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26 January 2022

SUPPLEMENTARY PACK 2

ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) - **BY MS TEAMS** on **WEDNESDAY, 26 JANUARY 2022** at **1:00 PM**

I enclose herewith **item 6 (NHS HIGHLAND DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2021)** which was marked to follow on the Agenda for the above meeting.

ITEM TO FOLLOW

6. NHS HIGHLAND DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2021
(Pages 3 - 74)

Report by Director of Public Health

Argyll and Bute HSCP Integration Joint Board (IJB)

Contact: Hazel MacInnes Tel: 01546 604269

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The Annual Report of the **Director of Public Health**

NHS Highland

2021

Suicide and Mental Health

Acknowledgements and list of contributors

Thanks are due to the following colleagues for their contributions to this year's report:

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Contents

Introduction

This is my second annual report as Director of Public Health for NHS Highland. It is both a significant privilege and responsibility to be a Director of Public Health and presenting a report on the health of the local population is an important part of this. The report this year focuses on suicide. The consequences of suicide are enormous for the community and for individuals and I expect that almost everyone reading this report will have experienced the impact of suicide on their lives.

This report is not a comprehensive review of suicide as it relates to NHS Highland. The demands of COVID have meant that there is less time for undertaking other activities including work to prepare this annual report. There are issues that are not considered and initiatives that have not been included, and I do apologise to those who may feel that their concerns or work are not reflected appropriately. However, what this report does is highlight a range of different issues relating to suicide including epidemiology, mental health and illness, background influences and what is being done to improve mental health and reduce the rate of suicide. COVID has affected the writing of this report, but it is also a major influence on the mental wellbeing of the population of Highland and Argyll and Bute, and it is vital that we address the consequences.

Although this report is not comprehensive, I hope that it will be a stimulus for effective action on suicide in Highland and Argyll and Bute. The work to write this report has come from many people and I would like to offer them my thanks, especially as there have been so many pressing responsibilities within public health over the past year.

Reports are useless if they merely sit on shelves or these days in inboxes unread and if no one takes any actions on the recommendations. So please consider what the report means for you and others and please offer feedback on the report and recommendations.

Dr Tim Allison MD MRCP FFPH

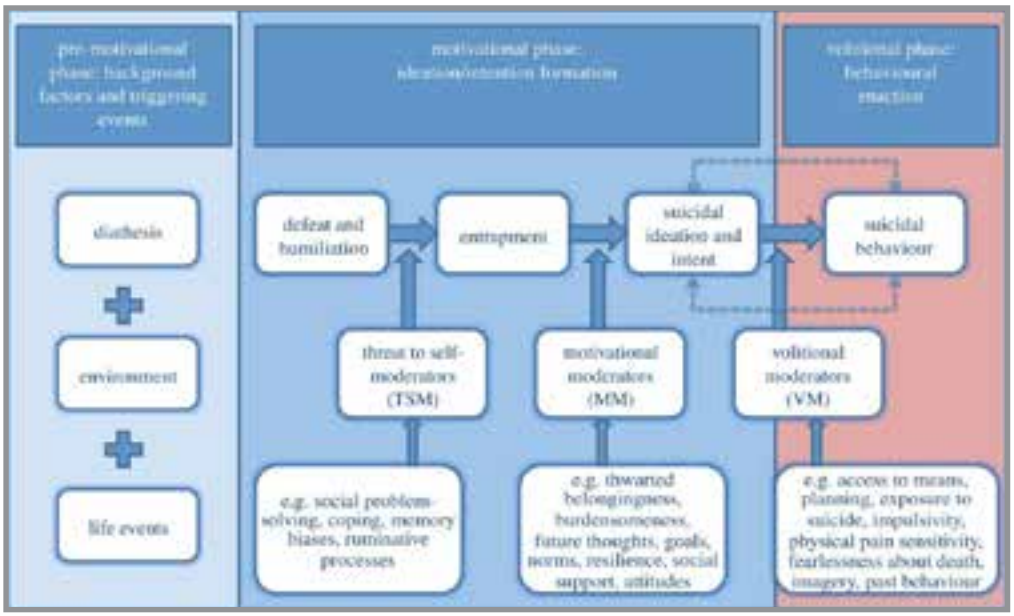
Director of Public Health and Health Policy, NHS Highland
Stiùriche na Slàinte Phoblach, Bòrd Slàinte na Gàidhealtachd

Chapter One - Key concepts in suicidal behaviour

Suicide is an important Public Health issue. In Scotland in 2020 there were 805 probable suicide deaths[1], 1.25% of all deaths[1,2]. As deaths from suicide often occur in younger people, the number of years of life lost compared to average life expectancy at the time of death were five times higher for suicide than for road traffic accidents[2].

There is no single explanation of why people die by suicide and there are many academic and other models of suicide and risk. One model, the Integrated Motivational Volitional (IMV) model of suicidal behaviour, is shown below (Figure 1.1)[3]. This model considers the life circumstances that may motivate a person to consider suicide and what could move those suicidal thoughts to action. The IMV recognises the cyclical nature of some suicidal behaviour and identifies previous suicidal or self-harming behaviour as an important risk factor.

Figure 1.1: The Integrated Motivational-Volitional Model of Suicidal Behaviour



Source: O'Connor R, Kirtley 0[3]

There are very substantial demographic and socio-economic inequalities in suicide risk. Suicide is more common in men than women, with men generally around three times more likely to die from suicide[2]. Mental illness substantially increases the risk of death by suicide[4,5,6] and most people who die by suicide are thought to have a mental illness at the time of their death[7,8,9].

Suicide rates are higher in people who live in deprived areas[1,10]. Adverse life events increase suicide risk[11] and previous exposure to traumatic events, including sexual and interpersonal violence also increases risk[12,13,14,15].

Some rural parts of Scotland have higher than average suicide rates[2,16] and some occupational groups, including some rural occupations such as farming and forestry have a higher proportion of deaths from suicide than average[10,17,18]. Occupational risk may be partly due to access to lethal means of self-harm, but low-paying jobs probably contribute[19].

A public health approach to suicide and suicidal behaviour is important and is widely regarded as the approach that is most likely to achieve sustained reductions in suicide[20,21].

A public health approach helps us understand the epidemiology, risk and protective factors for suicide both in the general population and in groups of people at elevated risk of suicide. It also helps us to understand how we can work to prevent suicide in the first instance and to improve support for those in crisis or bereaved. These themes for the population and communities of NHS Highland are explored throughout the rest of this report.

1 It is conventional to combine deaths by intentional self-harm with deaths of undetermined intent. Research indicates that most deaths of undetermined intent are likely to be suicides.

Chapter Two - Epidemiology of suicide and mental illness in Highland

In this chapter we describe the epidemiology of suicide in NHS Highland and consider suicide within the wider context of mental illness and self-harm.

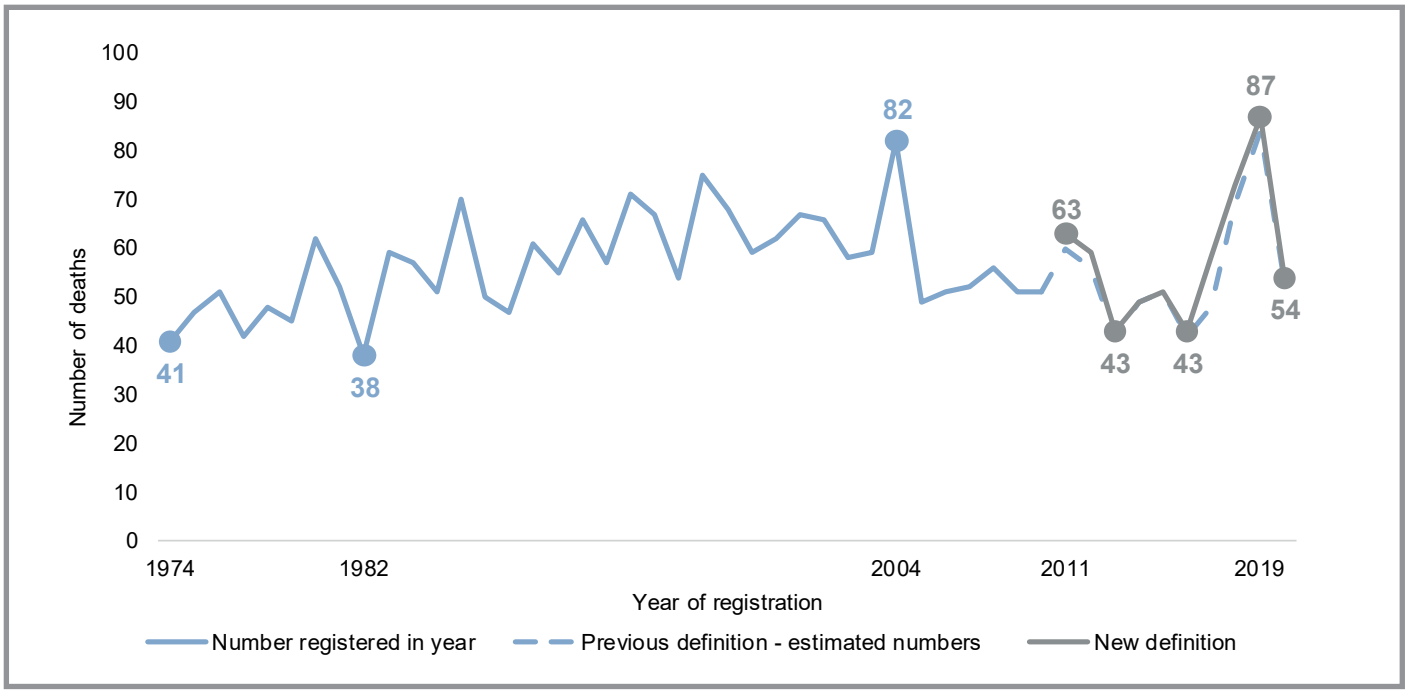
Deaths by probable suicide

This section summarises data on the number of deaths due to probable suicide (deaths from intentional self-harm or by events of undetermined intent) in the NHS Highland area from 1974 to 2020. When reporting suicide data it is standard practice to combine the numbers of deaths where the underlying cause was intentional self-harm and deaths where the intent was unknown (undetermined intent). This is because research indicates that many deaths where the intent is unknown are likely to be suicide[1,2]. The terms 'probable suicide' and 'suicide' are both used in this report.

There were 54 deaths recorded as a probable suicide in the NHS Highland area in 2020, compared to 87 in 2019. These figures are based upon new coding rules used by the National Records of Scotland (NRS) from 2011 onwards. The coding change results in some deaths that would have previously been reported under 'mental and behavioural disorders' now being classified as 'self-poisoning of undetermined intent' and therefore included in the combined total for deaths by probable suicide[1].

Figure 2.1 shows the number of deaths by suicide reported in NHS Highland from 2011 compared with the number of deaths estimated to have occurred had previous coding applied. NRS estimate that under old coding rules 53 deaths would have been reported in 2020 and 84 deaths in 2019. Given the similar number of annual deaths in NHS Highland under both definitions, data in this chapter are presented using the new definition of a probable suicide.

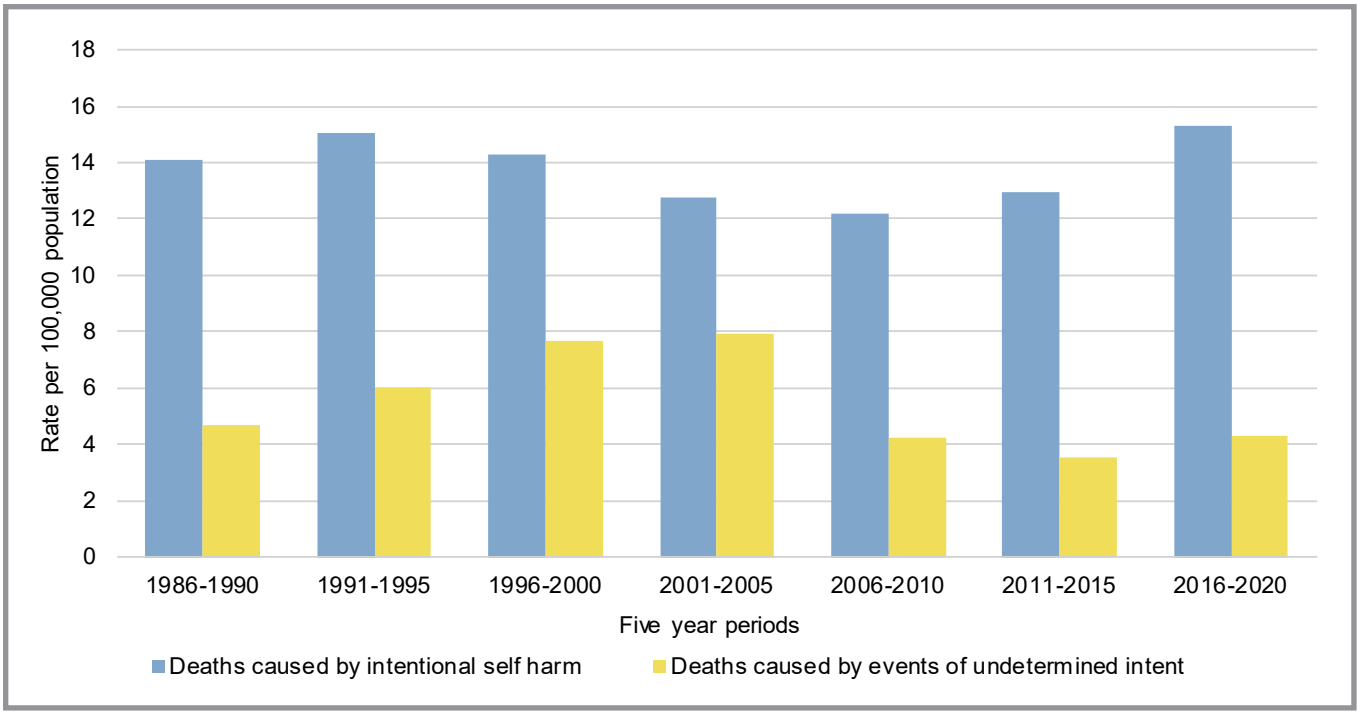
Figure 2.1: Number of probable suicide deaths reported in the NHS Highland area under old and new coding rules, 1974-2020



Source: National Records of Scotland[3]

In NHS Highland, undetermined intent deaths reached a peak in the years between 2001-2005. Deaths from intentional self-harm declined in the years between 2001-2010, but have increased in recent years (Figure 2.2).

Figure 2.2: Deaths for which the underlying cause was recorded as intentional self-harm or event of undetermined intent in NHS Highland, 1986-1990 to 2016-2020

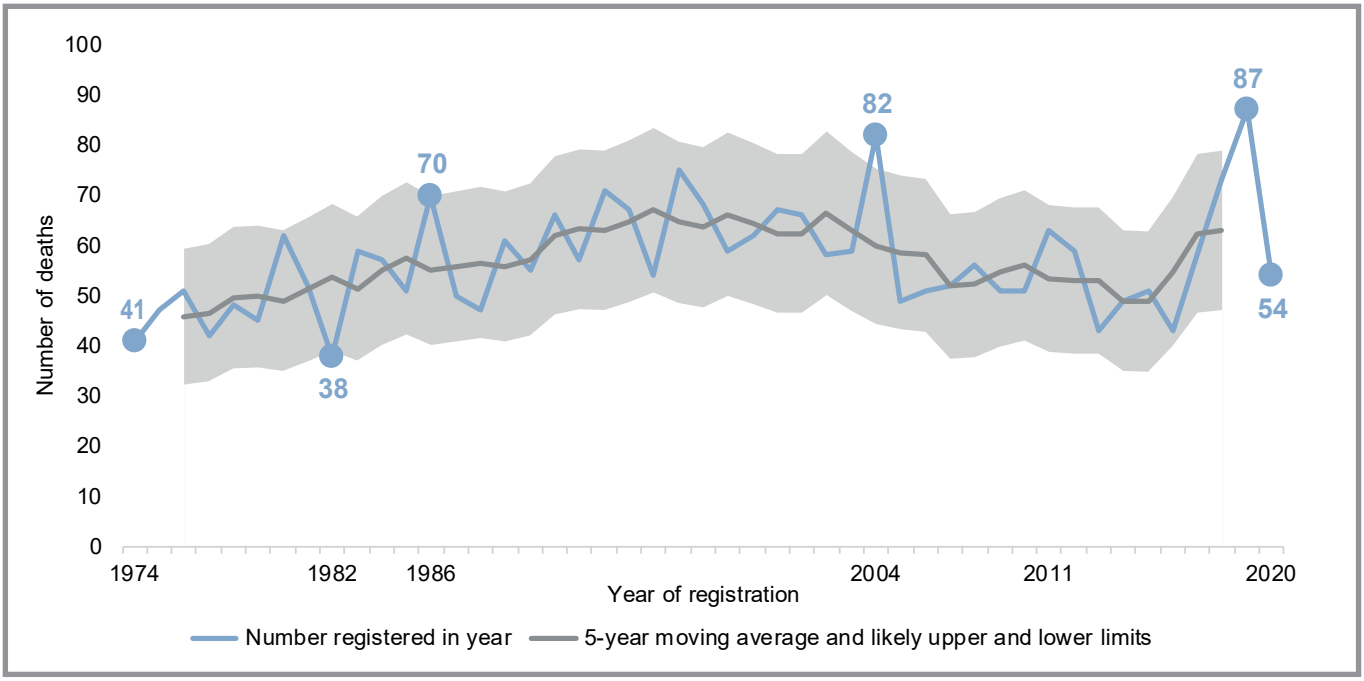


Source: National Records of Scotland vital events death recording

Number of Deaths by Suicide

Figure 2.3 shows the number of deaths by probable suicide recorded each year in the NHS Highland area. The numbers of deaths each year are subject to quite large annual variations so the five-year annual averages shown provide a more stable guide to the long-term trend.

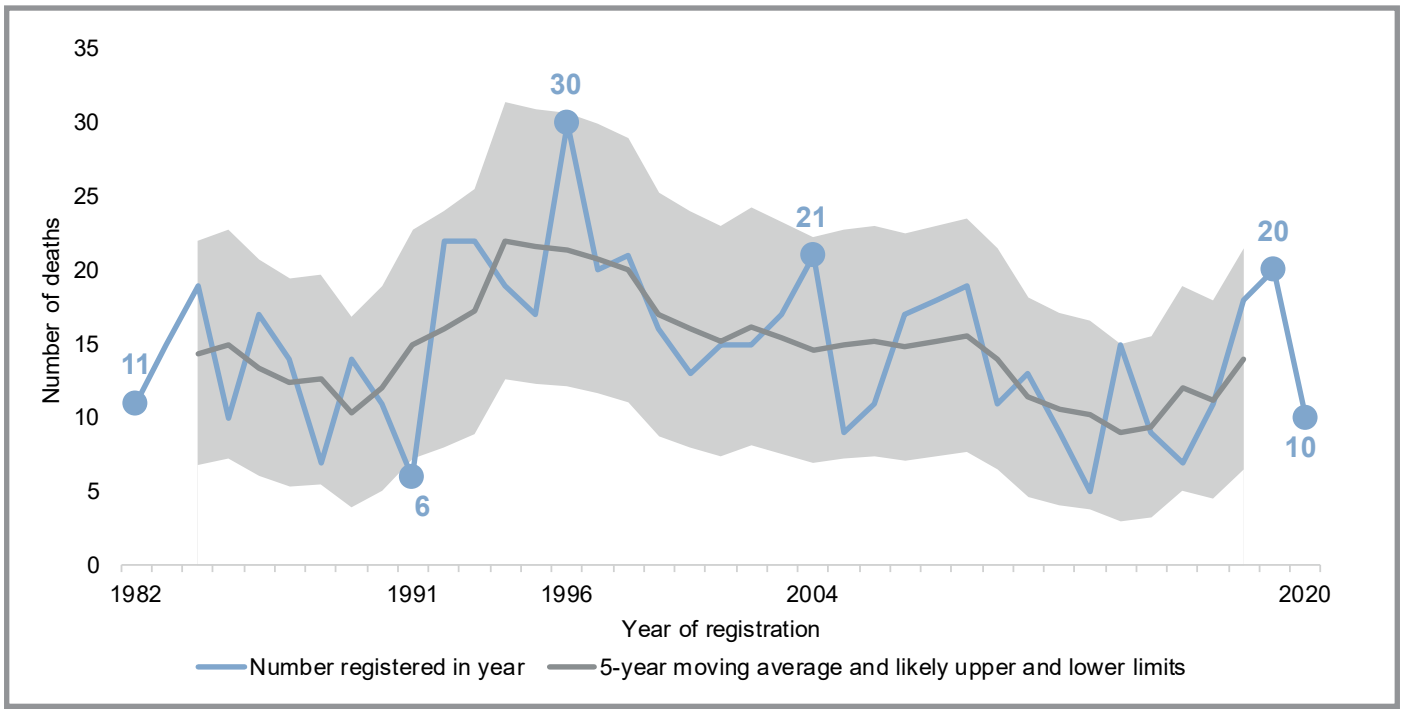
Figure 2.3: Number of deaths by probable suicide in NHS Highland, 1974-2020, with five-year moving averages



Source: National Records of Scotland[3]

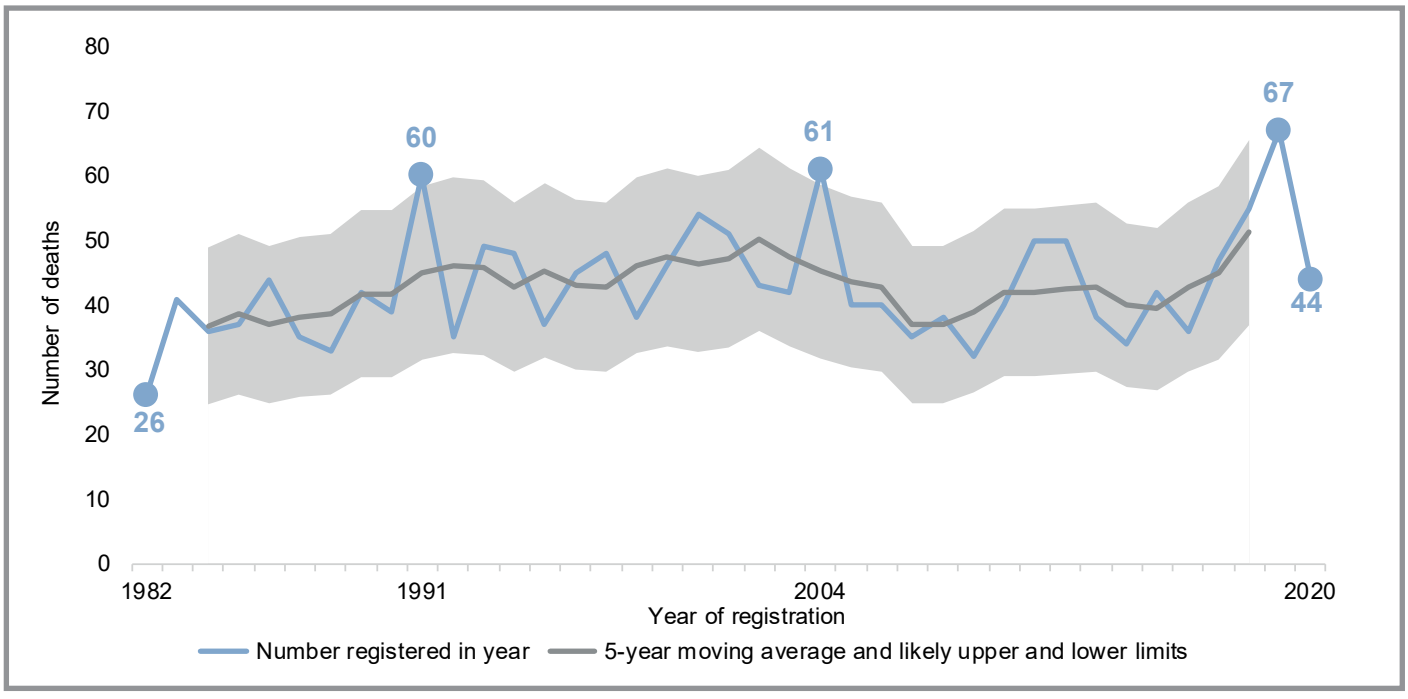
The same information is shown for the Argyll and Bute (Figure 2.4) and Highland (Figure 2.5) council areas. There were higher numbers of deaths in 2019 in both local authority areas.

