for Scotland's mental health

Engagement Process of the Draft Suicide Prevention Action Plan 2018 – SAMH Response

Introduction

SAMH is the Scottish Association for Mental Health. Around since 1923, SAMH operates over 60 services in communities across Scotland providing mental health social care support, primary care, addictions and employment services, among others. These services together with our national programme work in See Me, respectme, suicide prevention, sport and physical activity inform our public affairs work to influence positive social change

SAMH welcomes the opportunity to respond to the draft Suicide Prevention Action Plan consultation. An average of two people die by suicide in Scotland every day, with 728 people dying by suicide in 2016.[1] Scotland should rightly be proud of the significant 17% reduction in the number of people dying by suicide between 2002-06 and 2012-16. However, 2017 saw an increase in the number of deaths. We must be cautious about drawing conclusions from a single year of data, but this is an early sign that we need urgent action to prevent any further increase in deaths. This context makes it essential that the Suicide Prevention Action Plan is ambitious and supported by sufficient resource.

We broadly welcome the proposed four actions, but we want to see a stronger, more specific and clearly resourced plan to take Scotland forward. We have sought to craft a consultation response that is both helpful and hopeful: helpful in proposing constructive improvements to the Plan, and hopeful in our sincere belief that many deaths by suicide can be prevented. Transparent funding, clear leadership, evidence-based practice, a new national target for driving down suicide deaths and strong local action plans are all needed to build on Scotland's excellent recent record on suicide prevention: a record which may otherwise be at risk.

Key Points

- We need a new national target for driving down deaths by suicide, to replace the previous target of reducing deaths by 20% between 2002 and 2013
- We want to see an all-age Plan which combines a universal approach with targeted action towards people and areas who have the greatest need
- The role, structure and status of the new Knowledge into Action Group and Suicide Prevention Confederation should be clearly set out and based within the public health sphere: we make specific proposals in our response
- The new Suicide Prevention Confederation should award funds to local partnerships and assess their work plans to ensure they target evidence-based actions at areas and people with the greatest need
- All elements of the proposed suicide prevention landscape must be given sufficient, recurring and transparent budgets
- ASIST training should be retained

[1] ISD Suicide Statistics for Scotland 2017

- We must draw on good practice from other parts of the UK, which now have well-developed suicide prevention plans
- We must develop proposals to address the stigma associated with suicide
- We propose a new set of Post Suicide Family Support Standards to help families deal with the emotional and financial effect of losing someone to suicide

In considering our response SAMH has had discussions with other third sector bodies including the Samaritans and Mental Health Foundation. We look forward to working together as this Plan is finalised and implemented. SAMH views suicide prevention as a key priority for our own work in the coming months and years. We are actively consulting our supporter base on the issue and have plans to invest charitable money in ambitious suicide prevention activities.

Action 1 - Improving the use of evidence, data and guidance on suicide prevention

Questions

1a) Do you agree that we should establish a "knowledge into action" group for suicide prevention? (Tick one only)

Yes X

1b) Please explain your answer.

We welcome the commitment to include people with lived experience of suicide in the group's membership. We suggest both the KIA and the proposed Confederation should sit under the remit of the new national Public Health body which will replace NHS Health Scotland in the coming year. We say more on this in our response to question 5.

The relationship between the KIA and proposed Suicide Prevention Confederation (action 3) needs to be clearly set out. The KIA should report directly to the Confederation and its role should be to identify evidence-based practice to inform the Confederation's work plans.

We must use well-established evidence, for example regarding the link between suicide and gender and deprivation, to inform practice. The Young People Improvement Collaborative (CYPIC) provides a good model for the development of innovative improvements to service delivery and shared learning.[2]

The final Action Plan should identify a realistic and recurring budget for the KIA. For example, the UK government in England allocated £1.5 million to suicide prevention research through their 2012 "Preventing Suicide in England" suicide prevention strategy.[3] This was delivered across six funded projects through the Department of Health hosted Policy Research Programme (PRP) and National Institute for Health Research (NIHR).[4] Projects have examined issues such as the role of the internet and social media in relation to suicide behaviour and self-harm and suicide ideation among risk groups.[5] We need a similar commitment in Scotland to adequately funding research and innovation in suicide prevention.

