A New Suicide Prevention Strategy for Scotland

Early Engagement Summary Report

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COSLA

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Notes about the content of this document:

This document contains information gathered during the first stage of engagement for Scotland's New Suicide Prevention Strategy and Action Plan.

This analysis offers no commentary on the content of participants' contributions, and as such, some comments may mention areas where work should be carried out but is already happening. At the end of this report, you will find details of work/resources which were highlighted by participants throughout the engagement sessions, no work has been undertaken to establish their effectiveness and therefore their inclusion in this document should not been seen as an endorsement.

This analysis, which was undertaken independently of the Scottish Government, the Convention of Scottish Local Authorities (COSLA) and Public Health Scotland (PHS) is being used to inform the development of the new suicide prevention strategy and action plan. This report does not reflect the structure or content of the future strategy and action plan. Information contained will be considered alongside the available evidence of what works to reduce suicide to ensure any actions identified in the next strategy are safe and effective. This will not however, prevent the development of an ambitious strategy and action plan which will provide the opportunity to add to the evidence base.

Background

In June 2021, the Minister for Mental Wellbeing and Social Care announced the Scottish Government and the Convention of Scottish Local Authorities (COSLA) would jointly publish a new long term suicide prevention strategy, and action plan, in September 2022.

The new strategy, and an associated action plan, replaces the current Suicide Prevention Action Plan 'Every Life Matters' which was published in 2018.

The Scottish Government and COSLA have committed to engage with stakeholders, partners and communities in the development of the new strategy and are determined that the voices of those with lived experience sit at the heart of its development and implementation.

Engagement will also be supplemented by published research, insights from practice, and learning from Scotland's previous work on suicide prevention, to ensure actions are backed up by evidence.

Purpose

This report seeks to provide an overview of the findings of the extensive initial engagement process undertaken by the Scottish Government, the Convention of Scottish Local Authorities (CoSLA) and Public Health Scotland (PHS) into all aspects of suicide. This early engagement process ran between September 2021 and January 2022. As almost six hundred contributions of varying degrees of complexity, were received issues on which there was a degree of consensus, or which demonstrated effective or innovative approaches have been highlighted.

Engagement Process

To gather as many views as possible, and to encourage participation in the development process, a series of online workshops were organised, which ran alongside an online questionnaire. There was an open invitation to share views and this gained input from professionals across various fields, as well as members of the public with an interest in suicide prevention. The engagement process also sought to ensure that the voices of those with lived experience were heard.

41 online workshops were held, with some of these having a regional focus and the rest a national focus. Organisations, groups and individuals could self-select which type of event they wanted to attend. Participants could also attend more than one event, depending on what they wanted to focus on.

The survey received 190 responses, 162 responses from individuals, as well as 28 responses from organisations across the public and third sectors working in areas including mental health and wellbeing, children and young people's services, and social care.

Both data collection processes asked for views on the current situation from their perspective and sought to identify innovative ideas and best practice. Participants were also asked to identify priority areas for future action.

Responses were sought in relation to several themes:

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

Respondents to the survey and attendees at the workshops were also asked about other policy areas, outwith health and social care, that ought to be involved in suicide prevention, such as housing, addiction, and poverty and to provide examples of effective practice both locally, nationally and internationally. Please note the terms ‘respondent’ and ‘participant’ are used interchangeably and are not reflective of engagement channel.

Analysis

At each of the workshops a standard set of questions was used. Notes based on the responses from the workshop were provided to the Improvement Service (IS) and these were used as the basis for the analysis. Whilst the notes identified the geographical location at which the event was targeted, they did not provide any identifiable information about participants. This approach was taken to support openness in conversations, and in recognition of potential restrictions this might cause during analysis. Accordingly, whilst it was possible to identify specific suggestions emanating from geographical areas it was not possible to ascertain who had made them. For example, in relation to individual comments it was not clear if they had come from an individual participant with direct experience of suicide or a professional working in a relevant, but unspecified, area. Whilst this was important to respect confidentiality and guarantee anonymity it means that it has limited the scope of analysis that can be undertaken in relation to the workshop sessions.

In relation to online survey responses, whilst all were anonymised it is possible to distinguish between respondents who were taking part on an individual basis and those coming from organisations, and indeed the type of organisation. Accordingly, where differences in the nature of survey responses have been identified these have been reflected in the analysis.

A small team in the Improvement Service (IS) analysed all the responses and categorised data.

Each theme will be considered in turn, however there were several examples of ‘golden threads’ that ran through the responses to many of the identified themes. To avoid repetition, and to highlight that these responses were not unique to one area but were crosscutting these will be highlighted separately.

Overarching Considerations - common to multiple themes

“Need to move away from silos and see all topic areas as part of a journey and crisis support should be embedded throughout so we address the underlying issues leading to suicidal ideation.”

Training and Capacity Building

Training and ongoing learning was consistently identified as key across all themes and it was emphasised that this should not only be aimed at professionals but should be widely available to all. It was stated that building capacity, particularly in communities, would help individuals to recognise the early warning signs of suicidal ideation and at the same time reduce stigma. Others suggested a more targeted approach should be adopted; this could include frontline service providers such as GPs and GP receptionists, other NHS staff, and teachers. These individuals would then be capable of identifying issues and would know how to respond appropriately and could act as champions by developing the knowledge, understanding and skills of others. This was considered particularly relevant for teachers and those working in educational settings.

Communities should be actively involved in planning and delivering training/learning opportunities and the possibility of identifying and upskilling community champions considered. In Borders there have been facilitated sessions for community groups such as rugby clubs to raise awareness. Clarity on what signs to look for and how to intervene should be the goal of such training.

Some survey respondents mentioned that training should be made available in all workplaces to tackle ignorance and preconceived notions around suicide. Others felt that every workplace should have a trained Mental Health First Aider, similar to existing legislation that requires physical first aid provision to be made available in all workplaces.

There were also many positive reviews of the Distress Brief Intervention (DBI) programme, delivery of Applied Suicide Intervention Skills Training (ASIST) and the more recent Ask Tell Respond learning resources on mental health, self-harm and suicide prevention. Requests were made that there be more funding and provision of this training as it was suggested it is effective, and already has a degree of familiarity. However, offering a range of options including shorter courses should be provided. It was strongly opined that any learning programme needed to focus on what is known to be effective.

Skills building was a stronger theme among organisations than individuals; while both emphasised the importance of active listening, organisational representatives attached greater weight to trauma-informed approaches and training for primary care, social care and education staff.

Campaigns

To help prevent suicide and get rid of any stigma and shame it was stated that campaigns premised on the principle that ‘suicide is everyone’s business’ should be run. These should be delivered both nationally and locally, be linked to training and

built on evidence of what works. Suggestions as to the form of campaigns included celebrity endorsements, sharing lived experience and adopting a multi-agency approach similar to the approach adopted successfully in tackling knife crime.

Language

Language was identified as a potential barrier on multiple fronts - in reducing stigma, encouraging people to seek help and in service delivery. It was agreed more guidance around language was required, especially for the media. In particular, people need to be informed about the right language to describe suicide, moving away from using the phrase “commit suicide”, which could imply illegality and instead using “died by suicide” or “took their own life”.

