OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 12 June 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 12 June 2018

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HEALTH AND SPORT COMMITTEE
19th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Kate Forbes (Skye, Lochaber and Badenoch) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Toni Giugliano (Mental Health Foundation Scotland)
James Jopling (Samaritans in Scotland)
Dan Proverbs (Brothers in Arms)
Craig Smith (Scottish Association for Mental Health)
Scott Walker (NFU Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 12 June 2018

[The Convener opened the meeting at 10:31]

Draft Suicide Prevention Action Plan

The Convener (Lewis Macdonald): Good morning and welcome to the 19th meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are switched off or switched to silent. It is acceptable to use mobile devices for social media purposes, but please do not record or film the proceedings, as we have people who do that for us.

Members of the committee greatly appreciated our informal engagement earlier with people with experience of suicide in their lives, which will certainly inform our views at the end of this evidence session.

Our main session in the formal meeting is also on the Scottish Government's suicide prevention action plan. I am delighted to welcome to the committee Dan Proverbs, founder, Brothers in Arms; James Jopling, executive director, Samaritans in Scotland; Craig Smith, public affairs officer, Scottish Association for Mental Health; Toni Giugliano, policy and public affairs manager, Mental Health Foundation Scotland; and Scott Walker, chief executive officer, NFU Scotland. I thank the witnesses for joining us; we all look forward to hearing what they have to say.

As always, questions and answers should be through the chair. We will endeavour to cover the territory in a substantial policy area. To get us started, I ask each of the witnesses to give their views on the extent to which the Scottish Government's draft suicide prevention action plan addresses the recommendations that were made in the suicide prevention strategy report.

James Jopling (Samaritans in Scotland): We were quoted publicly as saying that we were very disappointed with the first draft that the Scottish Government produced. Given that we had waited for over two years for a new national plan, that suicide took 728 lives in Scotland in the last year that we have data for and the impact of suicides across communities and families in Scotland, we thought that the plan needed to do more, that it needed to show more ambition, that more investment was needed in resources to support those in crisis care and others before, during and after suicide, and that more effort was needed to address the stigma relating to suicide, which can be deep seated in communities and families.

We are undoubtedly getting better at addressing some mental health issues and at talking and listening more, but there is far more that we can do, and we need to address that, because Scotland has a higher suicide rate than other countries in the United Kingdom have, particularly for men. That business has not been completed, and that work has not been given the attention that it needs. We absolutely acknowledge the impact of work that was done in the early 2000s and that the suicide rate has declined over time, but our worry is that, with the increase last year, there might be a return to the rate increasing. That is why a plan is so critical at this point.

The Convener: Does any of the other witnesses want to add to that general point?

Craig Smith (Scottish Association for Mental Health): My point is kind of similar to James Jopling's. SAMH took a hopeful and helpful view when the original draft was published. We were disappointed with the scope of some of the proposed actions, but we are happy to see progress made. The Government announced in a recent parliamentary debate that the final plan will have provisions for reviews of all deaths by suicide—which SAMH has called for over a significant period—and increased bereavement support. Those are welcome moves in the right direction.

It is key for us that the plan is ambitious. Deaths by suicide increased in 2016, although we have to be cautious about looking at a year's deaths, bearing in mind the context of an overall reduction in suicide in the long term. However, we do not want 2016's increase to become a trend, so suicide prevention needs to be a key focus for government, nationally and locally. We would like a plan that has clear and transparent funding and which restates the link between the national and the local by providing national leadership and infrastructure to implement local suicide prevention activities to build on the reduction in suicides over the past decade.

We are concerned that there has appeared to be a lack of focus, or a reduction of focus, on suicide prevention activities in recent years. We are happy with some of the Government's recent movement in the further iterations of the plan, but it needs to go forward and we need a clear understanding of how the plan will be transparently resourced.

Toni Giugliano (Mental Health Foundation Scotland): I welcome and agree with everything that has been said so far. The Mental Health Foundation has taken a clear view about the structures of suicide prevention in Scotland. We

think that a new organisation or body needs to be set up to drive forward suicide prevention work in Scotland. That work has been eroded locally, with regard to funding and transparency, and there is not a clear view or understanding about the work that is going on, primarily because no single organisation can give us that information, given the diverse work that is happening locally with no national oversight at any level.

New ambition, leadership and drive need to be instilled at a national level, and the way to do that is to create a new body that will pursue that work with local organisations on the ground. It could be created in conjunction with third sector organisations that have expertise in suicide prevention, to ensure that the public trusts the organisations that are involved in the suicide prevention strategy. Choose life has been perceived as a marketing tool or brand, but it is not an organisation that people would turn to for help. We need to create a trusted body that can put new leadership, drive and ambition into suicide prevention in Scotland and work with organisations on the ground, and we have been clear in our meetings with the minister that that is what we want.

Another priority area that I hope we will explore in greater detail is families who have been bereaved by suicide, which Craig Smith has touched on.

Dan Proverbs (Brothers in Arms): As a fairly new kid on the block, it seems fairly simple to me—although it is almost the elephant in the room—that there is a lack of recognition that 75 per cent of all UK suicides are male. It says something that we are the only charity that is specifically trying to reduce male suicide.

However, the fact that SAMH has put funding into research about male suicide in Scotland is a positive step forward, and we wait to see what we will learn from that. We need to start looking at the fact that men in Scotland are at risk of taking their own lives, especially in the more rural parts.

Scott Walker (NFU Scotland): I agree with everything that has been said so far. For us, the issue is how to have a multistrand approach that engages with rural areas. The feedback that I get is that anonymity is hugely important, which goes back to the issue that has been touched on a couple of times this morning to do with the stigma of suicide and mental ill health. That is not just about those who unfortunately die from suicide; it is also about the families, who need support and engagement going forward. The strategy needs to look at how we prevent suicide and how we support the families who are unfortunately affected by it so that we can get to a situation where we can talk about it openly and, I hope, prevent people from getting to the stage of a crisis.

The Convener: I have been struck by some of the evidence about the change in focus and levels of activity around suicide prevention at the local level. My recollection of the early years of the choose life network was that it was dynamic and it had a co-ordinator in every local council area. What has changed and why has it changed, if that dynamism has indeed been lost?

Toni Giugliano: Through our freedom of information requests, we have found that a number of local authorities have been reducing their funding for suicide prevention. There is no longer strong ministerial guidance to local authorities on directing money towards suicide prevention. Undoubtedly, that has resulted in some local authorities not prioritising this agenda.

Some of the FOI information shows that there are great disparities in plans across the country. The vast majority of areas do not have updated plans, and most of the plans are not strategic plans. There is not a great deal of detailed information about the work that is being done on the ground.

We have been clear that we need to look at what the local data is telling us about suicide and whether the action plans mirror that. It is difficult to know what is happening on the ground, particularly in rural areas, which I think we will be talking about a lot today. We need to ensure that the action plans mirror the data in rural areas. We need more clarity on what is being done on the ground. We cannot have that clarity and the Government cannot have it if we do not have updated plans.

On posts and positions, some areas will have co-ordinators who might be employed for a handful of hours a week to deal with the issue. There are great disparities right across the country. Although we need local dimensions, at the same time, there needs to be national leadership. We need a national body that can provide best practice and leadership.

Funding is also a huge issue. Areas need to be able to bid for funding from a central pot of money to ensure that funding is not being eroded. We are not confident that, in the future, local authorities will continue to prioritise suicide prevention funding, which is why we believe that it should not be left purely and fully in their hands. We need an innovation fund that could be managed by the national body, working in tandem with local areas, to ensure that local suicide prevention work is being done on the ground.