Suicide Prevention Targets

[2] https://beta.gov.scot/policies/improving-public-services/children-and-young-people-improvement-collaborative/
[3] HM Government Preventing suicide in England: A cross-government outcomes strategy to save lives 2012
[4] HM Government Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives 2017
[5] HM Government Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives 2017

Much progress was made during the original Choose Life programme against a national target to reduce deaths by suicide. A national target will provide strong direction and urgency to suicide prevention activities. SAMH took an active role in the Scottish Government's review of health and social care targets and indicator chaired by Sir Harry Burns.[6] We made clear that we believe there is a role for targets in healthcare.

A priority early action for the KIA should be the setting of a national suicide reduction target. The KIA should engage with a wide range of stakeholders to build a clear evidence base to set a realistic but ambitious target. We note that the Five Year Forward View for mental health in England has a target to reduce suicide by 10 per cent by 2020/21.[7]

1c) Please provide any additional comments or suggestions about improving the use of evidence, data and/or guidance on suicide prevention.

Much progress has been made in reducing suicide over the last decade, primarily during the original ten year Choose Life strategy. It's crucial that we maintain the most effective components of this strategy, given its demonstrable success. We urgently require a full evaluation of both the original Choose Life strategy and its successor Suicide Prevention Strategy 2013-2016. Only partial evaluations of Choose Life phase 1 and 2 were undertaken in 2006 and 2010 respectively.[8,9]. The previous evaluations of phase 1 and 2 of the Choose Life strategy and their recommendations should also be revisited. In particular the phase 2 evaluation called for NHS Health Scotland to consider the feasibility and practicality of developing a consistent approach to local evaluation for Choose Life. [10] This recommendation should be acted on. The role of the KIA should include the evaluation of local suicide activities with good practice disseminated to the proposed Suicide Prevention Confederation to inform their activity planning.

A systematic approach to evaluate local suicide prevention should be developed. Work is currently underway in England by the Department of Health in partnership with the National Suicide Prevention Strategy Advisory Group (NSPSAG) to develop and test an assurance process and criteria for English local authority local prevention plans.[11] The KIA should undertake a similar process.

Action 2 – Modernising the content and accessibility of training

2a) Do you agree that we should develop a new mental health and suicide prevention training programme? (Tick one only)

Don't Know

2b) Please explain your answer.

SAMH has reservations about the development of a new mental health and suicide prevention training. SAMH has significant experience in delivering existing suicide prevention training including ASIST and safeTALK. Since 2014, SAMH staff have undertaken at least 500 ASIST interventions, both with members of the public and people using our services. We value the emphasis in ASIST on developing the confidence and skills to directly intervene to support

[6] Scottish Government Review of Targets and Indicators for Health and Social Care in Scotland 2017
[7] HM Government The Five Year Forward View for Mental Health 2016
[8] Scottish Government Evaluation of the First Phase of Choose Life: The National Strategy and Action Plan to Prevent Suicide in Scotland - Research Findings 2006
[9] Scottish Government Evaluation of Phase 2 Choose Life 2010
[10] Scottish Government Evaluation of Phase 2 Choose Life 2010
[11] Department of Health Government Response to the Health Select Committee's Inquiry into Suicide Prevention 2017

someone who is having thoughts or plans of suicide. This is fundamental to the success of ASIST as an internationally recognised and valued training package. The Scottish Government should reconsider the decision to move away from ASIST. Academic evaluation of ASIST has shown it to lead to significantly improved outcomes for people receiving an ASIST intervention, including a reduction in suicide ideation and an increase in the person's exploration of reasons for living and informal support contacts.[12] The Scottish Government commissioned evaluation of the use of ASIST in Scotland in 2008 and found it was an effective programme.[13]

Suicide prevention training should remain separate from wider mental health training. SAMH are concerned that the amalgamation of mental health and suicide prevention training will result in a loss of focus on the 'intervention' nature of ASIST.

2c) To what extent do you agree that there should be *mandatory* suicide prevention training for specific professional groups? (Tick one only)

Strongly agree X

2d) Please explain your answer.

SAMH strongly endorses the recommendations on mandatory training in the recent Suicide Prevention Strategy Report.[14] The report, which was fully informed by the experiences of people with lived experience of suicide, recommends mandatory suicide prevention training for groups including GPs, social security staff and educational providers.

