Creating Hope Together: Scotland's Suicide Prevention Strategy and Action Plan

Analysis of Public Consultation Responses (consultation ran 13 July to 23 August 2022)

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Scottish Government
Riaghaltas na h-Alba

Introduction

The Scottish Government and the Convention of Scottish Local Authorities (COSLA) published a new Suicide prevention Strategy and Action Plan in September 2022. This replaced the previous Suicide Prevention Action Plan: *Every Life Matters*[1] which was published in 2018.

The new strategy and action plan builds on the work already happening across Scotland – nationally and locally – to prevent suicide, whilst being ambitious and going further than before, to ensure fewer lives in Scotland are lost to suicide.

The new strategy takes an outcomes focused approach. Outcomes are the results or changes we want to see as a result of the strategy and action plan. These include changes in knowledge, awareness, skills, practice, behaviour, social action, and decision making.

The strategy aims to address the inequalities which contribute to suicide. The action plan includes actions that bring about change across the whole of government policy and society. In practice, this means the strategy and action plan sets out how suicide prevention will be embedded within existing and future policies across national and local government, and how that translates into effective action on the ground - across all sectors and communities.

The strategy will run over the course of ten years, and the initial action plan accompanying it that will run for three years.

The strategy was developed with an extensive and inclusive engagement and consultation approach. This included early engagement and a formal public consultation on the draft strategy and action. Details are set out below.

Early engagement to develop the Strategy and Action Plan

From autumn 2021 to summer 2022, the Scottish Government, COSLA and Public Health Scotland (PHS) carried out extensive early engagement with key stakeholders, partners, groups and communities across Scotland to inform the strategy and action plan - participation levels were extremely high.

We sought to ensure the views of stakeholders, partners, communities and people with lived and living experience of suicide were central to the strategy's development. The multi-stage engagement approach that was taken meant that people across Scotland helped co-produce the vision, guiding principles, outcomes and priorities of the strategy, as well as the action in the accompanying action plan.

[1] Suicide prevention action plan: every life matters - gov.scot (www.gov.scot)

We also engaged proactively with key sectors and partners who have a key role to play in preventing suicide, within and beyond the health and social care sector.

A range of methods were used to engage in this phase, as set out below:

- We ran 41 online workshops. Some had a regional focus and others a national focus. Organisations, groups and individuals could self-select which type of event they wanted to attend. Participants could also attend more than one event, depending on what they wanted to focus on.

- We ran an online survey which received 190 responses, 162 responses from individuals, and 28 responses from organisations across the public and third sector. Sectors represented included: mental health and wellbeing, children and young people's services, emergency responders, primary care, and social care.

- We convened a series of roundtable meetings bringing together partners working in specific sectors or on particular issues. This included criminal justice, education and first responders. These events enabled greater insights and understanding on the issues they face and the actions needed.

- We carried out one-to-one engagements with mental health services teams in each of the geographic NHS Health Boards.

We structured each of these engagement to seek feedback and data from participants on the current situation, as well as innovative ideas and best practice. Participants were also asked to identify priority areas for future action.

Responses were sought in relation to several themes:

- prevention
- early intervention
- crisis intervention
- postvention
- tackling stigma
- raising awareness
- capacity building.

Participants were also asked about other policy areas, outwith health and social care, that ought to be involved in suicide prevention, such as housing, addiction, and poverty; and, to provide examples of effective practice both locally, nationally and internationally.

Further information on the early engagement process and findings can be found in the Suicide prevention strategy development: early engagement - summary report.

Formal Public Consultation on the draft Strategy and Action Plan

A consultation on the draft strategy and action plan was open for 6 weeks, from 13 July to 23 August 2022.

The consultation set out a series of questions about the proposed content of these documents. Specifically, we looked for views on the following:

Draft Strategy:

- the proposed vision
- the proposed priorities (which would become the focus of the initial 3 year action plan)
- the proposed outcomes
- the proposed principles
- the proposals for delivering and overseeing the strategy and action plan.

Draft Action Plan:

- the relationship and connection between the strategic long-term outcomes in the strategy and the actions
- the new actions proposed under each outcome
- which outcomes and actions should be prioritised
- continuing to build on the current actions from the previous Suicide Prevention Action Plan - *Every Life Matters*.

Respondents

We received 213 responses to the consultation: 195 submitted via the online consultation platform Citizen Space and a further 18 submitted by email in an alternative format. As some respondents did not answer every question, the total responses for each question does not always total 213.

135 responses were from individuals and 78 from organisations.

We also offered a small number of online consultation events to hear informal views from the public.

We have published individual responses received on https://consult.gov.scot where the respondents have given permission for us to do so.

Approach to Analysis and Reporting

The Scottish Government undertook a robust analysis of the responses to the consultation. This report presents the range of views expressed and trends made in comments. This analysis is structured around the themes identified in responses to each question. Where response themes span questions, a thematic analysis is provided, with signposting to other parts of the report (to avoid duplication).

We Asked, You Said, We Did

A good consultation should be transparent in showing what people have said and how these views have been considered by decision-makers.

One of the main ways we do this is on the "We Asked, You Said, We Did" section of our consultation website. We have also used this approach to structure this report. This briefly summarises the main points of the consultation (We Asked"), how many responses there were and key messages coming out of the responses ("You Said") and what we have done, or plan to do as a result of the consultation ("We did").

Vision

The vision was developed based on the views collected during the first phase of engagement. We heard very strong messages that communities needed to be at the centre of the work to prevent suicide. We also heard that timely, compassionate support - which created a sense of hope - needed to be available to everyone affected by suicide.

We Asked

Do you agree with the proposed vision, described below, for the new Suicide Prevention Strategy:

"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."

You Said

There were 202 responses to this question and the table below shows how people responded.

Option	Total	Percent
Yes	174	84%
No	28	14%
Not Answered	4	2%

A large majority of respondents agreed with the proposed vision for the new Suicide Prevention Strategy, in particular its focus on everyone working together to prevent suicide, the role of communities, and the focus on ensuring people have a sense of hope. However, 28 people did not agree. In a follow up question we asked those respondents what they would change about the vision and why. The common themes were:

- The wording of the vision was could be more ambitious, this included feedback that more emphasis was needed on tackling the root causes and inequalities of suicide.

- A clearer focus was required on the reduction in suicide, with some respondents explicitly asking for a numerical target to be included.

- A desire to see stigma included within the vision.

- Although it was recognised that communities have a key role to play, some suicide risk factors, such as poverty, were outwith the control of communities and needed to be addressed at a higher level. This linked to feedback about the importance of highlighting the role of businesses and workplaces in preventing suicide.

- A recognition that suicide affects people of all ages, including children and young people, and this should be explicit in the vision.

Relevant quotes:

> “Make an explicit reference to Children and Young people not just people”.
>
> “While we don’t disagree with any of the sentiments within the proposed vision, there is a sense that this feels unambitious in not featuring the vision of seeking a significant reduction in suicide rates in Scotland, building on previous achievements. We appreciate the challenges of selecting a specific numeric target for reduction, but feel this should be seen as a part of the vision for Scotland’s long term strategy.”

We Did

We listened to what respondents told us when they said they thought the vision should include something different, however we also needed to make sure that

people who liked the vision would not be disappointed by any changes – given that a large majority agreed with the proposed wording.

