

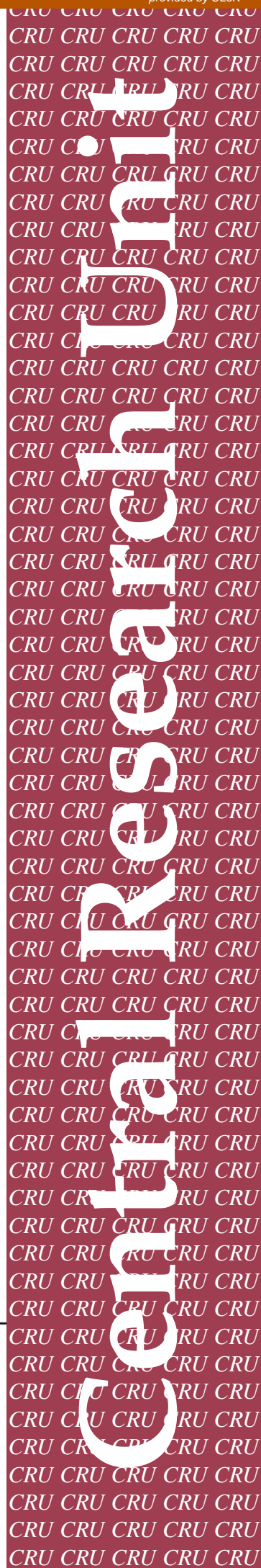
# NATIONAL FRAMEWORK FOR THE PREVENTION OF SUICIDE AND DELIBERATE SELF-HARM IN SCOTLAND:

## Analysis of Written Submissions to Consultation



SCOTTISH EXECUTIVE

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**NATIONAL FRAMEWORK FOR THE PREVENTION  
OF SUICIDE AND DELIBERATE SELF-HARM IN  
SCOTLAND –  
ANALYSIS OF WRITTEN SUBMISSIONS TO  
CONSULTATION**

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June 2002

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## **PROJECT TEAM/ACKNOWLEDGEMENTS**

### **THE RESEARCH TEAM**

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Over the last thirty years the rates of suicide and self-harm in Scotland have been increasing, especially among young men. This poses a challenge, not just to individuals and families, but to society as a whole, and makes a shared responsibility approach imperative across all agencies. Coordination and joint working are key principles behind the development of a national framework document by the Public Health Division of the Scottish Executive with support and input from the Scottish Development Centre for Mental Health and the National Planning Group on Suicide and Deliberate Self-harm to tackle these issues. The Framework was drafted following two national seminars held in 2000 and 2001, and is one element among an array of measures proposed by the Scottish Executive to improve mental health and well-being.

Between October 2001 and February 2002, the Scottish Executive Health Department consulted major stakeholders about a draft National Framework for the Prevention of Suicide and Deliberate Self-Harm. Around 1400 copies of the consultation document were sent out.

The aim of the research was to provide an analysis of the responses received to the Consultation Document so that future development of the National Framework took account of the information, views and insights offered, and so that remaining gaps in the Framework might be addressed. It would also help assess what support various agencies were likely to require.

### **PROFILE OF RESPONDENTS**

Responses were received from 140 organisations or individuals. The vast majority (94%) were organisational responses, while 8 came from individuals. In addition, 4 further responses were received after the final cut-off date and are therefore not included in the analysis reported here. Most responses came equally from Health bodies and voluntary organisations, followed by local authorities, but the views of user and carer organisations and others were also represented.

The breadth and scope of responses varied enormously from 2-10 pages in length. The majority (3 out of 5) of respondents chose to structure their responses around the consultation questions asked in Part VI, while others addressed the issues more generally. The weight of comment appeared to be around the priorities, roles and responsibilities as defined in the consultation document and general issues. Least comment was received on question 12.15 about 'Other Issues'.

### **COMMENTS ABOUT PARTS OF THE NATIONAL FRAMEWORK**

Ironically, what some respondents highlighted as positive features of the Framework, for example, the broad overarching framework that was not overly proscriptive and left the details to be decided at the local level, was for others its weakness. Despite some respondents considering the approach "too broad brush" and being critical of the lack of a

clear distinction between suicides and DSH, the Framework was widely welcomed by a variety of organisations and individuals as a constructive way forward.

Predicted difficulties of achieving joint working on implementing the Framework were hinted at, along with the resource implications, and a number of gaps in terms of explaining suicides, self-harm and prevention. Responses demonstrated the wide range of views on the subject that existed. Respondents raised a number of practical concerns about the collection and sharing of information, and about the difficulties of measuring successful outcomes.

The responses gave a clear impression of the complexities of the issues, and of an inherent tension concerning central direction and local control and achieving commitment across a variety of statutory, voluntary and community organisations. In spite of such tensions and potential challenges, there was enthusiasm for the notion of shared responsibility and a multi-layered approach to prevention within the context of the promotion of health and well-being. A number of organisations offered their support to implement the Framework.

## **RESPONSES TO THE CONSULTATION QUESTIONS**

Responses to the consultation questions covered a vast range of issues about implementing the Framework document, which it is difficult to summarise. The tension between central coordination and local control was a recurrent theme. There were the realities of significant competing priorities and finite resources and a sense that mental health services generally were struggling to cope with existing demands. The Framework would only likely assist local organisations if the barriers to joint working were faced squarely and the resources required for implementation identified.

The natural link with local planning mechanisms was obvious to some but not others as the variety of planning forums were considered. There was a concern not to over-medicalise the issues by automatically assuming Health as the lead agency, but many local authorities stated they would be hard pressed to take on a lead role. How local responsibilities should be carried out, how best to engage key local players, and the relationship between national and local bodies was identified as requiring further detailed consideration in the Framework.

Despite referring to community and neighbourhood focus and community development as a major plank of the approach, the voluntary and community sectors were felt to be almost absent from the document in terms of being key players. This was a fundamental issue that respondents felt should be addressed both in the national planning group and local action groups. A key issue for many voluntary sector organisations was the short term nature of funding which militated against their involvement in long term planning.

While there was enthusiasm for the approach proposed, there was a fear that this would be implemented without proper evidence about the efficacy of key approaches and interventions. Respondents highlighted a number of areas for future research including evaluations of the range of interventions, particularly those perceived as preventive strategies, and more research about the issues for specific groups of people, such as elderly people and 'looked after' young people.

## **KEY ISSUES RAISED**

There was broad support for the general approach advocated by the Framework document, particularly for a longer-term strategy focusing on prevention with children and young people. This was perceived as an ‘investment in the future’, so long as it did not disadvantage those ‘at risk’ in the present. An important aspect of primary prevention was directing efforts at tackling stigma and negative public attitudes towards mental illness. However, according to respondents, particularly those in health services, the proposals for preventive strategies were rarely based upon sound evidence. They identified both the need for, and difficulties of, measuring the impact or benefits of preventive policies.

One of the most exercised issues to arise from this consultation was that the document failed to make sufficient distinction between the issues of suicide and DSH. It was argued the definition of self-harm was not clear enough and there was confusion about whether the Framework was aimed at people who attempted suicide or parasuicide, or included people who engaged in self-injurious behaviour without suicidal intent. There was in the words of one voluntary project “a world of difference” between suicides and self-harm in terms of aetiology and the approaches and interventions each required. Secondly, some respondents suggested that the focus should lean more towards action plans than providing a general Framework. It was suggested that discussion of, and research about, the issues of suicide and DSH could readily be gleaned elsewhere. This was not a view shared by all respondents however.

Acknowledgement that the Framework would have an impact on and would itself be impacted by, other national strategies and policies was criticised for being “intangible”. Respondents wanted a clearer map of what and how these different strategies would affect each other. Agencies, particularly local authorities were doubtful that the necessary joint working and partnerships would happen without specific central intervention or direction, and without acknowledging the resource implications. Agencies needed a range of support to implement the strategy including designated resources, training and awareness raising for staff, systems for disseminating information about good practice, central coordination to ensure focus and momentum, and investment in joint information systems to enable sharing of information.

The importance of ensuring a broad ownership of the agenda was emphasised. There was agreement about setting local priorities, although local areas might require support to help them identify priorities. The Framework had to ensure that many people recognised that they had a responsibility in this difficult area. In its present form however, many respondents felt it placed responsibility and onus almost exclusively on the statutory health and local authorities. Opinion was divided on whether the Framework provided sufficient detail on the action planning and implementation process. Respondents felt there was insufficient detail about key roles and responsibilities, especially in relation to the ‘lead agency’ role and ‘developing community capacity’. If voluntary and community service providers were to be included, their input needed further consideration and consultation with these bodies. The same was true for the involvement of people affected by suicide or self-harm. There was deep concern expressed, especially from church bodies and counsellors, that only tackling the structural and organisational issues in society would not get to the ‘heart of the matter’ as they saw it – that is, alienation and disaffection within society and social exclusion.



# CHAPTER 1: INTRODUCTION

## BACKGROUND

1.1 Over the last thirty years, the rates of suicide and self-harm in Scotland have been increasing, especially among young men. The pain and distress that such actions represent and in turn cause, are a major cause of concern. The challenge is not just one to individuals and families, but to society as a whole, making it imperative that agencies coordinate and work together to prevent suicidal and self-harming behaviour. The Public Health Division of the Scottish Executive has sponsored a process of policy development since 1999 leading towards the development of a *National Framework for the Prevention of Suicide and Deliberate Self-Harm*. The draft Framework built on the principles and values of the Scottish Executive's commitment to improving well-being through its social justice programme and its efforts to reduce social exclusion and health inequalities. This included social justice milestone 11 regarding young people, and specifically included a commitment to improving health through reductions in suicide rates among young people.

1.2 Using the results from two consultative seminars held during 2000 and 2001, Scottish Executive and its National Planning Group produced a Draft Framework for Consultation with the assistance from the Scottish Development Centre for Mental Health. The proposed Framework was one element among an array of measures indicated in *Our National Health a plan for action, a plan for change* (Scottish Executive, 2000) to improve mental health and well-being. The National Framework was drafted in response to four key points raised by delegates at the national seminars. In particular, delegates wanted:

- A national framework to support actions at national and local levels as one element of a broader programme of work to improve mental health and well-being in Scotland
- A framework that was nationally supported and locally driven in order to create the necessary pressure on the system to deliver
- A coordinated national programme of work that encompasses strategic planning, action, learning, and research and development
- A national programme given the time and the resources to deliver improved outcomes.

(Consultation Document, page 7)

1.3 In October 2001 the Consultative Document was circulated widely to interested parties including NHS Boards and Trusts, Local Authority Departments of Social Work, Education and Housing, Police Forces, the Scottish Prison Service, Voluntary Organisations, all who attended the seminars on suicide prevention in November 2000 and May 2001 and many others who specifically requested a copy. The Consultation Document was also available on the Scottish Executive website. Consultees were invited to comment by the end of January 2002. The Central Research Unit (CRU) of

the Scottish Executive commissioned Scottish Health Feedback, an independent research company, to analyse the responses received and this report is an analysis of these responses.

1.4 During the period of formal consultation on the draft Framework, the Scottish Executive commissioned the Scottish Development Centre for Mental Health to undertake two interlinked pieces of work designed to feed into continuing policy development and to act as a resource to inform subsequent implementation. The first project explored perspectives on suicide and DSH with three sets of informants: groups affected by suicide and self-harm either directly or indirectly; service providers; and key influencers of opinion such as the media. The second exercise set out to identify examples of good practice in Scotland.

1.5 The Draft Framework for the Prevention of Suicide and Deliberate Self-Harm consultation document was in six parts. Part I provided the background and context of why a national framework was needed, the policy context and explanation of suicide and DSH and what was meant by prevention. Part II outlined the scope of the Framework including guiding principles. Part III offered an action plan with proposed steps for implementation of the strategy. Part IV presented priorities for action and identified success factors and Part V offered a timetable to 2004. Finally, Part VI presented specific consultation questions to ascertain the extent to which the Framework supported local and national agencies in planning and delivering the range of activities required. The analysis is built around the document structure as well as the consultation questions in Part VI.

## **RESEARCH AIMS**

1.6 The aim of the research was to provide an analysis of the responses received to the Consultation Document. The results of this analysis will inform the further development of the National Framework, so that it may take account of the information, views and insights offered, and so that remaining gaps in the Framework may be addressed. It was also envisaged that it would help to assess what support various agencies were likely to require implementing the measures recommended or implied by the Framework in planning and delivering activities aimed at preventing suicide and DSH.

1.7 The responses were many and diverse. A detailed analysis of respondents by sector/interest group and type of response is provided in Chapter 2. The central purpose of the work was to provide as much assistance as possible to those undertaking the next phase by presenting the content in a clear, unbiased way and to assist by summarising wherever appropriate. Where there were different schools of thought on a topic, this was made clear.

## **RESEARCH DESIGN AND METHODS**

### **Overall approach**

1.8 Each response document was logged and entered onto a database, along with relevant details of the respondent, dates and so on. If not already in electronic form (e.g. email attachment), it was converted to digital text form using *Textbridge* with relevant information about the respondent attached.

1.9 Each relevant part of every response was coded, using computer software for qualitative analysis (QSR N5), in one or more of the following three ways (a comment or section of text might be multiply coded):

- in relation to the question(s) in Part VI, Section 12 of the Consultation Document to which it refers
- in relation to the Part and/or Section or paragraph to which it referred in the remainder of the Consultation Document
- in relation to a more general theme or themes that emerged as significant from the content of the responses themselves.

1.10 Towards the end of the project, “coding reports” were generated that extracted all the comments on particular Parts/Sections, questions and themes. In particular, all comments relating to each of the questions set out in Section 12 of the Consultation Document, Parts or Sections of the remainder of the Document, and the main themes were extracted so that they could be read together.

1.11 Each of these coding reports consists of the verbatim text of the relevant portions of the responses – that is, those sections of the responses referring to a particular paragraph or theme. Each extract has been identified with the details of the relevant respondents. To each coding report is attached an analysis of the characteristics of the respondents who have made comments about this paragraph, section or theme. These reports together form the “digest” of responses asked for in the Research Specification.

### **Preparatory work: planning**

1.12 At the start of the contract, Scottish Health Feedback met with the commissioners from the CRU and Health Department to fine-tune the methods proposed and to help anticipate any main themes expected to emerge from the analysis. At that meeting, it was also identified that the commissioners wished to examine the extent to which the contextual background in the Framework was provided in sufficient detail, views on the guiding principles and approach and what respondents’ views were of the proposed actions and whether these stood up to measurable scrutiny.

## **Preparatory work on responses**

1.13 Responses were received from the Scottish Executive in paper and electronic form, and an initial batch was available immediately at the start of the project on 14<sup>th</sup> January 2002. Subsequent batches were received on a weekly basis until 14<sup>th</sup> February, two weeks after the official deadline for responses.

1.14 All paper responses were scanned, converted into digital text format, checked and corrected for conversion errors. Each response was logged on to a database with the name, position and profession of the respondent, the organisation to which he/she belongs (if any), the sector (Social Work, Education, Health, Police, voluntary, private, legal etc.), and whether the respondent was commenting on behalf of the organisation or in a personal capacity. The categories were agreed with CRU following this initial meeting. This information has been used to calculate response rates by sector and/or type of respondent.

1.15 The analysis was carried out in two passes. In the first pass, coding concentrated on identifying text relating to specific questions and paragraphs, while at the same time notes were made about emergent themes. A second analysis pass was then carried out, in which all responses were re-visited and coded according to any emergent themes. These are discussed under 'other issues' at question 15 in Chapter 4 and more generally in the summary and discussion in Chapter 5.

## **INTERPRETATION OF THIS REPORT**

1.16 This Report is essentially a presentation of the views of respondents, sorted by topic, analysed and summarised as accurately and faithfully as the authors have been able. It does not purport to make any judgements about where the balance of arguments lies, or make independent recommendations about changes to the Framework.

1.17 In order that those who have responsibility for reviewing the documents might have direct access to the comments of the respondents, in their original verbatim form, these comments have been made available to Scottish Executive staff in the form of the coding reports described above. In these reports, all the comments have been sorted according to the coding scheme as described.

1.18 While this Report therefore provides a full and detailed picture of the responses overall, it only forms part of the output of the process of analysis. The definitive product is the combination of this document and the totality of the coding reports.

## **STRUCTURE OF THE REPORT**

1.19 Chapter 2 provides a profile of the organisations and individuals who responded to this Consultation Document. Chapter 3 identifies and analyses the responses corresponding to Parts I-V of the Framework document. Chapter 4 analyses the responses to the individual questions contained in Part VI, Section 12, and Chapter 5 summarises and discusses the main issues arising from the responses. The Appendices contain details of the consultees and respondents, how they were categorised, the consultation questions and lists the members of the planning group.

## CHAPTER 2: PROFILE OF RESPONDENTS

### INTRODUCTION

2.1 In this Chapter, information is presented about the organisations and individuals consulted, those who responded and their characteristics.

### SECTOR AND INTEREST GROUP

2.2 The Scottish Executive received 140 responses by its internal cut-off date (14<sup>th</sup> February 2002), to its consultation on the *Framework for the Prevention of Suicide and Deliberate Self-harm in Scotland Consultation Document*. Although to be treated with some caution, this was a response rate of approximately 10% given that around 1400 copies of the consultation document were sent out. The vast majority (94%) were organisational responses, while eight came from individuals. In addition, 4 further responses were received after the final cut-off date and are therefore not included in the analysis reported here. However, their views will be taken into account by the Health Department. A detailed list of the respondents, including the 4 late responses, according to sector and interest group is given in Appendix 4. A full list of the consultees to whom the consultation documents had been sent is given in Appendix 2.

2.3 An explanation of how consultees and respondents were categorised is provided in Appendix 3. Due to the diversity of organisations and individuals consulted, some were difficult to classify. In addition, lack of specific information made some of the categorisations doubtful - for example, many of those consulted appeared in the list as "individuals" without organisational affiliation, but were almost certainly responding in some official capacity.

2.4 Table 1 below summarises the respondents according to sector and interest group. Comparison is made between the list of consultees and respondents to arrive at response rates, although we suggest in footnotes that these should be treated with caution. Additionally, figures are given for the number of responses to the consultation questions. These have been grouped according to the question headings given in Part VI of the Consultation Document as follows:

General	Questions 12.1, 12.2, 12.3
Roles and Responsibilities	Questions 12.4, 12.5, 12.6, 12.7
Priorities	Questions 12.8, 12.9, 12.10, 12.11, 12.12, 12.13
Research	Questions 12.14
Other Issues	Questions 12.15

2.5 For the purposes of Table 1, a response was counted as referring to the content of a question if the respondent did so explicitly, that is, quoting the question number. During the second stage of coding, it was discovered that others had made responses about the topic or area of a question without mentioning it specifically but these are not included in these figures. These figures should therefore be taken as an approximation of interest in the different areas.

**Table 1: Responses to consultation by interest group/sector**

*Note: Respondents who made no substantive comment are omitted from this Table.*

Interest group/sector	Invited*	Response	Response rate * %	Numbers Responding to Specific Sections of Part VI of the Consultation Document				
				General	Roles etc	Priorities	Research	Other Issues
Health Bodies	205+	32	16	16	16	16	9	11
Local authority	261	25	10	18	18	18	13	5
- <i>Social Work</i>	71	11	15	9	9	9	4	2
- <i>Education</i>	56	9	16	6	6	6	6	1
- <i>Housing</i>	32	3	9	1	1	1	1	0
- <i>Other</i>	102	2	2	2	2	2	2	2
Criminal Justice	35	4	11	1	1	1	0	1
Public Bodies	32	4	13	2	2	2	2	1
Commercial	11++	1	9	0	0	0	0	0
Patient/user/carer	44	7	16	3	3	3	2	3
Voluntary orgs	187	30	16	15	15	16	16	7
Academic/research	24	5	21	1	1	1	1	1
Professional bodies	67	8	12	5	6	7	4	2
<i>Health</i>	40	8	20	5	6	7	4	2
<i>Social Work</i>	5	0	0					
<i>CJS</i>	5	0	0					
<i>Education</i>	13	0	0					
<i>Other</i>	4	0	0					
Individuals	24	8	33	3	2	3	1	0
Other	35	10	28	6	6	7	7	5
Multi-agency	-	6		6	6	6	5	2
<b>Subtotal:</b>	925*							
Extra copies sent:	at least 475*							
<b>TOTALS:</b>	<b>1400*</b> (approx)	<b>140</b>	<b>10*</b>	<b>76</b>	<b>76</b>	<b>80</b>	<b>60</b>	<b>38</b>

\*The term “response rate” needs to be treated with great caution. The denominator is the figure in the column entitled **Invited**. This is based on a count of organisations included in the distribution list (see Appendix 2). In some cases, it is indicated in that list that two or more copies were distributed to a single organisation (see page 5 onwards of Appendix 2), and in these cases the number of individual copies distributed is included in the totals in the Table. (“Borders Primary Care NHS Trust (5 individuals) for example was counted as 5.) However, some organisations on the list had been marked with an asterisk and the footnote: “Further copies,

already on main consultation list” (see pages 7-8 of Appendix 2). In each case, these were counted as *only one extra*. Other consultees will have certainly ended up with more than one copy.

