Health and Sport Committee

Suicide Prevention Action Plan call for views

Written submission from the Mental Health Foundation Scotland

Suicide Prevention – It's Time for Whole System Change

The Mental Health Foundation (MHF) is Scotland's charity for everyone's mental health. Our vision is for a world with good mental health for all. Our mission is to help people understand, protect and sustain their mental health.

Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place. We inform and influence the development of evidence-based mental health policy at national and local government level. In tandem, we help people to access information about the steps they can take to reduce their risk of mental ill health and increase their resilience.

This consultation

No caring society or government should tolerate the suffering and despair that leads a person to take their own life. Each and every suicide is a tragedy which can be devastating and life-changing for those they leave behind. But suicide is preventable, and more needs to be done to identify suicidal ideation at an early stage and provide compassionate and appropriate responses without delay.

It is disappointing that while mental health has taken a more prominent place on the political agenda over the past decade, suicide prevention has lost impetus and drive at both national and local levels. This has got to change. Suicide is a serious public health challenge that requires adequate resourcing, leadership and efficient structures – themes which we will explore later in this response.

In Scotland, on average, two people will die by suicide every day. While we welcome the significant reduction in suicides over the past decade, Scotland still has the highest suicide rate in the UK after Northern Ireland. And for the first time in six years, the most recent statistics showed an increase in suicides in Scotland. While we urge caution with interpreting these statistics, due to yearly fluctuations, it's important that the increase does not turn into a trend.

That's why in this consultation we are calling for radical redesign of suicide prevention services, strong national leadership and a newfound impetus to place Scotland as a world leader again in suicide prevention, as it was during early years of Choose Life.

The Scottish Government's consultation has significant gaps and lacks clarity over fundamental issues, including resourcing, timescales, structures, the future of Choose Life and policy based strategies such as gender specific interventions. Notwithstanding this, we see this consultation as an opportunity to shape and influence the new suicide prevention landscape going forward.

Local authorities do not ring-fence suicide prevention in local spending plans. Freedom of Information data obtained by the Mental Health Foundations reveal a significant drop in spending on suicide prevention in a number of local authorities in recent years. Continued improvement in the reduction of suicide relies on appropriate funding for suicide prevention,

especially initiatives targeted at higher-risk groups, such as men and the most socioeconomically disadvantaged.

In September 2017, on World Suicide Prevention Day, the Foundation published a 12 point plan to tackle Scotland's suicide rate. This consultation response builds on that work, which aimed to kick start a national conversation about suicide prevention with the ultimate intention of influencing policy makers at national and local levels, increasing public awareness and drive change. Our 12 point plan will form part of this consultation response.

A Knowledge into Action Group

We would welcome the establishment of a knowledge into action group to improve the use of evidence, data and guidance on suicide prevention. Direct survivors as well as those bereaved by suicide and professionals should play a central role in such a group and their valued experience utilised in the development of any new guidance on suicide prevention.

The group's membership should involve a broad set of disciplines, including the third sector and academics. Applied research methods could be deployed to consider specific studies, such as inequalities and socio-economic factors, vulnerable or at risk groups, postvention or public mental health strategies. It should consider international best practice and work with international partners to further learning in this field.

It's pivotal that the data and evidence gathered through this group is then turned into meaningful resources for local suicide prevention groups and not merely published as academic literature. The output should be practical and purposeful.

We know that the causes of suicide are many and varied, with a range of complex factors often involved, however, the underlying factors that lead to a person's decision to take their own life is less known. Given that (according to the latest figures) approximately 70% of those who died by suicide had some form of contact with healthcare services in the year prior to death, and that we are not making great strides in predicting suicide, greater research is needed in the psychological factors that lead a person to choose to take their own life. Direct advice for at risk groups should be developed by the Knowledge into Action Group, ensuring that advice and language is appropriate and up to date.

Research into why Scotland continues to have a higher suicide rate than other parts of the UK should also be explored.

As a research charity we know that the evidence exists to achieve the transformation of the mental health of people across Scotland through prioritisation of investment in prevention. A greater understanding of, and clear plans to address inequality is required to ensure a mentally healthier society for everyone. It is also essential for working out how to allocate suicide prevention interventions in an evidenced based, meaningful way to ensure proportionate investment.