We have therefore refined the vision so that it includes a clear statement on the ambition to reduce suicide in Scotland, and to tackle the inequalities which contribute to suicide. This new vision provides a clear statement of our ambition to reduce the number of suicide deaths in Scotland, and includes a key focus on the inequalities need to be tackled to achieve that goal. We have also added two supplementary statements relating to the vision; the first highlights the need for all sectors and communities to work together and to address stigma, and the second sets out the commitment to support anyone affected by suicide and reinforces the importance of people having a sense of hope. Crucially the revised vision underpins our approach to implementing the strategy, and flows through to our long-term outcomes, priorities and the action plan itself.

A small number of responders suggested there should be a reduction or zero suicide death target specified in the strategy as a vehicle to track progress.

However, the majority of respondents supported the strategy's focus on making improvements across 4 outcome areas – recognising that a target is not always meaningful, or helpful, at a local level, and the need to affect change across society to prevent suicide. We were also aware that including a specified reduction target can lead to increased stigma for bereaved families and communities, and does not sufficiently capture the range of changes the strategy aims to deliver (including supporting people with suicidal ideation, supporting loved ones who are caring for someone who is suicidal, or for people who have been bereaved by suicide). Taking all this feedback on board, a numerical target has not been included in the vision.

We were extremely grateful for the feedback we received on the draft vision and believe we now created an improved vision, which reflects the range of views we received. The new vision for suicide prevention in Scotland is:

Vision

Our vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide.

To achieve this, all sectors must come together in partnership, and we must support our communities so they become safe, compassionate, inclusive, and free of stigma.

Our aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope.

Guiding Principles

We want to ensure there is an effective approach to implementing the strategy which builds on the 'ways of working' used to deliver the previous suicide prevention action plan, *Every Life Matters,* such as, considering the needs of children and young people. Throughout the engagement, we heard it was important that these ways of working were enhanced in the new strategy and action plan. To achieve these we developed a set of guiding principles, and asked for feedback as part of the consultation.

We Asked

Participants were asked to what extent they agreed with the following guiding principles:

Guiding Principle 1: Suicide prevention is everyone's business. We will provide opportunities for people across different sectors at local and national levels to come together to connect and play their part in preventing suicide.

Guiding Principle 2: 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.

Guiding Principle 3: All developments and decisions will be informed by lived experience. We will also ensure safeguarding measures are in place across our work.

Guiding Principle 4: 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.

Guiding Principle 5: 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.

Guiding Principle 6: To build the evidence base, quality improvement methodology and testing of new, creative and innovative practice will be embedded in our approach.

You Said

During the engagement people said stigma around mental health and suicide was an important issue which is why it was included as a key guiding principle, to ensure that addressing stigma around suicide will encourage people to talk more openly, seek help, and be aware of where to signpost others to if they need it.

201 participants responded to this question with the table below showing how they responded:

To what extent do you agree with the following Guiding Principles						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Answered
GP1	6%	1%	5%	20%	65%	2%
GP2	6%	2%	2%	18%	69%	2%
GP3	4%	3%	4%	20%	66%	2%
GP4	5%	0%	1%	14%	77%	2%
GP5	5%	0%	3%	19%	70%	2%
GP6	5%	2%	4%	25%	61%	3%

Due to rounding, the total of some of these figures may add to 99%, rather than the expected 100%

Across each of the guiding principles, less than 10% of those who responded, disagreed with what they were setting out to achieve. This is illustrated by:

- Only 5% of respondents, disagreed with Guiding Principle 4 which outlines the availability and access to effective, timely and compassionate support, with no follow-up changes recommended.

- Almost 90% of respondents either agreed or strongly agreed with the commitment of Guiding Principle 5 which highlights the needs of children and young people.

In follow up comments, these themes were identified:

- Lived experience is essential however it must reflect the wider diversity of experience; it must also be considered alongside professional expertise and research.

- Clarity is needed on the importance of engaging with children and young people across the strategy and action plan.

- The risk factors and groups who are at higher risk of suicide (highlighted under Guiding Principle 2) need to be more explicit.

- The cost of living crisis, and its wider impacts on mental health, should be recognised.

- Recognition is needed that cross-sector partnership working is needed at all levels, and should explicitly recognise the valuable role of third sector organisations.

- Data and evidence are crucial, however there are some concerns about the accuracy of existing suicide data, and the fact it tends to be clinically focussed.

- Providing compassionate support for people who are suicidal needs to be a central part of the strategy and action plan.

Relevant quotes:

> "In relation to 1.5 (GP3), we fully recognise the value and importance of lived experience but think that the principle would be enhanced by acknowledging the importance of this complementing professional knowledge / expertise and research / evidence. One should not be at the expense of the other".
>
> "Reference to children and young people (CYP) is essential but we would like clarity on how CYP are to be fully engaged and their influence embedded into the strategy and actions".
>
> "(We) don't just want children's views, we want children to be fully involved in the co-production and design of supports & services".

We Did

Based on the feedback, we reworded the original six guiding principles to strengthen their message. This included:

- Naming risk factors and inequalities so it was clear what was meant.

- Being clear that we need diversity across our lived experience insight, which is also representative of the risk factors and groups who are at higher risk of suicide.

- We are also explicitly setting out our commitment to Time, Space, Compassion as an underpinning set of principles, to improve the responses people who are suicidal receive.

We have also focussed specific actions (in the action plan) to reflect the cost of living crisis.

Given the emphasis across the feedback on continuing to focus on the stigma of suicide, we created an additional principle which focused on this.

Guiding Principles

We were extremely grateful for the feedback we received on the draft guiding principles and believe we now created improved guiding principles that reflect the

range of views we received. The new guiding principles for suicide prevention in Scotland are:

1. We will consider inequalities and diversity – to ensure we meet the suicide prevention needs of the whole population whilst taking into account key risk factors, such as poverty, and social isolation. We will ensure our work is relevant for urban, rural, remote and island communities.

2. We will co-develop our work alongside people with lived, and living, experience (ensuring that experience reflects the diversity of our communities and suicidal experiences). We will also ensure safeguarding measures are in place across our work.

3. We will ensure the principles of Time, Space, Compassion are central to our work to support people's wellbeing and recovery. This includes people at risk of suicide, their families/carers and the wider community, respectful of their human rights.

4. We will ensure the voices of children and young people are central to work to address their needs, and co-develop solutions with them.

5. We will provide opportunities for people across different sectors at local and national levels to come together, learn and connect – inspiring them to play their part in preventing suicide.

6. We will take every opportunity to reduce the stigma of suicide through our work.

7. We will ensure our work is evidence informed, and continue to build the evidence base through evaluation, data and research. We will also use quality improvement approaches, creativity and innovation to drive change – this includes using digital solutions.

Outcomes

From the very start of its development, partners and stakeholders shared the view that the new strategy should be outcomes focused to bring about the changes that were needed to reduce suicide in Scotland. The four outcomes were developed based on the feedback received during the first phase of engagement. People were clear about three key areas for improvement, which reflect outcomes one, two and three. These are:

- The environment we live in should offer protection against suicide.

- The powerful role that people in our communities can play in suicide prevention.

The importance of people affected by suicide having access to effective and compassionate support, when they need it.