Suicide prevention training should also be provided to allied health professionals as part of their core training and continual professional development. In particular pharmacists and their staff should be provided with mandatory training. Fifty nine per cent of those who died by suicide between 2009-15 were prescribed a mental health drug in the year prior to their death, so training pharmacists presents a key opportunity to intervene and provide advice.[15] This training could be developed in partnership with Community Pharmacy Scotland.

2e) Please provide any additional comments or suggestions about modernising the content and/or accessibility of training on mental health and suicide prevention.

N/A

Action 3 Maximising the impact of national and local suicide prevention activity

Questions

3a) Do you agree that we should establish a Suicide Prevention Confederation? (Tick one only)

Yes X

3b) Please explain your answer.

SAMH believe that a properly funded and constituted Suicide Prevention Confederation has the potential to provide strong national leadership to support effective local suicide prevention

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[12] Gouls, M, S et al. Impact of Applied Suicide Intervention Skills Training (ASIST) on National Suicide Prevention Lifeline Counselor Suicide Life Threat Behav. 2013 Dec; 43(6): 10.1111/sltb.12049. 2013
[13] Scottish Government The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation 2008
[14] Scottish Government Suicide Prevention Strategy Report 2018
[15] ISD Scotland A profile of deaths by suicide in Scotland 2009-2015 2017

activities. Its success will require purpose, resource and teeth in the form of sufficient resourcing, leadership, governance and infrastructure. This is urgently needed at a time when the very welcome downward trend in the numbers of suicides appears to have stalled. Therefore, we would like to see the Confederation housed within the Public Health landscape, reporting directly to Scottish Ministers and awarding funds to local partnerships.

The initial years of the Choose Life strategy demonstrated the progress that can be made in preventing suicides. A strong national framework supported local Choose Life coordinators, with access to dedicated resources, to actively progress the suicide prevention agenda. Indeed the phase 2 evaluation report of Choose Life called for continued national support function to give support and direction to local work (e.g. in targeting, training supporting cross sectoral activities and sharing learning).[16] Changes to the Choose Life programme, including the move of the National Implementation Support Team to NHS Health Scotland and a loss of ring fenced funding, have undermined the strengths of the original programme. This conclusion was supported by Freedom of Information requests SAMH lodged in 2017 to all Scottish local authorities to gain details on their suicide prevention spend and staffing. We found almost half of Scotland's 32 local councils did not know, or failed to provide, information on their own suicide prevention budgets and the associated workforce.

It is particularly concerning that at a time when other nations in the UK are replicating much of the initial Choose Life work, momentum in Scotland appears to have stalled. In England, 95% of local authorities in 2017 had a local suicide prevention plan or were actively developing one. This is supported by dedicated resource and the National Suicide Prevention Strategy Advisory Group.[17]

SAMH has a number of suggestions about a model for the Confederation:

1. The Confederation should sit within the Public Health landscape and be supported by the proposed new national public health body
2. The Confederation should report directly to Scottish Ministers on an annual basis. This will ensure accountability of the Confederation's activities.
3. The Confederation must be adequately resourced by the Scottish Government to carry out its functions. For example the National Suicide Alliance in England is funded on a block grant basis from the Department of Health.[18]
4. The Confederation should be a budget holding body. Local partnerships should submit their work plans, informed by the Confederation's annual work plans, to the Confederation. The Confederation should then fund these plans, provided they meet local need and the Confederation's directions on evidence-based activities.
5. The proposed membership of the Confederation should also include people with lived experience of suicide. We welcome the proposal to include the third sector.
6. We strongly support the Confederation creating annual work plans which will inform the work of local partners. This will allow flexibility to incorporate innovative practices and approaches.
7. There should be a formal link between the KIA and the Confederation with the KIA. The researching and testing of innovative practices by the KIA should inform the development of the Confederation's annual work plans.

