Submission to the National Office for Suicide Prevention on a National Suicide Prevention Framework

6 June 2014

Mental Health Reform (MHR) welcomes this opportunity to contribute to the development of a National Suicide Prevention framework following on from the *Reach Out* strategy.

Suicide is a complex issue that demands a national, cross-departmental, coordinated response. Not everyone who engages in suicidal behaviour will have poor mental health, though having poor mental health increases one's risk of suicide. Suicide has been defined as "a conscious or deliberate act that ends one's life when an individual is attempting to solve a problem that is perceived as unsolvable by any other means" (*Reach Out*, p.9). The definition of suicide as relating to not being able to solve a problem links with an understanding of mental health problems as having to do with not being able to cope with life.

There are many risk factors for suicide. To summarise from a 2008 review of the evidence, living in an area of socio-economic disadvantage and being unemployed are each risk factors. So too, having a diagnosis of some mental disorders including depression, schizophrenia, a personality disorder or a childhood disorder can increase one's risk of completing suicide. Substance misuse, both of alcohol and drugs, is a known risk factor as is having previously self-harmed. Adolescents who have experienced sexual abuse are at higher risk.[1]

In general, the National Suicide Prevention Framework will require a cross-departmental response. It is vital that Government Departments beyond health, particularly the Department of Education & Skills, the Department of Children & Youth Affairs and the Department of Environment are involved in developing the actions under the framework.

As the national coalition of 45 organisations advocating for improved mental health services and implementation of the Government's mental health policy *A Vision for Change*, MHR makes the following submission in response to the NOSP's submission questions.

1. **What do you think should be the priority actions for the new framework on suicide prevention in Ireland?**

   A key priority for suicide prevention in Ireland is the development of an adequate 24/7 crisis support service for people experiencing severe mental or emotional distress. *A Vision for Change* states that a protocol for crisis intervention should be agreed upon for each area by the

[1] McLean, J., Maxwell, M., Platt, S., Harris, F. and Jepson, R. (2008) *Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review,* Scottish Government Social Research, available at www.scotland.gov.uk/socialresearch

local CMHT and that the agreed-upon response should be available 24/7. The policy also recommends that each mental health service area should have the facility of a crisis houses that should offer brief respite to those suffering a crisis where hospital admission is not appropriate. The HSE should ensure that 24/7 crisis intervention is available in every mental health service as a matter of urgency. It is also important that such 24/7 crisis services are culturally competent so that they are effectively accessible to people from Black and Minority Ethnic (BME) communities, including the Traveller community. Finally, it is important that there is an effective 24/7 crisis service available to people who are homeless.

A second priority is improving the coordination of existing suicide prevention initiatives. Lack of coordination leads to confusion among members of the public who may not know where to turn for quality information, advice and training. There is a need for all sectors and groups working in the area of suicide prevention to share resources and to work together more effectively and efficiently. The NOSP's initiative to provide a centralised website of information is a welcome step.

The NOSP needs to ensure that programmes it is funding fulfil agreed standards and are grounded in evidence of what works. The NOSP also needs to coordinate its funded programmes towards agreed strategic priorities and ensure that programmes are funded to a level that can meet identified population risks/needs, e.g. that initiatives are available across the country and targeted at higher risk groups.

Thirdly, the suicide prevention framework should prioritise marginalised groups including the deaf community, people from Black and Minority Ethnic (BME) communities, including the Traveller Community, and homeless people, all of whom have a higher risk of experiencing mental health difficulties.

Fourthly, the suicide prevention framework should prioritise children and young people, given the clear evidence that early intervention is cost effective. The framework should incorporate clear commitments from the Department of Education & Skills and the Child & Family Agency on mainstreaming mental health promotion within schools.

