Suicide Prevention Action Plan 2018

Public Engagement - Analysis of Responses

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Executive Summary

Introduction

1.   Between 8 March and 30 April 2018 the Scottish Government undertook a public written engagement exercise to gather views for consideration in preparing their new Suicide Prevention Action Plan. The engagement received a total of 290 responses, with the majority (n=196) submitted by individual members of the public and the remainder (n=94) submitted by organisations. This engagement was structured around four action points: the formation of a "Knowledge Into Action" group, the modernisation of training arrangements, the establishment of a Suicide Prevention Confederation and the development of an online suicide prevention presence in Scotland. This report gives an overview of the responses.

Main Findings

Action 1: The Formation of a "Knowledge Into Action" Group

2.   A majority (93%) of respondents agreed that a "Knowledge Into Action" (KIA) group should be established. Respondents from all sectors commented that any KIA group must be informed by evidence. Most sectors agreed that the sharing of evidence and good practice was important, and that there needed to be more monitoring and evaluation of existing suicide data. There was agreement that the KIA should have a varied membership, to enable collaboration between different stakeholders, and should include the voices of those with lived experience. Respondents stressed that the KIA should be action focused, investigating factors that contribute to suicide and targeting groups that may be at risk.

3.   Some respondents raised concerns over the proposed KIA group. They felt that more clarity was needed regarding its purpose and how it differs from the proposed confederation (see Action 3). There were questions about the group's hierarchy and governance, with some respondents commenting on the need for strong leadership. There were also concerns over whether KIA was an appropriate acronym. In addition, it was noted that the KIA proposals would require increased resources and funding.

4.   A number of respondents commented that there was not enough data or evidence available to practitioners and some organisations called for greater sharing of information between partners. However, some individual and third sector respondents mentioned a potential over-reliance on data and not enough emphasis on the experience of those affected by suicide.

Action 2: Modernising the Content and Accessibility of Training

5.   In total, 83% of respondents agreed that a new mental health and suicide prevention training programme should be developed. Respondents expressed a broadly positive view of existing training provision. However, they also suggested that a modernisation or refresh would be welcome, to update the presentation of training materials, tailor training to the Scottish context and to address the stigma of suicide. It was recognised that increased funding and resource would be required to modernise training. Some respondents highlighted that there needs to be wider access to mental health training and there should be parity with physical health. It was also suggested that youth should be prioritised, including training in schools.

6.   A majority of respondents (90%) supported mandatory suicide prevention training for specific groups. There was a consensus that suicide training should be mandatory for healthcare workers and frontline service staff (e.g. emergency responders). Some felt that mandatory training should be implemented within schools and for care workers. Non-mandatory training was suggested for communities and the private sector, including for public facing services (e.g. bar staff, taxi drivers, hairdressers). There was a general sense that training should be tiered to an employee's need or context, and should be regularly updated (continuous/rolling).

7.   Many respondents expressed concern regarding mandatory training for specific groups from a resource and capacity perspective. There were also concerns that existing training packages would be removed and about what would happen to trainers currently trained in these programmes.

8.   There were a number of additional comments and suggestions on the content and/or accessibility of mental health and suicide prevention training. These included requests for multiple media formats (video, images, podcasts etc.), evidence-based training content, the retention of current training methods, training to increase the understanding of mental health medicines, for training to be delivered in schools and communities, and for barriers to access to be addressed. There were also calls for awareness raising to provide help and advice, to increase the understanding of suicide and to tackle stigma.

Action 3: The Establishment of a Suicide Prevention Confederation

9.   A majority (78%) of respondents agreed that a Suicide Prevention Confederation should be established. They felt that the confederation should improve collaboration between stakeholders and that it should be at a national level. Some respondents called for greater leadership or for the confederation to report to Scottish Ministers to ensure impact and accountability. Others wanted a flatter hierarchy or requested a flexible leadership model for the

confederation that included multiple partners. Some wished to maximise impact through community-focused activities and involvement of those with lived experience of suicide.

10.   Some respondents had concerns regarding the establishment of a suicide prevention confederation. For example, some felt there was a lack of clarity and detail around the proposal, some questioned how it would practically reduce suicide or queried the level of investment required. It was also noted that a national group could overshadow local efforts and there was the potential for unnecessary duplication with others' work. Others disliked the name or wanted to retain the ChooseLife branding.

11.   There was little consensus about where local leadership for suicide prevention should be located. The most popular answer was Health and Social Care Partnerships (37%), followed by "other arrangements" (17%), Community Planning Partnerships (15%) local authorities (13%) and the third sector (5%), (with the remainder saying they did not know or did not have an opinion). The most popular "other arrangement" suggested was a hybrid leadership between partners/agencies.

Action 4 The Development of an Online Suicide Prevention Presence

12.   A majority of respondents (93%) agreed that an online suicide prevention presence should be developed across Scotland. Respondents generally thought that online platforms should be developed to support awareness campaigns, and that any online activity should provide accurate information and signposting. It was also suggested that social media platforms should be used to promote suicide prevention messaging and that apps could be developed to support any online presence. There were also calls for an online platform to be created for professionals. It was acknowledged that an advantage of an online presence is that a wide range of people can be accessed.

