Coproduction for the Suffolk Suicide Prevention strategy

October – December 2020

Suffolk user forum

Foreword

Thank you to everyone who worked with us to start this coproduction journey for further developing suicide prevention in Suffolk.

This publication has only been made possible through the trust we have grown together, which has enabled us to share very personal experiences of living with suicidal thoughts, of bereavement by suicide and our experiences of professionals providing mental health services.

Working in small groups on Zoom and in one-to-one conversations we have collated 142 experiences (which show us where changes need to take place) together with initial thoughts, and recommendations for improving services, support, and information. Together we have been able to start conversations and begin to grow ideas that can help us influence suicide prevention.

This publication has been shared with the Suffolk Public Health team responsible for suicide prevention and we look forward to working together to further coproduce for suicide prevention.

Contents

Lived Experience and changes that can be made for Suffolk suicide prevention.

1. Peoples Experiences of reaching out for help when experiencing extreme distress and suicidal feelings

1.1 Primary Care – GP's and Link Workers

1. One day I did call my GP at 5.30pm asked if I could have an appointment as I had snapped. I was told nothing was available and to call crisis line on Monday, which is not helpful. So, I found my GP's email address and told him what I thought of the service I had received. I got a phone call back within an hour from him. I did not answer the phone and when I got home my partner said the Doctor had been trying to get hold of me. I said I bet he did. I then got taken to hospital by police. So, this was a good service in a way eventually.

2. My GP in Felixstowe is fantastic and tries to install mental health in his other GP's. He has been fighting for the last 10 years, trying to get money freed up from CCG to get my mental health with another trust, but this has still not happened.

3. Had medication increased by Dr no one has checked on me to see if all is ok and it would be great if GP could follow up and if they had concerns, they could contact someone.

4. You get prescribed medication and feel that you are forgotten about.

5. GP's need to do a follow up appointment maybe in a month to see how things are going, some surgery's do this but not all do.

6. It is a brave step to go to your GP and then to tell them your story.

7. Some GPs' just give medication and just want to get rid of the patient as they just do not want to know.

8. GPS can be hit and miss you get good ones who understand and will give medication and then follow you up with an appointment in a few weeks and others do not.

9. There is a problem contacting Link workers at GP surgeries. I missed their call and then had to call the surgery to get them to call me back as they are working from home and the surgery cannot give out their numbers. It is just another barrier.

10. We need to understand what training professionals and GP's have had around mental health and suicide awareness.

11. I did an exercise and went into my GP surgery and one in Diss – they did not have anything about suicide or wellbeing on display. There needs to be consistency across Suffolk. We also need to look at the root cause of what is going on and not just giving people medication and sending them on their way.

12. If GP's are undertaking medication reviews for medication for anxiety and depression, they really need to think about what is going on for a person, understanding the impact of COVID-19, the time of year, as its unhelpful to ask someone to reduce or even stop their medication right now.

1.2 Experiences at acute hospitals Accident & Emergency (A&E) Departments and interventions from Psychiatric Liaison which service users refer to as the crisis team.

13. The last two times I was taken to A&E, I saw the crisis team, but they said to A&E staff I did not need to see them. I knew and said this is what they would say, and the A&E staff worryingly agreed with me.

14. The first time the police took me to A&E, the crisis team were condescending to me. They asked me who had brought me to A&E? I said the police and they said they should have called us, and we would have told them not to bring you to A&E. I do not think this is right. I knew what they were going to say to me, which was go away and go home. Which is what they did say. The day I was brought in by paramedics and saw same two staff who said why did they bring you in, they could have patched you up at the side of the road and left you there.

15. I went to A&E and was told we do not need to see you, and this was with 65 cuts. The first night they sent me home in a taxi with a warning that I was not do this again. The next night I was kicked out at 3am in the morning covered in blood looking like a serial killer and walked home to Felixstowe. I know they are stressed. But I am not the only person who has experienced this service at Ipswich A&E.

16. I went to A&E about ten years ago had an OK experience and was treated with compassion.

17. I was brought into A&E by police or ambulance as a I was of concern. I did call an ambulance as I knew I had gone too far and thought they were going to patch me up and that would be it. The police and paramedics were fantastic, they have empathy and understanding. Ambulance staff even suggested I could have a quick shower to clean up and then go to hospital which was amazing. I agreed with ambulance crew's assessment as I knew they were concerned about me. But, when I was seen by the crisis team, I hit three crisis team conditions; People like me were self-harming to seek attention; so, we would not get the attention and if we do not get the attention, oh dear, we are dead!