Communities

Many respondents stated that community involvement was critical at all stages from reducing stigma and increasing awareness of suicide to providing locally based support. It was suggested that communities could be involved in many ways. For example, training and upskilling could be provided for ‘community champions’ and relevant strategies and policies could be included in Local Outcome Improvement Plans.

Lived Experience

A recurrent theme was that it was crucial to involve and listen to those individuals who have lived experience of suicide. This should include those who had experienced suicidal thoughts, or attempted to take their own life or supported someone who had been bereaved by suicide.

Focus on Schools

There was a widespread recognition of the importance of schools across all themes. It was suggested that instilling in young people an understanding that life involved both pleasure and pain and that support could, and should, be sought when challenges occurred was essential. Support should be provided by adopting a ‘whole school’ approach which could include an enhanced role for the school nurse, compulsory teacher training in suicide prevention, the creation of youth champions and greater availability in counselling services at all stages. Suggestions for awareness raising activities included advertising within schools and participation in school events by representatives from local or national mental health organisations

Strategic Support

It was stated that adequate funding and resources needed to be made available to ensure that a range of support services were provided across Scotland on a consistent basis, but which could be tailored to meet local needs. This was particularly important when awareness raising campaigns that are likely to result in additional demand are planned. In addition, the provision of potential frameworks or guidance to plan and support service delivery would be helpful. Improved communication and connection between national and local levels it was noted would

increase the impact of activities. It was posited that a regular newsletter might help with this.

Areas for Further Consideration

In the course of the analysis, points emerged on which there were clear divergences of opinion and it may be useful to consider these in addition to the overarching themes. Whilst it is not suggested that one approach is ‘better’ than the other, it was considered important to emphasise areas in which there was not consensus, and to highlight that a range of solutions which address different needs may be required.

Social v Medical models

There are mixed views on the extent to which suicide prevention should be considered a medical/mental health issue. Some respondents suggested that linking suicide directly to mental health and clinical treatments could create barriers and there should be greater emphasis on wider social causality.

Central v Local

Several organisations sought national frameworks or guidance that could be used to plan and support service delivery at local level. Others, particularly individuals, suggested that resources and decision making should be devolved to communities and that any strategy needs to support communities without being too directive or prescriptive.

Targeted v Universal

Mixed views were expressed as to whether or not a universal approach should be adopted or activities targeted at individuals and groups who were considered to be vulnerable or most at risk of suicide. This cuts across all aspects from awareness raising, prevention, early intervention and crises.

Digital v Face to Face

There were diverse opinions on the way services should be provided. For some respondent’s face-to-face services were of paramount importance whilst others took the opposite view and stressed the need to prioritise web chat (and other digital options).

Expansion v Recruitment

Whilst some organisations have been able to expand services through increased funding it has been challenging to recruit suitable qualified staff.

Theme One - Suicide Prevention

Some of the suggestions that were made in this section are more relevant to later sections dealing with early or crises intervention particularly in relation to the comments on resources. However, they are included here because they were considered by respondents to relate to preventative activities.

Resources

Participants in both the workshops and surveys emphasised the need for adequate resources to be provided. Definitions of what constituted resources encompassed increasing support staff numbers and reducing waiting lists. In addition, there were several references to a lack of awareness of existing resources which, it was suggested, could be overcome through better signposting and publicity. This view was much more frequently expressed by participants from organisations.

> "Scoping exercise in Glasgow showed services exist but people don't know about them and long-term resources are not there yet!"
>
> "Local mapping of services and ease of access to this - community learning development staff are brilliant at this."
>
> "Long waiting times for some benefits and support can lead to suicidal ideation – systems need to be appropriate and prompt social service support provided to allow independent living etc."

Whilst not directly addressing resourcing issues, there were practical suggestions that might help and which could be introduced quickly, such as using recordings of people with lived experience who have survived suicide attempts when help lines are busy.

Service Provision

Comments were received in relation to how organisations should work together to provide services particularly in relation to greater collaboration between public and third sectors.

In both the workshops and survey responses it was suggested that there should be a greater focus on multi-agency/interdisciplinary approaches based on clear organisational responsibilities being established and put in place. This included ensuring that when multiple agencies were involved individuals were enabled to gain access to all using a single point of contact. This was considered to be especially important and would provide a 'safety net 'when individuals were transitioning between services especially from child to adult services.

> "People seem to be moved between services before we find the right support for them with no safety net while the right support is found."
>
> "There should be no wrong door – no matter where you turn up you should be supported to find the right part of the system without having to retell your story,"

Better information sharing between organisations was seen as a key element in improving joint working.

> “Are we sharing the right information, often bogged down in the red tape rather than focusing on the things which are important – a national approach would be useful so the right information is shared - especially for someone who has a history of self-harm or suicide attempt so that wherever they are in ‘the system’ people who may support them are aware.”

There were mixed opinions on the type of service provision, with some appealing for more face-to-face access and others for web chat (and other digital options). It is clear that offering a menu of different options will encourage engagement of different individuals, for example it was suggested middle aged men may be reluctant to engage in face-to-face therapy whilst young people may feel more comfortable with digital options.

Creating a clear concise map of options and ensuring there is awareness of these in primary care/schools/workplaces to help direct people would be helpful.

Adopting a person-centred approach was considered to be essential with services tailored to meet individual needs. There was a general agreement that someone to talk to or who would listen was more important to people than self-help resources. This view was expressed most strongly by individuals.

> “Wide ranging holistic interventions taking account of a number of different lenses”

> “Need to work together and not put people in ‘boxes’ look at what is in communities to help, signpost or refer and take person to the service/appointment.”

The challenges experienced by people in rural communities were highlighted.

> “Rural communities are a difficult place to hide - if you talk about it then others will know and that puts people off talking about it in these communities.”

> “Consider implications of rurality on prevention (limited access to social support networks) – also farming/fishing as at-risk occupations”

It was suggested that there would be benefits in raising awareness of the existing national Mental Health Improvement and Suicide Prevention Knowledge & Skills Framework, so that it becomes as well known as the National Trauma Training Framework.

Enhance the Role of Preventative Health Measures

In addition to the wider links with mental health, it was suggested that social prescribing and integrating mental health into activities such as sport, art and music could make a significant contribution to improving health and wellbeing. Whilst this can, and does, happen locally, there is a need to raise awareness of this approach at a national level. This was highlighted as a priority by respondents participating in a personal capacity but to a much lesser extent by participants representing organisations.

> “Social prescribing and community building helps people take control of their own mental health.”
>
> “Support could be integrated into locality plans - this would bypass the need to medicalise normal experiences and build resiliency.”

Concerns were expressed about the processes currently used by GP practices. Respondents described how they felt they “were not listened to” and that services were acting as “gate-keepers”. As a result, some people, and their families, stated that they had missed opportunities for support at an early stage. There was a general consensus that “you have to be in crisis to get help”. While some individuals acknowledge this is a resource issue, resulting often from a lack of time to listen, others felt that their treatment by medical professionals when raising concerns about their mental health was “cold” and even “callous” and as a result made them reluctant to speak out.

