OFFICIAL REPORT
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DRAFT

Equalities, Human Rights and Civil Justice Committee

Tuesday 28 May 2024

Session 6

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EQUALITIES, HUMAN RIGHTS AND CIVIL JUSTICE COMMITTEE

13th Meeting 2024, Session 6

CONVENER

*Karen Adam (Banffshire and Buchan Coast) (SNP)

DEPUTY CONVENER

Maggie Chapman (North East Scotland) (Green)

COMMITTEE MEMBERS

Meghan Gallacher (Central Scotland) (Con)
*Marie McNair (Clydebank and Milngavie) (SNP)
*Paul O'Kane (West Scotland) (Lab)
Evelyn Tweed (Stirling) (SNP)
*Annie Wells (Glasgow) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Alastair Cook (Scottish Government)
Eddie Follan (Convention of Scottish Local Authorities)
Councillor Paul Kelly (Convention of Scottish Local Authorities)
Haylis Smith (Scottish Government and Convention of Scottish Local Authorities)
Maree Todd (Minister for Social Care, Mental Wellbeing and Sport)
Morag Williamson (Scottish Government)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equalities, Human Rights and Civil Justice Committee

Tuesday 28 May 2024

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Karen Adam): Good morning, and welcome to the 13th meeting of 2024, in session 6, of the Equalities, Human Rights and Civil Justice Committee. There are apologies from Maggie Chapman, Meghan Gallacher and Evelyn Tweed.

The first item on our agenda is to decide whether to consider in private the correspondence that the committee has recently received from Shelter Scotland. Do members agree?

Members *indicated agreement.*

Suicide Prevention

10:00

The Convener: Our next agenda item is an evidence session with the Scottish Government and the Convention of Scottish Local Authorities on suicide prevention in Scotland. I refer members to papers 2 and 3. I welcome to the meeting Maree Todd, Minister for Social Care, Mental Wellbeing and Sport, who is supported by Scottish Government officials Morag Williamson, the head of the suicide prevention and distress interventions unit, and Dr Alastair Cook, principal medical officer. Also joining us are: Haylis Smith, national delivery lead for suicide prevention on behalf of the Scottish Government and COSLA; Councillor Paul Kelly, spokesperson for health and social care; and Eddie Follan, chief officer in health and social care, both from COSLA. I welcome the witnesses to the meeting. The minister and councillor Paul Kelly will each have five minutes to make their opening remarks. We will then move on to questions from members.

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): I begin by welcoming the committee's inquiry. Tragically, suicide continues to impact all parts of society, so we all have a role to play in preventing suicide. That includes us individually as MSPs and collectively as a Parliament. Suicide is, indeed, everyone's business. I strongly believe that we must all talk more openly about suicide and deepen our understanding of its complexity. By doing that, we can tackle the stigma that surrounds suicide and help to find new ways to support people when they have thoughts of suicide.

I am very proud of the work that is happening right across Scotland to reduce suicide and I want to record my personal thanks to everyone who is already playing their part in helping to keep people safe and to support their recovery. I am impressed with the volume and range of evidence that the committee has already considered and I am pleased that our creating hope together suicide prevention strategy, has been described as "innovative" and "ambitious." The strategy was developed through Scotland-wide collaboration with communities and the many partners who are working to prevent suicide. Listening to people with lived experience of suicide was key, as was learning from the past 20 years of suicide prevention in Scotland and around the world. That helped us to understand how Scotland's approach could be more progressive.

First, the strategy recognises the importance of creating societal shifts, which we describe as outcomes, so that our environment protects

against suicide, we are all better equipped to respond to someone who may be suicidal, and that anyone who is or has been affected by suicide in any way gets the right support. Secondly, we must tackle the inequalities and life circumstances that increase suicide risk, which are often called "social determinants". Those include people living in poverty, experiencing homelessness, or living with addiction; people having care experience; having been in prison; and being LGBT, neurodivergent, or coming from some minority ethnic communities.

Much of Government's policy and investment are already addressing those factors by, for example, tackling child poverty through our progressive Scottish child payment; addressing unemployment through our multimillion-pound investment in employability services; supporting people who are affected by substance use through our national mission; and improving Scotland's mental health and wellbeing through the delivery of our mental health and wellbeing strategy, including through evidence-based approaches such as our world-leading distress brief intervention programme and action on self-harm. Although those policies are already helping to prevent suicide, we are going further by actively weaving suicide prevention into wider action across Government and society.

I will talk about our progress on delivering our strategy. Our first annual report will be published this summer, with an assessment from our national suicide prevention advisory group, whose members represent and advocate for many of the groups that are disproportionately affected by suicide.

I will touch on a few highlights. We have improved suicide awareness and the availability of peer support across our communities, used clinical evidence and our "Time Space Compassion" approach to suicidal crisis to drive improvements in statutory services and created new systems to capture data and evidence so that we can seize every opportunity to intervene and support someone who is suicidal. For example, we have introduced a suicide review and learning system.

The progress has been achieved thanks to our new collective delivery model, suicide prevention Scotland, which brings together partners and communities across Scotland to collaborate and learn about suicide prevention. It also includes our strategic outcomes lead partners, Samaritans Scotland, Scottish Action on Mental Health, Penumbra, Change Mental Health and Public Health Scotland, which are bringing their valuable leadership and expertise to bear to support delivery.

Looking ahead, our delivery plan for 2024-25 will be published shortly. That plan will continue the breadth and pace of work, including our drive to meet the needs of people who are at higher risk of suicide. It is backed by a significant commitment to double our investment in suicide prevention to £2.8 million by 2026, which is well on track. The wider financial context is extremely challenging, and I am sure that we will discuss how Government is continuing to prioritise mental health.

