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Evaluation of the First Phase of *Choose Life:* the national strategy and action plan to prevent suicide in Scotland

EVALUATION OF THE FIRST PHASE OF *CHOOSE LIFE:* THE NATIONAL STRATEGY AND ACTION PLAN TO PREVENT SUICIDE IN SCOTLAND

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Scottish Executive Social Research
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EXECUTIVE SUMMARY

Background

Over the past 50 years suicide incidence in Scotland has not been exceptionally high by international standards. In the mid-1990s the male suicide rate was about the average, and the female suicide rate below the average, compared with 17 Western European countries. Nevertheless, there had been a pronounced and dramatic increase in suicide among men in Scotland, with the rate more than doubling since the 1970s. The cost of suicide falls on everyone in society and can be substantial. In Scotland this is estimated to have been just over £1bn in 2004. There are considerable potential economic benefits if the number of suicides can be reduced. Every 1% reduction in the number of suicides (from the current level of 835 suicides) could avoid costs of up to £10.7 million (including tangible, intangible and indirect lost productivity costs) over the lifetimes of these individuals. Suicide also has a devastating emotional impact on surviving family members and friends, inducing feelings of abandonment, rejection and helplessness.

Choose Life

Choose Life: the National Strategy and Action Plan to Prevent Suicide in Scotland was launched in December 2002. The *Choose Life* plan is being implemented in phases, with an initial phase of three years (April 2003 to March 2006). A budget of £12 million was allocated by the Scottish Executive over this period to suicide prevention activities. Of this, £3 million was allocated to national activities and the remaining £9 million to local area partnerships for suicide prevention work. A further £8.4 million is being invested nationally and locally over the period 2006-2008.

Choose Life identifies the main suicide prevention actions that are required at both national and local levels. A designated National Implementation Support Team (NIST) coordinates and supports development and implementation at national level. NIST's core functions include awareness raising/campaigning; working with the media; development and dissemination of information and knowledge; and supporting local implementation. In each of Scotland's 32 local authority areas *Choose Life* action plans have been developed by the Community Planning Partnership (CPP) and a key lead/coordinating person has been identified with responsibility for liaising with NIST and sharing information with other local planning partners and stakeholders.

Evaluation of the first phase of *Choose Life*

In line with the growing commitment to evidence-based policy making within modernised government and the evidence-based practice within public health and health promotion, the Scottish Executive signalled the intention to commission an independent evaluation of *Choose Life* in the strategy and action plan. In 2004, following a competitive tendering process, the Scottish Executive commissioned a research consortium to evaluate the first phase of *Choose Life*.

The main aims of this evaluation study were to:

- Establish and apply measures to assess whether a sustainable infrastructure is being developed nationally and locally to support the *Choose Life* strategy in achieving its objectives
- Measure and review progress towards implementation of the 27 milestones identified in the *Choose Life* document (page 35) and set findings in context, nationally and internationally
- Examine whether and how *Choose Life* is stimulating effective forms of practice (nationally and in individual local areas)
- On the basis of findings, and in consultation with the Scottish Executive and the Research Advisory Group steering the evaluation, provide detailed and staged recommendations to guide the next phase of the action plan to achieve a 20 per cent reduction in suicides in Scotland by 2013, and the targeting of any funding available to support the next phase.

The evaluation focus was deliberately formative, rather than summative, with the evaluation team expected to contribute a detailed understanding of processes and to work collaboratively and developmentally with key *Choose Life* actors (nationally and locally).

Structure of the report

Part one of the report provides background contextual information, covering: suicide trends in Scotland, the cost of suicide, the Scottish Executive policy response and the *Choose Life* strategy (chapter one); the aims and objectives of the study (chapter two); and the study methodology (chapter three).

The main research findings and commentary can be found in part two. Chapter four considers the development of national and local infrastructures to support suicide prevention. Chapter five covers the allocation of *Choose Life* funding both nationally and locally and provides a number of different breakdowns on how these resources have been used. Chapter six illustrates innovative practice underway in local areas, providing examples of relevant community, voluntary and self-help activities and describing how funding has been used for innovative ways of working. Chapter seven explores the progress towards, and prospects for, sustainability during phase two of *Choose Life* (and beyond), at both national and local levels. Chapter eight considers the different stages of decision making for *Choose Life* and provides an outline and discussion of the learning resources used at each stage. Chapter nine reports on local coordinators' level of satisfaction with progress towards national milestones and their self-assessment of performance for each of the local milestones.

The conclusions of the study and recommendations arising from the study findings are set out in part three (chapters ten and eleven, respectively).

There are three annexes: annex 1 reviews national suicide prevention strategies across the world; annex 2 considers the economic costs of suicide in Scotland in 2004; and annex 3 assesses practical and methodological challenges associated with assessing the cost-effectiveness of area-based suicide prevention strategies.

Methods
The overall approach taken to the evaluation was theory-based, with particular use being made of Theories of Change (ToC), in which the evaluator, in conjunction with key stakeholders, seeks to identify prospectively the underlying rationale or 'theory' of the planned programme. Different models of how best to implement a suicide prevention programme were explored at both national and local levels, with a particular focus on *why* particular actions and activities were anticipated to lead to *which* kinds of goals.

Research methods used in the course of the study included electronic surveys of local coordinators, qualitative interviews with key informants at national level, workshops with local coordinators and national informants, observation and documentary analysis.

Main findings and conclusions

Sustainable infrastructures for implementation
At a national level, the NIST has played a pivotal role in working towards the mainstreaming of suicide prevention activity within the wider Scottish Executive policy arena. Despite a lengthy process to establish the team, NIST has made demonstrable progress and built momentum in relation to all its key functions, while also recognising the need to be increasingly strategic. There are challenges ahead for NIST, including: building clinical involvement and engagement at national and local levels; and facilitating local capacity building in key areas of identified weakness, e.g. monitoring and evaluation.

CPPs have been the best available mechanism to take forward local planning, coordination and implementation of *Choose Life* objectives, in view of the importance attached to local, cross-sectoral ownership of, and grass roots engagement in, suicide prevention activities. Progress has been made in encouraging the adoption of suicide prevention objectives in a range of local policies and service plans and *Choose Life* partnerships have generally sought proactively to achieve this, by building links with key partners, seeking engagement with key decision makers locally and linking into other relevant policy priorities. This has proved to be a gradual process that requires time and concerted effort. It cannot be said that, as yet, *Choose Life* had been mainstreamed, although it is making progress in that direction.

However, the variability in the maturity of local CPPs has had a critical influence on *Choose Life* progress at local level. CPPs have been less effective in engaging with clinical services and planning structures (both primary and secondary health care, in particular drug and alcohol services and mental health services).

It is important to consider the focus of activity required at national level for the future stages of implementation, to make use of resources of all national players, recognising what it is that NIST is uniquely placed to do and what contributions can be made by other agencies. The evaluation suggests that progress towards *Choose Life* objectives is predicated on effective activity at national level in respect of:

- Policy advocacy within the Scottish Executive and with other relevant national bodies
- Raising awareness and influencing those who shape opinions
- Promoting engagement and facilitating dialogue
- Coordination across boundaries, acting as catalyst
- Performance management to track and oversee progress
- Building capacity, in particular to use and generate evidence.

Various models of local coordination had been developed and subjected to refinement as local work progressed. A dedicated (full-time) coordination post tended to be preferred. However, the evaluation has not been able to provide conclusive evidence that this model is more, or less, effective than alternatives.

Allocation and use of resources

In the first phase of *Choose Life*, CPPs attracted substantial additional investment in suicide prevention activities at local level (£1.6m), and there has also been a substantial level of in-kind contribution. On the other hand, not all areas have been equally successful in raising additional monetary funding and a high degree of variability is evident among local areas in terms in the way resources are allocated to the key functions of coordination, training and support for voluntary and community sector, priority groups, and specific activities and interventions.

There are grounds to conclude that there is a degree of unnecessary duplication of effort at the local level: a greater effort to undertake some work on a collaborative basis would ensure that best use is made of common approaches and effective tools and resources. Steps towards building collaborative models of development are already in evidence.

Overall, the evidence would suggest that the emphasis to date has been on gaining local engagement with *Choose Life* and on supporting local initiatives that facilitate such engagement. The broad range of priorities set in the *Choose Life* strategy allowed local areas a high degree of latitude to determine their local focus. It may be that, in future stages of implementation, more attention needs to be directed towards considerations of equity on at least two counts: to take account of what is known about relative importance of particular risk and protective factors in determining suicidal behaviour; and to ensure that interventions are targeting inequalities and focusing on how to reach those for whom support is currently least accessible.

Seeking to make resources and responses more accessible and acceptable to certain groups who tend to be deemed ‘hard to reach’ will have implications for the types of interventions offered and methods and mechanisms of delivery, as well as for the partners who need to be involved.

From an economics perspective, under the evaluation team’s baseline assumptions, the *Choose Life* would become cost saving if five additional lives per annum were saved. This suggests that investing in the strategy represents value for money. However, only when evidence of the effectiveness of individual initiatives is available will it be possible to claim definitively that investing in *Choose Life* represents value for money.

Choose Life has stimulated a considerable amount of activity relating to self-harm, but the findings suggest the need for further consideration by NIST about how to integrate action on self-harm into the wider suicide prevention strategy.

Innovative practice and the use of evidence
Twenty-one local areas provided examples of locally defined innovative community and voluntary practice. Activities covered prevention/promotion, intervening/ supporting vulnerable groups, developing new partnerships better to support those at risk, and improving the capacity of those working with vulnerable groups. Almost all areas that provided examples of community and voluntary initiatives reported that they had achieved what they set out to do or exceeded this.

Fifteen local areas provided specific examples of self-help activities. In four areas, links were established with the local Doing Well by People with Depression project. Group support was a common approach and included mental health service user-led support groups; groups in arts, drama, poetry and writing; and support for those who had experienced childhood sexual abuse. Supporting the development of self-help initiatives tended to be regarded as means to add value to existing interventions and services. Developments were often initiated in response to local need or demand.

The process of setting up community, voluntary and self-help initiatives generated important learning points, including: the importance of bringing agencies together at an earlier stage to decide on priorities; allowing time for needs assessment before commissioning in order to establish requirements for a service prior to funding; the value of proactive engagement with national/established organisations; and the need to support the infrastructure of self-help groups and budget for unanticipated costs associated with this.

Coordinators reported that good progress had been made in respect of innovative partnership working. Partnerships with and between voluntary organisations continued to be seen to reap benefits. Improved partnership working within local authorities and across the neighbourhood authority was commonly highlighted as a factor contributing to success. Some areas pointed to an improved ability to impact on vulnerable risk groups through the development of new ways of working.

There was limited progress at local level in generating evidence of impact. Multiple sources of information and types of evidence, including research, were used to inform local planning and activity. However, research was rarely used systematically. There remains an absence of accessible, robust, definitive evidence of effectiveness.

Sustainability
NIST identified a number of achievements in building a sustainable infrastructure for suicide prevention. Several mechanisms and activities are now in place to encourage and support the exchange and dissemination of information, including the *Choose Life* website, NIST summits held annually and the resource database. NIST has worked in partnership with other elements of the National Programme, such as *Breathing Space*, *HeadsUpScotland* and *see me,* to promote activities. The Suicide Information, Research and Evidence Network (SIREN) is intended to improve access to research. NIST has established a national resource to oversee development and integration of training. The main programme used to date, Applied Suicide Intervention Skills

Training (ASIST), is seen nationally as a vehicle for raising awareness, building longer term capacity, and widening ownership of suicide prevention beyond professional health specialists.

National networks and alliances have developed with solid foundations and there are appropriate mechanisms on which to build in phase two. However, NIST is aware that the infrastructure is still fragile and that it will take time to mature. The challenge of generating local investment in suicide prevention was highlighted as a key issue that required on-going national attention and support. In line with this, the issue of sustainability and mainstreaming was emphasised as a key action in the national guidance issued to local areas for phase two of *Choose Life*.

At the local level, most success has been achieved in mainstreaming training activities (particularly ASIST) (18 areas). Considerable potential was seen for training as a sustainable resource that would benefit the broader community by building capacity and strengthening existing skills and knowledge, thus reducing reliance on specialised professionals. At least 27 local projects have been earmarked for mainstreaming, covering:

- Children and young people
- People who have been bereaved, including those bereaved by suicide
- People with mental health problems.

Suicide prevention has most commonly been incorporated in Joint Health Improvement Plans and Community Plans. Suicide prevention is also included in Regeneration Plans/Regeneration Outcome Agreements, Domestic Abuse Strategy, Alcohol Action Plan, Children's Services Plan, NHS Director of Public Health Annual Reports and mental well-being and improvement strategies. Inclusion of *Choose Life* in local policies was thought to support mainstreaming of suicide prevention.

With respect to future plans for mainstreaming *Choose Life* activities, the need to raise the profile of *Choose Life* with strategic (particularly Community Planning) partners was highlighted. It was felt that work was needed to generate a broader multi-disciplinary approach to achieve longer term sustainability (rather than mainstreaming of individual projects and activities).

Decision making processes and learning

Local stakeholder consultation was a key approach used across local areas in order to set priorities for implementation. Around half of the local areas stated that some form of needs assessment was undertaken to identify local priorities in terms of risk groups and gaps in local services and/or to inform overall planning. Practitioner/professional led approaches were highlighted as a key resource in decision making about interventions. There appeared to be infrequent use of international research evidence in order to aid decision making about interventions. Some local areas were keen to generate innovative approaches to suicide prevention and this affected the approach taken to decision making. Local knowledge could also inform the development of interventions. It was believed that, if the intervention was developed in response to locally defined needs, it would be more likely to gain acceptance from the local community in which it operated.

A key challenge acknowledged both locally and nationally was the short timescale in which to develop the first action plan (December 2003). It is evident that plans in local areas reflected a broad set of priorities that were then refined in the implementation stage. Where initial planning had stayed primarily within the confines of the *Choose Life* partnership (without wider consultation) some stakeholders expressed unease about the transparency of the decision making process.

The implementation stage resulted in the design of new processes to share learning and knowledge. Sharing between local areas, e.g. at national events or though regional networks, led to instances of learning and uptake of training across different areas. National support for learning has been delivered through several channels, including: NIST hands-on support to local areas, commissioning research reviews, developing a web-based resource database of relevant resources/materials, establishing SIREN and commissioning an independent national evaluation of the first phase of *Choose Life.*

With regard to future planning, NIST has highlighted a strong commitment to, and emphasised the importance of, evaluation. However, as a result of the lengthy process which had to be undertaken to establish NIST, and limited capacity within the team, a national framework for evaluation remains to be completed. In local areas different levels of priority and attention have been attached to evaluation. Challenges in evaluating local action plans were identified by both local and national informants, particularly in understanding how effectiveness of interventions should be evaluated. A lack of capacity locally to develop evaluation was also noted.

Perceived progress towards milestones
Local coordinators were more satisfied than dissatisfied with national action on 12 of 13 milestones. Coordinators were most satisfied with action on publishing guidelines for the media; with education and awareness raising; and supporting, disseminating and developing national and local indicators, figures and trends on suicide and deliberate self-harm. Most coordinators reported some level of implementation action in relation to 10 of the 12 local milestones. The most reported progress has been made with establishing local action plans to implement *Choose Life;* and developing and implementing local training programmes in line with national and local strategy and plans.

Recommendations

Future investment in suicide prevention
Any future economic evaluation of the *Choose Life* strategy would almost certainly be one of the first (if not the first) evaluations worldwide to be undertaken of a national strategy. In addition to issues of outcome measurement, it will be critical to collect data on the cost and uptake of different components of a suicide prevention strategy. This should include measurement of all in-kind resources, including the contribution of volunteers.

Immediate decisions about the allocation of funding for *Choose Life* in phase two have to be based, therefore, on what is required in terms of the further development and maintenance of national and local infrastructures so as to maximise successful progress towards the key strategic target (20% reduction in suicide). We have not

collected any evidence to suggest that radical changes should be made in the current allocation to local partnerships. Consideration might be given to an increase in funds to the national coordinating body, since current capacity means that development of existing and new partnerships is not being maximised. This has a potential impact on future sustainability.

Sustainability
Key steps at national level to promote mainstreaming in the next stages of *Choose Life* implementation might encompass the following:

- Using opportunities presented by recent developments in national health and social care policy to demonstrate the relevance of *Choose Life* to overarching policy goals
- Involving clinical services in population-based suicide prevention activities
- Strengthening the engagement of national bodies
- Harnessing the energies and skills of national voluntary sector organisations in awareness raising and campaigning
- Promoting the incorporation of *Choose Life* objectives and priorities into other national and local policy streams and initiatives as an ongoing priority
- Purposive innovation to test out, evaluate, learn and implement, with a view to building knowledge and enhancing capacity to work towards key objectives and priorities.

At local level, key steps to promote mainstreaming of *Choose Life* activities might include:

- Using intelligence from a range of sources, including needs assessment, research evidence on risk and protective factors, local evaluations and service reviews as tools in planning for sustainability
- Building in mechanisms to track and review progress towards objectives across policy areas.

Targeting of action
There should be more focused targeting of action in order to maximise the value of the ring-fenced *Choose Life* investment. Issues to be taken into consideration include:

- The need to avoid unnecessary duplication of effort at local level
- The importance of intervention by the national coordinating body where key suicide prevention actions are not taken at the local level (e.g. failure to integrate substance misuse treatment services into delivery plans)
- A more 'experimental' approach to assessing the merit and worth of local suicide prevention interventions should be adopted
- The need to distinguish between what is best done at local level and what is best done at national level. The national coordinating body should engage in a dialogue with national partners and local areas in order to reach consensus on the appropriate division of responsibility
- The achievement of a balance between the application of 'established' suicide prevention interventions and innovative practice

- The importance of assessing local priorities and taking these into account in local action plans, even if the priorities differ from those identified at national level.
- The need to reinforce the equity focus of current priorities. In particular, socio-economic deprivation and low socio-economic status, which are known to be highly associated with the incidence of suicidal behaviour, should be given more prominence
- The need to ensure the adoption of an evidence-based approach at all levels.

Strategic integration of self-harm
In phase two, more consideration should be given to the integration of self-harm into *Choose Life*. We recommend that the strategy continues to encompass the high risk end of self-harm, but note several issues that need to be addressed.

- The national coordinating body needs to provide guidance about how to identify and reach the subgroup of people whose self-harming behaviour puts them at high risk of future suicide.
- The less 'serious' component of self-harm cannot be ignored, even if it is not included in the scope of *Choose Life*. In particular, the Scottish Executive/NHS Scotland should ensure that health and social care professionals in Scotland adopt the NICE guidelines on the treatment of self-harm (NICE, 2004)
- If self-harm remains a focus of *Choose Life*, there should be guidance about how incidence is to be measured and what target for its reduction is to be set.

The role of the Community Planning Partnership
The limitations of the community planning partnership (CPP) as the key *Choose Life* coordinating body at local level need to be recognised. In particular, CPPs have been less effective in engaging proactively with clinical services and planning structures (both primary and secondary health care, in particular drug and alcohol services and mental health services).

- CPPs need to review progress and examine the partners and partnerships that have yet to be put in place in order to achieve their CL objectives. Priority should be given to establishing effective links with clinical and drug/alcohol services where these are found to be absent or inadequately developed.
- In order to counterbalance the limitations of using CPP mechanisms, the Scottish Executive might adopt a more directive approach in relation to key priorities, using other policy implementation mechanisms to ensure engagement of key partners in clinical services and following through the proposed integration of clinical perspectives within national *Choose Life* support capacity.
- Despite the above, the CPP remains the most appropriate vehicle for developing strategy and overseeing delivery in relation to *Choose Life* at the local level. However, NIST, on behalf of the National Programme, should continue to work closely with CPPs in order to ensure that *Choose Life* budgets are fully spent on suicide prevention activities, reducing the risk of claw back of unspent allocations by parent local authorities.

- The coordination function is crucial, but that does not necessarily imply that there has to be a dedicated coordinator post. The task of the CPP is to devise the most appropriate arrangement for delivering the function.

Options for delivering the national coordination function

Some type of central coordination body will continue to be required (at least in the immediate future) to provide national oversight/guidance, assess and support performance and ensure accountability at local level, promote learning/review/reflection and effective knowledge transfer, and coordinate action, i.e. act as the 'glue' that holds together the various *Choose Life* elements, nationally and locally. While we recommend the continuation of a central coordinating function, we propose a review of how this is delivered and where it is situated. The ideal location would maximise mainstreaming opportunities and promote an integrated approach to suicide prevention, incorporating both general population health improvement (public health) and risk group (e.g. clinical services) perspectives.

***Choose Life*: a ground-breaking approach**

Although there are many similarities between *Choose Life* and other national suicide prevention strategies, Scotland's approach is distinctive in several respects. *Choose Life* forms one element of the Scottish Executive's National Programme for Improving Mental Health and Well-being, which was established as a key driver of the commitment to improve health, tackle health inequalities and achieve social justice in Scotland. The location of *Choose Life* within the Scottish Executive ensures that suicide prevention work is undertaken within a wider framework of policy objectives and initiatives that share the overarching goals of population mental health improvement. *Choose Life* sets out a clear approach and plan for implementation, which includes dedicated national capacity to support and coordinate implementation, underpinned by an earmarked national and local budgetary allocation.

Scotland has also been committed from the beginning to reviewing progress and taking forward learning. This formative evaluation has been a key part of the process. By reviewing the situation after three years, Scotland should have a clearer picture about the strengths and limitations of the unfolding strategic approach and what the next steps should be. The methodology and findings of the evaluation are also intended to contribute to international understanding and knowledge about effective national suicide prevention (at both strategic and operational levels).

ABBREVIATIONS

A&E	Accident and Emergency
ADAT	Alcohol and Drug Action Team
ASIST	Applied Suicide Intervention Skills Training
CCI	Centre for Change and Innovation
CL	*Choose Life*
DSH	Deliberate self-harm
DWBPWD	Doing Well by People With Depression
CPP	Community Planning Partnership
GROS	General Register Office for Scotland
HDASD	Health Department Analytical Services Division
ISD	Information Services Division
JHIP	Joint Health Improvement Plan
LA	Local authority
LGBT	Lesbian, gay, bisexual and transgender people
MHFA	Mental Health First Aid
National Programme	National Programme for Improving Mental Health and Well-being
NIST	National Implementation Support Team
NICE	National Institute for Clinical Excellence
NUJ	National Union of Journalists
RUHBC	Research Unit in Health, Behaviour and Change
RCP	Royal College of Psychiatrists
SAMH	Scottish Association for Mental Health
SDC	Scottish Development Centre for Mental Health
SE	Scottish Executive
SPHO	Scottish Public Health Observatory
SIREN	Suicide Information Research and Evidence Network
SPS	Scottish Prison Service
STORM	Skills-based Training on Risk Management
UN	United Nations
WHO	World Health Organization

PART ONE INTRODUCTION, AIMS, OBJECTIVES AND METHODOLOGY

CHAPTER ONE INTRODUCTION

1.1 Suicide in Scotland: international comparison and temporal trends

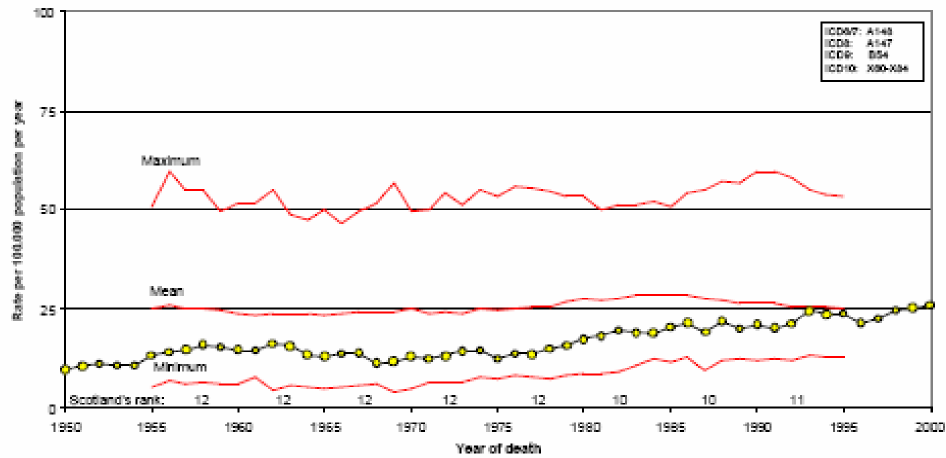
Over the past 50 years suicide incidence in Scotland has not been exceptionally high by international standards. In the mid-1990s the male suicide rate (defined as intentional self-harm only, i.e. excluding 'undetermined' deaths) was about the average for 17 Western European countries[1], while the female suicide rate was below the average for these same countries. Figures 1.1 and 1.2 illustrate Scotland's suicide incidence (illustrated by a line with markers for each year) in the context of minimum, maximum and average rates for these 17 countries over the period 1950-2000, among men (figure 1.1) and women (figure 1.2) aged 15-74 years.

Nevertheless, there had been a pronounced and dramatic increase in suicide among men in Scotland, with the rate more than doubling over the last 30 years (while the trend among women has been downwards over the same period) (see figure 1.3). The sharp drop in male suicide in 2003 should, therefore, be noted with considerable interest. Although there was an increase in 2004, the crude male suicide rate was still below the 2002 peak (in fact, at its lowest level since 1996). Whether or not the 2002 peak turns out to be a turning point in suicide incidence among men in Scotland will not be known for several years.

In both sexes there has been a dramatic shift over time in the age-related pattern of suicide, with younger age groups now showing the highest risk (figures 1.4 and 1.5). Among young-mid aged adults suicide constitutes a far more significant cause of death than was previously the case. Male suicide rates have approximately tripled in the 15-34 year age groups. While suicide incidence is considerably lower among women, there has been a marked increase in rates among 15-24 year olds (by over 200%). Compared to England & Wales, suicide rates in Scotland are now about twice as high among all adults aged 15+ years, with an even more pronounced risk in the 15-24 age group.

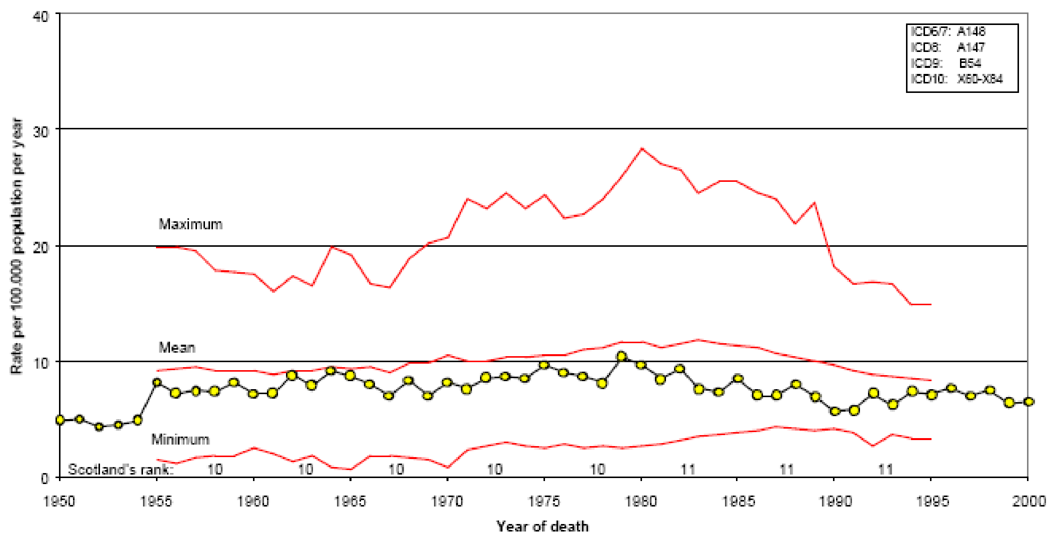
[1] The 17 countries are: Austria, Belgium, Denmark, England & Wales, Finland, France, Germany, Ireland, Italy, Northern Ireland, Netherlands, Norway, Portugal, Scotland, Spain, Sweden and Switzerland.

Figure 1.1 Suicide mortality age standardised rates among men aged 15-74 years, 1950-2000, Scotland and 16 other Western European countries



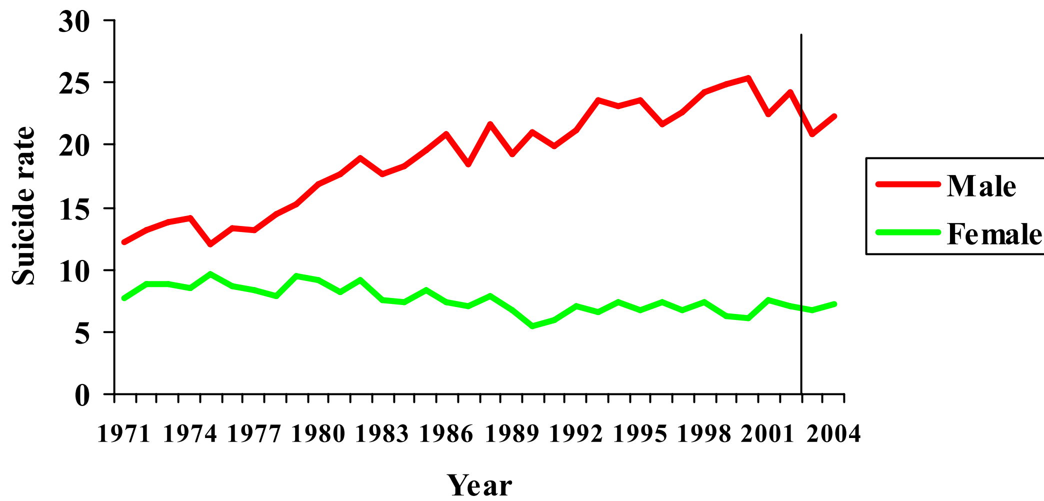
Source: Leon et al (2003).

Figure 1.2 Suicide mortality age standardised rates among women aged 15-74 years, 1950-2000, Scotland and 16 other Western European countries



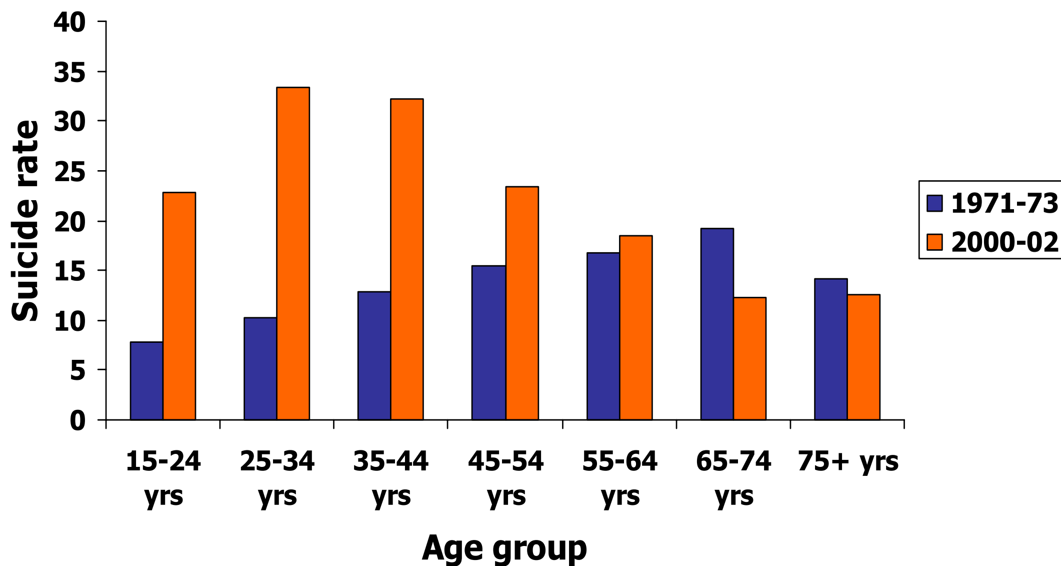
Source: Leon et al (2003).

Figure 1.3 Crude suicide rates per 100,000 aged 15+ years, Scotland, 1971-2004



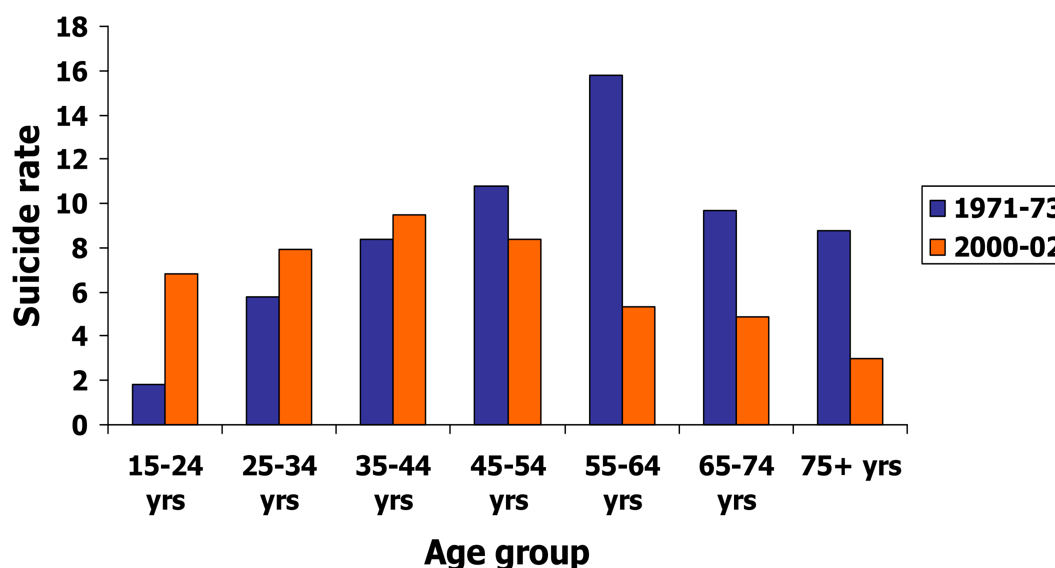
Source: General Register Office (Scotland)

Figure 1.4 Crude suicide rates per 100,000 by age group, males, Scotland, 1971-3 and 2000-02



Source: General Register Office (Scotland)

Figure 1.5 Crude suicide rates per 100,000 by age group, females, Scotland, 1971-3 and 2000-2002



Source: General Register Office (Scotland)

1.2 The cost of suicide

The impact of suicide can be immense. The cost of suicide falls on everyone in society and can be substantial. Most obviously there are *direct costs* arising from demands placed on the emergency services, potential life saving interventions to be delivered within the health care system, investigations to be carried out by the police and coroner, and of course costs associated with funerals. For those individuals who survive suicide attempts, lengthy physical and psychological rehabilitation may follow.

There are also what economists call *indirect costs*. As a result of premature death, individuals lose the opportunity to contribute productively to the national economy, whether this be through paid work, voluntary activities, or family responsibilities such as looking after one's children or parents. The most fundamental impact of all, of course, is the loss of the opportunity to experience all that life holds as a result of suicide. The pain and grief that suicide can have on immediate family members and friends can be immense and long lasting. These very personal impacts are known by economists as '*intangible costs*' because they are often hidden and difficult to value.

As part of this study, an estimate has been made of the costs of suicide in Scotland, informed by a review of previous studies worldwide (annex 1). This review indicated that few international studies have estimated the costs of suicide. Costs here have been converted to £ sterling and use 2005 prices. Available estimates include one from the Canadian province of New Brunswick where the average direct and indirect costs of each suicide in 1996 were estimated to be £443, 076 (CAN$1,019, 210) (Clayton and Barceló, 2000). In New Zealand another estimate from 2002 including intangible costs was £1,158,768 (NZ$ 3,094, 243) (O'Dea & Tucker, 2005). In

Ireland, using a similar methodology, costs in 2002 were estimated to (£1,402, 438 (€1,982,667) per suicide. (Kennelly et al, 2005)

1.2.1 Cost of suicide in Scotland

We have undertaken an incidence-based costing study – that is, we have estimated the total lost lifetime costs for all suicides in Scotland that occurred in one year, 2004. The results are shown in table 1.1. (The methodology and detailed results, broken down by age and gender, are available in annex 2.) In total these costs are estimated to be £1.08 billion, with 75% of the estimated costs accounted for by male suicides. This represents an average cost of £1.29 million per completed suicide and is similar to estimates produced using comparable methods in Ireland and New Zealand. The estimate is conservative as it does not take account of additional suicide attempts that did not result in death. It is important to note our assumption that those who complete suicide are as productive as the general population, but only 97.5% as likely as the general population to be in employment.

By far the largest single component of the total costs of suicide (more than 70%) are the intangible human costs experienced by families; indirect lost productivity costs account for 21% of the total costs. For both men and women, these productivity costs are highest for those aged 35-44 years at the time of death. Given these high costs, there are substantial potential economic benefits if the number of suicides can be reduced. Every 1% reduction in the number of suicides could avoid costs of up to £10.7 million over the lifetimes of these individuals. These figures are also broadly in line with the value of a life saved used by the Department of Transport in England.

Table 1.1 Total costs (£sterling) of completed suicides in Scotland in 2004*

Type of Cost	Men (n=609) £	Women (n=226) £	Total (n=835) £
Lost waged output	201,415,422	30,875,011	232,290,433
Lost non-waged output	36,633,297	29,728,443	66,361,740
Intangible human costs	564,396,632	209,447,683	773,844,314
Direct costs	5,663,012	1,441,714	7,104,726
Total	**808,108,363**	**271,492,850**	**1,079,601,213**

** 2005 prices used*

1.3 The policy response

There was a rather muted policy response to the adverse trends in suicide rates among young adult males until 1999. In November that year the Centre for Theology and Public Issues at the University of Edinburgh organised a major conference, 'The Sorrows of Young Men'. The intention of the conference was to raise awareness among policy makers and practitioners about suicide in Scotland, particularly recent trends among young to mid-aged adult men, and to explore possible future directions for practice, policy and research. A year later the proceedings of the conference were published (Morton and Francis, 2000). At the time of the original conference and on publication of the proceedings there was a considerable amount of mass media interest, indicating the extent to which suicide was considered to be a priority public health and public policy issue. The Scottish Parliament also signalled its concern during a debate held in April 2000, during which the then Deputy Minister for

Community Care articulated the Scottish Executive's determination to "tackle [the issue] through both general and specific measures that are informed – as is appropriate – by the available research" (Scottish Parliament, 2000).

The start of the formal developmental process, guided by the Scottish Executive and intended to lead to the publication of a national framework for suicide prevention, began in November 2000 with a consultative seminar, and continued through 2001, during which a second consultative seminar took place (May 2001). The seminars were attended by over 200 people from a wide range of backgrounds, including health and social care professionals, service providers (from both statutory and voluntary sectors), mental health service users, suicide 'survivors' (family members and others directly affected by suicide), and others with an interest in suicide prevention. Participants fully endorsed the plan to develop a national strategic approach to suicide prevention, highlighting the importance of the goal of reversing the suicide trend in Scotland but also supporting a broader, integrated approach to tackling the determinants of mental health and well-being in its widest sense.

Following the first consultative seminar, a National Planning Group was established to advise on the development of the draft suicide prevention framework. Members came from statutory services, the local government sector, voluntary and user representative groups, and the research community. Drawing on the presentations, discussions and recommendations arising out of the consultative seminars, the National Planning Group prepared a draft 'Framework for the Prevention of Suicide and Deliberate Self-harm' which was issued for formal consultation from October 2001 to January 2002 (Scottish Executive, 2001). A detailed analysis of the 140 written responses to the consultation was undertaken by Scottish Health Feedback (an independent research consultancy) on behalf of the Scottish Executive and published in July 2002 (Scottish Executive Central Research Unit 2002). In a separate, but linked, process, the Scottish Development Centre for Mental Health (SDC) was commissioned by the Scottish Executive to undertake two projects: 'Exploring Experience', a series of discussions with the media about the reporting of suicide and with groups and services affected by suicide and self-harm; and 'Laying the Foundations: Identifying Practice Examples', a compilation of work carried out by statutory and voluntary agencies with those at risk of suicide and self-harm. Reports based on the two SDC projects were published with the main consultation report (Scottish Executive Health Department, 2002a and 2002b)

1.4 *Choose Life*

Choose Life (Scottish Executive 2002), the national strategy and action plan to prevent suicide in Scotland, was launched in December 2002. The Scottish Executive had established an overall commitment to improving health of the people of Scotland and in shifting the emphasis away from ill health to one that focused more significantly upon prevention and health improvement (Scottish Office 1999, Scottish Executive 2000, Scottish Executive 2003). This commitment was aligned with the Executive's strategies for promoting social justice with a particular focus on tackling health inequalities as the 'overarching aim' of the health improvement agenda (Scottish Executive 2003).

The National Programme for Improving Mental Health and Well-being was established as a key driver of the Scottish Executive's commitment to improve health and achieve social justice. *Choose Life* was launched as a major strand of the National Programme's contribution towards achieving these twin aims of improving the overall health improvement and in reducing inequalities (box 1.1)

The *Choose Life* plan is being implemented in phases, with an initial phase of three years (April 2003 to March 2006). A budget of £12 million was allocated by the Scottish Executive over this period to suicide prevention activities. Of this £3 million was allocated to national activities and the remaining £9 million to local area partnerships for suicide prevention work. A further £8.4 million is being invested nationally and locally over the period 2006-2008. Although it has not been possible to 'ring-fence' *Choose Life* funds at the local level, since they are absorbed into local authority budgets, there has been a clear expectation that this funding should be allocated to support local suicide prevention work.

Box 1.1 National Programme for Improving Mental Health and Well-being[2]

Key aims

- Raising awareness and promoting good mental health and well-being
- Eliminating stigma and discrimination
- Preventing suicide
- Promoting support and recovery.

Priorities

- Infant mental health (early years)
- Childhood and young people
- Employment and working life
- Later life
- Community mental health and well-being
- Mental health promotion and prevention in local services.

Main strands

- Implementation of Mental Health First Aid (MHFA) project
- Development of national framework and training strategy for suicide intervention and prevention
- Communications, including sustained press and public relations programme
- Anti-stigma campaign ('*see me*') using mass media advertising
- Suicide prevention strategy and action plan (*Choose Life*)
- Telephone advice line targeted at men suffering from depression ('*Breathing Space*')
- Supporting the Scottish Recovery Network (promoting recovery for people affected by long-term serious mental health problems)
- Development of core set of public mental health indicators (including suicidal behaviour)

[2] http://www.wellscotland.info/mentalhealth/national-programme.html

The guiding principles, overall aim, objectives, priority groups and implications for national/local implementation relating to *Choose Life* are set out in box 1.2. The strategic approach recognises the importance of investing in partnership working, the need for effective leadership and the value of combining targeted intervention (reducing suicide risk in especially vulnerable groups) with a broader, public health perspective (reducing the risk conditions, e.g. high unemployment, which create more vulnerability in the population).

Box 1.2 *Choose Life*: principles, aim, objectives and priority groups

Guiding principles

- Shared responsibility (across Scottish Executive departments, sectors, agencies and organisational boundaries)
- Effective leadership (nationally and locally)
- Taking a person-centred approach (recognising variation in individuals' experiences, often associated with key life stages)
- Focus on priority approach (without losing sight of the broader needs of society as a whole)
- Continuous quality improvement (drawing on, and developing, better information and evidence of what works)

Overall aim

To reduce the rate of suicide in Scotland by 20% by 2013

Main objectives

- Early prevention and intervention
- Responding to immediate crisis
- Longer-term work to provide hope and support recovery
- Coping with suicidal behaviour and completed suicide
- Promoting greater public awareness and encouraging people to seek help early
- Supporting the media
- Knowing what works

Priority groups

- Children (especially looked after children)
- Young people (especially young men)
- People with mental health problems (particularly service users and people with severe mental illness)
- People who attempt suicide
- People affected by the aftermath of suicidal behaviour
- People who abuse substances
- People in prison
- People who are recently bereaved
- People who have recently lost employment or who have been unemployed for a period of time
- People in isolated or rural communities
- People who are homeless

Table 1.2 provides a timeline of key national and local events relating to *Choose Life*, from its launch in December 2002 to the end of phase 1 in March 2006.

Table 1.2 *Choose Life* timeline

NATIONAL EVENTS	LOCAL EVENTS	*DATE MM/YY*
Launch of *Choose Life*		*Dec 2002*
	Funding announced for local areas	*Apr 2003*
Choose Life guidance issued to Local authorities for Community Planning Partnerships to decide on allocation of resources	Local planning initiated	*July 2003*
1st *Choose Life* summit involving key partner agencies in potential delivery of national and local action plans		*Nov 2003*
	Local action plans submitted	*Dec 2003*
Head of Implementation in post		*Jan 2004*
Suicide and Suicidal Behaviour: Establishing the Territory for a Series of Research Reviews commissioned		*Jan 2004*
1st pilot intervention training of trainers programme introduced to Scotland		*Mar 2004*
	Individuals with key responsibility for local plans met and discussed objectives with Head of Implementation	*May 2004*
	1st full-time *Choose Life* Coordinator appointed	*May 2004*
Regional meetings involving all coordinators in decision making on national and local awareness raising materials and branding materials (3 meetings across Scotland)		*June 2004*
Launch of NUJ Guidelines on reporting mental health and suicide		*July 2004*
National Advisory Board – Prison to progress prison work agreed		*July 2004*
National Operations Manager in post	Monitoring implementation of action plans & finance commenced	*Aug 2004*
1st national meeting of trainers to review learning and exchange good practice		*Aug 2004*
Business Support Officer in post		*Aug 2004*
National evaluation commissioned		*Sept 2004*
ISPAW International Suicide Prevention Awareness Week introduced to Scotland	Local Activity across Scotland to support ISPAW	*Sept 2004*
1st Parliamentary motion on suicide prevention strategy in new Scottish parliament building		*Sept 2004*
National Information Manager in post		*Oct 2004*
Suicide and Suicidal Behaviour: Establishing the Territory for a Series of Research Reviews published		*Oct 2004*
Commencement of collation of information from electronic local action plan templates - to help feed into proposed Management Information System		*Nov 2004*

NATIONAL EVENTS	LOCAL EVENTS	*DATE MM/YY*
National partnership work with Samaritans agreed and suicide prevention post for Samaritans activated	Commencement of links with *Choose Life* coordinators -	*Nov 2004*
2nd *Choose Life* summit		*Dec 2004*
Training Coordinator in post	Commencement of links to local *Choose Life* coordinators and trainers	*Jan 2005*
National Stakeholder consultation meeting		*Feb 2005*
National partnership work with ChildLine agreed and coordinators appointed	Commencement of links to local *Choose Life* coordinators and trainers	*Mar 2005*
Training and Development manager in post		*May 2005*
Consultation to identify data needs of stakeholders		*Jun 2005*
Launch of Suicide Information, Research and Evidence Network (SIREN)		*Jun 2005*
Launch of *Choose Life* website following needs assessment at summit . All of the following and more , now available to the public:- ▪ Information on local action plans ▪ Data on suicide trends and statistics ▪ Support booklet for bereaved families / friends ▪ Information on research ▪ Information on training ▪ Media reporting guidelines ▪ Resource database Management Information for monitoring local action plans and expenditure built in behind web	Information gathered from local areas	*Sept 2005*
Scottish epidemiology study commissioned		*Sept 2005*
Marketing & Communication Manager in post	Commencement of links to local coordinators	*Oct 2005*
Review of effective interventions commissioned		*Nov 2005*
Choose Life guidance for phase 2 issued	Dissemination to CPP	*Dec 2005*
3rd *Choose Life* summit		*Feb 2006*
End of phase one of *Choose Life*		March 2006

1.4.1 National and local infrastructures established to support implementation

Choose Life identifies the main actions that are required at both national and local levels. Broadly speaking, the responsibility of national actors (e.g. the Scottish Executive and national agencies) is to set out the strategic view, give guidance and provide support (especially, but not exclusively, financial), while local actors (e.g. health sector, local government, voluntary organisations) are tasked with developing and implementing local plans for suicide prevention.

National Implementation Support Team (NIST)
In comparison to other national strategies, Scotland is well placed in having a designated national team to coordinate and support development and implementation.

The National Implementation Support Team (NIST) is led by the national head of implementation who came into post in January 2004 (see *Choose Life* timeline, table 1.2). The team reports to the National Programme for Improving Mental Health and Well-being, which sits within the Mental Health Division of the Scottish Executive Health Department. NIST's core functions include information; operations; training and development; and marketing & communications (see figure 1.6).

NIST's role, as outlined in the strategy and action plan 2002, is to:

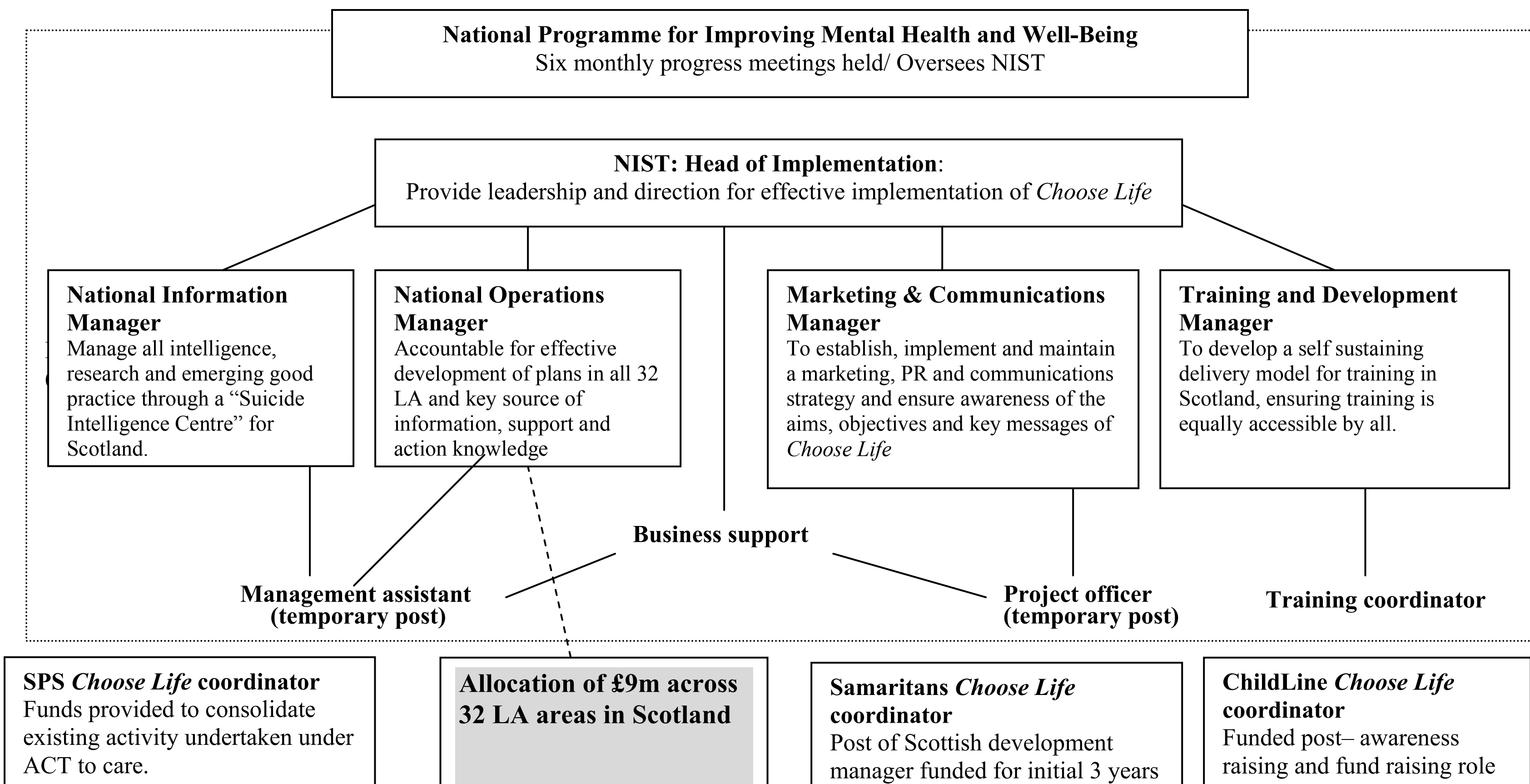
- establish and support a national *Support and Learning Network* involving local agencies
- collect and disseminate information on practice, evidence and research findings and training programmes
- support the development of a national data set of indicators, figures and trends on suicidal behaviour and completed suicide
- support the commissioning of additional research work on suicidal behaviour; and commission a detailed independent evaluation of the national strategy and action plan to report by March 2006.