Individuals stated that when people seek medical assistance or ask for help from medical services, the support provided does not seem to work. There appeared to be a disconnect between expectations and the reality of the support that was provided. For many individuals the response to their request for help was to be prescribed medication by their GP or added to a very long waiting list for support services.

> “Waiting lists are very long and require a GP referral (if you meet the threshold), all that is on offer is prescription of medication and the Samaritans crisis line.”
>
> “People are not sure what their options are, what’s out there, and what to expect”.
>
> “More robust action in primary care rather than medicating and referring.”
>
> “Should be able to self-refer and not be reliant on GP referrals when there are capacity issues for GPs.”
>
> “Access to crisis services can only be referred by GPs, this should change.”

The support received from third sector organisations, in particular Samaritans, was rated highly. It was suggested that there should be better collaboration between third and public sectors which would result in a joined up holistic approach to service provision.

> “When people cancel appointments, no-one follows up with them and they can fall through the cracks”

Contextual Considerations

Preventative strategies and approaches should take account of the current context, particularly from a socio-economic perspective. Concerns were expressed about the impact of cuts in universal credit and other welfare reform aspects on vulnerable individuals. There was a widespread recognition of the adverse impact of the COVID-19 pandemic on mental health, particularly as a result of social isolation. At the same time, limitations on service delivery had been necessitated, especially in

relation to those provided on a face-to-face basis. However, it was also suggested that the pandemic may have resulted, for some individuals, in improving their self-reliance and reducing their need for support from services.

There was recognition that the Scottish Government is not in a position to address many of the socio-economic issues that were identified as they are reserved matters.

> "Covid has shone a light on mental health but people don't always know where to go for help."
>
> "Health poverty is a big issue – demand can be bigger in some areas than others."

Improving the Evidence Base

Decision making in relation to suicide prevention measures should be driven by robust evidence. Concerns were expressed about the quality and relevance of the data and information that was currently available.

> "Suicide data needs to be improved; we need to know more …. to help prevention work."
>
> "Current research evidence is equivocal, and more is needed to determine which actions will be most effective."
>
> It should be noted that this was highlighted as an issue by representatives of organisations but not by individuals.

Theme Two - Early Intervention

As with other themes the need for training/capacity building and increased use of the media to raise awareness were highlighted. Given that the suggestions made were along similar lines to those already outlined in the crosscutting themes or developed in other themes they will not be considered further in this section.

The starting point for many comments was that there was a need to make people aware of available support services and to encourage individuals to use them. Both individual and organisational respondents stressed the need for timely intervention.

> "People don't know when they should seek help, 'others are worse off than me' type of approach and therefore wait until they are in crisis – need to raise awareness that seeking support earlier would be better."

Access to Support Services

Many of the respondents commented on support services at different stages - in relation to how they are accessed, the nature of the provider and the method of delivery.

The need for services to be provided consistently on a universal basis was regularly stated. It was suggested that the threshold for accessing services should be reviewed to make access easier. Aligned to this, it was stated that clearer routes for accessing support and making referrals were required.

There were suggestions that the majority of support happens outwith formal support services and that having an informal support network is essential. It was suggested that peer support was important and should be promoted.

> "A good support network can be the answer for people and helping them understand this would be beneficial – family, peer to peer etc. – if people don't have these networks, we need to support them to develop these."

As in other themes, reference was made to the need for public and third sector services to be better linked and co-ordinated

There were mixed views on the role of health services with some suggesting a greater focus on support from primary care and others stating that it should be kept separate.

Information Sharing

Sharing relevant data in a proportionate manner could contribute to supporting early intervention.

> "Data sharing challenges can limit what can be done around early intervention, something needs to change so we can focus more on early intervention rather than learn from suicide events."

> "People do not want to have to retell their story but need to get the balance right so that e.g. your physio doesn't get the info that you have attempted suicide."

Actions supporting early Intervention

Various activities were suggested that might reduce the risk of crises being reached. These included recognising the value and importance of non-clinical approaches such as social prescribing or community based activities along similar lines to those suggested in relation to the prevention theme.

> "Emotional support and active listening can prevent people getting to crisis point – increase peer support (walking groups/tea & toast sessions)."

Many respondents proposed that support should be targeted at individuals who were likely to experience challenges as a result of life changing events e.g. unemployment, retirement, serious medical diagnosis, bereavement etc.

Support should be made readily available when certain events acted as 'warning signs' that all was not well in an individual's life. Several examples of when this might occur were given. The importance of such proactive responses was considered to be more important by individuals than organisational representatives.

> "Missed appointments by vulnerable people being flagged by services (GP, DWP)."

> "Where there has been a suicide attempt which is not considered a 'serious' attempt"

> "When anti-depressants prescribed"

When an individual had previously reached crises point then support measures should be offered to avoid it happening again and this should be considered in discharge safety plans and through regular routine follow-ups.

Theme Three- Crisis

Respondents stressed that individuals in crisis had to be supported quickly and effectively. Concerns were expressed that in the current system there was both a lack of clarity in how to access services and a lack of consistency in the availability of services. It was also suggested that there were issues with the type of services provided.

Examples were offered of individuals requiring crisis support on several occasions, and whilst it was acknowledged that this could happen it was posited that, in some instances, this could be avoided by improving follow-up processes and interventions.

> "There is a revolving door and lack of follow up from emergency/acute distress interaction."
>
> "Intervene successfully the first time."
>
> "Better safety planning for those who have attempted suicide"
>
> "When someone has been in crisis a follow up should happen – does not need to be a professional service, communities can and should also be involved to make sure people are not isolated and alone."

Accessing Services

It was suggested that sometimes individuals found it very difficult to make contact to seek the help they needed and so it was vital that they could engage in a way that suited their needs. Once contact was established individuals needed to be connected to the most appropriate type of support quickly.

> "An emergency number- not necessarily 999 (but could be) should be provided to access support in a crisis situation."
>
> "People often need help to actually pick up the phone to call services like Samaritans - need to have a range of options available, telephone, text, email, face to face etc."
>
> "Need to build on the good elements of digital/technological support which have developed through the pandemic."

Many respondents suggested that there were issues with the thresholds that had to be met to access services. The criteria that had to be met often acted as barriers. There were many requests for the referral processes to be reviewed and simplified. Several suggestions were offered as to how improvements could be made.

> "Need a triage system which someone in crisis can easily access which can then link the person to the local service which can support them."
>
> "There should be no wrong door – no matter where you turn up you should be supported to find the right part of the system without having to retell your story."

> “3rd sector organizations struggle to be able to refer into statutory organisations which would alleviate need to engage with 999/GP/ Out of hours

> “Need to make onward referral part of the process and not ‘an additional’ – it needs to be embedded.”

> “When someone turns up to service and doesn’t meet threshold for that they aren’t always sent on to the place they need to go to – there needs to be wider knowledge in these services about the other services available.”

> “More clarity on where/what services can be accessed (pathways should include 3rd sector)”

It was suggested that the services offered depended on the initial point of contact and this could mean that individuals were not always able to access, or be referred to, those services that could be of the greatest benefit.

