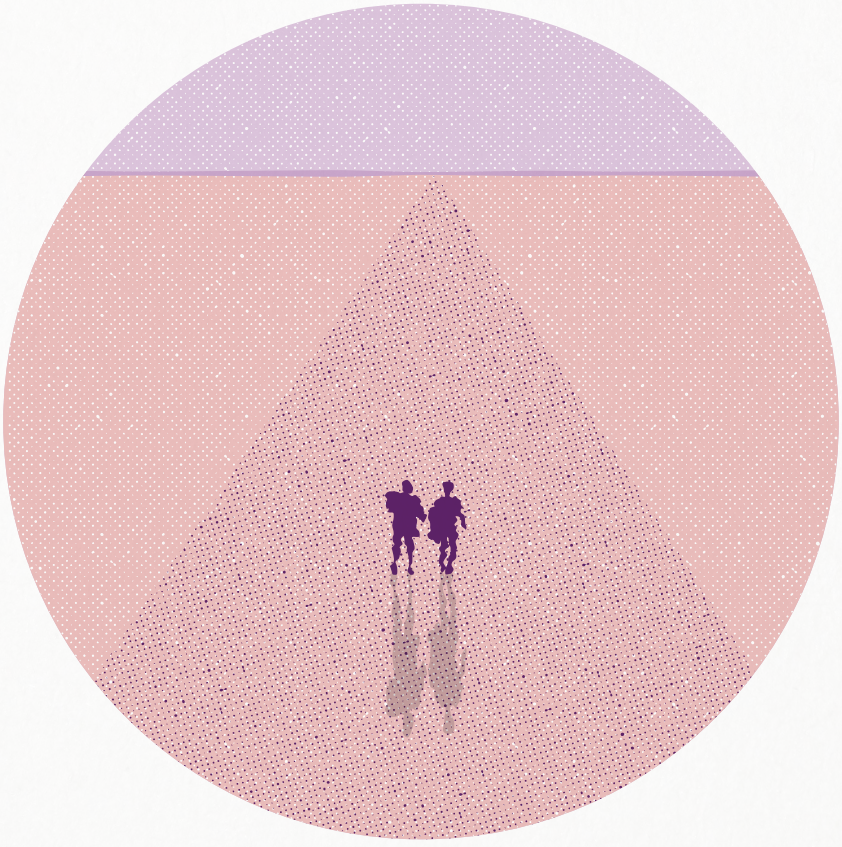
Suicide Prevention Strategy Report

Views from people affected by suicide as part of the co-production of the Scottish Government Action Plan on Suicide Prevention, October 2017 to January 2018



ALLIANCE
HEALTH AND SOCIAL CARE ALLIANCE SCOTLAND
people at the centre

Health and Social Care ACADEMY

NHS Health Scotland

SAMARITANS

The Scottish Government
Riaghaltas na h-Alba

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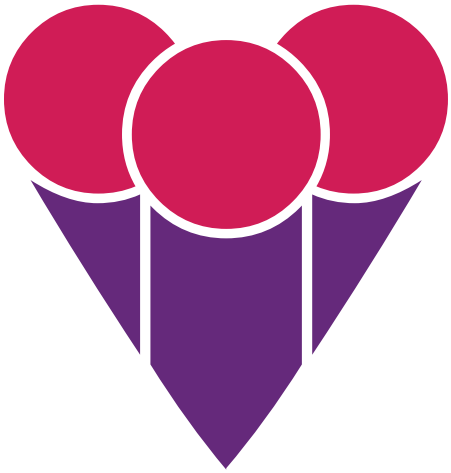
Introduction

In late 2017 and early 2018, the Health and Social Care Academy, a programme of the Health and Social Care Alliance Scotland (the ALLIANCE), Samaritans Scotland and NHS Health Scotland, supported by the Scottish Government, worked jointly to host a series of engagement events aimed at supporting the development of a new action plan on suicide prevention.

The purpose of these events was to engage those close to or affected by suicide and providers of relevant support and services to capture their views and experiences. During the discussions we referred to the creation of a new strategy. The Scottish Government has subsequently clarified that an action plan will be developed in the near future.

The partnership held six events from Inverurie to Dumfries, engaging with approximately 100 people. Full write ups from all the events are available on the ALLIANCE's website.



Overview of engagement

- Glasgow, 30th of October 2017
- Dumfries, 1st of November 2017
- Inverurie, 7th of November 2017
- Dundee, 28th of November 2017
- Glasgow, 23rd of November 2017
- Inverness, 8th of January 2018

Those affected by suicide expressed the tragedy, devastation and human impact upon their lives. We heard from many of the participants that support, services and attitudes had a significant effect on them during the distressing time following the loss of a life. Whilst there was some good practice to share, many people highlighted negative interactions that they wanted to see services, organisations and the general public learn from and use to improve their approach.

The Health and Social Care Academy, a programme of the ALLIANCE, Samaritans Scotland and NHS Health Scotland would like to thank all those who took the time to share their views on suicide prevention. This document aims to summarise those views and outlines a number of recommendations to support the development of the Scottish Government's forthcoming action plan.

Key Themes

Public Awareness and Campaigns

Participants were clear that there needs to be more awareness of the scale and prevalence of suicide in Scotland, and that national and local campaigns should address this. These campaigns should focus on breaking down stigma and common misconceptions around suicide, and encouraging people to talk more openly, and ask their loved ones about their feelings and thoughts.

> "Positivity is more powerful than negativity."

> "No one talks about it until it happens."

> "Suicide needs to be everyone's business, not just frontline staff."

The goal of campaigns should be to make it normal and acceptable for people, in a variety of contexts, to feel free to discuss their feelings and be told that they matter. At the moment, most people are too nervous to ask others whether they have considered suicide as they fear they could plant the idea in their head or accidentally say the wrong thing. Therefore, campaigns should focus on breaking down this misconception and giving everyone the confidence to have these tough conversations. This should include giving people the right vocabulary to talk about suicide, as common phrases and reactions can increase stigma, and the academic language used by professionals can be alienating to many.

On top of this, there was a belief that knowledge of local and national suicide prevention groups and services is poor amongst the general public, and participants said there should be more local advertising of these services so that community members are able to effectively signpost their colleagues, friends and family to the correct service if necessary.