National Choose Life coordinators

Additionally, three national organisations were funded by *Choose Life* to appoint national coordinators: Scottish Prison Service (SPS), ChildLine and the Samaritans. The remits of these posts vary according to each organisation and include developmental work, fundraising and awareness raising (see figure 1.6).

SPS's budget was intended to consolidate work in progress which contributed to the organisation's existing suicide prevention strategy (ACT). A series of local SPS initiatives, which are overseen by the SPS *Choose Life* coordinator, has also been funded.

Figure 1.6 National infrastructures for *Choose Life* (March 2006)



Local infrastructures to support implementation
At a local level, key objectives of *Choose Life* were implemented through suicide prevention action plans, agreed and supported by community planning partnerships (CPPs). It was anticipated nationally that CPPs, which operate in all 32 local authority areas with a range of partners, would be the most appropriate structure to coordinate and maximise opportunities for joint working, shared responsibility and sustainability of suicide prevention work.

Community planning was given a statutory basis in the Local Government in Scotland Act 2003. The Act placed duties on local authorities to initiate, facilitate and maintain community planning and encourage core partners such as health boards, enterprise networks, police and fire service to participate. In addition, local areas may involve other relevant agencies/organisations, such as further education colleges, business representatives and the voluntary sector. The CPP in each area comprises an overarching partnership which is supported by a number of themed (e.g. health and well-being) and neighbourhood partnerships[3].

In most areas, a *Choose Life* partnership was established as a sub-group of a CPP. The *Choose Life* partnerships were responsible for setting priorities for the local suicide prevention action plans and for overseeing implementation of phase one of *Choose Life*.

Choose Life coordinators
As part of the action planning process, each local area was expected to nominate a key lead/coordinating person with whom NIST could communicate and who was responsible for sharing information with other local planning partners and stakeholders. In some areas, *Choose Life* coordinators were specifically employed for the task, while in other areas the role of coordination was carried as part of the postholder's existing remit.

Links to NIST
NIST has no direct authority over CPPs or *Choose Life* partnerships or line management responsibility for coordinators, but issues guidance in order to support and advise local areas.

Local areas provide reports to NIST on expenditure through the NIST performance management structures, typically on an annual basis. The Chair of the CPP is mandated to provide a phase one progress report to NIST by July 2006.

1.4.2 Comparison with other national suicide prevention strategies

Scotland is one of at least 10 countries (the others being Australia, England, Finland, France, Ireland, New Zealand, Norway, Sweden and USA) to have developed a national strategy on suicide prevention. Such strategies are characterised by a set of integrated, multi-component activities that are coordinated by government and intended to promote, support and link inter-sectoral programmes at local, regional and national levels. *Choose Life* appears to incorporate most, if not all, of the essential

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[3] http://www.improvementservice.org.uk/commplan/index.php

core elements of a national strategy, as recommended in United Nations guidelines (United Nations, 1996):

- Coordination and integration to promote cross-sectoral collaboration at all levels, from governmental to community level
- High level political support for strategic aims, to lay the foundation for the strategy and its implementation
- A coherent conceptual framework for suicide prevention that provides a means to understand suicidal behaviour in order to inform suicide prevention activities and to foster relevant research that has practical application
- Community involvement and engagement in formulating, implementing and evaluating programmes
- Objectives that are achievable and measurable, some of which may be expressed as targets for change
- Monitoring and evaluation to inform implementation and the review of strategy.

A review of international strategies undertaken by the national evaluation team highlights points of similarity and contrast between *Choose Life* and other international strategies (see annex 1). Strategies tend to be focused on action at the population level and share broad goals and priorities, while there is more variation in specific objectives and approaches adopted.

Scotland's suicide prevention strategy is distinctive in the extent to which suicide prevention is embedded in the wider policy agenda as part of a drive towards health improvement, including mental health improvement, and social justice. As an example, *Delivering for Health* (2005a) sets out a programme of action for the NHS in Scotland. This signals a "move towards a system which emphasises a wider effort on improving health and well-being, through preventive medicine, support for self care, and through greater targeting of resources on those at greatest risk." The Mental Health Delivery Plan (anticipated December 2006) is expected to contain a commitment to enhance mental health services in Scotland in line with the principles of *Delivering for Health* and to set out a programme for service improvement.

1.4.3 Evaluation of national suicide prevention strategies

There is relatively little knowledge about the types of strategic or programme-level interventions that successfully prevent suicide (Beautrais, 2005) and there has been little attempt to evaluate the impact of a national multi-dimensional suicide prevention strategy. For example, in their review of suicide prevention strategies Mann *et al* (2005) focused upon effectiveness of interventions undertaken as elements of strategies. In general 'monitoring and evaluation' activities described in national strategies refer to the evaluation of interventions that are the means of delivering the objectives and not to the evaluation of the strategy itself. One exception is Australia where a summative evaluation was undertaken of its national youth suicide prevention strategy. Scotland's commitment to a strategic and national level process evaluation of the strategy's early implementation is highly unusual.

1.4.4 Economic evaluation of suicide prevention strategies

It can be difficult to identify the levels of expenditure on national suicide prevention activities, due in part to a lack of earmarked funding, and also because strategies may be delivered across many sectors, by many different public and private agencies, often funded in completed different manners. Nevertheless, it is clear that substantial levels of funding may be allocated to such strategies – for instance £19.5 million ($A48 million) was invested in suicide prevention in Australia between 2000 and 2004. Economic evaluation, which compares both the effectiveness and costs of one or more programmes or individual interventions, can be a useful aid to policy makers in assessing whether such an investment in suicide prevention activities represents value for money.

We have undertaken a review to assess the extent to which economic evaluation is used in the area of suicide prevention (annex 3). Given the limited knowledge about the effectiveness of national strategies at the programme level, it is unsurprising that no economic evaluations of national suicide prevention strategies were found. Much economic analysis has focused instead on looking at how potential society-wide conditions, such as the state of the economy, might impact on the level of suicide in society (e.g. Berk *et al* 2006) rather than on interventions to prevent suicide *per se*. Any future economic evaluation of the *Choose Life* strategy would almost certainly be one of the first evaluations undertaken of a national strategy.

This is not to say that no economic evaluations of area-based suicide prevention strategies have been conducted, but rather they have been modest in scope. For example, multi-intervention suicide prevention programmes targeted at reservation based, Native Americans (Zaloshnja *et al* 2003) as well as university students in Florida (de Castro *et al* 2004) have been assessed. A small number of studies has also looked at the cost-effectiveness of individual interventions (often clinical) for high risk groups – for instance social work interventions in England for children and adolescents who have deliberately poisoned themselves (Byford *et al* 1999) or the use of cognitive behavioural therapy with people with a history of deliberate self-harm in centres in both England and Scotland (Byford *et al* 2003).

CHAPTER TWO AIMS AND OBJECTIVES

In line with the growing commitment to evidence-based policy-making within modernised government and to evidence-based practice within public health and health promotion (NHS Health Scotland, 2005), the Scottish Executive's intention to commission an independent evaluation of *Choose Life* was signalled in the national strategy and action plan. The broad purpose of the evaluation during the first phase was to "assess … infrastructure and early impacts" and to "set the template for the next phase of the *Choose Life* strategy." The evaluation focus was deliberately formative, rather than summative, with the evaluation team expected to contribute a detailed understanding of processes and to work collaboratively and developmentally with key *Choose Life* actors (nationally and locally).

As stated in the invitation to tender (subsequently revised to take account of early developments in the implementation of the strategy), the main aims of this evaluation were to:

1. Establish and apply measures to assess whether a sustainable infrastructure is being developed nationally and locally to support the *Choose Life* strategy in achieving its objectives
2. Measure and review progress towards implementation of the 27 milestones identified in the *Choose Life* strategy and action plan (page 35) and set findings in context, nationally and internationally
3. Examine whether and how *Choose Life* is stimulating effective forms of practice (nationally and in individual local areas)
4. On the basis of findings, and in consultation with the Scottish Executive and the Research Advisory Group steering the evaluation, provide detailed and staged recommendations to guide the next phase of the action plan to achieve a 20 per cent reduction in suicides in Scotland by 2013, and the targeting of any funding available to support the next phase.

More specific objectives were to:

1. Track the resources allocated by the Executive to the implementation of the strategy and action plan and investigate whether and how the money allocated to national and local initiatives is:
   - stimulating local investment from Community Planning Partnerships (CPPs)
   - targeted at relevant priority groups
   - being spent on proven effective practice and interventions
   - stimulating innovation
2. Investigate the structures established to support actions between agencies in each of the local authority areas (CPPs) and nationally (for example, the Scottish Prison Service)
3. Review the ways in which examples of effective practice are collected, assessed, disseminated and used, nationally and locally
4. Identify and (if necessary) develop measures to be used to track progress towards meeting the goals set out in *Choose Life* and in local action plans

5. Use the measures to assess progress towards the 27 national and local milestones and identify factors facilitating or hindering progress, engaging all relevant stakeholders
6. Contribute to the identification of data, additional to that collected at present, which would be useful for tracking and monitoring suicide trends
7. Make comparisons of findings, within Scotland, nationally and internationally (where appropriate and relevant). In particular, compare the suicide prevention strategy and action plan in Scotland with those of other countries.

Following a competitive tendering process, the Scottish Executive's Mental Health Research Team on behalf of the National Programme for Improving Mental Health and Well-being commissioned this consortium of researchers to conduct the evaluation of phase one of *Choose Life*. The evaluation was funded for a period of 24 months, starting in September 2004.

CHAPTER THREE METHODOLOGY

3.1 Introduction

The purpose of this chapter is to provide a summary of the overall approach and methodology used for the evaluation. It also highlights any changes made to the proposed original methodology and discusses strengths and limitations of the data collected.

3.2 Overview

The research process encompassed three key stages: scoping and mapping; conduct of case studies; and, development of recommendations/production of outputs. A longitudinal component was built into the evaluation study design; this provided some opportunity to determine whether the local (and national) priority given to suicide prevention had changed over time and to capture and reflect upon such changes.

3.3 Theories of change

The overall approach taken to the evaluation was theory driven. The increased attention to theory driven approaches has arisen as a response to the challenges of evaluating complex interventions for health improvement that target significant social problems. A key strength is that this approach does not seek to judge a programme in its entirety, but attempts to determine whether a programme has been delivered as intended, and what aspects of programmes work, for whom and in what circumstances (Weiss, 2004).

Within the context of *Choose Life* the specific theory-based approach that was utilised was Theories of Change (ToC) (Connell *et al* 1995; Fulbright-Anderson *et al* 1998), in which the evaluator, in conjunction with key stakeholders, seeks to identify prospectively the underlying rationale or 'theory' of the planned programme. Further strengths of the ToC approach are its value as a tool to improve programme planning and in addressing some of the problems associated with efforts to establish causal attribution.

In the *Choose Life* evaluation different models of how best to implement a suicide prevention programme were explored at both national and local levels, with a particular focus on *why* particular actions and activities were anticipated to lead to *which* kinds of goals.

A theory-driven approach does not exclude or encourage the use of any particular research method. Research methods used (and outlined below) included qualitative interviews, analysis of documentation and action plans (including NIST templates), workshop discussion and survey questionnaires.

There were two main ways in which our use of the ToC approach differed from that recommended by its proponents. The first was that data were not gathered until after

the overall programme was commissioned and the local partnerships established (rather than in the early stages of programme planning). This limits the potential of the approach to influence the planning process and is a common feature of its use within the UK due to the way in which evaluations are funded (Sullivan *et al* 2002; Mackenzie and Blamey 2005). On the other hand, there is growing evidence that the process of planning extends well beyond the initial set up phase of policy programmes; indeed planning was an integral part of the first phase of *Choose Life*.

Second, the majority of theories articulated within the project were not probed in sufficient detail to allow the emergence of robust and testable pathways linking resources, activities, processes and outcomes. As has been demonstrated across a range of programme evaluations (Blamey *et al* 2005; Mackenzie *et al* 2005) such an approach is extremely resource-intensive for both evaluators and key stakeholders within the programme.

In addition to the above limitations, there is a growing body of evidence that the Theories of Change approach itself has serious limitations in practice. Two key challenges are: the extent to which stakeholders are prepared or able to specify precisely the level of change anticipated within a complex policy setting to allow for their theories to be adequately tested (Judge and Bauld 2001; Mackenzie and Blamey 2005); and the degree to which the relatively linear approach adequately captures complexity (Barnes *et al* 2003).

There is currently no consensus about which evaluation approach is most suitable for which purpose (King's Fund 2004) and there are limitations with any approach favoured. A multi-method approach such as ToC is of clear benefit in the evaluation of a complex intervention such as *Choose Life* in its early phase, particularly in determining whether the programme has been delivered as intended and in understanding rationales underlying the programme's activities.

3.4 Review of national strategies

An early component of the evaluation was the conduct of a review of national strategies for suicide prevention (annex 1). The purpose of this review was to consider suicide prevention strategies across the world and to gather evidence about effective policy and practice at both national and local levels. (The review criteria restricted selection of countries to those that had a national strategy.)

There are some limitations in an exercise focused upon what is contained in published strategy documents. It was not possible to explore how policy statements were implemented in practice. Additionally, there was little information available on the process and pace of implementation or on the relative influence of non-government organisations or community groups.

However, key strengths of this exercise were that the review enabled Scotland's suicide prevention strategy and action plan to be compared to suicide prevention activity underway internationally.

3.5 Coordinator surveys

Invitations were issued to all *Choose Life* coordinators in the 32 Local Authority areas to complete a questionnaire in stage one of the evaluation (November 2004) and at follow up in stage two (November 2005).

The questionnaires covered the following areas:

- Local vision for change
- Progress towards vision for change
- Progress in the development of the local infrastructure
- Resource allocation and generation
- Examples of innovative and effective practice
- Monitoring & Evaluation
- Sustainability and Mainstreaming
- Collection of data on suicide and deliberate self-harm
- Reflections on national support and on local progress.

Both open and closed questions were used in the questionnaires, although open questions predominated. Rating scales were also developed to measure satisfaction with national action towards the achievement of the national milestones set out in *Choose Life,* and to review local implementation progress towards the achievement of the local *Choose Life* milestones.

For the first survey, responses were received from 27 local authority areas (26 fully completed questionnaires and one partially completed questionnaire). Five local areas did not respond, of which three gave an explanation for inability to participate in the survey and two gave no reason. A complete response was also received from the SPS. For the second survey, 28 responses were received from the 32 local areas. Only two local areas failed to respond to either survey, although very sparse data were received from one area for both surveys.

A limitation of the survey resulted from changes in the coordinator post. In six areas the questionnaire was completed by a new coordinator at follow up. The comparison of scores on rating scales between surveys should therefore be treated with caution.

3.6 Interviews with national informants (including National Implementation Support Team)

Interviews were undertaken with members of NIST and a sample of key national informants, including the National Programme for Improving Mental Health and Well-being, ChildLine, Penumbra, the Samaritans, the Scottish Association for Mental Health (SAMH), SPS, the Royal College of Physicians (RCP), the Royal Air Force (RAF) and the National Union of Journalists (NUJ). The first round of interviews was held in November 2004 and repeated 12 months later. The purpose of the interview was to develop a national perspective on the implementation of *Choose Life*. Key elements of the interviews involved:

- Considering progress towards the achievement of the national milestones set out in *Choose Life*
- Understanding the criteria applied at the national level to assess local implementation
- Considering the quality of collaboration between the NIST and major national agencies for the achievement of *Choose Life* objectives.

3.6.1 Changes to the original methodology

A component of data collection developed in addition to the original plan was exploration of the NIST 'story'. It was agreed to undertake data collection with NIST to gather information pertaining to the NIST perspective on key events, decisions and outputs. This involved both individual interviews with members of the team and a joint 'workshop' session.

3.7 Case studies with local areas

The case studies were the main vehicle for exploring the processes of implementation and to identify the overall theoretical framework within which local suicide prevention teams were working. It was decided that eight was the optimal number of case studies that could be undertaken, providing a representative sample of local approaches to suicide prevention within prevailing time constraints.

3.7.1 Selection of the case study sites

Geographical type (rural/remote, urban and mixed rural-urban) was the primary criterion used to categorise local authority areas. Additional criteria, which were considered to be important for understanding the diverse and innovative approaches to the implementation of *Choose Life* at local level, were applied, including: the local suicide rate, focus on priority groups, interaction between national and local level organisations/services and approaches to coordination. The selection of sites was intended to ensure adequate variation in these primary and secondary characteristics.

The sample of case study sites comprised East Ayrshire, Fife, Glasgow, Highlands, Inverclyde, North Lanarkshire, Shetland Isles and West Lothian. Consistent with our longitudinal approach, there were two site visits, one in the spring/summer of 2005 and a follow up visit in autumn/winter 2005.

3.7.2 Interviews with case study informants

Following endorsement by NIST of the sites recommended for selection as case studies, the relevant coordinators were approached. Access to each site was negotiated and preliminary in-depth meetings with the coordinator and other relevant personnel were arranged.

Participants for the first round of interviews within each case study site were purposively sampled. Interviews were undertaken with four key informants involved in the decision making process (e.g. members of the *Choose Life* partnership responsible for setting priorities) and two representatives involved in *Choose Life* funded activities. Six was the optimal number of interviews that could be conducted in the time available.

In identifying the four key informants the evaluation team made every effort to ensure a mix of professionals from a range of statutory and community and voluntary organisations. As part of this process, local coordinators provided guidance about the key decision makers in partnerships.

One researcher conducted all the interviews and detailed notes were taken throughout. Interviews were recorded and, when necessary, the researcher cross-referenced notes with the tapes to ensure accuracy of information.

3.7.3 Selection of project examples

Sixteen project activities were selected for more detailed examination (two per case study site). Two projects per site was the optimal number that could be explored in the time available. The evaluation team made provisional recommendations for the selection of activities in each local area, with a view to ensuring that the full set would provide a representative selection across *Choose Life* priority groups and objectives. These recommendations were negotiated with coordinators at the first site visits. Interviews were conducted with a representative of each project, generally the project lead or manager.

3.7.4 Observational activities and collection of documentation

Choose Life events, most commonly *Choose Life* partnership meetings but also training events, evaluation days and practitioner fora, were observed by the research team. Meetings were arranged with national organisation representatives involved in local implementation where this existed (for example with SPS and Penumbra).

Key documents were collected, including minutes of *Choose Life* partnership meetings/subgroups, information pertaining to the project examples in each area, locality reports on progress and reports of previous needs assessments or research used to inform the local action planning process.

A key challenge faced by the research team was to decide the level at which theory should be (most usefully) articulated in the case study area and the degree to which detailed information about project activity was required. As highlighted by other evaluations of complex community initiatives, it was often more feasible to explore the theory and rationale for an individual project activity than across a local area undertaking an array of diverse approaches. It was important, however, to bear in mind that *Choose Life* did not solely fund individual interventions but was also acting as a mechanism to stimulate other non- funded activity and collaboration and to create synergy in tackling suicide prevention. For these reasons the evaluation team aimed

to understand theories of change at an overall programme level as well as undertake more detailed explorations of selected projects within the case studies.

3.7.5 Changes to approach

The evaluation team wished to ensure throughout that the collection of data was guided by the need to answer the main aims and specific objectives of the evaluation. There was some concern that repeat individual interviews would not significantly contribute new learning in respect of case studies at the second fieldwork visit and that the short time lapse between site visits would not provide a realistic opportunity to reflect upon progress. To this end workshops were held in each case study area and facilitated by the evaluation team. These replaced repeat individual interviews with stakeholders, as originally proposed.

The use of group discussion rather than individual interview provided an opportunity for joint local testing of, and refection on, the local area's theories. The workshops also involved local participants in assessing their progress towards *Choose Life* objectives and milestones and discussing how best this could be demonstrated. Attention was paid to considering the implications arising from phase one for future planning of *Choose Life* implementation, e.g. local area partnerships' ability and capacity to sustain change and to change direction, where necessary.

The wide range of stakeholders attracted to the case study workshops did create some limitation in terms of data collection. Although this interest positively reflected local awareness and participation in the strategy's implementation, workshop discussions were not limited only to stakeholders from the initial planning stages or those working at a strategic decision making level. This could be problematic when individuals were asked to consider local decision making for *Choose Life* but were not involved in the decision making process.

A debriefing meeting was held with the *Choose Life* coordinator following the workshops. The purpose of the meeting was to identify and rectify any gaps in factual information and to collect any outstanding first visit case study data (e.g. information relating to outputs and outcomes of key activities).

3.8 National workshops

The first national evaluation workshop was held in February 2005 to bring together the evaluation team, NIST, local coordinators and a number of key national stakeholders. This workshop set out to develop understanding of the different models of national and local actions and activities being put in place; explore the evolving relationship between the approaches of the centre and of local areas; and identify ways in which progress could be measured. The second workshop, in February 2006, was held with the same range of stakeholders and represented the final stage of data collection. It set out to explore learning and test out key themes emerging from the evaluation. Key elements of the day were to:

- Review progress and learning in relation to the objectives of *Choose Life*
- Identify future priorities for development, support required to facilitate this, measures of progress and outcome and implications for information collection and sharing and research.

3.9 Economic focus

One of the key purposes of the evaluation was to track resources allocated by the Executive to the implementation of the strategy and action plan, and to investigate whether and how the money allocated to national and local initiatives:

- stimulated local investment from CPPs
- targeted relevant priority groups
- was spent on proven effective practice and interventions
- stimulated local innovation.

The economic analysis within the evaluation did not involve a separate data collection exercise. Instruments developed for the evaluation, such as data collection tools for local case studies and the survey of coordinators, were tailored so as to address issues of relevance to the economic analysis. Much data of relevance were also routinely collected by NIST. Three key sources of information were used for this analysis. The key resource was information returned to NIST by each local area using a standard template. The NIST template provided financial breakdown of activities that received *Choose Life* funding in each local area and further information, such as relevance of activities to *Choose Life* action areas (training, community/voluntary and self-help initiatives and coordination); relevance to *Choose Life* priority groups and objectives; target groups; intended outcomes of activities; evaluation; partners in delivery; and in-kind support received.

Funding was intended to act as a stimulus for additional support for local suicide prevention work. The template information was augmented by information collected through coordinator surveys which included questions about whether or not projects received additional funding and on project challenges and successes. The third source of information for the economic analysis was a survey of the 16 project examples, which was intended to capture the economic costs of providing *Choose Life* activities, e.g. total staff and associated costs incurred through the delivery of *Choose Life* projects. The survey also enquired about additional funding, including support generated by local statutory agencies and charitable organisations, as well as in-kind contributions, including the unpaid time of professionals and volunteers.

The analysis of the templates was subject to a number of important limitations. A challenge was that these templates were not completed in a consistent way. Although NIST and the evaluation team made attempts to clarify sources of data, it remains the case that details of funding allocated to some activities had not been submitted to NIST by the end of the evaluation period. In particular, data for the financial year 2005-06 remained incomplete at the time this report was being finalised Data from case studies, and to a lesser extent from the survey, also suggested that most areas did not provide as much information as they could on additional sources of funding or in-kind contributions to projects.

3.9.1 Changes to original proposal

In addition to the approach set out above, discussions between NIST, the commissioners and the evaluation team identified further potential areas that would benefit from attention. The evaluation team agreed to produce two additional outputs, namely:

- A review of economic aspects of international evidence and paper on economic aspects of suicide prevention and cost-effectiveness of suicide prevention strategies
- Estimation of the potential economic benefits that may be realised if *Choose Life* does reach its goal of reducing the suicide rate by 20% over a ten year period.

3.10 Data analysis

Data analysis was conducted as a continuous (iterative) process throughout the evaluation. An evaluation database was designed and used to store (and retrieve) data on all 32 local areas, including surveys with local coordinators and case study areas. Findings from each element of data collection (case studies, workshops, national interviews and surveys) were written up in detailed reports which were then used for comparative analysis.

Data were analysed according to predefined themes, for example, sustainability and partnerships. Themes were also developed from inductive analysis of data and built upon analysis conducted in each phase of the evaluation.

An analytical framework was developed to guide the team throughout the evaluation; this was expanded and developed according to themes emerging from the data. Analysis of data primarily drew upon the 'charting' method of systematically handling complex datasets by drawing out the dimensions that related to each theme across all cases.

PART TWO FINDINGS AND COMMENTARY

This part of the report presents the main findings from the study in six chapters: sustainable infrastructures; allocation of resources; innovative and effective practice; sustainability; decision-making and learning; and perceived progress.

Analytic commentary by the evaluation team is clearly identified and separated from the descriptive text (through the use of boxes). In chapters four to nine, the descriptive text is based upon findings reported to the evaluation team via national interviews, case study work, coordinator surveys and workshops. The commentary boxes assess and reflect on the themes emerging from these data.

Where relevant, boxed examples of funded *Choose Life* implementation activities provide the reader with more descriptive examples from the case studies that reflect issues discussed in the main text.

CHAPTER FOUR SUSTAINABLE INFRASTRUCTURES

4.1. Introduction

The action plan to implement the *Choose Life* strategy attached considerable importance to the development of infrastructures at both local and national levels to ensure the achievement of objectives for suicide prevention in Scotland.

In this chapter, the development of national and local infrastructures to support suicide prevention is considered. At the end of each main subsection there is a table summarising the progress made in developing infrastructures to support implementation. This examines similarities and differences in approaches taken and identifies some of the challenges that remain.

4.2 Development of a national infrastructure to support suicide prevention

This section considers the development of a national infrastructure to support suicide prevention and considers the role of NIST, national *Choose Life* coordinators, cross-cutting links and collaborative working between NIST and national organisations and networks.

4.2.1 Role and placement of National Implementation Support Team

As described in chapter one, NIST was established to oversee implementation of the *Choose Life* objectives and to support local action. The start up process was lengthy (see the *Choose Life* timeline, table 1.2), largely as a result of the number of different strands of work that had to be established.

NIST reports to the National Programme for Improving Mental Health and Well-being which is situated within the Mental Health Division of the Scottish Executive Health Department. National informants (primarily NIST) highlighted ways in which alignment to Scottish Executive structures impacted upon implementation of phase one of *Choose Life*. Advantages of this model included:

- commitment from the Scottish Executive to support good practice on suicide prevention, within the broader contexts of social inclusion, equalities and mental health improvement
- facilitation of links to other national organisations, e.g. General Register Office for Scotland (GROS), Scottish Public Health Observatory (SPHO), NHSScotland and the Armed Forces.

The following disadvantages of this model were noted:

- operational problems, e.g. impact of governmental procedures, such as lengthy tendering processes
- lack of lead-in time for strategy development by the Scottish Executive and tight timescales for implementation.

Goals for NIST

NIST described a number of goals (see figure 4.1) that were driving their work at national level to support implementation and contribute to the prevention of suicide. These were:

- To increase awareness of the *Choose Life* strategy and promote ownership and engagement across wide range of sectors and departments in the Executive
- To improve knowledge and understanding of suicide epidemiology and evidence of effective interventions
- To promote a better understanding of the contribution that different agencies and individuals can make to suicide prevention.

Clarity about these goals and the precise role of NIST in supporting national infrastructure development emerged over time. This was influenced by the following factors:

- initial delays with recruiting staff; as a result, key members of the team were not in post until half way through phase one
- newness of national operational model; as a result, the development of roles and functions was a lengthy process.

Figure 4.1 A composite national theory of change

Key functions	Goals	Longer term vision
Collaborative working: between NIST and national organisations/ among national organisations	To increase awareness of the *Choose Life* strategy and promote ownership and engagement across wide range of sectors and departments in the Executive	
Building capacity in national organisations		
Influencing cross cutting policy	To improve knowledge and understanding of suicide epidemiology and evidence of effective interventions	Reduction in suicide
Information and knowledge		
Media work	To promote a better understanding of the contribution that different agencies and individuals can make to suicide prevention	
Awareness raising / campaigning		
Work with local areas		

Functions
In national interviews, four main functions of NIST were identified: awareness raising/campaigning; working with the media; improving and disseminating information; and supporting local implementation. These are discussed in turn below.

Awareness raising / campaigning
According to the Scottish Executive, an essential function of NIST was to bring national attention to suicide prevention, on the grounds that a purely local approach would not be sufficiently powerful to achieve the long-term suicide reduction goal. NIST considered that, in the early stages, this aspect of their work had tended to be reactive; over time, the team has taken an increasingly strategic approach.

NIST and their national partner organisations indicated that a great deal of awareness raising work had been undertaken and informants considered that *Choose Life* had been effective in raising the profile of suicide with the public and among services and in communicating the message that suicide is not only a medical problem. However, there was a shared awareness that further work was required. National organisations considered that closer coordination to link the awareness raising activities of different organisations would create a more effective united front in work with the media, with clear, consistent messages, and the opportunity to pool resources and expertise.

Working with the media

NIST's work with the media was regarded by national informants as important and highly effective. The team had made considerable progress towards the *Choose Life* objective of 'supporting the media' and NIST had worked actively to implement the NUJ media guidelines[4] (launched in July 2004) in local areas. These guidelines were developed collaboratively between NIST and the NUJ in order to help journalists report more appropriately on mental health and suicide.

National interviews and two case study areas cited examples of joint working between NIST and individual local areas, for instance where NIST had been able to work with local stakeholders and improve reporting practice following instances of previously poor coverage.

The factors that contributed to NIST's ability to perform this function effectively were:

- the team's national status (as this allowed NIST to challenge poor media reporting and to have access to the Scottish Executive press office)
- productive contacts within the NUJ
- the publication of national media guidelines that were supported by the Scottish Executive and other national organisations.

National informants emphasised the need to sustain media work and to take an increasingly strategic approach to partnership working and proactive intervention. This was important in order to avoid irresponsible reactions to suicides by the local media that might impede achievement of longer term objectives.

Improving and disseminating information

The Scottish Executive expected NIST to develop a performance management infrastructure to monitor activity (the NIST local action plan templates are discussed in chapter five). Over time, NIST had become more familiar with the information needs of national organisations and the National Programme for Improving Mental Health and Well-being, and more adept at meeting these needs. NIST had developed various approaches to improving and disseminating information:

- *Choose Life website*[5]

The *Choose Life* website was launched in suicide prevention week (September) 2005. NIST sought feedback from local coordinators on the design and content of the website to ensure that it was appropriate to local needs. The *Choose Life* Website acts a key mechanism to synthesise information on national and local activities, contacts, tools and resources and was intended to be accessible to both professionals and the general public. The website includes resources such as:

- Information on local action plans
- Data on suicide trends and statistics
- Support booklet for bereaved families / friends
- Information on research

[4] http://www.chooselife.net/web/site/Media/Media.asp
[5] http://www.chooselife.net

- Media reporting guidelines
- Information on training
- The resource database commissioned by NIST is a web-based resource of materials relevant to activity in suicide prevention, intervention and postvention (see also chapter eight).

- *Suicide Information, Research and Evidence Network (SIREN)*

The Suicide Information, Research and Evidence Network (SIREN), launched in June 2005, aims to increase understanding of suicide and its prevention through information sharing and networking, and ultimately create a sustainable Scottish association for the study of suicide. SIREN is designed to improve access to research for non-research communities, and involves a range of stakeholders, including coordinators (national and local).

- *Data on suicide statistics*

Data on suicide statistics are made available to lay and professional communities via the *Choose Life* website and through circulation of data on suicide statistics to local *Choose Life* partnerships. In phase one, NIST has worked with the Scottish Public Health Observatory (SPHO) to ensure that data on suicide statistics will be updated regularly. (The SPHO is a collaboration of key national organisations involved in public health intelligence in Scotland, which works to provide the public health community with easy access to clear and relevant information and statistics to support decision making.)

Strengthening of dissemination role

National and local informants were keen that NIST should continue to strengthen its coordination and dissemination role as well as to increase its efforts in supporting effective implementation. In particular, it should give further attention to:

- Providing information on 'what works' and on gaps in research
- Providing information geared towards stimulating partnerships and innovation
- Strengthening support for a 'community of learning'
- Collecting the type and level of information that would be useful as implementation progressed.

Supporting local implementation

NIST's role in supporting local areas is explored in section 4.3.

Box 4.1 Commentary

The placement of NIST within Scottish Executive structures has been helpful in aligning suicide prevention activity with wider mental health improvement work and the broader social justice and equalities agendas. This operational model has helped engender links to some national organisations, such as the GROS and SPHO.

Since NIST has been established, demonstrable progress has been made in relation to: awareness raising/campaigning; working with the media; and development and dissemination of information and knowledge. This progress occurred despite the lengthy process of establishing the team.

An increasingly strategic approach towards awareness raising and training has improved clarity and focus about unmet priorities and targeting. Similarly, NIST's role in supporting the media should now result in closer links with local areas where there has been inappropriate media attention to suicide. A further likely impact would be the integration of good practice by national media groups and media education courses (i.e. beyond immediate impacts on individual editors and journalists).

Existing national resources have been well utilised to develop information and knowledge, particularly epidemiological data on suicide and the media guidelines, resulting in increasingly standardised information and guidance. NIST outputs such as the website and resource database also provide welcomed mechanisms, both nationally and locally, to share information. NIST has responded to locally defined needs in developing public resources such as their approach to the development of the *Choose Life* website. It will be important to ensure that optimal use continues to be made of the national resources developed to support implementation and that these continue to be in line with local and national requirements. Attention should continue to focus on encouraging learning about 'what works' in disseminating and sharing of information through these mechanisms.

4.2.2 Role of Choose Life national coordinators

As discussed in chapter one, three organisations (ChildLine, the SPS and the Samaritans) have national coordinators funded through *Choose Life*. There was a general view among national informants that the establishment of these funded coordinators had strengthened the national infrastructure by:

- Stimulating the development of links between national organisations. For example, although the SPS and the Samaritans already had a good working relationship, *Choose Life* added value by providing opportunities for the Samaritans to consider new areas of work in 'anticipatory' support. ChildLine and the Samaritans worked together for the first time in considering preventative work targeted at young people.

- Facilitating the identification of joint goals with other national organisations in pursuit of a common vision. *Choose Life* helped the Samaritans to feel part of a wider infrastructure of support. For example, although the organisation was not directly working with *Breathing Space* (a free, confidential phone-line for people experiencing low mood and depression), closer links had been established and there was an understanding that the organisations were working towards achievement of a similar objective.

- Creating an identifiable key contact point. For example, the ChildLine coordinator had focused upon making links and consolidating relationships with *Choose Life* partnerships. This provided local areas with a point of contact for information about activities supporting young people and also helped to break down misconceptions, e.g. about how ChildLine is funded.

- In the early stages of phase one these three coordinators lacked clarity about how they were expected to report back to NIST and their parent organisation. One informant highlighted a further challenge in that coordinators had come into post at different times and had employed different models of coordination. This could create difficulties in establishing a common approach in overlapping areas of work. Another national organisation without a coordinator highlighted that there had been some uncertainty about how funding decisions for national coordinator posts had been made. Reporting mechanisms improved with the introduction of regular meetings with NIST. In addition, NIST was a member of the SPS Management Board and the Samaritans UK management group

Further work was still required to ensure that the expertise of the organisations was utilised optimally and links with other relevant national organisations continued. Although there was praise for NIST's work in relation to suicide prevention week in 2004 and 2005, there was also a view that activity around this event could be even better coordinated across national organisations to strengthen approaches to awareness raising.

4.2.3 Establishing the foundations for collaboration

This section considers progress made by NIST in establishing cross-cutting policy links and in building collaborative working with and between national organisations and networks.

Cross-cutting policy links

Choose Life promotes a public health approach to suicide prevention that rests on broad ownership and shared responsibility across Scottish Executive policy departments. National informants had expectations that awareness raising by NIST with policy colleagues would lead to increasing inter-departmental commitment to suicide prevention objectives. An overarching structure to facilitate this had been built through the development of good relationships between NIST and other initiatives and organisations linked into the National Programme. However, data generated in the national interviews suggested that links with non-health departments of the Scottish Executive had been slow to develop in the first phase of implementation. NIST was aware that there was still 'a lot of work to do'. A lack of capacity within NIST was held to be the main factor: the head of implementation had worked single-handedly for the first eight months. In addition, with the agreement of the National Programme, the team had initially prioritised building links with local areas. Consequently, the development of contacts with other national policy developments were largely opportunistic.

In recognition of the problem, the head of the Mental Health Division and the director of the National Programme assumed responsibility for influencing and developing cross-cutting policy. It was agreed that the policy division of the National Programme would act as a catalyst to identify links between policy areas and NIST would take forward the operational implications.

As *Choose Life* progressed, increasingly extensive links were made between *Choose Life* and other Scottish Executive policy departments and policy arenas. This included shared links with criminal justice to the National Confidential Inquiry into Suicides/Homicides by People with Mental Illness. Outside NIST and the National Programme, however, there was little awareness of the cross-cutting work that had been undertaken. The change in approach documented above had also not yet trickled down to other national or local stakeholders.

Collaborative working between NIST and national organisations and networks
Following the active participation of many national organisations in the development of the *Choose Life* strategy, there was perceived to have been a loss of momentum in maintaining levels of engagement and communication during the early implementation stages, when NIST was being established and the primary focus was on local areas. This had resulted in a loss of communication with organisations such as the Royal College of Psychiatrists. National organisations had been disappointed by this initially but reported subsequent improvements.

Organisations without a direct link to NIST (e.g. those without a national *Choose Life* coordinator) suggested that NIST should continue to expand its use of the expertise within national organisations. This was though to have potential in terms of leading on specific topics such as crisis, bereavement or self-harm.

National informants considered it a matter of urgency to develop stronger links with several key sectors, including drug and alcohol agencies and mental health services. Latterly, the creation of a clinical advisor post within NIST was seen as a welcome indication of progress in generating clinical involvement at national level. NIST had also identified the recent report on *Taking action to reduce Scotland's drug-related deaths* (Scottish Executive, 2005b) as an opportunity to raise awareness of suicide prevention on this agenda. A representative from NIST had also been asked to join the newly formed National Forum on Drug Related Deaths.

Box 4.2 Commentary

Throughout the course of phase one, links were evolving between NIST and national organisations and to other cross-cutting policy departments, although these are at different stages of maturity. Despite this, commitment generated from organisations involved in the early planning stage of *Choose Life* has not been systematically sustained, resulting in the loss of key stakeholder input. This has been particularly noticeable in respect of contact with organisations representing clinical services.

Lesser success in establishing cross-cutting policy links has in part resulted from NIST's decision to give early priority to supporting local areas. Gradual links are now evolving across policy areas and NIST is working alongside the National Programme to foster connections. The challenge in mainstreaming suicide prevention across policy areas that do not recognise their potential role in suicide prevention is not unfamiliar and is echoed in other areas of (mental) health improvement.

Levels of activity have been high within individual national organisations and coordinating capacity in key agencies has added value to the mainstreaming of suicide prevention in their work. Although there is evidence of new partnerships developing

between national organisations, these have occurred on a relatively opportunistic basis or where there was already existing partnership working.

There is scope for nurturing relationships more purposively and further capitalising on the interest, expertise and commitment of national organisations. The utilisation of organisations with expertise in key fields in order to develop leadership on topic based activities (e.g. bereavement, self-harm and clinical services) has not been maximised, although work around crisis is developing in this vein. This is increasingly important in view of new learning arising from national organisations (and existing knowledge that such organisations possess), which are working across key priorities and objectives. Other national organisations also possess links to other agendas where NIST is not naturally represented. This presents further opportunity for mainstreaming suicide prevention activity.

Figures 4.2a and 4.2b show, respectively, the links that NIST had established by December 2004 and the partnerships that evolved in the following year.

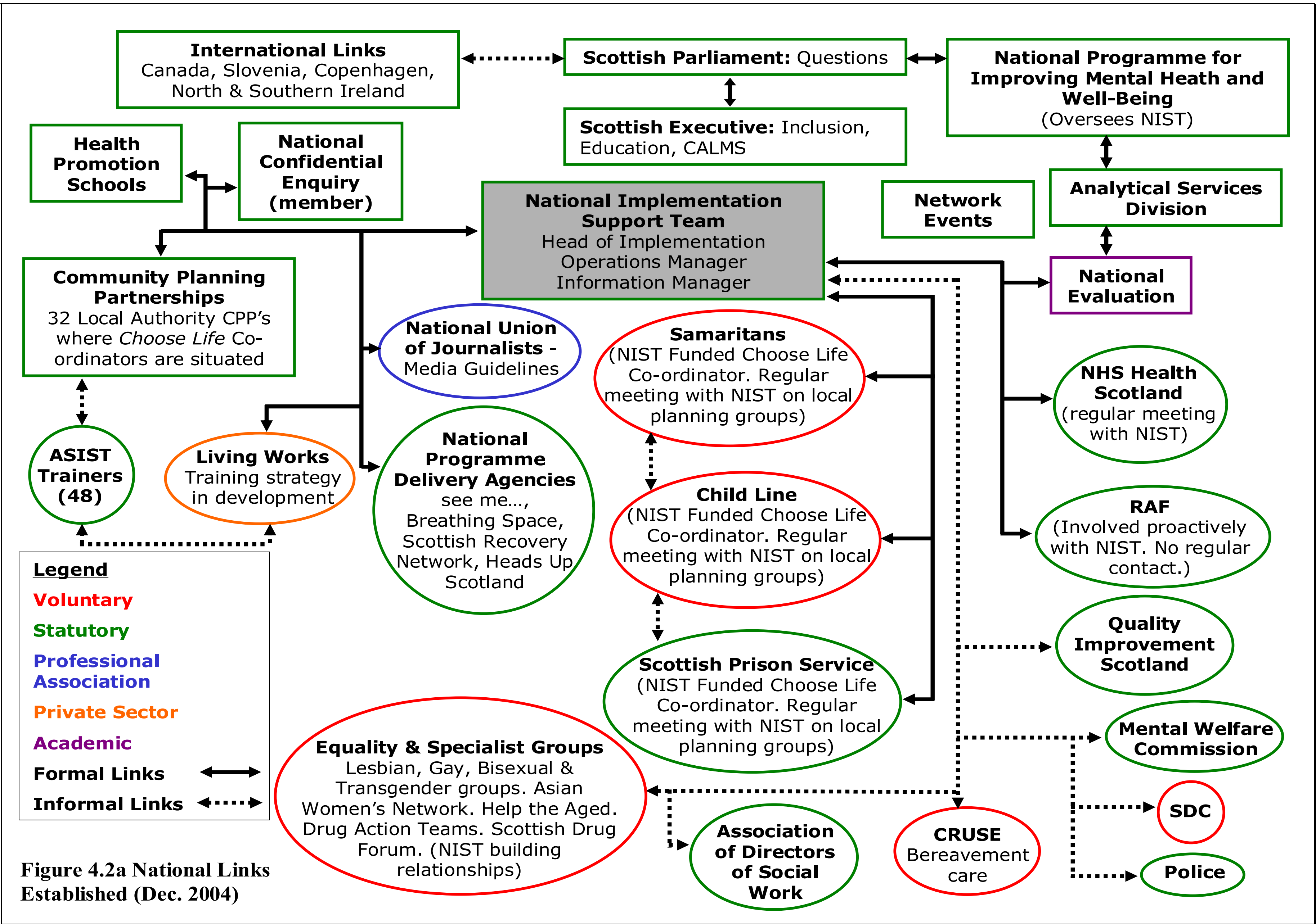


Figure 4.2a National Links Established (Dec. 2004)

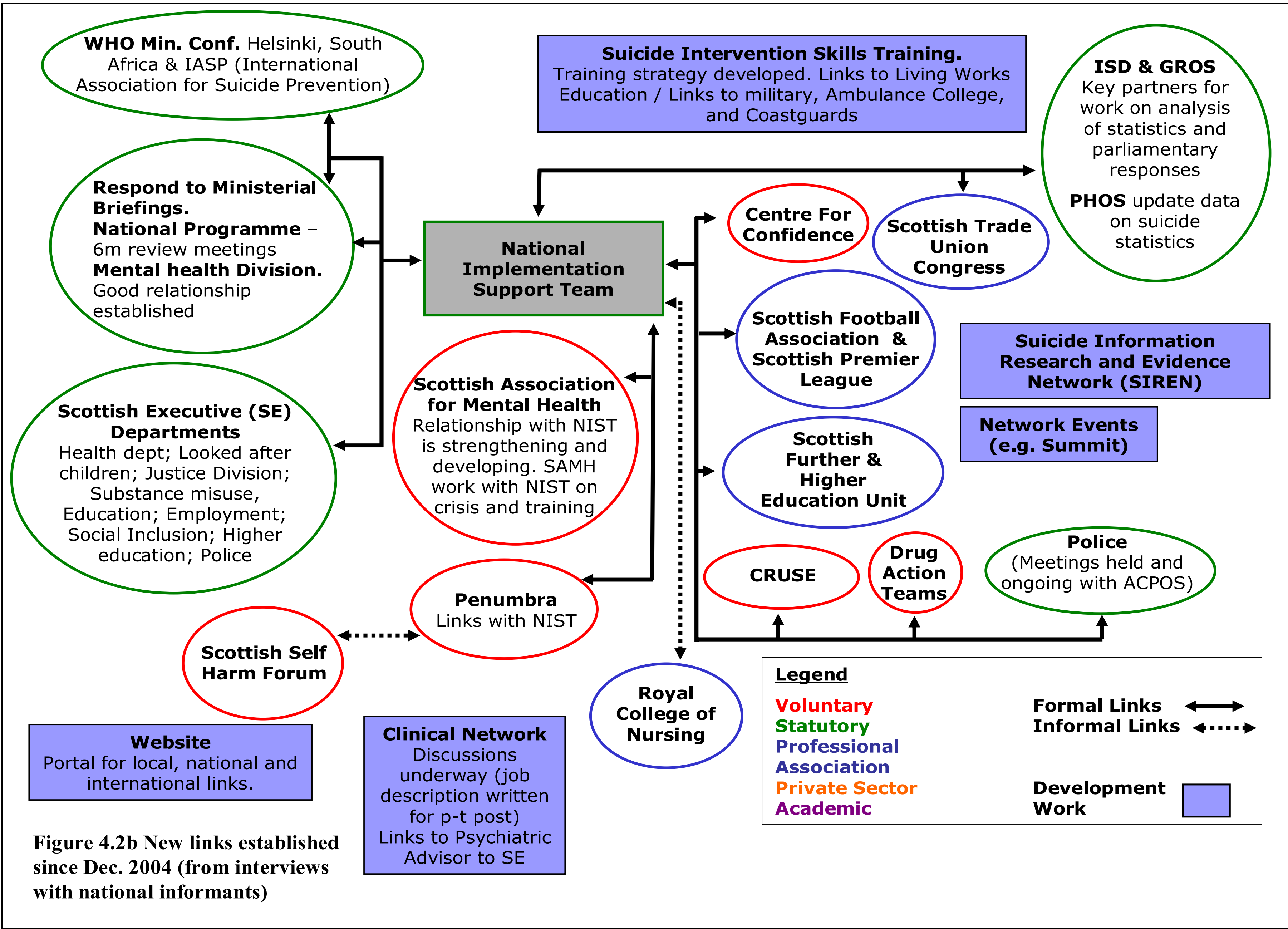


Figure 4.2b New links established since Dec. 2004 (from interviews with national informants)

4.2.4 Progress made in developing national infrastructures

Overall progress made in developing national infrastructures to support implementation is summarised in table 4.1. This considers progress and emerging issues/gaps in relation to awareness raising/campaigning, media work, information and knowledge, influencing cross-cutting policy, building capacity in national organisations, and collaborative working between NIST and national organisations and among national organisations.

Table 4.1 Progress in developing a national infrastructure to support implementation

Infrastructure development	Progress	Challenges/issues/gaps
NIST and placement in Scottish Executive	Development of suicide prevention strategy and activity linked to key policy arenas (social inclusion, inequalities and mental health improvement) Facilitates links to other national organisations	Operational challenges and delays resulting from impact of governmental procedures
Awareness raising/ campaigning	Considerable work undertaken by NIST and national partners to raise awareness of suicide prevention.	Importance of a shared and responsible public message regarding suicide prevention. Closer coordination of activity required across organisations
Media work	Effective support to local areas Development of media guidelines	Increased communications capacity will assist more strategic, proactive approach
Information and knowledge	More strategic approach to awareness raising is developing and training and mechanisms for sharing information and knowledge are improving Good use of national resources to inform implementation and information (e.g. suicide data) Key mechanisms developed to share and disseminate information (SIREN, website)	Need clearer structures for information sharing and learning among national and local players
Influencing cross-cutting policy	Good links within the National Programme Increasing NIST contact with other SE policy departments and more strategic approach developed to influence cross-cutting policy	Important to continue to foster policy connections at national level and communicate this to local areas
Building capacity in national organisations	National coordinating capacity in key agencies has added value	Need to strengthen links among national organisations
Collaborative working: **between NIST and national organisations**	Links are evolving between NIST and national organisations though these are at different stages of maturity	Further work is required to capitalise on interest, expertise and commitment of national organisations
Among national organisations	New partnerships developing between national organisations	Gradual links are evolving. Scope to nurture relationships more purposively

4.3 Development of local infrastructures

This section considers the development of local infrastructures to support suicide prevention. It begins by illustrating key goals for suicide prevention as articulated by local areas. The implementation of *Choose Life* through community planning processes and variations in the characteristics of the infrastructures are outlined. The section returns to consider the role of national organisations (including NIST) in terms of support for local implementation and concludes by reviewing progress in relation to local infrastructures.

