Suicide Prevention Strategy 2013-2016

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SCOTTISH GOVERNMENT

Suicide Prevention Strategy 2013-2016

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Contents

Ministerial Foreword

Every suicide is a tragedy that has a far reaching impact on family, friends and the community long after a person has died.

This paper sets out the Scottish Government's work to reduce suicide from now until the end of 2016. It focuses on key areas of work that we believe will continue the downward trend in suicides in Scotland that we have seen over the past 10 years. We want this strategy to deliver better outcomes to people who are suicidal and who come to services, to their families and carers, to those not in contact with services, and to improve our knowledge of what works in this field.

The strategy marks another milestone in the progressive story of suicide prevention in Scotland. It continues the trend in previous strategies to focus on where the evidence leads. It echoes key messages – learned from practice and research – that suicide is preventable, that it is everyone's business and that collaborative working is key to successful suicide prevention.

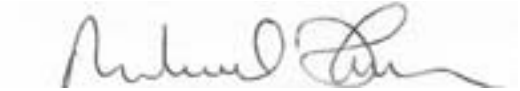
National leadership by the Scottish Government on reducing suicide – supported by NHS Health Scotland – together with the retention of local Choose Life coordinators, will provide support and direction for national and local work.

We acknowledge that there is a broader focus of activities not directly related to suicide prevention but which, if taken forward effectively, contributes to reducing the overall rate of suicide.[1] Activities within this broader focus include building resilience and mental and emotional wellbeing in schools and in the general population; work to reduce inequality, discrimination and stigma; the promotion of good early years services; and work to eradicate poverty. All of this work is undertaken in a context of being vigilant about improving mental health, about supporting people who experience mental illness – and about preventing suicide.

We know that many people who die by suicide have a history of self-harm, but that the relationship between suicide and self-harm is complex; for that reason we have limited the scope of this document to suicide and suicidal self-harm, with our first commitment being to undertake separate work, in 2014, on supporting people at risk of non-fatal self-harm, including those in distress.

[1] http://www.scotland.gov.uk/Publications/2010/10/26112102/0

I take this opportunity to thank not only the members of both the Working and Reference groups for their generous and invaluable contributions to the drafting of this strategy but also to all those whose work in suicide prevention over the past 10 years has yielded such positive progress. This strategy reflects a changing landscape but we still need commitment and energy to implement this strategy and continue making progress.



Michael Matheson
Minister for Public Health

Introduction

This strategy sets out the actions the Scottish Government will take to prevent and reduce suicide in Scotland. It outlines our progress and identifies areas for further attention. Experience and research tell us that we need to act in a number of areas in order to reduce suicide and deliver better outcomes for people contemplating suicide. The strategy seeks to improve our engagement with people in distress, to change the way we talk about suicide in Scotland, and to support improvements in how the NHS responds to people who are suicidal.

As in previous documents,[2] we use the following definitions:

Suicide is death resulting from an intentional, self-inflicted act.

Suicidal behaviour comprises both death by suicide and acts of self-harm that do not have a fatal outcome, but which have suicidal intent.

Self-harm is self-poisoning or self-injury, irrespective of the apparent purpose of the act (excluding accidents, substance misuse and eating disorders).

Information on sources of support for people who may be at risk of suicide or self-harm is provided in Annex 1.