Moreover, participants highlighted that although national TV campaigns and programmes (e.g. Finding Mike) are very helpful, they are not enough on their own. This sort of awareness-raising should be complemented by more local campaigns on the ground, which grow from the bottom up and involve face to face interaction between community members. These campaigns will make sure that local communities are talking to each other about suicide and driving change themselves. The 'No Substitute for Life' football tournament in Renfrewshire was highlighted as a good example of this kind of project.

Targeted Education and Training

Adverts for mental health first aid training and programmes such as Applied Suicide Intervention Skills Training (ASIST) should be well-known and accessible to everyone. It was highlighted that some people who complete suicide are not in contact with professional services beforehand but may have expressed their feelings to others. Therefore, as many people as possible should have training and knowledge of how to handle these situations to provide support and prevent escalation.
Beyond campaigns and training for the general public, it was felt that there were certain groups who should have mandatory suicide prevention training, and be aware of how their role impacts on those who are considering suicide, or have been affected by suicide.

GPs were seen by many to be a key target group for receiving training and support. Participants highlighted inconsistent support from GPs, some of whom did not seem to know how to talk to those who had contemplated or attempted suicide, and who did not know what services were available to support the person outside of formal mental health services (which often have long waiting lists). People believed that it is crucial to challenge the assumption that suicide training for primary healthcare professionals is not essential, and to make sure that GPs know the signs to look for, and how to support those they suspect or know are considering suicide.

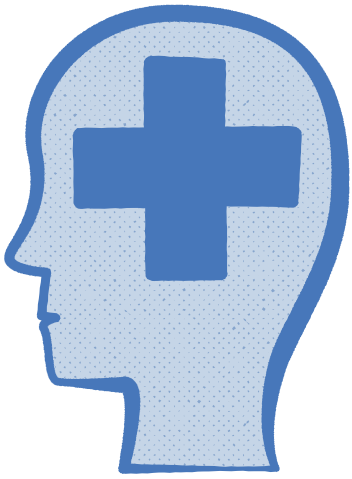
However, participants also stressed that training needs to be extended beyond GPs. Key groups highlighted included:

- GP receptionists and NHS 24 staff
- Prison officers
- Job centre staff and social security entitlement advisors
- Teachers and school staff
- University/college staff and lecturers
- Transport workers

Participants commented on the need for those working within the social security system to be much more sensitive to the stresses affecting their clients and how to be compassionate at these times of difficulty. For many people, their interaction with the social security system may come at a time of great difficulty – e.g. they may have lost a job, had their access to entitlement changed, or may have become disabled. All of these life events can be a trigger for suicidal thoughts, and so social security staff should be aware of this bigger picture whilst supporting their clients, and should be prepared to signpost them to appropriate support.

Receptionists and NHS 24 staff were also seen as a group that should be better trained in recognising and supporting callers in distress. Participants felt that calls with these staff could be key to identifying suicidal people and signposting them to the right services, but that at the moment these staff have a poor understanding of what to look for, and where they can signpost vulnerable callers to. One suggestion was that NHS 24 should offer the option of being automatically linked to mental health services, so that those in distress can get support immediately, without being transferred through a receptionist.

Specific support for children and young people is covered later in this report, however it is worth highlighting here that participants believed that teachers, lecturers, and staff at schools, colleges and universities are currently not prepared to support students who are in distress, or who have been impacted by suicide in other ways. It was felt that those in colleges and universities need to take more responsibility for students during the transition from adolescence to independent living, and that there should be a greater emphasis on recognising and addressing the signs of suicidal ideation early and effectively. Finally, it was also suggested that every company and organisation should have at least one mental health first aider, and that managers should be encouraged to undertake training in suicide prevention.



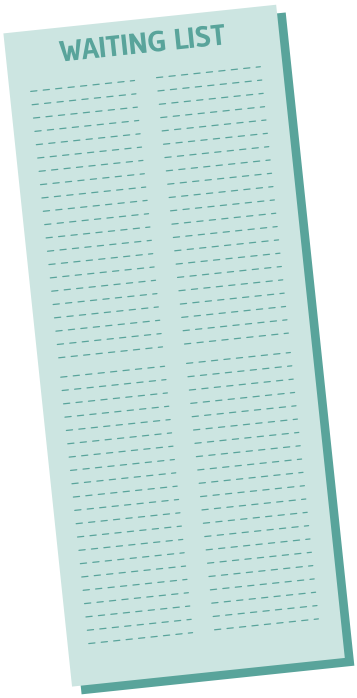
As stress at work or job loss can often trigger suicidal ideation, participants believed that having more staff equipped to support people in this position would help address these particularly difficult life events and create a more supportive culture within workplaces.

The key themes of the training for all of these groups were that services should always take people with suicidal ideation seriously, and should understand that the intention to harm oneself matters – they should understand that a suicidal person cannot wait for help, and should know where to signpost the person to, if they are unable to help. Participants stressed that all public-facing professions should be able to identify and support a distressed person, and remain calm, respectful and compassionate whilst providing support.

Access to Support

Participants were clear that early intervention must be a primary aim of the new action plan, given that timely and effective services are critical to preventing people from reaching crisis situations. However, it was felt that the availability of such services was too limited at present, and services must be faster to respond when someone is struggling to cope. People shared the view that 'gatekeeping' is tight at many services and there is a need for networks of services to support people who present at a less acute level.

People commented that the barriers (including lengthy waiting lists) which people must overcome before they gain access to services can mean that it is often those with the most determination and eloquence to articulate what they need that are likely to get support. The new action plan

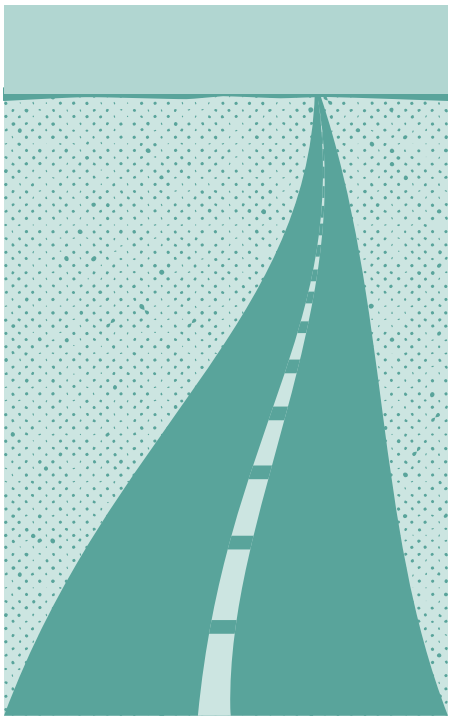


should therefore consider how people who are traditionally least likely to engage with statutory services can be reached and most effectively supported, in order to mitigate health inequalities. This includes consideration of the needs of people with protected characteristics under the Equality Act 2010.