4.3.1 Goals

In the longer term, the local vision for change to be achieved through the implementation of *Choose Life*, as described by coordinators and case study stakeholders, was to reduce suicide and to improve the mental health and well being of local populations (see figure 4.3). There was recognition of the continuing need to strengthen capacity and commitment in communities and in mainstream services and to challenge and change attitudes.

In taking forward the *Choose Life* strategy, local areas articulated three main sets of objectives to be pursued in phase one:

- Capacity building among services and professionals in order to: build networks and alliances; improve service response particularly for risk groups; raise awareness and confidence among staff; support development of the voluntary sector; and enhance systems for training
- Mainstreaming suicide prevention both in policy and in practice, and promoting awareness of the connection between health improvement and social justice priorities and activities and those of *Choose Life*
- Capacity building in the community by: reducing the stigma associated with suicide and mental health problems more generally; and raising awareness among the general public about when and how to seek, and give, help and support.

Figure 4.3 A composite theory of change pathway for the local areas

Key activities	Goals for phase one	Longer term vision
Capacity building amongst services and professionals	Established networks and alliance	
Implementation of enhanced training	Improved service response for risk groups	
Demonstrating the connection between health improvement and social justice priorities	Raised confidence/ awareness in staff	
	Development of the voluntary sector	Reduction in suicide
Capacity building within the community	Mainstreamed suicide prevention in policy and practice	Improved mental health and well-being of local populations
	Reduced stigma associated with suicide and mental health	
	Raised awareness about seeking and giving help within the general public	

With these short- and long-term goals in mind, the following sections consider approaches taken to phase one implementation within local community planning structures and review progress in establishing a sustainable local infrastructure for suicide prevention.

4.3.2 Structures to support Choose Life implementation

Implementation of *Choose Life* was primarily conducted through the establishment of a *Choose Life* coordinator and partnership in each local authority area. National guidance stipulated that the development of local *Choose Life* action plans should be linked to Community Planning Partnerships (CPPs). Suicide prevention was a new priority for many local policy makers and planners. CPPs were deemed the most appropriate vehicle for ensuring that the necessary linkages were made with overarching policy priorities, such as health (including mental health) improvement, social justice and social inclusion. Devolving responsibility to local CPPs was intended to encourage broad ownership in the interests of sustainability, to promote cross-sectoral collaboration, and create synergy by making best use of expertise and skills of local and national players.

Impact of CPPs
In some areas, partners had already worked together as part of the wider process towards integrated health and social care. Similarly, some *Choose Life* partners already came together in fora relating to mental health and health improvement. In the survey, half of the coordinators reported that the amount of local partnership working had increased as a result of working on *Choose Life*. A key development was increased partnership working with the voluntary sector. In some areas, *Choose Life* provided the first opportunity for a wide range of partners to came together to discuss a public mental health issue. For other areas, the process of participation in *Choose Life* had strengthened partnership working as part of CPPs.

The placement of *Choose Life* funds within community planning structures had both advantages and disadvantages. CPP engendered broad ownership of suicide prevention: as a result of its potential to be sustainable, *Choose Life* tended to become part of wider agendas. More practically, Councils could permit greater carry forward of unallocated funds. This was helpful when projects were delayed due to personnel issues or if areas required further time to reflect and review implementation decisions. However, the operational model could create delays in implementation. In one case study area, the local authority required each *Choose Life* funded project to submit a portfolio; and a requirement for funding was that these were signed off by a Community Planning committee that did not have regular meetings.

Links to CPP and Joint Health Improvement Planning
In the first phase of implementation there were variations in infrastructure development in relation to the coordination function, partnership development, links to CPP and other relevant structures, and levels of authority and decision making.

Most areas established a new strategic partnership with a specific remit for *Choose Life* implementation. Elsewhere pre-existing partnerships that focused on suicide prevention were allocated responsibility. The majority of partnerships reported directly through Joint Health Improvement Planning (JHIP) structures of the local CPP. There were some exceptions. One area reported through community safety and in three areas the *Choose Life* strategy group was accountable to the mental health strategy group. In general, local coordinators and NIST considered that links into the JHIP had developed well, enabling the objectives of *Choose Life* to be incorporated into future health improvement activity and related areas of policy and planning (e.g. regeneration, housing and equalities). Local coordinators thought that the positioning of *Choose Life* in CPPs through the JHIP was a sign of multi-agency strategic commitment and responsibility. This presented an opportunity to generate or lever additional funding from other sources to ensure that the aims and objectives of *Choose Life* were promoted and mainstreamed across sectors and agencies.

A range of examples illustrate how the alignment with CPP and JHIPs has been used:

- Inclusion of *Choose Life* objectives as a priority in JHIP
- Incorporation into Children's Services Plans, regeneration plans and other health improvement strategies for key risk groups
- Piloting of health improvement work with local social housing providers including suicide prevention work

- Assimilation of the strategic components of *Choose Life* coordination into the local authority health improvement post.

Box 4.3 Commentary

The visions for implementation (figure 4.3) reflect local area understanding of the message from the Scottish Executive: by devolving responsibility to local CPPs, broad ownership and promotion of cross-sectoral collaboration would be encouraged. The alignment of *Choose Life* with community planning was particularly identified as an asset where the CPP was mature and/or there was a strong local commitment to driving forward mental health improvement activity. CPP structures were generally beneficial in enabling areas to establish new partnerships and capitalise upon existing joint working. *Choose Life* added value by linking people and organisations who had not previously worked together. The commitment to engage community and voluntary organisations in the planning process has been particularly notable.

It is evident that there has been significant success in integrating *Choose Life* in JHIPs and, to a lesser extent, across other plans and policies. The role of partners in championing *Choose Life* in other agendas has facilitated inclusion in some wider plans and policies (e.g. children, mental health or regeneration). Successes have been influenced where proactive work has been undertaken by the partnership/coordinator to engage representatives at a senior level on local cross-cutting agendas. Currently, however, there is uncertainty about the extent to which inclusion in such plans will result in tangible outcomes. It will also be important to ensure that implementation of the plans is tracked across sectors to monitor and evaluate impact at this level.

Links to local mental health improvement strategies

The long-term goals expressed locally were to address suicide prevention as part of wider activity on population mental health improvement. In phase one of implementation, links had been established between *Choose Life* and broader mental health improvement activity as one of a set of key relationships. This needed to be balanced with links into clinical mental health services where there were fewer inroads (see sections 4.3.6 and 4.3.7). *Choose Life* had served in some areas as a vehicle to encourage wider awareness and commitment to the mental health improvement agenda and here implementation activity tended to focus on mental health improvement work within the local community. *Choose Life* had also facilitated development of more formal mental health improvement structures and had been able to support those working in other strands of mental health improvement, such as *see me*. In a small number of areas the coordination and supporting structures of *Choose Life* were becoming more closely aligned with mental health improvement.

Box 4.4 Commentary

In some areas, *Choose Life* has fostered wider attention to mental health improvement and suicide prevention work has become increasingly aligned to mental health improvement structures. It is difficult to gauge the potential impact on sustainability in the longer term arising out of closer alignment with mental health improvement. A

potential concern is that, if *Choose Life* is too closely linked to mental health improvement, the opportunity to mainstream across wider cross-cutting agendas may not be fully grasped. Alternatively, however, the linkage of *Choose Life* to mental health improvement in the short-term is important to promote shared responsibility towards delivery of National Programme objectives, and avoid duplication and overlap of activities targeting similar local priorities. A united local approach may additionally provide a stronger lever with which to influence mainstreaming of mental health improvement and *Choose Life* objectives on cross-cutting agendas.

Links to mental health services planning structures
In a minority of areas *Choose Life* was located within mental health strategic planning. In two areas, the *Choose Life* partnership is a sub group of the mental health strategy group and, in another area, the principal link was to a planning group that oversees the management and development of mental health service. This model appeared to give the NHS a stronger role in the planning and allocation of resources than in the health improvement model but, based on case study data, resulted in weaker links into the CPP at strategic level. One area decided to restructure in phase two in order to integrate *Choose Life* more closely into the CPP.

Box 4.5 Commentary

It is difficult to assess the impact of the NHS model. Only a minority of areas had strong links to NHS planning structures; evaluation findings are therefore based on limited information. An identified barrier has been the reduced opportunity to engage with community planning structures and a wider range of local organisations. Initially, in one area, there was some reluctance of local community groups (supporting those bereaved by suicide) to engage with the *Choose Life* partnership. This resulted from concern about the strategy's alignment to clinical services. There is some evidence that, where an NHS model has operated, this has increased the focus on interventions targeting clinical workers and clinical priorities. There is potentially some learning from this model in relation to mainstreaming. For example, the work funded on depression management in one area has fed into the development of the Doing Well by People with Depression (DWBPWD) initiative.

It is clear, too, that work with clinical services has evolved where a health improvement model is in place. A key factor driving this activity is the enthusiasm of visionaries in the NHS who are championing *Choose Life* and where the coordinator has links to the development of planning structures or service redesign.

The establishment of joint reporting mechanisms, e.g. where *Choose Life* reported both to the CPP and (less formally) to NHS strategic partnerships, provides potential benefits in terms of closer alignment to CHPs and to partnerships overseeing local mental health (including mental health promotion) strategies.

4.3.3 Coordination of Choose Life implementation

The diverse professional background and differing remits and levels of responsibility of local coordinators influenced their approach to the coordination of implementation. Broad approaches included: employment of a full time coordinator; coordination through a professional's existing remit; and shared responsibility for the function of coordination. This section examines the implications of these three models of coordination.

Employment of a full time coordinator
Some coordinators highlighted that dedicated time and resources created an opportunity for effective networking and the proactive development of collaborative work. For example, if a coordinator was approached by a local partner who expressed interest in taking forward suicide prevention activities, then the coordinator was able to respond quickly and capitalise upon unanticipated opportunities.

National organisations valued the accessibility that a local funded coordinator afforded them, in seeking routes into local planning structures. It was important, however, that the coordinator possessed influence and access to strategic partners.

Local and national informants tended to favour a full-time coordinator to ensure sufficient capacity, knowledge and continuity to make full use of opportunities to promote *Choose Life* objectives proactively. Several areas noted that the establishment of dedicated development capacity had been extremely valuable.

A perceived disadvantage of this model was that partners might ascribe responsibility for suicide prevention to the individual coordinator and be less prepared to acknowledge their own potential contribution.

Coordination through existing remit
Where coordination was undertaken as part of an existing remit, this was perceived to enhance the opportunity to draw on coordinators' links into other structures and to contribute to the mainstreaming of suicide prevention in local policies and plans and on other agendas. On the negative side, this model could have disadvantages where a coordinator had poorly developed links into relevant partnerships and organisations (e.g. NHS), although this could be offset by ensuring that the *Choose Life* partnership had appropriate cross-sectional representation from relevant organisations (from health improvement to clinical services). Sufficient capacity to carry out all aspects of coordination was a further challenge with this model. In a number of areas, partnerships where coordination was undertaken as part of an existing remit had moved to, or were considering, employing a full-time or part time coordinating post.

Shared function of coordination
In this model, the function of coordination is shared by two or more people. In some areas, the role was shared 'vertically'. Here, a coordinator or the Chair of *Choose Life* partnership provided 'top down' support and links into strategic planning partnerships. The second coordinator had operational responsibility for day to day coordinative functions, e.g. writing minutes of meetings and overseeing project monitoring. In other areas the function was shared 'horizontally', as in a job share arrangement.

Shared coordination afforded greater capacity for coordination and brought the richness of different perspectives from diverse professions (e.g. in one case study areas, coordination was represented in health improvement and clinical services). It could also ensure that both strategic and operational aspects of coordination were included in the function.

Issues arising

Local coordinators recognised that, while coordination was important, it was also essential to take a proactive role to stimulate development in policy, partnerships, networks and service delivery and a number of areas had taken steps to increase capacity to undertake developmental work. The discontinuity resulting from change in personnel had been a challenge in several areas in maintaining key relationships, although some considered that having a well defined local action plan as a clear framework could help to minimise disruption.

Box 4.6 Commentary

Models of coordination of *Choose Life* vary across each local authority area and coordinative functions are also closely aligned to *Choose Life* partnerships. There are key factors that facilitate successful coordination, and these issues are also linked to the function of leadership (discussed in the following section).

Coordinating functions worked well where these were undertaken facilitatively in order to promote the engagement and involvement of a wide range of stakeholders. An appreciation of the wider policy, practice and research context within the planning process also helped facilitate effective links to cross-cutting agendas. Inclusion of developmental capacity proved valuable in proactive work towards mainstreaming activity with local organisations and services, and additionally in being able to respond quickly to unanticipated opportunities. Coordination was required at a strategic level (in order to raise strategic awareness) and also at operational level (in terms of overseeing and supporting funded implementation activities)

There has been a gradual evolution in local arrangements. This has helped to ensure coordination of planning and activity to enhance the ability to achieve *Choose Life* objectives and adaptation in the face of changes in personnel and in the wider organisational and policy environments. In general, coordinating capacity has been strengthened and refined. However, there were also indications that in some areas the infrastructure remained fragile and reliant on a small number of key individuals, with possible implications for longer term sustainability.

4.3.4 Leadership

In the early stages of phase one implementation, leadership at a local level tended to be associated with the coordinator and chairperson of the *Choose Life* partnership. Case studies illustrated the importance of leadership style in being able to bring together a range of agencies, including those whose role and contribution were less clearly defined, and focus on action without overly influencing decisions.

Over time, there was growing recognition that leadership needed to be shared by those who were members of the strategy group, championing suicide prevention in their own organisations and services, and should involve senior players able to link into strategic partnerships. This was seen as crucial in being able to diffuse responsibility for *Choose Life* objectives into policy priorities, planning and resource allocation decisions. Local coordinators saw leadership development as a necessary part of building capacity in selected agencies working with key priority groups.

Although there were some concerns relating to the loss of continuity where there were changes to leadership structures, the local view was that such changes tended to be beneficial, resulting in better defined processes for strategic planning and development, a higher profile for the suicide prevention and a broadening of the range of interests and areas of expertise involved.

Box 4.7 Commentary

Taking forward leadership as a shared function, e.g. between members of the partnership, helped to create spin-offs of activity within other organisations and helped the process of integrating *Choose Life* objectives into policy and planning.

Experience from previous initiatives demonstrates that facilitation and leadership are needed to ensure that an initiative works at an operational as well as strategic level (Mackenzie et al, 2005). A model of developmental leadership focused on facilitating ownership across agencies in *Choose Life* helped to create less reliance on funded coordinators and individuals. A sense of increased ownership of *Choose Life* was evident where areas purposefully developed engagement and support for those working across projects. This approach has also helped to generate new partnerships between local organisations in order better to support those at risk.

4.3.5 Partnerships to support Choose Life implementation

Membership of *Choose Life* partnerships was left to local discretion, although implementation required cross-sectoral representation. In practice, *Choose Life* partnerships generated interest from local champions and activists, and those engaged in other related National Programme activity. The size and diversity of partnerships and differences in perspective could pose challenges in reaching consensus in the local action planning process. Local stakeholders in some case study areas indicated that the commitment of partners to suicide prevention was crucial in ensuring that partners remained at the table. Where there was strong divergence of opinion, some partnerships had involved NIST and found this helpful. For example, in one area, consultation with NIST helped overcome disagreement in the action planning process where there were disagreements between NHS and council representatives.

Local informants and NIST regarded the development of local partnerships as a significant contributory factor in achieving progress in phase one implementation towards:

- Raising the profile and promoting ownership of *Choose Life* at all levels within partner organisations and in the eyes of the public, as *Choose Life* work widened its reach in local communities
- Creating a 'focus for action' and a forum for discussion on suicide prevention, among people and organisations who had not worked together previously
- Better mutual understanding and clarification of roles and areas of expertise
- The development of a range of practical initiatives including joint work on training
- Embedding *Choose Life* in the plans and activities of local services and teams.

A key factor in success indicated by local areas was that the partnership had sufficient status and links into relevant strategic planning groups and service delivery fora to ensure influence over other agendas. Nearly half of local *Choose Life* partnerships reported complete decision making authority. All partnerships had authority to identify and advise on local priorities and most partnerships had decision making authority on the allocation of *Choose Life* funding resources.

Changes to partnerships

Local areas were reviewing their partnerships in the course of phase one in order to ensure that partners who did not immediately understand their role in suicide prevention work were increasingly engaged. In some individual areas, partnerships were revised in response to sustainability issues (e.g. to ensure sufficient strategic representation from statutory organisations).

Two out of three local areas reported that their *Choose Life* partnerships had evolved in the course of phase one by:

- Extending the range of partners involved to include other strategy groups (e.g Children's Services Planning groups, Community Care partnership groups, criminal justice services and addiction services) and key service providers
- Strengthening existing partnerships: partnerships had become more structured as a result of better coordination and more effective use of local resources; there was more cross-boundary working; local networks had been established among partner agencies to review what works and to develop action plans; policies and procedures had been developed between key agencies; and there was closer involvement of senior officers.

Box 4.8 Commentary

There was diversity and range in partnerships in terms of size, membership and commitment from key players, both strategically and across health improvement and clinical sectors. It was possible, however, to identify a number of key factors that increased the effectiveness of the *Choose Life* partnership, including:

- Links established at senior level
- Strong multi-agency membership with commitment to objectives and ability to champion the work in their sector
- Maturity of the partnership in being able to debate and agree priorities

- Continuity of coordinating functions and capacity to use information (on needs, evidence of effectiveness, local evaluation).

These factors reflect key ingredients of success known to other types of partnerships(Dowling, 2004). This is important because, if these key factors are not present, the likelihood of successful partnership working is reduced.

Clear leadership and facilitative skills were influential in maintaining relationships with a wide range of sectors, particularly those not in receipt of *Choose Life* funding or where differing/divergent perspectives were evident. The impartiality/neutrality of the chair of the partnership and/or coordinator appeared to be critical in ensuring representation and involvement from each relevant sector (e.g. health improvement and clinical services). This is unsurprising as previous initiatives have demonstrated the need for high quality leadership with relevant domain knowledge, good track record and reputation (Blamey et al, 2005; Department of Environment, Transport and the Regions, 2002).

Evaluation findings demonstrate that many local areas are proactively reviewing membership and structures for phase 2. This is also supported by evidence that suggests partnerships can benefit from renewal and revision throughout their lifecourse (Department of Environment, Transport and the Regions, 2002). However, it cannot be assured that all local areas are undertaking reviews of partnership membership in an effective and consistent fashion.

4.3.6 Involvement of mental health services and clinicians

As a consequence of the location of *Choose Life* within community planning structures, engagement with statutory mental health services in *Choose Life* planning and activity proved to be challenging for many local areas. National level feedback suggested, however, that psychiatrists across Scotland generally welcomed the approach taken by *Choose Life* and enthusiasm for the policy at a national level was supported by psychiatrists interviewed in case study areas.

The national programme *Doing Well by People with Depression* (DWBPWD) was launched in April 2003 and is supported by funding from the Scottish Executive's Centre for Change and Innovation (CCI) (McCollam et al, 2006). The CCI has funded 12 local development projects across Scotland. The DWBPWD programme aims to:

- Improve mental well-being for people with depressive disorders
- Improve access to interventions which have an appropriate evidence base.

Many areas with operating DWBPWD programmes have established links between the two initiatives, including: joint funding of a bibliotherapy service; supporting domestic abuse work; and review of existing guidelines and support packages for depression management. In one case study area, a key rationale for this joint approach was that this provided a strategic way of targeting similar priority groups.

Other approaches used to facilitate and strengthen clinical involvement in suicide prevention included:

- Building on the early participation of local representatives from mental health services in national consultations on the development of *Choose Life* to promote awareness and commitment in mental health services to local *Choose Life* objectives
- Some *Choose Life* partnerships established informal feedback loops and cross-representation with mental health clinical structures
- In a minority of areas, *Choose Life* built on prior work on suicide prevention that was led by clinicians
- Links through the *Choose Life* coordinator with the implementation process for the Mental Health (Care and Treatment) (Scotland) Act 2003
- Through structural change, e.g. shifting strategic leadership for *Choose Life* to new, devolved partnerships for health and social care (including mental health), so that *Choose Life* becomes imbedded within and led by these structures, to engender closer links with NHS statutory partners.

Different data sources, national workshop and case studies highlighted the importance of further collaboration with primary care and A&E which also support people who self-harm, attempt suicide or have mental health problems.

Case studies demonstrated mixed success in the ability to link to and engage with these frontline services. Success was evident when the partnership had strong links to NHS planning structures or there were representatives from clinical services championing *Choose Life* in their parent organisation. In one case study area, for example, this resulted in a new model of service delivery between A&E and the Samaritans. In a handful of areas, GPs or A&E managers/nurses were members of the *Choose Life* partnership. In another area, where risk management training was funded through *Choose Life*, there was good attendance from clinical services.

Less successful attempts to engage clinical services were attributed to time constraints among health professionals, lack of national leadership that encouraged local clinical engagement and a lack of capacity within frontline services to carry out preventative work.

4.3.7 Involvement of substance misuse services

Evidence from case study areas suggests that representatives from substance misuse services have not been consistently engaged in local suicide prevention partnerships. Stakeholders from case study areas suggested several explanations for this, including:

- Insufficient time for the *Choose Life* partnership to engage a diverse range of partners in planning stages and nurture relationships with parties who did not immediately understand their role in suicide prevention
- Significant reorganisation in structures and voluminous agendas of teams
- Culture and attitudes, e.g. suicide prevention not seen as the business of addiction services; concern from within addiction services that this agenda might create additional work that there was insufficient capacity to support

- Substantial substance misuse funding channelled into a reactive response rather than preventative work
- Compartmentalisation of substance misuse, suicide and mental health issues at a strategic level.

Throughout the course of phase one, many areas fostered engagement with the substance misuse services. This was particularly encouraged by NIST. The operations manager for NIST met with *Choose Life* partnerships and actively encouraged local areas to make links to their Alcohol and Drug Action Team (ADAT). National guidance for phase two highlighted the importance of engagement with clinical and substance misuse services.

Increased engagement is also thought to have been facilitated by:

- Time to nurture relationships with partners in substance misuse, leading in one region to a regional seminar on alcohol and suicide prevention
- Training used as a mechanism to engage operational staff
- JHIP as a potential facilitator for engagement (where alcohol/drug misuse is local priority for the JHIP)
- Recent Scottish Executive (2005b) recommendations to local areas in *Taking action to reduce Scotland's drug-related deaths*, which included reference to *Choose Life*
- In one area, an ADAT coordinator had participated with *Choose Life* in a previous local authority area and wished to continue this involvement.

Box 4.9 Commentary

Distinctions are important in the engagement of different clinical services. Psychiatrists have demonstrated support for the *Choose Life* strategy and, in a number of areas, mental health services have taken an active role in planning and in coordination. This has occurred less frequently with substance misuse services.

In relation to mental health services, there may be some tension between the national guidance that does not permit funding of services and the need to ensure that *Choose Life* objectives are taken forward within these services. There are also challenges in that little is known about how such services are contributing to achieving the objectives of the *Choose Life* strategy.

The level of commitment and engagement nationally from substance misuse services to *Choose Life* objectives remains less clear. The identification of people with substance misuse problems as a priority group in *Choose Life* has been used by NIST to encourage local areas to engage representatives in this field (often successfully).

Substantial gaps remain in activity relating to primary care and, to a lesser extent, A&E Services. Consideration of the leadership role that national organisations can play in facilitating engagement by local services may be important in addressing this.

4.3.8 Involvement of national partners

In some instances, national partners considered they had not been engaged with local area partnerships in a way that made effective use of their expertise and ensured continuity of support for key risk groups that used the services of national organisations. The turnover and variability in availability and accessibility of local coordinators was regarded as a contributory factor. It was also considered that further work was required for national organisations and local partnerships to identify common priorities.

Choose Life partnerships provided the Samaritans with their first major opportunity to become involved in local decision making partnerships. As a result, the organisation had more interaction in local areas and felt more 'visible' in local communities.

For ChildLine, networking undertaken by the coordinator had improved links to, and understanding of, the organisation in local areas.

Nationally, the SPS was considered to have networked well in local areas and, in one case study area, this had led to joint funding of a *Choose Life* initiative. In some areas, SPS had found it challenging to engage with local partners. This was attributed to prisoners not having been identified as a local priority in the community. Local areas also reported that funding had often not been allocated to this priority group locally because of the national *Choose Life* funding available to the SPS. However, opportunities for the SPS to present at the NIST summits had increasingly built relationships with, and generated interest from, local areas.

4.3.9 NIST support to local implementation

National interviews highlighted that there were several dimensions to NIST's role in supporting and guiding local implementation and working alongside local infrastructures. Key elements of this role included:

- Promoting consistency of approach within the framework of objectives and priorities specified in *Choose Life*
- Providing guidance and advice and advocating for *Choose Life* objectives and priorities with local decision makers
- Enabling and supporting local coordinators and other key players to lead developments regionally and nationally
- Maintaining an overview and coordinating developments that have local and national relevance, e.g. training initiatives
- Building capacity to generate and use information and research
- Acting as a conduit between the National Programme and local areas.

NIST members adopted different approaches in their work with local areas, depending on the nature of the task:

- Taking a 'hands on' approach to support local areas (e.g. working closely with individual coordinators) in translating the strategy into local planning systems

- Building alliances with interested coordinators and encouraging leadership independent of NIST, e.g. through membership of SIREN
- Striking a balance between being directive and being nurturing.

Box 4.10 Commentary

Choose Life has added value to relationships between national organisations and local areas. This occurred particularly where there was a national *Choose Life* coordinator in place as a clear point of contact in the organisation.

Local areas have appreciated the hands-on guidance and support from NIST. They are keen for this to continue (e.g. in relation to evaluation approaches and evidence of what works). It is important, however, to ensure a balance between building local capacity and avoiding over-reliance on NIST for support and guidance. There are potential challenges in reconciling the (directive) performance management and (nurturing) support functions of NIST.

4.3.10 Progress in developing local infrastructures

Local areas recognised that it was important to continue to review and refine their approaches to implementation in order to achieve greater integration with other areas of policy and service development. Towards the end of phase one, some areas were actively working to shift *Choose Life* to a structural/policy context within the authority, thus promoting longer term sustainability (see chapter seven). Closer contact among partners was also considered necessary to promote the exchange of learning at different levels.

Progress made in developing local infrastructures to support implementation is summarised in table 4.2 below. This considers progress and emerging issues/gaps in relation to the positioning of *Choose Life* in the CPP, development of local action plans, coordination, partnerships for implementation, local visions and NIST support to local areas.

Table 4.2 Progress in developing a local infrastructure to support implementation

Infrastructure development	Progress	Challenges/issues/gaps
Positioning of *Choose Life* in Community Planning Partnerships	*Choose Life* has added value to CPP by developing partnership working, particularly with the voluntary sector. Multi-agency approach and devolved funding has fostered ownership CPP gives access to planning and service provision in range of sectors as basis for future mainstreaming of *Choose Life* priorities/objectives. Inclusion of *Choose Life* objectives in range of local plans and strategies	Maturity of local CPP and JHIP processes impacts on prospects for *Choose Life*. Important to track implementation across sectors to monitor and evaluate impact.

Infrastructure development	Progress	Challenges/issues/gaps
Local Action Plans	Local alliances well established Provided a useful framework for drawing in stakeholders (national and local) and a firm basis for joint working	Challenges in marrying stakeholder engagement with an evidence-based approach. Maintaining 'sign up' to priorities.
Vision: building capacity in services	Local infrastructures have proved valuable to build awareness/ engagement and open up access for joint working with national bodies. Increased access to training	Potential for more collaboration between local areas and national organisations.
Vision: mainstreaming	Various changes made to local *Choose Life* infrastructures to facilitate mainstreaming. Too early to be able to identify *Choose Life* impact on local policy development	Further work required to use information/research to advocate for mainstreaming.
Vision: building capacity in local communities	National coordination of training has been beneficial. Community capacity strengthened through development of partnerships/ networks. Considerable early investment in development of community projects and in training.	Pressures of time, multiple priorities and short-term funding are challenging
Coordination	Variety of models of coordination had evolved to fit local structures and priorities. Although one model cannot be favoured outright, there are key cross-cutting elements to successful coordination. Particularly, inclusion of developmental capacity has proved important in fostering partnership working. Valuable for national organisations to have identified point of contact	Staff turnover creates discontinuity. Important that coordination covers strategic and operational levels.
Partnerships for implementation	Partnerships had grown in range and depth, including links with other National Programme work locally	Further development of links required with: • Substance misuse • Mental health services/ clinicians • National organisations.
NIST support to local areas	Regular communication and contact established between local areas and NIST, individually and collectively. NIST has assisted local areas with critical issues e.g. media, priority setting.	Need to balance NIST role to support/facilitate and to manage performance.

CHAPTER FIVE ALLOCATION OF RESOURCES

5.1 Introduction

One of the key issues for the commissioned evaluation was to track resources allocated by the Scottish Executive to the implementation of the strategy and action plan, and to investigate whether and how the money allocated to national and local initiatives was:

- stimulating local investment from CPPs
- targeted at relevant priority groups
- being spent on proven effective practice and interventions
- stimulating innovation.

This section considers the allocation of *Choose Life* funding both nationally and locally and provides a number of different breakdowns on how these resources have been used. These include: looking at the split between national and local resources, targeting across key action areas for *Choose Life* (training, community/voluntary & self-help initiatives, and coordination), national and local priority groups, *Choose Life* objectives and type of intervention.

The issue of additional investment and in-kind support is of key importance. Funding was intended to act as a stimulus for additional support for local suicide prevention work. It was expected that CPPs would take steps towards fostering partnerships and generating additional resources which could aid in potential long term mainstreaming and sustainability of suicide prevention activity. Projected levels of expenditure over the first three years of *Choose Life* are also compared with actual levels of expenditure on projects and activities. The section concludes by considering progress made in targeting of resources, and identification of emerging gaps/issues.

5.2 Allocation of national funding

Over the three financial years 2003-2004, 2004-2005 and 2005-2006, £12 million was set aside by the Scottish Executive to fund the initial phase of Scotland's suicide prevention strategy.

One quarter of all funding was earmarked for national activities including support for implementation of the strategy.

Funding at both national and local levels was broadly evenly spread across the three year period. This commitment was also intended to "*encourage local investment from NHS Boards, NHS Trusts, local authorities and other agencies, in developing effective interventions and, in particular, in coordinating efforts between agencies.*" (Scottish Executive, 2002).

Earmarking funding for *Choose Life* was important both symbolically in terms of highlighting the important of the issue, and also practically in terms of providing a period of time during which appropriate infrastructures might be developed or

enhanced to reduce suicides in Scotland. While ring-fencing of funds at the national level appears clear, it should be noted that at the local level ring-fencing of funding for *Choose Life* is somewhat weaker as funds are absorbed into local authority budgets. Theoretically, local funds set aside for *Choose Life* might be used for other purposes; local authorities might also seek to recover unspent *Choose Life* monies at the end of any financial year. In practice this has not proved to be a major concern thus far, with less than 1% of the overall budget being retained by local authorities in this fashion. Mechanisms (if feasible) to ensure that *Choose Life* funds can only be used for *Choose Life* activities would of course minimise this potential risk.

5.2.1 Planned allocation of resources

Table 5.1 sets out the initial planned allocation of resources at the national level and also across all 32 local authority areas. National funding was allocated to NIST and other national organisations. National support has included running many events, providing training opportunities, working to improve communication and coordination between different groups, website development and the publication of information materials. This has also included financial support of £150,000 for the Samaritans, £500,000 for the Scottish Prison Service and £50,000 to ChildLine for *Choose Life* related activities, as described in chapter four. Almost £424,000 from national funding has been used to support training, including £275,000 for the National Training Strategy Development Fund. Funds were also used to support the initial training of ASIST trainers across all 32 local authority areas. The category of research and evaluation in this table includes activities such as commissioned research reviews related to suicide and suicidal behaviour, and a resource database to gather information about suicide prevention activities. It also includes commissioning of this independent evaluation of phase one of the strategy. These activities are detailed in chapter eight.

Funds at the local level consisted of a universal flat sum for all, plus population-related supplementary funding. Funding at local level was intended to promote and strengthen local partnerships as well as support training and innovation.

Table 5.1 Planned allocation of resources between national and local activities in phase one

	2003-2004 £m	2004-2005 £m	2005-2006 £m	Total £m
Funds for national activities				
NIST, network and information provision	0.45	0.51	0.56	1.52
Research and evaluation	0.45	0.51	0.52	1.48
Total national funding	0.90	1.02	1.08	3.00
Funds for local activities				
Promote local alliances	1.90	2.00	2.10	6.00
Local training & innovation support	0.90	1.00	1.10	3.00
Total local funding	2.80	3.00	3.20	9.00
Overall totals	**3.70**	**4.02**	**4.28**	**12.00**

5.3 Allocation and use of funds at local level

This section looks at how all source of funding for *Choose Life* in each of the 32 local areas has been allocated. This includes: targeting across key action areas for *Choose Life*, national and local priority groups, *Choose Life* objectives and type of intervention. It also looks at how successful local areas have been in obtaining additional resources, both monetary and in-kind. Most of this information is based upon a detailed analysis of data collected from local areas by NIST using a standard template (as outlined in chapter three). This information has been supplemented by information from case studies in eight areas and a survey of all 32 areas.

5.3.1 Strengths and limitations of data

It is important at the outset to flag up strengths and challenges in data collection. When NIST was first established, little financial information was available in local areas. The first local action plans submitted in December 2003 were, in general, not costed. Thus, an early priority for NIST was to develop a system that would capture how resources were being put into budgets for different activities and how money was in fact being spent. A bespoke template represented the first attempt at a management information system. It was a multi-purpose tool that captured both financial information about projects and other information such as links to priority groups and objectives, any local evaluation design in place, etc.

There have been practical challenges for some local coordinators to complete the template; for instance, not all possessed the basic spreadsheet skills needed to complete the first version of the template. A further continuing difficulty is that, while NIST can request information, CPPs are under no formal obligation to comply. Providing information to NIST may be less of a priority at a local level than dealing with day to day matters; thus, there can be delays in receiving feedback from some local areas. Moreover, in many instances, even when this information when received, it can be incomplete or inconsistent.

NIST has adapted their templates to try and ensure these are more 'user friendly', allowing local areas to provide text based information using a Word format. They also provide hands-on support to coordinators to help them complete the template. A management information tool has been developed using information from the templates. For example, this enables someone looking at the *Choose Life* website to search across *Choose Life* funded implementation activities in Scotland. Nevertheless it should be stressed that, at the time of writing this report, some information gaps on how local resources are being used still remain.

Box 5.1 Commentary

The monitoring systems in place (e.g. templates) provide a wealth of information on *Choose Life* activities underway across Scotland and represent a significant achievement in gathering substantial information about funded suicide prevention activities. There have been some practical challenges in ensuring completeness of the information that has been gathered. NIST has responded to these difficulties and has revised and developed systems to encourage local areas to provide more information. Careful analysis will be needed to assess the success of these new systems and consider any additional approaches or modifications to these systems that may be required to improve data collection.

Given the diversity of backgrounds of coordinators and/or *Choose Life* project managers, further consideration may need to be given to training needs of local managers of *Choose Life* projects/coordinators who may have variable levels of skills in project management and leadership. Such a consideration would go beyond the remit of NIST and would apply to voluntary and community delivered projects generally. Individuals might be encouraged to participate in short courses providing basic skills, such as those regularly run by the Scottish Council for Voluntary Organisations.

A further issue relates to the utilisation of information gathered by NIST. While this information is available through the website, our analysis represents the first time that information from local areas has been brought together to determine how funds have been allocated between priority areas and target groups. (It is acknowledged, however, that, when complete, the management information system at NIST should enable similar information breakdown). There are implications for how current and future information can most usefully be shared and disseminated.

5.3.2 Planned and allocated funding including complementary investment

Table 5.2 provides information on funding distributed to CPPs from central government by the Scottish Executive. Local areas differ in the extent to which they have already designated how this funding will be used for specific activities. For instance, while Aberdeen has allocated all its core budget to activities, neighbouring Aberdeenshire had not allocated £8,500 at the end of 2005/2006. This may reflect a gap in information provided on the templates; alternatively it might also be due to delays in getting activities and projects up in running in some areas, in part resulting from the short lead in time to the initiative (see *Choose Life* timeline in annex 2).

The table also highlights the amount of additional complementary investment (both monetary and in-kind) generated for *Choose Life*, where information is available. What is clear is that the majority of areas have been successful in raising some additional funds from a variety of sources, including local councils, the NHS, national charities and the national lottery. In total more than £1.6 million has been identified. According to data derived from the templates, 13 areas have not obtained any additional funding; some of this may be due to an information deficit.

CPPs may be able to learn from successful experiences on how to increase their fund raising potential. In Glasgow, for example, on application for funding, each project or initiative was asked to state additional funding or costed in-kind support which could be bought to their bids. This led to significant levels of new investment to back the *Choose Life* fund and investment in terms of actual funding and in-kind support.

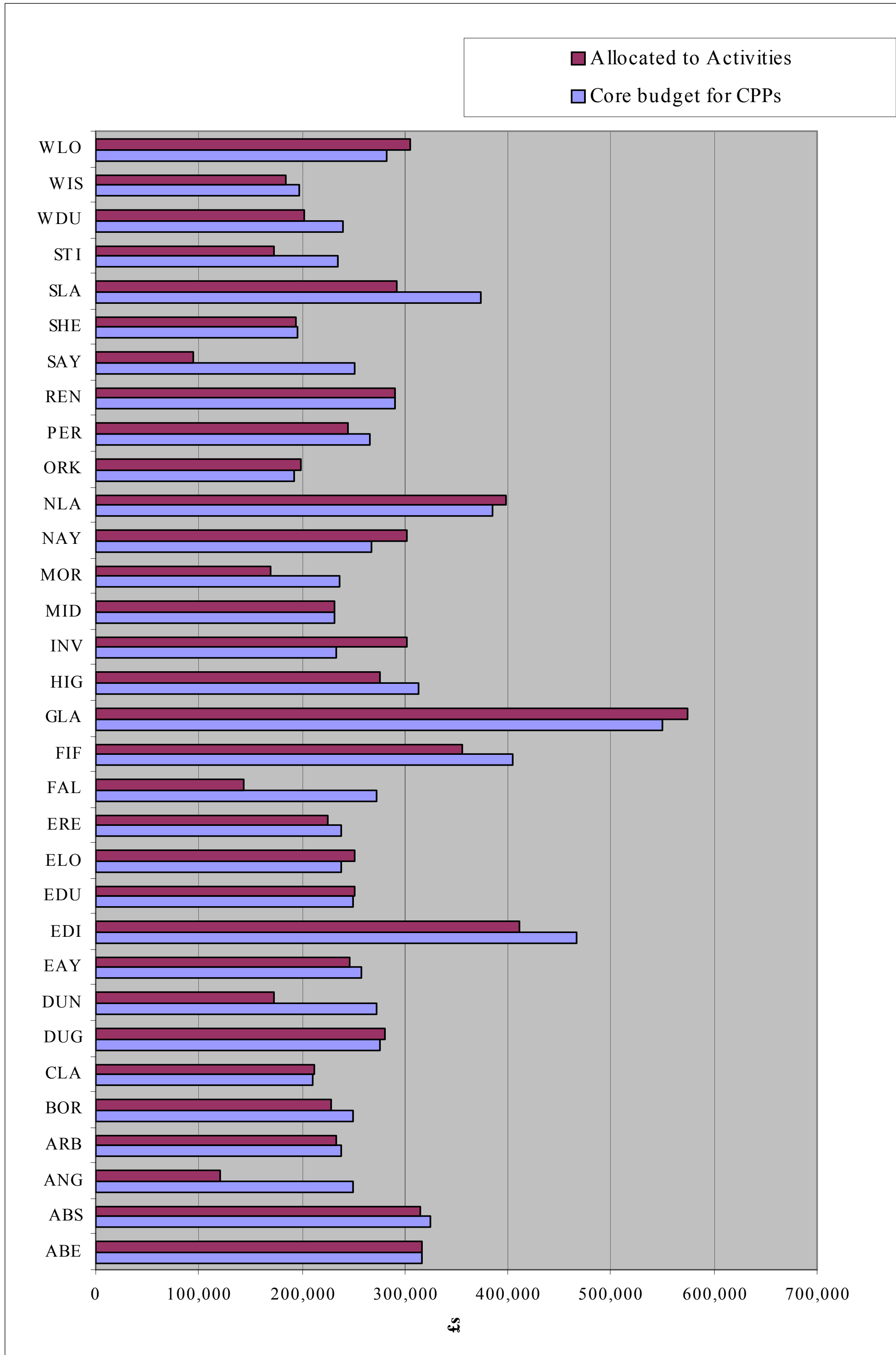
In Inverclyde**,** funding was secured from Changing Children's Service Fund for a post employed through National Children's Home's (NCH) Gap project in phase one. The bid was developed by a representative from Integrated Children's Services, Child & Adolescent Mental Health Services and the Social Work service manager. The NCH project received existing funding through youth justice monies for young offenders and had also received Scottish Executive monies for a mental health nurse to work with multiple/complex needs. The funded post through *Choose Life/*Integrated Children's Services was identified as an opportunity to put in a peer for this worker.

Table 5.2 Planned and allocated funding including complementary investment for phase one

Local authority area	Planned funding for CPPs	Allocated to activities	Balance	Additional monetary investment	In-kind investment	Total allocated to activities
ABE	316,000	316,000	0		77,465	393,465
ABS	324,000	315,428	-8,572	0		315,428
ANG	249,000	120,500	-128,500	3,000		123,500
ARB	238,000	233,149	-4,851	41,575		274,724
BOR	249,000	227,723	-21,277	0		227,723
CLA	210,000	211,800	1,800	2,205		214,005
DUG	275,000	280,000	5,000	700		280,700
DUN	273,000	172,877	-100,123	0		172,877
EAY	257,000	245,679	-11,321	34,451	4,066	284,196
EDI	467,000	411,500	-55,500	500		412,000
EDU	249,000	251,170	2,170	156,000		407,170
ELO	238,000	251,270	13,270	52,208		303,478
ERE	238,000	225,750	-12,250	369,989		595,739
FAL	273,000	143,500	-129,500	0		143,500
FIF	404,000	356,000	-48,000	26,251	12,810	395,061
GLA	550,000	574,915	24,915	549,390	56,500	1,180,805
HIG	314,000	276,237	-37,763	0	42,500	318,737
INV	234,000	302,600	68,600	132,440	77,928	512,968
MID	231,000	231,000	0	5,000		236,000
MOR	236,000	170,293	-65,707	16,000		186,293
NAY	267,000	302,618	35,618	0		302,618
NLA	385,000	398,500	13,500	0		398,500
ORK	192,000	199,863	7,863	61,000		260,863
PER	266,000	245,113	-20,887	0		245,113
REN	291,000	291,000	0	0		291,000
SAY	251,000	93,985	-157,015	0		93,985
SHE	195,000	193,814	-1,186	77,191		271,005
SLA	373,000	292,131	-80,869	0		292,131
STI	235,000	172,611	-62,389	30,000		202,611
WDU	240,000	202,794	-37,206	50,200		252,994
WIS	198,000	183,610	-14,390	0		183,610
WLO	282,000	305,520	23,520	50,742		356,262
Total	9,000,000	8,198,950	-801,050	1,658,842	271,269	10,129,061

Figure 5.1 demonstrates the planned versus actual allocation of *Choose Life* core funding in phase one across the 32 local areas.

Figure 5.1 Core Community Planning partnership (CPP) budgets versus actual allocation of *Choose Life* core funding in phase one



Case study data also suggest that levels of additional funding may be much higher than those actually reported (see section 5.4). Few areas have reported and put a monetary value on any in-kind investment identified. Such in-kind funding is almost certainly being provided in most CPPs and it is important to quantify this to get a true sense of the potential of CPPs through the *Choose Life* partnership model to obtain additional resources.

Box 5.2 Commentary

Under the *Choose Life* partnership model, it was anticipated that CPPs would complement funds from the Scottish Executive with additional sources of funding. This could potentially contribute towards the long term sustainability and possible mainstreaming of activities. Substantial additional monetary investment (£1.6.m) has been raised by CPPs. Some areas have been much more successful than others; £1.15 million has been raised by four areas alone, while as many as eight do not appear to have raised any additional monetary funding. This may partly reflect reporting gaps, but it also may reflect training needs or the lack of time early in the project, where initial planning and implementation of activities were seen as the priorities, for local coordinators to seek such funding. Dedicated help and support in seeking such funding, as well as thinking about long term about issues of sustainability and mainstreaming, may be appropriate.

Few areas have sought to put a monetary value on in-kind funding. It is clear, however, that enormous amounts of goodwill and unpaid time from professionals, including trainers as well as volunteers, have been contributed to *Choose Life*. This is likely to be a substantial value added benefit of this approach. It is vital, however, that information is collected as a matter of course on both these in-kind contributions to *Choose Life* so that some value can be placed on this added benefit. If the level of in-kind benefits identified in case studies were to be repeated across all areas, this might be worth several million pounds.

5.3.3 Allocation of resources by Choose Life action area for phase one

This section considers how available resources have been allocated across the *Choose Life* action areas: community/voluntary/self-help initiatives, training initiatives and coordination of local area activities. The 'training initiatives' category includes research activities, while the 'coordination' category covers planning, management, and partnership working issues, including the funding of local coordinators.

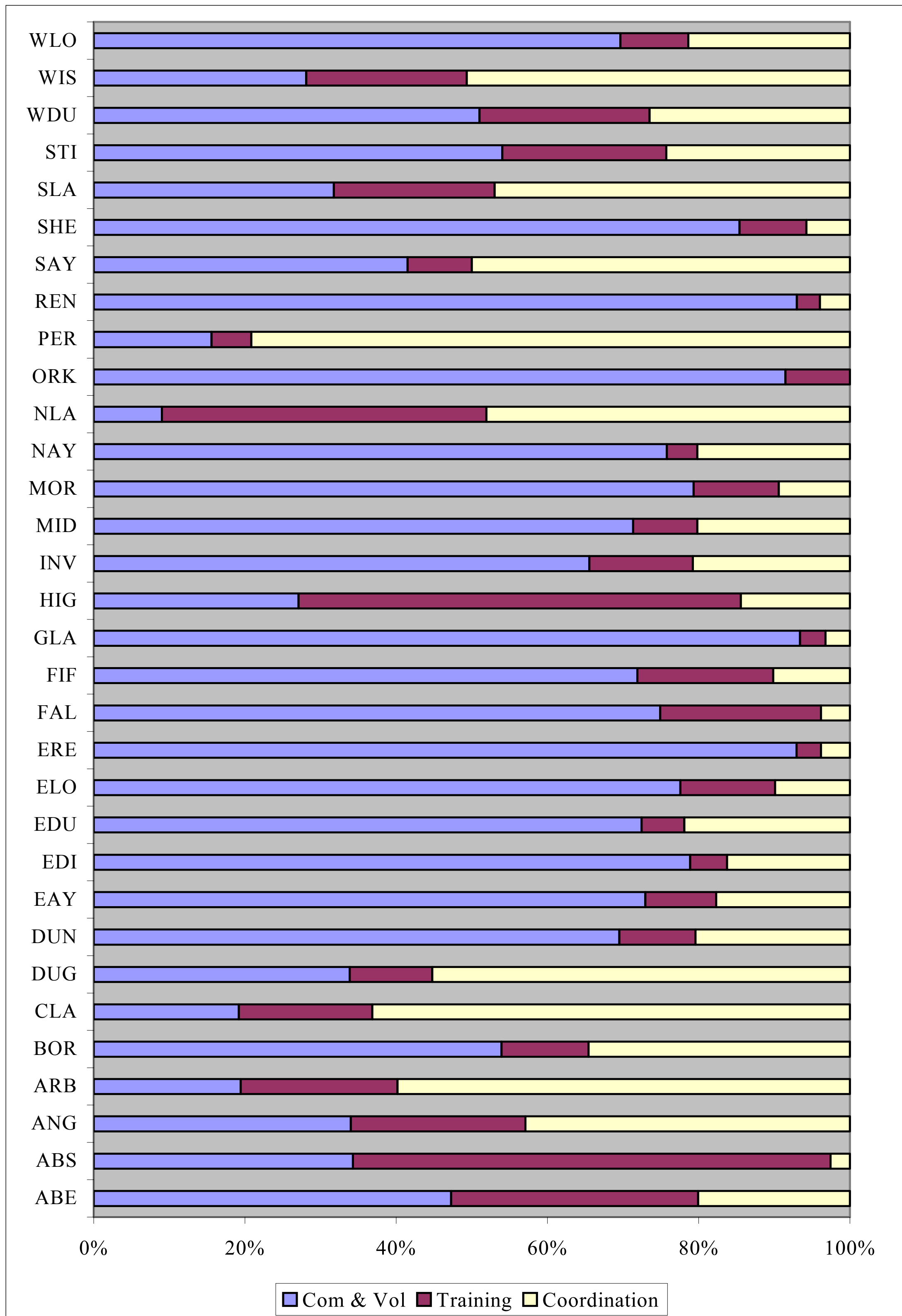
Table 5.3 and figure 5.2 highlight the allocation of resources by *Choose Life* action area for phase one. Overall approximately 62% of funding from all sources has been allocated to community/voluntary and self-help initiatives, 22% to coordination activities and 16% to training. Local areas can differ markedly in how they have allocated resources between these three areas, reflecting different needs and potentially also the availability of pre-existing services or skills. Glasgow, for instance, has a very high level of investment (93%) in community/voluntary and self-help initiatives – this is to a large extent due to the fact that additional monetary

support has focused on this area. Highland has concentrated quite heavily on training (59%) (see below), while Argyll & Bute (60%) and Perth (79%), for instance, have devoted much of their funding to coordination.

