Consulting with professionals and the public about depression, self-harm and suicide

Final Report

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Glossary of Terms

**Child and Adolescent Mental Health Services (CAMHS):** specialist NHS children and young people’s mental health service.

**Cognitive Behavioural Therapy (CBT):** a talking therapy that can help you manage your problems by changing the way you think and behave. Most commonly used for depression and anxiety.

**Community Mental Health Team (CMHT):** support people living in the community who have complex or serious mental health problems. Different mental health professionals work in a CMHT.

**Depression:** one of several disorders generically called ‘affective disorders’, referring to the manifestations of abnormal affect, or mood, as a defining feature. People with depression can also experience disordered thinking where they experience negative thoughts about themselves, their situation and the future.

**Mental health:** ‘a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’.

**Self-harm:** ‘an intentional act of self-injury irrespective of the type of motivation or suicidal intent’.

**Suicide Ideation:** thoughts about an act of self-harm or suicide, including wishing to kill oneself, making plans of where, when and how to carry out the act, and having thoughts about the impact of one’s self-harm or suicide on others.

**Suicide:** deaths directly resulting from acts of deliberate self-harm.

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Executive Summary

Introduction

Between June and November 2015, a consultation on depression, self-harm and suicide was conducted in the Royal Borough of Kingston for the Public Health Team.

The aim of the consultation was:

To assess the needs of individuals who live in the borough of Kingston aged 11+, affected by, or at risk of, depression, self-harm and suicide, either directly as the affected individual or as family and friends.

More specifically, the consultation covered a range of key issues. These were:

- Identifying triggers for people’s depression, self-harm and suicide and their ease of access to support to deal with these
- Awareness of local advice and support available to deal with their depression/self-harm, what worked well and what could be improved
- Experience of local services and community support including services’ responsiveness to their needs, any barriers they experienced accessing services, what worked well and what could be improved
- The impact of the depression, self-harm or suicidal ideation on social and family networks from the perspective of the individual and their family or friends, including experience of loneliness and isolation
- What prevents help-seeking and what would enable/encourage help-seeking
- Any issues related to seeking help out of normal office hours and/or when in crisis

During the consultation period the following was achieved:

- 16 one-to-one interviews with individuals with personal experience of depression, self-harm and suicide between 18 and 68 years of age
- 11 one-to-one interviews with people affected by the depression, self-harm and/or suicide of a family member
- six focus groups with professionals and family members took place
- 64 adults completed our online survey
- 73 young people completed our case study questionnaire

In addition, a review of the academic literature and epidemiological profile of depression, self-harm and suicide in the borough was produced.

Key findings

Epidemiological Profile

- Kingston CCG has a smaller proportion of its population in contact with mental health services than either NHS London or England.
- Kingston CCG area has consistently lower prevalence and incidence of depression than England and the London NHS.
The rate of hospital admissions and stays for self-harm in Kingston upon Thames are generally lower than the averages for England and London and have been consistently lower over the last five years.

However, the data also show that the rate of hospital stays for self-harm is increasing in Kingston upon Thames at a faster rate than it is in the England average in the latest year of data.

In Kingston upon Thames suicide rates seem to be decreasing (although individual years of fluctuations can be misleading) and suicide rates for both males and females are the lowest they have been since 2008. This seems different to the trend being experienced in England and the UK where rates are going up overall.

Triggers for depression, self-harm and suicide

The consultation concludes that depression, self-harm and/or suicidal ideation are not triggered by one thing, but a complex combination of feelings, life events and personal circumstances.

The top three reasons respondents to the adult survey cited as contributing to their feelings were low self-esteem, loneliness and mental illness (other than depression, self-harm or suicide).

In the adult survey the least frequently cited triggers were concerns about sexuality and concerns about gender identity.

Triggers most discussed in the qualitative data were coping with long term mental illness, employment issues (being unemployed, bullying in the workplace, retirement), social isolation, relationship issues and being the victim of abuse.

Analysis showed that men and women aged between 45-54 years old were more likely than other age groups to indicate that benefits, being the victim of abuse, housing problems, physical ill-health were triggers. Debt and body image were also issues for this group. This is a toxic combination of challenges and provides insight into their elevated level of suicide risk.

In the qualitative data, professionals reported treating people with a complex range of social and emotional difficulties. Those who had worked in the borough for an extended period of time reported that they were more likely to see people with complex difficulties now than in the past.

Young people identified the significance of mental health issues in young people’s low mood/anxiety, self-harm and suicide. This demonstrates a high level of mental health literacy amongst the young respondents in Kingston.

In addition, problems at home were considered a key trigger for young people, as was low self-esteem for depression, being the victim of abuse for self-harm and losing a loved one to suicide.

Knowledge of and access to services

Those who completed the adult survey reported high levels of depression, self-harm and suicidal ideation or behaviour. However, their knowledge of local services available to support those in this situation was very limited.
The top five services adult survey respondents had either heard about and/or used were Accident and Emergency, Kingston Samaritans, Mind in Kingston, Kingston IAPT service and Community Mental Health Team.

The data showed that there are many barriers to help-seeking. Previous negative experiences was one of the most significant, but others included not being able to articulate feelings, worrying about employers finding about help-seeking and treatment, concerns about losing control and feeling like they would not be believed.

Having bad experiences in the past, long waiting lists, not being taken seriously/believed, not feeling comfortable talking to services and not knowing how to contact them were the top five reasons why respondents were not able to access the services they wanted to.

65% of respondents did not feel that their GP could help them with emotional issues. Men, single people and those aged 18-24 or 44-55 and not born in the UK were more likely to hold this view. Men, living alone in middle life are a particularly high risk group for suicide.

A number of gaps were identified in current services. The largest was the lack of long term counselling/therapeutic services for people with a mental health diagnosis who did not meet the current threshold for the CMHT. There was concern that this group were at risk from self-harm and suicide.

Other gaps were: lack of services that appealed specifically to men; lack of services for individuals with a mental health issue and substance misuse problem; access to services for BAMER groups; concerns about what was available for those with autistic spectrum difficulties; support for families coping with a relative who is depressed, self-harming and/or suicidal.

There is a lack of consistency in the emotional and mental health support provided in schools across the borough.

Young people do not have access to a drop-in community based service that specifically supports emotional and mental health issues.

**Experience of services**

The data showed that there was a lack of consistency of services across the borough. Some individuals and families reported receiving excellent joined-up care from committed professionals who, they felt, were genuinely invested in their recovery.

Other participants reported mixed experiences of excellent care in some of the services they accessed and poor or negative experiences in others.

While others felt that their experiences of services had been negative because they had not been taken seriously and/or had been unable to make a meaningful connection with professionals, or get access to the services they felt were right for them, or access any services at all apart from primary care and those offered in the community and voluntary sector. There was concern expressed that some parts of the system were under such pressure that even extremely vulnerable and risky individuals were not being provided with the support required.

When people are depressed, self-harming or suicidal they need to be able to access support from people who recognise and understand their symptoms,
show empathy and are able to refer them to treatment that is appropriate for them. Continuity of care is vital as it promotes trust and engagement from service users. If this breaks down, service users can feel abandoned and their feelings of distress and isolation can increase.

Crisis support

- 37% of respondents reported being unable to access crisis support when they needed it.
- A number of concerns were raised about the ability of the Crisis Line to support people during a mental health crisis. These included not being able to access the service, the quality of the advice provided and communication difficulties.
- Having someone to talk to who will listen was highlighted as important to help prevent or resolve crisis.
- Reports about accessing support in a crisis via A&E highlighted the importance of being referred via the mental health, not general A&E, pathway. Not doing this left some people having negative and extremely distressing experiences.
- Young people do not have any alternative crisis support and can only go to A&E. Professionals considered this an issue because A&E is not the best place for many young people who are depressed and/or self-harm.
- The Home Treatment Team was considered a good service by those who received it. However, family members reported being very worried about keeping their loved one safe during the times the Home Treatment Team was not present. Also, there was some concern that some individuals who are suicidal present with specific care needs that are not currently being met.

Impact on family and social networks

- Feeling depressed, self-harming and/or being suicidal has an enduring impact on people’s social networks, which leads to social isolation and feelings of loneliness.
- Having social support from family and friends is absolutely critical to preventing and recovering from depression, self-harm and suicide.
- The impact on families of this, however, is significant and includes social isolation, emotional distress and financial cost.
- Families need support, and currently feel that they do not have enough information about the support that is available in the borough. Or, if they are able to access services that this can be later than they want or need.
- Building social networks with other families and/or people with similar experiences was high on the list of priorities for family members. However, there was a range of other types of support families requested.
- Importantly, many participants in this consultation did not have family support, and mechanisms to address the needs of this group are important.
Recommendations (for a full list see p93-96)

Triggers for depression, self-harm and suicide

- All prevention work developed in the future should address the social as well as psychological and clinical needs of individuals who are affected by depression, self-harm and suicide. Key consideration should be given to make any services as accessible as possible for suffering from depression, self-harm and/or suicidal ideation and behaviours.
- Existing services should review how accessible they are to people suffering with mental ill-health, which might include depression, self-harm and suicide. Assertive outreach should be considered as people who are depressed, self-harm and/or are suicidal do retreat, can feel that they do not deserve help and can struggle to express their needs.
- Projects and programmes to support social inclusion and reduce social isolation should be supported. More opportunities for people with experience of these issues to get together informally should be created. Projects and programmes that reduce social isolation for older men (50s plus) should be commissioned. Existing social inclusion projects should review their provision for people in their middle years, and those who may be isolated due to long term mental health conditions.
- Opportunities to develop a programme of mental health education for employers in Kingston should be explored. This should include information on the links between workplace stress and mental ill-health, legal responsibilities, returning to work and employing people who have had mental health issues.
- Supporting families and educating parents about the connection between family life and young mental health and what families can do to help young people should be a part of any future prevention strategies.
- Work that raises awareness of mental health issues should be continued in all schools. Work around healthy relationships, how to cope with family conflict and reducing social isolation should be included in this work.

Knowledge and access to services

- Clear and easily available information on which services are available in the borough for people with depression, self-harm and/or suicide and their families and what they do should be developed. This should be made available to doctors’ surgeries, A&E and specialist services as well as community spaces and all other organisations working with those who might have/be at risk from emotional distress, including faith groups.
- Efforts should be made to re-engage those struggling with depression, self-harm and suicide who will not seek help because of previous negative experiences.
- Consideration needs to be given in any local planning about ways to close the accessibility gaps identified in this consultation.
- The Public Health Team and its partners should review the implications of the finding that 65% of respondents to the adult survey (and more men than women) felt that a GP was not able to provide them with help for emotional
issues. A plan should be developed which has the goal of educating residents, particularly young people, in the role of the GP, and engaging with older groups to give concrete examples of what GPs can do when people are in emotional distress. Alternative processes of referral into services should be better advertised.

- Developing a more proactive approach to men’s mental health and suicide is vital and services should review how they engage and encourage men to seek help before things reach crisis.
- Action needs to be taken on how services protect or promote the confidentiality of young people, particularly as so many reported that problems at home could be a key trigger for depression, self-harm and suicide.
- There is no community-based specialist emotional health service available for young people in Kingston. This should be considered.
- Work needs to be done in schools, particularly with boys, which addresses the view held by young people that they would be in trouble or bullied if they disclosed depression, self-harm or suicidal ideation.

**Experiences of services**

- A review of the demand, capacity and referral processes into the Home Treatment Team and Community Mental Health Team needs to be conducted.
- Longer-term counselling services should be commissioned in the borough to meet the needs of those who need therapeutic support, but who do not meet the threshold of the CMHT.
- Training for GPs and other staff on managing patients with depression, self-harm and/or suicide ideation or behaviour should be continued and extended in the borough.
- Services should ensure that those on waiting lists are reviewed and individuals on waiting lists are communicated with regularly to ensure they do not get lost in the system.
- Individuals suffering from depression, self-harm and/or suicidal thoughts or behaviours should not have to repeat their histories again and again to different professionals/clinicians. Pathways of care should be reviewed to ensure that this is minimised.
- More robust transitional arrangements should be made for those being discharged from the care of the CMHTs.
- More opportunities to provide peer support or networks so that people can meet others with similar experiences should be actioned.

**Support in crisis**

- The review of the Crisis Line that has recently been conducted should be revisited. This should include an examination of any case management processes in place to respond to the needs of repeat callers and the provision of alternative ways to connect (such as instant messaging).
- A&E should ensure that people who are experiencing a mental health crisis do not get placed into the pathway for general A&E admissions. If this is
occurring because of capacity or staffing issues this should be addressed in a systematic way.

- When decisions are made to provide home treatment rather than admit someone who is suicidal to hospital the family (if present) should be involved in those discussions and the capacity of the family to provide sufficient care to keep people safe should be central to that process.
Chapter One

1.1 Introduction
This is the final report of the public and professional consultation conducted in Kingston upon Thames by researchers from North RTD, led by Dr Carlie Goldsmith, between June and November 2015 on depression, self-harm and suicide. The consultation was commissioned by the Royal Borough of Kingston’s Public Health Team as a response to concerns raised by Kingston Samaritans that not enough was known about the needs of people suffering from depression, self-harm and suicide in the borough.

The aim of the consultation was:
To assess the needs of individuals who live in the borough of Kingston aged 11+, affected by, or at risk of, depression, self-harm and suicide directly either as the affected individual or as family and friends.

More specifically, the Public Health Team asked that the consultation cover a range of key issues. These were:

- Identifying triggers for people’s depression, self-harm and suicide and their ease of access to support to deal with these;
- Awareness of local advice and support available to deal with their depression/self-harm, what worked well and what could be improved;
- Experience of local services and community support including services’ responsiveness to their needs, any barriers they experienced accessing services, what worked well and what could be improved;
- The impact of the depression, self-harm or suicidal ideation on social and family networks from the perspective of the individual and their family or friends including experience of loneliness and isolation;
- What prevents help-seeking and what would enable/encourage help-seeking;
- Any issues related to seeking help out of normal office hours and/or when in crisis.

1.2 Methodology
In order to meet the aim and objectives of the research a mixed methodological consultation was designed. This included:

1.2.1 Quantitative Methods
- **Adult survey**: this explored an individual’s knowledge of services, access to services and experiences of service as well as impact of depression, self-harm and suicide on families. This was a survey of those with experience (either personal or of family/friends) of depression, suicide and/or self-harm; it was not a survey of the general population of Kingston. The survey was available online in English and hard copies translated into community languages were made available to relevant local organisations.
Young people's case study survey: this utilised a case study approach to explore young people's attitudes towards depression, self-harm and suicide, their knowledge of services and views on help seeking. The survey was conducted in Kingston secondary schools with pupils in Years 10 and 11. An edited version was also available online.

Epidemiological profile: a review of the publically available statistics on depression, self-harm and suicide in the Royal Borough of Kingston.

1.2.2 Qualitative Methods
A review of the academic literature: to highlight key issues, inform the design of the adult and young people’s surveys and contextualise the local findings.

One-to-one interviews: with individuals who had either been affected by depression, self-harm and suicide themselves or had been affected by these issues through a family member. These were included in the consultation to generate more in-depth and detailed insights into the key objectives of the consultation. The importance of interviewing people of different ages, genders, income scales and ethnicities were recognised.

Focus groups: with professionals and family members with experience of depression, self-harm and/or suicide. Focus groups were included in the consultation as they are a particularly effective method for generating a range of experiences, views and opinions on a specific area of study.

1.2.3 Consultation Recruitment
It was very important that the consultation recruit participants via a range of channels in order that a range of different experiences and views were captured.

A news item about the consultation was published in the Kingston Independent. It included the link to the adult survey, which provided a mechanism for individuals to express an interest in being interviewed for the consultation.

The consultation was advertised over a period of 10 weeks on the Royal Borough of Kingston’s social media pages.

A range of statutory and community and voluntary sector mental health services advertised the consultation online and via service user newsletters.

The lead researcher visited relevant local groups and organisations in person to talk about the consultation.

A number of other local authority and community and voluntary sector services publicised the consultation to their service users in person, via newsletters and email.

Leaflets publicising the consultation were made available in the reception areas of the IAPT service, Kingston Women’s Centre and New Malden Counselling Associates.

By the end of the data generation and consultation period in October 2015 the following had been achieved.
109 individuals accessed the online survey. 64 respondents completed the survey in full. All respondents had either personal experience, or had family/friends who had experience of depression, suicide or self-harm, and had lived in Kingston in the last five years.

**Young People’s case study survey**

73 young people, between the ages of 14 and 17, completed the survey in full.

**Epidemiological profile**

Produced

**One-to-one interviews**

16 individuals with personal experience of depression, self-harm and/or suicide

11 individuals affected by a family member’s depression, self-harm and/or suicide

4 professionals

**Focus groups**

Six focus groups were conducted: five with professionals from statutory, CVS and private services and one with family members.

**Literature Review**

Completed

1.2.4 Data Analysis

All quantitative data was analysed using the statistical package SPSS. All qualitative data was subject to a thematic analysis where the key themes were identified. After the quantitative and qualitative data sets were analysed the whole data set was triangulated so that any cross cutting issues could be identified and explored. This process informed the issues discussed in the later sections of this report.

1.2.5 Ethical Issues

Because of the sensitive and distressing nature of the issues the consultation focused on, a number of things were put in place to ensure all aspects of it were ethically sound.

- Before the consultation commenced, an application for ethical approval was made to the North RTD independent advisory board, which consists of four senior academics in the social sciences who are based at British Higher Education Institutions. The application provided a comprehensive overview of how the consultation was designed to protect participants and the research team from harm. All correspondence between the advisory board and the lead researcher, Dr Carlie Goldsmith, were made available to the steering group. The application was approved in July 2015.
All participants were provided with information about the consultation including who it was commissioned by, its aim and objectives and what its findings would be used for.

All participants were able to withdraw from the consultation at any time and without explanation.

All participants were made aware that their participation would remain confidential unless members of the research team had concerns that they posed a risk to themselves or others.

Additional sources of support were detailed in the introduction to both surveys and provided to other research participants if requested or required.

To avoid causing harm, interviews did not focus on interviewees’ mental health histories but on triggers, the knowledge of services, access and experience of services, crisis and the impact on the family.

All data, including recruitment information and surveys, were stored on password protected devices that were only accessible to the research team.

All participants were given a pseudonym and these have been used wherever extracts of data are included in this report.

1.2.6 Profile of Participants

Adult survey sample

- 64 adults completed the survey in full
- 30% were male; 70% were female
- The majority of respondents (51.6%) were between 35-54 years old.
- The majority of respondents (89%) were either married or single:
- The majority of respondents (85.9%) were White:
- Three participants completed the Korean survey and three completed the Arabic
- The majority of respondents were either in full time employment (25.9%) or unable to work due to illness/disability (25.9%)
- 7.4% of respondents were unemployed/looking for work for more than one year.

Self-harm and suicide; personal and friends/family experiences

Respondents could complete the survey if they had experiences of self-harm or suicide themselves, or if they had family/friends who had experienced them.

- 29 respondents had both personal experiences of self-harm/suicide and had family/friends who had experiences of self-harm/suicide (45.3%)
- 14 respondents had personal experience of self-harm/suicide only (21.9%)
- 21 respondents had family/friends who had experiences of self-harm/suicide only (32.8%)

Personal experiences of depression, self-harm and suicide

Forty-three of the 64 respondents had personal experience of self-harm and/or suicide, of these:

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6 Percentage of those who provided detail of these gender; one respondent selected ‘prefer not to say’.
42 had suffered from depression (97.6%)
10 had suffered from depression but had never been diagnosed (23%)
32 had been diagnosed as suffering from depression (77%)
31 had self-harmed (72%)
42 had experienced suicidal thoughts/behaviours (97.6%)
12 participants had made a suicide attempt (27.9%)

Adult interviewees (personal experience)
16 adults with personal experiences of depression, self-harm and/or suicide were interviewed, of these:

- Six were male, six were female
- Five were aged 18-27, six were aged 28-45, and 5 were aged 45+
- The youngest participant was 18 years old and the oldest was 68 years old
- 12 were White British, two White Other, one British Asian, one Dual Heritage
- 16 suffered from depression (either in the past, or currently) and 15 had been diagnosed by a GP
- Nine had self-harmed
- 15 had experienced suicidal thoughts
- Seven had made at least one suicide attempt

Adult interviewees (family members)
11 adults who had been affected by the depression, self-harm and/or suicide were interviewed, of these:

- Four participants were affected by the depression, self-harm and/or suicidal thoughts or behaviours of a spouse or partner. 1 participant had lost a spouse to suicide.
- Two participants were affected by the depression, self-harm and/or suicidal thoughts or behaviours of a sibling.
- Four participants were affected by the depression, self-harm and/or suicidal thoughts or behaviours of a child. 3 out of 4 of these were now adult children, but had been experiencing issues since adolescence.
- One participant was affected by the depression, self-harm and/or suicidal thoughts or behaviours of a child and parent.