[2] http://www.scotland.gov.uk/Publications/2010/10/26112102/0

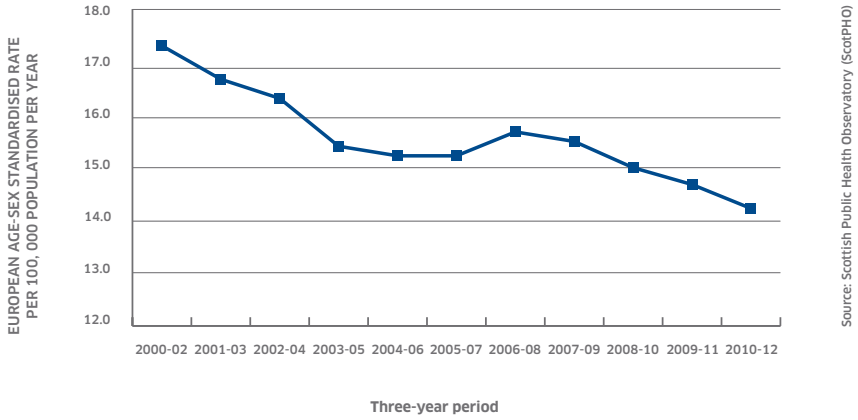
Progress since 2002

The Scottish Government's target is to reduce the suicide rate in Scotland by 20% by 2013. Since 2002 – when the target was originally set as part of the *Choose Life* strategy and action plan – we have seen an 18% reduction in the suicide rate. In the years 2009 to 2012 we have seen the lowest number of suicides since the early 1990s[3] and a reduction in the number of suicides at a time when most other jurisdictions are seeing an increase.

Taking probable suicide figures for 2011 and 2012 together, almost three quarters (1,112 – or 72.5%) of those who died were male. This gender imbalance has been broadly consistent for much of the last 10 years – a major element of the 18% reduction in the suicide rate since 2000-2002 has been the reduction in male suicides, whereas those for females have been more stable. Indeed, female suicide rates have been fairly stable since the early 1990s.

The graph below shows the change in suicide rates over time using three-year rolling averages.[4]

Scottish Suicide Rate



[3] For comparative reasons we have used the coding rules which were in place when the target was set. New rules from the World Health Organisation (WHO) for coding the causes of death mean that 'drug abuse' deaths from 'acute intoxication' previously counted under 'mental and behavioural disorders due to psychoactive substance use' are now classified as 'poisoning', so some of them will be counted as probable suicides. We will continue to use the old coding rules for comparative purposes so as to see the underlying changes and longer-term trends without the break in series caused by the introduction of the new coding rules. (General Register Office for Scotland http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/main-points.html.)

[4] Annual changes are based on relatively small numbers, so may not be statistically significant. For monitoring purposes it is conventional to pool rates over a three-year period, and develop three-year rolling averages. The three-year rolling average from 2010-12 is 14.3 per 100,000. http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/data/scottish-trends

Though comparative figures are problematic given the different approaches to reporting suicide across the world, Scotland's rate of 14.0 deaths per 100,000 population in 2012 is below the "global" mortality rate of 16 per 100,000 and around the EU average.[5]

Suicide is a complex phenomenon and it is difficult to attribute increases or decreases in the overall national suicide rate to particular changes in circumstances, services or policy, but there are a number of factors which may explain why the experience in Scotland has been different from elsewhere:

- The emphasis on tackling problem drinking – this work has been in place since 2008 and in the most recent year to end March 2013, over 61,000 alcohol brief interventions were delivered in primary care, A&E and antenatal care settings with a further 33,000 interventions carried out in other locations, exceeding the target by 55%.[6]

- The increased focus on identifying and treating depression in primary care settings – since 2006 the GP contract has targeted this work with the consequence that more people who are ill receive treatment, with that treatment since 2008 being more likely to be through access to an evidence-based psychological therapy.[7]

- Local patient safety improvements introduced on the basis of evidence developed by the UK-wide National Confidential Inquiry into Suicide and Homicide by People with Mental Illness,[8] in particular work on discharge planning taken forward as part of the previous reducing readmissions target.

- Work to increase workforce knowledge and understanding of suicide – by September 2013 more than 50% of frontline NHS staff had received at least one specific course on suicide intervention (STORM, ASIST, safeTALK or SMHFA).

- Having a 10-year national strategy and action plan that has been regularly evaluated and refreshed, giving us a sustained focus on suicide prevention actions and outcomes.

5 Scottish Public Health Observatory http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/data/scottish-trends and WHO http://www.who.int/mental_health/prevention/suicide/suicideprevent/en
6 http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2013-06-25/2013-06-25-ABI-Report.pdf
7 http://www.isdscotland.org/Health-Topics/Mental-Health/Psychological-Therapies.asp
8 http://www.hqip.org.uk/national-confidential-inquiry-into-suicide-and-homicide

Our approach

The strategy focuses on suicide prevention activities in communities and in services. It is structured around five themes that contribute to the delivery of the National Outcome[9] to enable people to live longer, healthier lives.

