



SCOTTISH EXECUTIVE

Health Department

Public Health Division

**Reducing Suicide and Deliberate Self
Harm**

**Exploring experience: a discussion
process**

Final report

July 2002

*Prepared for The Scottish Executive by Scottish Development Centre for Mental
Health*

1. Introduction

1.1 Background

In October 2001, the Scottish Executive Health Department issued for consultation the Draft Framework for the Prevention of Suicide and Deliberate Self Harm in Scotland. This draft was the product of a process of inclusive policy development, with the participation of a range of public sector agencies and services as well as groups and individuals whose input to the process helped to ensure that the policy was informed by experience 'on the ground'. During the period of formal consultation on the draft Framework, the Scottish Executive commissioned the Scottish Development Centre for Mental Health to undertake two interlinked pieces of work. These were designed to feed into continuing policy development and to act as a resource to inform subsequent implementation, by exploring in more detail key areas of concern in relation to suicide and deliberate self harm reduction and the promotion of mental health and well being. The two pieces of work comprised:

- Firstly a series of discussions with groups and services directly affected by suicide and self harm issues and with the media
- Secondly the collection of material on practice examples that illustrate the range of activity that is already taking place, using a variety of different approaches, working with different client groups

This report provides an account of the discussion process.

1.2 Discussion process

Purpose and Aims

The discussion process set out to generate additional ideas, information and perspectives to enhance the Framework and to inform the process of implementation:

- Developing understanding of perceived risk and protective factors for particular communities and population groups
- Examining experiences about what helps and routes to sources of help and support for people at risk of suicide or self harm
- Exploring with a range of services the challenges and opportunities they face in addressing risk of suicide and self harm and in promoting mental health and well being
- Eliciting views about future steps locally and nationally to take work forward
- Exploring the role of the media in reporting issues relating to suicide and self harm and in shaping public perceptions and opinions in this arena

Who was involved?

The discussions reported here engaged three main groups:

- People affected by or with experience of issues relating to suicide and self harm
- Services - mental health services, local health services, education, police, prisons
- Media - national and local press, radio and television

Details of those who took part in the discussion process are shown in the appendix.

Process

Contact was made with networks, groups and services explaining the purpose of the work and inviting people to take part. In some instances the SDC set up and invited people to a meeting, in some instances we were able to attend existing meetings, in other places groups or networks convened a 'special' meeting to have a discussion with us. Meetings therefore varied in size and in composition. The membership was sometimes highly diverse (for example, users of mental health services, carers, workers and community activists) and on other occasions involved people from a similar discipline (e.g. liaison psychiatrists) or similar situation (e.g. parents whose adult children had a long term mental health problem).

Because of the sensitivity and emotive nature of the issues involved, we stipulated that we would only meet with groups of individuals who had been affected by suicide or self harm personally, if the group had previously discussed these kinds of issues together. In a small number of cases people preferred to meet with the SDC individually or in pairs. We were particularly concerned to find ways of including people who had experience of self harm, and found opportunities both to speak to individuals affected and to workers who supported people who self harmed.

The discussion process snowballed as we gathered information and the range of contacts expanded. For example the SDC was approached by several New Community Schools whose Integration Managers had been unable to attend a meeting, to which all Integration Managers were invited. This led to two visits to schools for individual discussions with staff in each setting.

Of the range of interests and perspectives we aimed to include in the discussion process, young men proved hard to reach. The services and networks contacted were working with young men but invitations to take part in group or individual discussions were not taken up by them. The exception was a group of young prisoners in Polmont Young Offenders Institution.

In addition to the above, interviews were held with a cross section of senior staff working in the press, radio and television: three from the press, four from radio and two from television.

It should be noted that the discussion process set out to explore experiences with a selected range of people and services. Those who took part provide useful insights and understanding of issues relating to the reduction of suicide and self harm and the promotion of mental health and well being, but may not be regarded as 'representative'.

Approach

The discussions followed common themes within a loose structure. The meetings with individuals affected by suicide and self harm focused on:

- Perceptions of the factors that may lead a person to consider suicide or self harm
- Impact on those around them, particularly family
- Experiences of help seeking – what was useful, what would have helped
- Perceptions of the factors that influence mental health and well being
- Views about what needs to be different if we are to get better at promoting the mental health and well being of individuals and groups in order to reduce suicide and self harm

Discussions with people in services covered:

- Perceived role of their service in improving mental health and well being of the people they work with and in addressing issues of suicide and self harm
- Factors perceived to influence the mental health and well being of the people they work with
- Factors associated with risk of suicide and self harm
- The challenges and issues their service faces in these areas of work
- Ideas for future action - What would help? What role can national policy play?

Interviews with the media explored media policy and practice in reporting suicide and deliberate self harm and the factors that influenced policy and practice. The role of the media in shaping public attitudes and perceptions was also considered.

The material from the discussion process is described below by looking at three perspectives: individuals, services and strategy / policy. The first sections of the report consider the main points from the discussions that relate to individuals, by focusing on two main themes: firstly, factors associated with risk for suicide and self harm and secondly, help seeking and access to services. The main risk factors identified by participants in the discussions are described in some detail as they pertain to a range of population groups, insofar as they have particular relevance for action to promote mental health and well being and for the development of service responses to address risk of suicide and self harm.

The following sections explore the perspectives of services and the media (Sections 4-8) and wider strategic considerations (Section 9). The concluding section draws together the principle issues and themes to indicate implications for action.

Each section draws on the full range of discussions and therefore includes points raised by individuals and by those working in services.

2. Influences on mental health and well being and on risk of suicide and deliberate self harm

2.1 General

The discussions with lay individuals and groups identified characteristics of modern life that were perceived as a potential threat to our mental health and well being:

- Advertising to take loans, acquire goods, leading to people getting into debt and to associate contentment with material possessions
- Pressures on young people to achieve and perform well
- Promotion of unhealthy lifestyles
- The message conveyed by the media's representation of 'airbrushed' individuals, that we should all be 'perfect' and that a certain type of physical appearance is synonymous with well being

People frequently made reference, in different ways, to the importance of what might be called emotional literacy, which encompassed capacity to recognise and manage one's own emotional needs and relate to the emotional needs of others. One line of discussion suggested that the current educational system is not enabling children to learn how to cope with emotional needs. Perhaps more fundamentally, some participants in the discussions observed that we do not have a common currency of language and concepts, with which people can identify and feel comfortable and confident to be able to be open about mental health, emotional health and well being. This was seen as important if we are to get better at communicating what we feel and how we are feeling and at responding to the emotional needs of others.

2.2 Young people

The range of factors identified that were associated with the mental health and well being of young people fell into several clusters: social circumstances, social supports and relationships, expectations / pressures to achieve and traumatic experiences.

Social circumstances

It was considered that young people in certain situations were more likely to be vulnerable to mental ill health and at potential risk of attempting suicide or self harm:

- Young men can often be socially isolated
- It was thought that many young men use drugs and alcohol to cope with stress
- Young people who are 'looked after' or who have left care, were reported to be highly vulnerable. A considerable number of these young people were said to be involved in self harming behaviour
- Attention was drawn to the fact that, within some disadvantaged communities, suicide and self harm may be regarded as 'normal' and as accepted ways of dealing with life stresses

Identity

Issues of gender identity and sexual orientation can lead young people to feel confused, frightened of the reactions and attitudes of others and isolated. Lack of self confidence and even self loathing were described as characteristic of some young people, for whom their identity was a concern.

A project for gay, lesbian, bisexual and trans-sexual young people reported that a large proportion of the young people with whom they work self harm or have an eating disorder.

Social supports and social pressures

Young people were considered to be exposed to powerful pressures and influences in school and in their local communities, which were perceived as potentially damaging to their mental health and well being. The group of guidance teachers held that these negative influences both affected individuals directly and also diminished the capacity of schools to provide support and protection against these influences. Young people were under considerable pressures to achieve educational results. At the same time, it was stated that the capacity of schools to create a caring and supportive environment was being eroded by the drive to achieve exam targets and to demonstrate ability to deliver results. This meant, for example, that staff had less time for non-curricular activities and contacts with young people.

One education worker noted that, ironically, pressures on young people to perform well academically coincide with adolescence, a stage in life when self confidence may be at its most fragile.

There was a view from the discussion with guidance professionals that the emphasis in education should be redirected to recognise that young people need to feel valued and to develop a sense of belonging. Academic and other forms of attainment would then follow, rather than being pursued as the primary goal. It was felt that the weight given in education to improvement and achievement could lead to the implication 'you are never good enough'.

Relationship issues

People who worked in education and prison service staff both drew attention to the effect on young people of changes in family structures, and the impact on young people of fractured or disrupted family relationships. It was also stated that young people are likely to be vulnerable where parents are involved with drug and alcohol misuse.

Traumatic experiences

Childhood abuse was recognised as a major factor in later self harming behaviour. These traumatic experiences can impact on a person's capacity to make use of support services e.g. a young women's experience of abuse may mean she refuses to be seen by a male worker. Deep seated and painful issues associated with experience of abuse can mean that people do not engage readily with services, leading to the perception of repeated rejection and further isolation.

A help line support service reported that many of the young people who contacted the service had experienced bullying or physical or sexual abuse. There was said to be an important role here for a neutral agency to liaise with the school and act as mediator on behalf of the person being bullied. Where people have had experience of abuse, the service was able to support the young person in disclosing the abuse to the police and to others.

2.3 Young people and self harm

In the discussions, self harm was considered largely as an issue that affected young people rather than other age groups, although this may have been an artefact of the groups and services targeted for discussion.

In some of the discussions with individuals, people described their personal experiences of self harming as a way of regaining control over or relief from powerful feelings of anger, pain or panic. Sometimes people also recounted how feelings of self loathing and hatred led them to inflict pain through self harm.

Appendix 1 gives accounts of some of the personal experiences of young people who took part in the discussion process.