In addition, feedback confirmed the importance we needed to give to creating the right conditions and enablers to support the delivery of these three improvement aims / outcomes. We have therefore created a fourth outcome which sets out our commitment to:

- ensuring data and evidence of all types (lived experience, practice and academic evidence) are central to how we take forward design and delivery of the strategy and action plan;
- evaluation and review being built into every stage; and
- an integrated approach to planning suicide prevention which brings together our national, local and sectoral levels.

We Asked

Respondents were asked for their views on the following outcomes:

Outcome 1: The environment we live in promotes the conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.

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.

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.

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.

You Said

There were 200 responses to this section of the consultation with more than 100 follow-up comments.

The table below shows how people responded to questions relating to the outcomes we outlined.

To what extent do you agree with the following Outcomes?						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Answered
Outcome 1	7%	4%	2%	23%	61%	3%
Outcome 2	15%	8%	3%	25%	47%	2%
Outcome 3	12%	3%	5%	12%	66%	3%
Outcome 4	5%	4%	7%	23%	58%	3%

Due to rounding, the total of some of these figures may add to 99%, rather than the expected 100%

In all outcomes, over 75% of respondents said that they agreed or strongly agreed with those originally presented.

However, more than 22% of respondents did not agree with outcome 2 which was focussed on the understanding of suicide and the ability to respond confidently when someone required support. This quote highlights the point: “For outcome 2, while the gold standard would be ‘everyone’ having a clear understanding of suicide, this is something which will take time to achieve and may not be realistic”.

The other key messages which came from this section of the consultation were:

- A real need for investment in current services and early intervention. This quote highlights the point: “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”.

- Clarification on care options and pathways should be included, for example, self-referral routes and expansion of peer support offerings.

- As already mentioned, addressing stigma was also highlighted as a specific aspect that merits inclusion in the outcomes. This quote highlights the point: “Currently there is no mention of (stigma) in the guiding principles, outcomes, or the priorities, which we believe leaves a major gap”.

- There was a call for the strategy to be more accessible and relevant to those it was aimed at supporting, and highlighted the ways in which society could protect against suicide. This quote highlights the point: “We wonder if the population would be more likely to engage with more specific messaging, which feels more immediate to their everyday lives - around the associated risk and protective factors. Examples, all pertinent to suicide prevention include: using social media safely, social isolation and

community cohesion, a society with values where people can feel hopeful, engaged, and able to better understand and develop relationships".

- As mentioned under the vision section, the commitment to tackling the causes of suicide needs to be more explicit in the outcomes. This quote highlights the point: "We would agree with the outcomes set out in the strategy, however, there is little mention of early interventions and addressing the causes of suicide, no mention of alcohol and drugs, homelessness, criminal justice etc. To prevent suicide, other issues have to be addressed and intertwined into the strategy and correlate with other policy areas".

We Did

We listened to what people said about the outcomes, where there was a high level of agreement with the outcome wording, such as outcome 1, there were no changes made. However, where necessary, the outcome wording was changed to reflect suggested improvements. This included:

- Moving away from the use of 'everyone' in outcome 2 to wording which not only reflected what we had heard through the feedback for outcomes, but also the strength of opinion that communities needed to be at the core of suicide prevention.

- Being explicit that the strategy's outcomes relate to both adults and children and young people.

- Ensuring the outcomes reflect the broad range of work required across early intervention, crisis response, postvention and recovery. We have also embedded these different types of responses that need to be there for people right across the action plan.

We were extremely grateful for the feedback we received on the draft outcomes. Some of the specific areas highlighted within the feedback on outcomes were incorporated into the changes we made to actions, within the action plan. For example, a focus on peer support became a key action under outcome 3 rather than included in the wording of the outcome – as it would have been difficult to itemise all types of support in the outcome descriptor.

- **Outcome 1:** The environment we live in promotes conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.

- **Outcome 2:** Our communities have a clear understanding of suicide, risk factors and its prevention – so that people and organisations are more

able to respond in helpful and informed ways when they, or others, need support.

- **Outcome 3**: Everyone affected by suicide is able to access high quality, compassionate, appropriate and timely support – which promotes wellbeing and recovery. This applies to all children, young people and adults who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways.

- **Outcome 4:** Our approach to suicide prevention is well planned and delivered, through close collaboration between national, local and sectoral partners. Our work is designed with lived experience insight, practice, data, research and intelligence. We improve our approach through regular monitoring, evaluation and review.

Priority Areas

We recognise that to help reach the proposed outcomes, we will need to prioritise which aspects of the strategy to focus on first. We suggested the priority areas below, which are based on the areas identified by stakeholders through our extensive early engagement. These key areas form the focus of this first action plan.

We Asked

We asked for views on four Priority Areas, for the new Suicide Prevention Strategy:

- **Priority Area 1:** Build a whole of Government and whole society approach to address the social determinants which have the greatest link to suicide risk.

- **Priority Area 2:** Strengthen Scotland's awareness and responsiveness to suicide and suicidal behaviour.

- **Priority Area 3:** Promote & provide effective, timely, compassionate support - that promotes recovery**.**

- **Priority Area 4:** Promote a co-ordinated, collaborative and integrated approach.

You Said

There were 201 responses to this section of the consultation. The table below shows how people responded to questions relating to the priority areas we outlined.

To what extent do you agree with the following Priorities?						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Answered
Priority 1	5%	3%	3%	24%	62%	3%
Priority 2	3%	0%	3%	20%	71%	2%
Priority 3	3%	0%	2%	14%	77%	3%
Priority 4	3%	1%	3%	16%	75%	2%

Due to rounding, the total of some of these figures may add to 99%, rather than the expected 100%

Over 90% of respondents consistently agreed with each of the priority areas we had outlined. In the corresponding comments the following points were highlighted:

- The need to consider realistic timescales.
- Some respondents asked for the inclusion of KPIs or another way of measuring and monitoring impact.
- A recognition of the conflicting demands already being placed on our health and social care services, of which suicide prevention is only one.
- If the purpose of the strategy is to address some of the societal issues which contribute to suicide, those responsible policy areas need to be explicitly referenced in this section.
- The need to capture the important role of employers and workplace given the impact work related stress can have on people.
- A call to prioritise the needs of children and young people. This quote highlights the point: “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”.
- The importance of effective support being given to people who are suicidal, to support their immediate wellbeing as well as recovery.

We Did

We listened to what people said about the priorities. It was clear there was a lot of agreement with the priority areas, and so there was only one material change which was to include wellbeing under the third priority. The feedback has also resulted in other changes across the strategy and action plan; such as, the

feedback on role of employers and being explicit about the policy areas which will lead actions to tackle the societal issues which are risk factors for suicide.

- **Priority Area 1:** Build a whole of Government and whole society approach to address the social determinants which have the greatest link to suicide risk
- **Priority Area 2:** Strengthen Scotland's awareness and responsiveness to suicide and people who are suicidal
- **Priority Area 3:** Promote & provide effective, timely, compassionate support – that promotes wellbeing and recovery
- **Priority Area 4:** Embed a coordinated, collaborative, and integrated approach

Delivery and Governance

Scottish Suicide Prevention Delivery Collaborative

To help us deliver the strategy and achieve the actions in our Action Plan we are proposing a new Scottish Suicide Prevention Delivery Collaborative. We proposed the following description for the 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).

We also set out that 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.

