Consultation on a New Suicide Prevention Strategy and Action Plan for Scotland

SAMH Response

Questionnaire

1. Questions

1.1 Section One – Strategy

This section relates to the **Strategy** document.

We want to hear your thoughts about the proposed vision, principles, outcomes and priorities. We have described what we mean by these terms below.

Vision – The ambition for suicide prevention activity in Scotland.
Principles – The *ways* in which we will work to help achieve vision.
Outcomes – The results or changes we want to see as a result of the Strategy and Action Plans.
Priorities – What we need to focus on first - based on feedback from the public and organisations who have engaged to date.

We want to know what you think about each of them by answering the following questions:

Vision:

1.1. Do you agree with the proposed vision, described below, for the new Suicide Prevention Strategy. **[Y/N]**

"Our ambition is a Scotland where everyone works together to prevent suicide.

To achieve this we will work with communities to become safe, resilient and inclusive - where people who have thoughts of taking their own lives, or people affected by suicide, are offered effective, compassionate and timely support, and a sense of hope."

No

1.2. If you answered **no**, what would you change about the vision and why? You may also wish to outline what you think the vision should be.

SAMH and Suicide Prevention
SAMH has a long-standing commitment on suicide prevention. Over many years we have influenced public agendas, developed our own suicide prevention national programme, and created a dedicated team to deliver. In 2021 we launched a new SAMH strategy, placing suicide prevention as one of three strategic priorities and making a commitment 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). We are a key partner in the Distress Brief Intervention (DBI) programme, including as the lead tier 2 DBI provider in the Borders and, later this year, we will launch a new Grampian-wide multi-agency strategic partnership and associated delivery programme that builds on many years of suicide prevention in the North East. With thanks to our supporters, in collaboration with the Suicidal Behaviour Research Lab at the University of Glasgow, we are able to 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 to understand suicide risk.

Ahead of the 2021 Scottish Parliamentary election we published our manifesto – Standing Up For Scotland's Mental Health.[1] Suicide Prevention was one of three key priorities. SAMH also has a strong history on providing thoughtful leadership, excellent delivery and critical friendship to Scottish Government's approach to suicide prevention. We have made significant contributions over the last twenty years to the formation and delivery of previous strategies and action plans. This is an issue of great importance to our constituencies and we remain committed for the long term.

More recently, as a founding member of the National Suicide Prevention Leadership Group, (NSPLG), we took lead/host sponsorship on two of the ten actions in the Every Life Matters action plan. In addition, SAMH hosts and manages the co-ordination of the national Lived Experience Panel which supports the delivery of Every Life Matters

Vision

SAMH warmly welcomes the opportunity to respond to the Scottish Government's consultation on the upcoming national suicide prevention strategy and associated action plan. Significant progress over the lifespan of the Every Life Matters Action Plan has been achieved, not least the successful incorporation of lived experience and academic advice into the design and delivery of suicide prevention in Scotland. Despite the significant challenges arising from the pandemic, many of the actions of Every Life Matters have been achieved, including the launch of the United To Prevent Suicide social movement and associated campaigns and the pilot bereavement support programme for families and communities.

As we move into the next national strategy, we look forward to seeing the full benefits of activities begun under Every Life Matters, such as the scaling up of the suicide bereavement pilot, mainstreaming of multi-agency reviews of suicide deaths and the embedding of local suicide prevention action plans.

We strongly welcome the commitment to a 10-year national suicide prevention strategy, with shorter term action plans. This provides the time and scope for ambitious activities to significantly reduce deaths by suicide and associated harms, while also allowing a reflective approach to respond to external factors or trends that arise over the lifespan of the proposed strategy. A 10-year strategy also provides the opportunity to continually evaluate and learn from suicide prevention activities to inform future iterations of the three-year action plans.

While we warmly welcome much of the proposed vision, including the aspiration for everyone in Scotland to work together to prevent suicide, we believe it could be strengthened further. Informed by consultation with people who have lived experience of suicide, we believe the vision and overall aim for the upcoming strategy must include a direct reference to reducing deaths by

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1 [1] SAMH Standing Up For Scotland's Mental Health 2021

suicide in Scotland. Our impact on suicide rates/numbers will be how the public measure the success of this strategy and we believe it is imperative to set this out clearly in the vision.

Ahead of the publication of the Every Life Matters Action Plan we made the case for the inclusion of a national target to reduce deaths by suicide, in recognition of the role a target can play in driving ambition, activity and resource.[2] Our position was informed by the successful adoption of this approach during the ChooseLife strategy period (2003-2013) when, accompanied by ring-fenced funding and dedicated local leadership, a 19% reduction was achieved[3][4] . This was backed by a budget of £12m over the first three years (2003-2006).

It should be an early action for the Government, in partnership with Academic Advisory Group, to determine a target for reducing deaths by suicide for the 10-year lifespan of this new strategy. We note that the 2017 Independent national review into targets and indicators for health and social care (which we contributed to), found them to be effective in improving many aspects of healthcare. The framework outlined in the independent review should inform the setting of a new target to reduce deaths by suicide.[5]

Principles:

We have developed six guiding principles as our way of working to ensure effective delivery of the Strategy and Action Plan. We want to know if you agree with the principles proposed.

For each one, please indicate your selection with a tick under the corresponding option. You will have a chance to write your thoughts about any of the proposed principles after you have reviewed them all.

1.3.