The relationship between inequalities related to socio-economic status and protected characteristics and poor mental health is two-way: experiencing disadvantage and adversity increases the risk of mental health problems and experiencing mental health problems increases the risk of experiencing disadvantage. Mental health problems can create a spiral of adversity where loss and related factors such as employment, income and relationships are impacted, and these things in turn are known to compound and entrench mental health problems, sometimes leading to suicide.

“It is time to adopt a wider lens for suicide prevention, and to implement population-level strategies that address societal influences and inequalities in the contexts in which suicide occurs. A public mental health model provides a framework for action for the range of approaches needed to address suicide prevention[1]”.

Suicide prevention should be progressed through a whole community approach, making the most of opportunities to reach people in a range of settings including workplace, schools and the criminal justice system. While mental health services have a part to play, we need to focus on the contributions of all public services and government departments, and the vital role of the voluntary and community sectors and businesses.

Training

The multiple range of mental health and suicide prevention training available to employers and schools, for example, can be confusing. These include ASIST training, Mental Health First Aid Training, SafeTalk, and a range of resources provided to schools and teachers to deliver wellbeing classes. It's time to bring these together under a "National Mental Health Training Programme". Training should be accredited, in order to increase uptake, and modularised, with a number of different 'levels'. Parts of the training could be delivered online.

The different strands of mental health and suicide prevention training are extensive. For this reason we propose modularising the training, from a baseline level (general mental health awareness training) all the way to crisis management and suicide prevention. People can be trained at different levels depending on their role and contact with others. Work settings, schools and community groups should ensure that baseline mental health training is delivered with the same commitment as physical health training and that a minimum number of people are trained on suicide prevention.

As per First Aid for physical health, mental health and suicide prevention training should be renewed every three years. Requalification should be a requirement for anyone seeking to deliver the training - this should be no different from physical health. The consultation paper states that according to NHS Health Scotland 92,521 people have been trained in mental health or suicide prevention training across Scotland, however much of this will be historic and many of those trained will be in urgent need of a refresh.

As stated in our 12 point plan, embedding compulsory suicide prevention training for all clinical health workers, allied health professionals and pharmacists must be a key plank of any suicide prevention strategy.

59% of people who die by suicide in Scotland have received a prescription for their mental health in the preceding twelve months. Indeed, evidence shows that in many cases, contact was made with more than one health service. Around 25% had at least one psychiatric inpatient stay or psychiatric outpatient appointment in the year before death. Suicide prevention training should be embedded in core training for all clinical staff. Given that antidepressants can lead to suicidal ideation, pharmacists should play a role in signposting and giving people information about managing potential side-effects.

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[1] Beautrais, AL & Larkin, GL. Chapter 7. Suicide Prevention. In, Knifton, L & Quinn, N. (2013). Public Mental Health: Global Perspectives. New York: Open University Press. p.68

Consultation rooms in pharmacies should be available to discuss suicide and distress and resources and advice should be available. The Foundation believes that building stronger suicide prevention strategies into primary care, such as GP brief interventions, particularly for people with existing or ongoing mental health problems or those on a mental health prescription, can help to prevent suicide.

It's not only health professionals that are in need of suicide prevention training as this would severely limit the reach of those at risk of suicidal ideation. Key frontline services should include DWP and jobcentre staff, staff at the Scottish Government's new social security agency, schools, workplaces and communities. Compassion and empathy should be at the heart of the training, as well as ensuring that people are treated respectfully and taken seriously.

Whole System Change

We are calling for the establishment of a national body composed of expert organisations (a mixture of third sector and statutory organisations) that can give impetus, drive and leadership to suicide prevention at a national level. The See Me or Alliance models are strong examples of the kind of partnerships that could be created.

Involving trusted and respected charities to lead from the front will hopefully increase trust among those who need help or those who are suspicious about existing structures. Choose Life is often seen as a marketing brand rather than a place people would turn to for help. A new body should include organisations directly involved in suicide prevention, whether through delivery or research.