A project worker, many of whose clients included people who self harmed, observed that self harming among young people can take the form of excessive risk taking, through promiscuity, putting yourself in dangerous situations or not taking care of yourself. This definition of self harm could extend to include eating disorders.

The discussions indicated that the relationship between self harm and suicide is a complex one. It was evident that self harm was generally not seen as a form of suicidal behaviour and it was felt to be important to distinguish the intent behind self harming actions. Self harm was often a way of dealing with strong feelings and with emotional pain, but did not necessarily signify that the person set out to kill themselves. However, for some people self harm could be a precursor to attempted or completed suicide.

2.4 Adults

Debt problems can be one of the main reasons why people approach a suicide prevention help line. Demands from debt collectors for repayment or threat of declaration of bankruptcy can be precipitants that lead people to contemplate harming themselves. Pressures arising from debts were said to be exacerbated by actions of debt collectors acting on behalf of Sheriff Officers or by the interventions of the Child Support Agency.

According to this help line, other factors that push people to consider harming themselves include involvement with criminal proceedings. It was reported that when a case is due to come up for trial, often long after the alleged offence, this can lead to enormous anxiety and disruption in people's lives.

2.5 Older adults

Issues of loss, bereavement, and isolation were regarded as associated with risk of suicide and self harm in older people. One set of discussions made reference to the poor long term health among many older men, now of retirement age who may have had prolonged periods of unemployment.

2.6 Gender based perspectives

There was awareness that gender based conditioning and social expectations shape how men and women experience mental health and ill health and influence the strategies they use to cope and to seek help.

‘Men are only allowed to show passion through football!’

Discussions with carers suggested that, where there is long term mental illness in the family, male carers are less likely to engage with available sources of mutual support than women, some of whom seem to find it beneficial to talk with others in similar situations.

2.7 Black and ethnic minority communities

A discussion with multicultural health workers in Glasgow made a distinction between indigenous black and ethnic minority communities and asylum seekers and refugees. The experiences and circumstances of each were very different, and required careful differentiation of the risk and protective factors for mental health and well being and for suicide and self harm for each group.

Asylum seekers

It was emphasised that the arrival of asylum seekers in Scotland was not a new phenomenon, but what is currently different is the volume of people currently arriving in Scotland as part of the Government’s dispersal programme.

People arrive unexpectedly in the UK with little preparation or possibly little prior knowledge of the country. Workers stated that services and local host communities have often been ill prepared, geared to provide an emergency response that is led by need for accommodation. Asylum seekers may have had traumatic experiences prior to coming to Scotland, involving torture, rape and loss.

The asylum seeker population is highly diverse, encompassing many languages and cultures and people with vastly differing levels of education and professional training. Local capacity to respond has been hampered by the absence of an infrastructure of resources and facilities to provide support, unlike some other cities in UK where people settled. Of those who arrive in Glasgow, one in five move on to other parts of Scotland. Concerns were expressed about spreading awareness of the needs of asylum seekers and raising the skills base in this area of health and social care as people move to other parts of Scotland.

Indigenous ethnic minority communities

For the indigenous ethnic minority population, many of the issues identified related to cultural differences between generations and between the values and aspirations of Western society and ethnic minority communities:

- Arranged marriages bring pressures for some young Asian women –instances were reported of suicide attempts by women said to be desperate to avoid arranged marriages
- A considerable number of young women were reported to be on antidepressants, with underlying issues of abuse, eating disorder and conflicted family relationships
- Older people who come to this country to join their family, may not speak English, and may find it hard to adapt to culture change and in particular to their own role, when they are no longer regarded as the respected elder

Young ethnic minority women were thought to face particular difficulties as they moved into adulthood. A counselling project in Edinburgh that worked with black and ethnic minority women reported that self harm occurred among young women who found it hard to communicate with their families. Practice experience indicated that these young women were not able to express their emotional needs within the family or have their feelings recognised. Girls in their early teens had described to workers the effects of feeling they had no choices and no control over their current and future lives, leading some of them to desperation. Young women were said to be caught between the cultural values and aspirations of their families and of the wider community. It was suggested that families find it difficult to balance the different cultural demands and can react defensively.

A worker from another service drew attention to the potential tension between respect for diversity and multiculturalism and protecting and promoting the rights of women. The work of the counselling service described above was interesting in this regard. It sought in a number of different ways to raise awareness and confidence and to give support and encouragement, so that women could negotiate what they wanted and take more control over their lives. Work focused on the ‘small victories’ that women could achieve within their sphere of influence, in recognition that the service offered could not change social structures or culture but could have an impact by empowering women.

From the discussions it is possible to identify the following protective factors that promote mental health and well being for black and ethnic minority communities:

- People having choice and not feeling trapped
- Regaining hope for themselves and their families
- Clear sense of identity
- Developing connections and feeling valued
- Services that recognise the cultural aspects specific to different ethnic groups
- More emphasis on early intervention
- More involvement of people from ethnic communities in strategic planning and service development
- Reconsidering the value attached to individual independence to the neglect of family and community values

- Capacity to work with families as well as with individuals, where tensions within the family may be implicated in the person's distress and affecting their well being

2.8 Family members

Family members who took part in the discussions were mainly women who had relatives (usually an adult child) with a long term serious mental health problem, some of whom had attempted suicide (often repeatedly), others had completed suicide. Individual stories illustrated the difficult and highly stressful situations they had endured, often for many years. Their accounts of their experiences of living with the risk of suicide by their relative highlighted two main themes: firstly, the stress and anxiety that they themselves experienced as a result of the poor mental health of their relative and the fear of the harm the person might come to; secondly, the often difficult nature of their relationship with services, which were not perceived to offer support when required. This was experienced as a further source of stress.

Impact on carers

Family members described in the discussions how the mental health problems of their relative and concern for that persons' well being and safety had adversely affected marital, parental and sibling relationships.

In addition, in many cases the carer's own health was reported to have been affected. One group of carers described how the stress on them was manifested as physical health problems such as eczema, chronic pain and digestive problems. In several instances the situation reached the stage where the carers contemplated or attempted to kill themselves.

'If this is my life then no thank you'

One woman described how the continuing strain led to her becoming 'numb' and desensitised, as she could only await the next disaster to befall her child.

The experiences of several family members are described in Appendix 1.

Women noted in one discussion that the men in their families were less likely to engage with support groups and services, seemed unable to cope and were more likely to retreat from the situation by leaving.

Identifying risks, getting support

Family members or close friends would often be the first if not the only people to know that someone was thinking about killing themselves. This was thought to indicate the importance of services listening to what carers and friends tell them. However, the experience of some family members had been that their concerns were dismissed and they were regarded as 'over-involved, over-caring or interfering'.

Family members recounted how they struggled to get help in a crisis and could be left to cope with little support from formal services.

2.9 Prisoners

Discussions with the Scottish Prison Service focused largely on young offenders and on women prisoners. However, the issues relating to risk and protective factors identified below may also have relevance to other parts of the prison population.

Transitions

The periods post admission and immediately prior to discharge were recognised as times when prisoners can be at increased risk of self harm. Admission means loss of contact with familiar supports and surroundings and prisoners feel cut off. Many young offenders come in with drug and alcohol problems and can therefore experience withdrawal. During the two weeks prior to release, young offenders have been shown to be vulnerable. This may also be the case before they go out 'on pass'. Support and preparation have been set in place to help with practical arrangements to alleviate concerns.

Dealing with emotions

Being in prison was said by young offenders to entail a loss of identity, reinforced by not having your own clothes and own possessions. It is said that, when they go out, long term prisoners may find it hard to remember who they are or how to handle things.

Prison can have the effect of magnifying emotions and diminishing capacity to cope. In some instances, it was said that particular prison programmes can make prisoners feel stressed, if emotional issues and experiences are not 'handled well' by prison officers.

Isolation

Isolation and loneliness are common experiences. Some prisoners do not get visits. For young offenders night-time can be when you are at your lowest, when you are on your own. Special occasions such as Christmas are difficult to handle.

Prison procedures

The way in which the Prison Service responds to risk can have the effect of exacerbating the situation. One young offender commented that 'suicide cells' make people feel worse:

'Putting someone in a suicide cell is like saying they can't help you'.

'The longer you are in there [suicide cell], the harder it is to come out'

The use of observation cells was seen by these prisoners as a means for the Prison Service to protect itself, not as a means of supporting an individual in distress and at risk of harm.

‘Being in there for 24 hours or more does your head in.’ ‘ You need to get out because what helps people is contact with others.’

Vulnerabilities / Previous experiences

The experiences that people bring with them when they are sentenced are highly relevant and can influence their mental health and well being and their risk of suicide and self harm. A high proportion of women prisoners in Cornton Vale have experienced abuse. Many have come from poor social circumstances, and have low levels of educational attainment. Levels of drug abuse are high. Prisoners include a considerable number of women with personality disorder. Many are reported to have attempted suicide or harmed themselves prior to admission to Cornton Vale. Sometimes the disturbance that led to a sentence may have involved self harming behaviour.

3 Help seeking and getting help

The discussions covered many different aspects of help seeking and service responses. The material has been shaped under main themes:

- Signposts and barriers
- Access to help
- Shaping responses to requirements
- Tackling root causes
- Sticking with people

3.1 Signposts and barriers on the way to getting help

According to research undertaken by the Samaritans, for every person who makes contact with them when suicidal, there is likely to be one who does not. It was thought difficult to explain this or to discern what precipitates or inhibits help seeking. The experience of the organisation did suggest however that people suffering from depression might be less likely to feel anyone can help or will be interested in them.

It was reported that people often contact Samaritans after a third party recommendation, perhaps a friend, or a doctor. This led to the suggestion that all Accident and Emergency (A and E) and mental health staff should be drawing attention to the Samaritans as a useful resource if people want to talk.