1.2.7 Reflections on the Consultation
- The scope of the consultation was very broad and the time frame quite tight. This meant there was limited scope to follow-up members of the public and professionals that were not represented in the first round of recruitment and data generation. This means there are some data gaps. For example, despite attempts to follow-up a representative from the Community Mental Health Team, they did not participate in the consultation.
- It was planned that the consultation would include interviews with a sample of young people under 18 years of age. Very strict ethical criteria were set for this, given the sensitive nature of the research and potential risk of harm. Due to a range of factors we were unable to meet these criteria and so these interviews did not take place. This means that any qualitative perspectives on
the experiences of young people in this report are limited to those offered by parents and professionals.

- Individuals who participated in the consultation were asked to reflect on their personal experiences, or those of a family member. For some, these experiences were very recent, but for others, particularly those who had been living with depression, self-harm or suicidal ideation for a long time, they stretched back over many years. It is not possible in a report of this kind to capture the intricacies and complexities of all of those individual lived experiences, however much the authors would have loved to do so. What is presented in this report, therefore, are the results of the analysis of the data that are linked directly to the aims and objectives of the consultation.

- Notwithstanding all of these limitations, the consultation was successful on a number of levels. It was able to engage a good balance of participants, with a wide range of experiences and views on these issues. Given the sensitive nature of the consultation, this was a real achievement. Furthermore, the data generated was good quality and rich with insight. This has allowed this final report to include a good range of specific recommendations that will support the development of future prevention strategies and the shape of services in the future.

1.2.8 Structure of the Report

- The report begins with the epidemiological profile. This provides an analysis of publically available data on depression, self-harm and suicide in the Royal Borough of Kingston, and, crucially, how the borough compares nationally.

- Where appropriate, each subsequent chapter of the report begins with a short summary of the key issues raised by the review of the academic literature conducted for this consultation.

- This is followed by a presentation of the key findings from the empirical data generated for this consultation, and finished with a discussion section.
Chapter Two

2.1 Epidemiological Profile

This chapter presents the findings from the research conducted on the publically available data on depression, self-harm and suicide in Kingston upon Thames.

2.1.1 Depression

The last national study of prevalence and incidence of psychiatric morbidity in England (Adult Psychiatric Morbidity Survey, APMS)\(^7\) shows that:

- 16.2% adults met the diagnostic criteria for one Common Mental Disorder (CMD) one week prior to interview.
- Half of adults with a CMD presented with mixed anxiety and depression and 2.5% with a depressive episode.
- Rates of diagnosis varied by a range of demographic characteristics. Women were more likely than men to present with both mixed anxiety and depression (male 6.9%, female 11%) and a depressive episode (male 1.9%, female 2.8%).
- Men and women aged 45-54 had the highest rate of CMD.
- Divorced men and women presented with higher rates of mixed anxiety and depression than other marital status groups.
- South Asian women and male ‘Other’ (included Chinese and Mixed Ethnic groups) presented with highest rates of mixed anxiety and depression.
- People in the lowest quintile of equivalised household income were more likely to have CMDs than the highest quintile. This trend was most marked for men. 8.8% of men in the highest quintile had CMD compared to 23.5% in the lowest\(^8\).

More recently, figures in a self-report study (for those aged 16+) on wellbeing show that in the UK 15.9% of men and 26.1% of women report evidence of depression or anxiety\(^9\).

- This study showed that younger and older groups are more likely to report feeling very happy, whilst people in the middle years report lower levels of happiness. Indian and Other Asian groups report highest average happiness ratings (7.4 out of 10) and Black/African/Caribbean/Black British report lowest (6.9 out of 10). White 7.3 out of 10.


\(^8\) This data was not broken down geographically.

Further breakdown of this data show that levels of personal wellbeing vary according to region. The data was extracted for Kingston upon Thames and comparison was made with averages for London and England (see table 1).

Table 1. Personal wellbeing in Kingston, London and England 2015

<table>
<thead>
<tr>
<th></th>
<th>Kingston upon Thames</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>% reporting low levels of happiness</td>
<td>7.08</td>
<td>8.37</td>
<td>8.95</td>
</tr>
<tr>
<td>% reporting high levels of anxiety</td>
<td>21.96</td>
<td>19.02</td>
<td>19.36</td>
</tr>
</tbody>
</table>

Happiness is scored on an 11-point scale; ‘low levels of happiness’ represents scores 0-4. Anxiety is scored on an 11-point scale; ‘high levels of anxiety’ represents scores 6-10. Table 1 shows that:

- Kingston residents report proportionally less low levels of happiness than the London or England average. Indeed, the data show that Kingston reports the lowest levels out of all the outer London boroughs apart from Brent.
- Kingston residents report proportionally more high levels of anxiety than either the London or England average.

Given these findings on levels of happiness, it is perhaps unsurprising that NHS Kingston CCG area has consistently lower prevalence and incidence of depression than England and the London NHS region (as shown in Table 2).

Table 2: Levels of mental health and illness, England and NHS Kingston CCG; 2012/13

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NHS Kingston CCG</th>
<th>London NHS Region</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression: QOF prevalence (18+)</td>
<td>4.0%</td>
<td></td>
<td>5.8%</td>
</tr>
<tr>
<td>Depression: QOF incidence (18+)</td>
<td>0.6%</td>
<td>0.8</td>
<td>1.0%</td>
</tr>
<tr>
<td>Depression and anxiety prevalence (GP survey)</td>
<td>9.5%</td>
<td>11.2%</td>
<td>12%</td>
</tr>
</tbody>
</table>

---

% reporting a long-term mental health problem | 3.2% | _ | 4.5%

Comparable data was only available for Depression: QOF prevalence, and it indicates that between 2011/12 and 2012/13 prevalence rates in CCG Kingston reduced from 7-4.5% (see figure 1).

Figure 1: Depression: QOF prevalence (18+) Kingston CCG and England; 2011/2012-2012/13

![Figure 1: Depression: QOF prevalence (18+) Kingston CCG and England; 2011/2012-2012/13](image)

Table 3 presents a range of other data on the treatment\(^{11}\) of depression and other mental illness in Kingston.

<table>
<thead>
<tr>
<th></th>
<th>Kingston CCG</th>
<th>NHS London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in contact with mental health services (per 100,00 population) 2012/2013</td>
<td>1914</td>
<td>2143</td>
<td>2160</td>
</tr>
<tr>
<td>% with severity of depression assessed at the outset of treatment 2013/2013</td>
<td>94.8</td>
<td>88.6</td>
<td>90.6</td>
</tr>
<tr>
<td>Rate of attendance at Accident and Emergency for psychiatric reasons per 100,000 population 2012/2013</td>
<td>94</td>
<td>215.8</td>
<td>243.5</td>
</tr>
</tbody>
</table>

Table 3. Treatment of depression and other mental illness Kingston CCG, NHS London and England

It shows that Kingston CCG has:

- A smaller proportion of its population in contact with mental health services than either NHS London or England.
- A higher rate of the assessment of the severity of the depression at the outset of treatment than either NHS London or England.
- A significantly lower rate for attendance at A&E for psychiatric reasons compared to NHS London or England. And lower rates than the surrounding boroughs of Richmond (105.7) and Sutton (292.8) but not as low as the lowest Enfield CCG (17.3).

2.1.2 Children and Young People

- According to the House of Commons Select Committee report on CAMHS, there is a lack of reliable data about the state of children and young people’s mental health, with the most recent figures (from 1999 to 2004) indicating that 10% of five-16 year olds have a mental illness.\(^\text{12}\)
- Research by The Children’s Society found that in 2013 25.9% of the children it asked reported low levels of happiness the day before the survey.\(^\text{13}\)
- The European KIDSCREEN project used a range of measurements tools to examine mental health in just over fifteen thousand adolescents across 12 European countries.\(^\text{14}\) It concluded that the highest rates of general mental health problems in children were observed in the UK (borderline 13%, abnormal 10.4%).
- The study also found that low socio-economic status, poor social support, poor parental relationships and parental mental health problems are associated with a higher risk of adolescents’ mental health problems.
- Young people are higher risk of mental ill-health include Looked After Children and those involved with the criminal justice system.
- A recent national study conducted by the Girl Guides UK reported that 62% of sampled girls aged 11 to 21 knew a girl their age who has experienced a mental health problem, while almost half of girls aged 17 to 21 (46%) reported personally needing help with their mental health.\(^\text{15}\)
- In Kingston upon Thames, child hospital admissions for mental health conditions are 48.7 per 100,000 of the population. This is approximately half the number of the average for England.\(^\text{16}\)
- Figures produced for the CAMHS Transformation Strategy estimate that in NHS Kingston in 2014 there were 1,185 children between the ages of 11 and 16 with a mental health disorder.
- As Table 4 illustrates this includes a disproportionately higher rate of girls and young women than boys and young men.

\(^\text{12}\) http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf
Table 4. Prevalence estimates mental health in children and young people NHS
Kingston, 2014

<table>
<thead>
<tr>
<th>Disorder Type</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depressive disorder (16-19 years)</td>
<td>225</td>
<td>615</td>
</tr>
<tr>
<td>Depressive episode (16-19 years)</td>
<td>40</td>
<td>135</td>
</tr>
<tr>
<td>Emotional disorders (11-16 years)</td>
<td>235</td>
<td>320</td>
</tr>
</tbody>
</table>

The Care Quality Commission Review on Health Services for Looked After Children and Safeguarding published in 2014 did, however, note that:

“A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Kingston upon Thames. The average score per child in 2013 was 15. This score is considered to be a borderline cause for concern. The average score over the last two years has slightly been increasing which maybe an indication that the emotional wellbeing of children is starting to deteriorate.” (CQC, 2014 p5)

2.1.3 Summary of Depression

- A significantly lower proportion of Kingston residents are in touch with mental health services than in London or England.
- Kingston CCG has a significantly lower incidence of depression and lower levels of long term mental illness in the population that either the England or NHS London average. It also has a significantly lower prevalence that the England average.
- Recent self-report data show that Kingston upon Thames has a higher rate of anxiety than averages in London or England.
- There are significantly fewer attendances at Accident and Emergency in Kingston for psychiatric reasons than the England, London NHS or surrounding boroughs.
- Rates of psychiatric A&E attendance for adults is significantly lower than the London or England average and for children it is significantly lower than England.
- There is limited publically available data on prevalence and incidents of depression in children, but estimates produced show that in NHS Kingston girls were significantly more likely than their male counterparts to be diagnosed with mixed anxiety and depression, a depressive episode and emotional disorders.
Concern was expressed by the CQC on the about mental health amongst looked after children in the borough.

Generally, national data illustrates that there is a higher rate of CMD amongst those with lower socio-economic status and those in middle life. Disadvantaged men are a group particularly likely to have a CMD.

The data provide a limited picture of the prevalence of depression in the general population because it does not account for people whose depression remains undiagnosed, either because individuals do not recognise their feelings as a diagnosable condition, or because they do not seek help from primary care.

The *Adult Psychiatric Morbidity Survey (APMS)*\(^{17}\) shows that 82% of individuals, who self-reported with mixed anxiety and depression, were not receiving treatment, and, furthermore, 50% of those who self-reported with a depressive episode were not receiving treatment.

### 2.2 Self-harm

This section presents publically available data on self-harm in Kingston upon Thames. These data are based on hospital admissions and stays as a result of ‘self-harm’.

Data generated from hospital admissions and stays are a common way of understanding self-harm in the general population. However, this kind of data only gives a partial picture of the prevalence of self-harm. It tells us about the amount of self-harm that results in hospital treatment, it does not tell us about the amount of self-harm within the community that is not so severe that individuals do not need medical attention and hospitalisation. The APMS shows, for example, that of the 4.9% of adults who reported self-harming, only 42% of men and 53% of women received medical attention.

As such, this data might be viewed as an indication of suicide attempts, rather than ‘self-harm’ often commonly understood as non-suicidal, and a way of coping, instead of harm so severe that the individual’s life is in danger. This data should therefore be treated with caution in terms of interpretation to indicate the prevalence of self-harm in Kingston upon Thames.

### 2.2.1 Hospital Admissions

Data were extracted from Public Health England (PHE) Area Profiles for health indicators relating to self-harm for Kingston upon Thames\(^ {18}\). All indicators related to hospital admissions resulting from self-harm: ‘Hospital admissions as a result of self-harm’, ‘Young people hospital admissions for self-harm: rate per 100,000 aged 10 – 24’ and ‘Emergency Hospital Admissions for Intentional Self-Harm’.

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\(^{18}\) [http://fingertips.phe.org.uk/search/self%20harm#page/1/pid/1/pat/6/par/E12000007/at/102/are/E09000021/iid/21001/age/1/sew/4](http://fingertips.phe.org.uk/search/self%20harm#page/1/pid/1/pat/6/par/E12000007/at/102/are/E09000021/iid/21001/age/1/sew/4)
These data show that, for all three indicators, Kingston upon Thames rates were consistently lower than the London region and England average rates; see table 5 and figure 2.

Table 5. Health figures related to self-harm, Kingston upon Thames

<table>
<thead>
<tr>
<th>Self-harm indicator</th>
<th>Kingston upon Thames rate*</th>
<th>London rate*</th>
<th>England rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions as a result of self-harm**</td>
<td>212.3</td>
<td>228</td>
<td>412.1</td>
</tr>
<tr>
<td>Young people hospital admissions for self-harm: aged 10–24***</td>
<td>131.4</td>
<td>204.8</td>
<td>352.3</td>
</tr>
<tr>
<td>Emergency Hospital Admissions for Intentional Self-Harm**</td>
<td>84.3</td>
<td>106.8</td>
<td>203.2</td>
</tr>
</tbody>
</table>

*Age standardised rate per 100,000

** Period 2013/14

*** Period 2010/11-2012/13

Figure 2. Public health indicators related to self-harm; rates per 100,000

2.2.2 Hospital Stays
Data were extracted from annual local health profile reports relating to hospital stays for self-harm19.

The data show that the rate of hospital stays for self-harm in Kingston upon Thames, has been significantly lower than the England average in the five-year period between 2009/10 and 2013/14; see table 6 and figure 3. Comparable data for previous years is not publically available.

The Kingston upon Thames rate is consistently lower than the England average rate. During this five-year period both the England average and Kingston upon Thames rates have fluctuated and both seem to follow similar trends; notably recently increasing between 2012/13 and 2013/14. However, Kingston upon Thames has seen an overall increase from 48 to 84.3 per 100,000 (75.6% increase), while the England average has only increased from 198.3 to 203.2 per 100,000 (2.5% increase).

Table 6. Hospital stays for self-harm, per 100,000, Kingston upon Thames and England average; 2009/10 – 2013/14

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital stays for self-harm; rate per 100,000*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kingston upon Thames</td>
</tr>
<tr>
<td>2009/10</td>
<td>48</td>
</tr>
<tr>
<td>2010/11</td>
<td>66.6</td>
</tr>
<tr>
<td>2011/12</td>
<td>75.9</td>
</tr>
<tr>
<td>2012/13</td>
<td>62.2</td>
</tr>
<tr>
<td>2013/14</td>
<td>84.3</td>
</tr>
</tbody>
</table>

*Age standardized rates per 100,000

Figure 3. Hospital stays for self-harm, per 100,000, Kingston upon Thames and England average; 2009/10 – 2013/14

2.2.3 Summary of Self-harm in Kingston upon Thames

The data in this section shows that:

- The rate of hospital admissions and stays for self-harm in Kingston upon Thames is generally lower than the averages for England and London and has been consistently lower over the last five years.
- However, the data also show that the rate of hospital stays for self-harm is increasing in Kingston upon Thames at a faster rate than it is in the England average in the latest year of data.
As noted in the introduction of this section, the data should be treated with caution if being interpreted as an estimate of community self-harm in Kingston upon Thames, since this is most likely an underestimate of the rate of self-harm overall. This data is a record of self-harm which is severe enough to result in hospitalisation and does not account for incidents of self-harm where individuals need no medical attention, which account for the majority of cases.

2.3 Suicide
This section presents publically available data on suicides in Kingston upon Thames and UK/England comparisons. It also presents the results of one audit of coroners’ records which gives more detail to the risk factors and types of people more likely to take their own lives in Kingston upon Thames.

Suicide is defined as deaths resulting from ‘intentional self-harm’ (codes X60–X84, Y87.0 of the International Classification of Diseases, Tenth Revision (ICD10)); and ‘events of undetermined intent’ (ICD10 codes Y10-Y34, Y87.2).

This definition of suicide, which is accepted and used to report on the number of suicides across the UK and many other countries, is adopted because of the known issue of underreporting of suicide when counting only deaths which are classified as ‘intentional self-harm’. For further explanation of the problem of under-reporting and classification of suicides see Samaritans’ suicide statistics report\(^{20}\).

Data on suicide are for the deaths registered, not necessarily occurring, within each year.

2.3.1 Suicide in the UK
The latest national suicide rates for the UK were published by the Office for National Statistics (ONS) in February 2015; the most recent data is for deaths registered in 2013\(^{21}\). Table 6 below shows the number and rates of suicide in the UK and constituent nations for 2013.


Table 6. Rates of suicide in the UK and constituent nations, 2013

<table>
<thead>
<tr>
<th></th>
<th>Number of suicides in 2013</th>
<th>Suicide rate per 100,000 in 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overall</td>
<td>Male</td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6,233</td>
<td>4,858</td>
</tr>
<tr>
<td>England</td>
<td>4,722</td>
<td>3,684</td>
</tr>
<tr>
<td>Wales</td>
<td>393</td>
<td>317</td>
</tr>
<tr>
<td>Scotland</td>
<td>795</td>
<td>611</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>303</td>
<td>229</td>
</tr>
</tbody>
</table>

For the UK as a whole, the male suicide rate of England, Scotland and Northern Ireland is approximately 3.5 times higher than the female rate. In Wales, the male suicide rate is approximately 4.5 times higher than the female rate.

2.3.2 Suicide in Kingston upon Thames

The data presented in this section are based on data for persons aged 15 years and over. It is common practice when reporting on the rates of suicide for all ages that this includes ‘persons aged 15 years and older’. In the UK, coroners are able to pass a verdict of suicide for individuals aged 10 years and over. However, because of known subjectivity between coroners in the classification of children’s deaths and because of the low number of deaths in those under the age of 15 years, rates are often calculated for those aged 15 and over to improve the reliability of the overall statistics and to protect the identity of children who may be identified from data where there are low numbers.

Suicide in all persons, males and females, 2011-2013

Data published in February 2015, by the NHS Health and Social Care Information Centre (HSCIC) provide the age standardised (to the European population) suicide rates for local authorities in England and Wales for years 2011-2013 (pooled, to provide one rate for this time period), data were extracted for Kingston up Thames and England; see table 7 and figure 4.

These data show that in Kingston upon Thames the suicide rate for all persons and males is lower than the comparable rate for England, but for females is higher than the average rate for England.

22 https://indicators.ic.nhs.uk/webview/
The male rate is approximately 2.3 times that of the female rate in Kingston upon Thames; for England the male rate is approximately four times that of the female rate (UK average is 3.5 times).

Table 7. Age Standardised suicide rates for 2011-2013 (pooled) for persons age 15 years and over

<table>
<thead>
<tr>
<th></th>
<th>Kingston upon Thames</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide rate per 100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All persons</td>
<td>6.53</td>
<td>7.89</td>
</tr>
<tr>
<td>Males</td>
<td>9.16</td>
<td>12.80</td>
</tr>
<tr>
<td>Females</td>
<td>3.95</td>
<td>3.23</td>
</tr>
</tbody>
</table>

Figure 4.

Suicide in all persons, males and females, 1995-2013

Data published in February 2015 by the NHS Health and Social Care Information Centre (HSCIC) provide the age standardised (to the European population) suicide rates for local authorities in England and Wales for individual years from 1995-2013. Data were extracted for Kingston upon Thames and England (see table 8 and figure 5.).

https://indicators.ic.nhs.uk/download/NCH00/Data/31C_113ORT15++_D.xls
Table 8. Age standardised suicide rate per 100,000 for males, females, and all persons 1995-2013, Kingston upon Thames and England.

