HIGHLAND USERS GROUP (HUG)

SUICIDE

A Report on the views of the Highland Users Group on services for people at risk of suicide and of ways of reducing the suicide rate in the Highlands

January 1997

(Amended February 1998)

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HIGHLAND USERS GROUP

The Highland Users Group (HUG) was established on 11 June 1996.

Its aims are to:

1. Represent the interests of users of mental health services living in the Highlands.

2. To identify gaps in services and to find ways of improving services for mental health services users.

3. To provide information about mental health issues to users living in the Highlands.

4. To participate in the planning and management of service for mental health service users.

5. To pass on information and news amongst mental health user groups in the Highlands and to interested parties.

6. To increase knowledge about resources, alternative treatments and rights for users of mental health services.

7. To promote co-operation between agencies concerned with mental health.

8. To promote equality of opportunity and to break down discrimination against mental health users.

At present (13 January 1998) HUG has 145 members, and has branches in:

- ◊ Caithness
- ◊ Easter Ross
- ◊ Lochaber
- ◊ Skye & Lochalsh
- ◊ Inverness
- ◊ Craig Dunain

Wherever there are any, HUG tries to work with local user groups that are already established in the Highlands.

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1. SUICIDE AND THE REASONS FOR THIS REPORT

Among the two targets for the Health of the Nation Report 1992 (England) were to

- Reduce the suicide rate by at least 15% by the year 2000 (from 11/1000,000 to 9.4/100,000)
- Reduce the suicide rate for severely mentally ill people by at least 33% by the year 2000.

The suicide rate in the Highlands stands at 19.1/100,000.

The suicide rate for young men has been increasing over the last few years, but in the Highlands the largest increase is in men between the ages of 35 - 44 and 65 - 74 years.

In response to these figures, to the recent action by Highland Health Board in this area, and to concerns amongst members of HUG about the subject, we had a round of meetings in October 1996 to discuss the subject of suicide.

The comments on the nature and quality of services in the report are based upon members experiences. About 57 users participated in the meetings and, in all but one group, there were one or more members who had attempted suicide or committed self harm upon themselves. Everyone had knowledge of someone who had either attempted suicide or committed suicide.

2. SELF HARM AND SUICIDE - WHAT ARE THEY?

Although self harm and suicidal feelings are linked and one may lead to the other, they are very different things.

There was complete agreement that suicide was an attempt to die, whilst self harm was hurting yourself.

Suicide was described as a point where the pain and distress was so much that there seemed to be no solutions other than dying. With self harm, the pain and distress was so great that there were no other ways of expressing it other than in this dramatic way. Self harm could be some people's way of answering their problems or a way of trying to get an inner anguish addressed by seeking help or attention by hurting themselves. There was also the view that suicide was one step beyond self harm. A related view of suicide was that it was a point where the person had tried everything, given everything but everything seemed to be against them and this was the only solution.

3. WHAT CONTRIBUTES TO THE SUICIDE RATE IN THE HIGHLANDS, AND WHY IS IT SO MUCH HIGHER THAN IN OTHER PARTS OF THE COUNTRY?

Numerous reasons were given for this, such as:

- The environment and the climate with its extreme weather conditions.
- The existence of small isolated communities.
- Unemployment and poverty.

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- The absence of anything to do.
- Lack of services to obtain help outside Inverness.
- A feeling of being cut off from people whilst at the same time everyone seems to know your business.
- There is a lot of stress here, and yet there is a culture where people prize their independence and are unwilling to ask for help.
- There is an attitude that suicidal states are a sign of failure, and the act a "cowards way out" which only serves to increase people's guilt.
- People have moved to the Highlands as a solution to problems they have experienced elsewhere, only to find that they have taken their problems with them.
- Alcohol problems are rife in the Highlands and serve to increase people's likelihood to commit suicide.
- The means to commit suicide are relatively easy to obtain in the Highlands - for instance through ready access to guns, cliffs and the sea and rivers.
- In the Highlands there is a culture where other people are judged and singled out if they are perceived to be different - an insular inhibited culture.

A view expressed by a minority of people was that religion and sexism played a part too.

Why is the suicide rate amongst young men increasing so rapidly?