We Asked

We asked participants if they agreed with the proposed approach to delivery through the new Scottish Delivery Collaborative.

If participants answered No, we asked them to provide an explanation for their answer, and also to suggest any alternative delivery approach.

You Said

There were 194 responses to this section of the consultation. The table below shows how people responded to the following question:

Do you agree with the proposed approach to delivery and the new Scottish Delivery Collaborative?

Option	Percent
Yes	76%
No	18%
Not Answered	6%

More than three quarters of respondents agreed with the proposed approach to delivery and were supportive of the creation of a Scottish Delivery Collaborative. Over 18% did not agree with this delivery approach, and 69 respondents provided further detail as to their reasons why. Some key highlights in the comments made included:

- Many people want to understand how the new approach to delivery will actually work in practice. This quote highlights the point: "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".

- Some concerns and questions were expressed about the potential for the new approach to be more centralised and add another layer of bureaucracy. Suggestions were made about inclusive approaches, such as community empowerment and citizens panels, rather than a national group.

- There was also calls for more clarity on the enabling and supporting role that the National Suicide Prevention Leadership Group (NSPLG) would have, as well as the role of the Delivery Collaborative, to understand how they could further support, and not conflate, the role of other partners. This quote highlights the point: "The approach needs to recognise all the existing organisational responsibilities and accountabilities for suicide prevention, as well as the existing infrastructure for integrated working".

- Some questioned, based on the detail set out, whether the new delivery structure might add another layer of bureaucracy.

- In terms of membership, some respondents highlighted the need to consider representation from primary care settings, such as GPs and Community Pharmacists.

- There was also calls to give more recognition to the work being undertaken in workplaces, and the need for even greater involvement of

industries and business sectors, especially in areas where evidence suggests that workers are at greater risk of suicide, such as construction.

We Did

To emphsise, the Delivery Collective model is intended to create a collaborative leadership model alongside clearer national and local accountabilities, we will strive to ensure its purpose and accountabilities are always clear, including how it relates to other structures. Further clarification is provided in the next section, on NSPLG.

We listened to the feedback about the Delivery Collaborative and in recognition of the identified need for strong accountability and leadership from Scottish Government and COSLA to deliver the strategy, whilst ensuring collaboration with delivery partners across sectors, we introduced the role of National Delivery Lead. This role will oversee the Delivery Collaborative and ensure all efforts are made to achieve the suicide prevention community that is outlined; a community to further drive national, local and sectoral action, ensuring synergies and learning across our collective work. The recruitment of the National Delivery Lead role will make clear they hold responsibility for delivery of the strategy on behalf of Scottish Government and COSLA, and will lead the Delivery Collective.

We also heard that it was important that there were opportunities for everyone to play their part in the new delivery model, and plans are underway to engage more systematically with the key sectors highlighted in consultation responses, such as, primary care, pharmacy and the business sector.

Finally, we heard through the consultation that the word collaborative didn't seem to fit the aim of the group and therefore, we changed the name to the Delivery Collective, recognising the collective approach needed across sectors to achieve the outcomes.

National Suicide Prevention Leadership Group

At a national level, we propose adjusting our existing National Suicide Prevention Leadership Group so that it plays an oversight role. This includes: advising Scottish Government and COSLA on progress on the strategy and recommending any changes needed to the overall direction and priorities of the strategy; providing advice to the Delivery Collective on strategic delivery issues; and, in itself, championing suicide prevention.

The Group's membership will be revised to ensure it is best placed to support this new role, through a wider representation of sectors and organisations which have experience of suicide, including its social detriments. This will include organisations focused on poverty, those that work to support minority and marginalised groups, as well as organisations working in key settings, such as

justice and education. We will also ensure the membership of the Group continues to reflect people with lived experience of suicide.

We Asked

During the consultation we asked respondents if they agreed with the proposed approach to national oversight by adjusting the role of the National Suicide Prevention Leadership Group.

Again, if the answer given was No, we asked for a further explanation for their answer, and also suggestions for an alternative delivery approach

You Said

There were 195 answers recorded to this question, with 51 responses as a follow up.

The table below illustrates the breakdown of responses.

Option	Percent
Yes	84%
No	11%
Not Answered	5%

More than 4 out of every 5 respondents agreed with the shift of the National Suicide Prevention Leadership Group to an oversight role.

However, 23 of the 195 participants did not approve of the new approach.

The following key themes were identified in the subsequent comments:

- There needs to be better engagement with statutory bodies.
- Some local practitioners felt isolated from the work of the NSPLG in the past and requested that communication was open and transparent.
- Local voices, such as Health and Social Care Partnerships, NHS Boards, and representation from grassroots organisations, should be represented on any revised Group. This quote highlights the point: “The Leadership Group needs to be accessible to those working on the ground with direct lines of communication where possible”.

We Did

The feedback confirms the need for Scottish Government and COSLA to continue its work and communications on building these structures (the new Delivery Collective and the revised NSPLG), in a way that gives real clarity on their respective roles, how they will interact, and the opportunities for wider engagement (which is significant).

We are continuing to design these structures in partnership with national, local and sectoral partners who are working on suicide prevention, as well as new partners who have engaged with the strategy's development. In doing so we are being absolutely clear where accountabilities for suicide prevention lie, and signalling when we are creating more enabling/ learning spaces for collaboration and joint planning.

We are also keen to ensure there is openness and transparency in the way NSPLG carries out its oversight role. To assist with this, the NSPLG role and remit (which will be published when finalised) will clearly state its advisory function - both to Scottish Government and COSLA, and to the Delivery Collective.

Finally, we are very clear that the membership of the new Group will be selected to ensure it can effectively and meaningfully deliver its new oversight role, which means it needs the right skills and representation of members. We are already developing options to achieve this which will ensure a strong focus and representation on: inequalities, children and young people, and health and social care experience/ expertise. The Group will also have ready access to the lived experience panels, academic advisory group, and practitioners (including statutory partners) – who will be linked into the Delivery Collective as the delivery environment is where they can add most immediate value. Having this access will allow the Delivery Collective to make robust and rounded assessments of progress in delivering the strategy.

General Delivery & Governance

We advised that the NSPLG and Delivery Collective 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 and 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 (CPPs) 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.

We Asked

We asked respondents to share any other comments they have in relation to the delivery and governance proposals described.

You Said

There were 94 responses to this part of the consultation. Key themes included:

- A question about whether considerations have been made to accommodate the new National Care Service when Chief Officers' will no longer have the responsibility for Health and Social Care for adults (and potentially Justice Services and Children's Services too).

- A request for more clarity on job roles and responsibilities, in particular around the role of 'Chief Officers'.

- A need to review the membership of the NSPLG, including to see education as having a key role on the Group.

- The suggested links with Community Planning Partnerships (CPPs) seem logical in terms of addressing the wider impact of poverty and inequality. However, a recognition that CPPs would need to be supported to exercise the level of leadership and resource - which would be required to deliver against this vital agenda. This quote highlights the point: "(in some areas), there are well developed Suicide Prevention partnership arrangements in place which provide a locus for a collaborative strategic approach. CPPs should take cognisance of these arrangements and ensure integration between suicide prevention strategies and plans and local outcome agreements".

- A call for achievement indicators for local partners to work to, to maintain their engagement and ongoing support.