The World Health Organization has adopted a global target that suicides will be reduced by 10% by 2020.[10] During the period of this strategy, we want to continue the downward trend in the rate of suicide in Scotland and make progress towards the WHO target.

A. Responding to people in distress

People who are in distress and who may be at risk of suicide, whether they are looking for help or as a consequence of their actions, will come into contact with a wide range of public and voluntary sector services. Often the first person they may see will be from one of the emergency services. Some people in distress will have a mental illness, but for many the distress may be temporary and linked to life events.

We will do better in engaging with their distress if we are compassionate and have a common understanding of what it means to respond in a person-centred and safe way. If we do that, the evidence tells us that people are more likely to engage with or stay connected to services or support that may help them over time.

The relationship between suicide and self-harm is complex. Many people who die by suicide will have a history of self-harm, but most people who self-harm will not go on to die by suicide. As such, self-harm is a clear risk factor for suicide, but it is also a phenomenon that we need to understand and address in its own right. On that basis, while we believe that many of the activities we will engage in to reduce suicide will have benefits for those who self-harm, the focus of this document is on prevention of suicide.

[9] http://www.scotland.gov.uk/About/Performance/scotPerforms/outcome/healthier

[10] The target is informed by a decision adopted at the Sixty-Sixth World Health Assembly of the World Health Organization (WHO): "Global target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020)." http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf

Commitment 1: We will take forward further work on self-harm as part of the publication of a document on responding to people in distress. This work will take into account feedback from the public engagement process which helped inform the development of this strategy (see Annex 2), the current work in Tayside in relation to Commitment 19 of the Mental Health Strategy and the Scottish Government's report *Responding to Self-Harm in Scotland: Final Report*.[11]

While we have seen improvements in how services respond to people, too often we know that people who present in distress still feel stigmatised for their self-harm or intoxication and are referred elsewhere or have their physical condition addressed while their mental distress is ignored. We know that, in some cases, this is their last contact with services before they take their own lives. This needs to change. We require a continued focus on how to improve the collective way in which we respond to distress.

We need those who are the first point of contact to have the necessary information, skills and attitudes to make it more likely that their engagement is positive and supportive. This needs to be complemented by the general public health work of awareness-raising and training, so that people in the workplace, families, carers and friends of those who communicate suicidal thoughts know how to be supportive.

NHS Health Scotland already supports work to enhance skills in suicide intervention through the provision of coaching, mentoring and training. It ensures that trainers are supported to deliver training and it also monitors the quality of training delivered. The HEAT target to train 50% of frontline NHS staff in suicide prevention techniques was delivered in 2010 and will continue to be monitored. In addition, all probationer police officers in Scotland and all undergraduate mental health nurses now receive training in this area.

We know from extensive research evidence and from the pilot work in NHS Tayside in relation to Commitment 19 of the Mental Health Strategy[12] that people in distress seek a more compassionate response, and as indicated above, the evidence is that people are more likely to achieve a positive outcome where they do receive such a response.

[11] http://www.scotland.gov.uk/Publications/2011/03/17153551/0
[12] http://www.scotland.gov.uk/Publications/2012/08/9714

Commitment 2: NHS Health Scotland and NHS Education for Scotland will work together to develop and extend the current approach of workforce development activity to address a wider range of experience and in a wider range of contexts. In doing so we will consider how this support can be made available to families and communities. This work will also be linked to the work under Commitment 1 on distress.

In addition to addressing the workforce capability we also need to consider the current processes and pathways that determine the response that people receive when they present in distress. This work needs to cover the practicalities of what happens for people who present in A&E or who come into contact with the police when intoxicated. It needs to include, but extend beyond, protocols and agreements about what should happen in more serious cases, such as those that would be covered by Psychiatric Emergency Plans,[13] and should build on the Commitment 19 work in NHS Tayside mentioned above.

Commitment 3: We will map existing arrangements for responding to people in distress in different environments and localities and will use this information to develop guidance which supports safety and person-centredness.

Commitment 4: For those presenting to A&E we will examine how existing local and national data sources, such as the Scottish Patients at Risk of Readmission and Admission (SPARRA), can be used to provide benefit to those at risk of suicide. We will also support improvement programmes that are aimed at linking available data sources to inform service responses for those at risk of suicide or repeat attendance, such as currently exist in NHS Greater Glasgow & Clyde and in Tayside.