Some respondents felt that people should be able “to re-refer to services if they feel they need the support from a service they found useful in the past”.

The lack of equity across the country was frequently referenced, particularly in relation to accessing services in rural locations.

It was suggested that different communities had different needs and a higher priority should be awarded to equalities issues.

Many respondents expressed concerns about the waiting times for services and the need for them to be reduced.

> “People don’t stop thinking about suicide whilst waiting for support”

Service Provision

A need was identified for 24-hour support and it was suggested that this could be delivered through improved partnership working and the use of a generic framework that could be adapted to meet local circumstances.

Many participants expressed the view that there should be a shift away from a medical model of support and consideration given to other types of assistance.

> “A menu of support options – beyond home or hospital – needs to be made available.”

> “Develop a crisis model of care rather than an illness – so can respond to distress rather than illness.”

> “Places of safety – where people can go and be kept safe.”

> “People in crisis may want to just talk about how they are feeling when they are suicidal to get things out their head and may not act on their thoughts.

> Mental health services automatically risk assess and detain when you express suicidal ideation, but this may not be what someone wants, they want to talk about the feelings,"
>
> "There is a need for increased resource for people in crisis, so they get a safe place to go which isn't a hospital or prison cell – somewhere for people to go when they are deemed medically fit but not safe to be left."

In those instances where medical support was necessary it was highlighted that, although exacerbated by the pandemic, there had been occasions in which there were no beds available in mental health inpatient units for females anywhere in Scotland

Concerns were expressed by many about the lack of support from individuals working within the criminal justice system.

The work of Samaritans, and indeed other third sector organisations, was viewed positively. Although yet again the disconnect between public and third sector service providers across all areas was highlighted. This has already been reflected in a previous part of this report.

> "Samaritans works well as a crisis response; the aftermath is the main issues."
>
> "The anonymity of things like the Samaritans can be helpful."

Theme Four- Postvention

From the outset respondents highlighted that there was limited awareness and understanding of the term postvention. As with other themes, issues relating to the use of appropriate language and the need for widespread training were identified. Many comments focused on the need to take earlier action to reduce the number of individuals reaching this stage and indeed one respondent suggested, "postvention is suicide prevention for the next generation."

There were widespread concerns about the lack of support available. Some respondents suggested that the support they have been led to believe would be on offer had failed to materialise. As a result, it was proposed that services should be held accountable for delivering support that it is claimed is being provided.

> "Audits should be taken to ensure services are being delivered"

Support

In their responses participants differentiated between the people who needed support and the organisations and staff that should provide it.

It was stressed by many participants that support was required for anyone who had been affected and that this should be provided on an ongoing basis. There should be a recognition that the stage at which this support was required would vary from individual to individual. Some might need support in the immediate aftermath whilst others would prefer to wait a few weeks or months.

> "Tailored support for all is needed from first responder to family members"
>
> "Multicultural society needs multicultural solutions; is enough being done to reach groups who speak different languages?"
>
> "Need to understand the pathway of an individual – a long bumpy road with multiple touchpoints – so we can provide something of value so that suicide is not the only answer."
>
> "Need to ensure the wider circle of people affected by suicide can access support. Friends don't feel as 'entitled' as family members do."

In terms of who should provide support, and how it could be provided, there was a degree of uncertainty and a variety of responses were received. Some participants suggested that specialist staff could fulfil this role and others noted that whilst there were lots of online support groups not all of them were free.

> "Dedicated liaison officer (suicide bereavement) to help families/relatives is needed – should be flexible so they can look for support when ready."
>
> "Clinicians fear they will be blamed if they engage with families post suicide."

Although there was universal agreement that bereavement by suicide support is needed, a model that could be tailored to meet individual needs has not yet been identified.

> “No model yet which fills all the gaps after a death by suicide, even the pilots won’t fill all of these – what are the referral routes, support for those beyond the wider family, who speaks to the family so we can get the right support to them at the right time.”

A continuing theme was the lack of parity in how to access and receive support services. This was also reflected in the wide variations in post suicide debriefs which were described as part of responses, however, it is unclear where or who this relates to.

Concerns were expressed about the consequences of digital exclusion experienced by some individuals.

As has been indicated in other themes, options for support varied depending on where individuals lived.

> “Huge geographical variations, a lottery for people who need support, need more equality across the country.”

Information and Access

As with other themes it was suggested that Information and visual aids should be available in a wide range of settings and in a form that meets the needs of all. It was noted that mental health and national telephone hubs could be provided.

> “Age-appropriate materials to help children understand – everyone in a small community tends to know about a suicide – can miss the impact on children.”

Wider Assistance

It was proposed that a wide range of support activities should be considered. This might happen in different ways. It could involve identifying other groups/ individuals who would need support. Another option might be follow up activities targeted at individuals who had experienced suicide indirectly and hence as a consequence might themselves experience suicidal ideation. It was acknowledged that initiatives that address the wider impacts of suicide can be resource intensive and there was interest in exploring how this approach could be replicated in communities. Several participants suggested that work continue to develop the suicide bereavement pilot activities to make sure people get help when they need it.

> “Bereavement support pilot for families – learning needs to be part of the new strategy and needs to be built on into a national plan.”

> “Postvention work is also required in workplaces, prisons, armed forces all ‘communities’ where there has been an impact by suicide.”

> “Follow people up for two weeks post suicide attempt”

Improving the Evidence Base

Several respondents stressed that there was limited information on which to base effective decision making and this should be addressed both in terms of data collection and sharing examples of effective practice. As has previously been noted these suggestions came almost exclusively from respondents representing organisations.

> “Mapping of incidents which helps us understand who has been impacted by the suicide – vicarious trauma.”
>
> “Need to learn from the activities undertaken during covid which support connection and not lose sight of this and build on.”
>
> “Don’t have access to the data needed to help shape services and responses.”
>
> “Need a consistent response – a protocol for people in suicide prevention roles to follow when a suicide happens rather than an ad hoc approach,”
>
> “Guidance around managing suicide clusters is needed from a national level”.

Theme Five -Tackling Stigma

Many survey respondents noted that suicide can be an outcome of poor mental health, and so tackling stigma around mental health alongside suicide should be the focus of any work. It was also suggested that mental health was a public health issue and should be treated on a par with physical health. The following areas that have been identified for consideration are premised on tackling both suicide and mental health.

In tackling stigma, a common point raised was normalising conversations around suicide, mental health, and mental illness. By doing so those who need help would be encouraged to seek support. At the same time, many responses noted concern around normalising, trivialising, or encouraging the act of suicide. Some respondents pointed to recent shows such as “13 Reasons Why” and its depiction and “glorifying” of suicide. There is therefore a balance to be found between these points.

Language

As already indicated, using the right language was believed to be crucial, and likely to be the focus of any advertising or promotional campaign. As well as using appropriate descriptions of suicide, it was suggested that the issue should be described as one of “wellbeing”, rather than “mental health”. The language used to describe other mental health conditions, and general perceptions of these, such as post-traumatic stress disorder and obsessive-compulsive disorder were raised with respondents noting that these are often discussed in a flippant manner that diminishes their seriousness and downplays the damage that they can cause.