Table 5.3 Allocation of resources by *Choose Life* action area for phase one

Local authority area	Total allocated to activities	Community/ Voluntary	%	Training	%	Coordination	%
ABE	393,465	186,000	47	128,500	33	78,965	20
ABS	315,428	108,140	34	199,175	63	8,113	3
ANG	123,500	42,000	34	28,500	23	53,000	43
ARB	274,724	53,450	19	56,916	21	164,358	60
BOR	227,723	122,811	54	26,200	12	78,712	35
CLA	214,005	41,073	19	37,805	18	135,127	63
DUG	280,700	95,000	34	30,700	11	155,000	55
DUN	172,877	120,173	70	17,372	10	35,332	20
EAY	284,196	207,338	73	26,648	9	50,210	18
EDI	412,000	325,000	79	20,000	5	67,000	16
EDU	407,170	295,000	72	23,000	6	89,170	22
ELO	303,478	235,478	78	38,000	13	30,000	10
ERE	595,739	553,670	93	19,250	3	22,819	4
FAL	143,500	107,500	75	30,500	21	5,500	4
FIF	395,061	284,061	72	71,000	18	40,000	10
GLA	1,180,805	1,102,768	93	40,000	3	38,037	3
HIG	318,737	86,354	27	186,462	59	45,921	14
INV	512,968	336,268	66	70,200	14	106,500	21
MID	236,000	168,347	71	20,000	8	47,653	20
MOR	186,293	147,793	79	21,000	11	17,500	9
NAY	302,618	229,401	76	12,130	4	61,087	20
NLA	398,500	36,000	9	170,900	43	191,600	48
ORK	260,863	238,588	91	22,275	9	0	0
PER	245,113	38,221	16	12,849	5	194,043	79
REN	291,000	270,587	93	8,913	3	11,500	4
SAY	93,985	39,000	41	8,000	9	46,985	50
SHE	271,005	231,447	85	23,983	9	15,575	6
SLA	292,131	92,805	32	62,121	21	137,205	47
STI	202,611	109,457	54	43,954	22	49,200	24
WDU	252,994	129,114	51	56,880	22	67,000	26
WIS	183,610	51,610	28	39,000	21	93,000	51
WLO	356,262	248,093	70	32,000	9	76,169	21
							0
Total	**10,129,061**	**6,332,547**	**62**	**1,584,233**	**16**	**2212281**	**22**

Figure 5.2 Allocation of resources by *Choose Life* action area in phase one



5.3.4 Training

Highland has invested heavily in training activities; for example around one third (£42500) of the total costs of STORM training have been identified as in-kind contributions, much of which have been funded by complementary resources. This included staff time from local statutory agencies, the provision of accommodation and the time contribution of volunteers from the Highland Users Group. In Highland, skills gaps for different groups (e.g. mental health professionals, generic health professionals and community members) were identified through local consultation during the *Choose Life* planning process. Training was expected to meet needs quickly and to provide a sustainable approach to improving the skills of the local community and professionals. It was also thought that the chances of mainstreaming training interventions beyond the *Choose Life* funding period might be more likely than for mainstreaming community and voluntary initiatives.

In Perth, a significant proportion of funding was allocated to learning in phase one. This has resulted in funding of research on young people, self-harm issues and needs assessment.

It should be borne in mind that many other activities, which support the delivery of local suicide prevention plans, are not listed in the template information because they are not funded by Choose Life. In East Ayrshire, Fife, Shetland and Glasgow, coordinators undertake this role as part of their non-Choose Life activities (including, for example, training).

Targeting of training

There was additionally diversity in types of training undertaken (see table 5.4). Applied Suicide Intervention Skills Training (ASIST) was endorsed as a national training approach by the Scottish Executive. LAP data show that 23 areas have allocated some funding to ASIST related activities. This is probably an underestimate, due to the limitations of existing information. ASIST training is almost certainly included in the 'other' undefined training category as well, as all are committed to delivering ASIST as part of *Choose Life*. Some areas may also include activities such as Mental Health First Aid within this general 'training category'. This is the key reason why the 'other' training category appears to have the highest level of funding. Moreover, as noted in section 5.2.1, £424,000 has been allocated from the national budget to training activities, including funding for the initial training of ASIST trainers in all 32 local authority areas.

Applied Suicide Intervention Skills Training (ASIST)
ASIST is a two-day intensive, interactive and practice-dominated course aimed at enabling people to spot the risk of suicide and provide immediate help to persons at risk. ASIST develops the skills necessary for suicide first aid. It is suitable for anyone, including professionals, volunteers and members of the community.

Skills-based Training On Risk Management (STORM)
STORM is a Suicide Prevention training package for all healthcare, social care, criminal justice staff and volunteers, particularly for those working with individuals vulnerable to feeling suicidal.

Mental Health First Aid (MHFA)
Mental health first aid is the help given to someone experiencing a mental health problem before professional help is obtained. MHFA does not teach people to be therapists. However, it does teach people:

- how to recognise the symptoms of mental health problems
- how to provide initial help
- how to guide a person towards appropriate professional help.

SuicideTALK
SuicideTALK is a short exploration and awareness session. It can take between one to three hours with the content adapted to meet the needs of the group. The talk encourages participants to explore their attitudes towards, and feelings about, suicide, based on the question "should we talk about suicide?"

A minority of activities are focused on postvention training (to help deal with the aftermath of suicide); this is supported by information on the allocation of resources by intervention type later in this section. Few areas invested in STORM initially, although case study data suggest an increased interest in this approach. This has been particularly influenced by learning between areas of the experiences of implementing STORM in Highland.

In relation to ASIST, a key approach to training rationalisation has been to target workers who support vulnerable groups, although there has been diversity according to locally perceived need. In Glasgow, for example, the general public did not receive training. This was influenced by the need to prioritise training for those regularly in contact or working with vulnerable groups and the lack of resources to target the general public in a large urban population. In comparison, significant numbers of the general population have participated in training in rural and remote areas (Highland and Shetland Isles). In the case studies, factors thought to influence this were rural isolation and perceptions that many vulnerable people come into contact with, or are supported by, community members.

A variety of local training/awareness raising approaches has also been funded. Common approaches are:

- Schools/community based with young people (promoting emotional literacy)
- Awareness raising in schools settings with staff/in the community
- Mental health promotion training
- Training for workers supporting people with mental health problems/people who self-harm.

National training strategy

NIST has also taken an increasingly strategic approach to training, as reflected in the employment of a training manager and development of a training strategy. National interviews highlighted an increase in the popularity of training across Scotland in phase one and revealed that local areas required support in terms of delivery of training and in understanding whom to target. All trainers' time was delivered in-kind during working hours. An important need was not only to harness enthusiasm and goodwill locally but also consider the quality of training and the availability of support systems.

Although a training coordinator was in place, a key decision was to appoint a training manager in summer 2005. The purpose of this post was to support development of a training infrastructure across Scotland, including an overarching training strategy that would support sustainability of training and coordinate different training approaches (local and national) and in prevention, intervention and postvention training.

The development of the strategy was supported by local and national consultation and NIST commissioned an international suicide prevention training expert to support the strategy's development.

Table 5.4 Allocation of resources by type of training

Local authority area	ASIST £	STORM £	MHFA £	Suicide Talk £	Other £	Total £
ABE					128,500	128,500
ABS	7,500				191,675	199,175
ANG			1,000		27,500	28,500
ARB	35,705				21,211	56,916
BOR					26,200	26,200
CLA	4,205				33,600	37,805
DUG	30,700*				30,700*	30,700
DUN	1,800				15,572	17,372
EAY	19,148	4,500	3,000			26,648
EDI	10,000		10,000		0	20,000
EDU					23,000	23,000
ELO	8,000		15,000		15,000	38,000
ERE	14,250		5,000		0	19,250
FAL					30,500	30,500
FIF	71,000					71,000
GLA	40,000*				40,000*	40,000
HIG	17,000	141,434	6,400		21,628	186,462
INV	45,100*		45,100*		60,100*	70,200
MID	13,000		7,000			20,000
MOR	16,500				4,500	21,000
NAY	2,323		2,107		7,700	12,130
NLA				5,000	165,900	170,900
ORK	7,500		10,000		4,775	22,275
PER					12,849	12,849
REN						8,913
SAY					8,000	8,000
SHE	23,063*		23,063*	23,063*	920*	23,983
SLA	45,595				16,526	62,121
STI	7,954				36,000	43,954
WDU	22,380	10,000	10,000		14,500	56,880
WIS	24,000	9,000		3,000	3,000	39,000
WLO	30,000				2,000	32,000
Total	**496,723**	**164,934**	**137,670**	**31,063**	**941,856**	**1,584,233**

* Some areas have indicated that training funds have been used for more than one category of training, but no split of funds has been provided. These are indicated with an asterisk – totals for each category of training will therefore be higher than the total amount of expenditure on training in the table.

Type of interventions

Table 5.5 outlines how resources have been allocated to specific interventions intended to reduce the risk or suicide, as well as to other tasks, such as coordination of activities and awareness raising events. Additional information on the number of specific projects in each category is provided in table 5.6. Universal preventive interventions are distinguished from selective preventive interventions. The former are aimed at specific groups within a population not known to be of high risk of suicide; this, for instance, would include interventions targeted at school populations. The latter refer to interventions targeted at individuals known to be at higher risk of suicide, such as people with diagnosed mental health problems. Postvention

interventions deal with the issues arising in the aftermath of suicide. Population-wide activities largely consist of education and awareness raising events and campaigns.

Table 5.5 Allocation of resources to type of intervention

	Community and voluntary £	Training £	Coordination £	Total £
Universal preventive interventions*	1,909,078	1,175,433	127,824	3,212,335
Selective preventive interventions*	5,478,277	491,802	387,602	6,357,681
Postvention activities*	782,883	110,275	63,175	956,333
Population awareness raising	62,075	70,016	75,785	207,876
Partnerships & inter-agency working	6,500	0	175,845	182,345
Staff posts	0	100,000	1,147,004	1,247,004
Educational events, research & evaluation	5,000	31,071	274,404	310,475
Not stated	218,370	0	108,936	327,306

* Some activities may fall cover both prevention and postvention

Table 5.6 Number of projects by type of intervention

	Community and voluntary N	Training N	Coordination N	Total N
Universal preventive interventions*	73	58	9	140
Selective preventive interventions*	143	26	17	186
Postvention activities*	20	9	3	32
Population awareness raising	10	7	13	30
Partnership and inter-agency working	4	1	39	44
Staff posts	0	2	18	20
Educational events, research and evaluation	2	6	30	38
Not stated	2	0	2	4

* Some activities may fall cover both prevention and postvention

It is clear from this breakdown that the overwhelming majority of resources are devoted to delivering, coordinating and providing relevant training for suicide prevention activities. Only £1.2. million (approximately 10%) of all funds identified for *Choose Life* have been allocated to dedicated staff posts, such as coordinators and development workers whose positions cannot be linked directly to specific activities. It is reasonable to expect that this is also an information deficit – these individuals may spend a significant amount of time coordinating and delivering specific interventions

Of universal prevention initiatives, over half target young people and children (e.g. schools/community based mental health awareness). Population-wide approaches to community awareness can be seen across areas (e.g. material for the public, training sessions, beer mats and postcards, links to football/rugby clubs), and it is evident that a range of different approaches, materials and messages is being developed locally. Activities focused upon mental health awareness are funded in a number of local areas, although the extent to which these complement or overlap with other relevant initiatives (e.g. MHFA) is unclear. Feedback from the second evaluation workshop noted that the continued shared understanding of 'messages' should be developed in partnership (to ensure ownership) and must be responsible/evidence based.

Intervention responses target a variety of priority groups and include counselling for at risk groups or crisis response in the community and voluntary setting and funding to national organisations such as the Samaritans. There are also commonalities in approaches in new partnerships that link voluntary sector services with statutory services (see chapter six).

Of the main categories (prevention, intervention and postvention), the latter has received least attention. Activities include CRUSE, support for those bereaved (including by suicide), and support for the families of those who attempt suicide. Potential explanations for this relatively low level of priority were lack of capacity in local areas, e.g. insufficient service providers, and reliance upon volunteers who then leave.

Box 5.3 Commentary

The overwhelming majority of *Choose Life* resources have been invested directly in activities to prevent or deal with the consequences of suicide. There are common themes in the approaches to different types of interventions (both within community/voluntary/self-help and training), although the approaches developed independently at a local level. This has implications for quality control and monitoring. It will be important to ensure that responsible and shared messages around suicide prevention are articulated.

The variety of intervention types in place provide a significant opportunity to learn in phase two about common themes in these approaches (e.g. awareness raising with different groups/contexts) and an opportunity to reflect upon interventions targeted at risk groups and those who work with these groups.

5.3.5 Allocation of resources by Choose Life objectives

Table 5.7 shows the allocation of resources by the seven *Choose Life* objectives across the three key action areas.

Table 5.7 Allocation of resources by *Choose Life* objectives*

	Community and voluntary £	Training £	Coordination £	Total £
Early prevention and intervention	5,696,672	1,356,774	1,550,530	8,603,976
Responding to Immediate Crisis	3,973,888	658,984	1,492,274	6,125,146
Long term work to provide hope and support recovery	3,795,344	568,853	1,502,306	5,866,503
Coping with suicidal behaviour and completed suicide	3,328,298	543,305	1,388,275	5,259,878
Promoting greater awareness and encouraging people to seek help early	3,863,157	881,189	1,795,291	6,539,637
Supporting the media	1,394,635	229,798	1,356,801	2,981,234
Knowing what works	1,228,277	386,998	1,247,144	2,862,419

* Many activities fall into one or more category as activities are often stated to target a number of objectives.

The majority of activities target several different *Choose Life* objectives. Table 5.7 indicates that there has been less funding directed at a local level to 'knowing what works'. This appears to be influenced by a lack of skills/experience to assess the evidence base locally and a similar lack of local evaluation capacity.

Box 5.4 Commentary

Good progress is apparent in terms of targeting five of the key objectives, although there is inconsistency in how local areas decide how objectives are targeted by activities. This has led to reporting of projects targeting multiple objectives, with little clear sense of how these activities contribute to the desired outcomes.

This information also underplays existing work in local areas to meet *Choose Life* objectives. For example, section 5.8 below highlights activity in A&E around self-harm and suicide attempts but this is often not *Choose Life* funded or linked to *Choose Life* plans.

Less progress is reported (in terms of funded activity) with respect to evaluation and media work. This is an underestimate to some extent, particularly where it is known from case studies that work to support the media had been undertaken by the local coordinator (but was not 'funded' as a separate activity). Types of activities included the promotion of National Union of Journalist media guidelines; and providing the press with good news stories about events held in suicide prevention week and on ASIST training. However, it is likely that evaluation remains significantly underdeveloped.

5.3.6 Allocation of funding to national priority groups

Table 5.8 provides a breakdown of funding allocation to nationally defined *Choose Life* national priority groups, while table 5.9 shows the number of projects targeting each national priority group.

Table 5.8 Allocation of funding to *Choose Life* nationally defined priority groups*

National priority groups	Community and voluntary £	Training £	Coordination £	Total allocated £
Children	2,310,750	459,633	661,925	3,432,308
Young people	3,575,323	792,560	1,213,065	5,580,948
People with mental health problems	3,333,635	662,360	1,039,386	5,035,381
People who attempt suicide	2,631,712	648,526	1,059,508	4,339,746
People affected by aftermath	2,224,789	360,113	902,084	3,486,986
People who abuse substances	2,472,203	583,155	1,047,295	4,102,653
People in prison	1,025,609	295,984	745,569	2,067,162
People who are bereaved	669,550	162,728	343,540	1,175,818
People who have lost employment	1,324,949	122,620	526,102	1,973,671
People in isolated or rural communities	1,056,164	235,566	261,575	1,553,305
People who are homeless	1,375,045	185,498	490,775	2,051,318
Risk group not stated	408,943	159,617	311,830	880,390

* Many activities fall into one or more category as activities are often stated to target a number of priority groups.

Table 5.9 Number of initiatives stated to target nationally defined priority groups*

National Priority Groups	Community and voluntary N	Training N	Coordination N	Total N
Children	42	17	27	86
Young People	90	32	51	173
People with mental health problems	101	34	53	188
People who attempt suicide	79	32	46	157
People affected by aftermath	61	22	39	122
People who abuse substances	55	21	43	119
People in prison	13	10	29	52
People who are bereaved	19	12	22	53
People who have lost employment	18	10	20	48
People in isolated or rural communities	24	11	22	57
People who are homeless	16	14	22	52
Risk group not stated	17	8	17	42

* Many activities fall into one or more category as activities are often stated to target a number of priority groups.

The majority of activities targeted multiple priorities. This breakdown demonstrates that a substantial proportion of funding was allocated to children/young people, people with mental health problems and those who attempt suicide.

The focus on children and young people, particularly in targeting prevention activities, is illustrated by case study examples that demonstrate approaches taken to targeting risk factors, e.g. tackling stigma in schools, family issues (e.g. parents with substance misuse problems), barriers to help seeking (bullying, mental health), and in

promoting protective factors, e.g. more normalised understanding of mental health, increased coping skills and improved self esteem.

People with mental health problems
Interventions targeted at people with mental health problems are generally focused upon mental health improvement activity in the community and voluntary sectors. Of 101 community and voluntary projects stated to target people with mental health problems, fewer than five allocated resource to statutory services. This is in line with the phase one guidance that specified funding should not be used as a substitute for existing services. Funding allocation underplays links established in some areas to *Doing Well by People with Depression* (DWBPWD) and clinical services (as discussed in the previous chapter).

Substance misuse
Links to substance misuse services have been considered in chapter four. Typically, there were few instances where funding was targeted at services directly supporting people with substance misuse problems. Data from the case studies indicate that, in one area, the link between suicide and substance misuse was identified as a priority prior to *Choose Life* and the *Choose Life* partnership was strongly championed by campaigners. This led to funding being allocated to substance misuse services. In another area, the substance misuse service manager was involved in the *Choose Life* partnership and implementation activities. This was thought to be facilitated by existing partnership working and co-terminosity of the local service boundaries that resulted in significant cross-over.

There is also evidence in some cases study areas that substance misuse has been identified as a local priority but there was insufficient community/voluntary capacity or willingness to develop activities. In two cases, for example, community and voluntary organisations were encouraged to submit bids but these did not materialise. Although it is uncertain why this occurred in one area, there was some apprehension from a second organisation about the potential impact upon the service and lack of capacity to deal with any increased demand for its service.

Progress in targeting priority groups
Local coordinators reflected on the targeting of priority groups in the second survey. Most progress had been made in supporting children, young people, mental health and substance misuse. Least progress was thought to have been made in targeting those in prison, unemployed or homeless people. National level feedback on progress in targeting priority groups identified the following key points:

- Local variability in what constituted a high risk group
- Challenges in achieving the 20% reduction in suicides: uncertainty about where the focus on priority groups should lie in order to meet this target; whether this meant a 20% reduction among key priority groups, e.g. young men
- Good progress in targeting young people, although there was some uncertainty how effective this would be in reducing suicide
- Lack of understanding of prisoners as priority group for local communities
- More attention required around the needs of those who abuse alcohol and drugs, recent bereavement by suicide, and those experiencing mental illness.

5.3.7 Allocation to locally defined priority groups

In the NIST templates, local coordinators indicated that action plans were targeting a number of locally defined priority groups. Table 5.10 provides a breakdown of the most significant locally defined priorities (those that have received at least £20,000 in funding), while table 5.11 provides a breakdown of the number of projects targeting each of these locally defined priority groups.

Table 5.10 Allocation of funding to *Choose Life* locally defined priority groups

Locally defined priority groups	Community and voluntary £	Training £	Coordination £	Total allocated £
People who self-harm	1,058,475	0	148,365	1,206,840
Women who experience post-natal depression	277,994	8,000	0	285,994
Older people	114,039	0	154,000	268,039
People who are lesbian, gay, bi-sexual or transgender	70,576	15,000	69,000	154,576
Survivors of sexual abuse	830,184	920	0	831,104
People with physical disabilities	26,200	0	3,000	29,200

* Caution should be noted about the term ‘self-harm’ as there is clear potential for overlap with the national priority group of people who have attempted suicide. The category ‘self-harm’ is included where this was specifically noted as a local priority or target group.

Table 5.11 Number of initiatives stated to target locally defined priority groups

Locally defined priority groups	Community and voluntary	Training	Coordination	Total
People who self-harm	14	0	5	19
Women who experience post-natal depression	6	1	0	7
Older people	7	0	4	11
People who are lesbian, gay, bi-sexual or transgender	2	1	2	5
Survivors of sexual abuse	11	1	0	12
People with physical disabilities	2	0	1	3

* Caution should be noted about the term ‘self-harm’ as there is clear potential for overlap with the national priority group of people who have attempted suicide. The category ‘self-harm’ is included where this was specifically noted as a local priority or target group.

The case studies indicate that various factors contributed to the direction of emphasis on locally defined priority groups. In some cases, the priority was identified through a local consultation process (e.g. the role of the church in rural areas). Another area highlighted the impact of national media attention on older people. In others, the priority was identified through implementation, e.g. from discussions in the partnership, local needs assessment or looking at the experiences of other areas. The coordinator’s background was sometimes a factor, e.g. in working with hard to reach groups (e.g. people who are hearing impaired).

Box 5.5 Commentary

The issue of targeting is considered in relation to priorities and action areas. It is important to balance what is best implemented nationally with local priorities and to ensure that, where possible, effective interventions are targeted at these different groups.

5.4 Identifying the level of resources invested in *Choose Life*

It is important to identify the 'true' level of investment of resources in *Choose Life* activities, not only as a prerequisite to any future analysis of their cost-effectiveness, but also to identify the level of resources that may have to be found in future to sustain these activities. Activities that are currently provided by community groups might, for instance, rely heavily on in-kind resources, such as rent-free premises or volunteer time. Should these activities be mainstreamed and provided by the statutory sector in future, then additional funding may be needed to substitute for many of these in-kind inputs.

Tables 5.2 and 5.3 provided a breakdown of all resources invested in *Choose Life* and how they have been allocated across different *Choose Life* action areas. As we have noted, most of these figures do not fully reflect the level of investment in *Choose Life* projects: 20 areas indicated in the second survey that they had received additional funding and/or in-kind investment, but few provided information on these sources of funding in their returns to NIST. This is especially true for in-kind investment.

A better sense of the full investment in *Choose Life* can be obtained from the evaluation case studies. As part of the analysis of eight case study areas, information was requested on resources invested in sixteen activities, two per area. This included not only information on the allocation of official *Choose Life* Funds but also on how any additional funds raised were used. Respondents had to indicate the proportion of staff and volunteer times spent on the activity, and indicate sources of in-kind funding. Substantive and sufficient information was provided on nine of these projects to provide the breakdown between different sources of funding, as shown in table 5.12 below. In seven of the nine projects at least 45% of funds invested in *Choose Life* projects came from non core-funded sources. In-kind support was particularly high in those projects which relied on volunteer input or time provided free of charge by trainers; in the case of the ASIST/STORM training, for example, this was particularly significant, as both the time of trainers and venues for training were in-kind investments in the project.

While in some areas no monetary value could be put on in-kind investments, two of the four projects in table 5.12 listed as having no in-kind investment indicated that some additional in-kind assistance was in fact received. On average, across these nine projects almost one third of the investment in activities came from additional financial support raised by the project and just under one quarter from in-kind contributions.

While we have no information to judge whether the experience of these projects is representative of *Choose Life* as a whole, it is noteworthy that in our survey 20 areas reported receiving some additional monetary or in-kind funding. Little information is

kept across areas on the time inputs of volunteers and unpaid time of professional staff to projects. Nor is much information provided on equipment and premises received in kind.

In our analysis of resources invested in case study projects, the time of volunteers has been valued very conservatively using the 2004 level for the national minimum wage. The opportunity cost, that is the next best use of the time of volunteers, is likely to be considerably higher. In addition to these costs there are economic benefits generated by increasing the skills of volunteers and/or staff from attending training courses and from managing community-led health projects. However, due to a lack of detailed information, it is difficult to place a monetary value on these benefits. Experience from other similar community orientated initiatives, such as Healthy Living Centres, suggests that some individuals use skills acquired in such projects to enhance their career prospects.

Table 5.12 Source of funding for nine projects in case study areas

	Percentage of total investment		
Project	***Choose Life* funding** %	**Other financial support** %	**In-kind support** %
Befriending scheme	34.28	31.12	34.59
Family support project	78.62	0.00	21.38
Crisis intervention project	44.33	55.67	0.00
ASIST/STORM training	22.57	0.00	77.43
Bibliotherapy	55.45	33.27	11.27
School based training	15.44	26.99	57.57
Crisis support project	51.96	17.70	30.34
Self-harm support group	46.04	53.96	0.00
Older men's stress project	98.33	1.67	0.00
Lifecoaching	16.62	83.38	0.00
Average across 9 activities	**46.36**	**30.38**	**23.26**
Average across all 412 projects	**82.32**	**15.19**	**2.48**

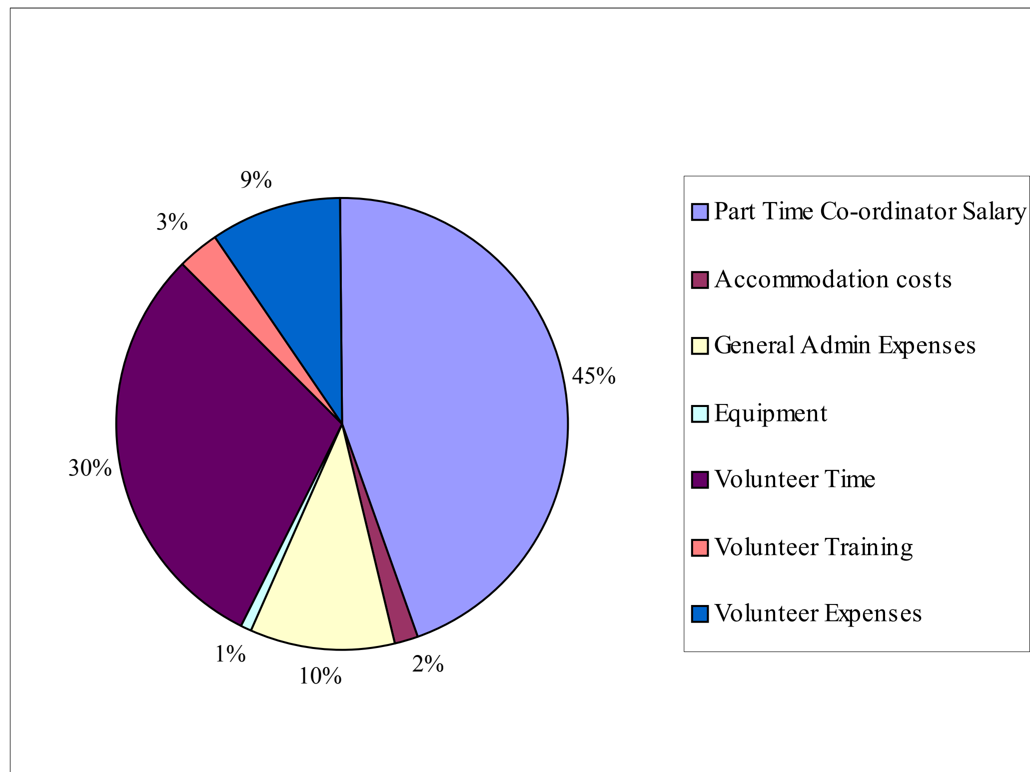
Two examples of how resources are being used in case study projects are provided below.

Example 1: Befriending Scheme for Younger People

This case study provides an example of the substantial additional amount of funding and in-kind contributions that also help to support and deliver *Choose Life* services. This is a befriending project for young people. A core *Choose Life* grant of £10,000 per annum is used to cover most of the costs of one part-time project worker. Several grants from local organisations have also been generated, helping to cover the costs of the project. There are additional substantial in-kind resources. The project relies heavily on 17 volunteers befriending young people for between two and three hours at a time, typically on a fortnightly basis. The time of trainers to run courses for these volunteers, together with the venue for these training courses, have been provided free of charge. The project worker uses her home as her office, again incurring maintenance costs.

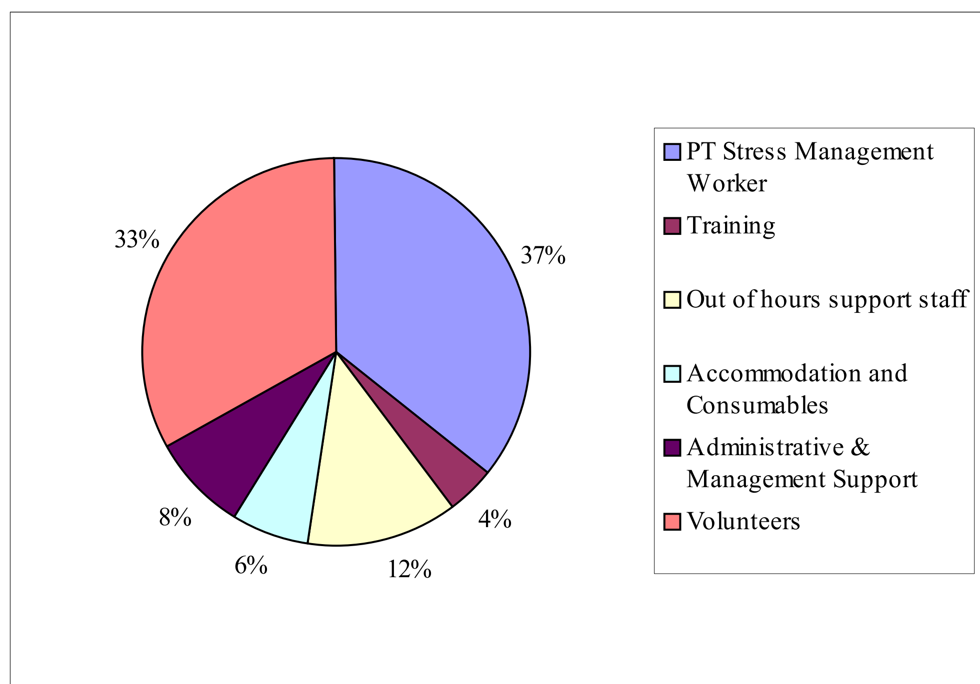
An estimate of annual costs for the scheme suggests that these are in excess of £29,000. The estimate is conservative as the time of volunteers, the key driver of in-kind costs (who are all of working age) has been valued at the level of the minimum wage. The opportunity cost of the time of these volunteers may in fact be much higher. It also does not seek to put a value on the costs of coordination and steering of the project by a management committee. As Figure 5.3 indicates, the input of volunteers, together with their training, accounts for one third of all investment.

Figure 5.3 Resources required per annum to run befriending scheme



Example 2: Crisis support intervention
This project experienced initial difficulties in recruiting the primary project worker; as a result, the project is now running on a two year rather than three year basis. Surplus funding available because of the shorter time frame was used to fund additional support workers to provide out of hours and weekend support. In addition to *Choose Life* funding, the project also benefits from the provision of shared services that are funded through a grant from the Big Lottery Fund. Up to 10 volunteers contribute around 5 hours of time per week, largely providing cover during out of service hours (see figure 5.4). These volunteers are all fully qualified holistic therapists with stress management qualifications. A tentative estimate of the potential value of this volunteer input is included here, although a detailed analysis of time contributed to the project would be required to estimate this input more accurately. Conservatively, it would appear that around half of the total investment in this project is complementary to *Choose Life* funding. Volunteers and staff have opportunities to further develop their skills through training courses which are funded through Big Lottery Fund monies. This is one additional benefit of such a project in addition to the potential long-term impact on suicide that might be realised.

Figure 5.4 Breakdown of allocation of resources for crisis support



Box 5.6 Commentary

It is very likely that funding information on the 450 projects undertaken in all 32 areas (calculated largely using data provided by local areas to NIST) seriously underestimates additional contributions, both financial and in-kind. This may involve sums as large as several million pounds. The only way of fully testing this hypothesis, however, would be through a detailed analysis of resource use across all 32 areas. Even if such an analysis is not considered feasible, a number of steps might be taken to enhance the financial monitoring of projects. It is of critical importance that local areas collate information on these additional sources of funding. The ability of local areas to demonstrate that the partnership approach between the statutory sector and other partners generates added value through raising additional streams of funding may be critical to the longer term sustainability of *Choose Life*.

NIST might, for instance, explore how to encourage and improve the quality of information on resources for *Choose Life* across areas. One critical component of this would be to look at ways in which *Choose Life* coordinators or perhaps specific project leads might provide more information on the level of volunteering and either the typical or (preferably) their actual time spent on these activities.

5.5 The economic case for investing in Choose Life

A key pre-requisite to understanding whether investing in *Choose Life* is a cost-effective approach to suicide prevention is to capture fully all the costs associated with delivering the *Choose Life* initiative. These go well beyond the resources

invested by the Scottish Executive and must also take account of the additional resources invested by all other partners, both statutory, non-statutory and individual volunteers. Our analysis of case studies suggests that these resources are significant – indicating a partnership approach between government, local authorities and other stakeholders can create a synergy by which additional resources are committed to community based initiatives. These resources may not be forthcoming if an intervention is funded and delivered by the statutory sector alone.

This information, however, is insufficient to make an economic assessment of the case for *Choose Life*. Information is required not only on the costs of interventions and any potential tangential benefits in terms of additional skills required, but also on the effectiveness of *Choose Life* interventions in reducing the rate of suicide. Measurement of the effectiveness of *Choose Life* is a critical component in economic evaluation. As yet no such analysis of effectiveness has been conducted, although this is planned for phase two.

As very little evaluation of the effectiveness of population wide strategies for suicide prevention has ever been conducted (see annex 4), there is hardly any comparable economic evaluation of population-wide suicide prevention strategies from other countries. Discussion on how economic evaluation can be conducted alongside any effectiveness analysis in phase two of *Choose Life* is briefly discussed in chapter one and in more detail in Annex 3.

Nevertheless, it should be noted that the lifetime costs of suicide in Scotland are profound; the lifetime costs of all completed suicides in 2004 are estimated to be more than £1 billion. A 1% reduction in the annual suicide rate as a result of the strategy could therefore reduce economic costs to society by approximately £10.8 million in lifetime costs. This strongly suggests that, if approaches adopted by local areas can be demonstrated to be effective, given the relatively modest level of funding in *Choose Life* any economic evaluation may well indicate that the strategy is cost saving – i.e. it leads to better outcomes and also reduces costs (this potential cost-effectiveness is briefly illustrated in section 5.5.1 below)

Box 5.7 Commentary

The profound human and economic of cost of suicide in Scotland strongly suggests that, if *Choose Life* does prove an effective approach to suicide reduction, this is likely to be a highly cost-effective use of resources.

In order to fully test this hypothesis it is essential that robust data on the effectiveness of the strategy can be synthesised alongside more complete data on the costs of delivering *Choose Life,* as well as any cost offsets that may occur as a result of suicides avoided.

Skills and knowledge acquired by individuals through participating in training courses or being involved as in delivering activities are examples of other indirect benefits of *Choose Life* which may strengthen the case for investment.

5.5.1 An estimate of the potential cost-effectiveness of *Choose Life*

In the absence of information on the long term outcomes of *Choose Life* compared with appropriate alternative interventions, what can be done to help policy makers assess whether investing in *Choose Life* represents value for money?

One possibility is to undertake what economists call a *threshold analysis*. This simply refers to the threshold at which different societies consider interventions and programmes still to be cost-effective. It is a subjective judgement depending on many factors, including the level of resources in a country. In this context a reasonable benchmark might be that implicitly used by the National Institute for Health and Clinical Excellence (NICE) in England and Wales, a body which looks at the cost-effectiveness of public health and health care interventions within the NHS. If the cost per additional year of full quality life gained is no more than £30,000, then a decision to recommend the use of the intervention by NICE is usually forthcoming.

If costs are higher the decision becomes more complex, but in any case decisions never are (nor should they be) made on the basis of cost-effectiveness alone; other factors, such as fairness, as well as ethical and political considerations, will also be important. We may, for instance, be willing to sacrifice some efficiency in how we allocate resources in order to reach a sub-group of the population who might have very poor levels of health, or in this case a greater risk of suicide.

Nevertheless, by undertaking such a threshold analysis (see box 5.8) we can look at what the maximum level of investment in *Choose Life* might be under different circumstances if we wish to invest no more than £30,000 per life year saved. (Further details on the methods used are provided in annex 3.) This can then be contrasted with the current level of investment in the programme. The technique can also be used to crudely estimate how many lives would need to be saved in order for the strategy to represent value for money or even become cost saving, that is where the net benefits from investing in Choose Life outweigh the costs of the strategy.

Box 5.8 Using threshold analysis to assess the level of investment in *Choose Life*

Net investment in *Choose Life* / Life Years Saved = £30,000 per life year saved.

Where £30,000 per life year saved is the key threshold parameter of acceptable value for money

Net Investment in *Choose Life* is the suggested annual investment less the value of lifetime cost offsets reported at their net present value

Life Years Saved are the total number of years of expected life saved as a result of suicides averted in any one year.

5.5.2 Potential years of life that could be saved

In 2004, using data on average life expectancy, approximately 28,400 lifetime years could potentially have been saved if all suicides in Scotland had been avoided.

However, in economic analysis, the concept of time preference is often applied. This assumes that both costs and benefits incurred/gained in the future, are considered to be of less value than those costs/benefits gained immediately. In our analysis, if future lifetime years are discounted to reflect time preference (using the same rate we have for costs – 3.5% per annum), the number of lifetime years saved would be reduced to just over 16,000.

5.5.3 Estimated current annual investment in Choose Life

The total costs of investment in *Choose Life* includes £4m in core funding per annum plus an identified £0.52m per annum in additional monetary funding and £0.09m in in-kind investment. We have noted evidence from case studies suggesting that these additional investments are underestimated. Extrapolating this level of investment across all 32 CPPs, the total annual cost of investment in *Choose Life* would rise to £6.01 million, with in-kind investments accounting for £0.9 million and monetary funding for £1.11 million.

5.5.4 Potential level of acceptable investment in Choose Life

Table 5.13 provides information on the maximum level of investment that would be consistent with our threshold under different circumstances. Even when future years of potential life saved are discounted at a rate of 3.5% per annum and the success rate of *Choose Life* in reducing the annual rate of suicide is just 1%, the value for money of investing in *Choose Life* appears highly promising. Our analysis would indicate that, if we were willing to pay £30,000 for each additional year of life gained as a result of *Choose Life*, we could invest up to £15.6 million per annum as cost offsets of some £10.79 million would be generated. This is well in excess of the current level of investment in *Choose Life*. If the annual rate of suicides were to fall by 20%, then the programme would be highly cost saving. We would save more than 5600 life years (undiscounted) or 3200 (discounted) and generate cost offsets to society of almost £216 million. We would have to be spending more than £386 million per annum before the cost per (undiscounted) life year gained was above our threshold.

Table 5.13 Maximum levels of investment in *Choose Life* permissible to maintain a cost per life year saved of £30000 or less (2005 prices)

Discount rate for life years saved	Projected 1% reduction in suicide rate	Projected 5% reduction in suicide rate	Projected 10% reduction in suicide rate	Projected 20% reduction in suicide rate
0%	19,318,712	96,593,561	193,187,121	386,374,243
1%	17,880,265	89,401,327	178,802,655	357,605,310
1.5%	17,299,901	86,499,505	172,999,011	345,998,021
3.5%	15,609,735	78,048,675	156,097,350	312,194,700
5%	14,781,410	73,907,048	147,814,096	295,628,192
6%	14,361,508	71,807,538	143,615,075	287,230,151
8%	13,733,303	68,666,515	137,333,030	274,666,060
10%	13,292,278	66,461,390	132,922,780	265,845,560

Another way of looking at this is to explore the impact of varying the number of potential lives saved on the potential cost per life year saved (see table 5.14). Again, we use our baseline assumptions on total investment per annum in the programme and potential costs avoided. We also assume that on average an additional 34 (undiscounted) years of life would be saved in any one year from each suicide averted. In the base case scenario only 3.2 lives would need to be saved for the strategy to cost less than £30,000 per life year saved (the threshold below which interventions are generally considered to be cost-effective). This analysis also suggests that five lives would need to be saved in any one year for the strategy to be cost saving (dominant) compared with no action, that is for the value placed on suicides averted to be in excess of the annual investment in the strategy.

Table 5.14 Potential cost per life year saved varied by number of suicides averted (2005 prices)

Discount rate for life years saved	1 suicide averted	2 suicides averted	3 suicides averted	4 suicides averted	5 suicides averted
0%	138,644	50,321	20,880	6,160	Dominant*
1%	166,796	60,539	25,120	7,410	Dominant
1.5%	181,680	65,941	27,361	8,071	Dominant
3.5%	245,470	89,094	36,968	10,905	Dominant
5%	296,489	107,611	44,652	13,172	Dominant
6%	331,405	120,284	49,910	14,723	Dominant
8%	402,283	146,009	60,584	17,872	Dominant
10%	473,357	171,085	71,288	21,030	Dominant

** CL strategy is dominant compared with no action with both lower costs and additional lives saved*

5.5.4 Varying perspective

Much economic analysis is conducted not from a societal perspective but from a very narrow public sector perspective. In this case we would only be interested in the direct public sector costs of investing in *Choose Life* (£4 million per annum), while the only cost offsets of interest would be any costs to the public sector, such as emergency and health care services, that can be avoided as a result of not having to respond to a suicide.

In this case, where only a 1% reduction in suicide was achieved, with life years saved discounted at the base rate of 3.5 %, the threshold for investment would be £4.88 million. This is still in excess of the current £4 million level of investment. If our analysis also included indirect costs avoided, i.e. productivity losses from lost opportunities for paid and non-paid work, then this threshold for investment would rise to more than £7.87 million.

Considering the impact on the cost per life year saved, 11 lives would have to saved for the strategy to be considered cost-effective. It would, however, take more than 700 lives to be saved for the strategy to become cost saving because of the very low level

of direct costs avoided per life saved. If the analysis also included indirect costs avoided, i.e. productivity losses from lost opportunities for paid and non-paid work, then the number of lives per annum that would need to be saved for the strategy to be cost saving would be just over 17.

5.5.5 Limitations

There are important limitations of this analysis to note. First, we have not adjusted future years of life to take account of their quality – this would reduce the value of life years saved. (It might be argued, however, that value placed on the intangible benefits of life foregone reflect this on the cost side of the equation). Second, we have here compared investing in *Choose Life* with taking no other action (over and above what is already in place) to tackle suicide. There may be other alternative models or programmes of suicide prevention, i.e. those that are more closely controlled and delivered centrally, that might be better options against which to compare *Choose Life*. Again, the challenge here is to identify the effectiveness of alternative models and consider whether these could work in a Scottish context. We have, however, been highly conservative in not including the potential added benefits of avoiding non-fatal deliberate self-harm events in this analysis. A third limitation is that the value of the intangible benefits of lives saved has had to make use of data related to road traffic accidents rather than death by suicide. One final limitation noted here is that our analysis looks at what would happen if we can reduce the current rate of suicide in Scotland; it may be the case that this rate might naturally fall (or rise) substantially in future years. This might have implications for the value for money of investing in Choose Life.

Box 5.9 Commentary

Threshold analysis cannot tell us whether investing in *Choose Life* represents value for money, nor what should be the appropriate level of investment to make.

However, it does suggest that, if the *Choose Life* initiative achieves even a very modest reduction in the rate of suicide of just one per cent, at the current level of investment this is likely to generate costs per life year saved below £30,000. This is the case even if a narrow public sector cost perspective, rather than a societal perspective, is adopted.

From an economic perspective, under our baseline assumptions, the *Choose Life* strategy would become cost saving if just five additional lives per annum were saved.

This would suggest that investing in the programme would represent value for money and that the level of success required by the strategy is modest.

However, when evidence of the effectiveness of individual initiatives is available, will it be possible to claim definitively that investing in *Choose Life* represents value for money.

5.6 Expenditure 2003 – 2006

Table 5.15 provides information on expenditure on *Choose Life* activities for the first three years of the initiative. It should be stressed that information relating to last financial year is still provisional and not complete and the final level of expenditure will be higher still. As the table indicates, approximately £0.7m and £2.5m were spent during the first two years respectively. The relatively low level of expenditure in the first year is not unexpected; coordination, staff recruitment and needs assessment are some of the factors that need to be in place before funds can be expended.

The strength of pre-existing partnership working arrangements in some areas was also a factor; some areas needed to focus upon building new partnerships as an early priority before final decisions could be taken on what activities to fund. There have also been specific structural issues relating to how funds could be distributed within the *Choose Life* initiative. For example, at a local level, local suicide prevention plans were required to be signed off by the CPP and this process was not always without delay. In one case study area, for example, the LA required each *Choose Life* funded project to submit a portfolio; and a requirement for funding was that these were signed off by a senior committee. This committee did not meet regularly, however.

The timescales for expenditure were also affected by delays in the local action planning processes (see *Choose Life* timeline, table 1.2). Many local action plans submitted in December 2003 were broadly defined and did not always detail specific planned activities. This resulted from the short lead-in time between appointment of coordinators/*Choose Life* partnerships and the submission of the first plans. In one case study area, a steering group wished to commission research in order to establish a baseline and inform an approach. There was a delay of some months, however, due to a lack of suitable responses to the tender and personnel turnover both in the steering group and in the coordinator's role. As a result the steering group experienced some challenges in operationalising the local action plan. Guidance was sought from NIST who advised the area to proceed in allocating funding to implementation activities.

It is also important to note that the costs of delivering some services may have been over-estimated, while some areas have been relatively successful in raising additional funds from other sources, leading to a substantial increase in funds available to be spent on *Choose Life* activities. In these cases less core funding than originally anticipated may have been required to deliver activities. (Case study examples discussed later also highlight the important contribution of these other sources of funding and suggest that these funding sources may be underreported.) This occurred particularly in the delivery of training where all trainers' time was provided in-kind from their parent organisation (including both statutory and voluntary organisation providers).

Preliminary data from the third year of the strategy (2005/2006) indicate that expenditure on *Choose Life* activities has continued to increase sharply as more and more projects are fully implemented; total expenditure is already well in excess of the notional £3 million allocated to that financial year and will rise still further.

Table 5.15 Reported expenditure in *Choose Life* areas 2003 - 2006

	2003-2004 £	2004-2005 £	2005-2006* £
ABE	0	113,267	117,134
ABS	99,000	108,000	110,163
ANG	0	15,000	58,000
ARB	0	80,844	129,156
BOR	31	77,833	121,782
CLA	0	19,284	65,828
DUG	38,000	114,025	116,306
DUN	0	60,841	68,632
EAY	2,000	69,402	116,193
EDI	0	46,060	206,456
EDU	0	156,909	92,584
ELO	67,578	67,196	80,871
ERE	0	79,118	105,161
FAL	85,000	91,000	97,000
FIF	10,000	75,462	209,112
GLA	4,992	186,381	358,627
HIG	50,000	126,837	98,636
INV	0	78,575	155,000
MID	3,700	8,496	141,870
MOR	6500	76,184	90,845
NAY	2,000	89,916	169,900
NLA	116,000	111,000	53,000
ORK	29,025	89,838	36,000
PER	64,724	31,035	149,354
REN	6,280	77,833	104,010
SAY	0	79,000	84,485
SHE	36,400	41,447	35,253
SLA	0	47,405	179,432
STI	0	74,211	81,042
WDU	0	73,704	106,647
WIS	2,550	59,912	22,230
WLO	70,000	41,869	166,434
Totals	**693,780**	**2,576,596**	**3,727, 142**

* Data for 2005/2006 are provisional and incomplete

Box 5.10 Commentary

Expenditure on activity during the first year of the project was well below the notional minimum local budget of £3m. This low level of expenditure in the first year of a community based initiative is not uncommon. Development of partnership working arrangements, needs assessment and the need to recruit staff are just some of the key factors leading to a delay in spending funds.

In the case of *Choose Life* these issues were exacerbated by the short run-in period. The time between the appointment of coordinators/*Choose Life* partnerships and the submission of the first plans was limited; local action plans were only submitted in December 2003, three-quarters of the way through the financial year. These were

sometimes only broadly defined and did not list specific planned activities. Some areas wished to conduct more detailed assessment of needs before developing a plan.

Expenditure on *Choose Life* activities continues to rise sharply as more activities are fully implemented, with expenditure in 2005/2006 projected to be well above levels in 2004/2005 as CPPs make use of funding carried over from the first year of the initiative.

5.7 Funding decisions : phase two 2006 – 2008

A further £8.4m has been allocated to help support the continuing implementation of *Choose Life* and suicide prevention action across Scotland for 2006-2008. National activities will receive up to £2m while local *Choose Life* support funds will receive a total of £6.4m over 2006-08 (£3.2m per annum).

In addition, a further £200,000 has been allocated to Highland in 2006-8 (£100,000 per annum) to help support suicide prevention action and to help increase knowledge about effective suicide prevention in other remote and rural areas of Scotland. Key factors in taking this decision were the rate of suicide in the area and national level aspirations to further work on rural/remote issues. A proportion of funding was used to support coordination of *Choose Life* activities and the remit of the post included a focus on rural issues.

5.8 Supporting people who self-harm and rationales behind investment in related activities

Choose Life addresses "only those aspects of [non-fatal] self-harming behaviour which might be considered as an indication of risk of suicide. It is recognised that there are other dimensions and manifestations of deliberate self-harm [DSH] that are not covered within the strategy's scope" (Scottish Executive 2002).

At both local and national levels, it was evident from observation of national NIST events and from other evaluation data that there has been considerable uncertainty about how to operationalise the commitment to tackle high risk self-harm.

In the case studies, the extent to which the group of people who self-harm was identified as a local priority was explored alongside approaches to implementation activities and rationales behind investments. Identified approaches to implementation activity included:

- Projects are not providing a direct service for people who self-harm but are targeting associated risk and protective factors
- Intervening with young people/adults: funding national organisation to establish new project, e.g. one to one, group work with young people, awareness raising with professionals, carers and family/friends; immediate (non-clinical) support for adults after the episode, referred from A&E, and other agencies

- Building capacity: training workers and those supporting children and young people.

5.8.1 Rationales

Case studies demonstrate that there has been varied understanding across partner organisations of what constitutes high risk self-harm and its relationship to suicide, and variability in the interpretation of the definition of self-harm. It was also thought that the spectrum of self-harm was diverse and approaches to targeting self-harm and suicide could not be homogeneous. In one area, self-harm was not identified as a priority for the *Choose Life* action plan because existing local services were already in place. This had, however, created some frustration with other partners working with young people who felt that there was a gap in provision. In other areas, self-harm had been a local priority prior to *Choose Life* (for example, local research had already identified need among young people and existing local relationships established with a national organisation working in this arena influenced funding decisions) or was raised by those working with children and young people through local consultation processes for *Choose Life*.

There is evidence that some areas have developed links with A&E through phase one and are considering how work is to be taken forward in this area. Examples of work underway are links to the Samaritans; and working to improve information and support to those who attend A&E after self-harming.

Choose Life is thought to have raised awareness of the issue of self-harm in *Choose Life* partnerships and at training events. Increased focus on self-harm has led some areas to develop new activity throughout implementation, where self-harm had not been identified as an original priority in the action plan. In a number of areas, self-harm training has evolved following local requests from workers.

NIST has additionally facilitated debate about self-harm at a national level and a national organisation working in this field has reported increasing interest in their work by local areas.