B. Talking about suicide

How we talk about suicide is important. We know that talking openly about suicide in a responsible manner saves lives. We have adopted that approach through the Choose Life campaigns "Suicide: Don't hide it. Talk about it" and "Read Between the Lines".[14] We will continue to campaign in this way during the period of this strategy.

[13] http://www.scotland.gov.uk/Publications/2012/08/9714
[14] http://www.chooselife.net/Media/index.aspx

Recent years have seen the introduction and growth of various forms of "social media" and new technologies. Used positively, these can enable people to access information and support around prevention of suicide, such as those listed in Annex 1. At the same time, concerns have been expressed that people who are vulnerable to suicide can be exposed to inappropriate material through social media or through other internet sources. This is a challenging area but it needs to be part of our approach to reducing suicide in Scotland.

Commitment 5: We will work closely with NHS Health Scotland, *see me*[15] and other agencies to develop and implement an engagement strategy to influence public perception about suicide and the stigma surrounding it and will use social media, in addition to other communication channels, to communicate key messages about suicide and its prevention.

We know that media reporting of suicide can increase the number of suicides in a locality. The quality and nature of that reporting can be a factor and we have worked with the National Union of Journalists (NUJ) to develop guidelines and deliver training on sensitive and appropriate reporting. We will continue to work with the NUJ and others to encourage the implementation of media guidelines and challenge inappropriate reporting when it occurs.

Finally, we will continue the work to reduce the stigma and discrimination of mental illness, primarily through the *see me* programme, which is funded by the Scottish Government and Comic Relief. We know that increasing the identification and treatment of mental illness is one of the factors in the success of reducing suicide in Scotland and we need to continue to build on that achievement.

C. Improving the NHS response to suicide

Analysis from the National Confidential Inquiry into Suicides and Homicides[16] into the changing patterns and risk factors behind cases of suicide and homicide by people in contact with mental health services, has informed safety improvements for patients, prioritised attention to follow-up of patients after discharge from hospital, and supported the focus on action to tackle problem drinking and drug use. Healthcare Improvement Scotland[17] leads on a range of improvement programmes, including the Scottish Patient Safety Programme for Mental Health (SPSP-MH) and the Suicide Reporting and Learning System (SRLS). Much work is already underway to improve quality and safety; we want to harness this work in the service of those at risk of suicide.

15 http://www.seemescotland.org
16 http://www.hqip.org.uk/national-confidential-inquiry-into-suicide-and-homicide
17 http://www.healthcareimprovementscotland.org/about_us.aspx

Commitment 6: We will work with Healthcare Improvement Scotland to support improvements for NHS Boards that focus on areas of practice which will make mental health services safer for people at risk of suicide, for example, transitions of care, risk management, observation implementation and medicines management. This will be delivered through the SRLS and SPSP-MH.

Data from the Scottish Suicide Information Database (ScotSID)[18] indicate challenges that we need to look at further. Those who die by suicide tend to have had quite extensive contact across the range of health care services including GPs, A&E and acute hospitals, and there is a high correlation between serious self-harming and death by suicide. The ScotSID report also shows that, at the time of death, many people are receiving some form of medication used in the treatment of mental illness. Drawing on the National Confidential Inquiry, 30% of general population suicides were identified as having been in contact with mental health services in the 12 months before their death.

In addition to many chronic health conditions and morbidity highlighted in the Equally Well Report on Health Inequalities,[19] suicide rates feature strongly in the most deprived populations in Scotland. The rate is three times higher in the most deprived 20% of the population compared to the least deprived 20%. Over the course of the Choose Life programme there has been a reduction of 20% in the deaths by suicide of males. Deaths by suicide for females have reduced by 10%. Despite this greater reduction in suicide among men, suicide is an overwhelmingly male behaviour.

The charts in this document[20] highlight the areas of A&E, acute hospital admission and mental health prescriptions that present particular challenges within our current system and require a developmental approach towards improvement.

[18] http://www.isdscotland.org/Health-Topics/Public-Health/Publications/2012-12-18/2012-12-18-ScotSID-2012-Report.pdf
[19] http://www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf
[20] The charts present data from different time periods for reasons of data availability.