Below is our vision of the future suicide prevention landscape:

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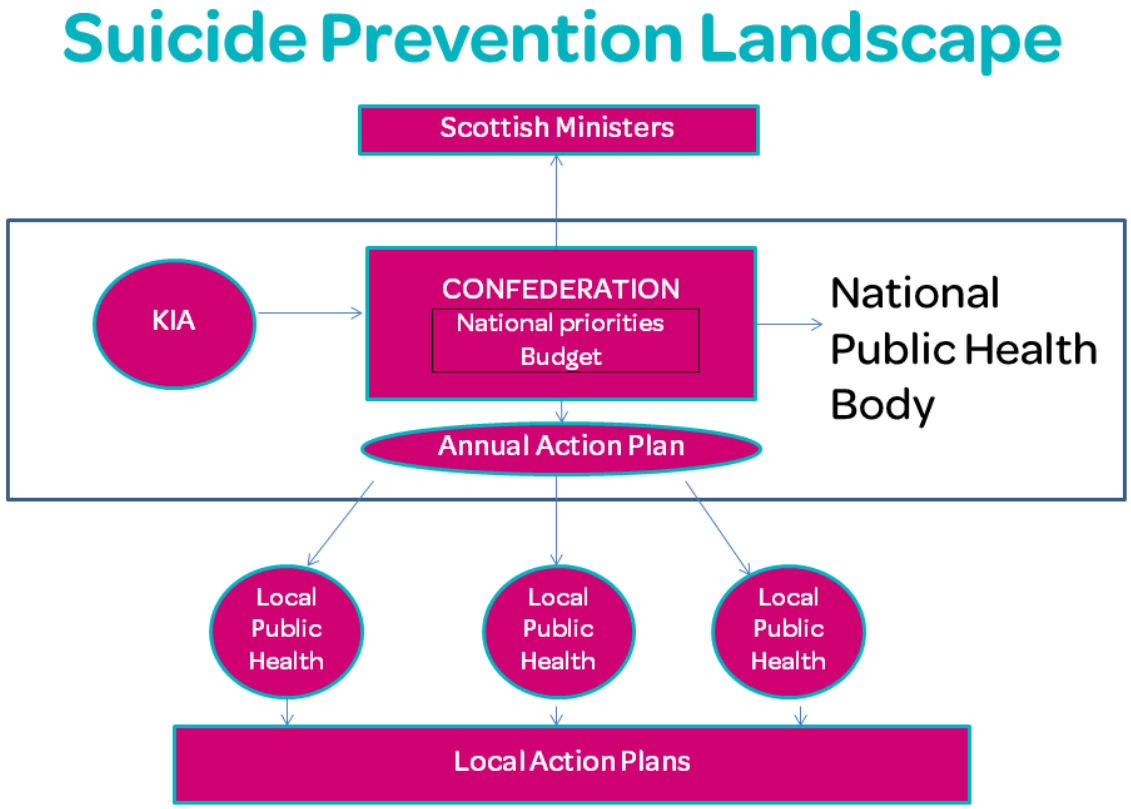
[16] Scottish Government Choose Life Evaluation of Phase 2 2010
[17] UK Government Keeping our focus on suicide prevention 2017
[18] HM Government Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives 2017



The proposed Confederation should be designed to revitalise suicide prevention activities in Scotland and provide a strong national framework to support local activities. We welcome the proposal in the draft Action Plan to include public, private and voluntary organisations in the Confederation. We also welcome the proposed role of the Confederation to agree and share annual work plans to promote consistent good practice locally. It must be mandatory that these action plans and priorities are reflected in local action plans. It must also be mandatory for all local areas to have a local action plan.

Suicide Prevention funding

We need greater transparency and accountability in the funding of suicide prevention activities. Other nations in the UK have a dedicated resource to support the implementation of their suicide prevention strategies, as Scotland used to have during the original Choose Life strategy. The UK Government through their Five Year Forward View for Mental health has dedicated £25m for suicide prevention activities between 2018/19 – 2020/21.[19] The funding is held centrally and allocated directly to Clinical Commissioning Groups (CCGs) in line with agreed local suicide prevention activities.[20] The Confederation could also use an Innovation Fund model, such as the Mental Health Innovation Fund, to test local practices, which could then be scaled up.

Northern Ireland has a dedicated budget to support their national suicide prevention strategy, Protect Life. The Northern Irish Department of Health has invested £6.2m to implement the

[19] UK Government IMPLEMENTING THE MENTAL HEALTH FORWARD VIEW
[20] UK Government Implementing the Five Year Forward View for Mental Health 2016

strategy, of which £2.2m is specifically to support communities develop local suicide prevention initiatives.[21]

Finally, the Suicide Prevention Confederation is not the most appropriate name for this body. We feel 'Confederation' is not a clearly understood term. An alternative could be the National Suicide Prevention Leadership Group.

3c) Where do you think *local* leadership for suicide prevention is best located? (Tick one only)

1. Other arrangement – Public Health

3d) Please explain your answer.