13.   However, some respondents were concerned that an online presence could end up replacing face-to-face contact, or that online education or training would replace traditional delivery. Others noted that some populations do not have the same degree of internet access or that the tone of messaging can sometimes be lost online. Some individual respondents noted that social media can be considered a contributory factor to suicide and some had concerns about moderating online services to tackle cyber bullying and misuse. The need to monitor and evaluation online resources was also highlighted.

14.   Respondents gave further comments about developing online and social media resources for suicide prevention. These included: unifying current online resources; increasing the use of multimedia resources; ensuring

user interfaces are user-friendly; involving young people and those with lived experience in the design of online resources; and co-producing resources with the third sector, academia, private sector and experts.

1. Introduction

1.1   This report presents an analysis of written responses to the Scottish Government's public engagement on themes and draft actions for possible inclusion in the Suicide Prevention Action Plan[1], which ran from 8 March 2018 until 30 April 2018.

Engagement background

1.2   The aim of this engagement exercise was to gather feedback on a range of draft actions under consideration for inclusion in the Scottish Government's new Suicide Prevention Action Plan. These actions were developed through consultation with a range of stakeholders, including individuals with lived experience, and fall under four broad themes: (1) improving the use of evidence, data and guidance on suicide prevention; (2) modernising the content and accessibility of training; (3) maximising the impact of national and local suicide prevention activity; and (4) developing the use of social media and online resources.

1.3   The engagement paper consisted of six closed, and eleven open ended questions (see Appendix 1). The questions were designed to gather respondents' views on the development of a "Knowledge Into Action" group; the development of new mental health and suicide prevention training materials in Scotland; whether suicide prevention training should be mandatory for specific professional groups; the establishment of a suicide prevention Confederation; and where local leadership for suicide prevention is best located. Respondents were also provided with space to provide any additional comments or suggestions for maximising the impact of national and/ or local suicide prevention activity.

Profile of Respondents

1.4   The written engagement received 290 responses. The majority (n=273) of responses were received through the Scottish Government's online Consultation Hub. The remaining 17 responses were received by post or email.

1.5   Respondents were asked to identify whether they were responding as an individual or on behalf of a group or organisation. Those responding on behalf of an organisation were also asked what type of organisation (using a checklist). A breakdown of the number of responses received by respondent

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[1] Scottish Government (2018) Engagement Paper on Themes and Draft Actions for possible inclusion in the Scottish Government's New Suicide Prevention Action Plan

type is set out in Table 1 below and a full list of organisations can be found in Appendix 2.

Table 1: Type and Number of Respondents

Type of Respondent	Number	% of all respondents
Individuals	**196**	**68%**
Organisations	**94**	**32%**
Third Sector	*34*	*12%*
Public Sector	*31*	*11%*
Multi-Agency Group	*16*	*6%*
Academic	*4*	*1%*
Other*	*9*	*3%*
Total	**290**	

Notes: Percentages do not sum to 100% due to rounding. *Others included private sector, social enterprises, trade unions and organisations representing professionals.

1.6   Individual respondents were members of the public submitting their personal response to the engagement. Some of them had experience of suicide in their personal lives or professionally. A small number of respondents listed the organisation they were a part of, but selected to be considered as an individual rather than an organisation.

1.7   Among the organisations, the "third sector" consisted mainly of organisations registered as charities. Those categorised as "public sector" included NHS organisations, local authorities and other public bodies. "Multi-agency groups" were joint submissions and partnerships, often consisting of a number of different bodies from the public, private and third sectors. "Academic" respondents consisted of those responding from academia, including universities and student associations. Those categorised as "Other" included the private sector, social enterprises, trade unions and professional associations.

Analysis and Reporting

1.8   This report presents a question-by-question analysis of responses, relating to the four actions asked about in the engagement and finishing with a chapter on additional comments. It presents both quantitative findings (numbers responding a certain way) as well as qualitative (detailed information about written responses). It also looks at differences in responses by individuals, organisations and types of organisation.

1.9   As with any public engagement exercise, those responding generally have a particular interest in the subject area and their views are not necessarily representative of broader public opinion. Any figures quoted

cannot be generalised to the wider population. The main focus in the analysis is therefore to understand the range of views expressed and the reasons for these.

1.10   The analysis and report writing was undertaken in-house by a temporary member of staff with an analytical background. The report was quality assured by two Scottish Government researchers.

Quantitative Analysis

1.11   The engagement questionnaire contained a number of multiple choice questions (see Appendix 1). For example, these asked whether people agreed (Yes/No/Don't Know), about their level of agreement (ranging from strongly agree to strongly disagree) or which choice of options they agreed with. The multiple choice questions were analysed by looking at the number of responses to each option, which are reported in tables of results. In some of the tables percentages do not add up to 100%, as they are rounded to the nearest percent.

1.12   A small number (n=17) of respondents did not make their submission on the engagement questionnaire, but submitted their comments in a statement-style format. When these responses contained a clear answer to one of the Yes/No/Don't Know questions, then this was recorded.