The remit of the proposed "confederation" is not clear from the consultation document, however - if the intention is to establish a network of supporters with little scope for leadership and direction we would not be supportive. Scotland doesn't need a talking shop on suicide prevention - it needs a new body with teeth, purpose and drive that can influence and support local suicide prevention work as well as national partner organisations.

The confederation (or "national partnership") should have the following functions:

1. Link with the Knowledge into Action group and ensure that its findings are incorporated into national and local strategies. The Knowledge into Action group should report directly to the confederation. 2. Develop an annual set of guidelines to assist local bodies shape their work plans. 3. Play a role in consolidating and modernising training for suicide prevention. 4. Initiate national and local campaigns on suicide prevention, such as targeting individuals with low mood. 5. It should report directly to Scottish Ministers. 6. Its work should be independently evaluated.

With regard to local delivery, we are clear that this should not be restricted to sitting with a single body such as IJBs or CPPs. We are calling for a partnership approach between statutory and non-statutory organisations, including the third sector.

As things stand, local Choose Life delivery plans are rarely updated on the Choose Life website, however from what we have seen, these are not strategic plans but broad aims and objectives. While we acknowledge that much laudable work is being undertaken locally, it is extremely difficult to assess the impact of Choose Life on the ground. It is also the case that Choose Life coordinators are not full time roles in many local areas, with some areas employing coordinators for only a handful of hours a week.

Our Freedom of Information data show that some local areas are failing to prioritise suicide prevention with some substantial reductions in some local areas. Lack of guidance from the

Scottish Government to Community Planning Partnerships on suicide prevention post concordat means that local authorities no longer need to prioritise this agenda. It's difficult for the Scottish Government or even NHS Health Scotland to know exactly what suicide prevention work is being funded.

Without clear leadership and guidance from government, and in light of local budget pressures, local suicide prevention work will continue to be eroded and marginalised. This lack of transparency and commitment cannot continue and propose two possible budgetary solutions:

One option could be the creation of an innovation fund where local projects bid for funding from a national pool. A second option would be the introduction of ministerial guidance to statutory bodies (LAs, IJBs and CPPs) to ensure that spending is directed towards suicide prevention.

Crisis

In a state of crisis people often don't know where to get help. The Foundation is clear that early intervention is crucial and calls for a co-ordinated approach in responding to crisis between emergency services.

We need a more co-ordinated, consistent and compassionate response to people in crisis and distress. However, research shows that existing service models are inconsistent and patchy and not enough co-design with people that use the services has been undertaken. Effective and regularly evaluated crisis plans should be implemented by all Health and Social Care Partnerships.

The Foundation believes that the successful NHS Greater Glasgow and Clyde Community triage service should be rolled out across Scotland and that out of hours services should be available and accessible.

Triage allows mental health professionals to intervene directly, avoiding hospital admissions or detention in a police cell and ensures people receive help in the community, with local emergency services working more efficiently together. Intensive home treatment teams have also proven to provide fast, effective treatment in the community and reduced hospital admissions.

The ongoing DBI pilots are a real opportunity to provide compassionate, person-centred support when people are in distress. We look forward to the evaluation of the pilots, however, we cannot afford to wait years for an effective system to be put in place nation-wide.

When people call NHS 24 in a mental health crisis they should be directed towards a mental health team that will provide support fast, either in A&E or in local settings, depending on local provision.

It is extremely worrying that when many people present to A&E with severe emotional distress, mental health teams often refuse to see patients unless they are experiencing suicidal ideation. People in crisis should always be supported by mental health teams and we call for the urgent resourcing of mental health staff.

Supporting families and friends bereaved by suicide

Support for individuals directly impacted by suicide, particularly family and first responders. There should be a concerted effort to support family members in the aftermath of a suicide, as well as first responders, who are often close relatives or friends of the deceased. Such individuals often struggle to cope with the trauma of the bereavement and are themselves at a higher risk of suicide. A recent survey of bereaved young adults who lost a friend or relative by suicide found that 20% had received no mental health support. This has to change.

Families have told the Foundation that very little support is available in the aftermath of a suicide, such as liaising with the coroner. Research suggests that families and close friends affected by suicide are at greater risk of suicide themselves and the Foundation believes that they should receive support as a matter of priority.

