The Scottish Parliament
Pàrlamaid na h-Alba

Ms Maree Todd, MSP
Minister for Social Care, Mental Wellbeing and Sport
Scottish Government

Via email only

Equalities, Human Rights and Civil Justice Committee
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28 June 2024

Dear Minister

Suicide Prevention in Scotland

Thank you for your attendance at our recent Committee meeting in relation to our work on Suicide Prevention in Scotland.

The Committee is pleased to set out our findings from our evidence sessions and looks forward to receiving your response once you have had the opportunity to consider our conclusions.

Should you have any questions, please contact the Clerk to the Committee at EHRCJ.committee@parliament.scot.

With best wishes

Yours sincerely

Karen Adam MSP
Convener
Equalities, Human Rights and Civil Justice Committee

Suicide Prevention in Scotland: Findings and recommendations

Introduction

1. At its work programme discussion on 19 December 2023, the Committee agreed to undertake a short inquiry into suicide prevention in Scotland.

2. The focus for the inquiry was that the Committee would:

   - Scrutinise the Scottish Government and COSLA's Suicide Prevention Strategy and Action Plan, its anticipated outcomes and progress to date.
   - Assess to what degree budget allocation to the Strategy and Action Plan are sufficient, and to what degree budget allocations in other areas of Government will assist or hinder its delivery.
   - Establish to what degree the unequal distribution of deaths from suicide across different population groups are being accounted for in the Strategy and its implementation.
   - Determine to what degree the voices of those with lived experience are being meaningfully heard within the Strategy and how it is implemented.

Background

3. Suicide is often defined as death resulting from an intentional, self-inflicted act. Suicidal feelings can vary. They can include thoughts about ending your life, feeling that people would be better off without you, thinking about methods of suicides, or making plans to take your own life. Suicidal feelings may also be referred to as suicidal thoughts, suicidal ideation, or suicidal ideas.

4. The most recent National Records of Scotland report (NRS report) shows that the age standard mortality rate for Scotland for 2018-2022 had increased to 14.4 suicides per 100,000 population compared to a rate of 13.3 in 2013-2017.

5. There are also significant inequalities in the suicide statistics. The NRS Report shows:

   - The rate of suicide mortality in the most deprived areas in Scotland was 2.6 times as high as in the least deprived areas in Scotland. This is higher than the deprivation gap of 1.8 times for all causes of death.
   - The mortality rate for suicides in 2022 was 2.9 times as high for males as it was for females.

6. In November 2023, the Equality and Human Rights Monitor 2023: Is Scotland Fairer identified a number of factors that were related to suicide risk. A higher suicide rate/ or reported suicide risk was identified among:

    - People living in areas of socio-economic deprivation
    - People in prison
    - Men
    - People aged between 45 and 54 years (NRS figures use the 45 to 64 age range)
    - Trans and non-binary people
    - Lesbian, gay and bisexual groups.

7. It also referred to Scottish Government research in which participants reported the effect of racism on exacerbating mental health illnesses and increasing their propensity towards suicide.

Scottish Government and COSLA policy

8. In 2022, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) published Scotland's Suicide Prevention Strategy 2022-2032: Creating Hope Together in 2022. The Strategy's vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide. Published alongside this strategy was an Action Plan covering the period 2022 to 2025. A Year 1 Delivery Plan (2023-24) was published in December 2023.

9. The Strategy also notes that the Scottish Government's 2021-22 Programme for Government committed to double the specific funding available for suicide prevention over the course of the current Parliamentary term, from £1.4 million to £2.8 million.

10. The Minister for Social Care, Mental Wellbeing and Sport wrote to the Health, Social Care and Sport Committee with an update on the Suicide Prevention Strategy in June 2023. This letter informed the Health Committee that an update from this strategy is expected in July 2024.

11. The Scottish Government has also established a Suicide Prevention National Advisory Group (NSPAG), comprised of professionals with expertise in the social determinants of suicide. The group will provide independent advice regarding the progress and delivery of the Strategy, including making recommendations for redirection of efforts in response to the ongoing evaluation of the Strategy if necessary.

12. This strategy is intended to build on the 2018 strategy Every Life Matters. This previous strategy had the overall aim of reducing the rate of suicide by 20% from a 2017 baseline, by 2022. The most recent National Records of Scotland report shows that the age-standardised mortality rate for Scotland for 2018-2022 had increased to

14.4 probable suicides per 100,000 population compared to a rate of 13.3 in 2013-2017.

Consideration by the EHRCJ Committee

13. The Committee issued a call for views which closed on 29 March. Responses to the Call for Views are published online.

