



EuroHealthNet Country Exchange Visit

Approaches to suicide prevention and Mental Health Promotion in Stockholm and in the European Union

Host: Stockholm
County Council



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Introduction

EuroHealthNet and Stockholm City Council organised a country exchange visit on Approaches to suicide prevention and Mental Health Promotion in Stockholm and in the European Union. The aim was to explore ongoing initiatives to support good mental health in Member States and at the European level, and to facilitate exchange of best practices, best policies, and experience between senior staff from national and regional organisations.

Participants from Belgium, Greece, Italy, the Netherlands, Slovenia, Sweden, and the United Kingdom took part in the visit. The country exchange visit was hosted by the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP).

The visit took place within EuroHealthNet's contract agreement with the European Commission DG Employment, Social Affairs and Inclusion under the EU Programme for Employment and Social Innovation (EaSI).

Day one

Introduction

Participants introduced themselves and expressed what they hoped to gain from the country exchange visit. Overall, all wished to learn from experiences and promising practices in Sweden and in other countries involved around the topic of suicide prevention (e.g. increasing the capacity of health care professionals, health promotion and prevention plans, advocacy to put suicide prevention on the political agenda).

Suicide Prevention in Stockholm county (SPIS) – *Sebastian Hökby, NASP*

There are around 1500 suicides in Stockholm annually and around 8000 attempters every year in Sweden, of which 20% are in Stockholm.

The aim of the SPIS project, which began in 2009, was to improve collaboration between first responders (and between first responders and other organisations) and to enhance suicide prevention work. They also worked on opportunity reduction through physical and infrastructure measures.

The members of the project were brought together through shared interest. They began working without a mandate and before a budget had been approved. The partners included:

- NASP
- Other members of Stockholm county council
- Emergency call centre (SOS Alarm)
- Police authority
- Fire and rescue department
- Ambulance service
- The Swedish Prison and Probation Service
- National association for suicide prevention and bereavement support (SPES)
- The Swedish Transport Administration
- Stockholm Public Transport

SPIS Alerts

The creation of 'SPIS alerts', a new emergency code for suicide threats, was an important output of the project.

Previously when suicidal behaviour or threats were reported, emergency call centre staff made referrals to emergency services, mostly fire, which dealt with minimising chance of injury and or clearing the scene rather than engaging with the individual. When several emergency services arrived on the scene it was sometimes unclear who should take charge of the situation, and the person in danger may have dealt with multiple service providers which could cause confusion and further distress. The emergency services recognised the need to change.

Now, when suicidal behaviour is reported, a specific alert is triggered. There is an agreement that the first team on the scene takes charge and one service provider is the main personal contact for the patient. There is now a protocol for handling emergency suicidal behaviour on site and between organisations, and working with the people affected by suicidal behaviour after the emergency has ended. Information is also available for people who may have witnessed such behaviour.

Training for First responders

NASP has developed training for emergency responders in such situations. It is based on the experience and practices of each service, and is unique in being based on the ways the services work together. Due to limited funding, this training course had to be self-sufficient; therefore the course is given in a 'cascading' way – those who take the course train their colleagues. The main course is three hours long and the instructor course is two days.

The course content covers:

1. Information on mental health
2. Myths, prejudice, attitudes, approaches
3. Risk factors for suicide and self-harm
4. Available help resources
5. Legislation and collaboration between organizations
6. The importance of the conversation, active listening
7. Case reports

Blue light psychiatric service

As part of the initiative, a 'blue light psychiatric service' was trialled, which saw nurses traveling in police cars to help manage suicidal behaviour related situations. This proved to be cost prohibitive. Instead, the 'Psychiatric Emergency Mobility' (PAM) initiative was developed, a dedicated psychiatric mobile unit. This is explained in more detail below.

Opportunity Reduction

A 'suicide hotspot group' was assembled to identify areas where suicide attempts were made. The relevant authority could then install physical opportunity reduction measures such as barriers. These were positively evaluated. For example, the public transport recognised the benefits of installing physical barriers in terms of the mental health of their staff potentially involved in such incidents, the financial costs related to service delays, and the service they were providing to citizens.

Statistical monitoring

A statistics group began collecting unofficial suicide prevention data. They concluded that it was not possible to unite existing databases.

Conclusion

The project ended officially in 2012 but SPIS Alerts, PAM, and the barriers remained. Training courses are ongoing.

The psychiatric emergency care and the psychiatric care system in Stockholm County – *Fredrik Bengtsson, Northern Stockholm Psychiatry*

There is one psychiatric hospital unit in Stockholm. It hosts around 60 consultations per day- mostly depression. It also has 14 acute beds. Abuse is dealt with in a separate unit.

Stockholm now also has PAM, a mobile psychiatric unit. It is a vehicle similar in appearance to an ambulance which is staffed by two nurses and one paramedic. It can be called by the police and ambulance services, and often accompanies them. It is available seven days a week between 13:00 – 01:00 as these are the times during which most suicidal behaviour is reported, however the operational hours may soon be extended. PAM deals mostly with suicide prevention, for which it receives around 15 calls per day, and other acute psychiatric care. PAM staff are able to access a patients' medical records through 4g technology, and use the same communication network as other emergency services.