Qualitative Analysis

1.13   The open-ended questions were analysed and categorised into broad themes. The aim was to identify the most common points made, but also to identify the range of views expressed in relation to each question or group of questions, together with areas of agreement and disagreement in the views of different types of respondent.

Comments on Analysis

1.14   In addition to the points above, it is also important to note the following points about the analysis:

- There was not always a straightforward relationship between respondents' answer to the multiple choice questions and their accompanying comments. The high number of respondents answering "Yes" to these questions may have been because they agreed with the idea in principle, but expanded on their answer and/or voiced any concerns in the follow up "explain your answer" question.

- Some respondents commented that they found it difficult to give a clear answer to some questions, either because the question was unclear,

was too prescriptive or was perceived to be leading (e.g. "do you agree").

- Respondents did not always answer every question. This means that a different base number was used to calculate the percentage of respondents who answered each question in a particular way.

- Comments varied considerably in their length and complexity. A small number of respondents made extensive and detailed comments, which included reports and published research papers. This report's scope was to present a summary analysis, focusing on the most frequently raised themes and considering the range of views expressed.

- Some of the responses – especially from individuals – covered detailed personal anecdotes and experiences. This included information about their own suicidal ideation, supporting others after a suicide attempt and bereavement following suicide. Due attention was paid to all responses (including issues regarding side-effects of medication and chronic pain), even if the detail is not captured in this report.

2.   Action 1: The Formation of a "Knowledge Into Action" Group

2.1   One of the proposals in the engagement paper was to establish a "Knowledge Into Action" (KIA) group, consisting of key national statutory and third sector agencies, and people with lived experience. The KIA group would track data analysis about self-harm and suicide, along with the emerging evidence base for effective interventions and would develop and test improvements. The engagement paper asked three questions relating to the proposed KIA group.

2.2   Around 9 out of 10 respondents (93%) agreed with that a "Knowledge Into Action" group should be established for suicide prevention (see Table 2). Both individual and organisational respondents overwhelmingly selected Yes. Some of those who answered No to stated that they were not in favour of setting up the KIA group, but others said they answered no because they did not have enough clarity about the KIA group, but were not necessarily against something like this being set up.

Table 2: Responses to Question 1a - Do you agree that we should establish a "Knowledge Into Action" group for suicide prevention?

Yes		No		Don't know	
n=261	93%	n=5	2%	n=15	5%

Note: 97% of respondents (n=281) answered this question.

2.3   A total of 229 respondents provided an explanation of their answer in response to question 1b and 168 provided additional comments about improving the use of evidence, data and/or guidance on suicide prevention in answer to question 1c. The key themes that emerged are discussed below.

Purpose and Arrangements

2.4   The most common theme that emerged was around the purpose and arrangements of the KIA group. A frequently-made point was that any KIA group must be evidence-led and grounded in existing knowledge, and that the overarching purpose of this group should be to put evidence into action. Some third sector respondents called for the commissioning of new research and more up-to-date evidence on suicide prevention. Others called for better use of existing data or for processes to be put in place to improve the sharing of data, evidence and good practice. Respondents strongly suggested that more monitoring and evaluation of suicide data should be carried out. It was recognised that local data should be considered alongside national data

2.5   A further point was that people with lived experience – such as those who had attempted suicide and those affected by suicide (including the bereaved) – should be included in any KIA group. It was noted that this must go beyond "tokenistic" inclusion.

2.6   Respondents suggested that the KIA group would provide an opportunity to increase collaboration between agencies and stakeholders. Some specifically requested a KIA group that was co-produced, whereby the members decide on the design, purpose and arrangements from inception. A high number of respondents suggested that a varied membership would be vital to its success.

2.7   Some respondents expressed concerns about the purpose and arrangements of a potential KIA group. The main critique was that there was not enough information or clarity provided about the proposed group, for example about its leadership, structure, purpose and objectives. Some respondents requested more information before being able to give their opinion. Another concern was whether existing initiatives would continue - most notably ChooseLife[2] - and whether funding and resource would be taken away from other areas in order to fund the new KIA group. There was also a feeling of ambiguity regarding how the KIA group would be distinct from the proposed confederation and whether there was unnecessary duplication.

2.8   A small number of respondents expressed concern over the initials KIA, noting that this is a military acronym for "Killed In Action".

The Need for Action

2.9   The second most common theme was the need for action on suicide prevention. Some respondents did not comment on the arrangements or purpose of the proposed KIA group, but stated that any group should be "strongly action focused". This was especially prevalent in responses from individuals, who were frustrated with a perceived slow progress in this area. Some respondents indicated that whatever is decided, it must build on previous work.

Targeting Specific Groups and Risk Factors

2.10   The third theme that emerged from the responses was that any KIA group should target specific groups and consider suicide risk factors. A number of specific groups were mentioned, including those in chronic pain (notably mesh implant survivors), members of the LGBT community, veterans, people with autism and those who self-harm.