Box 5.11 Commentary

Different interpretations and understandings of self-harm are well documented in the research literature. This diversity of opinions was reflected among the different partners in *Choose Life*. It is evident that *Choose Life* has stimulated activity and funded interventions that range across the spectrum of self-harm. The commitment in the strategy to tackling high risk self-harm is not, however, evident in all local areas, and is potentially influenced by a lack of certainty or agreement of what constitutes 'high risk'.

5.9 Progress in the allocation of resources

Table 5.16 provides a summary of overall progress and identifies emerging issues/ gaps in relation to targeting across priority groups, objectives and type of interventions in addition to economic investment and performance management structures.

Table 5.16 Progress in the allocation of resources

Development	Progress	Challenges/issues/gaps
Performance management structures	Monitoring systems (e.g. templates) provide wealth of information on activity. Management information system in place through *Choose Life* website Templates adapted to help facilitate easier completion	Templates not consistently completed and some gaps in information collected Limited recourse available to NIST to encourage areas to provide information in a timely manner as there is no formal obligation to report this information Ensuring that *Choose Life* coordinators and others have some basic project management skills
Economic investment	Evidence that there has been substantive in-kind support for *Choose Life* and that the level of additional contributions across all 32 areas is underestimated. Some areas highly successful on obtaining additional funding Additional benefits gained by individuals through training and also through volunteering for *Choose Life* Overwhelming majority of resources have been allocated to the delivery of interventions; modest level of overall resources allocated to CL staffing. High cost of suicide and comparatively low cost of *Choose Life* likely to mean approach if effective will be cost saving to society	True level of investment currently not captured through monitoring structures – essential for these to be refined to provide robust evidence of additional monetary and in-kind benefits received. Opportunities for shared learning from experiences of raising additional funding Recognition that trying to obtain more information adds complexity to data collection which already is problematic Need to have a better understanding of knowledge and skills acquired by individuals from participating in *Choose Life* Data on the effectiveness of *Choose Life* and more complete data on costs are needed for any future economic evaluation

Development	Progress	Challenges / issues / gaps
Allocation across action areas	More strategic approach developed to training and implementation through national manager/strategy Flexibility to allow areas to increase spending in years 2 and 3 of project to compensate for initial low level of expenditure Strong evidence indicating that expenditure in 2005/2006 is substantially higher than in 2004/2005 as more activities became fully operational.	Some delays in allocating and spending budgets due to challenges in implementing projects and loss of time in year 1 due to short run into initiative. First local action plans not available until December 2003 While funds are earmarked nationally for *Choose Life* at a local level there is no strict legally binding ring-fence for *Choose Life* monies. Potentially funds could be used for other purposes by local authorities although this has been minimal thus far The initial estimated costs put forward by local areas for *Choose Life* projects may not be an accurate guide to actual financial cost.
Targeting of priority groups	Most progress apparent in relation to children and young people, People with mental health problems, people affected by the aftermath of suicide, people who misuse substances Locally developed priorities have increased activity on risk relating to postnatal depression, older people, LGBT and survivors of sexual abuse	Less focus in local areas on people in prison, people who are bereaved, people who have lost employment, people who are in isolated/rural communities, people who are homelessness
Targeting of objectives	Good progress identified in terms of five key objectives (although diversity in split across action areas)	Lack of consistency as to how local areas decide on the targeting of objectives by activities Less progress reported (in terms of funded activity) in respect of evaluation and media work
Relationship to self-harm	*Choose Life* has raised awareness and attention to self-harm both locally and nationally, concurrent with developments such as the National Inquiry into Self-harm among Young People[6] (Mental Health Foundation, 2006)	Lack of clarity about where/how self-harm fits into suicide prevention Opportunistic approaches developed to tackle self-harm Activity undertaken by A&E and other services on self-harm is not necessarily linked to *Choose Life* or included in plans.

[6] http://www.selfharmuk.org/

CHAPTER SIX INNOVATIVE PRACTICE

6.1 Introduction

The *Choose Life* action plan and supporting guidance contained an expectation that local areas would use a proportion of their funding allocation to support innovation in the voluntary and community sectors and that this would include self-help initiatives.

Innovation was seen in two main ways: first, in terms of interventions, as a means to introduce new ways of working and widen the range of available options; and, second, as a means of promoting partnership development and local 'ownership' and engendering learning and wider system change.

The scope of this chapter is to illustrate examples of innovative practice underway in local areas, as defined by *Choose Life* coordinators. In the survey, coordinators were asked to provide examples of innovative practice indicating: types of activities; factors that influenced decision making; progress towards implementation; factors that influenced success; barriers to implementation; and key learning points. The survey also gathered information about how these practice examples were being evaluated.

We are able to report on the extent to which innovations were perceived to be based on evidence of what is known to be effective. However, we cannot *assess* the effectiveness of innovative developments initiated in phase one. The use of evidence as a part of decision making is discussed in chapter eight and will therefore not be covered in detail here. Similarly, findings relating to the monitoring and evaluation of initiatives are also provided in chapter eight.

Where possible, this chapter provides contextual information about initiatives (e.g. location and target group). However, this is not possible in all examples as the detail was dependent upon the level of information fed back in the survey.

6.2 Innovative community, voluntary and self-help practice

This section considers examples of innovative community, voluntary and self-help practice as defined by local coordinators.

6.2.1 Community and voluntary initiatives

In the first survey, 21 local areas provided examples of locally defined innovative community and voluntary practice. In the majority of cases, the activity was thought to be innovative because it was new to the client group or to the local area.

Prevention/promotion activities
Highland has funded the continued implementation of a STIGMA play delivered to 15-18 year olds across high schools. The main aims of the project were to help young people gain a greater understanding of a range of mental health issues that affected their age group, to challenge young people's misinformed views about people who

experience mental health problems and to inform young people about where and how to access help and support. Workshops for professionals on the topic of self-harm for professionals were linked to the 2005 tour of the STIGMA play, to ensure that there is a whole package of support, preparation and debriefing with both pupils and teaching staff.

In two areas (Moray and Midlothian), links were established to existing Healthy Living Partnership projects. In Midlothian, this involved linking to a new Healthy Living Partnership project /information service. In Moray, alternative therapies were provided as part of the healthy living leisure centre for people with mental health problems.

Intervening/supporting vulnerable groups
Innovative approaches identified also included group and one to one support for people who self-harm, a counselling service for carers, support groups for people with mental health problems, and extended services supporting people misusing substance:.

- In West Lothian, the Hawthorn project was a new project to the area. This supported young people (aged 12-25 yrs) who self-harmed though individual and group work. The project is jointly funded by Penumbra and *Choose Life* West Lothian. Key activities of the Hawthorn project included: support to young people; counselling; education/awareness raising with professionals, carers and family/friends (email, phone, 1-1, drop in); training; signposting into other resources; one to one support services; and group work.
- In East Ayrshire, funding was allocated to East Ayrshire Carers' Centre to develop and fund counselling services. Funding was used for counselling in order to work with young people at particular risk.
- In Shetland, two drug and alcohol support teams extended the hours of their outreach workers to provide a full-time service to people with substance misuse problems.

Developing new partnerships better to support those at risk
Areas had developed new partnerships in service delivery in order better to target those at risk.

In Fife, an initial intervention outlined in a local action plan was to support men with depression by linking a mental health worker into the local Opportunity Centre. The activity was based upon the results of a previous local pilot. Changes were made to the delivery model of this intervention.

East Renfrewshire funded implementation of a schools-based youth counselling service, jointly managed by a mental health association and the local education department. Intended outcomes of the project were to provide earlier and easier access to counselling and associated services for young people; to provide effective counselling that clinically reduces the level of stress experienced in young people's mental health; and engage and encourage families, parents, teachers and other staff in a dialogue that promotes the emotional well-being of young people.

Work was also underway to link voluntary organisations such as the Samaritans and Citizens Advice Bureau with clinical services. In East Lothian, direct Citizens Advice

Bureaux support was provided to the psychiatric admission ward and local mental health resource centre.

Funding was provided for the local branch of the Samaritans to upgrade equipment and obtain support and training to allow the organisation to introduce an e-mail service in the Western Isles. In Angus, the Samaritans were promoting their service locally, and one proposed development was to build direct contact arrangements to the Samaritans into the A&E department locally.

In North Lanarkshire, the Association for Mental Health was initially funded to develop a support programme for adults who have attempted suicide/adults at early risk of suicide and support for people affected by suicidal behaviour. Again, there had been changes to this model of delivery.

Improving capacity of those working with vulnerable groups
There were examples of activity that were intended to improve the skills and knowledge of those working with risk groups.

- Glasgow stated that they were considering the gender and race equality dimensions of their work, initially through the development of voluntary sector liaison groups.
- In Dumfries and Galloway, voluntary organisation staff groups were invited to become trainers for ASIST.
- In Inverclyde, a local Practitioners' Forum was established with the aim of facilitating multi-agency working and sharing of expertise from different fields. The forum focused activity upon two key tasks in phase one that included workplace health and stress and bereavement.
- In East Dunbartonshire, the area had linked coordination with community and voluntary developments by placing the *Choose Life* coordinator within a key local voluntary sector organisation.

Factors influencing decision making
Commonly, multiple factors influenced the decision to develop particular interventions. One stimulus was an identified gap in service provision highlighted in local needs assessment, while other factors included local demand, the wish to build on pilot work or the need to provide support to existing groups which were unable to sustain themselves. Fewer areas highlighted evidence of effectiveness as a rationale, either locally generated (e.g. results of local evaluation) or from published research evidence.

In a number of examples, activities focused upon developing new ways of working between existing services such as clinical and voluntary organisations. In some case study areas, informants highlighted that building capacity within existing services offered a more sustainable approach as it harnessed local expertise and skills. (This issue is discussed in chapter eight, along with other key decision making factors, e.g. use of evidence).

Perceived progress made in community and voluntary initiatives
In the second survey, almost all areas that had provided examples of community and voluntary initiatives reported that they had achieved what they set out to do or exceeded this. For example, an evaluation of the East Renfrewshire schools counselling service was able to demonstrate the positive results achieved for young people using the service, which led to expansion to all local secondary schools. A key facilitator was said to be the good working relationships developed between the counselling service and other local agencies.

In Midlothian, there had been an extension of the Information Officer's hours to develop a suicide prevention and mental health information bank.

East Ayrshire counselling service was fully operational and additional support work with young people was ongoing to enable vulnerable young people to participate in a range of activities and access additional support as appropriate to their needs.

In East Lothian, the Citizens Advice Bureau support service was reported to be operational. A weekly service was held at local psychiatric hospital and monthly contact at a local mental health resource centre. In the first six months, 25 patients accessed the service which involved 163 client contacts. Here, it was though that the holistic service provided by Citizens Advice Bureau was helpful in dealing with multiple and complex problems of clients.

Three sites identified changes to their original plans, including changes with regard to the initial target group, and a new scoping exercise to determine the level of need and current service response. For example, Lanarkshire Association for Mental Health identified that that there were some barriers to developing and using support programmes both from professionals and people who had attempted suicide/people affected by suicidal behaviour. The proposal was changed and a scoping exercise carried out to examine the level of need and service response for adults who present to frontline services where suicide is an issue. It was felt that the close working arrangement between the development coordinator and Lanarkshire Association for Mental Health allowed the proposal to be revised when it became clear that the original formulation was not workable.

Glasgow had stated that they were considering the gender and race equality dimensions of their work and initially voluntary sector liaison groups were to be established. By the second survey, it was decided that creating specific structures for equality aspects of *Choose Life* would be less effective and less sustainable than taking an integrated approach to link into broader work on equalities issues as part of existing equalities and diversity work undertaken by the Council and NHS.

6.2.2 Approaches taken to self-help initiatives

Fifteen areas provided specific examples of self-help activities underway.

Links to primary care
In four areas, links were established with the local Doing Well by People with Depression project. East Renfrewshire funded a primary care liaison worker to offer guided self-help to patients with mild to moderate depression and anxiety.

Supporting risk groups
Group support was a common approach and included mental health service user-led support groups; groups in arts, drama, poetry and writing; and support for those who had experienced childhood sexual abuse.

Factors influencing decision making
Supporting the development of self-help initiatives tended to be regarded as means to add value to existing interventions and services e.g. DWBPWD or primary mental health care teams. In one area, the introduction of a self-help initiative was thought to provide a more strategic approach to targeting risk groups. In another area, it was anticipated that the development of capacity at primary care level would divert people away from services and empower people to take responsibility for their own recovery.

Developments were often initiated in response to local need or demand. In Inverclyde, bereavement work was already an identified priority in the local JHIP. In another area, self-help groups were viewed as a more practical way of providing support due to the rurality of the area (although the area was not able to identify an example of a self-help development underway). In West Dunbartonshire, research and discussion with national organisations had informed the development of a support group for people bereaved by suicide.

Progress made in self-help initiatives
In eleven areas, the planned self-help services or resources were operational by the time of the second survey. In three of these, services were also making links with other organisations or inputting into strategic planning structures, multi-agency partnerships and joint fora, or were expanding their activities. For example, in Highland, collaboration locally with the funded groups for survivors of sexual abuse resulted in a Sexual Abuse Survivors forum for Highland and a successful conference aimed at clarifying level of need, provided services and future requirements. Subsequently, two members of the forum were invited onto a national group to determine the allocation of funding by the Scottish Executive to support people affected by sexual abuse.

Appointment of a manager of the Western Isles Association for Mental Health was thought to provide a better structure to the organisation and more certainty for clients about the availability of services. The services had been extended to allow the drop-in centre to open more frequently and for organised activities such as art and gardening groups to take place.

Publicity and/or events had taken place in two sites, and one area pointed to an increased local recognition of the benefits of self-help in the area. For example, the

multi-media group developed in East Lothian had attracted new volunteers and had developed a range of performance and visual material highlighting issues around mental health, stigma and suicide. A performance about mental health issues had been offered to all East Lothian Secondary schools by the group, and was performed at mental health/community care networking events. Supporting a mental health service user group to produce their own material and vision was identified as a key success factor in this initiative.

The process of designing the website undertaken by the support group in Shetland was thought to have been therapeutic. It had enabled some members to express and explore issues and other members had learned new coping strategies.

In the other four areas work remained at the planning/assessment stage.

6.2.3 *Key factors contributing to success in community, voluntary and self-help initiatives*

In the second survey, coordinators highlighted the following key factors as contributory to the success of their initiatives:

- *Partnerships and coordination*: in particular the presence of good partnership working arrangements, stakeholder willingness to collaborate and negotiate on decisions, consistent commitment and motivation of stakeholders, and time to build and establish trusting relationships between partners
- *Increasing capacity:* new services were increasing capacity by filling gaps and offering acceptable alternatives as demonstrated by good up-take of self-help initiatives
- *Service implementation:* better working practices within organisations combined with enthusiasm, motivation and commitment of staff to develop projects.

6.2.4 *Identified challenges in set up and implementation of community, voluntary and self-help initiatives*

Delays in setting up projects and lack of progress were highlighted by around one quarter of areas.

- *Set up issues:* In one area, the parent organisation for an activity had to temporarily close due to alleged criminal behaviour within the organisation. For another project there were delays in the disclosure forms process for staff in a group seeking to develop a self-help model with adults who experienced childhood sexual abuse.
- *Implementation issues* associated with the functioning of a service user-led group, such as an unclear role for the group and difficulties in providing staff supervision. Low level of up-take and infrequent attendance of the service and inability to provide quality assurance were highlighted in relation to self-help projects. There were also some reported challenges in the evaluation of community, voluntary and self-help activities.

- *Funding issues:* several different funding problems had affected the success of local community and voluntary and self-help developments, including an over-reliance on *Choose Life* funding and lack of alternative funding of individual projects, and potential imbalance in funding allocation to particular priority groups. Obstructions in delivering training caused by charging for training were also highlighted in two instances.
- *Understanding/buy-in:* some sites had encountered resistance from managers over staff involvement in *Choose Life*, or differences of opinion among partners leading to disruption of joint work.

6.2.5 Perceived learning points

For coordinators, the process of setting up community, voluntary and self-help initiatives had generated important learning points, as follows:

- It is important to bring agencies together at an earlier stage to decide on priorities
- It can be worth allowing time for needs assessment before commissioning in order to establish requirements for a service prior to funding
- Proactive engagement with national/established organisations is valuable
- It is important to support the infrastructure of self-help groups and budget for unanticipated costs associated with this.

Coordinators also stressed the importance of securing 'buy-in ' from the early stages using a range of tactics such as:

- Encouraging better awareness of national and local *Choose Life* strategic objectives within the voluntary sector
- Focusing less on formal administration and more on informal sharing of ideas
- Awareness raising activities around local initiatives
- Strengthening monitoring and evaluation of activities to provide more regular feedback.

Box 6.1 Commentary

Findings from this section have shown that examples of innovation were often based upon developing new ways of working with existing resources (e.g. by building new partnerships) or in adding capacity to existing established community and voluntary services. This is similar to findings from other evaluations of complex community initiatives. For example, the evaluation of Healthy Living Centres in Scotland found that many services were 'tried and tested' rather than highly innovative and that a balance was required between both approaches: "while novel mechanisms can attract groups which are hard to reach … established approaches, which incorporate new ways of targeting such groups, can also prove useful" (RUHBC, 2005).

Less progress had been made in the establishment of self-help approaches and resources. This may have influenced by different perceptions and notions of self-help by professionals and lay people (*McCollam et al, 2006*). Initiatives tended to occur

where these could be grafted on to existing infrastructures (e.g. DWBPWD; existing local or national groups, e.g. CRUSE bereavement). Opportunities presented by recent developments in national health and social care policy highlight the relevance of *Choose Life* to other policy goals which give emphasis to self-help and self management.

Successes in the developments of new partnerships and collaboration across voluntary and statutory services are key themes identifiable in innovative community and voluntary practice. It should, however, be taken into consideration that research on the outcome successes of partnerships is currently limited and links between partnership working and its perceived benefits have often been inferred rather than proven (Dowling et al, 2004). It is important to ensure that evaluation is strongly linked to innovation to maximise opportunities for learning about what works, for whom and in relation to the Scottish and local contexts.

6.3 Innovative ways of working

This section outlines how funding was used for innovative ways of working. Fifteen areas offered examples of approaches that included: partnerships to delivery training or provide services, and support for new types of interventions, to reach new client groups, as follows:

- *Training:* In South Lanarkshire, a new partnership was formed with a voluntary sector organisation to prove ASIST. West Lothian was instrumental in moving the ASIST training forward in Scotland and was the local host for the first Scottish training for trainers' event in 2004.
- *Grant scheme* in Dumfries and Galloway had attracted interest from a wide range of local organisations and led to the establishment of a range of projects designed to increase capacity and improve mental health and well-being, including the redesign of the Women's Aid hostel in Stranraer and a self-help group for young women at risk of self-harm in an area of deprivation in Dumfries
- *Networking opportunities* were created in several areas, for examples in Borders, voluntary organisations came together to share learning from their activities
- *Supporting risk groups:* in Western Isles, an existing men's health project has been visiting communities throughout the Isles conducting health screen . A 'Headstrong' pack for mental health promotion in schools was developed in East Lothian and sessions were delivered in schools with a range of socio-economic profiles.

6.3.1 Factors contributing to the establishment of innovative working practices

Innovative activities were sometimes developed in response to identified need/gaps in service and based on discussions in subgroups, the *Choose Life* partnership and anecdotal evidence from practitioners. In two areas, the work evolved based on an original pilot undertaken in the local area. One area taking forward work in relation to ASIST had taken ideas from the LivingWorks website. Three areas highlighted that the activity was developed as a way of promoting local innovation.

6.3.2 Perceived progress made in innovative ways of working

Coordinators reported that good progress had been made in respect of innovative partnership working. Partnerships with and between voluntary organisations continued to be seen to reap benefits. For example:

- In Edinburgh, the joint supervision/peer support for three schools projects led to the sharing of best practice for the school projects.

- In Inverclyde, the out of hours service had expanded a local stress management project and this offered a service to previously unknown clients. Common reasons for referral include anxiety, relationship problems, bullying and bereavement.

- In East Ayrshire, large cross-sections of interests were brought together in suicide prevention week including Kilmarnock Football Club, bars, clubs and pubs. Partnership with Dumbarton Football Club and Clydebank Football Club led to distribution of *Choose Life* postcards at two games early in 2005. This had had a good response from fans; local agencies were making use of the cards in day to day work and the idea and design had been adopted nationally.

6.3.3 Factors contributing to success

Improved partnership working within local authorities and across the neighbourhood authority was commonly highlighted as a factor contributing to success. For some areas, learning how to work together and how others work was an on-going process with improvements being made continually.

Some areas pointed to an improved ability to impact on vulnerable risk groups through the development of new ways of working. In one area, there had been success in changing working practices (e.g. in a men's health project, project workers had initially focused on physical health assessments but now recognised the impact of mental ill-health). A positive response from the local community, including schools, parents, football fans, and clubs, had facilitated the delivery of activities, such as football postcards in Dunbartonshire. Cooperation from schools and parents had helped facilitate the Headstrong pack for mental health promotion in schools in East Lothian.

6.3.4 Identified challenges in set-up and implementation of activities

There was less feedback provided from local areas in relation to this issue and reasons for this are not stated in the survey. Challenges that were noted included a lack of sustained funding for innovation and lack of capacity to make the most of opportunities or further develop activity. An additional challenge for some had been inadequate publicity to attract applicants to development schemes, and clients to new services. Some areas reported problems within individual projects (e.g. finding rooms to meet young people and staff turnover).

6.3.5 Perceived learning points

Eight areas cited learning points from implementation of innovative activities:

- Three areas highlighted increasing awareness of initiatives, e.g. using the press to celebrate achievement rather than to publicise the scheme; issuing an advertisement in advance of the training and holding a launch event
- Two areas noted the need to include a wider range of partners at an earlier date in the decision making process
- Two areas cited the appointment of a coordinator at an earlier stage in order to lead and develop links and networks.
- Need for closer follow up of impact of mental health initiatives was cited in relation to a men's health project that had been unsuccessful in achieving further funding for the initiative

Box 6.2 Commentary

A diverse number of approaches emerged when local areas were asked to provide examples of innovative ways of working, although there were also similarities in the work underway and priorities targeted. There was evidence that *Choose Life* was stimulating opportunities for reflective practice and networking within local services and organisations. Local funding was also used as a springboard to encourage small scale innovative projects that supported vulnerable people.

As with community and voluntary and self-help developments, success was often attributed to the willingness of organisations to work together. It was particularly important that this process of partnership working continued when changes to initial plans and proposals were required.

6.4 Progress towards innovative practice

Table 6.1 provides a summary of progress and remaining gaps and issues in targeting innovative and effective practice.

Table 6.1 Progress towards innovative practice

	Progress	**Challenges/gaps/issues**
Community, voluntary and self-help	Majority of projects had set out what they wanted to achieve Increased support for priority groups including improved and better partnerships in delivery of services and support	Learning points were to use wider consultation/needs assessment/ support staff/awareness/more focus on monitoring and evaluation Constant focus on innovation from policy makers. Can be challenge to marry what is known to be effective and 'innovation'/lack of evidence of effectiveness
Innovative ways of working	Improved and better partnerships in delivery of services and support for workers	Lack of sustained funding/capacity to take advantage of opportunities in partnership building

CHAPTER SEVEN   SUSTAINABILITY

7.1 Introduction

This chapter explores the progress towards, and prospects for, sustainability during phase two of *Choose Life* (and beyond), at both national and local levels. Sustainability issues were explored both with national informants (including NIST) and at a local level (coordinator surveys and case studies). Boxed examples are intended to illustrate information provided in the main text by providing descriptive examples of activities from the case studies.

7.1.1 Definitions of sustainability

Although 'sustainability' is a contested term, lacking agreed conceptual or operational definitions, we follow Shediac-Rizkallah and Bone (1998) and Pluye et al (2004) in emphasising the persistence or continuation of a programme (rather than the benefits that these activities deliver). Thus, a sustained programme is defined as a set of durable activities and resources aimed at programme-related objectives (Pluye et al, 2004; Scheirer, 1994). Sustainability is important in the context of public health activities for four main reasons: maintenance of effects over a long period, allowing for the study of long-term impact; latency period between the beginning of programme-related activities and their health impacts; the absence of sustainability can result in an investment loss for the organisations and people involved; and discontinued community programmes bring disillusion to participants and therefore pose obstacles to subsequent community mobilisation (Pluye et al, 2004).

A study funded by the Department for Transport, Local Government and the Regions by Murray Stewart and colleagues (Department for Environment, Transport and the Regions, 2002) identified three levels at which mainstreaming can occur:

- Mainstreaming projects – securing funding to continue particular projects.

- Mainstreaming good practice or ways of working – ensuring that a mainstream agency adapts and reproduces examples of good practice from an initiative or activity

- Mainstreaming policy – when policy lessons from the work and experience of initiatives have a direct influence on the policy process. (Mackenzie et al, 2003)

This framework will be used (section 7.3) to explore local approaches to mainstreaming suicide prevention work.

7.1.2 Sustainability issues for Choose Life

The section provides a description of issues that were required to be addressed (nationally and locally) in developing a sustainable infrastructure for suicide prevention.

Issues to be addressed nationally included:

- Developing public awareness and ensuring that the issue of preventing suicide and reducing rates of suicide was clearly on the agenda of Scottish Executive departments and reflected in relevant policies
- National capacity for the collection of data on suicide and self-harm
- Development of national support networks and providing opportunities to exchange information and learn from developing activities
- Establishing a national training resource to oversee the development and integration of training
- Research programme on suicide prevention to guide and support development
- Publication of guidelines for the media with awareness raising and education.

Local issues to address included:

- Community Planning partners were (and continue to be) expected to work towards securing additional and long-term sustainable resources that would contribute significantly to mainstreaming suicide prevention activity
- Community Planning partners were (and continue to be) expected to ensure that *Choose Life* activities are cross-cutting at policy and local organisational level. For example, suicide prevention and related activities should be recognised as key elements of and embedded within Joint Health Improvement Plan and related local policies and plans.

7.2 National approaches to sustainability

The chapter considers approaches and successes achieved in developing a sustainable infrastructure for suicide prevention by NIST and other national organisations.

7.2.1 NIST activities

NIST identified a number of achievements in building a sustainable infrastructure for suicide prevention. As examples of NIST's activities have already been detailed in other sections of the report, for the purpose of this chapter, examples of activities are summarised and rationales underlying these activities in terms of building a sustainable infrastructure are outlined.

Providing opportunities to exchange information
A number of mechanisms and activities are now in place to encourage and support the exchange and dissemination of information. These include, for example, the *Choose Life* website, annual NIST summits and the resource database. The website is an important portal for information sharing and exchange about what is potentially

effective for suicide prevention and how to become involved in suicide prevention/*Choose Life*.

Raising public and professional awareness
Evidence of increased awareness was evidenced by the high number of hits (over 2000) made on the website on a monthly basis. Suicide prevention week contributed to improved awareness, as demonstrated by positive media coverage and statements from business, unions and the public sector about their commitment to suicide prevention.

'Branding' of *Choose Life* has additionally raised awareness of suicide prevention work and helped to provide a consistent public face. Coordinators will have media training, which should lead to the delivery of a more consistent message to Scottish public.

Generating ownership of suicide prevention across organisations and communities, e.g. prisons, schools and workplaces, was noted by NIST as a key issue that would help build in sustainability to suicide prevention work. At the NIST workshop, it was felt that links made with national organisations to engender ownership of suicide prevention had evolved and were increasingly more 'proactive' (rather than reactive).

NIST has worked in partnership with other elements of the National Programme, such as *Breathing Space*, *HeadsUpScotland* and *see me,* to promote activities. For example, awareness raising seminars for *Breathing Space* were held in conjunction with *Choose Life* in rural parts of Scotland.

Suicide Information, Research and Evidence Network (SIREN)
SIREN represented efforts to 'sow seeds' for a self-sustaining suicidology association in Scotland. SIREN was intended to improve access to research and involved a range of stakeholders, including national and local coordinators. There has been success in attracting additional investment by charging for a forthcoming conference.

Data on suicide statistics
NIST has ensured freedom of information and equality of access for professionals and lay people. Information will be maintained and updated by the SPHO.

Training
ASIST was seen nationally as a vehicle for raising awareness, building longer term capacity, and widening ownership of suicide prevention beyond professional health specialists.

NIST has established a national resource to oversee development and integration of training. The Training Manager has sought support from an international expert in connection with the development of a training strategy. Based on evidence from elsewhere and United Nations criteria for suicide prevention strategies, this provided the foundation for a sustainable training infrastructure.

Although the pricing policy for training has been unpopular at a local level, findings from the survey of coordinators suggest that charges were often made at local level in order to help sustain training activities. NIST felt that the policy would have been

less challenging to implement if the charge had been ‘top sliced’ prior to the allocation of funding to local areas. There was also concern locally about the amount (£400) requested for the delivery of each workshop, particularly in rural/remote areas. As it stood, it was necessary for local areas to return funding for training costs that had already been allocated to the Scottish Executive. NIST learnt from the pricing policy and has lowered costs that are returned centrally in phase two.

Issues requiring attention
National networks and alliances have developed with solid foundations and there are appropriate mechanisms on which to build in phase two. However, NIST is aware that the infrastructure is still fragile and that it will take time to mature. Continuing facilitation and maintenance are required to foster a culture that encourages and nurtures ownership of suicide prevention objectives.

The challenge of generating local investment in suicide prevention was highlighted as a key issue that required on-going national attention and support. In line with this, the issue of sustainability and mainstreaming was emphasised as a key action in the national guidance issued to local areas for phase two of *Choose Life*.

Box 7.1 Commentary

NIST’s approach is not so much to provide information to coordinators but to engage them in working with information and to develop a sustainable infrastructure to support this effort.

NIST has developed a number of core activities as building blocks for a sustainable infrastructure. It is recognised, however, that infrastructures remain fragile; and continued work is required to build relationships and networks, and to ensure that sustainability is built in (locally and nationally).

7.2.2 Other national organisations

Nationally, the model of the national coordinators (ChildLine and Samaritans) was implemented with a view to develop sustainable change.

The *ChildLine* coordinator is charged with recruiting volunteers, which helps with awareness raising. Attracting funding from local *Choose Life* partnerships is also important for sustainability and it is felt there has been more success with the former activity. Progress was hampered by organisational changes over which NIST had little or no control. ChildLine is merging with Children First and the focus of attention has been on internal restructuring. The post for the *Choose Life* coordinator has not been renewed. NIST intends to wait until this is concluded before refreshing partnership working arrangements. ChildLine appreciates the transparent approach to funding adopted by NIST. The organisation recognises that funding is time-limited and welcomes the additional two years to provide evidence about effective practice. The link between demonstrating value for money and enhanced sustainability is understood.

The funding allocated to the *Samaritans* in phase one allowed the organisation to employ a Scottish Development Manager, whose role is to support the Samaritans in Scotland in the areas of volunteer recruitment, publicity, awareness of work, and liaison with other organisations. In terms of sustaining suicide prevention activity, it was highlighted by the Samaritans that the organisation's vision (independent of *Choose Life*) is to reduce suicide, and that the organisation would continue to participate in suicide prevention whether funding continued or not. The Samaritans have agreed to continue funding the post that was originally supported by *Choose Life*. The organisation had recognised the value of the post for developing a distinctive Scottish approach.

National informants highlighted that allocation of funding to existing organisations such as Samaritans at a local level was a good example that demonstrated value for money when seeking to maximise work. There was evidence that such existing organisations could provide substantial activity (e.g. the provision of training courses) on a cost-effective basis. Similarly, ChildLine believes that, as a result of voluntary organisations' access to seed corn funding, they manage to get a lot out of very little.

For the *SPS*, *Choose Life* had legitimised the efforts that colleagues were already making and brought national policy guidance and funding to suicide prevention. An SPS pilot has been used in order to secure an additional £1 million for work to support vulnerable prisoners. Following on from the successful experience of the Life Coaching project in Barlinie prison, Glasgow, SPS submitted a proposal entitled 'Routes out of prison' in response to the call for bids issued by the Scottish Executive Social Inclusion Unit for projects tackling multiple disadvantage. The primary aim of the project is to recruit ex-offenders as peer support workers to help other ex-offenders with multiple disadvantages in acquiring life, relationship and employability skills that will help to resume their place within the family and society, reducing harm and re-offending, and improving work prospects and health.

Choose Life supported *Penumbr*a to implement research that predated *Choose Life* and to take their message to other parts of the country. Penumbra is a Scottish voluntary organisation working in the field of mental health and provides a range of person-centred support services for adults and young people. No national *Choose Life* funding has been provided to Penumbra, but six projects have received funding at local level from *Choose Life*. While Penumbra does not have the resources to provide on-going funding support to projects funded by *Choose Life*, strategies have been developed to sustain new activity. The organisation has conducted rigorous monitoring and evaluation of activities. Penumbra engaged with local partnerships to consider how projects funded by *Choose Life* fit into local work and to provide regular feedback on its projects to key local planning groups.

Several national organisations have been actively involved in the delivery of ASIST. SAMH has achieved targets set in training their organisation's staff and are now in a position to increase connections locally. There are three trainers in the ambulance service and a team of nine military defence trainers has been working across different parts of Scotland. The military have also been looking to work with local areas to make connections to remote areas (e.g. supporting capacity for training if there is a gap in local trainers).

SAMH is contributing to sustainability through its inputs to developments around crisis responses with NIST. The organisation will continue to produce and disseminate the booklet '*After a suicide*'.

Work undertaken by *NIST* and *NUJ* (detailed in chapter four) has helped to ensure that practising journalists and editors have been made aware of the media guidelines. The target over next year for the *NUJ* is to ensure an ethical approach to reporting suicide in guidelines for students in colleges and universities.

Box 7.2 Commentary

The model of the national coordinators has contributed to the development of sustainable change, e.g. the Samaritans have provided funding for the coordinator post and the SPS has achieved substantial investment for vulnerable prisoners as a result of piloting activity using *Choose Life* funds.

Organisations such as Penumbra and the SPS provide good examples of how existing infrastructures can be used to good effect to inform learning from initiatives funded in phase one.

There is little evidence that other national organisations have been successful to date in attracting additional funds for suicide prevention work, although significant in-kind work has been forthcoming, for example, provision of training and roll out of bereavement support booklet.

7.3 Local approaches to sustainability

7.3.1 Successes in mainstreaming Choose Life funded activities

Local coordinators were asked to identify current activities that they would anticipate being mainstreamed beyond *Choose Life* and how this would be achieved. In the survey of local coordinators, most local areas were able to provide examples of activities that would be mainstreamed. A further three respondents did not answer this question and six areas felt that it was currently too early to anticipate what activities would be mainstreamed

Mainstreaming training
Most success has been achieved in mainstreaming training activities (particularly ASIST). This is highlighted by 18 areas.

In some case study areas, considerable potential was seen for training as a sustainable resource that would benefit the broader community by building capacity and strengthening existing skills and knowledge, thus reducing reliance on specialised professionals. Training also met locally identified needs quickly and provided short term gain.

Means of mainstreaming training include: charging for places in five areas, use of existing local trainers (five areas), incorporation within local policies on training

(three areas), coordination by other initiatives (two areas) and in-kind support (one area). Two areas do not yet know how training will be mainstreamed.

Mainstreaming project activities
There is evidence from the second survey of coordinators that 27 projects have been earmarked for mainstreaming. It is very likely that this is a gross underestimate of the number of projects that will in fact be mainstreamed. Findings from the case studies highlighted that *Choose Life* partnerships often felt that it too early to make judgements about mainstreaming of projects. This was because some newly established projects were at a relatively early stage of implementation and, in some areas, project workers for key local projects had only recently been employed at the time of the second case study site visit. (The impact of these delays in phase one have been documented in chapter five.) *Choose Life* partnerships were awaiting the outcome of projects before making decisions about which would be mainstreamed. It should also be noted that some of these projects earmarked for sustainability were activities existing prior to *Choose Life*. This is addressed in the following section.

The survey provided some examples of activities where decisions about mainstreaming had been made. Examples of projects are included where information about the project activity is available from local action plans:

Projects targeting children and young people
- School nurse project (structured approach to the delivery of mental and social health amongst school children in East Lothian and Agony Aunt service)
- School project (raising awareness of children around the information and supports available at times of crisis or emotional difficulty. The sessions are supported by the utilisation of the Samaritans Young Persons pack and the Young Minds 'Stay Cool in School' booklet)
- National Children's Home project (a nurse therapist post has developed in partnership with National Children's Homes and aims to offer direct support to young 'looked after' people on issues of emotional well-being, suicide and self-harm, while also facilitating the effective integrated working of professionals in the local area in a development role)
- 'Seasons for growth' training is a loss and grief education programme catering for young people aged 6 - 18 years. The core element of this programme is the promotion of social and emotional well-being for young people who have experienced significant loss due to death or family breakdown.
- RUOK? (see case study example in next section).

Projects targeting people who have been bereaved, including those bereaved by suicide
- including support to CRUSE.

Projects targeting mental health
- Local Association for Mental Health: funding for equipment and publicity and the appointment of a drop in centre manager have allowed this resource to grow and provide ongoing support to the community
- A stress management initiative has built on existing structures, e.g. established voluntary organisation and Health & Safety departments in statutory organisations.

Means for mainstreaming Choose Life funded activities

The most common stated means for mainstreaming is where the role/activity is taken over by statutory organisations or the activity has been built on to existing structures (six areas). In three areas, it is stated that the budget has already been agreed. In two areas mainstreaming has been achieved through an evaluation and prioritisation process. For a counselling service, following commissioning and evaluation, proposals will submitted for the mainstreaming of the service. In a further two areas the use of volunteers in order to support activity was a means to sustainability, particularly for existing organisations working with volunteers. For a Samaritans project, *Choose Life* had added value to the organisation by providing support for fund raising activities and in recruiting more volunteers. It can be suggested in relation to this point that a reliance on pool of volunteers might create challenges for sustainability (e.g. if an insufficient number of volunteers were recruited). CRUSE, however, highlighted that the actual existence of this organisation for 20 years was testimony to its sustainability.

Sustainability for existing activities in receipt of Choose Life funding

In many *Choose Life* partnerships, funding was allocated to existing local projects or service activities that were not 'new' (e.g. local existing project or national organisations such as CRUSE and Samaritans (see case study example opposite).

North Lanarkshire case study example
Project: RUOK?

In North Lanarkshire, sustainability was a key consideration from the start of phase one and an objective of the development coordinator's post was to develop sustainability of new initiatives.

RUOK? is an existing resource and *Choose Life* is funding implementation of the activity across local schools in North Lanarkshire. The resource pack will be widely available on the internet.

In Highland, for example, activity was structured to take into account the short term nature of funding and the area did not initially fund revenue intensive posts. It was agreed that projects funded through statutory organisations would be mainstreamed if proven successful. Similarly, *Choose Life* funded one-off or existing activities in voluntary organisations and it was anticipated that that projects taken forward through community/voluntary organisations would be able to compete for voluntary funding.

Conversely, some projects in case study areas highlighted from their experiences that short term funding can create a barrier to sustainability by increasing the difficulty of forward planning, particularly in developing a business plan. Time spent seeking funding detracted from the actual time spent with clients and the concerns surrounding sustainability put strain on workers. The case studies also provide examples of projects that were subsequently unsuccessful in applying for future funding from other sources.

Mainstreaming functions of coordination
Some areas considered how coordination of suicide prevention could be sustained locally. This was a particular consideration where areas had employed local coordinators. In Inverclyde, in the latter part of phase one, the coordinator was appointed as the health improvement officer. The new post is positioned in Social Work and Housing and is employed through the community planning partnership. The coordinator has been successful in ensuring that strategic elements of *Choose Life* coordination are carried into this new role. In North Lanarkshire, suicide prevention has been built in to the job description of a senior social work post. In another area, the NHS plan to take over funding of mental health improvement posts on a permanent basis.

Case study examples of how suicide prevention has been incorporated in policy, plans and strategies

Joint Health Improvement Plan Mental health and well-being is a theme for priority action and a key aim is to focus on suicide prevention as a first step

Community Plan cross references suicide prevention action plan

Regeneration Outcome Agreement (Draft) Core objective regarding mental health & well-being; stated as a *Development & Regeneration Services* service objective

Suicide attempts and self-harm are considered to be psychiatric emergencies in *Psychiatric Emergency Plan*

Embedded in thinking around particular service developments, e.g., early intervention strategies in *Mental Health Strategy (Draft)*

Included in *NHS Children's Health Strategy* in relation to health promotion and development of preventive services

Links established between suicide and community safety in *Community Safety Strategy*

7.3.2 Successes in incorporating suicide prevention in policy, plans and strategies

Suicide prevention has most commonly been incorporated in JHIPs and Community Plans. To a lesser extent, suicide prevention is also included in Regeneration Plans/Regeneration Outcome Agreements; Domestic Abuse Strategy; Alcohol Action Plan; Children's Services Plan; NHS Director of Public Health Annual Report; and mental well-being and improvement strategies.

Respondents in the first survey felt that the inclusion of *Choose Life* in local policies such as the JHIP helped to mainstream suicide prevention and links up efforts to generate or lever additional funding from other sources. For example, it was indicated that the incorporation of *Choose Life* into the JHIP would generate strategic responsibility to ensure that the aims and objectives of *Choose Life* were mainstreamed. This was thought to provide potential for support and development beyond core funding. Additionally, incorporation brought joint ownership of suicide prevention that was maintained upon other agendas as plans are monitored and reported upon.

Some coordinators report mainstreaming awareness raising and raising the profile of *Choose Life* (and suicide prevention) at a strategic level as a mechanism to achieve sustainability. For example, one area intends to raise the profile of *Choose Life* through the linkage of suicide prevention issues to other planning frameworks, such as children's services planning. In Highland, high-level representation on the *Choose Life* steering group was thought to put *Choose Life* in a position of influence in future discussions of investment priorities.

Box 7.3 Commentary

Training
Most success has been achieved in mainstreaming training activities and in achieving in-kind support to deliver this activity. The national endorsement of ASIST and its availability as a ready available training package has helped roll out this approach. Local enthusiasm and willingness to deliver training in-kind has also been key in success. The pricing policy, albeit unpopular, has helped build an approach for longer term sustainability.

Project activities
When this national evaluation reported, many partnerships were not at a stage of making decisions in relation to future priorities and this led to only a small number of possible projects being earmarked for sustainability. Feedback from funded projects highlighted learning from their experiences of other time-limited initiatives and implications for sustainability such as loss of expertise, knowledge, skills and morale. These are issues experienced by projects over a number of years and across different initiatives and are not only associated with *Choose Life*.

Mainstreaming 'learning'
Sustainability of 'activities' relates not only to the continuation of the project itself but also refers to the process whereby learning from piloted activities is integrated into mainstream ways of working (both voluntary and statutory organisations). This approach can be controversial for individual projects, however, when the actual project is not sustained, leading, for example, to loss of morale.

Policies and plans
Local areas have achieved the milestone of incorporating suicide prevention in local JHIPs. This has been facilitated by the inclusion of JHIP as a milestone in the *Choose Life* strategy and action plan, access to strategic partnerships and a willingness of partners to champion suicide prevention work. However, mainstreaming in other policies and plans has been opportunistic and has often been dependent upon the composition of the *Choose Life* partnership itself (e.g. whether members possess access to other relevant partnerships)

7.3.3 Intentions around mainstreaming in the future

Respondents were asked about their future plans in relation to mainstreaming *Choose Life* activities.

Several coordinators highlighted as a key task for the next phase the need to raise the profile of *Choose Life* with strategic (particularly Community Planning) partners. It was felt that work was needed to generate a broader multi-disciplinary approach to achieve longer term sustainability (rather than mainstreaming of individual projects and activities). Examples from local areas include:

- Link to strategic planning for health improvement, e.g. as part of JHIP planning; embedding the health improvement outcomes within corporate priorities and mainstreaming within the body of work of all partner agencies
- More engagement with the Community Planning Partnership and other associated agendas (e.g. regeneration): encouraging ownership of the strategy and integration of activity within the Community Planning process, in order to encourage a broad approach to suicide prevention
- Focus on integrating activity in partnerships targeting key risk areas, e.g. Children's Service Planning, Mental Health Action Group, Mental Health Strategy
- Proactive feedback of successes during phase one to other organisations at senior management level.

Box 7.4 Commentary

Moving beyond individuals and champions
Continuity and consistency have proved invaluable in developing the depth and range of relationships required to work towards sustainability. Over-reliance on individual champions to carry the work forward in a key sector can mean significant disruption if/when the champions leave. In the longer term, it is important to identify strategies to off-set the likely decline in capacity available for coordination and for delivery, when the momentum generated by initial good will and enthusiasm slows down.

Competing priorities
National policy sets the scene for local work towards sustainability and can help or hinder progress. Local areas set store by predictability and report that they are better able to make good use of short-term funding where there is clarity from the outset about funding conditionality. The existence of many simultaneous initiatives, each working within a limited time frame and targeted at specific priorities, can have a potentially negative effect on overall local capacity and capability to achieve the desired impacts. The prevailing financial climate in local authorities and in the NHS further exacerbate the ability to put principles of plans in practice.

Managing expectations
Local areas face a difficult and complex task in raising awareness of and engagement with *Choose Life* objectives and managing expectations about what can be funded in the short and longer term.

7.4 Progress in sustainability

The table 7.1 below summarises key elements of progress and highlights key challenges and issues to be addressed.

Table 7.1 Progress in developing a local infrastructure to support implementation

Sustainability development	Progress	Challenges/issues/gaps
NIST	NIST has encouraged an open, two-way communication link with coordinators Core activities have been successfully developed to support sustainability of information sharing, learning, research and data, public awareness and training	Fragility of infrastructure Continued work is required to nurture and build relationships/ encourage sustainability at a local level
National coordinators	National coordinators have contributed to the development of sustainable change; some successes in additional investment;	More success in developmental model than fund raising approach
Other national organisations	Valued added in developing the work of existing organisations. In-kind support has been provided, for example, training; bereavement support booklet; media guidelines	Implications for longer term sustainability of newly funded activities
Local areas: mainstreaming activities	Most success achieved so far in mainstreaming training	Short-term funding can lead to a loss of morale, expertise, knowledge. Prioritisation of ‘innovative work’ can have negative consequences without plans for sustainability
Local areas: mainstreaming in plans, policies and strategies	Range of strategies to build sustainability, influence plans and infiltrate other structures	Impact of simultaneous initiatives, each working within a limited time frame and targeted at specific priorities
Local areas: future considerations	Areas are proactively seeking links with strategic partners to facilitate sustainability	Need to off-set the likely decline in capacity when the momentum generated by initial good will and enthusiasm slows down

CHAPTER EIGHT DECISION MAKING PROCESSES & LEARNING

8.1 Introduction

It is already known that decision making processes are a complex interplay of influences and evaluation of other complex initiatives shows that decision making is often based on a combination of factors that includes 'common sense' and experience and, rarely, research evidence alone (King's Fund, 2004). As has been shown in chapter four, *Choose Life* work is being taken forward through partnerships which are often large, diverse and evolving. Local decision making processes for *Choose Life* varied depending on the strategy group's locus, authority, links and membership.

With this in mind, the section considers the different stages of decision making for *Choose Life* and provides an outline and discussion of the learning resources used at each stage.

8.2 Descriptions of approaches to learning and planning/decision making

Key decision making stages were the initial planning process (and revisions to the initial plan), implementation and future planning. In line with other planning processes, learning resources and knowledge varied at each stage of the process. This is outlined in table 8.1.

Table 8.1 Stage of decision making/planning and types of knowledge and learning

Stage of Decision making	Type of knowledge and learning
Stage O: Pre-*Choose Life* activities and learning/knowledge	Existing, e.g data already collected
Stage One: Initial planning process	Needs assessment/service mapping Consultation/open space Local knowledge/stakeholder knowledge/input Evidence of effectiveness Suicide data *Choose Life* strategy document and national guidance
Stage Two: Revising initial plan	Negotiation and reflection by stakeholders
Stage Three: Implementation	Monitoring, e.g. outputs/outcome data Programme/project evaluation Specifically commissioned resources, e.g. Resource toolkit or research reviews. Sharing learning across local areas/nationally
Stage Four: Future Planning	Monitoring e.g. outputs/outcome data Programme/project evaluation

We intend to illustrate below how different sources of learning are utilised at distinct decision making stages, and identify key issues and implications emerging from these.

8.2.1 Stage 0: pre-Choose Life activities and learning/knowledge

In many areas, there were existing resources in place to aid decision making, including existing data, local research evidence and learning infrastructures.

Use of data
A variety of sources routinely collected data prior to *Choose Life*. For example, GROS, the police, health boards and procurator fiscals were able to provide data on suicide and self-harm. Less commonly, suicide data that helped decision-making were collected locally from corporate personnel records, counselling services, drug related death records, records of hospital presentations, Local Authority, Psychiatric Liaison Service, Registrar and Suicide Review Groups (in one area each).

A key use of data, as stated by coordinators, was to provide a better picture of local prevalence and risk factors and to assist in the identification of gaps and priorities. Data were also used as an awareness raising tool. In some areas, data were specifically collected to inform the planning process. For example, in one area, procurator fiscal data on all local suicides and undetermined deaths were collected across a five year period. This fed into the decision making process by illustrating key themes in suicides around substance misuse, bereavement and mental health issues, resulting in a strong focus upon these priorities in the local action plan.

Some local debates reflected the challenges presented when there is an indication of high rates of suicide within small geographical areas. This could lead some partners to demand a strong focus on a localised approach to suicide prevention. Individuals in partnerships with skills in data interpretation expressed caution in the use of data alone in planning and highlighted concern regarding small numbers across local authority areas and fluctuating/unstable trends. More often in these areas, data were combined with other learning resources or were used in conjunction with national statistics. An early task for NIST was to provide local areas with standardised data.

Existing research and knowledge
There were some examples where research or consultation on particular risk groups (e.g. young men, children/young people) had been undertaken prior to *Choose Life*. In some cases suicide prevention partnerships that pre-dated *Choose Life* had already reached decisions about local priorities that then fed into the *Choose Life* planning process.

Box 8.1 Commentary

Decision making was rarely based on data alone; other sources of knowledge were also accessed. Information as a resource was most effective where there were skills within the partnership that could advise on the most appropriate use of data and advise caution on its limitations. However, it was also evident on some occasions that data were used to back up and influence decision making in support of individual priority groups, even when numbers of suicides were low. The provision by NIST of

standardised information and guidance has helped to improve local 'intelligence' in the planning process.

Where work was underway or existing research on local priorities existed, this was helpful in developing a partnership for *Choose Life* and in setting priorities for action based upon locally identified need. It was important to ensure that partners did not use their position to favour particular groups, especially where evidence of local need was not lacking.