Do you agree with the following guiding principle?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Suicide prevention is everyone's business. We will provide opportunities for people across different sectors at local and national levels to come together to					X

[2] SAMHEngagement_Process_of_the_Draft_Suicide_Prevention_Action_Plan_2018_SAMH_Response_1.pdf 2018

[3] scotpho-suicide-statistics-publication-2018-archive.pdf

[4] Suicide rate in Scotland falls by a fifth in a decade - BBC News

[5] Scottish Government Review of targets and indicators for health and social care in Scotland - gov.scot (www.gov.scot) 2017

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connect and play their part in preventing suicide.					

1.4.

Do you agree with the following guiding principle?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We will take action which addresses the suicide prevention needs of the whole population and where there are known risk factors such as poverty, marginalised and minority groups.					X

1.5.

Do you agree with the following guiding principle?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
All developments and decisions will be informed by lived experience. We will also ensure safeguarding measures are in place across our work.					X

1.6.

Do you agree with the following guiding principle?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Effective, timely and compassionate support – that promotes recovery - should be available and accessible to everyone who needs it including people at risk of suicide, their families/carers and the wider community					X

1.7.

Do you agree with the following guiding principle?

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	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We will ensure the needs of children and young people are addressed and their voices will be central to any decisions or developments aimed at them.					X

1.8.

Do you agree with the following guiding principle?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
To build the evidence base, quality improvement methodology and testing of new, creative and innovative practice will be embedded in our approach.					X

1.9. Please use the box below for any other comments you have in relation to principles:

SAMH broadly welcomes the proposed principles which will underpin the strategy. Suicide prevention is everyone's business and we are pleased to see this as a fundamental element of the strategy. Over the past few decades, charities including SAMH have worked closely with the Scottish Government and the wider public sector to provide advice, expertise and leadership. As the successes of Every Life Matters demonstrates, this joint approach has been invaluable. Tackling the complex reasons behind suicide is not something the Scottish Government, nor the wider public sector, can do alone. We are pleased to see the new strategy continue the commitment to cross-sector working and leadership.

In particular we support the ongoing commitment to fully involve 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).[6] We strongly welcome that the LEP will be retained in the forthcoming strategy. Learning from the panel experience should be used to further inform the embedding of lived experience into suicide prevention activities, particularly at the local level and through the proposed Delivery Collaborative.

In regards to 1.4 we understand and support the need to balance whole population approaches to suicide prevention – recognising that suicide can affect all – and the need to target action and resources on groups and demographics most at risk of suicide. Work undertaken through Action 7 of Every Life Matters highlighted the particular issues and barriers to support experienced by

[6] WHO LIVE LIFE: An implementation guide for suicide prevention in countries (who.int) 2021

risk groups including LGBT people, racialised people,[7] people experiencing physical disability and veterans amongst others. Many risk factors identified were held in common amongst groups, such as a history of trauma, stigma, and barriers to help seeking and services. Findings from Action 7 should form the basis of further academic and importantly practical work to target interventions and resource at groups most at risk to suicide.

Action to tackle the persistent inequalities in regards to suicide around sex and deprivation must be a cornerstone of activity under the forthcoming strategy. Despite some progress over recent years, the rate of suicide for people living in our most deprived communities is still 3.5 times higher than for people living in our most affluent communities, with men accounting for three quarters of all suicide deaths in 2021.[8] Recognition of the poverty related and gendered nature of suicide and a commitment to tackle this should be included directly in the principles of the strategy.

In relation to 1.6, we agree there must be effective, timely and compassionate support available to everyone who needs it, including people at risk of suicide, their families/carers and the wider community. There has been positive progress under the Every Life Matters plan to make this a reality, including the piloting of a project to support those bereaved by suicide. We would like to see a specific mention of support for those bereaved by suicide in the principles. either through the inclusion of a new principle on bereavement support or expanding the principle under 1.6.

We also agree there must be effective, timely and compassionate support for those at risk of suicide. We suggest the new strategy needs a stronger statement on this to ensure this ambition becomes a reality. People with experience of suicide have told us of significant barriers to support including restrictive eligibility criteria; a lack of knowledge from referrers of what is available in the community and long waiting lists. While we appreciate and support the strategy's aim to tackle the societal causes of suicide and suicidal ideation, it is vital that appropriate weight and urgency is given to supporting those currently at risk of suicide, especially those in crisis.

Action 4 of the previous strategy promised improved crisis support for those at risk of suicide would be made available through the implementation of the Scottish Crisis Care Agreement model. We previously called for this based on positive evidence from England's Crisis Care Concordat model, which brings local services and agencies involved in caring for people in crisis together to ensure there is high quality and immediately accessible crisis support available in an area. SAMH supported the Scottish Crisis Care Agreement (SCCA) model and was pleased to see its inclusion in the previous strategy. The need for such an approach was supported by the Time, Space, Compassion report produced as part of Action 5,[9] which called for Community Planning Partnerships to ensure 24/7 suicide support was available in their communities. While we were supportive of the SCCA model, we recognise there are a number of ways to ensure anyone at risk of suicide can access high quality support as soon as they need it. We look forward to the development of detailed, fully-funded and time-specific plans to achieve this across Scotland.