<table>
<thead>
<tr>
<th>Year</th>
<th>Kingston upon Thames Suicide rate per 100,000</th>
<th>England Suicide rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>1996</td>
<td>8.86</td>
<td>1.29</td>
</tr>
<tr>
<td>1997</td>
<td>8.51</td>
<td>2.11</td>
</tr>
<tr>
<td>1998</td>
<td>16.93</td>
<td>2.40</td>
</tr>
<tr>
<td>1999</td>
<td>13.57</td>
<td><strong>4.78</strong></td>
</tr>
<tr>
<td>2000</td>
<td>8.04</td>
<td><strong>3.93</strong></td>
</tr>
<tr>
<td>2001</td>
<td>11.13</td>
<td>1.26</td>
</tr>
<tr>
<td>2002</td>
<td>7.60</td>
<td><strong>6.53</strong></td>
</tr>
<tr>
<td>2003</td>
<td>7.94</td>
<td><strong>5.81</strong></td>
</tr>
<tr>
<td>2004</td>
<td>20.06</td>
<td><strong>6.87</strong></td>
</tr>
<tr>
<td>2005</td>
<td>13.85</td>
<td><strong>5.35</strong></td>
</tr>
<tr>
<td>2006</td>
<td>9.21</td>
<td>2.86</td>
</tr>
<tr>
<td>2007</td>
<td>3.89</td>
<td>1.03</td>
</tr>
<tr>
<td>2008</td>
<td>9.55</td>
<td><strong>6.14</strong></td>
</tr>
<tr>
<td>2009</td>
<td>8.95</td>
<td><strong>4.78</strong></td>
</tr>
<tr>
<td>2010</td>
<td>7.57</td>
<td><strong>4.74</strong></td>
</tr>
<tr>
<td>2011</td>
<td>8.25</td>
<td><strong>6.36</strong></td>
</tr>
<tr>
<td>2012</td>
<td>14.16</td>
<td><strong>3.31</strong></td>
</tr>
<tr>
<td>2013</td>
<td>5.36</td>
<td>2.25</td>
</tr>
</tbody>
</table>

**Bold figures show where Kingston upon Thames rate is higher than the comparable England rate.**

Figure 5.
These data show that the suicide rate in Kingston upon Thames has fluctuated over the 19-year period. The rate for all persons, males and females was at the highest point of this period in 2004; all persons was 12.16 per 100,000, males was 20.06, and females was 6.87. At this point, the rates for all three groups were higher than the England rate.

The female suicide rate in Kingston upon Thames has been higher than the England rate for 11 of the 19 years reported in this data and 2013 was the first in six years that the rate was lower than the female rate for England. The rate for all persons has been higher than the comparable England rate in six years, and the male rate has been higher in three years (2004, 2005 and 2012).

The male, female and all person rates of suicide in Kingston upon Thames are the lowest since 2008.

When looking at figure 6 as a comparison, the data shows that the Kingston upon Thames trend fluctuated much more over time than that of England. This may in part be due to changes in suicide rates appearing more severe in smaller populations that experience few deaths. It is for this reason that agencies will often produce three or five year averages (or pooled rates) like those in the previous section, in order to even out over-estimated fluctuations.

There is a discrepancy between this section and the previous section, where the most recent data seems to show that when pooled with previous years to produce an average, the female suicide rate in Kinston upon Thames is higher than the England rate, whereas if separated into individual years, the Kingston upon Thames rate is lower than the England rate. However, in both sets of data the most recent data show that the male rate is approximately 2.3 times that of the female rate in Kingston upon Thames; for England the male rate is approximately four times that of the female rate (UK average is 3.5 times).

In the most recent data (2013) Kingston upon Thames rates seem to be decreasing while those in England are increasing (as are the UK as a whole).

Figure 6. Suicide rates in England 1995-2013

---

Suicide in all persons, 2004-2012

Data published in February 2014, by the Office for National Statistics (ONS)\(^\text{25}\) provide details about the crude rate of suicide for persons aged 15 years and older between 2004 and 2012, in three year averages, for all local authorities in England and Wales. Data were extracted for Kingston upon Thames. No England average rate was available for comparison; see table 9 and figure 7.

These data show that there was a decrease in the suicide rate in Kingston upon Thames between 2004-2006 and 2007-2009, but then a slight increase during 2010-2012. The trend of this data seems to follow that described for Kingston upon Thames in the section above.

Table 9. Crude suicide rates in Kingston upon Thames, 2004-2012

<table>
<thead>
<tr>
<th>Years</th>
<th>Suicide rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2006</td>
<td>10.8</td>
</tr>
<tr>
<td>2007-2009</td>
<td>7.0</td>
</tr>
<tr>
<td>2010-2012</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Figure 7. Crude suicide rates in Kingston upon Thames, 2004-2012

Suicide in adults of working age (all persons, males, and females aged 18-64 years), 2002-2013

Data published in July 2015 by the Office for National Statistics (ONS)\(^\text{26}\) in response to a Freedom of Information (FOI) request, provide details about the rate of suicide for adults of working age (18-64 years) over a 12-year period between 2002 and 2013,
for all local authorities in England. Data were extracted for Kingston upon Thames, no England average rate was available for comparison (see table 10 and figure 8.)

Table 10. Suicide in adults of working age (all persons, males, and females aged 18-64 years), 2002-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>All persons</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>13.7</td>
<td>20.7</td>
<td>6.4</td>
</tr>
<tr>
<td>2003</td>
<td>7.3</td>
<td>8.3</td>
<td>6.4</td>
</tr>
<tr>
<td>2004</td>
<td>15.5</td>
<td>22.4</td>
<td>8.4</td>
</tr>
<tr>
<td>2005</td>
<td>12.2</td>
<td>16.1</td>
<td>8.2</td>
</tr>
<tr>
<td>2006</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>2007</td>
<td>5</td>
<td>8.1</td>
<td>2</td>
</tr>
<tr>
<td>2008</td>
<td>12</td>
<td>14</td>
<td>9.9</td>
</tr>
<tr>
<td>2009</td>
<td>7</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>2010</td>
<td>6.9</td>
<td>10</td>
<td>3.9</td>
</tr>
<tr>
<td>2011</td>
<td>9.8</td>
<td>9.9</td>
<td>9.7</td>
</tr>
<tr>
<td>2012</td>
<td>4.8</td>
<td>7.8</td>
<td>1.9</td>
</tr>
<tr>
<td>2013</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Figure 8.

In 2013, the suicide rate in adults of working age for all persons, males and females was the same, 3.8 per 100,000.

These data show that the suicide rate for adults of working age in Kingston upon Thames has fluctuated over this 12-year period, but there has been a decrease in the
overall rates. Since 2012, both the male and all person rates have decreased, whereas the female rate has increased.

Since 2002, in adults of working age in in Kingston upon Thames, there has been a decrease of:

- **72.3%** in the overall suicide rate from 13.7 to 3.8 per 100,000
- **81.6%** in the male suicide rate from 20.7 to 3.8 per 100,000
- **40.6%** in the female suicide rate from 6.4 to 3.8 per 100,000

**Characteristics of those who die by suicide in Kingston upon Thames**

An audit of coroners’ records of suicide deaths in Kingston upon Thames was carried out and reported in 2015 (Public Health Team, 2015).

This analysis provided further details about those who die by suicide, giving more detail than can be obtained from statistics collated from death records; gender data are routinely collated and published as shown in the preceding sections, but, for example, ethnicity is not. In national suicide data, rates are routinely broken down by age also, but this does not seem to be the case for data which is already broken down by local authority. To break down further to smaller numbers would probably yield unreliable results and could lead to problems with identifying individuals from the data if this were performed.

This audit of coroners’ records shows that during the period 2010-2014:

- There were 47 suicides in Kingston upon Thames.
- The majority of these deaths were male and aged between 45-54 years (in both males and females).
- The majority were born in the UK (84%).
- Around half of those in the audit had lived alone prior to their suicide; the analysis suggests that living alone is a risk factor for suicide and notes that in Kingston 29% of people live alone.
- There were fewer suicides in people who were in a relationship; positive family relationships were seen as a protective risk factor for suicide.
- A quarter of men in the audit had experienced a relationship break-up in the two months prior to their death.
- Unemployment/retirement seems to be a strong risk factor for suicide. Employment status was analysed for 23 individuals who died by suicide; of these, 23 were not in paid employment at the time of death.
- There were fewer suicides in those of higher socio-economic groups.
- Those in ‘intermediate occupations’ (e.g. office administrators, cashiers) also seem to be a group at increased risk.
- Financial worries were recorded as a potentially contributing factor for approximately 1/3 of cases.
- Those who died by suicide were more likely than the general population to be suffering from a long term physical illness.
- 87% were known to have a mental health/substance misuse problem; 82% were known to have a mental health problem alone.
- 34% were known to have a history of self-harm.
72% of men chose ‘violent/lethal methods’ (e.g. firearms or hanging) compared with 54% of women. This difference is well recognised nationally and is a common trend between methods and gender.

- 30% of suicides were in ‘public places’ e.g. train stations, rivers, or parks.
- Almost half had contact with their GP or a mental health professional in the week prior to their death.

2.3.3 Summary of Suicide in Kingston upon Thames

Analysis of suicide data can be confusing, because there are many sources of suicide data that are calculated in different ways by different agencies, and broken down into different subgroups (e.g. gender, age groups, crude rates vs age standardised rates). The picture of suicide for one particular group or area can look confusing when piecing together all of the available information from many sources to give a general overview.

Some data sets can produce difference in the numbers and rates based on difference in the calculation. However, in order to build a picture of suicide it is important to look at trends over time in any particular group or area to see whether risk of individuals dying by suicide is increasing or decreasing and therefore where action is most needed.

- Looking at trends over time, Kingston upon Thames suicide rates seem to be decreasing (although individual years of fluctuations can be misleading) and suicide rates for both males and females are the lowest they have been since 2008. This seems different to the trend being experienced in England and the UK.
- Males are routinely more at risk than females, which is consistent with the general population. The ratio of male to female seems to be consistent between data sets; males in Kingston upon Thames are approximately 2.3 times more likely to die by suicide then females; males in England are between 3.5 and four times more likely to die by suicide than females; males in the UK are approximately 3.5 more likely to die by suicide than females. With the exception of the data set which presents the rate for those only of working age, where the male, female and all person rates are identical.
- Other characteristics that indicate risk include those aged 45-54 years, living alone, not being in paid employment (unemployed or retired), having a long term physical health problem, having a mental health problem and being from deprived socio-economic groups. All of which are characteristics related to increased risk of suicide in the general population.
Chapter Three

3.1 Triggers and Access to Support

3.1.1 Depression

There is a vast body of published academic literature that explores the causes of depression, self-harm and suicide ideation and behaviours. It is commonly accepted that mental illness and ill-health are caused by a complex interaction and combination of biological, psychological and social factors; bio-psycho-social theory:

- **Biological**: for example, neurochemistry such as deficiencies in serotonin, imbalances in hormone levels and/or genetic inheritance.
- **Psychological**: for example, personality traits, psychological constructs and cognitive styles.
- **Social**: for example, experience of adverse life events such as bereavement, unemployment or relationship breakdown and experiences of social inequality, marginalisation and exclusion.

This theory purports that none of the individual level factors are sufficient to *cause* mental ill health such as depression or suicidal thoughts, but that different factors will influence whether a person suffers from these things.

Understanding what role different factors play for people who suffer from depression is, therefore, extremely difficult. We know, however, that people who develop depression are more likely than the general population to have:

- Been the victim of abuse and/or suffered acute trauma (such as physical, sexual or emotional violence, war and conflict)
- Have faced/lived through adversity (because of family breakdown, bereavement, displacement and forced migration or other significant life events)
- Be socially isolated
- Have a family history of depression and/or negative thoughts
- Have faced social exclusion and marginalisation, including poverty

Additional issues for children and young people include:

- Having parents with a mental health condition
- Being the victim of bullying in school

27 Others include structural, humanistic, cultural, feminist and psychoanalytic.
29 Ibid
- Being in local authority care
- Involvement in the criminal justice system
- More recently, there is evidence of exam pressure resulting in worsening mental health amongst secondary school age children\(^{31}\).
- And growing evidence that social media use in children and young people results in poor quality sleep and can trigger mental health problems, such as depression and anxiety, amongst this group\(^{32}\).

### 3.1.2 Self-harm

Self-harm encompasses a range of different behaviours that are situated on a spectrum of harm from highly lethal to less lethal. The term ‘self-harm’ is most commonly used to describe self-injurious behaviours, which are non-suicidal, however research has shown that these behaviours are not necessarily always clearly distinct from one another\(^{33}\).

Research\(^{34,35,36}\) suggests that individuals self-harm for a range of reasons including:

- A way of coping with mental illness, most commonly depression\(^{37}\)
- Coping with, or representing physically, emotional pain caused by negative or adverse life events, such as experiences of abuse or trauma, loss and bereavement and difficult family relationships
- In response to conflict about sexual or gender identity
- Poor body image and low self-esteem
- To take control
- To communicate distress
- To prevent suicide
- To inflict self-punishment
- To relieve tension

Girls and young women have the highest self-harm rates, but rates become more even into adulthood\(^{38}\).

Research shows a high level of psychiatric disorders amongst adult self-harmers. For example, in a follow-up study of 150 self-harmers in Oxford, 92% were identified as having at least one psychiatric disorder, 36.7% at least two and 10.3% 3 or more\(^{39}\).

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\(^{32}\) http://www.gla.ac.uk/news/headline_419871_en.html


3.1.3 Suicide
Despite being a leading cause of death worldwide, there is still very little understanding about why people take their own lives. Some of the most commonly cited explanations in the literature include:

- Poorly treated, newly diagnosed, undiagnosed or changes in mental illness, as with self-harm, depression is the most common mental illness in people who take their own lives
- Positive and negative stressful life events (such as relationship breakdown)
- Being the victim of abuse and trauma
- Feelings of social isolation and absence of social relationships
- The inability to think positively about the future and ruminating on negative feelings or situations. This, research shows, combined with feelings of entrapment is a high risk situation where suicidal ideation can escalate to suicidal behaviour\(^40\).

Analysis of those who die by suicide also indicates a range of other issues for consideration.

- **Gender**: as already stated in Chapter Two men are between 3.5 and four times more likely to die by suicide than women because they use more lethal methods. Within this group, socio-economically deprived men in middle life are the most at risk group. Samaritans research into this group concludes that a range of factors contribute to this risk including: men feeling out of control because they are unable to perform traditional ‘male breadwinner’ role; being expected to not show emotions; profound social disconnection and over-reliance on partners for emotional support; greater use of drugs and alcohol to cope with emotional difficulties.

- **History of self-harm**: Previous non-fatal self-harm is the strongest predictor of suicide. A mortality follow-up study of 11,583 patients who were seen in hospital following an episode of non-fatal self-harm showed that in the first year post discharge this group were 66 times more likely to commit suicide than the general population\(^41\).

- **Mental Illness**: 30% of all suicides in 2013 were patient suicides -suicides of those already in the care of mental health services\(^42\). The suicide audit conducted in the borough highlighted that 82% of those who had taken their own life were known to have a mental health condition, and half had been seen by a GP or mental health professional the week before death.

- **Socio-economic**: irrespective of gender poorest groups are 10 times more at risk from suicide than most affluent\(^43\) (see figure 9). In addition, a recent study

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\(^{41}\) Hawton K, Harris L, Zail D. Deaths from all causes in a long-term follow-up study of 11,583 deliberate self harm patients. *Psychol Med* 2006; 36: 397–405


of coroners’ reports from 2010/2011 implicated financial issues in 13% of suicides\textsuperscript{44}.

Figure 9. Lifetime suicide attempts by equivalised household income and sex

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Lifetime suicide attempts by equivalised household income and sex}
\end{figure}

\textbf{Cultural:} suicide rates vary considerably worldwide and the evidence shows that some societies and cultures seem more prone than others to suicide. According to OECD \textit{Health Statistics}\textsuperscript{45}, South Korea has had the highest suicide rate amongst OECD countries for the past 11 consecutive years. This is significant for this report as New Malden is estimated to have the highest population of Koreans in Europe\textsuperscript{46}. Explanations for this rate of suicide include: expectation of academic and professional success; non-recognition of mental distress and stigma of mental illness; social isolation; breakdown of the traditional family unit.

\section*{Suicide and self-harm}

It is important to acknowledge that self-harm and suicidal behaviours are not necessarily distinct. Self-harm is the single biggest predictor of future suicide attempt\textsuperscript{47}. They are thought to exist on a continuum of intention and much research into self-harm does not differentiate between non-suicidal self-harm and suicide attempts; "self-harm" will often refer to all self-injury and poisoning behaviours regardless of suicidal intent. There is considerable overlap in these behaviours; we would therefore expect research to show considerable overlap in the triggers for the behaviours.

\begin{itemize}
\item \textsuperscript{45} \url{http://www.oecd.org/els/health-systems/health-data.htm}
\item \textsuperscript{46} RBK (2013) \textit{Borough Profile}
\end{itemize}
3.2 Adult Survey Findings
Respondents were asked to indicate how much certain ‘triggers’ affected their mental and emotional wellbeing at times when they felt depressed, had self-harmed or been suicidal. Respondents were asked ‘how much’ each of the triggers affected them. The table below shows the number of respondents who selected either ‘quite a bit’ or ‘a lot’ – that each was the ‘main reason’ for them feeling low.

Table 11. Triggers that affect mental health and emotional wellbeing

<table>
<thead>
<tr>
<th>Triggers</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low self-esteem</td>
<td>74.4</td>
</tr>
<tr>
<td>Loneliness</td>
<td>58</td>
</tr>
<tr>
<td>Mental health/illness (other than feelings of depression, self-harm and suicide)</td>
<td>54.4</td>
</tr>
<tr>
<td>Body image</td>
<td>44</td>
</tr>
<tr>
<td>Problems at work</td>
<td>39.5</td>
</tr>
<tr>
<td>Relationship worries</td>
<td>39.5</td>
</tr>
<tr>
<td>Debt</td>
<td>32.5</td>
</tr>
<tr>
<td>Physical illness</td>
<td>32.5</td>
</tr>
<tr>
<td>Housing problems</td>
<td>30.2</td>
</tr>
<tr>
<td>Bullying</td>
<td>27.9</td>
</tr>
<tr>
<td>Exam/education worries</td>
<td>27.9</td>
</tr>
<tr>
<td>You were the victim of abuse (emotional or physical)</td>
<td>27.9</td>
</tr>
<tr>
<td>Unemployment</td>
<td>25.5</td>
</tr>
<tr>
<td>Worries about benefits</td>
<td>25.5</td>
</tr>
<tr>
<td>Bereavement</td>
<td>18.6</td>
</tr>
<tr>
<td>Addiction problems</td>
<td>9.3</td>
</tr>
<tr>
<td>Concerns about sexuality</td>
<td>2.3</td>
</tr>
<tr>
<td>Concerns about gender identity</td>
<td>0</td>
</tr>
</tbody>
</table>

As table 11 shows:
- Depression, self-harm and/or suicidal ideation are not triggered by one thing, but a combination of feelings, life events and personal circumstances.
Low self-esteem is the trigger cited most frequently as contributing to the feelings of respondents ‘quite a bit’ or ‘a lot, the main reason for me feeling low’. Followed by loneliness and mental illness.

The least frequently cited triggers were concerns about sexuality (one) and concerns about gender identity (0).

Respondents were also able to give other reasons for their feelings, however, all of the additional comments made did fit into the established categories apart from coping with the ill-health of family members.

Which groups are more/less likely to be affected by triggers?
Additional analysis was conducted on the data to identify which, if any, groups were more likely to be affected by each of the triggers for depression, self-harm and suicide. This analysis indicated that:

Gender

- Women were more likely than men to report being triggered by a range of issues including: low self-esteem; body image; problems at work; relationship worries; physical illness; housing problems; exam and education worries; being the victim of abuse; bereavement.
- Men were more likely than women to report being triggered by worries about benefits and bullying.

Age

- Perhaps unsurprisingly, those aged 18-24 years old were more likely than any other age groups to report education and exam worries were a trigger for their feelings.
- Mental illness was a particular issue for those aged 65+.
- Those aged between 45-54 years old were more likely than other age groups to indicate that benefits, being the victim of abuse, housing problems, physical ill health were triggers.
- Body image was more likely to be a trigger for those aged between 18-24 and 45-54 years old.
- Those aged 25-34 years old were more likely than other age groups to report bullying as a trigger.
- Debt was seen as a trigger most frequently for those aged between 35-44 and 45-54.

Ethnicity

- Chinese respondents were more likely than any other ethnic group to report physical illness as a trigger for depression, self-harm and suicide.

Employment Status

- People unable to work due to illness or disability were more likely than the other employment categories to report that their feelings were triggered by: mental illness; relationship worries; physical illness; housing problems; bullying; worries about benefits; bereavement.
Students were most likely to report education and exam worries as a trigger. Those in part-time employment and students were more likely to report unemployment as a trigger.

**Place of birth**

- People born in the UK were more likely than those not born here to cite exam worries and problems as triggers.
- People not born in the UK were more likely than those born here to cite loneliness, low self-esteem, housing problems and physical illness as triggers.

### 3.3 Qualitative Findings

A majority of participants with personal experience of depression, self-harm and suicide who participated in this research described highly complex personal situations involving a range of issues. Professionals also described having people present at services facing multiple difficulties.