The distributors have told us that the total number sent was around 1400, and in addition the document was posted on a website, available to anyone interested.

Some responses came from groups containing interested parties from two or more agencies. These are included in the table using the additional category “Multi-agency”.

+ Does not include 100 copies handed out at a conference at Fife Health Board.

++ Does not include 180 copies sent to at HMSO Bookshops to meet public requests.

## **RANGE OF RESPONSES**

2.6 Table 1 shows that the greatest number of responses to this consultation came equally from Health Bodies, (including NHS Trusts and Boards, the State Hospital and individual health service initiatives/projects), and Voluntary Organisations representing a range of client group interests. The next largest number of responses came from local authorities which included Social Work Departments (or their equivalents), Education, Housing and Other Departments. Among the respondents were a wide range of bodies that included user and carer organisations, public bodies, academic/research bodies, professional health organisations, and a range of individuals. Only one commercial organisation chose to respond. Six responses were received as multi- or inter-agency responses and these were categorised separately. A significant number of respondents could not easily be categorised and were therefore placed under ‘Other’ in Table 1.

2.7 As well as categorising responses according to organisation, they were categorised as far as possible according to the profession of the “author” of the response (usually the person who signed the response or covering letter). This provided limited information and did not necessarily reflect the breadth of professionals that had been involved in formulating the response. In many cases it was not possible to identify the profession of the author; in local authorities, for example, it is now often the case that various combinations of Social Work, Housing, Education and other functions are contained within larger composite departments, and it is unclear which profession the Director or senior manager belongs to. This means that all the senior local authority respondents had to be classified as “managerial” because their original profession could not be safely deduced from their organisational title.

2.8 Analysis of these categories shows that around half (71 authors) were classified as managers, 24 (17%) could not be categorised (usually because they did not indicate their designation), 19 (14%) were health professionals including consultants, and the remainder were ‘other professionals’, honorary appointments, academics, educational professionals, legal or criminal justice professionals, and one was an elected representative. There were no responses specifically from users, patients or carers, although there were seven responses from user/carers/patient bodies.

2.9 The breadth and scope of responses varied enormously from 2-10 pages in length. The majority or three out of five respondents chose to structure their responses around the consultation questions asked in Part VI, while others addressed the issues more generally. Some responses were clearly the result of multi-



disciplinary or inter-departmental consideration, while others represented only the opinions of a specific profession or interest group such as psychiatrists or in some cases, of an individual consultant. The weight of comment appeared to be around the priorities, roles and responsibilities as defined in the consultation document and general issues. Least comment was received in relation to question 12.15 about 'Other Issues'.

## **CHAPTER SUMMARY**

Responses to the draft Framework were received from 140 organisations and individuals. Although to be treated with caution, this represented an approximate response rate of 10%, given around 1400 copies of the document were sent out. While most responses came from health bodies, voluntary organisations and local authorities, other groups such as users and carers were represented among the respondents. The vast majority (94%) were organisational responses, with only 8 individual responses. The breadth and scope of the responses varied from respondent to respondent. Most were structured around the consultation questions in Part VI, but some addressed the issues more generally.

## **CHAPTER 3: COMMENTS ON THE PARTS OF THE NATIONAL FRAMEWORK**

### **INTRODUCTION**

3.1 This Chapter presents the findings in respect of respondents' comments about specific Parts and their Sections of the National Framework for the Prevention of Suicide and Deliberate Self-harm in Scotland Consultation Document. Additionally, comments referring to aspects covered by the Consultation Document for example, comments relating to definitions of suicide and DSH, trends and risk factors, but not specifically referring to the appropriate Part (and/or Section) of the document, have been included. The structure of the Chapter follows that of the Document itself, being sub divided into Parts I to VI, and Sections 1-12. This Chapter deals with Parts I-V, while Chapter 4, concentrates solely on the responses to the consultation questions asked in Part VI.

### **GENERAL**

3.2 The Framework attracted both positive and negative comment. At one level, the Framework Document was warmly welcomed as a "positive initiative" and perceived as "balanced and comprehensive." For the North Edinburgh Social Inclusion Partnership for example, the Framework was a "very welcome and much-needed initiative". Out of those respondents who made general comments about the Framework, around 61% were positive about the document overall. In addition, 68% of respondents to the consultation question 1 (see Chapter 4) commented that the Framework would assist them in taking forward actions to reduce suicide and self-harm in their own organisation or local area. Essentially, the document was perceived as "forward thinking" in that it recognised the importance of national leadership and central co-ordination, coupled with appropriate support for local alliances and initiatives. The notion of a "shared responsibility" was particularly welcomed.

3.3 The emphasis on education and prevention and a strategic approach were applauded, whilst there was a call for balance between long-term changes with appropriate short-term measures. By bringing initiatives together "under the umbrella of national leadership", the Scottish Executive would be taking the necessary steps towards "breaking down the barriers of stigma and discrimination". It was also appreciated that these issues were being dealt with in the wider context of promoting mental health and well-being:

*"The approach proposed in the draft framework is a very sound one in that it recognises the need for a long term perspective and for wider societal as well as individual causes of suicidal behaviour to be addressed. It recognises that the national suicide rate is a measure of social health as well as mental health. It takes a developmental and reflective approach and is well laid out. The emphasis on partnership working, collaborative working and a combined approach to include Voluntary Organisations and others is a positive step as is the*

*recognition that effective multi-agency working will take time and require top level strategic direction and support.”*  
(Mental Welfare Commission)

3.4 At the other extreme of opinion however were both national and local organisations such as the City of Edinburgh Housing Department who was “disappointed” with the document and the Mental Health Governance Group at the Royal Cornhill Hospital who considered the measures proposed in the paper were “too broad brush”. Either the respondents were diametrically opposed to the approach proposed in the Framework or it did not quite ‘hit the right notes’. For instance, one respondent stated that the document “did nothing to advance knowledge”, and one consultant psychiatrist working with young people commented:

*“I’m afraid I didn’t find the document very accessible - it took careful reading to discern what the key points were, in particular what was ‘original’ i.e. innovative rather than a rather wordy recitation of a lot of things most of us could have anticipated without the additional work of a committee, concepts we would readily agree with.”*

3.5 In relation to the issue of accessibility to a wider readership, a Housing Department was critical of the language used in the document, which they stated was “obscure and inaccessible”. Others stated that terms such as ‘social capital’ and ‘primary, secondary and tertiary intervention’ needed to be explained. The use of abbreviations and acronyms was highlighted as generally “unhelpful”, and one respondent felt the overall style was “inconsistent” and “inappropriately informal” at times. Additionally, gaps in the document were perceived by one respondent as resulting from gaps in the membership of the planning group. For instance, the group had not included representatives from acute trusts, general practice, police, ambulance services or voluntary organisations such as the Samaritans. There was a perceived lack of emphasis on the role of alcohol and drugs, as well as specific mental illnesses as significant risk factors in suicide and self-harm.

3.6 A key source of dissatisfaction with the Framework document was that it did not sufficiently address the differences between suicide and self-harm. In some respondents’ view, the document “failed to grasp the opportunity to consider the complex issues surrounding self-harming”. Around 30 respondents sought greater clarification of the differences within the Framework and a clearer definition of what was meant by ‘deliberate self-harm’. This included health bodies (e.g. Lothian Primary Care NHS Trust; Forth Valley Primary Care NHS Trust, Fife NHS Board Mental Health Strategy Group), voluntary organisations (e.g. NSF Scotland, GCSH, the Samaritans, St Aubin’s Project, Say Women), user groups (e.g. Aberdeen Mental Health Reference Group, Edinburgh Users Forum) professional health bodies (e.g. BMA and the Independent Federation of Nursing in Scotland), local authorities (e.g. Aberdeenshire Council, City of Edinburgh), academic bodies and multi-agency respondents:

*“The language of the framework does, however, confuse in relation to ‘deliberate self-harm’. It is recognised that deliberate self-harm, although perhaps in some an indicator of suicide risk, is not a suicide*

*attempt and the intention to die is not present” (Manic Depression Fellowship Scotland)*

3.7 The City of Edinburgh Housing Department and other multi-agency respondents were “very concerned” about linking DSH and suicide as if they were aspects of the same phenomenon and suggested they be treated separately. The Glasgow Council for Single Homeless suggested there was a “fundamental ‘lack of fit’” between the two issues within the document and the experiences of the issues among many front line practitioners and service providers within homelessness and other areas of service. This was perceived as a “significant difficulty” within the Framework that “militates against its general and more specific usefulness”. A handful of respondents, including the British Medical Association and SCSH, expressly asked that two separate strategies were drafted – one relating to suicide, the other to DSH or self-injury and focusing mainly on action plans.

3.8 The Edinburgh Users Forum did not believe the Framework would truly deal with the fundamental problems of suicide:

*“The elimination of methods can only serve to prevent or limit the number of deaths (referring to paracetamol availability). It cannot affect the utter despair and misery experienced by people before they go so far as to engage in “suicidal behaviour”. Is this evidence for saying that the whole thrust of this work is purely based on the reduction of a measurable statistic, that is deaths resulting from “suicidal behaviour” and not from any desire to have people actually feeling better?”*

3.9 The draft Framework was criticised for not referring to the concrete resources required for its implementation, other than references to £4 million to promote positive mental health and well-being (*Our National Health*, page 25). Organisations in the mental health field commonly pointed out how existing services were already “overstretched” and “under-resourced”. Furthermore, respondents highlighted the lack of so-called local “analytical services” (perhaps referring to organisational capacity to undertake research and information tasks), and called for this to be addressed at national level.

3.10 Respondents’ comments specifically about Parts I-V of the Consultation Document and the Sections within them are analysed below in more detail.

## **PART I: BACKGROUND & CONTEXT**

3.11 The Document in Part I, introduces the argument for creating a National Framework, goes on to examine definitional issues between suicide and DSH, looks at the policy context, and explains suicide and deliberate self-harming behaviour according to a ‘model’ informed by research. It is explained that the implication for policy and practice from this model is that a coordinated strategic approach has to encompass three levels: primary, secondary and tertiary prevention.

3.12 Twenty-eight or a fifth of respondents made comments about Part I, the majority of these being in respect of the ‘distinctions and definitions’ in Box 1, and the ‘risk factors’, ‘societal risk conditions’, ‘psychosocial environment’, and ‘individual risk factors’ identified in Boxes 2-4. Health bodies, local authority social work departments, public and professional bodies, voluntary organisations, user or carer organisations, individuals and other types of organisations, all provided comments.

### **Section 1 – Why do we need a National Framework?**

3.13 Only 5 respondents altogether chose to provide comments specifically about the text in Section 1. Given the nature of overall comments received about the document, it would seem reasonable to assume that this reflected almost universal agreement with adopting a strategic and coordinated approach at both national and local level. While this was the consensus, one Social Work Department cautioned that it might not happen in practice:

*“This could end up being yet another strategy that everyone says they need and want but lack commitment to follow it through. Where does it fit in the scale of priorities for agencies, especially Health and Social Services?”*

3.14 It was further suggested by Childline Scotland that adopting a “developmental approach” within the Framework would stand a better chance of addressing issues for children and young people in a mainstream way rather than being marginalised in a separate table for example. In its opinion, while the Framework identified young people as at risk and a key target for intervention, it did not go on to specifically address many of the issues they faced. The issue of the Framework paying insufficient attention to age as a factor was repeatedly highlighted in several other respondents’ comments.

3.15 There was objection to the statement contained in paragraph 1.5 on page 7, ‘we can provide intensive support when a person’s problems become severe and the possibility of a suicide response increased’, which was according to a voluntary sector respondent, “naïve in the extreme” because most mental health services providers were struggling to provide even a basic service.

3.16 The Public Health Institute for Scotland doubted the document provided sufficient information about people committing suicide in Scotland to allow either national or local agencies to prioritise the best ways to prevent future deaths. This body called for further detailed breakdown of epidemiological data by geographical area, occupational groups, antecedent circumstances for example mental illness, recent imprisonment, substance abuse and mode of death and for information to be collected at the Scotland level rather than locally in view of the small numbers involved and the finite analytical resources locally.

### *Box 1 – Suicidal behaviour: distinctions and definitions*

3.17 In relation to Box 1 and elsewhere in their comments, respondents requested a clearer distinction to be made between suicides and DSH throughout the Framework. Although there is a statement in Box 1 that ‘the distinction between suicide and DSH is important’, the rest of the Framework Document was said to proceed to “inappropriately link two quite separate issues together”. The lack of separation of two very distinct areas was perceived as a “fundamental flaw” in the whole Framework influencing the nature of the comments on other aspects of the Consultation Document.

### *Box 2 – Suicide: trends and risk factors*

3.18 The use of proportions rather than absolute rates to highlight a rise in deaths by suicide, was criticised as “misleading” to the non-specialist reader as the rise may well have more to do with a reduction in deaths by other causes, than a real rise in the number of suicides. Only absolute or actual figures were thought to explain the extent of the problem. The inclusion of a graph of actual rates of suicide and self-harm per 100,000 population (shown in 10 year age bands) was proposed.

3.19 While the list under ‘trends’ made no mention of children under 15 years, Childline Scotland highlighted that the majority of their calls were from 13/14 year old females.

3.20 Overall, there was “substantial agreement” with the list of ‘risk factors’, but the following additional factors were identified:

- Bullying, family and personal relationship, physical and sexual abuse are risk factors especially for young people;
- Say Women argued that the statement ‘the risk of suicide is inversely associated with socio-economic status’ was “misleading” and “gives a negative picture of working class people”. It would be more accurate to refer to suicide being associated with poverty, lack of sufficient income and social exclusion. Although this point is made in the document later on, it was felt the text of Box 2 appeared “clumsy”.
- Uniquely, the UK Men’s Movement sought the inclusion of “feminism” among the list of ‘risk factors’. This was because of its perceived “deep rooted cultural notion that society at large does not view male life and well being as important”;
- Risk factors might also include “concerns over sexual orientation living in a transcultural society when there are clashes in expectations for young people from ethnic minorities” (NHS Trust).

3.21 The Scottish Association for Mental Health argued that ‘risk factors’ as drafted did not recognise the complex mix of biological and psychosocial factors and the differences in socio-economic status.

3.22 In addition to ‘risk factors’, it was proposed the Framework should include identifiable ‘protective factors’, as this might help with goal setting.

*Box 3 – Deliberate self-harm: trends and risk factors*

3.23 Respondents recommended that under ‘Trends’, evidence should be given for the statement that changes in law have brought about the difference in use of paracetamol or aspirin. Bullet points 9-10 only obliquely suggested that by far the biggest majority of people who self-harm do not go on to commit suicide.

3.24 Under ‘Risk factors’, respondents identified child sexual abuse and rape/sexual assault to be included under ‘stressful life events’. Again, the ‘risk factors’ were identified as not including factors for 15-24 year olds when this was important. The Royal College of Psychiatrists argued that the document made a “spurious distinction” between ‘depressive disorder’ and ‘severe psychiatric illness’:

*“We would regard depressive disorder as a severe psychiatric illness. The psychiatric disorder produces the most significant burden on the health of the population and is by definition a recurrent disorder in most who experience it. To imply that it is not a severe psychiatric illness and to reserve the term “severe psychiatric illness” for schizophrenia/bi-polar disorder is erroneous.”*

3.25 In respect of identifying the risk factors leading to suicide and DSH, a wider point was made by two respondents (an NHS Trust and an individual) that the very nature of modern society was causing “despair and the feeling of personal failure” in young and old alike. One went further to suggest that a “fundamental change in attitudes and behaviours” was needed and that this should be led by the Scottish Executive who should aim to create “a more caring society which is engaged in supporting individuals to develop healthy coping strategies in local communities.” In many ways, such comments appear to reiterate the need for strategic approach outlined in the consultation document.

## **Section 2 – The policy context**

3.26 Few respondents made any comments about the policy context in Section 2, and those who did, felt that the Section explained the Framework well in the context of other strategies. However, others pointed out areas of existing policy that were working counter to the approach espoused. It should be noted that such comments did not relate directly to the Document, but were observations about national policy generally.

3.27 Ironically, in the opinion of the St Aubin’s Project, the current Health Education Board for Scotland’s (HEBS) anti-stigma campaign was reinforcing negative perceptions of mental illness. The UK Men’s Movement considered national policy and the media to be “actively militating against social capital in males”. Lothian Primary Care Trust urged the Scottish Executive to go further than “urging sensitivity” to:

*“actively promoting “a more tolerant and inclusive society in Scotland which celebrates, and accommodates, not tolerates, diversity related to age, gender, ethnicity, sexual orientation, religious belief and disability”*

### **Section 3 – Explaining suicide and deliberate self-harm**

3.28 Comments about Section 3 focused on the contents of Box 4 in the main. Stonewall Scotland was critical that paragraph 3.7 and the description of the Executive’s Equality Strategy on the previous page, were the only two expressions of the term “sexual orientation” in the whole document, and that it was perceived as subsidiary to the basic model when in its view, it should be more central.

#### *Box 4 – Possible explanations for suicides and deliberate self-harm*

3.29 Respondents suggested that combining possible explanations for both was confusing. Separate explanations were required for suicide and DSH. It was pointed out that it had been previously stated in Box 1 that there was evidence of variation in causal factors, the ‘profile’ of those most at risk, and in the responses required.

3.30 The following comments were made about the list of factors in ‘Societal risk conditions’:

- There appeared to be a “total oversight” of the impact of sexual orientation and the impact of gender stereotyping on the incidence of suicide. Stonewall Scotland commented that “lesbian, gay, bisexual and transsexual people may feel shame, low self esteem and inferiority in relation to those in the majority.”
- The organisation Say Women, suggested the addition of “male violence towards women and children”.
- Availability of illicit substances was an additional factor not mentioned.
- Disability was identified by the Scottish Council on Deafness as a societal risk factor due to negative attitudes from society, communication breakdown, social exclusion resulting in loneliness.
- The College of Occupational Therapists felt that difficulty in accessing social and recreational activities on low incomes should be included.

Under ‘Psychosocial environment’:

- The Earl Haig Fund Scotland proposed that ‘mental abuse’ be included in relation to the disadvantageous position of males in disadvantaged communities and subsequent role conflict. “Positive discrimination” in favour of women was resulting in “serious identity crisis” for men, thus affecting their mental health.



3.31 A significant factor identified as missing by several respondents was the incidence of bullying.

*Figure 1 – Model of Suicidal Behaviour*

3.32 Figure 1 was felt to be “confusing” by a range of different respondents, even “impenetrable” according to one Housing Department. A multi-agency response from one area suggested it might be more helpful to present the model as the pathways that lead to suicide and deliberate self-harm, as this might better demonstrate the complexity of the problem. Another suggestion from Warrington Community Trust to represent how the factors identified affected each other, was to present the model as a series of concentric circles containing each of the four areas with suicide and deliberate self-harm in the centre. No other redrafting suggestions were made, although later in the document the model of suicidal behaviour is highlighted as an area for future research.

**Section 4– What do we mean by the prevention of suicide and deliberate self-harm?**

3.33 That prevention measures must include all three levels as described was generally accepted. The terminology of ‘primary, secondary and tertiary’ however was felt by some to be unhelpful jargon and should be further explained. The Patients’ Association response proposed greater emphasis on changing public perceptions about mental illness and the common experience of low mood and “transient suicidal thoughts”.

*Table 1 – Levels of prevention: implications for policy and practice*

3.34 Table 1 attracted two specific comments: one that the three levels of prevention do not really map as discretely onto the population, group and individual approaches as the table implied:

*“For example, a health education campaign (primary prevention) may be required to alert the public to symptoms in at risk adolescents (individual level).” (Academic)*

3.35 The second comment was that the Table showed the necessity for two separate frameworks for suicide and deliberate self-harm. In the secondary prevention focus, for deliberate self-harm early ‘intervention’ would be replaced with “support”, and ‘prevention repetition’ would be replaced with “harm reduction”.

**PART II: SCOPE OF THE FRAMEWORK**

3.36 This Part of the Document presents the focus of the Framework and the need for it to be relevant to a wide range of sectors and organisations that have the potential to influence the incidence of suicidal behaviour. It also offers a series of ‘guiding principles’ and outlines the approach that requires to be taken.

3.37 There were in fact few comments about Part II of the Consultation Document (8 respondents). These have been dealt with according to the Section on which they commented.