James Jopling: We lack accountability, ownership and evaluation of local plans, which is different from where things started in 2002. I have been to two local structures in the past week—one in Glasgow and one in Highland—and there were

very different people at each. One is led by someone from the third sector and the other by someone from the mental health division. Different organisations were around the table, some of which are first responders and some not. In Highland, there is no choose life co-ordinator at the moment.

The structures worked when they were introduced in 2002, but we have lost the sense of whether there is a reasonable plan to address the highest-risk groups in a local area. Are we investing in programmes to support those individuals? How can we evaluate what has worked?

When we started our efforts in the 2000s, we saw a reduction in the number of suicides and other colleagues of mine in Samaritans looked to Scotland as the model. Last year's inquiry by the Health and Social Care Committee at Westminster identified that 95 per cent of local areas had local plans in place and that there was a commitment to evaluating those plans. Neither of those things is the case in Scotland, and that is where we need to make up ground.

10:45

The Convener: We have gone from being ahead to being behind.

James Jopling: It feels that way.

Craig Smith: Much of what I was going to say has been covered by James Jopling and Toni Giugliano. I will reiterate some of their points and talk about the key link with funding.

Back in the early 2000s, there was transparency with regard to funding and there was a stronger national choose life infrastructure to support the development and delivery of local plans. With the change in the local funding arrangements, we have completely lost that transparency of funding. As the Mental Health Foundation has done, SAMH has submitted freedom of information requests to local authorities on whether they had a choose life co-ordinator and, if they did, for how many hours that person worked, and what dedicated funding they had for suicide prevention. Fewer than half of local authorities could give us the answers to those questions.

We know that there is a huge disparity in the activities that are undertaken across the country. SAMH manages the north-east choose life co-ordinator, who covers Aberdeen and Aberdeenshire, where excellent local work is done. The award-winning choose life app, which has been developed in Aberdeen and Aberdeenshire, allows people to access information about suicide and suicide prevention anonymously and then get linked to support, but we do not know whether that good work has been replicated across the country. That is a huge issue.

We would like there to be a national infrastructure to help local partners to develop plans to share good practice and to have transparent funding arrangements. We are very keen for the national leadership group to be a budget-holding organisation that can fund local areas directly, perhaps through an innovation fund-type arrangement. Alternatively, we could learn from what has been done in England. As James Jopling said, we know that 95 per cent of local areas in England have a suicide prevention plan or are actively developing one and are developing arrangements for evaluation of those plans. In England, there is also dedicated suicide prevention funding—£25 million is to be provided over the next three years. Part of that funding is disbursed directly to clinical commissioning bodies in line with the local action plans, so there is a linkage between activity and funding, which has been lost in Scotland. Having that arrangement, or a similar model, in Scotland, which makes it possible to track the funding against activity and to evaluate the activity robustly, would make a huge difference to making Scotland a leader again in suicide prevention.

It is very sad that many of the early choose life activities that were pioneered in Scotland are being taken up in England and Wales but appear to have been lost in Scotland.

Dan Proverbs: We are at the sharp end, because we deal with many members of the public who have been affected by suicide. They would not know what choose life is, because there is no visibility. That in itself tells us something.

Emma Harper (South Scotland) (SNP): I am aware that, in Dumfries and Galloway, the NFUS and NHS Dumfries and Galloway have a wee pilot programme to work collaboratively to look at isolation as well as mental health issues. Perhaps Scott Walker could say a few words about the rural mental health forum, which I assume will feed into the process of establishing how well people are working together to address rural isolation and suicide.

Scott Walker: I will start off with a negative comment before moving on to the positive side. I am not sure how that project will feed into what happens elsewhere. On the ground, it is highly visible and has been very well received, and it is hugely important on prevention, before people get to a crisis stage, but I am not aware of how that good practice down in Dumfries and Galloway will feed into change that could influence what happens elsewhere in Scotland.

We have initiatives in Aberdeenshire that involve working with the national health service up there on a programme of soft engagement with rural communities. That activity is about going into rural communities and doing something as simple as starting a conversation with somebody who has a back problem, which could lead into further engagement with them. It is a case of getting that early engagement wherever possible.

The scheme that you highlight in Dumfries and Galloway is a good one, and it is one of many schemes that we have in that neck of the woods. However, it is disconnected from what could be a national project.

Craig Smith: Shared learning is important. There are models in Scotland that work very well and which could be adopted. The children and young people improvement collaborative and the Scottish patient safety programme both pioneer local innovations and bring people together to disperse that learning nationally. The national leadership group for suicide that is being prepared could be a key body for the facilitation of that shared learning. There is potential for that to be built into what is being done.

Alex Cole-Hamilton (Edinburgh Western) (LD): Before the meeting this morning, committee members met a group of families and individuals who have been affected by suicide. I thank them for their candour and for sharing their moving stories. One of the consistent themes that came up in that meeting was the lack of access to talking therapies. Capacity issues are such that a general practitioner's first recourse when someone comes to see them with a mental health problem will be to medication, because there is no talking or psychological therapy intervention available. How do we increase that capacity? Where is the system working well in that regard and how do we replicate that elsewhere?

Another issue is that, even when there is access to talking therapies, there is no continuity of care. We heard about the horrific case of an individual who, in the five months during which they were unwell before their suicide, saw five different psychiatrists. Someone with cancer would not see five different cancer surgeons. Why do we not have continuity of care, and how do we change that?

The Convener: Those are two big questions. Who would like to start?

Toni Giugliano: The first thing to say is that psychological therapies and talking therapies play a crucial role in mental health on a wider level. It is important to state on the record that we should never stigmatise people who are on medication for mental health purposes, for whatever reason. Medication has an important place in treatment. It is safe and it works for a lot of people. It is not for everyone, and, in many cases, GPs and health professionals will have to go through a trial-and-error process to find out what works for an individual. Patient choice has to be at the heart of what is going on. Patients and professionals have to come to an agreement together about what the best course of action is for each individual.

The Mental Health Foundation has pointed out that a problem arises when medication is given in situations only because there is, essentially, no alternative. We need to be honest about that issue. Is it happening? If it is happening, we need to address it. We have previously said that we would like there to be an independent review across the UK of how decisions are being made about the various options—whether they be psychological therapies, social prescribing, which is very effective for many people, or medication—and of whether resource issues impact on such decisions. The National Institute for Health and Care Excellence guidelines make clear, especially with regard to children and young people, that medication should not be the first port of call in most circumstances, and that talking therapy should be.

I completely take the point that Alex Cole-Hamilton made about continuity; it is unacceptable that anyone should have to see five different psychiatrists. We would not accept that situation for a physical health condition and it is not acceptable that anyone could have to undergo that process for mental ill health.

Craig Smith: I will comment on both aspects of the question. We should be honest that there is not enough talking therapy. The committee will have seen the statistics published last week by the Information Services Division, which showed that only one or two health boards met the 18-week target for talking therapies—NHS Ayrshire and Arran did so—and that is a long-term trend. There is a huge issue with the resourcing of talking therapies.

Talking therapies are an important part of the overall suite of mental health treatments. As Toni Giugliano has said, medication plays a very important role and can be crucial for some people. There needs to be a range of social prescribing, activity-based therapies and talking therapies. Talking therapies are crucial in the suite of treatments. There needs to be a focus on how we bring down those waiting times and how we increase resources for talking therapies.

The other very important aspect of the question is crisis care support and continuity of care. It is absolutely unacceptable that someone has to keep asking for help—from different places, from different people—does not get that help and then

is pushed further and further into crisis. We need much better crisis care pathways.