More broadly, people have to be empowered to have the right language to talk about suicide and not use euphemisms. It was noted that the media, and social media, have an important role to play in the language they use.

Training and Knowledge Building – especially in schools

The second most discussed theme across the survey and by organisations and individuals was a need for widespread training on how to think and talk about mental health and suicide. Several commentators noted that this should be done from an early age at school to build a “suicide-safe generation”.

Many survey respondents mentioned that NHS staff can appear to be unsympathetic. This could be addressed through more training, perhaps involving individuals with ‘lived experience’.

> "Definitely more compassion from NHS professionals when dealing with someone with mental health problems"
>
> "Approach from nurses, admin, support workers is fantastic, however NHS staff can be very abrupt matter of fact and unkind."

Schools were frequently identified as a key location for activities related to tackling stigma. As mentioned above, training for teachers, and others working in school settings, was seen as crucial to this for many respondents. It was noted that good work was ongoing in Personal and Social Education classes in school, but that

teachers needed more support and that conversations about mental health should begin at an earlier age. Some respondents suggested that these topics should form part of the school curriculum.

> "Start from a younger age so it's not a stigma"

> "Major programme of work to tackle stigma across all sections of society, including use of influencers/celebrities etc. Inclusion of suicide awareness and mental health first aid within the curriculum."

It was also suggested that if children were more aware of mental health issues, they would be more comfortable talking to their parents about it, in this way spreading the benefits beyond the school into the home. Other educational settings, including universities and colleges, were also highlighted as important locations where children and young people requiring support should be able to access it, with trained individuals available to provide this.

Involve Community Groups

Involving community groups and building their capacity to start conversations that challenge stigma were suggestions proposed in both the workshops and survey. Some suggestions were to include suicide prevention within locality plans, running awareness and outreach sessions with community groups, and seeking out and building on existing work by community groups. The need for consideration and sensitivity of cultural differences was also mentioned. For example, different religious, faith or ethnic groups may talk and think about mental health and suicide in a specific way or indeed not at all. Therefore, it is crucial to engage with these communities directly to find out what language to use to describe these issues and to identify what works within these cultural contexts.

> "People are frightened to talk about suicide in case they get it wrong and make things worse."

Advertising/Promotions/Campaigns

By far the most common area, perhaps unsurprisingly, under the tackling stigma theme was the success of advertising and a call to do more of this. It was suggested that this should be used to promote messages around mental health and suicide including around the language used, encouraging conversations, and how to seek help. Some of the mediums suggested for sharing these messages were TV, posters, promotions at sports and other events, celebrity endorsement, and through social media.

Some organisations tended to argue for more advertising of available local services, while individuals were generally focused on larger national campaigns. However, in both cases there was agreement of the need for a balance between advertising how to help, the support that is available, and generally a greater level of awareness of the issue and how to talk about it. Many described @FCUnited and United to Prevent Suicide, which is discussed below, and also football clubs, such as Motherwell, and other role models and respected figures and institutions promoting positive messages.

Sharing lived experience also featured prominently in discussions of how and what adverts should be shared. This included the families of those who had taken their own lives, survivors, and people who have struggled with their mental health. It was again mentioned that celebrities speaking about their experiences was particularly powerful.

Sharing statistics with the public around suicide and mental health was another suggestion.

> "By promoting in the public arena on all fronts, all the simple but effective messages around listening tips and conversations with those we care about and complete strangers that every one of us could engage in."

Lastly, a number of comments noted that any campaigns should be based on an evaluation of what works.

Media and Social Media

Survey respondents were specifically asked what could, and should, be done around the influence of the media and social media on conversations and perceptions around suicide. This area was also addressed in the workshops, although not asked in the same way.

Traditional Media

In general, traditional media was praised for raising awareness around the issue, for example, celebrity involvement in campaigns and sharing of stories. This was something that it was felt should be encouraged and expanded. Many respondents noted that traditional media had an important role to play, highlighting use of language that can encourage stigma. Several were critical of how mental health problems have been portrayed in Soap Operas, for example, or in the treatment of public figures or celebrities.

It was widely suggested that the media need to be suicide informed, with training targeted in this area. Although the crucial role of the media was recognised, however, there were very few suggestions for other practical steps that could be taken. One suggestion was to:

> "Bring the media charter to Scotland; get the Press Complaints Commission to update their regulations in line with the Equality Act 2010 and stigmatising and damaging use of language."

> "One major challenge… is inappropriate and unhelpful reporting of attempted and completed suicide incidents by local press and certain social media groups. We have reported these specific incidents to national Samaritan's colleagues for review against their media guidelines and we are keen to arrange delivery of a media workshop for our local press. However, the action we can take to address this at a local level is extremely limited. In terms of supporting local areas in relation to media and social media reporting, it would be necessary for national colleagues through the next strategy and the

> NSPLG to consider what further action can be considered to address this worrying increase of traditional media and social media reporting of incidents."

Social Media

Social media was also recognised as having a complex relationship with this area, having on occasions both positive and damaging impacts. Firstly, a large number of survey responses highlighted that social media had played a very important role in normalising conversations around mental health and suicide. Campaigns such as @FCUnited and movements like United to Prevent Suicide, were praised, as was the willingness of famous figures to discuss their own experiences related to mental health or suicide. Many respondents suggested that this should be further encouraged

> "We live in a celebrity culture and so young people pay attention to people who are famous. This is the best way to get young people listening, using celebrities from all walks of life."

In addition, respondents suggested targeted campaigns could be effective, for example using "hashtags such as #AskTell."

> "We need to harness the power of social media to share the positive side of mental health awareness and as a vehicle to quickly and effectively share reliable content."

On the other hand, however, there was strong recognition of the potentially dangerous impact of social media. Reference was made to online bullying and sites that might encourage suicide. While it was recognised that regulation in this space was challenging it was suggested that by working with social media companies, steps could be put in place to report and remove harmful messages. It was pointed out that action had been taken against Covid-19 misinformation, and so something similar could be done for suicide.

> "Social media regulation is difficult with the younger and more tech savvy people being able to circumvent restrictions and accessing negative perceptions with relative ease, as they navigate faster than the tech companies can shut down sites."

> "Cyber bullying - there should be zero tolerance, you should be banned from Facebook or Instagram for a period of time and asked to complete a training course to make sure they abide by user policy agreements and standards."

> "Work with social media companies to develop algorithm that picks up when suicide is mentioned and send link to suicide prevention support."

Target Vulnerable Groups

Some respondents noted that certain groups of individuals can be most at risk of suicide and are less likely to seek advice or support, perhaps because of perceived

stigma. It was suggested that these groups of individuals should be targeted with training and messaging, with reference to some good work already ongoing, such as directing support to new mothers through health visitors. It was also noted, however, that although some groups of individuals are most at risk, everyone's mental health is important and that anyone can have struggles in this area.

Some of the suggested groups were (please note that some of these groups have also been mentioned under other themes):

- Deprived communities
- Men
- New mothers
- Farmers and other isolated groups including rural communities
- Students

As stated above, it was also recognised that different cultures may discuss and look at suicide or mental health in different ways, and that a simple one-size fits all approach would therefore not be appropriate.