### **Section 5 – Focus of the Framework**

3.38 There were no specific comments on Section 5.

### **Section 6 – Guiding principles**

3.39 Generally, the Guiding Principles were considered as “clearly set out”. One respondent considered Section 6 as an “example of the wise and lucid” style of elements of the document in contrast with other sections that they considered were “goobledgook and pompous jargon”.

### **Section 7 – Approach**

3.40 In relation to the ‘local agencies and networks’ in paragraph 7.4, the point was made that Community Councils role should be acknowledged. It was also suggested that this paragraph displayed “a lack of understanding and experience on the ground” as few agencies had a supportive approach to self-harm, and further the statutory sector did not co-operate with these agencies. Difficulties around hospital A&E departments and psychiatric wards were hinted at but not expanded upon at this point.

3.41 It was agreed that the media had an important part to play and according to Lothian Primary Care Trust, could build on the Royal College of Psychiatrists’ work in relation to tackling stigma of mental illness and HEBS work on domestic abuse.

3.42 In paragraph 7.7, clarification was sought as to who the ‘main players’ were assumed to be.

3.43 In relation to paragraph 7.8, any research programme needed to be centrally concerned with “the needs of those who are at risk”, rather than the “pursuit of academic preference”. A voluntary sector organisation wished to ensure a balance between quantitative and qualitative research in this area and for the value of “anecdotal evidence” to be recognised.

## **PART III: A PLAN FOR ACTION: PROPOSED STEPS FOR IMPLEMENTATION**

3.44 Part III envisages moving the agenda forward in two separate Phases: Phase 1 which it entitles ‘getting attention and making the case for action’ proposes action at a national and local level by way of ‘building the required national policy and local implementation infrastructures’. The development of detailed action plans is the main objective to be achieved in Phase 2.

## Section 8 – Suggested initial action programme

3.45 There was little detailed comment on the suggested initial action programme other than to reinforce how the detail of local action plans should identify which outcomes are measured. The Common Services Agency welcomed the references to the need for better information and outlined the programme of improvement for mental health information currently being undertaken by the Information and Statistics Division. Better information on the determinants and outcomes of suicide and DSH were being considered as part of the wider need to improve data collection on mental health and mental health services. The production of the Framework had helped to steer its thinking. In addition, the Common Services Agency underlined the importance of careful management of local databases.

### *Table 2 – Phase 1: activity, key objectives, key steps*

3.46 There was strong support from a Consultant Psychiatrist for the proposal for a ‘development network’ (page 20) and for the suggestion that local exemplars be disseminated nationally along the example of the NHS Beacon Sites in England & Wales.

3.47 The National Board for Nursing, Midwifery and Health Visiting for Scotland was concerned to ensure that local data collection complied with data protection legislation as such information was generally only available in individual medical notes. Further, the development of national standards would require to be integrated with existing standards, such as National Care Standards, CNORIS, SHAS and relevant CSBS standards (abbreviations not explained in the response).

3.48 A health body suggested potential for conflict between pursuing performance management and quality standards (page 19), alongside the need to ‘move away from a blame culture’ (page 14). Although supportive of the need to measure performance, it was not clear to the Common Services Agency who would carry out the performance management of the Framework. Additionally, building capacity for research and development to support implementation appeared to be “quite ambitious”, and would require coordination and project management. More detail therefore on how the national research and development programme is to be taken forward would be useful.

3.49 While agreeing with the importance of ‘joined-up’ local initiatives, one health body highlighted the central importance of joining up the “many, varied and onerous initiatives” at a national level as a first step. In its view, a more rounded picture of how suicide and self-harm is being and will be tackled in the future, would be achieved by explicit reference to the overlapping initiatives in the ‘Context’ (Part 1, Section 2) of the Framework. Lothian Primary Care Trust similarly highlighted the importance of tackling broader issues at national level:

*“There is evidence that reductions in alcohol consumption leads to reductions in suicide. There is no evidence that this issue is going to be addressed in the framework so far. To be effective this will require changes at the national level requiring commitment. This will then*

*need to be implemented at the local level involving including Licensing Boards, the police, alcohol misuse specialists in health and primary care, social work, community planning and a range of other partners.”*

3.50 More critical voices were a Housing body who considered the objectives in both Tables 2 and 3 as “far from SMART or clear”, and Say Women who suggested use of the word ‘champions’ on page 18 was “absurd” as it was unclear who they would be and whether they would be paid posts with additional funding.

*Table 3 – Phase 2: activity, key objectives, key steps*

3.51 A number of additional suggestions were made in respect of Table 3:

- Action regarding mental health services should be complemented by action to improve primary care;
- An area-wide planning group may be beneficial to support local activity;
- The mental health and well-being of ‘looked after’ children should have more prominence;
- Resources will be needed to ensure staff are released for inter-agency training;
- Page 22 (d) assumes that the recommendations of the confidential enquiry are valid;
- Page 22 Key Steps, point 2, while recognised as good practice, it is not common practice at present;
- Should not be assumed that specialist adolescent services have the capacity to cope with new demands;
- The needs of people with learning disabilities who have attempted suicide will need to be looked at in light of the hospital closure programme.

3.52 The Mental Welfare Commission for Scotland volunteered to be involved in the proposed working group producing guidelines on media reporting and portrayals of suicide (p25).

## **Section 9 – Phase 1 and Phase 2 outcomes**

3.53 Only two comments were made in relation to outcomes. Concern was expressed that because in practice it might be easier to measure outcomes from health service interventions, the focus may shift inevitably from primary prevention. The Common Services Agency offered to contribute its expertise to establishing data collection capacity both locally and nationally.

## **PART IV: PRIORITIES FOR ACTION**

### **Section 10 – identifying areas for action**

3.54 Only one respondent commented on Section 10 overall, while more respondents provided comments about the contents of Table 4 and 5. It was suggested by Glasgow Council for Single Homeless that the Framework would have

been “significantly enhanced” if it had better reflected the research about what service users wanted. This included better accident and emergency treatment, peer support groups with appropriate support, befriending or social support for people ‘at risk’ of suicide or deliberate self-harm, awareness raising through training of nursing, education or social care staff, self-help literature, and extending the accessibility of therapeutic interventions such as counselling.

*Table 4 – Population-based strategies: possible interventions*

3.55 As a general point, the National Schizophrenia Fellowship (NSF) Scotland commented that the population-based strategies needed to better reflect the need to engage diverse groups and individuals. The following comments were received about each ‘theme’ in Table 4:

3.56 Access to means - Glasgow Council for Single Homeless suggested that without a “more considered appreciation of the underlying or precipitate factors”, reducing access to means of suicide would have limited impact. The Medical Council on Alcohol wanted a reduction in availability of alcohol and illicit drugs included.

3.57 Inequalities in suicide risk – An individual respondent proposed that it was perhaps not ‘attainment’ in itself that should be seen as important, but the importance of “acquiring ‘a love of learning’”.

3.58 Societal conditions that impact on suicide – No comments received.

3.59 Gender-related aspects – One organisation, Say Women, felt that male violence against women and children should be mentioned specifically.

3.60 Professional education and development – No comments received.

3.61 Public attitudes to, and awareness of, mental health and mental health problems – In relation to the HEBS video produced as part of its anti stigma campaign, St Aubin’s repeated its criticism that this initiative actually reinforced “perceptions of negativity” in respect of the experience of mental illness.

3.62 Specific settings – Respondents were sceptical about making institutional settings ‘suicide-proof’ as stated in the Table 4 of the Framework. One multi-agency respondent stated this was “impossible”. Two other multi-agency respondents argued that making settings suicide-proof as suggested was too sweeping and would contravene individual human rights:

*“The only way to achieve this would be to remove the freedom, comfort and civil rights of the entire population of the institution i.e. mandatory body searches, removal of all personal possessions, increase in detentions under the Mental health (Scotland) Act etc. The aim should be to reduce the risk where practical not to remove it.”  
(Multi-agency)*

3.63 For one Primary Care NHS Trust the thrust of this theme conflicted with a statement on page 13 of the Framework that not all suicides are preventable.

Collectively they suggested shifting the emphasis towards practical risk assessment, and one even went so far as stating allowing patients to be in an environment where “suicide was possible although not easy to complete”, might be part of the therapeutic process.

*Table 5 – High risk group strategies: possible interventions*

3.64 The following comments were received about each ‘target group’ in Table 5:

3.65 Experience of mental health problems – No specific comments.

3.66 Accumulated life problems or disadvantage – Two points were made in relation to peer groups and families. National Schizophrenia Fellowship Scotland was concerned that peers and families might be part of the problem leading to self-harm or suicide. A consultant psychiatrist was concerned that self-harming behaviour might be reinforced as an “acceptable coping practice”.

3.67 People with a long-term or terminal illness – It was suggested by St Aubin’s Project that the ‘possible interventions’ under this heading should be something that is being done already.

3.68 Life crises, loss, transitions, change – The St Aubin’s Project stressed the importance of the social work role in delivering such interventions. Clarification was sought on what was meant by “‘simple” ways of maintaining or creating good mental health’. It was argued that this ‘target group’ was also applicable for population-based strategies for example, in the case of insecure, short-term employment, unsocial or long working hours.

3.69 People who have been sexually or physically abused - Earl Haig Fund Scotland proposed that the text “*mentally*” should be added after ‘physically’ and before ‘abused’. Again, it was suggested that ‘possible interventions’ was misleading as this should be happening already.

3.70 People who misuse substances – While not disagreeing with the substantial point about ‘effective links between mental health and substance misuse services’, one consultant psychiatrist working with young people observed from experience that this would “not be easy” because currently provision within current NHS mental health services for younger adolescents with substance misuse problems was sorely limited.

3.71 Occupational groups eg doctors, pharmacists, farmers – No specific comments.

## **Section 11 – Success factors**

3.72 By far the most comments about Section 11 were about respondents’ concern about measuring success and were received from health bodies, professionals and multi-agency respondents. For instance, the Royal Cornhill Hospital Mental Health Clinical Governance Group asserted that putting a range of initiatives in place would

make it “impossible to decide in retrospect which, if any of them, have had any impact on suicide rates”. This group were also sceptical that the impact of community wide interventions could be measured because it would require large-scale and long-term studies. Similarly, an individual consultant psychiatrist suggested that evidence of a downturn in rates of suicides and DSH, may take as long as 10 years to appear.

3.73 A medical director for mental health felt that the clinical outcome indicators were “vague” and “difficult to measure”, and queried which “core data” would be collected and how the bureaucratic challenges of sharing information across agencies were to be overcome. One NHS Board was concerned about using reduced suicide rates as an accurate measure of success and asked that success indicators were developed under the Performance Assessment Framework. The Common Services Agency identified that new information would need to be collected on whether people were receiving appropriate and effective treatment:

*“This kind of data collection has been pioneered in surgical specialities in Scotland and is now being developed in medical specialities. It is high time it was extended to mental health and primary care.” (Common Services Agency)*

3.74 There was support from the College of Occupational Therapists for ‘timely help and support’ for those who self-harm as it was aware of many “horror stories” about the treatment of such patients by NHS staff in accident and emergency wards and mental health settings.

3.75 The National Schizophrenia Fellowship Scotland sought more evidence on how changing views on the use of alcohol would reduce suicides and DSH:

*“If people experience alcohol use (rightly or wrongly) as a coping strategy, would changing views on its use reduce or increase suicides?”*

3.76 The need to place many of the identified success factors in the context of social justice was reminded by an academic who stated:

*“Most societal change, such as improvements in educational attainment, employment and income should maybe be seen as important and valued ends in themselves and not merely as a means to reducing suicide or improving mental health. These are matters of justice which might have health consequences.” (Academic)*

## **PART V: TIMETABLE**

3.77 Only one comment was received in relation to the approximate timetable for the developmental stage set out in Part V, although respondents’ views about the proposed timescales are discussed further in terms of their responses to question 9 of the consultation questions (see Chapter 4). The comment was from an NHS Board who welcomed a “phased and pragmatic approach”. However, while the overarching

10-year vision given elsewhere in the document appeared “realistic”, the Board were sceptical that two years was sufficient for the developmental phase. For example, the Board commented:

*“The proposed setting up of the national telephone helpline for young men (as mentioned in the Social Justice Annual Report, 2001) will undoubtedly contribute positively to the Framework; but it will take time to have an impact.” (Lothian NHS Board)*

## **CHAPTER SUMMARY**

3.78 Ironically, what some respondents highlighted as positive features of the Framework, for example, the broad overarching framework that was not overly proscriptive and left the details to be decided at the local level, was for others its weakness. While respondents welcomed the emphasis within the Framework on prevention and strategies at a societal level, as well as the notion of a shared responsibility and of national and local roles, others were more critical. The main criticism levelled at the Framework was that it failed to properly separate the different issues of suicide and DSH. It was suggested this could be addressed by providing a clearer explanation and definition of DSH within the Framework, and for some, there needed to be two separate strategies altogether.

3.79 In the responses discussed in this Chapter, predicted difficulties of achieving joint working on implementing the Framework were hinted at, along with the resource implications, and a number of gaps in terms of explaining suicides and self-harm and prevention. Responses demonstrated the wide range of views on the subject that exist. Respondents raised a number of practical concerns about the collection and sharing of information, and about the difficulties of measuring outcomes, particularly the impact of community-wide interventions.

3.80 The responses gave a clear impression of the complexities of the issues, and of an inherent tension concerning the balance between central direction and local autonomy, and achieving commitment across a variety of statutory, voluntary and community organisations. In spite of such tensions and potential challenges, there was an underlying enthusiasm for the notion of shared responsibility and a multi-layered approach to prevention within the context of promoting health and well-being, and this was supported by a range of agencies who were prepared to play key roles in its implementation.



## CHAPTER 4: RESPONSES TO PART VI CONSULTATION QUESTIONS

### INTRODUCTION

4.1 This Chapter analyses the responses to each of the 15 questions asked in Part VI, Section 12 of the Consultation Document regarding how the Framework supports or otherwise, local and national work to prevent suicide and DSH. In the analysis, attention is drawn to comments made by specific organisations or their organisation type, and individuals where this is felt to be helpful or relevant.

### GENERAL

**Question 1: Please comment on whether the Framework would be likely to assist you in taking forward actions to reduce suicide and self-harm in your own organisation, and in your local area.**

4.2 This question attracted 71 out of 140 responses (51%). The Framework was recognised by around 70% of these respondents as at the least a “useful starting point”, a way of raising the profile of suicide and DSH. The existence of a national Framework was thought to increase the probability that voluntary organisations such as the Depression Alliance would become involved in multi-disciplinary work in this area. Fife Council Services argued that the Framework provided a “much needed focus to an issue that has wide ranging implications for a number of services.”

4.3 Drawbacks of the Framework included that it was being introduced into “an already crowded policy arena” and the “conspicuous avoidance” within the document of any mention of resources for implementation. For instance, while the ‘coordinator’s’ role was recognised by respondents as the key to success, there was no mention of new funding for such a post. Consequently, the Framework was also met with cynicism:

*“The Framework per se will be unlikely to assist me. Indeed there is a risk that I will be drawn into meetings, committees etc. discussing it when I could be preventing more suicides by getting on with my clinical work. The Framework for Mental Health Services Development has been similarly unhelpful; it contains a lot of good stuff but there are not the resources to implement it and a great deal of time and enthusiasm (of professionals, service users and carers) have been squandered in a planning process with no outcome.” (Consultant Psychiatrist)*

4.4 Structural solutions were of limited value in addressing the core problems underlying suicide and despair in the view of the Church of Scotland. Further, the lack of more concrete action plans meant that to some it was of “limited use” (Scottish Association for Mental Health). While considered “timely” by Facilitate (Scotland), the “social science bias” of the document was felt to “overshadow other

disciplines to the detriment of the longer term reduction of suicide”. However, the Glasgow Council of Single Homeless commented:

*“It is evident from the paper that the framework is informed by clinical psychiatric research almost exclusively and that it thereby adopts a view of self-injury which supports its definition as a disorder, pathology or syndrome. We would argue that it is important to engage in a discourse that locates ‘self-injury’ as an indicator of emotional or mental distress as opposed to one of mental ill health.”*

4.5 Respondents felt that the Framework would only likely assist local organisations if the barriers to joint working were openly acknowledged and faced squarely, and secondly, if the resources required to implement the action plans were identified.

#### *Key points*

- The Framework provided a useful starting point for some, but not enough concrete action plans for others.
- It would have to compete with other priorities.
- The resource implications were not mentioned in the Framework.
- The theoretical approach to self-harm as pathological was not perceived as useful to devising helping strategies.

#### **Question 2: How can/should the Framework link into existing local planning arrangements?**

4.6 Question 2 attracted comment from 62 or 44% of respondents. The common proposal was that the Framework should link “seamlessly” into the joint planning and commissioning arrangements for Community Care and the Health Improvement Plans (HIPs). However, the limitation in this was that Community Care Plans referred only to local authority boundaries, while HIPs were at the broader NHS Board level. It was therefore considered inappropriate that the Framework should be specifically linked to local authority areas as in Table 2, because the unit for some existing strategic partnerships were based on Social Inclusion Partnerships, or NHS Board area boundaries. Consideration needed therefore to be given to how to engage wider community based services and organisations.

4.7 Collectively, respondents identified that the Framework would need to link with a plethora of other local planning processes including Children’s Services Plans, Social Inclusion Partnerships, Education Departments’ Service Plans, Community Schools, Healthy Living Centres as well as strategic planning groups for Criminal Justice Services, Homeless Persons and Mental Health. One local authority suggested a role for local child protection committees and only Fife Mental Health Strategy Group identified Community Planning to be the appropriate link. For a multi-agency respondent, the “natural link” with local planning arrangements was far from clear other than it should link with the wider health and well-being plan. A role for the new national commissioning & registration body was identified as ensuring that home providers had adequate policies in place.

4.8 The suggestion was made that specific local planning or “core” groups needed to be set up and that their action plans should be included within joint Community Care Plans and any other joint strategies looking at health and social care. The Association of Chief Police Officers in Scotland for instance wanted to establish a “consultation group” amongst local agencies to share ‘best practice’. In some areas including Glasgow, specific groups had already been set up to deal with some aspects of the Framework, specifically the issues of DSH. A multi-agency respondent from the Highlands area favoured creating a “core group” as follows:

*“It would not be possible, or desirable, for a separate suicide prevention strategy group to steer the work of existing organisational alliances. We think it makes more sense to identify a small core group with multi-agency representation, which identifies and integrates relevant work already being conducted. This group could also take on the role of representing suicide and suicide prevention as an issue in the existing groups. It would be obviously perverse to restructure the entire joint working structure on the basis of suicide prevention alone”*

4.9 Respondents emphasised the importance of ensuring users had a say in the development of local services perhaps through Community Care Forums, as these bodies could co-ordinate consultation and involvement and that staff “on the ground”, carers and voluntary organisations should be involved as they were the “people who can make a difference”.

4.10 Some Health bodies felt the link should be around clinical risk management, good discharge planning and critical incident review practice. Others like Paisley LHCC felt that tackling men’s health generally within LHCCs and through initiatives such as Have a Heart Paisley, were the key links.

#### *Key points*

- Consideration should be given to boundary and local issues when deciding appropriate planning arrangements.
- There were already a plethora of planning structures and the most obvious links were with joint community care planning mechanisms, HIPs, and community planning.
- Other possibilities were with Healthy Living Centre and Health for All alliances.
- Local suicide and self-harm planning or consultation groups were proposed.

#### **Question 3: Does the Framework offer sufficient/too much/too little detail on the action planning and implementation process?**

4.11 Of the 59 (42%) of respondents who answered question 3, opinion was equally divided about whether or not the Framework offered the right amount of detail on the action planning and implementation process, and indeed, in whether respondents expected this to be decided within the document. For some, it was “quite explicit and

detailed”, offering sufficient detail to “provoke thought” and stimulate local areas into action. It was then up to local action plans to clarify points of uncertainty, determine local priorities and reflect local circumstances. In this sense, the Framework was a “clear and achievable” way forward and it was up to agencies locally to provide the “goodwill and preparedness for people to share expertise and resources”. In short, the Framework was felt to:

*“Offer a sensible and methodical guide to which relevant agencies would be able to refer when determining how to shape their own services.” (National Childrens Bureau)*

4.12 However, some respondents from a similar range of agencies were not so positive. They felt the document gave insufficient detail in terms of how collaboration “can be made to work” and in terms of the resources required to support local initiatives. Even where respondents felt there was sufficient detail, the point was made, that the Framework would require “translation” for different settings, from “awareness raising to providing a basis for action”. This might include development work in schools, youth settings, prisons and pharmacies.

