Scottish Government
Engagement Paper on the
Prevention of Suicide and Self-Harm

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1 Introduction

This paper has been written to support the development of the Scottish Government’s new strategy for the prevention of suicide and self-harm in Scotland. It provides an outline of our understanding and of progress to date. It is not a draft strategy or statement of policy, but is intended to prompt discussion of key issues, with all views and perspectives on the challenge being welcome. Our belief is that collaborative working remains integral to the prevention of suicide and self-harm in Scotland.

The causes and reasons for self-harm and suicide are complex. One of the objectives of the original Choose Life strategy was to build our knowledge both of causative factors and of effective public policy interventions. We have made progress with that objective, but our knowledge is still incomplete. Where we know what to do to make suicide or self-harm less likely we will work on that basis, but we will also continue to build our knowledge.

Definitions and Information

For the purpose of this paper we have used the following definitions:

**Suicide** is death resulting from an intentional, self-inflicted act.

**Suicidal behaviour** comprises both death by suicide and acts of self-harm that do not have a fatal outcome, but which have suicidal intent.

**Self-harm** is self-poisoning or self-injury, irrespective of the apparent purpose of the act (excluding accidents, substance misuse and eating disorders).

Information on sources of support for people who may be at risk of suicide or self-harm is provided in Annex 1. Information on the engagement process is provided in Annex 2.
Background

In 2002 the Scottish Executive launched *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*. Recognising the devastation and impact that suicide has on people and communities, *Choose Life* sought to set the direction and necessary actions to be taken to prevent suicide in Scotland. It took a largely population-based approach with a focus on raising awareness, community based approaches and training. It also prioritised research and set a national target for reducing suicide.

In 2008 an additional target was set, to train at least 50% of all frontline NHS staff in suicide prevention awareness techniques by the end of 2010. This target was achieved and continued delivery is being monitored.

In 2010 there was a refresh of the objectives for the *Choose Life* strategy, based on evidence and learning since 2002. A greater focus on clinical services was introduced, linked to work on depression and alcohol, and to a growing understanding of the links between common mental health problems and suicide. The refreshed objectives listed below (which are the basis of the current strategy) clarified where national and local efforts need to be targeted to allow for a more focused evidence-based approach, in particular with people in high risk groups.

**Objective 1:** Identify and intervene to reduce suicidal behaviour in high risk groups;

**Objective 2:** Develop and implement a coordinated approach to reduce suicidal behaviour;

**Objective 3:** Ensure interventions to reduce suicidal behaviour are informed by evidence from research and evaluated appropriately;

**Objective 4:** Provide support to those affected by suicidal behaviour;

**Objective 5:** Provide education and training about suicidal behaviour and promote awareness about the help available;

**Objective 6:** Reduce availability and lethality of methods used in suicidal behaviour.

The *Choose Life* programme is recognised internationally as a leader in the field. Its successes include its national leadership and co-ordination of training output, quality
control, the delivery of training for trainers, its media watch and awareness raising work and its evidence-informed guidance. Frontline suicide prevention training and related activities delivered through an agreed multi-agency action plan result in local areas being able to respond to local needs. As the current Choose Life strategy comes to a close, it is important to take forward what worked well, to reflect on what we have learned, and to adapt to an altered socio-economic and policy context.

**Progress**

The Scottish Government target is to reduce the suicide rate in Scotland by 20% by 2013. Since 2002 we have achieved a 17% reduction in suicide with the number of suicides in 2009 being the lowest since 1991 and the numbers for 2010 and 2011 also being among the lowest in the past twenty years. The following graph shows the change in suicide rates over time using three-year rolling averages.
Developing the Evidence Base

Historically, information on suicide tended to focus on population level data such as gender, deprivation and employment rates as well as on data related to people with mental illness, who are known to have higher rates of suicide.

Suicide rates in Scotland rise with increasing deprivation, with rates in the most deprived areas of Scotland significantly higher than the Scottish average. The rate is four times higher in the most deprived 10% of the population compared to the least
deprived 10%. Among men, suicide risk in the lowest social class, living in the most deprived areas, is approximately 10 times higher than the risk of suicide among those in the highest social class, in the most affluent areas.

Over the course of *Choose Life* there has been a reduction in the deaths by suicide of men by 19%. Deaths by suicide for women have reduced by 9%. Despite this greater reduction in suicide among men, suicide is an overwhelmingly male behaviour with about 75% of all suicide deaths being by men. There is data that suggests a correlation between economic growth, unemployment and male suicide, while female suicide has remained relatively stable through varied periods of economic growth and decline. There are therefore questions regarding how the causal factors of suicide may differ among men compared to women and how best to address these in a new strategy.

An average of 235 mental health patients die by suicide each year, which is 29% of all suicides in Scotland. Most people who die by suicide in developed countries have a mental illness or disorder (if we include in that definition people with substance misuse disorders and illnesses that are managed in primary care). At the same time it is important to recognise that relatively few people with a mental disorder attempt suicide or die by suicide. Increased attention in primary care to depression and higher treatment rates have been linked to falls in the suicide rate.