In England, MIND, the Government and NHS England have pioneered work on crisis care concordats. SAMH has called for those in Scotland—we should have national crisis care standards on what is expected if someone in crisis presents to any statutory or non-statutory service. There would also be local guidelines and care pathways that are shared by the statutory sectors, accident and emergency departments, GPs and the third sector, so that someone who is placed on the pathway will get routed into care as quickly as possible.

When someone is in crisis, it is crucial that they get an empathetic, humane response, as quickly as possible. It is important that no additional barriers are put up, whether that is in A and E or wherever. Getting crisis care right is important. That support for crisis services and crisis pathways will be a key aspect of the suicide prevention strategy.

The current approach is unacceptable and we hear about that often from people who use our services. SAMH has carried out more than 500 applied suicide intervention skills training interventions since 2014. Suicide prevention is a key priority for us, working with people who ask us for help and working with our own service users. Time and again we hear that the experience of crisis support is not up to standard. It works really well for some people and there are some great crisis services. However, there are other people who continue to face a stigmatised response when they ask for help, either with self-harm or suicidal ideation.

That is another priority that the national suicide prevention group will need to tackle and it must support local areas in developing a good crisis response.

James Jopling: Last year, we did some research in the Highlands with people who had experienced suicidal thoughts or lost relatives to suicide. There is a disproportionately high suicide rate in the Highlands. I will give a brief, verbatim quote from the research:

> "Services are terrible, terrible, almost on the verge of non-existent. Theoretically, I'm supposed to see a psychiatrist every three months, but we haven't had a permanent psychiatrist in post for about seven or eight years now. We have a series of locums and I must have seen eight, nine different locums in the last few years because they don't stay. They stay a couple of months and then move on, there's no continuity of care and at the moment, the backlog of appointments for psychiatry is enormous."

That comment is from someone who lives on the Isle of Skye. I make that point because I know that you spoke to people from the central belt today. As others have said, it is a very common theme.

Another issue that we have looked at recently is about people knowing about the first place to go. Like other organisations, Samaritans has done work on the admirable approach of encouraging people to talk and listen and mean it when they do so. We can all do that. The question is what happens after that. If you go to an app or an online resource and you are signposted to somewhere that you might get help, what happens after that?

When we asked a sample of the Scottish population back in April whether, if someone close to them was experiencing distress or trauma or was in crisis, they would know where to turn to get help for that person, 40 per cent of people in Scotland said that they did not know where to turn. If it were a physical injury, people would hazard a guess or they could plump for 999 if nothing else. If it is not physical, those first stages are not in place and after that there is no continuity in resources. Crisis in such situations might be something that someone goes in and out of over a period of months or years. Samaritans can sometimes be there in that emergency situation, but what happens after that?

Dan Proverbs: I use medication and I have used talking therapies so, as somebody with lived experience, I appreciate that talking therapies are out there. However, there can be waiting lists, especially for talking therapies. If somebody is not in a position to self-manage, that can be very difficult.

11:00

A digital strategy should be part of the strategy. We should use apps, which have just been mentioned, or other forms of digital technology to support those who are on waiting lists for a talking therapy or waiting to see the GP. We launched our own app and had 1,500 downloads in 90 days, and our app has reached Stornoway and all parts of Scotland. Apps are not the answer, but they are part of the available support. It is easy, especially for men who do not want to talk about their stuff, to download them to use in private and in confidence. A digital strategy needs to be part of the suicide prevention plan.

Emma Harper: The SAMH submission says that there needs to be a new national target for reducing the number of deaths by suicide. Is there merit in developing such a target?

The Convener: Short answers are allowed for this question, because of the time.

Craig Smith: Yes. SAMH definitely believes that there is value in having a national target. We reflect back to the choose life strategy in which

there was a 20 per cent target and a significant reduction was achieved. I know that there is a debate about targets in healthcare. I reflect on the Harry Burns review, which SAMH took part in, that found value in healthcare targets.

Suicide prevention would benefit from a target as it would provide ambition, drive and focus at a national level. However, there are some caveats around that. Although we very much support a national target, it would not be for us to decide. We are clear that a target needs to be evidence based, robust and ambitious, and we see it as an early action for the national leadership group to bring together experts, academics and stakeholders, particularly those with lived experience, to devise an ambitious target for Scotland that can push resource. A target is not the be-all and end-all, but it would help to frame the issue. It does not need to be just a simple target; although we would like a reduction target, it could be multilayered and look at inequalities, deprivation and the inequality between the deprived and least deprived areas.

Although we strongly believe that a target would have its use, it is not the be-all and end-all. What is important is that it is evidence based and robust.

James Jopling: I am less minded to have a specific target. If the ambition is right and compassionate, and if we aim to make sure that nobody who is facing suicide is alone, we can deliver against such an ambition, which we can get behind locally and nationally. I would not want the success or failure of the plan to be judged only on the suicide rate, as there are so many factors involved in driving it. Of course we want there to be fewer suicides, but I am less sure that setting an absolute target is the way to do it. I am sure that expressing an ambition—we are beginning to see the green shoots of that since the first draft came out—is the right way to go.

Toni Giugliano: Targets are probably the only issue on which SAMH and the Mental Health Foundation might not entirely share a view. We made it clear to the minister that we are not in favour of a target. We are not interested in an arbitrary target that might turn into a political football.

We need to focus on prevention and evaluation. We have not had an evaluation of suicide prevention in Scotland. Evaluating suicide prevention programmes is tough, complex and difficult, but it is not impossible and there are a very few countries—including, I believe, New Zealand—that have done it. Just because very few countries have done it does not mean that we should not, and unless we evaluate what does and does not work, we will never fully understand which programmes work.

We know, for example, that the identification of low mood and the management and treatment of depression are effective ways of preventing suicide—the evidence is clear on that. We do not have evidence on many other programmes, which is why it is time to evaluate those. For us, the focus is very much on the evaluation of what works and what does not. It is about taking a preventative approach that is also a public health approach. It is therefore not purely about what will be happening in the suicide prevention strategy but is about what is happening in our schools and in our workplaces. That public health perspective on suicide prevention is what will reduce—we hope—the number of suicides in Scotland.

Dan Proverbs: We already have the fact that 75 per cent of all suicide in the UK is male. For me, we should be looking at that and working towards reducing that figure. That is where we are when it comes to men and how we cope with our emotions: we tend to take our own lives.

The Convener: So there is no specific view on the national target in Scotland.

Scott Walker: A target can be a blunt instrument and people become focused purely on that headline figure; whereas, from listening to the evidence that has been given so far, it seems to come down to local action plans, best practice and targeted evidence, which seem hugely important. That would be the way to go forward, rather than just focusing on a single figure and a single target to achieve.

David Stewart (Highlands and Islands) (Lab): I will raise the issue of inequality, which is important irrespective of the subject of the inquiry that our committee undertakes. The Samaritans in Scotland have pointed out that suicide rates are three times higher in disadvantaged areas. Does the draft strategy adequately deal with inequality? Perhaps we can start with the Samaritans.

James Jopling: In addition to the statistic that you just quoted, we know that the poorest men in the poorest communities in Scotland have a suicide risk that is ten times greater than that of the wealthiest men in the wealthiest communities. Inequality is inextricably linked with increased suicide risk. In a recent report, we looked at some of the reasons why that is the case.

Inequality is one of the reasons why any approach to suicide needs to be embedded in other key Government functions, both nationally and locally, so that we understand that connection. Not every suicide prevention project has that title plastered above the door. There are projects that are about increasing employability, supporting people who have been out of work for a considerable period of time and supporting those who are in a period of uncertainty around

employment. We know that those are periods in which suicide risk can increase and supporting people at those times needs to be addressed. That is why it is so important that the draft plan stretches into those areas of Government and speaks honestly about suicide being one of the risks associated with inequality. We think that that is critical, but we do not see it addressed consistently enough across local plans. It is something that we would certainly expect to be taken account of in any future plan.