PAM began as a 2 year pilot project with €1.1 million financing, but has now been made permanent.

Results

The outcomes of PAM callouts in the first year are as follows:

- Referral to psychiatric emergency ward: 25%
- Referral to dependency emergency ward: 18%
- Referral child/adolescent psychiatric emergency ward: 4%
- Left at home: 34%
- Other: 8% (referral to somatic emergency ward, direct admission to psychiatric ward)
- Number of suicides at arrival: 4

It is notable that 'left at home' is the most common outcome; none of the patients in this group have gone on to commit suicide.

The review of the first year of operation also found that PAM is

- Providing effective suicide prevention services;
- Relieving pressure on police/somatic ambulances;
- Increasing the quality of medical assessment outside of hospital, and providing the right type of care from the beginning of interaction with health services;
- Decreasing the stigma of psychiatric illness.

National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) activities – Gergö Hadlaczky, NASP

Suicide globally and in Sweden

Suicide is a Global problem. It is the 2nd leading cause of death amongst young people globally, and the 1st in economically advanced countries. It results in 1 death every 40 seconds.

Rates are probably under reported globally. In Sweden deaths both *certainly* and *probably* from suicide are included in the statistics, whereas most countries only count certain deaths. If we only look at certain deaths in Sweden, the rates are roughly the same as the European average. The suicide rate is however declining, particularly among men.

Question: How are health topics prioritised in Sweden?

Answer: It comes through a combination of social and political pressure. For example, until recently lots of work was being done on HIV and STDs; this has now become a less urgent issue compared to mental health, so the money has been redistributed to mental health work.

About NASP

The National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) is Stockholm

County Council's expert in suicide research and prevention, and prevention of mental ill-health. It joined the Karolinska Institute in 2007. This link between the institute and the council helps the flow between research and practice. The institute focuses on intervention programmes, monitoring suicide activities, knowledge transfer and exchange. The main activities of NASP are

- Universal and selective prevention
- Development and evaluation of preventive methods
- Consultation
- Education
- International collaboration

NASP will soon start mapping suicide prevention activities in Stockholm city.

Mental health and governance in Sweden

A National action programme for suicide prevention was passed in parliament in 2008. It forms the base for 9 strategies for suicide prevention.

In Sweden there are 3 levels of government each with own tax-based funding: national (in many cases, the work usually done by ministries is carried out by agencies), regional (which is responsible for health and institutional health), local (which is responsible for schools, elderly care, social services).

The public health agency of Sweden has a commission from the government to coordinate the work related to the national action plan for suicide

Group Discussion: Sweden has a 'zero approach' to suicide. Is this a good thing?

Some participants felt that this approach could be problematic as professionals may be less likely to report incidences - health care providers in particular. It could seem that they don't want to deal with suicidal people and be stigmatising.

To avoid this, the approach is presented as meaning 'Suicide should not be the only option for anyone.' Suicide is described as an accident not a choice, the same way that other medical emergencies are described.

prevention. There is also a regional coordination network, which the agency is also part of. The workload is spread across three divisions: coordination, knowledge, and monitoring.

Coordination. Representatives of high risk groups as well as national agencies and authorities are included in the coordination work. At the beginning of the action, time was taken to map who does what and how people can work together, and to look together at certain topics to see how they can be approached.

Providing knowledge. No new research has been done, but literature reviews have been conducted. They have been looking at effective interventions which come from within and outside the health system.

Monitoring. This involves mapping the situation and progress, and Spreading knowledge online through a dedicated website on suicide prevention.

Group Discussion

The methodology of working together between governmental levels and sectors is simple, but the reality is complex. What are the milestones in finding ways to work together? How can other agencies approach this? How do we know what's going on at different levels?

National and Regional Guidelines for Suicide Prevention – Birger Forsberg, Stockholm County Council - Healthcare Administration

Birger Forsberg stressed the peculiarity of competency for health being held at the regional level. Health is still a national issue, so the national government tries to gain influence by setting aside funds to collaborate with councils and sometimes municipalities on certain issues. This has been the case with mental health and chronic diseases.

As each level of government has its own tax income, they are somewhat independent. This adds a level of complexity. Considerable effort is needed to ensure equality of service provision across the country, as the tax income of and health needs in different municipalities can vary immensely- Stockholm is rich with lots of white collar workers while other areas are more rural, poor, and blue collar. There is a national equality index but this is complex and difficult to agree on, however it allows for money raised on one area to be (partly) be redistributed to others.

The national suicide prevention strategy contains nine elements which relate and are managed at national, regional, and local levels. They are:

1. To promote better life opportunities in order to support the groups that are most at need
2. To minimize alcohol consumption in target and high-risk groups
3. To reduce the availability of means to commit suicide
4. To educate gatekeepers about effective management of persons with suicide risk
5. To support medical, psychological and psychosocial services in preventing suicide
6. To disseminate knowledge about evidence-based methods for reducing suicide
7. To raise the competence of health care personnel
8. To systematically analyse all suicides which occur in the health care system during care and 28 days after discharge from the hospital, so-called 'Lex Maria' regulation
9. To support voluntary organizations

The national strategy has reached a point of high acceptance.