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“More and more people are presenting to us with more complex problems. They may have a drug or alcohol issue, a housing problem, problems with debt and work. Their depression is a big part of this, but only one element of often very complicated lives.” (Professional)

“I've worked in mental health in Kingston for 25 years and the people I am seeing now are having a really hard time with different things going on.” (Professional)

“We have people now who have refugee status, or people who have been tortured, housing issues, there's a client waiting to see us who has been trafficked. We wouldn't have seen that five years ago.” (Professional)
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Analysis of the qualitative data showed that they issues raised in the data were:

#### Mental health

- Of the 15 who had been diagnosed with depression by their GP, 10 (66%) had been diagnosed with at least one other condition (these included other CMDs such as general anxiety disorder and post-traumatic stress disorder as well as severe and enduring mental illnesses such as bipolar disorder and schizophrenia).
- Clinicians in the Home Care Treatment Team perceived that those with severe and enduring mental health problems were at particularly high level of risk of suicide.

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“People with severe and enduring mental health like schizophrenia and bipolar and are problems under the CMHT, in the nine months that I've been here. They're the group who are taking their own lives. And sometimes, I suppose the sense is sometimes that they come to us and there hasn’t been a huge amount of contact with them since the last time they were under our team for a crisis and so that’s something that we feel acutely, basically how stretched the community mental health teams are and how little contact they may have with a patient who is stable and well, and it’s sort of them that end up killing themselves.” (Professional)
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Living with more than one condition presented a number of challenges that participants felt did trigger and affect their depression, self-harm behaviour or suicidal ideation, or intensify it.

The difficulties included i) having problems accessing appropriate care or support ii) changes to medication iii) disruption in packages of care iv) the stress of living long-term with mental health conditions.

“I know that my depression is wrapped up in my bipolar. When I crash, my depression comes at me with a vengeance and it’s like I’ve got no defences to cope. That’s when I want to hurt myself the most.” (Brian)

For 81.2% (n13) participants their last episode of depression, self-harm and/or suicide was not their first. Many reported depressive episodes, self-harm and suicidal ideation stretching back into childhood, adolescence or young adulthood.

Participants coping over long periods of life with these issues described the situation as ‘exhausting’. This triggered suicidal ideation.

“I know I’m not that old, but I feel like my soul can’t take much more, and god next time could be the last….It’s going to sound pessimistic, when I was on my last medication I told my doctor that when I was at my best it was like I was standing on very thin ice, and with a bit of stress it was like the ice cracked. And when, once the ice cracked, you’re treading water and you’re wearing all of this heavy boots and a coat and y’know mittens and it’s weighing you down in the icy water and you just get so tired you just want to stop.” (Lola)

Adverse life events

Victim of abuse

Six (37.5%) participants disclosed being the victim of abuse, either childhood sexual abuse, sexual abuse at another time in their life or experiences of domestic violence in adulthood. Women were significantly more likely to report being a victim of abuse than men.

Those providing services for women in the borough also reported that experiencing domestic violence, rape and childhood sexual abuse, as well as housing, were primary reasons that women sought help.

This group felt strongly that open ended therapeutic support that included talking therapies was crucial for recovery.

Relationship issues

Seven (43.7%) reported that relationship issues were a part of their depression, self-harm and/or suicidal feelings. Marriage breakdown or relationships under stress because of alcohol issues were the most commonly cited issues. Men were more likely to report than women.
“My marriage ended and all of this started [depression and suicidal ideation]. It’s as simple as that.”

“Why do you think that happened?”

“[long pause] We were together a long time, she had an affair and I was left looking like an idiot.” (John)

Social isolation

- 75% (n12) of participants said that being socially isolated triggered their depression, self-harm and/or suicidal and made it worse.
- It was recognised that when their feelings were very acute they responded by isolating themselves from friends, family and other activities.

“I think it’s a vicious circle, but with being so overwhelmed, I do have low self-esteem and so going out in public is an issue but I think that when you’re like this [depressed] I could go easily for one or two weeks and not go out of the house at all.” (Lily)

“Isolation is the worst thing because I don’t have any family around here, and because I lost my job through ill-health, because you’re not at work that kind of social thing that you have when you are at work eventually that dies away and also when I was on all my medication and stuff apparently I was quite aggressive and quite horrible. I don’t remember that, but the friends that you do have they can’t handle that, so eventually they all kind of drift away.” (Lisa)

- Those who reported less isolation had family support, even though some of them expressed concerns that they were a burden to their family.

“I think, I can’t sit back and stay in bed all day but that’s because of my [adult] children, they keep me on my toes. They have a go at me (laughs). Not nastily, although I do worry that I am demanding.”

“What are some of the things you’ve been involved in?”

“MIND had a group for people under the psychiatrist. I’ve done swimming, Tai Chi, belly dancing, I sung in a band for six years. I love music.” (Rose)

Employment Issues

81.2% (n13) of interviewees faced challenges in employment, which they saw as either triggering their depression, self-harm or suicidal ideation, or having a negative impact on their recovery.

- Impact of retirement

“As part of the government’s austerity drive I took voluntary redundancy, I’d been a [job title] for 35 years, but I’d been wrapped up in my career for so long a lot of my identity was wrapped up in my work, and my social life was heavily dependent on it as well really, so quite quickly things started to go wrong for me... I ceased to function as a person, my cognitive space was taken up with destructive and obsessive thinking.” (Mathew)
Experiencing bad management or workplace bullying

“I had some unpleasant time at work where my boss, well he was suddenly made my boss was very negative, he was shouting at me. And other people involved in my work were very aggressive towards me, my boss just changing the goalposts and being unhelpful really despite me asking, then I just flopped, then I just crashed, I could not function at all, I couldn’t speak or anything. I was crap.” (Wendy)

Participants also reported:
- Stress in the workplace
- Wanting to change career or struggling to get back onto work after being out of work due to mental illness.
- Feeling ‘redundant’ because of long-term mental health problems.

Employment was also highlighted as a crucial issue for families because:
- They felt that stress at work had played a particular role in the depression, self-harm or suicide of their family member.
- They perceived the lack of work opportunities for their family member was hindering recovery.

Finance and Debt

Six participants reported financial hardship specifically during interview. Two were concerned about their benefits, one reported facing financial hardship as a result of the bedroom tax and three worried about being able to meet their basic needs because they were living on a low income.

“I’m subject to the bedroom tax and that eats into whatever benefits I get. I can’t afford to heat the flat and so I get bronchitis and pneumonia in the winter and then that starts me on a downward spiral again. The council have said they can rehouse me but it’s just unfortunate that over the last two years nothing has come up.” (Lisa)

More participants talked about finances in the context of paying for counselling and other mental health services outside of the NHS. Many couldn’t afford them, and others reported the cost as an additional burden on their finances.

“It’s £15 a time, which for me is a lot of money but I can manage it. I’ve had to take loans to do it but it’s worth it. But that’s part of the problem, if I’m going to have to go privately I’m going to have to borrow money to do it and that puts lots of pressure on the therapeutic process because it’s not going to happen quickly.” (Eloise)

Access to help

- Chapter Five examines their experiences of statutory and community based mental health services in detail.
- Given the scale of many of the challenges participants reported approaching/using a limited range of additional services. They included:
Relate for relationship counselling; KCABS; Kingston Voluntary Action; local leisure facilities. These services were reported as making a positive difference to participants’ well-being if effective communication was established.

- Only one participant disclosed receiving support from Balance, a local organisation that provides employment and support to vulnerable groups, and when asked specifically about the service most were unaware of its existence.
- The overall impression during interview was that addressing mental health difficulties, unsurprisingly, took up a lot of mental and emotional space and that additional support to access help would have been beneficial.
- Some participants reported wanting additional help but being unsure of who to approach and how to contact.
- Others reported approaching local organisations for support and not getting calls returned or struggling for other reasons (distance, mobility, lack of confidence) to access them.

### 3.4 Young People’s Survey Findings

Young people were asked to read three short scenarios (see Appendix A), one each focused on low mood/anxiety, self-harm and suicide, and to answer a range of questions including what they thought could have caused these issues.

**Low mood/Anxiety**

Respondents were asked to indicate reasons (other than those stated in the scenario) that the boy in the scenario might suffer from low mood/anxiety.

- Young people perceive that low mood and anxiety can be triggered from multiple feelings and circumstances; the most commonly endorsed reason for low mood/anxiety was “mental health/illness”.
- There was no difference between males and females answers to this question in general.
Table 12. Reasons for low mood/anxiety

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health/illness (e.g., depression)</td>
<td>66</td>
</tr>
<tr>
<td>Problems at home</td>
<td></td>
</tr>
<tr>
<td>Low self-esteem</td>
<td></td>
</tr>
<tr>
<td>Falling out with friends</td>
<td></td>
</tr>
<tr>
<td>Lonely</td>
<td></td>
</tr>
<tr>
<td>Losing a loved one</td>
<td></td>
</tr>
<tr>
<td>Worries about body image</td>
<td></td>
</tr>
<tr>
<td>Relationship break-up</td>
<td></td>
</tr>
<tr>
<td>Drug use</td>
<td></td>
</tr>
<tr>
<td>Physical illness</td>
<td></td>
</tr>
<tr>
<td>Alcohol use</td>
<td></td>
</tr>
<tr>
<td>Hating school</td>
<td></td>
</tr>
<tr>
<td>Nothing in particular, some...</td>
<td></td>
</tr>
<tr>
<td>No attention from their parents</td>
<td></td>
</tr>
<tr>
<td>Social media</td>
<td></td>
</tr>
<tr>
<td>Obesity*</td>
<td></td>
</tr>
</tbody>
</table>

*reasons added by respondents in ‘other’

Self-harm

Respondents were asked to indicate reasons (other than those stated in the scenario) that the girl in the scenario might self-harm.

- The most common reason chosen was “Mental health/illness (e.g. depression)”; 66 respondents.
- There was no difference between males and females answers to this question in general.
**Suicide**

Respondents were asked to indicate *reasons* (other than those stated in the scenario) that the boy in the scenario might feel suicidal.

- Young people perceive suicide to be something that can be triggered from multiple feelings and circumstances; the most commonly endorsed reason for self-harm was "mental health/illness".
- It is encouraging that a relatively small proportion of the respondents chose reasons that indicate that suicide is perceived as a trivial behaviour that is done "to impress their friends".
- These results suggest a gender difference in that males were more likely than females to suggest this is a reason for suicide attempt.
Table 1. Reasons for suicide

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>45</td>
</tr>
<tr>
<td>Problems at home</td>
<td>37</td>
</tr>
<tr>
<td>Losing a loved one</td>
<td>31</td>
</tr>
<tr>
<td>Falling out with friends</td>
<td>27</td>
</tr>
<tr>
<td>Drug use</td>
<td>21</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>23</td>
</tr>
<tr>
<td>Being the victim of abuse</td>
<td>19</td>
</tr>
<tr>
<td>Exam/school work worries</td>
<td>18</td>
</tr>
<tr>
<td>Worry about body image</td>
<td>17</td>
</tr>
<tr>
<td>Worry about sexuality</td>
<td>16</td>
</tr>
<tr>
<td>To impress their friends</td>
<td>13</td>
</tr>
<tr>
<td>Physical illness</td>
<td>12</td>
</tr>
</tbody>
</table>

Analysis of the top 6 triggers across the categories highlight:

- Mental health (for example depression) was given as the main trigger for low mood/anxiety, self-harm and depression. This is extremely encouraging as it indicates that young people recognise the significance of mental ill-health or mental illness in all three scenarios.
- Young people highlighted the significance of relationships, or absence of relationships, in low mood/anxiety, self-harm and suicide. Problems at home, falling out with friends, relationship problems, loneliness and losing a loved one were all cited as important triggers.
- Low self-esteem was in the top six triggers for low mood/anxiety and self-harm.
- Exam worries was in the top six triggers for low mood/anxiety only.
- Being the victim of abuse was in the top six triggers for self-harm only.
- Drug use was in the top six triggers for suicide only.
- Perhaps unsurprisingly, worries about sexuality and gender identity were more prominent than in the adult population.

Qualitative findings

- These insights are drawn from professionals working in various capacities with young people in the borough and parents.
- Analysis of this data illustrate that these groups understood the primary causes of distress and anxiety in young people as including: problems at home (including family conflict, parental mental health, academic pressure); worries about education; friendship issues; bullying (including cyber-bullying); the pressure of social media.

“Some of them have got families that are really high pressured and if they’re not working until ten o’clock at night then they think they’re failing. Then you’ve got some where there’s family breakups, parents arguing, problems with step-parents, parents, siblings. It can be anything and everything.” (Professional)
“Cyber-bullying is quite a big thing that I’ve seen. Young people aren’t coping with it any better. There’s more and more technology and no education about how to deal with it.” (Professional)

“School was one of the main triggers, when she [daughter] went into Y12 they suddenly started going on about UCAS forms and University and she wasn’t even sure that’s what she wanted. To think of leaving home is a big thing for her, and at just 16 they started pushing this on to her, and having mocks for her ASs in that first term, it just got too much for her.” (Fabien, mother)

3.4 Discussion

- Adult participants in this consultation reported experiencing a combination of challenging life events that triggered or compounded serious mental ill-health issues including depression, self-harm and suicide. This reflects the academic research in this area.
- Self-esteem, loneliness and mental health issues (other than depression, self-harm and suicide) were identified in the adult survey by over half of respondents as triggers.
- Analysis showed that men and women aged between 45-54 years old were more likely than other age groups to indicate that benefits, being the victim of abuse, housing problems, physical ill-health were triggers. Debt and body image were also issues for this group. This is a toxic combination of challenges and provides insight into their elevated level of suicide risk.
- The qualitative data illustrated the importance of living with multiple mental health issues, social isolation and employment issues.
- Combined, this illustrates the importance of addressing social as well as the psychological and clinical needs of those who may be depressed, self-harm and/or suicidal.
- Participants did access a limited range of services, other than those for mental health. However, not as many as expected, given their high levels of need. Problems knowing where to go for support, communication issues and finding it difficult to communicate due to a lack of confidence could help explain this.
- Young people identified the significance of mental health issues in young people’s low mood/anxiety, self-harm and suicide. This demonstrates a high level of mental health literacy amongst the young respondents.
- Experiences of conflict in relationships such as problems at home and falling out with friends were considered key triggers, as was loneliness.
Chapter Four

4.1 Awareness of Local Advice and Support Available to Deal with their Depression/ Self-harm and/or Suicidal Feelings

➢ There is a lack of published academic research that explores public knowledge of statutory health and community based health services. Perhaps the only area where this is given much thought or attention is in research that explores migrants understanding of health care delivery. In this research, it is accepted that one of the ways refugee and migrant health can be improved is if they are taught how the public health system works.
➢ There is an assumption that British nationals, because they are socialised into the public health care system will have developed an understanding of how it works and how to access it.
➢ This is problematic in two ways. Firstly, although GPs are the gateway into the health service, secondary care services are often poorly understood, complex and remain hidden from public view.
➢ Secondly, the increased, and increasing, role of multiple forms of service delivery, for example, via social enterprises, the community and voluntary sector and other non-profit organisations plus private healthcare providers, could further cloud public understanding of local services.

What research does highlight, however, is that the majority of people surveyed for the Adult Psychiatric Morbidity in England household survey who self-reported depression, self-harm and suicide ideation and behaviours were not receiving treatment for these issues. Indeed, it highlighted that:

➢ 82% of individuals who self-reported with mixed anxiety and depression were not receiving treatment, and furthermore that 50% who self-reported with a depressive episode were not receiving treatment\(^{48}\).
➢ Of the respondents who disclosed self-harm 30% of men and 29% of women had received help with physical injuries and 35% of men and 47% of women had received psychological help (from a psychiatrist, psychologist or counsellor)\(^{49}\).
➢ 63% of men and 58% of women said they had sought help after their last suicide attempt\(^{50}\).
➢ Among men who had ever attempted suicide, 35% had gone to a hospital or specialist medical or psychiatric service; 30% had sought help from a GP; and 23% had sought help from family, friends or neighbours. These were also the most commonly reported sources of help for women\(^{51}\).

\(^{50}\) ibid
\(^{51}\) ibid
Relatively few people sought help from community-based (1%) or local authority (2%) run services\textsuperscript{52}.

Younger adults were more likely to seek help than older adults: 70% of those aged 16-34 reported seeking help after an attempted suicide compared to 51% of those aged 55 and over\textsuperscript{53}.

This ‘treatment gap’ is not just applicable to adults as research about treatment in children reports similar patterns with only 25-35% of children with a diagnosable mental health condition (not just depressive illnesses) accessing support\textsuperscript{54}.

It is clear that knowledge of services is only one aspect that might explain why so many individuals do not access support and services for depression, self-harm and suicide. This chapter, however, will present key findings from the consultation that shed light on the extent of people’s knowledge of services\textsuperscript{55} and what reasons might prevent people from accessing them.

### 4.1.1 Knowledge of Local Services

Given the profile of the respondents to the adult survey and the high levels of depression, self-harm and suicidal ideation or behaviour the knowledge of local services was very limited.

Table 15 shows the top six services respondents reported they had ‘Used’ or ‘Know about, but not used’ in relation to their depression, self-harm and/or suicidal ideation or behaviours.

**Table 15. Top 5 Kingston services respondents knew of or had used**

<table>
<thead>
<tr>
<th>Service</th>
<th>Used (%)</th>
<th>Know about, but not used (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td>48.8</td>
<td>32.5</td>
<td>81.3</td>
</tr>
<tr>
<td>Kingston Samaritans</td>
<td>16.2</td>
<td>44</td>
<td>60.2</td>
</tr>
<tr>
<td>Mind in Kingston</td>
<td>4.6</td>
<td>37.2</td>
<td>41.8</td>
</tr>
<tr>
<td>Kingston IAPT Service</td>
<td>23.2</td>
<td>16.2</td>
<td>39.4</td>
</tr>
<tr>
<td>Community Mental Health Team</td>
<td>25.5</td>
<td>6.9</td>
<td>32.4</td>
</tr>
</tbody>
</table>

The table shows that:
- The most commonly used service by respondents was A&E.
- The most known about service was Samaritans.
- The service with the biggest gap between knowledge and use was Mind in Kingston. 37.2% knew about the service but only 4.6% had used.

\textsuperscript{52} Ibid
\textsuperscript{53} Ibid
\textsuperscript{55} Not every service available in Kingston was listed, but 21 were included from across the statutory and community based services that could be accessible to people experiencing depression, self-harm and suicide.
Only A&E and Samaritans were known about and used by more than 50% of respondents. Levels of knowledge and use of the other 16 services included in the survey were very low with an average of 1.5 respondents using these services and 63% ‘Never heard of’.

This list included Kingston Relate (41.8% Never heard of, 34.8% Heard of, don’t know about). Important given the significance of relationship issues/breakdown in self-harm and suicide.

4.1.2 Barriers to Help-seeking
Respondents were asked about how they felt about seeking help from others with regards to their problems with depression, self-harm and suicidal feelings; they were asked to indicate how much they agreed with these statements.

Generally these responses showed that for various reasons, respondents would avoid seeking help from others.

- Most respondents felt that they didn’t want to burden others with their problems.
- Less than half of respondents were worried about the stigma attached to seeking help.
- More than half said they would wait as long as possible before seeking help.
- More than half ‘agreed’ or ‘strongly agreed’ that they won’t be taken seriously or be believed.
- Nearly two thirds ‘agreed’ or ‘strongly agreed’ that they would lose control of the situation.
- Over two-thirds ‘agreed’ or ‘strongly agreed’ that they would try to deal with the situation first, before asking for help.
- Most respondents disagreed that they would wait for someone to offer help, rather than seeking it for themselves.
Respondents were asked to provide additional comments on what would prevent them from seeking help. The most common reasons included: concerns that employers would find out; previous negative experiences of help-seeking; not having the language to explain their feelings; being unable to seek help when at their worst.

- “If you have had problem with depression in my work industry they will not employ you so you need to keep it secret.”
- “1. Previous negative responses to asking for help; 2. The complexity of my mental health issues; 3. Difficulty in finding the language to express feelings, particularly when very distressed.”
- “I’ve tried to get help so many times before and it always screw up, I’ve given up now, I’d rather not waste my time and face more rejection and humiliation.”
- “I’ve sought help before and have received some and it sort of helped but I am reluctant to seek further help as there doesn’t seem to be any further help out there unless I get considerably worse.”
4.1.3 Encouraging Help-seeking
Respondents were asked what would make it more likely that they sought help in future. A range of suggestions were provided but key themes were:

- **Making it easier to contact services and book appointments**
  “Online GP booking would have been amazing, time to read and respond and pick when struggling to comprehend things. More info about the ability to self-refer to IAPT online would also have helped.”

