PE1716/E
Samaritans Scotland submissions of 7 May 2019

About Samaritans

Samaritans is the leading organisations for suicide prevention in Scotland. We provide free, confidential and anonymous emotional support to anyone in distress or crisis, 24 hours a day, 365 days a year. Across the UK and Ireland, someone contacts Samaritans every 6 seconds.

In Scotland, Samaritans has 19 branches, stretching from the Borders to the Highlands and Islands, with around 1,000 volunteers. Last year volunteers in Scotland:

- Were contacted more than 249,000 times or once every two minutes
- Spent more than 60,000 hours providing emotional support – the equivalent of over 2,500 days around £840,000 in time*
- Delivered more than 600 outreach events promoting emotional wellbeing in schools, workplaces and communities across Scotland[1]

In addition to running our listening service, we're working to make suicide prevention a priority at a national and local level, through research, campaigning and national & local partnerships.

Our service is entirely volunteer-run and our volunteers receive specialist training to equip them to support people in distress and crisis. To continue meet demand, we need to recruit at least 200 volunteers in Scotland alone, each year.

How we support people in crisis

Our listening service provides 24-hour, year-round emotional support to anyone experiencing crisis or distress by phone, text, email, and face to face conversation. Around a third of the people who are contact us express suicidal thoughts and feelings.

Our service is free, confidential, anonymous. Providing non-judgemental emotional support is at the core of what we do. That means we listen to people who contact us and encourage them to explore their feeling, worries and options. We don't provide advice or clinical support and we don't make decisions for our callers or tell them what to do. However, where appropriate, we will sign-post to trusted organisations at a UK wide level who can provide specialist support on specific issues (e.g.: domestic abuse, money concerns, addiction). Due to the nature of operation and the nature of the way people contact us (one number puts a caller through to the volunteer anywhere in the UK who is available and 80% of calls are from mobiles so we do not know where someone is calling from) we are not in a position to signpost to local services closer to where someone may be at the time of their call.

In recent years we have taken steps to make our service as accessible as possible. This includes moving to a centralised Freephone number, which means that calls to us are now completely free from any landline or mobile, even where callers do not have phone credit.

[1] Samaritans Scotland Impact Report 2018

We are also in the process of a digital transformation project that will enable us to offer new forms of support including web chat and self-management tools.

Understanding suicide as a public health issue

Context: During the committee's consideration, petitioner Karen McKeown and a number of members raised concerns that suicide and mental health were treated in isolation and that there is not a joined-up approach to addressing risk factors, such as addiction.

At Samaritans we view suicide as a public health issue. We're working to improve understanding of the complex risk factors that increase the risk of suicide and ensure that policy is informed by evidence and research.

There are a range of social, economic and health factors that can contribute to an increased risk of suicide.

Men are around three times more likely to die by suicide than women and middle-age men have the highest suicide rate. [2]Men are also more likely to use alcohol and drugs as a coping strategy, which contribute to increased risk, and when men do attempt suicide, they are more likely to use more lethal methods.

Socio-economic deprivation increases the risk of suicide for both men and women. People living in the most deprived areas are three times more likely to die by suicide than those living in the most affluent areas. And evidence shows that men in the lowest social class, living in the most deprived areas are ten times more likely to die by suicide than those living in the highest social class in the most affluent areas. Indebtedness and unemployment are also associated with increased suicide risk.

Experiences of mental ill-health, self-harm and bereavement - particularly bereavement by suicide - also contribute to increased risk.

Conclusions and Recommendations

- There are a number of complex risk factors which contribute to suicide risk. Many of these factors are not medical and instead reflect social and economic inequalities.
- Policy and services should take a joined-up, cross-government approach which recognises and addresses the health, social and economic factors that contribute to suicide risk.

Sign-posting to support services

Context: During the sessions the committee heard evidence that the NHS does not sign-post to charities; it's not something they advocate." More broadly, the session highlighted challenges around awareness and understanding of the support available and how to access this.

Sign-posting to Samaritans

As Samaritans is one of the few organisations able to operate a 24-hour listening service, a wide range of other organisations including health, emergency and local

[2] ScotSID: A profile of deaths by suicide in Scotland 2011-2017

services sign-post to us to as a source of out of hours support, particularly during holiday periods.

This includes a number of Scottish Government funded and connected websites including NHS Inform, Choose Life, Breathing Space, Scottish Government messaging and other third sector organisations at a national and local level.

Many health professionals at a local level do sign-post to our services and may, where the client is happy for them to do so, make a direct referral to their local Samaritans branch. However, awareness and understanding of our service and other third sector services will vary among health professionals. Our 19 branches across Scotland will provide information to NHS Boards or other services as requested but we do not keep any register of these relationships or organisations.

Last year Samaritans Scotland produced a report in partnership with the Health and Social Care Alliance and NHS Health Scotland, which explored the views of people with lived experience of suicide. Participants highlighted that sign-posting arrangements could inconsistent and that there were a number of barriers to people accessing appropriate support including waiting lists for services and geographical challenges of access, particularly in rural areas.[3]

When sign-posting is appropriate

We also recognise it would not be appropriate to signpost to Samaritans or other third sector organisations in all circumstances. As a listening service, Samaritans offers emotional support but are unable to provide medical advice or professional counselling. Where someone presents to health services with severe mental health problems, there may be more appropriate services to meet their immediate needs.