8.2.2 Stage One: initial planning process

For planning/identification of priorities

<u>Consultation/open space</u>
Local stakeholder consultation was a key approach used across local areas in order to set priorities for implementation. Approaches taken to consultation varied from small stakeholder events to open space activities that generated interest from large numbers of stakeholders. This process generally explored the relevance of *Choose Life* priorities to the local area and highlighted gaps in service provision based on local practitioner expertise and knowledge. In only a few areas was consultation used to identify the foci for intervention. Consultation was also believed to have engaged local stakeholders in the planning process and to have raised awareness of *Choose Life* across local services and organisations.

<u>*Needs assessment*</u>
Around half of the local areas stated that some form of needs assessment was undertaken to identify local priorities in terms of risk groups and gaps in local services (e.g. information and awareness raising) and/or to inform overall planning. In some cases a needs assessment was undertaken to clarify evidence from other sources. For example, in one case study area a decision to fund a needs assessment was made because it was felt that while available data, evidence and stakeholder events had led to the identification of broad priorities, they had been less successful in pinpointing local community needs.

<u>*Local knowledge/stakeholder knowledge/input*</u>
In some areas planning was primarily focused upon the experiences and knowledge of those within the *Choose Life* partnership or was combined with the use of other resources (e.g. data) to inform decisions. This model relates to the role of infrastructures in decision making and the links that are in place to different structures and services.

Examples of this were where stakeholders identified priorities from working with a specific client group, or were aware of other local risk factors (e.g. substance misuse culture, or socio-economic inequalities). The dominance of partners representing certain priority groups or where research on a particular priority group existed could influence strategic direction. This was suggested in three case study areas in relation to a focus on children and young people.

The negative effects of strategy being influenced by personalities around the table were also apparent. For example, a lack of representation from substance misuse services led to lower prioritisation of this issue in some areas.

The role of local politicians and pressure groups working on suicide prevention varied and appeared to have been of most significance where there were high profile suicides in the locality. In one case study site the impact of media attention to suicides generated interest in the local action plan from stakeholders lobbying for suicide prevention and by local counsellors and senior managers who had questioned the priorities set and focus of implementation for the local action plan. Feedback from the case study workshop, however, indicated that awareness raising through *Choose Life* had improved local political understanding and support for the issue throughout the implementation process.

Box 8.2 Commentary

The importance of neutrality in leadership of the partnership appeared to be key in ensuring that decisions were not biased in favour of particular agendas or priorities. Where a clear and transparent process had been undertaken this had also improved ownership and the commitment of partners to the strategy. Where areas had undertaken a process, e.g. through the use of consultation, this had helped to raise local awareness of *Choose Life* at an early stage (although it was also important for areas to continue to sustain this early interest throughout phase one and build partnerships with local services/organisations). It could be difficult to separate the decision making process from the impact of wider contextual influences. (In the case of children and young people, for example, it is difficult to separate out the impact of dominant partners from other concurrent national policy pressures in relation to this group.)

For interventions

<u>Interventions based upon practitioner/professional knowledge</u>

Practitioner/professional led approaches were highlighted as a key resource in decision making about interventions in both coordinator surveys and case studies. This approach generally led to the allocation of *Choose Life* funding to pre-existing activities or to known local organisations which were piloting new approaches. Local stakeholders stated that such interventions (or organisations) were trusted by and familiar to professionals, and were considered to have a good track record (e.g. clients were already being referred to the service/organisation by local professionals). This approach was also influenced by issues of sustainability. That is, it was felt that funding existing local activities would contribute to building local and organisational capacity, e.g. by drawing upon existing skills and experience. A further issue influencing this approach was that it avoided the often lengthy start up period for new projects that could affect the potential to demonstrate impacts within the set funding period.

Stakeholders in some partnerships were encouraged to use local networks to identify interventions and approaches that would meet agreed priorities. In one case study area, the coordinator encouraged local partners to use their networks in order to identify ideas for community and voluntary activities that were then presented back to

the group for review. Although feedback from local stakeholders emphasised that the decision making process had been transparent, one stakeholder was uncertain about the inclusiveness of the process.

Targeting innovation
Some local areas were keen to generate innovative approaches to suicide prevention and this affected the approach taken to decision making. For example, in one case study area, the priorities for the local action plan were agreed through consultation and use of existing commissioned research on suicide prevention. In order to generate innovation, invitations for all community and voluntary project bids were circulated across the city. Another approach was to combine support for innovation with the need to achieve 'quick wins' by drawing upon more 'trusted' approaches, e.g. funding to national organisations or existing local organisations.

Interventions based upon local evidence of effectivenes /evidence from elsewhere in Scotland
Local knowledge could also inform the development of interventions. It was believed that, if the intervention was developed in response to locally defined needs, it would be more likely to gain acceptance from the local community in which it operated. This also applied to interventions that had been undertaken in other areas of Scotland, e.g. through organisations with expertise in key *Choose Life* areas (e.g. self-harm, bereavement or crisis).

Research evidence
There appeared to be infrequent use of international research evidence in order to aid decision making about interventions. Challenges in using the evidence base were primarily attributed to an overall lack of evidence about effective suicide prevention interventions (see box 8.3 below). Lacking skills in being able to interpret evidence was also highlighted as a barrier to its use. In one case study area, the local coordinator considered international evidence as part of a local needs assessment but had felt that reviews of available interventions had reached disappointing conclusions about their effectiveness.

Typically, use of research evidence was highlighted in the case studies when stakeholders noted some knowledge of the evidence base for the intervention rather than a systematic approach to the use of evidence. Where local areas considered evidence, this generally arose when there were relevant skills in the partnership (e.g. public health background or where coordinators had specialised knowledge in suicide prevention). An issue raised both in local areas and identified from observation of national events was the perceived absence of evidence which was transferable to the Scottish context. In one area, for example, awareness raising and training for staff emerged as a priority following a survey of local practitioners. This led to a literature review commissioned locally, which highlighted cognitive behavioural therapy as an effective intervention but did not provide evidence of approaches known to be effective in meeting the locally defined needs of awareness raising and improving generic suicide prevention knowledge and skills. Subsequently, ASIST became an approach favoured by the Scottish Executive and the area became closely involved in piloting the course in Scotland.

At the level of national organisations there was a commitment to the use of evidence, but this commitment pre-dated or was independent of *Choose Life*. For example, SAMH was already considering crisis models used overseas and this information contributed to *Choose Life* developments both nationally and in a local area. The RCP had drawn upon information from New Zealand and Australian policy guidelines, but, again, this was independent of *Choose Life*. The NUJ was informed by the Australian guidelines and journalist networks both in Europe and elsewhere. Penumbra had learnt from UK National Inquiry into Self Harm Among Young People.

Box 8.3 Commentary

Choose Life has fostered a commitment to draw upon "evidence of effective interventions" and to "shar[e] … practice experience' (*Choose Life*, 2002).
Recent reviews highlight that there is a lack of evidence on which to make firm recommendations about the most effective forms of interventions (Guo et al 2003; Hawton et al 2006; Mann et al 2005).

Some interventions are noted to be promising but have been based upon interventions with small sample numbers. Hawton et al (2006) and Guo (2003) found:

- Promising results for problem solving therapy
- Positive trends favouring provision of an emergency access card
- Promising results from a single study of dialectical behaviour therapy among small subgroup of female patients with borderline personality disorder who have a history of multiple episodes of DSH.
- Some very limited evidence of the benefit of cognitive behavioural therapy in a small controlled setting.

Mann et al (2005) suggest that the education of physicians and restricting access to lethal means help to reduce suicide.

- Education of physicians increased numbers of diagnosed and treated depressed patients with apparent accompanying reduction in suicides (although effects on rates of suicide need to be measured)
- Restriction of access to lethal means (where method is common) has led to lower overall suicide rate
- However, other methods including public education, screening programs, and media education require further testing
- Programmes directed towards at-risk groups in student populations (e.g. skills training and social support) appear promising in reducing risk and increasing protective factors
- Guo et al (2003) highlight insufficient evidence about the effectiveness and safety of school-based prevention programmes for adolescents, although WHO (2004) concludes that schools based programs focusing on behaviour change and coping strategies in the general school population lower suicidal tendencies, and improve ego identification and coping skills

Intervention studies are often inconclusive because of small sample size. There is a need for larger-scale to assess effectiveness (Hawton et al, 2006, Guo, 2003). Serious methodological issues are also often noted in reviews of interventions (Guo, 2003). This can mean that, where there is some evidence of effectiveness, interventions may not be relevant for the Scottish context.

Areas would further benefit from guidance about effective approaches to suicide prevention which have been tested in other contexts, and appropriate data to learn about innovation in their own areas.

Both locally and nationally, there is also further opportunity to draw upon the expertise of organisations that possess knowledge of evidence in relation to their area of practice.

8.2.3 Stage two: reflecting on and revising initial plan

A key challenge acknowledged both locally and nationally was the short timescale in which to develop the first action plan. It is evident that plans in local areas reflected a broad set of priorities that were then refined in the implementation stage.

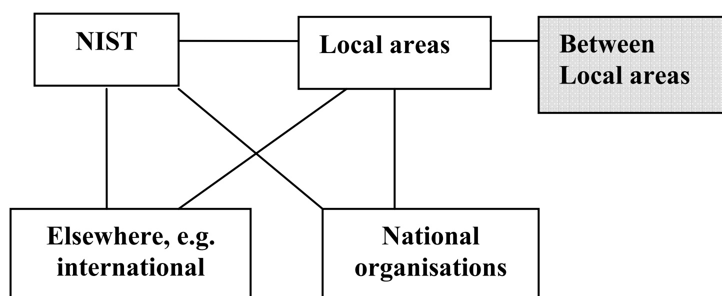
Different factors influenced reflection and revision of initial plans. In some instances, lack of clarity about initial priorities and focus resulted in funding allocation to needs assessment or research (see above).

Where initial planning had stayed primarily within the confines of the *Choose Life* partnership (without wider consultation) some stakeholders expressed unease about the transparency of the decision making process. In two case study areas, for example, there were concerns that the plan had not been consulted upon widely enough or that the process was not informed by evidence of what worked or a local needs assessment. Each area undertook a different process to revise their initial plans. In area one, consultation was held across the local authority area with a variety of stakeholders, including service users. This led to new emerging priorities that were acknowledged in the revised action plan. In the second area, conflict within the partnership was overcome through negotiation with senior partners and in consultation with NIST. This led to a scaling down of the initial plan in a manner that was thought to be equitable to all interested parties.

8.2.4 Stage Three: Implementation

The implementation stage resulted in new processes being designed to share learning and knowledge. In relation to *Choose Life*, there is an opportunity to share knowledge or 'learning' at different levels, as illustrated in figure 8.1.

Figure 8.1 Levels where knowledge or learning can be shared



Sharing information between local areas, e.g. at national events or though regional networks, led to instances of learning and uptake of training across different areas. In one area, in response to national recommendations, ASIST was initially implemented as a universal training approach for professions and the community. Local implementation revealed that this approach was felt to be less suitable for those who provided ongoing support and care management to people at risk of suicide. The local coordinator attended the NIST summit in December 2005 and learnt about the STORM training from a presentation made by the Highland coordinator. The evidence base for STORM is stated to have influenced decision making.

National organisations have undertaken coordinated approaches to evaluation of local projects and are starting to learn from activities. For example, implementation of one SPS project demonstrated that this had been less successful and resulted in the discontinuation of funding support. However, the successful pilot of another SPS project had helped achieve substantial new funding for vulnerable prisoners (discussed in chapter seven). For another national organisation, implementation activities have provided evidence in relation to self-harm and suicide risk and interest from local areas in supporting these issues.

8.2.5 National support for learning

NIST support to local areas

As highlighted in chapter four, there were a number of dimensions to NIST's role in supporting local implementation, including the provision of guidance and advice and advocating for *Choose Life* objectives and priorities with local decision makers. Substantial hands-on support was provided by NIST to local partnerships throughout the planning and implementation process. This is illustrated by case study examples:

- Planning stages: for example, in preventing funding allocation to activities not supporting suicide prevention; supporting areas that had become 'stuck' in the local action planning process; mediation at times of conflict in the partnership.

- Implementation: development of infrastructures to support learning; continuation of advice and support, e.g. raising attention to mainstreaming/

evaluation or particular priorities on local partnerships; participating in feedback events; and consultations/performance management.

An example of how NIST responded to local coordinators is highlighted in approaches to information sharing. Feedback from coordinators at an early stage of phase one that the level of information circulated by NIST was potentially overwhelming resulted in NIST refining information sharing. Subsequently, NIST has produced a newsletter in response to further requests for further information.

Supporting the objective of 'Knowing what works'

'Knowing what works' (improving the quality, collection and availability of information on issues relating to suicide and suicidal behaviour and on effective interventions) is a key objective of *Choose Life.* This section documents planned and implemented activities in order to support work towards achieving this objective in phase one.

Commissioning research reviews

Researchers in the Scottish Executive Health Department Analytical Services Division (HDASD) are responsible for developing and managing a programme of research and evaluation to support delivery of the National Programme for Improving Mental Health and Well-being. Links were established between NIST and researchers in the Health Department, including HDASD, to interpret findings and help with research and information strategy. HDASD has commissioned, and continues to commission, research reviews to help ensure that the implementation of *Choose Life* is supported by a reliable and relevant evidence base.

To date, an initial scoping study reported on how a series of reviews could most usefully coordinate the evidence base, identify gaps and inform thinking and activity in the prevention of suicide and deliberate self-harm (McLean et al, 2004). A review on 'Effectiveness of interventions to prevent suicide and suicide behaviour' has been commissioned and an epidemiological analysis of recent trends in suicide in Scotland has reported to the Scottish Executive. Reviews relating to the determinants of suicidal behaviour will be carried out before April 2007.

Evaluation stakeholders reported some dissatisfaction that the commissioning of these reviews was delayed in phase one of *Choose Life.* The delay resulted from a lack of capacity within the HDASD.

Resource database

NIST commissioned work to develop a web-based resource database of existing resources/materials relevant to activity in suicide prevention, intervention and postvention. This was developed as an on-line resource and was in direct response to requests from those working in the field.

Some concern was reported at the national evaluation workshop that the resource database was not being used to maximum effect. This led to NIST to raise awareness of different resources available in the database as part of a *Choose Life* newsletter.

Suicide Information Evidence and Research Network (SIREN)
Although still in its infancy, SIREN was perceived by national interviewees as key to the successful implementation of learning networks. An inaugural conference has been organised for autumn 2006 that will bring together those with an interest in suicide and suicide prevention.

Independent national evaluation of Choose Life
The Scottish Executive's commitment to a strategic process evaluation of a suicide prevention strategy is relatively uncommon (from an international perspective). Some national and local stakeholders reported a lack of clarity about the purpose of the national evaluation and concern that there had not been significant opportunities to share good ideas or receive feedback. The national evaluation team and NIST have agreed to deliver a series of local road shows across Scotland in November 2006, in order to disseminate findings to relevant stakeholders and encourage discussion of the their implications for local suicide prevention partnerships.

Box 8.4 Commentary

Structures that support the objective 'knowing what works' have developed in phase one. National stakeholders need to ensure that new resources and information are used to improve future planning and that dissemination of information is timely, accessible and of relevance to decision makers and planners.

Scotland is unique in its commitment to a strategic and national level process evaluation. This approach will help to provide a clearer picture of the early impacts of the strategy in its first three years, which in turn will inform both future implementation of *Choose Life* and contribute to international learning and understanding of suicide prevention strategies.

8.2.6 Stage four: future planning

NIST has highlighted a strong commitment to, and emphasised the importance of, evaluation. However, as a result of the delay to the establishment of NIST and a lack of capacity within the national team, a national framework for evaluation remains to be completed. Nationally and locally there is demand for an evaluation framework and work is underway to pilot a Scottish version of an Australian instrument. In the second survey, local areas highlighted that they intended to use the instrument to plan future evaluation activity.

Local approaches
Different levels of priority and attention have been attached to evaluation in local areas. For example, some areas have ring-fenced funding for research, needs assessment and evaluation, while in other areas only basic monitoring information is collected.

To a limited extent, areas have adopted a strategic approach to learning from phase one. Learning about local need and priorities and learning from pilot activity were highlighted as a key goal for the short-term in only a few areas. In one area, for

example, there is commitment to ensure that lessons learnt from pilot activity in phase one is mainstreamed in statutory activity. It was evident from the case studies, however, that local areas were reflecting and refining work underway in phase one in order to shape future planning for phase two. A number of areas had, for example, held specific events/sessions in order to consider progress and emerging priorities.

In some areas, funding was ring-fenced to support research and evaluation, through the employment of a research assistant or to fund support for evaluation training/expertise. Since the first survey, a few areas have planned to establish a research/evaluation post or expressed the intention of commissioning evaluation expertise to support local evaluation activities in phase two. This development arose because it was recognised that a more rigorous approach to local evaluation was required. In the case study examples, ring-fencing research monies, however, did not always result in significant activity. Key challenges identified were a loss of local capacity (e.g. departure of postholder) and a lack of clarity around local evaluation needs and how these linked to national support for evaluation.

Challenges in evaluating local action plans were identified by both local and national informants, particularly in understanding how effectiveness of interventions should be evaluated. A lack of capacity locally to develop evaluation (in terms of time, resources and skills) was also noted.

Collection of monitoring information

Feedback from coordinators and project case study examples indicated that most monitoring information was collected on community and voluntary practice examples and least information was collected about innovative approaches to working. The sixteen case study projects identified a number of outputs that were being used as evidence of local progress towards achieving aims and objectives. These can be categorised as outputs related to individuals, 'developing infrastructure' and information and promotional work.

Outcomes for individuals included suicide prevention, personal skills and increasing self esteem/coping skills.

Outcomes for interventions included the development of staff skills, capacity and awareness. At this stage, most information was available on outputs and process outcomes that included the nature of the intervention e.g. increased capacity for earlier intervention; previously unmet need now met; learning, partnerships and sustainability.

Highland STORM Training

STORM is a suicide prevention training package for all healthcare, social care, criminal justice staff and volunteers, particularly for those working with individuals vulnerable to feeling suicidal.

Process Outcome: Increased staff skills

Description: Staff more confident that they could recognise potential suicide risk.

How known:
The main providers of STORM training are based in the University of Manchester who train locally based facilitators in the delivery of STORM. There is a commitment to the evaluation of STORM and in exploring the dissemination of STORM by the providers. Trained STORM facilitators are asked to hand out pre and post questionnaires to participants during training. The questionnaires assess confidence and attitudes and telephone interviews are used in order to understand the dissemination process.

Data were based upon a sample size of 149 participants who attended STORM training

Approaches to measuring success of interventions were variable. In some cases, local stakeholder workshops highlighted some uncertainty about the actual outcomes towards which interventions were working. There were few instances where validated tools were used to measure success. Case study workshops, the surveys and national workshops often provided anecdotal feedback about the ways in which unmet need was targeted and how capacity for suicide prevention was increasing. However, such feedback was not consistently based on demonstrable evidence.

Evaluation of projects
A range of approaches was used to evaluate projects, including both well known approaches (e.g. Learning Evaluation and Planning [LEAP]) and locally developed tools. Evaluation generally occurred where independent evaluations were to be commissioned (as reported through the NIST template) or, as described above, national organisations working locally undertook systematic approaches to monitoring and evaluation. Existing activities (or activities hosted by established organisations) were often collecting monitoring information or had planned evaluation as a consequence of reporting requirements by other funders. Rigorous information collection was evident where there was a desire to 'prove' the worth or need for a service and to provide evidence that would make the case for an intervention with mainstream organisations or for continuation of existing funding. An example of this occurred in a case study area where it was hoped that a student counselling service would become mainstreamed in the local college.

In the survey, coordinators highlighted that they intended to use the results of evaluations of practice examples (key steps) to assess progress and plan for the future: reviewing implementation and funding allocation; identifying needs/gaps in implementation; and supporting and encouraging mainstreaming and in sharing learning. However, as highlighted above, the quality of information collected was not consistent across or between local areas.

Box 8.5 Commentary

The issues identified above are common to other local evaluations.

Although experiential learning is continually being used to shape practice across individual projects and local areas, it is being less commonly formally embedded within local policy and practice.

It is clear that local areas are supportive of future national tools/frameworks to support the local evaluation process. The challenge will be to ensure that these are taken up in local areas. This has to remain in doubt, given deficits in evaluation capacity and skills and the scant use of existing evaluation tools at the present time.

8.3 Reflections on decision making and learning

Table 8.2 summarises progress in respect of decision making and learning.

Table 8.2 Progress made in decision making and learning

	Progress	Issue/gap
Decision making processes	Local areas are refining planning processes, e.g. wider consultation, more transparent bid processes, improved reporting and monitoring structures Local developments informed by (local) evidence and by sharing of practical experience	Approaches to planning and decision making remain highly variable across local areas (this also has implications for *equity* in process). Local decision making processes varied depending on the strategy group's locus, authority, links and membership Lack of local capacity to analyse and make full use of available data. Uncertainties in how existing evidence should be interpreted in the Scottish context.
National support	Good progress reported locally and nationally in standardising statistics and suicide data (national milestone 5). Helpful contact from NIST (local milestone 9) included evaluation and research input, information, regular meetings and support from individual team members. Information was available for a range of sources, including Health Scotland, SDC, Scottish Health on the Web website and local Public Health departments Convergence of understanding between the evaluation team and NIST, for example, with respect to links to clinical services, continued awareness raising and strengthening of the approach to generating learning	Some criticism that the research reviews had been delayed. Lack of clarity about the purpose of the national evaluation and concerns that there have not been significant opportunities to share good ideas or receive feedback in relation to activity
Knowing what works	Support for this objective demonstrated by work such as research reviews and national evaluation. NIST has shown commitment to learning and sharing of information through website, summits, research database, SIREN and newsletter	Ensuring that learning and new information are disseminated in a timely and accessible manner
Monitoring and evaluation	Information is being collected by local areas, but is variable across and within local areas and types of projects.	Needs identified by coordinators were for guidance about evaluation using a tool adaptable for local needs, information about indicators, outputs and outcomes and on types of existing resources/tools available; training for organisations which are implementing *Choose Life* activities

CHAPTER NINE PERCEIVED PROGRESS TOWARDS MILESTONES

9.1 Reflections on national support

Table 9.1 and Figures 9.1a and 9.1b indicate local coordinators' satisfaction with NIST's action on national milestones (see box 9.1), based on the results of the second survey of local coordinators.

Coordinators were more satisfied than dissatisfied with action on 12 of 13 national milestones. Coordinators were most satisfied with action on publishing guidelines for the media with education and awareness raising (milestone 10) and supporting, disseminating and developing national and local indicators, figures and trends on suicide and deliberate self-harm (milestone 5). The only area where coordinators were more dissatisfied than satisfied was in performance management arrangements to monitor impact of the strategy and action plan on service provision (milestone 12). Milestone 9 ('Providing guidance and support on making local decisions regarding allocation of *Choose Life* funds') elicited the most 'mixed views' responses.

Box 9.1 *Choose Life* national level milestones

1. Establishing and supporting a national support Learning Network involving local agencies
2. Collecting and disseminating information on relevant research findings
3. Providing a mechanism for sharing information on 'what works'
4. Developing a structure to share information on training programmes
5. Supporting, disseminating and developing national and local indicators, figures and trends on suicide and deliberate self-harm
6. Publishing guidance on priority groups
7. Establishing a research programme on suicide prevention/commissioning of new evidence reviews (e.g. on risk factors or effective interventions)
8. Providing advice on specific suicide awareness raising methods and practices
9. Providing guidance and support on making local decisions regarding allocation of *Choose Life* funds
10. Publication of guidelines for the media with education and awareness raising undertaken
11. Evaluation and monitoring of national and local impact of strategy and action plan on service provision
12. Performance management arrangements established to monitor impact of strategy and action plan on service provision
13. Providing opportunities for consultation and feedback on national progress

Table 9.1 Frequency of responses (satisfaction/dissatisfaction) to action on national milestones

	Mile-stone 1	Mile-stone 2	Mile-stone 3	Mile-stone 4	Mile-stone 5	Mile-stone 6	Mile-stone 7	Mile-stone 8	Mile-stone 9	Mile-stone 10	Mile-stone 11	Mile-stone 12	Mile-stone 13	Total N	Total %
Very Dissatisfied (1)	1	1	0	1	0	1	1	2	2	0	3	4	2	18	4.95
Quite Dissatisfied (2)	5	2	2	2	1	6	2	2	1	1	4	5	2	35	9.62
Mixed Views (3)	10	7	9	10	7	7	8	7	13	6	7	8	8	107	29.40
Quite Satisfied (4)	10	14	11	7	11	9	6	10	7	4	8	5	8	110	30.22
Very Satisfied (5)	0	3	4	5	7	1	2	2	4	16	1	0	7	52	14.29
Too early to say (6)	1	0	1	2	1	1	6	2	0	0	3	4	0	21	5.77
No Response	1	1	1	1	1	3	3	3	1	1	2	2	1	21	5.77
Total	28	28	28	28	28	28	28	28	28	28	28	28	28	364	100.00

Figure 9.1a National milestones: frequency of responses (satisfaction / dissatisfaction)

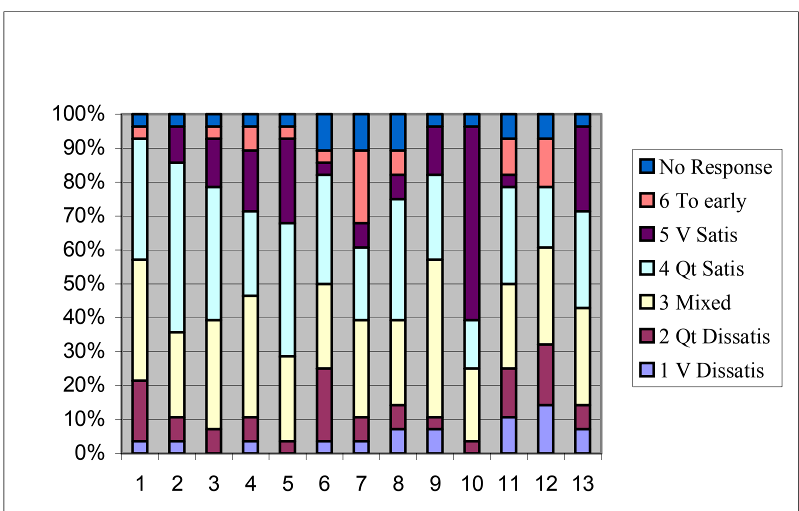


Figure 9.1b Mean satisfaction ratings for national milestones (where 5 is high, and 0 is low)

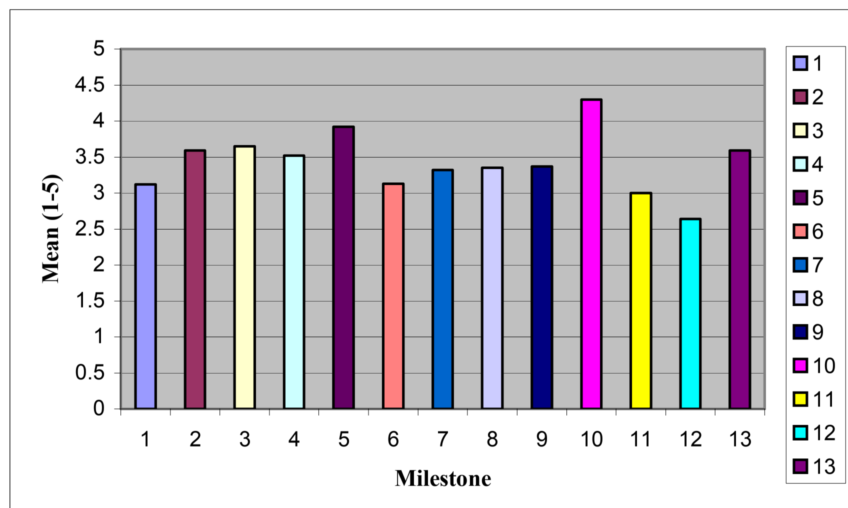


Figure 9.2 Coordinators' satisfaction rating of national milestones (2004-06)

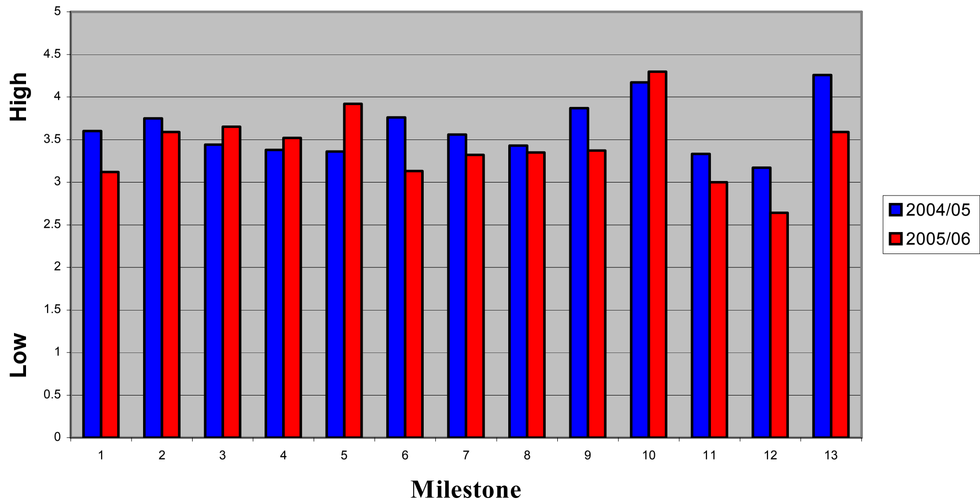


Figure 9.2 compares the mean satisfaction rates for national milestones in the 2004/05 and 2005/06 surveys. Table 9.2 ranks each of these milestones out of 13 in terms of the mean satisfaction scores received in the first and second surveys (where 1 is the highest scoring milestone, and 13 the lowest).

Variances in the mean satisfaction scores between the two surveys are small. Changes in rank of milestone are more revealing. Milestone 5, for example, was ranked third lowest of all milestones in terms of satisfaction in the first survey but second highest in the second survey, suggesting that local coordinators feel national progress has been made in terms of supporting, disseminating and developing national and local indicators, figures and trends on suicide and deliberate self-harm. The creation of the *Choose Life* website and SIREN and work with NHS Health Scotland, GROS and ISD to ensure annual provision of suicide statistics were highlighted by the *Choose Life* Head of Implementation as evidence of progress towards Milestone 5.

Milestone 10 has retained high ratings relative to other milestones, whereas Milestones 11 and 12 continue to be rated lowest in terms of coordinator satisfaction over the two surveys. While the *Choose Life* Head of Implementation indicated that an electronic management information system has been created, and an independent evaluation commissioned, these ratings would suggest that local coordinators are still to be convinced that adequate progress has been made in terms of evaluation and monitoring of national and local impact and performance management arrangements.

Table 9.2 Variance in satisfaction between first and second survey, by national milestone

Milestone	1		2		3		4		5		6		7		8		9		10		11		12		13	
Year	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**
Rank (1-13)	6	11	5	=4	8	3	10	6	11	2	4	10	7	9	9	8	3	7	2	1	12	12	13	13	1	=4
Difference	▼5		▲ 1		▲ 5		▲ 4		▲ 9		▼ 6		▼ 2		▲ 1		▼ 4		▲ 1		=		=		▼ 3	

9.2 Reflections on local progress

Table 9.3 and Figures 9.3a and 9.3b indicate local coordinators' self-assessment of performance for each of the local milestones (see box 9.2), based on their responses in the second local coordinator survey.

Coordinators were more likely than not to have reported some level of implementation action in relation to 10 of 12 local milestones. For the two remaining milestones (7 and 11), no action was as common a response as some level of action. This could suggest that establishing and maintaining local self-help groups (milestone 7) and gaining access to and using evidence from a Public Mental Health Resource Service (milestone 11) are areas that local coordinators are finding more difficult to implement, or are less confidence in their progress towards implementation. The fact that, to date, there is no structure or entity with the name 'Public Mental Health Resource Service' may well have influenced this perception.

The most reported progress has been made with establishing local action plans to implement *Choose Life* (milestone 1) and developing and implementing local training programmes in line with national and local strategy and plans (milestone 8).

Box 9.2 *Choose Life* local milestones

1. Local alliances in place with recognised coordination
2. Local action plans established to implement *Choose Life*
3. Local Health Improvement and Community Plans incorporating key points of local suicide reduction plans
4. Action underway to implement local action plans with additional local investment
5. Funding support provided as an incentive to direct resources and expertise at priority groups within mainstream programmes and activities
6. Local innovative practice established and undertaken by local voluntary and community groups
7. Support provided to establish and maintain local self-help groups
8. Local training programmes developed and implemented in line with national and local strategy and plans
9. Local areas provided with effective support and information by NIST and involved proactively in National Implementation Support Network
10. Local areas have access to national and local data in suitable formats with evidence of use of data in local planning and implementation processes
11. Local areas have access to Public Mental Health Resource Service and use this evidence (and others) to inform implementation of action plans
12. Local developments informed by evidence of effective interventions and by sharing of practical experience

Table 9.3 Frequency of responses to progress on local milestones

	1	2	3	4	5	6	7	8	9	10	11	12	Total	Total %
Not Recognised (1)	0	0	0	2	1	1	1	0	2	1	3	0	11	3.27
No plans for action (2)	0	0	1	4	7	1	4	0	2	1	3	1	24	7.14
Not yet implemented (3)	1	1	5	4	2	1	8	2	4	4	5	8	45	13.39
Partially implemented (4)	13	11	11	16	7	13	10	9	14	15	9	11	139	41.37
Well implemented (5)	12	14	9	0	9	10	3	15	3	4	2	5	86	25.60
No Response	2	2	2	2	2	2	2	2	3	3	5	3	30	8.93
Invalid Response	0	0	0	0	0	0	0	0	0	0	1	0	1	0.30
Total	28	28	28	28	28	28	28	28	28	28	28	28	336	100.00

Figure 9.3a Local milestones: frequency of responses (implementation progress)

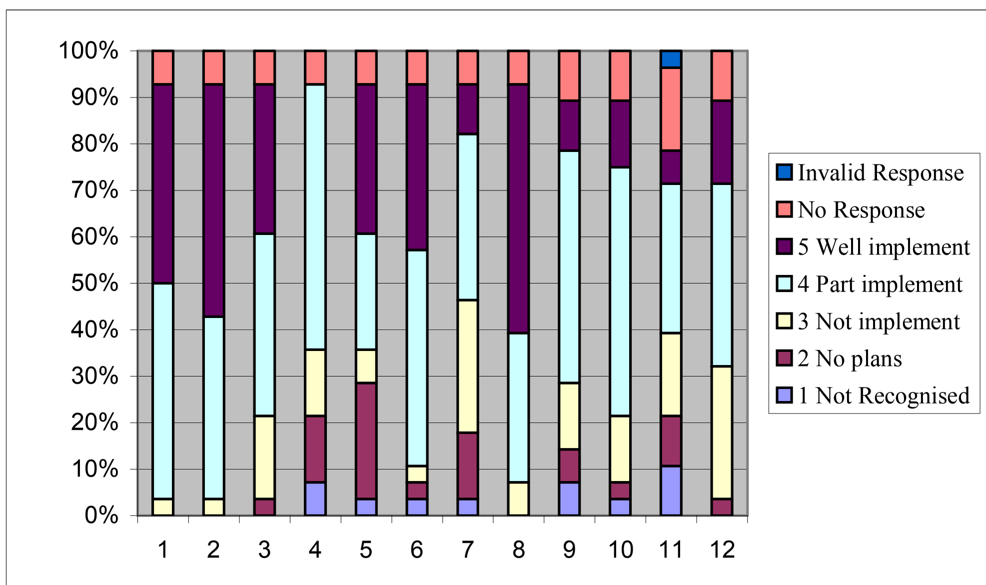


Figure 9.3b Mean scores for local milestones (where 5 is high, and 0 is low)

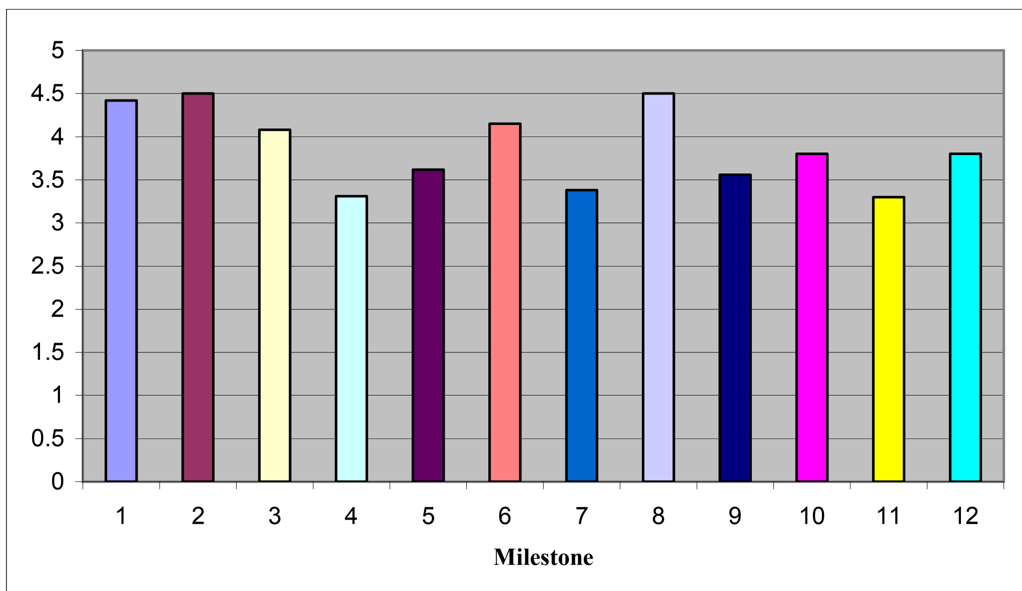


Figure 9.4 Coordinators' self-assessment of performance on local milestones (2004-06)

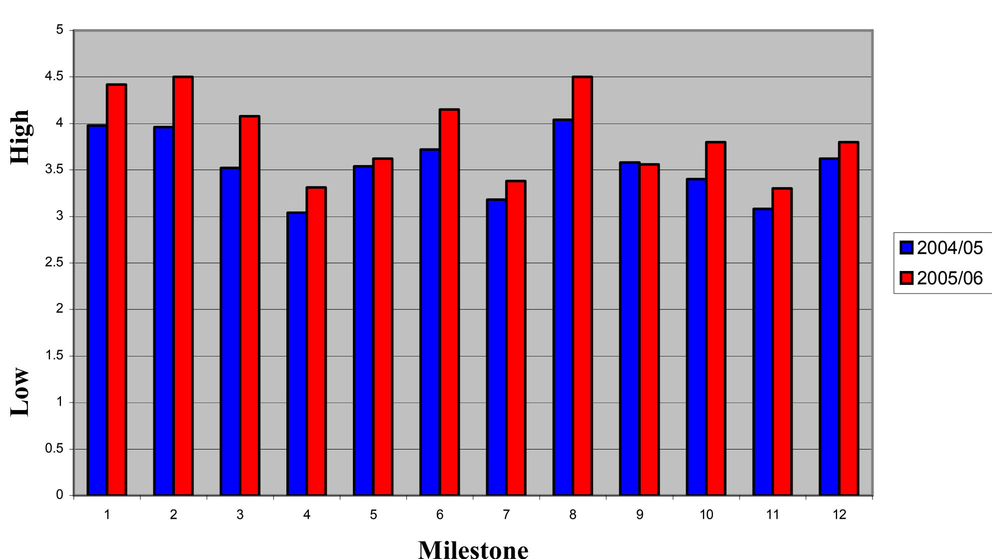


Figure 9.4 compares the mean self-assessment scores of local coordinators in terms of implementation action on local milestones in the 2004/05 and 2005/06 surveys. Variances between the surveys are small, although all milestones except 9 ('Local areas provided with effective support and information by NIST and involved proactively in National Implementation Support Network') show a slight increase in self-assessment scores over time.

Table 9.4 ranks each of these milestones out of 12 in terms of the mean self-assessment scores received in the first and second surveys (where 1 is the highest scoring milestone, and 12 the lowest). The table indicates consistency over the two surveys in terms of how progress towards individual local milestones has been ranked by local coordinators. Coordinators continue to suggest that most progress has been made in terms of developing and implementing local training programmes (milestone 8) and continue to rate milestones 4 and 11 lowest in terms of implementation action taken.

Table 9.4 Variance in ranking of local milestones between first and second survey

Milestone	1		2		3		4		5		6		7		8		9		10		11		12	
Year	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
Rank (1-12)	2	3	3	=1	8	5	12	11	7	8	4	4	10	10	1	=1	10	9	9	=6	11	12	5	=6
Difference	▼ 1		▲ 2		▲ 3		▲ 1		▼ 1		=		=		=		▲ 1		▲ 3		▼ 1		▼ 1	

9.3 Summary

This section reports on perceived, rather than actual, progress towards national and local milestones, based on local coordinators' satisfaction with national action towards milestones, the *Choose Life* Head of Implementation's views on national action and local coordinators' own assessment of their progress towards implementing local milestones.

These findings are based on the results of two local coordinator surveys and an interview with *Choose Life*'s Head of Implementation. Because of changes in some personnel between the two surveys, and some areas choosing not to respond, we have not investigated change in individual local areas over the two surveys. However, by combining responses from across the 32 sites, a general pattern does emerge.

In terms of the national milestones, coordinators reported general satisfaction with national action taken towards all milestones, except milestone 12 ('Performance management arrangements established to monitor impact of strategy and action plan on service provision'), where dissatisfaction levels were higher.

In terms of the local milestones, coordinators were more likely than not to have reported some level of implementation action in 10 of 12 milestones. Most self-reported action had been taken in terms of developing and implementing local training programmes (milestone 8) and least action was recorded for milestone 11 ('Local areas have access to Public Mental Health Resource Service and use this evidence (and others) to inform implementation of action plans').

With one exception (national milestone 5), there was considerable consistency over the two local surveys in those national and local milestones that were rated highest and lowest by local coordinators.

PART THREE CONCLUSIONS AND RECOMMENDATIONS

CHAPTER TEN CONCLUSIONS

10.1 Introduction

The main aims of this evaluation were to assess progress towards the development of a sustainable infrastructure nationally and locally to support the implementation of *Choose Life* objectives, to review progress towards the key milestones identified in the *Choose Life* strategy and set the findings in national and international context, to examine whether and how *Choose Life* is stimulating effective forms of practice nationally and locally, and to make detailed and staged recommendations to guide the next phase of *Choose Life*. In this chapter we draw together the main findings relating to the first three aims of the evaluation under the following headings: progress, focus and targeting, innovative development and the use of evidence and sustainability. In the following, and final, chapter we make our recommendations for the next phase of *Choose Life*.

10.2 Progress

10.2.1 Scotland in context

A growing recognition of suicide as a major public health issue has fuelled interest in and commitment to national strategic approaches to suicide prevention, to promote coordinated and multi-sectoral interventions towards long term goals (Anderson and Jenkins, 2005).

Choose Life has much in common with other national strategies to address suicide which tend to draw on a common set of international guidelines and a growing body of evidence on risk factors and causal pathways leading to suicide and suicidal behaviour. As yet, however, there is little indication that national suicide prevention strategies have a positive impact on trends in suicide (De Leo and Evans, 2004). This may reflect the challenges associated not only with achieving change in behaviour where causal pathways are complex and multi-factorial and where change is likely to occur (if at all) over protracted time scales, but also in evaluating the effectiveness of multiple and multi-level interventions that aim to tackle a broad range of upstream and downstream determinants. It is vital, therefore, to gain a better understanding of the means by which strategies are translated into effective interventions and actions.

Although there are many similarities between *Choose Life* and other national suicide prevention strategies, Scotland's approach is distinctive in several respects. *Choose Life* sets out a clear approach and plan for implementation, which includes dedicated national capacity to support and coordinate implementation, underpinned by an earmarked national and local budgetary allocation and guided by the findings of an early formative evaluation.

One of the distinguishing features of *Choose Life* is that is placed within a national public mental health programme, that is part of wider Scottish Executive policy

commitments to improve population health, promote social justice and tackle inequalities. This allows suicide prevention work to be undertaken within a wider framework of policy objectives and initiatives that share the overarching goals of population mental health improvement.

The approach taken to *Choose Life* implementation follows the model of transformational change espoused by the National Programme (Kotter, 1996): building coalitions and alliances, developing a joint vision for action and using resources and initiatives as catalysts to facilitate system change and promote mainstreaming.

10.2.2 Infrastructures for implementation

The National Implementation Support Team has played a pivotal role in working towards the mainstreaming of suicide prevention activity with wider Executive policy agendas. Despite a lengthy process to establish the team, NIST has made demonstrable progress and built momentum in relation to all its key functions (awareness raising/campaigning; working with the media; development and dissemination of information and knowledge; and supporting local implementation), while also recognising the need to be increasingly strategic. Challenges ahead for NIST include: building clinical involvement and engagement at national and local level; and facilitating local capacity building in key areas of identified weakness, e.g. monitoring and evaluation. In view of the early experience in the first stages of NIST, it would be valuable to have agreed objectives for NIST for the next phase which recognise the changes in implementation support requirements and the external policy and organisational landscape.

The findings from the evaluation of phase one suggest that Community Planning Partnerships have been the best available mechanism to take forward local planning, coordination and implementation of *Choose Life* objectives, in view of the importance that was attached in the *Choose Life* strategy and action plan and in subsequent guidance to local, cross-sectoral ownership of, and grass roots engagement in, suicide prevention activities.

Our findings demonstrate that considerable progress has been made towards the establishment of the kind of infrastructure which the Scottish Executive and partners in the development of *Choose Life* considered to be important to achieve these goals.

Choose Life has provided a powerful, unprecedented rallying call to bring partners together in order to expedite cross-sectoral planning and action to tackle suicide prevention as part of a mental health improvement agenda. The challenge now will be to maintain the momentum and translate this into sustained action, to track implementation across sectors and, where possible, to achieve measurable impacts.

Progress has been made in encouraging the adoption of suicide prevention objectives in a range of local policies and service plans and *Choose Life* partnerships have generally sought proactively to achieve this, by building links with key partners, seeking engagement with key decision makers locally and hooking into other relevant policy priorities. This has proved to be a gradual process that requires time and

concerted effort. It cannot be said that, as yet, *Choose Life* had been mainstreamed, although it is making progress in that direction.

However, the variability in the maturity of local Community Planning Partnerships has had a critical influence on *Choose Life* progress at local level. Key factors that are likely to aid progress include: facilitative leadership style, strong strategic focus on jointly agreed priorities for action, early attention to mainstreaming (see below) as a desired intermediate outcome, capacity to draw on a range of intelligence to inform decisions, and feedback mechanisms to review, learn and adjust.

Local experiences in phase one of *Choose Life* implementation have highlighted that Community Planning Partnerships have the potential to be effective vehicles to build engagement among partners in the community and voluntary sector and to build *Choose Life* objectives into the fabric of other policy structures and priorities. However, at this stage, for a number of reasons it is difficult to be able to make judgements about outcomes and impacts, in part because implementation of *Choose Life* is not yet fully developed and, more fundamentally, because of the difficulties with outcome measurement and causal attribution in respect of complex interventions.

In tackling complex issues and seeking to engender systemic change, it has been noted that it is the interactions between and among partners that are critical for success (Berwick, 1997).

This was borne out strongly in the evaluation on a number of dimensions:

- Interactions within local areas, where local coordinators played a key role in fostering and supporting relationships with strategic players, service providers and local communities
- Interactions among local areas, which had the potential to facilitate exchange of learning and resources
- National: local interactions. It was clear that the maturity of links and connections at national level had implications for partnership engagement and development at local level. Endorsement of *Choose Life* objectives by the relevant policy community and support from key national bodies helped prime local activity and provide levers for change.
- National: national interactions, bringing together areas of expertise, working to promote awareness and to advocate for change. To date, there has been an under-utilisation of national organisations and bodies. They should be encouraged to contribute their proven expertise in particular topic areas. Their engagement in key stakeholder groups at national level would undoubtedly benefit local partnership development.

In looking ahead, it is important to consider the focus of activity required at national level for the future stages of implementation, to make use of resources of all national players, recognising what it is that NIST is uniquely placed to do and what contributions can be made by other agencies. The evaluation suggests that progress towards *Choose Life* objectives is based on effective activity at national level in the following arenas:

- Policy advocacy within the Scottish Executive and with other relevant national bodies
- Raising awareness and influencing those who shape opinions
- Promoting engagement and facilitating dialogue
- Acting as a catalyst for coordination across boundaries
- Performance management to track and oversee progress
- Building capacity, in particular to use and generate evidence.

There are indications that these activities are instrumental in facilitating local progress. In addition the effective engagement of key national stakeholder groups has been found to benefit local partnership development by proving a mandate to support the participation of key sectors. There is a need to build on the effective and extensive developments of links and alliances achieved in phase one, to ensure that this is carried forward in ways that enhance capacity to attain the objectives of phase two, both locally and nationally. The findings from the evaluation provide an opportunity for NIST and the National Programme to take stock of relationships established within and beyond the Scottish Executive and to identify key next steps.

The evaluation found that various models of local coordination had been developed and these had often been subject to refinement as local work progressed. A dedicated coordination post tended to be preferred, for reasons of clarity of communication, capacity to be proactive and forge effective strategic and operational links, and to develop expertise. However, the evaluation has not been able to provide conclusive evidence that this model is more effective than alternatives. It is worth noting that the financial data indicate that only 10% of all funds allocated for *Choose Life* were spent on staff posts which were exclusively dedicated to coordination and development activity. More commonly coordination was combined with delivery of specific interventions or activities.

10.2.3 Phases and stages

It is important to recognise that phase one was focused on development. It brought particular challenges and requirements and was a key opportunity to gain interest and attention, test out ideas and approaches and establish capacity for action.

The infrastructures developed in phase one were shaped by the key tasks identified at that stage, especially to build capacity and influence mainstream policy and practice. Initial partnerships grew up among those with immediate interest in, and commitment to, *Choose Life* goals. There is a need to reflect on the infrastructure and partnerships in place and to consider what is required to ensure the achievement of goals in the next stages of implementation, in particular how to widen engagement as part of the drive to influence mainstream policy and activity. *Choose Life* partnerships now need to engage in learning from phase one and adjust their status and composition accordingly. There is evidence that this is already happening in some local areas.

Getting and keeping partners involved proved to be time consuming and demanding in phase one. Challenges lie ahead in balancing the involvement of an increasing range of players with the delivery of an achievable programme of work. Major

players have to be able to articulate and demonstrate how actions are contributing to desired goals and outcomes within a coherent framework.