Several discussions referred to the need to ensure that any efforts to raise awareness of ‘early warning signs’ that people were at risk of poor mental health or of harming themselves had to go hand in hand with better signposting of services and sources of support. Comparison was made with national and local campaigns to tackle domestic violence.

One carer summarised what she wanted in the way of help as ‘a combination of compassion and practical help’. What this person had in fact encountered from the local mental health services was far from that. She described staff attitudes that she had experienced as highly punitive. Others in the same support group wanted more

willingness on the part of services to work with families. The perceived failure of services to provide the help and support required had led carers to take out complaints against services. Persistence was a key attribute that carers had had to develop:

‘I didn’t set out to be a thorn in the side of the system but you want justice for your child’.

Several carers in this same group described instances when someone who had been expressing suicidal thoughts was brought to an admission ward, only to be turned away and told to see the GP. For carers this was deeply frustrating and unsatisfactory. Their experience had sometimes been that the police provided a quicker and more sensitive response to a crisis than other front line services, including mental health services, which had previously treated the individual.

There were also concerns expressed by carers elsewhere that it was not acceptable for people with severe mental health problems in crisis to be expected to look to sources such as the Samaritans for help, when the latter did not have the necessary experience or expertise in mental health. This was perceived as an abnegation by mental health services of their responsibilities.

A key issue that was common to discussions with family member and to individuals in a range of circumstances was the need to ensure faster access to help in crisis. This would require that people know where to go and that they have confidence in the service to allow them to speak about issues that may be painful and highly personal. From the perspective of people who may need help, what mattered was to know where to turn: places you can go to, people you can trust who will treat you with respect as an individual, have regard for confidentiality and protect your rights to make choices for yourself.

For carers however, confidentiality had sometimes become a major obstacle to their getting the information and support they sought and could be perceived as an excuse:

‘Confidentiality is no protection to you when you are dead.’

3.2 Promoting access to help

Taking steps to reach the target group

Some groups of the population are less likely to seek help from their family doctor – e.g. young people and men. It was suggested that men be more prepared to use occupational health services than other forms of health services to talk about emotional problems. In Greater Glasgow, the Men’s Health team had been working on access to primary care by men and had undertaken research into men’s attitudes to health, awareness of health including mental health issues and views about services.

Workers in the discussions related that, in their experience, young people tended to be poorly informed about health issues and about primary care health services. Confidentiality was a key concern for many young people, who wanted to see a health professional in their own right not the 'family' doctor; to go to a setting where they would not be known to the receptionist or others in the waiting room. In one area school health services had taken these suggestions on board and had developed a drop-in health advice service off the school premises.

Another area had set up a web site as a means of accessing information and services, following a number of suicides among young people. This was seen as a valuable resource, not least because of the transport difficulties in getting to services in this rural area. Young people are able to ask questions and get advice from a health professional through the web site, which has been well used. Initial concerns from schools about anonymity and the disclosure of personal details were overcome.

Getting first line responses right

First points of contact remain important and this can often be with receptionists or telephonists. The LHCC discussion raised the issue of untrained staff in these roles being ill prepared to deal with people in distress.

The same discussion stated that having a single point of access to mental health services had been helpful for the primary health care team, as GPs could get ready access for a psychiatric assessment.

From the perspective of liaison psychiatrists, it was considered important to ensure that when people come into contact with A and E services, their needs were fully assessed. This discussion strongly recommended that all those who present at A and E after self harming should have a full psychosocial assessment.

3.3 Shaping responses to particular requirements

A recurring motif throughout discussions was that help and support should be tailored to the situation and requirements of individuals, both on pragmatic grounds to promote accessibility and uptake and in the interests of more effective and satisfactory long term outcomes.

One worker with considerable experience in suicide prevention work suggested that there is a need to distinguish situations and circumstances where people require professional expertise to undertake assessment and treatment and not to assume that self help and mutual support are an adequate substitute, although these resources play an important and complementary role.

Young people

The experiences of looked after young people indicated that links are not always in place to ensure access to expertise in mental health when required. It was also thought that child care workers and support workers who work with young people should have more awareness of mental health issues, to be able to engage people who are vulnerable to self harm and to know where and when to seek specialist advice and input.

A different point was made by a project worker, that some young people lead lives which are highly disorganised and do not find it easy to fit in with appointment systems. They can find it difficult if they are turned away when they seek help. This would suggest a need for support which they can access readily, for example being able to go to a drop-in when you feel vulnerable, to feel safe. For people who move around a lot, it may be important to look at one point of access to services to ensure continuity of contact and support.

People who self harm

Young people who self harm described their experiences of meeting with punitive, sometimes aggressive responses from services: staff in A and E, GPs and consultants. Attendance at A and E in particular was reported as a negative experience with instances of people's injuries being sutured without anaesthesia. People had sometimes decided to self treat after they had harmed themselves, because of previous experiences of how services reacted to them. Where people recounted more positive experiences when they attended A and E or Minor Injury Clinics, the critical key factors were that the person was treated with care and respect and was given support, rather than being 'blamed' or 'forced to see a psychiatrist when I didn't want to'.

The experiences recounted contained some key messages about how best to support people who self harm. People with experience of self harm have suggested that the following things are important *in a crisis* when they have self harmed or are at risk:

- Being treated like an individual, not 'a condition' or 'a problem'
- Showing empathy, not being shocked or judgemental
- Making you feel safe, supported and protected
- Acknowledging your pain and distress
- Being able to get advice and information (e.g. phone help lines)
- Access to a safe place or crisis house which offered protection from means of harm and support to cope with distress

In the longer term, people want:

- Support from someone who understands and believes you, someone you can trust and talk to
- Persistence, people and services that stick with you and convey hope of recovery
- Help to make choices and take control over your life – for example by talking when well about what support and help you would like when you become unwell
- Help to understand why you do it - the source of the pain and the immediate triggers that lead you to self harm
- Support to develop alternative strategies you could use to cope with powerful feelings. This included finding a language, concepts or tools to talk about emotional health and well being so that someone can express what they are feeling in ways other than through self harming behaviour. Finding out more about how other people have learned to cope would also be valuable, for example the Bristol Self harm Support Network

One set of discussions suggested that a young person may not be looking for help for their self harming behaviour, but for support to work on what is happening to them

and on what they are feeling. When a relationship of trust has been established then there may be opportunities to tackle the self harming behaviour.

People from black and ethnic minority communities

Cultural barriers were said to prevent people seeking help in the first place and to stand in the way of their getting services that were culturally sensitive and competent. These two factors were intertwined and mutually reinforcing in complex ways.

Barriers to seeking help

- For people from black and ethnic minority communities, the high value attached to family honour can be a disincentive to seeking help from services and thereby dishonouring the family
- In addition the stigma associated with mental health problems is considered to damage the family
- Language and cultural sensitivity can impede access for those from ethnic minority communities
- Use of interpreters can be perceived to reduce confidentiality

Cultural sensitivity and competence in services

- Services work with models of health and of health services that are rooted in the values of Western European culture and that do not fit readily with other models, for example where interdependence is valued more than independence
- Lack of cultural sensitivity may mean people are not referred for specialist help or do not accept it. An example was cited of a GP who does not refer his patients to secondary mental health care because the latter is perceived to lack cultural sensitivity and capacity to practice transcultural psychiatry in ways which will be relevant and useful for his patients.

3.4 Tackling root causes

In several of the discussions it was suggested that responses to people in distress had to be able to get beyond the presenting signs and symptoms of that distress, to work on causes.

It was remarked in at least one discussion that many people who harm themselves do not have a diagnosable mental health problem. However many will have been abused as children. Responses to self harm tend to be crisis oriented with limited capacity to work with an individual on causes and on developing other ways of coping. Several discussions stated that work to prevent the long term effects of abuse needs to start early and should be a priority for front line workers. This would mean they would need to know where to get advice on their own practice and be aware of how to refer elsewhere for specialist support and therapy.

Dealing with root causes requires good communication and links between services so that for example health services can direct people into marriage counselling and/or debt counselling to help with and resolve the sources of their distress. It may pose a challenge to the way in which we traditionally conceive of professional roles and the skills required to discharge those roles.

3.5 Sticking with people: through care and after care

Continuity and consistency of response emerged as key issues and as a measure of service quality and of capacity to support vulnerable people in and through difficult situations. This could mean, for example, ensuring that support was on hand at the times when people are most vulnerable and need to talk or need support. For people in hospital, this can be at night when feelings of distress may be most acute, but there were reports of patients being told not to disturb staff.

Whilst signposting to services and resources was important, several people stressed that help has to go further than giving people information about a service or setting up an appointment for them – reference was made to the high ‘Did Not Arrive’ rates for follow up out patient appointments.

Also relevant here is the extent to which services are able or prepared to outreach assertively to the target client group, to engage with hard to reach individuals whose behaviour may be difficult for services to manage.

Perspectives from services

This section takes a service perspective to look briefly at the main services included in the discussion process: prison, schools, police, and mental health services. It concludes by considering the role of the media.

4 Prisons

There were three strands of discussion, the first relating to issues that spanned the prison service, the second and third to particular issues and concerns for Cornton Vale and for Polmont Young Offenders Institution. There was limited input to the discussion process from Barlinnie.

4.1 Scottish Prison Service

The Prison Service's ACT strategy on suicide risk management aims to address risk of suicide and suicidal behaviour and promote a caring environment where those in distress can ask for help. The strategy was said to have helped create an ethos of care and support in prisons. A major programme of training was introduced to support implementation, with annual refresher training. In addition, procedures were introduced to detect, assess and manage risk. ACT is said to have promoted multidisciplinary team working, with an understanding that reducing suicide and self harm and promoting mental health is everyone's business and a responsibility that prison officers share with health colleagues. The introduction of case conferences provides a forum for review and communication, involving the prisoner, prison officers and health care staff. ACT policies are now being reviewed and updated, partly because it is thought that people may be getting 'over-familiar' with the process.