2. What do you think has worked well in suicide prevention in Ireland? What do you think could be improved?

NOSP has been successful in providing ASIST training to hundreds of individuals across the country and this is likely to lead to better quality and more effective responses to individuals expressing suicidal intent. NOSP's support for the crisis support and listening telephone services provided by Console and the Samaritans is also vital for ensuring easy access to such support 24/7. The Suicide Crisis Assessment Nurse (SCAN) project and roll-out of SCAN in sites across the country is an important strand of work that can improve access to crisis and follow-up support for individuals who are at immediate risk of suicide. It would be a welcome step to provide SCAN specifically to liaise with homeless services. Also important are the self-harm liaison nursing posts being piloted in some services and which provide a vital follow-up service to individuals attending A&E services with self-harm. It would be helpful if the self-harm liaison nurses had good working relationships with homeless services to ensure effective liaison and follow-up for people who are homeless.

In terms of what could be improved, our detailed recommendations are contained in answer to question number 4 below.

3. What do you think are the gaps?

a. Lack of a national mental wellbeing strategy and action plan

Suicide prevention programmes are more effective where they are part of an overall positive mental health strategy and are supported by effective, community-based mental health services. For example, encouraging people to seek support must be matched with the availability of adequate primary care, secondary and tertiary mental health services. While the *Reach Out* strategy contained some commitments on promoting positive mental health, and the *Healthy Ireland* framework incorporates mental health and wellbeing in its vision, goals and actions, there is a need for an over-arching, cross-departmental strategy to promote mental wellbeing. Mental health promotion is aimed at promoting the well-being of the entire population and focuses on protective factors, prevention of mental health conditions and early intervention in mental health conditions. Mental health promotion acts on three levels:

- Strengthening individuals
- Strengthening communities
- Reducing structural barriers to mental health[2]

Significantly, *A Vision for Change* notes that sectors other than health impact on the mental health of the population. Due to the cross-departmental nature of such a mental wellbeing strategy, it is unlikely that the NOSP could drive its implementation unilaterally. It would be logical for such a strategy to promote mental wellbeing to be led through the Department of Health's Health & Wellbeing Programme and, in the HSE, through the Health & Wellbeing Division. The suicide prevention framework would be an important part of a mental wellbeing strategy. Roles and responsibilities between the HSE's Health & Wellbeing Division, the HSE's Mental Health Division and NOSP would need to be clarified in order to ensure full implementation of the strategy.

b. Lack of crisis support

The lack of crisis support for people experiencing suicidal thoughts is an urgent issue that needs to be addressed. Mental Health Reform has heard from individual service users and family members and from our member organisations working with people with mental health difficulties in a variety of settings, including homeless organisations, that it can be difficult to get access to support when in crisis. Having to wait for hours in A&E is an inappropriate option for someone in severe mental or emotional distress. It is also unrealistic to expect individuals who are homeless and in distress to wait lengthy periods in A&E.

There is also a need for an health service-wide programme to develop cultural competence among HSE mental health and primary care staff. Mental Health Reform's Ethnic Minorities and Mental Health advisory group has reported that there is a lack of cultural competence among some primary care and mental health professionals. For example, standard assessment tools may reflect the dominant culture and mental health professionals may be unaware of this cultural bias. The group also reported that there is a lack of awareness among staff in primary health care services about cultural issues. Representatives advised that cultural competency

[2] *A Vision for Change*, pp. 44-45.

needs to extend to how health service staff accommodate people from BME communities, for example by ensuring that common practices of people from BME communities are accommodated within services. They advised that the word 'family' can have different interpretations; some families from ethnic communities can be large and their attendance to visit family members in hospital needs to be accommodated. For further analysis of this issue along with good practice examples, see Mental Health Reform's *Ethnic Minorities and Mental Health: A Position paper* (attached to this submission).

c. Lack of availability of suicide and self-harm prevention services and anti-stigma programmes for people in high-risk groups