10.3 Focus and targeting

10.3.1 Use of resources

It is difficult to gain a clear picture of the balance of resource allocation and the range of activity supported due to:

- Gaps in data which create problems in mapping resource allocation
- Problems with categorisation of activity, so that an accurate breakdown is difficult to obtain
- Underestimation of additional/complementary investment in *Choose Life*
- Absence of data on activities relevant to *Choose Life* but funded through other routes, including as part of mainstream service delivery.

Nevertheless, in the first phase of *Choose Life* CPPs attracted substantial additional investment at local level (£1.6m), and there has been a substantial level of in-kind contribution which is grossly under-recognised. On the other hand, not all areas have been equally successful in raising additional monetary funding.

A high degree of variability is evident among local areas in terms in the way resources are allocated to:

- Three key functions of coordination, training and support for voluntary and community sector
- The seven priority groups
- Specific activities and interventions.

A range of factors has influenced the determination of local priorities for investment of *Choose Life* monies: local consultation, lobbying of groups advocating for a particular issue or set of interests, needs assessment data, building on previous initiatives, local concerns including recent incidents of suicide, and other national policy priorities.

It is important therefore to bear in mind the expectations set for the early implementation of *Choose Life*. The availability of resources for local partnerships to allocate to agreed priorities appears to have had instrumental value at this stage of development, as a means to stimulate involvement and bring people together. It will remain very difficult to demonstrate the specific outcomes achieved by this tactic but qualitative evidence suggests that the value should not be underestimated. However, if strategic planners (local and national) want to achieve demonstrable outcomes and impacts in relation to stated objectives, there may be case for adopting a different or complementary approach which requires greater specificity of inputs, outputs and outcomes, and which operates on a larger scale.

The evaluation documented considerable commonality in many of the initiatives and projects developed in local areas, in particular in terms of training and public

awareness raising. There are grounds to conclude that there is a degree of unnecessary duplication of effort and some aspects of local work might be better undertaken on a collaborative basis, ensuring that best use is made of common methodologies and effective tools and resources. Steps towards building collaborative models of development are already in evidence (for example, some neighbouring areas were making arrangements to pool coordinating capacity; and the work to support local evaluation has given nominated local coordinators a lead role).

The tentative conclusions relating to potential cost-effectiveness of delivering Choose Life should be noted. If Choose Life proves to be an effective approach to suicide prevention, it is likely to be a good use of relative modest resources, in view of the costs associated with suicide.

10.3.2. Equity

The degree of variability gives rise to questions about why some groups tend consistently to feature more prominently (in particular children and young people) and others tend to be given a low priority (e.g. prisoners and homeless people).

There are also striking variations in the types of interventions and approaches used to address similar issues or target similar groups. This may suggest a need to pool information and experience and review what is known from research and practice experience.

Overall, the evidence would suggest that the emphasis to date has been on gaining local engagement with *Choose Life* and on supporting local initiatives that facilitate such engagement. Funded interventions often aim to tackle several objectives suggesting a lack of specificity and focus that has been identified in reviews of other mental health improvement interventions. This is consistent with findings from a recent review of mental health improvement activity (SDC, 2004). Evaluation can provide a useful lens through which projects and partnerships can clarify objective setting (Patton 2005).

The broad range of priorities set in the *Choose Life* strategy allowed local areas a high degree of latitude to determine their local focus. It may be that, in future stages of implementation, more attention needs to be directed towards considerations of equity on at least two counts: to take account of what is known about relative importance of particular risk and protective factors in determining suicidal behaviour; and to ensure that interventions are targeting inequalities and focusing on how to reach those for whom support is currently least accessible.

Seeking to make resources and responses more accessible and acceptable to certain groups who tend to be deemed 'hard to reach' currently will have implications for the types of interventions offered and methods and mechanisms of delivery, as well as for the partners who need to be involved.

10.3.3 Self-harm

Choose Life has stimulated a considerable amount of activity relating to self-harm, but there is evidence of widespread differences across local areas in definitions of what constitutes 'high risk' suicidal behaviour and in the range of activities which have been developed to address the problem. While this diversity is in keeping with *Choose Life*'s dual emphasis on a broad public health approach combined with targeted interventions aimed at high risk groups, the findings suggest the need for further consideration by NIST about how to integrate action on self-harm into the wider suicide prevention strategy.

10.4 Innovative development and the use of evidence

The *Choose Life* action plan and supporting guidance contained an expectation that local areas would use a proportion of their funding allocation to support innovation in the voluntary and community sectors and that this would include self-help initiatives.

Innovation was seen in two main ways: in terms of interventions, as a means to introduce new ways of working and widen the range of available options; and in instrumental terms, as a means of promoting partnership development and local 'ownership' and engendering learning and wider system change.

The evaluation is unable to assess the effectiveness of innovative developments initiated in phase one. Documented examples and experiences of introducing innovation do, however, exemplify some of the conceptual and practical difficulties involved in the context of *Choose Life* implementation:

- Short-term funding cycles and concerns about long-term responsibilities for the resourcing of developments
- Fragility of the infrastructure within the non-statutory sectors which can militate against commitment to new ventures
- Imbalances in the status and resources of statutory and non-statutory sectors and cultural differences in values and beliefs
- The tension between risk taking and using tried and tested vehicles for/ methods of delivery.

In particular, there were some indications that 'instrumental' innovation required certain preconditions to flourish:

- Capacity for reflexive practice and evaluation to allow innovative developments to act as a test bed for wider learning and implementation
- Established partnerships to ensure that learning from innovations could be readily imported into mainstream working.

We have been encouraged by the evidence that many local *Choose Life* partnerships were engaging in a process of reflection and review at the end of phase one with the revision of local action plans. This suggests the importance of using key staging posts in the implementation of policy initiatives working towards long-term goals to prompt review. In other recent initiatives, a readiness to reflect and learn and to build in data

gathering and analysis was found to enhance capacity to use innovation to engender wider system change (McCollam et al, 2006).

There was limited progress at local level in generating evidence of impact. Multiple sources of information and types of evidence, including research, were used to inform local planning and activity. However, research was rarely used systematically. There remains an absence of robust, definitive evidence of effective practice that is framed in ways which are useful and useable in local contexts to inform planning and priority setting. Local areas were more likely to be familiar with the evidence to support a particular project or intervention than to have a broad understanding of the evidence base. Local capacity to identify, interpret and apply this information in the local context was not consistently present. There are also tensions between a 'rational' model of evidence-based decision making and the more consultative approach espoused in community planning.

Taken together, these factors signal the importance of proactive signposting, framing and interpretation of research evidence in ways that are relevant and accessible to practice communities. At the same time, it is important to acknowledge gaps in the available evidence base and work with planners and practitioners to explore opportunities to develop theoretically robust models to guide decisions on priorities and project design.

10.5 Sustainability

The evaluation found evidence of some progress towards sustainability at the three levels identified: delivery of interventions, assimilation of good practice and incorporation of objectives and priorities into other policy streams and initiatives.

The main emphasis in local *Choose Life* implementation has however tended to be focused on sustainability at project level, although it has been argued that mainstreaming of effective ways of working and influencing policy are more important (MacKenzie et al, 2005). These more abstract notions of sustainability are contingent on champions and culture carriers to advocate in other arenas and make connections with other agendas. This is inevitably complex long-term work. Where policy diffusion and implementation have been accomplished in other arenas (for example, in relation to equalities issues), it has required considerable investment of time and resources, supported by persistent campaigning and favourable legislative and policy frameworks.

Training activities accounted for a significant proportion of *Choose Life* investment and local and national informants attached considerable weight to the anticipated benefits to be derived by building capacity and skills at community level and among key staff groups. It will be therefore be important in phase two to track and assess the impact of training in view of what is known about the difficulties of ensuring that those equipped with skills and confidence are enabled to make best use of these.

CHAPTER 11 RECOMMENDATIONS

We make a number of recommendations, relating to future investment in *Choose Life*, sustainability, targeting of action, the strategic integration of self-harm, the role of the Community Planning Partnership, options for delivering the national coordination function, and outcomes and targets. We do not stage these recommendations, since all are considered to be of high priority and therefore require consideration and action early in phase two.

11.1 Future investment in suicide prevention

Threshold analysis carried out for this report suggests that, if *Choose Life* achieves even a very modest reduction in the rate of suicide, at the current level of investment this is likely to generate costs per life year saved below £30,000. This is the case even if a narrow public sector cost perspective, rather than a societal perspective, is adopted. Investment in suicide prevention at the current level would appear, therefore, to represent value for money and the level of success required by the strategy would be modest. With greater success the programme would even be cost saving. However, cost-effectiveness analysis cannot be conducted (even less, cost-effectiveness demonstrated) if there is no evidence of effectiveness – and at present such evidence is not available.

Any future economic evaluation of the *Choose Life* strategy would almost certainly be one of the first (if not the first) evaluations worldwide to be undertaken of a national strategy. In addition to issues of outcome measurement, it will be critical to collect data on the cost and uptake of different components of a suicide prevention strategy. This should include measurement of all in-kind resources, including the contribution of volunteers. It is also important to link the results of any economic evaluation to the context in which interventions are delivered. In the case of *Choose Life*, the wealth of information emerging from phase one of the evaluation could play an important role in describing this context. (See annex 3 for more discussion of these issues and arguments on the potential use of different economic evaluation techniques, including cost benefit analysis,)

Immediate decisions about the allocation of funding for *Choose Life* in the early years of phase two have to be based, therefore, on what is required in terms of the further development and maintenance of national and local infrastructures so as to maximise successful progress towards the key strategic target (20% reduction in suicide). We have not collected any evidence to suggest that radical changes should be made in the current allocation to local partnerships. Given the amount of unspent funds at local level, there might be calls for a redistribution from local to national elements, but we believe that this move would be premature and should be resisted. There were valid reasons for the underspend in the first two years of *Choose Life* and budgets are now moving into balance. In time, more resources may be required at local level to enhance the integration of clinical and drug/alcohol services into suicide prevention activity. Consideration might be given to an increase in funds to the national coordinating body, since NIST has been overwhelmed at times by the support needs of local partnerships.

11.2 Sustainability

Key steps to promote mainstreaming in the next stages of *Choose Life* implementation might encompass the following:

At national level:

- Using opportunities presented by recent developments in national health and social care policy, including *Delivery for Health* and the emergent *Mental Health Delivery Plan,* as well as the *Review of 21st Century Social Work*, to demonstrate the relevance of *Choose Life* to overarching policy goals, such as promoting self help and self management; anticipatory/preventive care
- Involving clinical services in population-based suicide prevention activities
- Strengthening the engagement of national bodies, e.g. COSLA and Communities Scotland, that can promote involvement of key sectors at local level
- Harnessing the energies and skills of national voluntary sector organisations in awareness raising and campaigning
- Promoting the incorporation of *Choose Life* objectives and priorities into other national policy streams and initiatives as an ongoing priority
- Purposive innovation to test out, evaluate, learn and implement, with a view to building knowledge and enhancing capacity to work towards key objectives and priorities.

At local level:

- Using intelligence from a range of sources, including needs assessment, research evidence on risk and protective factors, local evaluations and service reviews as tools in planning for sustainability
- Building in mechanisms to track and review progress towards objectives across policy areas.

11.3 Targeting of action

There should be more focused targeting of action in order to maximise the value of the ring-fenced *Choose Life* investment. The following issues should be taken into consideration when addressing this recommendation.

- Unnecessary duplication of effort at local level should be avoided. This particularly applies to training initiatives and the implementation of innovative suicide prevention interventions. The possibility of pooled/collaborative initiatives across several local areas should be given serious consideration. The national coordinating body should seek to influence this process.

- The national coordinating body should intervene where important aspects of suicide prevention are being ignored at the local level. A prime example would be the failure to integrate substance misuse treatment services into *Choose Life* delivery plans. However, the first challenge to the national coordinating body is to ensure better integration of clinical services and *Choose Life* activities at

national level. Local areas cannot be expected to follow if the national body is not leading by example.

- A more 'experimental' approach to assessing the merit and worth of local suicide prevention interventions should be adopted, especially at early stage of phase 2. Developmental work still remains to be done in order to test the transferability to the Scottish context of interventions which have shown promise elsewhere and also to evaluate promising innovative practice. Rather than take a *laissez faire* attitude towards this vitally important work, the national coordinating body should seek to ensure that the whole of Scotland becomes a laboratory for a rigorous assessment and evaluation of potential suicide prevention interventions. The achievement of successful outcomes in one (or several) local areas should then be followed by roll-out across the rest of the country.

- In considering candidate activities/interventions for suicide prevention, it is important to distinguish between what is best done at local level (e.g. identify and respond to local need) and what is best done at national level (e.g. awareness raising). The national coordinating body should engage in a dialogue with national partners and local areas in order to reach consensus on the appropriate division of responsibility.

- In taking forward action in phase two, a balance should be struck between the application of 'established' suicide prevention interventions (recognising that these may still be to some degree unproven in the Scottish context – evidence of positive impact may not be transferable from another country/health system/policy context) and innovative practice. At this stage in the evolution of *Choose Life*, both approaches are required. The expectation of appropriate and adequate evaluation of innovative practice should be built into performance review

- The limitations of the priority group approach should be recognised. Priorities tend to be rather general and to depend heavily on the international research literature or the epidemiological picture at national level. The epidemiology of suicide at the local level, however, may be crucially different in many respects. The assessment of local priorities should be encouraged and taken into account in local action plans, even if the priorities differ from those identified at national level. Additionally, the number of priority groups should be as small as possible. When there are too many, it is inevitable that there will be further differentiation or rank ordering among them. Lower order priorities will tend to be overlooked.

- The national coordinating body should reinforce the equity focus of current priorities. In particular, it is surprising that socio-economic deprivation and low socio-economic status, which are known to be highly associated with the incidence of suicidal behaviour, are not highlighted in the strategy.

- The national coordinating body should ensure that all participating organisations and players, both national and local, adopt an evidence-based approach, drawing on findings from research (especially primary evaluated

intervention studies and systematic reviews of effectiveness), local needs assessment and intelligence, and practitioner expertise, when drawing up plans for suicide prevention interventions. This expectation should be built into performance review processes.

- The national coordinating body should ensure that evidence about effective interventions accruing at local level is collated and disseminated to relevant *Choose Life* organisations and beyond, and that this evidence has an impact on practice.

11.4 Strategic integration of self-harm

In phase two, more consideration should be given to the integration of self-harm into *Choose Life*. We recommend that the strategy continues to encompass the high risk end of self-harm, but note several issues that need to be addressed.

- The national coordinating body needs to provide guidance about how to identify and reach the subgroup of people whose self-harming behaviour puts them at high risk of future suicide. An operational 'case' definition of the subgroup might be all those who are admitted to hospital following an episode of self-harm. However, there is no perfect correlation between hospital treatment and the (medical or psychosocial) 'seriousness' of the behaviour: many (perhaps even the majority) of those treated in hospital will not represent a high suicide risk and a small, but significant, minority of those who do not attend hospital (not referred or refusing to attend) will be high risk (and will go on to commit suicide). Whether an alternative approach to 'case' finding can be devised, which offers better sensitivity and specificity and is practical and feasible, remains to be seen.

- The less 'serious' component of self-harm cannot be ignored, even if it is not included in the scope of *Choose Life*. The majority of people who self-harm are probably not at high risk of suicide but nonetheless constitute a group with a high level of unmet psychosocial need and extensive experience of stigmatised and hostile responses from both the public and professionals. The Scottish Executive/NHSScotland should ensure that health and social care professionals in Scotland adopt the NICE guidelines on the treatment of self-harm (NICE, 2004), pay attention to recommendations of the National Inquiry into Self-harm among Young People (2006) and continue to focus anti-stigma campaigns on this behaviour.

- If self-harm remains a focus of *Choose Life*, there should be guidance about how incidence is to be measured (which depends in turn on the operational definition – see above) and what target for its reduction is to be set (see below).

11.5 The role of the Community Planning Partnership

The limitations of the community planning partnership (CPP) as the key *Choose Life* coordinating body at local level need to be recognised. In particular, CPPs have been less effective in engaging proactively with clinical services and planning structures (both primary and secondary health care, in particular drug and alcohol services and mental health services). How can these and other currently excluded partners be integrated into the *Choose Life* effort and be encouraged to 'own' the *Choose Life* agenda?

- CPPs need to review progress and examine the partners and partnerships that have yet to be put in place in order to achieve their CL objectives. Priority should be given to establishing effective links with clinical and drug/alcohol services where these are found to be absent to inadequately developed.

- In order to counterbalance the limitations of using CPP mechanisms, the Scottish Executive might adopt a more directive approach in relation to key priorities, using other policy implementation mechanisms to ensure engagement of key partners in clinical services and following through the proposed integration of clinical perspectives within national *Choose Life* support capacity.

- Despite the above, the CPP remains the most appropriate vehicle for developing strategy and overseeing delivery in relation to *Choose Life* at the local level. However, NIST, on behalf of the National Programme, should continue to work closely with CPPs in order to ensure that *Choose Life* budgets are fully spent on suicide prevention activities, reducing the risk of claw back of unspent allocations by parent local authorities.

- The coordination function is crucial, but that does not necessarily imply that there has to be a dedicated coordinator post. The task of the CPP is to devise the most appropriate arrangement for delivering the function.

11.6 Options for delivering the national coordination function

Some type of central coordination body will continue to be required (at least in the immediate future) to provide national oversight/guidance, assess and support performance and ensure accountability at local level, promote learning/review/reflection and effective knowledge transfer, and coordinate action, i.e. act as the 'glue' that holds together the various *Choose Life* elements, nationally and locally. While we recommend the continuation of a central coordinating function, we propose a review of how this is delivered and where it is situated. The ideal location would maximise mainstreaming opportunities and promote an integrated approach to suicide prevention, incorporating both general population health improvement (public health) and risk group (e.g. clinical services) perspectives.

- A key question is whether this function should remain as a separate section/department within population mental health policy. Currently

Mental Health Division is the policy and delivery home for suicide prevention. However, because core Scottish Executive Departments focus on the making of policy, the delivery of policy is more usually carried out by Scottish Executive agencies, local authorities and other bodies. Awareness raising, working with media, improving information capture/dissemination and supporting implementation are functions that relate to mental health improvement work more generally. Thus, some of these functions could also be taken on by organisations which already have delivery responsibilities in these areas, e.g. NHS Health Scotland and the Scottish Public Health Observatory. Such changes could improve opportunities for mainstreaming suicide prevention.

- However, suicide prevention is by no means secure. There is a danger that the momentum and progress gained over the past few years will be quickly dissipated. Another consequence of the dilution of a dedicated coordinating body might be the withering away of a public health perspective and privileging of a clinical, high risk approach. This could be counteracted if the policy home for suicide prevention were moved to Health Improvement Strategy and Support. But (assuming that some of the functions of the national coordinating body were still taken on by other organisations) this might be a similarly unbalanced solution, leading to the continued marginalisation of clinical services.

11.7 Outcomes and targets

Although this is not an area which was explored in great detail in the course of the evaluation, we draw on a wider literature to offer some recommendations concerning the development and operationalisation of outcomes and targets for the second phase of *Choose Life*. Many issues need to be addressed, including:

- At the national level, the definition (and therefore measurement) of suicide should be clarified (we recommend that undetermined deaths are ‘counted’ as suicide for the purposes of tracking progress towards the strategic target), an appropriate measure of high suicide risk self-harm should be established (see above), and a target for reduction of self-harm should be adopted (assuming that targets for *Choose Life* continue to be set – see below)

- At local level, there are very large ‘natural’ major fluctuations in suicide incidence and small numbers of deaths (therefore wide ‘confidence intervals’ around ‘average’ trends). As a consequence, it makes no sense to translate the 20% suicide reduction target at national level into a similar target at local level. It will be virtually impossible in the majority of areas to demonstrate that such a target has been reached or, if reached, that the reduction in suicide is attributable to *Choose Life* interventions. We suggest that, if targets are to remain, consideration should be given to the identification of a ‘proxy’ measure that is more robust in terms of establishing and monitoring trends. Hospital-treated self-harm is probably

the best candidate, but the problems with this measure have been noted above.

- In view of the difficulties of establishing trends at the local level, more attention should be paid to the collection of data on measures of process (implementation) and output, ensuring that: (a) the measures are few in number and, as far as possible, agreed through negotiation with local *Choose Life* planning teams; (b) the measures are logical intermediate steps towards the ultimate outcomes (reduction of suicidal behaviour); and (c) relevant data can be collected routinely through existing datasets. Evidence of positive change in these measures (e.g. more professionals and public receiving suicide intervention training) would help to establish a plausible case of progress towards ultimate (but difficult to measure) suicidal behaviour outcomes.

- While targets can be helpful in 'concentrating the mind' and galvanising action, disadvantages also have to be recognised. Not all national strategies have adopted targets (Ireland is a recent example). If *Choose Life* is to continue in its use of a target, care needs to be taken to ensure that this is set at a level, and presented in such a way, that it inspires (rather than demotivates) key national and local actors. This suggests the need to consider the appropriateness of setting the intended reduction at 20% (which is exceptionally ambitious, given the trends during the previous three decades) and replace it with a lower quantitative target or even a directional (i.e. non-quantitative) target.

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ANNEX 1 REVIEW OF NATIONAL STRATEGIES FOR SUICIDE PREVENTION

Introduction

Suicide is an issue of global concern, with between 500,000 and 1.2 million people worldwide dying by suicide each year (Hawton and Heeringen, 2000). Scotland is one of a number of countries to produce a national strategy on suicide prevention (Scottish Executive, 2002). The early implementation of this strategy is being evaluated and the work of the evaluation team includes a review of suicide prevention strategies across the world (especially England, Ireland, Australia, New Zealand, Finland, Norway, USA and Canada) to learn from other countries and to provide a basis for contrast and comparison.

The paper begins with a summary description of the strategies included in the review. It then considers the goals and priorities set out in these strategies before examining the processes and mechanisms described for implementation. The review concludes with brief observations and discussion of key points.

Methods

Definition of national suicide prevention strategy and selection criteria for review
A strategy for suicide prevention is taken to mean a set of integrated, multifaceted activities that are coordinated by government. A strategy aims to promote, support and link inter-sectoral programmes at local, regional and national levels.

A distinction has been drawn between strategies thus defined and programmes of prevention which involve one or more targeted activities, without coordination between the activities (Anderson and Jenkins, 2005). This review considers exclusively strategies which have been developed at national level. It was beyond the scope of this exercise to include strategies developed at regional / federal level. The review was restricted to strategies available in the English language.

Some countries may have suicide prevention goals and plans within their mental health policies without addressing suicide prevention in a separate policy. This review focuses only on those countries which articulated a separate suicide prevention strategy. It draws mainly on national strategy documents and selected literature that provides commentary on and, in a limited number of cases, evaluation of national approaches. The analysis that follows therefore is informed by what is stated in formal published policy documents. No attempt has been made to explore the extent to which or how policy statements have been implemented in practice. Nor is it possible, by simply reviewing published strategies, to ascertain in every case how strategies were developed, or to discern the relative influence of non-governmental organisations and community groups in this process.

Identification of national strategies for review
The main source for identification of strategies from other countries has been the Canadian Center for Suicide Prevention (Center for Suicide Prevention, 2004) which has an extensive bibliography of suicide prevention strategies and related literature. Searches of the literature published in the last 20 years were also conducted and an

international expert from the Center for Suicide Prevention was consulted to guard against the omission of key strategies.

Process of analysis
The key areas that were examined in reviewing the ten strategise were the following:

- Origins and evolution of the strategy
- Scope: goals and objectives, the extent to which strategies make reference to evidence and to evaluation; the approach taken to suicidal behaviour and deliberate self-harm
- Structures within which the suicide prevention is located (table A1)
- Comprehensiveness including target setting for suicide prevention (table A2)
- Strategic components (table A3)
- Priority groups targeted (table A4)
- Mechanisms set out in strategies to support implementation (table A5).

Elements of a comprehensive suicide prevention strategy
The review uses the framework developed by the Center for Suicide Prevention (CSP, 2004), based on the UN guidelines (1996). The core elements of a national strategy are as follows:

- Coordination and integration to promote cross-sectoral collaboration from governmental to community levels, undertaken by an identified coordinating body
- High-level political support for strategic aims, to lay the foundation for the strategy and its implementation. The guidelines suggest this is of particular importance in view of the need for cross cutting, interdepartmental support.
- A coherent conceptual framework that provides a model for understanding suicidal behaviour, to generate programmes of activity directed towards prevention and to foster research programmes
- Community involvement and engagement in formulating, implementing and evaluating programmes, recognising the important contribution of local / community based organisations and networks in implementation and review
- Objectives that are achievable and measurable, some of which may be expressed as targets for change
- Monitoring and evaluation to inform implementation and review of strategy.

Goals, strategic components and priority groups
The goals of national suicide prevention strategies can focus on:

- Universal, population level public health interventions e.g. to reduce risk conditions such as high unemployment, or to equip families, communities and organisations with skills and knowledge that promote mental health and well being and foster resilience. Core components include public awareness campaigns, media education, means restriction
- Selective interventions to address high risk sub groups within the general population e.g. to improve access to mental health care; to enhance the self esteem and coping capacity of high risk school students. Core components include training and access to services

- Indicated programmes targeted at groups at high risk e.g. pharmacological and behavioural treatments for people with specific mental illnesses. Core components here are access to services
  (Beautrais, 2005; De Leo and Evans, 2004).

Suicide prevention interventions may therefore be targeted at a range of priority groups. In Scotland for example seven priority groups are identified: children, young people, people with mental health problems, those affected by suicide, people who abuse substances, people in prison / convicted of crime.

Strategic components of a strategy can encompass the following areas of activity: public awareness; media education; access to services; building community capacity; means restriction; training; and research and evaluation (De Leo and Evans, 2004).

Implementation mechanisms
There are a number of roles that an identified coordinating body can play in supporting implementation:

- to articulate how strategic goals are to be implemented through local and national structures and processes
- to provide leadership and direction in strategy development and implementation
- to facilitate vertical and horizontal coordination and linkages
- to maintain focus and commitment for the long term, including resource prioritisation
- to monitor trends and maintain surveillance of problems and issues.

(United Nations,1996; Anderson and Jenkins, 2005).

Key coordinating tasks include surveillance, research for example to identify risk and protective factors, programme development, programme evaluation to test effectiveness of interventions.

The UN Guidelines (1996) also suggest that effective national suicide prevention strategies require executive, financial and technical resources to carry out responsibilities effectively.

Results

The review has been able to identify ten strategies, which fit the definition given earlier: Australia, England, Finland, France, Ireland, New Zealand, Norway, Scotland, Sweden and USA.

Origins and comprehensiveness of national suicide prevention strategies
Table A1 summarises the origins, scope and broad content of the ten strategies. The table also describes the structures that support the strategy.

Table A1: Features of national suicide prevention strategies

Country and time span of national strategy	Origins	Scope and content	Structures to support implementation
Australia *National Youth Suicide Prevention Strategy* 1997 *Living is for Everyone* (LIFE) 2000	Starting in 1994 with 10 year targets to achieve a 15% overall suicide reduction and 10% among people with schizophrenia, the strategy developed incrementally, leading to the National Youth Suicide Prevention strategy. This promoted cross sectoral evidence based responses in education and health services and incorporated social change programmes and measures to reduce access to suicide means. LIFE builds on the Youth Strategy, taking a whole systems / whole population approach to suicide prevention, supported by a 4 year budget of $48 m, with a particular focus on young people. LIFE, informed by extensive pilot work, provides a strategic framework for identifying priorities for national action to alleviate suicide, promote mental health and resilience.	LIFE identifies broad goals, action areas, target groups, partnerships and performance indicators. It presents data on patterns of suicide and suicidal behaviour. Objectives include targets to reduce the incidence of non fatal suicidal behaviour and to improve access to mental health care for those who present in hospital emergency departments. Self-harm is equated with attempted suicide and the only data cited on self-harm relate to hospitalisation episodes.	National Advisory Council on suicide prevention operates at Commonwealth level to advise Minister, to promote evidence based intervention and review national suicide prevention activities. State/territory specific programmes are developed in partnership with national advisory bodies to maintain cohesion and coordination in line with national priorities and the evidence base
England *National Suicide*	In 1994 targets aimed for a 15% reduction in overall suicide, 33% among people with severe mental illness, by 2000. Revised targets set in 2002 aim for a 20% suicide rate	The 2002 strategy sets out to be: comprehensive and cross sectoral; specific, built around identified actions that are practical and open to monitoring;	The strategy is a core programme of the National Institute for Mental Health. It contains an implementation plan that builds

Prevention Strategy for England 2002	reduction by 2010, from a 1997 baseline.	evidence based (e.g. in determining high risk groups and in designing interventions); and subject to evaluation. The strategy sets goals, measurable objectives and detailed actions. Deliberate self-harm is regarded as a risk factor for suicide. The strategy includes an objective to reduce the number of suicides in the 12 months after an episode of deliberate self-harm.	on actions underway and links into wider policy context. Strategy is one of the core programmes of NIMHE which has responsibility for its implementation. It contains an implementation plan that builds on actions underway and links into wider policy context. Progress towards objectives is reviewed by a national strategy group and reported annually.
Finland *Suicide can be prevented* 1993	Finland's strategy began, uniquely, with a psychological autopsy of 1397 suicides. Findings from this, along with expert advice, informed the suicide prevention strategy, with identified target areas and responsibility for action	Finland was the first country to introduce a comprehensive national strategy for suicide prevention that works across sectors and at multiple levels. The strategy focuses on awareness raising and education, on building networks of support and on the effective treatment of depression. It is concerned with suicide and suicidal behaviour and stresses the need to identify signs of self-destructive behaviour in young people.	Shared responsibility for suicide prevention is central to the strategy, which provides a framework for implementation at regional and municipal level. Three consecutive phases of research, implementation and evaluation were overseen by an NGO with dedicated staff and central funding (1992 –96).

France *Strategy to address suicide* 2000	The national Programme for Suicide Prevention dates from 1996/7, followed by an action plan for 2000-5. In 2003, the Health Dept issued a series of public health reports for consultation, including one on suicide.	This proposes a suicide reduction target of 20% in the general population, halving suicides among young people and men over 75 and reducing rates among prisoners. Key priorities for action cover: improving the identification of risk, including depression; enhancing access to services; and reducing access to and lethality of means. The strategy does not describe structures or processes for implementation.	Government requested the Minster for Health & Disability to develop a suicide prevention action plan for 2000 – 05. Suicide prevention is a stated public health policy priority.
Ireland *Report of the National Task Force on Suicide* 1998	Analysis of suicide trends in 1996 led to the production of the strategy in 1998.	The 3 strands of work proposed encompass: public health measures; good quality health services; and comprehensive responsive community based services and resources. The strategy offers over 100 recommendations relating to: health service provision; training and awareness of professionals; prevention; interventions to identify, assess and treat mental illness; support for those affected by the aftermath of suicide; and research and evaluation. ‘Parasuicide’ is used to signify both a ‘cry for help’ and a “failed suicide”. It also refers to those who deliberately injure themselves ‘in a suicidal manner’. Data presented on trends in parasuicide and associated costs relate to self poisoning only. The Action Plan covers 4 levels of activity: population approaches, targeted approaches,	A National Task Force produced recommendations that informed the national strategy.

Reach Out. National Strategy for Action on Suicide Prevention 2005	Building on the work of the National Task Force and local developments to address suicide, the action plan was developed through wide-ranging consultation, informed by reviews of evidence and best practice.	responding to suicide and research and information.	A National Office for Suicide Prevention is to be established to drive implementation forward and is expected to develop programmes to address key strategic priorities. A Steering Group will guide its work, and a national representative forum will encourage information sharing. The NOSP will produce an annual report of progress.
New Zealand *In our Hands: New Zealand youth Suicide Prevention Strategy* 1998	The Youth Suicide Prevention Strategy grew out of extensive stakeholder involvement and a review of the evidence base. In Jan 2005, the New Zealand Government announced that the strategy will be broadened to all age groups. A stock take of activity since 1998 and a review of the evidence base for suicide prevention have been produced.	There is a general population strategy and one focusing on Maori communities. Goals comprise: promoting well being; early identification and help; crisis support and treatment; support after suicide; and information and research. The strategy offers examples of evidence based interventions relating to: parenting programmes; the detection and treatment of depression; improvement in health services management of suicidal patients; the reduction of social and economic inequalities e.g. labour market disadvantage and employability. Self-harm is equated with attempted suicide.	The strategy for youth suicide prevention proposed a coordinated, inter-agency approach supported by national bodies to undertake an extensive range of programmes.

Norway *The National Plan for Suicide Prevention* *1994*	National Government Departments identified suicide as an issue of shared concern.	The plan focuses on: research; training and professional development; piloting interventions and service models to raise awareness; improved access to help; and the promotion of intersectoral collaboration. There is less attention to universal prevention and promotion factors. The strategy does not make clear distinctions between suicide and suicidal behaviour. People who have 'shown suicidal behaviour' are regarded as future suicide risks.	The National Plan for Suicide Preventions encourages a cross government approach, coordinated by the Board of Health, with a budget for implementation.
Scotland *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland* 2002	*Choose Life* was created and is intended to be implemented collaboratively. It grew out of concerns about trend in suicide among young men and developed against backdrop of wider policy development on public mental health.	The 10 year strategy aims to reduce suicide by 20% by 2013, with a budget of 12m for the first 3 years, for local and national actions. The strategy includes objectives and milestones to assess progress. The focus is on building capacity, commitment and leadership and utilising existing structures and processes to ensure sustainability. The relationship between suicide and suicidal behaviour is considered in some detail, to distinguishing between deliberate self-harm (DSH) and an intent to kill oneself but also recognising DSH as a risk factor for suicide.	*Choose Life* was issued as a cross departmental government policy. A National Implementation Support Team was established to work with local areas and national and local bodies on programme development and on data gathering and evaluation.

Sweden *Support in Suicidal Crises. The Swedish National Programme to Develop Suicide Prevention* 1995	National cross sectoral collaboration led to a programme on suicide prevention.	The strategy sets objectives and gives guidelines for suicide prevention. It stresses the importance of marrying an understanding of the evidence base with an understanding of the cultural / philosophical significance of suicide. Three levels of intervention are described: measures to enhance individual coping capacities; measures to minimise or reduce the impact of risk conditions; and interventions to prevent suicide including reduced access to means. The focus of the strategy is on suicide and attempted suicide. Suicide is regarded as 'inwardly directed violence'.	A National Council for Suicide Prevention which encourages education, research and development. The strategy details tasks and assigns responsibility for these to named bodies but does not explain how the strategic programme is to be coordinated or resourced.
USA *National Strategy for Suicide Prevention* 2001	The strategy emerged from concern about suicide as a public health issue, from international attention to suicide prevention by WHO and UN and from grass roots networks which lobbied for the development of a US strategy. Goals and objectives for suicide prevention were subject to consultation and discussion with clinicians, scientists, professionals and the public up to 2000.	The US strategy is a framework to strengthen collaboration, guide priorities and support States, communities and tribes in developing their own suicide prevention plans. Informed by analysis of risk and protective factors for suicide and reviews of international experience of developing suicide prevention strategies, the strategy sets out goals that encompass: building awareness and support for suicide prevention, reducing stigma associated with particular conditions and services, public health measures to reduce access to means of suicide, training and professional	The strategy is intended as a framework to encourage, inform and motivate key stakeholders and as a model to guide State strategies in using the evidence base.

		development, media reporting, access to community resources and specialist services and improved surveillance. Suicide attempts are viewed as 'self destructive behaviour'.	

Table A2 examines the comprehensiveness of national strategies, using the framework developed by the Center for Suicide Prevention (CSP, 2004), summarised above.

There is considerable convergence among those countries which produced a strategy after 1996, as these tend to make reference to the UN guidelines as an important source document.

Targets
Jenkins and Singh (2000) note that target setting can be an important mechanism to promote action. Targets can influence the activities of government, public services and professional education and training bodies. Targets can also impact on the activities and priorities of a wide range of agencies in the community, voluntary and private sectors which can make a contribution to strategic suicide prevention objectives. In addition, targets can help set an explicit framework in which the responsibility for achievement of objectives does not rest with individual clinicians/practitioners alone but with all sectors.

As shown in table A2, several countries do not set identified targets in their strategy. Ireland's strategy, for example, contains wide-ranging recommendations recently supplemented by an implementation plan but no targets. Sweden has clearly defined objectives, but these are not developed into targets for implementation.

Evaluation and evidence
In general 'monitoring and evaluation' tend to refer to the evaluation of interventions that are the means of delivering the objectives and not to the evaluation of the strategy itself. Notable exceptions are Norway and Scotland. Australia has undertaken a comprehensive programme of research and development to inform the planning and implementation of interventions. This work is reported in detail in supporting documents that accompany the strategy. Finland built its strategy on extensive research into the scale and nature of the problems associated with suicide and suicidal behaviour. The evaluation of the strategy that was subsequently implemented was, however, very limited. Although the implementation process was described as 'learning by doing' the external evaluation was undertaken retrospectively and this limited its value, as did the adherence to a psychiatric / medical paradigm.

Key findings from the evaluation of the Finnish strategy include the following:

- The strategy had highlighted problems and complexities of suicide in Finnish society
- Although rates of suicide had decreased it was not possible to attribute this to the strategy
- There were gaps e.g. in projects that addressed suicide among older people and access to means of suicide
- The strategy had not fostered the level of professional and political commitment required for sustainability
- Projects were insufficiently integrated with mainstream health care systems
- The planning of the implementation and evaluation phase did not allow for adequate evaluation of effectiveness.

Table A2: Comprehensiveness of national suicide prevention strategies against CSP framework

Country	Date of publication	Gov policy	Model	Coordinating body	Community engagement	Clear objectives/ targets	Monitoring & evaluation
Australia	1997* 2000	+ +	+ +	+ +	+ +	+ +	+ +
England	2002	+	+	+	+	+	+
Finland	1993	+	+	+	+	+	+
France	1999	+	-	-	-	+	+
Ireland	1998, 2005	+	+	+	+	Clear objectives, no targets	+
New Zealand	1998**	+	–	–	+	5 goals relating to levels of suicide prevention, each with objectives	+
Norway	1994	+	-	+	+	+	+
Scotland	2002	+	+	+	+	+	+
Sweden	1995	+	+	-	+	Clear objectives, no targets	
New Zealand	1998**	+	–	–	+	5 goals relating to levels of suicide prevention, each with objectives	+
USA	2001	+	+	-	+	11 goals with objectives and targets for 2005	+

Key

+ indicates that the strategy includes this element
- indicates that the strategy does not include this element
* Australia: earlier strategy covered young people only, the later strategy covers the whole population
**New Zealand strategy currently covers young people only
Gov Policy indicates that the strategy is a formal statement of policy issued by Government
Model indicates the presence or absence of a model for understanding suicidal behaviour

It is common for strategies to provide an analysis of trends and patterns in suicide and suicidal behaviour and many also compare national trends with more global or international trends. Trend data are only one source of intelligence considered in setting goals and identifying priority groups (see below). The other two principal sources are consultation with stakeholder groups and analysis of evidence for effective interventions to reduce suicide.

Goals, strategic components and priority groups

All of the strategies reviewed identify goals that relate to each of the three levels of intervention: universal, selective and targeted. Table A3 summarises the main components described in the strategies of different countries (De Leo and Evans, 2004). Almost every country makes reference to the full range of suicide prevention components. However, the French and Norwegian strategies do not make specific provision for public awareness or media education. Norway, and to some extent Finland, do not give priority to tackling access to the means of suicide.

Table A4 maps out the priority groups identified in each strategy. There is much similarity in the priority groups identified with the exception of those countries where young people were the main priority initially. The French strategy does not include those with substance misuse problems. Norway's strategy makes no reference to prisoners / those involved with the criminal justice system nor does it refer to those affected by suicide as key target groups, although it does make specific mention of the high risk of suicide among medical practitioners. England also refers to high risk occupations, including farmers and medical professionals. Several strategies, including those of Australia, New Zealand and England, make reference to particular ethnic groups. While young people receive considerable attention as one (if not the main) priority, Norway, Ireland and England also regard older people as a risk group. England, Ireland and Scotland make explicit reference to social exclusion and socio-economic disadvantage.

Implementation mechanisms

National strategies vary in the extent to which they give an indication of the approach and methods of implementation that will be utilised to achieve their goals. Table A5 reviews the implementation approaches described in national strategies.

In one set of strategies, including those of Australia, England, Finland, Norway and Scotland, the mechanisms to ensure effective coordination are relatively clearly identified in an implementation plan with identified resources. Scotland's strategy, gives more detail than others of the level of financial resource available locally and nationally and indicates how support is to be provided for capacity building and implementation. Ireland's recent implementation plan identifies mechanisms for coordination and indicates that unspecified levels of additional funding will become available for implementation.

A second set of strategies, including those for France, Sweden, New Zealand and USA, does not include an implementation plan. The New Zealand strategy anticipates the development of an implementation plan.

Table A3: Strategic components of national suicide prevention strategies

Country	Public awareness	Media education	Access to services	Building community capacity	Means restriction	Training	Research and evaluation
Australia							
1997	+	+	+	+	+	+	+
2000	+	+	+	+	+	+	+
England	+	+	+	+	+	+	+
Finland	+	+	+	+	(+)	+	+
France	-	-	+	-	+	+	+
Ireland	+	+	+	+	+	+	+
Norway	-	-	+	+	-	+	+
Scotland	+	+	+	+	+	+	+
Sweden	+	+	+	+	+	+	+
New Zealand	+	+	+	+	+	+	+
USA	+	+	+	+	+	+	+

AfterDe Leo and Evans, 2004

Key

\+ indicates that the strategy covers this component
(+) indicates that the strategy makes limited reference to this component
\- indicates that this component is not included in the strategy

Table A4: Priority groups in national suicide prevention strategies

Country	Children	Young people	Older people	People with mental health problems	People who attempt suicide	People affected by suicide	People who abuse substances	People in prison/ convicted of crime	Occupational groups	Ethnic groups	Socially excluded/ disadvantaged	Other
Australia	+	+	-	+	+	+	+	+	-	+	-	
England	+	+	+	+	+	+	+	+	+	+	+	1,2
Finland	+	+	-	+	+	+	+	+	-	-	-	-
France	-	+	-	+	+	+	-	-	-	-	-	-
Ireland	+	+	+	+	+	+	+	+	+	-	+	-
Norway	-	+	-	+	+	-	+	-	+	-	-	-
Scotland	+	+	-	+	+	+	+	+	-	-	+	3,4
Sweden	+	+	-	+	+	+	+	+	-	+	-	2,5
New Zealand	+	+	-	-	-	-	-	-	-	-	-	-
USA	+	+	+	+	+	+	+	+	+	-	-	-

Key

\+ identified as a priority setting / group in the strategy

\- not included as a priority setting / group in the strategy

Other groups: 1. Expectant mothers; 2. Survivors of abuse; 3. Recently bereaved; 4. People living in rural / isolated communities; 5. Those with HIV/AIDS

Table A5: Implementation approaches in national suicide prevention strategies

Country	Surveillance	Research	Programme development	Evaluation: programmes of action	Evaluation: strategy	Resources identified (exec/ technical/ financial)
Australia	+	+	+	+	+	+
England	+	+	+	+	-	+
Finland	+	+	+	+	+	+
France	-	-	-	-	-	-
Ireland	+	+	+	+	-	-
Norway	+	+	+	+	+	+
Scotland	+	+	+	+	+	+
Sweden	-	-	-	-	-	-
New Zealand	-	-	-	-	-	-
USA	-	-	-	-	-	-

Key
+ indicates that the strategy adopts this approach
- indicates that the strategy does not adopt this approach

Discussion and conclusions

Inevitably there are limitations associated with an exercise that has only focused on what is contained in published national strategy documents. Expert sources (Richard Ramsay, personal communication) suggest that the pace and process of implementation in certain other countries provide important points of comparison with Scotland and potential learning opportunities. However, this would not be achievable without more proactive investigation to explore how the strategic intentions set out in the documents reviewed above have, and have not, been followed through to implementation. In addition, there are likely to be regional/federal strategies (e.g. Nuremberg) which may be of potential interest to and sources of learning for Scotland, but these were beyond the scope of this review.

The evidence of a growing commitment to national strategic approaches to suicide prevention is fuelled by a growing recognition of suicide as a major public health issue which has complex causes and which requires coordinated multi sectoral and long term interventions (Anderson and Jenkins, 2005).

Despite the limitations of the review and the necessary qualifications attached to what can be read into strategy documents, several points emerge. The strategies reviewed have been informed by and drawn heavily on a common set of international guidelines and a growing body of research on the risk factors and causal pathways for suicide and suicidal behaviour. Strategies therefore tend to have many similarities in terms of broad goals and priorities. However there are also striking divergences.

Firstly is the variability in the definitions used in and the parameters set by national strategies in tackling the common issue of suicide. The UN guidelines (UN,1996) regard suicidal behaviour and the conditions antecedent to it as the appropriate focus for preventive actions. This is taken to include completed suicide and attempted suicide/parasuicide, as well as those 'conditions, states and disorders which herald or predispose self destructive behaviour'. The review indicates (table A1) that the relationship between suicide, attempted suicide and deliberate self-harming behaviour is understood in a number of different ways. Scotland is unusual in that it acknowledges that, although there is a degree of overlap between deliberate self-harming behaviour and attempted suicide, the two phenomena are to a large extent discrete and distinctive. Other countries tend to regard self-harming behaviour as a marker for increased risk of suicide only. Where data are provided on rates or trends in self-harm or attempted suicide these tend to relate to hospitalisation following episodes of self poisoning.

Secondly, there is very limited attention to the evaluation of the implementation of national strategies (table A2). Scotland stands out in this regard and is in a good position to ensure that anticipated outcomes and impacts are well articulated for the purposes of evaluation. This would make it possible to go beyond the surveillance of trends in suicide, to evaluate intermediate and long term outcomes related to suicide and suicidal behaviour.

Thirdly, national strategies represent a response to an identified problem – in this instance suicide - which is considered to merit attention and intervention by government. The triggers that led to the development of national strategies for suicide prevention are broadly similar in most countries (table A1): evidence of worrying

trends in suicide rates; pressures from stakeholders at community level to address this; increasing knowledge and understanding of the causes and contributory factors and evidence of effective interventions; examples of what is happening in other countries to tackle suicide; and cultural and philosophical concerns about the meaning of suicide as part of the human condition. What may vary is the relative weight given to these factors in different countries.

All 10 strategies indicate the involvement of stakeholders to varying degrees in formulating objectives and identifying priorities (table A4). While there is considerable similarity in the broad content of national suicide prevention strategies, which have been influenced by international guidelines, there is greater disparity with regards to the focusing of priorities. The identification of priority groups is likely to have been influenced by particular features of national populations and / or the specific epidemiological features of suicide in the country and by the interventions of stakeholders and grass roots organisations.

A fifth differentiating feature can be found in the approaches taken to, and mechanisms for, implementation (table A5). Some strategies scarcely go beyond the stating of objectives and do not address implementation. Others pay this considerable heed and provide detailed plans for action. From the information available, Scotland seems to be well placed in this regard in having an identified budget, a designated team to coordinate and support development and a process evaluation.

Developing more robust evidence to support suicide prevention strategies and programmes is one of the central challenges for the 21st century (Beautrais, 2005)
It has been remarked that, while enthusiasm for suicide prevention activities is increasing throughout the world, there is as yet little indication that national suicide prevention strategies have a positive impact on death by suicide (De Leo and Evans, 2004). To assess the impact of national suicide prevention strategies, these authors conducted an analysis of trends in suicide rates in four countries (Finland, Norway, Sweden and Australia) where sufficient pre and post implementation data were available. This study investigated suicide rates five years before and five years after implementation. There was promising, though inconclusive, evidence that the Finnish national strategy was associated with a reduction in suicide rates in both men and women of all ages. However, in each of the other three countries suicide rates increased following implementation. It is suggested that longer time frames are required, first to offset the wide variations in suicide rates observable in a five year period and, second, to allow for the full implementation of strategies which tend to have multiple components.

The dearth of evidence on the effectiveness, including the cost effectiveness, of national suicide prevention strategies on suicide rates makes it all the more important to gain a better understanding of the means by which strategies are being or can be translated into effective interventions and actions (Anderson and Jenkins, 2005). Others (Beautrais et al, 2005) urge caution in extrapolating from as yet limited knowledge about risk and resiliency factors for suicidal behaviour to formulate programmes and interventions.

This review of national strategies has thrown up some interesting points of comparison that provide a context within which to locate Scotland's *Choose Life*

policy. It has also highlighted aspects of other national strategies that would that merit further more proactive investigation, beyond documentary analysis.

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ANNEX 2 THE ECONOMIC COSTS OF SUICIDE IN SCOTLAND IN 2004

Introduction

The profound impact of suicide both on the individuals themselves and their immediate family and friends are starkly clear. Avoiding such tragedies in itself is a strong justification for action. Policy makers are however faced with many competing claims as to how they should prioritise between different needs and wants. Having an understanding of the socio-economic impact of suicide can help inform this process. It should be stressed, however, that this is of limited use unless interventions of proven effectiveness, in either preventing suicides, or in alleviating some of the post event consequences, faced by families and friends are available.

The costs of suicide fall on everyone in society and can be substantial. Most obviously there are *direct costs* arising from demands placed on the emergency services, potential life saving interventions to be delivered within the health care system, investigations to be carried out by the police and coroner, and of course costs associated with funerals. For those individuals who survive suicide attempts, lengthy physical and psychological rehabilitation may follow.

There are also what economists call *indirect costs*. As a result of premature death, individuals lose the opportunity to contribute productively to the national economy, whether this be through paid work, voluntary activities, or family responsibilities such as looking after one's children or parents. The most fundamental impact of all, of course, is the loss of the opportunity to experience all that life holds as a result of suicide. The pain and grief that suicide can have on immediate family members and friends can be immense and long lasting. These very personal impacts are known by economists as '*intangible costs*' because they are often hidden and difficult to value.

As part of this study, an estimate has been made of the costs of suicide in Scotland, informed by a literature review looking at previous studies worldwide. In addition to estimating the costs of suicide, we have also estimated the potential economic gains that might be realised should the rate of suicide by reduced as the result of an effective national suicide prevention strategy.

International estimates of the cost of suicide

Three bibliographic databases, Medline, Psychlit and Econlit were used to search for 'cost of illness' studies relating to suicide. In addition a Google search was conducted to identify governmental publications and grey literature. References of relevant publications were also searched to identify additional studies. There were no date or language restrictions on the search. Cost here have been converted to £ sterling and use 2005 prices.

This review indicated that, despite these profound human and socio-economic costs, surprisingly few international studies appear to have estimated the total population wide costs of suicide, although a number of studies have sought to put a value on suicides associated with any one specific mental disorder, as for instance with

depression in one recent study in England (Thomas & Morris 2003). Of those studies of most relevance to a Scottish context, in the Canadian province of New Brunswick average direct and indirect costs of each suicide in 1996 were estimated to be £443, 076 (CAN$1,019, 210) (Clayton & Barceló 2000). In New Zealand in 2002 the estimate including intangible costs was £1,158,768 (NZ$ 3,094, 243) per suicide. (O'Dea & Tucker 2005). In Ireland, using a similar approach, costs in 2002 were estimated to £1,402, 438 (€1,982,667) per suicide (Kennelly *et al.* 2005).