We believe Samaritans and other third sector organisations have a vital and complimentary role to play alongside wider mental health services and not as a replacement for others forms of care and support.

For some callers, a conversation with Samaritans, can act as a first step to seeking wider support, by giving them a safe space to talk, sometimes for the first time, about what they're experiencing.

For others, who are engaged with existing health services, we can be an additional source of support throughout their mental and physical health journey, particularly at weekends, holidays and out of hours. Samaritans and other national or UK wide services can also reduce some of the geographical barriers to seeking support as they can be accessed remotely and by those for whom direct access to services is more limited.

Improving sign-posting

We are exploring opportunities to develop greater awareness and understanding of our services among health professionals in Scotland and encourage a more consistent approach to sign-posting and referrals.

[3] Samaritans Scotland: Suicide Prevention Strategy Report

In England, pilot programme *Think Samaritans*, explored new referral pathways. Funded by the Department of Health in England, *Think Samaritans*, has seen Samaritans branches develop partnerships with A&E Departments, Mental Health Teams and GPs.

Pilots with Mental Health Teams and GPs focussed on improving sign-posting & referrals by strengthening relationships with local branches, developing online referral tools and improving data recording of referrals. Pilots with A&E departments trained and placed small teams of Samaritans volunteers within emergency departments to provide on-site emotional support to patients experiencing distress of crisis at peak times.

Work around partnerships with A&E departments may be particularly relevant to the committee's consideration of how appropriate A&E is as service for people in distress and how departments can find new approaches to better support patients presenting in distress.

While *Think Samaritans* only applies to England, we would welcome opportunities to explore if similar models could be developed for the Scottish health context, to improve signposting and referral pathways between our services and the NHS.

However, increasing awareness and sign-posting to our service will naturally result in increased demand with implications for our funding and capacity. Samaritans currently receives limited public funding to cover the cost of our Freephone service and the actual costs of running our service and training and recruiting volunteers far exceeds this sum.

Continuing to meet existing demand and developing innovative approaches to how we work alongside health services will require additional sources of funding and increased volunteer capacity.

Conclusions and Recommendations

- There is a wide variety of support available through national and local third sector organisations, however sign-posting can be inconsistent.
- Innovative approaches, such as basing third sector volunteers within health services and developing partnership between health professionals and third sector organisations, could increase understanding of services and consistency in how and when patients are sign-posted.
- Sign-posting to Samaritans or third sector services should not replace robust and accessible mental health services available for those who need them. Instead services like Samaritans should provide an additional and complimentary source of support, or a route to seeking help that relies on the confidentiality and anonymity which we offer and some people seek.
- Increased signposting to third sector services will have capacity and funding implications for service provision for Samaritans and others who rely on volunteers to meet demand.

Crisis Support

The committee highlighted challenges around accessing crisis support services outside of office hours and ask us to provide our thoughts on this. In particular, the petitioner suggested that a central hub for mental health patients would be much more effective for patients than referring people in distress to A&E. The committee also highlighted concerns around consistency and gaps in service.

Challenges facing crisis support

While our service provides a vital source of support to people in distress and crisis, we recognise responding to people in crisis requires a joined-up approach, that encompasses a range of services and agencies.

This need was reinforced through our consultation with people affected by suicide. Over the course of this consultation participants told us:

- Support services should be open-ended and flexible
- Support is focussed on people in acute crisis, with insufficient early intervention
- Health professionals need to have the confidence and knowledge to effectively sign-post to a range of services
- Crisis services should be equipped to support people who are under the influence of or struggling with drug and alcohol. Currently people are often directed to the police, which can increase trauma and distress.
- The period following a suicide attempt is a crucial time for effective and compassionate support.
- Support for people bereaved by suicide must be timely, effective and easily accessible. [4]

Improving crisis support

Samaritans Scotland sits on the National Leadership Group for Suicide Prevention (NSPLG) and is one of the organisation leading on implementation of the National Suicide Prevention Action Plan, published last year.

Our research with people who have lived experience of suicide has been instrumental in shaping this plan. We have been encouraged by commitments within this plan to improving crisis support both for people who are experiencing suicidal thoughts and feelings and for people who have been bereaved by suicide.

Action 4 and 5 of the Action Plan commit to developing best practice for crisis support informed by models and approaches across Scotland. This includes recent approaches such as the Distress Brief Intervention pilot which provides tailored support to individuals in distress for a set time period, and which is due to be extended to under 18s.

[4] Samaritans Scotland: Suicide Prevention Strategy Report

We also welcome the Plan's commitment to developing a Scottish Crisis Care Agreement that will establish common standards and referral pathways to ensure people bereaved by suicide receive effective support.

We also welcome commitments from the Scottish Government to increase provision of mental health workers in a range of settings including Accident and Emergency Departments, primary care settings, police custody suites and prisons, and improvements to the NHS 24 service to provide additional out of hours support.