14. On 23 April 2024[1] the Committee heard from:

- Rob Gowans, Policy and Public Affairs Manager, Health and Social Care Alliance Scotland (the ALLIANCE)
- Neil Mathers, Executive Director, Samaritans Scotland
- John Gibson, Chief Executive Officer, The Canmore Trust
- Dan Farthing, Head of Suicide Prevention, Scottish Action for Mental Health (SAMH)
- Jason Schroeder, Chief Executive Officer, Scottish Men's Sheds Association
- Rebecca Hoffman, National Policy Lead, LGBT Health and Wellbeing
- Aidan Mitchell, Policy and Public Affairs Officer, Change Mental Health
- Dr Richmond Davies, Head of Public Health Analytics and Intelligence, Public Health Scotland

15. On 30 April 2024[2] the Committee heard from:

- Professor Rory O'Connor, a researcher at the University of Glasgow and leader of the University's Suicidal Behavioural Research Laboratory and President of the International Association for Suicide Prevention and
- Dr Hazel Marzetti, Researcher, University of Edinburgh; and then from
- Dr Amy Knighton, East Scotland Chair, Royal College of General Practitioners
- Dr Murray Smith, Vice Chair of the Liaison Psychiatry Faculty, Royal College of Psychiatrists in Scotland
- Sam Campbell, Health Improvement Principal, Argyll and Bute Health and Social Care Partnership
- Dr Jane Bray, Consultant in Public Health, NHS Tayside

16. The Committee also undertook engagement work with participants who have lived experience of suicide. Notes from those meetings are published online under the Committee's 'Engagement'.

17. The Committee would like to thank everyone who gave evidence to this short inquiry and are particularly grateful to the individuals for the time they took to share their

[1] Official Report of the 10th Meeting of 2024 of the Equalities, Human Rights and Civil Justice Committee, 23 April 2024
[2] Official Report of the 11th Meeting of 2024 of the Equalities, Human Rights and Civil Justice Committee, 30 April 2024

lived experiences. It recognises this took enormous courage and many of the stories were difficult to hear. This evidence was invaluable to our inquiry.

18. Finally, at its meeting on 28 May 2024[3], the Committee heard from:

- Maree Todd, MSP, Minister for Social Care, Mental Wellbeing and Sport
- Morag Williamson, Head of Suicide Prevention and Distress Intervention, Scottish Government
- Haylis Smith, National Delivery Lead for Suicide Prevention on behalf of Scottish Government and COSLA
- Dr Alastair Cook, Principal Medical Officer, Scottish Government
- Councillor Paul Kelly, Spokesperson for Health and Social Care, COSLA
- Eddie Follan, Chief Officer, Health and Social Care, COSLA.

Key themes

Previous suicide prevention initiatives in Scotland, and the Creating Hope Together Strategy

19. The Creating Hope Together suicide prevention strategy builds on the Scottish Government's previous suicide prevention strategy, Every Life Matters. The Creating Hope Together Strategy was jointly developed by the Scottish Government and COSLA, with input from stakeholder organisations and people with lived experience of suicide.

20. The Committee heard support for the Strategy's ambition and vision over the course of its inquiry. Professor Rory O'Connor stated that the Strategy's approach to suicide prevention as a public health issue represented an important shift in rhetoric around suicide. He said:

> "The Creating Hope Together strategy is incredibly ambitious, because, for the first time ever—in any strategy ever published in the world, to my knowledge—we are saying that we want to reduce not only suicide but the inequalities that drive suicide. That is a fundamental shift. When I started working in the area, about 30 years ago, suicide was still considered to be a mental health concern. Mental health is, of course, important and we need to tackle it. It is an important driver, but it is only one driver. It is vitally important that we see suicide as a public health challenge, which is what we do now."

21. However, we also heard concerns from healthcare providers and third sector stakeholders that the funding allocated to the Strategy may not be sufficient to achieve its vision. Rob Gowans of The ALLIANCE said:

[3] Official Report of the 13th Meeting of 2024 of the Equalities, Human Rights and Civil Justice Committee, 28 May 2024

> "The latest strategy—the Creating Hope Together strategy—is welcome. It contains a lot of really good content, and there is good consideration of equalities and human rights and an engagement with lived experience. In common with other strategies, much of what will determine whether it is successful will be the action that is based on it and the funding that is attached to that, particularly for third sector organisations, which play a huge part in suicide prevention and work with people on an early intervention basis."

22. The Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, told us there are significant differences between the two strategies and the new strategy was focussed on outcomes rather than just actions. She told us "One is that tackling inequalities is ingrained as part of the core work in the new strategy, whereas in previous strategies there was recognised increased risk in communities who experienced inequalities but there was a challenge in how to respond to that".