Despite the progress described within prisons over recent years, the prison service remains concerned that the gains achieved when someone is in custody are forfeited in view of what happens on release. The accessibility of support and the high level of health care in custody are often not matched when prisoners return to the community.

Approach

In addressing suicide and self harm, the following features of the Scottish Prison Service (SPS) approach appear important and may have resonance in other settings:

- The focus on mental health and well being is viewed as an integral aspect of SPS' work, not a specialist area for medical staff alone. To bring this about is reported to have required top down commitment coupled with opportunity for local establishments to develop ownership. Time and effort have been invested in raising awareness and building skills and trust
- A holistic approach, going beyond presenting problems, providing a range of supports
- The creation of a culture of care, with a proactive approach to prevention – 'it is OK to talk about feeling suicidal, people know they will get help'

- Emphasis on promotion and prevention – dealing with suicide has moved beyond the immediate resort to anti-ligature cells for observation to a point where it is now more about the relationships between staff and prisoners
- Potential opportunity within the prison environment to spot issues and problems and to act early

Evidence of effects

- People who self harm are no longer ‘patched up’ and punished with loss of remission
- There has been a reduction in the number of people put on ACT procedures as identified risks – assisted by the introduction of mental health teams and the prisoner listener scheme (see below)
- Prisoners themselves are more actively involved in their own care planning and case conferences
- Prisons are still working on developing links with local communities, organisations and groups including faith groups

Listener scheme

This involves prisoner volunteers, trained and supported by the Samaritans, providing a confidential listening ear for fellow prisoners. Prisoners can ask to see a listener. Listeners are able to go to different parts of the prison. The exchange between listener and prisoner remains entirely confidential. Listeners can call the Samaritans if they need to talk about issues that occur in an encounter with another prisoner.

The scheme was introduced in the last 12 months and development has been variable in different establishments. Strategic will has not always been evident in the translation into practice. Some prisons have 10 listeners, others none.

In Cornton Vale there are problems with retaining listeners as women move on. Staff report that women like the scheme as it gives prisoners more ownership of problems and solutions. Data collected in Cornton Vale indicate the scheme is used to help with problems or worries relating to issues outside prison and not so much by people who are actively suicidal.

In Polmont, listeners are not currently involved with people in anti-ligature cells, although this is under consideration.

In Barlinnie, the scheme met with suspicion when first introduced, with concerns about confidentiality. Staff were said to be reluctant to support it initially. However, there is now much stronger backing. Statistics demonstrate that its increasing use has been accompanied by a fall in the number of people on ACT. It is thought to have taken time for trust and credibility to develop.

4.2 Cornton Vale

On a given day there may be 10 women categorised as high risk and another 30 as low risk. Assessment on arrival includes implementation of ACT strategy where indicated, with risk assessed by Prison Officer, Nurse and Doctor. However,

experience has suggested that if someone knows the system and has firm intent to harm herself then ACT cannot necessarily avoid this happening.

Self harm is a significant issue for many of the women prisoners in Cornton Vale. The approach taken by the Prison Service is to manage risk of self harm very differently to risk of suicide. Placing a woman who self harms in an anti-ligature cells would be likely to make things worse.

There are plans within Cornton Vale to establish an 'enabling day care model' for people with self harm issues, where the person would work with an RMN, or other mental health professional. This is not envisaged as a unit in a separate part of the prison but a way of providing tiered therapeutic service that manages contact more effectively and provides capacity to do constructive work with high risk groups.

The mental health team in Cornton Vale has an open referral system. Uptake of the team is considerable. A third of the women seen have anxiety problems, a small proportion have a severe and enduring mental illness. A large number have personality disorder or drug related problems.

Through and after care

Cornton Vale is considered to have good relationships with mental health services and has in-reach from psychiatrists and forensic CPNs. The prison recently held an open day for all providers of acute psychiatric services and IPCUs. There are established links and liaison arrangements with IPCUs and other hospitals to which prisoners may be referred. Links with GPs are reported to be good.

A range of voluntary organisations come into the prison to provide support – Open Secret, Rape Crisis, CRUSE, Samaritans.

Challenges of prevention

Experience within the prison suggests that if someone is intent on self harming, procedures cannot stop this. Unless people are locked up in an inappropriate manner you cannot exclude risks. This is regarded as a debate for society to have and not just an issue for SPS to resolve. Media coverage persists in focusing public and political attention on suicide incidents. Fatal Accident Inquiries can be a good forum in which to put across the view that suicide is society's problem and that it is for society to deal with.

Two relatively recent suicides in Cornton Vale occurred after a 4 year gap, which is considered by the service as a remarkable achievement. The prison would wish to see a shift in focus to look at what can be achieved, rather than criticising and blaming. The alternative may be that the service retreats into proceduralism, and a reliance on defensive practices, with loss of capacity to provide care and support to those who require it. There is a need to enhance support for staff caring for a highly vulnerable group of people. The 200-plus women in Cornton Vale are among the most vulnerable people in Scotland.

4.3 Polmont Young Offenders Institution

Mental Health Team members act as named links, assigned to each hall. This makes the Team more accessible to prisoners who can self refer or speak informally. The team provides early intervention and support, and follows up anyone placed on ACT procedures because of risk.

On release, the team makes every effort to ensure follow up appointments are made and information is passed on to the person's GP or consultant psychiatrist. There can be problems with long term prisoners who do not have a GP, where the person is on medication. Staff cited the example of one young man on depot medication for schizophrenia, who left prison with no identifiable doctor in the community.

An increasingly wide range of therapeutic work is undertaken, including complementary therapies and art therapy. The initial scepticism these elicited are said to have been largely overcome. Members of the MHT have a range of specialist therapeutic skills.

Over time, prison officers are reported to have become more confident about supporting people at risk without immediate resort to formal measures. Staff described how, through supportive relationships, they have been able to manage behaviours, which would previously have led to invoking ACT procedures, and to work with the person on factors that trigger self harming behaviours.

Staff attribute this to the fact that they feel more empowered themselves and have developed the trust and confidence to assume responsibility. They have been able to take the original ACT strategy further than was envisaged.

A point of concern was raised by staff about transitions for prisoners coming from the private establishment at Kilmarnock. It has been found that the same level of attention to risk assessment and management was not evident in the practices of Kilmarnock staff with responsibility for transferring prisoners into the SPS establishment.

4.4 Barlinnie

Through care issues are a major concern for people on remand. For those serving a sentence, there is increasing contact with their GP and follow on contact from the forensic CPN service.

The pressures associated with transitions (see earlier) are manifest in Barlinnie, sometimes in surprising ways. Recently a number of prisoners in the 'top end' of the prison, due for release required support from the mental health team. For graduates from Polmont, arrival in Barlinnie is said to be a huge culture shock.

5. Schools

5.1 Background

The issues and opportunities for schools were explored from two main angles: the pastoral role of schools, accessed through the guidance function and the functions of New Community Schools in promoting health and well being by working in partnership. Inevitably this represented only a limited range of the possible gamut of experiences and views that exist within the school system. However, the discussions did afford valuable insights into some of the work that is currently underway in schools which was directly related to the promotion of mental health and well being in young people (sometimes also in their families and communities) and more indirectly related to the reduction of suicide and self harm.

5.2 Impetus to address emotional and mental health

The concept of New Community Schools (NCS) provided a mandate for schools to engage with a broad swathe of health related issues that influenced the well being of their student population. Results of a health needs assessment undertaken across the Greater Glasgow area had lead one NCS to establish a programme of work on emotional health development. The needs assessment showed the extent of young people's worries and fears and suggested that they often felt they had nowhere to turn to get support. Schools in other parts of Scotland also described how preliminary work to explore what young people wanted pointed to broadly similar conclusions that prompted activity on mental health and emotional health issues.

The programmes of work undertaken were varied and innovative. Common features are described below.

5.3 Information and advice

As noted earlier young people can often be ill informed about health issues and be reluctant to seek help or advice from 'conventional' sources identified with family health care or with school.

It was of interest therefore that schools work included efforts to develop outreach information both for young people and wider members of the community:

- In one area, schools were working with the Social Inclusion Partnership to set up an advice bus targeted at young people
- In this same area, development money had been used to extend the role of the school library service to include health information and resources for local residents, not just students
- Other schools held health fairs and events to promote health related information, foster contacts among families and provide opportunities to experience a range of complementary therapies

5.4 Early recognition of problems

Frequent reference was made by those working in schools to the importance of ‘spotting things early’ and of ensuring that all staff who were likely to come in contact with young people had the ability to recognise that problems might be developing. The growing range of reference and source materials that staff could access was regarded as invaluable (e.g. the packs on depression produced by the Young People’s Unit at the Royal Edinburgh Hospital). However it was also noted that school staff needed to know where to take any issues and difficulties identified and that teachers may not be clear about how or where to refer a student or where they can get advice on how best to help. Experienced guidance staff indicated that it was difficult to know, for example, what could be done to support a young woman of 16 with exam terror or a teenager who makes repeated threats to harm herself.

5.5 Working with problems and issues

Work described in discussions included:

- Finding creative ways for vulnerable young people to ‘give shape to their pain’ and communicate their experiences. One NCS worked in partnership with a children’s organisation on a project for excluded young people and a separate project for young carers. Artists and writers participated alongside the young people to enable them to find ways of articulating their experiences and producing art work and written accounts
- Small group work on relationships / issues that did not fit easily in curriculum ‘Personal and Social Development’
- Projects on emotional literacy, that started with staff and were to include everyone, not just young people
- The use of a variety of approaches and methods to engage interest and to encourage young people to express themselves and gain confidence – expressive arts, peer support, buddying and mentoring, play leader schemes

One NCS was actively exploring the feasibility of establishing a counselling service for young people. This already exists in some parts of Scotland. In this particular area, the school had been unable to persuade primary health care services to invest in a counselling service. The school’s case was not helped by the low uptake of primary health care by young people.

