Supporting Life :

Suicide Prevention for Mental Healthcare Service Users

Schizophrenia Ireland
Lucia Foundation

Schizophrenia Ireland is the national organisation dedicated to upholding the rights and addressing the needs of all those affected by schizophrenia and related illnesses, through the promotion and provision of high-quality services and working to ensure the continual enhancement of the quality of life of the people it serves.

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Supporting Life :

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**John Saunders, Pat Seager and
Kahlil Thompson Coyle, Eds.**

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Foreword

John Saunders

This document entitled **Supporting Life: Suicide Prevention for Mental Healthcare Service Users** is the second occasional paper from Schizophrenia Ireland. We have chosen the issue of suicide prevention for this year's Lucia Week, the national schizophrenia awareness week, in an effort to better address the needs of those accessing mental healthcare services.

The prevention of suicide is an important issue for Schizophrenia Ireland. The reasons why people die by suicide are many and varied and in many cases it is difficult to ascertain a precise reason. We do know, however, that certain at-risk groups are more likely to attempt suicide and these include people with a diagnosis of schizophrenia, bipolar disorder and depression. The purpose of this document is to encourage discussion around these at-risk groups and to suggest ways that we can assist in reducing that risk.

The most important characteristic of the at-risk group is that they are an identified group of people in the population and so there is an obligation for us to focus on services that can ameliorate or reduce the likelihood of suicidal behaviour occurring. Suicide prevention can be a reality for many people, provided services can refocus themselves to pay specific attention to the at-risk behaviours and indicators. It is our hope that this document provides information on suicide prevention for people with severe mental illness, and encourages the mental health services to adequately address the needs of the people it serves.

Introduction

Dr. Tony Bates, Principal Psychologist at St. James's Hospital

We know from clinical experience and from research that people with schizophrenia are more vulnerable to suicide than any other group in the general population. In fact, they are 40 times more vulnerable to taking their own lives than people who do not have this particular form of human experience. These are disturbing statistics and understandably cause concern among service users and their families. Why does schizophrenia make a person more vulnerable to suicide? And what do these statistics say to those of us in mental health services whose role it is to care for them?

Let us consider what we know about suicidal behaviour in general. We know that people reach a point of taking their lives when they feel trapped by their particular circumstances, with no possibility of being able to escape their predicament and no likelihood of rescue. Could it be that schizophrenia leaves a person more vulnerable to feeling this way? Research suggests that some 10% of those with self-experience may well feel very trapped and overwhelmed by this disorder. Furthermore research has narrowed down the factors that suggest those who may be particularly at risk for suicidal behaviour. Being familiar with these factors should alert us to people who particularly deserve our attention. Knowing who may be vulnerable should encourage us to talk with them about the real difficulties they experience and prevent problems escalating to a point where they view self-harm as their only means of ending their pain.

For example, we know that among key risk factors are being young, being male, having a course of illness characterised by repeated lapses, short hospitalisations and also having a high IQ or higher education. In addition, we know there are times when these individuals are more at risk than other times, notably during their hospital admissions or in the weeks directly following discharge. What can we "read" from these cold "risk factors" that might inform us as to the state of mind of the service user, a state of mind that may lead them to feel despair and consider suicide?

For some of these individuals their experience of mistrust of others become so intense that their paranoia and suspiciousness leads them to feel increasingly isolated and alone. It may be difficult to engage these individuals in counselling, and medication may be the critical intervention they require. For others, their repeated hospitalisations may suggest they are non-compliant with medication, perhaps because they refuse to accept that they need this kind of help. For this group it may be important to hear how they understand and make sense of their own experience and work with them to see how a variety of interventions, including medication, make sense. And finally, for those with high IQ and insight, it may be that they understand all too well what's happening and see a future unfolding before them where their lives will be limited in painful ways by the experience of schizophrenia. This group particularly deserves an opportunity to grieve the life they may have wanted for themselves, and their crushed dreams.

This is not to imply that all is lost and it is critical to maintain an attitude of optimism in these

discussions. Adopting a "recovery" approach means being realistic about what has been lost, but also conveying a strong message that the experience of schizophrenia is never the whole story for any person. There is still a life to be lived. There are resources available both within and around this persona and these can help them achieve valued and meaningful goals in their lives.

Finally, working from what research so clearly reports over and over again, the time of great risk is during and immediately after hospital admission. This highlights the need to engage people in hospital in some form of realistic care planning as soon as possible following their admission. Having a plan, particularly one that you personally have been part of constructing, gives a person a feeling of hope that something good can happen, even when things feel chaotic. This plan needs to take into account what the service users themselves want to achieve and to address the real and practical problems that are making it hard for them to find their place in the world.

Even when a person achieves stabilisation in hospital and may feel very optimistic about their lives at the point of discharge, it is crucial we pay attention to ensuring continuity of care for them when they return to the community. The risk of suicide is not merely to do with how hard the experience of distress is for someone; it is also affected by those "protective factors" in their life, which support them in facing the challenges ahead of them when they leave hospital. Where these protective factors are not readily available, we should be alert to the risk of relapse and consider ongoing support after discharge for as long as it may be required.

Schizophrenia Ireland is committed to ensuring the very best quality services for its members. It is to be commended for bringing the issue of suicide prevention in this very vulnerable group to our attention. Let's hope an outcome of Lucia Week 2005 will be that service providers will think more sensitively about the real needs of service users, and insist that the issue of suicide risk is considered and addressed across all services.

Historical Context of Suicide Prevention in Ireland

Anne Callanan, National Suicide Review Group

Suicide prevention has accelerated in Ireland since the decriminalisation of suicide in 1993. The importance of suicide and its prevention in Irish society were acknowledged with the establishment of the National Task Force on Suicide in 1995. The Task Force published two reports, which shaped many of the developments over the following years. Significant events include the establishment of services within the statutory health services, namely the employment of suicide prevention resource officers in the health boards and the setting up of the National Suicide Review Group.

Major Milestones in Suicide Prevention in Ireland since 1993

1993	**Criminal Law (Suicide) Act**
1995	**National Task Force on Suicide** **National Suicide Research Foundation established**
1996	**Irish Association of Suicidology established**
1998	**Report of the National Task Force published** **National Suicide Review Group formed** **Health boards establish post of Suicide Prevention Resource Officers**
2001	**Suicide in Ireland: A National Study published** **Health (Miscellaneous Provisions) Act**
2005	**National Strategy for Action on Suicide Prevention**

National Suicide Review Group

The National Suicide Review Group (NSRG) was established by the CEOs of the health boards in 1998. There are currently two full-time staff employed by the NSRG, and heretofore the membership has comprised of representatives of each of the 10 health boards along with key stakeholder groups across the country. The specialisms that have been represented include nursing, public health, research, resource officers, mental health services, voluntary agencies and coroners. The Group has acted as a co-ordinating body liaising with the Department of Health and Children and reporting to the CEOs of the former health boards.