In addition, it must be recognised that timely, compassionate support – both in clinical and non-clinical settings – will only be achieved through adequate resourcing, staffing and prioritisation of

[7] Scottish GovernmentSuicide ideation - experiences of adversely racialised people: research - gov.scot (www.gov.scot) 2022
[8] ScotPHO Key points - ScotPHO 2022
[9] Conclusion - Time, Space, Compassion Three simple words, one big difference: Recommendations for improvements in suicidal crisis response - gov.scot (www.gov.scot)

local suicide prevention strategies and services. The context of commissioning of social care and community health services is changing though the pledged introduction of a National Care Service, and the Government's commitment to ethical commissioning. Local suicide prevention services (irrespective of their place within or out with a National Care Service) should be fully informed and co-produced by people with lived experience, with commissioning and procurement practices allowing sustainability with an adequate workforce to embed the time, space, compassion approach. Ethical commissioning practices should apply to local suicide prevention services/interventions. SAMH suggests all social care and community contracts, which would include peer support services, should be commissioned on a basis of minimum five-year contracts.[10] Shorter contracts negatively impact on the quality of services, making it more challenging to recruit and retain staff, causing confusion locally as to the services currently in funding, and disrupting the delivery of support, as well as referral/support pathways when contracts come to an end.

In regards to 1.8 we welcome the commitment to a quality improvement methodology. This should underpin the entire strategy and guide every decision, from the actions to be taken at a local level, to the Scotland-wide target for reductions in suicide this strategy will seek to deliver.

It is crucial robust evaluation and measurement of all activities against objectives is undertaken at a national and local level. This allows ongoing reflection of effectiveness and facilitates the sharing of good practice. As we will discuss below, we have some concerns about the measurability, ownership and trackability of some of the outcomes and actions. For example, we do not believe it is helpful to have actions "to consider" something. Instead, we would like to see actions that are clearly defined, time-limited and measurable, with clarity around who is responsible for the delivery, how much it will cost, and where the funding will come from.

While evidence for the effectiveness of particular approaches to suicide prevention is scarce in comparison to some other public health issues, there is a growing body of evidence in this area. It is vital this is used to shape the strategy, so we welcome the commitment to learning and sharing best practice. As well as looking at the best international and UK-wide evidence, we would urge the examination of services and models already operating in Scotland that are showing strong positive impacts on suicide prevention.

Outcomes

The four outcomes described below reflect what people have told us, to date, that they want to see in the New Suicide Prevention Strategy and Action Plan. Some of these describe how things might be better for individuals, some for communities, and some for the whole population of Scotland.

We'd like to know if you agree that the Suicide Prevention Strategy should aim to achieve each outcome. For each one, please indicate your selection with a tick under the corresponding option:

1.10.

Do you agree that the Suicide Prevention Strategy should aim to achieve the following outcome?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Outcome 1: The environment we live in					X

[10] SAMH SAMH_2022_manifesto.pdf

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promotes the conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.					

1.11.

Do you agree that the Suicide Prevention Strategy should aim to achieve the following outcome?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Outcome 2: Everyone has a clear understanding of suicide, its prevention, and associated risk and protective factors. Everyone is able to respond confidently and appropriately when they, or others, need support.					X

1.12.

Do you agree that the Suicide Prevention Strategy should aim to achieve the following outcome?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Outcome 3: Everyone affected by suicide is able to access appropriate, high quality, compassionate, and timely support - that promotes recovery. This includes people of all ages who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways.					X

1.13.

Do you agree that the Suicide Prevention Strategy should aim to achieve the following outcome?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Outcome 4: All suicide prevention activity is designed with lived experience insight. Action will be informed by up-to-date practice, research, intelligence, and improved by regular monitoring, evaluation and review.					X

1.14. Please use the box below for any other comments you have in relation to outcomes:

SAMH broadly supports and welcomes the four outcomes. As with our answer on the principles we believe there should be direct reference to people bereaved by suicide in the outcomes. This would fit into an expanded Outcome 3. In regards to Outcome 2. We warmly welcome a commitment to ensure everyone has an understanding of suicide and has the skills to intervene. We believe this can in part be achieved though expanding access to suicide prevention training across wide variety of settings including workplaces, health and social care settings, communities and community groups (of interest and geography) and workplaces.

In our 2021 Scottish Parliament manifesto we called for an immediate commitment to retain ASIST (Applied Suicide Intervention Skills Training) and SafeTalk, and furthermore to double the number of ASIST and SafeTalk trainers by the end of the next parliamentary term.[11] We were hugely encouraged to see the SNP incorporate this commitment in their own 2021 manifesto.[12] ASIST not only provides increased awareness of suicide but crucially provides people with the skills to intervene where they feel someone is at risk of suicide. Scottish and international evaluations of ASIST have consistently highlighted its effectiveness in reducing suicidal ideation and increasing connection support and social contacts.[13],[14] We would like to see the commitment to doubling ASIST trainers directly incorporated into the action plan, in support of achieving outcome two.

In regards to outcome 3 on support, we welcome the commitment to 'high quality, compassionate, and timely support - that promotes recovery'. As set out in our submission to the earlier phase of engagement people with lived experience of suicide told us of significant barriers to support arising from restrictive eligibility criteria; a lack of knowledge from referrers on what is available in the community, lengthy waiting lists and stigma (including self-stigma). As recent waiting times for CAMHS and adult psychological therapy highlight, far too many people are either rejected (in case of CAMHS) or have to wait many months to get the help they need.

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[11] SAMH SAMH_2021_manifesto_(3).pdf

[12] SNP SNP 2021 Manifesto: Scotland's Future, Scotland's Choice — Scottish National Party

[13] Gould 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.

[14] Scottish Government 2008 The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation

This can have a devastating impact on their mental health. No-one in Scotland who wants help to cope with suicidal thoughts or ideation should be turned away or put on a waiting list for help. It is crucial that easy, timely access to support both statutory and non-statutory becomes a reality rather than an aspiration. This strategy and its accompanying outcome frameworks/action plan must set out how it will achieve this, with detailed outlines of timings, the evidence base for action and how the work will be funded.