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[2] http://www.chooselife.net/

2.11   Risk factors, such as substance misuse (drugs and alcohol) and self-harm[3], were mentioned on multiple occasions as factors that should be considered by the KIA group. Others commented that the group would need to consider socio-economic and geographic disparities, and stigma surrounding suicide. Some respondents also felt that prescribed medication (including side effects and withdrawal) was an under-researched and neglected contributing factor.

Raising the Profile

2.12   Finally, there were calls for any KIA group to raise the profile of suicide prevention. This included the importance of education, general public awareness raising, young people's involvement and the continued implementation of mental health first aid.

Data

2.13   Data was a common additional theme raised in response to question 1c. Some respondents felt that there is not enough data available to practitioners, while others suggested that data currently being collected at a local level is not used enough or was not reaching front end staff in a timely manner. Some were concerned about the reliability of current suicide prevention statistics and others commented that data needs to be used/useful, rather than collected just for the sake of it. There were also calls for data to assist in dispelling some of the myths surrounding suicide in order to tackle prevailing stigma.

2.14   Some respondents called for more data to be publicly available (open-access) and for increased data sharing between partners. Some commented on an over reliance on "hard" data and felt that people's stories and experiences need to be considered alongside statistics. Respondents also called for data to be published more widely, including in the media, to raise the suicide prevention profile.

2.15   There were contrasting views on data privacy. Some stressed the importance of privacy for those who present themselves as suicidal to services. Others mentioned that data protection laws have been a barrier to friends and family of the bereaved as they tried to find out information about their loved one before and after suicide.

Service Improvements

2.16   Some respondents used question 1c to discuss how data, evidence and guidance could improve service provision. The most popular point was the

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[3] There were contrasting views as to whether self-harm should be considered separately or integrated into the suicide prevention agenda.

need to improve access to help for those who are feeling suicidal. Reported barriers included a lack of knowledge of where to go for support and waiting lists for mental health services. There were requests to improve the use of evidence to support local delivery and community-based approaches. A number of respondents also called for increased guidance in the education system, through school, colleges and university.

Increase Resources/Funding

2.17   Many respondents specifically mentioned the need for adequate (or increased) resources and funding to support the proposals. It was noted that if data is collected locally, local coordinators require increased budgets and time to monitor, evaluate and report this data. There were also general calls for increased resources and funding to support mental health services and training. Some respondents suggested that resources should be fed into tackling the social and economic risk factors of suicide (for example drugs, alcohol, debt, and unemployment), to improve suicide prevention.

3. Action 2: Modernising the Content and Accessibility of Training

3.1   The engagement process asked five questions relating to the second action, about the content and accessibility of training in suicide prevention. Just over 8 out of ten respondents who answered question 2a agreed that a new mental health and suicide prevention training programme should be developed (see Table 3). A total of 229 respondents followed up by giving an explanation of their answer to question 2b, which largely focused on two themes: current and future training arrangements.

Table 3: Responses to Question 2a - Do you agree that we should develop a new mental health and suicide prevention training programme?

Yes		No		Don't know	
n=231	83%	n=15	5%	n=34	12%

Note: 97% of respondents (n=280) answered this question.

Current Training Arrangements

3.2   Respondents generally had a positive view of the current training arrangements, and praised programmes such as ASIST, LivingWorks, SafeTALK, STORM and Mental Health First Aid. There were concerns over what would happen to existing trainers if there was a decision to replace these programmes. On the other hand, there was a sense that existing training needed to be modernised and refreshed, with some respondents commenting that it was out of date. A handful of individual respondents were also critical of what they perceived to be a traditional or clinical approach to current training.

Future Training Arrangements

3.3   Many of the respondents suggested a need to develop some new training methods, regardless of whether the current arrangements continued or changed. One of the most common suggestions for improvement was for training resources (including video clips) to be updated and tailored to a Scottish context. It was acknowledged that any new training suite must be backed up by adequate funding and resources. A number of respondents expressed a desire for parity of mental and physical health in regards to training provision. Some respondents called for a more uniform, consistent approach to training delivery, while others felt there should be more flexibility, believing current training arrangements were too rigid in how they could be delivered.

3.4   Many respondents suggested that there should be wider access to training, with some adding that training opportunities need to be affordable and better advertised. Some respondents felt that training delivery sits best within healthcare, while others called for more integrated delivery between agencies.

3.5   With regards to the content of the training, most respondents stressed that any training should: increase participants' understanding of suicide; provide practical help and advice on suicide prevention; and better equip people to help those who are suicidal. Many commented on the need to specifically address the stigma associated with suicide within training programmes. Some also called for the training to cover the suicide risks regarding mental health prescription drugs and medicine withdrawal. In addition, some individuals felt there was a greater need for training for crisis and for earlier interventions to prevent a crisis situation. Some respondents suggested involving people with lived experience in developing new training programmes or materials. Another suggestion was that training should be evidence-based.

Mandatory Training for Specific Professional Groups

3.6   Question 2c asked respondents the extent to which they agreed there should be mandatory suicide prevention training for specific professional groups. A total of 276 respondents answered this question and 209 provided an explanation of their answer (question 2d). Nine out of ten (n=248) agreed or strongly agreed. However, 12 disagreed or strongly disagreed, and 16 neither agreed nor disagreed.