We heard that it can be very difficult for someone experiencing less acute difficulties to build up the courage to go to a first appointment and that services that reach out first and perhaps offer home visits were particularly helpful in building trust.

Participants felt that the role of GPs was central to supporting early intervention. People stressed that GPs need to have the confidence, knowledge and resources to effectively signpost and refer people who are at risk to appropriate support services. Participants relayed a mixed picture of good and bad practice of signposting and referral within primary care. A representative from one third sector organisation highlighted that the process of GP referrals to their services was 'patchy'. One positive example cited to build signposting capacity within primary care was the Mental Health Directory Renfrewshire, which is a comprehensive and accessible guide to a range of mental health and associated services in the area.

Many consultation events raised issues encountered by people living in remote and rural areas, who shared frustration at often having to travel long distances (to large cities including Glasgow and Edinburgh) to access some services. In Dumfries, some people noted that services were closer to them in Carlisle but that the divide between English and Scottish services meant they had to travel further for support. Some participants felt



that services could easily benefit from greater investment and sharing of digital tools such as video-conferencing with people who require their support. Some noted that Skype had been used in the past to do this but its use was rare.

Support during a crisis

Participants stressed the need for services that respond to people in crisis in a consistent, respectful and person-centred manner, with key suggestions including:

Support to be provided in an open-ended and flexible manner where possible. We heard that when someone is experiencing suicidal thoughts, they often cannot imagine ever feeling any different, so in the words of one participant "being told by your counsellor that you only have six sessions isn't helpful."

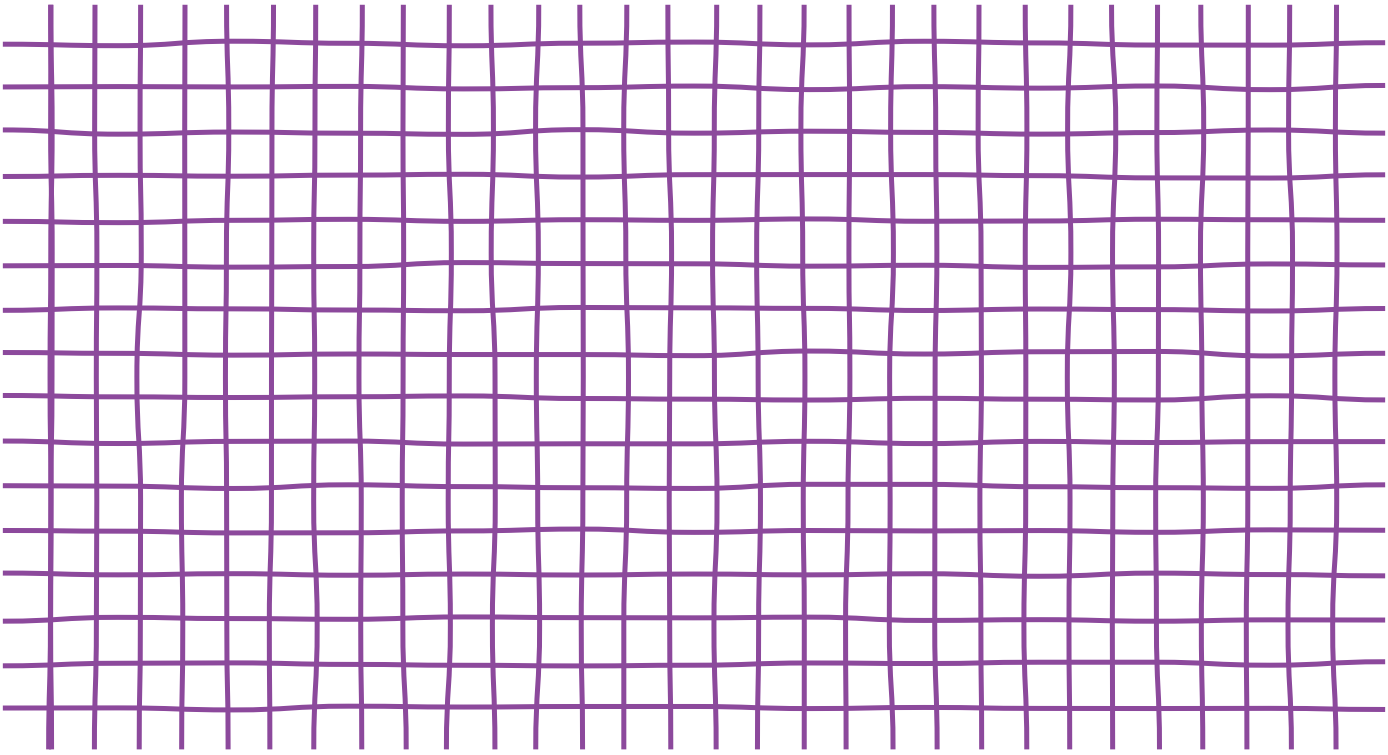
Improving access to services during the out-of-hours period, with calls to expand the length of time that the 'Breathing Space' service operates for.

More information being made available to inform people of the support services that are available to them during a crisis.

Improving crisis service pathways for people who may present whilst under the influence of alcohol or drugs. Participants told us that often these people are detained and taken to a police station which can exacerbate the trauma that they are experiencing.