Suicide is a cross cutting issue, including health, justice, housing etc. Suicide prevention work must be undertaken on a partnership basis nationally and locally. The Confederation should be the body to provide this cross sectoral approach and infrastructure nationally.

Local leadership will be crucial to the successful implementation of the action plan and its actions at a local level. Evidence from the initial 10 year Choose Life strategy demonstrated that well-resourced local leadership supported by a national infrastructure provided the drive to implement real change at the local level and reduce suicides. This local leadership has been diluted in recent years: many local authorities no longer have a designated Choose Life Coordinator or up to date action plans.

The ongoing reform of Public Health and the creation of a new local public health infrastructure provide the opportunity to refocus local suicide prevention activities. We believe that local leadership should therefore sit within the local public health environment, given its role in tackling health inequalities and improving population health on a population wide and targeted basis. While Community Planning Partnerships (CPPs) may appear as a sensible strategic fit for local suicide prevention leadership due to their membership including key statutory and non-statutory partners it is not easy for third sector bodies in particular to engage with some CPPs and there is a risk they would not be able to provide the clear drive and leadership required.

The third sector has historically, had a key role in the provision of support to people affected by suicide or at risk of suicide. It is crucial that as part of a partnership approach to local suicide prevention work, the third sector is fully involved in local action plan development and delivery.

The consultation paper states that "the final Action Plan on Suicide Prevention will sit within a significantly stronger strategic landscape than ever before", with actions across the range of Scottish Government activities, contributing to suicide prevention work. We also note aspirations to improve responses to people in crisis or with mental health problems in the justice system through the Policing 2026 strategy and the Justice Vision 2017-20.[22],[23] The Confederation should be the locus to coordinate this cross governmental approach.

As part of our 2016 Scottish Parliamentary election manifesto SAMH called for the creation of Scottish Mental Health Crisis Care Agreements.[24] This would bring together statutory and non-statutory bodies including the emergency service and third sector mental health providers to agree a common set of standards and referral pathways for crisis support and local action plans.

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[21] NI Department of Health Suicide prevention [accessed April 2018]
[22] Police Scotland 2026 – Serving a Changing Scotland 2017
[23] Scottish Government Justice in Scotland: vision and priorities 2017
[24] SAMH Ask Once Get Help Fast 2016

This takes learning from the English Mental Health Crisis Care Concordat was established in 2014.[25] We believe the Confederation provides the opportunity to realise these policy aims.

3e) Please provide any additional comments or suggestions about maximising the impact of national and/or local suicide prevention activity.

Local Action Plans

Central to the success of suicide prevention work will be local planning. The Confederation's annual priorities and work plan should inform local action planning, and local partnerships should produce and report on annual action plans. Resources will be required to support this as well as a national framework for local evaluation, as is being developed in England.[26] . Local action planning will allow key local health inequalities related to suicide to be targeted, within a set of national priorities set by the confederation. Our proposal to link funding to local action planning will provided the drive to deliver on their objectives.

4 Developing the use of social media and online resources

4a) Do you agree that we should develop an online suicide prevention presence across Scotland? (Tick one only)

Yes

4b) Please explain your answer.

The online space provides a growing avenue for people concerned about suicide to access advice and information. Recent research funded through the English Suicide prevention strategy on the internet and its use in suicide prevention was published in 2017.[27] The findings included 22.5% of young adults reporting some suicide-related use of the internet, with 9.1% discussing suicidal feelings on social media.[28] Worryingly 3.1% viewed information about how to kill yourself.[29] SAMH's own data on engagement with our website and online resources show that our wellbeing assessment tool was completed 8,761 times in 2017 and over 500 SAMH suicide prevention publications were downloaded in the last year.

It is important that any online support takes fully into account risk and safeguarding with clear pathways for people to access face to face or emergency help where required. Those supporting people online must have adequate training with peer support sites well moderated. The National Suicide Prevention Alliance in England has developed guidance on online moderation.[30]

The research cited above from Bristol University found that the internet and social media was used as a help seeking resource particular in regards to peer support; web-based apps (e.g.