Figure 2.4: Number of deaths by probable suicide in Argyll and Bute council area, 1982-2020, with five-year moving averages



Source: National Records of Scotland[3]

Figure 2.5: Number of deaths by probable suicide in Highland council area, 1982-2020, with five-year moving averages



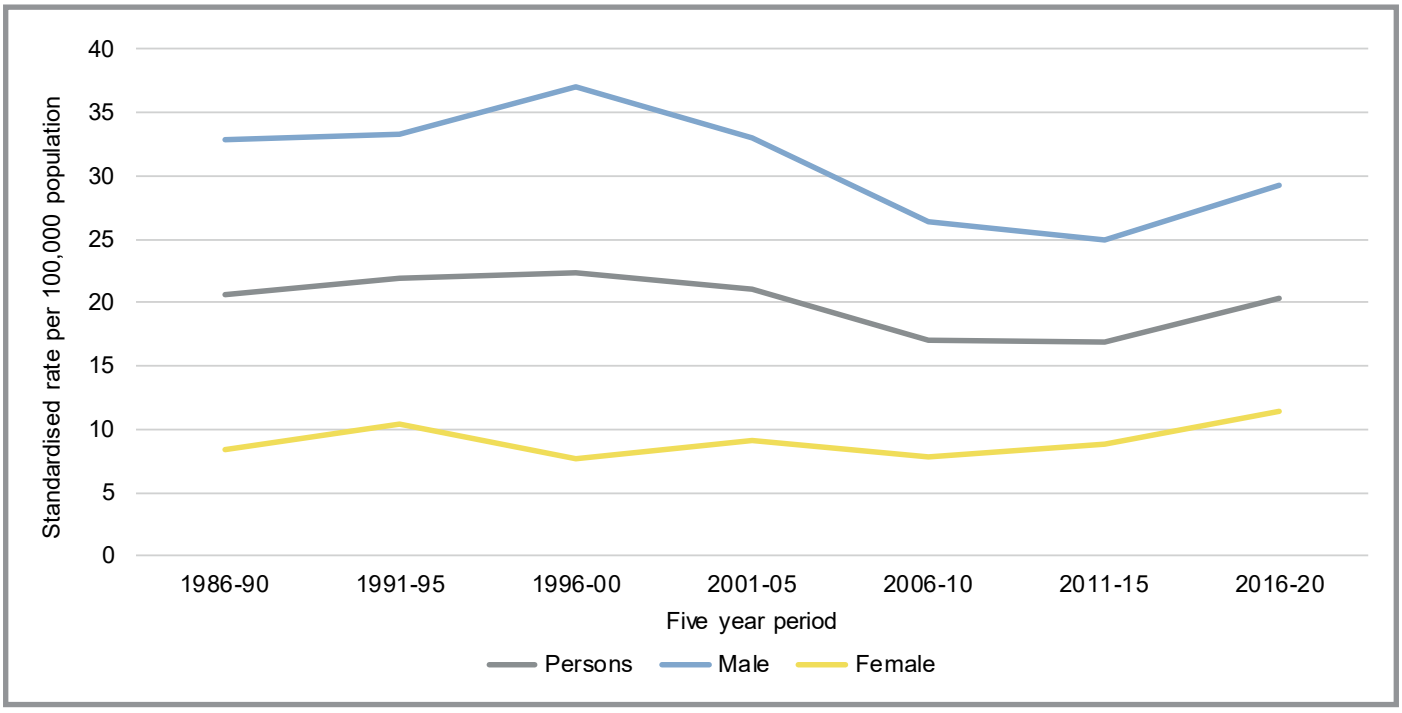
Source: National Records of Scotland[3]

Overall suicide rates

Figure 2.6 shows the trend in age-sex standardised suicide rates per 100,000 (among females, males and persons) for NHS Highland in five-year periods from 1986-1990 to 2016-2020. The age structure of the population has changed over this period and age-sex standardised rates are used to allow comparisons that are more reliable over time[4].

Suicide rates in males increased during the 1980's and 1990's before falling until 2011-15. Female rates changed less, but have increased in the last ten years. The overall age-sex standardised rate in 2016-2020 was 20.4 per 100,000 population and was higher than the figure in the previous five-year period of 18.9 per 100,000. For males, the age-standardised suicide rate was 29.2 per 100,000 in 2016-2020 compared to 25.0 in 2011-2015. For females, the age-standardised suicide rate was 11.5 per 100,000, higher than the rate seen in 2011-2015 (8.8 per 100,000). In 2016-2020, the age-standardised suicide rate for males was over two and half times higher than that for females.

Figure 2.6: Trend in suicide rates (persons, males and females) for NHS Highland, all ages, 1986-1990 to 2016-2020



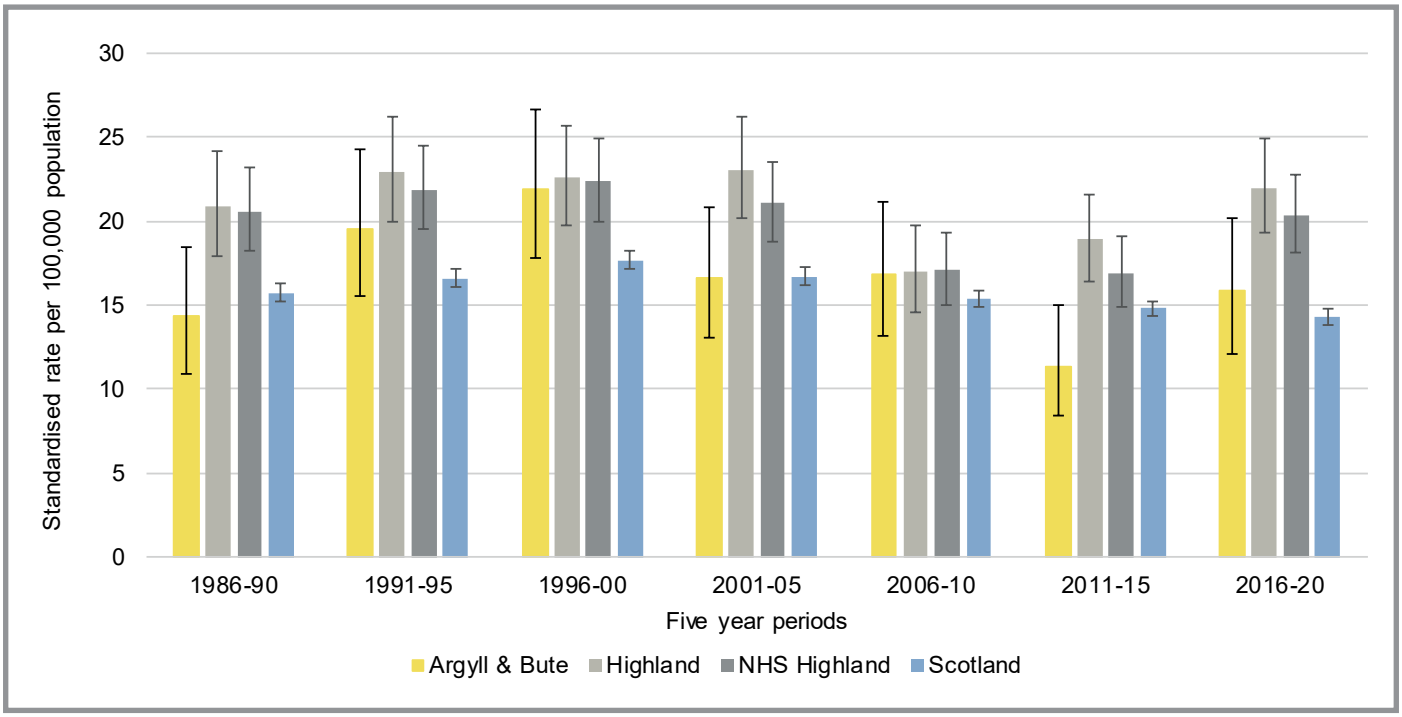
Source: Scottish Public Health Observatory[5]
Age-standardised suicide rates per 100,000 population, directly standardised to the 2013 European Standard Population. Rates for persons are age-sex standardised.

NHS Highland and NHS Tayside were the only two NHS Board areas that had significantly higher combined male and female suicide rates in 2016–2020 compared to Scotland as a whole.

Suicide rates by local authority area

Figure 2.7 shows the standardised suicide rates for local authority areas within NHS Highland in five-year periods. In 2016-2020, the Highland Council area had a statistically significantly higher rate than Scotland as a whole, 22.0 per 100,000 population compared to 14.3 per 100,000. The Argyll and Bute Council area rate (15.8 per 100,000) was higher than the Scottish average, but this difference was not statistically significant.

Figure 2.7: Age-sex standardised suicide rate for persons (all ages) by local authority area in NHS Highland, 1986-90 to 2016-20

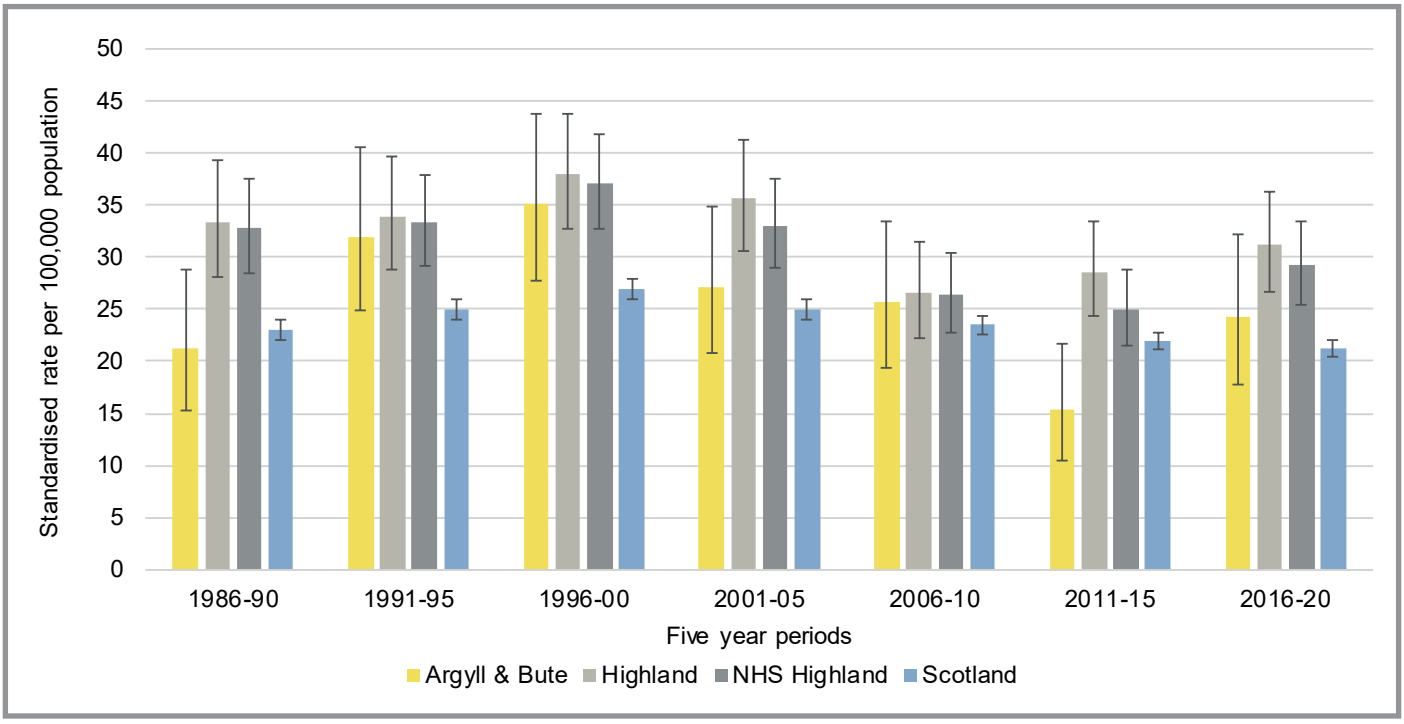


Source: Scottish Public Health Observatory[5,6]
Age-standardised suicide rates per 100,000 population, directly standardised to the 2013 European Standard Population. Rates for persons are age-sex standardised.

Looking at rates by local authority area, period and sex, the Highland Council age-standardised rate is significantly higher than Scotland for both men (Figure 2.8) and women (Figure 2.9) in 2016-2020. The Argyll and Bute male rate was higher than Scotland, but the difference was not statistically significant. The Highland Council male age standardised rate has been statistically significantly higher than Scotland in six of the previous seven five-year periods.

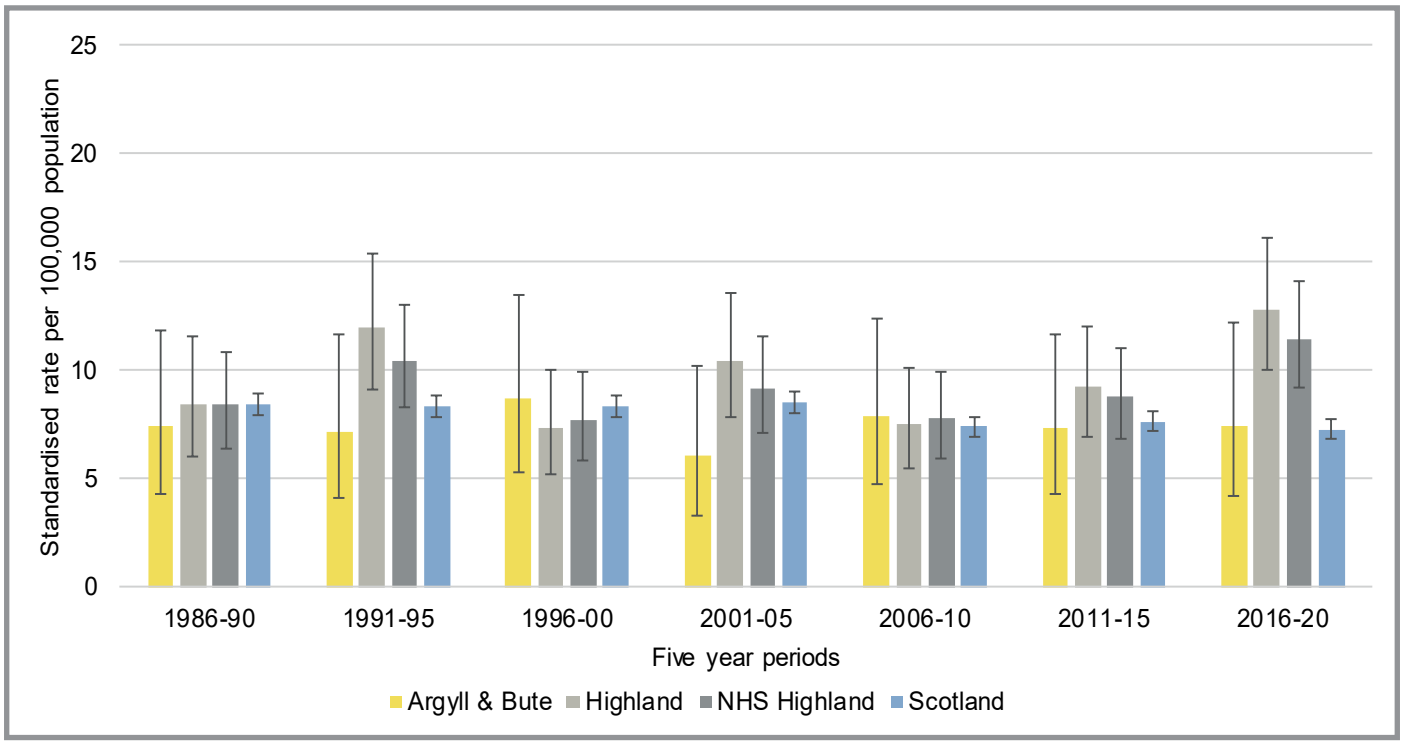
The Highland Council area female age standardised rate has been statistically significantly higher than Scotland in two of the last seven periods reviewed. The higher NHS Highland female rate in 2016-2020 is attributable to the higher female rates in the Highland Council area. Highland, Dundee City and Falkirk were the only local authority areas that had significantly higher rates of female deaths from suicide than the Scottish average in 2016-2020.

Figure 2.8: Age standardised suicide rate for males (all ages) by local authority area in NHS Highland, 1986-1990 to 2016-2020



Source: Scottish Public Health Observatory[6]
Age-standardised suicide rates per 100,000 population, directly standardised to the 2013 European Standard Population.

Figure 2.9: Age standardised suicide rate for females (all ages) by local authority area in NHS Highland, 1986-1990 to 2016-2020

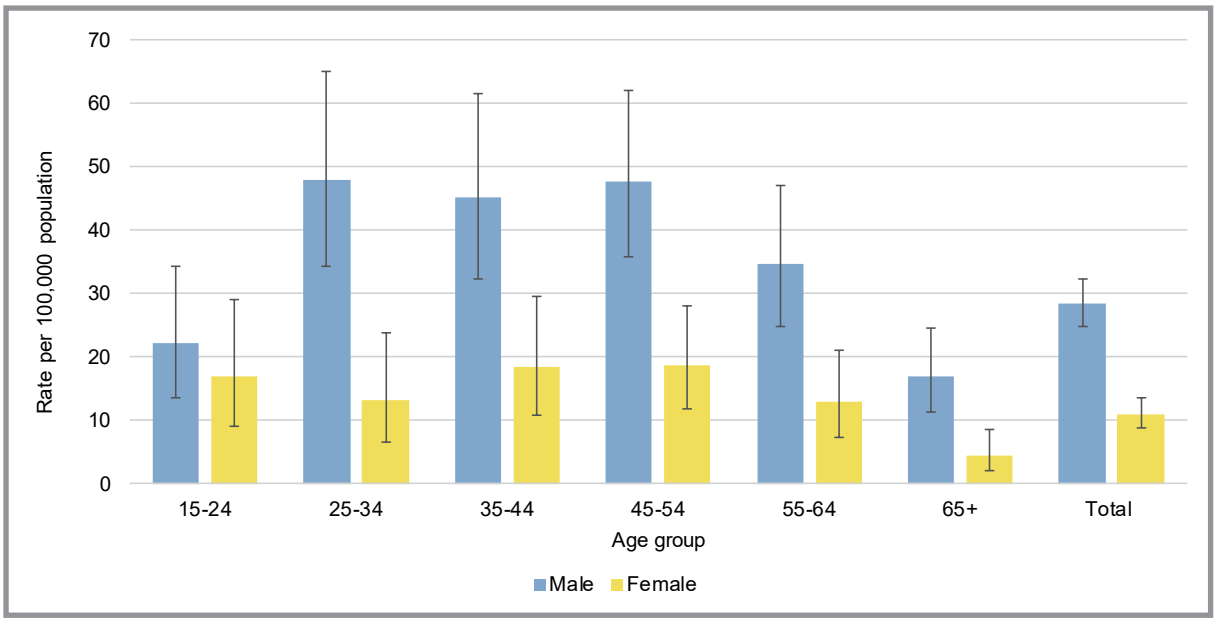


Source: Scottish Public Health Observatory[6]
Age-standardised suicide rates per 100,000 population, directly standardised to the 2013 European Standard Population.

Patterns by Age and Sex

Figure 2.10 shows the male and female suicide rate in the NHS Highland area by age for the five-year period 2016-2020. In this period, seven in ten deaths by probable suicide were among males (71.4%). Male suicide rates are higher in every age group, although the difference is smaller in 15–24 year old people. The differences are not statistically significant in every age group, but the pattern is very consistent.

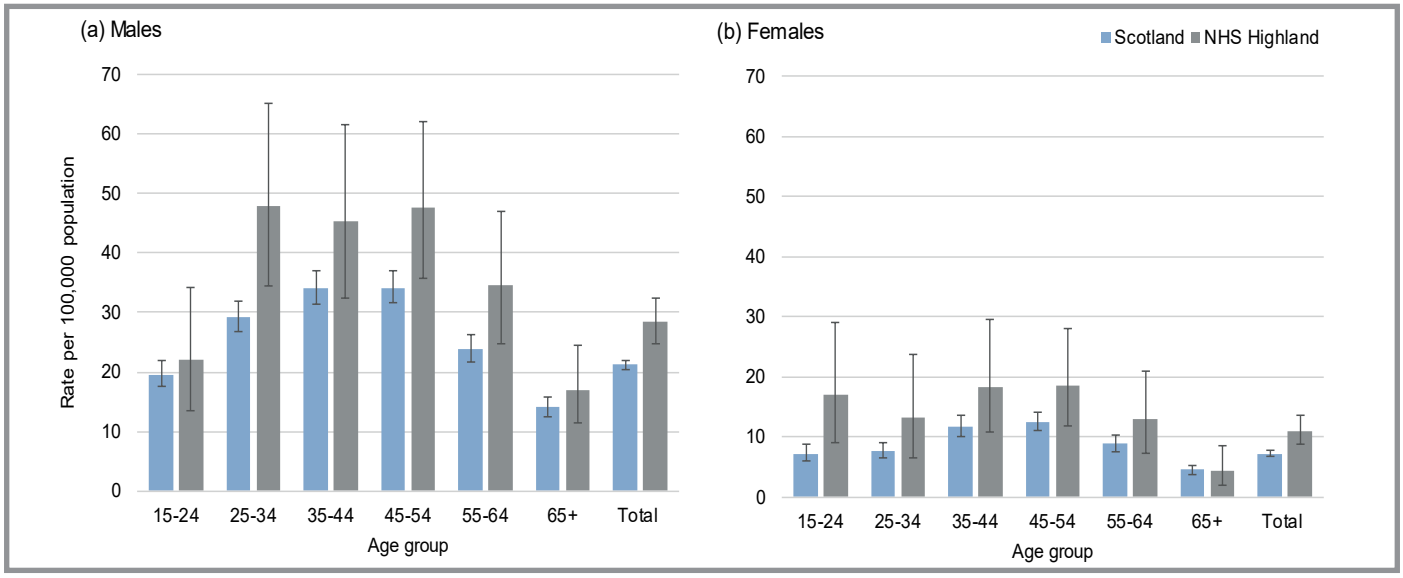
Figure 2.10: Age specific suicide rates in NHS Highland by sex and ten year age band, 2016-2020



Source: National Records of Scotland vital events death recording
Age-specific suicide rates per 100,000 population are calculated using the number of deaths divided by the estimated population for each age band and sex.