Scott Walker: Inequality is certainly part of the problem, but in rural areas it is also about isolation and going through change. In farming, we are going to go through a significant change. For people in the farming community, being involved in a farm is not just a job but an entire way of life; it is about how they view themselves. Brexit and common agricultural policy changes will create a period of change.

When the Government is looking at policies and how they impact on people, the key bit is the people and how they are impacted. How do we provide the networks or support mechanisms that reach out to individuals? If we look at the farming or rural community in isolation, agriculture inspectors are possibly the only Government individuals who connect with farmers on a regular basis and that connection could be used as a signposting mechanism.

Inequality is an issue in rural areas, but there are also issues of access and rural isolation.

Dan Proverbs: I agree that inequality is an issue, but we also need to consider what I call brothers hiding in plain sight. Because men hide their feelings and put on a suit of armour, we tend to forget that everyday man can be affected by this. Somebody who can be the life and soul of the party, is successful and has good status will take the same path if they cannot find a way of dealing with their mental health problems.

Toni Giugliano: There is simply no escaping from the fact that people in the most deprived areas are about three times more likely to die by suicide than people in the wealthiest communities in Scotland. There is no escaping from the fact that inequalities are likely to lead to mental health problems in general and depression in particular.

Generally speaking, people who experience suicidal ideation will have experienced some form of loss. It could be loss of income, loss of a job, loss of a relationship, loss of friendship, loss of pride or loss of self-esteem. Perhaps we will discuss training, but that is why we are clear in our written submission that we should not be looking purely at the health service and GPs. We also need to look at jobcentres and ensure that training is available for staff there, and places such as citizens advice bureaux, because debt is a huge issue and we know that financial burdens have a big impact on mental health. Lawyers should also be involved, because of their work on break-ups and divorce. We suggest in our submission that we should look at training, not just for clinical staff in our hospitals and for GPs, who should get core training, but for a wide range of key staff in a host of places.

In the Mental Health Foundation Scotland's recent report, which was published in mental health awareness week, we call on the UK Government to conduct an impact assessment of its austerity agenda and to look closely at the impact of welfare reform on mental health, particularly for people with mental health problems. There is clear evidence that the austerity agenda and welfare reform have had a huge impact on people's mental health, particularly around employment.

Employment is a significant area. The statistics show that about 70 per cent of people in Scotland who have taken their own lives were in employment. It is important to look at in-work poverty and job security. I could talk for hours about zero-hours contracts, for example, and the impact that they have on people who are forced to take such contracts because they have no other choice. The economic and welfare impacts on mental health are significant.

David Stewart: In other words, the wider picture is whether we understand the social determinants of poverty and inequality, and our suicide prevention policy should really be embedded in all policies that Governments engender.

The Convener: I think that we can record that everybody agreed with that proposition.

David Stewart: That is probably the first time in my life that everybody has agreed with something that I have said. [*Laughter.*]

Sandra White (Glasgow Kelvin) (SNP): We have heard from the panel about healthcare by GPs and hospitals and about national leadership. I want to talk about taking a whole-community approach. The Mental Health Foundation Scotland mentions the criminal justice system and workplaces in its submission, and Toni Giugliano talked about the importance of schools, colleges and so on. Your evidence shows the importance of all those places. What role do you see the suicide prevention action plan and the mental health strategy playing in schools, workplaces and the criminal justice system?

I will throw in another issue on which we have heard evidence. I mentioned hospitals, GPs and the health service, but should the money for the strategy and for mental health perhaps be given to public health or to education?

I throw open those questions to whoever wants to answer.

11:15

James Jopling: On your last question, we know that, in Scotland, 25 per cent of the people who take their life have been to A and E in the three months before their death. Of that 25 per cent, 40 per cent went to A and E in the week before their death. Although suicide is relatively rare across our society, there are key opportunities when dealing with people compassionately and ensuring that they receive support—not only at the point of contact with health services, but outwith that and afterwards—are critical in playing a role in suicide prevention. We need to look at those touch points during someone's life when there might have been an opportunity to change direction and focus. It is critical that people at those touch points know how best to respond in those situations.

Wider than that, our ability to support—for want of a better word—peer-to-peer support is critical. For more than 25 years, the Samaritans has run a programme that trains prisoners to be Samaritans and to support other prisoners across the UK, because they best understand the stresses and the strains of other prisoners. We can take that model and ensure that people in communities are equipped with the same basic skills that we equip prisoners with. Some of the best people to understand the stresses and the strains that you might face are the people alongside you, and some of the people you might trust to have conversations about that might be the people alongside you.

I completely agree that suicide prevention must sit foursquare within the new public health agency's approach, and be embedded in an approach that looks at resilience and developing compassion in all the engagements that we have, both individually and in more formal settings.

Craig Smith: I will build on Sandra White's last point about public health. We strongly believe that that should be the locus for suicide prevention. As has been said, suicide prevention covers all policy areas—it has to. There needs to be a focus in education, health, justice, housing and welfare.

Institutionally, suicide prevention policy should be located in the public health environment because of the role that public health plays in health inequalities. We would much rather see suicide prevention sitting at a local level in the public health space, which is under development as a result of the reforms, rather than solely sitting with local authorities or integration joint boards. Public health is the best place to get all the different actors around the table and to develop targeted responses.

We definitely need a whole-community approach. We need a multifaceted approach to suicide prevention, with strong national leadership and national priorities that are very much informed by local need.

Sandra White mentioned schools and education. We know that suicide is a leading cause of death among those under 25. Schools, colleges and universities have a key role to play. The organisations must have awareness of suicide prevention and staff must be adequately trained, so that they are able to identify the risks of suicide—that is very challenging to do—and support people in crisis. We need to see that in the context of wider mental health provision, such as through school-based and university counselling.

As Toni Giugliano said, training is key. We would like to see, for example, all staff members in the new social security agency, the wider welfare service and jobcentres receive suicide intervention training.

We know that, in primary care, GPs lack understanding about mental health and do not have any formal mental health training. An understanding of suicide prevention needs to be a key part in the role of link workers and GPs routeing people into support.

As I said, a multifaceted approach is needed. It always comes back to the balance between a whole-population approach and a targeted approach. That balance must be made clear. We need a clear and well-resourced national infrastructure to support national priorities, because we know that suicide impacts everyone, but we also need to take a targeted view. For example, we know that middle-aged men in deprived areas suffer disproportionately from suicide. We know some of what works; we know that—

Sandra White: I do not mean to interrupt, but I want to clarify my last point. Although we put money into the mental health strategy and the health service, should schools and colleges be able to get money from that budget, too, rather than it staying in health? That is what I meant.

Craig Smith: Yes, definitely. Suicide prevention needs to be funded across the board, although how that could happen is up for debate. We have proposed a national suicide leadership group that could hold a budget and do some funding. We also know that, at the moment, there is pupil equity funding, but we need a more long-term, robust form of funding for mental health provision in schools. Whether that would come from the existing mental health budget is up for debate.

While I am on a roll, my last point is that we know that there are populations that are at risk, such as men in deprived communities. We know

that there are things that work—such as peer support, which has been mentioned. In Edinburgh, SAMH runs a Movember-funded project called the changing room, in which we bring together Hibernian football supporters to discuss mental health, raise awareness and do shared projects. Men in their middle years are a group that is particularly at risk. We know that activity-based projects, such as those involving horticulture, sports and physical activities, have a key role there.