18. There is one nurse who has a bed manner of Harold Shipman and is very harsh. One time she came out and asked what had happened to me and surprised me, as her empathy had kicked in, as she had seen me the day before and this time, she realised it was serious and then offered to get me a coffee or sandwich. It is a shame this did not happen the first time I went and saw her.

19. 111 will call an ambulance and send you to hospital but there needs to be local minor injury's unit where I can get patched up and have a cup of tea and then go, but they took this service away. There needs to be places local people can go so they do not take up valuable services.

20. I was told to go to A&E. If you are told to go to A&E and you live in say Sudbury it is an hour on the bus, there and back, waiting time for the bus then walking to A&E. It is not good when you are feeling suicidal. Many people will not do that, as you are seen and then you must go home.

21. When you go to A&E you feel that because your legs not falling off and it is not a visible illness, that they do not want to know you; you feel like you are causing trouble, so you feel even worse. Also, it takes so much time waiting in A&E. You just need someone to talk to ASAP and just to say things are ok, you have had a bad day, but tomorrow is a new day. We need more empathy as we do not want to go there, but we need help and support.

22. At times I have requested help. I have asked them one to one and they could see the state of me. It was a friend or family member that said I needed a quick response, even though I was trying to tell them.

23. The crisis team at A&E chucked me out. They would not even let me eat my sandwich in the hospital. I was not given any leaflets on departure to say this was where to go to get help.

24. I mentally mapped out how far it was from the hospital to the Orwell Bridge, I then went back into A&E and said I just needed to come in as I had suicidal thoughts. But the two crisis nurses came out and asked what I am still doing here? My family carer and I just told them to go. But they were then told off by the A&E nurses.

25. The crisis team in Ipswich have said it is a choice that you are here at A&E, which is not good.

26. If you go into hospital in crisis, why cannot you be referred immediately to Suffolk Wellbeing to get help or support.

27. A&E is very poor, people are taken in after an overdoes and then sent home, no leaflets or follow up treatment. They need to look at this in this department, maybe having people in A&E who can pick up people afterwards like a reverse tri-age to check on them and maybe give them a call the next day, would really help.

28. If I am in crisis sending me home to cause collateral damage is not good, but it is the system.

29. When I am in crisis there is an assumption from handling things to not handling - I know I can ring you, but I pass that point very quickly and some people will not have time to make calls.

30. We need to be treated as individuals. In Colchester A&E I have been treated better than in Ipswich. In Ipswich I was discharged home, but they would not come out to me, so I had to go to Woodlands each time. No one is treated as an individual I am just a number in front of people.

31. We need an advocate or peer support workers in A&E who knows the process and can challenge staff regarding their behaviour, attitudes, and processes, as when we are in crisis, we cannot always challenge this as we are impaired. But an advocate or peer support worker can work with staff in the hospital, but this would be needed all hours, 24/7.

32. The LISTEN model used in crisis care for mental health transformation should be used by Psychiatric Liaison and the acute trusts A&E departments.

1.3 Norfolk & Suffolk NHS Foundation Trust Services, including community care in the Integrated Delivery Teams (IDT), Inpatient experience, and Home Treatment Teams.

33. I have been waiting for CAT therapy to start and it has been six months. There are lots of people in hostels who have mental health and substance abuse etc, Suffolk Police are good with dealing with us when we are feeling suicidal or in a state of crisis, but I worry about NSFT as their staff do not have sufficient compassion. I know they do not have many staff, but the empathy is missing from their staff and it does not help people in crisis.

34. I was told by a care coordinator that we can change your medication but if this does not work nothing will, which is not helpful, and therefore language is so important.

35. One psychologist I never met assessed me as a threat to my family and sent me a letter to say that. There is a lack of empathy in how they communicate things. I went into see him as I was not happy. I saw another person and was then assessed as not a threat to my family. None of helps my wellbeing. Staff need to assess people properly.

36. One time I have been discharged from Integrated Delivery Team (IDT) and I was not stable. I had a psychiatric assessment but had one already booked, I explained how I would do stuff to the nurse and psychiatrist as I said that I was unwell and in a place of anger so they deemed me as dangerous, but the problem is that this never gets reviewed so I am left with a label, and under GDPR this should be reviewed.