In accordance with the recommendations set out in the Final Report of the National Task Force on Suicide (1998), the health boards began appointing Resource Officers for Suicide Prevention in 1998. In 2005, there are 10 resource officers with responsibility for suicide prevention. The NSRG has been

in ongoing and regular liaison with these resource officers in monitoring trends in suicidal behaviour on a regional basis and in supporting regional prevention initiatives.

For four years the NSRG supported suicide prevention initiatives across the country by distributing funding to individual projects. More than €600,000 was distributed to almost 60 projects during this time period. These projects span the spectrum of suicide prevention initiatives, from general prevention through intervention and postvention (initiatives directed at those bereaved by suicide) to research. Many of these projects were pilots, whereby agencies examined the usefulness of various approaches in dealing with the issue of suicide. Innovative projects include providing counselling for at-risk youth; awareness training for GPs; film project for early school leavers; problem-solving programme following deliberate self-harm. These are but a few of the projects which have been competed under this programme of funding.

This method of distributing funds changed in 2004, when three priority areas were identified and supported. The first of these involved supporting the development of a national strategy for action on suicide prevention. The second related to training 24 professionals as trainers in suicide first aid. Living Works Education, a Canadian group that specialises in training programmes in suicide prevention, delivered the course, Applied Suicide Intervention Skills Training (ASIST). The final priority was to review the projects funded to date, and distil the learning from these projects in relation to national objectives. A national symposium will mark the end of the project review, which will showcase a representative selection of projects.

Suicide Prevention in the Health Services
In the main, the health services took their lead from the 86 recommendations listed in the final report of the National Task Force. As previously mentioned, the first suicide prevention resource officers took up post in 1998. Each works independently, but come together as a national group to support their work and the development of their role, and to share information and learning from local experience. They work in partnership with local services to deliver training and support general prevention initiatives; they liaise with local services to establish pathways of care for those in crisis, and they liaise with bereavement support groups to provide services for those who have been bereaved by suicide. They have developed regional strategies which prioritise their work and are supported by local steering committees. The following is a representative sample of the work of the resource officers and the health services.

In the area of general prevention, the resource officers have developed regional directories of support services. These directories provide information on all the services available to those seeking emotional and practical help in their local area. Additional information sources include information cards, a Concerned About Suicide leaflet and bereavement support booklets.

The resource officers co-ordinate the delivery of ASIST training workshops in their area. In the first 6 months since the trainers completed the Training for Trainers workshop, more than 30 workshops were completed across the country. This number continues to grow every month. Participants have included health service providers, teachers, Gardaí, community members, priests and many more. The programme is receiving very positive feedback from participants and is proving to achieve its objectives. Other training programmes include general awareness training, teacher training, gatekeeper training and Staff Training on Risk Management (STORM).

The services for those in crisis are continually developing. Many hospitals have a crisis nurse or liaison psychiatric nurse service available to those attending A&E after an episode of deliberate self-harm. It is widely accepted that individuals attending A&E in a state of distress have certain psychosocial needs. In many of our hospitals, patients are now offered a psychosocial assessment, which informs the development of an appropriate care plan.

Voluntary Groups

Ireland is in the fortunate position to have a significant number of voluntary and non-statutory groups dedicated to suicide prevention. The Irish Association of Suicidology (IAS) and the National Suicide Research Foundation (NSRF) are two of the most prominent.

The IAS seeks to disseminate information about suicide and suicide prevention to the general public and concerned agencies. Its work serves to inform public opinion and bring about coordinated action by all elements of society. Two conferences are run each year, which serve to disseminate international and national learning on specific issues. The topics that have been covered to date include schools, bullying and the elderly. The IAS has also been instrumental in developing key reference documents, in conjunction with other agencies, in the area of suicide prevention. These include guidelines for schools and for journalists.

The NSRF has established itself as a strong presence in the research domain, as it operates a multi-disciplinary research team and has contributed to national and international learning in this field. It is recognised by the World Health Organization as a centre of excellence and is a member of the WHO European Network on Suicide Research and Prevention and the European Alliance Against Depression (EAAD). Most notably, the NSRF co-ordinates the National Parasuicide Registry, which has provided us with information on episodes of deliberate self-harm in hospital A&E departments across the country. It also liaises with the Central Statistics Office to interpret data on suicide.

In the area of bereavement support, agencies such as Living Links, Console and the National Suicide Bereavement Support Network are working together to meet the needs of families and communities bereaved by suicide. Other community groups have developed across the country. It is anticipated that this will represent a key area of development and consolidation in coming years.

The contributions of other organisations including Schizophrenia Ireland, Samaritans, Mental Health Ireland and Aware among others have also been central in advancing the aims of suicide prevention across the country. Their efforts have been focused on their service users, and it is becoming more frequent that these agencies are collaborating together and with the statutory services to address suicide and suicide prevention. At a recent forum hosted by President McAleese all the key agencies, voluntary and statutory, came together for the first time in relation to this topic. The purpose of the meeting was to acknowledge the contribution of the individual groups and the clear message that emerged from the meeting was the commitment of each agency to collaborate to meet the objectives of suicide prevention. There was a clear understanding that suicide prevention is the responsibility of every agency, and that working together in a sustained way is the way to move our shared objectives forward.

Future Steps

The future of suicide prevention in Ireland will be shaped in the coming months. The NSRG, HSE and Department of Health and Children are preparing to launch a National Strategy for Action on Suicide Prevention, in early autumn. This document will be the result of extensive collaboration with key agencies nationwide. These include the major government partners such as Education and Science; Justice Equality and Law Reform; Social, Community and Family Affairs along with county development boards, voluntary agencies, community groups and many more. Suicide prevention no longer lies solely in the domain of the health services; rather it is the responsibility of all. The implementation of this strategy for action will integrate all of these agencies in a common objective: to reduce the incidence of suicidal behaviour in Ireland.

We are on the cusp of a unique opportunity to shape the Irish experience over the coming years. The health service reforms, coupled with the forthcoming mental health policy framework and the publication of the National Strategy for Action on Suicide Prevention, together with the expressed commitment for collaboration, will generate new ways of working together to develop a deeper understanding of suicide, and to tackle the problem of suicide in this country.

Suicide and Schizophrenia

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Suicide is always a tragedy, for the life that has ended and for the family, friends and community left behind. It is estimated that every suicide has a serious impact on at least six other people and the psychological, social and financial impact of suicide on the family and community are immeasurable. The rising rate of suicide among young people in Ireland is causing alarm, where it is now the most common cause of death in this age group today. The World Health Organization (1) estimates that in the year 2000, approximately one million people died from suicide and 10 to 20 times as many attempted suicide worldwide. Latest figures show that in Ireland, 444 people died by suicide in 2003, almost 100 more than died on the roads. The World Health Organization (2) recognises suicide as a complex problem for which there is no single cause. It results from the complex interaction of biological, genetic, psychological, social, cultural and environmental factors.