That's why we are calling for a dedicated support service for immediate family and friends who have been bereaved by suicide. This should be a pro-active service offered directly to family and friends impacted by suicide through GPs and the police. Support must extend to young people and work colleagues depending on individual circumstances.

Protocols should also be in place for providing support to nonrelative first responders such as peer support, advice and the opportunity to talk to someone about the experience through a trauma informed approach.

Victims of Crime and People in the Justice System

Victims of crime often experience psychological distress and trauma. Around 40% of victims of violence treated in hospital emergency departments are estimated to develop a mental health condition.

The Foundation fully supports Victim Support Scotland’s call for psychological support for people affected by the trauma of crime. Extensive research suggests that there are strong links between mental ill health and Scotland’s prison population. Prisoners are drawn predominantly from disadvantaged communities; they are more likely to have been victims of trauma or abuse, or have a drug or alcohol problem. Around 7% report a history of self-harm, including a suicide attempt.

The risk of death, including suicide, after leaving prison, is particularly high amongst men, which is why the Foundation calls for greater co-ordinated action on re-integrating people to communities. The Scottish Government should work closely with the Scottish Prison Service to improve the mental health of prisoners, including supporting young offenders. Scottish prisons should work towards creating psychologically and trauma informed environments and shift the focus from a punitive approach to one that is person-centred and recovery based.

The Foundation also calls for support to be available for those serving community sentences with a view to addressing psychological and social needs and prevent re-offending. In particular, mental health brief interventions should be rolled out as a preventative measure to assist recovery and reducing re-offending.

Stigma

Fighting stigma and discrimination from classrooms to boardrooms. Mental health stigma is still present right across Scottish society, although progress is being made. 40% of employers, for example, say they wouldn't hire someone with a mental health problem. Our young people can be victims of bullying at school and as adults, bullying in the workplace is commonly reported. Mental health stigma is still present in our health service. People with mental health problems have too often faced stigmatising experiences from frontline staff and this has got to change. It's unacceptable that those in crisis and at risk of suicide can still face stigmatising responses in A&E and other health settings. Such negative experiences will only make it less likely for people to seek help later down the line.

By reducing stigma and discrimination we also reduce the risk of social exclusion and isolation. Our workplaces, schools, health service, as well as government and the third sector should embrace drives to stamp out stigma and discrimination wherever they may be. As a managing partner of See Me, the Mental Health Foundation believes that the vital work they do must continue.

However the double stigma experienced by survivors of suicide is often even more overwhelming. People can be accused of attention seeking; branded as weak and will have feeling of blame and shame. Services should not dismiss people with suicidal thoughts who regularly ask for help, whether in A&E departments or GP appointments. It is wrong to assume that if a patient has threatened to take their own life in the past they will not do so in the future. Patients known to services should be treated with the same seriousness and respect as anyone else.

Schools, children and young people

A key plank of any resilience programme must be delivered in schools. Teachers and peer educators need the right training and the resources to support delivery, however too many teachers tell us that they're worried about "getting mental health wrong" in the classroom. Health and wellbeing should be on an equal footing to numeracy and literacy and not perceived as a box ticking exercise – but to do that, we need to give teachers the confidence to explore mental health. A universal approach is needed, which incorporates a classroom programme exploring mental health. This should become standard practice across all schools and Education Scotland's

"Applying Nurture as a Whole School Approach" framework should be implemented across the board. Creating a "whole school approach" where young people feel comfortable discussing mental health would help build confidence, particularly among young people with existing conditions such as anxiety or eating disorders. But a targeted approach is also needed. It is alarming that 70% of children and young people who experience a mental health problem have not had appropriate interventions at a sufficiently early stage. In some cases this can disrupt learning or lead to alcohol or drug problems. That's why school-based counselling should be rolled out across Scotland, to provide fast access to support. This would also help furnish children and young people with the emotional vocabulary to be able to talk about their feelings.

