Annex A – RCPsych in Scotland – Suicide Prevention Strategy Questionnaire (November 2021) response

Crisis Intervention (the most relevant section to our members)

What is currently working well to support those in suicidal crisis?

We're aware there's been different levels of innovations across Scotland, in particular during the pandemic. It created the ability for services to become much more flexible in the face of related restrictions, and this has produced or fast streamed developments that have benefited those needing crisis intervention.

Nationwide developments like mental health assessment centres were felt to have increased the speed of access to the right care when needed to crisis support.

What needs to improve from what currently happens in crisis intervention?

There is an opportunity through the proposed mental health quality standards work in a Scottish context to mainstream the expectations of services for those in crisis. As part of its initial focus on secondary services, the kind of services which should be available, the speed at which they can be accessed, and outcome-focused measures to track how areas are delivering on these can and should be considered. This would create the space to assess the quality of the crisis interventions in secondary settings.

The patient safety programme was seen as a means for developing more models for crisis intervention. Such work was felt to drive a focus on best practice, recognising during the pandemic particular tweaks to the process for referral and contact have led to better access based on the available staffing.

What additional or innovative things could be done to support people when they reach a point of crisis?

It was suggested there needed to be a recognition of the continued importance of specialist mental health services alongside continued support and development for third sector interventions. This includes retaining the frontline clinical voice around how to practically develop crisis intervention in services.

There is a need to recognise the population likeliest to need psychiatric support, those with a pre-existing mental health condition, have been most adversely impacted by the pandemic. The Scottish Government's Covid tracker highlighted that, during the pandemic, those with a pre-existing mental health condition were three times likelier to experience suicidal thoughts. We therefore need to ensure that the mental health services they interact with are supported to meet a potential increase in crisis presentations from those with moderate to severe mental ill health.

Is there anything else you would like to add about crisis intervention?

N/A

Prevention

When thinking about suicide prevention work in Scotland, what do you feel has worked well in the past? What is currently working well?

While we have to learn from others, we should also recognise that nations have also sought to learn from our attempts to record every suicide in an attempt to identify causal factors.

The Leadership Group was felt to have created the space for all the voices that are needed to input to effective prevention strategies across settings to be heard.

What do you know from other areas/countries you would like to see happen in Scotland?

We are still felt to be well behind other countries like New Zealand in reaching out to our ethnically diverse communities. Their success has been reaching minority communities through engagement, awareness raising, and creating the spaces for people to engage with supports and services before their mental ill health and wellbeing is exacerbated. Going forward, efforts should be made to learn from their work.

What should improve from what currently happens?

While there have been reasonable attempts to develop a strategy that has been inclusive, there must be more done on this. This was said to apply to our deprived communities as well as other minority groups, who we knew pre pandemic were more susceptible to suicidal thoughts.

We need to ensure that, in relation to the knowledge and training actions, an evaluation of the extent to which this has been rolled out among NHS staff takes place. It could identify whether staff feel confident in engaging with people expressing suicidal thoughts will allow us to better understand next steps.

What additional or innovative things could be done to help?

We as a College, alongside other partners, have called for mental health considerations to be mainstreamed across policy making through a mental health impact assessment. The opportunity such an assessment would present to ensure mental wellbeing is considered across policy areas like employment and transport would help prevent the conditions which exacerbate someone likelihood to commit suicide. It would also potentially create the space for more direct considerations on how to achieve this.

As part of the forthcoming review and refresh of the Mental Health Strategy, there is an opportunity to take the developments seen during they pandemic, such as innovative solutions to making supports and services more accessible, and mainstream them nationally if appropriate.

Is there anything else you would like to add about prevention of suicide?

N/A

Early Intervention

What is currently working well to support early intervention?

Work to target ‘high risk groups’ has helped target early intervention approaches, in recognition that particular groups and experiences place you in that category. While avoiding stigmatising particular groups and individuals, such an approach allows for targeted efforts alongside national awareness raising.

Connections with young people’s groups have expanded the engagement and communication with young people. Further evaluation of these efforts and whether it has made younger people more literate around suicide and supporting their friends through difficulties they experience has also been led by these groups.

It was also suggested remote consultations had enabled a new group of people to be able to access early support for poor mental wellbeing in a way that may be more comfortable for them. It was said this applied to our rural areas in particular. This allowed for people to not be left without support during the pandemic.

What needs to improve from what currently happens?

It was suggested using the knowledge of clinical frontline staff and their experiences of engaging with people with suicidal thoughts at ‘first’s ports of call’ like A&E would ensure early interventions in those settings could continue to improve, alongside training for those staff in those settings.

The pandemic is inevitably likely to exacerbate who is falling into high-risk groups, such as those facing economic deprivation. An expansion of capacity for these interventions will therefore be required. Based on the available evidence, the pandemic has exacerbated the risk factors, including the increased economic deprivation and loss of social/educational structure.

Retaining digital engagement and consultations as a mainstream option would enable early interventions in a setting that, for many, suits them as they prefer to engage digitally/remotely.

The distress brief intervention programme needs to be considered in this context. It is seen as a real success story in providing an empathetic and quick response to those presenting across health settings. Ensuring a further roll out of it across Scotland, as well as retaining the expert clinical voice in its continued development, was called for by members.

What additional or innovative things could be done in the area of early intervention?

There needs to be further targeted efforts regarding self-harm, which the proposed strategy for that population will help. It was noted that a single act of self-harm makes you up to ten times likelier than the rest of the population to die by suicide in your lifetime. We therefore know they fall into the ‘high risk category’, and the space a separate strategy affords to ensure there are specific interventions for this group is key.

