**DATE: 27 April 2018**

**RESPONSE OF: The Royal College of Psychiatrists in Scotland**

**RESPONSE TO: Engagement Paper on Themes and draft Actions for possible inclusion in the Scottish Government's new Suicide Prevention Action Plan**

This response was prepared by the Royal College of Psychiatrists in Scotland. For further information please contact: Elena Slodecki on 0131 344 4966 or at elena.slodecki@rcpsych.ac.uk.

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

**1a) Do you agree that we should establish a "knowledge into action" group for suicide prevention?**

☒ Yes
☐ No
☐ Don't know

**1b) Please explain your answer.**

The College supports the establishment of a 'Knowledge into Action' (KIA) group and welcomes the inclusion of those with direct experience in the group. The voices of those with lived experience must be heard, as well as the voice of practitioners.

**1c) Please provide any additional comments or suggestions about improving the use of evidence, data and/or guidance on suicide prevention.**

For this KIA group to be effective, we need more research into suicide. It is important to understand both the compounding and mitigating factors for suicide, so that better interventions can be developed. We know mental illness is often a factor in suicide and more research is needed to better understand how to identify and treat those patients. Any serious attempt to reduce suicide would be remiss not to recognise and understand the importance of socio-economic factors and healthcare spending on suicide rates. Additionally, we need better insight to understand why the suicide rate in Scotland remains higher than in other parts of the UK, despite recent improvements.

**2a) Do you agree that we should develop a new mental health and suicide prevention training programme?**

☒ Yes
☐ No
☐ Don't know

**2b) Please explain your answer.**

The development of new, comprehensive mental health and suicide prevention training is welcomed.

We in Mental Health services want to support primary care colleagues. There also needs to be absolute clarity across Scotland about where people in a mental health crisis can go for help at any time. Our hope is that the Mental Health Strategy's expansion of primary care mental health workers will help bridge the gap between the third sector, primary care and specialist services.

It is important medical practitioners across primary care are trained to recognise the need for intervention when a person is at risk of suicide. Many people at risk of suicide may not have accessed specific mental health services before expressing their suicidal thoughts, though are likely to have had contact with a GP in the 12 months before their death. Additionally, over half (59%) of people who died by suicide had at least one mental health drug prescription given to them within 12 months of their death (ISD Scotland, 2017). Between 2009-15, 12.7% of people received a diagnosis on discharge of mental and behavioural disorders due to psychoactive substance use in the 30 days prior to their death (ISD Scotland, 2017) with this figure rising to 18.6% in the 12 months prior to

death. This represents another vulnerable group of patients who should be considered in future training plans for professional groups. Research suggests that while suicide prevention training for GPs results in a positive shift in attitude towards suicide prevention, there is limited evidence for GPs being able to confidently deal with depression and suicide in daily practice (Coppens, et al., 2018).

More research should also be carried out at looking how practitioners in Accident and Emergency (A&E) departments can both receive and implement training on confidently supporting people who may have suicidal thoughts. It is universally accepted that anyone presenting to A&E with suicidal thoughts and/or behaviour needs a prompt physical and mental assessment by a trained clinician. Any issues lie with implementation of this principle. Between 2009-2015, 27% of individuals who died from suicide attended A&E within three months of their death (Coppens et al., 2018). A&E departments are often operating under full capacity, and demand for services is extremely high compared to other healthcare services. The Scottish Government should work with NHS Scotland to explore how medical practitioners in A&E departments can improve on their capacity building, and to increase their confidence with patients demonstrating suicidal thoughts and behaviour. Distress Brief Interventions (DBI) are one means of responding to people in distress.

First Aid training is a mandatory and an accepted part of most workplaces, schools and universities. We would hope mental health/suicide prevention training can become an equally accepted part of training for these and other relevant professional groups. For example, charity workers and public sector workers who are working with vulnerable people would benefit from greater support and training. Skilling up the general population to discuss suicidal behaviour and thoughts is also important and would help in reducing the stigma around suicide. It is also important that staff in places where vulnerable people may go are trained to recognise and respond to those in distress. Examples of this can be seen in North Lanarkshire where staff at McDonalds were trained in SafeTALK.

The Scottish Government must work with a range of statutory agencies and Third Sector Organisations to look at a variety of approaches to suicide prevention training. The long-term impact of Applied Suicide Intervention Skills Training (ASIST) requires more research to determine if there are clear and effective outcomes in providing more comprehensive suicide risk assessments (Gould et al., 2013). A literature review in 2016 of nearly 1,800 studies relating to suicide prevention highlighted more research must be done on gatekeeper training and the education of physicians, and concluded:

> *In the quest for effective suicide prevention initiatives, no single strategy clearly stands above the others. Combinations of evidence-based strategies at the individual level and the population level should be assessed with robust research designs (Zalsman, et al., 2016).*

**2c) To what extent do you agree that there should be *mandatory* suicide prevention training for specific professional groups?**

☐ Strongly agree

☒ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly Disagree

**2d) Please explain your answer.**
We are pleased to see over 90,000 people have been trained in either mental health awareness/first aid or suicide prevention across Scotland. However, we agree there should be parity of esteem between physical and mental health training. For example, the majority of workplaces mandate First Aid Training which focuses on physical distress, but do not place the same importance on training on mental wellbeing. Through collaboration with NHS Scotland, the Scottish Government should clarify which training programmes are available to medical practitioners and establish clear timescales for the delivery of training.