- Concerns regarding centralised structures taking the lead, coupled with a desire for much more community empowerment.

We Did

Based on the feedback from the consultation and discussions with relevant stakeholders, additional information was added on the responsibilities for local suicide prevention delivery and infrastructure. This included:

- The role of Chief Officers on suicide prevention being more explicitly linked to their public protection role, which is supported by suicide

prevention being set out as a key responsibility within Chief Officers' Public Protection induction pack.

- Continuing to engage with the development of the National Care Service to ensure continued prioritisation for suicide prevention. This includes ensuring consideration is given to how new structures can continue to support delivery of the suicide prevention strategy.

There are also areas of work which were implemented as part of *Every Life* Matters which have developed and provide opportunities to connect local and national work, such as the creation of a new team of implementation leads based in Public Health Scotland.

The Delivery Collective will also provide opportunities to enhance the connections and learning between local areas, and between work taking place at national, local and sectoral levels – drawing on evidence based practice to drive action right across Scotland. As mentioned, the design of the Delivery Collective, and the surrounding communications, will highlight its intended value as a space for collective learning and collaboration whilst making sure national and local accountabilities are clear. The National Delivery Lead will hold responsibility for creating this suicide prevention community which we know a range of partners and stakeholders are eager to be connected into, and play an active role within.

In response to feedback that the strategy and action plan did not give sufficient detail on the role of the private sector, we have strengthened this across the strategy. We see there are clear and early opportunities to developing new resources and networking opportunities to help the private sector understand their role further, and to inform and support the delivery of the whole action plan.

There was also feedback that the role of the third sector could be more explicit, and again we have taken that on board in drafting.

General Comments on the Strategy

Respondents were asked if they had further comments on the strategy. This section received 81 responses, and the main themes are highlighted below:

- Widespread support for the work already underway, including: reducing stigma, improving awareness and learning, ensuring compassionate and effective support at all levels of need (including digital), and valuing the role for communities and statutory services to support people affected by suicide.

- Desire to see funding commitment to deliver the ambition of the strategy and action plan.

- A recognition that the third / voluntary sector are crucial to the delivery of this work.

- Explicit references to the support required for carers and people bereaved by suicide.

- Greater understanding of how technology and innovation can be used to advance work in this area.

- Need to embed a public health approach consistently across the strategy and action plan.

- More explicit links between health inequalities and suicide.

We Did

In response to the themes highlighted above, the direct and indirect funding available to deliver the strategy has been set out. In addition, the new Delivery Collective model will provide continued transparency on the allocation of funds.

On the role of the third sector, we have now referenced that explicitly, recognising the significant and valuable role the sector already pay on suicide prevention, and the scope to extend that to a wider range of third sector partners through the new Delivery Collective model.

Clear actions have been included regarding the support for carers and people bereaved by suicide in the action plan. This builds on the Suicide Bereavement Support Service pilot which is already underway through the previous action plan.

To reflect the widespread support for continuing all areas of suicide prevention work that was commenced through the previous action plan, we have made the decision to continue delivery of all current actions, and this is set out within the new action plan. This includes ongoing consideration of work to understand how technology and innovation can support suicide prevention efforts.

We absolutely recognise that suicide prevention is a public health issue. Suicide prevention in Scotland has always had this focus and will continue to do so. Drawing on the feedback, we have now made this point more explicitly and clarified the role we see Public Health Scotland playing, both in the strategy and in many of the actions set out.

Finally, the need to focus on the inequalities which contribute to suicide was a strong message at all stages of engagement. This has been threaded throughout the strategy and set out explicitly in the vision.

Section 2: Action Plan

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

Theme One: Whole of Government and Society Policy

We recognise that we must strengthen our approach to suicide prevention by addressing the social determinants specific to suicide prevention. To support that we will adopt a whole of Government and society approach to suicide prevention.

This will involve aligning policy action to ensure all relevant Government polices take action to prevent suicide – from the policy design stage, right through to delivery.

Our approach will encompass the spectrum of need – prevention, early intervention, intervention, postvention, and recovery. We will focus on social, economic and spatial policies – and strive to reach communities most affected by inequalities and poverty.

We Asked

We sought views on the proposed actions contained in the accompanying action plan document.

In answering this question we advised respondents 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.

You Said

There were 113 responses to this part of the question.

The majority of respondents were very positive about the whole of Government and society approach, welcoming the focus on people most at risk of suicide, and tackling the social determinants of suicide. The following themes were identified from the corresponding comments:

- On the whole, participants were supportive of the whole of Government and society approach, particularly the focus on partnership working and the inclusion of the social determinants of health. This quote highlights the point: "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".

- The impacts of living in rural communities needs to be more explicit under this theme.

- Understanding the value of community based resources as an early suicide prevention tool could be further explored under this theme. This quote highlights the point: “Strengthening communities and developing community resources, including co-production of designing these by including communities, agencies and individuals experiencing suicide and their families as partners in this process is vital to ensure success and sustainability. This has not been represented within this theme”.

- The approach should also include a focus on groups where there is an higher risk of suicide. This quote highlights the point: “Many unpaid carers experience serious physical and mental health problems, are socially isolated, and tend to have more financial hardship. An emerging body of evidence suggests they might also be a high-risk group for suicide and homicide, yet this is an area which is under-researched and not addressed at policy or service development level.”

We Did

The actions set out under this action area are wide ranging covering mental health and wellbeing and wider Government policy.

Based on the feedback received, a number of additions were made, such as considering how volunteering can support delivery of the action plan, actions to address the needs of carers, and support people facing social isolation and loneliness.

The actions set out under this action area form the first stage of the whole of Government and society approach. There will be an ongoing process of identifying further cross Government policy opportunities to embed suicide prevention over the lifetime of the strategy and action plan - to ensure that every opportunity is taken to include a focus on suicide prevention.

The points raised on rural areas and role of communities, have led to changes in other areas of the strategy (for example as Guiding Principles) and feature across the action plan.

Theme Two: Access to Means

We recognise the need to ensure our communities are suicide safe places, and we will seek to proactively design-in suicide-aware places and buildings, and be responsive to practice and evidence on access to means of suicide, including locations of concern.

We Asked

We asked people to tell us what they thought about two particular actions focussed on this area, one exploring the use of a cross-sector action plan, and the other identifying priority actions relating to the recently launched Delphi Study.

You Said

There were 185 responses to the responding question A and 184 to question B, with over 70% of respondents who agreed or strongly agreed with the actions detailed under Access to Means.

Theme Two: Access to Means					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
A. 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).	2%	5%	12%	26%	44%
B. 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.	2%	5%	11%	30%	41%

The percentage figures given do not add up to 100% as not all participants answered this part of the consultation

From the corresponding comments, the following themes were highlighted:

- There is an opportunity to build and develop safer environments under this theme including physical builds and the online space. This quote highlights the point: “We would also specifically endorse importance of building safer environments (including civic design aspects – implying need to engage with a wider array of stakeholders – town planners, architects, emergency services, infrastructure specialists, leisure providers etc.) as well as including the online environment as an area of focus.”

- Value in building on international and local best practice, including to update PHS guidance on how to reduce suicides at locations of concern.

- There is value in delivering suicide awareness training for people who work in, and close to, specific locations of concern.

- Consideration should be given to the links between alcohol and suicide deaths at locations of concern.