Chart 1 illustrates that of the 757 probable[21] suicides in Scotland in 2010, more than one in five (21.5%) attended A&E at least once in the three months prior to death.

Chart 1

A&E Attendances	Number	Percentages
0	594	78.5
1	111	14.6
2	35	4.6
3	10	1.3
4+	7	0.9
Total	757	100

Source: ScotSID

In addition, combining the 2009 and 2010 totals for probable suicide (1,501), Chart 2 indicates that 890 (59%) had been inpatients in general hospitals in the five years before dying by suicide. Of those, almost one in four (24.5%) had a diagnosis of "Injury from intentional self-harm" and almost one in five (18%) had a diagnosis of "Unintentional injury (including assault by another person)", at discharge.

Chart 2

General Acute Hospital Discharge		
Main Diagnosis	**Number**	**Percentages**
Injury – intentional self-harm	218	24.5
Injury – unintentional	160	18
Other diagnosis	512	57.5
Total	890	100

Source: ScotSID

[21] For statistical purposes, deaths for which the underlying cause was classified as 'intentional self-harm' or 'event of undetermined intent' are counted as probable suicides. The figures will therefore be higher than would be the case if (say) one counted only those deaths which had been confirmed as suicide following the completion of the relevant legal processes. (http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/definition-of-stats/index.html)

As Chart 3 below illustrates, of the 757 probable suicides in 2010, 424 (56%) had mental health prescriptions dispensed within 12 months prior to death. There is scope here to support clinical assessments and treatments that provide greater benefit and that link to use of psychological therapies and social prescribing.[22] There is evidence to suggest that there are benefits in reviewing long-term use of mental health prescriptions.[23]

Chart 3

Deaths by Individuals with Mental Health Prescriptions		
Gender	**Number**	**Percentages**
Male	284	37
Female	140	19
Total	424	56

Source: ScotSID

Taking probable suicide figures for 2011 and 2012 together, almost three quarters (1,112, 72.5%) of those who died were male. The highest proportion of deaths for men and women occurred in the 35 to 54 age group (48%). We are concerned that there may be a number of people in their middle years living with depression and/or chronic conditions among this high proportion.

The evidence from ScotSID needs to be taken into account in how we develop and implement our strategy going forward. It suggests three particular programmes of work. The first is set out above (Commitment 4) and relates to how we respond to people when they present in A&E and other contexts in crisis. We will also link that work to the NHS work on unscheduled care.

In addition:

Commitment 7: We will work with the Royal College of General Practitioners and other relevant stakeholders to develop approaches to ensure more regular review of those on long-term drug treatment for mental illness, to ensure that patients receive the safest and most appropriate treatment.

[22] See Commitments 13 on access to psychological therapies and 15 on social prescribing in the Mental Health Strategy 2012–2015 http://www.scotland.gov.uk/Resource/0039/00398762.pdf

[23] "Reviewing long-term antidepressants can reduce drug burden" British Journal of General Practice Volume 62, Number 604, November 2012, pp. e773-e779(7)

Commitment 8: We will build on work already done in relation to Commitment 22 of the Mental Health Strategy[24] to test ways of improving the detection and treatment of depression and anxiety in people with other long-term conditions.

D. Developing the evidence base

Suicide and its prevention require ongoing analysis and research. We have access to a range of valuable information on suicides – through ScotSID[25] and the National Confidential Inquiry into Suicide and Homicide[26] – from which we have identified areas for attention in this strategy; and there is a strong research community in Scotland which is internationally recognised. The work from ScotSID over the last couple of years has given us access to insights and areas for improvement that were simply not available to us previously either nationally or from the international evidence.

All NHS Boards' mental health services carry out individual suicide reviews that examine the circumstances of suicides of patients who were under their care – with the aim of making mental health services safer. Healthcare Improvement Scotland provides a unique resource through the Suicide Reporting and Learning System which analyses these reviews to promote learning and improvement strategies throughout Scotland.[27] Recommendations from Fatal Accident Inquiries in relation to suicides, including the deaths on the Erskine Bridge,[28] provide invaluable lessons on suicide prevention.