I thank our lived and living experience panels, whose unique insights continue to direct all our work. I restate the strategy's aim, which is for any child, young person or adult who has thoughts of taking their own life or is affected by suicide to get the help that they need and feel a sense of hope.

I put on record the correct annual cost of the suicide bereavement support service, which is £309,688 in 2024-25.

I look forward to our discussion and the outcome of the inquiry, which is welcome.

The Convener: Thank you, minister.

Councillor Kelly, I invite you to make your opening remarks.

Councillor Paul Kelly (Convention of Scottish Local Authorities): Good morning and thank you for the opportunity to give evidence to the committee.

As the voice of local government in Scotland, COSLA has taken a strong position on the importance of mental health and the wellbeing of our communities, as well as the need to tackle inequalities that contribute to suicide risk. We remain committed to working in partnership with the Scottish Government to realise the ambitions of our joint strategies: the mental health and wellbeing strategy, the self-harm strategy and creating hope together, our suicide prevention strategy.

I acknowledge the significant progress that has been achieved in Scotland on suicide prevention over the first year of delivering the creating hope together strategy, both in developing its infrastructure and in the level of activity that has been developed and delivered. The establishment of a new delivery model—suicide prevention Scotland, which brings together key partners, sectors and communities at a national and local level—will also contribute significantly to achieving our vision of reducing suicide in Scotland. Our approach to suicide prevention aims to strengthen partnerships across communities, build on the collaboration between local and national work, ensure that the strategy is outcome focused and that lived and living experience remains at the heart of the work.

I highlight the importance of the work that is taking place across local areas in Scotland, which

supports the delivery of the creating hope together strategy. Local delivery of suicide prevention initiatives in our communities is led by local suicide prevention leads, who are key to driving work across local areas that responds to local needs. The work at that level is supported by locally anchored suicide prevention implementation leads, who are hosted by Public Health Scotland. They play an important role in ensuring that local action plans respond to local need, building connections across regions and helping to shape good practice and learning.

More broadly, local authorities provide in communities a wide range of supports that contribute to suicide prevention, including through social work, education, welfare, homelessness and health supports or leisure services, to name a few. That support at a local level, across all preventive factors, is crucial. However, it is becoming more and more challenging for local areas to provide such support with limited resources, particularly as all local government services are under pressure and we continue to see the impact of the cost of living crisis.

While celebrating the progress that has been achieved to date, it is crucial that we also acknowledge the challenging financial landscape and the wider system pressures within which the suicide prevention work has to operate. That includes the impact of cuts to core local government budgets, which will affect service provision that might already be in place, leaving a bigger gap between the current position and the asks of the strategy. We must recognise the size of the challenge that is ahead of us in driving forward the ambition of the strategy within the context of a system that is extremely stretched.

Driving the work forward will require effective partnership working across all levels of society and sufficient capacity and resources to support our vision to reduce suicide deaths in Scotland, while tackling inequalities. The strategy's whole of Government and society approach reflects the shared responsibility to prevent suicide, which must span right across society, recognising that no single agency can deliver on the suicide prevention agenda and that a collective approach is needed across public, private and third sectors. That will help us to realise the ambition that suicide prevention is everyone's business.

Local government is committed to continuing to work in close partnership with the Scottish Government and our partners across all sectors in order to reduce suicide in Scotland and tackle the inequalities that contribute to suicide risk.

I look forward to discussing that in more detail in today's session.

The Convener: I will ask the first question. During our evidence sessions, it has been noted that death by suicide increased over the course of the every life matters strategy. When you were looking at the new creating hope together strategy, what work was done to understand the impact of the previous strategy and what gaps there might have been in it?

Maree Todd: I am happy to start, and I think that Morag Williamson will probably want to come in and contribute a little as well.

A number of things are significantly different. One is that tackling inequalities, which will be of particular interest to this committee, 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. We have built the tackling of inequalities in with the bricks of this strategy, and we hope that that work will deliver for those particular communities. Of course, often, people do not experience just one inequality, and that overlap has a particular impact.

Morag Williamson (Scottish Government): You are asking about the trends that we saw over the course of the every life matters strategy and what that meant for how we developed the creating hope together strategy.

Our every life matters strategy was developed with as much consultation and evidence as we had at the time, and it gave us four years of delivering suicide prevention activity in Scotland and seeing which of those activities were making a difference. We absolutely took a lot of learning out of the development, work and impact of the every life matters strategy.

When we came to develop the creating hope together strategy, which is our current strategy, we did an extensive consultation in different formats. Haylis Smith and I were part of much of that engagement with communities and partners across Scotland. We listened to their experience of suicide and what measures they felt would make the biggest difference.

As you would expect, we also looked at all the data that we had in Scotland and we worked with our academics. You have heard evidence from Professor Rory O'Connor, who was closely involved in helping us to understand the data around suicide trends and suicide prevention activities that make a difference. We commissioned a review to look at international examples of suicide prevention strategies across the globe, and he was really helpful in helping us to understand that area.

The other important bit of that is that our national suicide prevention leadership group,

which oversaw the delivery of the every life matters strategy, was critical to helping us understand what was important to put in place for the new strategy, as were the lived experience panel and the youth advisory group that we had in place.

That is quite a lot of background as a way of saying that we took a lot of learning from that. The things that we really shifted in the new strategy were: the focus on putting equalities first—I hope that you can see that; the focus on outcomes rather than just actions; and looking differently at how we delivered the strategy.

10:15

The Convener: The focus on inequalities could be quite challenging in the circumstances that we are in. What challenges do you foresee being the hardest to overcome?