Some social groups are at higher risk of suicide and self-harm. These high risk groups include people with a diagnosis of depression or schizophrenia (as noted in *A Vision for Change*), people who are homeless, people who are deaf and people from Black and Minority Ethnic (BME) communities. Research has found that there are differences in the rates of suicide between some BME communities and majority populations.[3] One study found that suicide rates are higher where the ethnic minority group is smaller in density.[4] The *All-Ireland Traveller Health Study – Our Geels 2010* found that instances of suicide are seven times higher among Traveller men than in the general population.[5] With regard to people who are homeless, the Simon Communities of Ireland's National Health Snapshot study undertaken in 2011 involving 603 people using Simon services found that 19% of participants had engaged in self-harm behaviour while 17% reported having attempted suicide in the previous six months. Deaf people have the same range of mental health problems as the general population and have additional risk factors such as delayed language and social exclusion. However, their access to mental health services is very limited. Difficulties and delays in accessing assessment and treatment are common.

Such statistics point to the need to ensure that people from the deaf community, people who are homeless, and people from BME communities, including the Traveller community, receive widespread access to effective mental health promotion and suicide prevention programmes. Mental Health Reform has heard from the National Traveller Suicide Awareness Project, for example, that members of the Traveller community do not feel that current national mental health and stigma reduction campaigns are relevant to them or aimed at their minority group. Similarly, Mental Health Reform's Ethnic Minorities and Mental Health advisory group recommended that the national stigma reduction campaign 'Seechange' incorporate a specific strand of work targeted at reducing the stigma around accessing mental health services among people from BME communities, including the Traveller community (see *Ethnic Minorities and Mental Health: A Position paper* published by Mental Health Reform).

d. Gaps in the evidence base

[3] McKenzie, K., Serfty, M. and Crawford, M. (2003) 'Suicide in BME communities', *The British Journal of Psychiatry* 183:100-101.

[4] Neeleman, J., Wilson-Jones, C. and Wessely, S. (2001) 'Ethnic Density and Deliberate Self Harm; A Small Area Study in South East London' *Journal of Epidemiology and Community Health*, 55: 85-90.

[5] Quirke, B. (2010) *Selected Findings and Recommendations from the All-Ireland Traveller Health Study - Our Geels*, Dublin: Pavee Point.

While the National Suicide Research Foundation provides valuable evidence on rates of suicide and self-harm in Ireland, there is a need for a more-developed evidence base on the risks, behaviours and service responses for at risk groups including people who are homeless, deaf people and people from BME communities. For example, the National Traveller Suicide Awareness Project at Exchange House reports that it has been very difficult to track the rate of self-harm or suicide within the Traveller community because currently there is no ethnic identifier within the various A&E's, coroners' or Gardaí reporting mechanisms on self-harm and suicide. There is also a need to ensure that coroners are well-trained in distinguishing between accidental and intentional overdoses in order to ensure accurate reporting of suicides.

e. Lack of standardised, mental health promotion and suicide/self-harm prevention programmes for children and adolescents underpinned by a whole school approach

The high rates of suicide and self-harm among young people in Ireland are well-documented. While the *Wellbeing in Post-Primary: Guidelines for Suicide Prevention and Mental Health Promotion* have been welcomed by the Children's Mental Health Coalition as a valuable framework for school-based action on mental health, there is concern at the lack of a national implementation plan to support the guidelines. Schools regularly invite in mental health promotion speakers and there appears to be no coordinated approach to ensuring a consistent, safe and effective standard for these mental health promotion activities, nor a requirement that presentations are integrated into a whole school approach on mental health promotion that can provide follow-up support.

f. Gaps in GPs' knowledge of how to respond to individuals at risk of suicide or self-harm

There continue to be gaps in GPs' knowledge of how to support people with mental health difficulties and how to respond to individuals at risk of suicide or self-harm. GPs do not always have adequate communication and referral channels with mental health services.

g. Lack of regulation of counselling and psychotherapy

Professionals providing counselling and psychotherapy have an important role to play in responding appropriately to expressed suicidal thoughts and reports of self-harm. The lack of regulation over counselling and psychotherapy professionals in Ireland puts individuals seeking help at risk of receiving an inappropriate response in situations like these. Regulations covering counselling and psychotherapy professionals need to be progressed, and to incorporate skills in suicide/self-harm prevention.