> "Within Clackmannanshire and Stirling there are significant pockets of suicides and these are linked to deprivation."

> "Some cultures celebrate death in a different way rather than seeing it as something to be avoided as a topic of discussion. Less stigma surrounding death in general would help to discuss suicide."

Encouraging Conversations

As mentioned throughout the feedback, encouraging conversations about mental health and suicide was highlighted as the best way to begin tackling stigma around the issue. Therefore, creating opportunities to have these conversations, alongside the promotional campaigns mentioned above, was considered important. One suggestion was to create safe spaces in the community where people could drop in at any time to seek support, but without any "need to be part of the mental health system or referred somewhere." Others suggested that more counsellors, perhaps located in these safe spaces, were required. Not all respondents felt that this support had to be so formal, however, as long as organisations or communities had an identified person (or people) available to speak to about suicide and mental health, such as a mental health first aider/mental health champion.

> "Offering safe spaces and promote their existence as much as possible. I'm imagining a 'simply walk in' type of environment."

Themes Six and Seven - Raising Awareness and Capacity Building

Responses to this section of the survey were similar to those in the previous section which covered the theme “tackling stigma”. Several respondents referred to answers they had already provided and hence the focus will be on information that has not already been covered, nevertheless, there still remains some overlap in themes between the sections.

Offer training/learning opportunities (with a link to an awareness raising campaign)

By far the theme most often referenced in this section was to offer training and develop a national resource set to be used for building capacity. Some workshop attendees proposed that training should be mandatory across all public sector employees. As noted above in the stigma section, there was a suggestion to initially target this training to specific groups such as NHS staff, social workers, and health visitors as promoted through Ask Tell Respond resources.

In addition, it was noted that training and capacity building could also stress the importance for individuals to take care of their own mental health, with strategies for self-care. Similarly, others noted that long training sessions that last multiple days are less appealing to many who may otherwise have taken part and suggested that short day courses or even courses lasting a few hours would be more accessible. The offer of training should also be linked to a wider awareness raising campaign, which would point to the availability of these resources, as well as potentially offering advice for the less formal aspects of training such as questions to ask.

> “Stay clear of interventions that require in-depth knowledge and training. Teach peers how to ask relevant questions and how to talk with someone in emotional distress. Leave the psychology to the professionals. Be confident that resources are actually available and current.”

> “People need to be aware that just being there is hugely supportive - and not to be afraid of saying or doing the wrong thing. What is far more important in families and communities is not skills but relationships and caring.”

General Promotion Campaign

As mentioned in the “Tackling Stigma” section, and above, a large proportion of survey respondents suggested that a major advertising campaign to raise awareness and to promote training opportunities was required. This theme was also picked up in the workshops.

There were several suggestions as to how best to do this including through television, social media campaigns, art, posters, football and other sports clubs, and radio adverts. There appeared to be some desire to share this outwith digital platforms, such as social media, which it was recognised may not be accessible to all. Several responses suggested having celebrities sharing their stories and sharing details of the campaign on their social media accounts and through traditional media outlets would be particularly effective.

Some of the key messages to be promoted were that suicide prevention and mental health are everyone's business, encouraging conversations, how to ask questions and what questions to ask, as well as a more general message around mental health, such as "It's OK to not be OK." However, others pointed to the requirement for a campaign to promote positive action and interventions as awareness itself is not adequate to address the problem.

As with many themes, survey and workshop participants were very keen for those with lived experience, including families of those who have died or survivors, to be involved in the development of the campaign.

> "Only people going through crisis can explain what it's really like and what they really need."

Lastly, it was suggested that an evaluation exercise could take place to find out "what works" from current and historic promotional campaigns to raise awareness.

Schools, Colleges, Universities

As mentioned previously, schools and further and higher education settings were highlighted as key locations to raise awareness and to equip children and young people with the confidence and skills to have conversations around mental health and suicide prevention. Several respondents suggested that younger children should be educated in what mental health is and how to discuss it. Targeting messages to younger people was seen as a good way to practice early intervention and build support networks amongst peers. It was noted that while support was available for over 16s, that there was insufficient guidance for those under 16. Good work done by guidance teachers was mentioned, but it was suggested that more could be done and that teachers delivering Personal and Social Education and guidance teachers should be given further training in suicide prevention. As mentioned, it was also suggested that mental health and suicide prevention should be part of training for all teachers.

> "Schools and guidance teams do what they can in PSE lessons and in general incidents and issues. Please remember that Guidance teachers are not trained counsellors or medical practitioners. They are trained History teachers or Maths teachers."

> "Schools need more external support / Family Support workers etc. to support the complexities of the students' welfare concerns. Simply training up Guidance teachers seems the logical answer and most cost-effective one."

For young people at university and college it was highlighted that they often face challenging situations, perhaps living by themselves for the first time. Many young people are without suitable support networks or knowledge of how and where to seek support.

> "School, colleges and universities should be more involved in tackling the crisis. I am aware that most offer support, but from people's experiences it seems to not be functional. I think this currently happens because of how impersonal the message comes across and because of the fact, after all, that

> universities are organisations that need to preserve a certain image. However, especially young, isolated people (maybe that recently moved to a new city for uni or that just started high school) are at risk of falling in a cycle of dark thoughts."

Scotland's Mental Health First Aid Programme

A specific form of training and support that was raised by many respondents was Scotland's Mental Health First Aid and access to trained Mental Health First Aiders. This was in recognition of the important link between mental health and suicide.

> "Focus on suicide prevention should not be on just suicide, but on mental health more generally. Focus on suicides is not necessarily the best way to stop suicides."

It was suggested that mental health should be put on a par with physical health and legislation ought to be introduced to give effect to make training mandatory, or at least mandatory within the public sector in Scotland.

> "You could make it compulsory for every workplace to have a mental health first aider the same way as every workplace requires a physical first aider."

> "The ACSAT system in NHS Lothian works well, with an on call mental health team able to deploy at request of police or ambulance service."

Target Workplaces – private sector buy-in

Survey respondents and workshop attendees were keen to highlight that suicide prevention was a public health issue and should be addressed with interventions across society. This included a desire to see the Scottish Government and wider public sector engage with the private sector in recognition that "suicide prevention is everyone's business."

Workplaces were seen as key places to share messages and build capacity. It was noted that many people may feel uncomfortable in discussing these issues with their colleagues and that workplaces can be a source of negative stigma. Having at least one person in each workplace who is trained and can act as a champion for suicide prevention and postvention would help to address these issues.

> "Leadership being taken by orgs regardless of their ostensible relevance, if suicide is everyone's business"

> "Workplace mental health training was felt to be critical. Without this, stigma and perceptions around mental health and wellbeing would continue to negatively impact people in the workplace, making it less likely they will be properly supported. Considerations around this can and should include specific duties around suicide and mental health awareness for our public sector, recognising its role as a 'gold standard' employer."