4.13 Some respondents felt that the document was helpful in certain areas but not others. For instance, the Royal College of Psychiatrists commented that while the Framework provided a list of priorities for action, it was less helpful on the matter of who should be responsible for what, and what information and data should be collected. Similarly, the Scottish Parliament Cross Party Group on Mental Health felt that while it assisted in identifying priorities for action, it was “very weak in terms of outlining who should take responsibility for what”. Another issue that was not dealt with to the satisfaction of the Royal College of Psychiatrists was confidentiality and accessing patient information across different services and agencies.

4.14 A Primary Care NHS Trust preferred the examples of intervention in respect of particular client groups, but found the use of broad conceptual statements such as ‘developing community capacity’ of limited use in illuminating how different bodies might play a part. The fundamental challenge posed by the Framework was commented upon by a mental health advocacy project:

*“Very good to show key steps as well as key objectives but there is concern that it is fundamentally asking society to change – it may be raising expectations of change which may not be achievable locally.”*

4.15 The Common Services Agency sought further clarification and information about the way in which a national research base / programme was to be developed.

#### *Key points*

- Opinion was divided on whether the Framework offered sufficient/too much/too little detail on the action planning and implementation process.
- There appeared to be insufficient detail about key roles and responsibilities, especially in relation to ‘developing community capacity’.

## ROLES AND RESPONSIBILITIES

### **Question 4: Do you have any comments on the suggested local and national roles and responsibilities?**

4.16 The majority of the 66 (47%) respondents answering this question welcomed the statements about local and national roles and responsibilities as outlined in the document, but sought to underline the importance of getting central coordination and accountability right. West Lothian Community Care Forum for example, suggested a National Forum to take the lead nationally and to allow local alliances to share their experiences with other areas. The Common Services Agency agreed that national co-ordination was “essential” at the least there should be a “national project manager” responsible for communication and co-ordination, dissemination of information and good practice around the country.

#### *Greater central control*

4.17 As respondents approached this question differently, it was not straightforward to calculate the weight of opinion towards more centralised control, except to highlight responses from the Scottish Association for Mental Health and the Men’s Health Forum for example, who explicitly stated they wanted the balance within the document to shift more towards “centrally managed, strategic control”, and commented that the approach outlined put “too much onus” on local planning and delivery:

*“While there are regional causal variations, suicide is an issue of national importance and should be treated as such. Action is needed at the structural level of society and therefore requires powerful leadership...The current emphasis on local planning and coordination could lead to variations in quality as a result of, e.g. past experience of similar interagency work, geographical remoteness and lack of services or the extent of key individuals knowledge and experience in relevant issues. Different localities may also choose to afford the issue differing priority status.” (SAMH)*

*“Given the cultural shift needed to make men less hesitant to access services until absolute crisis point, strong and very visible messages are needed at a national level: Localised messages will not have the same impact or consistency.” (Men’s Health Forum)*

4.18 For the Royal College of Psychiatrists, this included establishing and maintaining systems for critical incident review at a national rather than local level. This body had “grave reservations” about accepting the recommendations from ‘Safety First’ in their entirety as suggested on page 22 of the Framework, as some of these recommendations were “not clinically sensible”. It was also suggested that some of the proposed local actions such as follow up of patients discharged from inpatient care within 3-7 days were not “evidence based” and would have “colossal resource implications”. Concern about implementing this proposal locally was shared by others including the Scottish Parliament Cross Party Group on Mental Health.

### *More guidance on local responsibilities*

4.19 Respondents wanted more direction in respect of defining local responsibilities, which agencies must be involved and with identifying a lead agency to drive and coordinate efforts. If the ‘lead agency’ was not spelled out in the Framework, it was feared that no agency would take the lead. NHS Boards and the Voluntary Sector were commonly highlighted as possible lead agencies. A designated ‘local coordinator’ was advocated. Respondents envisaged that public health departments, public health nurses in particular and health promotion departments would have key responsibilities.

### *Role of voluntary and community agencies*

4.20 The Mental Health Foundation Scotland made the point that despite regular reference throughout the document to community and neighbourhood focus and community development, that the voluntary and community sectors were almost absent in terms of being key players at both local and national level and this should be addressed. Emphasising this point, the Church of Scotland commented that the “mindset” of the paper assumed solutions were to be found through “the more thoughtful intervention of bureaucracies in the state sector”, when in reality the voluntary and community sectors played a greater role:

*“Informal relationships have a more potent and important impact than the action of formal services. It would, therefore, be beneficial that the faith communities and voluntary sector, who both have a far larger investment in Social capital than state agencies, are intensely involved and resourced to undertake more comprehensive responsibilities of rebuilding the confidence of the individual.”*

4.21 The Mental Health Foundation also sought more explicit reference in the Framework to the academic sector, and other stakeholders such as professional bodies, trade unions and business organisations.

4.22 The Commission for Racial Equality (CRE) sought specific guidance to assist local partners deliver an appropriate action plan to meet the needs of ethnic minority communities. Further, the importance of involving voluntary agencies in planning, delivering and improving of local services to ensure the needs of black and minority ethnic communities were considered, was emphasised by an individual academic.

### *Key points*

- The suggested local and national roles and responsibilities were generally welcomed, particularly the need for central/national coordination.
- Some sought a further shift in the balance towards more centralised control.
- There were concerns around identifying the appropriate ‘lead agency’ and the need for this to be specified in the Framework.
- The role of other key stakeholders such as voluntary and community bodies needed to be considered further.

### **Question 5: What support would be useful to enable you and your organisation to implement the Framework?**

4.23 There were 60 (43%) out of 140 responses to this question. Even though some felt it was difficult to “anticipate in detail” required levels of support until local action plans and strategy documents had been prepared, respondents were able to identify five main types of support that they anticipated would be useful. These were: (1) having “adequate” resources to implement the Framework, (2) training and awareness-raising for staff, (3) systems for disseminating information and good practice examples, (4) central coordination, and (5) investment in developing joint information systems.

4.24 Additionally, 2 local authorities sought a clearer direction in terms of which agencies should be involved in implementing the Framework and a “clear mandate regarding implementation” including more specific timescales and targets.

#### *Resources*

4.25 Local authorities and voluntary organisations in particular but not exclusively, were concerned that “dedicated resources” should be attached to the Framework, especially in light of the “current volume of demands” on mental health services in particular:

*“This is a time of major and rapid change in social work, education, housing and health services as well as the broader spread of local authority responsibilities and duties. New demands are being made on services and staff almost weekly. Inevitably, the framework will have to stand alongside other competing demands and priorities...it is essential that adequate resources are made available.” (West Dunbartonshire Council)*

4.26 To bring about “longer lasting change”, respondents highlighted the need to invest more in front-line services: there needed to be more suitably qualified and experienced staff trained and employed in both the statutory and voluntary sectors and with the time for “networking” envisaged by the Framework. The Royal College of General Practitioners in Scotland sought to expand the “concept of the ‘practice team’”, by having community psychiatric nurses and social work staff attached to GP practices. It was understood that implementing preventive agendas would almost certainly require new financial resources.

4.27 Respondents identified the need for an injection of resources to “kick-start” local initiatives such as database development, volunteer help lines, rape crisis and other support for people who have been sexually abused, and to build a better infrastructure of local voluntary and community services. For example, the Church of Scotland perceived the need for resources to expand their network of counselling services throughout Scotland:

*“Our organisation...offers a substantial Counselling Service. Resource limitations cause the latter service to only be available in Glasgow and Edinburgh. Recognising that the Church of Scotland has a locus in almost every village in Scotland, it would be useful to our organisation that a network of counselling services be resourced”*

4.28 Similarly, the Samaritans remarked:

*“We as the leading voluntary group dedicated to providing confidential emotional support to people experiencing feelings of despair and distress, which may lead to suicide, feel that continued and increasing financial support for the Samaritans is necessary.”*

4.29 Like all voluntary organisations, a key issue for the Mental Health Foundation in terms of implementing the Framework was access to sufficient funds to deliver its work effectively. Many were already involved in a wide range of work that contributed to the prevention of suicide and self-harm and would need to secure additional resources to enable them to achieve more.

4.30 For the Framework to be taken seriously, it was suggested that resources for services in the front-line of DSH and suicide prevention had to be “protected”. For example, concern was expressed about one NHS Trust’s ‘financial recovery plans’ running counter to implementation of the Framework:

*“The proposal, for example, on page 22 that patients should be followed up three to seven days after discharge from inpatient psychiatric care could not be achieved within existing levels of resource without neglecting something equally desirable which would also impact on suicide prevention.” (Sunnyside Hospital)*

4.31 The Depression Alliance Scotland identified the need for longer term secure funding with “inbuilt evaluation”. The Glasgow Council for Single Homeless agreed:

*“For those projects with a particular remit to support people who self-injure, there is an issue about the short-term nature of funding which militates against their capacity to discharge functions within a planning framework or to develop ongoing responses effectively”*

4.32 Other respondents also highlighted the need for financial support for research and development, especially research into “what drives individuals to suicide and DSH”.

4.33 An academic from St Andrew’s University suggested there was a need to fund minority ethnic link/ outreach workers who understood individuals’ needs and risk within a cultural context.

4.34 One multi-agency respondent identified the need for “working materials” to help with health promoting work, such as leaflets, videos, teaching and other educational resources.



### *Awareness raising & training*

4.35 Respondents drew attention to the urgent need for “suitably qualified and experienced staff”, and the need to raise staff awareness of the problems of suicide and DSH and the types of interventions that were useful, provide training and ongoing support. This was necessary to build staff confidence in dealing with people who had attempted suicide or were deliberately self-harming:

*“Training for staff when a person threatens suicide then asks them not to tell anyone, training on how to avoid this situation and action to take which preserves the client worker relationship but does not put the person at risk. Improved support networks for staff working with people who have self-harmed or taken their life, people working in human service provision are a risk group, so ensuring staff have support in order that they can support others is essential” ((Caring for Older People’s Emotions (COPE))*

4.36 Waverley Care suggested that a good starting point before implementing the Framework would be to undertake a ‘training needs analysis’ across all sectors.

### *Dissemination of information*

4.37 Respondents were supportive of setting up active mechanisms for disseminating information particularly about good practice examples at the “primary preventative level.” A national seminar once the Framework had been agreed was suggested, as well as making information available across the Internet including information about local “champions” and what was happening in different local areas.

### *Central coordination & responsibility*

4.38 Respondents highlighted the need for central coordination and focus to ensure the momentum and consistency. It was suggested there should be centralised funding for local ‘suicide prevention coordinators’ (as identified as operating in Ireland):

*“This would require central investment, but may be a small price to pay for potentially large returns in terms of area profile...the Scottish Executive make modest funds available for local initiatives, which could potentially include appointment of co-ordinator sessions.”  
(Multi-agency response Highlands)*

4.39 Another multi-agency respondent suggested there might be a need to set up pilot coordination projects in both urban and rural areas to discover, and disseminate knowledge about, the best methods of coordinating implementation. The St Aubin’s Project proposed that a lead agency or forum locally comprising a variety of disciplines would be useful in developing a local plan. Such a forum might include people who self-harm and those affected by suicide, and a subgroup could concentrate on “ethics”.

### *Information systems/databases*

4.40 Respondents hinted at a need for developing “compatible databases”, or information systems that allowed sharing of information between agencies pertaining to ‘at risk’ individuals. Access to information and specialist knowledge about the problems and effective interventions was highlighted. Additionally, there was a need to support the collection of comparative statistical and other information at both national and local levels, such as about the incidence of suicide and DSH.

### *Key points*

Five main types of support were needed to implement the Framework:

- Designated resources, including to ‘kick start’ new initiatives, for research and to support existing providers;
- Ongoing training and awareness raising for staff at the ‘front-line’ to build confidence, starting with a training needs analysis;
- Systems for disseminating information particularly about good practice examples at the primary prevention level;
- Central coordination to ensure momentum and focus, including appointment of local ‘suicide prevention coordinators’;
- Investment in joint information systems to enable sharing of information.

### **Question 6: Is there sufficient clarity on the lead agency role?**

4.41 The resounding answer to this question was ‘No’. The consensus from 63 (45%) of respondents was that while the need for, and role of, the ‘lead agency’ was clear, it was difficult, if not impossible, to ascertain who the appropriate ‘lead agency’ should be locally or how this might be decided. It was universally assumed the ‘lead agency’ would be either Social Work or Health based. Those respondents who were wary of “over medicalising” suicide prevention initiatives did not want to assume the lead should be taken by Health, while others including local authorities, felt that Health was the appropriate body as such roles were “traditionally left to Social Services”, with Health a somewhat reluctant and uncooperative partner.

4.42 The ‘lead agency’ might vary depending on the type of activity being considered:

*“Were the focus to be primary prevention...Health Promotion departments in the new Unified NHS Boards structures would appropriately be the Lead...For secondary prevention and tertiary prevention then I would consider the responsibility should lie within Health.” (Consultant Psychiatrist)*

4.43 There was further support for this line of argument among other respondents, especially those in public or health services. The Nursing Director from The State Hospital felt that a multi-agency/disciplinary group should take the lead, and that this

group should involve key players from local planning teams. Similarly, the Director of Housing and Social Work in Aberdeenshire Council felt that many agencies were experiencing “initiative and membership of groups overload” and that the idea that any one agency would volunteer to be ‘lead agency’ in such a complex area was “unlikely to produce results”. It was subsequently proposed that a number of named agencies take the lead for specific aspects of the work, while the overall lead should be allocated to one agency.

4.44 The organisation COPE in Drumchapel suggested there might be a need for ‘lead agencies’ at three levels to reflect current planning processes: that is, nationwide, city-wide and local. In short, what most respondents wanted was a “strict directive” on the ‘lead agency’ to enable “clear accountability”, but there was no clear agreement about which agency this should be.

#### *Key points*

- There was insufficient clarity about the lead agency role, particularly which agency should undertake this role.
- There was no consensus about which agency should take the lead role, and it was suggested as unlikely that any single agency would volunteer for the lead role.
- It was proposed the ‘lead role’ be related to specific tasks with overall coordination.
- It was suggested a lead role at three levels was needed: national, city-wide and local.

#### **Question 7: Is there sufficient clarity on how to engage key local players to work in collaboration?**

4.45 There were 59 (42%) responses addressing this question and the near universal view was that there was insufficient guidance on how to engage key local players, especially those in the community and voluntary sectors, employers, and faith communities. While the concept of joint responsibility and partnership working was accepted in principle, it was felt that the practicalities needed to be “fleshed out” more. The Depression Alliance Scotland felt it would be important to try to include user representation from groups that have traditionally been ‘hard to reach’, for example, young males. The document appeared to respondents to be unclear on how best to ensure representation from individuals who had committed acts of self-harm or those affected by suicide and DSH.

4.46 The Manic Depression Fellowship Scotland observed:

*“Partnership is the buzz word at present, however, there does not seem to be a specific way of doing this and can to a degree depend not on what you know but who you know.”*

4.47 While guidelines/suggestions would certainly be “helpful”, respondents acknowledged that it might be difficult to create a “recipe” for this. The Nursing Director at The State Hospital commented:

*“On paper the implementation seems very easy but in reality there may be practical difficulties in getting people together. The designated person/champion must have the full understanding of the commitment this would take.”*

4.48 The Association of Chief Police Officers in Scotland (ACPOS) proposed that key contacts should be established in each agency with responsibility for liaison with the co-ordinator, and to lead within their own agency. While guidance on creating good communication systems both within and between organisations and with the local community and vulnerable people in particular, would be welcomed by a number of the respondents, they also highlighted examples of good partnership working that could be built upon:

*“There is so much experience of joint working at local level, so this may not be critical. However, it may be useful to refer to this experience explicitly (e.g. experience of joint planning on mental health, community care, drugs, regeneration etc.) and to remind readers of the key challenges to joint working (e.g. different organisational goals and cultures, resource issues etc).” (Mental Health Foundation Scotland)*

#### *Key points*

- There was insufficient guidance in the Framework on how to engage key local players, especially those in the community and voluntary sectors, employers and faith communities.
- The document did not explain how to involve those affected directly and indirectly by suicide and self-harm.
- Issues from the literature about joint working and experiences from joint planning (e.g. community care planning) should be highlighted in the document.

## **PRIORITIES FOR ACTION**

### **Question 8: Is the proposal for local areas to select their own priorities for action acceptable?**

4.49 There was near universal agreement with the proposal that local areas select their own priorities for action, with the explicit caveat that these fitted with a “national and auditable Framework”. Altogether 57 of the 62 (93%) responses to this question were in agreement with the proposal, mainly on the grounds that deciding priorities locally provided the best opportunity for “tailored” services appropriate to the area (e.g. rural/urban/mixed), and because deciding locally would help to build “local ownership” as well as retaining the necessary “flexibility”. There was also universal agreement that local priorities for action should be “benchmarked” against a national strategy to avoid “postcode disparity” in terms of core services provision. The Church of Scotland for instance suggested that without establishing minimum

standards, the quality of service response could “drop below acceptable levels”. Other remarks included:

*“Some guidance on good practice is essential, otherwise the danger is everyone does their own thing in an uncoordinated and uninformed way.” (Common Services Agency)*

*“The proposal is acceptable, although examples of national priorities would be helpful or a core set of tasks that need to be accomplished to ensure that less ‘sexy’ areas are not forgotten by local preferences and ‘politicking’” (Fife Health Promotion Department)*

4.50 Four major voluntary organisations, the Scottish Association for Mental Health, National Schizophrenia Fellowship Scotland, Cruse Bereavement Care Scotland, Children in Scotland and the Mental Health Foundation Scotland, disagreed with the proposal, believing instead that priorities for action should be set at a national level but taking into account regional variations. This would, they argued, ensure the “consistency” and “synergy of effort” needed. Their view was that despite local demographic factors, needs were “not dictated by the local authority/health area that people live in”.

4.52 The Commission for Racial Equality commented that from their point of view the current priorities within the Framework did not provide “sufficient clarity on the question of ethnicity”. The Commission argued that priority should be given to identifying needs and appropriate responses within ethnic minority communities.

#### *Key points*

- It was agreed in principle that local areas set their own priorities, as long as this was monitored nationally and fitted with an overall national strategy.
- Setting priorities locally would provide the best opportunity for flexible tailor-made services and build local ownership.
- National voluntary organisations argued priorities for action should be set at national level while considering regional variations, as suicide and self-harm were national rather than local issues.
- The priorities within the Framework currently did not provide sufficient clarity on the question of ethnicity.

#### **Question 9: Please comment on priorities and timescales anticipated.**

4.53 There were 62 out of 140 (44%) responses to question 9. The comments have been divided into those about priorities and those about timescales.

#### *Priorities*

4.54 A mix of views was expressed about the priorities within the Framework. One respondent chose to further underline the relevance of deciding local priorities:

*“The important point from our perspective, is that local priorities and timetables are accepted in place of national suggestions.” (Multi-agency Highlands)*

4.55 One view was that the ‘priorities’ in the Framework were so “wide-ranging” and “all-encompassing” that prioritisation was difficult. Before deciding local priorities, Dundee City Council Social Work Department suggested there should be centrally commissioned research in localities to provide better statistical and other appropriate information. Glasgow City Council Housing Services felt that some local areas might find it difficult to select their own priorities for action, and might require support, advice and assistance to do so.

4.56 The Framework appeared to some respondents to neglect the difference in issues faced by people at different ages and stages of life. The document appeared to respondents to be aimed primarily at adults, and would require different approaches and priorities to be suggested if it were to recognise issues for different age groups (e.g. up to 25 years, and over 65 years). On this point, Children in Scotland argued that children and young people should be a priority and afforded a higher profile within the Framework. Although the need to focus on the issues for older people was mentioned by some organisations in relation to other aspects of the draft Framework, this was not mentioned under question 9.

4.57 There was disagreement between different respondents as to whether they favoured targeting particular ‘high risk’ groups or a general mental health promotion approach. For example, Falkirk Council Education Services were of the opinion that local planning groups should not be restricted to targeting ‘high risk’ groups and that education authorities would want to prioritise programmes and projects ‘to promote and develop emotional literacy and resilience among children and young people’ (as described on p24 of the Framework). In contrast, the Manic Depression Fellowship Scotland argued that because research shows those suffering from mental distress to be more ‘at risk’ than the general population, particularly those experiencing ‘enduring mental illness’ and ‘psychotic conditions’, these groups should be given priority. Drumchapel COPE and the Royal College of Nursing argued that actions in respect of young men should be prioritised, especially in areas where unemployment and drug misuse were major problems:

*“It would be good to see some serious measures taken early on to address the high suicide risks amongst young males -some acknowledgement and publicising of the problem at an early stage, may strengthen the aim in some way.” (Royal College of Nursing)*

4.58 Gaps were perceived in the priorities identified within the Framework. For instance, the Scottish Association for Mental Health highlighted a lack of reference to primary care services as an important omission:

*“Figures show that in 1 in 3 GP consultations in Scotland, issues of anxiety or depression are identified. Clearly, considerable numbers of people who may be at risk of suicide do access services and in a GP-setting, careful questioning and prompt treatment can save lives.”*

4.59 It was suggested by The Samaritans that greater emphasis should be placed on local joint training of all agencies involved, and early intervention with primary school children. Fife Health Promotion Department argued that the Framework should afford priority to changing the prevailing “expert - patient” culture in mental health services toward one of “partnership”, acknowledging the “essential role of advocacy services” and training. The Department were also critical of an approach advocating “maintenance of a condition” rather than recovery, which in its view, was “incredibly costly” and “short-sighted”, and emphasised the importance of promoting broad treatment strategies including creative and complementary therapies.