Question: The need for Mental health and suicide prevention is increasingly being recognised in social and political life in several European countries. Why is this?

Suicide is rising in the ranking of causes of death, as deaths from other causes have fallen.

As it is a visible and sudden cause of death is an easier topic to understand than chronic diseases.

Discussion: Low threshold clinics

Some countries operate 'low threshold' alcohol clinics, for alcohol users whose issues are not severe enough for substance misuse clinics to be appropriate. Could a similar style of clinic work for mental health? Could such 'low threshold' mental health and alcohol services be linked?

Discussion: Supporting those affected by suicidal behaviour

The group discussed the need to support **all** those affected by suicidal behaviour – the individuals as well as their family, friends, and wider network.

An action plan for Stockholm County

The city adopted its 'zero suicide' philosophy in 2006, and developed suicide prevention guidelines in 2008. These guidelines cover:

- Efforts directed by the national suicide prevention programme
- Focus on public health oriented prevention
- Focus on intersectoral collaboration, including healthcare services
- Implementation of evidence-based methods

In 2017 the city began developing a specific action plan for Stockholm County, which will be launched in 2019. In 2017/2018 the focus will be on updating existing guidelines. In 2018 the focus will be on mapping, feedback collection, and implementation.

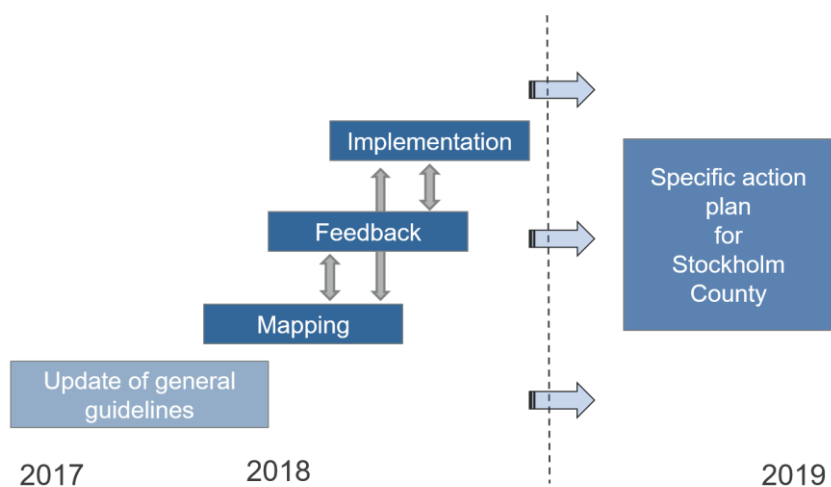


Figure 1 New action-plan for suicide prevention in Stockholm County

Inter-Sectoral Collaboration: Part of Sweden's National Suicide Prevention Policy – Jenny Telander, Public Health Agency of Sweden

The Public Health Agency of Sweden describes itself as 'a public health that strengthens the positive development of society'. It is responsible for all public health issues.

In implementing the nine-point national action plan for suicide prevention, they focus attention on the population groups at greatest risk of mental ill-health

The spread of responsibilities across different levels of government and the large number of stakeholders involved in trying to reduce suicides presents a problem; the effort is spread out, and there is little coordination, communication, or exchange of knowledge and best practice between them.

The agency is developing coordination through a group of national agencies and authorities, and a national interest group of representatives from NGO's and researchers. It is compiling and spreading knowledge by conducting studies and reviews, and publishing brochures. The agency is also monitoring suicide and preventative work by collecting data, performing epidemiological analyses, and mapping the work being done on local and regional levels. Annual reports are published.

Day 2

Presentation of EU Policy context and tools – *Claudia Marinetti, EuroHealthNet*

EuroHealthNet works across sectors using a health in all policies approach (HiAP) to reduce health inequalities, address non-communicable diseases (and the risk factors associated with them) and support sustainable health systems. This means that work focuses also on areas outside the immediate health domain, such as employment, social affairs, and economics. Every year, for instance, EuroHealthNet monitors the European Semester (a cycle of economic and fiscal policy coordination within the EU which is part of the European Union's economic governance framework). Country-Specific Recommendations (CSRs) for all EU Member States are analysed from a health equity and wellbeing perspective. EuroHealthNet members are encouraged to provide input to this process, in order to reinforce efforts to implement policies that have an influence on health and equity. In particular members can:

Discussion: Finance, employment, and mental health.

The group discussed the growing number of self-employed workers and workers with non-standard contracts, and the impacts on mental health. The effects of financial and housing issues on mental health were considered.

It was noted that the issues in the CSRs tend to be well matched to real national issues on the ground.

November 2017: Annual Growth Survey 2018

- Analyse what the proposal means to your specific area of expertise (i.e. do you agree? is there something missing?)