We need a wide vision of what is required to prevent suicide; it is about having national priorities as well as local information about need.

The Convener: Thank you. Before Scott Walker answers—which I know that he is keen to do—I will bring in a linked question from Kate Forbes, and perhaps the panel could address both questions.

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): My question is whether the approach should look at targeted areas or the whole population. There are two particular populations on which I would like to have the panel's views on how we use the whole-community approach to reach people. The first is people who live in rural areas. The point was made that people who best understand those at risk should reach out to them. How can we do that better in rural areas? The second is minority groups that might have language or cultural barriers or might not use services in the same way.

The Convener: Scott Walker, please—and feel free to answer Sandra White's point as well.

Scott Walker: Huge consensus is breaking out. It goes without saying that public health professionals are very important. For me, the approach is then about looking at the at-risk groups, identifying who the key ones are, what the touch points are, how we engage with such groups and who speaks their language. It is about finding who can engage with them, pull them back from crisis and show them the support that they can receive.

For agricultural and rural areas, I believe that one of the successful groups is the Royal Scottish Agricultural Benevolent Institution—RSABI—which, in the past, was a benevolent institution to help farm workers who had fallen on hard times. It has evolved over time and now reaches out to and deals with not just farm workers but farmers and farming families who have difficulty. It is an organisation that can engage with and signpost people elsewhere.

If we are looking at how to engage with people in rural areas, we must look at people who hold trust in such areas. Looking at the issue more widely, I would highlight the inspectors from the agricultural departments, who engage with people on farms and could see where there is a change in people's behaviour and signpost them towards help in the system. We must upskill such individuals. Again, it is key that such an approach should become embedded. We talk a lot about resilience in farming, but not always about the resilience of the individual. We must ask how we can build that, because we know that challenging times lie ahead.

Around this table, we have networks that have innovative ways of working. It might be helpful to ask how they might bring their skills to and engage with local community groups, of which there is a whole network of strong members. The networks could go to Shetland, Orkney, the Western Isles, Dumfries and Galloway or Aberdeenshire, but they would need to tailor their approaches slightly differently in each of those areas. We must give them access to funding, but another theme that we have touched on is that it is also important for them to have access to best practice. We must ask who can go and support local groups in training them so that they can deliver what is needed on the ground.

Brian Whittle (South Scotland) (Con): Good morning, panel, and thank you for coming in. Even in my short time in this place, the change in attitude towards mental health issues has been quite remarkable. There is a long way to go in destigmatising such issues, but that has already moved forward by a huge distance.

In this morning's evidence, and in the traumatic and compelling evidence that Sandra White and I heard on a visit last week, it has been obvious that the approaches are hugely diverse when people first ask for help—Toni Giugliano touched on that. There is huge diversity in the approach of our healthcare professionals, in how people are treated at school and in how the justice system and the police deal with poor mental health.

The witnesses have touched on social security staff and lawyers needing training. Where are we in the timeframe? By the time that a healthcare professional or a teacher gains their qualification, their approach seems to be already out of date. How do we deal with that?

Toni Giugliano: We have called for training to be modularised, streamlined and brought together. There is a host of types of mental health training and suicide prevention training and, to be frank, schools and workplaces are confused about what is what and about what is suitable for them.

The new body should bring together and modularise the training. A staff member's level of engagement with the public should determine the level of training that they get. As a minimum, each organisation should be trained in mental health

first aid and suicide prevention, as well as physical health first aid. We want to bring mental health first aid training to the fore, in the same way as physical health first aid training. The answer to your question is that we are nowhere near that.

The Scottish Government's consultation paper said that, according to NHS Health Scotland,

"92,521 people have been trained in ... mental health or suicide prevention across Scotland".

That is all very well, but a lot of that is historical data, and a lot of those people need to be retrained. Physical health first aid training needs to be done again after three years, and we need the same approach for mental health first aid training. Anyone who undertakes such training is likely to need further training, as with physical health.

That process is important, but I go back to Sandra White's point about a targeted approach, which I stress. We need to target transport workers, lecturers, prison officers, victim support staff, lawyers and those in jobcentres, in addition to those in health services, for training to perform interventions if and when necessary. However, we are not at all at that point.

Whatever the new body is called and whatever function it has, it should definitely bring together and modularise the training, to make it easy for and to incentivise workplaces to arrange training for their staff and particularly for line managers, who are critical to creating a working environment that people thrive in. As a minimum, workplaces must start looking at mental health in the same way as they look at physical health.

Dan Proverbs: Funnily enough, we have been involved in a pilot project with a major retailer on mental health awareness training for line managers. Line managers are the direct link with their team. When someone's performance dips, a line manager normally takes them into a performance management situation; now, the line manager will have the awareness to consider whether other things, such as depression, other mental health issues or events at home, have caused the dip. The fact that a major retailer is looking at that approach tells us that it is a good way forward.

11:30

Craig Smith: We have a slight concern with what the draft strategy says about training. What is key for us—and what we know works from being an ASIST trainer and having undertaken, since 2014, more than 500 ASIST interventions to support people in crisis—is intervention, so we do not want the intervention aspect of suicide prevention training to be lost. Giving individuals the skills to support someone who is thinking about suicide and who might have a plan around suicide, so that that the person can access help and develop a safety plan, is key and effective.

We would like ASIST to be retained. We know that there are issues to do with financing the licensing of ASIST, but we also know that it evaluates excellently—there are numerous international evaluations that show that it is a good programme. The Scottish Government evaluated ASIST in 2008 and found it to be very effective. We would like it to be retained, in particular for its interventionist aspect.

If ASIST is to go, we want to be reassured that a new suicide prevention training model will not be about just awareness raising. Awareness raising is key and there is a huge amount to do to tackle stigma around suicide, so it should be an aspect of the training, but it is essential that the training provide the skills to intervene and to provide crisis support.

Stigma is still a huge issue, as Brian Whittle hinted at in his question. The issue needs to be tackled for the whole population through a targeted response. We know that people with lived experience brought the issue up in the engagement work that was done prior to publication of the Government's draft strategy, so we are disappointed that it has not featured highly in the drafts that we have seen. We hope that tackling stigma is implicit in all the suicide prevention work that is planned. Although there has been significant progress around the mental health stigma that unfortunately still exists, the same progress has not been made around suicide prevention. There are particular issues to do with stigma that are hugely challenging for people who have attempted suicide and for their families.

James Jopling: One point to pick up from Brian Whittle's question is that there has been welcome investment by the Scottish Government in a programme of distress brief interventions, in four locations. The aim is to bring together the agencies that most commonly encounter people who are suffering distress and trauma to ensure that the agencies are equipped to have that first conversation compassionately, and to refer people immediately to a programme of support for a couple of weeks, in order to try to help people to deal better with future crises, to prevent readmissions and to prevent recurrence of concerns.

NHS Greater Glasgow and Clyde is developing a multi-agency distress collaborative—that is a very long title—that will try to make agencies work together more coherently and cohesively, so that the gaps that Brian Whittle talked about can be reduced. The important thing is that we learn from those programmes as they run and then embed the learning in a Scotland-wide approach.

Brian Whittle: In bringing mental health much more to the fore and according it parity with physical health, it seems to me that we are encouraging more people to come forward but do not have the capacity to deal with them. SAMH produces good literature about accessing physical activity, and the Mental Health Foundation has produced good literature about the importance of nutrition.

Sandra White and I were discussing those issues with a group last week, and we found that people know that physical activity and better nutrition will improve their mental health but are not in a position to take action. Social prescription is not enough: it is not enough to ask whether a person has someone to talk to or could improve their nutrition. How do we make the link? That seems to me to be the most important thing. I was surprised to learn that although people in such situations are aware of what could make them better, somehow that switch is not being pressed.