- **Feeling confident that making contact would lead to appropriate help and support quickly**
  “The guarantee of receiving help when I need it and coming to some sort of stable conclusion/resolution.”
  “Quicker access to services such as counselling - long waiting times; need a walk-in style service – e.g. Samaritans and 'listening services' offered at some churches - but they are not 'qualified profs'.”

- **Being taken seriously and consulted on treatment options**
  Reassurance from GPs that they understand; that they respect my insight into my own illness and treatment.

- **Less stigma about depression, self-harm and suicide**

4.1.4 Barriers to Accessing Local Services
Respondents were asked to think about services that they had thought about using before, but did not end up accessing, and the reasons for this. Respondents were asked to enter details of up to three services where this applied.

- Respondents had found it difficult to access 15 different local services that they wanted to access.

Table 16. Services not successfully accessed (adult survey)

<table>
<thead>
<tr>
<th>Service not successfully accessed</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Mental Health Team (CMHT), Kingston</strong></td>
<td>9</td>
</tr>
<tr>
<td><strong>Kingston Community Wellbeing Service</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Kingston Women’s Centre</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Accident &amp; Emergency department, Kingston Hospital</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Samaritans, Kingston</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>MIND, Kingston</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Relate, Kingston</strong></td>
<td>3</td>
</tr>
</tbody>
</table>
The top five reasons given for not being able to access services they wanted were:

1. I have had a bad experience with them in the past.
2. They have long waiting times/lists.
3. I wasn’t treated seriously/believed.
4. I didn’t feel comfortable talking to them.
5. I was unable to contact them.

Further insights can be gathered from some of the comments written by respondents on this issue:

- “They didn’t answer the phone to me once after countless phone calls at varying times of the day and week. Every single call went to voicemail and I wasn’t comfortable leaving a message so I gave up and didn’t get any help.”
- “Didn’t really know how to access them. Was scared about being forced to take medication or being sectioned. My health is very variable and when bad don’t have the resources to contact and when ok feel I don’t need them or they wouldn’t be interested in helping me.”
- “Didn’t want to bother them with my problems. Thought there were others more deserving of their help.”
- “I don’t really understand what they do. Once spoke to someone on the phone who was helpful but ultimately didn’t go anywhere. Always feel they are for people with more serious problems than me. Feel there is nothing for people like me.”
- “They saw me once and after assuring me they’d contact me for a follow up session they didn’t. I felt uncomfortable speaking to them about a follow up appointment when I’d not heard anything as I find phone conversations difficult.”
4.1.5 Barriers to seeking help from a G.P.
Respondents were also asked about reasons that might prevent them from seeking help from their G.P. with regards to depression, self-harm and suicidal feelings. They were asked to indicate to what extent they agreed/disagreed with potential barriers presented to them; they could also indicate that they neither agreed nor disagreed.

Table 17. Barriers to seeking help from GP.

<table>
<thead>
<tr>
<th>Barriers to seeking help from G.P.</th>
<th>% respondents who agree</th>
<th>% respondents who disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel like my GP can't help me with mental/emotional health issues.</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>I don't have enough time to talk to the GP about these things.</td>
<td>41.8</td>
<td>58.2</td>
</tr>
<tr>
<td>I feel too embarrassed or ashamed about my mental/emotional health to talk to my GP.</td>
<td>41.8</td>
<td>58.2</td>
</tr>
<tr>
<td>My GP is unapproachable/unfriendly so I don't want to talk to them about these things.</td>
<td>25.5</td>
<td>74.5</td>
</tr>
<tr>
<td>I am worried that what I tell my GP might not stay confidential.</td>
<td>18.6</td>
<td>81.4</td>
</tr>
</tbody>
</table>

- Respondents were confident that their confidentiality would be protected and three quarters of them disagreed that their GP was unapproachable.
- Just over 40% reported that time was an issue (this is discussed in more detail in Chapter Five). Men were twice as likely to say this as women.
- Just over 40% reported being embarrassed to mention mental health to their GP. Those who were 18-24 or 65+ were more likely to agree with this.
- The most common barrier was that respondents felt that their G.P. could not help with mental/emotional health issues. Men, single people and those aged 18-24 or 44-55 and not born in the UK were more likely to hold this view.

4.2 Qualitative Findings
- 15 of the 16 participants had been diagnosed by a GP.
- Eight out of the 16 were, or had been in the past, under the care of the Community Mental Health Team.
- Five reported being referred to, or using, the Kingston IAPT Service.
Three participants had used the Recovery College.
Eight participants had used other services including Kingston Women’s Centre, activities at Kingston MIND, Kingston Rise, activities run by Hestia Housing. Two participants also reported using the Rethink café, which has not run for some time. Two reported using Kingston Samaritans.
Four of the 11 family members used Kingston Carers’ Network.

Experiences of these services is discussed in Chapter Five.

4.2.1 General access issues
Echoing the qualitative comments in the survey, a number of participants mentioned the lack of information about the services available in the borough.
It was noted that the Royal Borough of Kingston website is hard to navigate and that lack of knowledge about services made it difficult for people to know who to contact.
The idea of having a booklet or a directory available across the borough was suggested lots of times by participants, although it was acknowledged that it would be a challenge to keep this up to date due to service and staff changes.
There is an electronic document already available online but this is very out of date.

4.2.2 Access to Primary Care
Generally people were satisfied to their level of access to the GP, although there were concerns about appointment wait times, with waits of up to three weeks reported. This was particularly the case for people who were experiencing crisis.

Professional 1: “They sit on big waiting lists before we [IAPT] see them and if they call in crisis while they’re waiting to see us we tell people where they can go and we tell them they can go and see the GP, and there’s a lot of sniggering because they have to wait two weeks for an appointment and they never see the same person.”

Professional 2: “I think some of the practices would see someone if they know they are personality disordered and self-harming.”

Professional 1:” I don’t think that’s true for all practices, and think they [service user] have probably tried to get appointments before and so don’t even bother.”

One participant disclosed not reporting his depression and suicidal feelings to his GP. This was because he did not feel that a GP was the right person to talk to about his mental health. He was not aware that he could self-refer to access other local services.
Interview participants in their 40s or 50s who had been struggling with depression, self-harm and/or suicide described not engaging with GPs because they felt strongly that they couldn’t help them.
Younger interview participants were less likely to understand the role the GP played in access to services and/or believe that there was little a GP could do to help with their feelings.
4.2.3 Access to Secondary Services

- Waiting lists/waiting times for Kingston IAPT Service, CMHT and community counselling provision was highlighted by participants as an important issue, particularly for those in crisis (discussed in Chapter Five).
- Some individuals were unable to access services because they do not exist.
- Much of the psychological help and support available to people suffering from depression, self-harm or suicide is time limited, and, so if help is accessed at all it is limited to a certain number of sessions (six, 10, 12 or 14 weeks were in the data). It was raised repeatedly across the interviews and focus groups (by professionals, clinicians, service users, family members) that this not enough for people with complex issues, such as those with a mental health diagnosis but who do not reach the CMHT threshold, who do need longer term therapeutic care.

“The issues that people present with for counselling that has changed, I haven’t got any figures to show that, but we are getting more women with a mental health diagnosis, particularly borderline personality disorder. I think that’s the kind of diagnosis of the moment [general agreement in the room] I mean it seems like a very popular diagnosis. I don’t know whether that’s because there used to be more help in the NHS for people with a mental health diagnosis. I mean my sense is that if we [CVS organisation] don’t take them on, no-one will take them on. There’s little provision for long-term counselling within the NHS.” (Professional, focus group)

“The main thing that we notice a lack of is long term, low cost or free counselling services. So there’s a lot of short term options, which is great, and we use them and work well with them together, but there’s a lot of people where it’s the same issue over and over again, lots of complex background issues, and there are more services for women than men” (Professional, focus group)

- This gap, according to professionals, has opened up for a number of reasons that include 1. Loss of the psychotherapy service at Tolworth hospital 2. Changes to the CMHT threshold 3. Demand for CMHT services and stress in statutory mental health services 4. Demand that services promote quick recovery in patients/service users, and not enough recognition of the impact on trauma 5. Changes to pattern of diagnosis.

“We used to have a psychotherapy service in Tolworth, so we’ve only ever seen people for a short amount of time and there would be a certain number of people who would engage with that and found that stabilising and it was a preparation for further work that they needed and that they wanted, and we used to be able to refer them over there, even though it was quite a long wait, and now we have no-where to send people after their 12 or 16 weeks.” (Professional, focus group)
"The [CMHT] threshold has definitely changed because they are pushing...to get their caseloads down and discharge everyone and in one sense because they’re saying we’re focusing on the more extreme end, rather than having a whole load of patients in out-patients being seen every six months. So I think the CMHT are much geared towards schizophrenia and bipolar. Which I do understand. And in some ways the IAPT service was developed to fit that but it’s predominately CBT it’s not set up for personality issues, it’s not set up for long term chronic attachment issues, it’s not set up for people who need long term counselling, but not the level of CMHT, but they need long term interventions” (Professional, focus group)

Professional: “You can’t get somebody with such complex problems who has tried to end their life back to functioning in 12 weeks. They need longer term treatment.”

Interviewer: “Is there anywhere that you can send them?”

Professional: “No, nowhere.” (Focus group)

- The gap in service is having an impact on those providing community mental health services, those working in community and voluntary sector organisations that provide counselling services and those who find themselves in this situation (discussed in Chapter Five).

Professional 1: “We are staffed almost entirely by trainee counsellors, a lot may have qualified but they are gaining their accreditation, so a lot of people who are gaining their experience and it’s very specialised area working with someone with a mental health diagnosis, so what we offer, we have some counsellors who are able to hold on to clients with personality disorder very well but what often happens is that they don’t manage to hold on to the client and it will end before they’ve really had a chance to gain anything much from the sessions. And probably we’ve lost them.....What happens is if you’ve got a complex issue you are going to be on the waiting list even longer because you’re waiting for a counsellor who’s got enough experience to take you on.”

Professional 2: “It’s the same with us, because I can’t give them to someone who is only in their second year of training but people who are robust enough to cope with the issues that come. I am actually erring on, and this is me just thinking out loud, not taking on certain clients whereas [name of organisation] used to take anybody, because I’m clinically responsible for the practice I’m thinking I’m not sure I want to do this, it shouldn’t be our [voluntary service] responsibility, I don’t think it should responsibility, it should be statutory responsibility. I think it should be the NHS. I am wondering how we can go forward with this. It’s those people are at risk of suicide and self-harm.” (Focus group)

- In absence of a long term therapeutic service, professionals were patching together a service when and where they could, so, for example, giving second rounds of treatment, making referrals to other services, and hoping for the best.

- Those in need of help were described themselves as ‘hopping from service to service, getting 12 weeks here, or six weeks there, none of it dealing with the actual
issues’ (Brian). This was also identified by community and voluntary sector organisations.

“We have a number of clients, who seem to be, that more and more people are getting discharged from the CMHT and ring us on a daily basis and then staff have to decide what would be helpful to them at the time, so it might be that we say ring the Samaritans or this service to kind of get you through today, but the CMHT have said that your needs are not complex enough. So these people are unsupported and just seem to be going round all of the services locally.” (Professional, focus group)

- Lack of action on this issue could, as suggested in the data, leave people with complex problems with even fewer places to get help.

Other gaps identified in the data were:

**Services for men**

- Given the gender profile of completed suicides, it was noted by professionals across the focus groups that additional effort was needed to encourage men to seek help.
- In particular there was concern at that services should think about the specific needs of men if they were committed to reducing inequality in this area and reorganise services to meet those needs56.
- Professionals highlighted that there is no shortage of men in private practice, and that they are often very solution focused, and not as willing to revisit historic trauma.
- However, not all men, and particularly men who are most at risk of depression, self-harm and suicide, can afford private treatment.

“I don’t know if there are any men’s services. For women there are more options, but they’re still limited. Where are the services that support men’s mental health?” (Professional, focus group)

“There aren’t enough services specifically for men and it’s an issue that we’ve discussed and discussed but it’s finding ways to engage with men. Maybe we need counsellors at football clubs and pubs.” (Professional, focus group)

**Services for people with autistic spectrum difficulties**

- It was felt that this group struggle to access services and were considered hard to treat.

“Clients with autistic spectrum difficulties are particularly vulnerable to suicide and we struggle to provide other services.” (Professional, focus group)

**Services for people with mental health and substance misuse issues**

56 Developing innovative approaches to working with men was one of the recommendations of the Samaritans *Men, Suicide and Society* report published in 2010.
The data showed that there was concern about access to treatment for individuals who presented with both depression, self-harm and/or suicide issues and substance misuse problems.

People working in community based services, and responsible for other services in the community and voluntary sector, were aware that this group found it difficult to access help, even if they were assessed as high risk.

“Just a week ago or go, I was talking to a GP about someone who had taken an overdose and even they’re aware because he said there was no point referring him to the CMHT because of his alcohol.” (Professional, focus group.)

People with personal experience and those who were affected by a family member’s depression, self-harm and suicide also talked about this during interview. One had paid for her son to go into a private rehabilitation clinic in order that he could access treatment in Kingston. The other, who has tried to take his own life on two previous occasions, is now unable to access any services because he is an alcoholic.

Although there are clinical reasons for excluding people with substance misuse issues from treatment for depression, self-harm and/or suicide, this does leave a population, often very vulnerable men, without support.

**Black, Asian, Minority Ethnic and Refugee (BAMER) residents**

Professionals reported that they were not seeing proportionate number of BAMER residents accessing either adult or child services.

Professionals working with refugee and migrant communities in Kingston felt that a lack of understanding of the public health system, not speaking English and the stigma around mental health in some populations were preventing people seeking and accessing the treatment needed.

It was also noted that some refugees and migrants needed specialist help because they may have experienced war, torture, trafficking and other forms of extreme adverse life event. The provision of specialist help in the borough is limited.

This consultation is unable to provide any insights into why British-born Black, Asian and other minorities are not presenting to services in numbers proportionate to their presence in the population because these groups engaged with the consultation in very low numbers.

Research shows, however, that this disparity is a national issue and is caused by socio-cultural (health beliefs and mistrust of services), systemic (lack of cultural competence in mental health services) and individual (not acting on symptoms) barriers.

57 The mental health needs of refugees, asylum seekers and migrants is discussed in great detail in the Asylum seeker, Refugee and Migrant needs assessment published in 2014 by Refugee Action Kingston and the Public Health Team.

Support for families

- This was highlighted particularly in the focus group with professionals working in the community and voluntary sector, and, of course, by families themselves.

Peter: “It feels there isn’t a similar amount of support for family members and I think that could have been a bit better.”

Interviewer: “What kind of support would have benefitted you do you think?”

Peter: “Counselling or something like that. At the time I felt like I could crash out myself, because [name of wife] didn’t just become ill on a Friday, it had been building up for months and months and months and things were getting quite stressful and I haven’t really dealt with it. I do get a bit teary talking about it, it’s been a bit tough. So that would be helpful for people, to have some support.”

Summary

- Given the high levels of depression, self-harm and/or suicide ideation and behaviour in the adult survey respondents there was only limited knowledge about local services.
- There are many significant barriers to help-seeking. Previous negative experiences was one of the most significant but others included not being able to articulate feelings, worrying about employers finding about help seeking and treatment, concerns about losing control and not feeling like they will be believed.
- Having bad experiences in the past, long waiting lists, not being taken seriously/believed, not feeling comfortable talking to services and not knowing how to contact them were the top five reasons why respondents were not able to access the services they wanted to.
- 65% of respondents did not feel that their GP can help them with emotional issues. Men, single people and those aged 18-24 or 44-55 and not born in the UK were more likely to hold this view. Men, living alone in middle life are a particularly high risk group for suicide.
- A number of gaps were identified in current services. The largest was the lack of long term counselling/therapeutic services for people with a mental health diagnosis who did not meet the current threshold for the CMHT. There was concern that this group were at risk from self-harm and suicide.
- Other gaps were: lack of services that appealed specifically to men; lack of services for individuals with a mental health issue and substance misuse problem; access to services for BAMER groups; concerns about what was available for those with autistic spectrum difficulties; support for families coping with a relative who is depressed, self-harming and/or suicidal (discussed in more detail in Chapter Five).
4.3 Young People
Results from the survey showed that:

- It was evident from the list compiled for the survey that there was no specific community-based service that helped young people with emotional difficulties.
- The service most commonly known about was “Doctor”.
- The least well-known service was “Say Goodbye Project”.
- There were no services suggested that none of the respondents knew of.
- Six of the suggested services had been heard of by more than half of the respondents – Doctor, School nurses, School counsellors, KU19 services, Private Counsellors and Kingston Youth Services.
- Increasingly, more services for children and young people are being moved online but this survey shows that only 24 respondents knew about Talk Safe. None had used it, but there was a low use of services overall. The most used services were ‘Doctor’, ‘KU19 services’ and ‘School nurse’.

Table 18. Knowledge of local services

<table>
<thead>
<tr>
<th>Knowledge of local services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents who have heard of services</td>
</tr>
</tbody>
</table>

4.3.1 Seeking Help
The survey asked young people where the three young people in the suffering from low mood/anxiety, self-harm and suicide in the survey should seek help.

Seeking help for low mood/anxiety
Respondents were asked where they think a young person could get help for low mood/anxiety.

- The most common service respondents chose was “Child and Adolescent Mental Health Services (CAMHS)” (38 respondents.)
- Six respondents said “I don’t know”
  ⇒ All of these respondents were male
- Twenty-one respondents chose “Doctor”
  ⇒ Most of these respondents were male (18 respondents)
The least common suggested service was “Young Livin’ Bus” (two respondents).

Three respondents suggested ‘other’ places to seek help for self-harm, which included “parents” and “family members”.

Table 19. Help-seeking for low mood/anxiety

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Mental Health Services (CAMHS)</td>
<td>33 respondents</td>
</tr>
<tr>
<td>Young Livin’ Bus</td>
<td>4 respondents</td>
</tr>
<tr>
<td>Parents</td>
<td>2 respondents</td>
</tr>
<tr>
<td>Samaritans</td>
<td>1 respondent</td>
</tr>
</tbody>
</table>

* added by respondents in ‘other’

Seeking help for self-harm

Respondents were asked where they think a young person could get help for self-harm.

- The most common service respondents chose was “Child and Adolescent Mental Health Services (CAMHS)” (33 respondents.)
- The least common suggested service was “Young Livin’ Bus” (four respondents)
  ⇒ All of these were male
- Three respondents suggested ‘other’ places to seek help for self-harm, which included “parents” and “Samaritans”.

Table 20. Help seeking for self-harm

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Mental Health Services (CAMHS)</td>
<td>33 respondents</td>
</tr>
<tr>
<td>Young Livin’ Bus</td>
<td>4 respondents</td>
</tr>
<tr>
<td>Parents</td>
<td>2 respondents</td>
</tr>
<tr>
<td>Samaritans</td>
<td>1 respondent</td>
</tr>
</tbody>
</table>

* added by respondents in ‘other’
Seeking help for suicide
Respondents were asked where young people might be able to get help following a suicide attempt.
- The most common place was “Counsellor or other therapy provided by the NHS” (33 respondents)
- Eight respondents did not know where a young person could get help.

None of the services were chosen by more than half of respondents. This could suggest that a large proportion of the respondents were not clear on where young people can get help following a suicide attempt.

Table 21. Help-seeking after a suicide attempt

4.3.2 Barriers to Help-seeking
Young people were asked to give their views on why the three young people in the survey suffering from low mood/anxiety, self-harm and suicide might not seek help.

Barriers to seeking help for low mood and anxiety
Respondents were asked what reasons Omar might have for not wanting to seek help about experiencing low mood/anxiety.
- The most common reason chosen was “It won't stay confidential and other people will find out” (41 respondents)
- 15 respondents chose “He'll be in trouble with his parents”
  ⇒ All but one of these respondents were male (14 respondents)
- The least common reason chosen was “He'll be in trouble with the school” (four respondents)
  ⇒ All of these respondents were male.
- One respondent also suggested “People won’t understand him.”

These results show that young people would worry about telling others about low mood/anxiety because others will find out and that there may be consequences of this. This suggests that there is a stigma attached to others knowing about such feelings.