[25] HM Government and Mind, 2014, http://www.crisiscareconcordat.org.uk/about/
[26] Department of Health Government Response to the Health Select Committee's Inquiry into Suicide Prevention 2017
[27] University of Bristol Exploring the use of the internet in relation to suicidal behaviour: identifying priorities for prevention 2017
[28] University of Bristol Exploring the use of the internet in relation to suicidal behaviour: identifying priorities for prevention 2017
[29] University of Bristol Exploring the use of the internet in relation to suicidal behaviour: identifying priorities for prevention 2017
[30] University of Bristol Exploring the use of the internet in relation to suicidal behaviour: identifying priorities for prevention 2017

Moodjuice); expressing feelings (e.g. blogs); and as a distraction.[31] These findings and further research should be used to develop Scotland's online suicide prevention presence.

Overall responsibility for the direction of online suicide prevention activities should sit with the Confederation.

4c) Please provide any additional comments or suggestions about developing social media and/or online resources for suicide prevention.

We are proud to line manage the North East Choose Life Coordinator, who has been involved in ground breaking, award winning work on online resources including a suicide prevention app and Google AdWords campaign.[32] The suicide prevention app and supporting website reached more than 13,000 users in the first six months. The app provides a range of guidance materials and tools to build a safe plan, with support or alone.[33] Learning from these projects should contribute to the development of the suicide prevention online presence nationally.

5 Additional Comments

5) Please use this space to provide any additional comments that you have about any of the issues raised in this engagement paper.

While SAMH broadly agrees with the draft actions set out in this consultation, we believe there are significant gaps which need to be addressed in the final plan. These have been set out below:

Timescales

As drafted there are no details on the timescales for the Plan. SAMH campaigned for and welcomed a ten year Mental Health Strategy, because a long term approach can remove mental health from the electoral cycle and facilitate transformative change. A long term approach should also be taken with suicide prevention, building on the success of the initial ten year Choose Life strategy and including ongoing monitoring and evaluation. The Confederation's role in developing agreed annual work plans allows for actions of the Action Plan to be updated regularly.

Priority Activity Areas - Demographics

Whilst suicide affects all of Scotland's communities, the suicide rate for males was more than two-and-a-half times that for females in 2016, and more than two-and-a-half times higher in the most deprived areas compared to the least deprived.[34] Men in age groups 40-49 are particularly at risk.[35] These correlations are longstanding, with explanations including the choice of method; the role of dominant cultural conceptualisations of masculinity; reluctance to pursue help seeking behaviour among men; self-medication through alcohol use, and the accepted masculine behaviour of excess alcohol use as a coping strategy.[36]

It is crucial that the final Action Plan reflects the need for activity to reduce suicide amongst Scottish men and people living in poverty. A priority area, both for the KIA in terms of research and the Confederation in developing its action plan should be the commissioning of evidence-based,

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[31] University of Bristol Exploring the use of the internet in relation to suicidal behaviour: identifying priorities for prevention 2017
[32] http://www.chooselife.net/uploads/documents/195-ChooseLife_NPS_Aberdeen_August2017.pdf
[33] http://www.chooselife.net/uploads/documents/195-ChooseLife_NPS_Aberdeen_August2017.pdf
[34] ISD Suicide Statistics for Scotland 2017
[35] ISD Scotland profile of deaths by suicide in Scotland 2009-2015 (2017)
[36] The Samaritans Men and Suicide (2012)

gender sensitive services, including peer support and activity based services, to tackle health inequalities impacting men and suicide. These should initially be targeted in areas of deprivation.

Age

Suicide affects people of all ages, but different age groups are at greater risk. Figures between 2009 and 2015 show people aged, 35-54 are most at risk with 47% of all deaths by suicide in Scotland occurring in this age group.[37] Suicide is also one of the leading causes of death for young people under 25.[38] The English strategy includes children and young people as a key target group for action.[39] It highlights the need for action within the educational setting and young people's mental health settings as well as the need for specialist resources for LGBT young people.

The final Action Plan must be an all-age plan which combines a universal approach with targeted action towards people and areas that have the greatest need. An early priority of the KIA should be to collate research on the relationship between age and suicide and develop innovative approaches to target people in their middle years and young people.