While we welcome these commitments we recognise there are still significant challenges to ensure crisis support is effective and accessible. In particular, crisis support services must consider the impact of social and economic inequalities which may mean those at an increased risk of suicide are less likely to ask for and access support.

Services should also consider geographical barriers and how support is best delivered in rural areas centralised services may not be effective.

Crisis support services should reflect public health approaches to suicide prevention, addressing the complex health, social and economic factors which contribute to suicide through a joined-up, multi-agency approach.

Conclusions and Recommendations

- We welcome commitments to improving crisis support for both people experiencing suicidal thoughts and feelings and for those bereaved by suicide
- Crisis support services should consider the impact of social and economic inequalities on how people ask for and access support
- Crisis support should consider geographical barriers and implications for rural areas
- Crisis support should reflect a public health understanding of suicide prevention and address health, social and economic factors

Risk assessments

Context: Risk assessments: the petition states that assessment tools are inadequate and not fit for purpose; are assessment tools "missing key aspects"? The petitioner feels that the more serious questions are getting missed, and there needs to be a more holistic, robust and patient centred approach; she does not believe that a thorough risk assessment

The majority of people who died by suicide in Scotland between 2011 and 2017 were not in contact with specialist mental health services at the time of their death (just 28% had a psychiatric in-patient or out-patient appointment within the year prior to their death). However, 72% had contact with some healthcare services prior to their death. 62% were in receipt of a mental health drug prescription, while just under a third (30%) had contact with A&E in the year prior to their death. [5]

These figures highlight the challenges associated with accurately assessing suicidality when an individual is in contact with health. There are a number reasons

[5] ScotSID: A profile of deaths by suicide in Scotland 2011-2017

why it may be challenging for healthcare professionals to accurately assess suicide risk when in contact with patients.

Suicidal feelings can wax and wane. *The National confidential inquiry into suicide and homicide among people with mental illness* (NCISH 201719) reports that immediate risk of suicide at last clinical contact was assessed as low or not present in 88% of people in Scotland who died by suicide within a year of last contact, and long-term risk was assessed as low or not present in 59% of the NCISH cohort.

Patients may also struggle to share their suicidal feelings and thoughts with health professionals. And evidence suggest some groups are less likely to seek help form health services for suicidal thoughts and feelings - particularly among men and young people.

The National Suicide Prevention Action Plan commits to delivering refreshed suicide prevention training for all healthcare professionals. This training should address common misconceptions around training and support professionals to better recognise distress. Refreshed training should also consider the needs of groups who are less likely to seek help from healthcare services. This training should support professionals to recognise, assess and respond to distress and suicidal thoughts and feelings in patients.

Conclusions and Recommendations

- Contact with health services can act as a protective factor and reduce the risk of suicide. However, evidence suggest there are a number of challenges to accurately assessing suicide risk.
- Improved suicide prevention training for all healthcare professionals should support improved recognition, assessment and response to distress and suicidal thoughts and feelings.
    - In particularly this training should address common misconceptions around suicide and ensure healthcare professionals are empowered to support groups who least likely to seek help from services.

Reviewing deaths by suicide

Context: Fatal accident inquiry: the witness indicated very strongly that she felt a fatal accident inquiry would help to identify where any failure within the mental health services process had occurred

Action 10 of the National Suicide Prevention Action Plan commits to developing appropriate reviews into **all** (our emphasis) deaths by suicide to identify learnings and inform prevention at a local and national level. Currently, all deaths by suicide where a person has been in contact with statuary services are subject to review by the relevant NHS Board, the Mental Welfare Commission for Scotland or by a Fatal Accident Inquiry initiated by the Procurator Fiscal (when there has been a death in a prison setting for example which may or may not be as a result of suicide).

However, these reviews currently only cover a fraction of total deaths by suicide in Scotland.

Developing reviews into all deaths by suicide in important to ensuring we gain a better understanding of the circumstances and factors, both where individuals have been in contact with services and where they haven't. More critical is ensuring that the learning from deaths by suicide is applied at operational and strategic levels to help reduce the risk of future deaths.

Around 50-60 FAIs are carried out each year though very few will relate to deaths by suicide. Expanding FAIs to encompass all deaths by suicide where the individual has been in touch with health services in the previous three months, as the petitioner suggests, might provide valuable insight and identify learnings for prevention at a national and local level.

However, this would dramatically increase demand for FAIs which already take years to conclude as there were 680 deaths by suicide in Scotland last year alone.

Conclusions and Recommendations

- We believe any system of for reviews of death by suicide should be informed by the voices of those who have been bereaved by suicide, ensuring they are fully involved at every stage of the process and are supported to share their views and experiences.
- We believe that reviews should be timeous and take a cross-agency approach, ensuring that information and data can be shared between organisations and that learnings from enquiries inform policy at a local and national level. We are not sufficiently informed as to the nature of FAIs to know if they can fit that purpose and remain committed to the delivery of Action 10 in the National Suicide Prevention Action Plan to achieve our desired outcome in the next 3 years.