Schools in another part of Scotland were frustrated by the lack of adolescent mental health services for young people who required specialist assessment and treatment. It was reported that schools had to manage as best they could pupils who were considered to be disturbed and in need of more support than schools alone could offer.

5.6 Creating relationships and networks

Individual

Implicit in the discussions about work to promote mental health and well being was recognition that relationships were critical. This required developing and sustaining trust and respect among teaching staff, students, support staff and parents as well as with the wider community. It could also mean ensuring that the boundaries and ground rules about confidentiality were well understood.

Staff described efforts made in one school in a very disadvantaged area to change the physical environment and create spaces that were relaxed and neutral, where people could come together to talk.

Interagency

Interagency partnerships were seen as a valuable feature of NCS that increased access to a range of resources and supports. These partnerships were represented in formal structures for integrated planning and management that linked schools into health, social work, social inclusion but were also characterised in the role of Integration Managers who worked at the interface between local service systems. Several areas referred to the risks that the momentum achieved through NCS would be lost as programme funding came to an end. Some areas were able to describe considerable commitments to mainstream the work and sustain commitment. One authority now describes itself as a New Community Schools Authority and has used the second phase of the programme to integrate the learning from its original NCS into all schools.

In another area, funding for a social work post with the NCS Joint Support Team has been taken up by the local Social Work Dept, in view of the decline in referrals to other child and family social work services since this post was set up.

5.7 Building capacity

Communities

From the discussions it appeared that some NCS had a facility to be outward looking and to link into, as well as enrich, community resources. In one area where the work of the NCS was closely integrated with the local Social Inclusion Partnership, community development and capacity building were clear objectives. The example was given of how a school cleaner had been enabled to develop the skills and confidence to become a teaching auxiliary and to make greater use of her considerable skills in relating to young people.

Capacity building entailed viewing the school as a resource for the local community and not just for current pupils, and working across generations with local people. It also meant shifting from a series of disconnected short term initiatives to achieve more lasting effects. One Integration Manager described that, in her experience, this could involve investing considerable early effort in structures that were needed to get NCS work set up, and to give it shape and momentum. In time, links began to develop into other processes and structures, such as the SIP programme and more

widely into community planning and it would then be possible to dismantle some of the original ‘temporary scaffolding’.

Young people

Within schools, NCS health development workers were working with teaching staff to enhance understanding of health as well as to undertake specific pieces of work with young people outside the curriculum. This could comprise group and individual work to build self esteem and confidence and to enable young people to ‘make wise choices’.

The discussion with the Guidance network placed stress on the importance of encouraging young people to learn to be adaptable and resilient. The view advanced was that supportive and trusting relationships are a key protective factor for young people and having even one sound relationship can make all the difference between a young person being OK and their not coping. For this reason it was important that support and guidance should be seen as integral to the role of all teachers and not reserved for staff with a ‘guidance’ designation.

5.8 Learning from the approaches of New Community Schools

Key features

There were certain features of the approaches used by New Community Schools that appeared of particular relevance in considering what is required to promote the mental health and well being of young people, in order to reduce the risk of suicide and self harm. These include the following:

- The prominence given to multidisciplinary thinking and working to address health issues
- Opportunity to dovetail local priorities of SIPs, NCS, health promotion etc
- Readier access to a range of supports for young people through the development of closer working links and a more coherent strategic approach
- Raised awareness of and information about health and welfare issues and a recognition of these as part of the core business of schools, including mental health and emotional issues
- Capacity building of individual students is placed at the heart of developments, both within the school and within the local community
- Opportunity to take a ‘whole school’ approach

Facilitating factors

Discussions with schools considered the factors that enable schools to improve the mental health and well being of their young people using some of the approaches described above. These included:

Capacity and capability

- Skills in community development and in cross boundary working as well as in health development
- Vision and enthusiasm: personal and social development seen as a priority, to enable young people to develop
- Leadership and support ‘from above’ to get these priorities embedded in the school plan and to follow through to realisation
- Devolved power, with responsibility for student welfare retained ‘at the top’

Values

- Enhancing capacity of school to care: prizing this as much as the achievement of academic targets – ‘if you take care of the young people, then attainment will follow’.
- Collaborative working not competitive working
- ‘Caring schools’ mean that all members of the school community are emotionally literate and that leadership is not the prerogative of the person ‘at the top’

Enabling policy framework

- Consolidating what has already been achieved through work to improve mental health and well being in schools rather than setting off on a ‘new’ direction
- National policy can give legitimacy for this area of work, which has been lacking until now
- Support to facilitate networking and information exchange would be valuable

6. Police

6.1 Perspectives on suicide and self harm

Discussions were held with various officers in one police force (Strathclyde) including senior officers, those with responsibility for liaison, for policy and for training as well as officers in a local division. The common themes highlighted were, firstly, that dealing with situations where there was a risk of suicide and self harm was a regular feature of police work. In this force, the number of completed or attempted suicides was high but the issues did not attract the same attention as drug related deaths.

Secondly, that the police were concerned about their capacity to provide appropriate responses to vulnerable people in distress, if access to other services and expertise could not be assured. The police were confident that they had a range of well developed strategies and procedures, but were concerned that in practice officers still struggled to find appropriate means of resolving individual situations. One of the main issues was associated with identifying other services, which were able to respond when police came in contact with someone considered to be at risk.

Police officers stated that from their perspective, mental health services should be expected to assume responsibility for a person who was attempting to harm himself or herself. In practice, situations such as these had to be resolved through a process of negotiation and discussion with mental health services. It helped if there were pre-established links and relationships with mental health services so that individual crisis situations could be more readily resolved.

6.2 Police custody

The experience within a local division was that many of the people 'picked up' over an average weekend are under the influence of drugs and/ or alcohol. This could make it hard to judge risk without getting access to psychiatric assessment. Hospitals tend to refuse to admit when intoxicated. A police cell was not considered a suitable environment for someone to detox and this could in itself add to risk of self harm.

In busy periods, it could be difficult to safeguard the welfare of someone who is vulnerable. An inner city police station might have between 30-60 people in cells, many drunk, and at least one person where there is concern about suicide or self harm. Facilities for observation are limited.

6.3 Incidents

The police are responsible for dealing with incidents in public places where someone may be putting himself or herself at risk (for example, threatening to jump from a bridge). This work is resource intensive for the police and can involve other emergency, social and health services.

Officers drew attention to the difficulties of knowing how best to deal with young people who have been drinking, where there may be a risk of self harm or mental health needs. Police actions in relation to young people are tightly regulated. Again, there were issues about where to get help or support for the young people concerned.

6.4 Courts

Recent local developments such as the Court Liaison Scheme of forensic CMHNs in Glasgow was widely regarded as useful in helping divert from custody, set up supports for people in community and provide follow up for people given a custodial sentence.

6.5 Interagency working

There was recognition that the issues identified above demonstrated the need for interagency responses to look at collective responsibilities and responsibilities of individual agencies within a local area. A key element in this would be to address differing perspectives and establish common ground. However, the police considered that currently there were limited opportunities to develop joint working and to promote inter-agency liaison and communication at operational level.

6.6 Staff training and awareness

In addition to basic input at Police College for all new recruits, which concentrates on the legislative framework for mental health work, each force develops its own training. In Strathclyde, basic training for police officers includes sessions on risk awareness and on sensitive communication with people in distress including people with mental health problems. Input in these areas tends to rely on the knowledge and experience of the instructors. A mental health organisation was previously involved in training the instructors and there are now plans to update this. Trainees also receive a session on sudden deaths which includes suicide/suspected suicide. It was thought to be helpful that in this force, S117 and S118 powers are set out in the Police Notebook but this is not so for all forces.

Responsibility for identifying the training needs of Duty Officers rests with local Divisions. The two day course for Duty Office covers a 50 minute session on mental illness and includes for example legislative powers, accessing a casualty surgeon, taking someone to hospital etc.

No joint training with other agencies takes place in Strathclyde on mental health, although this has been well developed for other subjects, such as child protection.

7. Mental health services

7.1 Background

In view of the extensive involvement of those working in mental health services in the process of developing the Draft Framework for the Prevention of Suicide and Self harm, the discussion process focused on selective aspects of the mental health service only, specifically liaison psychiatry and local multi agency service networks.

The main issues arising from these discussions were:

- The need to get better at the early identification of risk
- The continuing challenges of ensuring access to the right services
- Service responsiveness to individual requirements, including cultural sensitivity and competence

It should be noted that these issues are not specific to the area of suicide / self harm reduction but are often raised in more general assessments of the extent to which mental health services and the systems for the delivery of services are fit for purpose.

7.2 Early identification of risk

Being able to recognise where people may be at risk was considered to be a core part of the work of a mental health service. However, several discussions noted that improvements were needed. This was in part a question of capacity and priority: one local service network discussed how pressures on mental health services had meant it could be more difficult for urgent cases to be seen. If someone were referred to the CPN services as in urgent need, following a suicide attempt or an incident involving self harm, they would not necessarily be a priority and might wait for some weeks before being seen.

It was also perceived to require changes in practice, for example setting in place mechanisms in A and E that would ensure vulnerabilities were recognised, by undertaking a full psychosocial assessment in all cases of self harm. This would help to get beyond the presenting problem to look at causal factors and triggers and could help people find alternatives to repeat A and E attendance following further incidents of self harm. From the perspective of liaison psychiatrists, the development of A and E capacity needed to be undertaken urgently on the grounds that otherwise services were not doing what they should be doing well enough. There was a concern that the breadth of vision required in the Framework would mean that important core functions of mental health service might be neglected when in fact these still needed considerable development.

7.3 Access

Discussions with professionals, users and carers indicated the persistence of difficulties in accessing mainstream psychiatric services. There was a view that GPs should be able to request fast track access to mental health services when required in the confidence that this would be made available.