4. How do you think the quality, availability, responsiveness and accessibility of services and programmes aimed at reducing suicide can be improved?

a. Ensuring access to crisis supports

Mental Health Reform is aware of some services that have good systems in place for providing access to help out of hours. The West Cork mental health service operates a 24-hour listening service. The Celbridge community mental health team provides a 7-day-a-week service and also gives service users the telephone number of the acute unit to call out of hours. In the view of Dr. Pat Gibbons, Clinical Director of the Celbridge service, the home care service combined with the keyworker system and a 24/7 phone number gives people a sense of security in the mental health system and helps to reduce hospital admissions.

A Vision for Change states that a protocol for crisis intervention should be agreed upon for each area by the local CMHT and that the agreed-upon response should be available 24/7. The policy also recommends that each mental health service area should have the facility of a crisis houses that should offer brief respite to those suffering a crisis where hospital admission is not appropriate.

1. **The HSE should ensure that all community mental health teams provide a 24/7 crisis intervention service as recommended in *A Vision for Change*.**
2. **The NOSP and the HSE should roll-out Suicide Crisis and Assessment Nurses (SCAN) to be available to all primary care services across the country and to homeless services.**
3. **The HSE should continue to work with the Irish College of General Practitioners to improve GPs knowledge about how to respond to people with mental health difficulties and individuals at risk of suicide/self-harm.**
4. **The NOSP and the HSE should roll-out self-harm liaison nurses in all A&E units and provide training in suicide and self-harm to all A&E staff. Self-harm liaison nurses should be trained in liaison and follow-up with homeless services.**

b. Lack of availability of suicide and self-harm prevention services for people in high-risk, marginalised groups

The following recommendations can improve mental health promotion and suicide prevention services for people from marginalised groups including BME communities, the deaf community and people who are homeless.

5. **People from BME communities, including the Traveller community, and homeless people should be prioritised for suicide prevention initiatives which have the capacity to reach all members of these communities.**
6. **The NOSP should fund a dedicated strand of mental health capacity-building for BME community leaders.**
7. **The DOJ should include a specification in their Service Level Agreements with direct provision service providers to provide mental health awareness training for their staff. This should form part of any revised Reception conditions for asylum seekers**
8. **The NOSP should fund and ensure adequate capacity of mental health workers for BME communities including the Traveller community.**
9. **The SeeChange anti-stigma/discrimination campaign should develop a strand of action targeted at reducing the stigma around accessing mental health support among people from BME communities.**
10. **The HSE should develop a programme and implementation plan to develop cultural competence in primary care and specialist mental health services that includes guidance and a training programme for staff, and should clarify lead responsibility for this programme within the Mental Health Division's Senior Management Team.**
1. **The HSE should ensure that sign language interpretation is widely available in mental health and primary care services so that members of the Deaf Community can have equitable access to mental health services.**
2. **The NOSP should ensure that all homeless services have access to on-site mental health consultation and suicide prevention services**

3. **The NOSP should support the development of peer mental health 'ambassadors' in homeless services.**
4. **The NOSP should ensure that drug and alcohol treatment services have access to crisis mental health support.**
5. **Therapeutic programmes to address suicidal behaviour where the individual does not have a diagnosed mental disorder should be developed.**

c. Improving the evidence on suicide and self-harm among people from marginalised groups

The following recommendations can help to improve the evidence base on the need for and provision of effective suicide and self-harm prevention initiatives for people from marginalised groups.

6. **The NSRF should ensure that homeless status and ethnicity are included as identifiers in its analysis of suicide and self-harm statistics.**
7. **The NSRF should conduct specific research on the risk and prevalence of suicide among people in BME communities, including the Traveller Community, and among the deaf community, as well as research on effective service responses for these groups.**

d. Ensuring standardised mental health promotion and suicide/self-harm prevention programmes for children and adolescents underpinned by a whole school approach

A number of reviews of mental health promotion programmes for children and adolescents have concluded that for such programmes to be effective it is necessary to move beyond an individual, classroom and curriculum focus alone. Instead it is necessary to embed this work within a whole-school, complex, multi-component approach involving a wide range of people, agencies, methods and levels of intervention, and mobilising the whole-school as an organisation. A whole school approach enhances school climate and creates a supportive environment for mental health. There are some positive examples of this approach in Ireland (the Jigsaw Meath Schools model) and other jurisdictions.