Maree Todd: It is clear that poverty increases suicide risk—the link between the two is clear—and it is very challenging to tackle poverty in this environment. We have had 14 years of austerity. That political choice, which was made in Westminster, has had a profound impact on our public services and on our welfare system. Then we had the pandemic, which has stretched the health and social care system. We have also had Brexit, which has had a profound impact on our economy and on our societies. As we have come out of the pandemic, we have faced a cost of living crisis. There are real challenges in tackling poverty.

However, despite that, we in Scotland are taking measures that are making a difference. We are all very proud of the Scottish child payment, which prioritises money going into families with young children, recognising the profound impact that poverty has at an early age. That has lifted 100,000 children out of poverty. Obviously, that is a very long-term investment, and it is not a specific suicide prevention measure, but tackling poverty is a suicide prevention measure—make no mistake about it.

I have spoken openly before, particularly when I was the Minister for Public Health, Women's Health and Sport, about the challenge of the interventions that we make here in Scotland, as it feels like we give with one hand and it is taken away with another. We have one hand tied behind our back, because the focus and approach is so different from our Westminster Government. That makes tackling poverty very challenging.

The Convener: I put the same question to Councillor Kelly. What has been learned from the previous strategy, and what challenges might arise in tackling inequalities?

Councillor Kelly: The create hope together strategy has, as Morag Williamson covered, taken many important and successful elements of the previous strategy and embedded them. The focus is on inequalities, on making sure that people with lived experience are very much at the table, and on ensuring that the voices of different groups that we are reaching out to are heard. This is not just a strategy for 10 years that began last year and its development has ended; rather, it will continually develop throughout that period. That will be critical to addressing some of the issues that will probably come up, including in your evidence sessions, and ensuring that they are also part of the strategy.

In terms of the inequalities that we face in society, I think that we, as elected members, all know that these are some of the toughest times for our communities. The minister has outlined some of the challenges that they face—it is a unique set of circumstances—and, inevitably, that has a significant impact on people's mental health.

Local government and local authorities play a key role. Some of our services, which I outlined in my opening remarks, provide support for people. That provision is becoming difficult given our very challenging budgetary positions in recent years. That has an impact on some key services, such as leisure facilities, which a lot of people in our communities benefit hugely from in respect of their mental health and wellbeing. Those services are under threat, given the budget decisions that are forced on us.

We need to factor in—the strategy certainly does—that local government is very much committed to working with all partners across society to looking at inequalities and the impact that that has on suicide. I saw a statistic that people living in deprived areas are 2.6 times more likely to commit suicide. That is a tragedy in any area. The strategy commits to looking at the issues around that, working with lived experience and doing everything that we can to support people.

Marie McNair (Clydebank and Milngavie) (SNP): Some of my questions have been touched on, so I will just move on. Over the past few weeks, we have spoken with witnesses who have raised the issue of suicides being higher in rural areas due to limited access to services and people not wanting to access services in such small locations. Minister, what actions have you taken to support people at risk of suicide in those areas?

Maree Todd: As you might imagine, as I represent Caithness, Sutherland and Ross, that issue is very close to my heart. Work is being done in collaboration with Samaritans Scotland. I recently visited its project at its base in Fort William. The project is assessing the risk of suicide and is doing suicide prevention work

among lone rural workers, recognising that they are a particular risk. People can be very isolated working in the Highlands and, often, because of the work that they do, they have access and means. It is an important piece of work.

As you might expect, I was hugely impressed by the work that Samaritans Scotland is doing. It is a national organisation with a real level of respect among the community and the nation, but here it was, in a local community, working very carefully and sensitively with some of the groups that were already operating in the area.

A couple of local charities are very prominent in the area. They have sprung up—I am sure that it is the same in every part of the country—because of tragic events and in memory of people who have been lost by suicide. I was impressed by the sensitive way in which this national organisation had come into the local community and was working very carefully, thoughtfully and impactfully along with the rest of the community. I think that that work reports fully next year. I am keen to see the outcome of that, and it will be of interest to every other rural area in Scotland.

We have specific work going on in rural Scotland. As I said, during my recent visit, I was very impressed by the way in which Samaritans Scotland is conducting that project. I am keen to get on the record that the project recognises the importance of employers and work-based interventions. We look to learn from suicide and there is evidence that it is often the case that people have sought help from primary care or they have sought non-specialist medical help. Sometimes, people have sought specialist help. However, employers are a very common theme across the board, and ensuring that employers are equipped to have sensitive conversations, recognising the role that they play in the community and the role that a supportive employment environment can have in preventing suicide, is a new thing. We are pleased to be working alongside a group of employers in the delivery of our mental health and wellbeing strategy but in the suicide prevention work in particular.

Marie McNair: Councillor Kelly, is there anything that you or your colleagues from COSLA want to add?

Councillor Kelly: It is vital that we address the socialisation and rural aspects as part of the strategy. The same goes for the many issues that relate to specific groups and the consideration of suicide—we must look into the specifics of that, too.

I mentioned that we have local suicide leads. I think that 23 councils have action plans, and others are working on theirs. It is important that those are tailored to local areas, whether they are rural or urban, and to the support that is required. Those are supported by the suicide prevention implementation teams at Public Health Scotland. That really important work is on-going in local communities, supported by local councils. It is about making sure that that work takes place across society and that it takes into consideration the difficulties that there can be in accessing services in rural areas, as well as the difficulties with recruitment.

Eddie Follan (Convention of Scottish Local Authorities): I echo that. In response to the convener’s first question, one of the differences is that the every life matters strategy is a joint strategy: it is about national bodies working with local bodies, which is important. COSLA works closely with chief officers, who have a key role to play in that a lot of the strategy is channelled through them. We are constantly aware of the pressures in rural areas, because our rural members are usually our most vocal. We want to make sure that we are reflecting local needs, because we all know that there will be differences in the Highlands and Glasgow, for example, but there will also be similarities. Haylis Smith is quite passionate about that and has done a lot of work on it.