Again we had many thoughts about this:

- Young men often feel that they have no future.
- There are few jobs, where in the past young men would have expected to work.
- There is a huge pressure to succeed without having the means to do so.
- There is the development of a "risk taking" culture and alcohol and drug abuse is now a part of the life of many young people.

More specific to young men, as opposed to young people, was the awareness among young men that they are now expected to play different roles. In the past it was a patriarchal role where men were the providers and "in charge" and looked up to. Now there appears to be a different role where men are expected to be more equal, to help in the household and to help with childcare, to not feel superior and where employment is not guaranteed. Both roles exist at the same time nowadays and are often held by one individual causing conflict, confusion, guilt and a lack of confidence or belief in the future.

4. IF SOMEONE IS SUICIDAL, WHAT SERVICES CAN HELP THEM?

The view expressed by the great majority of people who attempted suicide was as follows:

ONCE SOMEONE HAS MADE A DECISION THAT THEY ARE GOING TO COMMIT SUICIDE THEY WILL USUALLY NEITHER SEEK, ASK FOR OR ACCEPT, SERVICES AIMED AT HELPING THEM.

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This potentially has big implications for service delivery for people who are suicidal. However the key point to notice in this statement is the word "decision". The decision to commit suicide may be taken relatively quickly, whilst the feelings of someone who is beginning to contemplate suicide may be more long term and in that situation it is possible that a person will be prepared to seek help.

The sorts of things that could help a person who is considering or feeling suicidal ranged from formal services to other factors as follows:

- Having someone close to you who understands you as a human being and who can draw you out - in that state it is important to express how you are feeling.
- Someone who can see the danger signs.
- Someone you can trust.
- Someone you know already - someone you know a little or only half know is no good (although a contrary view was expressed saying that confiding in people you know very well put everyone under so much pressure that the situation gets worse).
- Someone you can relate to but not someone in authority or control.
- Quick access to someone you can get help from.
- Human warmth.
- Contact with someone who can empathise.
- Immediate access to a short term stay in hospital.
- Compassion
- Uplift.
- Help before people lose hope.
- Acceptance of what you're going through. Getting an understanding of the reasons for feeling this way.
- Having someone to speak to who has already gone through the problem.
- Social contact.
- Having things to do.
- Having somewhere to sleep or relax in safety.
- Having access to a free crisis phone line.
- Having 24 hour access to psychiatric staff.
- Having access to a 24 hour drop-in centre where there is a chance to chat, to have counselling, and to have food provided.
- Direct access to your doctor - not a locum.

5. WHAT SERVICES ARE AVAILABLE AT PRESENT?

- The General Practitioner
- A Psychiatrist
- The Samaritans
- Drop-in Centres
- The Mental Health Team
- Hospital
- Birchwood

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- Community Psychiatric Nurses
- Emergency Social Worker
- The Police
- The Social Centre at Craig Dunain
- Friends

6. WHAT ARE THE SERVICES LIKE?

The service quality depends on the relationship that you have with the professional, and how approachable they are.

Although it was acknowledged that in some situations services had been good, services were also widely criticised. People had had difficulty accessing services outside the hours of 9am to 5pm on weekends and also in obtaining appointments.

Attitudes of some professionals were also criticised, especially those of GP's who sometimes didn't come out when people were in crisis, with the perception of users being that they had the attitude of "here we go again".

Many professionals found it very hard to provide empathy or to acknowledge distress, and often would just come in for a short time until they thought things had calmed down. There seemed to be a reliance on the use of pills as a form of treatment.

For those people not diagnosed as mentally ill, the Samaritans was perceived to be the only service available to them.

What are the Samaritans like?

Most people said that they wouldn't use the Samaritans, although one person said that he received an excellent service from them in the past. Another person said that they were very useful for carers and yet another person regularly used them when she began to feel suicidal.

The reasons for this were as already mentioned - having decided to commit suicide most people did not wish to talk about it.

Some people said that they wouldn't contact the Samaritans because it was a phone line: being able to talk did not necessarily solve or get to the root of the problem. The Samaritans were perceived as an organisation that would not give information or advice, which was what many people wanted.