23. Morag Williamson explained that the Scottish Government "did an extensive consultation in different formats. We listened to the experience of suicide and what measures they felt would make the biggest difference" That included, she explained, looking at all the data and working with academics who were able to help the Scottish Government understand the data around suicide trends and suicide prevention activities that make a difference. She told us that the national suicide prevention leadership group which saw the delivery of the previous strategy was critical in putting in place what was important for the new strategy as was the lived experience panel and the youth advisory group.

24. The Committee heard broad support for the Creating Hope Together Strategy and welcomes its shift in focus from viewing suicide as a mental health concern to one of a public health challenge with a focus on inequalities as a driver. We note that it is too early to meaningfully evaluate its impact, but that it is clear that tackling inequalities will require resource, cross government and a cross community approach. It is not yet evident that sufficient resources and cross government working is in place, and we look forward to monitoring progress in those areas alongside the strategy as it is implemented.

Factors affecting rates of suicide in Scotland

25. Respondents to the Committee's call for views highlighted a number of factors contributing to suicide including socioeconomic deprivation, financial stress, gender, and health-harming behaviours though respondents emphasised that the factors are complex and multi-faceted.

26. The most recent data available from National Records of Scotland states that there were 762 probable suicides in Scotland in 2022, an increase of nine from 2021. The age-standardised mortality rate for probable suicide deaths in 2022 was 13.9 per 100,000 people, a small increase from 13.7 per 100,000 people in 2021. National

Records of Scotland notes that age-standardised mortality rates can be a more helpful measure of mortality than numbers of deaths, as they take into account the size and age structure of the population, and provide more reliable comparisons over time.

27. The Committee's inquiry was informed by data concerning the higher rate of suicide among men. Although the most recent National Records of Scotland data reported a 10% increase in the number of women dying by suicide, and women are more likely to report having attempted suicide than men, men remain at significantly higher risk of death by suicide than women. The suicide mortality rate in Scotland in 2022 was 2.9 times higher for men than women, and this figure has been relatively consistent since 1994. In its written submission to the Committee's call for views, Scottish Action for Mental Health (SAMH) discussed some of the factors that contribute to the disproportionate risk of dying by suicide among men:

> "The reasons for the higher rate of suicide deaths for men are complex, with research from the Samaritans finding a range of psychological, cultural, relational and socioeconomic factors increasing the risk of suicide among men in their middle years. These include:
>
> - The role of specific elements of masculinity, including the centrality of "providing for the family" as part of male identity, which when lost, can be experienced as shameful
> - Greater use of alcohol and drugs in response to stress, compared with women
> - The use of more lethal methods of suicide
> - Fewer supportive peer relationships compared to women
> - Lower levels of help-seeking, including around mental health, than women.

28. Participants to our informal engagement session also spoke of a culture in Scotland where men can consider showing emotion as a weakness and have feelings of guilt if they are struggling. Financial pressure is also acutely felt. They emphasised the need to reduce the stigma around suicide and that spaces are created where people do not feel embarrassed or ashamed and where there is someone to listen.

29. Socioeconomic deprivation was also highlighted by a number of witnesses as a risk factor for suicide. Dr Jane Bray told us:

> "Socioeconomic deprivation is one of the strongest associations, and mental health disorder is equally strongly associated. We have particular challenges in Scotland, where socioeconomic deprivation has had greater impacts on our population than it has had in other areas of the UK… In looking at our preventative measures, that is a really important area to focus on."

30. Witnesses also discussed the impact of health-harming behaviours such as gambling, alcohol, and drug misuse upon suicide rates, noting that such behaviours can disproportionately affect people experiencing socioeconomic deprivation. Rob Gowans of The ALLIANCE said:

> "People who have experienced gambling harm are an important group to consider, because we know that there is a very strong link to suicide. It is estimated that there are between 250 and 650 gambling-related suicides every year in the UK, so it is very important to consider gambling as part of it."

31. Aidan Mitchell of Change Mental Health, an organisation that supports people living in rural Scotland, shared insight into the factors affecting suicide rates in remote and rural areas:

> "We know from the latest statistics that the Highlands, Tayside, and Ayrshire and Arran have some of the highest suicide mortality rates.
>
> Rural Scotland has some specific issues. It is not just about a lack of access to services because of remoteness. People are also emotionally isolated, with two thirds of the respondents to our 2017 study saying that they could not be open about their mental health within their community in a rural area. It is a double-edged sword of being physically isolated from services and being emotionally isolated."

32. The Committee also raised questions with witnesses concerning the higher risk of suicide among people in prison, and those who have recently been released from prison. Dr Richmond Davies of Public Health Scotland explored some of the factors informing this elevated risk:

> "We know that people who are more deprived are three times as likely to take their own life and that men are three times as likely as women to take their own life. Prisoners fall into both categories. Most of them are men and most of them are from very deprived areas. Therein lies the problem.
>
> We are working with QES, which will pilot a huge data set of about 100 variables in some local areas. We would like to understand whether granular data exists about individuals who have died by suicide, and whether that can be captured quickly, in order to better understand what is going on."