3.7   A number of respondents mentioned professional groups that they thought should receive mandatory suicide prevention training. The most commonly cited group were healthcare workers, particularly GPs, nurses and mental health professionals. Some respondents specifically mentioned that suicide prevention should be part of all medical students' training. Another common suggestion was frontline service staff, such as social services staff and emergency services staff and first responders, who may interact with people thinking about suicide. Other suggestions included staff working in schools and the care sector. One popular view was that training should be tiered, depending on the level of suicide prevention knowledge and skills required.

3.8   While not always specified as mandatory, some felt that public facing services, such as publicans, taxi drivers, hairdressers and beauty therapists could benefit from suicide prevention training, which would embed suicide prevention in the community. Another popular suggestion was to offer training within communities directly. There were also calls for increased employer engagement with suicide prevention training, including in the private sector.

Finally, several respondents made the more general comment that a wider spectrum of people should have access to training, without specifying any specific groups. Indeed, it appears that some selected disagree for this reason.

Concerns About Mandatory Training

3.9   A number of concerns were noted regarding mandatory suicide prevention training for specific groups. By far the biggest concern was the resource/capacity implications, with uncertainty around the value and effectiveness of the mandatory aspect. Several respondents questioned the value of delivering mandatory training to everyone within select professional groups, and suggested that there may be more value in targeting particular members of staff. There was also a concern that introducing mandatory training for specific professional groups may detract from the message that suicide prevention is everyone's responsibility. Some respondents believed that the emphasis should be on raising awareness within the wider population.

Further Suggested Improvements

3.10   A total of 152 respondents provided additional comments about training in response to question 2e. Much of this repeated the responses to earlier questions, although some new themes also emerged.

3.11   One of the most common suggestions for improving future suicide prevention training was to provide resources in multiple media formats, including online. However, some also noted that face-to-face training was important and should not be lost. There was a large proportion of respondents requesting more resources.

3.12   A large number of respondents underlined the importance of widening training access and accessibility. Suggestions included making training more accessible to disabled people, delivering training in everyday language and avoiding clinical terminology.

3.13   There were significant comments made in regards to the "targeting of specific groups" including young males, people suffering from chronic pain, those on medication, LGBT communities, alcohol and substance users and those on the autistic spectrum. Training in schools and prioritising youth were seen as important areas in re-shaping the training programme.

4. Action 3: Establishment of a Suicide Prevention Confederation

4.1   The engagement asked four questions about the third proposed action - the establishment of a Suicide Prevention Confederation. The majority agreed with the establishment of a confederation (see Table 4). Two hundred respondents explained their answer under question 3b and the main themes are summarised below.

Table 4: Responses to Question 3a - Do you agree that we should establish a Suicide Prevention Confederation?

Yes		No		Don't know	
n=217	78%	n=9	2%	n=52	19%

Note: 96% of respondents (n=278) answered this question.

Structure, Membership and Purpose

4.2   The most frequently discussed theme concerned the structure, membership and accountability of the proposed confederation. There was a desire for wider participation and varied membership. In particular, there were calls for greater involvement from the third sector, clinical professionals, the education sector and from those with lived experience of suicide. Some respondents suggested that the private sector should also be involved, although a couple of respondents were reticent about the "for profit" sector being part of the confederation. Some respondents mentioned the need for strong leadership, but others wished for a flatter hierarchy in the confederation, so that the views of smaller organisations and service users are given as much weight as policy-makers and clinical professionals. A small number of third sector respondents asked for the proposed confederation to report to Scottish Ministers, to ensure impact and accountability.

4.3   The next most common points were around work planning. Respondents suggested that the confederation should be a force for improved collaboration and cooperation between suicide prevention stakeholders. A number of respondents commented that the group would need to be action-focused, with agreed objectives and activities. Perceived advantages of the proposed confederation were developing a consistent approach across Scotland and realising efficiencies. Respondents had a range of ideas about what the priorities should be, including tackling stigma, early intervention, focusing on specific groups at higher risk of suicide, or on risk factors (e.g.

deprivation, substance use, depression and self-harm). A number of respondents asked for assurance that any decisions made are data-driven and founded in evidence.

Concerns

4.4   There were also concerns regarding the proposed confederation. The most common critique was the lack of clarity and detail around the proposals. Some respondents queried how a confederation would practically reduce suicide and felt there was a risk of it merely being a "talking shop". Some felt that setting up a confederation was not the best use of resources. Respondents also expressed concern that local issues could be overshadowed by outcomes or activities set by a national leadership group.

4.5   A number of respondents were concerned about unnecessary duplication or wondered how the confederation was different from the Knowledge Into Action group. Some respondents mentioned that they preferred the ChooseLife branding and would prefer that this name was retained, rather than rebranding any collective activity as a Confederation. A few mentioned that they disliked the proposed name.

Local Leadership Preferences

4.6   Question 3c asked where local leadership of suicide prevention is best located and offered 6 response options. The responses are shown in Table 5. A total of 181 respondents gave a further explanation for their answer at question 3d, which are summarised below.