Suicide has a strong association with mental disorders, particularly with schizophrenia and mood disorders, such as depression. It is estimated that 10-13% of individuals with schizophrenia die by suicide and suicide is the primary cause of death in this group (3). This compares with a 1% lifetime incidence of suicide in the general population. Making a suicide attempt has been shown to be a robust predictor of completed suicide and it is reported that as many as 40 to 60% of people with schizophrenia will have at least one suicide attempt in the course of their illness (4). Despite considerable efforts in research and progresses in drug treatments over the last decades, suicide rates have not dropped significantly in this diagnostic group.

Risk factors for suicidal behaviour in those with schizophrenia include demographic characteristics such as being young, male, Caucasian, unmarried, unemployed, having a family history of suicide and being socially isolated. Factors requiring special attention are having a history of suicide attempts, depression, hopelessness, awareness of illness and substance misuse. The increased risk of suicide immediately after admission and discharge from hospital, together with the high proportion of suicide cases during temporary leave of absence from hospital, suggest these may be periods when people with schizophrenia are particularly vulnerable. Having a recent diagnosis, an earlier age at onset, treatment resistance and treatment side effects such as akathesia and parkinsonism are other reported risk factors. Deteriorating health from a previously high level of functioning, recent loss or rejection, limited external support and family stress or instability are psychosocial factors associated with suicidal behaviour.

Delusions, particularly of the paranoid or persecutory type, have been associated with increased risk of suicide, although the evidence is conflicting (5). Paranoid delusions and command hallucinations may non-specifically increase violent behaviour and this may account for the increased risk. However, severe psychosis may distract the person and impair executive functioning to such a degree that plans and means of engaging in self-harm behaviours are not feasible. The presence of suspiciousness has been found to be a risk factor for the development of depressive episodes in schizophrenia (6), which in turn could influence suicidal behaviour.

Protective factors against suicidal behaviour include being female, non-white, pregnant or being a parent (female) of a child less than 2 years old. Young females with schizophrenia are at greater risk of suicide intent than older females, however, males show an increased risk of completing suicide. The presence of negative symptoms is associated with lower risk of suicide. Fenton et al, (7) found that patients lacking enduring negative symptoms were six times at greater risk of suicide than those with chronic negative symptoms.

"Recognising those at risk is at best an inexact science" according to the UK Department of Health. Measures of "intent to die" are the best predictors of suicide in the short term, but longer term predicting is problematic. Doctors should be particularly vigilant when people are in hospital and in the 3 month period after discharge. Between 25 to 50% of all suicides are committed during psychiatric hospital care (8) and about 50% of these occur within 3 months of discharge. The problem is that it is often difficult to clinically estimate suicide risk with individual people and the suicide risk may vary in different treatment phases. Suicide risk scales are usually developed for a particular population rather than for a specific psychiatric disorder and even within a certain diagnostic group such as schizophrenia, it is probably impossible to construct a structured assessment tool for suicide risk with both high sensitivity and high specificity.

People with schizophrenia who die by suicide tend to have multiple and lengthy hospitalisations and longer hospitalisations are associated with suicide completion after hospital discharge. Risk of suicidal behaviour is also highest in the first 10 years after diagnosis and particularly if the course of the illness is severe with frequent relapses. The period around hospitalisation can be very traumatic for a person with schizophrenia. The initial acclimation to ward life and/or plans for discharge and rehabilitation can be very difficult. Yarden (1974) drew attention to the importance of suitable discharge plans and aftercare programs. Supportive, supervised living arrangements are ideal. With chronic, incapacitated people, surveillance should be increased in times of personal crisis and impending environmental change, including staff, therapist, or contact person changes, hospitalisation, discharge, or re-hospitalisation.

Staff variables, such as low morale or the absence of key personnel, as well as lack of communication among staff about people with self-experience of mental illness judged to be at increased risk of suicide can have an impact on suicidal behaviour being acted out. Recurrent relapses and resistance to treatment in people at risk of suicide can cause enormous stress for clinical staff. The concept of "terminal malignant alienation" is important. It characterises how staff can perceive patients as manipulative, provocative, unreasonable, over dependent and feigning disability. People with schizophrenia with fluctuating suicidal ideation are particularly likely to fall into these categories and may lead to under-reporting of suicidal ideation by staff. The combination of 'alienation' and fluctuating suicidal ideation can lead to failure in the recognition of seriousness of suicidal risk.

Suicide attempts among people with schizophrenia are usually serious and require medical attention. The methods used to attempt suicide are considered more lethal than those used by suicidal persons in the general population. Attempts are often associated with the number of lifetime depressive episodes (9), as well as engaging in substance abuse or dependence, a duration of untreated psychosis for more than a year and being prescribed typical antipsychotics (10).

Atypical antipsychotics, such as clozapine, olanzapine, risperidone and quetiapine have shown some power in reducing suicidality among people with schizophrenia (11). Clozapine treatment has been reported to have the potential to decrease suicide mortality by as much as 85% (12). The US Food and Drug Administration recently approved clozapine for the treatment of suicidal behaviour in people with schizophrenia or schizoaffective disorder. Interestingly, clozapine has also been associated with increased insight or symptom awareness. Sudden increases in insight by more than 25% may lead to increased suicidality in people with schizophrenia (13). Therefore, people commencing clozapine therapy should be monitored closely to detect and appropriately deal with such abrupt insight increases.

From a psychosocial perspective, clinicians should acknowledge patient's despair, discuss losses and daily difficulties and try to help establish new and accessible goals. Social isolation and work impairment are frequently reported as risk factors for suicide. Comprehensive psychosocial interventions should be routinely available to all people with schizophrenia and their families; and provided by appropriately trained mental health professionals with time to devote to the task. Psychosocial treatments that are advocated in managing people with schizophrenia and which might help reduce suicidality in this patient group are depicted in the Figure below.

Figure Psychosocial treatments for people with schizophrenia that might reduce suicidality:

Stigma can be a powerful factor which influences the course of psychiatric illnesses. It is often the product of fear, ignorance and prejudice. Labelling someone as being mentally ill can increase the likelihood that that person will be considered unpredictable and dangerous (14). This in turn can have a negative impact on the public's willingness to engage in social relationships with 'mentally ill' people and social isolation in this population may occur as a consequence. Family members of people with self-experience of mental illness who are open and non concealing about mental illness can contribute to reducing stigma. It can be very difficult for a family member not to develop some negative feelings towards their family member with mental illness especially when they feel hopeless about the illness and are under pressure to care for them. Providing support and education about schizophrenia is essential in helping families come to terms with having mental illness in the family. Psychiatrists and mental health professionals may sometimes not take into consideration the turmoil and distress people with schizophrenia may be trying to communicate to them (15). It is a known fact that people with schizophrenia often have contact with a mental health professional prior to acting on suicidal thoughts.