Haylis Smith (Scottish Government and Convention of Scottish Local Authorities): We meet local leads regularly on a monthly basis. They are able to help us to shape what we are doing nationally and are embedded in that work, regardless of whether they are in rural, island or urban communities. The work that we are doing with the Scottish Community Development Centre to support some community-led action research will play a big role in the coming years. That research will take place in communities and will be led by them to help us to better understand their needs. It will help to shape the work for the future.

Marie McNair: We also heard—apologies, go ahead, Morag.

Morag Williamson: We all want to have a go at this one.

We were very thoughtful about the rural dimension when we were developing the strategy. One of our guiding principles is ensuring that all our work is relevant for urban, rural and remote and island communities. As Haylis Smith is looking at the delivery plan for each year, we are working through the guiding principles and thinking about the rural dimension. Working with the rural mental health forum and all its members is also helping us enormously. Its members are bringing perspectives and opportunities to the table, which I am sure that we could tell you more about. It is a fantastic organisation that is helping us to

understand the particular dimensions of mental health challenges rurally.

Finally, when we look at trialling new approaches, we often think about how we can ensure that we know that they will work in rural areas as well as they do in urban areas. Our suicide bereavement service pilots have focused on Highland, Ayrshire and Arran for a couple of reasons, one of which is because our approaches need to work in rural areas.

Marie McNair: We have heard about the increased risk to people who are in prison and about the issues with getting adequate support when they move on from prison. Could you give a bit of detail on that from COSLA's point of view?

Councillor Kelly: That is part of the work that is done when someone leaves prison. Support for them can be available through local authorities, which should be reflected in a lot of the local action plans that are coming together. As Haylis Smith 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. That is an important strand to the work.

Haylis Smith: Public Health Scotland is leading work to look at action plans for high-risk settings, such as prisons. I am working alongside colleagues in the Scottish Prison Service to look at a refresh of its talk to me strategy and what that needs to look like, thinking beyond what happens in prisons and how we support people after they are released. We need to ensure that connections are made between the prison setting and the local communities that people will go back to, and that that feeds back into criminal justice structures. The work should focus not only on the prisons but on what happens beyond those settings.

Marie McNair: Do you know of any charities that work specifically with people who are leaving prison? Sorry to put you on the spot. If you do not have the information, I think that the committee would be quite interested to find that out.

10:30

Haylis Smith: I do not have the information to hand. We recently visited HM Prison Edinburgh and spoke a lot with the Barnardo's service there that supports families of prisoners and follows up with them on release. We heard from the service about some of the challenges for families and for prisoners on release. I am certainly happy to follow up on that question.

Marie McNair: That would be really helpful. Thank you.

Maree Todd: We can certainly look at the work that we do alongside charities that work with prisoners. From previous roles in the Government, I know about the work that families do to support those connections and to maintain relationships between prisoners and their families on the outside. Although that work is not particularly focused on suicide prevention, it clearly has a role to play in that regard.

Marie McNair: Holistic support is really important as well.

Paul O'Kane (West Scotland) (Lab): Good morning to the witnesses. I will focus on the potential impacts of the strategy for groups that are disproportionately impacted by suicide. In the evidence that we heard, people said that, although the strategy's focus on the contribution of inequalities to suicide is very welcome, there is concern that taking a one-size-fits-all approach will mean that certain groups do not always receive the particular support that they need.

We have looked at LGBT+ people and at men in particular and at the issues that affect them. Will the witnesses comment more broadly on what is being done across the spheres of Government and across communities to support those groups and to have a laser-like focus on the issues that impact them?

Maree Todd: I am happy to start, but I am pretty sure that nearly everyone will want to contribute.

We agree that it is not appropriate to take a one-size-fits-all approach and that we need to really understand the particular circumstances that are enhancing the risk in those communities in order to find the solutions in relation to prevention.

There is some good work going on across the piece in preventing male suicide. We recently confirmed additional funding of £100,000 for the changing room—extra time programme, which is run by SAMH and is done via football. The Cabinet Secretary for Health and Social Care visited during mental health awareness week. The awareness week theme this year was mental health and physical activity, so it was a perfect match. The cabinet secretary was blown away by the work that the programme is doing and how it is reaching out to men who are at risk of suicide by using the power of football—which, as you can imagine, is something that I am very passionate about—to give them time and space to come together in a way that they normally would not, and to talk openly about challenges.

We work with other organisations that specifically reach men, such as Andy's Man Club and Men Matter Scotland, and we are very grateful for the work that they do to support us in understanding why men are more at risk of suicide and to reach a particular group that is perhaps stereotypically a little less inclined to ask for help and support.

On the LGBT prevention work, it is difficult because, as the committee will have heard from academics earlier on in the course of its evidence taking, the body of evidence, although improving, is perhaps a little scanty in relation to some of those specific characteristics. In that situation, all that we can do is work very closely with trusted organisations that we know work in that area effectively and are alongside those populations and try to find bespoke answers that work for them and support them in their work.

Haylis Smith: There are a number of areas that we are looking at. The minister mentioned the changing rooms programme and its focus on football. Just recently, there has been a new element of the campaign by FC United, which targets men through football.

We are doing work on how those campaigns target specific groups, recognising that tackling inequalities is part of our vision and one of our guiding principles. Those campaigns are one way of identifying work and targeting work at specific groups. We held an event at the end of November last year, which we called building connections, which is us recognising that we have not always got this right, but we want to do better. We brought together a wide range of trusted organisations that work with people with protected characteristics or with people who face stigma, discrimination and inequalities, to hear from them about how we can better work with them to help support those communities. We are working now to deliver new sessions over the course of this year, and we have some planned to focus on work around specific groups. The work that I described earlier with the SCDC, on community-led action research, will target two groups of populations of interest this year. We are beginning to build our understanding of what work needs to be done to support those groups.