We want every aspect of suicide prevention to be informed by evidence or, if evidence is not available, at least to be underpinned by an evaluative framework that will yield knowledge on either what works or what does not work. The updated guidance from the Medical Research Council[29] on developing and evaluating complex interventions provides helpful outline on methodologies and key questions to be taken into account in evaluating any work within health and social care settings.

[24] Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long-term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness.
[25] http://www.isdscotland.org/Health-Topics/Public-Health/Publications/2012-12-18/2012-12-18-ScotSID-2012-Report.pdf
[26] http://www.hqip.org.uk/national-confidential-inquiry-into-suicide-and-homicide
[27] http://www.healthcareimprovementscotland.org/our_work/mental_health/suicide_reviews.aspx
[28] http://www.scotland-judiciary.org.uk/10/895/Fatal-Accident-Inquiry-into-the-deaths-on-Erskine-Bridge
[29] http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC004871

Knowledge is vital to the work of improving engagement at first point of contact, throughout a person's journey through the health system and into the community. We want our knowledge sources to continue to be world-leading and to contribute substantially to our growing evidence base for suicide prevention.

Commitment 9: We will continue to fund the work of ScotSID and the Scottish element of the National Confidential Inquiry into Suicide and Homicide and we will also contribute to developing the national and international evidence base. In doing so we will work with statutory, voluntary sector and academic partners.

E. Supporting change and improvement

This strategy contains a range of elements covering health and other services, clinical and population interventions and the delivery of improvement through a range of approaches. No one agency has the capability to deliver across this agenda, but each element of the agenda requires support so that change will take place nationally and locally.

We will continue to have a National Programme for Suicide Prevention, hosted by NHS Health Scotland, that supports delivery of those parts of this strategy with a population health dimension – in particular, awareness raising, community activity, resource development and distribution, training and research. As part of its work with Community Planning Partnerships, Community Health Partnerships, Primary Care and voluntary agencies on health improvement and population health, NHS Health Scotland will support ways of improving the contribution to suicide prevention of local work in deprived areas, targeting men and women most at risk.

Commitment 10: NHS Health Scotland will continue to host the Choose Life National Programme for Suicide Prevention. This National Programme, in addition to the functions set out above, will continue to provide leadership and direction for local Choose Life co-ordinators and in respect of other health improvement aspects of suicide prevention.

Commitment 11: We will set up arrangements to monitor progress with implementation of all the commitments in this strategy. This will include an Implementation Board to be chaired by a Senior Manager from the Scottish Government.

ANNEX 1

Sources of support

If you – or someone you know – experience suicidal feelings or you/they are considering self-harming, you/they should speak to a GP. GPs are well placed to advise and guide you regarding appropriate treatment or management of symptoms. If you are ill and feel it can't wait until your GP surgery re-opens you can call **NHS 24** on **08454 24 24 24**. Please note this telephone service is not free.

It is also recommended that you speak – in confidence if need be – with any friends or family with whom you feel comfortable talking about the issues you are experiencing. If you do not feel comfortable doing this with friends or family, you can obtain confidential telephone support from the following sources:

- **Samaritans** provide confidential non-judgemental emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair. You can contact them on **08457 90 90 90**. NB this telephone service is not free. You can find more information about Samaritans at **www.samaritans.org**

- **Breathing Space** offers free and confidential advice for people experiencing low mood, depression or anxiety, whatever the cause. This service can be contacted on **0800 83 85 87**, 6pm to 2am Monday to Thursday; and 6pm Friday through the weekend to 6am Monday. Calls to Breathing Space are free from landlines and from most mobile networks. **www.breathingspacescotland.co.uk** provides a wide range of useful information and advice about coping with low mood, depression and anxiety.

If you ever feel **actively suicidal and have the means to carry this through**, you should **dial 999** and ask for an ambulance.