Another focus under outcome 3 must include clarifying care pathways to support, which currently can be highly confusing for people trying to access support and for referrers. We would also like to see a significant expansion of self-referral options to community support for people in distress or experiencing suicidal thoughts. As outlined in our 2021 manifesto, we want community triage models to be introduced to ensure everyone - adult, young person or child - is routed into the most appropriate support available and no-one is rejected when asking for help.[15] These models would be beneficial both in the context of suicide prevention and wider mental health and wellbeing support.

While for some people support from clinically led mental health services will be essential, there is growing recognition of the role other supports 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 through programmes such as SAMH's Changing Room.[16] We are very encouraged that expanding peer support capability is a key element of the draft action plan. We would like to see this acted upon and resourced as a priority in the first stage of the strategy's lifespan. More broadly we welcome commitments to build upon the Distress Brief Intervention (DBI) model, which we know – as a provider – and through formal evaluation, has been highly successful at supporting people when they most need it.[17]

As mentioned above, timely, compassionate support will only be possible through adequate resourcing, staffing and prioritisation of local suicide prevention strategies and services. This includes ensuring that all social care and community contracts, which would include peer support services, are commissioned on the basis of five-year minimum contracts.[18]

Priorities

We need to prioritise the areas that we want to work on first, in order to help us reach the proposed outcomes. We have suggested priority areas below, which are based on the areas identified by stakeholders through our extensive early engagement period. These priority areas form the focus of this first Action Plan.

For each one, please indicate your selection with a tick under the corresponding option. You may wish to refer to the Strategy document in considering these statements, further detail is contained under each.

1.15.

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[15] SAMH SAMH_2021_manifesto_(3).pdf
[16] The Changing Room | SAMH
[17] Scottish Government Distress Brief Intervention pilot programme: evaluation - gov.scot (www.gov.scot) 2022
[18] SAMH SAMH_2022_manifesto.pdf

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Do you agree that the Suicide Prevention Strategy and Action Plan should have this as a priority area?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Build a whole of Government and whole society approach to address the social determinants which have the greatest link to suicide risk					X

1.16.

Do you agree that the Suicide Prevention Strategy and Action Plan should have this as a priority area?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Strengthen Scotland's awareness and responsiveness to suicide and suicidal behaviour					X

1.17.

Do you agree that the Suicide Prevention Strategy and Action Plan should have this as a priority area?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Promote & provide effective, timely, compassionate support - that promotes recovery					X

1.18.

Do you agree that the Suicide Prevention Strategy and Action Plan should have this as a priority area?					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Promote a co-ordinated, collaborative and integrated approach	.				X

1.19. Please use the box below for any other comments you have in relation to priorities:

SAMH broadly welcomes and agrees with the priority areas outlined in the strategy. Many of our comments to the previous question on outcomes apply here as well.

A whole government/society approach is vital in building on the effectiveness of cross-sector leadership on suicide prevention demonstrated in the delivery of Every Life Matters. Furthermore, strengthening Scotland's awareness and responsiveness to suicide and suicidal behaviour is important. Increasing the opportunities for suicide prevention training will be key to achieving this. The 2021 SNP manifesto pledged to double the number of ASIST and SafeTALK trainers by the end of the parliament, we would like to see this commitment in the new strategy.

Tackling stigma is also crucial, not just with the population as a whole, but targeted where there is evidence to support increased stigma. The government-funded See Me programme has extensive research into this area and should be central to future work in this area. Similarly, United To Prevent Suicide, also government funded, has been very successful in reaching out to the wider population, and we would expect the movement to play a central role.

We have addressed the importance of high quality and timely support in earlier answers, however, to briefly restate, this is absolutely essential. There are some good examples of this being achieved, for example through the DBI service, the bereavement pilot and peer support services such as SAMH's The Changing Room, that will provide learning. We also know that we must clarify and expand care pathways for people seeking support, including at times of crisis. We need a system that recognises the vital role of community-based support services while also ensuring those who need urgent mental health support can access it rapidly.

As stated earlier, the reality of timely, compassionate support will only be achieved through adequate resourcing, staffing and prioritisation of local suicide prevention strategies and services. Local suicide prevention services should be fully informed and co-produced by people with lived experience, with commissioning and procurement practices allowing sustainability and with an adequate workforce to embed the time, space, compassion approach. Ethical commissioning practices should apply to local suicide prevention services/interventions. SAMH suggests all social care and community contracts, which would include peer support services, should be commissioned on the basis of minimum five-year contracts.[19]

An additional priority area SAMH would like to see in the strategy is on children and young people. While the 2021 suicide statistics were encouraging, with a reduction in suicides amongst 15-24-year-olds, we cannot be complacent. From our own work in Scotland's schools (SAMH Connects Project[20]), and the context of long waiting times and the persistently high rate of rejected referrals to CAMHS, we know too many young people and their families are not getting the timely support they need. For example, more must be done as a matter of urgency to equip school staff with the skills and resources to support young people in crisis, raise awareness of suicide and to better respond following a suicide.

Delivery and Governance

[19] SAMH SAMH_2022_manifesto.pdf
[20] SAMH Connect Project | SAMH

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To help us deliver the Strategy and achieve the actions in our Action Plan we are proposing a new *Scottish Delivery Collaborative*. A description of this collaborative can be found below:

Scottish Delivery Collaborative: a Scotland wide delivery team on suicide prevention. It will bring together local practitioners with the national implementation team and harness insights from the Academic Advisory Group (AAG), Lived Experience Panel (LEP) and Youth Advisory Group (YAG).

