**Equalities, Human Rights and Civil Justice Committee**  
**Suicide Prevention Strategy inquiry**

**SAMH submission**

We welcome the opportunity to respond to the Committee’s inquiry into Scotland’s Suicide Prevention Strategy. We have a longstanding commitment to suicide prevention. Over many years we have influenced public agendas, developed our own suicide prevention national programme, and created a dedicated team to deliver our ambitions. In 2021 we launched a [new strategy](https://www.samh.org.uk/about-us/we-wont-wait), making suicide prevention a strategic priority and committing to significantly increase our investment in this area.

Every day we support people affected by suicide or suicidal thoughts through our community-based teams and remain one of Scotland’s biggest suicide prevention trainers (including [ASIST and SafeTALK](https://publichealthscotland.scot/our-areas-of-work/health-and-wellbeing/services-support-and-recovery/mental-health-learning-resources/suicide-prevention-learning-resources/)). We are a key partner in the Distress Brief Intervention (DBI) programme, including as the lead tier 2 DBI provider in the Borders. This year we launched a new Grampian-wide multi-agency strategic partnership and associated delivery programme that builds on many years of suicide prevention work in the North East. With thanks to our supporters, and in collaboration with the Suicidal Behaviour Research Lab at the University of Glasgow, we fund research on suicide prevention and recently funded a second PhD exploring suicide and stigma. The first PhD delivered ground-breaking research focusing specifically on men and suicide risk.

We are the strategic outcome lead for outcome two of the current suicide prevention strategy, Creating Hope Together (CHT). In addition, we host and manage the coordination of the national Lived Experience Panel and the United to Prevent Suicide social movement.

1. **In your view, what factors contribute to the rates of suicide in Scotland?**

The causes of suicide and suicidality in Scotland are multi-faceted, with the circumstances contributing to each death unique. It is important not to view potential causal factors for suicide in isolation, as it will rarely be the case that a single factor explains someone’s suicide. An intersectional understanding of suicide risk is essential. Despite this, the Scottish suicide statistics and evidence exploring suicide risk clearly demonstrate the role that particular social, psychological and economic conditions play in relation to increased risk of suicide.

A helpful theoretical framework to better understand the complexities of suicidal behaviour is the Integrated Motivational Volitional (IMV) model, developed by University of Glasgow Professor Rory O’Connor.[[1]](#footnote-1) We welcome that the IMV model has been incorporated into Scotland’s Suicide Prevention Strategy. Importantly, the model highlights the central role of feelings of ‘defeat’ and ‘humiliation’ (which may be associated with a variety of life and psychological stressors and circumstances). Defeat and humiliation can result in feelings of ‘entrapment’ (where suicide is seen as the only response to life’s circumstances), leading to suicidal ideation and ultimately suicidal behaviour.[[2]](#footnote-2) Crucial to the model is the role that background motivational factors – such as deprivation, mental illness, or relationship breakdown – play, increasing risk. The model’s application provides a helpful framework to conceptualise risk (and inform efforts to mitigate it), by highlighting the need to understand and mitigate situations (which can be personal, social, or broader) which are likely to give rise to feelings of humiliation, defeat and entrapment.

The Committee may wish to invite evidence directly from Professor O’Connor.

* **Poverty**

The link between socioeconomic deprivation and suicide is well-established. The latest suicide statistics show that in 2022 the rate of suicide was 2.6 times higher in Scotland’s most deprived areas compared with the least deprived areas.[[3]](#footnote-3) This relationship is longstanding, with little change in the difference between suicide rates for people living in the least and most deprived areas of Scotland since at least 2001.[[4]](#footnote-4)

The ongoing cost-of-living crisis means that mitigating the most negative impacts of poverty and economic uncertainty has never been more important in the context of suicide prevention.