The long distance that the Samaritans is from people in some areas was mentioned, as was the feeling that they did not have much expertise in dealing with people with mental health problems. (Members and the author were not aware as to whether the Samaritans provided training to their volunteers in mental health issues).

Lastly, some people said that the religious connotations of their name put them off.

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What are users experiences of admission to general hospitals?

Members experience was that accident and emergency dealt with the physical problem well but paid little or no attention to the emotional underlying problems.

They also stated that very little attention was paid to follow up after the physical problem had been dealt with. However, some people said that they were very happy to get away from the hospital as soon as possible after physical treatment had been completed.

In some cases admission to a general hospital proved to be very traumatic. An example was given of someone who was admitted following a very serious suicide attempt. Due to the seriousness of her overdose she was treated by a series of nurses round the clock. They came in and did their job but with the exception of two nurses no one spoke to her directly in three days. The doctor spoke to her and said that she was very silly and that it was very likely that she would die. He then went into a detailed description of how you did die following paracetomol poisoning and concluded by saying "and then its bye bye".

This type of experience was repeated by other people, especially the fact that no-one talks to you and that you are treated as a stupid and silly person.

It was agreed by the groups that heard these experiences that such attitudes are examples of being judgmental and unprofessional and that nursing and medical staff are meant to demonstrate care, not just practical expertise. People spoke of the need to install in staff the attributes of care and compassion and to give the time to give it. There was also a feeling that staff in accident and emergency could benefit from training in mental health problems.

Despite these very negative feelings about general hospitals there were a few positive examples, for instance: The hospital in Portree, which in the past had been thought to be a terrible place to be admitted following a suicide attempt, was said (with a few exceptions) to now provide an excellent service. Changing attitudes of staff to people being admitted following suicide attempts was seen as the reason for the improved service. Another person spoke of being calmed down and reassured and hugged on admission recently to an Accident and Emergency Department.

7. HOW CAN THE SUICIDE RATE BE REDUCED?

There were two main themes to this:

1. The underlying causes of suicide should be discussed in greater depth. Society and government should address these issues which are such things as unemployment, poverty, unacceptable pressures to succeed and judgmental attitudes to certain people and sectors of society not perceived as conforming to the way everyone should live.

2. The other main factor to address in reducing suicide is our cultural view of emotional distress. There is a pressure not to reveal negative feelings or the fact that one can no longer cope. This is accompanied by views that the person is a failure and burden on other people. It may also be accompanied by the fear that the person is developing some form of mental illness which is, of course, surrounded with many negative attitudes.

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All the groups called for an education programme to help people come to the realisation that:

"IT IS OK TO BE DISTRESSED - IT IS OK TO TALK ABOUT FEELINGS - IT IS OK TO GET HELP"

Some people also thought that it should be harder to commit suicide, especially through making access to paracetomal more difficult.

There were mixed views on this - some people believed that making suicide harder was just a temporary solution as, in due course, other methods would become available leading to another increase in suicide rates.

However there was agreement that, if possible, an antidote should be put into paracetomal as it is a common form of overdose of which many people are ignorant of how dangerous it is. One group suggested that paracetomal should become a prescription only drug.

Detection of depression

Better detection and earlier treatment of depression was also called for. However many people also said that, in common with suicide, people were reluctant to seek help at first for depression. Better detection would follow from the education programme suggested in this report. There was also a view expressed that people found a gap in the understanding shown by professionals treating them because of the huge difficulty in communicating the effect of depression to people who haven't experienced it.

Lastly, there was a call for more awareness that people beginning to recover from depression may only then have the energy to take action on suicidal feelings, and that care is taken in treatment at this stage.

Access to services

For people at risk, or beginning to become suicidal, it was thought very important to have immediate access to services on a seven day a week 24 hour basis. People did not consider the present situation of being able to access a GP to be the answer to this problem.

Suicide and mental health problems

Many people with mental health problems commit or attempt suicide. Although this can be partly put down to the condition itself, there was also a widespread belief that suicide occurred because of the guilt and lack of hope that accompanies a diagnosis of mental illness. This has little to do with the illness and a lot to do with discrimination and prejudice from society.