James Jopling: What we understand about people who are at the point of considering suicide is that they experience feelings of worthlessness and purposelessness. A person can be equipped with all the knowledge in the world about ways out of the situation that they are in, but that does not mean that they are able, in that moment of crisis, to understand and to take action.

During the calls that people make to Samaritans, it is about listening—for minutes and, sometimes, for hours over a period. As many of you know, Samaritans does not provide advice: what we do is about listening to the person, helping them find the way out of the situation that they are in and being alongside them during that real challenge. That requires time, more than anything else. It requires the ability to be compassionate and to listen. There are many ways out of the situations that people find themselves in. Many options are available, and we have talked about some of them here, but we need to understand that, at that point of crisis, it might be very difficult for someone to see that those are the solutions that might best help them.

Toni Giugliano: I will come in at this point to talk about crisis, because we have not really touched on that.

It is important that people receive a compassionate and empathetic response when they are in a state of crisis. From what people tell us, it is not uncommon for people who are in a state of crisis to present at the accident and emergency department and to wait for four hours, only to be told to visit their general practitioner the next day. That is not because staff are not empathetic. It is because of resourcing: we do not have enough mental health staff in our A and E units. I am delighted that there is a commitment in the mental health strategy to provide 800 mental health workers, some of whom will go to A and E units.

The vast majority of people who are in crisis, whether of physical or mental health, go to A and E. Some people argue that A and E is not the best place for people who are in a mental health crisis. We argue that we need to have a situation in which, for example, someone who phones NHS 24 is automatically passed on to staff who can give them immediate help, or who will come to them, or will see them in a community setting. That would depend on the local arrangements of the health board, because there is no national framework.

The point is that people need to receive a compassionate and empathetic response, because if their experience of the NHS is negative, they might not go back for help a second time. It is also absolutely crucial that every time someone in crisis is seen, that crisis is addressed. One of the main challenges is that mental health teams sometimes will not assess a person who is not in suicidal ideation; if a person is not suicidal, they will simply tell the person to go home. That is not good enough: it is not good enough because every mental health crisis, regardless of whether the individual is feeling suicidal, needs to be addressed.

That is what DBI was brought in to do. We look forward to the evaluation of DBI, but unfortunately that is, by the looks of things, quite some time away. There are parts of the country that do not have a system like DBI. We think that the community triage service of NHS Greater Glasgow and Clyde works very well, and we would like to see it being rolled out as an out-of-hours system, as well. We need to make sure that we have throughout the country crisis systems that provide a fast and empathetic response and that reach people—even people who are already known to the system.

That is one of the main challenges. People who are not suicidal, but who could be next time, and people who are already known to the system are the two biggest challenges. In some situations mental health staff say, “Well, this individual is known to us”, and that person is not given the consideration and care that they should be given. That is an issue.

Dan Proverbs: I go back to what was said about community and education. Education has to be at the forefront. We have to start getting to the young children—especially boys at an early age, and as they are becoming men—so that they build up the resilience to cope with the knocks that will be ahead of them and can overcome such situations and not reach crisis. We should not wait until they reach crisis before action is taken. It has to start with education.

Scott Walker: Toni Giugliano spoke well about crisis and what needs to be done in crisis situations. It is even more difficult to achieve that framework in rural areas than it is in the central belt.

A report by Scotland's Rural College picked up very well the point about connection. It talks about people wanting to connect but who, for many different personal reasons, cannot. That is why we need early interventions. The Scottish Association of Young Farmers Clubs has run a very good and successful multimedia campaign to reach out to its members. It is about raising awareness of mental health issues and getting individuals to talk about mental health. There is a pretty even split between male and female members of the association, but there has been a big focus on getting the male members to open up and talk about mental health issues because they are more reticent. There is a greater hurdle for them to overcome in those challenges.

We absolutely have to have in place the right systems to deal with crisis, but if we are going to get the strategy right, there needs also to be early intervention. The system needs to be about getting as many people as possible away from ever reaching crisis point.

Miles Briggs (Lothian) (Con): I want to develop the point further. In its submission to the committee, the Royal College of Psychiatrists in Scotland said that

"There must be absolute clarity across Scotland about where people in a mental health crisis can go for help at any time."

From the conversations that we have had this morning and from evidence that the committee has taken, it is quite clear that many people are failed at weekends; they can be told on Friday to wait until Monday to see their GP. How can serious improvements be made to the draft strategy? What needs to change, in that context? We have heard, as Toni Giugliano outlined, what could be done, but it is quite clear that there needs to be a cross-portfolio approach, especially around trauma training for emergency services.

The Convener: Does anyone want to follow up on that? We have covered quite a lot to do with crisis in previous answers.

James Jopling: One of the things that we have welcomed since that first draft came out is the commitment in the parliamentary debate on mental health services in NHS Tayside to

"deliver more constant crisis support for people who have lost a loved one to suicide"—[*Official Report*, 09 May 2018; c 41.]

and for people who are affected by suicide. The test of that will be what "more constant" means, for exactly the reasons that have been highlighted.

I mentioned our survey, which indicated that many people do not know where to turn either for themselves or for people whom they are supporting. In a country our size, that should not be impossible to fix. Certainly, if we look at things such as online resources and where we could direct people from there, even if those resources are local, it should be possible to establish a way for people into what is a complex system.

Craig Smith: As I said before, England has a crisis care concordat, with local crisis pathways that are agreed between all partners, statutory and non-statutory. That is definitely one way we could go—or we could learn from it, and adapt it to the Scottish context.

There are significant issues around out-of-hours support. To come back to stigma, I note that although the majority of people who are in a mental health crisis who attend A and E or other emergency services will receive a good response, we are still hearing all too often about people not getting a proper or compassionate response. That is particularly the case in relation to issues around self-harm and people with suicidal ideation who are repeat attendees. That is a key thing that needs to change.

As Toni Giugliano has, SAMH has called very strongly for community triage projects to be rolled out nationally. NHS Greater Glasgow and Clyde and NHS Lothian have a mental health professional working directly with the police and emergency services to support people who are in mental health crises. Those projects have evaluated well: we think that there should be no delay in rolling them out. Such care pathways are missing and need to be improved at local and national levels. There also needs to be an infrastructure for shared learning, and resources need to be put in place for that.

11:45

Dan Proverbs: On out-of-hours services and online resources, I dealt with the mother of a 17-year-old boy who had attempted to take his life because his best friend had taken his own life. Luckily, there was an intervention, but when his laptop was found, every window that was opened was a search for "how to take my own life". That frightened her most and it really opened my eyes. He was 17, but the issue affects people who are younger than that: I have had emails from mothers of 12-year-olds and nine-year-olds. We need to consider the fact that they have access to such material but there are no online resources to balance it out.

Alison Johnstone (Lothian) (Green): In its submission, Samaritans says that

"There is no longer an effective structure of suicide prevention leadership or delivery in Scotland."

I note that it says "no longer", so Samaritans obviously feels that, at some point, there was such a structure. I would like to understand what has changed and what that leadership should look like. For the first time, we have a Minister for Mental Health. What difference has that made? What would you like to change, given that suicide is preventable, but we are still talking about

"the single biggest killer of men under 50 in the UK and young people aged 25-34"?

James Jopling: Something in a similar vein that I recently discovered and that really struck me is that the number of deaths from all cancers in people under 29 in Scotland is less than the number of deaths by suicide under 29. That is a measure of how seriously we need to take the issue.