More males than females chose reasons that related to ‘being in trouble’ if others found out about feelings of low mood or anxiety.
Table 22. Barriers to seeking help for low mood/anxiety

<table>
<thead>
<tr>
<th>Barriers to seeking help for low mood/anxiety</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>It won’t stay confidential and other people will find out</td>
<td>41</td>
</tr>
<tr>
<td>It will upset his family if they find out</td>
<td>38</td>
</tr>
<tr>
<td>It will make him feel worse, not better</td>
<td>35</td>
</tr>
<tr>
<td>He’ll be bullied at school</td>
<td>32</td>
</tr>
<tr>
<td>People won’t be bothered about his problems</td>
<td>26</td>
</tr>
<tr>
<td>He won’t be taken seriously, because feeling down is just a way of attention seeking</td>
<td>20</td>
</tr>
<tr>
<td>He should just be able to feel better on his own</td>
<td>19</td>
</tr>
<tr>
<td>He’ll be in trouble with his parents</td>
<td>15</td>
</tr>
<tr>
<td>People are not supposed to talk about this sort of thing</td>
<td>11</td>
</tr>
<tr>
<td>He’ll be in trouble with the school</td>
<td>4</td>
</tr>
<tr>
<td>People won’t understand him*</td>
<td>1</td>
</tr>
</tbody>
</table>

Grey shading indicates more than half of respondents chose this option.

*reasons added by respondents in ‘other’

**Barriers to seeking help for self-harm**

Respondents were asked what reasons a young person might have for not wanting to seek help about self-harming.

- The most common reason chosen was “It will upset her family if they find out”; 51 respondents
- Thirty-nine respondents chose “She’ll be bullied at school”
  - Most of these were male (30 respondents)
- Eighteen respondents chose “She’ll be in trouble with her parents”
  - Most of these were male (14 respondents)
- Eighteen respondents chose “People won’t be bothered about her problems”
  - Most of these were male (14 respondents)
- Twelve respondents chose “People are not supposed to talk about this sort of thing”
  - All but one of these respondents were male (11 respondents)
- Nine respondents chose “She should just be able to stop on her own”
  - Most of these were male (seven respondents)
- The least common reason chosen was “she’ll be in trouble with the school”; (eight respondents)
  - All of these were male

The most commonly endorsed barriers to potential help-seeking seem to be focused on the perceptions and opinions of others and the reactions this will cause, e.g. others being upset, not taking it seriously or bullying as a result of finding out. This indirectly
suggests that stigma of self-harm is an issue for young people, and would stop them from seeking help.

These results also suggest that the male respondents were more likely to think of self-harm as a trivial problem that should not be discussed, and that it is a behavioural trait that ‘Stacey’ should stop.

Table 23. Barriers to seeking help for self-harm

<table>
<thead>
<tr>
<th>Barriers for seeking help for self-harm</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>It will upset her family if they find out</td>
<td>51</td>
</tr>
<tr>
<td>It won’t stay confidential and other people will find out</td>
<td>49</td>
</tr>
<tr>
<td>She won’t be taken seriously, because self-harm is just a way of attention seeking</td>
<td>41</td>
</tr>
<tr>
<td>She’ll be bullied at school</td>
<td>39</td>
</tr>
<tr>
<td>It will make her feel worse, not better</td>
<td>36</td>
</tr>
<tr>
<td>She’ll be in trouble with her parents</td>
<td>24</td>
</tr>
<tr>
<td>People won’t be bothered about her problems</td>
<td>18</td>
</tr>
<tr>
<td>People are not supposed to talk about this sort of thing</td>
<td>12</td>
</tr>
<tr>
<td>She should just be able to stop on her own</td>
<td>9</td>
</tr>
<tr>
<td>She’ll be in trouble with the school</td>
<td>8</td>
</tr>
</tbody>
</table>

Grey shading indicates more than half of respondents chose this option.

Barriers to seeking help after an attempted suicide

Respondents were asked what reasons they thought Michael might have for not wanting to get help following his suicide attempt.

- The most common reason was “It will upset his family if they find out” (44 respondents)
  21 respondents chose “He’ll be in trouble with his parents”
  ⇒ Most of these were male (19 respondents)
- Twenty-six respondents chose “He’ll be bullied at school”
  ⇒ Most of these were male (20 respondents)
- The least common reason was “He’ll be in trouble with the school” (three respondents.)
  ⇒ All three respondents were male.

The most commonly endorsed barriers to potential help-seeking seem to be focused on the perceptions and opinions of others and the reactions this will cause, e.g. others finding out and being upset and bullying as a result. This indirectly suggests that stigma of self-harm is an issue for young people, and would stop them from seeking help.
These results also suggest that the male respondents were more likely to think of suicide as something you may be in trouble for.

Table 24. Barriers to seeking help following a suicide attempt

<table>
<thead>
<tr>
<th>Barriers to seeking help following a suicide attempt</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>It will upset his family if they find out</td>
<td>44</td>
</tr>
<tr>
<td>It won’t stay confidential and other people will find out</td>
<td>43</td>
</tr>
<tr>
<td>It will make him feel worse, not better</td>
<td>34</td>
</tr>
<tr>
<td>He won’t be taken seriously, because self-harm is just a way of attention seeking</td>
<td>28</td>
</tr>
<tr>
<td>People won’t be bothered about his problems</td>
<td>26</td>
</tr>
<tr>
<td>He’ll be bullied at school</td>
<td>26</td>
</tr>
<tr>
<td>He’ll be in trouble with his parents</td>
<td>21</td>
</tr>
<tr>
<td>People are not supposed to talk about this sort of thing</td>
<td>16</td>
</tr>
<tr>
<td>He should just be able to stop on his own</td>
<td>16</td>
</tr>
<tr>
<td>He’ll be in trouble with the school</td>
<td>3</td>
</tr>
</tbody>
</table>

Grey shading indicates more than half of respondents chose this option.

4.3.3 Qualitative Data

- It was highlighted that there was an inconsistency in the types and availability of pastoral support services across the schools in the borough, so not all young people have access to the same level of support.

> “A lot of schools are cutting their support staff because obviously they are having to make cuts and so a lot of support staff are losing their jobs or they’re not replacing them when they leave and actually [budget for support staff used to come from LA but now comes from central for academies and these budgets are being cut]. The best school for their student welfare is the school that has a whole learning support team of about thirty staff and the pastoral care is unbelievable, but that’s not the same in every school.”

(Professional, focus group)

- There was concern that academically high-achieving schools were more reluctant to acknowledge emotional difficulties amongst their pupils and were less likely to have robust support systems in place.

Access to services

- Younger interviewees recollected that they were reluctant to disclose emotional difficulties to teachers because they were concerned about confidentiality and the disclosure having a negative impact on their relationship with them.
“I didn’t think there was anyone I could confide in. I didn’t want to talk to my parents, I still don’t want to talk to my parents. It’s just it’s easier to be able to act at home, rather than them ask all the time and at school I didn’t trust any of the teachers and I didn’t really have the friends because I just couldn’t talk because I was feeling so low or there were a few teachers I liked and I didn’t want to tell them and ruin the relationship, not ruin the relationship, [pause] it felt like it would ruin the relationship. I didn’t want anyone to know and felt that a teacher might let it slip.” (Rachel)

- The data highlighted that a range of adaptations to services have been made to improve accessibility to services for young people including the introduction of the Single Point of Access (SPA) referral system, taking referrals from a larger range of professionals, such as teachers, and providing weekend and evening CAMHS appointments.
- School professionals felt that there had been a rise demand for support with emotional issues, specifically low mood, anxiety and self-harm, over the past few years.
- School professionals felt that increased demand had made it more of a challenge for young people to access services, particularly from CAMHS.
- Professionals working in schools did highlight that despite the introduction of the SPA it would be helpful if there could be a closer working relationship between CAMHS professionals and school staff. In particular, concern was raised about supporting young people on CAMHS waiting lists while they were at school and awaiting treatment.
- Concern was expressed about the low levels of mental health knowledge amongst parents.
- Access to treatment for those not transferring into adult mental health services, but being referred for continuing treatment in community based services was highlighted as a gap (discussed in Chapter Five).
- Access to treatment for young people not attending school. This was a group identified as difficult to engage by professionals and it is not clear if any additional efforts are being made to identify depression, self-harm and/or suicidal ideation or behaviours in this group.

Summary Young People

- There is a lack of specialist community-based emotional support services for young people.
- Young people were most aware of Doctor, School nurses and School counsellors.
- There is a lot of differentiation amongst pastoral support provided across schools in the borough. This affects young people’s access to informal support and treatment.
- The data showed that young people feel that low mood/anxiety, self-harm and suicide is best treated by professionals in the public health system.
- The data indicate that the two key things preventing young people accessing help is upsetting family members concerns about confidentiality. This is significant given that, unlike sexual health, young people are unable to access
mental health services confidentially. This, therefore, is a significant barrier to help-seeking.

- The results suggest that stigma and concerns about what others would think and do (i.e being bullied) also prevent young people from seeking help. Boys were more likely to express these views that girls.
- Boys were also more likely to think that they would be in trouble if they sought help for low mood/anxiety, self-harm and suicide.
- Young people seemed unsure who could provide help after suicide attempt.
- Efforts have been made to make mental health services more accessible to young people.
- Gaps include young people not at school and young people making the transition into community-based services after they turn 18.

4.4 Discussion

- The data highlight that there is a lack of knowledge and understanding on local services available to help those with depression, self-harm and/or suicidal ideation or behaviours.
- There are a number of barriers that prevent people from seeking help with their depression, self-harm and/or suicidal ideation or behaviours including previous negative experiences (discussed further in Chapter Five), concerns about employers finding out, worries about not being believed and losing control of the situation.
- Over two thirds of respondents stated that they would try to sort the situation out themselves first before seeking help, but this has implications for severity of depression, self-harm and/or suicidal ideation services are presented with.
- Having prior negative experiences did emerge as a significant barrier that stopped people from accessing services.
- Struggling to communicate effectively with services due to poor/non-existent responses from services, long waiting times and not being sure who to contact were another barrier to accessing services.
- 65% of respondents to the adult survey, and more men than women, indicated that they did not feel a GP was able to provide them with help for emotional issues. This may, in part, explain the shockingly low rates of treatment for depression indicated by the APMS survey in 2007.
- There are a number of gaps in services that mean that not everyone has the same level of access to services in Kingston.
- The research has also highlighted that the lack of long-term counselling provision that is free at the point of need has resulted in an important treatment gap that is preventing some from a full recovery from depression, self-harm and/or suicidal ideation.
- Having someone they can trust is absolutely vital to the process of help-seeking for young people. Young people’s concerns about confidentiality and causing distress to family need to be addressed as both are highlighted as key reasons why a young person would not seek help.
- Boys were more likely than girls to indicate that ‘getting into trouble’ would be a barrier to help seeking for depression, self-harm and after a suicide attempt.
They were also more likely to think that emotional distress was something you could ‘get over’ alone and that self-harm could be triggered by a desire to ‘impress others’.

- Young people felt that the best source of support for other in emotional distress was CAMHS.
Chapter Five

5.1 Experience of local services and community support

Published academic research on the experiences of services for people experiencing depression, self-harm and/or suicidal ideation or behaviours provides key insights into what constitutes positive help seeking and/or treatment. It shows:

- 80% of those treated for depression remain in primary care. The patient/doctor relationship is absolutely critical in a sufferer’s willingness to disclose and work with doctors in treatment.
- Individuals value being believed and listened to by professionals and having their views in treatment heard and considered.
- Individuals want to be treated with empathy by professionals when they seek help.
- Issues in the literature that may prevent this include: lack of time during consultations to disclose emotional issues; a lack of understanding of mental health issues by GPs; not listening to patients and not consulting them about their care; difficulty or delays in making onward referrals where necessary; feelings of helplessness amongst GPs, particularly those who understand depression as a normal response to difficult life events/circumstances rather than as a biomedical condition\textsuperscript{59,60}.
- Research on experiences of services for those who self-harm have primarily focused on the population who seek treatment in accident and emergency. This is perhaps understandable given the ‘hidden’ nature of most self-harm but does provide only a limited insight into this issue.
- Again, this research highlights the importance of having staff who believe people presenting with self-harm injuries, who listen to them and treat them empathetically.
- Provision of information about treatment results in better outcomes.
- Long waiting times can leave individuals feeling anxious and frightened.
- Lack of empathy from clinical staff, including perceived threats and routine humiliations are common reasons for negative experiences.
- Research shows that clinical staff can have a poor understanding of self-harm and that junior clinicians are often responsible for undertaking


assessments. In addition, it is noted that staff can focus on treating physical injuries and avoid the psychological.

- There is quite a limited body of published research that examines young people’s experiences of services.
- What is known is that, like adults, children and young people value help where they are listened to, are not judged, have their concerns treated confidentially, where the advisors are independent of family, friends and school and are professional and experts.
- Young people often feel listened to but not heard, by services and worry that their confidentiality is going to be compromised (as discussed in Chapter Four).

5.2 Findings from the adult survey

Respondents were asked to indicate which local services most and least helpful.

- 12 respondents had not used any local services
- 10 respondents did not find any local services they used helpful
- Three respondents found Kingston Women’s Centre most helpful
- Three respondents found Kingston IAPT Service most helpful
- Each of the following were found to be most helpful by one respondent: Accident & Emergency department Kingston Hospital, Community Mental Health Team (CMHT), Samaritans, MIND, South West London and St George’s Mental Health Trust.
- Four respondents did not find anything unhelpful about services they had used.
- Five respondents found Community Mental Health Team (CMHT), Kingston least helpful.
- Five respondents found Kingston IAPT Service least helpful.
- Each of the following were found to be least helpful by one respondent; Family Adolescent and Child Team (FACT), Kingston Women’s Centre, Relate, Kingston, South West London and St George’s Mental Health Trust.

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Analysis of the comments provided shows that the primary reasons given for services being considered ‘helpful’ was that they made them feel supported, less alone, were kind and non-judgemental and communicated effectively.

- “There is a number I can ring if things go bad, and they'll let my psychiatrist know. I don't feel quite so alone and scared.”
- “The counsellor I had was very good and I trusted her fully.”
- “They kept in contact during the referral stage; each step was easy and they reassured me through each step; they gave me choices to find the best solution for me and they provided effective therapy.”
- “To help you find different ways to stay positive and to understand what’s going on inside your head and how to communicate with those close to you without feeling ashamed.”

The primary reasons respondents gave for these services being considered ‘least helpful’ were a lack of understanding from professionals, poor service (poor communication, long waiting list, bad timekeeping), perception that service did not meet their needs and lack of integrated care.

- “They forgot about me. Told to call about a course & called for nearly ONE YEAR & no-one seemed to know anything. Initial telephone assessment not helpful or sufficient. Too large groups.”
- “The person I spoke to lacked understanding and re-worded what I said as if to mould it into a textbook definition so she could get things over and done with. I never went back.”
- “Like any service, it was down to an individual. My psychiatric nurse only saw me about once every few months, and always kept me waiting for up to an hour.”
- “My experiences with Kingston CMHT have been desultory and distressing, characterised by lack of consistency and ‘joined up’ practices. The mindfulness course was good albeit of limited usefulness.”

5.3 Qualitative findings

- The experiences of services shared by the participants of focus groups and interviews were complex and diverse. Some spanned over many months, while others stretched back decades. It is impossible, in a report of this kind, to include a detailed account of all of these. This section, therefore, offers an overview of some of the key themes that emerged from the data analysis about people’s experiences of services.

- Of the 16 interviewees with personal experience of depression, self-harm and/or suicidal ideation and behaviours three reported having a generally positive experience of services, six reported having a generally negative experience of services and seven reported mixed experiences.

- Of the 11 interviewees who had been affected by the depression, self-harm and/or suicidal ideation or behaviours of a relative, two reported having a generally positive experience, two reported a generally negative experience and seven reported mixed experiences.
5.3.1 Positive experiences of statutory and voluntary services

Participants reported receiving good services from a range of statutory and voluntary service providers including GPs (mentioned by sufferers and families), Kingston IAPT service, CMHT, Home Care Treatment Team, The Recovery College (mentioned by sufferers and families) CAMHS (mentioned by families), Kingston A&E (mentioned by sufferers and families), the police, the ambulance service (mentioned by families), Kingston MIND, Samaritans, Kingston Women’s Centre and Kingston Rise.

Analysis of the data showed that the positive aspects of people’s experiences of services included:

- Having a GP that was experienced and empathetic, interested in the patient, who listened, was professional and proactive and knowledgeable about mental health and services. There were many examples of good GP/patient experiences in the data.

“She looked at me, she was also, I’m very aware it’s a busy practice, she didn’t look at the clock, which I found.. I know my situation is complex and I find it incredibly stressful trying to spit the story out and try to get across what the problem is and she was actually, she saw me on a weekly basis when I was at my absolute worst and she would suggest - I want to see you at this time and she would block a longer appointment, she also, I was initially put on [name of medication], which had the most horrendous side effects and she was supportive when I said I didn’t want to continue down that route. I think also she had a sensitivity and maturity about her, I mean she was only in her late 30s, but she listened and I felt like I was being heard.” (Eloise)

“Her doctor has always listened and taken [wife’s name] feelings into account, which is good because she is very independent, wants to be have her views about her treatment heard. I know she [wife] feels that this relationship is one of the reasons she was able to recover. If she said she was going to do something, she did it. There was no need to chase her up or anything like that.” (Mark, husband)

“Confidentiality, someone who understands what I’ve been going through in a way, not that I’d want anyone to go through what I’ve been through. The doctor I’ve just seen seemed to understand, she was more my age, and she spent a lot of time with me. [...] I was able to explain myself more coherently and she was very thorough, physically and mentally.” (Rose)

- GPs being visibly committed to support their patients and showing an interest in their outcomes provided security for patients and promoted recovery.
“We saw my GP for an emergency appointment and he was great, very, very good. And he was great he got me a referral to Tolworth hospital to see a psychiatrist. After that I went downhill, downhill very quickly and he [GP] pushed for my appointment to be brought forward, which was wonderful, because I don’t know what would have happened, but my GP, he faxed them straightaway and followed everything up and now I see him once a month and I think he likes to see me improving and he has always said if I ever want something, or need something, to phone him. He’ll always send a fax or get a message to any department or do whatever. Really, really reassuring because when you’re feeling out there I always knew it was no problem so that was great.” (Wendy)

“My sister refuses to engage with other services but I know her GP has made a lot of effort to support her, seeing her last thing in the surgery, making emergency appointments when she’s been in crisis so that’s been very, very good.” (Joshua, brother)

- Being referred to a service that the individual felt met their needs was absolutely crucial to people’s willingness to stay engaged with services.

John: “I was referred to the IAPT service and did a course of CBT and mindfulness, the woman that ran the mindfulness course was superb, really supportive and it made me feel very comfortable. I didn’t want to sit and talk, talk, talk about my issues. That’s not for me.”
Interviewer: “So would you say your GP referred you to the right type of service for you?”
John: “Absolutely.”
Interviewer: “How did that make you feel at the time?”
John: “Like I he’d listened to me. And that everyone knew what they were doing.”

- Being treated by, and having skilled professionals involved in your care and who listen. The data showed that this was valued highly and that individuals did make a difference.

“The last person who was involved in my care [as care coordinator] was really good. They were a good listener and intelligent and I felt that they cared and that was important and that helped.” (Sam)

Marie: “I’ve got a really good psychiatrist now, I’ve had him for about two years now.”
Interviewer: “What makes him good?”
Interviewer: “He actually listens. He’s not the type of psychiatrist who says you just need to take this, this and this. I have a lot of confidence in him, he knows what he’s doing.”

Rachel: “The [CMHT] nurse was a real professional.”
Interviewer: “Can you explain that a bit please?”
Rachel: [Pause] “I was in such a bad place, a terrible state. She assessed me without making me feel worse. She was very professional, her interviewing skills were excellent. She just had this air of competence about her that gave me hope.”
Having a consistent and continuous service over time and being able to build trusting relationships was very important. Lack of continuity was one of the key reasons people reported feeling disappointed or upset with services.

“To be honest she [Women’s Centre counsellor] has stopped me from topping myself, to be really blunt because it is so overwhelming, I am so exhausted because of dealing with this [...] she’s the one thing that’s been consistent and she’s been there. And I know that I can go back to her if I need to and if I get desperate she can help....She’s the one, to be honest, who has saved my life.” (Eloise)

Receiving joined up and integrated care.

“The joining up of the service is absolutely vitally important. Our experience is that it’s very joined up. It was a very slick set up and so if [name of wife] had been swimming someone else would mention it at a meeting. It made us feel that work is going on behind the scenes.” (Peter, husband)

Having opportunities to learn how to connect with others who have had similar experiences.

“Recovery College, wonderful, absolutely phenomenal. Taking Back Control first of all. Tutors brilliant, the opportunity of the Recovery College is amazing. The peer tutors make it, I mean [names peer tutor] phenomenal and obviously they’ve been there and worn the t-shirt. Brilliant, brilliant, they give you tools.” (Wendy)

“In the recovery community (Kingston RISE) I’ve found out about the importance to your connection with other people, and your connection with other people who have had similar experiences. So the most constructive engagements I’ve had have been with other people with similar problems. That seems to have been the revelation really.” (Mathew)

Those who had received good quality care delivered by empathetic and professional staff were very vocal about the positive impact this had on their lives and futures. Wendy, who has been receiving treatment for severe depression with psychosis, said.