It is crucial that guidelines on mental health and emotional well-being are developed for primary schools, as well as for pre-schools and for the third level sector. Mental health promotion at primary school level is often referred to as social and emotional learning. These critical social-emotional competencies involve skills that help children to calm themselves when angry, initiate friendships and resolve conflicts respectfully. At primary school level, there is widespread evidence that social and emotional development impacts on a child's ability to engage with and adapt to the demands of school life.

Recommendations:

8. **The whole school approach in mental health promotion should be adopted within the suicide prevention framework**
9. **Funding must be allocated to put support structures in place to help realise the *Post Primary Guidelines on Mental Health*.**
10. **The roles and responsibilities of relevant Departments and agencies, including the Department of Health, the Department of Education & Skills, the Department of**

Children & Youth Affairs, the HSE, NOSP and Tusla - the Child & Family Agency should be clarified with regard to mental health promotion and suicide prevention

11. **Social and emotional learning guidelines, incorporating a whole-school approach, should be put in place for primary and pre-school educational settings.**

e. Regulation of counselling and psychotherapy professionals

Regulations covering counselling and psychotherapy professionals should address the appropriate response to individuals at risk of suicide/self-harm, including the requirement for adequate supervision from practitioners experienced in this area. Good responses involve, for example, swift liaison with a practitioner aware of the value of implementing psychotherapeutically informed engagement before the person returns to defensive coping and the accompanying dissociation from their emotional experience. Such engagement would involve both initiating a practitioner-patient relationship which is accepting of the sufferer's intolerable feelings, and helping the distressed suicidal person to become aware that a regular, reliable, accepting listening relationship would be available. Regulations should also encourage coordination between professionals involved in supporting individuals at risk.

Recommendation: Regulations covering counselling and psychotherapy professionals need to be progressed, and to incorporate skills in suicide/self-harm prevention.

5. What do you think can be done to encourage people to seek help for themselves who may be in emotional distress?

1. Ensuring widespread availability of a 24/7 crisis intervention mental health service;
2. Mental health promotion and outreach to BME communities, including the Traveller community, people who are homeless and people who are deaf.
3. Child and adolescent-friendly, direct access services for children and young people concerned about their mental health.
4. Services that provide therapeutic, follow-up support to individuals who have engaged in suicidal or self-harming behaviour, whether or not they have a mental health diagnosis.

6. What do you think can be done to encourage people to give help to those that they are concerned about?

Recommendation: The roll-out of ASIST training should continue in order to increase individuals' confidence in responding to someone they are concerned about. Community leaders and community development workers in marginalised groups including BME communities, the deaf community and people who are homeless should be a priority for ASIST training.

7. What do you think we can do at a community-wide level to reduce suicide and promote positive mental health?

A Vision for Change contains a full chapter on mental health promotion. The document recognises that there is growing evidence that mental health promotion programmes can improve mental health and quality of life as well as prevent mental health difficulties (page 44).

Despite the mental health promotion chapter in *A Vision for Change,* and despite the inclusion of positive mental health actions in the *Reach Out* strategy, there has been an inadequate level of coordinated, cross-departmental action to promote positive mental health and wellbeing in Ireland to date.