Table 5: Responses to Question 3c - Where do you think local leadership for suicide prevention is best located?

	Number of responses	Percentage of responses
Health and Social Care Partnerships	99	37%
Other arrangement	45	17%
Community Planning Partnerships	40	15%
Local Authorities	37	13%
Don't know	35	13%
Third Sector	14	5%

Note: 93% of respondents (n=270) answered this question.

Views on Leadership

4.7   Those who selected Health and Social Care Partnerships (HSCPs) commented that they have the necessary expertise and experience to lead on suicide prevention, and that they already lead on mental health services.

Some noted that HSCPs are not limited to office hours. However, others were more critical of HSCPs, for example for their tendency to prioritise physical health over mental health.

4.8   Those who supported Community Planning Partnerships (CPP) leadership pointed to their broader, less clinical scope. The CPPs were also credited for giving a platform to community voices and being effective at bringing agencies/partners together to collaborate. The arguments in favour of leadership by Local Authorities (LAs) were that they have the expertise, resources and facilities to lead on suicide prevention. Some individuals mentioned that suicide prevention could be led by specific departments, such as social work. A major criticism was that this could create a "postcode lottery" of suicide prevention.

4.9   In relation to the third sector, the most common view was that third sector organisations should be part of a collaborative leadership, rather than being led solely by a HSCP, CCP or LA. One respondent mentioned the key role the third sector has had historically in the provision of support to people affected by suicide and this should be reflected within any leadership model. The third sector was seen to have more freedom and flexibility compared to the more rigid public sector.

4.10   Respondents who answered "other arrangements" were given the opportunity to specify what they thought that should be. The most popular suggestion was a hybrid leadership between partners/agencies, particularly joint leadership between Health and Social Care Partnerships and Community Planning Partnerships. Other suggestions included involving third sector organisations, local GPs, regional coordinators and joint integrated boards. There were also calls for leadership to be localised in communities rather than centralised and for a new independent public body to be created to lead any confederation, rather than any existing organisations.

Maximising Impact

4.11   A total of 103 respondents gave additional comments about maximising the impact of national and/or local suicide prevention activity (question 3e). There were different views, although a common point was that activities should be community-focused, with local ownership of activities. Respondents also underlined that it is vital to include lived experience within any activities in order to maximise impact. As noted in response to other questions, there were also calls to focus on particular risk factors or groups at risk.

4.12   More collaboration and better local to national coordination were also seen as key to maximising impact. Suggestions of how this might be achieved included: increasing collaboration with education services in suicide prevention activities; fostering more third sector support; co-designing

services with those that use them; more corporate/employer engagement; and more sharing of information and good practice. Additional points were that there should be increased funding, resources and facilities for awareness raising/campaigning, so that key suicide prevention messages are communicated with more clarity.

5. Action 4: Development of an Online Suicide Prevention Presence

5.1   The fourth action of this engagement process asked three questions relating to the development of an online suicide prevention presence in Scotland. Over 9 out of 10 respondents who answered question 4a agreed that an online suicide prevention presence should be developed (see Table 5). There was no noticeable difference in the balance of opinion between individual and organisational respondents, who were both in favour. A total of 214 respondents went on to provide an explanation of their answer in question 4b and many also gave additional comments in response to question 4c. These views are summarised below under key themes.

Table 5: Responses to Question 4a. Do you agree that we should develop an online suicide prevention presence across Scotland?

Yes		No		Don't know	
n=259	93%	n=6	2%	n=13	5%

Note: 94% of respondents (n=273) answered this question.

Benefits

5.2   A number of respondents discussed the benefits of an online suicide prevention presence in Scotland. For example, they acknowledged that online resources provide help and information to people who are feeling suicidal, can reach a wide audience, provide a level of anonymity and privacy, and reduce stigma. This was thought to be especially helpful for people who are more introverted, isolated or prefer to search online than to speak to someone in person. Others noted that online resources may be particularly helpful for certain groups, including young people, people with autism and transgendered people. Another benefit was the perceived cost-effectiveness of an online suicide prevention presence.

Online Service Suggestions

5.3   Some respondents felt that too few people are aware of existing online services for suicide prevention. As such, there were calls for more awareness-raising and improved effectiveness of campaign message delivery. Many respondents called for greater use of multimedia (e.g. videos, podcasts, instant messenger chats) and social media, highlighting that young people – one of the potential target groups – commonly use a range of social media platforms. Another popular suggestion was the development of apps, with work by ChooseLife in the North East of Scotland[4] cited as an example of

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[4] http://preventsuicideapp.com/

good practice. Respondents commented on the importance of staying up-to-date with how people use the internet when developing an online presence, due to the pace of change with online technologies.

5.4   Another common theme was that an online presence should predominantly provide information and this information must be easily available and accurate. Some respondents noted the importance of online signposting to more traditional support, such as counselling and (round the clock) telephone helplines. Some respondents suggested using online advertising (e.g. through as Facebook adverts, Google Adwords or pop ups) or using data to target individuals with personalised messages. One respondent noted the success of a Samaritans initiative, whereby if someone performs a suicide related Google search, the Samaritans phone line number appears at the top of the webpage. Others felt that more use could be made of online forums, groups and web-chats. It was also suggested that online resources could be tailored to specific groups to produce maximum impact.