33. Participants to our informal engagement who had lost loved ones to suicide in prison felt more training was required for prison staff and across organisations in how to respond to individuals who are struggling.

34. Their view was that prisons have been overlooked in the strategy and the policy was incompatible with people's experience of being in prison as its principles could not be

applied within that environment. They questioned the removal without explanation of the “breathing space” policy which allowed prisoners to access support.

35. Participants also highlighted the elevated risk of suicide among people recently discharged from inpatient mental health treatment. Witnesses felt that insufficient support was offered to people during this transition, contributing to a higher risk of suicide in this population.

36. We heard that as a society we need to recognise the impact of trauma and early years targeted intervention is essential. Many participants highlighted the long waits for support services and the delay in early intervention.

37. The Committee heard that more resource is needed at grass roots level and that talking support can be more useful than being prescribed antidepressants. More training was also suggested for GPs. We heard that intervention needs to be immediate not a referral and a wait for services. However, we also heard of good work being undertaken in Fife on the provision of designated mental health workers.

38. Participants highlighted that long-term support for people who have experienced crisis is essential, but this is often absent or disjointed. If a person is admitted to hospital in acute distress, we heard that they are often discharged without any aftercare in place increasing their vulnerability.

39. In tackling inequality, the Minister highlighted that poverty increases suicide risk and that “the link between the two is clear” but said it is “very challenging” to address these against a background of austerity, the pandemic and Brexit which she said had had a profound impact on the economy.

40. Councillor Kelly told us that councils had faced “challenging budgetary positions” in recent years, and this has an impact on key services which benefit people hugely in terms of their health and wellbeing.

41. The Minister responded to concerns about rural communities and told us about work being undertaken in the highlands in collaboration with Samaritans Scotland and its current project in Fort William is assessing the risk of suicide among lone rural workers who can be vulnerable due to the isolated nature of the work that they do. She told us that local charities were also prominent in the area.

42. She told us “I am keen to get on the record that the project recognises the importance of employers and work-based interventions” and that “ensuring employers are equipped to have sensitive conversations recognising the role that hey play in the community and the role that a supportive employment environment can have in preventing suicide is a new thing”.

43. Councillor Kelly spoke of the importance that councils’ action plans are tailored to local areas whether they are rural or urban and to the support that is required. Eddie

Follan highlighted the importance of the new strategy being a joint one between national and local bodies. Haylis Smith told us that the Government meets with local leads regularly to "help us shape what we are doing nationally and are embedded in that work regardless of whether they are in rural, island or urban communities". She said the work being done with the Scottish Community Development Centre to support some community led action research will "play a big role" in the coming years and will be led by them to help better understand their needs.

44. In response to concerns about an increased risk to those in prison, Councillor Kelly said "local support should tie into any national support to ensure that the specific support on mental health is available for individuals who leave prison". Haylis Smith told the Committee that "Public Health Scotland is leading work to look at action plans for high-risk settings such as prison." And that she was working alongside the Scottish Prison Service to look at a refresh of its talk to me strategy and how people should be supported after they are released.

45. The Committee heard that the needs of specific vulnerable populations should be addressed and that enhanced support and intervention could have more impact. However, we note more could be done to address stigma and the impact of isolation particularly in rural areas, providing resource at grass roots level and on the prevention of health harming behaviours like gambling harm which can lead to suicide. We ask the Scottish Government to consider what measures it will take to address these concerns and to improve the continuity and longer-term support for vulnerable people who have been discharged from healthcare settings or from prison.

46. The Committee notes specific concerns around support for prisoners and heard that the aims of the policy are incompatible with the prison environment. We urge the Government to take a more targeted approach, with additional training put in place for prison staff to respond adequately to those in distress. The Committee asks the Scottish Government to update it on the withdrawal of the "breathing space" policy.

The potential impact of the Strategy for groups disproportionately affected by suicide

47. Suicide does not affect all demographic groups equally. The Equality and Human Rights Monitor 2023: Is Scotland Fairer? report identified a number of groups who face a disproportionately higher risk of suicide in Scotland, including men, LGBTQ+ people, people living in socioeconomically deprived areas, people in prison, and people aged 45 to 54.

48. The Creating Hope Together Strategy acknowledges the higher risk of suicide among certain groups, and the Strategy's vision commits to "tackling the inequalities which contribute to suicide." Outcome 3 of the Creating Hope Together Action Plan states that the Scottish Government and COSLA:

"will focus on areas and groups where suicide rates are highest, including deprived areas. This focus will include building protective factors, such as social connectedness, as well as a focus on risk."