The collaborative will use an agile planning approach and constantly develop and evaluate effective strategies to improve our reach and support for people who are at risk of suicide, including using technology. Public Health Scotland will play a key role in supporting the Collaborative to put knowledge into action and building an active learning approach.

1.20. Do you agree with the proposed approach to delivery and the new Scottish Delivery Collaborative? **Yes in part**

1.21. If you answered no, please provide details why. You may also want to provide suggestions for an alternative approach.

To bring focus, ambition and scale to the delivery of Scotland's Suicide Prevention Strategy will require an unprecedented level of co-ordination and we are mostly supportive of the approach to delivery and governance as set out in the strategy. We are particularly positive about the distinction between leadership and delivery which builds on the positive learning from the NSPLG delivery of the current action plan. The proposed adjustments to the existing NSPLG are welcome in creating independent and strategic leadership from across Scottish society that can advise, steer and integrate suicide prevention as a priority and where Government, COSLA (and others) are contributors.

Creating the conditions to deliver action, innovation, evaluation and knowledge sharing that is distinct from strategic leadership is also welcome. We support the proposal to set up a Scottish Delivery Collaborative that retains the important aspects of lived experience and academic advice to inform and support delivery of the action plan. Particularly where the approach plays to the strengths of stakeholders involved, such as Public Health Scotland who are acknowledged specifically. We believe third sector is also vital to this arrangement and would urge specific acknowledgement in this section.

Furthermore, we would like to see more detail in the mechanics of this arrangement, for example, to achieve impactful co-ordination will require a robust approach to management including leadership and direction of the overall programme of work and budget, ensuring collaboration with a community of cross-sector delivery partners and line management of a national programme team. There are good examples of co-management/hosting arrangements across Government, for example See Me. This creates a simple and efficient single contract for Scottish Government/COSLA as the enablers to this arrangement and avoids the current funding regime with multiple contracts managed by Government. We believe third sector is well placed in this regard as it brings the potential for additional funding sources along with significant delivery experience. We propose the commissioning of such an arrangement should sit with the new NSPLG.

Finally, we have some thoughts on the resources and budget to deliver. Whilst we welcome the commitment in the strategy to double funding for suicide prevention, over the course of the current parliament, from a baseline of £1.4m (as set out in the Programme for Government) and to direct other funds towards suicide prevention, we don't believe this will be sufficient to realise the ambition in the strategy and action plan. Not least the impact of inflation on the spending power of the pledged sum.

In addition, the pledged sum does not come close to previous spending levels on suicide prevention. From 2003-2006 the Scottish Executive invested £12m in the delivery of the Choose Life strategy, of which, £3m was allocated to national activity and the remaining £9m to local area partnerships. This funding was ring-fenced for suicide prevention work. That is equivalent to almost £18m today – more given the inflation rate in the UK. Furthermore, it is our experience that local suicide prevention funding is not always transparent and easily identified as specific to suicide prevention for local leadership.

While we acknowledge the resource challenges, we believe this makes the need to reassess whether a sufficient budget has been identified to deliver the new suicide prevention strategy particularly important. As referenced in the strategy, Scotland has the highest rate of suicide in the UK, so we must channel resource that supports the ambition to save lives and prevent suicide.

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At a national level, we propose to adjust our existing National Suicide Prevention Leadership Group so that it can champion and drive suicide prevention through a partnership approach; advise SG & COSLA on progress on the Strategy and changes needed to direction/ priorities; and, advise the Delivery Collaborative on delivery. We will include new members to ensure our leadership group offers a wider representation of the lived experience of people who are suicidal, organisations focused on poverty and minority groups, and organisations working in key settings, such as justice and education.

1.22. Do you agree with the proposed approach to national oversight the adjustments to the role of the National Suicide Prevention Leadership Group?

Yes

1.23. If you answered no, please provide details why. You may also want to provide suggestions for an alternative approach.

The NSPLG and Delivery Collaborative will be connected into wider Scottish Government governance structures to ensure strategic connections are made, including those addressing the wider determinants of mental health which we know are similar to those impacting on suicide.

Local leadership & accountability for suicide prevention will sit with Chief Officers in line with public protection guidance. As part of this role Chief Officers will connect into Community Planning Partnerships (CCPs) which will help ensure suicide prevention is considered as a priority in the wider strategic context, and that all local partners are engaged and supportive.

1.24. Please use the box below for any other comments you have in relation to delivery and governance:

Click or tap here to enter text.

Anything Else?

Is there anything else you want to tell us about the proposed Strategy document?

1.2 Section Two – Action Plan

This section relates to the **Action Plan** document.

The new actions which make up this Action Plan, are built around 7 themes which sit under the overarching 'Outcomes'.

Theme One relates to '**Whole of Government and Society Policy'** and we are seeking your views on the proposed actions contained on pages 6 – 11 of the accompanying Action Plan document.

2.1. Please use the box below to provide your thoughts about the actions contained under **Theme One: Whole of Government and Society Policy.** In answering this question you may want to consider:

- If you agree with the proposed actions outlined.
- If there are any proposed actions you disagree with and why.
- If there are any actions you think we should consider that haven't been included in the document.

