Executive summary of the public audit report

SUICIDE PREVENTION AND AID TO INDIVIDUALS RELATED TO THE RISK OF SUICIDE

23 February 2017, NO. VA-P-10-5-2

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DEFINITIONS AND ABBREVIATIONS

Action Plan for 2014–2016 – the Mental Health Strategy Implementation and Suicide Prevention Action Plan for 2014-2016[1].

Action Plan 2016–2020 – the Mental Health Strategy Implementation and Suicide Prevention Action Plan for 2016–2020[2].

Close relatives – direct-line relatives up to the second degree inclusive (parents and children, grandparents and grandchildren) and lateral-line second-degree relatives (brothers and sisters)[3].

EHS – emergency health services.

IH – the Institute of Hygiene.

Intervention – emergency mental health services, implemented either individually or in a group and focused on critical consequences or traumatic situations in order to restore the pre-crisis state of the relevant individual or group[4].

Prison department – Prison Department under the Ministry of Justice of the Republic of Lithuania.

Lithuanian Labour Exchange – Lithuania Labour Exchange under the Ministry of Social Security and Labour of the Republic of Lithuania.

NGO – non-governmental organisation.

Aid – psychological, psychotherapeutic, psychiatric, pharmacological, social, educational and other aid, oriented at suicide prevention, intervention and post-vention.

Police Department – Police Department under the Ministry of the Interior of the Republic of Lithuania.

Post-vention – psychological aid, crisis intervention and other aid, provided after a suicide to those affected either individually or at the workplace in order to decrease the potential effect of the suicide[5].

PPO – pedagogical-psychological office(s).

(Suicide) Prevention – strategies and means for decreasing the risk and effects of suicide[6].

Fire and Rescue Department – Fire and Rescue Department under the Ministry of the Interior of the Republic of Lithuania.

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1 Approved by Order No. V-417 of 28 March 2014 of the Minister of Health of the Republic of Lithuania (valid before 17 February 2016).

2 Approved by Order No. V-213 of 09 February 2016 of the Minister of Health of the Republic of Lithuania.

3 The Civil Code of the Republic of Lithuania, Article 3.135.

4 *The Workplace Postvention Task Force of the American Association of Suicidology and The Workplace Task Force of the National Action Alliance for Suicide Prevention "A Manager's Guide to Suicide Prevention in the Workplace"*, 2013. Available on the Internet at: http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Managers–Guidebook–To–Suicide–Postvention–Web.pdf.

5 Ibid.

6 Ibid.

MHC – a mental health centre, an establishment that provides primary out-patient mental health services.

CHIF – the Compulsory Health Insurance Fund.

WHO – the World Health Organisation.

Risk Factors – factors (related to lifestyle, heritable traits and the environment) linked to medical disorders via scientific research[7].

MSSL – Ministry of Social Security and Labour of the Republic of Lithuania.

MH – Ministry of Health of the Republic of Lithuania.

Standardised Mortality Ratio – the number of deceased individuals per 100,000 residents in accordance with the European Standard[8].

Individuals related to the risk of suicide – individuals who intended to commit or attempted suicide, close relatives of individuals who committed suicide, and other individuals who had any contact with suicide.

Individuals who had contact with suicide – individuals who are not close relatives, but may have been affected by suicide, especially officers and employees of different authorities who were in direct contact with individuals who had committed suicide.

MES – the Ministry of Education and Science of the Republic of Lithuania.

Deliberate self-harm – suicidal behaviour which manifests itself as successful and attempted suicides. Even though deliberate self-harm is not always intended to lead to suicide, such actions can sometimes end in death. Data on deliberate self-harm and death by suicide is classified by type: deliberate poisoning and deliberate self-harm (X60–X84[9]).

State Health Care Accreditation Agency – the State Health Care Accreditation Agency under the Ministry of Health of the Republic of Lithuania.

State Mental Health Commission – the State Mental Health Commission under the Government of the Republic of Lithuania.

Gatekeepers – experts (health care professionals, educators, police officers, fire fighters, social workers, etc.) trained to recognise suicide risk and react accordingly, in order to provide aid[10].

NHIF – the National Health Insurance Fund under the Ministry of Health of the Republic of Lithuania.

SMHC – the State Mental Health Centre under the Ministry of Health of the Republic of Lithuania.

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7 Law on Public Health Monitoring of the Republic of Lithuania No. IX-1023 of 03 July 2002 (edition No. XII-1402 of 09 December 2014), Article 2, Page 3.

8 Institute of Hygiene. Causes of Death 2015. Vilnius, 2016. Available on the Internet at: http://www.hi.lt/uploads/pdf/leidiniai/Statistikos/Mirties_priezastys_2015.pdf

9 Classified in accordance with the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM).

10 WHO, *Preventing suicide. A global imperative*, *2014*. Available on the Internet at: http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf.

SUMMARY

The number of suicides is one of the most important indicators of the public's state of mental health. Lithuania is one of the top countries in terms of suicide rate. Since 2004, the Standardised Mortality Ratio[11] per 100,000 Lithuanian residents due to suicide, which was at 42,89 during that year, started to go down – in 2012, it was 30,91. In 2013, the value of this indicator exceeded the European Union average[12] three times, and in 2015 it was at 30,41, which means it remained largely unchanged for three years.