Is there anything else you would like to add about early intervention?

N/A

Postvention

Postvention refers to work which takes place in the aftermath of a suicide or suicide attempt. This covers a range of work, so when answering the questions in this section you may wish to consider the needs of different groups. These may include:

- *those who have survived suicide*
- *their families and carers*
- *their wider community (e.g. colleagues)*
- *those who have lost someone to suicide*
- *family, friends and carers of the deceased*
- *wider community (e.g. colleagues of the deceased)*
- *first responders and frontline workers dealing with suicide and suicide attempts in a professional or voluntary capacity.*

What postvention activity is currently working well?

Efforts to involve families on the suicide prevention group around this issue were reflected on positively, ensuring lived experience voices were at the heart of developments.

Initiatives in individual areas like Ayrshire and Arran to provide crisis support to families who have faced a bereavement as a result of suicide were also felt to have been effective.

What should improve from what currently happens?

Rolling out a wider system to capture and disseminate best practice in this area was called for, including specific services to support families.

Providing support for staff whose patient has committed suicide was also highlighted as an urgent need. While recognising the voices of families and carers, for clinicians such situations bring a risk of moral injury and significantly negative consequences on their wellbeing.

What additional or innovative work could be done in postvention?

It was emphasised the system to review suicides, as part of postvention work, needed to be expanded on to share learning. This could extend to a national suicide reporting framework, to enable trends to be picked up and acted on. It was felt Public Health Scotland would be best placed to take a lead on this.

In order to better understand suicide postvention, the opportunity to develop near real time monthly or at least quarterly data on suicide incidents could enable better understanding of trends being seen nationally and a quicker response to these.

Is there anything else you would like to add about postvention?

N/A

Tackling Stigma

What is currently working well to address stigma?

Many of the interventions we have cited in the early intervention work, including FC United to Prevent Suicide, have also been effective in challenging stigma and creating the spaces for people to feel able to talk about what they are experiencing.

What needs to improve from what currently happens?

Greater engagement with health and social care professionals, ensuring their understanding of the experiences of people at risk of suicide, how to communicate with them in a non-stigmatising way, and to ensure their care is adaptive to the person's individual experiences can and always will need to improve.

What additional or innovative things could be done to tackle stigma around suicide?

Addressing the stigma faced by people who self-harm fits as part of a wider effort on address stigma around suicide. The proposed strategy will hopefully address this.

How can we encourage open, honest and safe conversations and discussion about suicide?

From our members' perspective, this sits as part of the wider conversations around ensuring people have an understanding not just poor mental wellbeing, but of more severe mental ill health. As already highlighted, those with mental health conditions were the likeliest group to report suicidal thoughts during the pandemic, and tackling the stigma they face can help mitigate the risk factors they face, including a lack of employment opportunities and physical health support.

What could/should we do around the influence (positive and negative) of the media and social media on conversations and perceptions around suicide?

The need to engage children and young people around the negative social media conversations on mental health and suicide was said to be a critical step going forward.

Is there anything else you would like to add about tackling stigma?

N/A

Raising Awareness and Building Capacity

What is currently working well?

Efforts to find ways to channel communication and engagement through settings at risk groups were comfortable in, such as football for young men, was seen as a really positive innovation. The FC United to Prevent Suicide work was particularly praised.

What needs to improve from what currently happens?

Any attempts to address health inequalities can and will be of benefit to addressing at risk groups of suicide. More widely, the opportunity to mainstream considerations of mental health across government departments through mental health impact assessments was also seen as likely to ensure suicidal risk factors and mitigating these were taken into account across relevant government policy areas.

What additional or innovative things could be done to raise awareness of suicide and suicide prevention work?

In order to ensure support and understanding is available across the mental health system, there has to be continued efforts to educate all professionals who may 'spot' or come into contact with people with suicidal thoughts. Matching this to the 'at higher risk groups' settings should also be considered, with training provided.

How do we improve the knowledge and skills of those who will support people with thoughts of suicide in different settings such as communities, families, workplaces etc?

Workplace mental health training was felt to be critical. Without this, stigma and perceptions around mental health and wellbeing would continue to negatively impact people in the workplace, making it less likely they will be properly supported. Considerations around this can and should include specific duties around suicide and mental health awareness for our public sector, recognising its role as a gold standard employer.

Is there anything else you would like to add about building capacity and raising awareness?

N/A

Cross-policy Work

Which other policy areas/interests need to be involved in the prevention of suicide?

There is almost no government department which, through interventions, couldn't play its part in addressing suicidal risk.

What makes this difficult?

From our members' experience, a lot of departments and organisations do still struggle to keep the links to suicide in their thinking. This applies to mental

health as a whole, which is to the detriment of the policy as those which improve mental wellbeing generally have a far greater positive impact on the population.

How can the effectiveness of cross-policy work be ensured?

A mental health impact assessment can and should be considered. This would ensure that, rather than bracketing decisions as within or outwith the scope of suicide prevention work and mental health generally, those aspects that do relate can be identified and informed by the potential implications they may have.

Anything else

Please use this space to highlight or raise any other areas you feel should be included in the next suicide prevention strategy for Scotland.

Any other points?

It was said that a quality improvement methodology was needed across suicide prevention work to drive further improvements. Much good practice was being developed locally and regionally, from our community organisations through to specialist in-patient services. The mechanisms to identify these, to measure their success and to disseminate them more widely existed but was said to not be fully realised. Adopting a quality improvement focus and creating the frameworks to spread good practice would also help different areas not fall behind the curve.