Another area, which Morag Williamson touched on, is building our understanding of what the contributing factors to suicide are. We are building in work to review deaths by suicide. We are bringing in a new system that will help to collect that information, which will help local areas to identify gaps in provision and support for people. That will also help us at a national level to shape the work that we do in the coming years and help us to understand better what we need to do.

Councillor Kelly: A lot has been covered. We also have to reflect on the evidence that has come through in your committee. Attempts have been made through the strategy to work with many groups through the lived experience panels and our youth work. However, as we have touched on, we need to tailor the strategy and the actions towards the groups that have specific issues that we want to support. A lot of that work happens in local areas. A lot of third sector and other organisations provide specific support, so we need to make sure that we match that up to what is happening nationally.

Haylis Smith's final point about getting the correct data for local areas so that we know what is going on is important. We have talked about collecting data on attempted suicides through Public Health Scotland, which is very important, because we know that a number of people do not complete suicide but attempt suicide. We are not aware of that information, but we want to provide as much support as we can to those individuals. Critically, we also want to break down the stigma, as we have said, to make sure that all groups and individuals know that there is support available to them.

Morag Williamson: I will add one thing. We have been focusing specifically on the suicide prevention work around men, but it might be helpful to look a little wider. One of our key investments in mental health and wellbeing looks at the groups that could be more likely to experience poor mental health and wellbeing, and that is the communities mental health and wellbeing funds. There is one for adults and one for children. We have not focused on men as one of the priority groups, but we are looking at how we can better reach men. We have a particular focus in that fund on suicide prevention.

We have tried to look at the opportunities for those wider programmes to support the work that we are doing. We are pleased that 300 projects in 2022-23 across Scotland that had a particular focus on suicide prevention were supported. We are trying to look beyond what is in our own suicide prevention strategy and look for those wider opportunities.

Paul O'Kane: On the point about good-quality data, measuring impact has been of interest to the committee throughout our evidence sessions. Measuring the overall impact of the strategy will be important, but in relation to this line of questioning, how will we understand the impact on the groups that we want to focus on? I understand that there are a range of factors and a range of outcomes. Does Haylis want to start with the data set, and then we can think about other issues?

Haylis Smith: I guess that the key way to measure impact will be to look at the outcomes, and to consider how we are working within the outcomes framework that we published last year, alongside our delivery plan. We have done a lot of work over the past year to work out how best to do that. It is not just a case of counting numbers; it is about being able to demonstrate the impact that we are having against the long-term outcomes and the nine short-term outcomes in the outcomes framework.

We have been working with an organisation called Matter of Focus, which has experts in collecting qualitative data and in support, so that we are not just counting numbers but really assessing the contribution that our work is making to reducing suicide and supporting people affected by suicide. We are getting towards the end point of creating our outcomes pathways, which have laid out a theory of action: if we are doing X, this is how we expect it to contribute.

We will be working with the organisations that we mentioned earlier and with people with lived and living experience to collect information as we go along. We have a range of delivery partners who are supporting the work and delivering specific actions. Part of their work will be to collect that information as we go, so that we have it all in one place and are able to demonstrate the impact that we are having over the term of the strategy. It is important to realise that it is a 10-year strategy, and it is important for us to consider the impact over that length of time.

Maree Todd: We have a national suicide prevention advisory group, which provides an independent assessment of progress to Government and COSLA every year, and it highlights any adjustment or redirection of our priorities that may be needed. 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 who are working in key sectors affected by suicide, such as the criminal justice sector. We have a broad group, and my impression is that they are constructive critics who are not afraid to hold power to account. That will be useful, particularly given the financial constraints that we are all aware of, in ensuring that our focus remains exactly where it needs to be.

Councillor Kelly: The advisory group is key for local government, national Government and all those involved. It is very important to have its evaluation and monitoring of the strategy. We need the evidence on its impact, which has been really clear, and I think that local and national Government are committed to that. In the first year of the strategy, a detailed infrastructure has been put in place around the plan, and that is still developing, as you will know from your evidence sessions. It is a key aspect of the plan to ensure that we are delivering reductions in suicides, and that needs to be monitored on a regular basis.

Paul O'Kane: On the broader approach, although the strategy is important and sits in certain portfolios within the Scottish Government and local authorities, it is clear that we will need societal approaches. To what extent has it been challenging to develop a cross-Government, cross-authority approach? We appreciate that a number of different challenges are faced by all spheres of government. Is there a sense that the strategy is and will be cross-cutting across various sectors?

Maree Todd: I think so. Mental health and wellbeing is a key focus for the Government, and it is a high priority for every ministerial portfolio in our work with local government. I do not think that you will find a minister and spokesperson who work more closely together than me and Paul Kelly, as we do in very many areas, which reflects the priority that both spheres of government give to this work. We work together on suicide prevention, and we have launched a joint strategy on it. We have worked together on the mental health and wellbeing strategy, and on the delivery plan and workforce planning for it.

We have also developed together 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. We listened carefully to our lived experience community about what, specifically, was required in order to meet their needs and reduce their risk. The will is there, and effort is being put in. There are always challenges—every sphere of government has financial challenges at the moment—but there is no doubt that this is a high priority for all of us; we can see that in the numbers.

10:45

Paul Kelly: Given that the issue is so important, we must all commit to breaking down any barriers that exist between national and local government. We all know the scale of the issues around suicide and mental health, so the strategies are critical. From a COSLA and local government point of view, we believe that we play a key role at a local level and that local plans should reflect and acknowledge that different areas have different requirements and needs. That is critical, too.