We have touched on some of the elements that have changed over time. In 2002, when choose life was first instigated, there was a dedicated national team at NHS Health Scotland who were tasked solely with developing national plans, strategies, support and guidance for suicide prevention, and there were dedicated resources within each local authority. The landscape has undoubtedly changed, but we do not have that resource. There is not the same commitment to the topic, which is strongly related to mental health but does not sit only within that policy area.

We need to ensure that resources are aligned and that leadership means something at local and national levels. Who is responsible for our local plan? Is it the local authority, the integration joint board or some combination? It is not clear. The danger is that suicide prevention disappears among the good work that is being done to integrate health and social care.

We have tasked the minister with showing the necessary leadership and ensuring that any leadership group that is discussed has teeth. It must have the ability to hold the minister to account for what needs to happen, and the ability to shape and direct activity locally. It should not define what every project is, but by using the best available knowledge and targeting groups of individuals whom we know are at high risk, it should ensure that we allocate the limited resources appropriately.

There is no line of sight from the minister to what is happening locally. If we want to hold the minister accountable for whether the suicide rate goes up or down over time, we need to ensure that there is greater alignment of resources.

Alison Johnstone: Thank you. Do other witnesses share that view?

Toni Giugliano: Absolutely. We run the risk of no one having ownership of suicide prevention. That is a problem not only in Scotland, to be frank, but for public mental health and how suicide is tackled throughout the world. We see it in many other places.

It is crucial that, as Samaritans has said repeatedly, we use this opportunity as a turning point to instil new drive and ambition through new leadership. We can certainly do that, but we need to ensure that we take the matter out of the current structures. There is no other way of doing it. We need to create a new system and a new body that can drive forward the agenda in partnership with local authorities and local groups, and which has the public mental health perspective.

Ivan McKee (Glasgow Provan) (SNP): I thank the panel for the interesting discussion this morning. I want to go into a wee bit more detail on specific groups, which we have covered to some extent. We know that certain groups are disproportionately affected, and we have talked about poverty, rurality, men—who are clearly a huge issue—and age. We have not talked about lesbian, gay, bisexual and transgender individuals, but there is also an issue for that group, and families affected by suicide are disproportionately affected.

To what extent should the strategy target actions to specific groups? There will be trigger events for individuals in those groups, so my follow-up question is whether it is possible to target the situations in which those issues are likely to arise. To what extent should the strategy be focused in that way?

James Jopling: If the leadership group is convened correctly and it can influence and shape the resources nationally and locally, a key task will be for it to lead the way in deciding where the priorities should lie. You covered the main groups on which we believe attention should be focused—men; people who are experiencing disadvantage, given how inequality plays across the issue of suicide; people who are bereaved by suicide and those who have survived it; and LGBT individuals, who we know are at a disproportionately higher risk of suicide. We need to make sure that the efforts that we make nationally and locally are targeted specifically to reach the different, discrete needs of those populations.

Many other elements can increase a person's risk of suicide. We also need to make sure that national attention is given to people who are not in contact with health services, who are remote and lost to us. We know from the data that they are not contacting their GPs and are not on mental health

drug prescriptions, but nothing else tells us that they might be at risk. How can we reach out and use our community insight to develop more compassionate approaches and reduce the stigma that is attached to discussing suicide, which is particularly deep-seated in rural and remote communities? Until we can do that, we will face a substantial challenge in breaking down the barriers to talking about the issue.

We need to prioritise and to make sure that resources are correctly allocated. People will argue about whether there are right and wrong choices, but we need to direct our attention in that focused way.

Toni Giugliano: I will focus briefly on people who have been bereaved by suicide—family members and friends. People tell us that, as things stand, no direct support is available to them. We are calling specifically for link workers, whom we believe should be available to people who have been bereaved by suicide. Link workers can deal with things such as the relationship with the coroner and asking for psychological help from the GP. We should not be waiting for people to go and speak to their GP following a suicide. We should have a system whereby link workers can offer that support, because there is clear evidence that people who have been affected by suicide are at risk of taking their own lives.

Why do we think it is acceptable for anybody to be on a 12-week waiting list for psychological therapies when a family member or friend has taken their own life and the person is vulnerable and at risk? That is completely unacceptable, and it is why we have called for link workers to provide trauma-informed approaches and support in the immediate aftermath of suicide.

Scott Walker: Nationally, across the board, it is about raising the issues of awareness and stigma, and then we have to focus on the individual groups according to the local action plans. We need to give those plans the flexibility to identify the groups that are most at risk in their areas and the tools to target those groups in the most effective manner.

There is a big difference between a rural area of Scotland and Edinburgh. Although the challenges are the same for individuals, the way in which people access health professionals is different. That is far easier in Edinburgh than it is in rural areas, because in rural areas everyone knows everyone and people are likely to come across greater stigma. People do not want their business to be known by everyone else. We talked earlier about ways of connecting people digitally, which is hugely important. We have to get over the connectivity problems in some rural areas of Scotland. However, it comes back to the local action groups asking how they can tackle the issue of the people who are most in need in those areas.

We need to be aware of trigger events and the need to embed a policy in everything that the Scottish and UK Governments do. We have talked about welfare reform, for example, and the risk of that for certain groups should have been highlighted so that we could tackle it. We are now looking at a change to the rural support system, which is a trigger event that could cause problems. How do we prevent those problems? How do we use networks that we already have in place, whether it is RSABI, the Scottish Association of Young Farmers Clubs or NFU Scotland, and the many touch points that people in rural communities already have? How do we build capacity in those groups so that they can tackle the problems as they come forward?

The Convener: There are some specific groups to ask about.

Ivan McKee: I have another question, on which I would welcome a professional perspective. When I read the committee papers, it struck me that, every time we talk about suicide, we talk about mental ill health at the same time. Are those two things inextricably linked, or are there situations where people who do not suffer mental ill health decide to take their own lives because of an external factor that, if taken away, would take away those suicidal thoughts?

Craig Smith: There is a strong evidence base for a link between mental health and suicide, but I reiterate that not everyone who takes their life by suicide has a mental health problem. With any diagnosable mental health problem, people's risk of suicide increases. However, there are definitely circumstances where people who do not have a diagnosable mental health problem are at a crisis point for any of a variety of personal, financial, employment or relationship reasons that brings them to a place where they feel that they have no choice other than to take their own life.

It is important not to minimise the link between mental health and suicide, because a large proportion of people who end up, tragically, taking their own life will have a mental health problem that has contributed to that, but it is certainly not the only factor.

Dan Proverbs: Specifically for men, it is absolutely right to say that most of the risk is linked to mental health. However, the high statistics for male suicide exist because that is our coping mechanism, as we cannot cope with what life throws at us. We will try risky behaviours involving alcohol, drugs or gambling, or use them as coping mechanisms, for example, but when they do not work and we can no longer put things

behind us, we take the other path out because we believe that it will solve the problem.

I want to add a point about bereavement support. I have a lot of contact with families, and we need a bereavement support service because, when a male in a family takes their own life, the family often had no clue that it was going to happen. The shock for them is astronomical, because men hide that stuff. For example, two weeks ago, a young boy at a family gathering took himself away and tried to take his own life, which shocked the family. We have to put bereavement support in place.

Alex Cole-Hamilton: On crisis support, in many cases, the first line of support that somebody who is self-harming or who attempts suicide will have will be the police. However, we were struck earlier this morning when we heard from families who have been affected by suicide that training for the police in mental health and suicide first aid is available only to those who sign up for it, and is not mandatory. Should we find a way of making that training mandatory at the Scottish Police College at Tulliallan?