49. Although witnesses broadly welcomed the Strategy's acknowledgement of the inequalities impacting suicide rates in Scotland, some witnesses shared with the Committee that they did not feel the Strategy sufficiently acknowledged the needs of at-risk groups. Jason Schroeder of Men's Sheds expressed a desire to see more explicit consideration within the Strategy of the risk factors affecting men:

> "With our movement, we have delved deeply into the masculine, obviously. The strong, silent type masculine model that has been around in society for the past 200 to 300 years is clearly failing us, and it is why I believe that we are in this situation right now. In relation to the strategy, I had hoped for there to be a discussion point among the different sectors of people in which we would be brave enough to identify and to say that it is okay to be different and to accept that there have to be different strategies for success, because there is no one-size-fits-all approach. However, I did not see that at all."

50. Dr Hazel Marzetti told the Committee that, although she welcomed the Strategy's identification of LGBTQI+ people as a group at higher risk of suicide, she felt that the societal factors contributing to this elevated risk needed to be acknowledged:

> "A person should be able to go somewhere and have easily accessible support when they do not feel able to keep themselves safe from suicide, but we should also be thinking more broadly about what is happening in wider society. If homophobia, biphobia and transphobia are much more acceptable in wider society—if that is seen as okay—crisis support is going to be limited in its effectiveness…
>
> …I am not certain that that is in the strategy, because the strategy does not have a tremendous amount of detail. LGBTI people are named as a group that might need prioritisation, but there is not a lot of detail about what that would look like."

51. Many respondents to the Committee's call for views felt that addressing the inequalities that contribute to higher rates of suicide was broader than could be achieved by the Strategy alone. Angus Health and Social Care Partnership stated that although the Strategy's focus on inequalities is important, the work must be linked to addressing broader societal issues such as poverty and deprivation:

> "In the strategy there is a lot of focus on inequalities and there is national work happening in this area so again one would be hopeful that a difference can be made. It is important that the Scottish Government link the Suicide Prevention Strategy to other strategies in an effort to address the issues that cause inequalities. We feel that a lot of work has to happen from other sectors to enable this and ensure that this strategy can have the maximum impact intended and

required.

"For example, the strategy and actions within it cannot address poverty and areas of deprivation. It can try to make things better for those groups in terms of support etc but until the bigger picture is addressed at the highest level, the actions from the strategy and delivery plan are limited."

52. The Minister agreed that it is not appropriate to take a "one size fits all" approach and that "we need to understand the particular circumstances that are enhancing the risk in those communities in order to find the solutions in relation to prevention". She told us that there is some good work going on in preventing male suicide and have confirmed additional £100,000 for the changing room extra time programme which is run by SAMH via football clubs.

53. She explained that the Government is also working with organisations such as Andy's Man Club and Men Matter Scotland but, on LGBT prevention, the body of evidence can be difficult to find in relation to those specific characteristics. However, she said the Government "can work very closely with trusted organisations and try to find bespoke answers that work for them and support them in their work".

54. She told the Committee about the national suicide prevention advisory group which provides an independent assessment of progress to Government and COSLA every year and highlights any adjustment or redirection of its priorities. She explained that the membership of that advisory group reflects a broad range of sectors that are leading work on the social determinants of suicide such as poverty and care experience with partners working in key sectors affected by suicide such as the criminal justice sector.

55. In addition, she said "We have developed a groundbreaking strategy to reduce self-harm which is a really important area for suicide prevention: self -harm is one of the biggest risk factors for suicide".

56. The Committee heard that the strategy needs to incorporate more specific and detailed measures tailored to the unique needs and risk factors of vulnerable groups such as men and LGBTQI+ individuals. We learned during our inquiry into HIV prevention, for example, that stigma and taboos around sexual health can contribute to poor mental health and increased vulnerability We ask the Scottish Government how it intends to address these concerns. We note and welcome ongoing work between the Scottish Government and organisations but heard concerns around sustainable funding of those supporting high risk groups. We urge the Scottish Government to commit to a sustainable funding model to ensure these organisations have the necessary resources to continue their support services. We ask the Scottish Government to update the Committee on progress.

Involving people with lived and living experience in the development and implementation of the strategy

57. The Creating Hope Together Strategy states that the involvement of people with lived and living experience, alongside relevant stakeholder organisations, was fundamental to the development of the Strategy. Initial engagement with those with lived experience helped to identify key areas of focus for the Strategy, and further targeted public engagement was used to refine the approach.

58. Witnesses broadly praised the involvement of people with lived and living experience in the Strategy's development, though some felt that some stakeholders involved in suicide prevention work had been excluded. Witnesses also queried how people with lived and living experience will be involved in local-level implementation of the Strategy.