There is no doubt that there are challenges between local and national government, but it is vitally important for all of us that we get the strategies right to support as many people as possible. It is critical that we take a whole-government and whole-society approach. As I said in my opening remarks, it is everyone's business. We need to get that message out. It does not matter whether it is local or national government or third sector businesses; everybody should take an active role in suicide prevention and on mental health and well-being.

Morag Williamson: I point you to annex A in our action plan, which sets out a package of policies and opportunities that we saw across

government and across local authorities when we were developing the strategy. I agree with the minister that, when we approached our counterparts in different government portfolios to ask them where they saw the opportunities, there was a real willingness to step in and see where there was an opportunity. We need to seize those opportunities and do even more. We will continue to look at the package and see what more we can do.

We have already achieved in some specific areas. For example, we have integrated suicide prevention into cross-policy action in the national planning framework, and we now require all proposals to consider suicide safety. Social Security Scotland has a process that allows it to be alert to suicide risk and to have an escalation policy. We have examples of achievements, and that work is on-going, but, as the minister said, the commitment is strong.

Annie Wells (Glasgow) (Con): Good morning, panel. The minister and Councillor Kelly spoke about how those with lived and living experience were involved in the strategy. Could you expand a little bit on how people from groups that are at a higher risk of suicide were involved in the development of the strategy please, minister?

Maree Todd: Members know that listening to the voices of those with lived experience is important to the Government. We 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. We find that it is a helpful way of working and of ensuring that we close the implementation gap—the gap between the ambition and what is happening on the ground. If the voice of lived experience is very strong during the development of a policy, that helps us to get it right and to deliver the policy well.

We have a couple of lived experience panels; Morag Williamson will probably enjoy telling you a little bit more about that. We wondered whether it might still be possible for the panel to contribute to the committee's inquiry, because it has been so helpful to us in our development.

Morag Williamson: Absolutely. We have two lived experience panels. One is called the lived and living experience panel, which is hosted and supported—safeguarding is really important to us—by SAMH. We make sure that the panel has an opportunity to help us to set priorities and to understand how best to deliver on those priorities. All of the panel members come with different experiences. There are people who have been affected by suicide, people who been bereaved by suicide and people who have been carers for someone who has been suicidal.

We also have a youth advisory group, which is hosted and supported by Children in Scotland and the University of Stirling. Again, it has had a really big input into the development of the strategy and at every point where we are developing new work.

In addition, as we developed the strategy, we engaged a number of times—it might have been two or three times; I cannot quite remember—with a forum that we have set up inside Government to help us to understand the experiences of different groups, particularly marginalised groups and groups who face inequalities. That forum, which is called the mental health equalities and human rights forum, represents a range of groups, including the LGBT community, and it was really insightful. The input from that forum, as well as the engagement with individuals and those with lived experience, was really helpful.

Annie Wells: During the strategy's development, some people felt that some stakeholders were excluded from the suicide prevention workstream. How would you respond to that criticism? Was there an element of people feeling excluded from the strategy?

Maree Todd: That can certainly happen in strategy development. When that has happened, we have tried to reach out to those stakeholder groups to ensure that we have a strong relationship as we go forward. I can think of a couple of stakeholder groups with which we have a stronger and closer relationship now, having worked together, than we had in the early days.

As you have heard from each and every one of us, we think that suicide is everyone's business. We want absolutely everyone, particularly marginalised communities, to be part of the solution and to feel involved. We do not want them to feel left on the outside, and we do not want to impose on them a one-size-fits-all solution. We are keen to work with anyone.

I am not sure whether the committee has had closed evidence sessions. Obviously, we are keenly observing your inquiry, but I do not think that we have seen that evidence. If, during your session with people with lived experience, particular issues came up that we need to be aware of, we are keen to hear about them. We want to work with people, and we think that the work that the committee is doing is really helpful. We are keen for the Parliament to scrutinise the work that we are doing, and we are keen to improve and to do the best job that we can, so we will take any pointers that you have for us.

Annie Wells: Councillor Kelly, you mentioned the need for those with lived and living experience to be involved in the strategy's implementation at a local level. Can you tell us a wee bit more about how you see that working?

Councillor Kelly: Absolutely. Obviously, local authority suicide prevention leads and co-ordinators, as well as the action plans, will be critical in reaching out to those with lived experience and other stakeholders and groups. I echo what the minister said about reflecting on the comments that have been made and taking feedback. It is really helpful that the committee has taken evidence from stakeholders who might feel that they have not been part of the process, because at the heart of the strategy is the need to ensure that those with lived experience are involved throughout the process of implementation and action.

That is certainly the case locally. As you know, different areas will have different networks and supports and will have different actions taking place that represent different groups. We must ensure that local authority leads feed back to Public Health Scotland suicide prevention implementation officers to ensure that what is going on at a local level is reflected nationally.

It is a 10-year strategy, and it is critical that, at every step of the way, we bring with us those with lived experience and marginalised groups, and that, if anybody feels that they are not part of the process at this stage, we reflect on that as we go forward.

Haylis Smith: It is important to build on a couple of things. You talked about lived experience at a local level. With the Scottish Recovery Network and SAMH, and with the support of the lived experience panel, we have produced national guidance for local areas to help people to understand how to support participation of, and engagement with, people with lived and living experience.

I guess that anything that we learn now will help us in the development of our action plan. Although we have a 10-year strategy, the first action plan covers only three years, and we are already beginning to collect the information and evidence that will help us to shape our next one. As a result, anything that we learn not only from the work that we do but from what the committee does is important, because it will help us to shape our plans. After all, the action plan is not something that is static for 10 years.

Annie Wells: Thank you very much.

The Convener: All our witnesses have raised the issue of adequate funding. How can the Scottish Government and COSLA ensure that there is adequate funding for healthcare—and the suicide prevention strategy in particular—and that that is a priority? Perhaps you could respond first, minister.