12:00

Craig Smith: Absolutely. Training on suicide prevention should be mandatory for the police, custody staff and all emergency services, particularly with regard to the skills around supporting someone who is in crisis, but also with regard to on-going suicide prevention. We know that there is a particular issue around emergency services—as I said earlier, people sometimes receive a stigmatised response. More can be done around that. That is why we strongly favour the roll-out of community triage nationally so that front-line police and other staff can phone someone to get advice and support in situations involving someone with mental ill health.

Another issue for the police around crisis concerns alcohol and drugs. We know that there are cases in which people are refused psychological assessments because they have alcohol or drugs in their system, and that needs to be tackled, too.

Alex Cole-Hamilton: We were also concerned about the apparent lack of communication between primary care staff and the police. It seems that the police are not always made aware of a mental health situation when they start to process someone through normal criminal justice channels. Further, sometimes, police officers are left waiting in hospital for hours because of their continuing duty of care to someone who has threatened to take their own life. How do we make the communication between those people better?

James Jopling: Craig Smith spoke about the crisis care concordat, which is critical with regard to bringing people who deal with those situations together at a national level, establishing what the pathways should be and following that up with action. There is a way to do that. We need to examine the model in England to see whether it is fit for purpose, but it represents an approach that we can take to make sure that that communication is much more joined up.

The Convener: We are pressed for time, so we will move on. The next question is from Emma Harper.

Emma Harper: We have spoken about the groups that are at risk, but there is obviously a need for us to engage children. The first meeting of the newly formed cross-party group on adverse childhood experiences is scheduled for tomorrow night. I am one of the members who have chosen to join that group, and I think that it will help to raise awareness of the issues. However, the suicide prevention plan needs to have a specific focus on children. Does anyone have any quick comments on that?

Toni Giugliano: Research that we published for mental health awareness week shows that 33 per cent of young people in Scotland have experienced suicidal thoughts. That is a shocking figure, and it relates back to the resilience programme that we need to look at in our schools. A lot can be done in schools and at home. However, we need to ensure that the health and wellbeing strand of the curriculum for excellence is not a token element, as some have argued that it is. We need to ensure that our teachers can deliver it, and in order for that to happen, they need to receive the training that will enable that.

The reality is that too many teachers are unable to explore mental health issues in our classrooms, including the big issues that are affecting many of our young people, partly as a result of our digital age, whether they involve body image, pressure to succeed or exam stress. Those are all themes that came out in our research earlier this year. In order to address those issues, we need to think about resilience building in schools. To do that, we need to ensure that the health and wellbeing strand of the curriculum for excellence is fit for purpose, that our teachers are well trained and that our universities are delivering the appropriate training for our teachers in their teacher-training curriculums.

Dan Proverbs: Particularly in relation to boys from the age of 12 up, we should approach the issue along gender lines. We would like to get our #BrotherBeingMankind project into schools, but we sometimes hit obstacles because it is gender specific. Given that 75 per cent of suicides are male, we need to begin to approach the issue of

young males separately and talk to them on their level.

Ash Denham (Edinburgh Eastern) (SNP): I am interested in picking up the aspect of monitoring and evaluation, which we have partially covered already. From what has been said, it seems that we are not doing a good enough job on that. Obviously, if we are not sure what is working well, it is difficult to know whether we are doing what we should be doing. I picked up on the suggestion earlier that local plans are not being evaluated. At strategic level, how should we be evaluating the action plan in the longer term? What should that evaluation look like?

The Convener: We have heard a bit of evidence on that already, but if there is anything that has not been said or any witness has not commented on evaluation, now would be the time for that.

James Jopling: There was no formal evaluation of the suicide prevention strategy, which gives us some challenges with regard to identifying which elements of the programme underpin the success that we have seen in the reduction of the suicide rate from 2002 onwards.

As is the case with any evaluation, we need to make sure that it is built in from the outset. We need to understand clearly what the objectives of the national leadership group are and how it is able to enact them, so that we can evaluate it against those and against the ambition that we set for the programme as a whole. I cannot tell you exactly how to do that evaluation, but I can say that there is a substantial gap in our understanding of how to address suicide risk in Scotland, and it would be remiss of us to enter into what we hope will be a step change in our efforts to address suicide in Scotland unless that evaluation is a central part of the process.

Toni Giugliano: We need to have an evaluation framework that is built in from the outset—I completely agree with what James Jopling said in that regard. Whatever new body is established will be able to think about that and create a framework for local groups that will enable them to understand what they need to deliver and how that should be independently evaluated. There should be a framework for that evaluation process.

The Convener: The draft plan that we have seen makes no specific commitments on timescales or on funding and resources. What do you think about that? Should they be part of the plan, or should they develop under the auspices of the plan?

James Jopling: We have clearly made the point that, if we want to see a step change, which we believe is the ambition of the Minister for Mental Health, we need to have the resources for that. However, we have not yet seen any evidence that we will have those resources. It is not as if there are not other policy areas in which the Government has made clear and specific resource commitments in relation to issues of clear concern. For example, last year, a £500,000 pot of resources was announced to support locally developed projects to address social isolation and loneliness, and £50 million was identified to meet homelessness targets.

Our belief is that the increase in the level of suicide that we have experienced—although, of course, we hope that it will be only a one-year increase—means that, when the plan is published, we need to see that there are resources behind the leadership group. If it is to be able to deliver everything that everyone on this panel wants it to deliver, it needs to be able to direct resources and shape plans effectively, and it needs resources in order to be able to do that.

The Convener: Does that mean specified, ring-fenced resources?

James Jopling: There is plenty of evidence that, since we lost the element of ring fencing in 2002, we have lost the ability to do what I have talked about. A number of my colleagues have spoken to that issue. In England, £25 million has been identified across three years for local suicide prevention priorities. To make sure that the necessary work happens, we need resources to be allocated to that.

Craig Smith: We need resources to be allocated, and we need clarity on timescales. I would like there to be resources and timetables against each action, and a pot for the national leadership group to hold to enable it to transparently fund local activities. As James Jopling has just said, that is what we have lost in Scotland. Under the original choose life strategy, we had a clear, transparent budget and we had local budgeting that could be tracked, but that has been lost.

I do not have a figure in my head for what the budget should be. That is partly due to the lack of clarity around what is being spent at the moment on suicide prevention. We need to know what is being spent, even if we do not necessarily have an audit as such.

The resources can be ring fenced or not, but there needs to be strong ministerial guidance on how the budget is spent locally. We believe that the best route for that to happen is through ensuring that the national body—the leadership group—is a budget-holding body that can, either through an innovation fund model or by direct funding, provide resources to local partners. Of course, that money should be tracked and the projects should be evaluated.

Dan Proverbs: I agree with what the guys have said. I think that the resources have to be ring fenced. However, within that, it is important to note that you cannot rely on the third sector to do everything. Speaking from the point of view of someone who works in male mental health and suicide, I believe that funds must be allocated specifically towards that. We cannot rely on charities being able to raise the funds themselves to combat those issues.

Scott Walker: I agree with what has been said about the budget and the timescales. However, there must also be compulsory delivery across the whole of Scotland. We do not want the work to be targeted only in specific areas. The whole of Scotland faces the challenge, so we want action to be taken across the entire landmass of Scotland.

Toni Giugliano: We have an opportunity to bring suicide prevention back on to the political agenda. We will be able to do that through creating a new national body that can lead that step change and bring the required leadership.

The Convener: Do you agree with what has been said about the funding and timescales being included in the strategic plan?

Toni Giugliano: Absolutely. We need teeth and resources.

The Convener: Thank you, gentlemen. This has been a thorough evidence session.

12:10

Meeting continued in private until 13:04.

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