- Importance of sharing research findings so to improve awareness and drive change, such as increasing awareness of the Delphi study. This quote highlights the point: “Further work in spreading awareness of findings of Delphi study and allied work would be beneficial in gaining buy in to additional actions on reducing means. There would also be merit in strengthening communication on proportionate risks from different kinds of means and how these can be experienced for different groups, plus continuing to track and report changes over time”.

We Did
Based on the feedback received, we added reference to the national Locations of Concern guidance published by Public Health Scotland. The Delphi study has also been published and is now publicly available.

The action to review the current learning offer will also ensure our approach to learning is fit for purpose, including to address the different needs across the workforce and communities, including those living and working at locations of concern.

The action plan also sets out a range of actions to create a safer safe environment.

Theme Three: Media Reporting

We recognise that responsible media reporting (including social media) of suicide is needed, and we will work with the sector to improve this.

We Asked

We asked people to tell us what they thought about a specific action relating to responsible media reporting.

You Said

There were 190 responses to this question, with the majority supportive of the proposed action and less than 3% disagreeing with what it set out.

Theme Three: Media Reporting					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
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.	1%	1%	7%	23%	60%

The percentage figures given do not add up to 100% as not all participants answered this part of the consultation

From the corresponding comments, the following insights were obtained:

- Social media should be seen as important as other methods of reporting if not more so. This quote highlights the point: “It is our view that social media is at least as important in terms of communicating policy messages, providing information support but also a contributing factor to suicidal behaviour, therefore there should be a specific focus on how government approach social media and support local authorities to address more localised issues in relation to social media inimical to suicide prevention”.

- References were made to the Online Safety Bill, seeking consideration to be given to balance regulation and using the online space for freedom of expression and peer support.

We Did

To reflect the range of media this action relates to, we have explicitly added reference to social media.

The Scottish Government continues to engage with the UK Government to ensure its Online Safety Bill offers maximum protection against suicide content, without restricting online spaces which offer compassionate peer support.

Theme Four: Learning and Building Capacity

We recognise the need for individuals, families, communities, workplaces and services to have a better understanding of suicide, so that they can be more confident and responsive to suicidal behaviour and risk.

Promoting awareness of suicide and reducing stigma is a core element of preventing suicide. We will therefore continue to work to increase awareness of suicide to create a foundation of understanding and compassion in our communities and services, thereby equipping people to respond more effectively to someone who is suicidal. This focus also helps to create the conditions for people who are feeling suicidal to understand their feelings and feel safe in expressing those to others, knowing they will receive a compassionate, timely response, and the support they need.

We Asked

Those who participated in the consultation were asked for their thoughts about a series of actions relating to Learning and Building Capacity, and which included activity in relation to the following:

- The suicide prevention social movement.
- A review of the learning approach to suicide prevention.
- Including suicide prevention in the Whole School Approach to Mental Health and Wellbeing.
- Materials for the school curriculum.
- A portal to host suicide prevention resources.
- Availability of workforce policies and supports for those affected by suicide.

You Said

There ranged between 188 and 191 responses to each sub question under Theme 4, as outlined as follows:

Theme Four: Learning and Building Capacity					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Continue to 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.	1%	0%	6%	28%	57%
Implement actions from review of learning approach to suicide	1%	0%	5%	30%	56%

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					
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	1%	0%	3%	20%	66%
Develop material for inclusion in the school curriculum which builds understanding on mental health, self-harm and suicide prevention	2%	1%	3%	15%	71%
Create a portal to host our suicide prevention resources and information in one, accessible digital space - and which links to other platforms.	1%	3%	3%	23%	62%

The percentage figures given do not add up to 100% as not all participants answered this part of the consultation

There was strong support across all of the actions proposed under this theme with more than 80% of respondents agreeing or strongly agreeing with the approach undertaken.

The following key themes were identified from the corresponding comments:

- A call to create a national database of relevant and local contact details for places to access support, with an opportunity to share learning, resources and best practice. This quote highlights the point: "We believe a central database is needed as we have experienced multiple instances where support phone numbers/ emails have changed as staffing changes, and it can be challenging to reach the support needed for individuals in a timely manner".
- Explore different ways to develop and deliver learning approaches. This quote highlights the point: "Ensure that any education resources, and learning, is mirrored with time and capacity to use the knowledge, and skills acquired. A range of learning approaches and platforms should be considered to enhance engagement".

- More emphasis on community awareness and capacity building.

- The approach to learning should be specific to suicide, as well as a broad approach to wellbeing and mental health. This includes treating suicide and self-harm as separate subjects in their own right.

- A need to review the public communications on suicide prevention, and specifically the social movement work and United to Prevent Suicide campaigns, so we are confident they are driving change and involving local communities more. This quote highlights the point: "There was a widely shared view among our consultees that the public communication function to-date is not meeting its potential, despite there being some very positive resource development through United to Prevent Suicide and allied initiatives. There needs to be significantly more depth and breadth of resource and campaign type support available, to meet diverse communities and needs, plus support for local campaign / engagement activity. There is still limited understanding of what the "social movement" aspect is trying to achieve and a feeling there isn't sufficient momentum around this aspect – meaning many opportunities for engagement aren't capitalised on. With little to no ring-fenced funding for suicide prevention in most areas of the country, many areas have no capacity to develop local campaign approaches and materials without central support."

- More detail was sought on suicide prevention as part of the whole school approach suggested. This quote highlights the point: "How will this be embedded? What support will be made available to schools? Will this be an opt-in for teachers or will it be mandatory? Will resources be made available? Will it be proactively promoted? Who will deliver and drive it?"

We Did

Overall, there was strong agreement with the actions set out under this action area. Where there were suggestions for enhancing the action, this was included in the final action plan. This included:

- Adding detail on the action around the social movement, campaigns and anti-stigma work, to include the breadth of evidence and experience which will be included in shaping this going forward.
- Expanding the key settings where promotion of suicide prevention learning resources will make a difference, and including suicide prevention action in the new Scottish Government Carers Strategy.

- Adding detail on who is the intended audience for actions, for example, confirming the action to develop an online portal is intended for both the workforce and individuals, families, and carers.

- Adding detail on which actions relate to children and young people.

Theme Five: Support

To prevent suicide, we need to create the conditions for good mental health and wellbeing and tackle the social determinants of suicide.

We must also ensure there is timely and effective support for anyone who feels suicidal – from the earliest moment.

As such, our support must span from early intervention, preventing crisis, support during crisis, and post crisis support and recovery. When providing support to anyone feeling suicidal, we must value their resilience and strength, and seek to create a sense of hope.

We Asked

Those who participated in the consultation were asked for their thoughts about a series of actions relating to support, and which included activity in the following areas:

- Help seeking and help giving.
- A single Scottish telephone number for support.
- Adapting Distress Brief Interventions.
- Responding to the diverse needs of communities.
- Embedding of counsellors in education settings.
- Development of resources to support family and friends affected by suicidal behaviour.
- Peer support models for suicide prevention.
- Embedding suicide prevention in perinatal care.
- Ensuring suicide prevention features in the student mental health action plan.
- How primary care settings can identify and support those at risk of suicide.
- Ensure clinicians in unscheduled care settings are alert to suicide risk.