SAMH agrees that to reduce deaths and the associated harm of suicide, a cross-governmental and cross-societal approach is required. As such we welcome the breadth of actions outlined in this part of the action plan (page 6-11). In particular we welcome the identification of key risk groups/factors, contexts and policy areas, such as trauma; homelessness; drugs and alcohol; social security etc. We recognise and welcome the Government's ambition to ensure suicide prevention is mainstreamed across wider policy areas and agree this is the right approach.

While we welcome these inclusions, the action plan could be significantly strengthened through more clarity on responsibility/ownership of each action, and explanation of the specific resource attached to each of these policy areas. A number of the proposed actions only commit to 'consideration' or 'exploration'. For example, the commitment around social isolation (page 11 of action plan). These could be strengthened by a clear commitment to implement a specific approach with measurable outcomes attached.

Similarly, to achieve radical change across these policy areas, significant funding beyond the Scottish Government's welcome increase in core suicide prevention funding will be required. It is not clear in the action plan as drafted, what level of funding is attached to each individual action and from what funding source resource is coming from. To ensure trackability and ongoing evaluation of the strategy and action plan, transparency and adequacy of spend is essential.

We would now like to hear your views on the other proposed actions, and have grouped all the actions which sit in each of the remaining six themes, together. This is not how they are laid out in the Action Plan document however, as individual actions will sit under the outcomes they will help achieve. We have grouped them in this way for the consultation so you can more easily compare each action and provide views.

2.2.

Theme Two: Access to Means					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Develop a comprehensive, cross sector Action Plan to address locations of concern, with an initial focus on falling/jumping from height (and which complements the national guidance).					X
Consider priority actions on access to means following the Delphi study – including wider work on locations of concern which includes waterways, railways and retail outlets.					X

2.3. Please use the box below for any other comments you have in relation to theme two:

Click or tap here to enter text.

The inclusion of commitments to address access to means and locations of concern is very welcome. We know from research that restricting means is an important element in reducing deaths by suicide[21].[22] Local planning guidance published by the NSPLG under Action 1 of Every

[21] Evidence review 6 for reducing access to means NICE guideline NG105 Evidence reviews September 2018

[22] Chen, Ying-Yeh & Wu, Kevin & Wang, Sherry Yun & Yip, Paul. (2016). Suicide Prevention Through Restricting Access to Suicide Means and Hotspots. 10.1002/9781118903223.ch35.

Life Matters highlighted the limiting access to means and tackling locations of concern as central to local suicide prevention strategies.[23] Actions in this area should build on both international and Scottish best practice including implementing the 2018 NHS Health Scotland guidance: Guidance on action to reduce suicides at locations of concern in Scotland.[24]

However, it is also important to note that most suicides happen in the home. A key issue that arose during work SAMH undertook in our capacity as action owner and delivery lead on Action 7 of Every Life Matters, was people with lived experience's concern about access to potentially lethal amounts of medication following hospital discharge after a suicide attempt or crisis.[25] The safe management of psychotropic and other medication in these cases should be an early action explored by the Delivery Collaborative, Lived Experience Panel and Academic Expert Advisory group.

2.4.

Theme Three: Media Reporting					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Work with national and local media sector to hold a series of awareness raising events about responsible media reporting (including social media) which begins to support change in media reporting of suicide. Scope to draw on lived experience insight.					X

2.5. Please use the box below for any other comments you have in relation to theme three:

SAMH warmly welcomes the commitment to work on a national and local basis with the media sector. We know the relationship between suicide risk and media reporting – including in the online space – is complex. Media and online representation and reporting of suicide and self-

[23] NSPLG / COSLA Suicide-Prevention-Guidance3.pdf (cosla.gov.uk)
[24] PHS 2018 Guidance on action to reduce suicides at locations of concern in Scotland (healthscotland.com)
[25] Scottish Government National Suicide Prevention Leadership Group minutes: October 2020 - gov.scot (www.gov.scot)

harm can positively challenge stigma and promote help seeking. However, if done inappropriately, can potentially increase risk of suicide.[26]

In regards to the online space, an Online Safety Bill was introduced in the House of Commons on 17 March 2022, and a Legislative Consent Memorandum for the Bill was lodged by the Scottish Government on 31 March 2022[27]. While this is welcome, it will be important to ensure the regulation of the online space balances the need for safety, freedom of expression and help seeking or peer-support as previously highlighted by the NSPLG's 2019 response to the UK Government's Online Harms White Paper[28]

2.6.

Theme Four: Learning and Building Capacity					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Evaluate our social movement and campaigns to ensure they reflect emerging good practice and are having the desired reach and impact, and draw on wider learning, for example from See Me.					X
Implement actions from the review of learning approach to suicide prevention to ensure it is fit for purpose and meets the different needs of the workforce and communities alike. This will likely lead to a tailored and targeted learning approach and resources – including to focus on areas where our learning approach can achieve the greatest system-wide impact. To support that we propose carrying out at least two					X

[26] Dr Lucy Biddle, Dr Jane Derges, Prof David Gunnell (University of Bristol) Dr Stephanie Stace, Jacqui Morrissey (Samaritans) Priorities for suicide prevention: balancing the risks and opportunities of internet use. Policy Report 7/2016
[27] Legislative Consent Memorandum: delegated powers relevant to Scotland in the Online Safety Bill | Scottish Parliament
[28] NSPLG Online+Harms+White+Paper+-+NSPLG+response.pdf (www.gov.scot)

tests of change to support learning and support.					
Support the embedding of the Whole School Approach to Mental Health and the Children and Young People's Mental Health and Wellbeing professional learning resource, which includes suicide prevention, and share good practice.					X
Develop existing and new resources for inclusion in the school curriculum which build understanding on mental health, self-harm and suicide prevention.					X
Create a portal to host our suicide prevention resources and information in one, accessible, digital space - and which links to other relevant platforms.					X
Consider how suicide prevention can be embedded in pre-registration training curricula e.g. for health & social care, youth work, and teaching staff.				X	
Provide reliable and easily digestible information in different formats about suicide and suicide prevention to communities, including to community based organisations, such as sports and youth organisations and community centres. This includes providing accessible information for everyone, including people who do not have English as their first language, or those with learning disabilities.					X