Some strategies for targeting and preventing suicidal behaviour in schizophrenia are listed:

1 Early detection and comprehensive treatment of first episode cases of schizophrenia should be a priority as this has been shown to improve outcome and reduce suicidality;

2 People with schizophrenia should be treated with the newer antipsychotic medications which have fewer side effects and some, such as clozapine, are associated with reducing suicidal behaviour;

3 The social and cultural environment of people with schizophrenia should be an essential arena for intervention. Adequate shelter, financial security, access to meaningful social roles and availability of social support are essential components of recovery and quality of life; and

4 Maintenance of good physical health and prevention and early treatment of serious medical illness is very important. Quality of medical care for people with schizophrenia should be equivalent to the general community standard.

Optimal treatment of schizophrenia requires a multidisciplinary team approach. Mental health professionals need to ensure proper guidelines that are designed to prevent suicide are in place. Adequate communication between staff involved in the care of people with suicidal ideation is essential. It must be remembered that the suicide risk continues throughout the lifespan of individuals with schizophrenia and mental health professionals are obliged to provide the proper care and attention that persons with schizophrenia deserve.

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Acknowledgements

Personal Story:
The Day I Took an Overdose

by Tim

Looking back I was deluded. I always associated delusions with the high phase of bi-polar depression, like believing that you were a famous person or that your life was in extreme danger. I've even read one academic study which suggests that depressed people have a more realistic worldview, and if we really wish for cold comfort, other researchers claim we have high intelligence.

I will explain my particular delusion later.

Some background: I was diagnosed with schizophrenia in 1983, aged 24, three years after completing a B.A. degree in Psychology. I'd had extreme mood swings exacerbated by cannabis use. I involuntarily entered hospital during a high phase. I believed my life was in danger.

Now I question that diagnosis of schizophrenia. My feeling is that I had mood swings, (bipolar if you wish to medicalise it) along with false beliefs.

The summer of 1983, living in France, had been the most unnaturally happy time of my life. I had lots of energy, dreams and schemes, with huge plans especially in the music area. While this euphoria may be blissful for oneself, it's grating and extremely tiresome for those close to the person. It can even come across as belligerence.

Following hospitalisation in 1983, I was on a monthly injection of depixol (a major tranquiliser) and remained stable living a full life for two years. However, I again experienced lows and highs in mood.

December 1985 saw a sudden resignation from work and the end of a five-year relationship. Again I was hospitalised. Shortly after this I accepted that I surely had some mental health issues. I became more careful about taking my medication. However, I continued to use cannabis, worked in the computer industry, and had a fairly erratic, if youthful lifestyle.

In 1988 my company seconded me to Holland, which was probably not the ideal place to be for one with a history of mental health problems and a liking for cannabis. My usage increased dramatically and was compounded by social isolation. I spent one year there and left early in a deep depression.

The depression continued into the spring of 1989. That's when I made an attempt on my life.

It was a stormy Friday evening in March. I returned from my work with the computer company to a nearby suburb of Reading, Berkshire. I was sharing a house with someone who was away a lot of the time. My girlfriend was due to arrive from London to spend the weekend with me. I had been contemplating suicide for a while. My depression consisted of a terrible self-loathing, deliberate avoidance of people and therefore excruciating isolation. I remember feeling addicted to comfort on

one hand and on the other dreading the pain that taking my own life would involve (e.g. that noose looks hideous I'll go back to bed).

That Friday evening at 6pm as darkness fell I sat myself down on the bedroom floor with a packet of 60 anti-psychotic tablets. It was probably Haloperidol medication. I slowly began swallowing one after the other thinking this would be the least painful way to die.

Poll-tax riots were rife in the UK at the time. A quote from the newspaper in front of me leapt out. A protestor said "There's a proud history of civil revolt in British politics." I had a marked delusional thought then while defiantly swallowing the tablets. "Yes" I thought "and there's a proud history of suicide also."

I cannot remember how many tablets I took or if I finished the packet. Afterwards I left the house, light-headed and took a bus into Reading. I remember going to bed that night with my heart thumping in my chest. I didn't tell my girlfriend about the overdose until the next day. It's an understatement to say it was difficult for her but she was 100% supportive.

I entered Reading General Hospital on Saturday afternoon and told them about my overdose. I was just kept one night and told that only that I had an extremely strong heart I would have died.

My depression continued following that. I would go high and low again. One aspect of that episode leaps out; when you're high and being a pain to everyone there's no problem in being involuntarily detained and getting help. However, when in a deep depression, despairing and inclined towards self-harm, it's harder to convince some services that you need help. On that occasion I spent just one night in hospital.

Since then my life has improved immeasurably. I stopped doing work I hate and now do work I love in the mental health area. My lifestyle is much more sensible and my relationships have improved. Work, lifestyle and bad relationships contributed to my poor mental health. I spent years working in the computer industry while being a technophobe. I smoked so much grass that as one musician put it, "I almost turned into a bush". I had open relationships, which really destroyed my peace of mind.
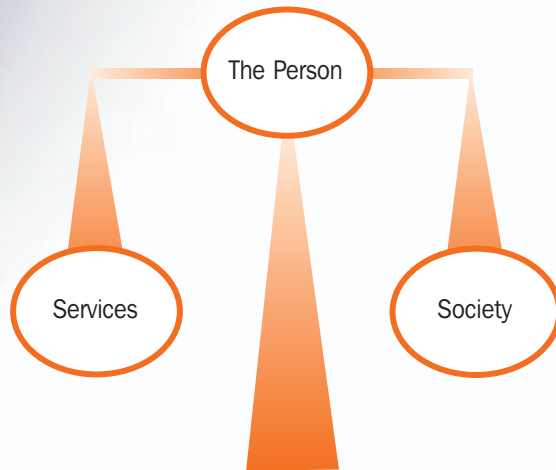
I'm so happy and grateful that I'm still around to enjoy this much more productive period of my life.

Getting the Balance Right:

Suicide Prevention for People with Self-Experience of Schizophrenia

**Richard Hansen, Damien Lillis, Cillian Russell,
Pat Seager and Kahlil Thompson Coyle, Schizophrenia Ireland**

The Person

Services

Society

Introduction

The experience of mental distress, coupled with the demands of 21st century life is a potent combination. Over the past twenty years, increasing efforts to reduce the number of suicides have mostly met with a stubborn refusal of the numbers to change in Ireland. Indeed—the incidence has increased.[1]

Suicide is about ending the pain. The many and complex theories that surround the act of suicide can sometimes distance us from the simple idea that no one takes their own life unless there is something very wrong with it. The focus of this paper is a very particular group of people who seem to find themselves with more wrong in their lives than many and present a very high suicide statistic rate.

Suicide is the leading cause of premature death for people with schizophrenia. With that said, it is absolutely imperative to highlight the facts that suicide is preventable and the future for people with schizophrenia has never been brighter. This is due in part to the increasingly acknowledged benefits of alternative and talking therapies; recognising the necessity for person centred and effective community based care; new research and medications; and recognising that people with experience of schizophrenia can and do recover.

What follows is a discussion of some of the main issues confronting people with a severe mental illness and their families in Ireland today, within a context of suicide prevention. The aim of this paper is to provide information and contribute to the current dialogue in the lead up to a national suicide prevention strategy. Specifically, our experience in SI has led us to focus on three main areas: society; the person; and services.