* **Sex**

Death by suicide is gendered. The 2022 suicide statistics show that in Scotland the rate for suicides was 2.9 times higher for males than females, with men in their middle years at particular risk.[[5]](#footnote-5) This gender divide is longstanding. In contrast, women in Scotland are more likely to attempt to end their life by suicide. The latest Scottish Health Survey shows 8% of women have attempted suicide at some point in their life compared to 6% of men.[[6]](#footnote-6)

The reasons for the higher rate of suicide deaths for men are complex, with research from the Samaritans finding a range of psychological, cultural, relational and socioeconomic factors increasing the risk of suicide among men in their middle years.[[7]](#footnote-7) These include:

* The role of specific elements of masculinity, including the centrality of ‘providing for the family’ as part of male identity, which when lost can be experienced as shameful
* Greater use of alcohol and drugs in response to stress, compared with women
* The use of more lethal methods of suicide
* Fewer supportive peer relationships compared to women
* Lower levels of help-seeking, including around mental health, than women.

Action at the community level – particularly around tackling stigma and promoting help-seeking for men – remains a key need, to ensure men can receive appropriate timely support. An example of our work in this area is our [Changing Room](https://www.samh.org.uk/get-involved/physical-activity-and-sport/our-projects/the-changing-room) project, in partnership with the SPFL Trust and delivered with many of Scotland’s professional football clubs, which aims to give men a familiar, safe and welcoming space to discuss and explore their mental health with peers.

* **Risk groups**

While suicide affects all groups and communities, there is clear evidence of increased risk of suicide for particular groups. These include, but are not limited to, LGBT people, people from minority ethnic backgrounds, physically disabled people, people affected by drugs and alcohol, and veterans. During the Every Life Matters Suicide Prevention Strategy we were the action owner for action 7, which aimed to identify and target suicide prevention activities to better support at-risk groups.

While contexts varied across groups (and within them), key themes which increased suicide risk that emerged during our action 7 engagement work included: a history of trauma, particularly childhood trauma; stigma (including stigma and discrimination associated with being a member of a minority group and stigma around mental health and suicide); and barriers to help-seeking and services, including a lack of cultural competence.

In relation to people from minority ethnic backgrounds, through Action 7 of Every Life Matters we commissioned lived experience-led research to explore racialised communities’ experience of suicide and experiences of accessing support around suicide.[[8]](#footnote-8) Key findings included:

* The experience of racism (and constant threat of racism) as a trauma contributing to suicidal ideation
* The experience of immigration processes in the UK impacting family life and mental health
* A mistrust of services, including health services, often based on a perceived lack of cultural competence and understanding of the experiences of racialised groups, which posed an additional barrier to the mental health support participants received
* A lack of awareness of services, including mental health services, for and by racialised communities.
* **Mental Health**

While not everyone who will die by suicide or attempt suicide has a mental health problem, experiencing a mental health problem is associated with an increased risk of suicide.[[9]](#footnote-9) Indeed, studies have shown that the incidence of psychiatric disorder among people who die by suicide could be as high as 90%.[[10]](#footnote-10)

The latest data from the Scottish suicide information database (ScotSID) illustrates the importance of the intersection between mental ill heath and suicide, which makes clear the need to ensure suicide risk is identified at key points of someone’s interaction with health services. The data shows that between 2011–2021:[[11]](#footnote-11)

* Over three-fifths (62%) of all suicides occurred within 12 months of a mental health drug being prescribed
* One-quarter (25%) had been offered an appointment at a psychiatric outpatient clinic in the 12 months before death
* A third (33.6%) had contact with the Scottish Ambulance Service in the 12 months before death
* Over a tenth (11.7%) had had a psychiatric in-patient stay in the 12 months before death.

1. **What actions could we take as a society to reduce suicide rates in Scotland?**

To reduce suicide requires action at societal, community and individual levels. For example, and as outlined in the previous answer, tackling, or at least mitigating, the impact of underlying social determinants which increase the risk of suicide is key. In particular, this should mean mitigating or reducing the impact of poverty, economic, and health inequalities. For example, although it is rarely thought of in these terms, an effective, well-resourced social security system is an essential component of suicide prevention.

