Samaritans Scotland, NHS Health Scotland, the Health and Social Care Alliance Scotland (the ALLIANCE) and the Health and Social Care Academy

Response: Engagement Paper on Themes and draft Actions for possible inclusion in the Scottish Government's new Suicide Prevention Action Plan

30 April 2018

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

Participants felt that clear steps needed to be put in place to make sure that the engagement of people with lived experience in the Knowledge Into Action (KIA) group was meaningful, amid a concern that it could be tokenistic. These included:

- Arranging the meetings at times (including outside business hours) and in locations that will maximise their accessibility to people with lived experience.
- Remunerating people with lived experience for the time and expense involved in participating in the group.
- Providing practical and emotional support to people with lived experience to support their full and effective participation in decision making.

These actions reflect the efforts that were made by the partners in the suicide prevention consultation process which preceded the draft action plan.

Participants expressed the view that the KIA group should be strongly 'action-focused', with clear, measurable and time-specific objectives established. Consideration should also be given to the mechanisms that could be put in place, beyond the KIA group, to work with people with lived experience in developing the evidence base. This should include gathering of qualitative, as well as quantitative, data. Learning may be drawn from initiatives such as the Our Voice Citizen's Panel[1], which is a large, demographically representative group of people which helps to assess public preferences and opinions in relation to health and social care.

Participants expressed the need for a range of methods (including anonymous options) to support people with lived experience to express their views, in light of the stigma and discrimination that people affected by this issue often experience.

[1] https://www.ourvoice.scot/citizens-panel

Participants also felt that a robust dataset needed to be developed which captured the prevalence of attempted (as distinct from completed) suicide across Scotland.

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

Participants explained that it was difficult to say whether training should be developed unless you had experience of the current programme of training.

If developed, it was felt that any new training must replicate what we know works, with some participants concerned that it would be difficult to develop 'world-leading' training within a two year period. This should involve an evaluation of existing training programmes.

Participants suggested that healthcare professionals and GPs require training, as well as job centre staff and teachers. These mirror suggestions given at the earlier events, with the Police and military personnel additionally suggested here. While a recommendation from the previous events was that some groups should have mandatory suicide prevention training, some participants here felt that workloads may make that impractical. There was also a concern that trainers would have to move from training the wider community to those groups who require mandatory training unless this was adequately resourced.

Participants at the earlier events emphasised that 'as many people as possible' should have training, however it was noted at this event that training can be unaffordable. It was recommended two places on each course be made available for free to those with lived experience. It was further noted that those with lived experience would be ideal trainers, as they will have a keen understanding.

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

The concept of a national body that could provide a framework to drive consistency of practice at national and local level is welcomed. There is, however, some doubt that this could be achieved in reality given the diverse needs of local areas and the governance arrangements of participating agencies. If this action is progressed, developing nationally and/or locally agreed work plans must reflect the needs of people affected by suicide. This can best be achieved by actively involving these communities of interest in identifying what is needed, addressing the gaps in service responses and in reviewing how activities work in practice. This reflects the call of pre-engagement event participants to value the voice of lived experience in the development, implementation and evaluation of national and local plans/services.

The Action Plan needs to set out how agencies at both national and local levels will be held to account for this.

The remit and membership of such a body needs careful consideration, especially in ensuring that participating organisations appropriately reflect the views of those who are at risk of suicide or who have been bereaved by suicide – reflecting the diversity of the Scottish population. One suggestion is that we could consider an approach that reflects that of the Getting It Right for Young People (GIRFEC) approach whereby multiple agencies are involved in delivering an approach together rather than separately. Bringing agencies and people together in this way would allow for the coordination of approaches to suicide prevention. The involvement of private/profit focused agencies, particularly those with pharmaceutical interests, was not supported by people with lived experience of suicide as it was viewed that this could skew the focus of actions.

4b) Please explain your answer.

Throughout the engagement process, participants welcomed an online suicide prevention presence. The pre-engagement suicide prevention report describes a belief amongst participants that knowledge of suicide prevention groups and services is poor amongst the public.