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1   Public health and violence – European facts and trends, World Health Organization, Copenhagen: 2002.

Suicide is the leading cause of premature death for people with schizophrenia. With that said, it is absolutely imperative to highlight the facts that suicide is preventable and the future for people with schizophrenia has never been brighter.

It is the hope of Schizophrenia Ireland that through coordinated efforts of the statutory and voluntary sector, with the participation of people with self-experience of mental distress and their families, together we can help prevent the unnecessary loss of life.

Background

Schizophrenia is characterised by disturbances in a person's thoughts, perceptions, emotions and behaviour. It affects approximately one in every hundred people worldwide and first onset commonly occurs in adolescence or early adulthood, although it can also occur later in life. It is estimated that in Ireland alone, there are approximately 39,000 people with schizophrenia.

People with schizophrenia represent a very high-risk group for suicide. Figures vary, however, it is widely acknowledged that 40% to 60% of individuals with schizophrenia will attempt to take their own life, and approximately 10% of people with schizophrenia will die by suicide.[2]

According to the World Health Organization (WHO), people with self-experience of schizophrenia have an increased risk of suicide if they are [3]:

- Young, single, unemployed males
- In the early stage of illness
- Depressed
- Prone to frequent relapse
- Highly educated
- Paranoid (suspicious)

People with schizophrenia are more likely to be suicidal at the following times [4]:

- In the early stages of their illness
- Early in their recovery, when outwardly their symptoms are better but internally they feel vulnerable
- Early in a relapse, when they feel they have overcome the problem, but the symptoms recur
- Soon after discharge from hospital

Protective factors, according to the WHO, include high self-esteem and social "connectedness", especially with family and friends, having social support, being in a stable relationship, and religious or spiritual commitment. Early identification and appropriate treatment of mental disorders is an important preventive strategy. Interventions based on the principle of connectedness and easy access to supports such as helplines, psychosocial interventions and suicide prevention centres are all

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2   Public Health Agency of Canada, http://www.phac-aspc.gc.ca/publicat/miic-mmac/chap_3_e.html.
3   "Preventing Suicide: A Resource for Primary Health Care Workers", World Health Organization (WHO), Mental and Behavioural Disorders Department of Mental Health, 2000.
4   "Preventing Suicide: A Resource for Primary Health Care Workers", World Health Organization (WHO), Mental and Behavioural Disorders Department of Mental Health, 2000.

promising strategies cited by the WHO.[5]

Through Schizophrenia Ireland's suicide prevention initiatives for people with schizophrenia and their families, the common themes that the participants speak about highlight concerns of stigma, isolation, fear and dissatisfaction with the services. They have also spoken of the hope that the unnecessary loss of life can be prevented.

Society

Stigma

Our ability to tackle the issue of stigma and mental distress has proven to be disappointing. In recent research there is the growing acknowledgement that broad based awareness campaigns often produce poor results. Direct access, however, to a person with self-experience of mental illness has the ability to actually change the way people think and feel about it. For very good reasons many service users and family members do not wish to become part of promotional or media campaigns so the promoters have to fall back on a more diluted message.

Stigma can be extremely damaging and hurtful for the person experiencing it. A person who feels shamed and disgraced because of their diagnosis may find it very difficult to face the world as well as to challenge negative public perceptions of mental illness. People do not choose to experience mental illness anymore than people choose their race or colour.

The reality is that stigma is discrimination. It is easier to tolerate stigma because it implies at some level the person being stigmatised is responsible for the problem. Awareness raising information campaigns can increase the level of public tolerance by creating a degree of empathy but they do not always effectively challenge the underlying prejudice. We need to strive for equality driven mental health legislation and mental health services that focuses on valuing the person and not simply treating some symptoms.

Young Men

Statistically, young men are most at risk of dying by suicide in Ireland.[6] What are the factors that contribute to this very specific age bracket that make these young men more susceptible to taking their own lives? Adolescence through to young adulthood is a very turbulent and crucial stage of psychological development – it is also the typical age of the first onset of psychosis. The sense of 'who am I' and 'what is my place in the world' combined with pressures from peers and social demands make this stage in development a major challenge to building a dynamic self-esteem, a healthy self

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5   "Suicide Huge but Preventable Public Health Problem", World Health Organization, 2004.
6   Suicide Rates for First Three Quarters of 2003 by Sex and Age Group, The Irish Association of Suicidology.

To ensure a clear and effective recovery pathway also requires that a person can remain integrated fully in their local community with access to basic life resources such as an education, a job, an income, a home, friends and hobbies.

image and find social validation.

When this is coupled with mental illness, such as schizophrenia, the situation can become extremely distressing. These young men in particular need to be reached and validated for the challenges that they face. These things need to be named for them, so that they can recognise the gravity of their psychological, emotional and social development. We must also endeavour to ensure that young men should expect and receive support.

The Person

Isolation [7]

Service users frequently talk of feeling lost or dislocated, the loss of friends, family and a future. Families often talk of the loss of a son or daughter to mental illness. It is as if they have disappeared. Medication, hospitalisation, low motivation all contribute to the gulf between their experience and the rest of the world. The experience of feeling strange, different and perhaps paranoid can initiate the need to withdraw.

The combination of public prejudice, remote services and personal fear can create a situation where people become immobilised. The person experiencing the early signs of distress has very little access to low level exploratory support or information. Family and friends often express concerns to their GP or other health professionals but again there are virtually no avenues open to them apart from referral to a Psychiatrist – usually some months and some miles away. Schools and colleges have nothing like the assessment, psychological or counselling tools that are needed to create a user friendly, easily accessible service for young people.

Voluntary sector information and Helpline services offer perhaps the most developed response but these too are limited to the provision of information-based support. Often a family member will be referred back to their GP.

The development of early intervention services (still in their infancy in Ireland) would go some way to enhancing the opportunity for recovery. To ensure a clear and effective recovery pathway also requires that a person can remain integrated fully in their local community with access to basic life resources such as an education, a job, an income, a home, friends and hobbies.

The partnership between the person experiencing the mental health issues and their mental health team, family and friends has to be equal and responsive. The family and wider community have to

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7   This section was written based on anecdotal information from Schizophrenia Ireland's members.

be considered as integral to the person's whole life and not just as backup support.

The segregation of a person's mental health from other routine physical health, family and social stresses is a significant contributor to an atmosphere of denial and isolation.

Recovery

Dr. William A. Anthony, Executive Director of the Center for Psychiatric Rehabilitation at Boston University defines recovery as being "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability."

To reduce the risk of suicide among people with schizophrenia and other severe mental illnesses, it is Schizophrenia Ireland's view that the notion of recovery must be the foundation of the mental health services. If we adopt the principle of recovery into our thinking, people with self-experience of severe mental illness will be encouraged to be hopeful. However, this will require a shift away from ideas like "cure" and "treatment" and a greater emphasis will need to be made on ideas such as self-determination, self-management and facilitation.