Figure 2.11 shows a comparison of age-specific suicide rates for males and females in NHS Highland and Scotland for the five-year period 2016-2020. Male rates are higher than for Scotland in all age groups, statistically significantly so for the age group 25-34 years. Female rates are higher than Scotland in every age group under 65 years of age. The rate in 15–24 year old women was more than double the Scottish average in 2016–2020.

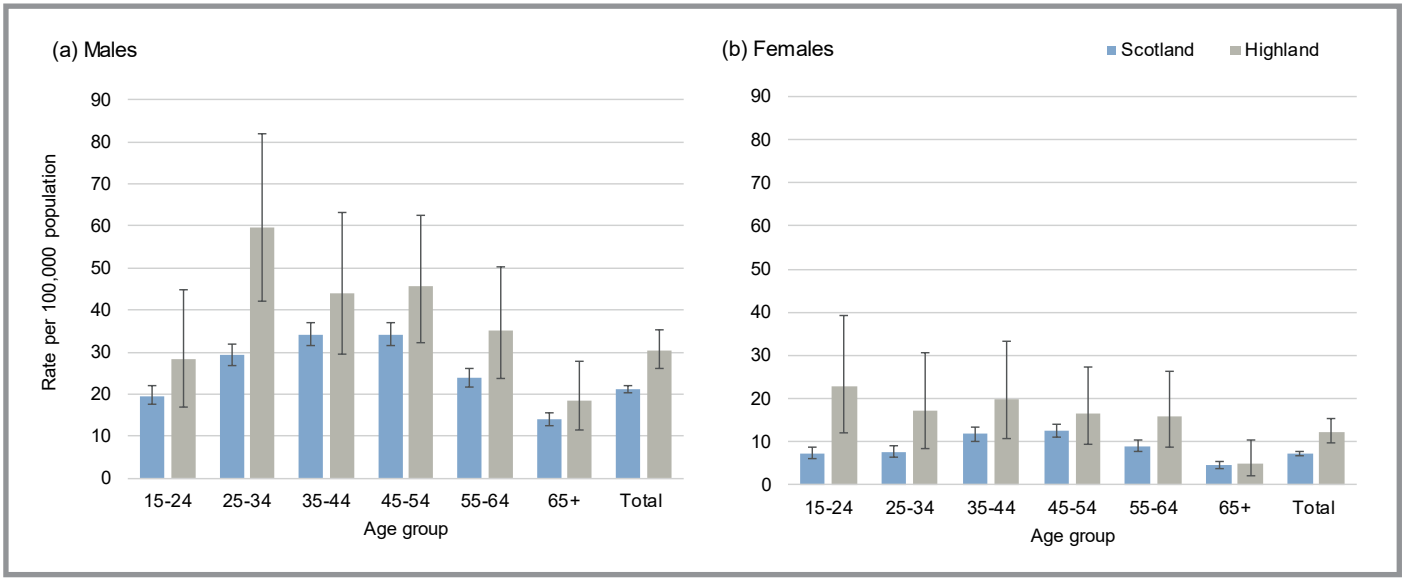
Figure 2.11: Age specific suicide rates for (a) males and (b) females in NHS Highland and Scotland, 2016-2020



Source: National Records of Scotland vital events death recording, National Records of Scotland[3]

Looking at Highland Council area rates alone, the age-specific rates and comparisons with Scotland are clear (Figure 2.12).

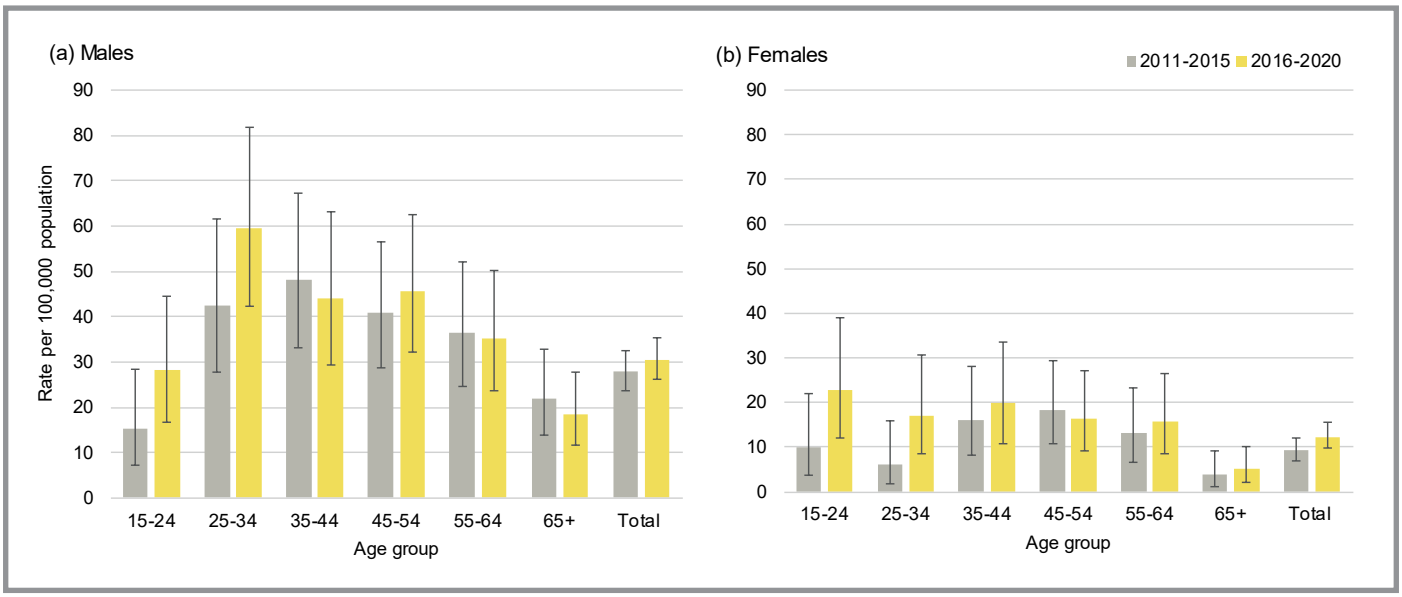
Figure 2.12: Age specific suicide rates for (a) males and (b) females in Highland Council area and Scotland, 2016-2020



Source: National Records of Scotland vital events death recording, National Records of Scotland[3]

Figure 2.13 compares age-specific suicide rates by sex in the Highland Council area in 2011-2015 and 2016-2020. Some age group rates were higher in 2016-2020 and there is no evidence of an improvement.

Figure 2.13: Age specific suicide rates for (a) males and (b) females in Highland Council area, 2011-2015 and 2016-2020



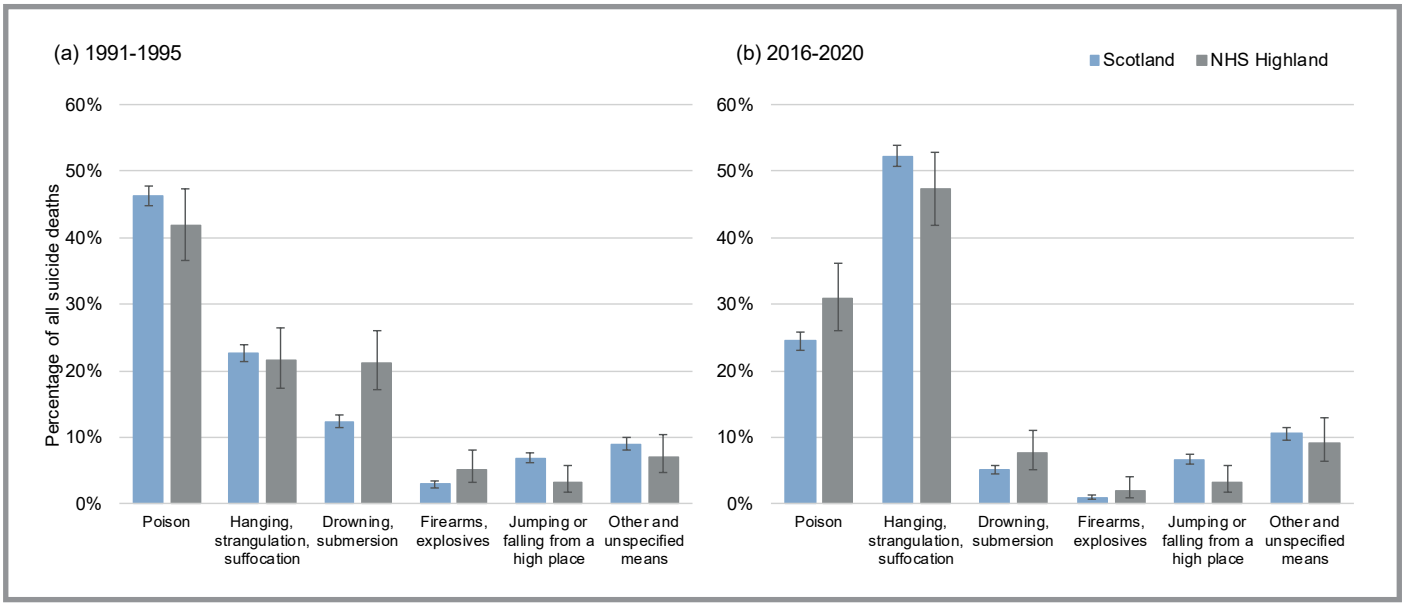
Source: National Records of Scotland vital events death recording

Method of suicide

Choice of suicide method is important, because some methods of self-harm are more likely to result in death[7,8]. Methods change over time[9], and media coverage can influence how people behave in a crisis and help to spread methods[10]. National reporting guidelines advise newspaper editors to not include the method of death in reports of deaths by suicide[9]. Restricting methods can reduce deaths, but it is very difficult to reduce access to some methods.

Figure 2.14 compares the proportion of suicide deaths by method of suicide in Scotland and NHS Highland in the five year periods 1991-1995 and 2016-2020. During 1991-1995, poisoning was the most common method of suicide in both areas. Deaths by drowning were statistically significantly higher in NHS Highland than in Scotland. By 2016-2020 this pattern had changed, with deaths by hanging, suffocation and strangulation the most common method. In NHS Highland, deaths by poisoning were statistically significantly higher compared to Scotland.

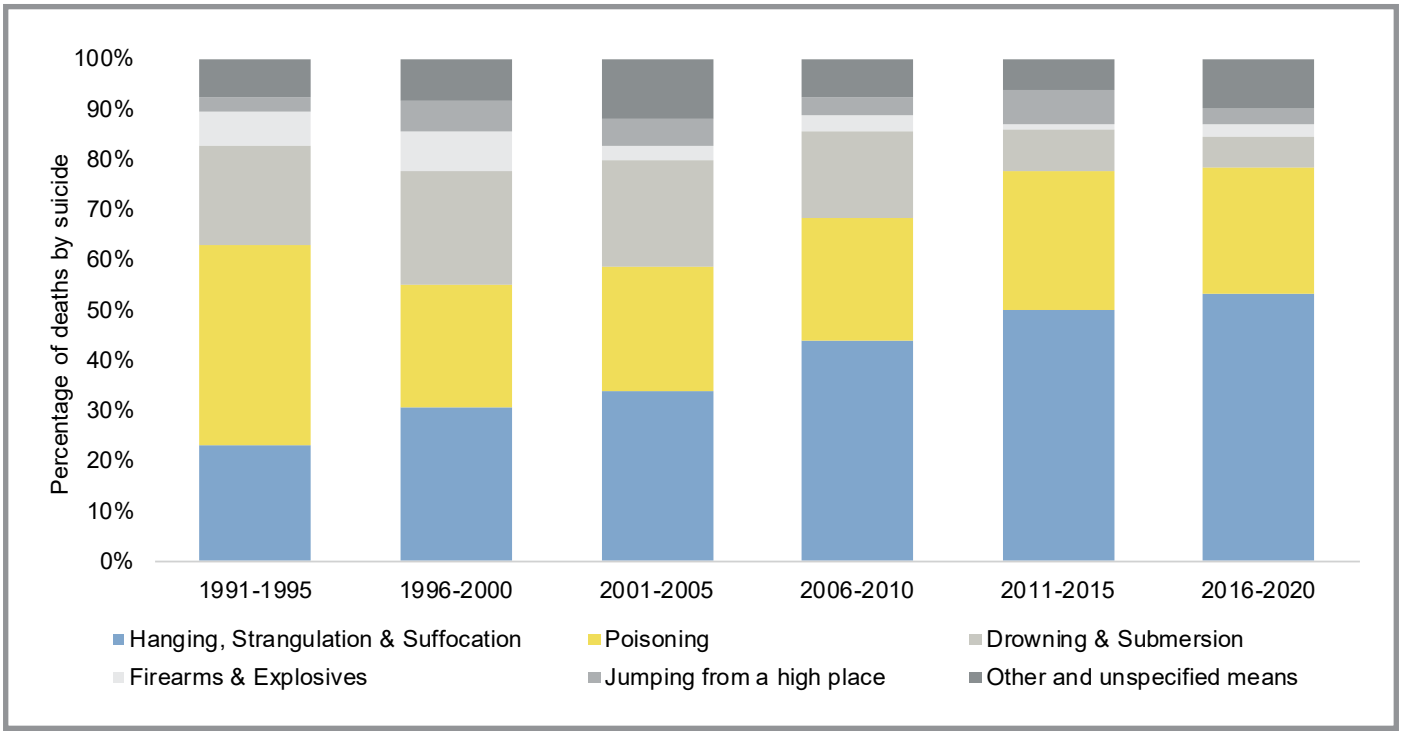
Figure 2.14: Proportion of deaths by probable suicide and method of suicide in NHS Highland and Scotland in (a) 1991-1995 and (b) 2016-2020



Source: National Records of Scotland vital events death recording, National Records of Scotland[3]

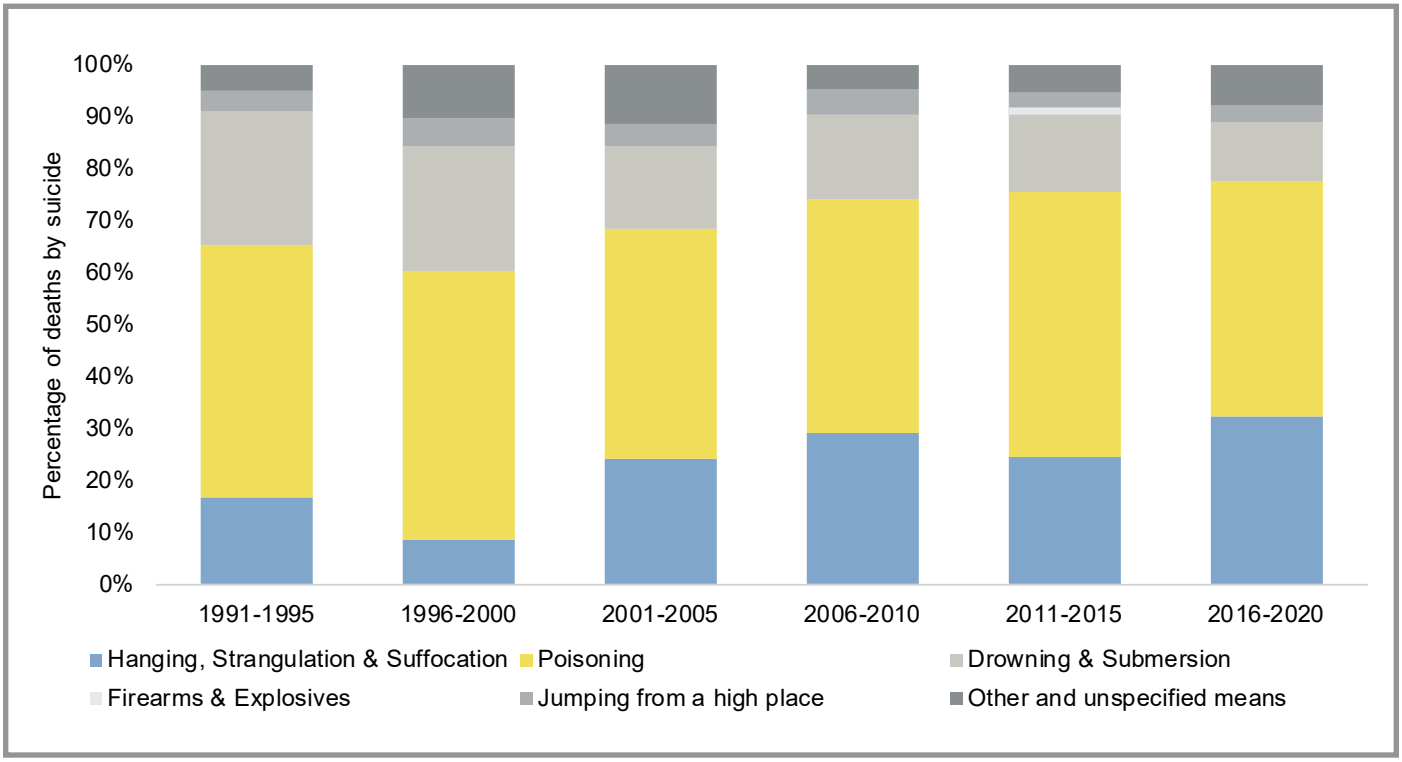
Changes in method over time in the NHS Highland area are shown for males (Figure 2.15) and females (Figure 2.16). Deaths by drowning have reduced in both sexes. Poisoning is a larger cause of death in women than in men. There are no marked differences in method of suicide in the Argyll and Bute or Highland Council areas.

Figure 2.15: Proportion of deaths by probable suicide and method of suicide for males in NHS Highland, 1991-1995 to 2016-2020



Source: National Records of Scotland vital events death recording

Figure 2.16: Proportion of deaths by probable suicide and method of suicide for females in NHS Highland, 1991-1995 to 2016-2020

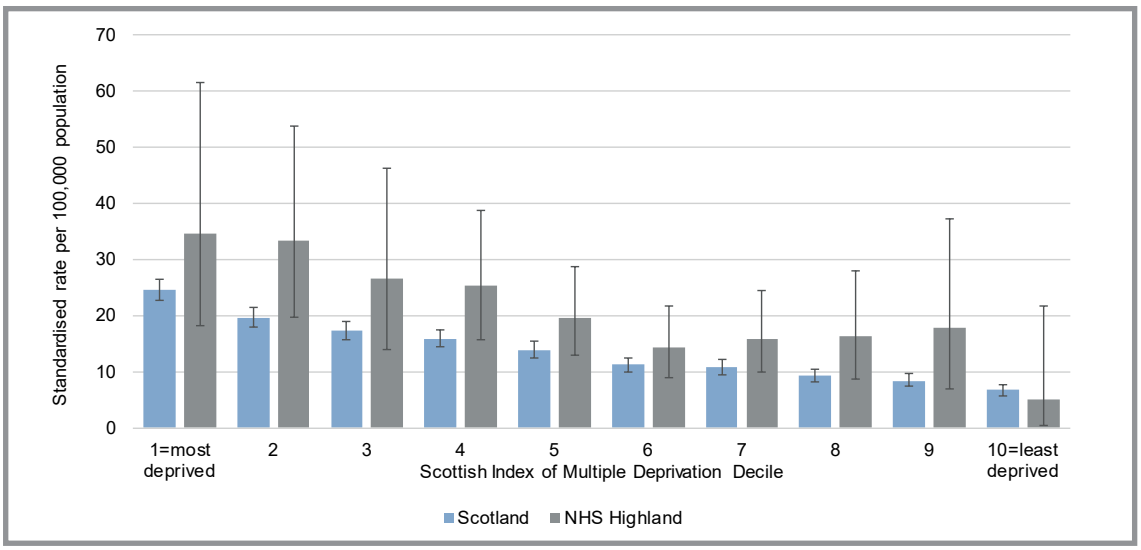


Source: National Records of Scotland vital events death recording

Deprivation

Figure 2.17 shows age-sex standardised rates for suicide by deprivation decile in NHS Highland and Scotland in the period 2016-2020. The deprivation gradient in NHS Highland is very clear, and has continued from previous reports on suicide in the NHS Highland area. Suicide rates in NHS Highland are higher in every deprivation level compared to Scotland except in the least deprived decile. The differences are not statistically significant but the pattern is very consistent.

Figure 2.17: Age-sex standardised suicide rate by Scottish Index of Multiple Deprivation deciles in NHS Highland and Scotland, 2016-2020

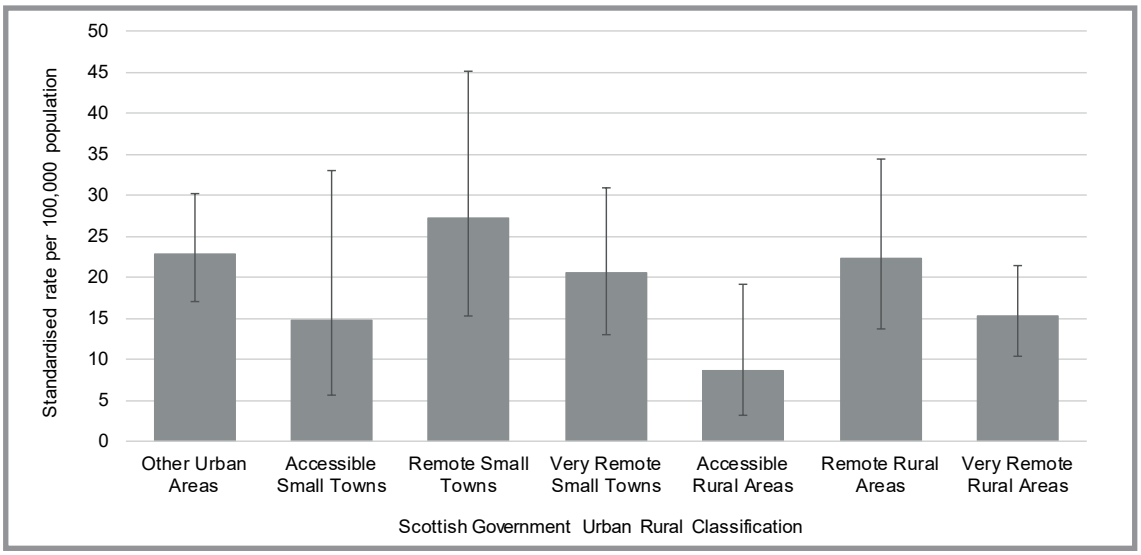


Source: National Records of Scotland vital events death recording, Scottish Public Health Observatory[11]
Calculated using the Scottish Index of Multiple Deprivation (SIMD) 2020 release. Scotland suicide rate based on old coding rules.