As recommended in the report, an online or media presence would be most beneficial in the following areas:

- Campaigns which work to break down the stigma and misconceptions surrounding suicide.
- Raising awareness about the common misconceptions regarding suicide.
- Signposting both professionals and individuals to the services and resources available locally or nationally.

Although participants are receptive to an online suicide prevention presence they have consistently and clearly stated that face-to-face interactions are an essential part of suicide prevention. These conversations between colleagues, friends and family members should not be overlooked or underestimated when considering possible online resources or services. Apps or websites which seem helpful at first can have limited efficacy at the point of crisis, due to a lack of human interaction. Participants saw value in an online suicide prevention presence that acted as a compliment to well-funded local campaigns that involve face-to-face interaction between community members.

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

Our pre-engagement events sought feedback from people with lived experience of suicide. Many participants were unfamiliar with existing resources, such as NHS Inform, Moodjuice or Breathing Support. It is important that the content and promotion of online resources is considered and well supported.

Participants suggested that consideration should be given to different social media platforms and how they are used by distinct demographics around Scotland to ensure online resources are being transmitted effectively.

As suicide rates in Scotland are highest among those who reside in remote areas or experience deprivation, participants discussed both deprivation and location as obstacles to the effectiveness of online resources or platforms. Participants also wanted to see that online resources would be developed for both survivors of suicide and for people who have been affected by suicide[2].

5) Please use this space to provide any additional comments that you have about any of the issues raised in this engagement paper.

The ALLIANCE, NHS Health Scotland and Samaritans Scotland held a joint event on 17 April 2018 to discuss the draft action plan directly with people affected by suicide. During the event, people with lived experience expressed concern that the engagement paper itself did not provide adequate scope to discuss the recommendations made in the Suicide Prevention Strategy Report[3]. This report highlighted a series of recommendations arising from events organised and led by the Health and Social Care Academy, Samaritans Scotland and NHS Health Scotland, with support from the Scottish Government. These are wide ranging and include reference to research, support at the point of crisis and ongoing engagement with people who have lived experience of suicide.

The pre-engagement events undertaken by the partners in this response showed the true value of collating the views and expertise of people with lived experience of suicide. Participants valued the opportunity to engage with government on the issue of suicide prevention, and highlighted the need for government and planning partners to engage with people with lived experience throughout the process of producing and reviewing strategies and action plans. Engagement with young people was considered a particular priority amongst participants, and given the 2018 Year of Young People Initiative there is a distinct opportunity to discuss the issue with young people and solicit their views.

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[2] https://www.alliance-scotland.org.uk/wp-content/uploads/2018/02/Suicide-Prevention-Report-2018.pdf p22
[3] https://www.alliance-scotland.org.uk/wp-content/uploads/2018/02/Suicide-Prevention-Report-2018.pdf

The final Action Plan should be ambitious. As part of this ambition we believe an overarching vision or statement included within the final plan would add value. We believe that this should reflect a challenge to the misconception that suicide is inevitable, a change in attitude and a commitment to reducing the number of suicides across Scotland. People with lived experience of suicide told us that they expected more research to be carried out into the reasons why people attempt suicide, as well as collecting data on the numbers of people who do. We believe that the Scottish Government should take a more curious approach and, on the basis of the research findings, resource approaches which have been proven to prevent suicide and address any contribution to the suicide rate made by the state or state actors.

The Suicide Prevention Strategy Report has twelve recommendations which all partners would like to see reflected in the final action plan. In addition to the four themes mentioned in the Scottish Government Engagement Paper the key priorities for action should be as follows:

1. Compassionate and immediate tailored support for survivors and others affected by suicide

2. The ongoing involvement of people affected by suicide in setting and monitoring local and national actions.

3. A greater focus on research into the causes of suicide and action on the data (qualitative and quantitative) gathered by research.