February 2018: Country reports

- Feedback on the accuracy of the Reports to EuroHealthNet; send concerns and recommendations towards us

March/April 2018: National Reform Programmes (NRPs)

- Get involved in the stakeholder consultation at national level

May/July 2018: Country Specific Recommendations (CSRs)

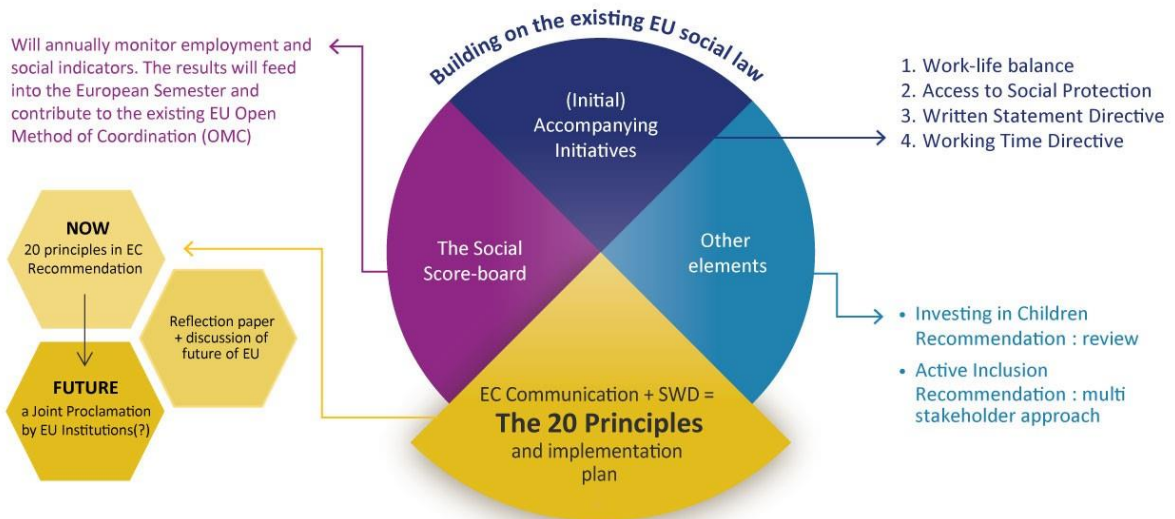
- Analyse the (draft) CSRs for your country and comment on their appropriateness

August /October 2018: Monitor and assess how the CSRs are implemented;

EuroHealthNet is also involved in monitoring and providing feedback to the newly established European Pillar of Social Rights. The Pillar sets out a number of **key principles and rights** to support fair and well-functioning labour markets and welfare systems and more resilient economic structures. The Pillar is designed as **a compass for a renewed process of convergence** towards better working and living conditions, which are key determinants of (mental) health and equity.

Question: How likely is it that governments pick up on recommendations?

Governments can incur sanctions if the EU Semester process reveals the emergence of potentially harmful macroeconomic imbalances and member states repeatedly fail to submit corrective plans as requested by the European Council.



Investing in Mental Health – Fredrik Lindencrona and Tomas Bokström, SALAR

SALAR, is the Swedish Association of Local Authorities and Regions. Through its mental health mission it is acting as a body between policy and practice, responding to separation of powers in Sweden.

SALAR recognises the need to move from considering mental health as a purely health issue, to considering it as a wider societal issue. This requires building mental capital and well-being (cognitive & non-cognitive skill building in all everyday settings through life; preventing stress and improving coping; early identification and self-management; person-centred services) and optimising mental capital (combating stigma)

Current systems and (lack of) action are not economically efficient. There is evidence that some actions have good Return on Investment (RoI), but action is not taken because the return is split between different areas and bodies; only 'diagonal accounting' shows this effectively.

There needs to be a move to an outcomes-focused approach which looks at social and economic consequences in both the short and long term.

Question: How does SALAR work and how does it help with the complex division of responsibility amongst authorities?

SALAR is driven by its members but has now aligned with the health ministry. This helps create links between the government, Public Health agency, and regional bodies with responsibility for health.

Social investment – who is spending what and how can we measure impacts?

SALAR describe social investment as ‘organisation and methodology to drive systematic change which focusses on improved outcomes.’ It includes generic methods (not specific to a certain policy area/silo/target group); outcomes focus in short and long term; an economic model; and iterative work (gradual improvement through experience and optimisation).

New economic models are needed where funding is strategic and involves multiple bodies. Small local authorities need to team up. The representatives added that a general lack of competencies in assessing needs, delivery, monitoring, and measuring impacts is holding back effective social investment.

Operational and strategic work should be separate but linked. Operational staff can’t be expected to make strategic changes at the same time as conducting regular work.

Question: How does SALAR work and how does it help with the complex division of responsibility amongst authorities?

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Social impact bonds

SALAR is working on Social Impact bonds, where returns are paid based on the social impacts of the intervention being financed.¹

With the bonds they hope to change the way impact assessments are made and how social and economic impacts are shared.

Social impact bonds are being used in a new scheme to try to reduce sick leave, which has been identified as a major cost for local authorities. The scheme will involve a health desk service, manager support, and decision-making support. It requires a 100% increase in investment, so the social impact bonds are being used to top up traditional loans. The scheme will see five local authorities teaming up, and should be operational by autumn 2018.