2.7. Please use the box below for any other comments you have in relation to theme four:

We welcome the commitment to learning and using evidence to shape future work and the focus on improving the knowledge and practice on suicide prevention in schools. It is good to see recognition of the importance of training in suicide prevention for staff across health and social care, youth work and teaching staff, however we would like to see this go further, with a commitment to make pre-registration suicide prevention training compulsory, and to be delivered by the promised additional SafeTALK and ASIST trainers. This would go some way to helping achieve the strategy's stated outcome of ensuring everyone has a clear understanding of suicide, its prevention, and associated risk and protective factors. We would also like to see suicide prevention training become an essential course for everyone working in the public sector or receiving public sector/government funding.

We warmly welcome the commitment to evaluate Scotland's social movement and suicide prevention campaigns. The United To Prevent Suicide (UTPS) movement has been one of the key successes of the action plan and is arguably the most recognised part of the delivery of Every Life Matters. SAMH strongly believes that UTPS, which is still in its infancy, should be retained and expanded through the forthcoming strategy. Central to the success and growth of UTPS has been the co-productive nature of the activity, fully involving people with lived experience in its development, allowing a genuine sense of shared ownership. Going forward any evaluation of UTPS should consider how to build on good practice such as the FC United resources to expand the movement into different contexts and environments, particularly exploring how best to engage groups and communities most at risk of suicide.

Theme Five: Support					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Increase our understanding and practice around help seeking and help giving (potentially through test of change), and share good practice.					X
Consider ways to adapt Distress and Brief Interventions to ensure it supports people at the earliest opportunity, and to ensure it is considered for everyone who has thoughts of suicide or has made an attempt, where appropriate. Potential for new referral pathways, and ways to re-					X

engage with support after discharge.					
Respond to the diverse needs of communities. To support this we propose at least two tests of change to reach particular groups / communities where there is a heightened risk of suicide. We plan to work with trusted organisations to (1) review the design and delivery of learning approaches to ensure they reflect the communities' experience of suicide, and (2) test new approaches to reaching and supporting people in those communities who are at risk of suicide. As part of this we will seek to understand help seeking behaviours and tailor support for cultural and diverse groups. We will use the learning to inform our overall approach to supporting communities and groups where suicide risk is high.					X
Build new peer support capability to enable further use of peer support models for suicide prevention.					X
Develop resources to support families, friends, carers (including children and young people), and anyone else affected by suicidal behaviour – building on existing resources.					X
Ensure counsellors in education settings are skilled and responsive to signs of suicidal concerns, whilst ensuring proactive approach to supporting children and young people					X

at key transitional stages, as part of a continuum of care.					
Consider how those working in primary care settings - including GPs, nurses, mental health teams and the broader primary care workforce - can identify and support people who are at risk of suicide, who may present in distress or with low mood, anxiety or self-harm. This could include: safety planning, referrals to DBI, community support (social prescribing), and proactive case management, especially for people with a high risk of suicide.					X
Undertake work to ensure clinicians in unscheduled care settings are alert to suicide risk - particularly those who have self-harmed - and respond effectively through the provision of psychosocial / psychiatric assessment and ensure care pathways and support are put in place, including in the community (which may include via primary care). Distress and Brief Interventions should be offered, where appropriate as part of an increased range of potential interventions. The pathways to these interventions will be monitored through implementation of unscheduled care pathways.					X
Statutory services to continuously improve the quality of clinical care and support for people who are suicidal, and share good practice and learning, both					X

individually and by working together across services. To achieve this a first step is for mental health services to adopt the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) guidelines into their operating practices, and the relevant Medication Assisted Treatment (MAT) standards.					
Consider value and impact of a single Scottish specific telephone number which will provide access to existing telephone support and resources.					X

2.8. Please use the box below for any other comments you have in relation to theme five:

SAMH warmly welcomes the actions outlined under theme five. In particular, we welcome the focus on the primary care setting, which we know is often the initial route, for people in crisis or seeking help for their mental health, to access support. In this regard we support the Scottish Government's recent commitment to fund and embed multi-disciplinary mental health services across primary care, with community link workers at their heart.[29] Suicide prevention should be fully embedded in the new multi-disciplinary primary care mental health services.

As stated earlier in our submission we strongly welcome the commitment to expand peer support capacity in suicide prevention. The Delivery Collaborative and NSPLG should take learning from existing peer support services in mental helth such as SAMH's Changing Room programme.

SAMH also welcomes the proposal to consider a single telephone number to provide access to existing telephone resources. This has potential to reduce confusion from the perspective of someone seeking support. Careful consideration of any potential unintended consequences will be required, alongside clear care pathways to existing resources such as Breathing Space and the NHS 24 Mental Health Hub. Clarity on messaging will be key to ensure people requiring immediate or emergency care are escalated to appropriate care (such as emergency services) seamlessly.

