that bereaved caregivers with prolonged grief disorder underutilised mental health services.<sup>11</sup>

### What do you think are the most important issues impacting risk of suicide in these groups?

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<sup>8</sup> Pitman AL, Osborn DPJ, Rantell K, et al (2016), Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. <https://discovery.ucl.ac.uk/id/eprint/1476423/>

<sup>9</sup> Sue Ryder (2022), A better route through grief: support for people facing grief across the UK.

<sup>10</sup> <https://www.sueryder.org/blog/men-and-grief>

<sup>11</sup> Lichenthal W et al (2011), Underutilization of Mental Health Services Among Carers With Prolonged Grief Disorder. [https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.10.pss6210\\_1225](https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.10.pss6210_1225)

Throughout this response we have emphasised the importance of bereavement support services in helping people to cope with their grief. Therefore, access to bereavement support is key when considering the issues which impact risk of suicide in the groups we have specified.

Each group faces different barriers in accessing bereavement support, some of which have previously been outlined. For some, the appropriate services simply aren't available. This is demonstrated by our finding that 1 in 5 people cited a lack of culturally-relevant services and services not being provided in their language as barriers to accessing formal bereavement support.<sup>12</sup>

Others face barriers which extend beyond the availability of services. For example, Sue Ryder's research suggests that gender stereotypes can influence the way in which men grieve and engage with support.<sup>13</sup> This is further substantiated by our online bereavement community users, of which the majority are women. Our research has also found that men are less likely to access support than women (though the difference was marginal),<sup>14</sup> with men more likely to say they did not want counselling because it did not feel relevant to them. Male focus group participants told us that a cultural narrative of "brave men" made them feel they couldn't reach out for support.

There is also a risk that those with suicidal ideation following a bereavement feel stigmatised, inhibiting engagement with support services. Whilst this can impact anybody, in some cultures there is greater stigma associated with poor mental health, meaning that people from certain Black, Asian and minority backgrounds may be disproportionately impacted.

There are a wider range of issues which, whilst not specific to those in the groups highlighted, can impact access to bereavement support. For example:

- **Employment circumstances.** People who work in shifts or for whom time off is unpaid may be less able to commit to regular appointments such as therapy sessions, due to time and financial constraints.
- **Awareness of support and how it can be accessed.** When asked why they did not try to access certain types of support following a bereavement, people told us they didn't know where to start (15%), didn't know support was available (13%), and felt overwhelmed (11%).<sup>15</sup>
- **Signposting and delays.** Most of the GPs interviewed for our bereavement support research shared that they knew of limited services available to signpost patients to. Of the services they were aware of, GPs expressed concern about long wait times.<sup>16</sup>

## **What more do you think could be done to reduce the risk of self-harm or suicide amongst these groups?**

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<sup>12</sup> Ibid.

<sup>13</sup> <https://www.sueryder.org/blog/men-and-grief>

<sup>14</sup> Sue Ryder (2022), A better route through grief: support for people facing grief across the UK.

<sup>15</sup> Sue Ryder (2022), A better route through grief: support for people facing grief across the UK. (Research Report)

<sup>16</sup> Sue Ryder (2022), A better route through grief: support for people facing grief across the UK.

Within this response we have outlined how different parts of society can improve access to bereavement support, in line with the recommendations put forward in our report, ***A better route through grief: support for people facing grief across the UK***. We believe that implementing these recommendations will help everyone to be better supported through their grief, including those in the groups we have highlighted..

However, there are also specific interventions that could be introduced in addition to the wider recommendations, aimed at those who are at higher risk of suicide or who face additional challenges in accessing bereavement support. For example, research has shown that caregivers were more likely to engage with mental health services in their bereavement when their psychological needs were addressed and monitored when the person was still alive.<sup>17</sup>

## **Section 4: What can we all do to improve support for people in crisis?**

**What can we do to improve the immediate help available to people in crisis?**

**How can we improve the support offer for people after they experience a mental health crisis?**

**What more can we do to support the risk management and safety planning process for people at risk of suicide?**

**What would enable local services to work together better to improve support for people during and after an experience of mental health crisis?**

**Thank you. Please submit your feedback and responses to the questions to the DHSC Suicide Prevention Plan mailbox by 5<sup>th</sup> July 2022:**

**[SuicidePreventionPlan@dhsc.gov.uk](mailto:SuicidePreventionPlan@dhsc.gov.uk)**

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<sup>17</sup> Lichtenthal W et al (2011), Underutilization of Mental Health Services Among Carers With Prolonged Grief Disorder. [https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.10.pss6210\\_1225](https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.10.pss6210_1225)