¹ More information about SALARS work and social impact bonds can be found in the 10th edition of EuroHealthNet Magazine.

Mental health promotion and suicide prevention through digital technology – *Vladimir Carli, NASP*

Digital technology opens up both risks and opportunities for mental health and suicide prevention. It should be noted that there is a big difference between developing and developed countries in terms of internet use. There is also a large gender gap.

NASP has conducted research into pathological internet use among adolescents in Europe, and has found it to be a problem. It is linked to mental health problems such as hyperactivity, depression, and suicidal behaviour. Pathological internet use is rising amongst adolescents. The research has also found that Internet use resulting in sleep loss and withdrawal consistently predicted longitudinal change in mental health.

How is the internet being used and what are the opportunities?

The USI model (universal, selective, indicated) is used in health promotion, but we need new models when dealing with new technology.

Machine learning opens up possibilities to develop systems for mental health support such as chatBOTS, virtual councillors, prediction mechanisms, and decision support systems.

Language technology could help manage and combine medical data. We have a lot of information but it is unstructured; sometimes notes are handwritten, and sometimes they have been typed. Language technology could help us analyse this data.

Some research has been conducted into **apps** related to **suicide prevention**, looking at what type of prevention strategy and the quality of the evidence they are based on. This research found that quality was low- there is little evidence that these apps are effective.

Online Cognitive-Behavioural Therapy (CBT) tools exist in Germany and Sweden. Unlike for suicide prevention, there is evidence that online CBT works.

NEVERMIND is a Horizon2020 project to help self-manage mental health. It targets people with severe somatic symptoms. Physical monitoring data is being collected through wearable sensors, whilst at the same time users self-report feelings through an app, which also shows data they are collecting. This data is processed in order to predict depression. The project has been piloted, and the next testing phase begun in December 2017 with around 300 patients. The main development challenges have been the different languages, expectations, and measurement methodologies used by technology providers and Mental Health specialists.

Discussion: **Could these apps be counterproductive? Are clinical interventions (not) irreplaceable?**

Rapport and relationships are important, but they are missing in with apps. We don't know if they work or not, but the fact alone that they exist means that we have to address them.

Discussion: **Reviews of online CBT**

The reviews of online CBT have not made comparisons between CBT with and without face-to-face contact. If someone is doing follow up work, people are more likely to continue treatment.

National interventions on mental health promotion and prevention – *EuroHealthNet Member representatives*

Participants shared the situation in their countries, and described action that was being taken. The text below provides a summary of their statements.

Italy

The Regional Reference Center on Relational Criticism (CRRCR), Tuscany, is looking at development of human relationships in order to offer high quality services.

The suicide rate is low in the Tuscany region. It is related to poverty, and it is mostly men that are affected. Most common methods are hanging, jumping, and firearms. People aged 74 years old and over have a higher risk. The suicide rate is 9 times higher in prison population than non-incarcerated population.

The suicide rate in Italy is lower than in most of Europe- it is roughly the same as Greece. Some studies say this is related to strong family relationships and religion.

The centre has set up a programme for psychiatric care in a hospital for people with somatic illnesses. It also addresses the family of patients.

A link has been made between psychiatric care and toxicology departments. It was found that 40% of suicide attempts were not directly related to mental illness; 60% of these related to bereavement, relationship breakdown, loss of work.

Attempts to create a national suicide observatory are ongoing

Training is being given to prison staff. Psychiatric prisons are closing so now patients without capacity are transitioning to regular prisons and mental health care is being taken over by regular health services. In the Netherlands the same health care providers see patients referred by court and by general practitioners. In UK good work is being done in forensic psychology, but there little attention is given to MH problems in main prison population.

The Netherlands

There are an average of 5 suicides per day in the Netherlands. Of these, 40% relate to people receiving care, and 75% to people who have received care at some point.

A service called 113 provides support by phone and mail. It runs campaigns for specific groups, for example a radio campaign aimed at young people. It also provides training for journalists on the risk of copycat behaviour with the theme 'journalists can save more lives than a doctor'. The other exchange visit participants were receptive to this idea – in Sweden they complain to journalists, but perhaps empowering and involving them would help. 113 also run 'gatekeeper training' for people such as barbers and taxi drivers, who are in frequent contact with people most vulnerable to suicide; it is about 'asking the right questions' and is based on an idea from the UK.

A collaboration similar to SPIS was trailed, where several organisations joined together, however there were issues with confidentiality. As many people who commit suicide already have contact with health care providers the issue is about trying to find ways to open up dialogue amongst providers.

There are around 390 municipalities in the Netherlands, which poses a risk in relation to equality of access. An organisation similar to SALAR exists and can help spread best practices.

Slovenia

Suicide is a huge problem in Slovenia, which has a population two million. In the past the rate has reached 600 suicides per year, while it is now down to 400 per year. There is a 4:1 male: female ratio in suicides. Two thirds of suicides happen through hanging.

There is no national mental health programme, although it has been under development for 15 years; it is difficult to get it through parliament. It is foreseen that suicide prevention will be part of this plan.