37. As a patient or service user you build a relationship with a nurse or practitioner. You get better attention from full-time staff than the agency staff – agency staff seemed to be in it for the money and do not engage with you. Most of them I could not understand because of their spoken English was not clear and it felt I was just a body. I could speak to three or four people when I was there, in hospital for a year and these staff understood me. But none of them expected me at the time to try suicide. My suicidal thoughts were sporadic and with no warning signs and even with a strategy, I still would have done it.

38. My IDT has been fantastic and had same support worker since I came out of hospital in 2015. I have had six psychiatrists and had to tell my story so many times. I then refused, as they had not taken the time to read my notes. I had even been thrown out of one session and was with my support worker. The Psychiatrist turned up 15 mins late and told me how they had been a Psychiatrist for 30 plus years and I could do this and do that. This was patronising to me. The problem is you get locum after locum and they do not read my notes, but they say they have and when I ask them about my last incidents, they cannot tell me. They have not read my notes!

39. I had a good experience from my care coordinator whenever I have been in crisis. My care co contacts me immediately when I am feeling suicidal. They contacted the home treatment team who came daily and brought my medication daily due to risks. Then I contacted the crisis team a few months back and it was someone who knew me from the wards, so they were able to talk to reassure me which was great.

40. Other people have been discharged from NSFT IDT as they were told they were drinking too much. I was told I had to not drink for three months and work with Turning point. Because I did not, they discharged me, which was not good, so no support, no care coordination.

41. It feels that the staff are too rushed and stressed and NSFT are not doing their best, even though the management has changed.

42. There is a lack of empathy even though they might not be able to help but they can listen and think about how they speak to people.

43. (In)Patient interaction is shocking but acknowledged by staff, which is more shocking.

44. I have numbers to IDT and the one number I would call is the Samaritans and they would be the only one I would call as they have such a breath of understanding.

45. I was discharged over the phone from NSFT services, which is not acceptable, then you are left with no support or no step down with another service.

46. People struggle to pick up phone, even professionals who call FRS line and say they would not call if they had a concern about someone as FRS do not want to know or follow up with people - so where do you go?

47. Can friends and family call the FRS as they should be able to ring number, but when I did, they did not want to help me and said my relative needed to call themselves, which defeats the object.

1.4 Norfolk & Suffolk NHS Foundation Trust - Recovery College

48. My interaction when telling people my story who have lived experiences at recovery college has saved me especially through lockdown. The support from SUF has been a life saver for some including me as they have been checking in on me.

49. Recovery college helps.

50. Professionals need to go to the recovery college and sit in the lessons, so they understand where people are coming from, so the barriers do not get put up.

51. There needs to be a suicide awareness course at the Recovery College and now everyone can attend its good.

52. Recovery College needs more young people and males to attend as most people who attend are females. There needs to be a Men's emotional health group course and a few others specifically for men. There is more work to do talking with groups. NSFT Recovery College has a signposting page on various courses so this could be a good way to get information out and maybe getting people to participate.

53. At the Recovery College you are an equal whether you are a service user or professional and that is what is needs to be, more of.

54. The Recovery College is in the wrong areas and needs to be central and inviting and maybe with a cafe. There also needs to be opportunities in the community especially rural areas.

2. Living with suicidal thoughts

55. Not a day goes by where I do not think of suicide and see an object and think I could that harm with that and its difficult.

56. I am not sure how medical staff could recognise this - I have tried to hang myself but was found. There was no indication that I was down or depressed and that I should have been watched. Another time I left the building and got to London by train. I was going to throw myself on the subway trains and was close to doing this. Then I thought about Heathrow Airport and considered throwing myself off the car park. I hired a car to drive there. I then stopped on the road and then called for help. I am not sure how I did this. My symptoms were not noticeable, and no one could stop me.

57. I do things on spur of the moment and I am afraid of failing - it is not predictable. I do not really get down. It started at school and then went onto my adult and working life.

58. It is my fear of failure, but I know I am successful at work.

59. I just have black clouds over me, that come on very quickly.

60. I dream to have someone call me rather than getting in crisis and then struggling to call someone and to say how I am are feeling. I do not want to keep telling my story every time. If someone were to call me just to check in and then this would give me more sense of purpose than me struggling to call. Could this be done by GP?

61. When I am unstable, I say not very nice things and there needs to be more understanding about this.

62. Stigma **–** suicide is a taboo subject and being associated with suicide can bring misconceptions and prejudice. Sharing might risk that information can be held against you.