World Suicide Prevention Day & Mental Health Awareness Week

Survey respondents noted that World Suicide Prevention Day is on the 10th of September annually and local initiatives around this, as well as Mental Health Awareness Week in May, were very effective in generating conversations and raising awareness. Many noted that it was frustrating that this was confined to a single day or week and suggested that the success of the day could be useful for further campaigns. One respondent pointed to National Suicide Prevention Week (4th – 10th September) in the United States as a successful example of building on World Suicide Prevention Day.

> "More awareness during year rather than focus on the national week."

> "Making mental health a topic for everyday and not one day/week a year"

Involve Community Groups/Communities

Many were keen for communities to be involved in awareness raising and capacity building work. Communities can play a key role in offering personal support and safe spaces for discussing and listening to issues, as well as signposting crisis and other support services. Community-led sessions displaying empathy and active listening were generally seen as far more effective than health-led medicalisation or assessment. It was also recognised that training could be delivered by community groups to help further develop awareness and capacity within members of those communities. To enable this, however, it was recognised that greater engagement with communities and community groups would be required and affordable or free training made available to them. In addition, they would require additional capacity, such as spaces to act as hubs or drop-ins. Provision of safe spaces in the community where support ranging from someone to talk to through to crisis support and support for bereaved families was a popular theme.

> "Non-medical crisis recovery centres are needed. Resources around towns that are not necessarily medical or mental health focused but can provide small measures of comfort for people approaching crisis or just having difficulty."

> "Groups in the community instead of only doctor/hospitals etc. I need to travel 30 miles to get to my local hospital and 10 miles for a doctor. This excludes certain groups that may have difficulty travelling or may put others off getting support as not easily accessible. More remote counselling sessions, more group sessions in local communities i.e. village halls etc"

> "For communities perhaps an easy to access website with information on what to do when helping someone with suicidal thoughts."

Building on and resourcing existing work: Local networks and partnership working, charities

Survey respondents and workshop participants were keen to build on existing good work to raise awareness and develop capacity. Survey responses from organisations in particular referenced good work done by local networks and partnerships. More

broadly, there was a desire to build on any ongoing work, and to develop interventions based on “what works”.

Proper resourcing for dedicated local suicide prevention capacity was also promoted. Respondents suggested that every local authority area could have a dedicated ‘champion’ who would promote the cause of suicide prevention, encourage partnership working across key agencies, highlight and deliver training activities, and share and learn from best practice nationally. It was also noted that sometimes service accessibility varies, with rural areas less likely to have the same range of available services, and that these local champions would help to ensure equity between areas.

> “The new strategy needs to provide ring fenced funding for local areas and ensure that there is……(a) dedicated suicide prevention lead in every local authority area in the country. These people should have a dotted line into a national organisation to ensure that best practise and learning is being shared equally across the country and implemented across the country.”

> “Feedback suggests that there is a need for increased and easier signposting of support within local communities and in particular equity of access within remote and rural localities. This is supported from feedback that states that National organisations supporting work (raising awareness/groups) in less populated areas needs to develop working with local organisations to support the agenda.”

There was praise for the existing work of many third sector bodies and a recommendation that they be properly resourced. Many respondents noted that rather than simply consider the total resource invested in this area a key success criteria would be how quickly resources could be accessed. It was suggested that the process to access small amounts of funding was too bureaucratic. Support and funding should be provided to allow good work to be scaled up. It was also felt that access to long-term funding was essential, particularly for smaller charities, which would provide security that could, for example address staff shortages.

Priority Areas

Respondents to the survey and participants in the workshop sessions were asked to identify the areas that they thought should be addressed as a priority. These are outlined below.

Training and Capacity Building

Training was seen as critical by the majority of participants. It was suggested that training should be tailored to meet the needs of a wide range of public sector workers. Some examples from a very long list include, teachers, first responders, general practitioners, public transport staff and school nurses. Workplace training, accessible to all staff should be provided that delivered, “ongoing training for professionals in the workplace.”
However, community based training was also referenced on numerous occasions and indeed many suggested “training for everyone.”

Improved Access to Support Services

A majority of workshop participants stated that easier access to support services should be provided. Typical comments included, “quicker and easier access to services” and “easily accessible non-stigmatising services available for any level of distress.”

Many respondents referenced the need to decrease waiting list times, provide a 24 hour drop-in service and ensure a simple and effective referral process with a single point of contact to access support.

Respondents also felt that access to a safe community base could be helpful and act as a support for people. This did not necessarily need to be a ‘mental health’ resource or service, but somewhere people felt comfortable to go so that it would support early intervention.

Education Settings

Schools were seen as key locations for preventing suicide by raising awareness and understanding from an early age. A ‘whole school approach’ to suicide could act by “promoting discussions for children and young people” and “building resilience in children” with support from “trained teachers, school nurses and counsellors”. It was also suggested that suicide prevention could be included in the curriculum so “kids are able to differentiate between low mood and suicidal thoughts”.

Raising Awareness

“Raising awareness and facilitating discussions”, “raising awareness in communities” and a “public awareness campaign” were all routinely mentioned by respondents.

It was also suggested that initiatives that “encourage people to feel that talking about suicide and their feelings was normal” should be encouraged.

Other responses included widespread advertising that reaches out to and engages with everyone. This will require a variety of approaches which could for example

include, advertising at education facilities across Scotland, sharing information on social media, and providing mobile phone apps.

It was also suggested that the contribution small local services can make to preventing suicide in communities should be recognised and supported financially.

Multi-agency Working

Greater efforts should be made to work collaboratively across sectors. “Working cross-sector”, “working together, locally and nationally”, “multi-channel approach” and “better links between national and local work” were all proposed.

Other Priority Areas

Other areas that were mentioned as a priority were the involvement of people with lived experience and better use of data and research evidence to determine the effectiveness of interventions.

Policy Areas

Many respondents both within the workshops and survey noted that there are a wide range of policy areas that can impact on suicide prevention strategies.

Mental Health

Alcohol, drug and gambling addictions and their potential to have an adverse impact on mental health were frequently mentioned by respondents. It was suggested that addiction is a "*huge issue*". Others suggested that mental health services should be provided to those still "*in the grip of addiction*" -in some areas this does not appear to be the case.

Perinatal mental health can also be a contributory factor to suicide ideation, and it was suggested that it would be beneficial to "*dovetail this area with others to ensure that the focus is on where the need for intervention is*".

Social Care

The main areas of focus were adult social care, care leavers and looked after children. Respondents in the survey mentioned that there needs to be an understanding of the "*support and experiences of difficulties*" in care settings.

Criminal Justice

Police and prison services were mentioned frequently as officers in these services have a high probability of coming into direct contact with individuals with suicide ideation. Many respondents noted that those who are experiencing suicidal thoughts and seek help may phone emergency services and are incarcerated whilst the relevant organisations are contacted. It was suggested this should be avoided, and that workers from relevant services and police officers offer support simultaneously. Training for police officers, call handlers and for staff and prisoners in the prison service was referenced on a number of occasions.

Education

Consideration should be given to raising awareness of suicide prevention at all educational stages from primary to tertiary. Many respondents noted the need for earlier intervention in a school setting as the "*earlier people are able to talk and build resilience to challenges that often lead to suicide the better for their future*".