Mental health

Research has shown that the suicide risk is raised for people experiencing virtually all mental health problems.[40] This is also reflected in the level of suicides of people who have had recent contact with NHS mental health and other health services. Over half (59%) of people who died by suicide between 2009 and 2016 had at least one mental health drug prescription dispensed within 12 months of death, with about a quarter (26%) having had at least one psychiatric inpatient stay or psychiatric outpatient appointment in the 12 months before death.[41]

We welcome the ongoing work of the Scottish Patient Safety Programme (SPSP), particularly its work on mental health. The SPSP Mental Health end of phase report 2016 shows a reduction in self harm by psychiatric inpatients of up to 70% in wards where data was collected by the SPSP.[42] The SPSP use a collaborative and innovative approach with involvement by service users and clinicians in designing, testing and scaling up interventions to reduce patient harm. There is also a strong focus on leadership, culture and human rights with the SPSP working in partnership with the Scottish Human Rights Commission to ensure its mental health Programme is based on human rights.

The Action Plan through the Confederation should work directly with the SPSP to develop interventions to prevent patient suicides.

Self-Harm

Self-harm is distinct from suicide - as a coping strategy it can be life preserving - but it is a clear risk factor for suicide.[43] People who have self-harmed are 100 times more likely to take their own life within a year.[44] We welcome the role the KIA will play in collecting and analysing data on self-harm. We also welcome the ongoing piloting and development of the Distress Brief Intervention

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[37] ISD Scotland profile of deaths by suicide in Scotland 2009-2015 (2017)
[38] National Records of Scotland Vital Events Reference Tables 2016 Section 6: Deaths – Causes 2017
[39] HM Government Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives 2017
[40] Harris, C, and Barraclough, B, (1997), "Suicide as an Outcome for Mental Disorders", British Journal of Psychiatry, 170, 205-28
[41] ISD Scotland profile of deaths by suicide in Scotland 2009-2015 (2017)
[42] Health improvement Scotland SPSP Mental Health End of phase report November 2016
[43] Scottish Government Responding to Self-Harm in Scotland Final report 2011
[44] Scottish Government Responding to Self-Harm in Scotland Final report 2011 [citing Self-Harm Scope Final version 3, NICE 2002]

programme. We believe the DBI approach once scaled up nationally will create clear pathways for timely support for people in crisis and distress, including associated with self-harm.

Further responses to self-harm need to be developed. SAMH has previously suggested approaches could include: mandatory training in responding to self-harm for all frontline NHS staff; information and training for parents and key professional groups about self-harm; and access to the full range of psychological therapies listed as effective for management of self-harm in Scottish Government's Psychological Therapy Matrix.[45] These actions should be incorporated into the Confederation's work planning and inform local activity plans.

Workplace

Seventy one percent of people who died by suicide between 2009 and 2015 in Scotland were employed at the time of their death.[46] The final Action Plan should include actions to support people in work and to access support when they require it. This should include actions to support employers to recognise the importance of suicide prevention and create clear pathways to support employees at risk. This should build upon the work of See Me to reduce mental health stigma in the workplace.[47]

Evidence from the ISD Scottish Suicide Information Database shows the increased risk of suicide for particular occupations. These include an increased risk associated with skilled traders, construction workers, and people working in the care sector.[48] The English suicide prevention strategy has identified specific occupational groups as a priority area. Research undertaken by The Office for National Statistics (ONS) published in 2017 to support the English Strategy provides an analysis of trends and risk factors associated with specific occupations in England.[49] Findings included that men working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average, and that for women, the risk of suicide among health professionals was 24% higher than the female national average.[50] Targeted research by the KIA group should build on these findings to develop specific tailored responses to these and other at risk professional groups.

Stigma

We know that the stigma that surrounds mental ill-health and emotional distress can prevent many people from seeking help, or talking openly about how they are feeling. Talking about suicide responsibly does not increase risk, it reduces it.[51]

The draft Action Plan contains no direct reference to stigma and suicide. This is disappointing as the Scottish Government's commissioned engagement with people with lived experience of suicide in preparation for this consultation highlighted stigma as a key concern.[52] The report highlighted negative attitudes from service providers, including mental health services and A&E, where suicidal ideation has been described as manipulative and repeat presentations of self harm have not been taken seriously. This results in a perception that service providers underestimate the risk of the person completing suicide.[53] The report recommends campaigns, training and community resources as examples of actions to tackle stigma. SAMH endorses this

[45] SAMH SAMH View Self Harm 2017
[46] ISD Scotland profile of deaths by suicide in Scotland 2009-2015 (2017)
[47] See Me See Me in Work [accessed April 2018]
[48] ISD Scotland profile of deaths by suicide in Scotland 2009-2015 (2017
[49] ONS Suicide by occupation, England: 2011 to 2015 2017
[50] ONS Suicide by occupation, England: 2011 to 2015 2017
[51] Choose Life Understanding Suicide
[52] Scottish Government Suicide Prevention Strategy Report 2018
[53] Scottish Government Suicide Prevention Strategy Report 2018

recommendation and calls on the action plan to include a commitment to work with See Me to tackle suicide related stigma with the public and within healthcare settings.