The recovery process is not characterised by staged recovery nor is it quantifiable in terms of objective success or failure. The recovery process is very individually based in contrast to current community models and it is essentially holistic. The role of the individual in his or her recovery is prominent. It must be understood that recovery is as personal and individualized as a life that is experienced by any citizen.

Recovery can be found in many forms. It can be framed as a process or as a model but in all instances it is structured to reflect the value and absolute importance of the needs of the person in recovery. The core philosophy associated with recovery is that recovery is not only possible but it is expected. It also emphasises the critical importance of the right of the individual to manage his or her own recovery from mental illness and emphasises the person in a holistic manner, addressing the multiplicity of needs faced by an individual.

Recovery is a mind set, a belief in the rights of everyone to a fair chance at achieving personal goals without judgement or bias. Much of this can be achieved with education. People, to develop themselves and to have an active and guiding role in their recovery, will need to have the time and space to consider their experience and its impact on them, to learn about the range of options available to them and then to have the opportunity to shape their future. When this happens early in their journey, it is at the heart of taking control of their future.

Recovery means different things to different people. For some it is an end to an experience of mental illness and distress, and for others a life long journey towards self-fulfilment and self-determination.

To reduce the risk of suicide among people with schizophrenia and other severe mental illnesses, it is Schizophrenia Ireland's view that the notion of recovery must be the foundation of the mental health services.

It is not an easily quantified process and as such is not attractive to any culture that values empirical and scientific risk assessment. What is important is the recognition that everyone has the potential to recover and the critical interactive role education, community based support and other services can have in fostering this process.

To have an effective recovery process, the predominant belief that only professionals can effectively contribute to mental wellness must shift to an attitude that respects the values and life experience of those experiencing mental health issues. The power and responsibility needs to be shared and shared with effective and timely safeguards. Recovery is not a panacea – rather it is a philosophy that respects the individual's right to achieve wellness on his or her own terms, in his or her own time.

Recovery is just another word until people recognise and use it in a context that gives it vigour and forces a richer and fuller understanding of the enormity of the human spirit.

In practical terms, and with regard to the development of supports and services, recovery can be described as two interdependent processes:
1   Spiritual recovery
2   Practical recovery

Spiritual recovery refers to a process of acceptance and personal growth and involves elements such as:
1   Ownership and self determination
2   The emotional process of accepting limits and capacities
3   Hope and optimism
4   Sense of self and self worth
5   Renewed values and purpose
6   Belief and faith

Practical recovery refers to dealing with real life issues such as:
1   Ownership and self determination
2   Knowing and managing one's illness
3   The practical process of accepting limits and capacities
4   Realistic goal setting
5   Positive thinking
6   Taking responsibility and control
7   Seeking and using supports
8   Meeting new challenges

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Mental Health Services

In setting out a strategy for action in the area of suicide prevention, mental health services need to be re-oriented towards partnership and recovery. Recovery should be the objective.

Our mental health services are not currently equipped to respond to the whole life experience of its users, their families and friends. Document after document, report after report point to the lack of basic elements for the enhancement of life, the belief in recovery and the possibility of a better future.

In the last three years many regional health boards have reviewed their services and produced blueprints for the futures. All of these future ideals include:
- A person centred service
- Integrated community supports
- Crises outreach services
- Availability of counselling and or psychological supports
- Dedicated community rehabilitation programmes

We would also suggest the necessity to add:
- Choice
- Partnership
- Hope
- Soul (Spirituality)

If we are really serious about reducing the number of suicides in Ireland we need to listen to voices of change. People must be enabled to and allowed to be an active participant in their own recovery. The presumption that "we know best" and the inevitable prescription of a medication based solution only places the individual experience in a powerless situation which diminishes the opportunity for their own resources to be utilised.

As well as educating people about the outward signs indicating an intention to suicide, we must also examine the whole life experience of the person. Classically, people who have experienced psychosis will take their own lives just when they appear to be getting better. Anecdotal evidence would suggest that some people simply cannot face the prospect of a continual struggle with their own symptoms. Coupled with this, the mental health services and society generally do not provide the supportive and empathetic engagement necessary for people to experience symptoms while still having hope.

Funding

It is possible to argue that one of the most stigmatising actions by the State is the failure to provide increased funding for the mental health services over the last ten years. Health Boards and mental health professionals have been consistently expressing the desire to change the approach to service

If suicide prevention is to be prioritised adequately within the planning of services, a strong ethos of spending more time with clients as well as family members needs to be developed and fostered.

provision. Their efforts, however, have been significantly undermined by the lack of Government investment.

To achieve quality of services, increased funding for mental healthcare is necessary. According to the World Health Organization (WHO), "People with mental health problems have to cope with stigma, exclusion, taboo, and refusal by their society to recognize the real cost of mental disorders and mental health. This is reflected in an inappropriate allocation of financial and human resources."[8] In Ireland, mental healthcare as a proportion of the overall healthcare budget has dropped from 10.6% in 1990, to just 6.8% in 2003.[9]

Planning

Mental health services need to be less function orientated and more person-centred. It is essential that the mental healthcare services be organised in such a way where professionals are able to give adequate time to spend with service users. If suicide prevention is to be prioritised adequately within the planning of services, a strong ethos of spending more time with clients as well as family members needs to be developed and fostered.

It is also essential that people with self-experience of severe mental illness and family members are part of the central decision-making process and are directly involved on an on-going basis in the development of a national strategy for action on suicide prevention. It must be recognised that people with self-experience and family members are experts through experience. Without this specific involvement, any new suicide prevention strategy will be lacking the authority of genuine personal experience. In order to implement this, resources must be invested in capacity-building and on-going support for service user and family member representatives within decision-making bodies.

Mental Health Promotion and Early Intervention

Mental health promotion is a central component of successful early intervention strategies and can significantly reduce the disability felt by those experiencing a psychosis related experience.

The benefits to the individual (in terms of health, well being and quality of life gains), the family and the state (in terms of economics) are well documented and in need of urgent investment. According to the WHO, early identification and appropriate treatment of mental disorders is an extremely important suicide prevention strategy.[10] Early intervention and identification programmes must be the norm in mental healthcare services nationally. The shorter the period of time between initial presentation and diagnosis, the greater the long-term prognosis for a sustained recovery.

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8   World Health Organization (WHO) Regional Office for Europe, (2003).

9   Mental Health Commission Annual Report, (2002), p. 22.

10   "Preventing Suicide: A Resource for Primary Health Care Workers", World Health Organization (WHO), Mental and Behavioural Disorders Department of Mental Health, 2000.

Information

Anecdotal experiences and a great deal of research demonstrate that the provision of accurate, person specific, and timely information, provided in an appropriate form that can be personalised and utilised, is central to supporting the development of insight and recovery. Information, education and support should be offered throughout all stages of service delivery in a form that is easily understood, and should be offered to both people with self-experience and relatives. This should be seen as the beginning of an ongoing dialogue. Opportunities to return and discuss matters as people with self-experience and relatives see fit should be afforded.