Urban-rural patterns

Figure 2.18 shows the pattern of suicide in urban and rural areas of NHS Highland in 2016-2020. Rates of suicide ranged from 27.2 per 100,000 population in remote small towns to 8.7 per 100,000 in accessible rural areas. The pattern of lower rates in accessible rural areas has been noted in previous Scottish work[12,13].

Figure 2.18: Age-sex standardised suicide rate by eight-fold 2016 urban rural classification in NHS Highland, 2016-2020



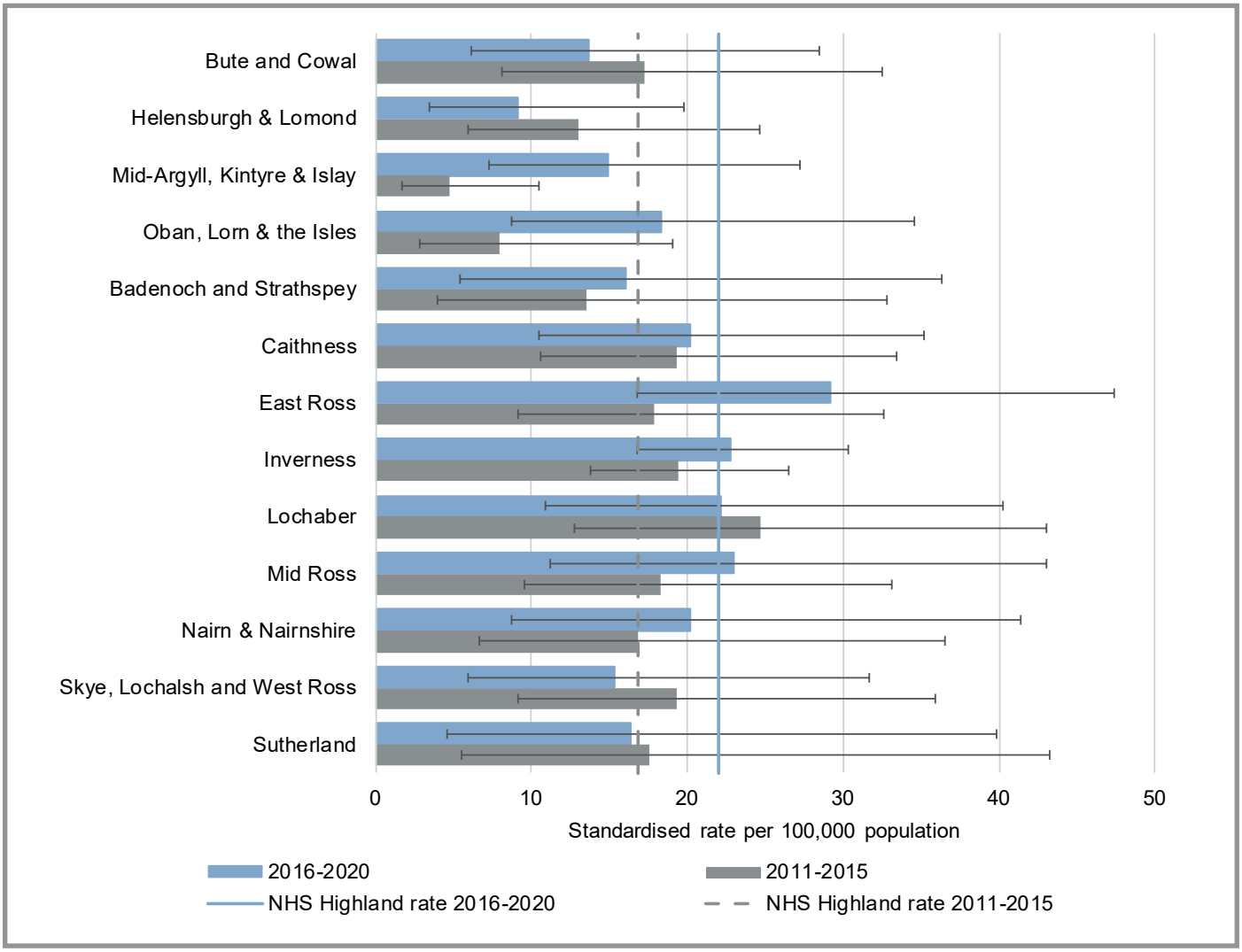
Source: National Records of Scotland vital events death recording
Based on Scottish Government Urban Rural Classification 2016

Geographical areas in NHS Highland

Small numbers of deaths make it difficult to be definitive about differences between areas within NHS Highland. Figure 2.19 demonstrates that areas in Argyll and Bute tend to have lower rates than areas in the Highland Council area.

In eight of thirteen areas, rates were higher in 2016–2020 than they had been in 2011-2015, notably so in East Ross. No area was statistically significantly higher than the NHS Highland average in 2016-2020. The only area to show a statistically significant difference is Helensburgh and Lomond, which was lower than the NHS Highland average in this period.

Figure 2.19: Age-sex standardised suicide rate in NHS Highland Community Partnerships and Localities, 2011-2015 and 2016-2020



Source: National Records of Scotland vital events death recording
Age-sex standardised suicide rates per 100,000 population, directly standardised to the 2013 European Standard Population.

Mental illness and suicide

The links between mental illness and suicide are well established[14]. A 2021 systematic review summarised that mental disorders including major depressive disorder, dysthymia, bipolar disorder, anxiety disorders, and schizophrenia were all significantly associated with higher rates of suicide[15]. Rates tend to be particularly high in people with depression[16]. A review of psychological post-mortem studies found that at least two-thirds of people dying by suicide have evidence of a mental illness at the time of their death, and in most European studies the proportion approaches 90%[17]. As most people who die by suicide have a mental illness at the time of their death, and mental illness is treatable, ensuring that people receive adequate treatment is important[18,19].

Mental health problems and mental illness

Mental health problems is the term used to describe a spectrum of symptoms from common mental health disorders like anxiety and depression to the most severe clinically diagnosed mental illnesses such as schizophrenia and affective psychosis. Mental illness refers to a diagnosable illness defined through a recognised classification, for instance, the International Classification of Diseases and Related Health Problems (ICD).

Mental health problems can occur at any age, but are increasingly common among younger people and those experiencing poverty and social disadvantage[20]. Risk factors for many mental health disorders are associated with social inequalities, whereby the greater the inequality the higher the risk[21]. This means that some groups in our society are more likely than others to experience mental ill-health, for example, people who have experienced trauma or adverse childhood events, people who have substance use problems, and people who are experiencing social isolation and social exclusion[22].

Key findings from the 2014 Adult Psychiatric Morbidity Survey:

One adult in six (17%) had a common mental disorder (CMD) at the time of the survey.

Prevalence of CMD symptoms were higher in women (21%) than in men (13%).

All types of CMD symptoms were more common in working age adults than in people aged 65 years and over.

Young women were a high-risk group, with high rates of CMD, self-harm, bipolar disorder and post traumatic stress disorder (PTSD).

Most mental disorders were more common in people living alone, in poor physical health, and not employed.

People in receipt of benefits aimed at those unable to work due to poor health or disability experienced particularly high rates of mental illness.

The best available data for the prevalence of mental illness in the UK comes from the Adult Psychiatric Morbidity Survey (APMS), most recently from 2014[20]. The APMS is a cross-sectional survey and covers a range of mental disorders, substance use disorders and self-harm behaviours in the general population. While the most recent version of the study was conducted in England alone, the findings are relevant to Scotland. While we do not have Highland wide survey data, application of age and sex specific prevalence rates can be used to derive estimates of the potential population in NHS Highland with each condition.

Common mental disorders in adults

The most common mental health disorders (CMDs) comprise different types of depression and anxiety. Symptoms of depression include low mood, and a loss of interest in ordinary things and experiences. Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive compulsive disorder (OCD). Symptoms of depression and anxiety frequently co-exist. CMDs range in severity from mild to severe and can cause marked emotional distress, impairment of functioning, and affect physical wellbeing and behaviour.

In the APMS, symptoms of CMD were identified on the basis of the Clinical Interview Schedule - Revised (CIS-R) screening tool[23]. A CIS-R score of 12 or more is the threshold used to indicate the presence of symptoms likely to benefit from primary care recognition. A CIS-R score of 18 or more denotes more severe symptoms of a level very likely to warrant active clinical intervention[7].

Prevalence rates and their equivalent numbers in the NHS Highland area are summarised in Table 2.1. Application of the rates from the survey shows that mental illness is common and that there could be 21,000 people aged 16 years and over with severe CMDs likely to benefit from active intervention.

Table 2.1: Estimated prevalence and number of adults with common mental disorders (CMDs) by severity in NHS Highland

Mental disorder or condition	ScreeningTool	Age group	Prevalence (%)	Estimated numbers:		
				Argyll and Bute	Highland	NHS Highland
CMD symptoms	CIS-R score 12 or more	16-64	17.4%	8,730	25,000	33,730
		65 and over	9.2%	2,060	4,980	7,030
		All adults	15.1%	10,790	29,980	40,760
Severe CMD symptoms	CIS-R score 18 or more	16-64	9.3%	4,650	13,310	17,960
		65 and over	3.8%	850	2,060	2,910
		All adults	7.7%	5,500	15,370	20,870

Source: derived from Adult Psychiatric Morbidity Survey 2014[20]
CIS-R: Clinical Interview Schedule - Revised
Application of age-sex specific prevalence to NRS 2020 mid-year population estimates

Specific mental health conditions in adults

Specific mental health conditions in adults reported in the APSM include posttraumatic stress disorder (PTSD), psychosis, autism, personality disorder, attention-deficit/hyperactivity disorder (ADHD) and bipolar disorder. Each illness was measured using condition specific diagnostic criteria and screening tools[23].

Data from the 2014 survey reported that one in ten (9.7%) adults screened positive for attention-deficit/hyperactivity disorder (ADHD), a complex neurodevelopmental disorder which starts in childhood and often persists into adulthood. The second most common condition reported was posttraumatic stress disorder (PTSD), affecting one in twenty adults (4.4%) in the last month. PTSD can be a severe and disabling condition, with prevalence rates particularly high among women age 16 to 24 (12.6%).

Bipolar disorder, a lifelong mental health condition associated with significant morbidity, had an estimated prevalence of 2.0% in adults. Rates were similar in men and women and more common in younger age-groups.

Less common conditions include psychotic disorders, such as schizophrenia and affective psychosis. Estimates suggest one adult in a hundred (0.7%) are affected by a psychotic disorder. A

similar prevalence (0.8%) was reported for autism spectrum disorders (ASDs), also referred to as autism.

Table 2.2 shows estimates of prevalence and the equivalent numbers expected for NHS Highland for each condition.

Table 2.2: Estimated prevalence and number of adults with specific mental health conditions in NHS Highland

Mental health condition	Age group	Prevalence (%)	Estimated numbers:		
			Argyll and Bute	Highland	NHS Highland
Posttraumatic stress disorder	16-64	5.0%	2,470	7,110	9,580
	65 and over	1.2%	260	620	880
	All adults	3.9%	2,730	7,730	10,450
Psychotic disorder	16-64	0.6%	310	910	1,220
	65 and over	0.2%	40	90	120
	All adults	0.5%	350	1,000	1,350
Autism	16-64	0.8%	430	1,160	1,600
	65 and over	0.7%	150	370	520
	All adults	0.8%	580	1,530	2,110
Attention-deficit /hyperactivity disorder (ADHD)	16-64	11.1%	5,610	15,820	21,430
	65 and over	3.9%	860	2,090	2,950
	All adults	9.0%	6,470	17,910	24,380
Bipolar disorder	16-64	2.2%	1,120	3,210	4,330
	65 and over	0.2%	50	120	170
	All adults	1.7%	1,170	3,330	4,500

Source: derived from Adult Psychiatric Morbidity Survey 2014[20]
Application of age-sex specific prevalence to NRS 2020 mid-year population estimates
Note that all estimates are subject to sampling error and confidence intervals are not shown. Conditions with low prevalence (autism, psychosis) may be over or under represented.

Suicidal thoughts, suicide attempts, and self-harm

Self-reported suicidal thoughts, suicide attempts and self-harming (without suicidal intent) are associated with great distress for the people who engage in them, as well as for the people around them. They are strongly associated with mental illness, and help to identify people at increased risk of taking their own life in the future[20].

Data from the 2014 Adult Psychiatric Morbidity Survey reported that one in five adults (20.6%) had suicidal thoughts at some point in their life and that one in fifteen people (6.7%) had made a suicide attempt in the past. There were comparable rates of lifetime self-harm without suicidal intent (7.3%) in the adult population. Suicidal thoughts, attempts and self-harm were more common in women than men, and rates were notably high in women aged 16 to 24.

Table 2.3: Estimated prevalence and number of adults with suicidal thoughts, suicide attempts, and self-harm (without suicidal intent) in NHS Highland

Mental health condition	Age group	Prevalence (%)	Estimated numbers:		
			Argyll and Bute	Highland	NHS Highland
Suicidal thoughts	16-64	23.3%	11,750	33,370	45,120
	65 and over	10.1%	2,260	5,480	7,740
	All adults	19.6%	14,010	38,850	52,870
Suicide attempts	16-64	7.7%	3,850	11,040	14,880
	65 and over	2.7%	810	1,470	2,080
	All adults	6.3%	4,460	12,510	16,960
Self-harm	16-64	8.2%	4,050	11,730	15,780
	65 and over	1.2%	270	650	920
	All adults	6.2%	4,310	12,380	16,700

Source: derived from Adult Psychiatric Morbidity Survey 2014[20]

Patterns of Self-harm in Highland

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of motivation or suicidal intent, and is an expression of emotional distress[24]. The level of suicide intent with self-harm may range from being completely absent at one end of a spectrum, where self-harm can be a behavioural coping response that is potentially life preserving. This is called non-suicidal self-injury (NSSI) or non-suicidal self-harm (NSSH). At the other extreme the level of suicide intent may be high, but the attempt was not successful[25]. Identifying motivation can be difficult in hospital settings and this section does not attempt to differentiate presentations by underlying motivation[26,27].

Estimating the amount of self-harm that occurs in the population is very difficult given that the behaviour is often private and often does not result in contact with medical services. Population studies suggest that in Scotland one in nine young people (aged 18 - 34) has attempted suicide and one in six has engaged in NSSH, which is far higher than the number of people admitted to hospital[28].

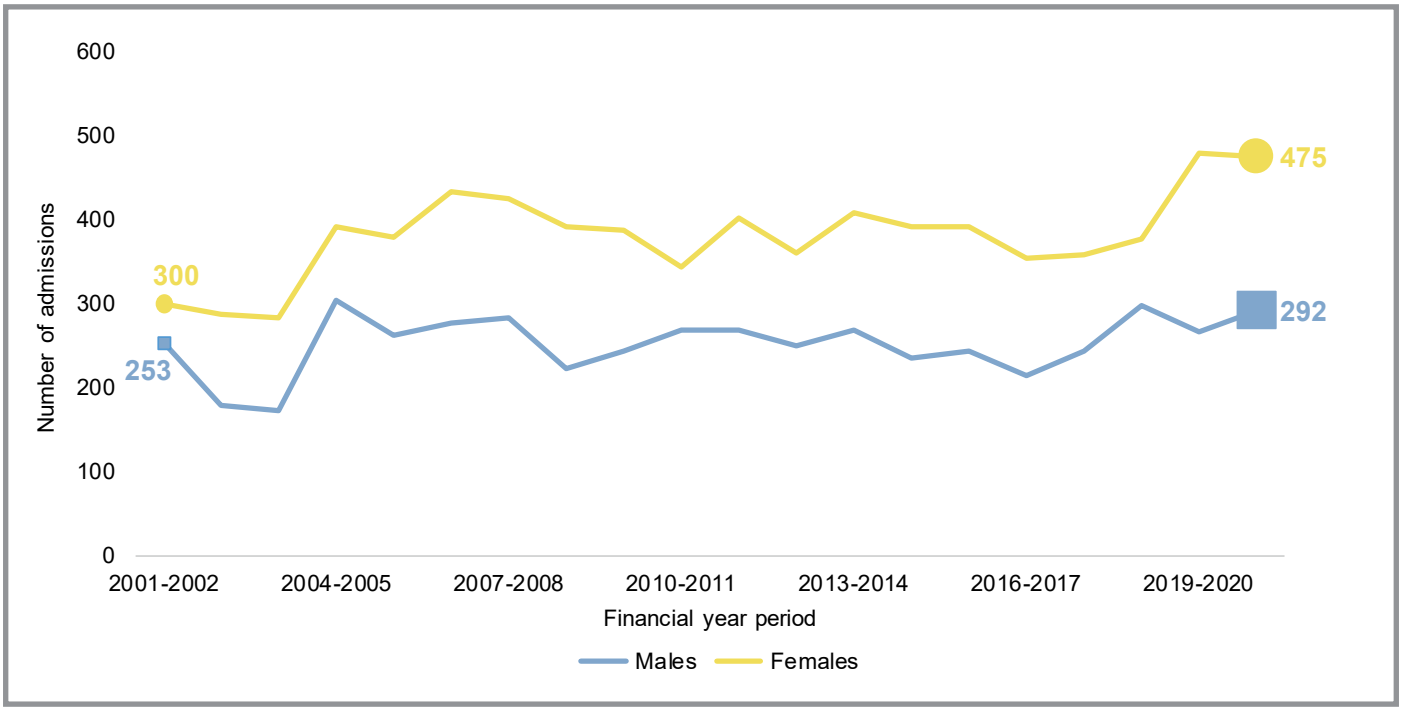
The section focuses on self-harm presenting in hospitals. For someone to be admitted to hospital, people have to identify, or be identified as having self-harmed; be seen at a hospital and be admitted. This means that differences in access to hospitals, differences in referral rates to hospital[29], and differences in admission rates at the acute hospital setting can all produce differences in the number of people hospitalised[30,31]. This may be particularly important in people who live further from a general hospital, such as more rural parts of Highland.

This section does not give a guide to underlying rates of self-harm by area. Linking to ambulance service and Emergency Department data can give a better idea of the number of people presenting with self-harm and the number admitted to hospital after being seen[32]. People who self-poison are more likely to seek help and be admitted than those who self-injure. In NHS Highland over ninety percent of self-harm related admissions to hospital are for self-poisoning. This will particularly underrepresent self-harm among adolescents and young adults who are more likely to self-harm by cutting or burning themselves[20].

The codes used for the analysis indicate the nature of any external cause of injury, poisoning or other adverse effects related to deliberate self-harm (International Classification of Diseases 10th Revision coding X60-X84).

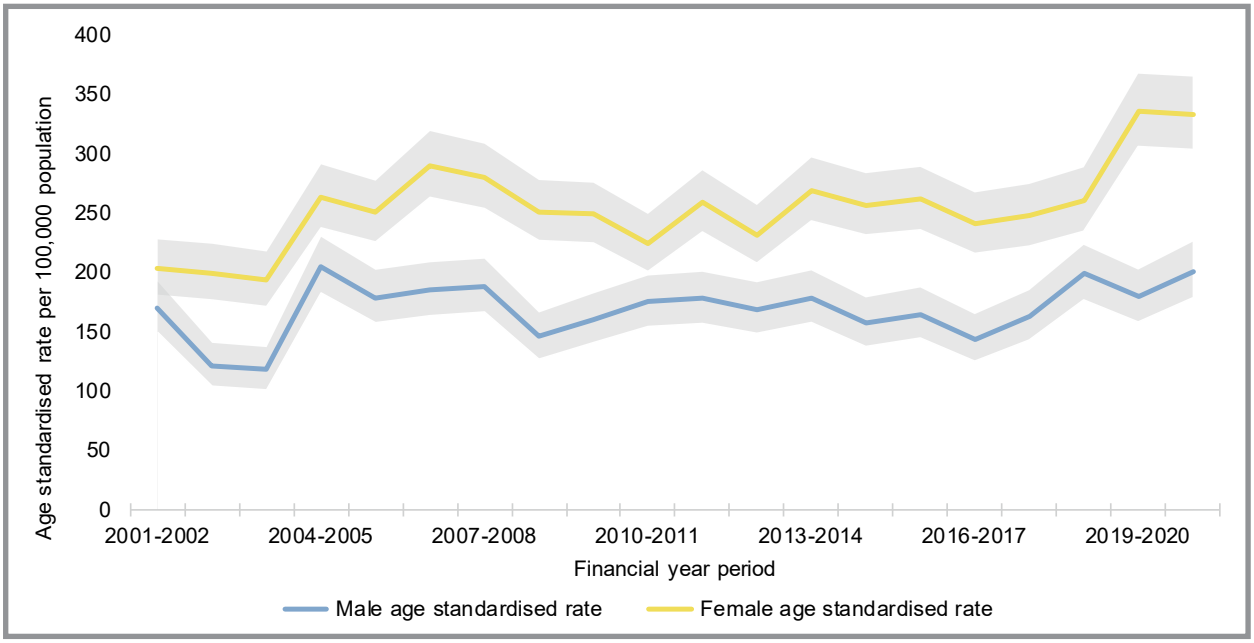
Figure 2.20 shows that during 2020-2021 there were 767 self-harm admissions to hospital for 598 NHS Highland residents. The number of admissions for females (n=475) were notably higher than for males (n=292). Male and female rates of admission were 201 per 100,000 population and 333 per 100,000 population respectively. In NHS Highland, as with national data, rates of self-harm admission are consistently higher in women compared to men. Figure 2.21 shows the rates of admission notably increased in 2019-2020 for women living in NHS Highland and these remained elevated in 2020-2021. For every ten men admitted in recent years there have been 16 admissions for women.