Across the breadth of actions in this section should be a commitment to tackle stigma around suicide and self-harm in all health and social care settings including A&E. As expressed to us in our engagement with people with lived experience of suicide and from research undertaken by the Alliance, we know that unacceptable cases of stigma associated with presentation at health

[29] Scottish Government Increasing mental health support in GP practices - gov.scot (www.gov.scot) 2022

services (including while in suicidal crisis) continue.[30] There should be enhanced mandatory training and a commitment to continue to work with See Me the national anti-stigma programme in tackling stigma in health and care settings.

2.9.

Theme Six: Planning					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
In settings where people are at higher risk of suicide, ensure there is a suicide prevention action plan in place which takes account of risk and protective factors, and connects to statutory partners (where appropriate) and local suicide prevention plans - to ensure smooth transition at discharge. Plans should include actions for the people they support as well as for their workforce, and the development of plans should include input from both groups. Key settings include: criminal justice settings, secure accommodation, residential care, and schools/ higher education (as appropriate).					X
Develop guidelines for communities to respond effectively to suicide clusters and contagion within their local context.					X

[30] Alliance Suicide-Prevention-Report-2018.pdf (alliance-scotland.org.uk) 2018

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2.10. Please use the box below for any other comments you have in relation to theme six:

We welcome these actions. As part of this work it will be vital to ensure there are clear referrals pathways available to both individuals and organisations/communities to ensure those at risk of suicide receive the support they need, whether that's specialist mental health care or help dealing with the factors contributing to their distress, from debt to relationship issues.

2.11.

Theme Seven: Data and Evidence					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Continue to embed and enhance our lived experience model, and ensure it is representative of groups experiencing suicidal behaviour. Enhancing the model could include developing resources/toolkit to support people with lived experience sharing their personal stories in safe, meaningful and impactful ways.					x
Improve data recording and reporting on suicide deaths and attempts, and bring that together with wider, relevant data to improve our understanding of suicide risks and trends. This intelligence will form a core part of our suicide prevention Delivery Collaborative to support planning, delivery and evaluation, both at a national and local level.					X
Introduce a horizon scanning function to produce a 6 monthly digest of new evidence, which					X

connections to the mental health Research Advisory Group. Priority areas may include: COVID and cost of living impacts, and the mental health of children and young people and other marginalised equality groups. Again, this intelligence will form a core part of our suicide prevention Delivery Collaborative to support planning, delivery and evaluation, both at a national and local level.					
Roll out multi-agency suicide reviews and a learning system (aligning with the serious adverse event reviews process within mental health services).					X
Host learning events to disseminate information and share learning and good practice between and across sectors on suicide prevention. This will build on the Suicide Information Research Evidence Network (SIREN) model.					X

2.12. Please use the box below for any other comments you have in relation to theme seven:

These actions are welcome. We have made comments relevant to these actions previously in this response, however briefly:

- We welcome the continued embedding of lived experience and would like to see this expanded. As well as looking to the Lived Experience Panel as a model, we would also suggest looking at the UTPS movement.
- Improving data recording is vital, as is work to improve our understanding of suicide risks and trends. Alongside this it will be important to ensure there is evaluation of interventions to prevent suicide, with the evidence shared widely and used to shape future interventions, from services to campaigns.
- As well as improving national data collection and analysis, appropriate access to, and sharing of, real time suicide data at a local level is essential. We note this was a priority highlighted by the NSPLG in their 2020 Covid-19 statement.[31] Enhanced real time local

[31] NSPLG National Suicide Prevention Leadership Group: COVID-19 statement - gov.scot (www.gov.scot)

data sharing will allow early identification of local trends and inform timely preventative actions.

- Beyond real time data gathering, we look forward to the full local implementation of multi-agency reviews of all deaths by suicide, currently being piloted under Action 10 of the Every Life Matters Plan. The roll out of these reviews across all areas of Scotland should be an early priority for the forthcoming strategy.

Anything Else?

2.13. Is there anything else you want to tell us about the proposed Action Plan document?

As with all the actions we believe accountability and trackability of activities and resource will be crucial to evaluate their progress and success. The final version of the action plan and strategy should include clarity on how each action will be resourced (including the actual resource allocated) and clear identification of who or which agency is responsible for delivering the action. Annual reporting against the strategy should include details of resource spend by action. Our preference would be ring fenced suicide prevention funding both at the national and local level to ensure resource intended for suicide prevention activities are spent on suicide prevention. This model worked successfully during the 2003-2013 Choose Life period where we had far greater transparency - and accountability - of suicide prevention spend, particularly at a local level

1.3 Section Three – Final Thoughts

This section gives you the opportunity to share any other thoughts you have on the draft Strategy and Action Plan.

2.1. Is there anything else you feel you want to tell us about the Strategy and Action Plan that you feel you haven't had the chance to as part of this consultation?

SAMH welcomes this new strategy and its continued recognition of the importance of cross-sector leadership in suicide prevention. We look forward to working closely with the Government and other partners to take forward the strategy, supporting the development of a detailed and measurable outcomes framework that will set out a clear path to achieving the strategy's ambitions.

There has been considerable progress over the past few decades to tackle suicide in Scotland, and there is a lot of good work to build on. It is important the lessons from previous successes and failures are learned.

While the broad focus on tackling societal factors that increase the risks of suicide are welcome, as is the whole society approach to tackling suicide, it is vital this work does not overshadow the need for urgent improvements in the support available to those at risk of suicide now, particularly those in crisis. We hear far too often from people who did not get the support they needed - this cannot continue. This new strategy must ensure everyone at risk of suicide can access high quality support as soon as they need it.

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