#### *Key points - priorities*

- Respondents disagreed about whether actions for ‘high-risk’ groups or general populations should be prioritised.
- It was difficult for local areas to prioritise actions from amongst the wide range of priorities in the Framework.
- Local areas might require support, advice and assistance with prioritising actions.
- Priorities should reflect the different issues for people at all life stages.
- Gaps were perceived in terms of the involvement of primary care; changing from a culture of ‘expert vs patient’ to one of partnership; focusing on recovery rather than maintenance; and the promotion of alternative therapies.

#### *Timescale*

4.60 Opinion on the timescales in the Framework were mixed. For some respondents, the timescales appeared “reasonable” and “realistic” particularly as the approach required a multi-agency response and this took time, and that research and information gaps needed to be addressed. The main contention was over the proposed two-year timescale for Phase 1, and whether on the one hand, this was achievable given the emphasis on prevention within the Framework, or on the other, too long given certain changes could be achieved in the shorter term. In general, the overarching 10-year period was welcomed in that it appropriately recognised the long-term nature of many of the proposals.

4.61 For one Clinical Services Development Manager the timescale appeared “rather lengthy” in comparison with other good practice standards and guidelines such as the CSBS/SIGN (no explanation was given of these abbreviations), and both Say Women and the National Schizophrenia Fellowship Scotland commented that it was “going to happen too slowly”. The Scottish Association for Mental Health was critical that local action plans would not be forecast until two years after the launch of the Framework, suggesting this was “a little lacking in ambition”, and that there evidence from elsewhere to support actions in the short term:

*“Health services are not entering this with no history of involvement. Indeed work was undertaken within the risk assessment sub-group of the Framework for Mental Health Services in Scotland which ought to have put the issue on the agenda for mental health services. The report of the sub-group, ‘Risk Management’ focussed on personal risk*

*issues including suicide and self-harm. It suggested amongst other things, that multi-functional Risk Management Committees reporting directly to local Trusts.”*

4.62 The Men’s Health Forum agreed there were issues that could be tackled on an immediate and on-going basis without resorting to a short-term or ‘quick fix’ mentality. For instance, the Forum identified the need to work with receptionists on how this group of staff dealt with men accessing mental health services, and targeting services directly at men. Further discussion regarding the timescale in respect of the different parts of the strategy was sought. In the view of SCSH, not all of the actions identified required were long term, but others, including the “rather optimistic media strategy” would be “unlikely to be fulfilled”. The Mental Health Foundation cited the following examples of interventions that it believed could be achieved within the short to medium term of 1-3 years:

- measures to further reduce access to the means of suicide
- safer institutional settings
- improved knowledge about sources of help for suicidal individuals
- assessment of the impact of public policies
- enhanced responsiveness of mental health services
- identifying risk and opportunities for early intervention for high risk groups (e.g. people with terminal illness, people experiencing life crises/transitions; people who have been abused; people who misuse addictive substances; key occupational groups)
- improved understanding of mental health amongst the public, professionals and others
- improved community support networks
- increased resilience and capacity to cope amongst individuals, communities and families

4.63 The following medium to long-term interventions were identified by the Mental Health Foundation, that is, were achievable in 3 or more years:

- measures to achieve improved educational attainment amongst lower socio-economic groups
- measures to improve help-seeking attitudes amongst men
- public policies that support mental health and well-being

4.64 In contrast, the timescales were perceived as “too tight”, either because of difficulties in implementing the Framework alongside other new duties and obligations, or because “engaging the less formal networks” would take longer. For some respondents, Phase 1 implementation would be achieved within 5 not 2 years. Fife Council Services considered it “ambitious” to expect the Development Network to deliver on the range of tasks implied within 12 months of being established. A local authority education department felt that Phase 2 might require a longer “roll-out” period. The North Edinburgh SIP concluded that whether the timescales were reasonable or not would depend upon whether the Framework was supported by new financial resources or it was expected to manage within current resources.



### *Key points – timescale*

- The overarching 10-year period was generally welcomed as it was felt to appropriately recognise the long-term nature of many of the proposals.
- The main contention was over the proposed two-year timescale for Phase 1 – this was either too short or too long as certain changes could be achieved immediately.
- Reasons why timescales appeared too short were that the Framework was being implemented alongside other priorities with limited resources, and because developing community networks was a long-term process.

### **Question 10: Does the Framework give sufficient weight to primary prevention and to the societal level?**

4.65 Opinion among the 57 (41%) of respondents who answered this question was variable. Some respondents felt the authors of the Framework should “deserve credit” for acknowledging societal factors and the place of primary prevention. In the view of major health bodies and national organisations in particular, this was a definite “strength” of the document. Primary prevention was highlighted as the “most important of all areas” to emphasise, and while obviously requiring a “long term investment”, it was the “right one”. However, consultant psychiatrists from one NHS Trust commented that the document did not appear to attribute “weightings” in terms of prioritising risk factors, nor in terms of preventative strategies and it was therefore difficult to answer such a question.

#### *An ‘underplayed’ role*

4.66 Others felt that primary prevention and the societal levels tended to be “underplayed” in the document. Either it was perceived as “very biased” towards service provision when it came to detail, or that this approach was not consistent throughout the document. Respondents wanted more emphasis to be placed on mental health promotion and the use of “creative, non-medical approaches”, as well as supporting people with chaotic lives, such as homeless people and young people leaving care. One Primary Care NHS Trust felt increasing the focus on primary care would strengthen the Framework, including recognising the role of the Public Health Practitioner and their potential contribution at a societal level.

4.67 It was suggested as a near impossibility that the three levels should be separated as they overlapped and influenced each other. The Men’s Health Forum for instance commented:

*“The societal view of people with mental health problems is still laden with stigma and prejudice, which seeps through service provision and into primary care delivery and is a large barrier to many people accessing services. Primary care providers need to address this through staff training, and through provision of innovative services that encourage access.”*

4.68 The Forum wanted to see more activity at a societal level to address men's fear of speaking out about their anxieties and improving the response of services.

#### *Need to address stigma*

4.69 Several respondents identified the need to better address the issue of stigma in relation to the public attitude to mental illness. Scottish Association for Mental Health wanted more emphasis to be given to reducing stigma and discrimination attached to mental illness and that to be effective, primary prevention must "encourage open and frank discussion of issues around suicide and deliberate self-harm". Drumchapel COPE sought a "major campaign" on breaking down the stigma associated with mental distress at local and national levels and supported by the media. The Scottish Parliament Cross Party Group on Mental Health felt the Framework was a "missed opportunity" to combat the stigma and discrimination attached to mental illness as a way of preventing suicide and DSH. Penumbra wanted more emphasis to be put on bringing suicide and self-harm "out of the shadows of 'shame and blame'".

#### *Challenge of measuring outcomes*

4.70 Some comments were received about the challenges of measuring the impact of preventive strategies. The Royal College of Psychiatrists agreed that the Framework placed sufficient emphasis on preventative and societal levels but that the evidence base on this was "perilously thin". The National Children's Bureau stated it was "essential" to ensure policies worked in practice and had some "genuine benefit". The Common Services Agency felt it was impossible to say how much priority primary prevention at a societal level should be in the absence of evidence about its effectiveness.

4.71 The Mental Health Foundation drew a distinction between 'primary prevention' and 'mental health promotion'. 'Primary prevention' was understood to be concerned with reducing or eliminating specific diseases, health or social problems before onset at population, group and individual levels, while 'mental health promotion' was concerned with developing well-being and capacity within individuals and populations. Although health promotion might directly contribute to the reduction of specific health or social problems including suicide and DSH, this was not easily measured.

#### *Key points*

- Respondents' views were polarised about the treatment of primary prevention and the societal level in the Framework. It was either a strength of the document or underplayed.
- An important aspect of primary prevention was directing efforts at tackling stigma and public attitudes to mental illness.
- Respondents identified both the need to, and the difficulties of measuring the impact or benefits of preventive policies.

**Question 11: Do you agree with the need to commit to long-term strategies that focus on children and young people (recognising that this would not yield quick returns)? If so, have you suggestions about how this aim could be strengthened further?**

4.72 Overall, the 75 (54%) of respondents who answered this question had little doubt about the need to commit to long-term strategies that focused on children and young people as “an investment in the future”. For some, the case for doing so was “undeniable”. Moreover, the Scottish Association for Mental Health suggested there was, if anything, a “lack of emphasis” upon the importance of longer-term preventative methods in schools and local authority care settings. Falkirk Council Education Services felt this commitment was “not emphasised strongly enough” within the consultation document particularly at the local planning level. Fife Health Promotion Department recommended that the strategic focus also encompass pregnancy and babyhood given the body of evidence demonstrating the importance of the early years, including foetal development, to future mental, moral and societal health.

4.73 However, a minority of respondents were hesitant to endorse this commitment, fearing that it would disadvantage other ‘high-risk’ adult groups:

*“Our group cannot support a complete focus upon children and young people. The high risk age group of today are the children of the high risk age group of the seventies and early eighties when deliberate self-harm was common...Concentration on modifying the beliefs of the current high risk age group may produce greater benefits than policies which commence with children. In addition, the Planning Group should note that if they wish to find economically disadvantaged, socially isolated people who are the victims of social inequalities they need look no further than older people.” (Scottish Division of Psychiatrists Elderly Services Directorate, Murray Royal Hospital)*

4.74 A psychiatrist at Sunnyside Hospital was concerned lest such a focus should “further impoverish mental health services for adults”, and St Aubin’s Project that it should not be at the expense of “other vulnerable groups”. The National Schizophrenia Fellowship Scotland argued that the focus should not be on children and young people, as “the whole community needs to be a part of this”.

*Suggestions for strengthening this aim*

4.75 Respondents identified a number of ways in which this aim could be strengthened. For example, Children in Scotland proposed nine broad areas for action:

- reducing stigma and discrimination in society
- coordinated media campaigns targeted at children and young people
- increasing accessibility of information and support
- building capacity and resilience
- involving children, young people and parents

- role of schools
- teacher training, recruitment and support
- setting up peer group circles of support
- establishing multi-disciplinary health promotion ‘teams’

4.76 The role for statutory education services and schools was the most obvious to many respondents:

*“Education Services will play a key role in preparing young people for an adult lifestyle, which optimises their potential, and by doing so avoids the development of those risk factors which make suicide and deliberate self-harm more likely. (Dundee City Council Education Services)”*

4.77 Commonly, respondents drew attention to the need for a variety of school-based interventions, as well as the need to improve specialist service responses for “adolescents in crisis” such as providing “properly resourced” intensive psychotherapeutic interventions:

*“The current services provided for them may be skilled and knowledgeable, but are woefully inadequate. Whether child and adolescent mental Health Services, or Social Work Services, neither is able to meet current needs for crises work, let alone prevention.” (East Lothian Community & Education Services)”*

4.78 It was suggested that equal weight should be given to the subject of ‘personal and social development’ within the educational curriculum as to the academic attainment of Standard Grades or Highers. The need for inputs on stress management during examinations was also highlighted. In the longer term, there was a request for school policies and procedures explicitly focusing on well-being and suicide proofing and for more effective anti-bullying strategies. Highland multi agency respondents proposed broad based “emotional literacy, problem solving and citizenship schemes” rather than narrowly focused suicide prevention activities. The importance of educational inputs on assertiveness, communication and negotiation skills especially for males, was highlighted:

*“By encouraging boys to be more emotionally self-aware and competent at an early age our education system could play a vital role in saving lives at a later date.” (Mental Health Forum)”*

4.79 An enhanced role for health promotion was recognized. Programmes for learning about child and adolescent social and emotional development were suggested by the Royal College of Psychiatrists for all adults “who spend time with teenagers”. This body was critical of recent work in schools to train teachers to identify depression on the basis that teenage suicides were often precipitated by incidents at school and were often unexpected and unpredictable. Several respondents referred to a need to improve the skills and knowledge of those who work with children and young people, for example:

*“There may be a need to help teachers to focus on the issues and close potential gaps in terms of skills and information in our appreciation of the specific issues and their potential contribution to the long-term aims.” (Glasgow City Council Education Department)*

*“This need for ‘skilling-up’ will be true of all those who meet children and young people, and will include GPs and Health Visitors. There is a need for a wider recognition of those factors which might lead to depression, self-harm and suicide, and for initiatives to build on protective factors.” (Mental Health Ayrshire & Arran NHS Board)*

4.80 The concepts of the ‘health promoting school’ and ‘healthy living centres’ were regarded as highly relevant to promoting the aims of the Framework, as was tapping into existing support agencies and structures, such as joint assessment teams and improving links between schools and health services. The Association of Chief Police Officers in Scotland and The Samaritans both recommended that education authorities and teachers should take the lead in coordinating regular school inputs by various agencies to highlight for young people what support is available and how to access it.

4.81 Respondents highlighted the need to focus on transitional arrangements from school to adult life, and to review the current resources focusing on this within Education and Health. Dundee City Council Education Services proposed there should be “supported transition” to support young people beyond school leaving, and for there to be “more structured ‘handover’” to adult support mechanisms for “vulnerable” young adults.

4.82 Perth & Kinross Council suggested a need to link in with the CAMHS National Review (no explanation of the abbreviation given, but is likely to be Child and Adolescent Mental Health Services Review) that was currently reviewing Mental Health Services for children and young people, including young offenders.

Psychological Services within Education Services at local authority level were perceived as well placed to advise on the personal and social development curriculum and policy development, to provide staff development to schools, work with high risk young people in consultation with Guidance Teachers and parents, and carry out research and evaluation of specific programmes and policies at both a school and local level. Procedures for review of critical incidents at a departmental level would provide opportunities for ongoing development of skills and knowledge in this area.

#### *Involving children & young people*

4.83 The importance of participative mechanisms was stressed by respondents including fpa Scotland (formerly the Family Planning Association) who emphasised the importance of involving young people and “giving them a voice” in developing strategies for children and young people.

*“Involve pupils themselves in developing the education packs to ensure it responds to their needs, again it’s not always one size fits all.” (COPE)*

4.84 Measures designed to improve mental health and general well being should, according to Children in Scotland, seek to involve children young people and parents at every opportunity. Children and young people should participate in both the design and delivery of strategies as well as services aimed at promoting mental health and well being. It was also suggested by COPE that young people could become involved in mentoring schemes encouraging other young people to talk about their feelings.

#### *Gaps in services*

4.85 Respondents identified gaps in current services for children and young people. In terms of DSH, The Royal College of Psychiatrists highlighted the need for intensive psychotherapeutic interventions, which tend to be “poorly resourced” on the NHS. However, the Royal College argued that such adolescents were likely to go on to have major difficulties as adults and to develop adult mental health illnesses. Stonewall suggested that given the impact of sexual orientation on individuals’ mental health and the problems faced by young people coming to terms with their sexuality, the provision of anonymous services such as help lines should be given more support.

4.86 Both Yorkhill Child Health & Psychiatry and Children in Scotland pointed out that the document did not refer to those under 15 years, despite this group being particularly vulnerable to the effects of suicide and self-harm in circumstances where parents were self-harming or contemplating suicide. Any interventions and preventive strategies therefore would need to provide support to children and families, as well as the family member/relative who self-harms or has suicidal tendencies. The User & Carer Involvement organisation also drew attention to the need to focus on carers and families because they carried the main responsibility for family members who had committed suicide or DSH.

4.87 Issues about both child protection and the sharing of information between agencies was highlighted by Fife Council Services. This was about the need for hospital accident and emergency staff to know whether children and young people who overdosed or self-harmed were on local authority child protection registers. Additionally, it recommended developing good interagency follow up procedures for such children and young people.

#### *Key points*

- A longer-term strategy focusing on children and young people was an ‘investment in the future’.
- On the other hand, such a strategy might neglect or impoverish services for older people or adults with mental health problems.
- The areas of ‘emotional literacy’, problem solving and citizenship could be strengthened within the school curriculum.
- The concepts of the ‘health promoting school’ and ‘healthy living centres’ were regarded as highly relevant.
- The importance of participative mechanisms to enable young people to have a voice in developing strategies was emphasised.

**Question 12: Are there other vulnerable groups that should be a priority, in considering actions to prevent suicide and reduce deliberate self-harm?**

4.88 Over half (52%) of respondents could identify ‘other vulnerable groups’ that they felt should be given priority in the Framework. The range identified closely resembled the particular specialisms of the representative bodies responding to this consultation. As a general point, several respondents perceived the consultation document as “light” in terms of its treatment of the issues for young people, older people and people with disabilities in particular. The following catalogue of ‘other vulnerable’ groups was established:

- **People with HIV** (although as Waverley Care point out, the advent of new treatments and of some "hope" has had a real impact within the HIV community and the subject of suicide arises less frequently)
- **Lesbian, gay and bisexual individuals especially young people** – the Lesbian Information Service claimed that up to 30% of completed youth suicides are by lesbian and gay young people and that they are 2-6 times more likely than heterosexual people to attempt suicide.
- **Elderly people** – respondents claimed compelling evidence to show higher rates of suicide among older people.
- **People who are homeless** - The ONS report, “Survey of the health and well-being of homeless people in Glasgow” by A. Kershaw, N. Singleton and H. Meltzer 2000, which examined the health needs of homeless people in Glasgow, revealed the scale of the problem (29% of those interviewed reported having attempted suicide at some time and 18% had deliberately harmed themselves without the intention of suicide).
- **People with learning disabilities and autistic spectrum disorders** - the National Children’s Bureau and Royal Scottish National Hospital suggested a propensity towards DSH among this group.
- **Individuals who have abused or subject to abuse** - both of who might be isolated and lacking in support. Included victims of domestic abuse.
- **Young offenders and prisoners** – before, during and after their sentences have been served. An individual respondent suggested that a stronger sense of vigilance was required with a greater importance given to the ‘pastoral’ needs of young offenders whilst serving their sentence.
- **People from black & ethnic communities, immigrant/ refugee populations** – the CRE argued they have diverse and different needs which should be included in such a strategy. Increased awareness of isolation, racist and cultural issues as well as specifically targeting those groups who have experienced severe trauma in their life

- **People with enduring mental illness**, particularly those known to self-harm and those with dual diagnosis.
- **Children and young people who were ‘looked after’, or carers, young adults with severe mental illness** particularly those with histories of alcohol and other drug misuse
- **New and young single mothers**
- **Women suffering postnatal depression**
- **People with personality disorders.**
- **Divorced persons**
- **Bereaved persons**
- **School pupils and higher/further education students undergoing exams**
- **People with chronic illness**
- **People with recent experience of redundancy/unemployed**
- **Individuals with eating disorders**
- **People with dual sensory impairment**
- **Individuals suffering from ‘munchausen syndrome’**

*Key points*

- The consultation document was felt to be “light” in its treatment of the issues for young people, older people and people with disabilities in particular.
- A catalogue of other ‘vulnerable groups’ was identified.

**Question 13: If so, what types of approaches and interventions should be developed for these groups to reduce risk of suicide and self-harm and to promote mental health and well being?**

4.89 The approaches and interventions suggested by the 42% of respondents answering question 13, closely mirrored that of the Framework itself. Respondents tended to advocate a range of preventive measures and emphasise health promotion measures, secondary and tertiary interventions, and included interventions targeted both at ‘high risk’ groups and broader population-based strategies. Interventions were also described in terms of whether they were short, medium or long term interventions.



### *General approaches*

4.90 In many respects, the evidence for advocating one particular approach over another was felt to be scant. Respondents therefore recommended that interventions should be developed in the context of funded research.

4.91 The point was made that the focus on secondary prevention should carefully consider different individuals' point of entry to services. For example, there would need to be more direct links between homeless persons' units and health services, given that many homeless people did not generally access many services.

4.92 Increasing support for voluntary and community organisations was proposed as a key approach that should be taken to tackling many of the problems identified. Respondents recommended greater support for voluntary and community organisations focusing on building friendships, individual and community capacity, meeting social needs and combating social isolation.

4.93 It was also recommended that approaches labelled as 'psychosocial', 'alternative' and 'complementary' therapies should receive greater emphasis as an approach within the Framework. The Argyll & Bute Hospital Mental Health Quality Improvement Group suggested a "multi-agency integrated care pathway" approach to reducing the risk of suicide and self-harm and to promote mental health and well-being.