Currently doctors and nurses are acting as gatekeepers, and this is working relatively well. A prevention programme has been established; all people over 35 are screened for depression and suicidality symptoms at the same time as cardiovascular screening takes place. If symptoms are reported, both the individual and their family are offered treatment. This is sustainably funded by health ministry.

There is, however, no standardised programme. The main problems are sustainability, including sustainable funding, and stigma. There is a need to disseminate best practice and develop long term funding.

Training for journalists has also been carried out. Work is ongoing to develop a programme to reduce stigma. There is a clear regional east/ west divide – stigma is highest in the East where most suicides happen.

Greece

There is no national suicide prevention action plan. The Psychiatric association says that Suicide prevention and self-harm prevention is left to NGOs and private bodies. 60% of people who committed suicide had had contact with a health professional in the last 6 months; this figure could be a missed opportunity to provide better support.

Stigma is a huge problem, and religion has played a big role in this as until recently the church could not bury suicide victims.

Greece has low levels of suicide compared to the European average, but a very high rate of road traffic accidents- particularly people driving alone at night. The traffic agency has made a study of suicides within traffic accidents, producing helpful but unclear results. The study looked at records of accidents which occurred amongst people driving at night or alone, and tried to make a rough assessment based on this.

Work has recently begun on assessing the levels of suicide and mental health issues amongst migrants. The main NGO working on suicide and suicide prevention this is called 'Ladder'. It was founded in 2000 to work on integration of marginalised groups, and receives some support from the health ministry. In 2007 they set up the only suicide prevention phone line in Greece and today more than 50% calls to the line are from people who want to commit suicide- but the issue is hidden in Greek society.

Ladder has recently started running a day centre in Athens which is the only one of its kind in Greece - this is an inequality problem as only citizens in the capital have access to this kind of support. Most people with mental health problems or demonstrating suicidal behaviour are referred to local hospitals.

Advice for media professionals and a guidebook for police officers have been produced by Ladder, whilst the Ministry of Justice has created guidelines on suicide prevention in prison.

Question: Has this been an estimation of the costs of inaction on mental health and suicide prevention in Slovenia?

Yes, but this is not helping things move forward as other health fields and illnesses are given a higher priority. The group discussed and suggested that high priority diseases can't be tackled without addressing mental health. We need to break out of the silo mentality.

United Kingdom

Suicide rates in the UK are going up. The mental health system is in crisis and is underfunded. The care system has been fragmented, and mental health problems are increasing. There has also been a huge rise in homelessness. Suicide is linked to alcohol and substance misuse, and with gangs. There seems to be a failure at primary care. The current thinking is that all services to be centred on trauma support.

In Kent, in the South East of the country, there is an inequality link: there are higher rates of suicide in deprived coastal areas. The people at highest risk are lorry drivers, migrants, and construction and agricultural workers. There is no data on whether suicide victims have had contact with care services.

The national suicide prevention strategy is localised and linked to other sectors. It is high profile and there is lots of visibility for suicide, but is driven by local champions.

Links are being made between vulnerability, and loneliness and isolation as well as between shame and social inequalities.

There is a need to achieve parity of esteem in mental health – there should be no difference between mental any physical health. Explanation of mental health issues in biological terms may be useful.

There is some work on military veteran health, which makes links with issues such as alcohol abuse and homelessness.

Further efforts are needed on the links between suicide and substance abuse.

Several campaigns have been successfully trialled in the Kent area. The 'release the pressure' communication campaign encourages men to seek support by calling a support line which is always open. The 'wheel of wellbeing' programme which encourages people to address 'body, mind, spirit, people, place, and planet' to achieve a sense of well-being. The 'Kent sheds' movement creates informal spaces in which men can interact and engage in new activities, which can also facilitate discussions around mental health and well-being. A website linking all mental health services has also been created.

Wallonia (Belgium)

In Wallonia the suicide rate is high at 20 per 100,000. This rate has been declining slightly since 1997. Governance and responsibility is spread across a large number of bodies and levels of government which has an impact on the continuity of care, completion between services, and communication. Wallonia still has a large number of psychiatric beds so there is a need to move away from institutionalisation towards a community-based care system.

There are ongoing attempts to develop a health promotion and prevention plan. Mental health is a political priority.

The current infrastructure includes hospitals with mental health beds, psychiatric care homes, 'protected housing initiatives', and mobile intervention systems.

The main problems in Wallonia are

- The high level of suicide.
- Socio-economic factors threatening mental health
- Slow progress in moving away from high number of beds.

GPs could provide a good solution to many of the problems, but there are too few in the area which is a big problem.

Workshop: Youth Aware of Mental health (YAM) – *Danuta Wasserman and Anna Johansson, NASP*

Professor Wasserman explained that a good relationship with mass media helped the development of suicide prevention. Work on prevention started early, but didn't get disseminated until 2009 when funding became available.

YAM

The YAM programme provides young people with a safe space to explore mental health topics – a space for expression, discussion, growth. It includes cognitive, emotional and experiential learning to understand how pupils can help others in need or how to seek help themselves.