5.5   Others felt that online resources could be more of an educational tool, with one respondent suggesting online resources could provide training at a lower cost. Indeed, some thought that an online platform for professionals would be useful, for sharing of evidence, data and good practice.

5.6   Some respondents commented on the importance of co-producing materials, involving partners from the third sector, academia, private sector, social media experts, employers, schools and young people. Another popular comment was that those with lived experience should be involved in the design of online resources, potentially including personal stories, to produce more engaging materials. It was noted that any online interface should be as user-friendly as possible.

Concerns

5.7   A number of respondents were more critical about the development of an online suicide prevention presence. The most frequent concern was that this should not replace face-to-face contact, which many saw as preferable. It was also stressed that any online suicide prevention presence (e.g. web-chat or forums) would need to be monitored and moderated to ensure its safety. Indeed, some respondents commented that social media can be a contributory factor to suicide, so this must be considered if asking people to engage with online platforms. There were concerns that unregulated information or advice could have unintended consequences, and there was a perceived need to ensure that information provided is accurate.

5.8   Some respondents questioned the true reach of an online presence, noting that there are at-risk and vulnerable populations (e.g. those in custody) who have limited or no internet access, or who are not IT literate. There were

also calls to monitor and evaluate online tools for effectiveness, in order to provide the best online support available. Finally, some respondents commented that there is already an adequate online presence, and questioned whether creating new online materials was the best use of resources. It was suggested that a priority would be to link/unify the current online resources.

6. Additional Comments

6.1   The final question in the engagement paper provided the opportunity to make additional comments about any of the issues raised in the engagement exercise. A total of 138 respondents provided additional comments. These were often brief and frequently reinforced points made in response to other questions. Other submissions were longer, with the inclusion of additional reports or materials in a small number of instances. Some people commented on the engagement itself. The paragraphs below summarise the issues that were raised in the additional comments section that are relevant to suicide prevention and have not been covered elsewhere in the report:

The Aftermath of Suicide

6.2   Some respondents commented on the need for more support for people, including family/significant others, following suicide or a suicide attempt. They explained how the loss of someone through suicide or caring for someone who has recently attempted suicide results in feelings of grief and pain that need to be considered. There were calls for better access to counselling, talking therapies and support services to tackle this. There was also a call to acknowledge that those who have had a loved one take their own life are at a higher risk of suicide themselves, and therefore support is vital.

Factors Contributing to Suicide

6.3   Some also took the opportunity to highlight specific examples of factors that may contribute to suicidal thoughts. These included socio-economic inequalities, people experiencing changes to their benefits, wage stagnation, financial problems, housing policies, rural transport, lack of access to education, unsatisfactory social service interventions, abuse and being in custody. Self-harm was also mentioned as an evidenced major risk factor, and there were calls for greater awareness, understanding and support services for people who self-harm.

Professional support

6.4   Some felt that there should be a wider network of healthcare workers available to identify and care for individuals who are experiencing mental health crises and suicide ideation. There were calls to ensure that healthcare workers are adequately resourced with the skillset to support suicide prevention activities. One respondent suggested having crisis teams within each health board area, whereby people experiencing a mental health crisis can be visited by a healthcare worker who can provide short term crisis support.

6.5   There were multiple mentions of instances in the responses where people have felt that medical professionals (including GPs) have been over-stretched, unsympathetic or unable to provide access to mental health support in a timely manner. There were repeated concerns for more understanding around mental health medicines and the effects of beginning treatment and coming off medication.

Training Programmes

6.6   Some respondents commented specifically on the suite of training currently being offered. There were requests not to give up the operating license for the LivingWorks courses and to continue the Choose Life programme, which were described as well-respected internationally and evidenced to have had a positive impact. Some people highlighted that a large number of individuals have been trained in ASIST, safeTALK and Mental Health First Aid across Scotland and we need to make use of this strong network. Some people also suggested that investment would be best spent tailoring and updating these programmes, rather than fully replacing them.

Self-Care

6.7   Some responses commented that there may be value in promoting self-care and well-being on a national scale, as part of a suicide prevention agenda. This could include the government increasing awareness of mindfulness and well-being.

Engagement Feedback

6.8   Respondents also provided feedback on the engagement process itself. Some stated that they were pleased to have the opportunity to provide their view and have these taken into consideration before the action plan is finalised.
There was also positive feedback regarding the pre-engagement events that were held and calls for collaborative meetings like this to continue.

6.9   Others provided more critical feedback. In terms of process, some felt that the written engagement could have been better publicised and that timescales for responding were too short. Some perceived that decisions had already been made. In relation to content, some respondents felt that the paper lacked detail, not enough themes were covered, there were no specific outcomes and that some of the questions were vague. Another critique was that the engagement paper did not have set timescales or mention funding/costs of delivery.

Appendix 1: Engagement Questionnaire

ACTION 1

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

☐ Yes
☐ No
☐ Don't know

1b) Please explain your answer.