4.94 Pro-active follow up of those who self-harmed was proposed to check whether other appropriate help could be offered. It was argued further research was needed to establish the effectiveness of interventions with people who self-harm. Three specific types of intervention were considered as "promising" – the use of 'crisis cards' (Bristol study); problem solving therapy; and dialectic behaviour therapy.

4.95 The Glasgow Association for Mental Health remarked that it was vital to improve access to support and care within 'mental health' provision generally and not to restrict this to 'institutional settings'. Additionally, it argued, it was important to consider the need for women only services and accommodation supports, and to ensure appropriate responses to women who have children. Research has shown that women who self-harm are disproportionately likely to be subject to child protection intervention where this may not always be the most supportive response for the family.

### *Approaches & interventions with specific groups*

4.96 Respondents highlighted the need for specific types of interventions to be used with certain groups. For example, improving the support to young people who were 'looked after' by the local authority or with experience of care was identified as important. Additionally, addressing the housing issues of young people was deemed important. There was a proposal for a screening tool to help identify 'risk factors' when young people came into care. The key to working with 'looked after' young people was believed to be a "closely integrated" approach between social work and mental health services, and 'follow up' support after leaving care.

4.97 Others argued interventions should focus on the condition of postnatal depression, including awareness raising among both mothers and fathers. In respect of individuals who were lesbian, gay and bisexual, the Lesbian Information Unit suggested the following approaches and interventions:

*“Long term: stop perpetuation of homophobia from institutions such as religion, medicine, law, media, family, education, language.*

*Medium term: ensure all mainstream services are accessible and relevant to LGB young people*

*Short term: provide LGB youth support groups; set up support groups within schools (see, e.g. many examples in the USA/Canada) which support young LGB people, teachers, parents; set up family education and support team (multi-disciplinary e.g. school, police, social services, health services, etc) to intervene and support families when child is coming out.”*

4.98 One multi-agency group proposed a more “open” approach by all services in dealing with older people. It was suggested there should be work towards removing the stigma of suicide, especially within the older age group and finding methods of engaging older people who self-harm.

4.99 In terms of approaches with black and minority ethnic communities, there seemed to be a need for “coherent set of policies and procedures to ensure effective advocacy practice” (academic respondent). The Mental Health Advocacy Project called for “more imaginative” ways of responding to the needs of people from black and minority ethnic communities. Penumbra stressed the importance of consulting community leaders from minority ethnic communities when developing specific approaches for this group of people.

4.100 To ameliorate some of the problems encountered by deaf/blind people who attempted suicide or deliberately self-harmed, it was proposed by Deafblind Scotland that there should be a guide/communicator to facilitate information giving and communication, and to help deaf blind people to access community resources:

*“Upon occasion, Deafblind Scotland’s services have been stretched to its limits in supporting a suicidal or self-harming deafblind person. Sadly, self-harm and suicide present themselves as very real alternatives to living a normal life to some deaf blind people.”*

#### *Key points*

- As evidence for advocating one approach over another was scant, it was recommended that interventions be developed in the context of funded research.
- There was a need for more initiatives focusing on building friendships, individual and community capacity, meeting social needs and combating social isolation.

- Respondents recommended that more explicit references are made in the Framework to alternative or complementary therapies, as well as psychosocial approaches.
- Support to specific groups, such as young people ‘looked after’ by the local authority, women suffering post-natal depression and people who were gay/lesbian/bisexual were highlighted as important.

## RESEARCH

**Question 14: We would welcome suggestions on research which might be carried out on the impact of measures for prevention of suicide and self-harm – in particular, research which would be amenable to follow up after given periods, and which would allow clear analysis of practical progress made in relation to the introduction of the Framework at both national and local levels.**

### *General Points*

4.101 There appeared to a multi-agency respondent in Dumfries & Galloway that there was already a lot of research in this area and to “signpost existing research”, whether in the Framework and/or by regular information updates, would in itself be helpful. Although different respondents did not express this so explicitly, they were able to identify a diverse body of knowledge that might be usefully coordinated. Respondents emphasised action research, “evaluating what is and what is not working” and reviewing the implementation of the strategy. Action research that set out to listen to young people’s view about the impact of the strategy was “particularly welcome”.

4.102 A general theme running throughout the responses to the consultation document was that many of the approaches and interventions, particularly preventive approaches, were not based upon sound evidence-based research:

*“The document suggests a large number of possible initiatives that might be taken at national or local level. However, no evidence is provided that any of these have been shown to be effective and cost-effective in reducing suicidal or self-harming behaviour or their consequences” (Public Health Institute of Scotland)*

4.103 Not surprisingly then, many of the suggestions from the respondents who answered question 14 sought to ground research in the experiences of those affected by suicide and self-harm, and research investigating “what works” in relation to different types of intervention, especially where there was little evidence for a particular approach or intervention. One view was that research should be based around evaluating the effectiveness of preventive methods having examined existing research into causal factors. The Royal College of Psychiatrists remarked:

*“We have a general concern that policy will be implemented without being adequately researched...the Care Programme Approach is an example of such a policy...We are pleased with the emphasis in the document in building in a reflective research capacity to inform policy*

*and practice development and would underline the importance of this, making a plea for properly designed trials being the corner stone of developments in suicide prevention”*

4.104 While many agreed that the development of monitoring and evaluation systems was central to the Framework’s implementation, the Scottish Association for Mental Health disagreed with the development of locally based information collection systems or ‘suicide databases’:

*“Consistent accurate, comparable and high quality data required central coordination, training and quality management control, particularly where those systems address outcomes.”*

4.105 Despite research being mentioned at several points in the document, the Mental Health Directorate, Lomond & Argyll Primary Care NHS Trust were “dismayed” by the statement that ‘targets will concentrate on action and the evidence of action rather than on specifying reductions in rates of suicide’. It was felt that this would not “take the field forward”. Instead, it recommended structured research including “pragmatic trials involving randomisation” and evaluations of cost-effectiveness. The Royal College of Psychiatrists commented further:

*“Our plea is for properly designed controlled trials being the research corner stone of developments in suicide prevention, rather than post hoc analyses after interventions have been implemented.”*

4.106 Others including Fife Health Promotion Department wanted the importance of process evaluation and the value of qualitative methodologies rather than a purely quantitative methodological focus to be recognised in the research commissioned. As a general strategy, a Health respondent suggested linking with other European countries, for instance Finland, who had established a reputation for research in this area.

4.107 It appeared to one respondent from the Young People’s Unit at Royal Edinburgh Hospital that the consultation document had not recognised the “dire state” of investment for research and development capacity in Scotland for child/adolescent mental health. That the professorial chair in Glasgow (Scotland’s only chair of Child and Adolescent Psychiatry) remained unfilled, coupled with the fact that attempts to build institutional support for such research capacity at Edinburgh had been unsuccessful, were highlighted as evidence for this concern.

#### *Specific research ideas*

4.108 There was no shortage of concrete ideas for research (see list below). Research was proposed to improve the knowledge base about patterns of incidence and the problems of suicide and self-harm, finding better ways of identifying those most ‘at risk’, evaluating the effectiveness of different approaches and interventions, and finding out what was needed from those affected by suicide and DSH:

(Not in order of priority/preference)

### Consolidation and coordination of current research:

- The document refers to “suicide prevention programmes around the world”. What can these tell us? What about evidence of suicide prevention initiatives e.g. for people with severe depression or other severe mental illness, prisoners or individuals suffering from drug or alcohol dependence? (Public Health Institute of Scotland)
- Establish a database of self-harming incidents enabling a demographical and geographically related database to be established nationally. (Forensic Medicine Section, Department of Pathology, The University of Edinburgh)

### Patterns of incidence and issues:

- Investigation of the link between borderline/ mild learning disability to suicide or DSH (NHS Trust).
- Research into the nature of the barriers to help-seeking (The Samaritans).
- Research in schools and colleges to see how much pressure examinations, on top of all the pressures of growing up, put on teenagers. (User & Carer Involvement)
- Research on public perceptions; stress factors which may lead to suicide and awareness of those; incidence rates and follow-up services (Dundee Social Work Department)
- Research into the increased risk of suicide or DSH in the lesbian, gay, bisexual and transsexual community particularly focusing on younger people, who are more at risk. (fpa Scotland)
- Research into the incidence of suicide and DSH in relation to younger children and ‘looked after’ children and young people. (Department of Education, North Lanarkshire Council/Renfrewshire Social Work Department)
- Further research on suicide risk assessment, its accuracy and usefulness (Royal College of Psychiatrists).
- One of the most pressing areas for research was thought to be repeated DSH in people with severe personality disorder. (Mental Health Directorate, Lomond & Argyll Primary Care NHS Trust)
- Basic research is required in Scotland to clarify which groups of patients who have self-harmed go on to completed suicide. (Department of Psychological Medicine, Royal Infirmary of Edinburgh)
- Research investigating possible links between physical, sexual and emotional abuse and self-harm, substance misuse, poor educational attainment and incidence of depressive illness (Fife Health Promotion Department).

- Research into the reasons for the over - 65 years old population self-harm indicating preventative measures. (Multi agency response)
- Research would be useful to examine the role played by alcohol in suicide and self-harm and the subsequent risk factors and potential treatment responses for the individuals. (Aberdeenshire Housing & Social Work)
- Research to develop the model of suicide behaviour outlined in the document (page 11). to demonstrate how interventions delivered fit, in terms of influencing risk factors, risk condition, environment and behaviour. (Multi agency response)
- There seems to be little or no research into defence mechanisms that can be employed to prevent Suicidal or Deliberate Self-harm Impulses. (The Samaritans)

Evaluation of approaches & interventions:

- Explore prevention/intervention efficacy through investigating hospital and school staff's awareness and confidence to confront issues of DSH and suicide (National Children's Bureau).
- Continued hospital monitoring and schools surveys (such as the CASE Study) to provide a gauge of how effective strategies have been. (National Children's Bureau)
- More UK wide research to highlight good practical interventions, which focus on children and young people, in relation to the prevention of suicide and self-harm. (Children in Scotland)
- Evaluation of specific interventions after DSH; e.g. educational interventions with young people; whether assertive follow up of recently discharged inpatients reduces risk of suicide. (Royal College of Psychiatrists)
- Evaluations of the impact of specific interventions such as emotional literacy programmes, peer support initiatives for young people, intensive support schemes, support for people in high risk occupations (Mental Health Foundation).
- The impact of a drug/alcohol liaison nurse intervention on outcomes in the DSH population, as well as research into the potential for community outreach services focusing on a problem solving intervention. (Department of Psychological Medicine, Royal Infirmary of Edinburgh)
- Evaluation of psychosocial interventions – e.g. befriending schemes, counselling and psychotherapeutic interventions (Fife Health Promotion Department/Greater Glasgow Primary Care NHS Trust).

- Evaluation of the effectiveness of various physical treatments using randomised control trials eg atypical antipsychotics, anticonvulsant mood stabilisers, certain antidepressants (Greater Glasgow Primary Care NHS Trust)
- Further research into the effectiveness of Dialectical Behaviour Therapy in addressing self-harming behaviour as carried out at the State Hospital (National Board for Nursing, Midwifery & Health Visiting for Scotland)
- In looking at the impact of preventive measures, explore the question: ‘does teaching mental health issues in infant schools through to secondary schooling have a long-term impact?’ (The State Hospital)

#### User/Carer/Community perceptions

- Research into community development to establish what the community perceives as being “the problem” (Dundee Social Work Department).
- Interviewing people who have given serious thought to suicide, or have considered or stopped self-harming behaviour would allow documentation of the reasons for not following through on the intention. (Lomond & Argyll Primary Care NHS Trust)
- Research seeking the views of people who self-harm about the services they would like, as well as relatives and friends of people who are feeling suicidal or who have actually committed suicide. (Fife Health Promotion Department)

#### Impact of the Framework

- Evaluation of media reporting about suicide and mental illness
- Investigating the use of the Framework to improve resources, awareness risk and service delivery. (East Ayrshire Council Social Work)

#### *Key points*

- Respondents identified a need to ‘signpost’ or better disseminate findings from existing research.
- Many of the approaches and interventions proposed in the Framework, particularly preventive approaches did not appear to be based upon sound evidence-based practice.
- Suggestions for further research served to ground practice in the experiences of those affected by suicide and self-harm, and investigations into ‘what works’.
- There was a request for controlled trials and evaluation of the cost effectiveness of different approaches, but also for process evaluation using qualitative methodologies.

- Specific research ideas were proposed which would improve the knowledge base about patterns of incidence and the problems/issues for different groups; to find better ways of identifying those most 'at risk'; evaluating the effectiveness of different approaches and interventions; and finding out what was needed by those affected by suicide and self-harm.

## OTHER ISSUES

### **Question 15: We would welcome comments on any other issues which you wish to highlight and which are not listed above.**

4.109 Respondents identified a number of single 'other' issues they felt had not already been covered. The issues raised included discriminating attitudes towards people who attempted suicide or deliberately self-harmed; the lack of information and isolation felt by those trying to help someone who has self-harmed; the neglect in the Framework of the role of primary care and community based teams; the 'paradox of suicide' and the difficulties with predicting self-harm; the inequality and hypocrisy surrounding male suicides; membership of the planning group; the need to address broad social issues as a preventive measure; the role of substance misuse in suicide; the role of the voluntary and community sector; the role of families and carers; and the media. Each of these issues will now be considered below.

#### *Discriminating attitudes*

4.110 The problem with discriminating and judgemental attitudes towards people who have attempted suicide or self-harm was specifically raised by the Manic Depression Fellowship Scotland and the Theatre Nemo. From anecdotal evidence, these organisations concluded that many people who survived a suicide attempt did not feel that they received appropriate support from professional services:

*“ Often the judgmental attitude of those they come into contact with is detrimental to their recovery, and often reinforces the already negative beliefs the person holds. The reasons behind the suicide attempt often go unheard or unheeded.” (Manic Depression Fellowship Scotland)*

4.111 Theatre Nemo highlighted a lack of “good manner” in the way people were treated, citing examples in the advice given by GPs:

*“When the families of sufferers are at their lowest ebb and need advice on how to cope, the most common advice is “If you can't cope put them out”. Quite often the end result of that is the Sufferer commits suicide. The pain and anguish that this advice causes after such an incident is unimaginable...or the comments from staff at A & E units who without thought for the pain and hurt they cause can be heard to say “well you won't do that again in a hurry?” and “try and*



*do it right next time?” or just making them wait longer than they need to because they have self harmed.”*

#### *Lack of information and support*

4.112 Another issue highlighted by the National Children’s Bureau was the problem of isolation and lack of information for both professionals and parents “desperate” for information on self-harm and where they can go for help. This sense of isolation was repeatedly commented upon, as well as not having access to services or ‘someone to talk to’.

#### *Role of primary care neglected*

4.113 While the Framework was “comprehensive” and clearly attempted not to over medicalise the situation, it was surprising to Lothian Primary Care NHS Trust that there was not more mention of primary care, community mental health teams and so on, especially as the majority of suicides occurred in community settings. However, the Depression Alliance Scotland drew attention to the variable treatment by GPs of those presenting with mental distress.

#### *Paradox of suicide & difficulties with predicting self-harm*

4.114 The Royal College of Psychiatrists highlighted what they dubbed the “paradox about suicide”. Although it featured in the commonest causes of death, particularly in those between 16 and 65, it was also a rare event. The average consultant psychiatrist had only one or even less suicides per year in his or her caseload despite seeing people on a daily basis who threatened suicide. This meant the prediction and prevention of suicide was inevitably “fraught with hazard”, as the prediction and prevention of any rare event. It was not “an exact science”.

4.115 It was also incredibly difficult to predict acts of DSH. For example, it was felt that self-harm repetition scales were inaccurate because the risk factors have poor positive predictive value.

*“Although most people who score high on self-harm repetition scales repeat, most people who repeat don’t have high scores on self-repetition scales. Interventions aimed at those at apparently high risk can therefore actually completely miss the larger number of people at lower apparent risk, according to the scale, who go on and repeat deliberate self-harm.”*

4.116 While the Royal College of Psychiatrists was not arguing against identifying risk per se, they did seek to point out the limitations of current strategies for tackling the public health problem of DSH.

### *Inequality & hypocrisy*

4.117 The inequality in terms of the ratio of male:female suicides and in the allocation of resources for prevention and health was highlighted by the UK Men's Movement. It argued that prevailing social attitudes appeared to place less value on male life and health, which reflected a "deep rooted anti-male prejudice" that must be challenged by the Framework instead of perpetuating such inequalities:

*"We contend that "Equality" SHOULD be a major principle in any actions consequent to this consultation, and that any resources allocated to suicide prevention should be made to achieve this end, preferably equalising both sexes well below the present level of female suicide."*

### *Membership of the Planning Group*

4.118 There was a general feeling that membership of the Planning Group should have been widened. Given that police are often "the first point of contact" for someone in crisis, it was recommended by ACPOS that representation on the planning group might be worthy of consideration. As already noted in Chapter 3, other respondents had suggested there should have been representatives from primary and acute care health services, ambulance services, and voluntary organisations such as The Samaritans.

### *Need to address broad social issues*

4.119 The need to address broader issues such as unemployment and men's poor access to health services was identified by the Men's Health Forum. The Forum felt that while employment/unemployment received a brief mention in the document, it played a "huge role" in how men viewed themselves in relation to society and in how it viewed them.

*"The disturbing, but indisputable, correlation between employment status and suicide would doubtless show a reduction if employment levels were to rise; this should not be ignored despite being difficult to achieve. Furthermore those deemed unsuitable for work through poor or inadequate education and/or health problems, would not significantly benefit from higher levels of employment. More realistic benefit levels that do not necessarily (as is currently the case) serve to alienate and exclude those not working from the rest of society so starkly, would undoubtedly bring savings in the longer term."*

### *Role of substance misuse in suicide*

4.120 The role of substance misuse in suicide was felt by 29 respondents to be underplayed in the consultation document. The prevalence of alcohol use not only in successful suicide but also the deterioration of mental health, family life and social

isolation meant it should be given priority in the Framework (Manic Depression Fellowship Scotland). Fife Alcohol Advisory Council counselled:

*“...a percentage of suicides could be avoided if there was a greater understanding of the far-reaching effects of combining drugs and alcohol amongst groups of people who are potentially suicidal e.g. young teenagers...”*

4.121 Several respondents, including Health bodies, commented that the Framework needed to explicitly consider the role played by alcohol in suicides. The link between alcohol and suicide was considered to be “well-established” (Medical Council on Alcohol). Those with dual diagnosis of alcohol or drug misuse along with a major mental health problem, were identified by the Academy of Royal Colleges and Faculties in Scotland as “particularly at risk”. Lochaber LHCC argued that its capacity to disinhibit and its toxic nature gave it “a unique place in the aetiology and completion of suicide and serious self-harming behaviour”. It was therefore recommended that an explicit link be made with national alcohol strategies.

#### *Role of the voluntary & community sector*

4.122 Three respondents answered questions about the role of the voluntary and community sectors that did not appear on the official consultation question. Their responses (two Health bodies and the Volunteer Development Scotland), argued that the role of the voluntary sector within the Framework needed to be “strengthened at all levels” as the voluntary sector played a “vital role” in offering services and support without the stigma attached to mainstream services. The Volunteer Development Scotland recommended that within the Framework, the role and “distinctive contribution” of volunteer-involving organisations engaged in the delivery of services with people who had attempted suicide or deliberately self-harmed, should be recognised and financial support made available to them.

4.123 Respondents perceived the voluntary sector to have a “valuable role” to play in providing non-stigmatising and responsive services, especially to people who were homeless and to younger people:

*“The voluntary sector and community...already contribute substantially to both raising awareness and trying to establish partnerships and secure help for people. One of the big problems they have is lack of ‘credibility’ in the eyes of the health services, particularly, as a referral source. There is growing evidence...of troubled young people refusing to seek help from the health services because services are not sufficiently responsive, appropriate to their age and able to meet their particular needs.”*

#### *Role of carers & families*

4.124 The consultation paper was perceived as having “little to say” on the impact of suicidal and self-harming behaviour on families, even though as the User and Carer

Involvement organisation pointed out many people will have had little to do with mental health or other services. This was felt to be a serious omission. SAMH argued that families and carers very often know most about a person who is suicidal or self-harming and may be best placed to discern changes in behaviour prior to a suicide attempt or self-harming. This familiarity and knowledge “must be better exploited as a valuable preventative tool”. It was suggested that families and carers should be more able to access and influence potential helping services.

4.125 A second point raised by the Church of Scotland Board of Responsibility was the need to strike a careful balance between making state provision and not undermining the role of the family in caring for individuals.