59. The Committee heard from witnesses that the involvement of people with lived and living experience of suicide had been instrumental in the development of the Strategy. Professor Rory O'Connor said:

> "Scotland leads the way on this, and, with my International Association for Suicide Prevention hat on, I know for certain that we have been one of the first to properly engage people with lived and living experience as equal partners. I am the chair of the academic advisory group, which feeds in evidence, and I am an equal partner to the people who have lived and living experience… That approach is fundamental to everything that we do in Scotland, it is recognised as an example of excellence by the World Health Organization, and it will only get better and more embedded."

60. However, some respondents to the Committee's call for views felt that only the "usual suspects" had been consulted in efforts to represent the lived experiences of people affected by suicide, and that the focus of these efforts was too narrow. The National Association of Link Workers said:

> "The voices of people with lived experience of suicide have not been adequately incorporated into the development and implementation of the Suicide Prevention Strategy. Organisations like the National Association of Link Workers, with extensive experience in both primary care and community settings practical delivery, have not been consulted despite our valuable insights. Our members are direct patient care workers who work closely with patients experiencing contributory social factors to suicide and they advocate for their needs, making their perspectives crucial for effective suicide prevention strategies. Our inclusion would ensure a more comprehensive and empathetic approach to suicide prevention. Coproduction is not only listening to the usual suspects, diverse voices with crucial experience on the ground should be included to reduce implementation bias."

61. Perth and Kinross Suicide Prevention Steering Group highlighted that although efforts had been made to include the voices of people with lived experience of suicide at a national level, engaging with people with lived experience at a local level can present a greater challenge:

> "There is a commitment at national level to have ongoing opportunities for adults, children, and young people to be involved in influencing the actions to implement the strategy. However, panels cannot effectively fully represent the wide range of views and many people who may want to have a voice are not aware of how that can be achieved on an ongoing basis both at national and local levels.
>
> "Involving those with lived experience at the local level is more challenging and can be influenced by capacity, conflicting priorities, lack of shared understanding about good practice and the reinforcement at times of the myth that lived experience only comes from service users. The reality is that due to the nature of suicide and impact, many people, including agency representatives have also been impacted on a personal and /or professional basis."

62. The Minister told us that the Scottish Government "put lived experience at the heart of our policy development and often legislation because doing so helps us to get it right but it also holds our feet to the fire on delivery." Morag Williamson told us that the Government have two lived experience panels one which is hosted and supported by SAMH and also a youth advisory group which is hosted and supported by Children in Scotland and the University of Stirling. She said the Government was also engaging with the mental health equalities and human rights forum representing a range of groups including the LGBT community and was set up to helps them to understand the experience of different groups who face inequalities.

63. Councillor Kelly emphasised that lived experience was crucial. He told the Committee "We must ensure that local authority leads feed back to Public Health Scotland suicide prevention implementation offers to ensure that what is going on at a local level is reflected nationally."

64. The Committee heard broad praise from witnesses for the involvement of people with lived and living experience in the strategy's development. However, we note that some stakeholders for example, the National Association of Link Workers, were not consulted. While the Committee welcomes the work that has taken place, we ask the Scottish Government to ensure it broadens and diversifies its engagement beyond the usual suspects. We suggest that better support and guidance could be provided to local suicide prevention initiatives on how to involve individuals with lived experience at grassroots level. We would welcome an update from the Scottish Government on work in this area as it progresses.

Implementation of the strategy

Funding and resources

65. The Scottish Government committed to double the direct funding available for suicide prevention over the course of the current Parliamentary term in its 2021-22 Programme for Government. This equates to an increase from £1.4 million to £2.8 million. In a briefing prepared for the Committee in February 2024, the Scottish Government stated that £2.5 million of funding was allocated to suicide prevention work in 2023-24. The letter added that the 2024-25 suicide prevention budget will be finalised following the passage of the budget bill through Parliament.

66. The Creating Hope Together Strategy also acknowledges the role of indirect funding for other areas of work involved in suicide prevention, such as the Mental Health & Wellbeing Communities funding for adults. Additionally, the Scottish Government's letter to the Committee highlighted the potential impact of funding spent to tackle inequalities upon people at higher risk of suicide, such as the Scottish Child Payment, which is intended to support children and families experiencing poverty.

67. Throughout the inquiry, stakeholders expressed concerns about funding for the Strategy's implementation. In addition to worries concerning whether the amount of funding directly allocated to the Strategy was adequate, witnesses identified the precarious nature of third sector funding as a key factor affecting the Strategy's implementation. Several witnesses noted that the year-on-year nature of funding allocated to third sector organisations was incompatible with the longer-term vision of the Strategy, including Dan Farthing of Scottish Action on Mental Health (SAMH):

> "We know that we need to make society-wide changes. One of the things that we like about the strategy is that it is ambitious about making society-wide change, but that requires a significant commitment of resource over a sustained period. We are in a year-to-year funding cycle, and it is hard to plan and spend the money effectively if you do not know where you will be in two or three years' time, especially if you want to make longer-term societal changes."