“I’ve been really lucky, I’ve had a superb service, received superb help and it’s had a real impact on my survival.”

Tom, whose wife was diagnosed with depression, and who was later treated in the borough for depression himself, was similarly clear about the benefits of the services his family had received.

“We’ve been able to go on and have a normal happy family life and the help and support we got from everyone involved has helped make that possible.”
5.3.2 Negative experiences of statutory and voluntary services

Participants reported having negative experiences in range of statutory and voluntary service including GPs (mentioned by sufferers and families), Kingston IAPT service, CMHT (mentioned by sufferers and families), Home Care Treatment Team (mentioned by sufferers and families), CAMHS (mentioned by families), Kingston A&E, the police, Samaritans, Kingston Women’s Centre.

Analysis of the data highlights some of the features of negative experiences.

- Having a GP that appears disinterested or lacks knowledge about mental health.

Sam: “I had a GP who didn’t care about mental health, he had no interest in mental health whatsoever and it shook my faith in doctors. It shook my faith in the medical profession. It shook me up a lot, a real hell of a lot. I found it very frightening actually. It really, really upset me.”

Interviewer: “What was your experience with your GP like?”
Joe: “I think where I’m from in the [names region] they are more interested in you as a person, probably because there’s a smaller population. I’m at [name of surgery] and I see someone different nearly every time so it’s pretty hard to build rapport. A couple of them might remember me and know, and I’ve had some good experiences with a couple of them but it’s very, very different every time I do, I don’t have one specific doctor I don’t think.”
Interviewer: “Would you like to see the same person?”
Joe: “Well yeah because it help with building rapport and someone that knows about you. It’s quite infuriating having to explain everything again. It’s not that I have to convince anyone, I’ve not had a bad doctor per se, I’ve had blasé doctors, maybe a bit of disinterest.”

- Not being treated with empathy or compassion by professionals was one of the reasons given for dropping out of services. It is important to note that professionals may consider themselves empathetic, but it is vital that this is demonstrated to service users.

“The lady I saw (at CAMHS) was as confused as me [about son’s symptoms]. I was asking her about what was going on and she just got cross [...]. She was very cross, she kept mentioning budgets, I don’t know why you’d talk about budgets? It was like 'we could be spending a lot of money on this.” (Samantha, mother)

Interviewer: “How did you know he wasn’t interested?”
Sam: “How can you tell when someone doesn’t care about your mental health? You can see it on their face, I suppose its body language really. Frowns, sort of slightly scowling and it is actually a lot like that and it’s shocking when it happens. It’s difficult to believe that people behave like that but they do.”

- As well as participants reporting their individual experiences with professionals who lacked empathy or compassion, there was a view amongst some professionals that services were under such pressure that this was a more embedded issue for some services in the borough.
“Mental health services are so stretched the only sympathy is for the people who actually do it [take their own lives], and that is wrong because mental health services should be about supporting people before they get that desperate.” (Professional)

“I had that yesterday with a client actually, she’s [number] years old, in-patient for [number] months, five suicide attempts and I wanted to get her to be seen and when I was making the referral they turned round and advised me to get the client to write to the commissioners to make them get more resources and funds. And that’s the advice they gave to me to give to the client.” (Professional)

- It is important to note, that this was understood by professionals as a consequence of stress in the system, rather than a lack of compassion by those working in it.

“I don’t think compassion fatigue is the fault of the clinicians, if you’ve got services getting stretched and stretched of course that’s the thing that’s going to go.” (Professional)

- Professionals missing opportunities to prevent harm in patients.

“I know GPs have to be good at everything, but they need to be able to spot the signs of self-harm in teenagers. I think if we’d had intervention at that point [when daughter first presented at GP] she would have had a much easier time of it. We had an excellent GP but she didn’t spot that pulling her hair out was a form of self-harm, she didn’t seem to know what to do.” (Fabien, mother)

Mike: “In the long build up to it [his second suicide attempt] I did go back to see a GP, I think it was for a renewed prescription, and I was in a very depressed state. In a way I was failed by the GP, but I understand that their time is very constrained, so I went and he said ‘how are you doing?’ and I said ‘not so well’. And then ‘do you want to stay with the drug?’ And I was hoping he was going to increase the dosage or do something but I just got a repeat prescription and as I walked away from the GPs I sort of thought to myself that was the final chance I was offering the services as it were and I realised then I was going to go through with it.

Interviewer: “What could the GP have said that would have made you talk to him?”
Mike: “He could have said ‘how are you doing’ and I said ‘not well’ he could have said ‘oh are you feeling worse? Have you been having some bad thoughts? Do you think it might be helpful if we got someone to speak to you or do you think we should take some further action?’, rather than ‘oh you’re still bad.’”

- Having to repeat your story again and again to GPs and other professionals.
“What I find difficult is that we always get a different GP and one of the big things we
anyone with mental health problems is that they don’t want to keep having to repeat the
same story over and over again, and that’s always what we have to do. And when you are a
private person like [name of son] who is embarrassed with your disability you don’t want to
have to open up to different people all the time, you want to open up to one person and stay
with one person.” (Sophie, mother)

“Having to tell the story over and over again, not knowing where they wanted to start and
my mind just started blanking out, and I felt really sorry for the poor man who was having to
do this because by that time [participant had been assessed four separate times by this
point] I was so traumatised by the process of actually getting help was becoming part of the
problem” (Eloise)

- Being referred to a service that they did not feel was right for them or does
  not meet their needs.

Mathew: “Now, that was quite distressing really [being referred to Kingston IAPT service]
because I had the naive notion that I would get some personal attention and I’d be able to
do that pretty quickly [he was diagnosed with severe depression, mild anxiety and disclosed
suicidal ideation]. But actually what I found when I did get to the process was that I was in a
big room with 60 or 70 other people and I saw a consultant with an overhead projector who
talked through how to recognise stress and what to do about the signs. From time to time
we would be asked to get into groups to discuss things and that didn’t seem appropriate to
me at all.”

Interviewer: What do you think would have been more appropriate for you at the time?
Mathew: “Finding myself in a one-to-one encounter with somebody who I could feel
confident understood, or at least believed they could help me, and moreover I could believe
they could help me. You want to believe, like with any condition, that there is an answer to
this and you want your situation to be taken seriously. I’ve got a feeling that if I had cancer
or if I had coronary heart disease I would get to see a professional pretty sharpish and I
would get some bespoke treatment and that’s not what I received. It’s shocking actually,
that’s probably the word I would use.”

“When you are just really, really, low and each day you are just tired and wish you wouldn’t
be around anymore CBT kind of doesn’t help.” (Lily)

- Getting ‘lost’ in the system was a familiar story in the data.

“I have been on a mysterious list (for counselling) since my daughter was born [eight years
ago]. I wish I knew who had the mysterious list because I’d call them. My psychiatrist has
said that I’ll be waiting for over a year this time, but it has been over a year and I haven’t
heard.” (Lola)

- Rationing, especially for counselling services was raised multiple times. CBT
  and Mindfulness were valued by some participants as tools to aid recovery
  but many felt that they were not the solution to their recovery. One-to-one
open-ended talking therapy with a counsellor with whom you could build rapport and trust was the thing people wanted.

"All throughout, there's a huge emphasis on not discussing your problems and that's the problem with mindfulness and CBT because to really get better you need to discuss what's wrong with someone eventually." (Lily)

“I think the machinery is broken. Getting 12 sessions of CBT doesn’t seem to me a meaningful treatment, it strikes me as something that presumes a preset criteria but this illness is individual and so the answers have to be.” (Mathew)

➢ The data showed that short term counselling was considered to have limited use.

“I did have six sessions a few years ago at the building on Acre Road but you need to find someone you click with, someone that you get and they get you and you can’t do that in six sessions. It’s like in six session as you’ve only just got started and the service is withdrawn. It’s like I’ve just made myself all open and vulnerable and we’ve just started doing this work and you’re going to shut it off. It’s like I almost wish that you hadn’t started because now I’m all exposed and I’d rather have all the callouses in place thank you.” (Lola)

➢ Lack of care and lack of continuity of care due to high staff turnover was an issue raised by service users and their families.

“[name of brother] care coordinators have not always said goodbye [brother had five care coordinators in one year alone], and so when they’re leaving and have spent some time with [name] they either emigrate, leave or they disappear or they just don’t turn up as I’ve said to his reviews. They have, very often, a lack of understanding of my brother and so the family have to explain over and over again the so called history, which is never ever put into context and yet when we invest in another practitioner they then leave and don’t say goodbye. And it’s become a joke actually, of the worst kind.” (Lillian, sister)

“The NHS, it seems like such a different thing. He’s [son] gone straight there [private counsellor] and this person is listening and this person is valuing him and this person is making him feel like a real person, that he exists that he’s believed, that he’s somebody, that he could be somebody whereas before [when seeking help in the public health system] it was [puts on bored voice] ‘what’s your story? Let’s write it down, okay, thank you, we’ll refer you on. Bye, bye.’ You never see the same person again.” (Michelle, mother)

➢ Being unable to find help, support or treatment often because cases were considered too complex for service, or because of substance misuse issues.

“She [psychiatrist] went to see a senior colleague who told her that my case was so complex [diagnosis of complex PTSD] they couldn’t do anything and that I would have to get treatment privately.” (Eloise)
“I was referred to the wellbeing service and they rejected me, which was a real blow because I was very, very low in the spring and to be rejected from there was devastating. What reason did they give? Because it was too long term. Maybe I said the wrong thing but I wish I hadn’t gone to that appointment.” (Lisa)

“I’m not getting any treatment because I won’t stop drinking and they [CMHT] have said they can’t help me [Brian has made previous attempts to take his own life].” (Brian)

- Three participants reported that being discharged from the CMHT was particularly stressful for them. All felt worried about the transition back to the care of their GPs and reported feelings of isolation and distress as a result.

“I was a bit worried but I thought I’d give it a go and stand on my own two feet. My case was closed for two years but a couple of weeks ago I was referred back because I was in such a state.” (Rose)

- The issue of having access to trained and experienced staff was raised by participants, particularly in the context of their experience of services in the community and voluntary sector, but not exclusively. Some participants were very clear that they wanted access to fully trained professionals and not those in training or volunteers.

“I have contacted Samaritans and it has been useful but they offer a very specific kind of service, they listen – which is great – but I feel like I need advice and they can’t give me that. Only people who know about mental health and have qualifications can give me advice.” (Brian)

- Problems with accessing services for young people between 16 and 18 years of age who are not in education and transition from child to adult services.

“My oldest daughter had quite a lot of anxiety problems when she was 14. I started taking to the GP because she was pulling her hair out, and not a lot was done, well nothing was done […] and she ended up having a major crisis when she was 16 [serious depressive episode with suicide ideation and some behaviour]. We went as an emergency to the GP and emergency to CAMHS and I felt that could have been avoided if her anxiety problems had been taken more seriously earlier. We went to CAMHS, were seen reasonable quickly, not that quickly given the crisis. She has some ongoing weekly treatment and they were happy that she was engaging because she needed treatment but at 18 they dropped us like a stone basically, they sort of called us in for a meeting, which I thought was one of the fairly regular ones to discuss how things were going, and in fact they said, that’s it now […] and they just got rid of all the treatment and we had to find treatment for ourselves. I could just see things falling apart and we just stepped in ourselves. They never offered us any services and said that there was no guarantee there would be any services because she’d have to start the whole assessment process again and the criteria in adult services is very different and all that sort
of thing. They didn’t know we went off privately and got help, we’ve never heard from them again.” (Fabien, mother)

5.3.3 Impact

➤ As the above extract outlines, if they could afford it, and in some cases even if they could not, individuals and families sought help in the private or voluntary sector.

Fabien: “I got her straight to see someone at [name of clinic] [...] he immediately put her in to a, they called it DBT scheme, and it was a group and individual therapy as well.”

Interviewer: “That must have been costly.”

Fabien: “It was extremely costly, it cost more than you can possibly imagine. It was just hideous, it would just not be possible, we’ve got some savings basically and that’s what we used.”

“By definition I was an amateur. I had the basic understanding about personal chemistry and that the relationship had to work. I tried several counsellors locally and saw how I felt about them. I just kind of toured around Kingston on Thames spending 50 minutes, that seems to be the duration...It was about £40 for each one of those and although I could pay there are probably lots of people that can’t. If I hadn’t been able to pay or have stumbled across a person to help me (Kingston RISE) it could have been a very bad outcome.” (Mathew)

➤ Others, unable to fund additional support, withdraw from services completely, seek whatever help they can find in the community and voluntary sector or go back to the beginning to try and access help again via their GP.

Brian: “After what’s happened [refused services because of alcoholism] I don’t think I’ll ever be back in services again.”

Interviewer: “But what happens if you have another episode of depression?”

Brian: “I don’t know.”

5.4 Discussion

➤ The data showed that there was a lack of consistency of services across the borough. Some individuals and families reported receiving excellent joined-up care from committed professionals who they felt were genuinely invested in their recovery.

➤ Other participants reported mixed experiences of excellent care in some of the services they accessed and poor or negative experiences in others.

➤ While others felt that their experiences of services had been negative because they had not been taken seriously and/or had been unable to make a meaningful connection with professionals or get access to the services they felt were right for them, or access any services at all apart from primary care and those offered in the community and voluntary sector. There was concern expressed that some parts of the system were under such pressure that even
extremely vulnerable and risky individuals were not being provided with the support required.

- When people are depressed, self-harming or suicidal they need to be able to access support from people who recognise and understand their symptoms, show empathy and are able to refer them to treatment that is appropriate for them. Continuity of care is vital as it promotes trust and engagement from service users. If this breaks down, service users can feel abandoned and their feelings of distress and isolation can increase.
Chapter Six

6.1 Crisis Support

- Research published this year by the Care Quality Commission\(^{69}\) explored just under 1000 people’s experiences of help, care and support in a mental health crisis.
- The report highlighted that 42% of respondents did not receive the care needed to resolve the crisis.
- Furthermore, there was a significant disparity between levels of care and compassion showed towards those in crisis between different service providers.

<table>
<thead>
<tr>
<th>Local Service</th>
<th>I received the help I needed in a timely way</th>
<th>My concerns were taken seriously and I was listened to</th>
<th>I was treated with warmth and compassion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteers or a charity</td>
<td>74%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>GP</td>
<td>52%</td>
<td>64%</td>
<td>65%</td>
</tr>
<tr>
<td>Telephone helpline</td>
<td>60%</td>
<td>62%</td>
<td>63%</td>
</tr>
<tr>
<td>NHS ambulance</td>
<td>63%</td>
<td>61%</td>
<td>63%</td>
</tr>
<tr>
<td>Police (in a public place)</td>
<td>65%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Crisis resolution home treatment team</td>
<td>41%</td>
<td>44%</td>
<td>46%</td>
</tr>
<tr>
<td>Community mental health team</td>
<td>38%</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>35%</td>
<td>37%</td>
<td>34%</td>
</tr>
</tbody>
</table>

6.2 Adult Survey findings

- 16 (37.2%) respondents were unable to get help they needed outside of office hours because services were not available during this time.
- Respondents were asked what they would find helpful in ‘out of office’ hours services and replies included:

*I get very anxious talking on the phone so a live chat service would be very helpful.*

*Someone who tries to understand what you’re going through, as opposed, to patronising with, have a bath or a cup of tea!!*

\(^{69}\) Care Quality Commission (2015) Right here, right now: people’s experiences of help, care and support during a mental health crisis.
A regular support person or persons who know me to talk to. Samaritans can be good but I can find it hard to talk to a complete stranger & having to repeat my history/stuff.

Talking therapy with a professional mental health person.

6.3 Qualitative Findings

- Many participants reported having regular periods of crisis, where they felt the need for quite a lot of support.
- Many reported finding it difficult to access services in a crisis, particularly if they were not under the care of the CMHT, and this caused a great deal of frustration.

“Last year when I had a massive crisis, so I rang up my doctors but they said they couldn’t see me because they were full up. So I told them I was suicidal and they said ‘well you need to go to the CMHT. So I went to the CMHT and they said we can get you to speak to the duty worker, but when you speak to the duty worker they go ‘have you had a cup of tea and calmed down?’ Sometimes it takes for you to say ‘look I’m going to throw myself in front of the train at Surbiton’, like do something really dramatic to see a doctor or see the CMHT or something.” (Lisa)

- Practitioners working with vulnerable groups in the community reported that calling the police had become their default position if one of their service users presented in crisis. They would not contact mental health services.

6.3.1 Crisis Line

- Some participants felt that having the Crisis Line number provided them with a great deal of security and the feeling that help was accessible if needed.
- Of those participants with personal experience of depression, self-harm and suicide, eight had used the Crisis Line. Out of these, only one participant reported that it was a positive experience.
- The other seven expressed concerns that the Crisis Line did not meet their needs at this point. The most common reason for this was that they were unable to speak to someone who was able to meet their needs.

“I have an out of hours number but that doesn't always work because sometimes I've rung it and it sounds like the cleaner has picked it up or something. Or the person on the other end of the line doesn't speak English, or I've been told 'yeah, there's no-one here, call back later.' Or there's this thing that if you can't see your doctor then someone from the CMHT will call you back, but they don’t call you back.” (Lola)

- Some professionals also questioned the effectiveness of the crisis line to meet the needs of people in crisis.
Professional: “One of the things is the mental health Crisis Line, I never hear good things about it at all. It’s a damning thing to say about any service but it doesn’t feel that it’s set up for the particular group of people that it is actually set up for, people in crisis. They don’t seem to have the correct response and if anything I meet with people who are even more distressed when they’ve used that service.”

Interviewer: “Can you explain?”

Professional: “Generally, when I was embedded in the community health teams I saw professionals, clinicians, all sorts of people struggling with the ongoing crisis, often presented by people with personality disorder. And they can tend to be the people that quite often need to rely on crisis services and things like that. Yes they can often be trying make a cry for help or what have you but that doesn’t make their cry for help invalid or any less distressing than any other person. But from what I’ve seen the squeeze on services means that there isn’t the space in clinicians time to really handle the need that some of those patients present and so because of that they tend to be serial presenters to crisis services, the service they receive has become eroded over time and their needs are not being addressed as part of the system. They’ve become barely tolerated and batted away.”

- When asked what would be most helpful for people in a crisis, participants were clear that having someone to talk to, and somewhere to talk would be the most beneficial.

“I feel that if there was someone you could talk to and somewhere you could talk I don’t think I’d even get into that state [of crisis].” (Lisa)

6.3.2 Accident and Emergency

- 5/16 participants with personal experience of depression, self-harm and/or suicide reported presenting at A&E when in crisis.
- 4/11 relatives reported their family member using A&E in crisis.

“When my dad realised my mum had taken the overdose he dialled 999 and was told an ambulance would be at least 40 minutes but that he should wait for it. I wanted to drive my mum to Kingston Hospital immediately and checked with an ambulance crew who happened to be nearby who were really helpful and thought it would be best for me to get my mum to A&E quickly so my dad cancelled the ambulance. When we got to A&E my mum was seen quickly and dealt with well – all the hospital staff were really helpful.” (Eleanor)

- The data showed, however, that there was a lack of consistency in the quality of service experienced at A&E. This is perhaps best illustrated Timothy’s experience.
Back in September she [wife] said I need to seek help now and we went to A&E at eight o’clock in the evening and everything worked exactly as you would imagine the pathways should work. We didn’t spend long waiting at A&E, we were immediately sort of channelled off toward the psychiatric services, when we were seen it was sort of eight or nine o’clock in the evening, there was, she had a long consultation with the duty psychiatrist and we came away from that feeling hopeful because there seemed to be something that came out of it positive, that there was a step forward, that it was the right thing to do. In January when we went it was the same time in the evening, it was identical circumstances expect that they’d put her on the wrong pathway. She was treated as, although she’d said clearly on arrival that she was suicidal, she was treated as a general A&E admission. We spent three hours sitting and waiting to be triaged and then when we did see someone they simply took her blood pressure, which was a completely pointless waste of time. He was utterly disinterested and he just said ‘go and wait in the urgent care room, didn’t tell us where it was so we were stumbling around the hospital […] with [wife’s name] in just the most awful state. We were stumbling around the hospital trying to find where we had to go, when we got there the place was just flooded with others, it was not coping, it was at breakdown point. We were told to go and sit in a cubicle where we sat with a group of others who were waiting and we sat there for another two or three hours, and by this point it was after midnight. And, I went to see a doctor on a couple of occasions and said ‘when are we going to be seen, my wife is suicidal’ and it was always ‘yes, soon, soon’. And eventually we were seen by a psychiatrist but at this point is was half past twelve in the morning and [wife’s name] was absolutely emotionally exhausted and she wasn’t in a position to engage with the consultation so the consultation was very perfunctory and we came home feeling nothing had been achieved, nothing had moved forward, she hadn’t been given any hope, it was an awful experience. And from my perspective, it was the first time I realised what risk there was and I got home that morning and thought, I’ve got a wife who’s suicidal and I haven’t got a clue how to keep her safe. [Wife’s name] had a helpline number to call but I haven’t been given anything for me. If [wife’s name] was a patient with cancer, or with a broken leg, or a heart condition there would be a clear pathway to treatment and if she was returning home you would be told what you needed to do to care for her […] so I was there at 1 o’clock in the morning thinking what have I got to do to keep my wife alive and I know that whether she lives or dies is largely dependent on me.” (Timothy, husband)

- Timothy’s experience of A&E were only six months apart, but were completely different.
- Timothy was not the only person to report suicidal individuals being triaged into general A&E admissions.
Jane: “Well, when we took him to A&E he had to wait to be triaged and you sit there and you wait, they take some blood tests and you wait, and then he got fed up waiting and he just walked out. And I said ‘please don’t do that because they are going to help you if you stay, you can’t walk away but he just walked away. But I said to them please can you help me because he’s just walked out, ‘he’s 16 he can do what he likes’, that’s it. End of.”