However it was also noted that there were many people in crisis for whom mental health services were not the appropriate source of help. Often what people needed was debt counselling or relationship counselling and those who were the first line of response - primary care, A and E and other duty services - needed to be able to recognise risks and to direct people to other sources of advice and support. However, one clinician observed that experience of giving patients seen at A and E a follow up out patient appointment suggested that this on its own was often not enough, as a considerable proportion of such appointments were not kept.

Discussion raised questions about the equity of provision. Some groups had concerns about the lack of consistency in 'what people get and how they get it'. Linked to this were concerns that service accessibility needed to take account of the barriers that impede access and use by certain population groups. Age, gender, ethnicity and culture may influence the way in which different groups experience mental health and mental health problems and their susceptibility to seek help. This poses significant challenges in providing services. There were indications of growing opportunities to gain a better understanding of what is required. For example, there has been a series of local research studies and pieces of development work that look variously at the perceptions of health and health care provision held by young people and of men. However, there remains a considerable ground to cover to raise awareness and to develop more creative and flexible ways of meeting needs. Language remains a major barrier for ethnic minority communities, along with cultural aspects that influence the acceptability of services provided (e.g. women may not want to see a male health worker).

7.4 Enhanced responsiveness to people's needs

One agency raised the question of how best to ensure that responses offered to people at risk of suicide meet acceptable standards of care. There was perceived to be a tension here with seeing preventative work as part of promoting mental health and well being and therefore the business of many, whilst also recognising that working with someone who is contemplating or has attempted suicide requires specialist skill and sensitivity.

Underlying several of the discussions were differing views about the type of help that should be available to people in emotional distress and who might be at risk of deliberate self harm. The police, for example, tended towards the view that mental health services had a responsibility towards this group. Others considered that this was not a suitable response and that there was a need for non-medical alternatives that might include a crisis house or safe place.

The discussions on self harm with service providers and with individuals who had self harmed highlighted that services and interventions can have diverse aims in view, which can be complementary or conflicting depending on how they are operationalised:

- Harm reduction / minimisation focused on the self harming behaviour itself
- Facilitating the development of alternative coping and problem solving strategies
- Resolving the deeper seated issues and conflicts (both internal to the person and in their personal relationship)

In considering capacity to provide a culturally sensitive service, health workers identified two distinct approaches. The first entailed the appointment of ‘experts’ who have a grounding in multi cultural work and whose role is to act as a resource and support for other staff and to raise awareness across the service. An alternative model is to train and support all staff in basic levels of cultural competence, to promote standards of practice that are sensitive to social and cultural issues affecting mental health and well being.

8. Media

8.1 Themes for discussion

Discussions with media representatives covered the following themes:

- Policy and practice on reporting/portraying of suicide
- Policy and practice on reporting/portraying of self-harm
- Guidelines used
- The role of the media in relation to shaping public attitudes
- The role of the media in relation to education about risk factors
- Challenges faced when reporting/portraying suicide and self-harm

8.2 Policy and practice on reporting/portraying suicide

Press

- Stories have to be pursued. The market is competitive and there will be other broadcasters interested in the story
- Each individual story and the background and circumstances would be looked at before deciding whether to report it or not
- A story would be reported if it were newsworthy, for example, if it involved young people, or if the family wanted to talk out about what had happened, or if there were wider principles involved
- Families occasionally don't want stories published. The story would be published on the basis of the information that has been gathered already through other contacts
- Sometimes families want to speak out about what has happened, in which case time and space would be devoted to this
- There have been copy-cat attempts at suicide after coverage in the media, particularly people attempting to jump off bridges. It is therefore best not to report

Radio

- The coverage of suicide is avoided. However, if there has been a series of suicides they would be covered in order to explore the reasons for the multiple suicides and to ask why so many young people are committing suicide. These issues would tend to be covered by phone-ins and talk shows
- Teenage suicides, such as the recent spate of suicides on the east coast, have been covered in particular as a main news story. The launch of relevant charities and initiatives is also covered
- There is a tendency not to report unless there is a strong news imperative
- However, if a story is news worthy (for example, a teenager committing suicide because of bullying) then it would be reported
- There is a policy not to cover suicides unless the case is particularly unusual, for example, at a public place, or if it is a well-known person
- If it were a local person who had committed suicide, then the fact that their death was the result of suicide would not be reported. The fact that 'no suspicious circumstances' surrounded the death would be reported instead, and it would be left to people to draw their own conclusions

TV

- Suicide tends not to be covered in drama
- Suicide will tend not to be reported, but several programmes are broadcast which cover a number of social issues including topics such as suicide. If suicide were the topic being investigated, then issues such as ‘what takes a person to that point?’ would be studied in depth
- The subject of suicide is sometimes covered in faith programmes, looking at people’s experiences of bereavement through suicide – both the general public and high profile people

8.3 Policy and practice on reporting/portraying self-harm

Press

- Self-harm is not an area that has been covered, although there is not a policy that would preclude this. However, if it is not a death (such as with suicide), then it is unlikely to be reported
- Self-harm and various other mental health issues have been covered in the features section. It can be an alarming subject, and the way that it is covered is crucial
- Self-harm would tend not to be reported unless there was some other element in the story such as self-harm by a celebrity
- The media would not hear about self-harm as often as suicide, and information wouldn’t come through the usual channels (emergency services). Information would only come in if it were related to a well-known person.

Radio

- There would be a differentiation between suicide and self-harm, and self-harm would not be reported. Self-harm is not a priority in terms of news. However, the person interviewed has been prompted by this interview to consider possible features in the future
- Self-harm would not be covered. How would you find out about it? Why would it be a story?

TV

- Coverage of the subject would not be an aim
- Self-harm would be treated on the same basis as suicide - part and parcel of the same issue. If people are harming themselves, then there is something wrong somewhere. The aim would be to not be prescriptive – mental illness is about a range of issues. The aim would be to portray these issues as best as could be done

8.4 Guidelines

Press

- A general code of conduct is followed. If a death is accidental or sudden, then a higher degree of sensitivity than usual would be adopted
- When reporting suicide, the practice used when reporting any story would be adopted to ensure that the facts were correct
- The Press Complaints Commission guidelines on intrusive reporting are used

Radio

- Each individual reporter judges what should be reported although the news editor decides how stories are covered
- The unofficial policy/guideline is not to report
- The aim would be to be tactful, for example, to not name the person who has committed suicide unless the police have already informed next of kin
- As a rule, suicide is not reported, but if a suicide case is reported, then the people who are involved would be treated sympathetically

TV

- As with most other subject areas, the aim would be to be sensitive as well as being aware of what's appropriate for pre- and post-watershed coverage
- Producers' guidelines cover various issues
- The ITC code of practice on various issues is followed. This is important as great care has to be taken not to offend close relatives

8.5 Shaping public attitudes

Press

- It is perceived to be a newspaper's job to shape public attitudes
- The aim would be to draw people's attention to issues through editorials, comments and features
- The media can raise awareness of the causes of suicide, such as bullying at school
- These issues come to the attention of people through the media. If this wasn't reported, then public concern about this issue might not have been raised to the extent that it has

Radio

- The aim is to relay facts as they are – it is then up to people to interpret them
- There is a media responsibility to say that, for example, young people should not be put under pressure, for example, academically at school. And in relation to women with post-natal depression, it is possible to get across the message that help is available
- It is the role of news bulletins to inform the public about individual cases. Suicide would also be covered in news programmes where the subject as a whole would be the focus, rather than individual cases
- The role of the media is purely to report, but it would be appropriate to seek input from organisations such as the Samaritans when reporting individual stories

TV

- The media are there to give the facts, and to leave it up to people to make up their own minds, but they are also in a position whereby they can act as a source of information on, for example, agencies that can provide help
- The role of the media is more one of informing and educating. The idea would be to leave it up to people to make up their own minds, but also to act as a catalyst to people getting information

8.6 Educational role

Press

- Educating the public about risk factors should be a role played by the media, however, the greater issues should be covered in a way that does not dilute the tragedy of the individual suicide on the day that it is reported
- The subject has to be treated sympathetically. The factors that contribute to an individual's suicide are impossible to cover in a news story. The aim is therefore to also feature stories on why people get depression, and the support available from organisations such as the Samaritans
- Involvement with campaigns such as those run by local authorities on bullying at school can help, as can the publication of articles from support groups and the provision of information on help-lines
- Can the media do any more in terms of public education than carry public information such as articles by help groups and information on help-lines

Radio

- Public education could not be done through news bulletins, but programmes with more depth can be broadcast that feature agencies who are out there and who can help
- If the Samaritans or a similar organisation launched a specific initiative or published a report, then this would be treated with news merit. The reporting of the issue of suicide would be tied to news pegs such as these
- There tends to be more discussion about difficult issues in society these days, and the media play a role in reporting what has happened (in terms of an individual case) and can give information to the audience on how to get help themselves

TV

- This is most definitely a role for the media
- The aim is to present an honest picture of the extent of the problem and make people think about the reasons why someone would take their life and the warning signs

8.5 Challenges

Press

- The main challenge is the need to be sensitive. Suicide is a unique situation that can be very distressing for family and friends. There may also be occasions when the reasons why a person committed suicide are linked to another person (for example, suicide following an argument). A degree of sensitivity that is higher than usual has to be adopted. Attempts would still be made by some reporters to speak to people, but they would not be pursued
- Straight facts are, in general, easy to gather. However, delving deeper into issues such as why a person committed suicide can be more difficult and challenging. It can be difficult to ascertain whether a death is accidental or deliberate (for example, a child may have hanged themselves by accident), but the story must be accurate, and this can present a challenge
- A further challenge can be achieving a balance between, on the one hand, the need to report on social issues and satisfy public interests with, on the other, the need to respect private grief