Maree Todd: You have heard us all mention the challenging financial backdrop. Against that, however, we are fully committed to doubling suicide prevention funding to £2.8 million by 2026, and we are well on track to achieve that. The allocation for 2024-25 is £2.6 million, which is very close to the target figure.

That is against a backdrop of increased investment in mental health and wellbeing as a whole, as well as specific investments—I have not mentioned the distress brief intervention programme. It is important that we see the investment in suicide prevention as part of the whole landscape of mental health investment and suicide prevention itself as part of the core work of mental health. All our investments in mental health in general and in specific programmes such as distress brief intervention have an impact on suicide prevention.

To date, we have invested £24 million in distress brief intervention. I do not know whether you have heard much evidence about it, but it provides timely, compassionate support for people in distress. It is not intended to be suicide prevention work, but when we evaluated it, we found that, for one in 10 people, access to the programme had reduced the risk of suicide. It is really impactful and about 62,500 people in Scotland have accessed it.

You have to be referred to distress brief intervention by front-line staff—those working in ambulances, NHS 24, the police and so on—and when I recently met the staff who can make such referrals, I heard them talk very powerfully about the programme's impact on the ground. It reduced their own distress in dealing with difficult situations, because they had a powerful, impactful and effective tool that they could utilise in really distressing situations and when faced with people in distress. The programme has been rolled out almost all over the country and within the next few months it will have been rolled out everywhere.

The programme came up in a parliamentary debate last week, when we were talking about the police's role in responding to people in distress. Distress brief intervention can be deployed by telephone operators when people phone the police, and it can save police time. It is a really impactful programme; again, it is not part of our specific suicide prevention work, but I am very confident that it is having an impact. It is important that we look at the suicide prevention budget within the work that is going on as a whole.

Councillor Kelly: Again, COSLA and local government are very supportive of the initiatives that the minister has outlined. They might not necessarily be part of the strategy itself, but they are still very important with regard to mental health.

However, as I outlined at the start, the local government settlement is extremely difficult. A lot of local government services provide support that might not necessarily be seen as suicide prevention but are nevertheless impactful—I am thinking of our welfare support, our homelessness and social work services and other interventions that local authorities make—and the issue for local authorities is that, if their budgets get reduced, there could be an impact on those services and thus on the strategy itself.

We need to keep discussing the matter with the Government, because that funding and those resources are vital in supporting people in our communities who need our help. When we withdraw from services as a result of budget cuts, it puts additional pressure on other areas of mental health support that are already under significant wider system pressure. We have to acknowledge all that in the strategy as we go forward. Other partners, such as Police Scotland, have also spoken about the impact of mental ill health on the job that they do and their direction of travel. We need to do everything that we can, working with the Government, to address those funding issues and consider what supports we can give to our communities and people who need our help. COSLA is certainly committed to that.

11:00

Marie McNair: My question is on a similar theme, which has been with us for the past few weeks: concerns about the funding that is available to the wider services that are involved in suicide prevention, wider mental health work and physical health services.

Some amazing work is happening with small pockets of money at the heart of communities. We all know of community-based groups in our areas that are making a real difference, providing a lifeline to many people and helping to empower and encourage individuals to develop the skills that they need to manage their own mental and physical health. It is not even possible to put a figure on the difference that those groups have made.

Will you commit additional funding? Those groups are asking for their funding to be sustained. They are asking for a small pocket of money and to be left to get on with their work.

Do you realise the importance of those services and how they can support the strategy's implementation? We are talking about really small pockets of money. I know that we are all skint, but we are working together.

Maree Todd: You have given me the opportunity to talk about the mental health and wellbeing communities fund, which is, as you say, a small sum of money. It has been £15 million per year since 2021 and, in the first two years of the fund, nearly 3,500 grants were dispersed, so we are talking about very small sums of money sprinkled like stardust across the country and doing really impactful, magical work.

The beauty of that fund is that it works closely with communities. It goes through a third sector interface, which means that it goes through people who really know what is happening in the community. I take pleasure in the fact that, everywhere I go, I can see the impact of that money in literally every community in Scotland.

I will fight for that money to continue, as you might expect, but I am pushing against an open door because we recognise the impact that it has and it meets a number of our targets. It is not solely about suicide prevention; it is about strengthening communities and, by doing that, we can achieve a huge number of our aims as local and central Government.

Councillor Kelly: You made a good point, Ms McNair, about the phenomenal organisations across the country in different forms and areas, what they can do with small pockets of money and the impact that they can have on communities. There are many organisations that do that, but a critical point is that local government often funds a lot of them so, when our budgets are exceptionally difficult, it proves challenging.

Most local authorities are still committed to funding those organisations, but we need to look at the strategy because they are vital on account of the work that they do and are often connected to groups and individuals in our communities that local authorities and Government might not be connected to. There is absolutely a commitment to giving that support and it will continually be raised between local and national Government.

Paul O'Kane: I will build on that theme of the sustainability of funding.

In the previous exchange that I had with you in the meeting, minister, I think that you mentioned men's sheds—or, certainly, men's groups—as being vital. We heard from the Scottish Men's Sheds Association about the challenges with the sustainability of funding. In the intervening period, the Government had to rethink its withdrawal of funding to the association, but we heard from it that it does not have sufficient money to plan because, sometimes, it has no more than six months to a year's funding.

I kept asking the third sector organisations who gave us evidence what the challenge is in that situation. We heard that the challenge is about being able not only to test what works and to test change, but to give security to people who feel that those organisations are literally a lifeline.

Does the minister want to reflect on whether the Government—as it has promised for a long time—will move towards more sustainable and longer-term funding?