The Organisation for Economic Cooperation and Development (OECD) notes that Lithuania's high suicide rate is tied to many different factors, including rapid social and economic changes which increase both psychological and social insecurity, as well as the lack of a national suicide prevention strategy[13].

In 2013, the 66th World Health Assembly, composed of the ministers of health of 194 member states, approved the WHO Mental Health Action Plan 2013-2020. Suicide prevention is integral to the plan. Member states committed to strive for the common goal of decreasing the number of suicides by 10 percent by 2020[14]. One of the goals of the Lithuanian Health Strategy 2014-2025[15] is to decrease the Standardised Mortality Ratio due to suicide down to 19.5 cases per 100,000 residents by 2020, and then to 12.0 cases by 2025. The achievement of such an ambitious goal necessitates the mobilisation and purposeful action on the part of all sectors (health, education, social security and labour, interior affairs, NGO, etc.).

The goal of the audit was to assess the effectiveness of suicide prevention and post-vention, and to answer the following questions:

- are the means of suicide prevention planned and implemented appropriately?;
- how effective is the provision of aid to individuals related to the risk of suicide?.

Having analysed and assessed the issues related to the organisation of mental health during the preliminary audit, most attention during the main audit was paid to the assessment of suicide prevention planning and implementation, and the provision of aid (by the police, ambulances and fire fighters) to individuals who intended or attempted suicide, close relatives of individuals who committed suicide and other individuals who had contact with suicide.

The audit was carried out at the Ministry of Health, and information was also collected at the Ministry of Social Security and Labour, the Ministry of Education and Science, the Institute of Hygiene, the National Health Insurance Fund, the State Health Care Accreditation Agency, the State Mental Health Centre, the Suicide Prevention Bureau, mental health centres, five crisis intervention centres and 18 hospitals; we have interviewed 40 pedagogical-psychological offices, the Fire and Rescue Department, six emergency medical aid stations, the Police Department, the

11 the number of deceased individuals per 100,000 residents in accordance with the European Standard.

12 According to Eurostat, the average rate of death by suicide in the EU in 2013 was 11.7 (per 100,000 residents), while the Standardised Mortality Ratio in Lithuania was 36.1 (per 100,000 residents).

13 OECD, *Health at a Glance: Europe 2014*. Available on the Internet at: http://www.oecd-ilibrary.org/docserver/download/8114211ec010.pdf?expires=1476278336&id=id&accname=guest&checksum=83CDADAC412B4C78D06C8694B99B2359

14 OECD, *Preventing suicide. A global imperative, 2014*. Available on the Internet at: http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf.

15 Resolution No. XII-964 of 26 June 2014 of the Seimas of the Republic of Lithuania "On the Approval of the Lithuanian Health Strategy 2014-2025 (edition No. XII-2383 of 19 May 2016).

Prison Department, 17 general schools and the Lithuanian Labour Exchange. During the audit, we had organised 20 meetings, discussions with NGOs, employees and experts working in the system, and the relatives of an under-age child who committed suicide.

Audited time period – 2012-2015; data analysis was carried out by also making use of data from past audits and 2016.

Having assessed the evidence collected during the audit (data analyses, conversations, interviews and document reviews), we present the national audit conclusions and recommendations.

CONCLUSIONS

Given that suicide prevention means in Lithuania are planned inappropriately and there is no comprehensive system for the provision of aid to individuals related to the risk of suicide, standardised mortality due to suicide during the audited period only decreased by 1.6 percent.

Regarding the planning and implementation of the means of suicide prevention

1. There is no approved suicide prevention strategy and no institution solely responsible for the coordination of the implementation of suicide prevention measures on a national level, which leads to a lack of systemic implementation of such measures and a solution to the suicide prevention problem (Section 1.3).
2. In Lithuania, the planning of measures for suicide prevention are limited to the monitoring of suicide mortality indicators – individual cases of suicide are not investigated and their causes no identified. The quality and accessibility of aid to individuals related to the risk of suicide, and the scope and results of suicide prevention programmes are not assessed (Section 1.1).
3. The measures for the implementation of the Mental Health Strategy and the Suicide Prevention Action Plan 2016-2020 had not been planned appropriately: no target values (assessment criteria) for assessing the appropriateness of and the potential changes related to the implementation of said measures, had been set. Out of the 11 suicide prevention measures, ten were given a four year implementation term (2016-2020), but no intermediate result-assessment stage was set, and funds necessary for the implementation of said suicide prevention measures had not been planned. For this reason, there is a risk that the measures will not be implemented in full or at all (Section 1.2).

Regarding the quality and accessibility of aid to individuals related to the risk suicide

4. Personal risk of suicide is not being assessed, and individuals related to the risk of suicide who are in need of aid are not being identified, because:

    4.1. There is no approved country-wide algorithm (scheme) for the provision of aid to individuals related to the risk of suicide: no actions were set regarding how and whom to transfer information to when an individual intends to commit suicide or had attempted to commit suicide, or in the case of the suicide of a close relative or another individual, and no sequence for the provision of aid or the responsible providers of aid – experts – had been specified. For this reason, establishments responsible for the provision of aid

are incapable of reacting in a comprehensive manner and providing aid to individuals related to the risk of suicide in time (Section 2.2).