With regard to users attitudes to mental illness, it was said that it was important to accept the illness and to come to terms with it.

Suicide and Accident and Emergency

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In addition to the previously mentioned points, it was thought very important to have trained liaison psychiatric staff attached to general hospitals and Accident and Emergency in particular.

Discharge from hospital

There was a lack of confidence in hospitals adhering to their discharge policies and a feeling that shorter stays in hospital reflected a climate of financial insecurity rather than a concern for the needs of the individual.

There was also a feeling that, however good the discharge policy, this would be worthless if the person did not have immediate access to community services straight after discharge from hospital.

One group spoke about how the practice of giving people in psychiatric hospital passes to go back to their own homes over the weekend had been changed to mid-week. This was highly praised - in mid-week there are services and people available for the person on pass whereas at the weekend there are virtually no services and therefore no help if the person starts feeling suicidal.

8. MANAGING THE RISK OF SUICIDE

We had a great deal of difficulty in dealing with this complex issue.

We agreed that hospital treatment should always be a possibility, as should the use of the Mental Health Act. Treatment should not rest solely on the criteria of whether someone is mentally ill or not, but also on the degree of distress and the likelihood that they will commit suicide. Whilst a very small number of people may have very good reasons for committing suicide, the vast majority of people are in a huge amount of distress and have a right to care that reduces that distress.

There was however agreement that, whilst we would want to intervene if we believed someone to be suicidal, we cannot take the final responsibility for that person's act which is their decision alone to take. This however gives rise to the discussion of when is someone's decision rational and justified and when is it not.

The most obvious thing to do when assessing the risk someone can be allowed to take is to discuss it with them and their relatives in the first place and act from that point.

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Carers and suicide

The effect of someone committing suicide, or attempting it, can be devastating on the people that they are close to. It is important that they have help.

After a suicide attempt

It was suggested that there should be a measure of the degree of risk of someone of committing suicide, and that services should be activated after a person crosses a threshhold point.

It was also suggested that people who repeatedly attempt suicide are in great need of services and help, and that this help should replace the judgmental attitude which persists, that they are just attention seeking.

Some people found that having access to services that allowed them to express understand and come to terms with their feelings following suicide attempts, such as art therapy and counselling were very helpful.

9. RECOMMENDATIONS

Reducing the rate of suicide:

1. Discover and address the societal causes of suicide.
2. Embark on an education campaign that allows people to express their feelings and ask for help.
3. Reduce the stigma, prejudice and discrimination that accompanies a diagnosis of a mental health problem.
4. Treat and detect depression earlier and better (accompanied by efforts to show people that they can ask for help with depression).
5. Avoid a crisis approach to all mental health problems - i.e. don’t wait until its too late.
6. Make the means of committing suicide harder to have access to.

    6a Incorporate an antidote into paracetomal

7. Ensure that discharge from hospital is dictated by the needs of the patient and that there are adequate community facilities for the person.
8. Do not let patients at risk of suicide out “on pass” at times when there are no services.
9. Establish, or adapt, services to provide immediate 24 hour access.

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Services for people who are suicidal

1. It is important to provide human warmth and understanding that is non-judgmental as well as professional skills.

2. Efforts should be made to combat lack of time, fear and judgmental attitudes among professionals.

3. Staff in Accident and Emergency Departments should have training in mental health, and time to demonstrate care and compassion.

4. There should be liaison psychiatric staff in general hospitals.

5. People recovering from suicide attempts should, at the appropriate stage, be given the chance to come to terms and an understanding of the suicide attempt and the reason for it.

6. Although someone attempting suicide may be seeking attention, the judgmental attitudes that accompany this view should be changed.

7. Carers and people close to someone who has committed suicide or attempted suicide need support and help.

10. ACTION TO BE TAKEN

This report will be discussed with representatives of the Health Board, Social Work Department and relevant NHS Trusts.

It is clear that many of the recommendations that we have made are not immediately achievable due to the large resource implications and degree of change that would have to occur.

However we hope that, through meeting relevant service providers and planners, we can agree a way forward.

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ACKNOWLEDGEMENTS

With thanks to the members of the Highland Users Group who participated in this round of discussions.

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