- Statutory services continuing to improve the quality of clinical care and support for people who are suicidal – (through NCISH[2] guidelines).

You Said

There ranged between 179 and 194 responses to each sub question under Theme 5, as outlined below:

	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 sharing of good practice.	0%	1%	4%	26%	62%
Consider value and impact of a Single Scottish specific telephone number which will provide access to existing telephone support and resources	3%	2%	10%	22%	54%
Consider ways to adapt Distress 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-engage with support after discharge.	1%	0%	4%	24%	63%

[2] https://sites.manchester.ac.uk/ncish/

Respond to the diverse needs of communities – we propose at least two tests of change, e.g. to reach particular groups and community setting by working with representative organisations (1) review the design and delivery of learning approaches to ensure they reflect the communities' experience of suicide, and (2) test new approaches to supporting people in those communities who are at risk of suicide. As part of this we will seek to understand help seeking behaviours and tailored support for cultural and diversity groups, by working with trusted organisations to develop approaches / interventions that work for groups who are at heighted risk of suicide. We will use the learning to inform our overall approach to supporting communities and groups where suicide risk is high.	1%	1%	6%	21%	64%
Continue to support embedding of counsellors in education settings, and ensure they are skilled and responsive to signs of suicidal concerns, whilst ensuring proactive approach to supporting CYP at key transitional stages, as part of a continuum of care.	1%	0%	4%	19%	64%

Develop resources to support families, friends and carers, or anyone else, affected by suicidal behaviour – building on existing resources.	0%	0%	0%	17%	75%
Build new peer support capability to enable further use of peer support models for suicide prevention	1%	0%	4%	22%	64%
Embed suicide prevention in perinatal care.	0%	0%	5%	16%	66%
Ensure suicide prevention is prioritised in the student mental health action plan	0%	0%	2%	15%	69%
Consider how primary care settings - including GPs, nurses, and mental health teams - can identify and support people who are at risk of suicide, who may present with low mood or anxiety or self-harm. This could include: safety planning, referrals to DBI, community support (social prescribing), and proactive case management, especially for high risk individuals.	0%	0%	1%	16%	76%
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	0%	0%	4%	15%	71%

are put in place, including in the community. DBI should also be offered, where appropriate.					
Statutory services to continuously improve the quality of clinical care and support for people who are suicidal, and share good practice and learning, both individually and by working together across services. To achieve this a first step is for mental health services to adopt the NCISH guidelines into their operating practices [in full], and the relevant MAT standards [in full]	0%	1%	3%	21%	66%

The percentage figures given do not add up to 100% as not all participants answered this part of the consultation

People were broadly supportive of the actions set out, with on average over 75% either agreed or strongly agreed across the board, compared with an average of less than 6% who either disagreed or strongly disagreed.

The following insights were identified from the follow-up comments made:

- This section of the plan was deemed by some to be over-medicalised and needs to consider the value of non-clinical support avenues.

- There were questions on the value of a national telephone line. Some thought it may cause confusion, whilst others thought the opposite. This quote highlights the point: “unsure of the value in undertaking this when we have existing helpline numbers in place which are recognised and widely utilised”. Also this quote, “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.”

- Primary care settings, particularly GPs, are an important point of contact and need to be better trained to identify suicide risk.

- Need to invest in person-centered support and understanding the needs of specific groups, including older people. Engaging with BAME communities was highlighted as important to this.

- Need to recognise the impact of the pandemic on groups, especially children and young people, and to recognise that services are more difficult to access post-pandemic.

- Scope for greater involvement of Community Pharmacies. This quote highlights the point: “There is an under-realisation of the potential that pharmacies hold given their frequent contact with not only those in treatment but PWUD (people who use drugs) within communities, and insufficient funding to fully support the needs of the people that we see each day”.

- Emphasis on providing continuous support. This quote highlights the point: “One issue highlighted by our volunteer focus group is that people feel once their crisis stage has passed, there is no continuous support. The wording around ‘re-engaging’ here suggests there will be a gap in support before re-engaging, but the support should be continuous”.

- Parity of support is needed between out-of-hours services and Monday-Friday services, as well as different services joining up to ensure people receive the range of support they need. This quote highlights the point: “There is also a critical need to invest in services and to ensure that they are equipped to provide person-centred support where needs are identified. i.e. that people are supported more holistically, rather than isolating different issues such as alcohol, mental health, and suicide risk from one another and placing processes above peoples’ needs”.

We Did

We heard what was said about an over-medicalised approach to providing support. There are a number of actions in this section which focus on clinical care. It was felt these were important in order to address the issues which had been raised during the early engagement. In areas such as unscheduled care, primary care and mental health services the evidence suggests there are opportunities for earlier intervention and improvements to assessment and care, therefore these actions were retained. These clinical approaches are however balanced (both in this section of the action plan and across the strategy) with a strong focus on the role for communities and the workforce, for example, staff working in schools and youth work have a significant role to play in suicide prevention activities.

The role of pharmacies has been made explicit in the action plan.

We have also sought to build in the need for ongoing support and care right across the strategy and action plan.

We also recognise that there were no actions which focused specifically on the needs of older adults, we therefore added an action which would build our understanding of the needs of this group and help address these.

Theme Six: Planning

This theme intended to address areas where effective planning for risk was required. This included action plans for settings where evidence indicates people are at higher risk of suicide and situations which may emerge within communities such as suicide clusters or contagion.

We Asked

- Those who participated in the consultation were asked for their thoughts about a series of actions relating to Planning, and which included activity in relation to the following areas:
- Ensuring all key settings with a higher risk of suicide have a suicide prevention action plan.
- Guidelines for communities to respond to contagion or clusters.

You Said

There were 190 and 188 responses recorded against each sub question under Theme 6, as outlined as follows:

Theme Six: Planning					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Proposed Actions:					
Ensure all key settings with a higher risk of suicide have a suicide prevention action plan, which connects to local suicide prevention plans (to ensure smooth transition at discharge). Plans should include actions for the people they support as well as their workforce. Key settings include: schools,	1%	1%	5%	22%	63%

further & higher education, criminal justice, secure accommodation, and residential care.					
Guidance: guidelines for communities to respond effectively to suicide clusters and contagion within their local context.	1%	1%	6%	22%	61%

The percentage figures given do not add up to 100% as not all participants answered this part of the consultation

Again, respondents to the consultation were supportive of the actions set out under Theme 6, with over 80%, strongly agreeing or agreeing with the planned need identified.

From the comments which followed, the corresponding observations were identified:

- A recommendation that local areas are provided with guidance about how to deliver on some of the policies and protocols highlighted in order to standardise practice. Whilst, also recognising the need to take a flexible approach to reflect the local context.

- A recognition that communities, can be wider than a geographical context. This quote highlights the point: “Support for communities should not only be geographical, but also those of interest. It is noted that the impact of drug related deaths has an impact on others using drugs, but may not all reside in the same locality”.

- The synergies of learning which can be gained from drawing evidence from different sources. For example, adverse death reviews which are co-ordinated by Alcohol and Drug Partnerships can also provide insight into wider issues, such as homelessness.

- When identifying key settings for targeted work, these should also include community and voluntary support providers.