63. Negative attitudes to and assumptions about people with lived experience – one participant commented that people with lived experience can be seen as victims, and people may be ‘fearful of us’ and not know how to respond.

64. Dealing with imbalances of power – there is a need for parity of respect, for a cultural change whereby lived experience – and not just professional expertise – is truly valued and respected, however uncomfortable it may be to hear the messages that people share.

3. Reaching out for help - A need for early, helpful support

65. I said to a friend I wanted to die by suicide, you can't really say this quickly on an app. My friend then said let us talk about it and get you help.

66. We need to get people as early as possible we do not want them to get to crisis, its detrimental to us it takes longer to recover which is not good for anyone.

67. Prevention is better than cure.

68. I do not always want to see professionals as I am not bad enough to have any help, we need to get help at the earliest point to stop crisis or even worse suicide. People need to be heard and validated - there is a need that needs to be met that is why we are ask for help.

69. We need to understand people's sudden urges and sporadic behaviour around suicide.

70. We need also to accept that we need to be able to communicate with simple statements like 'I need help'. Sometimes people need to talk in that moment, you need to understand what I am looking for when I make a statement that I will hurt myself. I do not want police to come along and section me unless I commit a crime, I just may need someone to talk to me.

4. Experiences of supporting others in distress

71. When I support people, the feedback I hear on suicide care is shocking; it is heart-breaking. They have been spoken down to, told that it is their choice. They are not at A&E because they want to be there, it is part of the care and support process.

Staff should not challenge their self-harm or suicidal behaviour; I have been able

to support people and challenge staff on their attitude, but most people do not have someone and maybe this needs to be looked at in the hospital. A role needs to be created for someone who can talk to someone -this would be invaluable and important and there needs to be more compassionate understanding.

72. Sometimes people say then they will not call an ambulance as they have been treated to badly. You do not choose to be in that position, you are there as a way of coping with the situation. It is a culture in the hospital that has been not been okay and which has not been addressed.

73. When people have been put in hospital after a suicidal attempt and then been assessed to go home, so then they are discharged with no support or help - there is no consistency.

5. Attitude of professionals

74. It is not just picking up the phone that is hard, it is the thoughts you have about being a waste of time, that they are not listening to me and you battle with this.

75. People judge you when you feel suicidal sometimes, as there is not a reason why you are feeling it, we do not want people in crisis we need a middle layer to prevent this. There are too many judgements when you are feeling suicidal, but professionals will not do anything. We know we do not want to do it, but we sometimes have no choice as we need to release the pain. Although there is no intent, it is the impulse attempt as no one knows what is in someone's brain, just because you do not have plans now does not mean that you are not thinking about doing something.

76. Professionals make judgements on us when they do not even know us or do not even spend the time with us.

77. Suicidal ideation is more important as we are living with it, and when you go to hospital, they say you are not going to do anything. Also get told you are not bad enough or you self-medicate as there is nothing else and no support.

78. Lack of consistency when you are in crisis everyone is ok and rally's around to help you but then you eventually get left with no one and you start to feel worse again.

79. Suicidal ideation is more important as we are living with it, and when you go to hospital, they say you are not going to do anything. Also get told you are not bad enough or you self-medicate as there is nothing else or support.

80. It feels like I must have serious suicide attempts to get back into services as this is my only option.

81. Language is important. Psychiatrists language is bad they do not have time and just work to get you off their case load. They are very clinical, and they make judgements in the first five to ten minutes which is not helpful. The recovery college use language right as its more peer support, peers who understand. Peer supports helps as people share how they cope as well as their experiences.

82. I have been told before it is my choice if I do something, which is not helpful, also I feel sometimes talking to clinicians that you are afraid of saying something wrong in-case it gets misunderstood but when you speak to peer support people it is just understood when you say stuff.

83. Also, police interaction needs to explain what they are doing if they do need to handcuff me or take me away. The Missing people programme was good, as the number one priority was to find him not the warrant.

84. Consistency is so key, you need to be listening, not judging, being caring, listening to family etc., be able to open a dialogue with a person and treat them as a human. How you come across can be judged in some many ways also if people make statements like I want to die by suicide, do not act surprised or panic.

85. It is very helpful to share stories, listen to one another, and develop a level of mutual understanding.

86. Some form of training is needed for professionals to reconsider why they came into health care in the first place - I know people are fed up etc, as it shows in their demeanour and behaviour.