Radio

- One challenge is to manage to report on suicide without then being a catalyst for copy-cat suicide attempts. For this reason it is thought that the media should look carefully at whether suicides should actually be reported at all
- When reporting on sensitive issues such as suicide it is important to stay within the bounds of taste and decency. An example of this would be by not ‘door-stepping’ the family of someone who had committed suicide. It is acknowledged that it can be difficult talking to people who have been close to someone who has committed suicide, such as relatives or teachers, about such a taboo subject. At the same time, the barriers caused by people not wanting to speak can also present the media with difficulties
- It is also argued that if you report on suicide in a straightforward, reserved fashion without resorting to sensationalism, then there should be no challenges in reporting this issue

TV

- It was thought that when reporting on suicide, the media have to be careful that what they are reporting is true and correct. It is also important to ensure that close relatives of someone who has committed suicide are not offended in any way by the way in which the suicide is reported

9 Strategic perspectives

9.1 The case for strategic development

In tackling suicide and self harm, a number of the issues raised lay beyond the sphere of influence or responsibility of a single service. This section aims to draw together those aspects of discussions that have a bearing on strategic development, including:

- Actions that need to be taken at a ‘high level’ as a means of facilitating development at other points in the service system
- Areas which require authorisation and commitment from senior sources to confer legitimacy and give impetus to work on the ground
- Cross cutting actions which are outside the scope of a single service or intervention and require joint engagement and implementation to be effective
- More deep seated issues that require to be addressed to enhance capacity to reduce suicide and self harm and promote mental health and well being

9.2 Culture and values

The material from discussions illustrated that efforts to tackle suicide and self harm need to go much further than getting the ‘right’ array of services in place. The analysis offered by participants of the factors that can lead people to be at risk of suicide and self harm raised questions about our social values and about what type of life we want for ourselves and our children. For example, there was a concern that the emphasis on attainment and achievement within the school education system was not easily reconciled with the desire for a socially just and inclusive Scotland.

9.3 Attitudes and awareness

Issues of attitudes, awareness and culture appeared, from participants’ comments and experiences, to be among the most deep seated challenges that confront us in seeking to reduce suicide and self harm and promote mental health and well being. There were several different dimensions to consider.

Firstly, if we want, in Scotland, to promote a greater awareness of mental health and well being, participants in the discussion stressed that we need to look to establish a common language and a common set of concepts. This is a core part of what some people described as emotional literacy – the basis to enable individuals to be more aware of their own mental health and well being and to have an emotional currency to use in their personal and social relationships.

In other contexts, reference is often made to the important role of the media in shaping public awareness and to the negative stereotypes often presented in the media of mental health, with a focus on risk and dangerousness. It was interesting that one carers’ group had found the media a useful ally in giving sympathetic coverage of their experiences of the suicide of a relative and in raising awareness of suicide and self harm issues in general.

Secondly, is the matter of attitudes towards individuals who self harm, as evidenced by the accounts from individuals of the responses they had encountered in some services. In seeking to take action to reduce suicide and self harm, the discussions suggest that services need to be guided by the experience of what those affected tell us about the help they want and about what needs to be improved, as well as by the research evidence on effectiveness. A particular challenge here is to address those aspects of staff attitudes and behaviour towards people who self harm which are experienced as punitive.

This raises a third issue relating to the training, support and supervision of staff who come into contact with people who have self harmed, including support and ancillary staff as well as care staff. The discussions drew attention to the role of receptionists and telephonists often as the first point of contact with a service. It was also suggested that social care staff who work with children, young people and adults should have a basic understanding of mental health issues and know when and where to seek more specialist advice.

9.4 Towards holistic approaches

Reducing suicide and self harm requires that agencies take action on a range of fronts that stretch from responding to crisis to providing opportunities to build resilience and coping capacity and supporting informal networks. There were also points raised in the discussion which pointed to the need for agencies to take a ‘whole organisation’ approach to these areas of work, including the following:

- Supporting staff after an incident: one discussion suggested that health services were less well geared up to support staff in stressful positions in comparison with the occupational health resources brought into play to support a train driver when someone jumps under a train
- Training and development for staff as above
- Facilities planning needs to include checking for the ‘obvious’ risks such as anti-ligature points
- Valuing the development and application of concepts of emotional literacy and emotional intelligence in the ways in which organisations work, not just as a resource for clients
- Moving beyond crisis management to risk reduction and health development: LHCCs were seen by some as an important vehicle for improving the well being of local communities
- Shifting from short term-ism to more sustainable developments: moving away from lots of disparate projects operating in isolation with limited short term funding, to ensuring sustainability and continuity

9.5 Developing capacity to make an impact, through effective interagency and cross sectoral working

Further improvements are required in interagency and multi-professional working to enhance the capacity of resources that serve a local population or client group by achieving:

- Strengthened capacity of primary care services to promote mental health and well being, at the same time ensuring that there are clearly defined routes into specialist services when required
- Effective communication and linkage between primary health care and local community resources that are able to provide advice and support
- Good working links between mainstream health, social, education and community services on the one hand and mental health services on the other, to get beyond the view that all mental health issues are the territory of mental health services
- Jointly agreed care pathways for key sets of individuals who are recognised as vulnerable: for example, ensuring that GPs are informed of impending discharge from hospital after someone has attempted suicide / self harm
- Good linkage between work to reduce suicide and self harm and other key initiatives such as alcohol and drugs strategies

9.6 Making a difference – some prerequisites

Tackling suicide and self harm requires cross cutting actions within a strategic approach, which has identified local and national leadership. Local agencies have responsibility to ensure that suicide and self harm reduction figures in their strategies and is a component of the services they provide.

It was said at several points in the discussion process that time and commitment invested in building local networks can be highly worthwhile as a means not only of sharing information about what is happening in different sectors, but also more fundamentally to establish links and communications and build the basis for collaborative action.

Further, while participants were aware that much good work is already happening that contributes to the reduction of suicide and self harm, they also recognised that this needed co-ordination to roll it out and support from senior people to sustain it. Comparisons were drawn with Zero Tolerance and Domestic Violence where major media campaigns were accompanied by concerted interagency effort, locally and nationally

10. Looking ahead

The discussion process set out to add to our understanding of the challenges and complexities associated with a commitment to achieving reductions in suicide and self harm in Scotland. This final section draws attention to the principal challenges that emerge from the views and experiences explored in discussion.

10.1 Starting from basics

The aspiration to tackle suicide and self harm as part of wider efforts to improve mental health and well being highlights the importance of being clear about priorities, core objectives and boundaries. Threading through some of the discussions was a concern that the breadth of vision required to encompass the multiple factors and pathways that might lead to self harm and suicide could result in an inability to focus down on key areas where action could make an appreciable difference. This line of discussion suggested we have to start by ‘getting the basics right’.

10.2 Taking a wider perspective

At the same time there was a recurring plea for more attention to be given to causes, not just symptoms. This means going beyond the provision of ‘first aid’ response to ask ‘why?’ and to explore alternative futures that may require deeper change.

10.3 Sharing responsibility as well as working within spheres of influence

Within services, there appears to be a desire to foster a stronger sense of collective responsibility for the well being of populations that goes beyond individual organisational roles and boundaries.

At policy level, there is potential to consider how the various priorities and initiatives within health, education and other areas could best be shaped to further the aims of improving mental health and well being.

10.4 Investing in future generations

Attention to the mental health and well being of our young people is recognised as essential. It is thought to entail developing emotional literacy to ensure the capacity, time and space to talk about feelings and identify when you need help, as well as greater awareness and understanding about relationships, including sexual relationships and differences in sexual orientation.

In this respect, the importance of early years interventions with pre school and primary school children should also not be overlooked in creating the foundations for healthy development in later life.

10.5 Training for workers in a range of services

Frontline staff, who are often the first or most regular point of contact for vulnerable people, need training and support to deal with distress in others and to respond respectfully and sensitively.

There are particular challenges for a range of services across sectors in reviewing their attitudes and behaviour towards people who self harm and opportunities to learn directly from those who have this experience about what helps and what does not. Further work is required to ensure that resources and services are accessible and acceptable to young people.

From a different perspective, building capacity to improve mental health and well being presupposes a human services workforce that is itself emotionally literate. There are challenges here in relation to the pre and post qualifying training of staff in a range of public services including education, health and social care.

10.6 An inclusive society

Finally, the discussions bring to the fore a set of fundamental issues that challenge us to consider how committed we are to promoting diversity. What steps are we prepared to take to promote awareness and understanding of different cultures, related to ethnicity, age, gender, and sexual orientation so that people feel valued and have a sense of belonging and hope for the future?

Appendix 1

The stories set out below are drawn from the discussions held with services users and with family members and carers. The stories have been anonymised to ensure that they do not include material which would reveal the identity of the individuals concerned.

Carer L

L described how she and her family felt they had been repeatedly let down by mental health services and left to cope on their own with their adult son's mental health problems. He became seriously unwell, lost a lot of weight, had difficulty sleeping, was agitated and eventually became 'catatonic'. The consultant psychiatrist diagnosed mild depression, but the mother was of the view that there was something more seriously wrong. Efforts to find help from other sources proved difficult as they were told they had to go through the GP.

Over time, the son's depression lifted and he had periods when he seemed well, capable and happy. However, after his marriage broke down he returned home and his mood swings increased. He saw a psychiatrist, was prescribed medication and began to see a CPN. Little seemed to improve his illness. One day he did not come home and was later found dead in his car. His mother said that she had been on the point of 'giving in' and accepting the professionals' view that her son was not seriously unwell. However, in retrospect she became more and more shocked and angry at the apparent lack of awareness among the health professionals he saw of his previous problems. Eventually two years after his suicide his mother felt able to raise her concerns and took out a formal complaint.

Carer B

B's adult son had made desperate and repeated attempts to end his own life. She described how, every time his mental health problems recurred, it seemed to take three months to get help. During one admission to acute psychiatric inpatient care following a suicide attempt, she had been appalled to find that her son had left the ward and his absence had not been noticed for seven hours, by which time he was in London.