Figure 2.20: Number of admissions where a diagnosis of intentional self-harm was recorded (males and females) for NHS Highland, all ages, financial year period 2001-2002 to 2020-2021



Source: SMR01

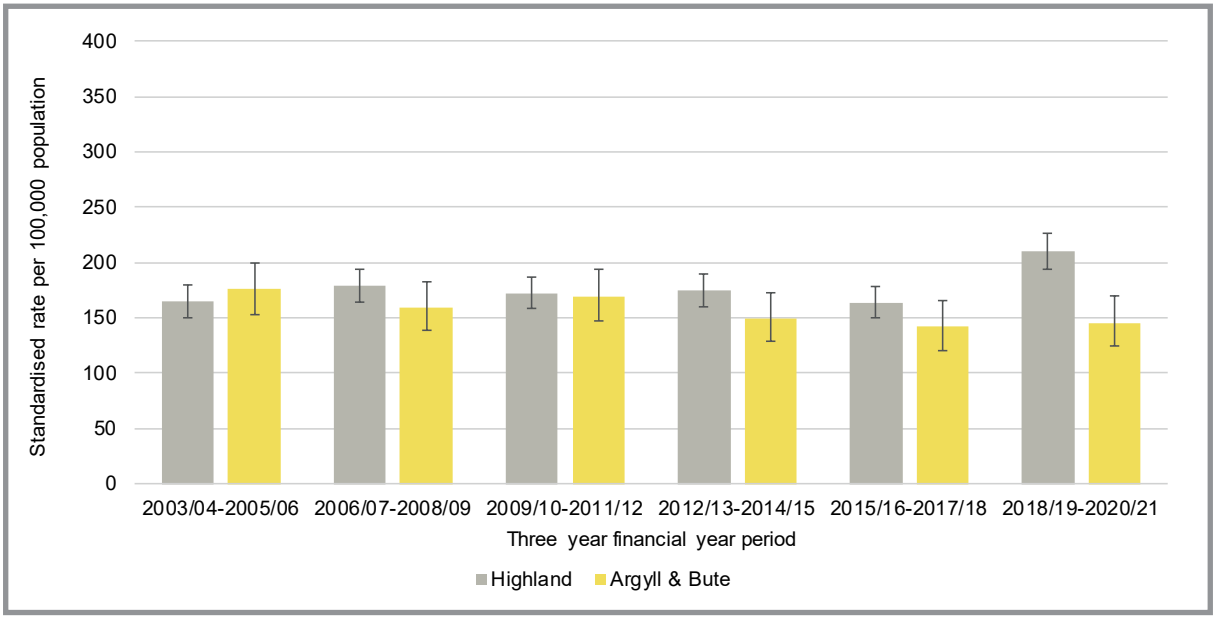
Figure 2.21: Age standardised rates of admission where a diagnosis of intentional self-harm was recorded (males and females) for NHS Highland residents, all ages, financial year period 2001-2002 to 2020-2021



Source: SMR01
Shaded area shows 95% confidence intervals around the age-standardised rates
Age-standardised rates per 100,000 population, directly standardised to the 2013 European Standard Population.

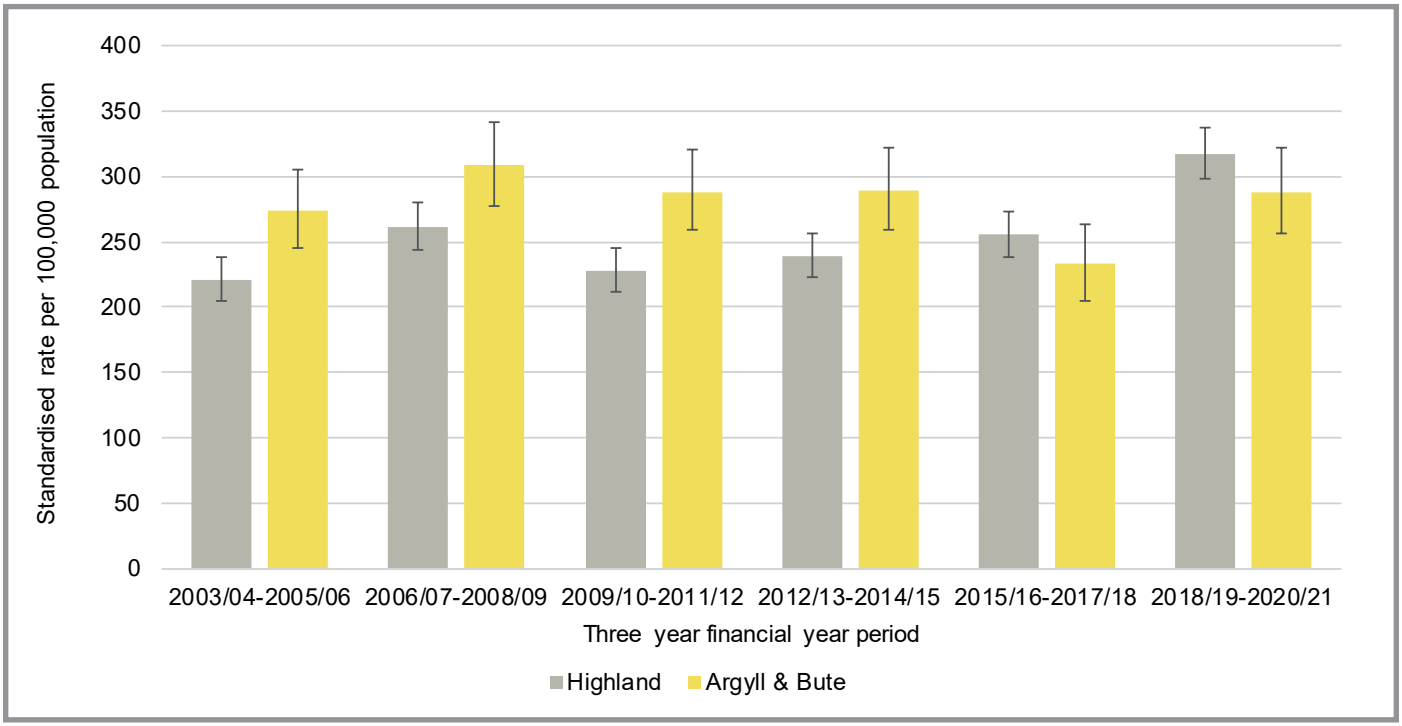
Figure 2.22 and Figure 2.23 show that a statistically significant increase in male and female self-harm admission rates occurred in the Highland local authority area in the most recent three-year period. In contrast, the rates in Argyll and Bute for both males and females are not significantly different to previous years. The rate of male self-harm admission in Highland in the three-year period 2018-19 to 2020-21 was significantly higher than that in Argyll and Bute. Female self-harm admission rates were not significantly different during the same period in the two local authority areas.

Figure 2.22: Age standardised rates of admission where a diagnosis of intentional self-harm was recorded for males (all ages) by local authority area in NHS Highland, three year financial year periods



Source: SMR01
Age-standardised rates per 100,000 population, directly standardised to the 2013 European Standard Population.

Figure 2.23: Age standardised rates of admission where a diagnosis of intentional self-harm was recorded for females (all ages) by local authority area in NHS Highland, three year financial year periods



Source: SMR01
Age-standardised rates per 100,000 population, directly standardised to the 2013 European Standard Population.

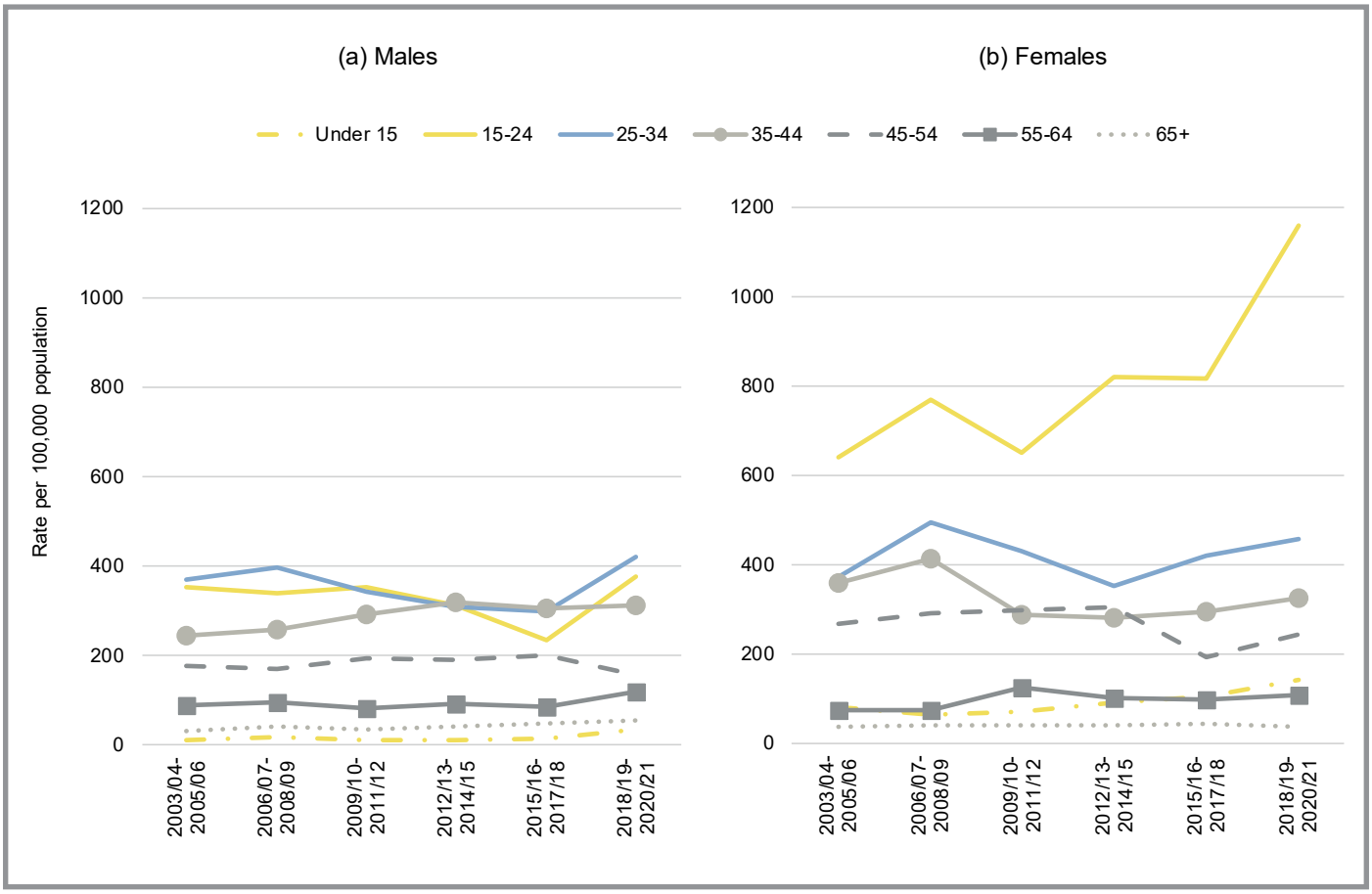
Self-harm can occur at any age, with the peak rate of self-harm in hospital admission data in the 15-24 year age group in women[28]. Figure 2.24 shows that rates of admission in women of this age have been increasing in NHS Highland since 2008/09. The number of admissions in the most recent three years show a large increase on previous periods. For women the risk of self-harm admission tends to decline with age.

Male hospitalisation rates are very similar in the age groups under 45 years with lower rates generally seen at older ages.

Risk factors for hospital admitted self-harm[24,25]:

- Age - peak in hospital admissions in 15-24 year-old women and 25-34 year-old men
- Deprivation
- Social isolation and perception of lack of social support
- Stressful life events, for example relationship difficulties, debt/financial worries, job loss or bereavement
- Adverse childhood experiences, including maltreatment and domestic violence
- Mental health problems as well as long-term physical health issues
- Problematic substance use
- Experience of custodial care with people in prison at higher risk
- Disengagement with services.

Figure 2.24: Age specific admission rates where a diagnosis of intentional self-harm was recorded for (a) males and (b) females in NHS Highland, three year financial periods

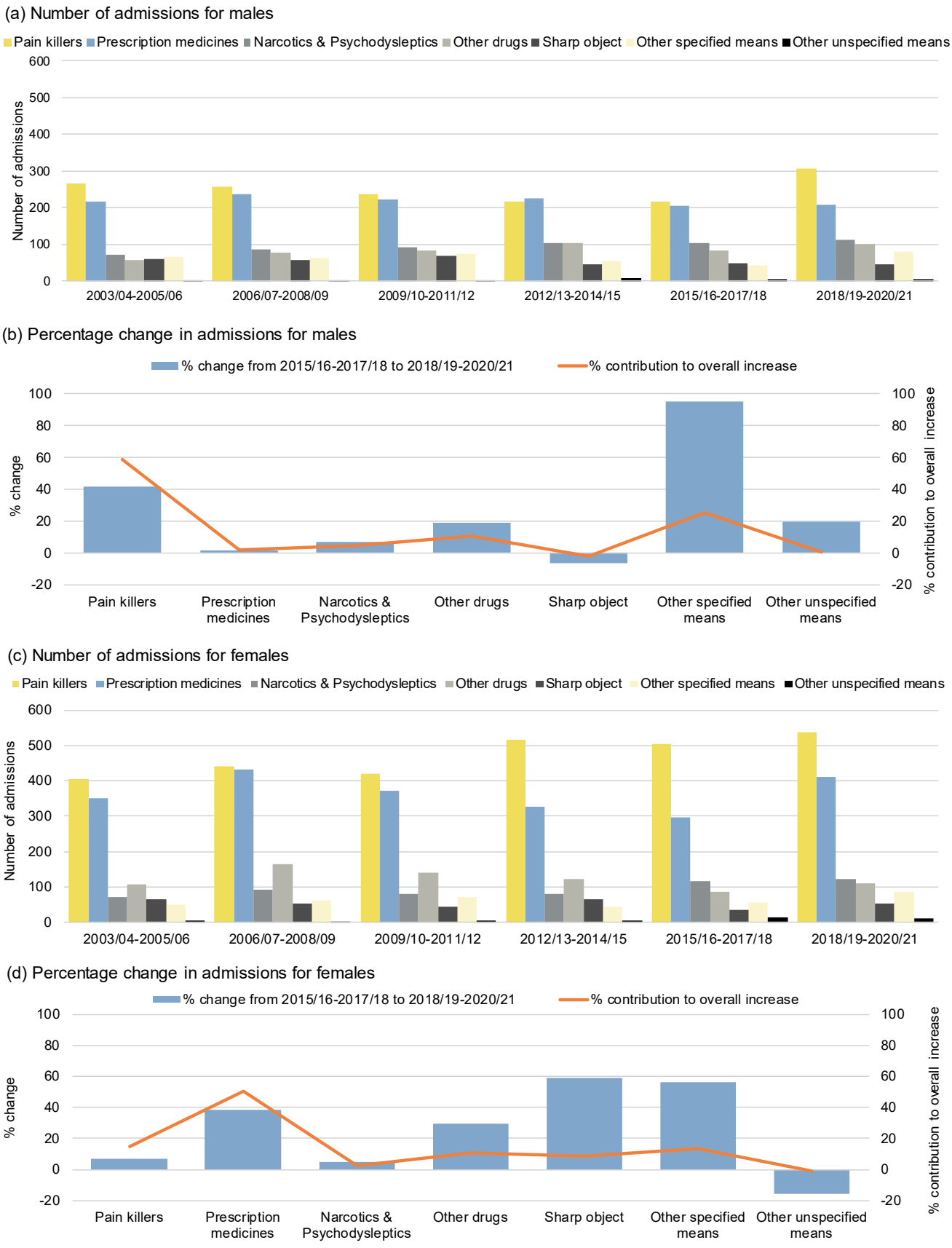


Source: SMR01
Age-specific rates per 100,000 population are calculated using the number of admissions divided by the estimated population for each age band and sex

The majority of self-poisoning admissions involve prescribed or over the counter medication, and a minority involve illicit drugs, household substances, or plant derived material. The majority of self-injury episodes involve cutting. Less common but other specified methods include burning, stabbing, drowning, swallowing objects, insertion, shooting, and jumping from heights or in front of vehicles[24].

Figure 2.25 shows that the majority of the increase in the male rate of admission for self-harm in the most recent three-year period in NHS Highland results from episodes related to self-poisoning with painkillers. In females the principal reason for the increase in the rate of admission for self-harm was self-poisoning with prescription medicines.

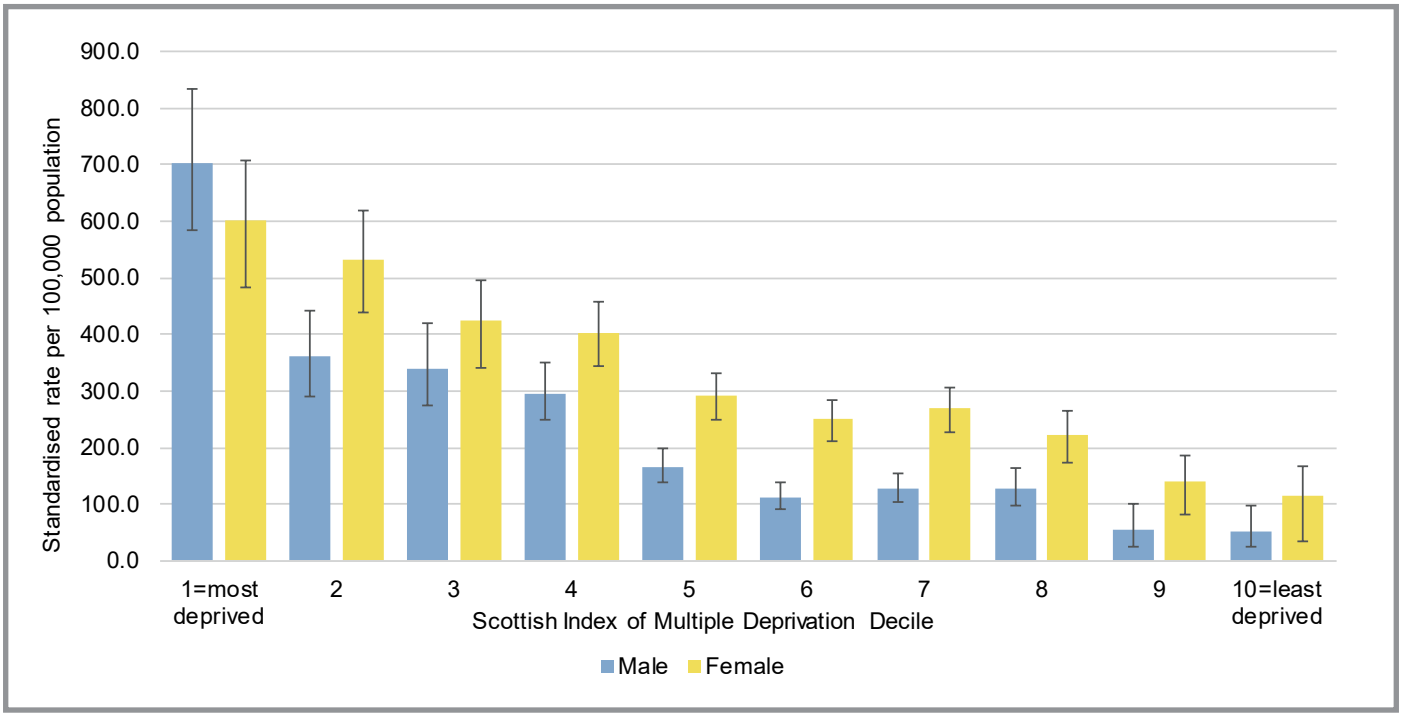
Figure 2.25: Number and percentage change in self-harm admissions by diagnosis and sex, NHS Highland residents, three year financial periods: (a) Number of admissions for males, (b) Percentage change in admissions for males, (c) Number of admissions for females, (d) Percentage change in admissions for females



Source: SMR01

Figure 2.26 shows age standardised admission rates for self-harm by deprivation decile in NHS Highland in the three year period 2018/19 to 2020/21. The deprivation gradient is very consistent. The highest rates of hospital treated deliberate self-harm in NHS Highland are from the most deprived areas in both males and females. Those living in the most deprived areas of NHS Highland are nearly eight times more likely to be admitted to hospital from self-harm than those in the least deprived areas.

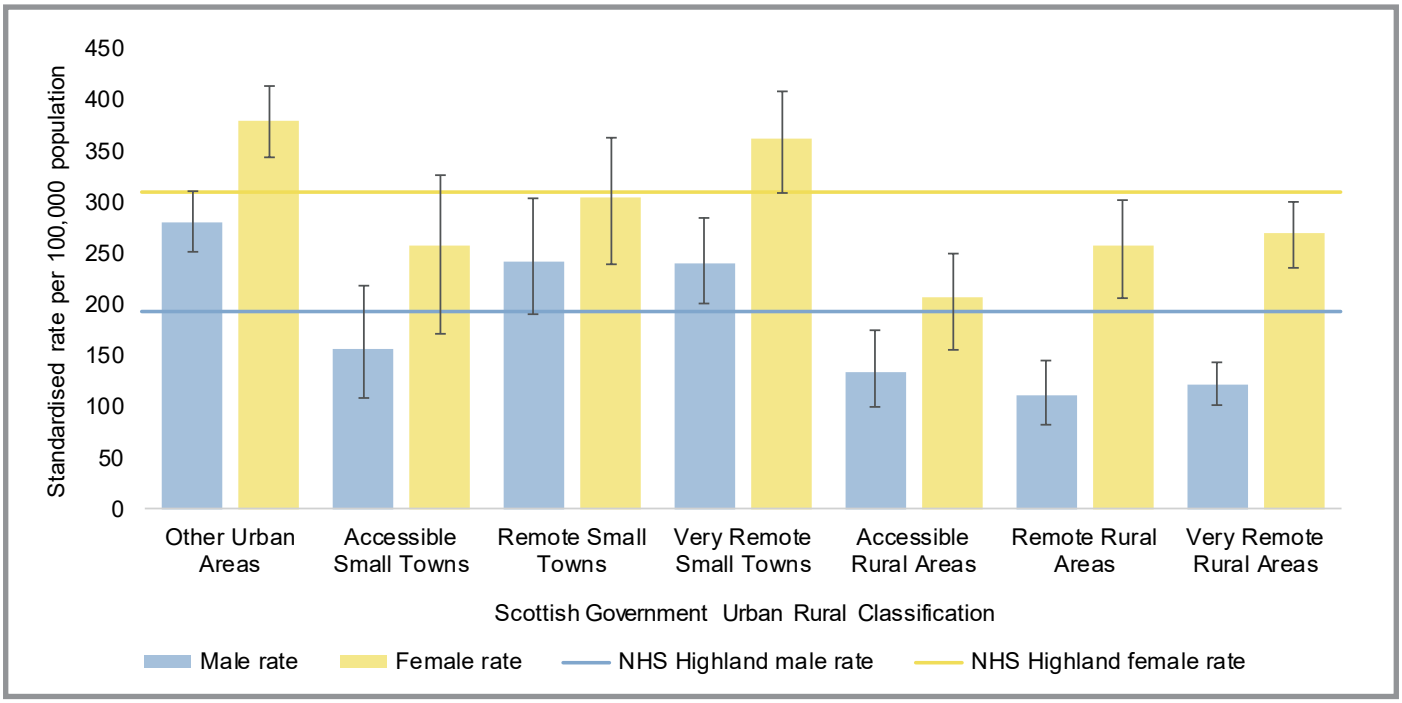
Figure 2.26: Age standardised rates of admission where a diagnosis of intentional self-harm was recorded, NHS Highland residents, all ages by sex and Scottish Index of Multiple Deprivation decile, three year financial year period 2018-2019 to 2020-2021



Source: SMR01
Calculated using the Scottish Index of Multiple Deprivation (SIMD) 2020 release

Figure 2.27 shows the pattern of self-harm admissions in urban and rural areas of NHS Highland in the three year financial period 2018/19 to 2020/21. Rates of hospital admission for intentional self-harm in both males and females were highest from other urban areas and very remote small towns. Self-harm admission rates for people living in accessible rural, remote rural and very remote rural areas were significantly lower than for NHS Highland as a whole. This is a different pattern to the suicide rate and could reflect a difference in services in more rural parts of NHS Highland.