**2e) Please provide any additional comments or suggestions about modernising the content and/or accessibility of training on mental health and suicide prevention.**
It is well-recognised that chronic physical illness and pain are a risk factor for suicide, especially in conjunction with mood and alcohol problems. This argues for *targeted screening* of patients in these classes and *targeted training* of the relevant clinicians, so they feel empowered to ask about suicidal thoughts and know what to do if they are disclosed.

**3a) Do you agree that we should establish a Suicide Prevention Confederation?**
☒ Yes
☐ No
☐ Don't know

**3b) Please explain your answer.**
We need to coordinate between members of the public, third sector, academics and those with clinical experience to arrange training and responses which go toward suicide prevention. We also need to tackle mental health stigma to ensure conversations can be easily had. Such a coordinated response should also assist in ensuring consideration of suicide prevention when planning infrastructure projects and transport safety.

**3c) Where do you think *local* leadership for suicide prevention is best located?**
☐ Local Authorities
☒ Health & Social Care Partnerships
☐ Third Sector
☐ Other arrangement – please specify
☐ Don't know

**3d) Please explain your answer.**
In this era of health and social care integration, suicide prevention should be the led by Health and Social Care Partnerships, working closely with third sector colleagues and local communities. We would also encourage the formation of

local suicide prevention collaborative working with national groups, such as Breathing Space, as well as the non-territorial boards, such as NHS24 and the Scottish Ambulance Service.

**3e) Please provide any additional comments or suggestions about maximising the impact of national and/or local suicide prevention activity.**

The Scottish Government should ensure the Health and Social Care Integration agenda remains cognisant of suicide prevention, and that there are means to monitor and evaluate suicide prevention activities undertaken by Health and Social Care Partnerships.

**4a) Do you agree that we should develop an online suicide prevention presence across Scotland?**

☒ Yes
☐ No
☐ Don't know

**4b) Please explain your answer.**

We know that many people, particularly the young, are high users of social media and, therefore, interventions to prevent suicide via social media could offer a promising way forward (Niedzwiedz, 2015). However, we need further research to understand the types of interventions which could be proffered on social media, the effectiveness of these interventions in preventing suicide and assisting those in distress, and to consider potential ethical issues.

**4c) Please provide any additional comments or suggestions about developing social media and/or online resources for suicide prevention.**

**5) Please use this space to provide any additional comments that you have about any of the issues raised in this engagement paper.**

We welcome the development of a new Suicide Prevention Action Plan for Scotland. The challenge of addressing suicide in Scotland is not a small one and should be recognised by a robust and ambitious plan. We are disappointed at the scale of the current proposals, though we recognise this is a first step in the development of the final Suicide Prevention Action Plan. The proposed themes and actions do not recognise the complicated and multifactorial nature of suicide. We would also like to see more detail about actions on the ground which will improve the care and response to those in crisis. Given this, we would like to make the following points and hope these can be included in the final plan.

The final Suicide Prevention Action Plan should recognise the need to tackle Mental Health stigma and discrimination across Scotland, ensuring no one is embarrassed to talk about mental health or seek support for mental health issues.

The final Suicide Prevention Action Plan should acknowledge better recognition and treatment of people with mental disorders is likely to reduce suicide rates, as has been clearly demonstrated by research into suicide prevention (Mann, et al., 2005).

The final Suicide Prevention Action Plan should give due consideration to the social determinants of health, reducing inequalities and the concomitant effect on suicide rates. For example, the plan should clearly recognise that socio-economic factors such as unemployment and inequality may have greater effects on suicide rates within a particular population than other factors. Data from Information Services Divisions (ISD) has shown that between 2009-2015, suicide deaths were approximately three times more likely amongst people in the most deprived areas than those in the least deprived areas (ISD Scotland, 2017).

We note a persistent issue is when intoxicated people in crisis are taken to emergency psychiatric assessment by police. Guidance on managing intoxicated patients with suicidal behaviour and self-harm should be developed. Consideration should be given to novel solutions such as short-stay self-harm units or safe places where people can be supported for a brief period, with ongoing access to mental and physical health care without formal inpatient admission. Figures from the Scottish Suicide Information Database (ISD Scotland, 2017) show between 2009-15 a significant proportion of individuals who died from probable suicide received a diagnosis on discharge of substance misuse prior to their death. It is important the final Suicide Prevention Action plan give due consideration to this vulnerable group of patients and develop interventions which can support those with a diagnosis of substance misuse.

Some thought should be given to those presenting in places other than A&E and consideration of a potential distinction between suicidal *behaviour* (e.g., overdose, cutting) requiring physical assessment and management and suicidal *thoughts* requiring a mental assessment. The former require transfer to A&E. However, there is an argument that those with suicidal thoughts could be seen in a more appropriate psychiatric emergency setting. More appropriate settings, which are not necessarily A&E, should make for less distress and, therefore, better assessments of risk.

We look forward to seeing the results from evaluation of DBI pilots which have been an innovative means of improving the response to people in distress. We would recommend further exploration of DBIs as a possible intervention for those presenting in acute distress with suicidal thoughts.

There are a lack of timescales and targets in the Suicide Prevention Plan, and no reference to the funding for resources which will be targeted across Health Boards and Local Authorities.

It is important some directive is issued to Health Boards, Local Authorities, Integrated Joint Boards and associated Health and Social Care Partnerships to ensure they are cognisant of suicide prevention within their local area, and are taking steps to help prevent suicide and respond to those in crisis.

**References:**

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