Maree Todd: At Government level, there is certainly a recognition that our third sector organisations need to be valued and supported, and that multiyear funding would be a way of improving their sustainability. They spend a great deal of energy living hand to mouth and lose a lot of talent because of the way that they are funded. There was a commitment within Government to move towards more sustainable and longer-term funding, but then the pandemic hit, and there has been a challenge in getting back on course for that.

There is no lack of understanding at Government level of how difficult that is for our third sector organisations, and there is no lack of appreciation for the incredible and impactful work that they do. However, getting from the emergency footing that we have been on in the past few years to that more sustainable—

Paul O'Kane: I take that point but, as recently as the gathering last year, the former First Minister was making the commitment to three-year funding, and we are some time beyond Covid. Is the Government still committed to that? Do you have influence on funding within the health budget that you are looking to move forward in that regard?

Maree Todd: I will ask Morag Williamson to come in on that, but that is a conversation that is still going on across Government. We have found ourselves in very difficult times in the past number of years, but we expect to get back on a sustainable footing at some point.

The other thing that we do is provide support. In the discussion around men's sheds, you heard a commitment from the Government to helping them to get on to a more sustainable footing than they are currently, so that they are more resilient in future years than they have been up until now.

Morag Williamson: I will focus on the delivery model that we have for the current three-year action plan. It was clear to us that the best way of delivering the action plan was to work with organisations that have expertise and are working in the field of suicide prevention. We are absolutely delighted that, for each of the four outcomes, we have a strategic outcome lead partner. For three of those outcomes, the lead partners are third sector organisations: we work with Samaritans Scotland on outcome 1; we work with SAMH on outcome 2; and we work with Penumbra Mental Health and Change Mental Health on outcome 3. They are leading the delivery of those outcomes, along with Haylis Smith.

Those organisations have been appointed to that role for the three years of the action plan, recognising very much that we want to work in partnership. We need to be able to work on more than a one-year cycle and to have longevity. That is very much embedded in the partnership model that we have put in place for the action plan.

Paul O'Kane: I will ask a similar question about local government. We understand the pressures that are on local government to deliver more sustainable funding within local communities, and third sector groups that are funded by local authorities are feeling that challenge. Does Councillor Kelly want to reflect on the challenges that local government is facing?

Councillor Kelly: COSLA has been very clear that, in the budget process, we want a fair settlement to local government. We want multiyear budgets, because we want to give funding security to third sector and other organisations in local authority areas, but we struggle to do that when we are dealing with significant budget reductions every year.

Despite this being probably one of the most difficult budgets that we have faced, a lot of local authorities are still committed to working with third sector organisations as best we can to support them, particularly because a number of them tie not only into the work of the creating hope together strategy, as I outlined earlier, but into the mental health and wellbeing strategy. They are critical partners to local authorities. We could not do the jobs that we do in areas such as suicide prevention or mental health and wellbeing without them. In the dialogue that COSLA has—as you can imagine, on a regular basis—with Government, we make it clear that it is absolutely critical that we are able to give not just funding but funding security to those third sector organisations.

Annie Wells: Minister, you mentioned earlier that the annual progress report is due in the summer. Is the suicide prevention delivery collective set to deliver that and will it include spending details?

Maree Todd: I have not heard of any delay—I think that we are on schedule.

Annie Wells: So, we are okay for July.

Maree Todd: We should be good—I mean, summer is quite a loose term, isn't it? In the civil service, every season is quite long. I am not sure whether an outturn is part of that, though.

Morag Williamson: We have provided information to the Parliament on the 2023-24 spend through parliamentary questions, but we can certainly include it in the annual report, too. In future years, our delivery plan will also contain an

outline of how that budget is being spent to ensure that the information is proactively shared. We are content to do that work.

Annie Wells: Thank you.

The Convener: Members have 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. What actions are being taken to improve healthcare data to better identify those individuals?

Haylis Smith: I am happy to respond, and I am sure that others will chip in.

Public Health Scotland is the lead for outcome 4 in the strategy, which is about looking at the data and evidence. For some time now, we have been working to ensure that we have more timely data on deaths by suicide, and local areas are now able to get that information really quite quickly—indeed, 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.

We are looking not just at health settings, though; it is important to look at where else we can capture evidence that will support our work, so we are looking at data collected, for example, by Police Scotland through its negotiations and in its vulnerable persons databases, by the Ambulance Service and by third-sector organisations to get a sense of the information that is out there before we look at how we can improve things. After all, we do not want to duplicate effort.

That is where we are at the moment. We are mapping the data sources that we are aware of and looking at where the gaps are.

The Convener: That was helpful.

Maree Todd: I know that Dr Cook wants to come in, but I should say that, with regard to the picture with data and its collection, we have a general concern about the quality and availability of mental health data and we are working hard to improve those aspects in our mental health and wellbeing strategy.

Often, when a suicide occurs, there is an extra level of investigation. A lot of learning comes from that. A common theme that emerges is the transfer of information across interfaces. We absolutely recognise that that is an important piece of work that needs to be embedded generally, with key information or data being made available across the interfaces as people work their way through the system.

Dr Alastair Cook (Scottish Government): The issue of healthcare data and its quality has come up in a number of areas. Public Health Scotland is working particularly on primary care data, although not with a specific focus on suicide prevention. That said, there will be opportunities to pick up on that issue through outcome 4.

Just before Christmas, we discussed the issue with the Public Audit Committee and it has produced a report on data in the mental health field. We are committed to producing a mental health dashboard in, I think, November, and that will be significant in helping us with some of these areas.

The Convener: That was helpful. As there are no other questions from members, I bring our evidence-taking session to a close and I thank the panel for their attendance this morning.

I now move the meeting into private to discuss the final items on our agenda.

11:14

Meeting continued in private until 11:31.

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