It is welcome that CHT recognises the importance of tackling the social determinants of suicide and mental ill health. Indeed, we warmly welcome the recognition in the strategy that reducing suicide requires a whole government and whole society approach. Actions against outcome 1 in the 2022-25 National Action Plan are also positive in this regard, not least: identifying key policy areas (such as homelessness, social security and the national drugs mission) in which to embed suicide prevention, including upskilling key workforces; and actions (2.1 and 2.2) to address locations of concern.[[12]](#footnote-12) How these actions are resourced and how a cross-policy approach is embedded in practice will be key to making real change.

As a society more must be done to reduce stigma, both in regards to suicide and mental health. Stigma, including self-stigma and discrimination, acts as a barrier to seeking help, including at times of suicidal crisis. Stigma is experienced – and needs to be addressed – across a range of settings, including health care settings such as A&E when people are seeking support for self-harm or suicide.[[13]](#footnote-13) The ground-breaking See Me Scottish Mental Illness Stigma Study explored the rate and impact of stigma on people living with severe and enduring mental health problems across key life areas, from friends and family, to employment and health services.[[14]](#footnote-14) Findings included: more than half of respondents stating that they had avoided calling an ambulance or attending A&E for emergency mental healthcare (58%) due to the fear of stigma; and had stopped themselves from getting mental healthcare for fear of receiving unnecessary treatment (52%).[[15]](#footnote-15) Learning from See Me’s findings should be used to ensure clear action – including training and cultural change – is taken across healthcare, workplaces and other key settings to increase understanding of suicide, mental health and to reduce stigma.

To reduce suicide, it is critical that appropriate support is available and easy to access, both prior to and during a crisis. This includes the urgent need for improved access to mental health care and treatment. CAMHS and NHS psychological therapies waiting time statistics show people are currently having to wait too long to access NHS mental health care and treatment, with the 18 week waiting time targets never having been met.[[16]](#footnote-16),[[17]](#footnote-17) We have consistently called for an increase in community provision to support psychological wellbeing and to reduce demand on other services.

While for some people support from clinically-led mental health services will be essential, there is growing recognition of the role other support can play in helping people. From speaking to people with lived experience and our staff in our community support services, we know that many people living with suicidal thoughts value the role of peer-support, for example at our Sam’s Cafe service in Fife.[[18]](#footnote-21593) We are encouraged that expanding peer support capability is a key element of the current action plan. We would like to see this acted upon and resourced as a priority in the first stage of the strategy's lifespan.

In regards to provision of support, while there are longstanding and significant barriers to accessing appropriate and timely support in the community, there has also been real progress. For example, the introduction and roll-out of Distress Brief Interventions (DBI) has been invaluable. We look forward to the completion of the national roll out of DBI this year, and believe ongoing resourcing of DBI to maintain and expand provision is essential.

1. **To what extent do you believe that the Scottish Government and COSLA’s Suicide Prevention Strategy 2022 to 2032 and delivery plan will achieve its vision of reducing the number of suicide deaths in Scotland?**

There is much to welcome in CHT and the associated action plan. In particular, and related to comments in previous answers, we welcome the explicit focus within the strategy on the role of inequalities and social determinants which can increase risk of suicide.

Work that we as strategic outcome lead for outcome 2 of the strategy will be coordinating has potential to make real change. In particular, continuing to grow Scotland’s suicide prevention social movement “United To Prevent Suicide” will support increased understanding of suicide and reduced stigma. We are working towards:

* A more strategic approach to campaigning
* Taking a new approach to learning and testing what that could mean in different settings
* Improving understanding of help-seeking and help-giving
* Developing an online portal to make it easier to find appropriate support and resources.

We are a founding member of the Grampian Suicide Prevention Strategic Partnership and are working closely with key partners in the region across five priority themes:

1. Building Capacity
2. Lived Experience
3. Children and Young People
4. Data Analysis and Death Review
5. Bereavement.

Overall we believe that CHT has appropriate guiding principles and outcomes. In particular, we support the ongoing commitment to fully involve academic expertise and lived experience at all stages of suicide prevention work, from design to delivery. The Lived Experience Panel (LEP) model set up through Every Life Matters, and coordinated by SAMH, has been recognised as an example of global good practice by the World Health Organisation (WHO).[[19]](#footnote-19) We strongly welcome that the LEP has been retained in the current strategy. Learning from the panel experience should be used to further inform the embedding of lived experience into suicide prevention activity, particularly at the local level.