The methodology is structured but content is open. It is delivered to 14-16 year olds.

The YAM materials include a booklet which covers general information about mental health, common or serious mental health problems, and points of contact for further support. The chapters cover 'What is mental health?', 'Self-help advice', 'Stress and crisis', 'Depression and suicidal thoughts', 'Helping a friend in need' and 'Who can I ask for advice?'. It is available in 11 languages. Other materials include posters, presentations, dilemma cards, and role-play scenarios.

The YAM programme lasts for 5 hours and is delivered over 3 weeks. Before starting, a baseline assessment of health is conducted in the form of a survey. This is both for scientific reasons and to help deliver the programme effectively- it shows if any students need treatment rather than prevention.

The opening session consists of a presentation and interactive role-play session. During the role-play students are given dilemmas and discuss possible responses. They then talk about the outcomes of different behaviour.

The week break before the next session gives students time to think and discuss.

In the subsequent session the students continue with different role-play activities. The role- plays cover three themes: (i) awareness about choices, and dilemmas and conflict resolution (ii) Awareness about feelings, and how to manage stress and crises situations, and (iii) awareness of suicidal thoughts and what to do. The final hour is a recap of what was covered in previous session, and includes time for questions. Workshop leaders note the outcomes of previous hours which informs what is covered in the final session.

Question: Isn't there literature which suggests that working with children on these topics is dangerous?

Yes, but there is also evidence which suggests that it is positive. Having a good instructor is important. It's a myth that we can induce something that is already there. Talking about suicide methods can be dangerous, but talking about suicide itself is not.

Question: What is the impact on bullying?

We don't know, but we do know that it improves group cohesion and resilience

Question: What is the effect on families and students with families that have MH problems?

We see increased discussions about MH at school and home.

Question: Is it scalable? Can anyone be a trainer?

It can't be a teacher as for the creation of a safe space, it is important that the instructor is slightly removed from the group. Teachers *are* trainers, but they deliver in other schools. That means there are problems delivering the programme in rural schools. Instructors can deliver a max of 4 classes/ day, 3x /week.

To assess the impact of the programme, qualitative interviews were conducted. Only 3/20 students were not interested, of which most were boys.

Ethical issues include the confidentiality of personal data, and ensuring children that need help get it. Consent is not always needed to run the programme, but consent *is* needed to collect research data. Most dropouts are due to lack of consent rather than course content.

SEYLE programme and measuring results – *Vladimir Carli*

The SEYLE intervention study aimed to promote mental health of adolescents in 11 European countries by helping them to develop problem-solving skills and encouraging them to self-recognize the need for help as well as how to help peers in need.

A comparison was made between three different interventions which involved the empowerment of teachers (Question, Persuade, and Refer (QPR)), Empowerment of professionals (Professional Screening (ProfScreen)), and empowerment of pupils (YAM), as well as a control group.

For the study, a random selection of 168 schools was made. A baseline evaluation was conducted, followed by three evaluations - one at the end of the intervention, one three months after, and one 12 months after.

The results of the QPR programme show no change in suicidal behaviour and depression. The programme was well received, but the willingness of teachers to help depends on their job satisfaction.

The screening programme was not well received by students and their families; 51.3% of pupils refused to attend the interview. Younger and those already showing factors which lead to mental ill health were the most likely students to attend. If the screening was held in school, students were more likely to attend but this also increases stigma.

YAM was found to be effective in preventing new cases of depression and suicidal thoughts, but had no effect on pupils who were already depressed. The study found that incidents of suicide attempts decreased by 55%, incidences of severe suicidal thoughts and plans decreased by 50%, and incidences of depression decreased by 30%. 91 pupils should participate in the YAM programme to prevent one new case of a suicide attempt or severe suicidal ideas.

The Incremental cost-effectiveness ratio (ICER) for YAM is €15,992 per QALY (Quality-Adjusted Life-Year) gained for suicide attempt and €16,298 per QALY gained for severe suicidal ideation.

It is believed to be effective because it gives an opportunity to think about coping strategies and practice possible scenarios, and because it increases group support, cohesion, and empathy.

Trimbos will soon start using this and other methods in India.

Now work has begun on collecting data on language comprehension to measure how much the students understand.

Question: Can you tell us more about willingness to pay?

Each country has an amount which they are willing to pay in order to achieve 1 QALY. The YAM costs are lower than the threshold in most countries.

Facilitated Discussion, including participants' experience and lessons learnt, next steps and potential collaboration

United Kingdom

It has been interesting to explore some myths about different countries. The UK shares so many problems with other countries: not matching up services, primary care, diagnostic, trying to evidence prevention.

The social bond is an interesting concept.

The conclusions of the visit will be presented at a suicide prevention group.

There is a need to focus on specific approaches, and make clear links between cause, effect, and possible impacts of action.

The description of suicide as an accident was appreciated and will be used.

The Netherlands

The take home message is the need for more research to get support.

Impressed by the similarities between countries and looks forward to collaborating.

Recognised the needs to move to a positive rather than a negative view of mental health.

Greece

It is interesting to see similarities and differences between countries and the influence of culture.