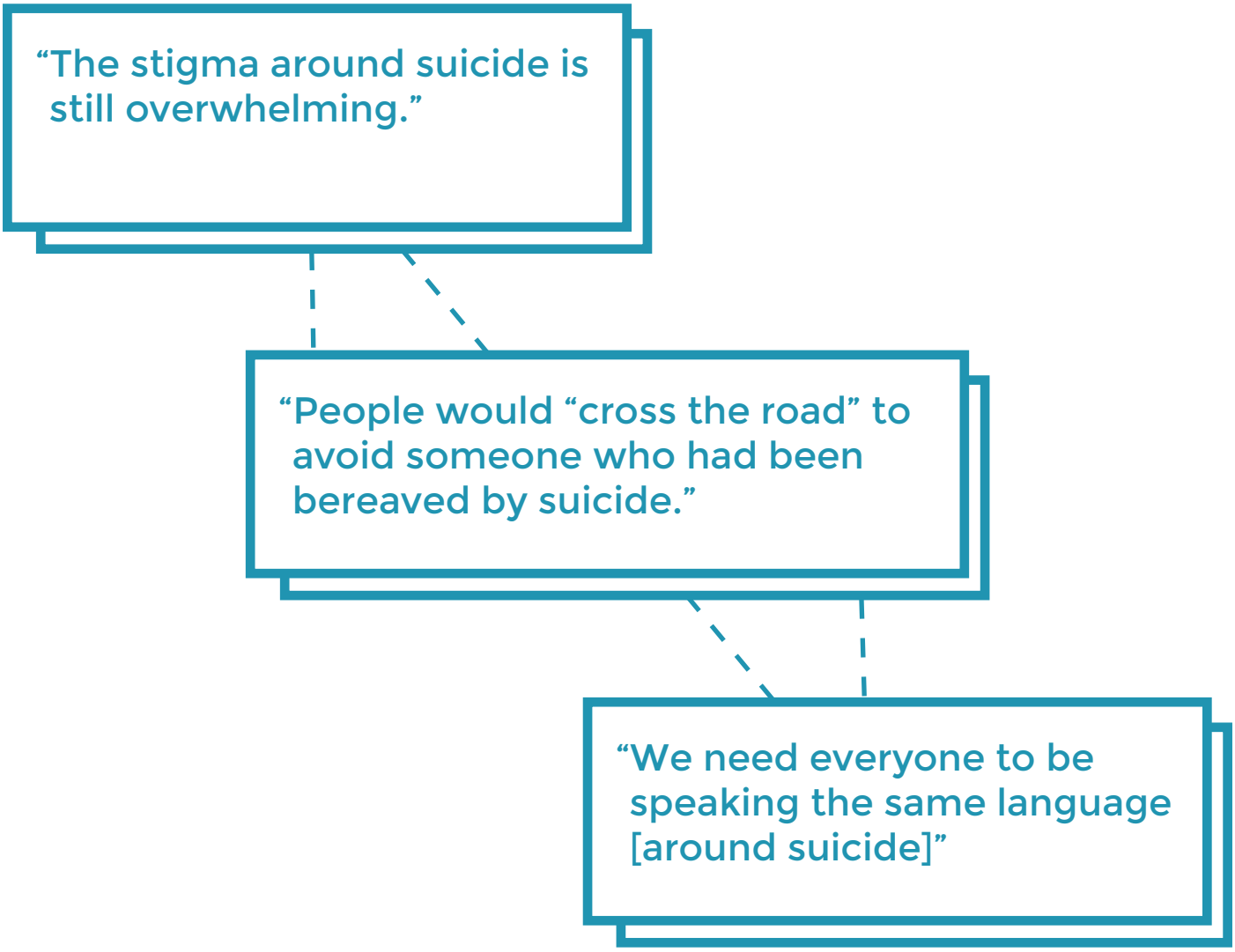
Post crisis support: for survivors, in the case of suicide attempts, and for families and networks in the case of completed suicides

Participants highlighted that the period of time following a suicide attempt represents a critical time for compassionate, high quality care, and the new action plan must consider how the care received by people at this vital juncture can be improved to ensure that an effective 'safety net' is in place to support them. Participants also expressed the view that the support and information that is available to people who have been directly affected by suicide, through the loss of a person close to them, must be improved. Evidence indicates that people who have been bereaved by suicide are themselves at a higher risk of suicide. We heard that the type of grief experienced by those bereaved by suicide is intense and the emotions experienced in the aftermath can differ considerably from those following other types of death. People spoke of the profound impact of losing someone close to them through suicide and the heightened social stigma experienced following a bereavement of this type, which can lead to isolation. Again, participants stated that the support provided must be timely in order to be effective. We heard that bereavement support should be accessible at the time when the person needs it, rather than having to wait for 6 months post-bereavement, which is a requirement for some providers.



Addressing Stigma

Participants told us that stigma affects not only those considering suicide, families affected by it, and wider communities but also the behaviour of services towards those who have attempted suicide. The phrase "*committed suicide*" remains in common use – a legacy of when suicide was still illegal – and reflects an inherent judgement. There was consistent feedback that this needs to change to a description of "*died by suicide*". The action plan needs to take a lead on using language that helps to build a more compassionate and empathetic culture.



The services themselves also need to change their attitudes to suicide. These following assumptions, experienced by participants, need to be challenged:

People with suicidal ideation are attention seeking, and using manipulative behaviours to get what they want – this leads service providers to underestimate the risk of the person completing suicide.

Self-harm is never related to having suicidal thoughts – again, this results in the behaviour not being taken seriously, and those who self-harm feeling isolated.

People who present repeatedly won't complete suicide as they have made many failed attempts before – there needs to be a recognition that intent matters, and this is backed up by many research studies.

If you ask people about suicidal thoughts you will plant a seed – this discourages the public and professionals from discussing suicide, when in fact people are usually relieved to disclose frightening thoughts.

People also shared examples of individuals who had presented at A&E and been told they had to go to the back of the queue as they 'did it to themselves', or were treated disrespectfully if they had presented before.

Strategies like the Zero Suicide initiative in healthcare settings were suggested as ways of breaking down stigma and increasing understanding across services and communities to challenge these assumptions and judgements, as well as creating multi-agency pathways of support.

As detailed previously, the need for campaigns to raise awareness, normalise conversations about suicide, and change attitudes was a consistent and strong theme at each session. The call is for a range of relatable and visible campaigns from local and national media to help break down the stigma of talking about suicide – this should include more people on the ground to speak directly to communities about suicide.