Interviewer: “Can you remember how long you’d been waiting?”

Jane: “Oh, over an hour to be seen by somebody who would actually talk. They’d taken some blood tests, they’d..what they’d done is they said they’d seen us because they’d triaged him so he’d had blood taken and therefore they could say he was in the system. But it was well over an hour and the way he was feeling it was too long because it needs someone to talk to him, and no-one had, so, yeah.”

- Accident and Emergency departments were considered inappropriate places by professionals and parents to treat self-harm that did not have suicidal intent.
- It was highlighted by professionals that for young people, who have no other form of crisis support, A&E was the only place they could go to get help if they had self-harmed in this way. It was suggested that an alternative service should be made available to this group because A&E could heighten young people’s anxiety levels and increase distress.
- When what would most improve the boroughs provision for people with depression, self-harm and suicide the second thing most suggested, after the provision of long-term counselling services, was better crisis management. When asked what this would look like one professional offered:

  “Something like a proper mental health A&E service that can mop these people up in their moments of crisis, at that time, out of hours, in a warm and compassionate way and follow-up and get these people into treatment, which might be short term, but might be long term to get them stabilised.”

6.3.3 Home Treatment Team

- Participants with experience of the Home Treatment Team were generally positive about the service.
- Mike, who saw the team every day for two weeks after his second suicide attempt described staff as “very nice, very human.”
- Family members also appreciated the Home Treatment Team, however, there was a lot of concern raised about levels of risk and their family members’ safety in the community. Asha’s husband has serious depressive episodes approximately once every two years. They have no family support in the borough, and her husband has recently tried to take his own life and is now being supported by the Home Treatment Team.
“Today, I am at home, I have not been at work for 10 days. My work have been very understanding and have given me the time off but okay, if I leave my husband home, I know the team will come at 12 a speak to him but once they are gone how can I be assured that he will be fine at home? I worry that he is not safe.” (Asha)

- Family members reported that making judgements about how to keep family members safe were made harder by 1. a lack of information and guidance on signs to look out for. 2. being mentally and emotionally exhausted by weeks or months of coping, which resulted in the crisis, and not feeling confident they themselves would see the signs even if present. 3. for those families without support and/or unable to afford to take time off from work the financial pressure combined with the emotion toll was acute.

- Another family member questioned whether Home Treatment Team staff are the right people to support other medical professionals who are in crisis and/or suicidal.

The Home Treatment Team came and visited her every day, or they called her every day or she went in to see them during the 10 day period they were monitoring her before she died. And I sat in when they came home and it was obvious that they were out of their depth dealing with a doctor. They sent psychiatric nurses, and they tried their best, but actually [wife’s name] went into doctor mode and she started telling them what needed to be done and she effectively diagnosed herself and they didn’t challenge it. The power dynamic was completely inverted […] she knew what questions they were going to ask her, and what answers to give to satisfy them.”

Later, reflecting on his wife’s death, he said of that time.

“I felt utterly and completely exhausted and overwhelmed. It blows apart your life. I was out on my knees and as a consequence and think I wasn’t picking up on the danger signs because they were just lost in the great storm of stuff that had been going on for months and months.” (Timothy, husband)

6.4 Discussion

- 37% of respondents reported being unable to access crisis support when they needed it.
- Again, having someone to talk to who will listen was highlighted as important to help prevent or resolve crisis.
- The majority of people who had used the Crisis Line were critical of the service.
- Reports about accessing support in a crisis via A&E highlighted the importance of being referred via the mental health, not general A&E, pathway. Not doing this left some people having negative and extremely distressing experiences.
- Young people do not have any alternative crisis support and can only go to A&E. Professionals considered this an issue because A&E is not the best place for many young people who are depressed and/or self-harm.
- The Home Treatment Team was considered a good service by those who received it. However, family members reported being deeply worried about keeping their loved one safe for the 23 hours of the day the Home Treatment Team were not present. Also, there was some concern that some individuals who are suicidal present with specific care needs that are not currently being met.
Chapter Seven

7.1 Impact on Families and Social Networks

Respondents of the adult survey were asked to read a series of statements about how their experience of depression, self-harm or suicide had impacted on their relationships with family/friends; they were asked to indicate how much they agreed with these statements. Generally, respondents felt that their relationships with others were affected negatively or that they felt alone:

- Most respondents felt lonely/isolated.
- Most felt that no one understood what they were going through.
- Very few respondents felt that their family/friends were supportive, that they could talk to their friends/family, or that their experience made them closer to them.

![Bar chart showing responses to various statements about relationships with family and friends.](image-url)

- I felt lonely/isolated at this time
- I felt like no one understood what I was going through
- My relationships with family/friends were affected
- My family/friends seemed distant
- My close networks became smaller
- I avoided my family/friends during this time
- My family/friends were open about their experience
- My family/friends took time to make me feel better
- My family/friends were supportive
- My family/friends stopped talking to each other
- Family/friends were open about their experience
- I became closer to my family/friends
- I felt like I could talk to my family/friends

The bar chart shows the percentage of respondents who strongly disagreed, disagreed, neither agreed nor disagreed, agreed, and strongly agreed with each statement.
50 out of 64 respondents had friends/family who had experiences of self-harm and/or suicide, of these:

- 47 have friends/family who have suffered from **depression**
- 25 have friends/family who have **self-harmed**
- 34 have friends/family who have experienced **suicidal thoughts**
- 23 have friends/family who have **attempted to take their life and survived**
- 16 have **lost friends/family to suicide**.

Respondents were asked how their relationships with those who were experiencing depression, self-harm or suicide were influenced; they were asked to indicate how much they agreed with these statements.

- Most respondents felt that they didn’t understand what their family/friends were going through.
- This corresponds with the results from those with ‘personal experiences’ where the majority of respondents who were experiencing depression, self-harm and suicide, didn’t feel like their family/friends understood what they were going through.
- More than half of respondents felt like those experiencing these feelings/behaviours stopped talking to them as much.
- Just under half of respondents felt that they tried to be supportive.
- Most respondents disagreed that their relationships became difficult or hard to maintain.
- This is unlike the responses of those who had experienced these feelings/behaviours, where the majority of respondents agreed that relationships had become difficult or hard to maintain.
7.2 Qualitative Findings

- As highlighted in Chapter three, people with personal experience of depression, self-harm and suicide, overall had high levels of social isolation. This contributed towards, and sometimes triggered, their depression, self-harming and suicidal thoughts.
- It was noted in the consultation that their mental ill-health was sometimes a direct cause of their isolation. So, for example, people talked about isolating themselves when very depressed, or talked about how they were worried that their actions in the past when unwell had alienated them from friends and family.

7.2.1 Contribution of Family Support

- Those with family support were aware of the strain this could place on other family members.

> “In this last [crisis] episode, I tell you, it’s so bizarre. I have no idea how they process it all my mum and dad because its 24 hours [...] I try to explain to them, but it’s difficult.” (Sam)

- Those with family support were aware of the positive contribution this had made to them, and how it had helped them stay well and supported recovery.
“[name of wife]’s family have been an absolute godsend. [wife] has two very down times a year, and has done for most of our marriage, some years it worse or better than others. When things get tricky her mum will come and sit with her while I’m at work and as she gets better they’ll potter in the garden or go to the shops. Her brother and his wife invite us round when she won’t really go anywhere else. I don’t know how other people cope when they don’t have family.” (Mark)

“I know how lucky I am to have a supportive husband and how important that’s been for my recovery. I’ve met people who don’t have that, or whose partners aren’t supportive and I can see the difference it’s made to me.” (Wendy)

7.2.2 Mental Wellbeing

- Some family members reported that coping with the depression, self-harm and/or suicidal thoughts or behaviours of a loved one did result in them becoming quite isolated themselves.

“My sister was speaking to me but everyone else in the family just avoided talking about it [her son’s diagnosis].” (Samantha)

- Thomas described what it was like in the months following his wife’s death.

“People do turn away very quickly, at first you get love bombed, but I’ve been astonished at how quickly very good friends, people who I thought would be with me all the way, actually have been barely in contact, and so you do in the end need an alternative network.”

- Family members talked about living with extreme stress in the process of supporting a loved one living with these issues.

“All the time we were stressed, everything I had to do was on my own. Dropping off children and picking them up, okay that my normal routine but also taking him to appointments and always keeping on a smiling face, being brave. I done it, but it is so hard to keep going like that for so long.” (Asha)

- Sophia, who has been trying to get help for her son since he was at school, (he is now a young adult) described this very powerfully.

Sophia: “At that stage [this summer] I was scared to go to work, every morning when I knocked on his door I didn’t know if he was going to be alive or not. The stress has been unbelievable and it’s affecting the whole family. He has a younger brother, and he’s out all of the time, because of the situation. It’s having a huge effect on my life of course.”

Interviewer: “Can you describe how you feel?”

Sophia: “Despair. Just don’t know what to do. It would have been nice to have a social worker who had specialist knowledge of Asperger’s. It would have been great to have had somebody that the whole family could trust. Even somebody who could come by once a
month and encourage [name] to get out. But it takes time to build trust. It would have been nice for the GP to ask if anyone else in the family needs help. Because living with it is hell. We can’t live our lives as we would like them to be. We need to be able to have lives.”

- Others talked about witnessing acts of self-harm and suicide attempts that were incredibly traumatic.
- Perhaps unsurprisingly, and particularly for families living with this over a long period of time with a loved one who struggled to access treatment, this resulted in their own mental and physical wellbeing being affected.
- Five of the 11 participants disclosed seeking help for depression and/or anxiety from a GP. Some took/had taken medication and been in counselling themselves.
- The data showed that the wider family were also affected. This included children, parents, grandparents, siblings and partners. Joshua, whose sister is now in her 50s but has suffered from depression and suicidal ideation since she was a teenager, described the impact on his family.

“It's affected all of our physical and mental health. My mother and father, my brothers, her children. Christmas time, family occasions, we don’t know how she’s going to behave. [...] It's like an emotional landslide.”

7.2.3 Financial Impact

- As well as the social and emotional impacts, participants described the financial implications for families.
- Some, like Asha in Chapter Six, had to take time off of work to ensure the safety or take care of a loved one. Others had to take time off because of the depression that was triggered as consequence of their loved one’s experience. Thomas, for example, took three months off of work after his wife’s recovery from depression. Family members also recounted job losses and reducing working hours.

“My husband did lose his job, he blames that on what was going on with her, even though I was at home.” (Fabien)

7.2.4 Wider Issues

- As well as supporting a family member with depression, self-harm and suicide, many of the participants in this research had a range of other caring responsibilities for children and elderly and/or disabled parents.
- Some participants were clear that having to engage with the mental health system was as, if not more, stressful than supporting their family member.
- Participants reported that poor communication between families and services, feeling excluded from key decisions about care, finding it extremely difficult to get complaints resolved or changes in care enacted. This was a major source of frustration and stress for families.
Families also reported having difficulty getting other support for their loved one put in place. Samantha, for example, is mother to a 12-year-old son who has been trying to arrange additional support for him at school, but because he is not assessed as having any learning support needs her attempts have been unsuccessful, despite school being a key trigger for him.

Participants also expressed a lot of concern about securing a stable future for their children, or being worried about their ability to continue supporting adult children as they get older.

7.2.5 Support for Families

A familiar theme with families was the need to have a pathway of family support that runs alongside the treatment of their loved one. Families wanted this to start as soon as their family member came to the attention of services.

Families wanted, first and foremost, the details of places where they could access help and support.

Families were accessing a range of support services, but it was suggested, this often started too late in the process because of a lack of information and/or long waiting times.

“It would be good if there was a support network in place for families. Bereavement counselling can take time, six months after [name] death, at which point it was useless.” (Timothy)

It was suggested, for example, that a pack with information for families should be made available and distributed by GPs to family members.

The types of support families wanted included: informal opportunities to talk to others in the same situation as themselves; opportunities to talk about their own feelings; opportunities for children to meet other families who had experienced mental health issues; opportunities to connect with the wider community; information about employment rights; information about benefits and other financial issues; information about mental health services and different types of treatment.

Some families did access Kingston Carers Network and Kingston MIND and felt these services were judged as extremely helpful. There were concerns expressed, however, at the future of services because of cuts to local authority budgets.

It is also crucial to recognise that not all family members supporting someone with depression, self-harm and/or suicide understood themselves as a ‘carer’, indeed some explicitly rejected this label.

Family members discussed seeking help in other boroughs, and being refused help, because they were not from that borough. It was suggested that
it would be helpful if cross borough arrangements could be made with some specialist support services.

7.3 Discussion

- The data are clear. Family support is absolutely crucial to people who have depression, self-harm and/or suicidal thoughts or behaviours.
- The impact on families of this, however, is significant and includes social isolation, emotional distress and financial cost.
- Families need support, and currently feel that they do not have enough information about the support that is available in the borough. Or, if they are able to access services this can be later than they want or need.
- Building social networks with other families and/or people with similar experiences was high on the list of priorities for family members. However, there was a range of other types of support families requested.
- Importantly, many participants in this consultation did not have family support, and mechanisms to address the needs of this group are important.
Chapter Eight

Recommendations

Depression, self-harm and suicide triggers

- All prevention work developed in the future should address the social as well as psychological and clinical needs of individuals who are affected by depression, self-harm and suicide. Any services that offer social support to this group as part of preventative activity should demonstrate they are experienced at working with this group. Key consideration should be given to make any services as accessible as possible for suffering from depression, self-harm and/or suicidal ideation and behaviours.
- Existing services should review how accessible they are to people suffering with mental ill-health, which might include depression, self-harm and suicide. Assertive outreach should be considered as people who are depressed, self-harm and/or are suicidal do retreat, can feel that they do not deserve help and can struggle to express their needs.
- Projects and programmes to support social inclusion and reduce social isolation should be supported. More opportunities for people with experience of these issues to get together informally should be created. Projects and programmes that reduce social isolation for older men (50s plus) should be commissioned. Existing social inclusion projects should review their provision for people in their middle years, and those who may be isolated due to long term mental health conditions.
- Making mediation and other relationship support services more accessible to people on low incomes should be reviewed.
- Awareness of existing bespoke services for people with mental health problems, such as Balance, should be raised amongst the public and professionals.
- Opportunities to develop a programme of mental health education for employers in Kingston should be explored. This should include information on the links between workplace stress and mental ill health, legal responsibilities, returning to work and employing people who have had mental health issues.
- Supporting families and educating parents about the connection between family life and young mental health and what families can do to help young people should be a part of any future strategies in the area (also see Chapter Four).
- Work that raises awareness of mental health issues should be continued in all schools. Work around healthy relationships, how to cope with family conflict and reducing social isolation should be included in this work.
Knowledge and access to services

- Clear and easily available information on which services are available in the borough for people with depression, self-harm and/or suicide and their families and what they do should be developed. This should be made available to doctors’ surgeries, A&E and specialist services as well as community spaces and all other organisations working with those who might have/be at risk from emotional distress including faith groups.
- Efforts should be made to re-engage those struggling with depression, self-harm and suicide who will not seek help because of previous negative experiences.
- Organisations should have multiple channels of communication with members of the public, not just the telephone, and all enquiries should be responded to in a timely and consistent way.
- The Public Health Team and its partners should review the implications of the finding that 65% of respondents to the adult survey (and more men than women) felt that a GP was not able to provide them with help for emotional issues. This is vital not only because although there are alternative routes to access services (such as self-referral), GPs are the gateway to the rest of the public health system and can provide the over-arching framework within which people’s mental and physical care is coordinated and managed. But also, as Chapter Five illustrates, many GPs provide excellent care for people who are depressed, self-harm and or are suicidal and can make a real difference to those individuals in the short, medium and longer term. A plan should be developed, which has the goal of educating residents, particularly young people in the role of the GP, and engaging with older groups to give concrete examples of what GPs can do when people are in emotional distress. Alternatively, alternative processes of referral could be better advertised. Close attention should be paid to the section on primary care in Chapter Five when developing any action.
- Consideration needs to be given in any local planning about ways to close the accessibility gaps identified in this consultation. Long term counselling provision that is free at the point of need for people who are depressed, self-harm and/or are suicidal should be commissioned.
- Developing a more proactive approach to men’s mental health and suicide is vital and services should review how they engage and encourage men to seek help before things reach crisis.
- Action needs to be taken on how services protect or promote the confidentiality of young people, particularly given so many reported that problems at home could be key trigger for depression, self-harm and suicide.
- There is no community-based, specialist emotional health service available for young people in Kingston. This should be considered.
- Work needs to be done in schools, particularly with boys, which addresses head on the view that young people would be in trouble in they disclosed feeling depressed, self-harmed or had suicidal ideation. In addition, concerns about depression, self-harm and suicide as a trigger.
- A closer working relationship between professionals at CAMHS and in schools should be developed.

**Experiences of services**

- A review of the demand, capacity and referral processes into the Home Treatment Team and Community Mental Health Team needs to be conducted.
- Longer term counselling services should be commissioned in the borough to meet the needs of those who need therapeutic support, but who do not meet the threshold of the CMHT.
- Training for GPs and other staff on managing patients with depression, self-harm and/or suicide ideation or behaviour should be continued and extended in the borough.
- Services should ensure that those on waiting lists are reviewed and individuals on waiting lists are communicated with regularly to ensure they do not get lost in the system.
- Individuals suffering from depression, self-harm and/or suicidal thoughts or behaviours should not have to repeat their histories again and again to different professionals/clinicians. Pathways of care should be reviewed to ensure that this is minimised.
- More robust transitional arrangements should be made for those being discharged from the care of the CMHTs.
- More opportunities to provide peer support or networks so that people can meet others with similar experiences should be actioned.

**Support in crisis**

- The review of the Crisis Line that has recently been conducted should be revisited. This should include an examination of any case management processes in place to respond to the needs of repeat callers and the provision of alternative ways to connect (such as instant messaging).
- A&E should ensure that people who are experiencing a mental health crisis do not get placed into the pathway for general A&E admissions. If this is occurring because of capacity or staffing issues this should be addressed in a systematic way.
- When decisions are made to provide home treatment rather than admit someone who is suicidal to hospital the family (if present) should be involved in those discussions and the capacity of the family to provide sufficient care to keep people safe should be central to that process.

**Family and social networks**

- The development of a family pathway that sits alongside treatment for sufferers should be strongly considered by the Public Health Team as part of any depression, self-harm and/or suicide strategy.
- Family members should be given specific information about caring for a relative and caring for themselves and others.
- Building informal social networks to support families should be considered as a way to reduce social isolation and provide support. This should be in
addition to reducing social isolation of those with depression, who self-harm and have suicidal thoughts or behaviours.

- The rights of carers should be respected by professionals and practitioners in primary care, statutory and voluntary mental health services.
Appendix A: Short vignettes used in young people’s survey

Scenario A

Omar is in Year 11 at school. A few months ago Omar started to feel down, but doesn’t know why. In the last couple of weeks, Omar has tried to make himself feel better by joining a local gym but he feels that this hasn’t helped much. Now, as well as feeling down, Omar has become anxious about going to school.

Scenario B

Stacey is a 14-year-old student at your school. Stacey has lots of friends at school now, but had a hard time at primary school, where she was bullied.

She has been self-harming for about a year. Stacey’s mum doesn’t know about her self-harm, neither do the teachers at school, but some of Stacey’s friends do. She doesn’t want to get help from anyone else and finds it hard to talk about how she is feeling. Stacey says that being bullied in the past is one of the main reasons that she now self-harms.

Scenario C

Michael is an 18-year-old college student who achieves good grades and has lots of friends. Earlier this year he was taken to hospital because he tried to take his own life following an argument with his girlfriend, which caused them to break up. Michael received some counselling at the hospital before he left and talked to his mum and dad. Michael had never hurt himself before this.