4.2. Not all experts who may come into contact with individuals who intend or attempt to commit suicide had been trained how to recognise the risk of suicide, how to act with individuals in danger of committing suicide, and how to provide them with the necessary aid (Subsection 2.1.1).

4.3. State-wide monitoring of the cases of self-harm is ineffective, and there is no sharing system between responsible establishments, which could help identify and aid individuals who had attempted to commit suicide. It is not specified, which experts at what regularity should communicate and keep in touch with individuals after an attempted suicide. The risk of repeated suicide and the need for aid are not being assessed (Subsections 2.1.2 and 2.1.3).

5. The accessibility of services to individuals related to the risk of suicide in the primary link is lacking because of:

5.1. Uneven accessibility of services at mental health centres, which arises due to differences in the work load of mental health experts, and the failure to ensure team work between said experts: in 38 percent of the surveyed mental health centres, the entire expert team does not work every day, and in 31 percent of the surveyed mental health centres, experts work for less than five hours per day. In 48 percent of the surveyed mental health centres, waiting for a consultation by a mental health expert may take up to three days or longer (Subsection 2.3.1).

5.2. More than half of general schools do not have a resident psychologist. In 36 of the surveyed general schools, the resident psychologist was not available every business day. The difference in the number of children assigned to psychologists working at general schools leads to uneven access to psychological services (Subsection 2.3.2).

5.3. The need for psychological aid is not identified, and employees in contact with individuals who had attempted to commit or had committed suicide, or whose work load is related to increased levels of stress are not ensured access to it (Subsection 2.3.3).

6. Conditions necessary for the provision of quality services by a psychologist of psychotherapist are lacking:

6.1. Given the lack of nation-wide provisions regarding the scope of services provided by psychologists, as well as the number and duration of consultations, 35 percent of the surveyed MHCs had set their own limited number of free psychological consultations to their patients (Section 2.4).

6.2. The inability of 58 percent of the surveyed medical establishments to ensure quality psychological services comes down to a lack of adapted methods for the assessment of emotional state, cognitive function, cognition, personality and the risk of suicide (Section 2.4).

6.3. The fields of expertise of psychotherapists, training for professional qualification, responsibility and licensing are not specified (Section 2.4).

RECOMMENDATIONS

To the Ministry of Health of the Republic of Lithuania

1. Implement measures necessary for basing suicide prevention on research, setting priorities, planning specific short- and long-term measures and requisite funding for their implementation, specifying intermediate terms and assessment criteria for the implementation of measures, and assigning an institution responsible for the coordination of the implementation of said measures (Conclusions 1, 2 and 3).
2. Organise assessments of the quality and accessibility of health care services to individuals related to the risk of suicide (Conclusion 2).
3. In order to identify and aid individuals related to the risk of suicide we recommend to:

3.1. Cooperate with other institutions in developing a scheme for the provision of aid to individuals related to the risk of suicide, which would specify and comprehensively describe the procedure of the organisation of aid and the exchange of information between the institutions responsible for providing such aid (Conclusions 4.1 and 5.3).

3.2. Organise and coordinate the training of gatekeepers in identifying the risk of suicide, providing initial support and referring individuals for further aid (Conclusions 4.2 and 5.3).

3.3. Improve the monitoring and filing of cases of deliberate self-harm (Conclusion 4.3).

4. In order to ensure immediate and continuous aid to individuals after a suicide attempt, set a procedure which individual health care establishments would refer to when conducting psychosocial assessments, providing psychological and/or psychiatric aid, sharing information, and providing proactive, continuous aid (Conclusion 4.3).
5. Initiate changes to legislation by specifying the number of serviced residents, as well as the weekly duration and work load of experts responsible for the provision of primary out-patient mental health services, such as to ensure the quality and accessibility of primary out-patient mental health services to residents (Conclusion 5.1).
6. In order to ensure the quality of services provided by psychologists and psychotherapists, we recommend to:

6.1. Increase the expertise level and administrative skills of experts working at health care establishments who are responsible for the provision of aid to individuals related to the risk of suicide (Conclusion 6.2).

6.2. Specify the psychotherapists' responsibility, fields of expertise and training for professional qualifications, and take a decision regarding licensing (Conclusion 6.3).

Given that the draft bill on the practical activities of psychologists of the Republic of Lithuania[16] has been registered at the Seimas of the Republic of Lithuania, we shall provide no recommendations regarding the regulation of psychologists' activities.

To the Ministry of Education and Science of the Republic of Lithuania

1. Cooperate with municipalities in ensuring the accessibility of psychological aid to all students who take part in the programmes of pre-school, pre-primary, general and primary professional education (Conclusion 5.2).

[16] Draft bill on the practical activities of psychologists of the Republic of Lithuania. Registration No. XIIP-553, 22 June 2016.