An approach like Safer Suicide Communities where communities have recognised suicide as a major public health issue and taken concerted action, was one suggestion, and the See Me campaign and Finding Mike were also highlighted as good models to address stigma. ASIST (Applied Suicide Intervention Skills Training) was consistently mentioned as an effective intervention at local or organisational level.

Stigma results in individuals being reluctant to admit to having suicidal thoughts and being "*put in a box*". This is even worse for young black men, and BAME communities generally. The action plan and any campaigns need to consider how to address stigma in at-risk communities in particular.

There was an overall theme regarding the need to emphasise the humanity of those who contemplate and are affected by suicide. Those who present in crisis in whatever context should be treated with the same respect and care each time, and approached by compassionate professionals. Stigma when accessing social security has led to people expressing the feeling that trying to obtain support for mental health issues is difficult and makes the situation worse.

Any campaign to tackle suicide should be set in a policy context of improving culture across public services.

Children and Young People

Participants were clear that the needs of children and young people required a specific focus as part of the action plan. This was seen to be a gap in current strategies around suicide, and engagement event attendees noted the lack of young people able to engage through the events.

"There needs to be more support for children affected by suicide – parents can't do it all, and are going through their own grief as well."

"Engage young people in the development of the strategy."

"We need to prioritise support for children in schools so that they become emotionally aware and resilient."

Improved support within educational settings was a key area where people identified potential actions which could support Scotland's children and young people, including:

Guidance and pathways for Schools and Universities in how to recognise and respond to trauma.

Ensuring that School Guidance Teachers and other key personnel can respond effectively following the suspected or attempted suicide of someone from within their community. There is a feeling that teachers are uncomfortable with tackling the issue, and avoid it where possible, which only increases the isolation of the young people affected.

Educational programmes that equip young people with the tools and understanding to discuss the topic with their peers – focusing particularly on the key signs to spot, practical listening skills and ways to ask people about their feelings.

Broader education to equip young people with the skills to manage their emotions and build resilience.

Education programmes designed specifically for children and young people with autism, who are particularly vulnerable to suicidal ideation – this may need to start earlier than for non-autistic children.

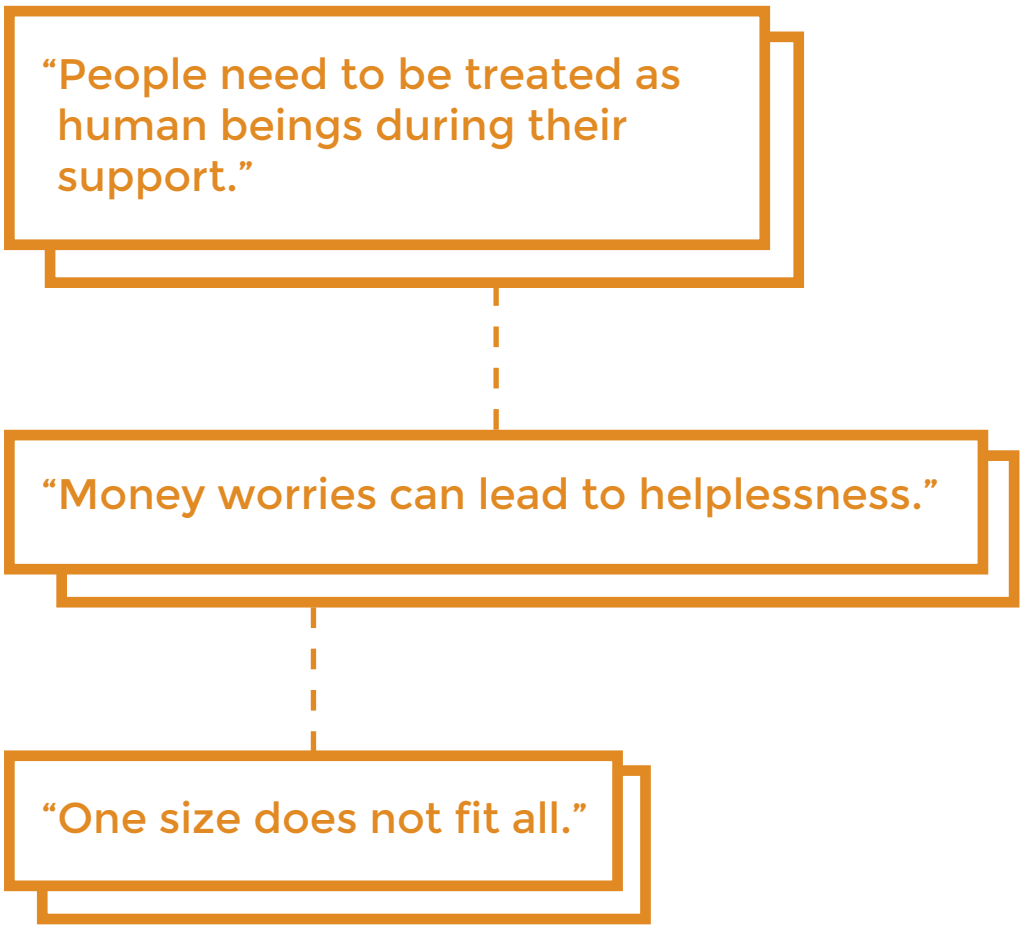
More post-bereavement services and counselling for children and young people affected by suicide – at the moment groups like SOBS (Survivors of Bereavement by Suicide) are not available to under 18's and adolescents often fall through the gaps in services that only accept certain ages.

Transitional periods in the lives of children and young people were also considered to be vulnerable periods. This includes the transition from adolescence to adulthood (often expressed through moving from school to higher education or employment), and from Children's to Adult services. As stated earlier, participants were concerned that universities and colleges were not taking a more proactive role in taking care of their students, and pushed for them to be more aware of the signs of stress and suicidal ideation.