68. Dr Murray Smith of the Royal College of Psychiatrists in Scotland highlighted the importance of funding for healthcare services peripherally involved in suicide prevention, such as mental health care, and alcohol and drug services:

> "There are some things where there may need to be additional focus, such as policies and plans that help with mental health, monetary issues, stigma, research or social circumstances. Such policies would be very welcome. As was said earlier, mental health should not be seen in isolation from physical health; they are very much interlinked. There may be gaps in areas where services attend to such groups.

> Some of those services are not recurrently funded—services end. Locally, we had a very good drug and alcohol team that worked with people in the Royal infirmary. There has been temporary funding for that and, with all the other funding issues, that funding is going to end, which I think will cause a lot of problems. It is important to fund things recurrently and to keep things going."

69. Sam Campbell of Argyll and Bute Health and Social Care Partnership highlighted the role of third sector organisations in addressing some of the risk factors associated with suicide, particularly in rural areas:

> "Support for third sector partners is absolutely vital. Those partners are not just supporting people to prevent suicide and to address poor mental health; they are reducing isolation and improving people's outcomes with regard to their physical fitness, too. Providing resource, sustained finance and support is vital to maintaining such services and enabling people to stay in post. In remote and rural island communities, third sector partners might have one or two members of staff in an organisation, and they could be providing sexual health services, drug and alcohol services, counselling services, walking groups, services and support for loneliness and a whole variety of things. If a small chunk of their money is withdrawn, the whole service can collapse, people will be out of work and a whole number of people are then not able to access that support and information. We have some very fragile third sector partners, and they are absolutely vital."

70. We also heard concerns about transparency regarding spending associated with the Strategy. In its written response to the Committee's call for views, SAMH stated the importance of ensuring that this information is publicly available:

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

71. The impact of funding and workforce challenges affecting the healthcare sector was also identified by witnesses as a potential difficulty affecting implementation of the Strategy. In particular, witnesses highlighted the importance of adequate funding for community link workers. Dr Amy Knighton of the Royal College of General Practitioners Scotland (RCGPS) said:

> "As a college, we support the deep-end group in the call for the Scottish Government to take steps to ensure the long-term funding of our community link workers, who help with so many of the factors that can increase suicides, such as housing, benefits, debt and the lack of investment in all services."

72. Dr Knighton also told Members that workforce and workload pressures may also be a risk factor for suicide among healthcare professionals, and stressed the importance of mental health support for the profession:

> "A recent STV article said that, in the United Kingdom, one nurse in the NHS dies by suicide every week, and one NHS doctor every three weeks. We in Scotland are fortunate that we have a wellbeing service that is particularly directed towards medics. The funding for that needs to continue. Two thirds of the registered users of that service were doctors, of whom half were GPs. Given that we are much smaller in number than our secondary care colleagues, a huge number of GPs are accessing that service."

73. In oral evidence, the Minister told us that the Government "are fully committed to doubling suicide prevention funding to £2.8 million by 2026" and are "on track" to achieve that. She said the 2024-25 figure is £2.6 million and this is "against a backdrop of increased investment in mental health and wellbeing as a whole as well as specific investments such as the distress brief intervention programme".

74. The Committee also heard that, to date, the Government has invested £24 million in distress brief intervention (DBI) which is a referral service by front line staff to support people in distress. The Minister explained that this was not intended to be suicide prevention work but, following evaluation, they discovered that for one in 10 people, access to the programme had reduced the risk of suicide. She told us "It is really impactful and about 62500 people in Scotland have accessed it".

75. Councillor Kelly highlighted that the local government settlement is "extremely difficult" and was having an impact on support services around welfare, homelessness and social work support which were all interventions local authorities provide. He told us they needed to continue to work with government as "funding and those resources are vital in supporting people in our communities who need our help. When we withdraw from service as a result of budget cuts it puts additional pressure on other areas of mental health support"

76. In relation to multiyear funding to increase sustainability for third sector organisations, the Minister recognised that this would be an improvement commenting that there "is no lack of understanding at Government level how difficult that is". She said "We have found ourselves in very difficult times in the past number of years, but we expect to get back on a sustainable footing".

77. Councillor Kelly told us that “despite this being one of the most difficult budgets” a lot of local authorities were committed to working with third sector organisations and “could not do the jobs in areas such as suicide prevention or mental health or wellbeing without them”.