87. We need to get the Professionals and the NSFT board to meet service users so they can get a better understanding of the issues, as there is a real lack of people at the top of organisations who understand the experiences of people receiving services from people at the bottom of their organisation.

6. Social, economic, and COVID-19 pandemic factors

88. It is important to highlight the impact of those social determinants of health, including mental health;

- So, for example, as the furlough scheme comes to an end in the UK now in March 2021 more and more people are bound to lose their jobs.
- Already the numbers applying for Universal Credit (worth less than £100 per week) have been increasing; this gets worse with each lockdown and the instigation of restrictions, particularly on certain businesses.
- Therefore, the poverty in Suffolk, as elsewhere, that will be experienced by families will increase.
- This necessarily will impact on family's physical and mental health. This will manifest itself in increases in depression, increases in domestic violence and so on.
- It is not mental health services that people will want, it is access to an income that can help them to avoid depression and domestic violence in the first place. Is that not what a preventative approach to ill health would look like?

89. It is the deprivation in our County that needs to be addressed as a priority in my opinion.

90. Life experiences have the biggest impact on men who take their life in the community and who are not known to mental health services; it is issues such as businesses failing, trying to live on Universal Credit.

91. We need to be planning for the consequences of the pandemic and how this has impacted and will continue to impact on people's lives in the longer term.

    For example, we know how loneliness has affected people for many years, this I think has increased with the lockdowns, many more people are lonely and alone. Children and young people have been missing out on seeing and being with their friends and the routines of school, this will not help them develop friendships and connections in their future life, we all need a circle of support around us to be healthy adults, people we can turn to for support when life gets tough.

92. I am concerned about COVID and the economic recession and how this will affect people.

93. We need to consider the impact of COVID when looking at suicide prevention understanding how much people have been affected by this second lockdown and

the impact on their mental health.

94. There has been an increase in suicidal thoughts in those who have long term mental health needs, alongside an escalation in self harm and eating disorders. We have also seen an increase in anxiety and depression in family carers and those who have previously not had previously diagnosed mental health needs.

95. I think Suffolk Constabulary has recently said that 50% of all incidents they are attending are mental health related.

96. I am worried that more people have anxiety and depression and people who have long COVID say they are more depressed.

97. We need to think about the longer-term impact on our children and young people's mental health, who by adulthood will have spent a big part of their lives living through COVID and this may well affect their adult mental health.

7. Suicide Prevention in the workplace

98. We need to talk more about mental health and suicides within workplaces, Inroads in Suffolk and North Essex Occupational Group and no one talks about it in this group and this needs to be done as a guest speaker to talk about this issue and how we are tackling it.

99. There needs to be more support in businesses for people.

100. Suicide Prevention in Workplaces - It can be easily brought into workplaces with slides, screen savers etc to get messages across that there is help there and were to go.

101. Health and safety people need to talk about well-being and mental health.

8. Suicide Prevention Information

102. There is an awful lot of information and you must find it.

103. Many participants had heard of or knew there was a suicide prevention strategy for Suffolk, but they had never looked at it in detail. Others were unaware of the strategy and did know what had been happening in Suffolk or their area. Participants stated.

- People need to know about the strategy.
- There needs to be a smaller strategy that is less wordy as goes on, we just need bullet point version, saying what is happening, where we can get help, what training is available, how people can get involved. We need current information about last year and this year and needs to be kept updated and current.
- It seems like there are resources issues within everywhere, we need to go to a service who are going to take us seriously and that consistency across the hospitals. We also need to know what the service is we expected from them.
- How do people on the street know what is going on, or how they can get signposted?
- Suffolk Public health strategy for Suicide Prevention needs to be written and provided in different formats to be inclusive to a range of people.
- Peoples mindset does not lead people to read strategy is etc. we need to make things simple and visual.

104. A saying I use is "When eating an elephant take one bite at a time and be careful where you eat from." So, do not try and chew off more than you can and that is what we need to do the strategy we need to concentrate on small bites and do not think we have to do everything at once.

105. Participants were not aware the Suffolk Life Savers campaign, they suggested more posters in public toilets, workplace toilets and school toilets.

106. Some people were not aware of the First Response Service 24-hour helpline and stated this needs more publicity.

107. Some people did know about the Stay Alive App, others did not or did not know it was still available.

108. Participants were surprised about the number of suicides in Suffolk.

109. People were not aware Suffolk police had triage nurses and did not know about their role.

110. Let everyone know what Suffolk is doing and what is available e.g., training etc so we can get more people involved.