Figure 2.27: Age standardised rates of admission where a diagnosis of intentional self-harm was recorded, NHS Highland residents, all ages by sex and eight-fold 2016 urban rural classification, three year financial year period 2018-2019 to 2020-2021

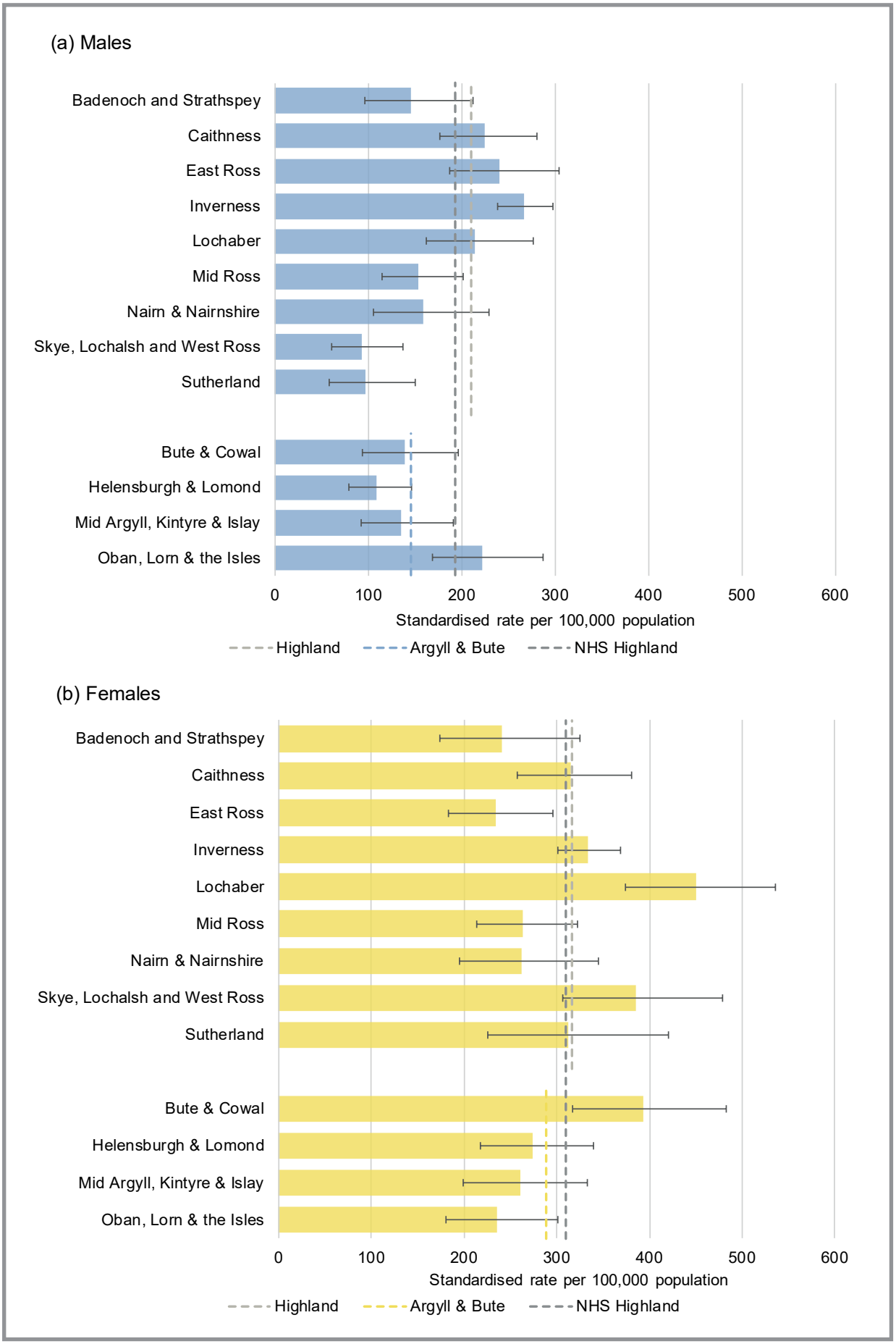


Source: SMR01
Based on Scottish Government Urban Rural Classification 2016

Patterns of admission for self-harm in geographical areas within NHS Highland are shown in Figure 2.28 for males and females. The only area to show a statistically significantly higher rate of admission for males in the most recent three-year period is the Inverness Community Partnership area. In Highland, rates of self-harm admission were significantly lower for males in Skye, Lochalsh and West Ross and Sutherland. In Argyll and Bute, Oban, Lorn and Isles has the highest rate of male admission, but this is not statistically significantly different from NHS Highland as a whole.

In the latest period female rates of self-harm admissions were significantly higher in Lochaber area and in Bute and Cowal. Self-harm admission rates for females were significantly lower in Oban, Lorn and the Isles and East Ross compared to NHS Highland as a whole.

Figure 2.28: Age standardised rates of admission where a diagnosis of intentional self-harm was recorded for (a) males and (b) females by NHS Highland Community Partnerships and Localities, three year financial year period 2018-2019 to 2020-2021



Source: SMR01

Conclusions

This section describes evidence on deaths by probable suicide, prevalence of mental illness and hospital presentations for self-harm in the NHS Highland area.

In 2020, 54 residents of NHS Highland died by suicide compared to 87 in 2019. Concerns were raised about the adverse effects of the pandemic on mental health and the possibility of an increase in deaths by suicide at the beginning of the coronavirus (COVID-19) pandemic[33]. A 2021 study, comparing the Scotland suicide rate in 2020 with the average annual rate during 2015-2019, found no evidence of a short-term increase in suicide during the early stages of the pandemic[34].

There is a concern however that there will be a delayed impact of the pandemic on the determinants of suicide, for example, poverty, anxiety and depression[35]. Further research and ongoing surveillance of suicide and self harm data is required to monitor the continuing impact of the pandemic on mental health in NHS Highland and respond to changing trends.

There are clear patterns of suicide by age and sex. Male rates were higher than the Scottish average in all age groups, significantly so for the age group 25-34 years. Female rates were higher than Scotland in every age group under 65 years. The most notable, and concerning, pattern is the suicide rate in young women aged 15 to 24 years, which was more than double the Scottish average in 2016–2020. The increase in female self-harm rates in this age group is particularly concerning.

The suicide rate in NHS Highland is higher than the Scottish average. This is largely because of a higher death rate in the Highland Council area and there is no evidence of an improvement. Research is required to examine the relationship between poverty, deprivation and urban rural variation in suicide rates in Highland, and to identify the extent to which the Highland picture contributes to rural suicide in Scotland.

Further work is also required to place suicide in a broader population mental health context that will inform local plans and strategies. This should include evidence on mental health hospitalisations, mental health prescribing and wider service access. The relationship between prescribing data and underlying population morbidity is contested[36] but prescribing data may provide insights into morbidity and the relationship with poverty[37]. An immediate priority is research and evidence to support mitigation of the mental health impacts of the pandemic in NHS Highland.

Chapter Three - Adversity in childhood - a life course lens

The primary focus of suicide prevention work tends to be individualised and orientated around individual risks as they present. Suicide prevention initiatives focus on consideration of assessment, awareness and skills training, addressing stigma and individual, family and community capacity building. While these endeavours serve an important purpose, there is a 'persuasive case' to be made for a wider lens of awareness and interventions that address the primary and root causes of individual, family and community distress that lead to suicide events[1].

This can be understood from the starting point of 'What happened to you?' rather than 'What is wrong with you?'. This involves a relational and life circumstances approach across life, rather than a primary orientation on mental illness and disorder.

There is emergent and growing evidence of the influence of early adversity and the intergenerational transmission of distress and related suicide risk. This can be explored through:

- consideration of early adversity as experienced in the home
- structural inequalities (income, food, housing insecurity, community violence)
- family distress (abuse, neglect, conflict and violence).

These factors influence brain and body development and the mediating role of relationships (attachment style, capabilities, skills and vulnerabilities).

Whilst exploring this territory, it is important to keep in mind that the positive experiences that underpin resilience (the ability to make sense of and navigate threat and risk) are more influential that those that are negative. As a consequence of how humans have evolved, the burden of the impact of risk and threat on health and wellbeing and contentment in life is of sufficient influence and impact to merit more attention than is generally the case.

> "A scientific consensus is emerging that the origins of adult disease are often found among developmental and biological disruptions occurring during the early years of life. These early experiences can affect adult health in two ways — either by cumulative damage over time or by the biological embedding of adversities during sensitive developmental periods. In both cases, there can be a lag of many years, even decades, before early adverse experiences are expressed in the form of disease.
>
> "From both basic research and policy perspectives, confronting the origins of disparities in physical and mental health early in life may produce greater effects than attempting to modify health-related behaviours or improve access to health care in adulthood."[1]

Early adversity

The term adverse childhood experiences (ACEs) is used to describe and define a wide range of stressful or traumatic experiences that babies, children and young people can be exposed to whilst growing up[2]. The term was first introduced as part of the American Adverse Childhood Experiences Study[3].

The dose response effect of exposure to more than four of the sentinel markers of early adversity leaves people at greater risk of poorer physical and mental health and of health behaviours that can compromise wellbeing, including problematic alcohol and drug use, being at risk of, or a victim of violence and mental illness and higher risk of suicide. Whilst these relationships are understood as correlations, the causal mechanisms have yet to be understood in full. A wide of range of cross-disciplinary research strands are beginning to establish these with optimism of more to follow. These will inform new and complement existing programmes and interventions to offset the pervasive impact of early adversity across people lives[4].

The 2019 Scottish Heath Survey looked at the population prevalence of adverse childhood experiences in Scotland for the first time. The survey found just over one in seven adults reported four or more ACEs, some 15% of the population. The most common reported experiences were verbal abuse (47%), physical abuse (28%), household domestic violence (24%) and parental separation (23%)[5].

For people living in more deprived areas of Scotland, there was doubling of risk of having experienced more than four of the sentinel markers of childhood adversity, with 11% of people in the least deprived communities compared to 20% in the most deprived. Noting these disparities, the burden of adverse experiences across the whole population is not insignificant, and more so when the influence on mental health and wellbeing is better understood.

Censuses in 2018 and 2019 of children and young people in secure care in Scotland[6,7] indicates that 64% children and young people had encountered more than four adverse childhood experiences in 2018, and 74% in 2019. Such data indicates the burden of adversity for care experienced individuals and associated risks for mental health and wellbeing, mental illness and disorder and suicide risk, even though care experience is not currently reflected in suicide statistics with no evidence of discussion in preparing this report identified since 2013[8,9].

A 2018 population study in Wales[10] looking at resilience factors and adversity in childhood concluded that experience of more than four adverse childhood experiences substantially increased risks of mental illness. Compared to individuals with no experience, adults were 3.7 times more likely to be currently receiving treatment for mental illness, 6.1 times more likely to have ever received treatment for mental illness and 9.5 times more likely to have ever felt suicidal or self-harmed.

A representative population study in the United States[11] concluded that the accumulation of adverse childhood experiences increased the odds of suicide ideation and suicide attempts. The authors found that compared to individuals with no experiences of childhood adversity, the odds of seriously considering suicide or attempting suicide in adulthood increased more than threefold among those with three or more adverse childhood experiences.

Brain and body

Adversity can be usefully understood as a stressor and not all stress is bad. Some stress is needed for healthy growth and development. Stress also indicates the presence of risk and threat that can be protective, even life saving. Over time, the human basic threat response evolved because of the presence of predator species that have since declined even as other threats to survival have emerged. For humans, stress can be experienced from conception, where the growing foetus is shaped by the mother's cortisol and adrenalin through the placenta, to the last moments of life.

Too much stress, particularly for infants, children and young people can be harmful and have a powerful influence on their growth and development. The effect can be greater during what are understood as time sensitive developmental windows. Infants set up their primary stress response at 6-12 months, speech and language development is established by 15 months and primary attachment styles by 24 months. These inform the core skills and competencies that underpin how children, young people and adults learn to navigate life, relationships, learning, work and the associated pressures and opportunities of the day to day, throughout their lives. These are the skills that support friendships and peer relationships, engagement with school and learning and reduce the likelihood of developing clinically defined anxiety and depression and related mental health conditions.

The United States National Scientific Council on the Developing Child[12] proposed the following taxonomy to describe three categories of stress experience (positive, tolerable and toxic) that can affect the development of young children.

Positive stress is characterised by moderate, short-lived increases in heart rate, blood pressure, and stress hormone levels. This can be understood as a normal part of healthy development, in the presence of relationships that are experienced as safe and containing. These create the environments for the stress response to return to normal. This could be a childhood immunisation or a toddler who is frustrated and angry/overwhelmed who is comforted and reassured by a parent.

Tolerable stress refers to a physiological state where there could be physiological effects that are harmful but exposure is time limited and there are adults who confer safety and support that allow the stress response to return to normal. The likelihood of a developing brain being impacted or damaged is reduced, as are the wider effects that the brain influences.

Toxic stress is where strong, frequent, and/or prolonged activation of the body's stress-response systems occurs and where there are no adult relationships/support that can buffer the impact. This can occur in circumstances of extreme poverty, enduring physical and emotional abuse and/or, chronic neglect and family violence. In these circumstances, the growing brain can be impacted and other bodily systems (nervous, immune, metabolic, endocrine, genonome) are impacted through an overactive stress response that can be triggered at a lower threshold across life, with enduring effects and impacts.

Attachment

The importance of adult relationships that confer safety to infants, children and young people can be understood as key to mitigating the impact of all types of adversity.

Infants are born seeking connection and a relationship from the moment they are born. Relationships can be understood as relational food that creates and sustains the emotional life of the infant as they grow and develop.

> "Attachment is the biological need for relationships that all human beings are born with. It is especially important in the early years of life because it shapes the ways our brains and bodies handle emotions."[13]

The primary relationship template, taken through life, is established in infancy and crafted between the infant and parent interactions within family settings and community environments.

For many months, even years, human infants and children are completely dependent for survival on the primary adults (parents and care givers) in their lives. Attachment can be understood as a fundamental evolutionary survival strategy. Experiences of these very early relationships are wired into the developing brain as the infant experiences their developing world as safe, predictable and secure, or not.

How parents understand and are supported to understand and respond to the cues from their infant sits at the heart of the attachment experience. When a baby seeks eye contact, cries with the discomfort of a wet nappy or from hunger, these are the cues; the invitation is there, for the parent to respond. This is understood as serve and return. While there are many situations where the parent might not respond (return) as the infant expects or wants, there are many opportunities to repair any disconnection with the key being the repair to a disrupted interaction; that is the experience that is wired into the infants developing brain circuits. This understanding helps takes away any guilt or shame that parents feel when an infant is distressed even as they seek to reassure.

As such, infants grow, develop and adapt in the context of the relationships they experience. These early relational experiences create what is understood as an internal working model, a mental representation of the world, of self and others. This shapes how infants, children, young people and adults predict, respond, control and manage or manipulate their interactions with others; how relationships are created and sustained; underpinning our relationships with self and others.

The capacity and skill of adults to provide a sense of safety and security for infants is informed in turn by their own style of attachment and the relational skills and capacity they bring to being a parent.

Awareness of the attachment system and the nature of different attachment styles (secure, anxious-resistant, avoidant or disorganised) brings additional insights to how the experience of early relationships informs the way people relate to themselves and each other and acquire the skills to make sense of emotions, relationships and critically, mediate internal distress.

When there is prolonged disruption to these primary relationships and in the absence of repair, there can be a physiological/biological impact that can be problematic and result in social, cognitive and emotional difficulties across life. These can leave individuals vulnerable in their relationships with their parents/primary care givers, poor relationship skills with peers and at school, impulsivity and anger, learning difficulties and children lacking a coherent sense of self. The greatest impact can be where there is an inability to show care for others with little regard for the consequences of their actions on others. These difficulties can also be understood through a lens of psychopathology.

The mental health and relationship consequences of significantly disrupted attachment experiences can be understood in the context of suicide events.

Summary

Understanding how shared and common experiences of adversity in childhood informs growth and development, lays the physiological pathways that increase the risk of mental illness and distress that lend to suicide events presents opportunities for suicide prevention programmes that start at the earliest moments in life. This involves addressing the wider determinants of health and structural inequality and a related focus on parent and adult relationships and relationships with practitioners and clinicians that confer safety and trust to parents, mediated through relationships with the starting point of ‘What happened to you?’ rather than ‘What is wrong with you?’.

Recommendations

Understanding and implementing preventive strategies that respond to stress in infancy and childhood is a policy issue that merits attention as a long term preventive strategy to reduce suicide rates in NHS Highland. This involves addressing health inequalities and the determinants of health, adult relationship skills and conflict/violence in the home and communities and empathetic and discerning support for parents who are struggling, the starting point being ‘What happened to you?’.

Chapter Four - The impact of the COVID-19 pandemic on mental health

This section summarises some of the emerging evidence of the impact of COVID-19 on mental health. The latest research highlights that the mental health of people across all sectors of society has been impacted, both negatively and positively, by the COVID-19 pandemic. What is becoming evident is that no particular population sector has been immune, but that the effects have been different across various sectors of society.

Mental health impacts in the general population

A high global prevalence of both depression and anxiety during the time of the COVID-19 pandemic has been reported (24.0% and 21.3% respectively)[1]. At country and regional levels a wide variance in the prevalence of these mental health conditions has been observed, making it difficult to accurately describe the impact of the pandemic on mental health and wellbeing at this point in time. The impact of COVID-19 on mental health has been described as a consequence of the COVID-19 pandemic, but also as a "concurrent epidemic"[1]. Reported positive effects on mental health during the pandemic include having the opportunity to spend more time with family, to help others and make a positive contribution to communities, and enjoy a better work-life balance[2].

The measures put in place to reduce the risk of COVID-19 spreading, such as physical distancing and quarantine measures are also likely to have taken their toll on mental health and wellbeing. Disease outbreaks prior to COVID-19 showed a link between negative mental health and quarantine[3,4].

The Understanding Society study reported that "working from home was associated with larger increases in mental distress even as these working arrangements became the 'new normal'". Mental distress and social isolation was also felt more strongly amongst people living alone compared to other types of workers irrespective of their work location[5].

Inequalities and the impact of COVID-19 on mental health

The impact of COVID-19 on mental health has been different across particular sectors of the population. A recent study undertaken in England, which explored the impact of COVID-19 on 50-70 year olds, reported that more than a third of individuals (36%) within this age group stated that their mental health had deteriorated as a result of the pandemic[2].

The mental health inequalities present before COVID-19 across Black, Asian, and Ethnic Minority (BAME) groups have been further exacerbated, with increased rates of post-traumatic stress disorder (PTSD), anxiety, depression and specific neuro-psychiatric conditions being reported[6].

Pregnant women and women who had recently given birth have also been negatively impacted by the COVID-19 pandemic with depression and anxiety being the most frequently reported changes. Factors such as social isolation and the fear of contracting COVID-19 disease were some of the factors reported to have increased distress in this population group[7].

The Understanding Society COVID-19 study found that people living on low incomes and facing multiple financial struggles had the highest levels of mental distress before the pandemic. The pandemic exacerbated this with levels rising from 39% pre-pandemic to 54% in April 2020. Reports of mental distress appear to have since reduced to pre-pandemic levels, suggesting that for at least some people mental distress linked to financial struggles was relatively short term. However, people seeking help from UK Government self-employment support schemes and Universal Credit experienced the largest and most sustained increases in mental distress. The proportion of people reporting being in poor mental health increased from 29% before the pandemic to 42% in early 2021[8].

Information on the impact of COVID-19 on individuals with a pre-existing mental health condition prior to the COVID-19 pandemic is limited. Likewise, there is little information on the impact of the pandemic on the delivery of mental health services. While some work has been done nationally to identify the issues that need to be addressed, there is a need to focus research on the impact of COVID-19 on people living with mental health conditions[9].

Children and young people

The latest research highlights the on-going difficulties children, young people and their families have faced during the pandemic. Children's mental health and behaviours have been negatively impacted by the disruption to education and measures to reduce transmission of COVID-19 such as school closures. Less play time, reduced extra-curricular activities and fewer social connections and interactions as a result of physical distancing and quarantine measures were also considered to be factors associated with an increase in child anxiety and depression. The mental health of young children and adolescents was affected differently. Parents of young children reported more behavioural difficulties whilst adolescents were more likely to have increased anxiety and depressive symptoms and increased suicidal ideation. Parental stress was also considered to be a factor in the association between exposure to COVID-19 control measures and poorer mental health in children and young people[10,11,12,13].

At particular risk of negative impacts on mental health were pre-adolescent children, girls, those identifying as LGBTQ+, those experiencing pre-existing mental health problems prior to the COVID-19 lockdowns (in the individual or a parent), those from low-income families and those with special education needs and disabilities. The severity or length of lockdowns also had a bearing[12,13]. The negative impacts of increased exposure to risk factors such as abuse, neglect, exploitation and parental stress, and reduced ability of health and social care systems to protect children during closure of schools and lockdowns were also reported. These may have led to harms and adverse events being experienced by children and adolescents resulting in negative emotional and mental health impacts[12,13].

Increased levels of stress, worry and feelings of helplessness were also reported in children and young people as well as increases in anti-social and risk taking behaviours[14]. The amount of time spent on-line or on social media by children and adolescents during the COVID-19 pandemic was reported to have increased which may be a contributing factor for negative mental health impacts for some young people[14].

There is limited information regarding the impact of the pandemic on the mental health of children and young people with pre-existing mental health concerns and little information on COVID-19 specific mental health interventions targeted at young people. However, proactive outreach services were thought to be helpful in supporting young people's mental health during the pandemic[15].

A preprint systematic review reported that presentations and admissions to hospital for mental health reasons, for example self-harm, were significantly reduced during the first wave of lockdowns[13]. There remains limited information on the impact of the pandemic on suicide in children and young people, although an increase in suicidal ideation, particularly in 16-18 year olds, has been reported[13]. Ongoing research will be required to understand the full impact of the pandemic on suicide in young people.

The impact of the pandemic on the mental health of children and young people was not all negative. Some young people experienced improvements in mean anxiety scores, sleeping better, feeling better and spending more time at home with family[12,13]. Positive mental health impacts due to school closures were seen particularly in those with pre-existing high anxiety scores and those with poorer relationships with school[13].

Health and social care workforce

The mental health of the health and social care workforce has been impacted by the pandemic, with workers in a variety of roles reporting anxiety, depression, distress and sleep problems[16]. Being at the frontline of supporting people in hospital, care home and care at home services has been particularly challenging for health and social care staff who may be anxious about getting COVID-19 but also fearful of contracting the virus and taking it home to their loved ones.

The unrelenting nature of the demands placed on staff throughout the pandemic and the changing environment in which they have had to work have all taken their toll on this group of staff. Factors affecting mental health outcomes include the use of personal protective equipment (PPE), staff shortages due to requirements to self-isolate and rapid redeployment into new roles during the lockdown phases of the pandemic. Clinical staff working in high-risk epidemic and pandemic health emergencies have been a particular focus of studies carried out to date, with quarantine measures reported as a risk factor for psychological distress and poor mental health[17]. Studies to date suggest that frontline medical staff were at higher risk of developing an anxiety disorder[18].