Reducing stigma around suicide is recognised as a key activity in the Welsh suicide prevention strategy Talk To me 2 (2010-2015).[54] The Welsh strategy recognises the need to tackle stigma associated with suicide beyond general efforts to reduce stigma around mental health due to the particular societal attitudes around self-harm and suicide. In England reducing stigma is also central to the National Suicide Prevention Alliance (NSPA) strategic framework 2016-19.[55]

Community Triage

SAMH believes the Action Plan should include an action for the national roll out of Community Triage. Community triage provides police officers with direct access to mental health professionals to support decision making and reduce inappropriate detentions of people in psychiatric distress or crisis. It has been successfully piloted in NHS Greater Glasgow and Clyde and the Lothians.[56]

Suicide Reviews

There are opportunities to improve the suicide review process. When someone dies by suicide in Scotland, an independent review into the circumstances of their death and factors leading up to it is only carried out in certain circumstances. The situation is markedly different in relation to drug related deaths. Currently all deaths where there is a suspicion that there are drugs involved are reviewed by multi agency local critical incident monitoring groups[57], commonly called a Drug Death Review Group (DDRG).

The suicide review process should be widened to cover all deaths by suicide, not only those of people in recent contact with mental health services. We would also like to see a reversal of the June 2017 change, which means NHS boards no longer need to provide complete suicide review reports to Healthcare Improvement Scotland, only summaries.[58] We do not see a clear rationale for this change and believe it could reduce the opportunities to learn from past suicides.

Bereavement Support

The emotional and financial impact of bereavement by suicide can be considerably different from other bereavements, including an increased risk of suicide for those bereaved.[59] The effect of bereavement by suicide may include feelings of guilt, shame and intense emotional distress for family members and friends of the person who has died. Financially, many life insurance policies do not cover death by suicide resulting in a significant financial impact on surviving family members. [60] SAMH believes this is discriminatory and provision to support families and friends bereaved by suicide need to be improved.

We note that both the Welsh and English national suicide strategies include support for people bereaved by suicide as key objectives.[61],[62] The third progress report on the English strategy has

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[54] Welsh Government Talk to me 2 Suicide and Self Harm Prevention Strategy for Wales 2015-2020
[55] HM Government Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives 2017
[56] Police Scotland & NHS Greater Glasgow and Clyde Community Triage – NHS Greater Glasgow and Clyde Crisis Out of Hours CPN(Community Psychiatric Nurse) Service Pilot Evaluation Report (2015)
[57] ISD Scotland The National Drug Related Deaths Database (Scotland) Report: Analysis of Deaths occurring in 2013 April 2015
[58] Healthcare Improvement Scotland Suicide review community of practice [accessed April 2018]
[59] Samaritans Bereavement by suicide [accessed 2018]
[60] Papyrus Life insurance policies must not exclude suicide 2017
[61] Welsh Government Talk to me 2 Suicide and Self Harm Prevention Strategy for Wales 2015-2020

called for all local multi-agency suicide prevention groups to include support for those bereaved by suicide in all local suicide prevention plans.[63] Public Health England in partnership with the National Suicide Preventing Alliance (NSPA) has also published guidance to local authorities to assist them in developing bereavement support. The guidance sets out existing provision and an evidence base for developing good local provision.[64] The final action plan should reflect this body of evidence, with the KIA making bereavement research and service design a key early priority for action. We also believe the KIA should take evidence from a wide group of stakeholders to produce a set of suicide bereavement support standards, to be adopted by public bodies and service providers. These standards would set out a minimum set of standards for families to expect when engaging with any public body or service in the wake of a suicide.

[62] HM Government Preventing suicide in England: A cross-government outcomes strategy to save lives 2012
[63] HM Government Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives 2017
[64] Public Health England Support after a suicide: A guide to providing local services A practice resource 2016