Discharge Planning

Once a person has successfully engaged with the mental health services, the process towards a resumption of independent or supported living must be actively considered. At all times, service providers, whether in a hospital or community setting need to be alert to the ongoing whole life concerns and needs of the individual.

Leaving acute care services can be a particularly vulnerable time for people, and evidence suggests that at this time they are at a higher risk for suicide. In light of this, it is fundamental that everyone should have a comprehensive discharge plan that has been agreed on in consultation with the person themselves, family members and all other relevant individuals. Community services and the GP should receive a copy of the discharge plan. Appropriate accommodation must be part of the discharge plan, and it is unacceptable to place people in temporary, short-term emergency accommodation.[11]

According to the New Zealand Ministry of Health,

> Discharge planning is a formal process that leads to the development of an ongoing, individualised programme of care and support which meets the objectively assessed needs of a patient/consumer on leaving hospital. It addresses the social, cultural, therapeutic and educational interventions necessary to safeguard and enhance that person's health and well being in the community. Discharge planning involves the patient, family…the treatment team, and other service providers. It is required when a patient leaves any inpatient facility, and it is particularly important in the case of patients with mental health disorders (including substance abuse) who have been in hospitals suffering from chronic mental illnesses with residual psychiatric disability.[12]

While the phrase "Discharge planning" has its merits, it also serves to heighten the dislocation and disruption that has occurred. The reasons why a person is deemed to be in need of hospitalisation may not have disappeared just because their "symptoms" have been reduced or eliminated.

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11 Such as bed and breakfasts, emergency shelters and homeless shelters.
12 New Zealand Ministry of Health, "Guidelines for Discharge Planning for People with Mental Illness", 1993.

Appropriate housing, meaningful occupation, access to money and supports will not necessarily have resolved themselves while the person has been withdrawn from daily coping. Without taking a comprehensive account of a person's whole circumstances, the opportunity for improved health and living in the community will be at serious risk of failure. Discharge planning must be viewed as a fundamental right of each person upon leaving hospital – and a cornerstone in the process of his or her recovery.

Meaningful Occupation

The occupational needs of people with self-experience of mental illness vary greatly from individual to individual and will change through the experience of his/her recovery. There is need for a range of meaningful occupational options both work based [13] and non-work based.

Living and Accommodation

Housing is a major cause of stress amongst people with self-experience of mental illness. Of particular concern are levels of homelessness and the high cost, uncertain tenure and poor conditions found in the private rented sector. Additionally, many people with severe mental illness find themselves having to remain in the family home beyond a time that is of their choosing.

Through Schizophrenia Ireland's contact with people with self-experience and relatives, housing is often cited as their most serious concern. Increased provisions for accommodation is paramount along with greater flexibility to meet the current needs.

SI recommends that:

1   Adequate levels of accommodation are needed which should be community based and supported at an appropriate level for the individual.
2   Supports need to include community based life skills training and development (as opposed to centre based training).
3   It should be acknowledged that some people might always require some degree of supported accommodation.
4   There is a need for a range of social housing to facilitate people who no longer require supported housing.

The Way Forward

Promoting Hope

"Do they (mental health professionals) not understand the fear we all feel?" This is a relative speaking at a support group meeting in the Dublin area. Her son, who had previously attempted suicide, was

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13   In general, SI supports the recommendations of the NCATE report (1997).

again expressing suicidal thoughts. He, with the help of his mother, sought an early appointment with his psychiatrist. Due to a technicality, he waited nearly two weeks for that appointment. Nothing was offered apart from a change in medication.

The fear surrounding mental health issues is profound. It takes many forms within the person themselves and within their family. The general public often associates mental illness with violence and, unfortunately, the media often supports this misconception.

It is not possible – indeed it might not be desirable – to eliminate fear totally. The degree of distress that people currently have to endure, however, is unsupportable. Basic one to one communication about options, medication and treatment plans enables people to begin to take ownership of their own situation. A range of expertise available to support different issues at different times strengthens a person's coping skills. Critical to this process, however, is a change in ethos on behalf of the mental health services. Services need to promote a person-centred approach whereby professionals spend more time talking with the person and their family. The participation of family and friends sustains and strengthens a crucial network.

These basic elements of information, communication and education are often not available at the time or in the way that people can easily use them. Education programmes for individuals and families are not available in many health regions. Social welfare advice and support is frequently not available, sometimes resulting in people losing their home or getting into debt while they are in hospital.

The prejudice, isolation and lack of services that people experience sometimes creates an unrelenting pressure of hopelessness that overwhelms the basic instinct to survive. If we allow people to be equal and active participants in their own health they will be enabled, over time, to describe and implement a recovery model that suits them. It will enable people to choose partners, groups, medications, that reinforce their individuality while keeping their natural networks and supports intact.

The maintenance of good mental health is different for all of us but there is no doubt that a sense of hope in the future, of belonging, of value to our lives are all essential ingredients.

Policy Implications

According to the WHO, the prevention of suicide and suicide behaviour is today one of the main public health concerns in Europe. This is most certainly true for Ireland. Suicide and attempted suicide are serious public health problems, necessitating everyone's attention. Nonetheless, the prevention of suicide is not an easy task and requires comprehensive policy measures, particularly in

If we allow people to be equal and active participants in their own health they will be enabled, over time, to describe and implement a recovery model that suits them.

the area of mental health.[14]

At a meeting in Helsinki in January 2005, the 'Mental Health Declaration for Europe' and the 'Mental Health Action Plan for Europe' were endorsed by the Ministers of Health of the 52 member states in the European region of the World Health Organization, including Ireland. In the 'Mental Health Declaration for Europe', each signatory undertook the responsibility to address suicide prevention. The document also indicated that the signatories would "support nongovernmental organizations active in the mental health field…We particularly welcome organizations active in: Running help lines and internet counselling for people in crisis situations suffering from violence or at risk of suicide."

In the 'Mental Health Action Plan for Europe', the signatories committed to working towards the prevention of mental health problems and suicide. Specifically, the plan urges signatories to consider increasing the awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.

It is hoped that Ireland will fully explore all possibilities to fulfil these undertakings. Schizophrenia Ireland calls on Government to continue working with and strengthening its partnership with mental health and related NGOs to better consolidate efforts in the area of suicide prevention. Furthermore, it is recommended that Government coordinate national awareness raising activities around suicide prevention and mental health, such as the Scottish 'See Me' campaign[15], which is a good example of a model aiming to stop the stigma of mental ill health.

The President's Forum

On 2nd March 2005, President Mary McAleese organised a forum to examine possible ways to reduce the number of suicides in Ireland.