Workplaces

The lowest-paid workers, who typically don't have much job security or control over their work patterns, suffer from the highest rates of suicide. Zero-hour contracts, for example, have created exploitative environments that keep people in low paid work because they're desperate to keep a roof over their head. It's all too common for people without a history of mental health problems to develop them because they've had to cope with the stress of living hand to mouth. Workplaces should end the silence on mental health and ensure employees have access to appropriate support during difficult times. Mental health awareness for line managers should be compulsory.

Indeed, NICE identify line manager training as one of the most important steps for mental health improvement in the workplace. We need to make sure employers accommodate reasonable adjustments (e.g. flexible working) for employees with mental health conditions and explore whether staff would benefit from welfare programmes like Access to Work, which can help people to stay in employment.

The Foundation believes that employers should respond compassionately to major life events, such as bereavements or relationship breakdown, to make it easier for people to return to work when they are ready. Finally, the impact of workplace restructuring and redundancies on the mental health of employees should be fully considered and acted upon.

Vulnerable groups

While death by suicide can happen across all ages and socioeconomic backgrounds, it's clear that men, as well as people living in poverty are at much greater risk. Indeed men in the most deprived areas are ten times more at risk of suicide than those living in the most affluent communities. This is why we are calling on the Scottish Government to commit to tackling the inequalities that too often are the root causes of suicide. By taking a preventative approach we can support people to thrive, become more resilient and live healthier lives.

We know that economic insecurity and poverty have an adverse effect on mental wellbeing. Indeed the primary health impacts of economic downturns are on mental health, including increasing the risk of suicide. We are asking policy makers to take a "mental health in all policies" approach which considers mental health across all areas including social, economic, and environmental policy. It's time for a compassionate welfare system that can support people with mental health problems during periods of ill health, an effective strategy to tackle homelessness, and investment in more disadvantaged communities and good quality housing. We need to do more to tackle in-work poverty, bridge the attainment gap in our schools, create more opportunities for our young people and take a preventative spending approach to health and wellbeing.

The Christie Commission concluded that as much as 40% of all spending on public services could have been avoided by prioritising a preventative approach. We believe that the Commission's recommendations should be implemented in full and that investing in prevention will foster more resilient and thriving communities.

Targeted approaches in some of Scotland's poorest communities are needed, including peer support, initiatives to tackle loneliness and isolation and support for people to find meaningful employment or volunteering opportunities. Scotland's new employability powers

must be focused on supporting the needs of people with mental health problems find and stay in work.

LGBTI people are also at higher risk of some mental health problems and alcohol and substance misuse. The rate of suicidal ideation and self harm for LGBTI people is 20-25%, compared with 2.4% for the general population. Coming to terms with an identity that is different to that of most of your peers, or coping with ignorance, prejudice and discrimination can be confusing and distressing, particularly for those who lack a supportive network of family and friends. Some people will face rejection and bullying which can adversely impact on self-esteem.

Greater support in schools should be available, particularly during puberty years, given the degree of emotional changes that can arise for many young people. This could include peer support or opportunities to meet others who are similarly exploring their identity. Ensuring that schools adopt a zero tolerance approach to bullying and nurturing an inclusive environment is pivotal in creating LGBTI safe environments and the opportunity for people to safely disclose their identity and be themselves.

Online

With more and more people spending more hours of the day online we very much support the development of online suicide prevention resources. This should be developed by mental health trained professionals and we agree that NHS 24 should take this forward.

We believe that online tools such as Facebook adverts and Google AdWords have the potential to target individuals who may otherwise not approach health professionals, GPs or A&E. It's crucial however that web chat is undertaken by fully trained mental health professionals.

People experiencing distress and suicidal ideation may also be experiencing loneliness and isolation, and where appropriate, once contact has been made with an individual in distress, face to face contact and local support should be offered and made available.

In the Netherlands since 2009, the Ministry of Health directly finances ‘113online’, a platform for the prevention of suicide that provides free support – anonymously – for people who are suicidal and their next of kin in pressing situations. 113online has a suicide hotline, a website with information and self-assessments, a moderated forum, online courses and online therapy. In 2011, 75,000 unique persons visited the website, 3,462 adults and 2,016 youth filled in the self-assessments, and 188 people attended the online course. Every day, an average of 143 persons visited the forum.