Taking home lots of practical examples.

Belgium

Interested in the evaluation of outcomes across several areas. We need a good sell for prevention, and this might help. It is a general problem that promotion is not well evaluated.

Mental health is not always just about health, but is also about capacity.

Italy

cultural change is important in Tuscany Region, so it is interesting to hear about different issues at different levels.

Slovenia

The more the participants exchanged, the more similarities between the situations emerged.

Discussion:

It is sometimes hard to supply evidence in traditional sense that particular interventions (RCT) are successful, therefore it can be hard to secure funding. There is a need to find other ways to prove, persuade, and convince. There is also a need to demonstrate different types of evidence. Interventions should be grouped together to make changes; complex problems can't be fixed by mechanical solutions.

Annex 1: Agenda

Monday October 30, 2017 - Sabbatsbergs hospital - Olivecronas väg 1, 113 24 Stockholm	
13:00	Welcome – <i>National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP)</i> and <i>Stockholm County Council - Healthcare Administration</i> Background and objectives – <i>EuroHealthNet</i>
13:10	Introductions from participants
13:20	Introduction to Suicide Prevention in Stockholm county (SPIS) – <i>Sebastian Hökby, NASP</i>
13:50	<u>Visit</u> to the Psychiatric Emergency Mobility (PAM) and <u>Presentation</u> of the psychiatric emergency care and the psychiatric care system in Stockholm County – <i>Fredrik Bengtsson, Northern Stockholm Psychiatry</i> Facilitated discussion on issues raised so far and exchange of experience
15:00	Transfer to NASP and coffee break
15:45	NASP activities – <i>Gergö Hadlaczky, NASP</i>
16:15	National and Regional Guidelines for Suicide Prevention – <i>Birger Forsberg, Stockholm County Council - Healthcare Administration</i>
16:45	Inter-Sectoral Collaboration: Part of Sweden’s National Suicide Prevention Policy – <i>Jenny Telander, Public Health Agency of Sweden</i>
17:15	Wrap up and end of Day One
19:30	Social Dinner – Tennstopet, Dalagatan 50, 113 24 Stockholm
Tuesday October 31, 2017 - NASP - Granits väg 4, 171 77 Stockholm, Karolinska Institutet	
9:00	Presentation of the EU Policy context, Structural Funds, EU policy tools, 3rd Health Programme – <i>Claudia Marinetti, EuroHealthNet</i> Facilitated Discussion on EU-level opportunities
9:45	Investing in Mental Health – <i>Fredrik Lindencrona and Tomas Bokström, SALAR</i>
10:15	Mental health promotion and suicide prevention through digital technology – <i>Vladimir Carli, NASP</i>
10:45	Coffee break
11:00	(sub) National interventions on mental health promotion and prevention – <i>EuroHealthNet Member representatives</i> Participants’ exchange on similarities and differences across countries
12:15	Lunch
13:15	Workshop: Youth Aware of Mental health (YAM) – <i>Danuta Wasserman and Anna Johansson, NASP</i>
15:15	Coffee break
15:30	Facilitated Discussion, including participants’ experience and lessons learnt, next steps and potential collaboration
16:15	Wrap up and end of Day Two

Annex 2: List of participants

EuroHealthNet thanked all organisers and participants for an extremely useful visit and hospitality.

Bengtsson, Fredrik

Northern Stockholm Psychiatry, Stockholm County Council, Sweden

Bokström, Tomas

Swedish Association of Local Authorities and Regions, Sweden

Carli, Vladimir

National Centre for Suicide Research and Prevention of Mental Ill-Health, Karolinska Institutet, Sweden

Forsberg, Birger

Stockholm County Council, Sweden

Giomi, Davide

Regional Reference Center on Relational Criticism (CRRCR), Tuscany Region, Italy

Hadlaczky, Gergö

National Centre for Suicide Research and Prevention of Mental Ill-Health, Karolinska Institutet, Sweden

Hökby, Sebastian

National Centre for Suicide Research and Prevention of Mental Ill-Health, Karolinska Institutet, Sweden

Johansson, Anna

National Centre for Suicide Research and Prevention of Mental Ill-Health, Karolinska Institutet, Sweden

Koning, Olfert

Dutch Association of Mental Health and Addiction Care (GGZ Nederlands), Netherlands

Latham, Alexandra

EuroHealthNet, Belgium

Lindencrona, Fredrik

Swedish Association of Local Authorities and Regions, Sweden

Marinetti, Claudia

EuroHealthNet, Belgium

Mookerjee, Jess

Kent County Council, United Kingdom

Nick, Laurence

Walloon Agency for a Life of Quality (AVIQ), Belgium

Roskar, Saska

National Institute of Public Health of the Republic of Slovenia, Slovenia

Telander, Jenny

Public Health Agency of Sweden, Sweden

Tsichlas, Fotis

Institute of Preventive Medicine Environmental and Occupational Health (PROLEPSIS), Greece

Wasserman, Danuta

National Centre for Suicide Research and Prevention of Mental Ill-Health, Karolinska Institutet, Sweden

Zurkirch, Vanessa

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