A summary of the report, "Suicide in Ireland – Everybody's Problem" collated the following specific recommendations by the forum's participants [16]:

■ Complete, publish, and implement as a matter of priority, the National Strategy for Action on Suicide Prevention
■ Move towards creating a co-ordinating structure within the Social Partnership model
■ Establish a leadership structure linked to government to co-ordinate, resource and administer the work of suicide prevention
■ Support community groups and voluntary agencies in forming linkages and arriving at a greater

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14 World Health Organization (WHO). Suicide Prevention in Europe: The WHO European monitoring survey on national suicide prevention programmes and strategies. Copenhagen: WHO; 2002, p. i.
15 www.seemescotland.org
16 Suicide in Ireland – Everybody's Problem: A summary of the Forum for Integration and Partnership of Stakeholders in Suicide Prevention, held at Áras an Uachtaráin, March 2nd 2005, Dr Tony Bates, Rapporteur.

mutual awareness
- Develop and resource safe, accessible and user friendly mental health services where relevant expertise is available on a 24/7 basis
- Support research into the range of issues across society that contribute to suicidal behaviour
- Consider a major media campaign to promote positive mental and emotional health and challenge the stigma surrounding mental distress

Notably the report calls for,

> "a structure [to] be developed which would extend beyond the concern of any one Government department, and be inclusive of the broad range of stakeholders who have a key role to play in responding to local and all-Ireland community needs. Such a co-ordinating structure would build on the learning from the President's forum and might best be developed on the basis of a Social Partnership model".

Schizophrenia Ireland supports all of these recommendations, particularly the creation of a national authority [17] to coordinate work in the area of suicide prevention and development of safe, accessible and user-friendly mental health services available on a 24 hours a day, seven days a week basis that are adequately resourced.

In relation to research, Schizophrenia Ireland particularly supports the recommendations made in the President's forum. The Mental Health Commission acknowledges that there is need for evaluation of models and dissemination of best practice.[18] Better information about the prevalence of mental illness in those who died by suicide, assessment of needs for treatment and rehabilitation, and processes and outcomes of treatment/rehabilitation are essential. According to the WHO, "even if the problem of suicide has to been seen in a comprehensive context of despair, helplessness and depression, resulting in self-destructive behaviour and lifestyles, data on suicide as such are of the utmost importance." [19]

Without urgent action to address information gaps, the development of responses to suicide prevention will continue to be piecemeal, inconsistent and inadequate to need. This is relevant not only in the area of mental health services, but also in developing broader social policy, particularly for people with self-experience of mental illness, of whom there are currently no accurate statistics.

The National Strategy for Action on Suicide Prevention
As we look forward to the publishing of the National Strategy for Action on Suicide Prevention this

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17 It is critical that such a national coordinating authority would work in close cooperation with the Mental Health Commission and voluntary organisations.
18 MHC Annual Report 2002.
19 World Health Organization (WHO). Suicide Prevention in Europe: The WHO European monitoring survey on national suicide prevention programmes and strategies. Copenhagen: WHO; 2002, p. i.

The national strategy for action on suicide prevention has an opportunity to build upon the increasingly shared conviction that suicide prevention must be approached holistically, taking into consideration the needs of all members of society.

autumn, it is hoped that the strategy will reflect both a healthcare approach as well as a public health approach. According to the WHO, both strategies should be combined for optimal impact with regards to suicide prevention strategies.[20]

Above all, however, the national strategy for action on suicide prevention needs to reflect the true lived experiences of people. It must focus on person-centred approaches and complexities, keeping in mind the simple idea that suicide is about ending the pain.

It will be necessary for everyone to play their part and those with policy responsibilities must be held accountable to ensure the full implementation of the recommendations set out in the strategy document. Schizophrenia Ireland urges Government and all those tasked by the strategy document to fully engage in the process without delay once it has been published.

Critical to the implementation of a national suicide prevention strategy is the necessity for cross-departmental cooperation working in partnership with communities, mental health service users and voluntary organisations. According to the World Health Organization (WHO), "suicide prevention requires intervention from outside the health sector and calls for an innovative, comprehensive multi-sectoral approach, including both health and non-health sectors."[21] For people with self-experience of schizophrenia, this is especially true, as their experiences of mental distress and social isolation can not be addressed solely through the conventional medical psychiatric model.

The national strategy for action on suicide prevention has an opportunity to build upon the increasingly shared conviction that suicide prevention must be approached holistically, taking into consideration the needs of all members of society.

The prevention of suicide should be an essential objective of Irish mental healthcare services. The achievement of this objective demands the full cooperation of government, health and social care services, professional and voluntary organisations and all of Irish society. It is important because life matters.

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20 World Health Organization (WHO). Suicide Prevention in Europe: The WHO European monitoring survey on national suicide prevention programmes and strategies. Copenhagen: WHO; 2002, p. 2.

21 World Health Organization (WHO), "The WHO Initiative for the Prevention of Suicide", 2003.

Dealing with Suicidal Thoughts and Depression

If you experience suicidal thoughts

Suicide is a very real risk for people who have self-experience of mental illness. If you experience suicidal thoughts yourself, there are a number of things you can do to tackle them.

- The most important action is to be open and confide in other people you trust or talk to a trusted health professional.
- If the thoughts are associated with depression, delusions or other symptoms, then a change in medication may help to get rid of them.
- Keep a list of people who you know you can telephone when you have suicidal thoughts.
- Also keep the numbers of 24 hour services that deal with these issues (Schizophrenia Ireland can give you a list of numbers).
- Make an agreement with one or more people that you will call them if you actually plan to attempt suicide.
- Remember that you do not have to act on your thought and that with time, they will pass.
- Tell your therapist a friend, a family member, or someone else who can help.
- Distance yourself from any means of suicide.
- Avoid alcohol and other drugs of abuse.
- Avoid doing things you're likely to fail at or find difficult until you're feeling better.
- Make a written schedule for yourself every day and stick to it no matter what.
- In your daily schedule don't forget to schedule at least two 30-minute periods for activities, which in the past have given you some pleasure.
- Take care of your physical health.
- Make sure you spend at least 30-minutes a day outside/in the sun.
- You may not feel very social but make yourself talk to other people.

Some of the Warning Signs of Suicide

Below is a list of some of the signs, which may indicate that someone is thinking of taking their life:

- Being withdrawn or unable to relate to people around them.
- Having definite ideas of how to kill themselves, and/or speaking of tidying up affairs or giving other indications of planning suicide.
- Talking about feeling isolated and lonely.
- Expressing feelings of failure, uselessness, hopelessness or loss of self-esteem.
- Constantly dwelling on problems for which there seem to be no solutions.
- Hearing voices, which may be instructing them to do something dangerous.
- Early morning waking and loss of appetite.

The most important action is to be open and confide in other people you trust or talk to a trusted health professional.

Remember, some of these warning signs/risk factors can be associated with everyday behaviour. Look at them in the context of the overall behaviour of the individual. It is also important to bear in mind that sometimes warning signs are not at all evident. However, the more warning signs/risk factors, the higher the risk.

Always stress to your relative or friend that their life is important to you and to others and that his or her suicide would be a tremendous and upsetting loss to you, not a relief. If suicide is attempted, contact the emergency services and phone someone to come and be with you.

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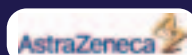T: 065 6844874
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