Addressing negative impacts is important to ensure that we protect the mental health and build resilience within the health and social care workforce. Examples of strategies to support mental wellbeing include providing additional education and training, specific mental health interventions, and peer and social support[19]. Protective factors to reduce the likelihood of experiencing poor mental health or psychological distress include social support, team cohesion and organisational support[17]. The evidence also points to the availability, training, use and confidence in infection prevention measures as potential factors to reduce mental distress[17].

Improving mental health of clinical staff working in high-risk epidemic and pandemic health emergencies through service management and provision of mental health services should be considered a priority[17]. Looking forward, strategies to protect mental health and develop resilience need to be part of planning for pandemic preparedness and should be supported with further research[16].

Pandemic preparedness

The emerging evidence suggests that there are different routes through which population mental health has been impacted during the COVID-19 pandemic. The response to this is therefore likely to require a range of measures at government, national, regional and local levels and across organisations and communities[5]. It will be important to develop future strategies and policies that are able to respond to local situations and to take account of the needs of local populations[20]. Further research is required to better understand the impact of COVID-19 on mental health and wellbeing and how protection of mental health can be built into pandemic preparedness planning[16].

Summary

The pandemic has affected people's mental health and wellbeing in different ways and at different points in time as the pandemic has progressed. These impacts have resulted from the wider effects of the pandemic on society and also from the measures put in place to control the spread of the virus. We do not yet know what the direct effects of the virus on the brain may be and the mental health consequences of COVID-19 infection. Further work is required to fully understand the impact of the pandemic on the mental health of specific groups within the population, including those with pre-existing mental health conditions prior to the pandemic.

The mental health effects of COVID-19 have not been the same for everyone. Unequal outcomes between different groups existed pre-pandemic, and the effects of the pandemic have worsened this. It has produced disproportionate impacts across a range of outcomes for a number of groups: people experiencing socio economic adversity, health and care workers, unpaid carers, people with long term physical or mental health conditions, young adults, disabled people, black and minority ethnic groups, women, and older people who are isolated or digitally excluded.

People with these characteristics were already at higher risk of some adverse mental health outcomes before March 2020. The pandemic has exacerbated these health inequalities and overlap between groups means that impacts may be magnified for some people. Evidence suggests that the pandemic may widen inequalities in income and wealth over the medium term, as well as being likely to make unequal outcomes more severe in a range of other areas. Ongoing work is required to take account of the emerging evidence relating to COVID-19 and mental health outcomes.


NHS
Test and Trace
COVID-19 Self-Test
(Rapid Antigen Test)
NHS
Test and Trace

Chapter Five - Current Activity

Good mental health is essential in achieving improved outcomes for individuals, families and communities. Good mental health is determined by a wide range of social, economic, environmental, physical and individual factors that operate throughout the life course. To achieve good mental health, we need to improve the circumstances in which people are born, grow, live, work and age[1].

This report details a compelling case for gaining better understanding of and responding to the mental health needs of our population. Across Highland and Argyll and Bute there is already a great deal of work underway, but we will need sustained, coordinated action across agencies that is focussed on prevention and early intervention if we are to make a difference to the mental health of our population.

Prevention and early intervention initiatives

The following information describes some of the services and initiatives currently being delivered to help improve mental health and wellbeing in our communities.

Survey of young people in Highland on the impact of the COVID-19 pandemic

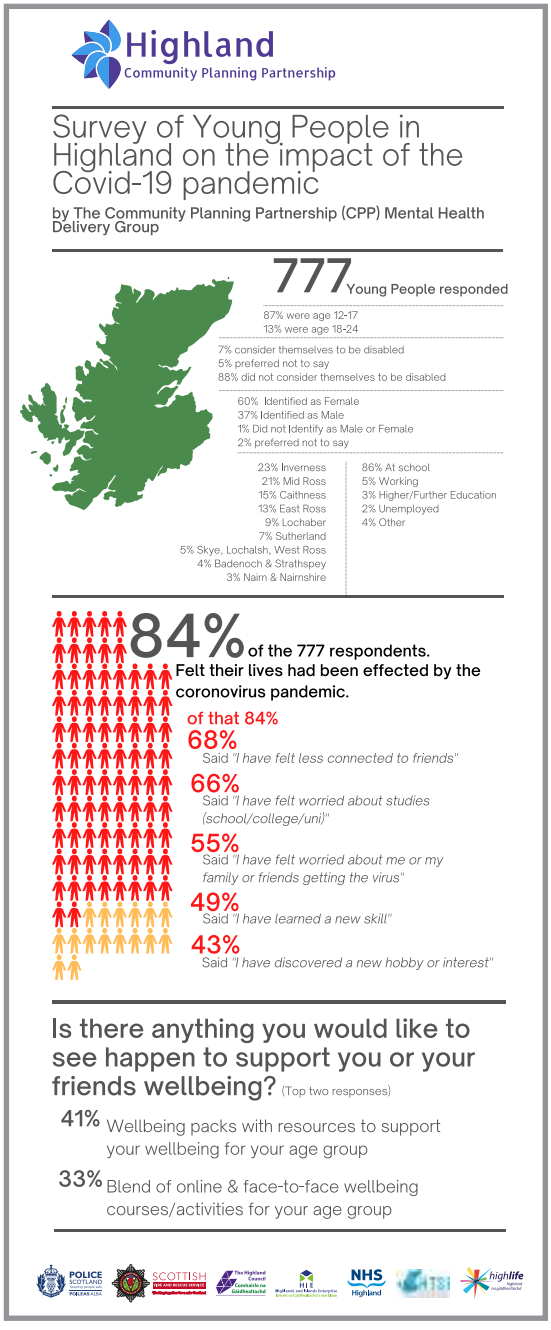
During February and March 2021, the Highland Community Planning Partnership's (CPP) Mental Health Delivery Group undertook an online survey which asked young people about the impact of the COVID-19 pandemic. The survey was undertaken to help inform any partnership response to support mental health and wellbeing for young people.

The findings from the survey were shared widely with CPP partners and with the nine local Community Partnerships in Highland and work is progressing to respond to the issues raised by young people who completed the survey. The single biggest 'ask' from young people was a request for wellbeing packs to be made available with resources to support wellbeing that are age specific. The Inverness Community Partnership reviewed the findings of the survey and have piloted the delivery of wellbeing packs to a cohort of S1 pupils at Inverness High School. Young people were consulted on the contents of the packs and funding for the packs was secured from the Inverness Common Good Fund.

Feedback from those who received packs was positive and provided insight into what young people found helpful. This included:

- Involving young people in deciding what should be in packs
- including some 'activities' in packs such as jigsaws, games, crafts and family activities
- having activities linked to the contents of wellbeing packs e.g. art and craft workshops
- including practical items such as a water bottles, notebooks, art materials and hand sanitiser.

It is hoped that this pilot initiative can be rolled out through schools in Highland.



Letters from Lockdown - young people's experience of lockdown

Highland Children and Young People's Forum initiated a creative approach to listening to children and young people by asking them to write a letter about their experiences during lockdown. Their words and pictures have created a legacy for generations to come as well as making clear demands on people with the power to affect change and make decisions that support recovery.

The letters highlight resilience in children and young people, and an understanding of the impact on their own and their peer's mental health. Describing the pandemic and the changes to their life, the letters highlight the positives, i.e. time with family, appreciation of nature, and of NHS and key workers. They also highlight the impact on mental health, expressing feelings such as stress, worry, anger, frustration and anxiety.

"Letters from Lockdown highlights the negative impacts: the loss of connection, the impact on mental health, bereavement, poverty and social exclusion. Children have shown incredible resilience, but even the most resilient children will need extra support."

Bruce Adamson, Children and Young People's Commissioner Scotland

Where's Your Head At: testimonies from young people in a testing time

Youth Highland Youth Workers facilitated conversations and collected testimonies from around 50 young people from across the Voluntary Youth Network in Highland about their experiences of the pandemic and beyond. The outputs from this activity were published in a book which was launched around Mental Health Awareness Week in 2021.

Where's Your Head At? is a collection of young people's personal experiences – looking at how issues around education, home life and lockdown have impacted on their mental health. They demonstrate the wide range of experiences and challenges that young people are facing in our communities, all in their own words.

"If you talk about your problems, they won't listen to you and most likely put the blame on you. They will tell you they will arrange a meeting and then they will forget about it and not have a meeting with you. Adults just need to start caring about how young people feel."

Young Person 2021.

The book is a powerful example of how organisations can engage with young people, and the value of supporting young people to have a voice in the decisions and services that affect their lives. This is more important than ever, as we look to recover from the pandemic.

"It is fundamental that young people who have lived experience are encouraged to start the conversation about mental health and vocalise their own experiences in a positive and constructive way. Most importantly, they need to be listened to and supported by decision makers and professionals."

Young Person 2021.

A Focus on Children and Young People

A focus on relationships, nutrition, play and exercise, and sleep capture the principle opportunities to offset experiences of adversity that can impact growth and development and contentment/ success throughout life with related consideration of poverty and inequality.

A staged, preventive approach works by nesting a range of layered interventions that reduce risk and harm to individual (parent, infant, child, young person) and collective family and community wellbeing across universal to more targeted services. For the purposes of this report, the following reflect a focus on relationships and structural inequality.

Supporting positive mental health and wellbeing in education

Currently within the Highland Council area, the Education service continues to strive to meet the mental health and wellbeing needs of our children and young people as well as developing resources in collaboration with children and young people with a lens on prevention and early intervention. Some examples of activities include:

1. Pupils in several Highland schools are providing information on defining the SHANARRI Wellbeing Indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included) in a child-friendly way, to inform an evaluation tool for schools to use alongside other existing measures of wellbeing. This will sit alongside the Equalities Guidance written by the pupils at Nairn Academy last year[1].
2. Supported by the Northern Alliance and in partnership with Education Scotland and Aberdeen University, a research project on the development of wellbeing in schools is being progressed. The research aims to pull together a number of case studies to guide and support schools with ideas of activities and approaches that are already working. These good practice examples will also allow staff to draw out the key components of 'what works' within schools to support positive mental health and wellbeing.
3. The value of well informed and skilled staff is constantly being acknowledged and supported through a series of training modules. Some are existing courses, i.e. Mental Health Awareness, Trauma Informed Approaches, Listening Skills, Nurture for All. Others are in development and will be offered to support all staff in schools over a period of time to incrementally enhance their understanding and skill in working with children and young people in a way that promotes emotional wellbeing and sustains positive mental health.

School health drama programme: You Are Not Alone

In 2017, Argyll and Bute piloted the School Heath Drama Programme called 'You Are Not Alone'. Every year, it was delivered to S3 pupils from each of the ten secondary schools, making it a stable and valuable part of the curriculum. Lead by Health Improvement and Education, the multi-agency investment and partnership working has enabled this interactive drama tour to reach remote and rural communities. In 2020, due to COVID-19 guidance the live drama production was offered online, allowing it to be presented in classrooms at the teacher's convenience.

You Are Not Alone delivered by Raenbow Productions

The programme delivers three short productions using comedy, music and interaction with the audience to get across powerful messages. It addresses social issues such as stereotypes and stigma, social media, peer pressure, relationships, sending sexually explicit photographs, alcohol, mental health, self harm and suicide. Pupils have an opportunity to discuss dilemmas characters present, ask questions, consider solutions and explore what support is available for them to access.

Bespoke resources including a booklet to encourage resilience and help young people think about their support networks are provided as well as valuable discussions with their teachers in class lessons. Through pupil, teacher and service evaluations, we know this programme is highly valued. It increases young people's awareness of services and helps to engage them in services.

Cool2Talk

The Argyll and Bute Health Improvement Team commission third sector organisations who specialise in working with young people to respond to questions from 12 - 26 year olds via an interactive website. Argyll and Bute Children's Strategic Group made an ongoing commitment to fund this service until the 31st of March 2023. The Argyll and Bute Alcohol and Drugs Partnership have agreed to be the main funders of this initiative; with an additional financial contribution from Argyll and Bute Children's partners; Public Health, Argyll and Bute Education Authority, Police Scotland, Scottish Fire and Rescue and the Argyll and Bute Health and Social Care Partnership.

Cool2Talk - free, anonymous, confidential advice for young people, aged 12 plus

Argyll and Bute's young people can anonymously post their health related questions and have them answered honestly and accurately within 24 hours. Questions concerning mental health are one of the top three issues young people take to Cool2Talk. The site offers a question and answer service, addresses stigma, promotes openness about mental health, offers reassurance, encouragement, information and advice. Cool2Talk respond to general questions young people have about the topic of suicide and signpost to other specialist support either local or national where appropriate. The site's target audience is young people aged 12-26.

Developing a trauma informed workforce

Living through traumatic events and adverse childhood experiences increases the risk of inequalities, disadvantage and poorer outcomes including poor physical and mental health and reduced educational and social attainment. Encouraging public sector services to change the way they think about people's difficulties and ask not "what's wrong with you?" but "what has happened to you?" is an important step in developing a workforce that is trauma informed. There is emerging evidence that trauma informed systems can have better outcomes for people affected by trauma and adversity.

The National Transforming Psychological Framework recognises the need for trauma related knowledge and skills across the whole workforce, not just for those with a remit to respond directly to the needs of those affected by trauma and adversity[2].

Within NHS Highland and The Highland Council, Trauma Champions have been identified and supported to embed trauma informed practice within their own workforce and the workforce of other agencies across Highland. The Mental Health Delivery Group of the Highland Community Planning Partnership is supporting work to engage partners in discussions about developing a trauma informed workforce and provide opportunities for reflection and planning, supported by training which meets the needs and context of individual organisations.

Universal/primary prevention: Getting by ~80% of population

Financial stress can impact and underline family relationships and wellbeing.

- The Highland Council Health Visitor Financial Inclusion Project has been recognised at the Children Young People's Improvement Collaborative winning an award.
- The Argyll and Bute Youth Advisory Panel was also recognised by the Children Young People's Improvement Collaborative by giving a voice in shaping services for children and young people.
- The Health Improvement Team (North Highland) has detailed a social mitigation plan to respond to the unintended societal and family impacts of COVID-19 measures.

A key insight from the discussion and learning of adversity and trauma in childhood and the influences and impact over the life course is how responsive relationships buffer and offset experiences of adversity and how language rich experiences for young children create the foundations for health and wellbeing across life. Relational health is associated with improved mental health, a healthy immune system and improved cognitive function while buffering the effects of adversity and trauma.

- Work in early years settings and schools across Argyll and Bute and Highland Council seeks to foster supportive relationships and embedding key lessons from the Highland-wide Promoting Positive Relationships training and the Argyll and Bute educational psychology teams.
- There are support and training sessions to parents in Argyll and Bute and North Highland on understanding and supporting teenagers (stress, relationships, mindfulness) and through respective youth and third sector providers.
- Improvements to the PSE course are being rolled out to Argyll and Bute and Highland Council schools as part of the Relationships, Sexual Health and Parenthood curriculum.
- Work is in progress in North Highland with Highland Sexual Health to develop a web-chat service to improve access of young people to sexual health support.

Secondary prevention Getting help ~15% population

- Infants, children and young people who are understood to be struggling by services have their needs explored and understood through antenatal and child's plan/Getting it right for every child (GIRFEC) processes in North Highland and Argyll and Bute.
- Recruitment is taking place to infant and perinatal mental health posts in Argyll and Bute and North Highland Partnership to support maternal and infant mental health from pre-conception to toddler times across universal and more targeted services.
- Plans to support the delivery of training in Adverse Childhood Experiences and Trauma informed practice at an appropriate level for all staff as advised by the NES training programme are in development in North Highland as Argyll and Bute delivers trauma training as a NES pilot site.
- Professionals and practitioners are being supported to create cultures and practice that are trauma informed and responsive. These approaches seek to raise awareness of the importance of children and young people experiencing safety and trust in their relationships, how this support collaboration and trust, supports resilience and individual and collective empowerment. These approaches feature in the integrated service plans for the Highland and Argyll and Bute Children and Young People Integrated Planning processes.

Tertiary prevention Getting more help and risk assessment ~5% population

Infants, children and young people who are identified as particularly vulnerable to family, individual and community pressures and stressors are generally captured in the Child Protection (Child Protection Committees) and Care Experience (Looked After) structures (Corporate Parenting Boards). In addition, adult needs that impact on children are often reflected in the work of the Alcohol and Drug Partnerships, Violence Against Women, and Community Justice Partnerships. This presents a range of opportunities to join the dots and work through family and community approaches to offset risks and harms.

- Chairs of the Public Protection Committees in both Highland and Argyll and Bute are looking to collaborate in their planning. In March 2021, the Highland Child Protection Committee and the Community Justice Partnership hosted a joint learning event to consider the needs of children and young people at risk of criminal exploitation, a cohort, also known to be at greater risk of suicide and related levels of distress/ family stressors.

Mental health engagement in Argyll and Bute

The Public Health Information Team in Argyll and Bute carried out a defined needs assessment on the impact of the pandemic during winter 2020-21. This identified increasing mental health needs and wider socio-economic impacts on employment and household income. Anticipated mental health impacts include more people experiencing distress and an increased need for mental health support. This has informed ongoing mental health improvement work in Argyll and Bute throughout 2021.

A live illustration drawn by Katie Chappell to describe feedback from people with service experience as part of the mental health engagement work undertaken by Jean's Bothy.

In response to this, the Health Improvement Team commissioned third sector organisations already working with people in receipt of mental health services to conduct engagement exercises between March and September 2021. ACUMEN, Support in Mind Scotland (SiMS) and Jean's Bothy delivered a range of engagement exercises and helped empower those with lived experiences to express what it was like accessing support during the pandemic and how the pandemic affected people who have mental health conditions.

Engagement work was undertaken with people known to services and their carers, people from island communities, men's groups and LGBTQ+ groups. All organisations reported that the pandemic had impacted on respondent's mental wellbeing. Some of the key themes that emerged were digital connectivity, community and peer support and access to professional support. Digital connectivity was reported as being essential during lockdowns and feedback recognised the benefits of staying connected using online platforms. Furthermore, there was widespread recognition that a blended approach of online and face-to-face support would allow more choice in future.

The role of community was found to be important to all groups. Feedback suggested that island communities fared better than other groups and that strong community cohesion on the islands pre-pandemic benefited island communities during the pandemic. The majority of respondents highlighted community connectedness as being beneficial to mental wellbeing. Responses in relation to professional support were generally negative. There was a recognition that support would be delivered differently during the pandemic, but many expressed the belief that changes were poorly communicated.

This engagement activity has helped put the voices of people with lived experience at the heart of service planning and delivery, forming an instrumental part of future strategic planning.

Paddlewell

Paddlewell is an innovative pilot to support Police Scotland - Highland and Islands Division police officers in their journey towards better wellbeing and managing day-to-day stresses and strains through the water-based activities of paddleboarding and kayaking. It is an example of 'blue health' which is based on the premise that being in or around water is good for our health and wellbeing.

The Paddlewell sessions were designed to explore four mental health strategies including mindfulness and peer support. The sessions supported activities that use the water to support feelings of wellbeing. The activities were coordinated so that candidates had one to one time with a peer paddle boarding and then kayaking. There was also time built in for group paddle and focus sessions to discuss the impacts of the activity on their feelings of wellbeing.

Nine participants took part in this pilot. Participants reported increases in:

- Contentment in self
- resilience and ability to cope with stress
- managing wellbeing
- connection with work and peers.

Further feedback indicated that the activity supported:

- Mindfulness - participants felt a focus on the task, felt away from distractions, had the space to be mindful, and felt relaxed
- 'blue therapy' - participants felt supported, able to talk, comfortable, and surrounded by people who understood
- immersion therapy - participants enjoyed being in the water and commented on this regularly e.g. peaceful, sound of water
- 'blue health' - participants felt an exhilaration of being in the water and a sense of achievement after the session.

It was clear that there was a shift in the participants feelings of wellbeing and resilience. The most notable change being that participants felt more able to cope with life's stresses. As a result of the positive feedback it is proposed to extend the pilot next year to more sessions across a wider area.

The project was initiated and led by a Chief Inspector within the Highland and Islands Division, and the division's Mental Health and Wellbeing Project Officer. The Paddlewell sessions were co-ordinated and facilitated by qualified paddle sports coaches, who were also serving and operationally active police officers. NHS Highland Public Health team supported and advised on the project, provided mental health training to coaches, and evaluation assistance.

Highland Green Health Partnership

The Highland Green Health Partnership was established in 2018 and is one of four initiatives in Scotland stemming from Our Natural Health Service which aims to show how Scotland's natural environment is a resource that can be used to help tackle some of our key health issues including mental health. Connecting with nature can promote good mental health by combating fatigue, boosting self-esteem, reducing feelings of depression and improving concentration. In Highland, the Green Health Partnership works with health and social care practitioners to encourage patients and service users to participate in green health activities. The overall aim is to get more people to connect with nature more regularly and target action at those most in need.

Activities can include walking, cycling, relaxation and mindfulness. Through a dedicated website - www.thinkhealththinknature.scot, the partnership hosts a directory of services and promotes a number of self-led tools and resources to encourage connection with nature from home or on the doorstep.

The Green Health Partnership also supports initiatives such as Branching Out - a 12 week programme for adults with mental health issues accessed through the Community Mental Health teams. A number of programmes have been established in Highland offering a range of woodland crafts and activities to develop confidence, self-esteem and promote team working.

In May 2021, the Green Health Partnership and Mental Health Delivery group worked in partnership to support the Mental Health Awareness week theme of connecting with nature for mental wellbeing through a range of outdoor activities.

Highland Community Planning Partnership Mental Health and Wellbeing Delivery Group - Mental wellbeing signposting resource

The Community Planning Partnership brings together public agencies, third sector organisations and other key community groups to work collaboratively with the people of Highland to deliver better outcomes, including outcomes around mental health and wellbeing. The Mental Health Delivery group is one of five thematic groups and aims to provide appropriate support and facilitation in order that people in Highland will benefit from good mental health and wellbeing.

Highland Community Planning Partnership

Signposting to mental health and wellbeing resources

The impact of the measures to reduce the spread of the COVID-19 has placed increased pressure and uncertainty on everyone so it's important to know where to find help and support for our mental health and wellbeing when it is needed. There are services where you can find confidential and trusted support, these include:

Help in a crisis

The following advice is intended for crisis situations which happen only rarely. A mental health crisis is when someone feels their mental health is at breaking point and they need urgent help and support.

If you are concerned that you are, or if you feel that someone else is, in immediate danger call **999**. If you are calling for someone else, try to establish the person's, name, contact details and location.

If the crisis is not life-threatening but you are concerned for your own or somebody else's mental health, advise them to call NHS 24 on **111** or speak to their GP. The route into formal mental health services is through a GP surgery. If someone discloses to you that they are already in receipt of support for their own mental health they should be directed to link in with that pre-existing support.