- Greater recognition should be given to rural settings under this specific theme. This quote highlights the point: "Serious consideration needs to include remote and rural communities where isolation, deprivation, housing, costs of living, and education, are all potential contributing factors - not to mention access to, and equal service provision of, health and social care”. And this quote: “Suicide rates are high in rural areas

(Highland region has the highest rate), therefore the rural dimension must be considered. This includes digital online methods of support, use of existing networks (National Rural Mental Health Forum), building of resilience and knowledge of suicide prevention and intervention".

We Did

In recognising the strong connection between Planning and Data and Evidence (as confirmed by responses), theme six in the consultation was combined with theme seven in the final action plan.

We clearly set out that this action area relates not only to settings but also to services and should draw on existing plans, resources and best practice approaches.

In relation to a specific point raise about clusters and contagion, the action was changed to include reference to 'timely' along with effective responses.

The rural theme has been picked up across the action plan, and sits as one of our Guiding Principles. Across the strategy and action plan we recognise social isolation as a standalone issue, i.e. that it doesn't only relate to people living in remote or rural areas.

Finally, the point about communities of interest has been highlighted right across the strategy and action plan, with examples, such as focussing awareness raising and tailoring responses for the LGBTI community, disabled people and racialised communities. We also have a number of areas within the action plan which refer to the need for integration of services, and data, to reflect the range of circumstances and type of support individuals need. This approach is needed to ensure people receive holistic support, and also to ensure we use all available data to inform our overall suicide prevention approach - nationally and locally. Specifically, we also included a focus on the action to improve data recording and reporting, the need to connect data which is available through other sources such as the drug related deaths and evidence around gender based violence, trauma, criminal justice etc. This will enhance the data currently available to support action on suicide prevention.

Theme Seven: Data and Evidence

By designing-in our data needs and taking a broad view of different types of evidence (including management / evaluation data, qualitative data and service insights) we will build an effective evidence informed approach to suicide prevention.

Our data, evidence, practice and lived experience insights are all essential for good design, delivery and evaluation of our actions, and will inform the continued evolution of our approach to suicide prevention.

Our outcomes framework will identify indicators and measures which will enable us to assess progress and evaluate delivery of the outcomes.

We Asked

Those who participated in the consultation were asked for their thoughts about a series of actions relating to Data and Evidence, and which included activity in relation to the following areas:

- Embedding and enhancing the Lived Experience model.
- Introducing a horizon scanning function to produce a 6 monthly digest of new evidence.
- The roll-out of multi-agency reviews.
- Hosting learning events as a way to disseminate information and share learning.

You Said

Between 187 and 191, respondents responded to the questions asked in this section, with a breakdown of results as follows:

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 [links to peer support].	1%	1%	5%	28%	58%

Introduce a horizon scanning function to produce a 6 monthly digest of new evidence, which connections to the mental health Research Advisory Group. Priority areas may include: COVID and cost of living impacts. This insights and evidence will form a core part of our suicide prevention planning, delivery and evaluation, both at a national and local level.	1%	1%	6%	27%	55%
Roll out multi-agency suicide reviews and learning system (aligning with the serious adverse event reviews process within mental health services).	1%	0%	8%	25%	57%
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.	1%	0%	5%	29%	57%

The percentage figures given do not add up to 100% as not all participants answered this part of the consultation

Across all suggested actions under this theme, respondents either strongly agreed or agreed with what was proposed, with the hosted learning events receiving the most support. Less than 2.5% of those who answered strongly disagreed or disagreed with the actions proposed.

From the corresponding comments, the following themes emerged:

- The importance of safeguarding when engaging with people with lived experience of suicide.

- A request to undertake research and evaluation of the interventions and therapies which can be used to support an individual.
- A proposal to include data currently gathered from Water Safety Scotland, who are also implementing the Drowning and Incident Review (DIR) process and as such, would have relevant crossover with suicide data.
- Agreement with the suicide review proposal but concerns raised regarding funding, capacity issues and impact on clinician time. There was also a proposal to include family members and also people bereaved by suicide. This quote highlight the point: “The lack of connection between services can cause serious issues for individuals, and any attempt to bring services closer together is welcomed. Families should always be involved as equal partners in multi-agency reviews”.
- Welcome of the horizon scanning function to identify emerging trends, which will help guide local partners. This quote highlight the point: “Horizon scanning will also allow for advance notice / consideration for local partnerships to amend the direction of their intervention services on the ground”.

We Did

We heard the need to ensure that people with lived experience who support and inform Scotland's work on suicide prevention are well supported. To address this we have included specific reference and actions on this with the action plan. This mirrors the continuous improvement approach we are already taking to ensure people with lived experience are engaged in our work in safe and meaningful ways.

We have included a timescale for the International Association for Suicide Prevention research we are funding ‘Interlinked systematic umbrella reviews of the effectiveness of interventions to prevent suicide’, which will publish in 2023. We will ensure the findings are disseminated widely and the learning informs our ongoing work.

General Comments on the Action Plan

Respondents were asked if they had any further comments on the proposed action plan. There were 60 responses to this section of the consultation with a summary of some of the key points highlighted below:

- Third sector / voluntary services need to be more prominently represented in the action plan.
- Funding and its allocation needs to be more explicit across the plan.
- Queries regarding the method of reporting to be used.
- Despite the comprehensiveness of the plan, greater focus on prevention is required.

- How will this translate from national into local action?
- Query raised about how this plan will complement the work of the Mental Health Strategy and also to avoid duplication of effort.
- Clarity on the criminal justice locations referenced in the plan.
- The impact of alcohol and drugs should be referenced more prominently throughout the plan.
- Although the whole society and tackling societal factors approach is welcomed, the needs of those at immediate risk of suicide should still be recognised.
- The plan needs to go further to address the needs of at risk groups who are unemployed or in low paid employment.
- A concern was raised that education has not been recognised as a core sector for developing and delivering the suicide prevention strategy.
- Greater clarity on how the action plan will be delivered including roles and responsibilities.

We Did

In response to these key points (many of which were also flagged through specific questions), the following areas were either added or strengthened in the final strategy and action plan:

- The need for collaboration and partnership working across the strategy was strengthened – with specific references to the value and importance of working with and supporting the third and private sectors to take action, alongside the public sector and communities.
- More detail on funding, and a commitment to a transparent funding approach.
- Confirming the development of an outcomes framework to underpin the strategy and action plan which will enable robust monitoring and evaluation of delivery, and the changes that result. Alongside that there will be a transparent reporting cycle.
- A commitment to continue the implementation support for local areas which ensures learning between areas, and also as a vehicle to ensure connections are made between local and nationally led work. The scope for local and national collaboration will be further strengthened through the Delivery Collective model.
- Clearly setting out how the Delivery Collective model will bring together partners at national, local and sectoral levels.
- Setting out how accountabilities and governance are being improved, including through the new National Delivery Lead role, the revised NSPLG role, and then the links to wider Government policy, such as the mental health strategy, self-harm strategy and the wider programme of work to support mental health and wellbeing of adults and children and young people.

- Explicitly setting out the settings where targeted action is necessary to reach people with higher risk of suicide, including specific criminal justice settings.
- Strengthened the actions where there are opportunities to connect linked policies and programmes of work, for example on alcohol and drugs, homelessness, poverty, and suicide prevention.
- Strengthened the focus on inequalities including its addition to the strategy's vision.
- Strengthened actions around education and explicitly set out the actions which relate to children and young people.

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