When her son was eventually discharged back home she reported that she did not get the help that she needed. His behaviour could at times be very disturbed and aggressive. She recounted how she would drive round and round the block trying to muster energy to go home and face the situation. It got to the stage where she said: 'If this is my life no thank you' and she herself made a suicide attempt. After years in this situation, she described how she had become desensitised and now tended to sit back and wait for disaster.

'It won't hurt me so much now, I have been hurt by my son but hurt more by the system'.

B now said that she would be prepared to sit with her son if he were to attempt suicide again and he wanted her to be with him. 'I would not persuade him to live. The price is too high'.

Carer R

R described becoming so tired that she felt tempted to give in to her son's plea that they should both kill themselves. She resisted because she felt she could not show such an example to other members of the family. She herself had had repeated physical health problems which she attributed directly to the stress of caring and of being worn down over a period of years. She described a continuing struggle to get support from services for her son.

Carer N

N felt that existing crisis services were unable to provide what was needed. During a time of concern about her son she had contacted the crisis service and told the Duty Doctor about the situation. The Doctor had said, "If your son says he is going to kill himself, then he won't do it". A week later she found him unconscious at home after an overdose and had to telephone 999 and have him admitted to hospital.

She related how she had to take him three times to the crisis service after her son had badly damaged the flat and himself. He was very badly bruised before she got any help.

She described an incident in which her son had told her he was in so much pain he wanted to die. He asked if she would hold him while he died. She said she could not do that. She had to watch him leave her flat, knowing that he was intent on taking his own life. At that time she spoke to another carer who gave her a lot of support. Up until then, no professional had approached her to ask her how she was doing and how she was coping during this difficult time until her friend contacted the Social Work Department on her behalf. They got in touch with her and tried to help her and her son.

Carer S

This woman carer related how her son would come to her home at night if he was feeling suicidal, wake her and want her to give him attention. S felt very sad and upset at the state that her son got into. However she was trying to distance herself from him, as she wanted to have a life of her own and could no longer cope with supporting him. She suggested a crisis/safe house would be good: somewhere safe where her son could go, have a meal, a shower, to be able to sleep, where there would be other people about who could give him support if he wanted it.

She was very concerned at the level of care being provided by the Acute Hospital, who let her son walk out without a psychiatric assessment after he had attempted suicide. She expressed frustration and anger with the range of services being provided, and the poor communication and co-operation amongst them. It would have helped her immensely if someone had telephoned her to let her know what the son had chosen to do, so that she could have been prepared when he turned up at her door.

Service user T

T spoke about her experience and history of self-harm. She had been self-harming for many years and perceived this as the best way for her to cope with her feelings of isolation, distress and despair. She had received various forms of treatment from GPs and Casualty Departments. T believes the support she is currently getting from the local Casualty Department is very helpful. She has agreed not to self-harm without first talking to someone there about how she is feeling and this does seem to be helping her a lot. She finds it is friendly, safe and offers support at night when she feels particularly vulnerable. Another service that she has high regard for is the Bristol Crisis Service, which has a telephone help line that can be accessed at weekends.

T's experiences of seeking help have not always been positive. In one instance, when she had taken an overdose, she said the staff allowed a porter to pump her stomach. At another time when she had cut herself, the Doctor refused to give her anaesthetic when he was dressing and stitching her wounds.

T believes that everyone needs to be treated with respect when they are in the position that she finds herself in, of cutting herself as a coping mechanism. She would like people to be treated as individuals - not everyone needs to be seen by a psychiatrist if they self-harm, for example. It is hard for some workers to accept that people could harm themselves as a means of coping and more could be done to educate workers about this.

At one point she had had a real worry that she might harm someone else. She has two children and when she spoke to the Doctor about this he said, "People with your disorder do not harm others". She was very angry at being treated as a condition not a person. She wants to see staff trained to treat people respectfully and non-judgementally, developing more awareness about why some people harm themselves and how best they can work with and support them. She believes that work is needed with children to educate them about emotional and mental health and the ways in which they can express themselves at different times in their lives.

Service user J

J started to harm herself at the age of 16, when she felt she was not 'fitting in' and her isolation led to feelings that she did not want to exist. She found puberty hard and wanted to be more like a boy than a girl. She confessed to being a perfectionist and wanting to do things to the best of her ability, sometimes to the point of obsession. J felt that she had low self confidence and self esteem and that no matter what she did, she would be found lacking. In fact she was very successful in exams and managed to go to university, although exams caused her a great deal of distress and anxiety. J remembers how she would cope by devising grids on different suicide methods to determine which was the best method and which would cause the least mess.

Before J sat her Highers she saw her GPs and was put on antidepressants. She was referred to the local mental health services for young people. She put on what she called a front, appearing well so that she could be discharged when she planned to kill

herself. She found over time that the antidepressants seemed to help and her mood improved although the suicidal feeling persisted. At this point she started to cut herself very deeply. She explained that seeing the blood made her feel calmer. The cutting was not painful, but helped her to decide to hold out and not commit suicide. J began to self harm a lot and the wounds started to need stitches. She was treated by the same mental health service, though she became what she says was paranoid about the treatment and also about people at school. At this point, she started to burn herself. J felt that if what she was doing did not kill her, it would make her stronger. There were also issues about control: if she was hurting herself this much, then no one else could hurt her more.

At university she was discharged by the CAMHS and told that if she needed further help she should go to adult services. She tried to come off antidepressants with medical support but her mood went down a lot so she went back on to a maintenance dose. At university she became very involved academically and socially being a student and this caused her to have an increased sense of stress and panic, leading to her feeling out of control and seriously harming herself. She was involved with a number of psychiatric services and seemed to get into a confrontational relationship with her consultant psychiatrist that she felt was not helpful. The consultant psychiatrist said “you either see me or you will receive no treatment from anyone else”.

J is now in contact with a social worker, whom she regards as very supportive. J also has input 12 hours a week from a support worker, linked to her accommodation. She was able to get a new GP and a referral to see a psychologist and has also started to receive support from an occupational therapist from the local community mental health team. She values the fact that the support provided is less medicalised and has included advice on how to relax and to manage her daily life in order to sustain her mood.

Service user W

W became full of self loathing and self hatred in her adolescence and had started to self-harm, finding that this gave her relief. In her mid teens she attempted suicide and was referred by her GP to the child and adolescent mental health services. Over the years W had a number of contacts with psychiatric services, as an inpatient as well as being supported in the community. During this time she felt that on the whole staff were not approachable and that they did not believe her when she was telling them some real things that were happening in her life. W never felt supported by her parents and her relationship with them had been poor for many years. She believes that her situation improved when she got help from a voluntary sector service linked with a housing association.

W currently gets support from her CPN and a support worker from this voluntary sector service and feels that she gets a good package of care. She is still involved in self harm and when she needs treatment she goes to the minor injuries clinic at a general hospital where she finds her treatment a positive experience. However her GP, whom she has had for many years, will still not talk to her about her self harm or her attempted suicide. W’s experiences have led her to establish a self help group as

she believes that this will help de-stigmatise self harm and ensure that women can get the kind of support that they need at difficult times.

Service user P

P experienced sexual abuse within her family from a very young age and began self harming from the age of three by banging her head against the wall. She has had very sad and difficult experiences within her family relationships. Over the years P has had a number of suicide attempts and has self harmed. P believes that she has always felt suicidal and did not really understand where these feelings were coming from as she had managed to 'blank off' the abuse she had experienced as a young child. She had tried to get help from a number of sources, including self help and therapy but found that neither could provide the sense of safety and acceptance that she needed.

When P tried to register with a GP after moving and explained that she did not want the GP to do a physical examination as she was fearful of being touched by men, the GP accused her of making up a conspiracy about the medical profession.

Eighteen months ago, P had what she describes as a complete break down, became homeless and moved to a different place. She had a voluntary admission to the local psychiatric hospital. Every time she told people there that she was going to self harm she did not feel she was being believed. Since the discharge she has been getting a lot of support from the GP attached to a project for homeless people and from services that work with homeless people. P feels that the staff in this project are very helpful and supportive and she is able to talk whenever she feels the need. If feeling distressed during the night, P now phones the Samaritans and finds this service very supportive.

Appendix 2

Participants in the discussion process

Education

- New Community Schools: focus group with Integration Managers, individual visits with 2 further Integration Managers; contacts with 2 others by phone and letter
- Schools Guidance Network: focus group

Strathclyde Police

- Chief Superintendent and Inspector with mental health brief
- Chief Inspector at Glasgow Sheriff Court
- Court Liaison Team
- Chief Inspector and Duty Officer, A Division
- Training Officer at Strathclyde Police Training College

Scottish Prison Service

- Polmont Young Offenders Institution: Deputy Governor; Health Centre Manager; Staff group, including Prison Officer and Clinical Service Manager for Mental Health Team
- Barlinnie: Training and Development Officer
- Cornton Vale Prison: Head of Health Care

Mental health services

Focus groups / discussions with:

- Liaison psychiatrists
- LHCC: 2 GPs, 3 clinicians, LHCC manager, social workers, facilities and operational support managers, clinical governance co-ordinator
- Multi cultural health workers and co-ordinators in Glasgow, including staff who work with asylum seekers
- A local mental health service network in Glasgow
- A community organisation supporting women from black and ethnic minority communities

Phone lines

- Samaritans: national co-ordinator; volunteer involved with prison Listener Scheme
- Facilitate Scotland which provides a helpline and support service for people at risk of suicide

Individuals were contacted through:

- Stonewall which supports gay, lesbian, bisexual and transsexual young people
- Penumbra's self harm support network

- Big Step which supports young people who were in care
- Wounded Wing, a mutual support group for people who self harm
- Papyrus, a UK wide support network for families affected by suicide and self harm, which led to meetings with three local groups, one exclusively of carers and two mixed forums involving carers, users and professionals

Media

Press

The Herald

Evening News

Press and Journal

Radio

Real Radio

BBC Radio Scotland

Northsound Radio

Forth FM

Television

Grampian TV

BBC TV