### *Media*

4.126 The role of the media as a powerful tool for awareness raising was not thought to be mentioned enough in the Framework. Several respondents including the Patients’ Association, thought the document could make further reference to the potential use of the media. The power to influence public perception of a topic such as suicidal behaviour and DSH could be exploited through greater proactive inclusion of the media. Glasgow City Council stated:

*“A media campaign, similar to the one pursued in relation to domestic abuse, would be a useful exercise in terms of awareness raising.”*

4.127 COPE felt the media had an important role to play in terms of responsible reporting to prevent copycat actions, "glamorisation" and critical analysis, and in the view of the UK Men’s Movement, the media had a role to ensure equality of treatment between male and female suicides.

4.128 However, the Edinburgh Users Forum suggested the Framework was ambiguous in the way it expected the media to help implement the strategy, and that the role of the media in an awareness raising campaign about suicide and self-harm was unclear:

*“It is entirely unclear what the media is intended to do to reduce your statistics. Are you planning to ban all the works of Sylvia Plath? Perhaps you intend that the next time someone hangs themselves on a TV soap we are shown more than a pair of trainers swinging gently in the breeze? Or might it be that you wish to show people in despair getting good quality help and support from friends, family and service providers, in which case I suggest that this may give people unrealistic expectations. If we are going for realism maybe we could show an individual at breaking point being sent home by the duty doctor with a bottle of Largactil?”*

### *Key points*

A number of issues were identified that respondents did not feel had been covered in the Framework:

- Discriminatory attitudes towards those who had attempted suicide or self-harmed.
- The lack of information and isolation felt by those trying to support someone who had self-harmed.
- The role of primary care and community based teams.
- The ‘paradox of suicide’ and the difficulties with predicting self-harming behaviour.
- Inequality and hypocrisy surrounding male suicides.
- Proposals about the membership of the National Planning Group.
- The need to address broader social issues.
- The role of substance misuse in suicide.
- Role of the voluntary and community sector.
- The role of families and carers
- The role of the media.

## **CHAPTER SUMMARY**

4.129 This Chapter has covered a vast range of issues on implementing the Framework document, which it is difficult to summarise without becoming repetitious. While the consultation was a useful starting point and offered a welcome focus on complex issues, the Framework would have to compete with other priorities and there were tensions to be overcome locally and between central coordination and local control. These included the reality of significant competing priorities and finite resources and a sense that mental health services generally were struggling to cope with existing demands. The Framework would only likely assist local organisations if the barriers to joint working were faced squarely and the resources required for implementation identified.

4.130 The natural link with local planning mechanisms was obvious to some but not others as the variety of planning forums were considered. Consideration would need to be given to boundary and local issues when deciding appropriate planning arrangements. There was a concern not to over-medicalise the issues by automatically assuming Health as the lead agency, but many local authorities stated they would be hard pressed to take on a ‘lead role’. How local responsibilities should be carried out, how best to engage key local players, and the relationship between national and local bodies was identified as requiring further detailed consideration in the Framework, especially in terms of who should take the ‘lead role’.

4.131 Despite referring to community and neighbourhood focus and community development as a major plank of the approach, the voluntary and community sectors were felt to be almost absent from the document in terms of being key players. This was a fundamental issue that respondents felt should be addressed in terms of the

national planning group and local action groups. A key issue for many voluntary sector organisations was the short term nature of funding which militated against their involvement in long term planning.

4.132 Finally, while there was enthusiasm for the approach proposed and for coordinating action nationally and setting priorities locally, there was a fear that this would be implemented without proper evidence about the efficacy of key approaches and interventions. Respondents highlighted a number of areas for future research including evaluations of the range of interventions, particularly those perceived as preventive strategies, and more research on the issues for specific groups of people.

## CHAPTER 5: SUMMARY & DISCUSSION

5.1 The comments received to the draft Framework were many and varied. Overall, the Framework received a general enthusiastic welcome. Many of the comments were about the practicalities of how to implement the Framework, and how the tension between central and local control could best be managed. In this brief Chapter, we have drawn attention to some of the key findings from this analysis, which it is hoped will inform the future development of the National Framework.

5.2 One of the most exercised issues was that the consultation document failed to make sufficient distinction between suicide and deliberate self-harm, in terms of the different causal explanations or aetiology and the approaches and interventions each require. Secondly, some respondents suggested that the balance in the document should be more on action plans as knowledge about suicide and DSH could be gleaned elsewhere.

5.3 Acknowledgement that the Framework will have an impact on and is itself impacted by, other national strategies and policies was criticised for being “intangible”. Respondents wanted a clearer map of what these different strategies were and how they would affect or impact on each other. They also sought assurances that there would be resources to implement local action plans.

5.4 The relationship between national and local planning was criticised for not being clear enough in the document, particularly in terms of the ‘lead agency’. A number of inevitable tensions and conflicts were identified in delivering the targets and priorities. While the overarching 10-year period was generally welcomed as recognising the long-term nature of many of the proposals, there was criticism both that the proposed timescales were too short to achieve the level of involvement required, and too long, given that significant gains could be made in the shorter term. The tensions were usefully summarised by the Royal College of Psychiatrists as between centrally determined targets and responding appropriately to local needs; tensions between the clinical priorities of professionals and needs perceived by service users; and the aspirations of policy makers and the practical problems of service delivery. In summary, the main perceived weakness was the lack of detail on the ‘how’ to take practical steps at a local level to make a difference.

5.5 Agencies, particularly local authorities, were doubtful that the necessary joint working and partnership would happen without central intervention or direction, and without acknowledging the resource implications. The importance of ensuring a broad ownership of the agenda was emphasised. The Framework had to ensure that many people recognised that they had a responsibility in this difficult area. In its present form, the Framework appeared to many respondents to place its emphasis almost exclusively on involving statutory authorities. If voluntary and community service providers were to be included, their input needed further consideration. The same was true for the involvement of people affected by suicide or self-harm. There was deep concern expressed, especially from church bodies and counsellors, that tackling the structural and organisational issues in society would not get to the ‘heart of the matter’ as they saw it – that is, alienation and disaffection within society and social exclusion.

## **APPENDIX 1: LIST OF CONSULTATION QUESTIONS**

### **GENERAL**

Question 1: Please comment on whether the Framework would be likely to assist you in taking forward actions to reduce suicide and self-harm in your own organisation, and in your local area.

Question 2: How can/should the Framework link into existing local planning arrangements?

Question 3: Does the Framework offer sufficient/too much/too little detail on the action planning and implementation process?

### **ROLES AND RESPONSIBILITIES**

Question 4: Do you have any comments on the suggested local and national roles and responsibilities?

Question 5: What support would be useful to enable you and your organisation to implement the Framework?

Question 6: Is there sufficient clarity on the lead agency role?

Question 7: Is there sufficient clarity on how to engage key local players to work in collaboration?

### **PRIORITIES FOR ACTION**

Question 8: Is the proposal for local areas to select their own priorities for action acceptable?

Question 9: Please comment on priorities and timescales anticipated.

Question 10: Does the Framework give sufficient weight to primary prevention and to the societal level?

Question 11: Do you agree with the need to commit to long-term strategies that focus on children and young people (recognising that this would not yield quick returns)? If so, have you suggestions about how this aim could be strengthened further?

Question 12: Are there other vulnerable groups that should be a priority, in considering actions to prevent suicide and reduce deliberate self-harm?

Question 13: If so, what types of approaches and interventions should be developed for these groups to reduce risk of suicide and self-harm and to promote mental health and well being?



## RESEARCH

Question 14: We would welcome suggestions on research which might be carried out on the impact of measures for prevention of suicide and self-harm – in particular, research which would be amenable to follow up after given periods, and which would allow clear analysis of practical progress made in relation to the introduction of the Framework at both national and local levels.

## OTHER ISSUES

Question 15: We would welcome comments on any other issues which you wish to highlight and which are not listed above.

## APPENDIX 2: DISTRIBUTION LIST OF CONSULTEES

Chief Executives, NHS Boards (15)  
Chief Executives, NHS Trusts (28)  
Medical Directors, NHS Trusts (38)  
Chief Executives, Local Authorities (32)  
Directors of Education, Local authorities (32)  
Directors of Housing, Local Authorities (32)  
Directors of Social Work, Local Authorities (32)  
Social Inclusion Partnerships (48)  
Health Promotion Officers, NHS Boards (15)  
Prisons and Young Offender Institutions (14)  
Chief Constables of Police Forces (8)

Aberdeen Council of Voluntary Organisations  
Aberdeen PMS Support Group  
Academy of Royal Colleges and Faculties in Scotland  
Action of Churches Together in Scotland  
Adolescent Forensic Unit  
Age Concern Scotland  
Allies in Change  
Alzheimer Scotland - Action on Dementia  
Angus Community Care Forum  
Apex Trust (Scotland)  
Asian Women's Action Group  
Association of Chief Police Officers in Scotland  
Association of Directors of Social Work  
Association of Head Teachers in Scotland  
Association of Indian Organisations  
Association of Scottish Colleges  
Association of Scottish Local Health Councils  
Ayr Action for Mental Health  
A1 LGBT Network  
Badenoch and Strathspey Association for Mental Health  
Barnardos Family Support Scheme  
Barnardos Scotland  
Beyond Barriers  
Borders Gay Switchboard  
Borders LGBT Project  
Boy's Brigade in Scotland

British Association of Social Workers Scotland  
British Deaf Association  
British Dental Association (Scotland)  
British Geriatrics Society (Scottish Branch)  
British Medical Association  
British Medical Association – Scottish Joint Consultants Committee  
British Psychological Society  
British Red Cross  
BUPA  
Carers National Association (Scotland)  
Carers Scotland  
Catholic Head Teachers Association of Scotland  
Catholic Parliamentary Office  
Catholic Union of Great Britain  
CEC Equality Unit  
Central Scotland Racial Equality Council  
Centre for the Child and Society  
Centre for Independent Living  
Centre for Women's Health  
Chartered Society of Physiotherapy  
Child & Family Trust  
Children 1st  
Children in Scotland  
Church of Scotland, Board of Social Responsibility  
Citizens Advice Scotland  
Clinical Standards Board for Scotland  
Coalition of Carers in Scotland  
College of Occupational Therapists  
Commission for Racial Equality (Scotland)

Commissioner for Local  
 Administration in Scotland  
 Common Services Agency  
 Community Care Providers Scotland  
 Community Health Project (North  
 Glasgow)  
 Community Integrated Care  
 Community Mental Handicap Nurses  
 Association  
 Community Mental Health Services  
 Community Practitioners and Health  
 Visitors Association  
 Community Psychiatric Nurses  
 Association (Scotland)  
 Community Service Volunteers  
 Community of Users Representatives  
 Consultation & Advocacy Promotion  
 Service (CAPS)  
 Contact Point Men's Group  
 Convention of Scottish Local  
 Authorities (COSLA)  
 Crew 2000  
 Crossroads Scotland  
 Crown Office  
 CRUSAID Scotland  
 Cruse Bereavement Care  
 Common Services Agency – Central  
 Legal Office  
 Deaf Women Support Group  
 Deafblind Scotland  
 Dementia Services Development  
 Centre  
 Department of Health – Health &  
 Social Services Group  
 Depression Alliance  
 Disability Rights Commission  
 District Nurses Association  
 Dumfries & Galloway Women's  
 Forum  
 Dundee University LGB Society  
 Dundee Voluntary Action  
 East Kilbride Mental Health Issues  
 Group  
 Eating Disorder Association  
 Edinburgh & East of Scotland Deaf  
 Society  
 Edinburgh & Lothians Racial Equality  
 Council  
 Edinburgh Association for Mental  
 Health  
 Edinburgh Hindu Mandir & Cultural  
 Centre  
 Edinburgh University Second Year  
 Medical Students  
 Education Committee – The Scottish  
 Parliament  
 Education Institute of Scotland  
 EIS Gay & Lesbian Network  
 Employment Service  
 Enable  
 Epilepsy Association of Scotland  
 Equal Opportunities Commission  
 Equality Network  
 Evangelical Alliance (Scotland)  
 Falkirk Users Network  
 Family Care  
 Fife Advocacy Project  
 Fife Racial Equality Council  
 Fife Women's Network  
 GALUP – YMCA Special Projects  
 Office  
 Gartnavel Royal Hospital, Dept of  
 Psychological Medicine  
 Gay Men's Health  
 General Medical Council  
 General Register Office for Scotland  
 General Teaching Council for Scotland  
 GLAD – University of Abertay  
 Glasgow Association for Mental  
 Health Services  
 Glasgow Caledonian LGB Society  
 Glasgow Council of Voluntary  
 Services  
 Glasgow LGBT Centre  
 Glasgow University LGB Society  
 GMB Scotland LGBT Group  
 Grampian Racial Equality Council  
 Group Around Self-harm  
 Guide Association Scotland  
 Head Injuries Trust for Scotland  
 Health & Community Care Committee  
 – The Scottish Parliament  
 Health and Social Services Councils  
 Health Education Board for Scotland  
 Health Service Commissioner for  
 Scotland  
 Healthy Gay Scotland  
 Help the Aged  
 Heriot Watt University LGB Society  
 Highland Community Care Forum

Highland Health Council  
Highland Users Group  
Inclusion Scotland  
Independent Federation of Nursing in Scotland  
Information and Statistics Division, Scotland  
Institute of Health Service Management  
Inverclyde Community Care Forum  
Justice 1 Committee – The Scottish Parliament  
Justice 2 Committee – The Scottish Parliament  
KEY Housing Association Ltd  
Lanarkshire Association for Mental Health  
Law Society of Scotland  
LGB Group – Strathclyde University Student's Union  
LGBT Community Safety Forum  
Lothian Anti-Poverty Alliance  
Lothian Coalition for Disabled People  
Lothian Lesbian & Gay Switchboard  
Manic Depression Fellowship Scotland  
Maudesley Trust  
ME Association (Scotland)  
Medical Defence Union  
Medical and Dental Defence Union of Scotland  
Men's Health Forum  
Mental Health Advocacy Project, St John's Hospital  
Mental Health Foundation  
Mental Welfare Commission for Scotland  
Minority Ethnic Learning Disability Initiative Ltd  
Moray Parentline  
Mums Supporting Mums  
National AIDS Trust  
National Autistic Society  
National Board for Nursing, Midwifery and Health Visitors for Scotland  
National Commission for Social Work  
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness  
National Farmers Union of Scotland  
National Foster Care Association

National Newpin  
National Schizophrenia Fellowship Scotland  
NCH – Action for Children  
NHS Psychologists in Scotland  
Nuffield Centre for Community Care  
NUS Scotland LGB Network  
Orkney Local Health Council  
Outright Scotland  
Outright Scotland – Dundee  
Paediatric & Epidemiology & Community Health Unit  
Pakistani Women's Welfare Association  
Parent Pressure  
Parents Enquiry Scotland  
Parkinson's Disease Society  
Parliamentary Mental Health Group  
Partners in Advocacy  
Partners in Mental Health  
Patient's Association  
PENUMBRA  
People First (Scotland)  
PHACE West  
Pharmaceutical Society  
Positive Steps Partnership  
Pride Scotland  
Princess Royal Trust for Carers  
Professional Association of Teachers  
Pro-Life Alliance  
Psychiatric Nurses Association  
Public Health Institute of Scotland  
QMC Lesbian & Gay Network  
Rehab Scotland  
Renfrewshire Association for Mental Health  
Richmond Fellowship Scotland  
Royal College of Anaesthetists  
Royal College of General Practitioners (Scotland)  
Royal College of Midwives – Scottish Board  
Royal College of Nursing Scottish Board  
Royal College of Physicians & Surgeons of Glasgow  
Royal College of Physicians Edinburgh  
Royal College of Psychiatrists (Scottish Division)

Royal College of Speech Therapists  
 Royal College of Surgeons of Edinburgh  
 Royal Faculty of Procurators  
 Royal Hospital for Sick Children  
 Royal National Institute for the Blind  
 Royal National Institute for the Deaf  
 Royal Pharmaceutical Society of Great Britain  
 Salvation Army  
 Samaritans  
 SANELINE  
 School of Law and Centre of Medical Law and Ethics  
 Scottish Association of Care Home Owners  
 Scottish Association for the Care & Resettlement of Offenders  
 Scottish Association of Sign Language Interpreters  
 Scottish Association for the Deaf  
 Scottish Association for Mental Health  
 Scottish Association of Health Councils  
 Scottish Care  
 Scottish Churches Parliamentary Office  
 Scottish Civic Forum  
 Scottish Community Care Forum  
 Scottish Community Learning Disability Nursing Network  
 Scottish Consumer Council  
 Scottish Council for Civil Liberties  
 Scottish Council of Independent Schools  
 Scottish Council for Jewish Communities  
 Scottish Council for Post Graduate Medical & Dental Education  
 Scottish Council for Single Homeless  
 Scottish Council for Voluntary Organisations  
 Scottish Council on Deafness  
 Scottish Courts Administration  
 Scottish Courts Service  
 Scottish Development Centre for Mental Health  
 Scottish Directors of Public Health  
 Scottish Disability Equality Forum  
 Scottish Ex-Service Charitable Organisations  
 Scottish Federation of Housing Associations  
 Scottish Health Advisory Service  
 Scottish Health Visitors Association  
 Scottish HIV/AIDS Forum  
 Scottish Homes  
 Scottish Human Rights Centre  
 Scottish Human Services Trust  
 Scottish Huntington's Association  
 Scottish Inter Faith Council  
 Scottish Inter-Faith Consultative Group  
 Scottish Law Commission  
 Scottish Legal Aid Board  
 Scottish National Federation for the Welfare of the Blind  
 Scottish Parliament Information Centre  
 Scottish Partnership Agency for Palliative Care  
 Scottish Partnership Forum  
 Scottish Pensioners Forum  
 Scottish School Board association  
 Scottish Schools Ethos Network  
 Scottish Social Inclusion Network  
 Scottish Society for Autism  
 Scottish Trade Union Congress  
 Scottish Users Network  
 Scottish Youth Parliament  
 Scout Association  
 Sense Scotland  
 Shared Scotland  
 Sheriffs' Association  
 Sheriff Clerks – 3 Area Directors  
 Sheriff Principals' Association  
 Shetland Welfare Trust  
 Skye & Lochalsh Council for Voluntary Organisations  
 Social Care Association  
 Social Inclusion Committee – The Scottish Parliament  
 Society of Solicitor Advocates  
 Soroptimist International  
 St Andrew's University LGBT Society  
 Stonewall Scotland  
 Stonewall Youth Project  
 Strathclyde Lesbian & Gay Switchboard  
 Stresswatch Scotland

Success Ltd  
 Tayside Forensic Voices Carers  
 Support Group  
 Tayside Racial Equality Council  
 Trust a Caress Connection  
 Turning Point Scotland  
 Uist Council of Voluntary  
 Organisations  
 UKIM - Muslim Women's Group  
 Union of Muslim Organisations of UK  
 and Eire  
 UNISON Scotland  
 United Kingdom Central Council for  
 Nursing, Midwifery and Health  
 Visiting  
 Universities Scotland  
 University of Edinburgh, Centre for  
 Theology and Public Issues  
 University of Edinburgh, Department  
 of Psychiatry  
 Values into Action Scotland

Victim Support  
 Voluntary Action Inverness  
 Voluntary Action Orkney  
 Volunteer Development Scotland  
 Waverly Care Trust  
 West Lothian Inclusion Network  
 West of Scotland Community  
 Relations Council  
 Western Isles Association for Mental  
 Health  
 Western Isles Community Care Forum  
 Who Cares ? Scotland  
 Women's Centre Information &  
 Support Project  
 Women's National Commission  
 Women's Royal Voluntary Service  
 Yorkhill Family Bereavement Service  
 Youthcon  
 Youth Link  
 Youthnet

External Members of the Scottish Executive's National Health Education Committee (8)

Individuals, by organisation who attended either the seminar in November 2000 or May 2001 on Developing a National Framework for Suicide Prevention and Self-harm Reduction in Scotland and those who wished to be kept informed of developments on the Framework.