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

ACTION 2

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

☐ Yes
☐ No
☐ Don't know

2b) Please explain your answer.

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

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

2d) Please explain your answer.

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

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ACTION 3

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

☐ Yes
☐ No
☐ Don't know

3b) Please explain your answer.

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

☐ Local Authorities
☐ Health & Social Care Partnerships
☐ Community Planning Partnerships
☐ Third Sector
☐ Other arrangement – please specify _____
☐ Don't know

3d) Please explain your answer.

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

ACTION 4

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

☐ Yes
☐ No
☐ Don't know

4b) Please explain your answer.

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

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.

Appendix 2: Organisation Responses

A total of 94 organisations responded.

Public Sector
Aberdeen City and Aberdeenshire Choose Life Steering Group
ASIST Trainers in Aberdeen and Aberdeenshire
British Transport Police
Care Inspectorate
Children in Scotland
Choose Life Coordinator Group (via Health Scotland)
Clackmannanshire and Stirling Health and Social Care Partnership
Dumfries & Galloway Suicide Prevention Strategy Group
Falkirk Health and Social Care Partnership
Fife Choose Life Steering Group
Glasgow City Choose Life Strategy Group
Health and Safety Executive
Inclusion Scotland
Inverclyde Alliance-Community Planning Partnership
Inverclyde Educational Psychology Service
Mental Welfare Commission for Scotland
Network Rail
NHS Education for Scotland
NHS Forth Valley Health Promotion
NHS Grampian
NHS Healthcare Improvement Scotland
NHS Orkney
NHS Tayside Public Health Department
NHS24
Perth and Kinross Council - Suicide Prevention Co-ordinator
Police Scotland
Scottish Borders Public Health & Mental Health Services
Scottish Prison Service
Scottish Social Services Council
Scottish Trade Union Congress
Water Safety Scotland
Third Sector
Affa Sair
ASH Scotland
Autistica
Barnardo's Scotland
CELCIS (Centre for Excellence for Looked After Children in Scotland)
COSCA (Counselling & Psychotherapy in Scotland)
GAMH (Glasgow Association for Mental Health)

LGBT Health and Wellbeing
LGBT Youth Scotland
Men's SHARE
Mental Health Foundation Scotland
Mental Health Network Greater Glasgow
Mikeysline & The Hive Project
Orkney Blide Trust
Penumbra
PKAVS Mental Health & Wellbeing Hub
Prescribed Harm UK
Sacro
Samaritans of Orkney
Samaritans Scotland
SAMH (Scottish Association for Mental health)
Scottish Ambulance Service
Scottish Drugs Forum
Scottish Independent Advocacy Alliance
Scottish Mesh Survivors
Scottish Veterans Commissioner
Stonewall Scotland
The Ayrshire Community Trust
The National Rural Mental Health Forum and Support in Mind Scotland
The Salvesen Mindroom Centre
The Wellbeing Portal
Victim Support Scotland
Voluntary Action South Lanarkshire
RCPCH (Royal College of Paediatrics and Child Health Scotland)
Multi Agency Groups
After A Suicide Working Group
Angus Suicide Prevention Collaborative
East Dunbartonshire Health and Social Care Partnership
East Lothian Choose Life Steering Group and associated organisations (Joint Submission)
Glasgow Third Sector Forum / Choose Life Third Sector Network
Highland Multi-agency Suicide Prevention Group
NHS Greater Glasgow and Clyde Mental Health Services, on behalf of the six HSCPs in Greater Glasgow and Clyde area
NHS Lanarkshire and associated organisations (Joint Submission)
North Ayrshire Health & Social Care Partnership
North West Glasgow Suicide Safer Suicide Communities Forum and North West Glasgow Mental Health and Wellbeing Forum (Joint Submission)
Older People Consultative Group (Dumfries and Galloway)
Rail Suicide Strategy Group (Scotland)
Samaritans Scotland, NHS Health Scotland, the Health and Social Care Alliance Scotland and the Health and Social Care Academy (Joint

Submission)
Scottish Mental Health Partnership
The Dundee Partnership
West Dunbartonshire Health and Social Care Partnership
Academia
Edinburgh University Students' Association
Glasgow Kelvin College and GKC Students Association.
Mental Health Academic Group, Edinburgh Napier University
The University of Edinburgh
Other
NAPC (National Association of Primary Care)
NUS (National Union of Students) Scotland
Recovery and Renewal
Royal College of Nursing Scotland
Royal College of Psychiatrists in Scotland
Scottish Hazards
The British Psychological Society
Inspire Community Coaching
Modo - Circus with Purpose

Glossary of Abbreviations

Glossary of Abbreviations	
ASIST	Applied Suicide Intervention Skills Training
CPP	Community Planning Partnership
DBI	Distress Brief Intervention
HSCP	Health and Social Care Partnership
KIA	Knowledge Into Action
LA	Local Authority
LGBT	Lesbian Gay Bisexual and Transgender
MHFA	Mental Health First Aid
NHS	National Health Service
ScotSID	Scottish Suicide Information Database
STORM	Skills-based Training On Risk Management for suicide prevention

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