Support, advice and resources can also be found at:

- Samaritans - 116 123 (calls are free and do not show on a phone bill)
- Breathing Space - **0800 83 85 87** (Monday to Thursday 6pm – 2am; Friday 6pm to Monday 6am)
- Miley's Line - **07786 207755** (Sunday to Thursday 6pm - 10pm, Friday to Saturday 7pm - 2am)
  - Young People can email yp@mileysline.co.uk for an appointment
  - The Hive , 19 Academy Street, Inverness – closed during lockdown - 10pm)
- National Scottish Domestic Abuse Helpline - **0800 027 1234**
- Rape and Sexual Abuse Service Highland (RASASH) - **03330 066 909** (Monday/Wednesday/Friday 9.30am till 12.30pm; Tuesday and Thursday 1.00pm till 4.30pm). Text support Service: **07451 288 080** Support email: support@rasash.org.uk
- Rape Crisis Scotland - **08088 01 03 02** (Phone free any day between 6pm and midnight) Text: **07537 410 027** (If no immediate response, let them know when is a safe time to contact you)
- LGBT Helpline Scotland **0300 123 2523**
- Childline - **0800 111**
- CRUSE Bereavement Care Scotland - **0845 600 2227**
- James Support group - **07563 572 471** (24 hour helpline)

Non-crisis situations

In most instances where mental health concerns are raised it will not be a crisis. If you have, or someone you are in contact with has concerns about mental ill health, a GP should be the first point of contact.

It is understandable in the current pandemic that many people will feel anxious, worried or stressed. For those who are in need of emotional/wellbeing support or who are affected by isolation due to the current COVID-19 circumstance, you might want to look for local voluntary organisation who can offer a 'regular welfare call or suggest contact with a befriending service.

Additional resources

While we can't control many of the challenges around us, there are still things we can do to protect our mental health and wellbeing. Check out any of the resources:

Befrienders Highland
www.befriendershighland.org.uk
A small voluntary organisation working to improve the lives of people who are lonely and isolated and have experience of mental ill health; memory difficulties or dementia and carers.

Clear Your Head
clearyourhead.scot
Great tips from the Scottish Government and partners to help get you through these difficult times.

Highland Mental Wellbeing
www.highlandmentalwellbeing.scot.nhs.uk
A collection of resources to support mental wellbeing

Highland Digital School Hub: Wellbeing for all
www.highlanddigitalschoolshub.com/wellbeing-for-all
Resources to use at home to help with going back to school, and resources for school staff to support themselves

SAMH Information Service
www.samh.org.uk/informationservice
You can talk to their Information team about mental health on **0344 800 0550**, and there is a range of information on support, including:

- If you urgently need help - http://bit.ly/3buW3OF
  SAMH have put together a list of organisations who can help if you need to speak to someone.
- Protect your wellbeing in winter - http://bit.ly/2NZ4WYs
  Some of us may struggle with our mental health and wellbeing during the colder months.

Prevent Suicide – Highland App
The 'Prevent Suicide – Highland' app can be downloaded for smart devices from:

- Apple App Store - https://apple.co/3ukb2nf
- Google Play Store - http://bit.ly/37FiFuS

NHS Education for Scotland (NES) national animations (each video is approximately five minutes in length)
A series of videos promoting children and young people's mental health and preventing self harm and suicide:

- What is mental health? - https://vimeo.com/450051310
- How to talk about mental health - https://vimeo.com/450052951
- Self-harm and suicide prevention - https://vimeo.com/450054407

A series of videos for adults are also available:

- Ask, tell, look after your mental health - https://vimeo.com/338176495
- Ask, tell, have a healthy conversation - https://vimeo.com/338176444
- Ask, tell, save a life – every life matters - https://vimeo.com/338176393

This resource has been produced by the Highland Community Planning Partnership Mental Health & Wellbeing Delivery group
If you require a copy of this guide in an alternative format please contact the Highland CPP by emailing admin@highlandspp.org.uk

The Mental Health Delivery Group listened to feedback from local communities about the impact of COVID-19 and what is most important to people when it comes to accessing support for mental health and wellbeing. Some of the priorities for Highland communities included knowing how and where to get help and support when needed and to be able to access trusted and reliable sources of information, recognising that getting news from unreliable sources can heighten worry and anxiety which is unhelpful when it comes to mental wellbeing. People recognise that being able to talk openly and honestly about mental health helps to break down barriers, reduce stigma and assists the recovery journey for people experiencing mental ill health.

In response to this feedback, The Mental Health Delivery Group created a new Partnership resource which includes a comprehensive list of reliable sources, which can help people to access the right support at the right time. The resource signposts individuals and communities to trusted sources of information and support to raise awareness of where to get help in a crisis and how to develop skills and confidence to have conversations about mental health with loved ones. The resource highlights that there are many options available in communities across Highland to support people in maintaining good mental health or to assist them on their recovery journey.

The Community Planning Partnership launched the Signposting resource to coincide with the start of Mental Health Awareness Week (10th-16th May 2021) and is available to download from the Health Information & Resource Service in various formats - https://bit.ly/3mnk68m

Highland Mental Wellbeing Toolkit

The Health Improvement Team in Highland created an online directory, designed to support quick and effective access to information and resources that support mental wellbeing. Designed as a toolkit, the website signposts people to organisations and services ranging from those nationally established, e.g. Samaritans, to those local, smaller organisations, e.g. Mikeysline.

Acknowledging how difficult it can be to navigate on-line information, the toolkit aims to highlight some of the best websites and sources of help directed at people of all ages. The toolkit enables people to look after their own mental wellbeing and recognise when help is needed.

It also provides information about training and resources, for those in a 'helping' or supporting role. Information is updated regularly to ensure that it is relevant and up to date for the population of Highland - www.highlandmentalwellbeing.scot.nhs.uk/

Living Well Self-management Grant

Recovery Across Mental Health (RAMH) in Argyll and Bute employs 180 full and part-time staff, promotes recovery from mental ill health and empowers people to build independent and fulfilled lives. The service (ACUMEN) received funding from a Living Well Self-management Grant and in partnership with national charity Support in Mind Scotland and the Lade Centre/Argyll and Bute Listening Service piloted a Supported Self Care Planning (SSCP) initiative. Supported self -care planning helps empower people to better self- manage their emotional and mental needs during and after the pandemic.

The service is accessible to everyone; however the focus is primarily on people who are not currently accessing mental health services support. The initiative aims to better connect people with assets in their local communities to encourage them to take a holistic approach to their wellbeing including, where appropriate, being more physically active.

The Living Well Self-management Grant enabled ACUMEN to raise awareness with people living and working in Argyll and Bute of the principles of self- care planning and self- management. ACUMEN aim to directly support up to 200 people to complete a self- care plan during a 12-month period and engage significantly more people indirectly in the initiative.

Argyll and Bute Living Well Networks

Emotional and Mental Wellbeing is one of four priorities within the Argyll and Bute Living Well Action Plan. The Health Improvement Team commission Argyll and Bute's Living Well Network Co-ordinators to develop and deliver a local action plan consisting of priorities from Argyll and Bute Alcohol and Drugs Partnership, Argyll and Bute Public Health Workplan and the Argyll and Bute Living Well Strategy. In 2021, seven out of the eight networks adopted the Argyll and Bute Living Well priority of Emotional and Mental Wellbeing to form part of their local action plan.

Many of the local networks have dedicated one of their quarterly meetings to Emotional and Mental Wellbeing by inviting speakers, discussing local needs and support and providing a local platform for networking and sharing of information. The Network Co-ordinators also have a role in representing their network and developing their action plan by attending other local meetings.

Suicide Prevention

Suicide prevention has been a key policy area in Scotland since 2002 with the launch of the Choose Life action plan. The Mental Health Strategy for Scotland 2017-2027[3] committed to developing a new suicide prevention strategy or action plan and in 2018, the Scottish Government published the current suicide prevention action plan 'Every Life Matters', Scotland's Suicide Prevention Action Plan 2018 – 2021[4]. This plan aims to further reduce suicide by 20% by 2022 from the 2017 rate. The vision is of a Scotland where suicide is preventable; where help and support is available to anyone contemplating suicide and to those who have lost a loved one to suicide. Consultation is currently underway to inform a new Suicide Prevention Strategy for Scotland beyond 2022.

Understanding and implementing preventive strategies that respond to stress in infancy and childhood is a policy issue that merits attention as a long-term preventive strategy to reduce suicide rates in NHS Highland. This involves addressing health inequalities and the determinants of health, adult relationship skills and conflict/violence in the home and communities and empathetic and discerning support for parents who are struggling; the starting point being 'What happened to you?'.

The following information describes some of the preventative initiatives currently being delivered to help reduce suicides in our communities.

Suicide Intervention and Prevention Programme (SIPP) training

In 2018, the Highland Community Planning Partnership (CPP) agreed to undertake some focused work on suicide prevention, reflecting concern about rates of suicide in Highland. The NHS Highland Public Health Directorate's Health Improvement Team developed the Suicide Intervention and Prevention Programme (SIPP) on behalf of the CPP to support staff from across the partnership to develop their knowledge and confidence in suicide prevention. The course includes information on how to recognise people at risk of suicide and how to support someone at risk of suicide. The course complies with national requirements for suicide prevention training.

Due to the COVID-19 pandemic restrictions, the SIPP course was developed to allow for delivery online. Demand for SIPP training has been very high. In 2021, 15 SIPP courses were delivered to more than 120 participants, and more are planned for 2022. Seven new trainers completed their 'training for trainers' in July 2021 and many have already delivered their first course. There are 20 trainers in Highland, from a range of partner organisations including Highland Council, Highlife Highland, NHS Highland, Highlands and Islands Enterprise, Scotland Fire and Rescue Service and a number of third sector organisations.

Feedback from those attending SIPP courses has been extremely positive. The majority of participants feel they are learning information that is new to them and will support them in their work. Almost all participants say that they would recommend the course to others.

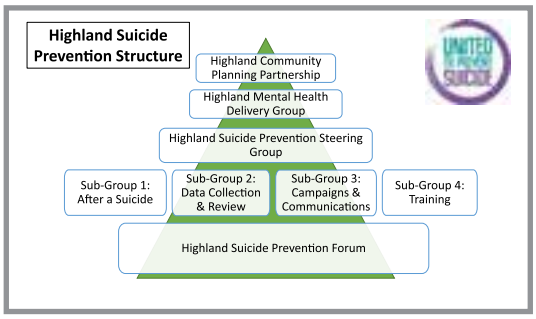
Argyll and Bute Suicide Prevention Strategy Group

The local structure for suicide prevention is well established within Argyll and Bute and complements Scotland's commitment to mental health and suicide prevention. The Argyll and Bute Suicide Prevention Strategy Group is a multi-agency and multi-disciplinary group with representation from Police Scotland, the Royal Navy, third sector partners, social work, child protection and other NHS Highland colleagues. Chaired by the Interim Chief Officer, Argyll and Bute HSCP, partners are committed to delivering a local action plan supporting the delivery of Scottish Government's 'Every Life Matters', Scotland's Suicide Prevention Action Plan 2018 – 2021[4].

The group has developed programmes of work on data, communications, training and bereavement support to deliver a range of interventions to meet the needs of both adults and children. The Argyll and Bute Suicide Prevention Action plan is being reviewed to take into account the unanticipated changes to our lives since the start of the COVID-19 pandemic and supporting local consultation and planning for the new national strategy for suicide prevention anticipated to be published in 2022. The strategy group sits within the Argyll and Bute Community Planning Partnership structure, reporting to the Community Planning Partnership Management Committee.

The Highland Suicide Prevention Steering group

The Highland Suicide Prevention Steering group is a multi-agency group, within the Highland Community Planning Partnership. The group oversee and manage delivery of local objectives in relation to suicide prevention, in line with the Scottish Government's 'Every Life Matters', Scotland's Suicide Prevention Action Plan, 2018 – 2021[4].



The key objectives of the group are to develop and support initiatives that will:

- Reduce the risk of suicide in key high risk groups
- provide timely information and support to those bereaved or affected by suicide
- deliver targeted prevention approaches
- support research, data collection and monitoring
- develop sensitive communication approaches to suicide and suicidal behaviour.

Four working groups have been created to support delivery of the local action plan including; targeted information and support for those bereaved or affected by suicide, establishing methods for reviewing all relevant local health intelligence data and monitoring, and targeted prevention approaches including workplace support for suicide prevention training.

The steering group has worked closely with communications teams across the partnership to support timely communications and messaging on all aspects of mental wellbeing and suicide prevention, including community-based awareness campaigns which aim to improve mental health and reduce stigma and discrimination which can make it difficult for people experiencing mental health problems or suicidal ideation to seek help.

The steering group sits within the Highland Community Planning Partnership structure, reporting to the Highland Mental Health Delivery Group and Highland Community Planning Partnership Board.

United to Prevent Suicide campaign

The United to Prevent Suicide national campaign arose from work with the National Suicide Prevention Leadership Group and partners to encourage a coordinated approach to public awareness campaigns including social media messaging around suicide prevention[5]. One aspect of the United to Prevent Suicide campaign is creation of FC United – branded as Scotland's second national team. The campaign aims to reach people through football-related social media with well-known names sharing personal stories. Local football clubs, Inverness Caledonian Thistle and Ross County, teamed up with local mental health charity Mikeysline on World Suicide Prevention Day to support the campaign. Many involved in football in Highland including John Robertson and Steven Ferguson have become ambassadors for Mikeysline; promoting conversations about mental health and suicide prevention, tackling stigma around poor mental health and encouraging people to reach out for support with their mental health and wellbeing.

Community Action to Prevent Suicide and Support People Affected

Across the Highlands are some excellent examples of community built responses for those affected by suicide. Initiated by people with lived experience, it is clear that the impact of stigma around mental health and suicide motivates communities and the bereaved, to raise awareness, challenge stigmatising words and behaviours and open doors with people who may otherwise be silenced by stigma and shame.

Suicide Bereavement Support Service

The suicide bereavement support service in NHS Highland is one of two pilot services in Scotland funded by Scottish Government to provide person-centred, compassionate support to families and individuals, including children and young people, who have been impacted by the loss of a loved one to suicide[5]. Penumbra and Support in Mind Scotland, two of Scotland's leading mental health charities, are working in partnership to deliver the services across two health board areas, NHS Ayrshire & Arran and NHS Highland.

The specialist teams of bereavement support workers provide customised support relevant to each family's circumstances, including offering practical support with tasks such as making funeral arrangements, or linking families with other local services. The staff are trained to recognise potential risks or wider safeguarding issues, including signs and symptoms of suicidal ideation and also listen and be a source of support as people come to terms with their loss.

The service is also intended to help reduce suicide, as evidence shows that up to 10% of people bereaved by suicide may go on to attempt to complete suicide. The service will be independently reviewed to learn how best to support families bereaved by suicide. The evaluation will also help inform future planning of bereavement support services.

The pilot Suicide Bereavement Support Service is available to people living in the NHS Highland area. For more information, email: suicidebereavementsupport@nhs.scot or call 0800 471 4768.

Mikeysline

People can struggle daily with a multitude of mental health and emotional issues, which impact their life and health, yet only a fraction of people feel able to talk about it. At Mikeysline, suicide prevention and mental health awareness work is at the core of the work to break down the stigma associated with seeking support for emotional distress. That it is 'okay not to be okay' and that no one should suffer in silence - www.mikeysline.co.uk/

Ewen's Room

Ewen's Room is a mental health and wellbeing charity based in the West Highlands of Scotland and is passionate about supporting mental health and wellbeing and working to raise awareness and reduce stigma around mental health issues.

Read Ewen's Story though the eyes of his mother - www.ewensroom.com/about-er/ewens-story/

Prevent Suicide Highland app

Launched in November 2018 alongside a program of SIPP Training, this app was adapted by the Health Improvement Team of NHS Highland on behalf of the Highland Community Planning Partnership. The app aims to help prevent suicide in the north of Scotland by providing quick and easily accessible information on:

- Safety Planning - the app allows users to complete a 'Prevent Suicide' safety plan including details of who they would wish to contact should they find themselves feeling distressed or suicidal.
- Support Services - telephone numbers for local and national helplines are included which can offer support in some situations where people are feeling distressed or suicidal.
- Guidance for members of the public - information on what do to help someone experiencing mental distress and perhaps contemplating suicide.

In the three year period from November 2018 to November 2021, the app has been used by 2,700 people and accessed more than 6,500 times.

Child Suicide Prevention Training

The Argyll and Bute Suicide Prevention Strategy Group identified a need for multi-agency and multi-disciplinary child suicide prevention training. The Lifeworks Assessing Suicide in Kids (ASK) Suicide Workshop programme was chosen to build workforce capacity, knowledge and skills. The programme focuses on children and young people aged five to fourteen years old. The workshops specifically address suicide risk in children and provides developmentally appropriate tools and strategies to identify, gather and organise key details needed to assess risk and inform safety planning. The course adopts a blended approach whereby participants individually complete online training modules before attending face-to-face sessions that are delivered using an online video platform.

A&B Suicide Prevention Strategy Training Sub Group purchased the Lifeworks Assessing Suicide in Kids (ASK) Suicide Workshop training. Within the first 6 months, demand lead to 80 places being secured and a comittment to running two courses in 2022.

The workshop sessions include mini-lectures, group work, case studies, and guided simulations.

The courses have evaluated well, and staff have commented on how helpful they found the workshop, one participant fed back:

> *"The course was extremely good. I found it to be very helpful, informative and I have come away with some tools which I feel can be put to good use in our school. I am working with pupils who have expressed suicidal thoughts at present and others that I am concerned about and who are self-harming. This is mostly related to bullying and anxiety in school. These pupils are unhappy in school, so lockdown was beneficial to them."*

Initially, the training was aimed at primary and secondary school staff before expanding it to third sector organisations and other public sector teams. The training received a high level of interest; at first, two courses offering twelve places each was offered but demand led to an additional two courses being delivered to secure a total of eighty places over six months. The training subgroup has committed to offering two courses each year as part of the Argyll and Bute Suicide Prevention Action Plan.

Friendship Benches

National resources "Ask, Tell, Save a Life: Every Life Matters" reminds us that we all already have the skills to start a conversation with someone who needs help, giving them the confidence to act. However, a recent YouGov poll showed how the pandemic has affected people's confidence when it comes to small talk. 1 in 5 people are more likely to want to make small talk with strangers now that restrictions are generally lifted. However, around 18% of those who said they are less likely to want to make small talk said it was because they were nervous about doing so after not talking to strangers for a prolonged period of time[6].

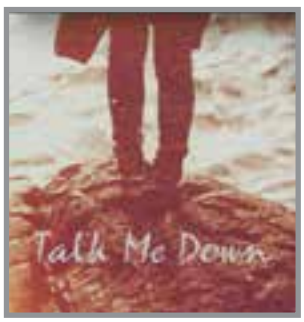
Every Friendship Bench in Argyll and Bute has a plaque attached to it to prompt conversation and ask "Are you ok?". Each one has signposting information for further support.

The Friendship Benches were made by the Men Sheds group in Dunoon. Community collaboration has enabled up to 56, brightly coloured and hand made Friendship Benches to be produced for Argyll and Bute.

As part of community engagement, Argyll and Bute Suicide Prevention Strategy Group in partnership with Police Scotland, identified friendship benches as a means to reduce stigma and encourage people to talk. It was agreed to create friendship benches to encourage people to get outdoors and start a conversation with others. The benches provide somewhere to sit, enjoy the outdoors and the signage encourages people to ask those sitting next to them "Are you okay?". The local community councils chose locations for the benches and Argyll and Bute Council placed and secured them for the communities to enjoy.

Talk Me Down

A local singer song writer, Jamie Titterton wrote a song called 'Talk Me Down'. The song was produced by his band, *Jacob and the Starry Eyed Shadows,* to raise local awareness about suicide and promote prevention. Jamie approached United to Prevent Suicide and the Argyll and Bute Suicide Prevention Strategy Group who welcomed the opportunity to work with Jamie and support the release of this song and accompanying video which provides messages of support, encourages people to talk and provides information about suicide.



Released on World Suicide Day, 2021, the single "Talk Me Down" by the local band Jacob and the Starry Eyed Shadows was released to raise awareness about suicide and encourage suicide prevention.

Chapter Six - Conclusion

Recommendations

- As part of information collection, suicide audit should be undertaken within NHS Highland to establish further information about the background to suicides and potential for future prevention.
- Consideration should be given to the development of a system of real time surveillance and support for those affected.
- The work of the Highland Suicide Prevention Steering Group and Argyll and Bute Suicide Prevention Strategy Group should be supported and effective up to date strategies and action plans delivered across Highland and Argyll and Bute.
- Evidence on effective interventions for the prevention of suicide should be reviewed. Where services or interventions with good evidence exist but are not in place within NHS Highland, cases should be made for implementation.
- Understanding and implementing preventive strategies that respond to stress in infancy and childhood is a policy issue that should be given attention as a long term preventive strategy to reduce suicide rates in NHS Highland.
- Research and ongoing surveillance of suicide and self-harm data should be developed to monitor the continuing impact of the pandemic on mental health in NHS Highland and respond to changing trends.
- The relationship between poverty, deprivation and urban rural variation in suicide rates in Highland should be researched and the extent to which the Highland picture contributes to rural suicide rates in Scotland should be identified.
- Health intelligence should be prioritised to place suicide in a broader population mental health context that will inform local plans and strategies, including evidence on mental health hospitalisations, mental health prescribing and wider service access.
- Intelligence and evidence should be provided to support mitigation of the mental health impacts of the pandemic in NHS Highland.
- The COVID-19 Social Mitigation Action Plan should be implemented involving all relevant services and partners and deliver specific actions relating to mental health and wellbeing and suicide prevention.
- Assessment should be undertaken of the impact of policies, plans and service changes on at-risk groups, taking a 'Health In All Policies' approach.
- Available resources should be targeted towards groups experiencing multiple disadvantage to mitigate the mental health impacts of the COVID-19 pandemic.
- A network of mental health first aiders in workplaces should be trained, developed and supported that puts provision of mental health first aid on an equal footing as physical health first aid.
- Where appropriate to do so, the use of self-help and self-management materials should be developed to help people build personal resilience.
- A Trauma informed community of practice should be developed; an identified, strategic network of Champions to implement the Transforming Psychological Trauma Knowledge and Skills Framework for the workforce.
- Suicide Prevention training should be delivered and use of the Prevent Suicide Highland app should be promoted.
- The suite of digital resources available to support positive mental health and wellbeing should be developed and where possible, a once for Highland approach taken.
- Consistent public messaging on mental health and suicide prevention should be promoted.
- Preventative approaches that increase personal and community resilience should be prioritised.
- The mental health and wellbeing of the workforce through promotion of local and national wellbeing resources and hubs should be prioritised.

Progress on Recommendations from the 2020 Report

Last year's report focused predominantly on COVID and its recommendations largely related to social mitigation. The social mitigation strategy and action plan has been approved by NHS Highland Board. Implementation work has started but considerable additional work will be needed.

Concluding statement

This report has set out a considerable amount of information relating to both suicide and mental illness. There is much more information both available and needing to be found, but it is most important that across NHS Highland we focus on what effective actions need to be put in place to improve mental wellbeing and reduce the rate of suicide.

I hope that all readers will take note of this report's content and recommendations and consider what actions both they and their organisations can take.

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Images

Photos found throughout the report have been provided by and are used under licence from the NHS Scotland Photo Library and Adobe Stock.

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Notes

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