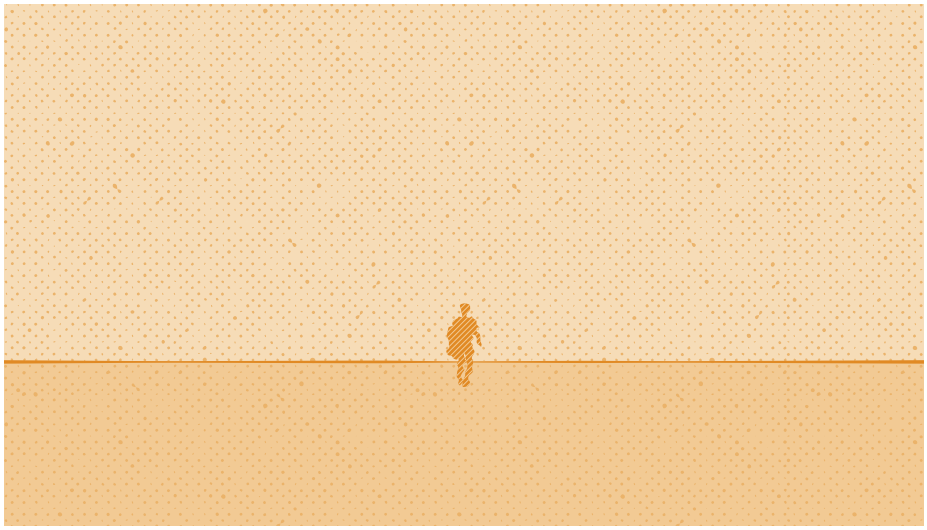
It was also suggested there is an opportunity in the first year of university, whilst most are living in university halls of residence, to gather students and educate them on how to take care of each other and where to go if they need help.
In keeping with the 2018 Year of Young People, the Scottish Government should engage with children and young people, and organisations that support / represent them, to identify how the new action plan can best meet their needs.

Addressing Wider Contributory Factors and Understanding Risk

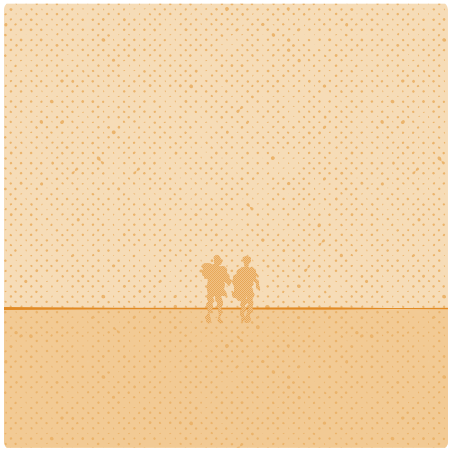
Participants highlighted that a range of factors were contributing to people contemplating suicide, and that many of these are not to do with mental ill-health (which is often presumed to be the cause of suicide). Many of these relate to stressful life events or changes in a person's life, where there are opportunities for public bodies and communities to support the person if they are able to recognise the signs.



For instance, participants acknowledged a perceived increase in the number of people completing suicide after interacting with the social security system. Deprivation, poverty and social exclusion are heavily linked to risk of suicide and many people experiencing these issues are likely to be close to the social security system in one form or another. Participants told us that in their experience, transition from (or in some cases into) the social security system is a key stage in someone's contemplation of suicide. For many people, losing their access to entitlements has led to them losing their self-worth and the state's involvement at this stage was considered an important opportunity to make a difference. For others, accessing social security means that they are experiencing financial crisis or an impairment which has recently developed.
Participants also noted that living with or developing an impairment or long-term condition could be a contributory factor. Some participants noted that without support people living with Post Traumatic Stress Disorder were more likely to experience mental health problems which could lead to suicidal ideation.
People on the autism spectrum were also seen as a key group – due to a disproportionate number of people living with autism who have died by suicide. Further research is required into tailored and accessible support required by people with autism, especially children and young people.