78. The Committee welcomes the commitment from the Scottish Government to increase funding of £2.8 million for the strategy specifically. However, witnesses identified the precarious nature of third sector funding as a key factor affecting the strategy’s implementation. Several witnesses noted that the year-on-year nature of funding allocated to third sector organisations was incompatible with its longer-term vision. The Committee also heard about the importance of funding for healthcare services peripherally involved in suicide prevention and that without recurrent funding these services fall away. We recognise that successful implementation of the strategy will require a significant commitment of resource over a sustained period and urge the Scottish Government to commit to a more sustainable model to enable organisations to plan effectively.

79. We also heard concerns about transparency regarding spending associated with the strategy and support the call from SAMH that the tracking of national spend against the annual delivery plan should be made publicly available in order for it to evaluate effectiveness.

80. Additionally, the Committee supports the call from RCGP that the Scottish Government take steps to ensure the long-term funding of community link workers and asks the Scottish Government to ensure continued funding of the wellbeing service for healthcare professionals is provided.

81. The Committee commends the distress brief intervention work being undertaken by the Scottish Government and its partners. It is clear this innovative and immediate cross sectoral intervention mechanism is making a difference to those in greatest need. The Committee notes from Professor O’Connor that work is ongoing with a view to increasing accessibility and rolling out DBI in schools. We would like to see this mechanism available for anyone who needs it and would welcome an update from the Scottish Government on its progress, challenges and further implementation once available.

Monitoring and Evaluation

82. The Creating Hope Together Strategy states that regular monitoring, evaluation, and review will be undertaken to understand the impact of the Strategy. In addition to monitoring changes in suicide rates, the Creating Hope Together Outcomes Framework details how each of the Strategy’s intended outcomes will be measured.

83. The proposed methods include drawing from existing surveys such as the Scottish Household Survey, introducing new tailored surveys, and incorporating feedback from

local and national-level delivery partners. An annual report will be produced by the Suicide Prevention Delivery Collective in May of each year and will be considered by the National Suicide Prevention Advisory Group in June before being published online each July.

84. During the Committee's meeting on 23 April 2024, we heard that the organisation Matter of Focus has been commissioned to develop the detail of the Strategy's monitoring and evaluation approach.

Data

85. The Committee heard that a more cohesive approach to the collection of healthcare data including improved access to primary care data could help identify people at risk of suicide. It also heard evidence regarding gaps in data on suicide and attempted suicide. Neil Mathers of SAMH said:

> "We do not have access to the data that we need. We certainly encourage having a focus on understanding attempted suicides, because that would give us a better indication, alongside deaths by suicide, of what more we need to do to address suicidality. There is definitely much more that we need to do in gathering data and understanding that data. That does not include just data from academic research; we need also to use service insight and insight from people with lived and living experience to help us and to inform us about what needs to change."

86. Dr Murray Smith of the Royal College of Psychiatrists in Scotland added that data that could be used to identify people at risk of suicide is not always available in a format that would enable ease of identification:

> "We do not always get all the data on people who frequently attend. I could look at emergency department data and see how many people have been in in the past six months, but we do not have a systematic way of identifying them. If they turn up in hospital a lot, that is fine, but if they have gone to their GP or a third sector provider a lot, there is no way of identifying those people and trying to intervene before something happens."

87. A 2024 Public Health Scotland report presented data from the Scottish Suicide Information Database, and found that two-thirds of people who died by suicide between 2009 and 2022 had no contact with acute care settings in the month before death. The report noted that no national-level data about contact primary care is available in Scotland, but other research has observed that people who die by suicide are significantly more likely to make contact with primary care providers in the month before death, as opposed to acute care or mental health care.

88. In response, the Minister told us that “we have a general concern about the quality and availability of mental health data and are working hard to improve those aspects in our mental health and wellbeing strategy”.

89. Haylis Smith said “we are working to ensure that we have more timely data on deaths by suicide and local areas are now able to get that information quickly, within a few weeks or months of somebody dying by suicide. We are improving in that respect, and we are also looking at how we capture information about suicide attempts and self-harm and are working closely with colleagues involved in the self-harm strategy”. She explained that the Government were also looking at data collected by others such as Police Scotland, the ambulance service and third sector organisations to look at where improvements could be made.

90. Dr Alastair Cook advised that the Government is committed to producing a mental health dashboard which would “be significant in helping us with some of these areas”.

91. The Committee heard that the single best predictor of whether someone will die by suicide is whether they have attempted suicide previously. We heard strongly expressed views that a more cohesive approach to the collection of healthcare data, including improved access to primary care data, is necessary and could help identify people at risk. Additionally, data that could be used to identify at risk individuals is not always available in a format that enables ease of identification. We heard that individuals are most likely to make contact with their GPs rather than acute services, yet that data is not routinely available. The Committee notes and welcomes the work that the Scottish Government is undertaking with support and front-line organisations to improve this and urges it to work closely with primary care providers too to ensure this gap is addressed.