Some people also noted that the detail outlined in the consultation did not provide sufficient information to allow them to evaluate whether each recommendation should be taken forward or not. Actions and desired outcomes should be clear, measurable and made easy to understand for the public. Moreover, monitoring and evaluation should be linked up with those with lived experience, so that stated outcomes reflect the experience of those on the ground.

There were also concerns raised about the nature of the wording used in the consultation paper and whether accessible language could be used. For example, references to a Suicide Prevention Confederation were considered inaccessible to some and named alternatives included “working group” or “strategic stakeholder group”.

Throughout our discussions with people affected by suicide early intervention has been a critical element of their ambitions for the action plan. They noted that it is essential that care and support is available before people reach a crisis point, and that community members and professional services are able to identify warning signs and intervene. The way in which people experiencing suicidal ideation are

responded to is also key with people emphasising the need for a calm, respectful compassionate response. Consistently we have heard of the need to ensure young people are aware that support for suicidal feelings is available from an early age.

People told us that in their experience the availability of services was limited at present, and that services were not quick enough to respond when somebody needed them. People in crisis cannot wait for help, therefore frontline services must be prepared to provide compassionate support when approached or be able to sign post to appropriate services who will provide support. Our most recent focus group highlighted the connection between living with chronic pain and suicide and noted that cuts to community and acute services in this area were visible and had directly resulted in incidences of attempted suicide they were aware of. Participants in our most recent focus group were keen to highlight that greater funding for frontline services was required across a range of areas to prevent suicides. Particular attention should be paid to rural and remote communities, where support for those in distress can be patchy or difficult to reach.

There was a general feeling expressed that mental health is not seen of as important as ‘physical’ health conditions. Clear pathways to action for professionals dealing with those impacted by suicide was repeatedly raised, these pathways could include things like knowing the right (high quality) local agencies that people could be referred onto.

Participants also told us that the draft action plan should be amended to recognise the role employment, or loss of employment, has in relation to suicide. Work should be taken forward that involves trade unions (possibly as part of the group/s described in Action Point 3).

A key recommendation from the involvement events held across Scotland was the need to value more and promote the voice of lived experience throughout the development, implementation, and evaluation of the new action plan. Participants in our events across Scotland told us that they valued the opportunity to engage with government on the issue of suicide prevention, and highlighted the need for government and planning partners to engage with people with lived experience throughout the process of producing and reviewing strategies and action plans.

In practice, this must involve people with lived experience being integral to the Knowledge Into Action groups. Our events across Scotland highlighted the depth of knowledge and energy for change that people with lived experience affected by would play a critical role in the proposed working group under Action 3 but we note that they are not mentioned in the draft action plan.

Measures to enable the involvement of people affected by suicide should be well considered in advance of the formation and implementation of Actions 2 and 3. This

should place an emphasis on building the capacity for people to be involved in sharing their experience, for example, holding meetings at times that suit people and not just professionals as well as reimbursing their time and costs. It should also involve creating a safe environment in which reflection is valued and challenge encouraged as a way of ensuring continuous improvement. This would show the Scottish Government's commitment to hearing the voice of lived experience and investing in it as a valuable resource.

There also need to be mechanisms created to support people with lived experience to remain involved and connected. People affected by suicide can have a significant peer support role, which has been highlighted as a very valuable resource in our discussions with people affected by suicide. Community resources to support people need to be widely available and accessible to all.

Participants also highlighted that survivors of suicide should be treated as a distinct group, with support and a care pathway in place which recognises that a different type of assistance is required. Some people felt that a discharge from hospital plan should be devolved in all instances of attempted suicide which recognises that higher chance of someone reattempting suicide after they return from hospital.

Greater levels of support are also required for families and friends of people who have attempted or completed suicide. As noted in our previous report, compassionate, high quality support should be available for survivors of suicide and people and their families who have been affected by suicide. This should flex to the need of the individuals concerned (e.g. services should not require a six month wait before admission) and include more support for children and young people affected, to address current gaps in support provision.

Many of those we spoke to were surprised that the word "carers" was absent from the draft action plan, given that carers can play a significant in support people who have attempted suicide.

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