There is now widespread support at European-level and in neighbouring countries for a focus on promoting positive mental health in national mental health strategies. The WHO's *Mental Health Declaration for Europe* (2005) stated that: "mental health and mental wellbeing are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.[6] In both Scotland and Wales, national policies have been developed that focus on promoting positive mental health. In Scotland, the Government has been developing its mental health promotion work over many years. In *Towards a Mentally Flourishing Scotland 2009-2011*[7] the Scottish Government made a commitment to improving the mental health of the population through not only a focus on better mental health services but also through its wider social policy and health improvement activities. Its current *Mental Health Strategy for Scotland: 2012-2015*[8] combines its mental health promotion initiatives with its strategy to improve delivery of mental health services. In Wales, the 2012 strategy *Together for Mental Health – A Mental Health and Wellbeing Strategy for Wales* aims to promote mental health and prevent mental health difficulties. It contains an outcome target that "the mental health and wellbeing of the whole population is improved."[9]

It has been argued that there are substantial savings to be made by a focus on prevention and mental health promotion. Friedli & Parsonage (2009) have calculated that life-time savings for 'conduct disorder' of £150,000 per case can be made through prevention programmes and £75,000 per case through mental health promotion.[10] The authors show that the benefits of positive mental health "include improved physical health, reductions in health damaging behaviour, greater educational achievement, greater productivity, reduced crime and higher levels of 'pro-social' behaviour or participation in community life."[11]

In this context, it is welcome that the Department of Health's *Healthy Ireland: A Framework for Improved Health and Wellbeing (2013-2025)* incorporates mental wellbeing into its definition of health. The Framework's definition of health also emphasises the concept of positive mental health "in which a person can realise his or her own ability, cope with the normal stresses of life, work productively and fruitfully, and be able to make a contribution to his or her community" (p.9). Under Theme 2 of the Framework, there is an action to "combine mental health promotio0n programmes with interventions that address broader determinants and social problems as part of a multi-agency approach, particularly in areas of high deprivation and fragmentation" (p.23).

---

[6] http://www.euro.who.int/__data/assets/pdf_file/0009/99720/edoc06.pdf?ua=1

[7] Scottish Government (2009) *Towards a Mentally Flourishing Scotland: Policy and action plan 2009-2011*, Edinburgh: The Scottish Government.

[8] Scottish Government (2012) *Mental Health Strategy for Scotland: 2012-2015*, available at http://www.scotland.gov.uk/Publications/2012/08/9714.

[9] Welsh Government (2012) *Together for Mental Health: A Strategy for mental health and wellbeing in Wales*, available at http://wales.gov.uk/docs/dhss/publications/121031tmhfinalen.pdf.

[10] Friedli, L. & Parsonage, M. (2009) *Promoting mental health and preventing mental illness: the economic case for investment in Wales*, the All Wales Mental Health Promotion Network, p.33.

[11] Ibid., p.67.

However, the *Healthy Ireland* Framework's actions do not represent a detailed roadmap for promoting positive mental health in the population of Ireland and there is still a need for a cross-departmental action plan on promoting positive mental health and mental wellbeing. *A Vision for Change* policy recommends a framework for inter-departmental cooperation on health and social policy and that the effectiveness of mental health promotion programmes should be evaluated. The mental health policy also recommends funding designated mental health promotion officers in has not received adequate attention in implementation to date.

There is a need for a national, cross-departmental mental wellbeing strategy to foster positive mental health and wellbeing in communities in Ireland. Such a strategy would require specific action by other sectors such as education and local government along with actions for the health sector.

Recommendations:

1. **The Department of Health's Health & Wellbeing Programme should develop a national, cross-departmental mental wellbeing strategy and action plan to foster positive mental health and wellbeing and prevent mental disorders; the national suicide prevention framework should form a part of the national mental wellbeing strategy.**
2. **National, regional and local mental health promotion programmes should be evaluated as a matter of priority a plan for implementing effective programmes on a nationwide basis be put in place on foot of the evaluation**
3. **A designated mental health promotion officer should be allocated in each mental health service area.**
4. **The HSE should ensure that CMHTs have allocated time to undertake outreach and mental health promotion.**

About Mental Health Reform

Mental Health Reform is the national coalition of 45 organisations working to promote improved mental health services and implementation of *A Vision for Change*. Mental Health Reform is available to discuss the above recommendations. Please contact Shari McDaid, Director at 01 874 9468 or via email at smcdaid@mentalhealthreform.ie