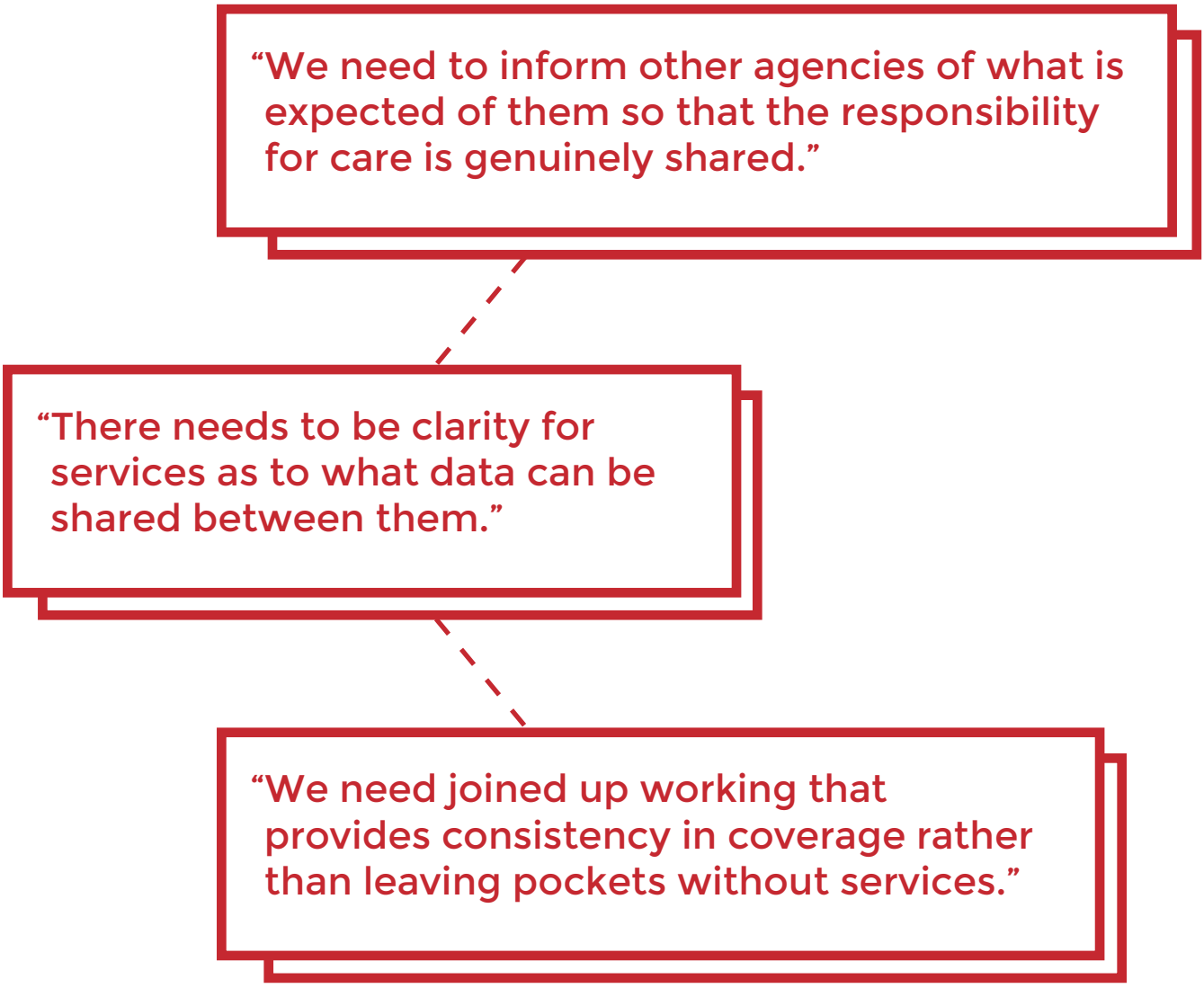


It was also recognised that social isolation could lead to disconnection from community and statutory support which would likely lead to a crisis. Mention was made of men in their middle years, people affected by drugs and/or alcohol, recent immigrants, international students, LGBTQIA+ people and people with experience of homelessness – who are all more likely to be experiencing social isolation.
Adverse Childhood Experiences (ACEs) were often discussed as relating to a higher risk factor of suicide in later life. Participants called for greater screening and understanding of the impact of trauma in young people, and for all public-facing services to be more trauma-informed. Participants, however, noted a general lack of understanding and focus on the links between these wider contributory factors to suicide prevention. This, they believe, is preventing good, outcome focused partnership working. The Scottish Government should ensure that awareness of the cross cutting nature of suicide prevention is built into the new action plan.



Joined-up Working between Organisations

Many participants noted that multi-disciplinary, joined up working was necessary for suicide prevention. However, it was highlighted that this needed to be improved, with better communication between services. It was often noted that services for those bereaved by suicide should be better linked up and communicating to one another. It was felt that the widespread use of a Bereavement Support Officer for suicide would be an effective way to address this.



Some participants felt that the lack of information sharing, for example between health services and police, had hindered suicide prevention work locally. Others believed that communication between services to flag at-risk people and support them needed to be improved.

Funding and Timescales

Inevitably these themes and recommendations are linked to a call for increased funding. The call is not only for increased funding of mental health services, which is seen as crucial, but the recognition that the solutions also lay beyond mental health services. As the themes within this report demonstrate, participants believed that a transformational approach to suicide prevention will require investing in and leading on work that has an impact across society; including across age groups, across education and the workplace, and across multiagency approaches. It is also crucial to improve the parity of funding between general health services and mental health services.

"Suicide prevention services need long-term, consistent funding."

"There's no point in knowing where to signpost people to if the services aren't resourced and flexible."

"NHS funding should be the same for mental as for physical health."

This action plan should be made with a long-term view in mind, thus allowing achievable goals to be set across the priorities identified by those with lived experience. Funding should therefore be targeted at the recommendations identified at the end of the report.

Importance and Recognition of Lived Experience

Throughout the events, participants were keen to express their support for early discussions to be undertaken in different communities across Scotland about a future suicide prevention action plan. For many it was the first time they had been involved in supporting the development of a Scottish Government action plan, though they had significant lived experience to share (both in professional and personal roles – and frequently both).

> "A bottom up approach is incredibly valuable – the experience of those with lived experience should be at the heart of support and prevention services."

> "What helped me the most was speaking to people who'd had the same experience."

> "We need to use the power of 'survivor' stories – we need to remember things can get better and give people hope."

The events highlighted the appetite for discussion of the issues related to suicide prevention across Scotland. Events in Glasgow and Inverurie were fully booked and subsequently the organisers chose to run further events which were also well attended. There was also a call for further events to be run in other areas of the country and any further consultation and engagement should allow for delivery of more local discussion and engagement.

Several participants noted the lack of engagement with children and young people that they had seen, which they believed would hinder the effectiveness of any action plan. Whilst the events saw attendance from a few young people, it was clear that the time of day was inaccessible to most who were in full-time education. From those young people who did attend, there was a clear feeling that this was a worthwhile event, and that there needed to be more engagement with this group.

Overall, many participants were keen to express the need to value and promote the voice of lived experience throughout the development, implementation and evaluation of the new action plan. In practice, this would allow for people who have lived experience of suicide to be fully involved in design and review of any future approach.

Evaluation and Ongoing Conversation

It was highlighted that to reduce suicide we must first understand the issue, know what works, and why. Some participants noted that while there has been a significant drop in the suicide rate over the past decade, we do not know why that is. This is unhelpful for understanding which prevention activities we should support.

> "If we can't understand the issue, how can we expect any of the actions put in place to be successful?"

> "Success isn't just saving his life. Success is saving his life and allowing him to recover."

It was felt that outcomes and actions within the plan must be 'SMART' (Specific, Measurable, Achievable, Realistic and Time-Specific). While it was noted that measuring outcomes would be difficult, the value of the voice of lived experience in this was highlighted. There is a need for both qualitative and quantitative evaluation. Participants said that success must fundamentally be measured in terms of what it means for people – not just policy. Many therefore called for the insight of those with lived experience to be at the centre of any review of support and prevention services. Others said that the views of those in rural areas should be sought early, as it was felt that policies or services were often amended around their needs afterwards.

Concluding Remarks and Recommendations

As demonstrated above, a consistent set of themes was present throughout the engagement events, and these fed into a strong set of priorities and recommendations which are outlined below. Event participants appreciated the opportunity to outline their thoughts and priorities, and expressed a hope that this would be clearly reflected in the final action plan.

Recommendations:

More campaigns and community resource to improve public awareness.

A whole population approach should be taken to suicide prevention with national and local campaigns to break down stigma and support people to feel confident in talking about suicide. Crucially, this needs to include more resource and more people on the ground to talk to communities and provide awareness and training.

Mandatory suicide prevention training for specific professional groups.

GPs were highlighted as the most important group in need of suicide prevention training, however other frontline services were also mentioned (including job centre staff and educational providers). Training should focus on ensuring that suicidal ideation is taken seriously, and helpful signposting information given to the person experiencing distress. Vitally, services should be trained to provide support in a calm, respectful and compassionate way.