Aberdeen City Council - Social Work  
 (2 Individuals)  
 Aberdeen City Council - Education  
 Aberdeenshire Council - Social work  
 Aberdeenshire Council - Mental  
 Health  
 Alcohol Problems Clinic, Royal  
 Edinburgh Hospital  
 Alcohol Problems Service, Royal  
 Edinburgh Hospital  
 Angus Council - Social Work  
 Anti-Bullying Network, University of  
 Edinburgh  
 Argyll & Bute Council - Education  
 Argyll & Bute Council - Social Work  
 Argyll & Bute Hospital  
 Argyll & Clyde NHS Board  
 Ayrshire & Arran NHS Board  
 Ayrshire & Arran Primary Care NHS  
 Trust

Bank Street Clinic  
 Barnardo's Scotland (2 Individuals)  
 Blantyre/ North Hamilton SIP  
 Borders NHS Board  
 Borders Primary Care NHS Trust (5  
 Individuals)  
 British Psychological Society  
 Cameron Hospital (2 Individuals)  
 Campbeltown Hospital  
 Care Resource & Support Team, The  
 Charleston Centre  
 Cathkin High School  
 Central Scotland Police  
 Centre for Theology and Public Issues,  
 University of Edinburgh  
 ChildLine Scotland  
 Children 1<sup>st</sup> (2 Individuals)  
 Children in Scotland (2 Individuals)  
 City of Edinburgh Council - Social  
 Work

Clackmannanshire Council - Social Work  
 Clackmannanshire Council - Education  
 Clinical Standards Board for Scotland  
 Common Services Agency  
 Community Alcohol & Drugs Service, Bannockburn Hospital  
 Community Clinic, Fort William  
 Convention of Scottish Local Authorities (2 Individuals)  
 COPE  
 Market Street Centre  
 Craigmillar Medical Group  
 Crichton Royal Hospital  
 Crosshouse Hospital  
 Depression Alliance Scotland  
 Dumfries & Galloway Council - Education  
 Dumfries & Galloway Council - Social Services Department  
 Dumfries & Galloway NHS Board (4 Individuals)  
 Dundee City Council - Social Work  
 Dundee City Council, Xplore  
 East Ayrshire Council - Children & Families  
 East Ayrshire Council - Social Work  
 East Dumbarton Social Work Department  
 East Lothian Council - Mental Health  
 East Renfrewshire Council -Social Work/Mental Health  
 Edenhall Hospital  
 Education Services, McLaren House, Polmont  
 Elderly Continuing Care, West Lothian Healthcare NHS Trust  
 Elmsclose Support Unit, Social Work Community Service  
 Essentia (2 Individuals)  
 Facilitate Scotland  
 Falkirk Council - Social Work  
 Falkirk Psychological Service  
 Fife Council - Social Work (2 Individuals)  
 Fife Council - Education (4 Individuals)  
 Fife Council - Corporate Policy  
 Fife NHS Board (2 Individuals)  
 Fife Primary Care NHS Trust (3 Individuals)  
 Forth Valley NHS Board (2 Individuals)  
 Forth Valley Primary Care NHS Trust (3 Individuals)  
 Gartnavel Royal Hospital  
 Glasgow City Council - Social Work  
 Glasgow City Council - Mental Health (3 Individuals)  
 Glasgow City Council  
 Glasgow Psychiatric Liaison Services, Stobhill Hospital  
 Govan SIP  
 Grampian NHS Board  
 Grampian Primary Care NHS Trust (2 Individuals)  
 Greater Glasgow NHS Board (2 Individuals)  
 Greater Glasgow Primary Care NHS Trust (2 Individuals)  
 Greater Glasgow User Network  
 Health Services Research Unit  
 Highland Council - Mental Health  
 Highland Primary Care NHS Trust (2 Individuals)  
 HMI Schools  
 Independent Health Consultant  
 Individuals (5)  
 Individuals (14 MSPs)  
 Information & Statistics Division Scotland  
 Joint Planning & Development, Community Care  
 LAMH  
 Lanarkshire NHS Board (3 Individuals)  
 Lanarkshire Primary Care NHS Trust  
 Lomond & Argyll PC NHS Trust (2 Individuals)  
 Lothian NHS Board (3 individuals)  
 Lothian Primary Care Trust, Royal Edinburgh Hospital  
 Manic Depression Fellowship Scotland (2 Individual)  
 Mental Health Foundation  
 Mental Welfare Commission for Scotland (2 Individuals)  
 Midlothian Council - Social Work (2 Individuals)

National Board for Nursing, Midwifery & Health Visiting for Scotland	Scottish Borders Council - Education
NEFAMH	Scottish Council for Postgraduate Medical & Dental Education
New Community School, Gorebridge	Scottish Enterprise
Newbattle Cluster New Community School	Scottish Health Advisory Service
NHS Executive, Dept of Health, Mental Services	Scottish Prison Service
Ninewells Hospital & Medical School	Scottish Users' Network
North Ayr Partnership	Social Work Dept, Dumbarton
North Lanarkshire Education Department	South Ayrshire Council - Education
North Lanarkshire Psychological Service, St Aloysius Primary	South Edinburgh Partnership
Office for Public Management	South Lanarkshire Council - Social Work (2 Individuals)
Open Futures Ltd	Springbank Resource Centre
Orkney Islands Council - Community Social Services	Springfield House, Elgin
Orkney Islands Council - Social Services	St Gregory's Primary School
Orkney Islands Council - Education	State Hospital (2 Individuals)
Propstress Centre	Statheden Hospital
Psychological Service, Lerwick	Stirling Council - Social Work
Public Health Institute of Scotland	Tayside NHS Board
Reach Out Project, Coatbridge Health Centre	Tayside Primary Care NHS Trust (3 Individuals)
Renfrewshire Council - Mental Health (4 Individuals)	The Big Step SIP
Renfrewshire Council - Psychologist	Tranent SIP
Renfrewshire Council	University of Stirling, Department of Psychology
Royal College of Nursing (2 Individuals)	Vale of Leven Hospital (2 Individuals)
Royal Cornhill Hospital (2 Individuals)	Victoria Infirmary
Royal Edinburgh Hospital LPCT	Warneford Hospital
Samaritans (2 Individuals)	West Dunbartonshire Council - Education
	West Lothian Council - Health Development
	West Lothian Healthcare NHS Trust
	West Lothian SIP (2 Individuals)
	XPLORE (SIP)
	Young Carers Partnership

The following organisations/individuals requested copies of the consultation paper after it was issued for consultation.

Aberdeen Mental Health Reference Group	Children in Scotland*
Aberlour Child Care Trust	Consultation & Advocacy Promotion Service (CAPS)*
Abuse Not	Department of Health, Trent Regional Office
Argyle & Clyde NHS Board*	Domestic Abuse Partnership
Ayrshire & Arran NHS Board*	Clydebank
BBVCS	Dumfries & Galloway NHS Board*
Carelinkline NSF Scotland	Edenhall Hospital
Carseview Centre	



Falkirk Royal Infirmary  
 Fife NHS Board (100 copies to be handed out at a conference)  
 Forth Valley NHS Board\*  
 Glasgow Association for Mental Health\*  
 Glasgow University Library  
 Glasgow Women's Aid  
 Greater Glasgow NHS Board\*  
 Greater Glasgow Health Council  
 Men's Health Forum\*  
 HYPE NCH Scotland\*  
 Independent Federation of Nursing\*  
 James Watt College of Further & Higher Education  
 Kirklands Hospital  
 Lesbian Info Service  
 Loganlea Centre Penicuik  
 Lomond & Argyle Primary Care Trust\*  
 Lothian and Borders Police\*  
 Lothian NHS Board\*  
 Men's Aid  
 Mental Welfare Commission for Scotland\*  
 Midlothian Council Education Dept\*  
 Murray Royal Hospital  
 National Library of Scotland  
 North Paisley New Community School  
 Oakbank School, Aberdeen  
 Orkney Island Council\*  
 Park Street Clinic Powys  
 POPYRUS  
 Police Surgeons Association  
 Ravenscraig Hospital  
 Samaritans Aberdeen  
 Samaritans Dumfries & Galloway  
 Samaritans Dundee  
 Samaritans Edinburgh  
 Samaritans Elgin  
 Samaritans Falkirk  
 Samaritans Glasgow  
 Samaritans Greenock  
 Samaritans Hamilton  
 Samaritans Inverness  
 Samaritans Kilmarnock  
 Samaritans Kinross  
 Samaritans Orkney  
 Samaritans Perth  
 Samaritans Shetland

Samaritans Slough  
 Samaritans Stornoway  
 Scottish Borders Council\*  
 Scottish Churches Parliament Office\*  
 Scottish Poisons Information Bureau  
 Scottish Prison Service\*  
 Social Care Commission  
 Social Work Dept Royal Edinburgh Hospital  
 Stationary Office Bookshop Edinburgh (180 copies - in response to public requests at HMSO Bookshops)  
 Stratheden Hospital, The Ceres Centre  
 Stratheden Hospital F.I.O.T  
 Stirling Royal Infirmary, Social Work Unit  
 Student Welfare & Development Edinburgh  
 Theatre Nemo  
 Thornliebank Primary School  
 Turiff New Community School  
 UK Men's Movement Glasgow  
 University of Edinburgh C.T.P.I  
 University of Strathclyde, The Counselling Unit  
 University of Strathclyde Psychology Dept.  
 Victim Support Edinburgh\*  
 Voluntary Health Scotland  
 Westbank Clinic Falkirk  
 West Dumbarton Domestic Abuse Partnership  
 West Highland Free Press

18 Individuals

\* Further copies, already on main A-Z consultation list.

## APPENDIX 3: CATEGORIES OF CONSULTEE

### Organisation Type

H	Health Bodies-Trusts, Boards, LHCCs, medical practices
LA-SW	Local Authority-Social Work
LA-EDU	Local Authority-Education
LA-HOU	Local Authority-Housing
LA-O	Local Authority-Other (e.g. employment service, SIPs)
CJS	Criminal Justice Service (Scottish Courts and legal bodies, incl. solicitors, police, prisons)
PB-Q	Public Bodies Quangos
COMM	Commercial
PUC	Patient/User/Carer (Health Councils, advocacy)
VOL	Voluntary organisations
AC	Academic/research organisation
PB-H	Professional Body-Health (Royal Colleges, nursing, medicine, etc)
PB-SW	Professional Body-Social Work
PB-CJS	Professional Body-Legal (including other justice professions e.g. police)
PB-O	Professional Body-Other
INDIV	Individual (anyone responding as an individual)
O/N	Other or non-identifiable
MULTI	Multi-agency response

### Profession Type

H	Health Professional (Psychiatrists, Nurses, Allied to Medicine)
S W	Social Work Professional
CJS	Legal Professional (Solicitors, Advocates)
EDU	Educational (Teachers, Heads of education)
MAN	Paid co-ordinators of voluntary organisations, Chief Execs/Directors of professional bodies
OTHER	Other Professionals-Deans, Royal Colleges unidentified, information officers, etc.
HON	Acting as Chair, Secretary to organisation-unpaid
PUC	Patient, user, carer-when responding as individual
ER	MPs, MSPs
AC	Professors of Universities, research fellows
O/N	Other or non-identifiable.

## **APPENDIX 4 – LIST OF RESPONDENTS**

### **HEALTH BODIES (31 RESPONSES):**

(Where organisations appear twice, responses came from different sections of the Board or Trust)

Argyll & Bute Hospital, Mental Health Quality Improvement Group  
Ayrshire & Arran NHS Board  
Ayrshire & Arran NHS Board, Clinical Risk Assessment Interest Group  
Ayrshire & Arran Primary Care NHS Trust  
Ayrshire & Arran Primary Care NHS Trust, Primary Care Clinical Governance  
Fife NHS Board, Mental Health Strategy Group  
Fife Primary Care NHS Trust, Health Promotion Department  
Forth Valley Primary Care NHS Trust  
Forth Valley Primary Care NHS Trust, Additional Support Team, Royal Scottish National Hospital  
Grampian Primary Care NHS Trust, Mental Health Governance Group, Royal Cornhill Hospital  
Greater Glasgow Primary Care NHS Trust  
Highland Primary Care NHS Trust, Lochaber LHCC  
Lomond and Argyll Primary Care NHS Trust  
Lomond & Argyll Primary Care NHS Trust, Mental Health Directorate  
Lothian NHS Board  
Lothian Primary Care NHS Trust  
Lothian Primary Care NHS Trust, Rosslynlee Hospital, Roslin,  
Lothian Primary Care NHS Trust, South East Edinburgh LHCC  
Lothian University Hospitals NHS Trust, Department of Psychological Medicine  
Lothian University Hospitals NHS Trust , Royal Edinburgh Hospital, Young People’s Unit  
Medical Council on Alcohol/Alcohol Problems Clinic  
Montrose/Brechin Mental Health Locality (Adult)  
Renfrewshire & Inverclyde Primary Care NHS Trust, Paisley LHCC  
Scottish Division of Psychiatrists, Old Age Section  
The Sandyford Initiative, Glasgow (Family Planning & Reproductive Health Care)  
The State Hospital, Carstairs  
Tayside NHS Board, Health Family in Tayside  
Warrington Community Trust, Health Promotion Service,  
West Lothian Healthcare NHS Trust, West Lothian Community Care Management Group  
Yorkhill NHS Trust  
Yorkhill NHS Trust, Clinical Board for Medicine, Child Health and Psychiatry

### **LOCAL AUTHORITY (SOCIAL WORK) (11 RESPONSES)**

Aberdeenshire Council  
Dundee City Council Social Work Department  
East Ayrshire Council, Department of Educational and Social Services  
East Dunbartonshire Council  
Fife Council Services  
North Ayrshire Council (Children, Families, Criminal Justice)  
Orkney Islands Council  
Renfrewshire Council, Social Work Department  
Scottish Borders Council, Lifelong Care Department, Community Care Services,  
Shetland Islands Council Social Care Service  
West Dunbartonshire Council

**LOCAL AUTHORITY (EDUCATION) (9 RESPONSES):**

Aberdeen City Council Education Department  
Dundee City Council Education Service  
East Lothian Council Education and Community Services  
Falkirk Council Psychological Service  
Glasgow City Council, Senior Education Officer  
Inverclyde Council Education Services  
North Ayrshire Council Education Services  
North Lanarkshire Council, Psychological Service, Department of Education  
South Lanarkshire Council Education Resources

**LOCAL AUTHORITY (HOUSING) (3 RESPONSES):**

Falkirk Council Advice Shop, Health and Homelessness  
Glasgow City Council Housing Service  
The City of Edinburgh Council, Care Housing

**LOCAL AUTHORITY (OTHER) (2 RESPONSES):**

COPE/ Drumchapel Social Inclusion Partnership  
North Edinburgh Social Inclusion Partnership

**CRIMINAL JUSTICE (4 RESPONSES):**

Association of Chief Police Officers in Scotland (ACPOS)  
Northern Constabulary, Inverness  
Policy Group, Crown Office  
Scottish Prison Service Headquarters

**PUBLIC BODIES (4 RESPONSES):**

Commission for Racial Equality Scotland  
Common Services Agency  
Mental Welfare Commission for Scotland  
Public Health Institute of Scotland

**COMMERCIAL (1 RESPONSE):**

Success Unlimited

**PATIENT/USER/CARER GROUPS (7 RESPONSES):**

Edinburgh Users Forum  
Lanarkshire Community Care Forum  
Manic Depression Fellowship Scotland  
Mental Health Advocacy Project, St John's Hospital, Livingston  
Panel of Reference, Ayrshire  
The Patients' Association  
West Lothian Service Users Forum

## **VOLUNTARY ORGANISATIONS (30 RESPONSES):**

Aberdeen Mental Health Reference Group  
Childline Scotland  
Children in Scotland  
Cruse Bereavement Care Scotland  
Deafblind Scotland  
Depression Alliance Scotland  
Fife Alcohol Advisory Service  
Fife Families Support Project  
The Earl Haig Fund Scotland & The Officers' Association Scotland  
Glasgow Council for Single Homeless  
Help the Aged Scotland  
Lesbian Information Service  
Men's Health Forum Scotland  
Men's Health Highland  
Mental Health Foundation Scotland Office  
National Children's Bureau, London  
National Schizophrenia Fellowship Scotland  
Penumbra  
Quarriers  
The Richmond Fellowship Scotland  
The Samaritans  
Samaritans Correspondence Branch, Stirling  
Scottish Council for Mental Health  
Scottish Council for Single Homeless  
Scottish Council on Deafness  
St Aubin's Project  
Stonewall Scotland  
User and Carer Involvement, Dumfries  
Volunteer Development Scotland  
Waverley Care

## **ACADEMIC/RESEARCH BODIES (5 RESPONSES):**

Academy of Royal Colleges and Faculties in Scotland  
The University of Edinburgh, Forensic Medicine Section, Department of Pathology  
The University of Glasgow, Department of Public Health  
The University of Glasgow Paediatric Epidemiology and Community Health Unit  
The University of St Andrews, Community Health Development, Department of Social Anthropology

## **PROFESSIONAL ORGANISATIONS (HEALTH) (8 RESPONSES):**

British Medical Association  
College of Occupational Therapists  
The Independent Federation of Nursing in Scotland  
National Board for Nursing, Midwifery and Health Visiting in Scotland  
Royal College of General Practitioners (Scotland)  
Royal College of Nursing  
Royal College of Physicians  
Royal College of Psychiatrists Scottish Division

(No responses were received from:  
Professional Organisations – social work; Criminal Justice Service; Education or Other)

## **PEOPLE WHO RESPONDED AS INDIVIDUALS (8 RESPONSES):**

Ms Kirsty Bannerman, Newbattle Cluster New Community Schools, Midlothian  
Mr Ronald Beasley, Counsellor, Supervisor, Trainer, Warrender Park Terrace, Edinburgh  
Dr Alan Drayson, Consultant Psychiatrist, Sunnyside Royal Hospital, Montrose  
Dr Robert McCabe, Consultant Adolescent Psychiatrist/Clinical Director, Adolescent  
Psychiatry Directorate, Greater Glasgow Primary Care NTS Trust  
Mr John Mackenzie (response by e-mail, no address given)  
Mr Douglas Seath, Member of Lothian Primary Care NHS Trust Suicide Review Group  
Mr Terry Veitch, Mental Health Liaison Nurse (response by e-mail, no address given)  
Dr Robert Wrate, Consultant Psychiatrist, Young People's Unit, Royal Edinburgh Hospital

## **OTHERS (11 RESPONSES):**

The Church of Scotland Board of Social Responsibility  
Cross Party Group on Mental Health  
Edinburgh and the Lothians LGBT Healthy Living Consortium  
Facilitate Scotland  
fpa Scotland (formerly Family Planning Association)  
Lothian Anti-Poverty Alliance  
SAY Women  
Scottish Liberal Democrats  
Theatre NEMO  
The UK Men's Movement  
Youth Stress Centre

## **MULTI-AGENCY 6:**

### **(1):**

Dumfries and Galloway NHS Board,  
Dumfries and Galloway Council,  
Dumfries and Galloway Primary Care (NHS) Trust,  
Dumfries and Galloway Police,  
Dumfries Young Offenders Institution,  
The Richmond Fellowship Scotland (D & G Office),  
Dumfries and Stewartry Women's Aid,  
Papyrus (D & G branch),  
User and Carer Involvement (D & G),  
Together Opening Door (D & G),  
The Samaritans (D & G Branch)

### **(2):**

Forth Valley Primary Care NHS Trust  
Forth Valley Health Board,  
Three local authorities: Falkirk, Stirling, Clackmannanshire

### **(3):**

Highland NHS Board  
Highland Primary Care NHS Trust  
Highland Council Social Work services

**(4):**

Lanarkshire NHS Board  
Lanarkshire Primary Care NHS Trust  
North Lanarkshire Council Social Work Department  
South Lanarkshire Social Work Department and Housing Department,  
Lanarkshire Community Care Forum  
Manic Depression Fellowship Scotland

**(5):**

West Lothian Mental Health Forum

**(6):**

Perth & Kinross Council Social Work Services  
Criminal Justice Services  
Education & Children's Services

## **LATE RESPONSES**

Four responses were received after the final cut-off date for inclusion in the analysis reported in this document (14<sup>th</sup> February 2002). These came from:

Grampian NHS Board  
Midlothian Council  
North Glasgow University Hospitals NHS Trust  
Voluntary Health Scotland

Although not included in this analysis, these comments will be used along with this report to inform the Health Department.

## **APPENDIX 5: MEMBERS OF THE PLANNING GROUP**

Jim Brown	Scottish Executive, Public Health Division
Nova Brown	Scottish Executive, Public Health Division
Gregor Henderson	Scottish Development Centre for Mental Health Services
Emma Hogg	Health Education Board for Scotland
George Kappler	Scottish Executive, Social Work Services Inspectorate
Patrick Little	Penumbra
John Loudon	Scottish Executive, Medical Division
Bob Luke	Scottish Prison Service
Ian McBean	Falkirk Council
Allyson McCollam	Scottish Development Centre for Mental Health Services
Linda Miller	Scottish Executive, Pupil Support & Inclusion Division
John Mitchell	Inverclyde Community Mental Health Team
Graham Morgan	Highland Users Group
Diana Morrison	Royal Edinburgh Hospital
Stephen Platt	Edinburgh University
Gavin Russell	Scottish Executive, Public Health Division
Robert Samuel	Scottish Executive, Directorate of Nursing
Cameron Stark	Highland NHS Board
Fiona Tyrrell	Scottish Executive, Public Health Division



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