The Suicide Problem in England

Suicide is clearly an issue which needs addressing in England due to the amount of lives lost and the amount of money which is spent on dealing with such incidents (South, 2015). To improve mental health and wellbeing, action will be required across all sectors, locally and nationally and all people will need to be involved (Farmer and Dyer, 2016). To ensure this happens health services need to be further developed in order for people from both sides of the social gradient to gain equal benefits from health services (Lansley and Burstow, 2011). The issue of gender needs to be addressed and males need to understand that it is acceptable to talk about their feelings and any issue which they are suffering from in order to gain the appropriate help (Scowcroft, 2017). There is a lack in research for models that can be used in mental health, current models are more related to the risks of suicide and not prevention methods. However, the five year forward view for mental health has aims to reach by 2020. This will help to improve mental health which is fundamental to physical health, relationships, education and work. Mental health is everyone's business (Farmer and Dyer, 2016).

One main subgroup which needs are not met by universal care is people who are physically disabled or have learning disabilities. Their mental health is normally overlooked even though they are three times more at risk of developing a mental health problem (NICE, 2016). 24% of people with a mental illness are moderately or severely disabled by their mental health condition. Many individuals will require full time care, while others may be able to live independently (Raingruber, 2012). Due to them taking longer to learn new skills they may need more support. Therefore, they cannot attend community groups or have universal care to help with their mental illness (Health Education England, 2016). Nurses and other professionals will spend one to one time with the individual to meet their needs (Edwards, 2015).

Working in partnership with families is also very important for the care of the patient and also the health of the family (Edwards, 2016). Family members feel that they are unsupported and are frustrated by the lack of information they receive even when the patient has given consent (Hughes et al, 2016). Studies show that family members and friends that are closely involved in supporting a patient can experience psychological distress. Nurses are in the best position to provide the support that family needs in helping them understand the treatment the patient is receiving (NICE, 2016).

There is a programme that is designed to meet the needs of men. It is known as CALM – Campaign Against Living Miserably. Although this service is based outside of Cornwall it is a nation charity with a helpline service available to all (Hughes et al, 2016). This service is available 24 hours a day with volunteers who answer the phone and provide support. CALM's

helpline workers are there to listen. They have links with other organisations which can offer the support the individual needs (CALM, 2017). Nurses and other health professional volunteer to work at this charity to ensure individuals calling get the best help possible (CALM, 2017).

Partnership working is crucial when it comes to mental health. One good example of positive outcomes from collaboration is street triage, also known as crisis groups. This group includes mental health workers, ambulance staff, nurses and police working together in one team to prioritise responses to mental health related crises (Hughes et al, 2016). There are also many services collaborating to tackle the early intervention in mental health. For example, there are special cafes set up, crisis centres and drop-in centres for sufferers (Trait and Shah, 2007). Fire services are also playing and important role as there is a strong link between house fires and mental health issues including alcohol and substance abuse (Carpenter and Dickinson, 2006). Fire fighters are now also offering training and support to vulnerable people in their home and are making room at fire stations available for training or other mental health activities (Hughes et al, 2017). Many of the fire fighters have also been trained in how to deal with vulnerable people. Sharing information with other professionals has become a crucial approach to helping mental health (Carpenter and Dickinson, 2006).

There are many benefits from this collaboration working. It reduces the amount of time police waste on mental health incidences where they are unsure of what to do (Hughes et al, 2017). It also reduces the about of admissions into hospital as the police gain control before anything happens (Trait and Shah, 2007). Its most significant impact appears to be in the reduction of community mental health services (Hughes et al, 2017).

Cognition models focus on the beliefs, attitudes and the values the individual has that will influence their decision making. As a nurse you will work with the individual's belief to change them or to adapt their way of what they think is healthy (Evans et al 2017). The limitations to this model are that hardly tailoring the behaviour change to individual people makes them only think of a suitable change (Raingruber, 2012). However, it does not cause the individual to change. The social cognition model introduces the influence of other people in an individual's behaviour. This may cause the individual to worry about whether they are "normal" or being "picky" (Evans et al, 2017). For example, men who give up drinking may be seen as "weak" for choosing soft drinks. However, the limitation of this is that it still does not enable people to be empowered to change despite showing what other people think of a certain behaviour (Evans et al, 2017). Empowerment models show how individuals need to be empowered through their own actions or by a health professional such as a nurse. The NMC (2015) standards include the role of the nurse in empowering patients to make their own decisions about their health (Raingruber, 2012). However, the empowerment does not come from the knowledge that you have gained from the nurse but being able to weigh up and judge the information. A limitation of this model is that an empowered person may still find it difficult to make that change even

though that have made the decision (Evans et al, 2017).

Another theory is the behaviour change theory. This exists to explain why people do and do not adopt certain behaviour. Many of these theories examine the predictors and precursors of health behaviour (Raingruber, 2012). Most behaviour change theories involve self-efficiency and motivation. However, criticism of the behaviour change theory is that many people doubt themselves, therefore leaving them with not much motivation (Evans et al, 2017). This theory also focuses on their emphasis on the individual's behaviour whilst ignoring the influence of the environment, sociocultural factors and economic issues (Regan, 2016).

The process of health promotion is to enable people to take control and to improve their health (WHO, 2014). Nurses will find strategies that will have an impact on the individual's behaviour with the aim of educating them and creating and change. There are many different models of health promotion that nurses can use (Evans et al, 2017). However, it is difficult to relate the health promotion models to suicide itself. It is easier to relate it to the behaviour of what causes the individual to be more at risk, such as; reducing substance use, physical diseases and unemployment (Kobau et al, 2011). Tannahills model of health promotion (1985) includes 3 topics which overlap with the aim of promoting health. It includes health education, prevention and health protection (Evans et al, 2017). Health education is designed to change the knowledge, belief and behaviour of the individual to a way that they can view themselves as being healthier (Raingruber, 2012). Prevention aims to decrease the risk factors and consequences of the illness. Health protection aims at policies and codes of practice aimed at preventing ill health and enhancing well-being (Tannahill, 2009). Tannahills model was criticised for only being suitable for promoting an individual's health and not for promoting health within a community setting (Evans et al, 2017). This model also does not take into account the socio-economic and cultural contexts. Tannahills model also does not inform you of how the individual will be motivated to change their behaviour or how the individual will be able to sustain this change (Raingruber, 2012).

There are different types of ways that nurses can help prevent people who are at risk of committing suicide. The first and most generic level is known as "universal", where a mental illness can affect anyone in a defined population regardless of the risk of suicide (Public Health England, 2013a). Public education programmes are used to help educate people on the dangers of the risk factors of suicide such as; substance abuse and depression. This helps the individuals to build a barrier to suicide (Evans, 2017). The next level is selective. This targets subgroups which are at a higher risk of suicide for example a group of people who suffer from a certain social determinant of health. For example, they may target a group of people who are unemployed (Public Health England, 2013a). The last group is called indicated. This group is for specific individuals who have a risk factor or condition that puts them at a very high risk, for example they may attempted suicide in the past (Public Health England, 2013b).

All nurses maximise their role in providing advice and support on mental illnesses. Nurses relationships with patients enable them to pick up, identify and intervene with patients who have a mental illness (Naylor et al, 2017). Nurses feel unprepared and afraid to talk about suicide with their patients. This is due to having no training on the topic. Training nurses on mental health and suicide is key to suicide prevention (Public Health England, 2013). Once they are trained in suicide assessment it is no different from assessing any other type of illness (Naylor et al, 2017).