At the level of individual actions there is much to be welcomed. For example, action 5.11 to provide suicide bereavement support across Scotland is vital. The bereavement support services piloted during the Every Life Matters strategic period evaluated positively and should be rolled out in full. Similarly, we welcome the commitment to roll out multi-agency suicide reviews, again piloted through Every Life Matters. This will ensure learning from every suicide can be gained and used to improve suicide prevention responses both locally and nationally. As stated in earlier sections, we very much welcome the roll out of DBI and increased peer support capacity and believe these can make a real difference by increasing support for people experiencing crisis or suicidal ideation.

Actions around capacity building (action area 4 of the current action plan) are also very welcome, both in regards to children and young people (such as embedding a whole school approach to mental health (action 4.3)) and building capacity among at-risk communities to support suicide prevention (through at least two test of change programmes (action 4.2)).

While we welcome the priorities, outcomes and many of the actions within the current strategy and action plan, we cannot be fully confident that a reduction in suicide will be achieved. A key reason for this is that tackling the underlying social determinants of suicide – while rightly centred in the strategy – will require significant resource and action outwith the scope of the strategy. We do believe, however, that actions within the strategy may mitigate some of the impacts of these social determinants.

Secondly, success – and a sustained reduction of suicide – will only be achieved if the strategy and associated actions are adequately resourced by the Scottish Government and local authorities. At this stage, the Scottish Government have only committed to direct funding to support the strategy of £2.8m per year by 2025-26,[[20]](#footnote-20) with £2.5m spend in 2023-24.[[21]](#footnote-21)

We do not believe this is sufficient to sustainably implement the many positive actions within the action plan nationally. Indicative of this lack of resource is that, of the £2.5m spend in 2023-24, £600,000 has been allocated to continued funding of the suicide bereavement pilot services and improvements to crisis responses.[[22]](#footnote-22) If the intention is to fully roll out bereavement services across all areas of Scotland (using the same model as the pilot services), significantly more funding than the total direct spending commitment of £2.8m per year to support the entire strategy would be required for the bereavement service commitment alone.

When compared to historic spending during the Choose Life National Strategy (which included ring-fenced national and local spend, and a 19% reduction in suicide deaths), spending levels today are significantly lower. Choose Life was backed by a budget of £12m over the first three years (2003-2006). The second phase of Choose Life (2006-2008) was supported by £8.4m.  £2m of this went to national activities supported by a national programme of research and evaluation, with local authorities receiving £6.4m (£3.2m per annum) to support local action plans.[[23]](#footnote-23) We believe that at least comparable spending is required to achieve the aim of reducing deaths by suicide, particularly in the context of the ongoing cost of living crisis, as noted above.

1. **To what extent do you believe the Suicide Prevention Strategy 2022 to 2032 and delivery plan will reduce inequalities which contribute to differing suicide rates between groups?**

We welcome reference to tackling inequality in both the vision and guiding principles in CHT. However, it is not realistic to expect this strategy to reduce the inequalities themselves, which are often national and structural in scale, and range across many other policy areas. As above, we think that CHT may be able to mitigate some of the impacts of these inequalities, but reducing them can only be done with significant national effort and resource – such as that given to the (very welcome) Scottish Child Payment, for example.

Reference to a whole government approach is important, but how this is delivered in practice will be critical. We welcome the acknowledgement in annex 1 of a range of related strategies, but more will need to be done to ensure that the strategies – and those tasked with their implementation – are aligned and talking to each other, potentially including shared outcomes. Listing them is not sufficient.

We also acknowledge the importance of outcome 2, for which we are the strategic outcome lead. Action 4.2 on capacity building in key settings (including social security, areas of financial distress and marginalised communities) will help to build confidence, skills, and awareness, with the aim of helping to make society easier to survive.