9. The need for connection and local support

111. We need to connect more with 5 ways to wellbeing and we need to take responsibility for ourselves on trying to do this e.g., going to cinema on my own and there were lots of people in there on their own. I have a small circle of good friends who know my story and you need to help yourself sometimes to move forward and ask for help.

112. Asking for help is hard and the upkeep help is hard, building relationships are key so they know your warning signals. Regular contact is key and to talk to someone if you are having a good day is just as important as when you are having a bad day. It is important that it is with one or two people not different people every time you call. Important that you are listened too, heard and you are validated in what you are saying and not just on a clock all the time, so you feel rushed.

113. We need to know what help there is, we need consistency, people maybe calling us on an ad hoc basis to stop us going into crisis.

114. People need to fill their days sometimes, so they have something to look forward to but needs to be local. Human contact is so important maybe something like a rural coffee caravan for mental health so people can be signposted or have a chat.

115. Ask people more about who they have contacted for help, for example 'Have you contacted the GP?' and make sure you signpost them to other agencies.

116. We need somewhere for people to go in Suffolk, a crisis cafe in local areas.

117. Not enough local support in our local areas, everything is Bury and Ipswich centric. The recovery college needs to become a local college. Lockdown has helped as more can be done over Zoom and it has taken away the need to travel and the anxiety, I have about traveling.

118. We need local support groups like a coffee morning or drop in either online or at a physical place.

119. More posters for suicide awareness need to be in towns and villages as I have not seen anything.

120. GP's need to hand more leaflets/factsheets, which should also get handed out, letting people know about support, about the recovery college, or a drop in or websites for wellbeing - it goes with the prescription.

121. Maybe more TV adds that go out to the public about suicide awareness and training etc as people do not know what is out there and what's going on.

122. Maybe posters at supermarkets or people giving leaflets out or a leaflet through people's houses as we have done this re COVID so we should be able to do it for mental health and wellbeing.

123. A phone call to us is good rather than ringing them but I know it does not always work. I would like an email or text option when I am in a state as I am not having to imagine what the thought process what the other persons thinking.

124. Also, someone making a follow up call after you have been in hospital or A&E just to see how you are doing and if there is anything you could be sign posted to

125. We need to get people connected in their community, so they have connections and links to activities etc. Also, people need to eat properly me included as you then start to cook for yourself and take little steps to take your mind off stuff.

126. We need to get people to think they add value to society whether its volunteering or doing courses etc.

127. Networks seem to be key to success.

128. Men and women use apps for support and connection, but the challenge is coming back to it once you have made a decision as you are not going to be ready to do anything on the app or you may leave you phone at home as your mindset is in a different channel and people - people who are spur of the moment do not look at their phone.

10. Language

129. Language of ‘man up’ puts barriers up for men to get help, but changes made to help men are not filtering through into real life.

130. Language is really import to people and how things are said. When you are in a bad place already you do not need any more stress caused by the way people talk to you.

131. If professional staff could treat you like a normal human being everything would be better, and things would be easier.

132. We need to be treated as individuals.

133. People are still being told, suicide is a choice - suicide is not a choice and we need a universal language across all areas. Communication is key when we are in that situation our cognitive functions are impaired, so language must be thought about, as you are not talking to a normal human being at the time we are slightly off set.

134. Empathy is needed - we are not making a choice which is what they say.

135. Professionals should just LISTEN!

136. Get professionals to listen to people’s stories as this is so powerful and important, it builds understanding and human connection.

137. Change the language, save a life suicide is not a choice.

11. Dual diagnosis

138. Why do drugs and alcohol and mental health services still not work with each other.

139. Dual diagnoses need to be sorted out as it is still not being addressed

12. Building coproduction

140. Some of the people would like to be a part of a service user group for the strategy and some training if available; one participant stated, 'I am happy to be a part of the SUF engagement group and to help further develop what is happening now in these coproduction conversations.'

141. Training – "You can't teach experience but can support people in how to make use of it." Co-produced training could include telling your story, confidence building, peer support, and public speaking, always ensuring that people's experiences are used in ways that are safe and useful to them and to others.

142. Sharing our stories – if you are a representative on a local suicide prevention planning group, for example, it would be important that you can represent and reflect more than your own personal experiences.

Suffolk user forum

your voice for emotional and mental health

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