The linkage between the availability of means of suicide and rates of suicide has also been well researched and followed up with action to reduce easy access to certain medications. Populations with greater access to firearms tend to have higher suicide rates and that is true also of sub-populations in largely gun-free societies.

Recent years have seen the provision of new sources of information regarding suicide and its prevention.

The Scottish Suicide Information Database (ScotSID) was established to improve the quality of information available on suicides in Scotland. Two ScotSID reports have been published so far, providing information on suicides in 2009 and 2010 (http://www.isdscotland.org/Health-Topics/Public-Health/Publications/). The most
recent report shows that those who die by suicide tend to have had quite extensive contact with health care services and that there is a high correlation between serious self-harming and death by suicide. It also shows that many people are receiving some form of psychoactive medication at the time of death.

Healthcare Improvement Scotland (HIS) provides a Suicide Reporting System to help NHS boards improve the way that suicide reviews are carried out and help reduce future risk. (http://www.healthcareimprovementscotland.org/our_work/mental_health/programme_resources/suicide_reporting_system.aspx) The reports produced by HIS have drawn attention to common factors, including the need for effective engagement of families where people are in crisis or at risk of suicide.

The National Confidential Inquiry into Suicide and Homicide examines deaths by suicide and homicide by people who had been in contact with secondary and specialist mental health services in the previous 12 months. Previous findings of the Inquiry have informed safety improvement in services and for patients, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK. (http://www.hqip.org.uk/sapphire/main.php?url=/national-confidential-inquiry-into-suicide-and-homicide/) One key finding relates to post discharge follow up, which was also prioritised as part of the NHS work to reduce readmissions. The Confidential Inquiry has also focused on the interaction with substance misuse and this is recognised in the greater focus on action to tackle or prevent problem drinking through programmes such as brief interventions.

A wide range of factors have been proposed as being related to suicide both at population and at individual levels, including the impact of the economic recession, alcohol and substance misuse, irresponsible media practices, poor physical and social environments, lack of social support, restricted social networks, early life adversity, trauma, discrimination, sexual orientation, life stages, gender and marital status and a wide range of personality and psychological characteristics, such as hopelessness. With many of these there are clearly complexities which make it difficult to assess whether there are correlations, whether they are outcomes from common antecedent causes or whether they are strongly causative effects. Equally,
even where a connection may be made it is not clear what the effective intervention would be to reduce suicide.

Though we know more now than when Choose Life started 10 years ago there is still more to do to increase our knowledge and we will continue to work to develop the evidence base and our understanding.

Self-Harm

Action to reduce self-harm is not as well developed as the work on suicide prevention. The relationship between suicide and self-harm is complex, self-harm being one of the strongest risk factors for subsequent suicide. Based on hospital-treated populations, individuals who have self-harmed have a higher risk of suicide in the year following an episode compared to individuals who are not known to have self-harmed. Individuals who repeat self-harm are at greater risk of suicide compared to individuals who have only one episode of self-harm. About 15% of people who self-harm and are seen at a hospital will present again within a year, and others will repeat without presenting. After nine years, more than 5% will have died by suicide. Up to half of all people who die by suicide will have a history of self-harm.

Though this shows a strong linkage between those who die by suicide and self-harm, most people who self-harm do not go on to die by suicide.

It is difficult to estimate the scale of self-harm in Scotland. A recent study among 15-16 year old adolescents in Scotland found that 13.8% of respondents had self-harmed during their lifetime (of whom 71% had done so in the past 12 months). Girls were more than three times more likely to report self-harm than were boys. Factors associated with self-harm in both genders included smoking, bullying, worries about sexual orientation and anxiety. In addition, self-harm among girls was associated with drug use, physical abuse, serious boy/girlfriend problems, self-harm by friends and low levels of optimism. An investigation of hospital re-admission with self-poisoning in Scotland identified the following risk factors: younger age, deprivation, ingestion of certain drug groups or multiple drug types, and prior
psychiatric hospital admission. International research indicates that self-harm in the community is common in female adolescents and presentation to hospital occurs in only about one in eight adolescents who self-harm. Adults are more likely than adolescents to be treated in hospital following self-harm, though it may be those figures are distorted because of stigma and shame making adults less likely to disclose information about self-harming.

The Choose Life programme initially prioritised suicide and attempted suicide. However, in response to growing concern regarding the need to address non-fatal self-harm, a National Self-Harm Working Group was established by the Scottish Government in 2009, and the Scottish Government plan ‘Responding to Self-Harm in Scotland Final Report’ was published in 2011. The working group identified the following primary objectives:

PO1. Reduce the number of people who are experiencing psychological distress through general approaches which reduce self-harm and increase capability in people and communities.

PO2. Improve the general service response to people who are experiencing psychological distress, whether exhibited through self-harming behaviour or not, to reduce the number of people who may already self-harm or who may go on to self-harm, or who may be failing to cope in other ways.

PO3. Increase the rate of identification of people who are self-harming, both through encouraging more people to seek help and through better recognition of self-harming behaviour by professionals working in different settings, and improve risk assessment at various levels of care.