1. **Do you think that sufficient funding is available to implement and support the Strategy and delivery plan?**

As set out in answer to question 3, we do not believe sufficient funding has been made available to fully implement the strategy and action plan. This is a particular concern in the context of a downturn in the economic cycle, which is associated with increased risk of suicide.

We are concerned that the level of funding will not allow the welcome actions within the 2022-25 action plan to be delivered at scale across Scotland. There is a real risk that effective preventative actions or responses to suicide – such as post-suicide bereavement support – will be restricted to limited pilot areas, and not fully rolled out despite positive evaluations.

Like suicide bereavement support, the provision of peer support is another area we have significant concerns about with respect to funding. As a provider of peer support, both formal and informal, we recognise the key transformational role it plays across a variety of at-risk groups, reducing stigma and distress. We very much welcome that the current suicide prevention strategy and action plan recognises the importance of peer support, which the Scottish Government states is a key priority for 2023-24.[[24]](#footnote-24)

Action 5.3 of the current plan intends to:

“Build new peer support capability to enable further use of peer support and recovery models for suicide prevention, working with key partners, such as Scottish Recovery Network.”[[25]](#footnote-25)

While this commitment is welcome, it has only been supported by £389,150 of funding over the next three years.[[26]](#footnote-26) This will not be enough to improve access to peer support across Scotland in any meaningful way.

Additionally, we are concerned by the lack of transparency in relation to suicide prevention spending. It is not possible to effectively track suicide prevention spend either at a national or, crucially, local level. This makes evaluating the effectiveness of current spend challenging. For example, the £2.5m 2023-24 Scottish Government spending on suicide prevention is published only as part of the core mental health budget, with no further disaggregation. We do welcome that, in answer to a written parliamentary question, the Scottish Government have stated that the suicide prevention National Delivery Lead will be tracking national spend against the annual delivery plan.[[27]](#footnote-27) It is important that this tracking is made publicly available.

In answer to the same written question, the Government confirmed they have no plans to track local spend. This is disappointing, as the bulk of suicide prevention activities – from preventative action to crisis support – is organised and delivered locally. We believe all local authorities should have up to date local suicide prevention plans, with costed actions against clear outcomes. As stated above, during the Choose Life strategic period – during which we experienced a significant fall in suicides – ring-fenced local suicide prevention resource (with support from a national strategic infrastructure) was key to reducing deaths.

We welcome the commitment to a cross-governmental approach to suicide prevention, and accept that many actions which can impact suicide positively (particularly where related to social determinants of suicide) will be funded through non-health budgets. Greater transparency is required to actively and clearly demonstrate where non-health spend is regarded as impacting suicide prevention. This will help show, at least in part, that the consequences for suicide of policy and spending decisions has actively been considered.

1. **To what degree have the voices of people with lived experience of suicide been meaningfully considered within the development of the Strategy and its implementation?**

The strong commitment to lived experience in CHT is very welcome. Lived experience has been and is an essential part of suicide prevention infrastructure. The development of CHT and its associated action plan has been influenced by the Lived Experience Panel from the last action plan. The current Lived and Living Experience Panel, which we host for Suicide Prevention Scotland, has attracted a wide range of people with valuable experience and insight. This panel is now meeting and influencing delivery of the current action plan.

However, there is more to do. In particular, it is essential that lived experience informs and shapes action and practice not just at the national level, but also contributes to the development of local suicide prevention plans and delivery. Lived experience must also be part of evaluation, as well as strategy development and delivery.

We must also build on the successes of the panels to further incorporate voices from a wider range of communities, particularly those who are at greater risk of suicide and those who are seldom heard in the context of suicide prevention. It may be that there is a need to adopt multiple models of participation and engagement, beyond the panel. One such model could be the development of a broader network which would enable a larger group of people, representing more communities and with insight into a wider range of circumstances, experiences and specific risk factors, to input into decision-making, delivery and evaluation. Additionally, meaningful engagement with a diverse range of stakeholders, including representative organisations, will be essential.

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