A focus on early intervention.

Early intervention was a strong theme from all events with participants highlighting the importance of timely access to services. It is essential that care and support is available before people reach a crisis point, and that community members and professional services are able to identify warning signs and intervene.

Compassionate and immediate support at the point of crisis.

Participants consistently highlighted that people in crisis cannot wait for help, therefore frontline services must be prepared to provide compassionate support when approached. In the event that primary healthcare professionals are not able to provide immediate support then there must be well-resourced community assets to provide support and safe spaces, and professionals must know where they can signpost vulnerable people to. Special attention should be paid to rural and remote communities, where support for those in distress can be patchy or difficult to reach.

Better support for people affected by suicide.

Compassionate, high quality support should be available for survivors of suicide and people and their families who have been affected by suicide. This should flex to the need of the individuals concerned (e.g. services should not require a six month wait before admission), and include more support for children and young people affected, to address current gaps in support provision.

Addressing stigma in professional circles and communities.

Stigma must be addressed, damaging assumptions challenged and people should be encouraged to discuss suicide openly. Campaigns, training and community resources will play a key role in this.

Improved support and training for children and young people.

Early education for children and young people was highlighted as critical – focusing not just on suicide awareness, but also on emotional intelligence and resilience. Participants also felt that educational providers (both at schools and colleges/universities) should take more responsibility for identifying and supporting at-risk young people, and those affected by suicide, and that mandatory training and continuous professional development should be provided to support them with this.

More research and better understanding of the role of wider contributory factors.

Participants felt that there needs to be recognition in the action plan that there are a number of factors and experiences that contribute to suicidal ideation, and that this is not just limited to mental health problems. The Scottish Government should ensure that awareness of the cross cutting nature of suicide prevention is built into the new strategy, and that stressful life events such as job loss and money issues are noted as trigger points, and support provided accordingly (e.g. through better workplace support).

Joined up working and knowledge sharing between frontline organisations.

There needs to be better knowledge sharing and joined up working between professional organisations so that people in crisis do not slip through the net, particularly between police/emergency services and health professionals. This should also apply to those recently bereaved by suicide, so that professionals are able to answer their questions promptly and provide appropriate support.

Increased funding.

Funding for mental health services should be at parity with those for general health services, but investment should go beyond these frontline health services and reflect the role of communities and all frontline staff in preventing suicide. As outlined, this should include increased funding in national and local campaigns, as well as vital training for professionals both in and outside health professions (e.g. for social security services and education professionals).

Early and consistent engagement with people who have been affected by suicide.

Participants valued the opportunity to engage with government on the issue of suicide prevention, and highlighted the need for government and planning partners to engage with people with lived experience throughout the process of producing and reviewing strategies and action plans. Engagement with young people was considered a particular priority amongst participants, and given the 2018 Year of Young People Initiative there is a distinct opportunity to discuss the issue with young people and solicit their views.

Effective monitoring of actions and outcomes.

To improve the implementation of the action plan, participants felt that actions and desired outcomes should be clear, measurable and made easy to understand for the public. Moreover, monitoring and evaluation should be linked up with those with lived experience, so that stated outcomes reflect the experience of those on the ground.

The views in this report are those of the participants and not necessarily those of the organisations who supported these engagement events.

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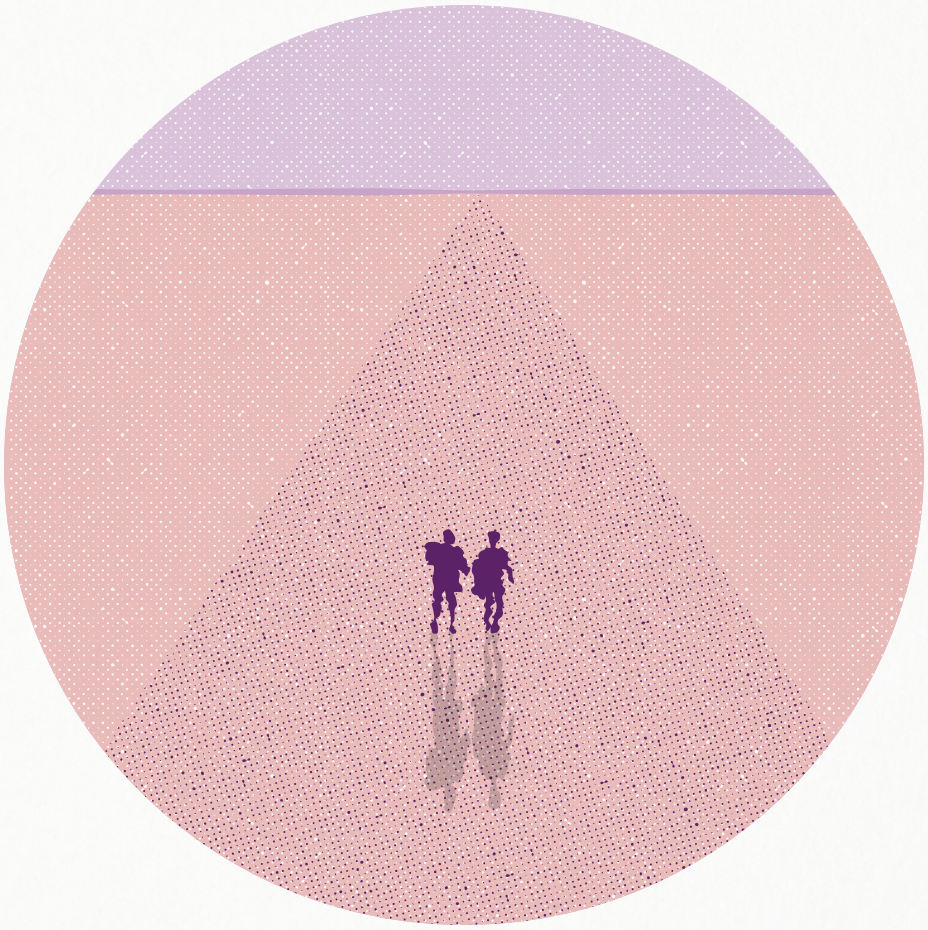

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