PO4. Improve the service response to people who self-harm with the objective of reducing the frequency, severity or occurrence of the self-harming behaviour, addressing the underlying causes of that behaviour and improving people’s experience of care services thus assisting them in moving towards safe and positive future goals.
The Mental Health Strategy for Scotland 2012-2015 recognises the importance of tackling the distress which underlies “a group of disorders, illnesses and behaviours which present particular challenges to services and to families”, including self-harm. We know that there are people within this group who have frequent contact with crisis, healthcare and justice services. Some of them will appear across the system with regular attendances at A&E and/or regular contact with the Police and/or with Social Work services. The challenges they present are very similar. At times they may seek or request help, but they are also likely to disengage or to fail to take up appointments.

Early indications from work in NHS Tayside relating to Commitment 19 of the Mental Health Strategy point to a need to better equip first responders in delivering a compassionate response with a view to promoting better engagement with services. A number of people who have suicidal thoughts and behaviours may also become intoxicated and behave in ways that result in a response or intervention by the Police or Fire & Rescue and other emergency services. It is not uncommon, however, for agencies to struggle to co-operate effectively and for activity to be focused on risk assessment and referrals processes, rather than on care and support.
Areas for Discussion

1. Are the six objectives for Choose Life Programme still valid (page 4)? If so, what should be prioritised under each of the objectives? Are there other objectives we should set?

2. While there has been a move to focus more on those in contact with services, is there more work that we should take forward at population level?

3. Are the objectives for work on addressing self-harm still valid (page 10)? How should we develop that work further? Is the linkage with the work on distress (page 11) a good way to take the discussion forward?

4. Can we strengthen the linkage with tackling health inequalities, given that the differences in suicide rates also apply to a wider range of behavioural health challenges? What might that look like in practice?

5. Should there continue to be a dedicated Choose Life Programme? If so what should the priorities for that programme be from 2013? Are there changes that we should make to the programme?

6. Should there continue to be a national target or targets? If so what should the target be?

These are the questions which we have framed to take forward the engagement process. Please let us know if you have other questions or suggestions that you would like us to consider for the future strategy.
ANNEX 1 SOURCES OF SUPPORT

If you - or someone you know - experience suicidal feelings or you / they are considering self-harming, you / they should speak to a GP. GPs are well placed to advise and guide you regarding appropriate treatment or management of symptoms. If you are ill and feel it can't wait until your GP surgery re-opens you can call NHS 24 on 08454 24 24 24. NB this telephone service is not free.

It is also recommended that you speak - in confidence if need be - with any friends or family with whom you feel comfortable talking about the issues you have described. If you do not feel comfortable doing this with friends or family, you can obtain confidential telephone support from the following sources:

- **Samaritans** provide confidential non-judgemental emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair. You can contact them on 08457 90 90 90. NB this telephone service is not free. You can find more information about Samaritans at www.samaritans.org

- **Breathing Space** offers free and confidential advice for people experiencing low mood, depression or anxiety, whatever the cause. They can be contacted on 0800 83 85 87, 6pm to 2am Monday to Thursday; and 6pm Friday through the weekend to 6am Monday. Calls to Breathing Space are free from landlines and from most mobile networks. www.breathingspacescotland.co.uk provides a wide range of useful information and advice about coping with low mood, depression and anxiety.

If you ever feel **actively suicidal and have the means to carry this through**, you should dial 999 and ask for an ambulance.

If you have been **bereaved** through suicide you may find the booklet *After a Suicide* a useful source of help and advice. Published by the Scottish Association for Mental Health, it is available at http://www.samh.org.uk/media/125564/after_a_suicide.pdf
ANNEX 2 INFORMATION ON ENGAGEMENT PROCESS

The engagement process is from 25 February 2013 to 28 May 2013. The aim is to gather views for consideration in the development of a new national strategy on preventing suicide and self-harm, to be published by the Scottish Government in late summer / early autumn 2013.

The engagement process consists of public events in Perth (26 February 2013), Edinburgh (28 February 2013), Inverness (5 March 2013) and Glasgow (11 March 2013). These events have been organised on behalf of Scottish Government by Choose Life. We encourage organisations and groups to hold additional engagement events and send their comments in writing or online to the address below. In addition, members of the public or anyone with a vested interest in this area are invited to send their comments in writing or online to the Scottish Government. The closing date for comments is 28 May 2013.

In late 2012 the Scottish Government set up a working group and reference group to consider future strategy and action on the prevention of suicide and self-harm. This paper is one of the outputs of their work.

The expectation is that the final strategy will:

1. contain ambitious but realistic commitments on reducing suicide and self-harm
2. be informed by evidence of what we know works
3. contribute to increasing our knowledge and learning in this complex area
4. contain milestones and outcomes against which to measure progress
5. be fit for purpose

We are extremely grateful to Choose Life and the members of both the working and reference groups for their contributions to this process.

Comments on this engagement paper can be sent by post to:
Mental Health Unit, Scottish Government, St Andrew’s House, Regent Road, Edinburgh, EH1 3DG.
Comments can also be sent by email to: suicideselfharm@scotland.gsi.gov.uk