Survey responses from organisations mentioned that tackling bullying and discrimination in schools could alleviate suicidal deaths in individuals who are LGBTQI, experience disability or are BME.

Transport

Access to affordable transport can play a key role in enabling individuals who have to travel to get the support they require that is not locally available.

Housing

Ensuring individuals have access to affordable housing along with support to sustain their tenancies was frequently mentioned by respondents. It was also suggested that individuals in hostels and residential units might need extra support to tackle loneliness and isolation.

Poverty

Poverty, according to some individual survey respondents, was an "*enormous factor*" that had to be considered in any suicide prevention strategy. It was suggested that addressing social, health and economic inequalities at a strategic level would assist in preventing suicide. At a local level specific community based activities targeted at the most vulnerable individuals were seen as offering practical support aimed at suicide prevention and crisis intervention. However, it was acknowledged that to continue to provide support services such organisations will need to be "*better resourced and supported."*

Examples of Training, Interventions, and Activity

There were many examples of activity highlighted in the workshop sessions and survey results. Information came from a wide range of individuals. A selection of the suggestions put forward are listed below. Please note these are based solely on participant responses and cover Scotland, the UK, and internationally.

Scotland - National & Local Initiatives

- Midlothian HSCP - Local mental health and wellbeing website Midspace - localised and consistent across all of Lothian Midspace | Mental health - information and support | Midlothian Council
- Support in Mind - https://ruralwellbeing.org/past-events/
- Fife HSCP - Suicide Prevention Network https://sway.office.com/DsmOtrNxCFtjYRMH?ref=Link
- Edinburgh Crisis Centre - http://www.edinburghcrisiscentre.org.uk/wordpress/
- Suicide review group in Tayside uses learning from deaths by suicide to influence action
- Perinatal mental health service in Fife - https://www.nhsfife.org/services/all-services/maternity/antenatal-care/enhanced-midwifery-support-services/perinatal-mental-health/
- Ayrshire Bairns app in Ayrshire & Arran – provides information on perinatal wellbeing and connect to health visitors - https://www.nhsaaa.net/news/latest-news/early-years-children-have-it-picture-perfect-for-new-ayrshire-bairns-app/
- The “S” word Ayrshire College - https://www1.ayrshire.ac.uk/news-events/news/2021/ayrshire-college-is-talking-about-the-s-word/
- Penumbra’s Crisis Centre, Edinburgh http://www.penumbra.org.uk/
- ‘Lyrics for life’, Edinburgh https://www.edinburghhsc.scot/lyrics-for-life/
- Mental Health nurses are located in all GP practices in Forth Valley
- DBI – Distress Brief Interventions https://www.dbi.scot/
- TRiM – Trauma Risk Management – a model of support for Police Officers and support staff involved in potentially traumatic incidents. https://www.scotland.police.uk/wellbeing/trim.html
- @_FCUnited to Prevent Suicide - “raising awareness and enabling conversations to happen” - https://mobile.twitter.com/_fcunited and https://unitedtopreventsuicide.org.uk/
- Scotland’s Mental Health First Aid (SMHFA) training – http://www.smhfa.com
- Learning from the work around trauma informed practice and Adverse Childhood Experiences (ACES) - http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces
- See Me - https://www.seemescotland.org/
- NES Trauma Training Programme - https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/
- Step on stress course - https://www.accesstherapiesfife.scot.nhs.uk/step-on-stress/
- Hot Chocolate Trust - https://www.hotchocolate.org.uk/
- 1000 students at UWS have participated in safeTALK training - https://prevent-suicide.org.uk/training-courses/safetalk-suicide-alertness/

- NHSGGC have developed peer support will include elements of suicide prevention but will also support wider MH and wellbeing
- 'How are you Dad' – Fathers Network Scotland. https://www.fathersnetwork.org.uk/so_how_are_you_dad
- 13 reasons why tv programme led to development of '13 ways to help your friends' for CYP https://young.scot/get-informed/north-ayrshire/13-ways-to-support-your-friends-if-they-are-struggling
- HUG Action for Mental Health - https://www.spiritadvocacy.org.uk/hug
- Seasons for Growth Training - http://www.seasonsforgrowth.org.uk/
- Talk to Me Scottish Prison Services - https://www.sps.gov.uk/Corporate/Publications/Publication-4678.aspx
- Chris' House Suicide Awareness - https://chrisshouse.org/
- Training in low intensity interventions for anxiety (for school nurses via CAMHS)
- Ask-tell-respond or ask-tell-ask approaches e.g. https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Curriculum_sample_14-0602.pdf
  Ask Tell Respond learning resources on mental health, self harm and suicide prevention for Scottish workforce (sign up to TURAS required for access).
  Course: Mental health improvement, self-harm and suicide prevention (publichealthscotland.scot)
- Suicide Prevention training (including safeTALK and ASIST) Suicide prevention training courses and resources - Suicide - Health topics - Public Health Scotland
- Samaritans 24/7 helpline - https://www.samaritans.org/?nation=scotland

UK

- 4 Mental health training developed in Wales https://4mentalhealth.com/
- Cancer care e.g. death cafes or bereavement support offered by Maggie's Centres. Could a similar approach be taken to talking about suicide?
- Postvention service in prisons in England and Wales; volunteers train staff - https://media.samaritans.org/documents/Samaritans_Postvention_in_prisons_FINAL_pdf.pdf
- Coroner's inquest (English model - Independent individual (i.e. coroner) takes responsibility for gathering info from all services and communicating it to the family
- Ripple initiative – https://rippleinitiative.wixsite.com/makearipple
- Stepping back safely - https://www.nsft.nhs.uk/news/news-stepping-back-safetly-1611/
- Roman Kemp documentary –Our Silent Emergency - https://happiful.com/roman-kemp-our-silent-emergency/
- Trieste model - https://www.coe.int/en/web/bioethics/-/trieste-model-open-door-no-restraint-system-of-care-for-recovery-and-citizenship-
- Decider skills - https://www.thedecider.org.uk/
- Beautiful Inside and Out - https://www.facebook.com/beautifulinsideandoutscio/
- VictimFocus - https://www.victimfocus.org.uk/

- New Medicines Service, England (increase adherence to medication) https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/pharmacies/new-medicine-service-nms/
- Psychiatry UK access, England https://psychiatry-uk.com/right-to-choose/
- WELL services https://www.wellshealthcentre.nhs.uk/

International

- Training in livingworks courses https://www.livingworks.net/
- Blue Knot Foundation, Australia (empowering recovery from complex trauma) https://blueknot.org.au/
- Orygen, Australia (Youth Mental Health Org) https://www.orygen.org.au/
- SUPRANET, Netherlands (mental health org network for suicide prevention) https://psychiatryamsterdam.nl/project/supranet/
- Vision Zero, Sweden
- http://www.welivevisionzero.com/vision-zero/
- Well man clinic 40-45 https://www.wellmanclinic.org/mens-health-services/mens-health-screening/
- Access to means intervention, farmers and pesticides sri lanka https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(17)30208-5.pdf
- Zero suicide approach, US https://zerosuicide.org/
- Suicide 1st responders for postvention, Netherlands (not found online)

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