If you have been **bereaved** through suicide you may find the booklet *After a Suicide* a useful source of help and advice. Published by the Scottish Association for Mental Health, it is available at **http://www.samh.org.uk/media/125564/after_a_suicide.pdf**

Cruse Bereavement Care Scotland can provide support to people who are experiencing difficulties coping with the death of a family member or friend – including instances where a person has died by suicide. They can help people through one-to-one counselling sessions which can enable people to work through grief. Cruse can be contacted on **0845 600 2227** or via email: **info@crusescotland.org.uk**. See also **www.crusescotland.org.uk**

Annex 2

Background to the production of this strategy

In late 2012, the Scottish Government set up a Working Group to consider future strategy and action on prevention of suicide and self-harm, in the context that the *Choose Life* strategy and action plan was ending its 10-year lifetime. The Working Group was supported by a Reference Group. The Working Group had nine meetings from November 2012 to October 2013. The Reference Group held four meetings from December 2012 to October 2013.

Engagement process

To help inform the development of a new strategy, the Working Group prepared an engagement paper in order to prompt discussion at public engagement events on key areas. The aim was to gather views for consideration in the development of a new national strategy on preventing suicide and self-harm.

Eight engagement events were run in February, March and May 2013 to allow stakeholders and members of the public the opportunity to discuss the engagement paper and their aspirations for future strategy and action on prevention of suicide and self-harm. Some 400 people attended these events in total.

Some 95 written responses to the engagement paper were received. A summary note of all the written comments, and summaries of themes and issues which emerged at the engagement events, were prepared for consideration by the Working Group and Reference Group at meetings over summer 2013. These summaries and the engagement paper are available on the Scottish Government website.[30]

[30] http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health/Suicide-Self-Harm/Working-Group

Annex 3

Summary of commitments

Commitment 1: We will take forward further work on self-harm as part of the publication of a document on responding to people in distress. This work will take into account feedback from the public engagement process which helped inform the development of this strategy (see Annex 2), the current work in Tayside in relation to Commitment 19 of the Mental Health Strategy and the Scottish Government's report *Responding to Self-Harm in Scotland: Final Report*.

Commitment 2: NHS Health Scotland and NHS Education for Scotland will work together to develop and extend the current approach of workforce development activity to address a wider range of experience and in a wider range of contexts. In doing so we will consider how this support can be made available to families and communities. This work will also be linked to the work under Commitment 1 on distress.

Commitment 3: We will map existing arrangements for responding to people in distress in different environments and localities and will use this information to develop guidance which supports safety and person-centredness.

Commitment 4: For those presenting to A&E we will examine how existing local and national data sources, such as the Scottish Patients at Risk of Readmission and Admission (SPARRA), can be used to provide benefit to those at risk of suicide. We will also support improvement programmes that are aimed at linking available data sources to inform service responses for those at risk of suicide or repeat attendance, such as currently exist in NHS Greater Glasgow & Clyde and in Tayside.

Commitment 5: We will work closely with NHS Health Scotland, *see me* and other agencies to develop and implement an engagement strategy to influence public perception about suicide and the stigma surrounding it and will use social media, in addition to other communication channels, to communicate key messages about suicide and its prevention.

Commitment 6: We will work with Healthcare Improvement Scotland to support improvements for NHS Boards that focus on areas of practice which will make mental health services safer for people at risk of suicide, for example, transitions of care, risk management, observation implementation and medicines management. This will be delivered through the SRLS and SPSP-MH.

Commitment 7: We will work with the Royal College of General Practitioners and other relevant stakeholders to develop approaches to ensure more regular review of those on long-term drug treatment for mental illness, to ensure that patients receive the safest and most appropriate treatment.

Commitment 8: We will build on work already done in relation to Commitment 22 of the Mental Health Strategy to test ways of improving the detection and treatment of depression and anxiety in people with other long-term conditions.

Commitment 9: We will continue to fund the work of ScotSID and the Scottish element of the National Confidential Inquiry into Suicide and Homicide and we will also contribute to developing the national and international evidence base. In doing so we will work with statutory, voluntary sector and academic partners.

Commitment 10: NHS Health Scotland will continue to host the Choose Life National Programme for Suicide Prevention. This National Programme, in addition to the functions set out above, will continue to provide leadership and direction for local Choose Life co-ordinators and in respect of other health improvement aspects of suicide prevention.

Commitment 11: We will set up arrangements to monitor progress with implementation of all the commitments in this strategy. This will include an Implementation Board to be chaired by a Senior Manager from the Scottish Government.

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