Estimating the costs of suicide in Scotland

Methods

We have undertaken an incidence based costing study – that is, we have estimated the total lost lifetime costs for all suicides in Scotland that occurred in one year, 2004. Data on suicides and deaths of undetermined cause, broken down by age and gender were obtained from the General Register Office for Scotland. We have included direct, indirect and intangible costs of suicide in our analysis. All data are reported in 2005 prices. It should be noted that this analysis can be viewed as a conservative estimate of costs, as we have not included the costs of non fatal deliberate self-harm events.

Indirect costs

Indirect costs can be valued in a number of different ways – the principle method being to use what is known to economists as the 'human capital' approach. Human capital models have been applied, for example, to measure the cost of suicide in Ireland (Kennelly et al 2005) , the United States (Kashner *et al.* 2000), New Brunswick (Clayton and Barceló, 2000) This assumes that the lost opportunity for individuals to contribute to the national economy (lost productivity) is equivalent to the lost gross lifetime earnings of an individual.

In the case of sometimes very premature mortality from suicide this can mean many years of potential participation in the labour market foregone. Of course future employment patterns may be very different from those seen today as economies change, however we have made the assumption that employment patterns seen today will continue over a period of as much as 50 years. This is potentially a significant limitation – moreover the demographic profile of the population is changing and it is likely that the retirement age of those entering the labour market in the UK today will be higher than 65. This might also mean that future productivity losses would be higher than those mentioned here, for instance in the state retirement age were to raise to say 67 or 68.

Ideally, in estimating these productivity costs we would use actual wages foregone by those lost to suicide. In the absence of such data we have used the average gross wage rate, adjusted for gender and age group. We have followed the convention adopted by Kennelly et al and made an adjustment to labour force participation. In our baseline analysis we have assumed that this would be 2.25% than in the general population. We recognise that this adjustment is controversial and conservative as it assumes that a significant proportion of individuals who complete suicide are more likely to have

mental health problems. We have also estimated the costs of suicide without making this adjustment and this is also reported in the section on sensitivity analysis.

The impact of mental health problems in childhood or early adulthood can also have an impact on success in school, higher education and longer term career prospects which again may limit individuals potential wage rates. It can be argued that the productivity levels of this group will be lower than that for the population as a whole due to increased levels of absenteeism, presenteeism (reduced performance when at work) and early retirement from the labour force (Almond & Healey 2003; Dewa *et al.* 2004). We have not however made an adjustment for this lower potential rate of productivity in our analysis. In some instances this impact may in any event be temporary: for instance around two thirds of individuals will recover from depressive disorders.

In addition to lost working time there are also productivity losses for the retired , the unemployed, those engaged in voluntary activities and those with family/home responsibilities. All of these individuals contribute to the national economy. We have used UK survey data on time spent on these activities to estimate the potential loss to society. (Short 2001). Life tables have been used to provide an estimate of the average life expectancy of an individuals by different ages and genders, so as to capture the costs beyond 65 (Government Actuary's Department 2005).

One limitation of our analysis is that we have not included any productivity losses experienced by the family and friends of those who take their own lives. In general these might be expected to be relatively short-term in nature, but such events can trigger potential mental health problems in individuals. Moreover it may be the case that the partner of someone who commits suicide may have to give up work to care for children, for instance. Ideally such costs should be estimated – at present we are unaware of any study that has incorporated these costs. Another limitation of our analysis which potentially might overvalue costs is that we have not adjusted our estimate of productivity losses to take account of the probability of death from all other causes below the age of 65.

Is it necessary to estimate long-term productivity losses? The friction cost debate

Some economists would argue that the calculation of long-term productivity costs are not necessary. They argue that no economy is in a position of full employment and if individuals fall out of the workforce, in this case because of suicide, they will be replaced by someone from the existing pool of spare labour. They also further argue that human inputs might also be substituted by additional capital investment in new equipment. They suggest that only the costs of one year's lost wages plus the costs of recruiting a replacement worker or investing in capital should be included in any economic analysis as in effect this is a temporary or 'friction' cost (Koopmanschap *et al.* 1995; Goeree *et al.* 1999). We consider the impact of this approach on overall estimates of the cost of suicide in sensitivity analysis.

Direct costs

We have insufficient data at this stage to estimate the total direct costs of suicide in Scotland (although some data has been collected on this). We have adopted the convention used by Kennelly at al in their analysis of the costs of suicide in Ireland and also used estimates reported in the international literature to provide a proxy value for these costs. In their analysis Kennelly et al followed the assumption set out by Clayton and Barceló, based on work undertaken in New Brunswick, that the direct costs associated with suicide mortality were equivalent 0.67 of one per cent of the indirect costs of suicide. In New Zealand a detailed attempt was made to estimate the costs of suicide including police and fire service attendance, funeral directors and funeral expenses victim support as well as the cost of post mortems and inquests. Direct costs in their analysis were considerably higher at 2.33 per cent of indirect costs; we have used this estimate in our base line analysis, and consider the impact of using the New Brunswick valuation method in sensitivity analysis.

Intangible costs of suicide

In addition to productivity losses and direct costs of suicide there are also intangible human costs. These can include grief experienced by relatives as well as the value individuals would generally place on years of life lost, with all their opportunity to enjoy life experiences. (Some have argued that the individual who completes suicide places a greater value on death than on life but we have decided not to follow this approach in our analysis). Economists have adopted different approaches to trying to place a value on these type of intangible costs – in some instances, individuals may de facto reveal their preferences – for instance the premium on wages to work in dangerous professions such as in the nuclear industry or in mining has sometimes been used to estimate the value of life, whilst other have used the level of compensation awarded by juries to individuals in the case of compensation claims for death and disabling accidents.

Another way in which economists have sought to estimate such values is through the use of elicitation techniques to measure the willingness to pay of individuals to fund interventions to reduce suicides. No such studies have as yet been conducted in respect of suicide, although work is currently underway in Ireland. A good proxy for this however may be the use of willingness to pay studies conducted in respect of road accidents. In our analysis we have made use of data from the UK Department of Transport's 2004 estimate that the public have placed on the value of the prevention of road fatalities (Department of Transport 2004). This provides specific data on the intangible costs of death including pain, grief and suffering and lost life experiences for both the potential victim and their relatives. This data source has previously been used in estimates of the cost of suicide in England and as it separates productivity losses from deaths from the human costs of death, it can avoids any double counting of these costs.

Results

Indirect costs

Waged time

Data on deaths from intentional injuries and undetermined deaths in 2004 were categorised by age and gender. As the distribution of deaths within age cohorts was not known, it was assumed that on average death would occur midway through each age category, with the exception of those aged 0-14. In this latter case, as there were only two deaths in 2004, it was assumed for simplicities sake, that these occurred at the age of 14 and costs of lost productivity would thus cover the whole of the first age category from 16 to 24. Productivity losses in this case would not begin until 2006 when these children would have reached the age of 16.

It was assumed that individuals would have earned average UK wide gross wage rates for each age and gender category. These wage rates taken account of the differences between those who work full and part time (Office for National Statistics 2004). However they do not take into account the income of the self employed and thus this is not factored into our analysis. The likelihood of being in work was determined using data on participation rates in the labour market by age and gender in Scotland (Office for National Statistics (Scotland) 2004). Average wages have been adjusted to take account of real wage growth over time and in our model this is set at a rate of 2% as the Bank of England in economic forecasts have observed that since 2001 this has remained below 3% and often well below 3%.To reflect the concept of positive time preference for money, that is a pound today is generally preferred to a pound at some time in the future, all future earnings have been discounted using the Treasury Green Book's recommended discount rate of 3.5% (H M Treasury 2003). Differences to the discount rate have been considered in sensitivity analysis.

To calculate lifetime lost earnings from premature death it was assumed that if individuals had proceeded through the life cycle they would have had the opportunity to earn the average gross wage in progressive age gender categories. For instance an individual who died at the age of 23 in 2004 would at the age of 30 in 2011 be projected to earn the average wage for men in the 25 – 34 age bracket and similarly at the age of 37 in 2018 they would have had the opportunity to earn the average wage rate in the 35-44 age group.

Table A6 presents the results broken down by age and gender group; overall lost lifetime output for men and women in Scotland due to premature death from suicide were £201 and £31 million respectively. As the majority of suicides occur in people between the ages of 35 and 44 this age group account for 35% of all lost productivity costs of suicide.

Table A6 Value of lost market output due to suicide in Scotland in 2004 by age and gender (2005 prices)

Age Category	Average male £	All men £	Average female £	All women £	Total £
0-14	617,449	1,234,897	0	0	1,234,897
15-24	585,473	45,666,881	313,322	6,579,763	52,246,644
25-34	524,804	57,203,584	263,819	7,123,124	64,326,709
35-44	375,175	68,281,908	195,291	11,326,883	79,608,791
45-54	183,005	19,398,575	76,825	4,379,000	23,777,575
55+	41,567	5,486,850	13,194	831,202	6,318,052
Total		**197,272,695**		**30,239,972**	**227,512,667**

Non waged outputs

Table A7 provides an estimate of the costs of non waged productivity losses as a result of suicide. The relative similarity in costs reflects both the greater contribution of women to these activities and their longer life expectancy. Time spent on daily unpaid household activities were taken from a time survey undertaken as part of the UK Household Satellite Accounts (Short 2001). This survey, using data from 1999, estimated that on average men spend 90 minutes a day on household activities and women 196 minutes. This covered the task of cleaning and maintaining one's house, cooking, washing, caring for children and adults, charitable work and attendance and religious, political and other meetings. Time spent gardening and looking after pets were not included in the analysis. We have followed the assumption of Kennelly et al that household production would drop by 25% at age 65 for both men and women. Household production time was valued using the three minimum wage rates set in 2004 of £3 for 16-17 year olds, £4.10 for 18-21 and £4.85 for those aged 22 or over. The value of household production was assumed to grow at the same rate of 2% per annum as the predicted increase in real wages. Again we have discounted future household production at a rate of 3.5% per annum.

Table A7 Value of lost non-waged output due to suicide in Scotland 2004 by age and gender (2005 prices)

Age Category	Average male £	All men £	Average female £	All women £	Total £
0-14	101,015	202,029	0	0	202,029
15-24	77,697	6,060,328	177,368	3,724,734	9,785,062
25-34	79,279	8,641,367	182,839	4,936,644	13,578,011
35-44	65,919	11,997,186	152,918	8,869,231	20,866,417
45-54	50,615	5,365,205	120,905	6,891,570	12,256,775
55+	33,085	4,367,182	84,226	5,306,264	9,673,446
Total		**36,633,297**		**29,728,443**	**66,361,740**

Direct costs

As shown in table A8, if direct costs as a proportion of indirect costs in Scotland are similar to those found in New Zealand, it is estimated that the direct costs for suicides of men and women respectively were approximately £5.66 and £1.44 million

respectively. Using the more conservative estimate advocated by Clayton and Barceló these costs would be £1.62 million and £0.41 million.

Estimating the human costs of suicide

In 2004 using figures from the UK Department of Transport the intangible human costs of suicide were estimated to be £927, 035 per fatality. Caution must however be exercised in making use of this estimate, as we do not know how comparable the risk level used for road accidents is with suicide. Moreover we might hypothesise that in addition to the pain and grief that relatives may endure regardless of whether a fatality occurs through suicide or road accident, there may also be additional costs associated with dealing with the stigma, shame and guilt of suicide.

Overall costs of suicide in Scotland

Table A8 provides a breakdown of the total costs of suicide using our baseline assumptions. In total the lifetime costs of suicides in 2004 are estimated to be almost £1.08 billion of which 75% of costs would be due to suicides by men. This represents an average cost of £1.29 million per completed suicide and are comparable to those reported in New Zealand and Ireland. By far the largest single component of the total costs of suicide (more than 70%) are the intangible human costs experienced by families; indirect lost productivity costs account for 21% of the total costs.

Again we should emphasise that this estimate is conservative as we do not include the costs of non-fatal deliberate self-harm events. Their costs can be substantial and in Ireland were recently estimated to be almost £22 million (€31 million).(Kennelly *et al.* 2005) These include both the direct health and other costs from dealing with deliberate self-harm events plus the loss of both waged and non waged contributions to the economy.

Table A8 Total costs of suicide in Scotland in 2004 (2005 prices)

Total costs of suicide	**Men (n=609) £**	**Women (n=226) £**	**Total (n=835) £**
Lost waged output	201,415,422	30,875,011	232,290,433
Lost non-waged output	36,633,297	29,728,443	66,361,740
Intangible human costs	564,396,632	209,447,683	773,844,314
Direct costs	5,663,012	1,441,714	7,104,726
Total	**808,108,363**	**271,492,850**	**1,079,601,213**

What would the potential socio-economic benefits of a reduction in the rate of suicide?

Using our baseline assumptions if a 20% reduction in the overall level of suicide (based on 2004 suicide rates) were to be achieved for any one year then the lifetime costs averted for all suicides avoided during that year those would amount to some £216 million. Even just a 1% reduction in the suicide rate would reduce overall costs by £10.8 million over the lost lifetimes of these individuals.

Given the modest cost of investing in *Choose Life* compared to the potential lives that may be saved and costs averted, if effective interventions that reduce the rate of suicide at reasonable cost can be identified, investing in *Choose Life* is likely to be cost saving that is leading to better health outcomes and also reducing overall cost.

Of course as we have indicated the total costs of suicide vary by gender and age of the population – clearly if most significant progress was made in reducing suicides among younger populations then cost savings would be greater. However from an ethical perspective it may be deemed inappropriate to target suicide interventions simply on the basis of lifetime costs that might be avoided. It might also be argued that some of these costs are not in fact averted, but merely delayed – for instance some of the costs associated with dealing with death; moreover some costs might even be greater – for instance treating the complications of poor health in older age. Again in conventional economic analysis when looking at preventive interventions it is usually deemed unethical to argue against preventive interventions on the basis that individuals might potentially face later in life.

Sensitivity analysis

It should be noted that these cost estimates of suicide can vary substantially. By far the most significant decrease in costs would be observed if we adopted the 'friction' cost approach and only included the productivity costs for the first year following death in our analysis. However overall these costs only account for just over 20% of total costs. The value of intangible human costs is the key factor; the appropriateness of using the Department of Transport's estimation can only truly be judged if an elicitation exercise to place a value on these costs were to be undertaken in Scotland. While this may be an expensive undertaking much might be learnt from analysis currently underway in Ireland by Kennelly and colleagues which is anticipated to be completed in late 2006.

One important factor in sensitivity analysis can be the discount rate used to reflect the present value of present earnings. In this case the overall costs remain robust even at a high discount rate. Table A9 indicates how overall costs will change if the discount rate is varied – however even discounting at a rate of 8% total costs remain well in excess of £0.9 billion. The adjustment to labour force participation has little impact on costs. With no adjustment these costs increase slightly to £1.085 billion. If participation is adjusted downwards by 10% compared with the general population then costs would still be £1.06 billion. Again there is little difference in overall costs if the assumption about decreased productivity after the age of 65 were dropped. This would see total costs rise to £1.085 billion, while if productivity halved after age 65 costs would still be more than £1.07 billion.

Table A9 Impact of discount rates on overall total costs

Discount rate	£
0%	1,381,933,875
1.5%	1,216,805,709
3.5%	1,079,601,213
4%	1,054,848,577
5%	1,013,324,127
6%	980,208,963
8%	931,676,071

Conclusions

The lifetime costs associated with completed suicides in any one year are substantial and many time in excess of the annual investment in *Choose Life*. From a societal perspective, taking account not only of direct costs to health and other services, but also the loss of contribution to the economy and intangible costs including grief and the loss of the future opportunity to enjoy life, even a modest level of success in reducing the rate of suicide is likely to be highly cost effective and potentially cost saving.

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ANNEX 3 ASSESSING THE COST EFFECTIVENESS OF AREA-BASED SUICIDE PREVENTION STRATEGIES: PRACTICAL AND METHODOLOGICAL CHALLENGES.

Introduction

Economics is concerned with how we allocate resources between competing activities in society and what the consequences are of such resource allocation decisions. It is based on the fundamental tenet that there is a finite level of resources and therefore most decisions to use resources in one way will mean that resources are not available for other activities.

It can be difficult to identify the levels of expenditure on national suicide prevention activities, due in part to a lack of earmarked funding, and also because strategies may be delivered across many sectors, by many different public and private agencies, often funded in completed different manners. Nevertheless it is clear that substantial levels of funding may be allocated towards such strategies – for instance £19.5 million ($A48 million) was invested in suicide prevention in Australia between 2000 and 2004.

Economic evaluation, which compares both the effectiveness and costs of one or more programmes or individual interventions, can be a useful aid to policy makers in assessing whether such an investment in suicide prevention activities represents value for money. Ultimately, for *Choose Life* and other national suicide prevention strategies, we would want to be able compare the cost of implementation with their impact on the rate of completed suicides and non fatal deliberate self-harm events.

Aims

This paper has a number of aims. Firstly it briefly defines different approaches to economic evaluation. It then looks at the extent to which these different methods of economic evaluation have been applied to the assessment of area based suicide prevention strategies drawing on evidence from a literature review. We then consider what practical and methodological challenges there may be to the greater use of economic evaluation. A practical approach is outlined that, in the absence of robust information on the effectiveness of suicide prevention strategies, may be helpful to policy makers in informing initial decisions about the potential cost effectiveness of suicide prevention strategies. Finally we suggest some key steps to facilitate the potential inclusion of economic evaluation in any future evaluation of *Choose Life* or similar programmes.

A brief primer on economic evaluation

It is perhaps helpful to start by briefly outlining the concept of economic evaluation. Useful guides some which deal with these issues in more depth, including some with a relevant focus on health promotion and complex interventions are available (Byford *et al.* 2003; Drummond *et al.* 2005; Hale *et al.* 2005).

There are several different approaches; they all estimate costs in the same way but differ in they way they treat outcomes. Cost minimisation analysis only compares the costs of interventions; it can only be undertaken where there is strong evidence that interventions are equally effective. The most frequently used approach, cost effectiveness analysis (CEA) measures effects using a natural measure, in this case the number of suicides or deliberate self-harm event averted.

While intuitively easy to understand, this approach makes it is difficult to compare investment in mental health interventions with that of investment in other areas of health policy as no common unit of outcome is used. In respect of prevention of suicide, there may also be additional outcomes that may be of importance, so focusing on one measure of effectiveness alone may not be helpful. One variant on CEA that can be seen in mental health economic evaluations, the cost-consequence analysis (CCA) seeks to address this problem by presenting the costs and a range of outcomes for interventions without making any judgement as to whether one outcome is of more importance than another.

Cost utility analysis (CUA) uses a common outcome measure where benefits are measured in utilities, i.e., the individual's preference for a specific level of health or a specific health outcome, with examples being the Quality Adjusted Life Year (QALY) and the Disability Adjusted Life Year (DALY). This would allow the benefits of investing in suicide prevention to be compared with other health programmes. Many different instruments can be used to identify different levels of states of health. These can include generic instruments such as the EuroQol, which assesses health status along five dimensions including anxiety /depression, as well as disease specific instruments such as the McSad health state classification system for depression (Bennett *et al.* 2000). Different techniques can then be used to get individuals to estimate the utility (or their level of satisfaction) associated with these health states (See (McCulloch 2003) for a description of some of these approaches). In the case of the DALY – different levels of disability e.g. level of mobility and their relative weights have been determined by a small expert group rather than the general population. The use of CUA for suicide prevention is complex; some individuals experiencing suicidal thought may place a greater value on death compared to life (Chisholm *et al.* 2006).

In cost benefit analysis all costs and benefits are valued in the same (monetary) units. With two or more alternatives, the intervention with the greatest net benefit would be deemed the most efficient. CBAs are thus intrinsically attractive, but conducting them can be problematic because of the difficulties associated with valuing outcomes in monetary terms and their use in mental health has been limited (Healey & Chisholm 1999). If the methodological and practical challenges facing CBA can be overcome it has the potential to allow decision makers to consider the merits not only of allocating resources within health care but also whether it would be more appropriate to invest in

other sectors such as housing, education or defence. This is clearly important given that the benefits of suicide prevention go well beyond the health care system.

Literature review - methods

To what extent has economic evaluation of suicide prevention strategies taken place? An extensive review of the literature was conducted. A number of bibliographic databases were searched including Medline (Pubmed version incorporating HealthStar), Econlit, and Psychinfo. Searches combined key economic terms such as the Medical Subject Heading (MESH) term "costs and cost analysis" with various terms for suicide, attempted suicide and deliberate self-harm. No language restrictions or time limits were employed. Evaluations of drug therapies were explicitly excluded from this analysis.

A hand search of a number of journals to identify relevant papers during the four years 2002 to 2005 inclusive was also conducted. Journals searched include Crisis, Journal of Socio-Economics, and Acta Psychiatrica Scandinavica. National websites for suicide prevention strategies were also examined, firstly to identify information on the level of investment in these strategies where available, and secondly to identify any economic studies or plans to conduct economic evaluation.

Results of review

Over 100 published papers, book chapters, governmental documents and grey literature that potentially were of relevance on the basis of their abstracts and titles were retrieved. Our review suggests that there have been few economic evaluations generally in the area of mental health promotion and mental illness prevention. Studies that do exist focus on secondary prevention or targeted interventions for specific individuals or sub population groups.

Given the limited knowledge on the effectiveness at programme level of national strategies, (a necessary prerequisite to economic evaluation) it might be considered unsurprising that no economic evaluations of national suicide prevention strategies were found. Similar observations have been seen elsewhere, for instance the US Preventive Services Task Force in its review of the evidence on the effectiveness of screening for suicide risk, failed to identify any studies that included an economic evaluation (nor for that matter any evidence that screening for suicide reduces suicide attempts or mortality) (US Preventive Services Task Force 2004).

Yet despite this lack of cost effectiveness studies, what was also apparent from our review is that many agencies and reviews have for some significant time argued for the greater use of cost effectiveness analysis in reviewing suicide prevention strategies. Most notably the US Surgeon General stressed the importance of economic evaluation when setting out his public mental health strategy for suicide prevention (US Public Health Service 1999)

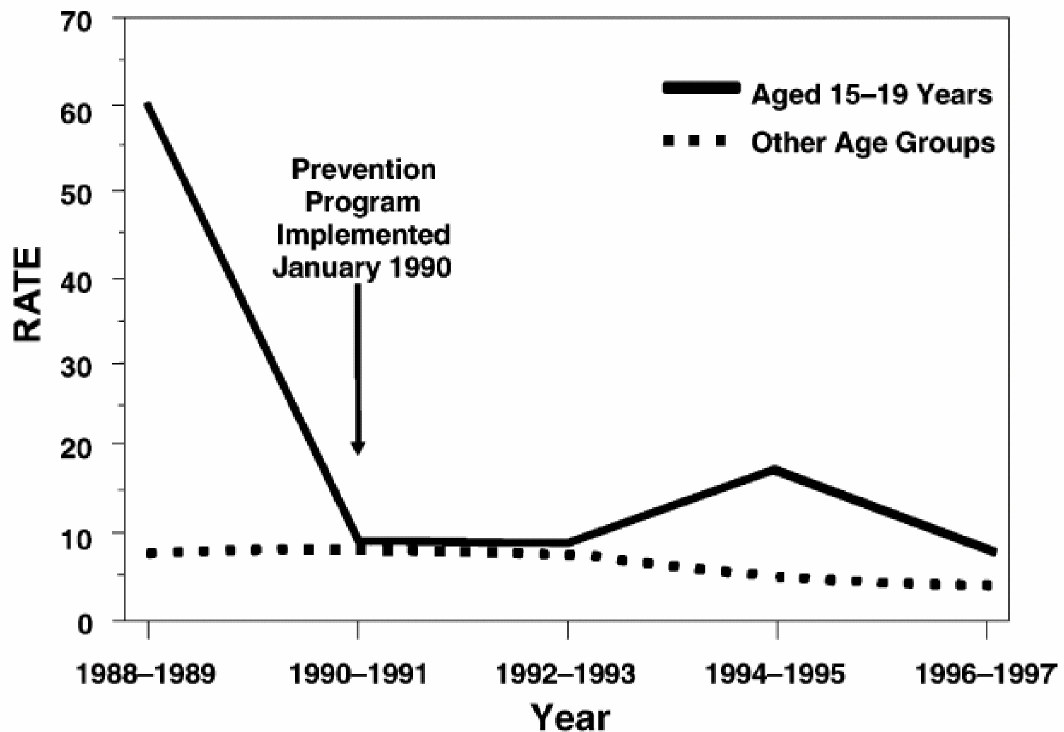
This is not to say that no economic evaluations of area based suicide prevention strategies have been conducted, but they are rare and modest in scope. Perhaps the most complete, albeit still with many limitations, is a retrospective analysis of an area based multi- intervention suicide prevention programmes for the Western Athabaskan

Native American Tribe living in a reservation town in New Mexico (Zaloshnja *et al.* 2003). This mental health status of this indigenous population in the US is poor; the rate of suicide is high, around 1.5. times higher than the general population.

The New Mexico prevention strategy primarily focused on young people between the ages of 15-19 but had the whole community as a secondary target group. The initiative included the training of between 10 and 25 youths per annum to respond to young people in crisis and to refer individuals to the appropriate mental health services. This was one element of a many different elements within the programme including: postvention outreach, community education on suicide prevention, and suicide-risk screening in health and social care programmes.
Both a cost benefit analysis and a cost utility analysis were performed. Costs in the analysis included direct costs associated with the use of emergency services as well as public health and social care services. Broader costs to insurers, local government and the general public were also included. The evaluation of outcomes took the form of a before and after study. Rates of suicidal acts (completed and attempted suicides) 8 years before the introduction of the intervention were compared with the rate over the subsequent 10 years.

As figure A1 indicates, the rate of suicidal acts (completed suicide and suicide attempts) fell markedly after the introduction of the programme from 59 per 1,000 to under 11 per 1,000 ten years later. Direct costs of $120,000 were avoided and it was estimated that the value of suicides averted was some $1.7 million. The cost per QALY saved was just $419, while the value of benefits gained were 43 times greater than costs incurred. While this study might suggest that such a programme can be highly cost effective there are many limitations. Most notably no comparator group was included in the evaluation; cyclical increases and decreases in the suicide rates in the tribe had in fact been observed every six years between 1957 and 1987. Moreover the analysis by its nature makes it difficult to determine which individual elements of the strategy were effective.

Figure A1 Long term change in suicide rates following introduction of suicide prevention initiative



[a]Per 1000 population. Includes suicidal attempts and completions.

[b]Rates calculated in 2-year intervals for rate stability.

Source: Morbidity and Mortality Weekly Report, US CDC, 1998

Another US based study is a hypothetical cost benefit analysis of two suicide prevention programmes targeted at university students in Florida (de Castro *et al.* 2004). One was a five lesson general suicide education programme and the other a peer support group programme. Data on the effectiveness of the two interventions were obtained from a review of the literature and costs estimated of delivering the two interventions to all university students in the state. In fact this study was a cost-offset analysis as the potential costs of delivering the intervention were compared with the lifetime costs that would be avoided if suicides were prevented – nevertheless both interventions the study concluded would be cost saving as these cost offsets would be far greater than the costs of implementation. The peer support programme had a lower cost and potentially greater level of costs avoided, however the costs of implementation are underestimated as the authors themselves admitted that they had not put a value on the significant time input of volunteers in delivering peer support programmes.

Although our brief here is not to look systematically for evidence of cost effectiveness studies targeted at the individual rather than population level, it is worth noting that other than evaluations of antidepressants and other medications which sometimes consider suicide as an outcome, few such evaluations appear to have been conducted. One exception is an analysis in England of a home based social work intervention targeted at children who had deliberately poisoned themselves.(Byford *et al.* 1999) This concluded that family-based social work intervention for children and

adolescents who have deliberately poisoned themselves is as cost-effective as routine care alone. Suicidal ideation was lower in a sub group of children without depression at a six month follow up, with no difference in costs.

A more recent study looked at the use of cognitive behavioural therapy with people with a history of deliberate self-harm in centres in both England and Scotland. This study suggested that manual cognitive behaviour therapy was likely to be cost effective in reducing the number of deliberate self-harm events, but it did not look at suicide as a potential outcome.

The potential costs and consequences of suicide prevention centres in the US were assessed in the 1980s (Medoff 1986). These relied on the provision of a 24 hour telephone service whose primary action was to initiate crisis intervention services. A regression model was used to estimate the impact of suicide prevention centres on suicide rates. The economic analysis suggested that the value of human lives saved was at least five time greater than the costs of providing suicide prevention centres. Again however little evidence on the effectiveness of these centres was provided.

An economic analysis of an educational programme for general practitioners, so as to improve their ability to recognise and treat the symptoms of depression, was conducted on the Swedish island of Gotland in the late 1980s (Rutz *et al.* 1992). Although called a cost benefit analysis, in fact this study actually reported costs avoided, including those associated with suicide, rather than using a formal cost benefit analysis technique such as assessing willingness to pay for this programme. It was concluded that the programme was cost saving, although evidence on the effectiveness of the intervention was limited by the lack of a comparison group.

While no studies of the cost effectiveness of screening strategies for suicide in the population were identified we did identify one study that had evaluated the costs of delivering a school based mental health screening and treatment programme in New York, one of whose stated objectives was the prevention of suicide (Chatterji *et al.* 2004). This study not only included the direct costs of delivering the programme but also resource inputs in-kind such as the time of student volunteers. Elsewhere there has been some economic appraisal of various safety measures (such as safety nets and barriers for bridges) and restriction of access to means such as firearms and poisons, the latter usually in the context of injury or violence prevention rather the suicide per se.

Macroeconomic factors, economic behaviour and suicide

It is worth noting that while little work has been done to look at interventions. Economists and those from other disciplines have sought to use to economic theory to explain the rationale for suicide and suicide attempts and thus identify potential ways in which to influence individual behaviour. (Hamermesh & Soss 1974; Yaniv 2001; Marcotte 2003). Other analysis has focused more on the impact of, and changes in the socio-economic circumstances of the individual and their community. For instance much research has looked at the links between unemployment and socio-economic deprivation and suicide or suicide attempts e.g. (Platt & Hawton 2000; Rodriguez-Andres 2005). One study looked at attempted suicide trends in Helsinki, during an economic recession that Finland experienced during most of the 1990s (Ostamo &

Lonnqvist 2001). This particular study observed that suicide attempt rates remained high but stable, rather than increasing during the recession, with the authors suggesting that this indicated that there were individuals at risk of suicidal behaviour regardless of social and economic change in society.

Increasingly complex econometric analysis has been used to examine the interaction of a whole range of socio-economic factors on suicide rates e.g. (Lucey *et al.* 2005; Berk *et al.* 2006). There remains much scope for further work to identify the specific impacts of individual factors or combinations of factors on the risk of suicide. The nature of the relationship between various socio-economic factors and suicide is complex; there is conflicting evidence from studies as to whether factors such as poverty or the level of interest rates etc are risk or protective factors for suicide.

These factors might also vary depending on the age and gender of the individual for example. The different conclusions reached by studies are also likely to reflect differences both in methodologies and in the size and type of study populations and their environs e.g. access to social welfare support. One recent review of the association between the socio-economic status of an area and completed suicide sought to disentangle some of these factors. It came to the conclusion that suicide prevention resources might best be concentrated in 'communities of a relatively lower socio-economic level, in particular those at high levels of concentrated disadvantage' (Rehkopf & Buka 2006).

Practical and methodological challenges

Why has there been so little economic evaluation of suicide prevention strategies to date, despite the many calls for such evaluations? There do not appear to be any insurmountable problems in applying conventional methods of economic evaluation to this area. It might be argued that economic analysis focusing on a single outcome such as the rate of suicide or quality adjusted life years saved may be too reductionist for the evaluation of any public health or health promoting intervention (Kelly *et al.* 2005) – but we have noted pragmatic approaches such as cost consequences analysis, or the more theoretically robust cost benefit analysis method, can be used to take account of multiple outcomes of interest.

One additional problem however for cost benefit analysis may potentially be the undervaluing by the general public in willingness to pay studies of interventions intended to promote and improve mental well-being, because of negative attitudes towards poor mental health. While we are unaware of any empirical evidence testing this assertion, some public surveys have indicated that mental health is seen as a low priority when it comes to determining how to allocate health system funds (Matschinger & Angermeyer 2004).

Instead the primary reason for the limited application of economic evaluation appears to be the lack of evaluation of the effectiveness of area based suicide prevention strategies; evaluation has concentrated on the impact of individual interventions such as primary care physician training programmes or restricting access to means.

We do not seek here to discuss the challenges of outcome evaluation, but raise two key issues for illustrative purposes. Firstly attributing changes in the rate of suicide to

the delivery of complex multi-faceted programmes are difficult to determine. For national strategies, the possibilities of having comparator group may be limited, and instead analysis tends to focus on changes in long term suicide trends. This makes it more difficult to determine what change in suicide rates would have occurred in the absence of any strategy. Programme level evaluation may also mask the effectiveness of individual components of the strategy, again adding an additional layer of complexity to any evaluation.

It would be interesting to compare the relative success across different local areas that may deliver a different mix of interventions as part of a national suicide prevention strategy. Yet despite the profound and terrible consequences of suicide, in absolute terms the number of suicides in many areas can be very small – this can make it difficult to identify any significant impact of programmes. Other potential measures, such as levels of suicidal ideation at suicide attempts may be used instead, but the relationship between these measures and the level of completed suicides is not necessarily straightforward.

What then of the use of economic evaluation as part of the evaluation of individual components of a suicide prevention strategy? Again there is little evidence suggesting that much analysis has been conducted. Again methodologically there do not appear to be any great challenges, although there may practical issues in data collection, such as both obtaining accurate information, and subsequently valuing the level of inputs, from volunteers to suicide prevention activities.

In some respects the lack of studies may reflect the relatively low interest, until recently at least, in funding economic evaluations (of non drug therapies)in the area of mental health. It is also consistent with the limited number of economic evaluations of public health and health promoting interventions; again an area where funding for economic evaluation (in comparison to evaluation of health care interventions) has been more limited. Another reason may be the limited amount of multi-disciplinary work between health economists and those in the public health community. Clearly the evaluation of national suicide prevention strategies requires the input of individuals from a number of disciplines, including economics. Commissioners of evaluations can play an important role by including an economic dimension in study specifications.

Illustration of potential cost effectiveness of Choose Life using an economic threshold analysis

We have argued that the primary reason for the limited used of economic analysis would appear to be the challenge in obtaining data on effectiveness rather than difficulties in using existing methods of economic evaluation.

This does not mean that we cannot provide an input into the policy making process. A practical approach is outlined below, in the absence of robust information on the effectiveness of suicide prevention strategies, that still may be helpful to policy makers in informing initial decisions about the potential cost effectiveness of suicide prevention strategies. If the level of improvement in outcomes required in order for the strategy to be considered cost effective is modest, then the risks in implementing the strategy may be low. Implementing the strategy, including an evaluation, to help

answers questions on effectiveness may then seem sensible. On the other hand, if the level of improvement in outcomes required is substantial then it may be prudent to consider different approaches. This approach is known as *threshold analysis* and we illustrate here how it can be used taking data from our analysis of *Choose Life*.

Threshold analysis

This threshold simply refers to what different societies consider to be cost-effective. This is a subjective judgement depending on many factors, including the level of resources in a country. For instance the National Institute for Health and Clinical Excellence in England and Wales generally consider that if the cost per year of full quality year of life gained is under £30,000 then this represents value for money. Of course decisions never are (nor should they be) made on the basis of cost effectiveness alone; other factors such as fairness, as well as ethical and political considerations will also be important considerations. We may for instance be willing to sacrifice some efficiency in how we can allocate resources in order to reach a sub group of the population who might for instance have very poor levels of health, or in this case a greater risk of suicide. The technique can also be used to crudely estimate how many lives would need to be saved in order for the strategy to represent value for money or even become cost saving, that is where the net benefits from investing in *Choose Life* outweigh the costs of the strategy.

Assumptions

Box A1 sets out the key components of threshold analysis. In order to complete the analysis we will make use of information that we have collected on the level of resources invested in *Choose Life* as well on the estimated costs of suicide in Scotland discussed in annex 1.

Initially we will set our threshold for this analysis at a level of £30,000 per life year saved. (We assume that all years saved would be spent in full quality health.)

The next step in the analysis is to obtain evidence on the potential effectiveness of the strategy. In this case, we have little empirical evidence on which to draw, and so instead consider the implications for potential cost effectiveness, by varying the rate of effectiveness between a 1% and 30% reduction in the annual rate of suicide in Scotland.

Our previous analysis which has estimated the lifetime costs of all suicides occurring in Scotland in 2004 can be used to estimate any cost offsets associated with a reduction in suicides.

Information (albeit incomplete) taken from our analysis of the resources invested in *Choose Life* can be used to provide an estimate of the total cost of investing in *Choose Life*. This includes not only funding for national programmes, core funding distributed to all 32 CPPs, but also the additional monetary and in-kind resources necessary to deliver the programme.

We also assume here that the comparator against which we could compare this investment is simply to maintain the status quo prior to the introduction of *Choose*

Life – i.e. no new interventions are developed nor additional resources invested in *Choose Life*.

Costs are discounted at a rate of 3.5% per annum. The discounting of future life years saved is controversial – we present findings here using both non discounted as well as discounted life years saved.

We have taken average life years lost per suicide in 2004 (34 years) as the potential number of years to be gained for each suicide averted.

All results are presented using 2005 price years

Box A1 Using threshold analysis to estimate maximum investment in Choose Life

Net investment in *Choose Life* / Life Years Saved = £30,000 per life year saved.

Where £30,000 per life year saved is the key threshold parameter of acceptable value for money

Net Investment in *Choose Life* is the suggested annual investment less the value of lifetime cost offsets reported at their net present value

Life Years Saved are the total number of years of expected life saved as a result of suicides averted in any one year.

Results

Potential years of life that could be saved

For suicides in 2004, and using data on life expectancy from the General Actuary's Office, approximately 28,345 (non-discounted) lifetime years would be lost as a result of suicide in Scotland across all age groups. If discounted at the same base rate used for future costs of 3.5% per annum then the number of years of life lost is reduced to 11,893. In this simple analysis we have assumed that a suicide successfully averted in any one year is permanently averted, i.e. there will be no future suicidal attempts by the individual concerned. More complex models could be built in future to take account of this and other simplifications.

Estimated current annual investment in Choose Life

The total costs of investment in *Choose Life* currently identified are £4m in core funding per annum, plus an identified £0.52m per annum in additional monetary funding and £0.09m in in-kind investment. We have noted evidence from case studies suggests that these additional investments are underestimated. We have also calculated total investment assuming that the same share of in-kind and monetary investment in the case studies is seen across the whole programme. This would raise the total annual cost of investment in *Choose Life* to £6.01million with in kind investments accounting for £0.9 million and monetary funding for £1.11 million.

Potential level of acceptable investment in Choose Life
Table A10 provides information on the maximum level of investment that would be consistent with our threshold under different circumstances. Even when future years of potential life saved are discounted at a rate of 3.5% per annum, and the success rate of *Choose Life* in reducing the annual rate of suicide is just 1%, the value for money of investing in *Choose Life* appears highly promising. In total, some 160 (discounted) or 284 (non discounted) life years would be saved. Our threshold analysis would indicate that if we were willing to pay £30,000 for each additional year of life saved as a result of *Choose Life* then we could invest up to £15.6 million per annum, taking account of the £10.79 million in cost offsets generated. This is well in excess of the current level of investment.

If the annual rate of suicide were to fall by 20% then the programme would be highly cost saving. We would save more than 5,600 life years (undiscounted) or 3,200 (discounted) and generate cost offsets to society of almost £216 million. We would have to be spending more than £386 million per annum before the cost per life year saved was above our threshold! Only if the reduction in the rate of suicide was less than 0.4 of one percent would our current level of investment mean that the cost per life year saved was above our threshold.

Even if what society is prepared to pay to save one additional year of life is reduced, this makes little difference to the maximum level of investment. Keeping all our baseline assumptions, reducing this threshold by one third to £20,000, the maximum we could invest would be only be reduced by 11% to just over £14m.

Table A10 Maximum levels of investment in *Choose Life* to have a cost per life year saved of £30000 or less (2005 prices)

Discount rate for life years saved	Projected 1% reduction in suicide rate	Projected 5% reduction in suicide rate	Projected 10% reduction in suicide rate	Projected 20% reduction in suicide rate
0%	19,318,712	96,593,561	193,187,121	386,374,243
1%	17,880,265	89,401,327	178,802,655	357,605,310
1.5%	17,299,901	86,499,505	172,999,011	345,998,021
3.5%	15,609,735	78,048,675	156,097,350	312,194,700
5%	14,781,410	73,907,048	147,814,096	295,628,192
6%	14,361,508	71,807,538	143,615,075	287,230,151
8%	13,733,303	68,666,515	137,333,030	274,666,060
10%	13,292,278	66,461,390	132,922,780	265,845,560

Another way of looking at this is to look at how varying the number of potential lives saved impacts on the potential cost per life year saved (see table A11) Again we use our baseline assumptions on total investment per annum in the programme and potential costs avoided. In the base case scenario only 3.2 lives would need to be saved for the strategy to cost less than £30,000 per life year saved; the threshold below which interventions are generally considered to be cost effective by NICE. This analysis also suggests that only five lives would need to be saved in any one year for the strategy to be cost saving (dominant) compared with no action, that is for the value placed on suicides averted to be in excess of the annual investment in the

strategy. As the number of suicides averted increases this benefit: cost ratio would begin to rise considerably.

Table A11 Potential cost per life year saved, varied by number of suicides averted (2005 prices)

Discount rate for life years saved	1 suicide averted	2 suicides averted	3 suicides averted	4 suicides averted	5 suicides averted
0%	138,644	50,321	20,880	6,160	Dominant*
1%	166,796	60,539	25,120	7,410	Dominant*
1.5%	181,680	65,941	27,361	8,071	Dominant*
3.5%	245,470	89,094	36,968	10,905	Dominant*
5%	296,489	107,611	44,652	13,172	Dominant*
6%	331,405	120,284	49,910	14,723	Dominant*
8%	402,283	146,009	60,584	17,872	Dominant*
10%	473,357	171,085	71,288	21,030	Dominant*

** CL strategy is dominant compared to no action, with both lower costs and additional lives saved*

Varying perspective

Much economic analysis is conducted not from a societal perspective but from a very narrow public sector perspective. In this case we would only be interested in the direct public costs of investing in *Choose Life* – £4 million per annum, while the only cost offsets of interest are any costs to the emergency and health care services etc that can be avoided as a result of not having to respond to a suicide.

In this case where only a 1% reduction in suicide was achieved, with life years saved discounted at our base rate of 3.5 %, the threshold for investment would still be £4.88 million, which is still in excess of our current £4 million level of investment. If our analysis also included productivity losses avoided then the threshold for investment would rise to more than £7.87 million. Even if it was assumed that the total level of direct costs attributed to suicide was just 0.67 of one percent of indirect costs (Clayton & Barceló 2000) and with a threshold of just £20,000 per life year saved, society would still be willing to invest £3.2 million in the strategy.

If we look at how this impacts on the cost per life year saved, then 11 lives would have to saved for the strategy to be considered cost effective. It would however take more than 700 lives to be saved for the strategy to become cost saving because of the very low level of direct costs avoided per life saved. If the analysis also included indirect costs avoided, i.e. productivity losses from lost opportunities for paid and non-paid work, then the number of lives per annum that would need to be saved for the strategy to be cost saving would be just over 17.

Implications
Threshold analysis cannot tell us whether investing in *Choose Life* represents value for money, nor the appropriate level of investment to make. However it does suggest that if the *Choose Life* initiative does indeed achieve even a very modest reduction in the rate of suicide of just one per cent, then the cost per life year saved is likely to be well below £30,000. This generally would suggest that investing in the programme would represent value for money and the level of success required by the strategy modest. This is also reinforced by looking at the very modest number of lives that would have to be saved in order for the net benefits from the strategy – that is the value placed on lives saved to be greater than the costs of investing in *Choose Life*. In our base scenario here, this is just five lives per annum. If our perspective was more restricted and we excluded the intangible value placed on life then, we would need to save 17 lives in order to have a positive net benefit. Looking at direct costs only, saving 11 lives per annum is likely to mean that the strategy has a level of cost effectiveness comparable to that of many other interventions recently recommended for funding by the NHS. However it will only when evidence of effectiveness is available that we can more definitively state that investing in *Choose Life* represents value for money.

There are important limitations of this analysis to flag up – firstly we have not adjusted future years of life to take account of their quality – this would reduce the value of life years saved (it might however be argued that value places on the intangible benefits of life foregone pick this up on the cost side of the equation). Second, we have here compared investing in *Choose Life* with taking no other action (over and above what is already in place) to tackle suicide. There may be other alternative models or programmes of suicide prevention, i.e. those that are more closely controlled and delivered centrally, that might be better options against which to compare *Choose Life*. Again, the challenge here is to identify the effectiveness of alternative models and consider whether these could work in a Scottish context.

We have however been highly conservative in not including the potential added benefits of avoiding non fatal deliberate self-harm events in this analysis. Our analysis looks at what would happen if we can reduce the current rate of suicide in Scotland; it may be the case that this rate might naturally fall (or rise) substantially in future years. This might also have implications for the value for money of investing in *Choose Life*.

A final observation is that it that simply looking at the cost per life year gained, or in this case life year saved, is somewhat simplistic. As this is a ratio between costs and expected benefits, it is quite possible to have an intervention which appears highly cost effective, but also has substantial budgetary implications. This does not appear to be the case in the scenario mapped above, but it will always be important to also consider the budgetary impact of any public investment. However we have also made a crude estimate of the costs and benefits of investing in the *Choose Life* strategy; although the value of the intangible benefits of lives saved used in our analysis has had to make use of data related to road traffic accidents rather than death by suicide. One potential area for future work would be to elicit specific suicide related value for the intangible benefits of lives saved.

Bridging the gap - including economic evaluation in future analysis of suicide prevention programmes

We have illustrated the potential use of economic methods to provide some sense of the economic case for any programme or intervention. Any future economic evaluation of the *Choose Life* strategy, would almost certainly be one of the first (if not the first) evaluations worldwide undertaken of a national strategy. How might we facilitate the potential inclusion of economic evaluation in any future evaluation of suicide prevention strategies of similar programmes? We set out some steps below.

Identify and collect data on relevant health and non-health outcomes
Information from any previous review of effectiveness studies may identify some outcomes of importance to the evaluation (in this case suicides averted). There may also be additional outcomes that merit attention. In all prospective evaluations (not just economic evaluation) consultation should take place at an early stage to agree on health and non-health outcomes of importance to the analysis. The not inconsiderable challenge then is to ensure that it is feasible to collect data on these outcomes and possible to attribute them to the implementation of *Choose Life*.

Collecting data on the cost and uptake of components of a suicide prevention strategy
Currently there is only limited information on the uptake of different interventions at local level within the *Choose Life* programme. For some interventions it is important to have a basic understanding of how many and how frequently individuals use a service. Basic socio-demographic data are also important to help address questions of equity and the effective targeting of *Choose Life*. Is it in fact being delivered to those intended? The challenge is then how to collect and record such information in a non obtrusive fashion; for some activities it might for instance be easy to use an attendance register – for others this may actually dissuade participation. Many activities will not be done on a face to face basis and there will also be issues of confidentiality and anonymity.

Equally it is vital that more information is collected on the contributions of volunteers. Not only is this important for economic evaluation, it is also essential to building a case for the continued use of the partnership model used by *Choose Life*. Our case study analysis has indicated that volunteer contributions can be substantial; but they are almost certainly not being fully captured. A simple monitoring form might periodically ask those delivering projects to record the number of volunteers and estimate the aggregate number of hours they donate to an intervention. This might be backed up by some limited validation exercises, for instance observing the use of volunteer time in some project, or by asking volunteers to keep diaries etc. Practical approaches to quantify this significant input have been developed, e.g. (Gaskin & Dobson 1997).

Information on the use of resources provided in kind by host organisations, as well as additional monetary investment is required. As we have noted, there have been challenges in obtaining this information through the initial template that local CPPs were asked to complete. In the case of in-kind resource use and time given by paid staff, a variant of a data collection tool such as the Client Service Receipt Inventory,

widely used in social care and in mental health evaluations, might be considered (Beecham & Knapp 1992).

Consider the type of economic evaluation that is most appropriate
If the focus of evaluation is narrowly on suicides averted then simple cost effectiveness analysis or perhaps CUA using quality or disability adjusted life years would be practical. If additional outcomes of importance are also identified (for instance reduction in non fatal suicide events) a cost consequences analysis (CCA) – similar to CEA, but comparing costs with more than one outcome may be appropriate.

The case for cost benefit analysis
Any future evaluation of a complex suicide prevention strategy may well wish to consider using cost benefit analysis. Theoretically this is the most robust of the approaches to economic evaluation, although it can have a number of practical difficulties (Healey & Chisholm 1999).

Members of the public might, for instance, be presented with a range of information (taken from the effectiveness evaluation) on the impact that *Choose Life* has on the rate of suicide (and other outcomes of interest). Using a technique called 'contingent valuation', they may be asked to express their 'willingness to pay' for public investment in *Choose Life*. This use of this technique in relation to suicide and other injuries has, to a limited extent, been used in the United States; currently work is also underway in Ireland.

An alternative approach, increasingly used in health economics, may be 'conjoint analysis' e.g. (Sassi *et al.* 2005) whereby individuals are presented with a range of different scenarios which can include information on the effectiveness of *Choose Life* as well as the costs of delivering the programme and other issues of interest that may impact on the willingness of individuals to use *Choose Life* interventions. The ranking of these scenarios might then be used to estimate willingness to pay for an intervention. The major drawback of these two approaches however, is the need to interview what may be several thousand people, preferably on a face to face basis. For an evaluation of a national programme this may however be practical.

Putting any future economic evaluation into context

Our phase one evaluation has emphasised the importance of understanding the context in which interventions are delivered. This use of contextual information in economic evaluation has been rare, although a few economists have argued for the use of ecological or holistic economic evaluation methods (Jan *et al.* 2004). These would have to be tailored to suicide prevention but box A2 illustrates how this has been used alongside an economic evaluation of a maternal health intervention in Australia. In the case of *Choose Life* the wealth of information emerging from phase one of the evaluation could play an important role in describing this context. Further such context setting work would be helpful to any evaluation of effectiveness and cost effectiveness in phase two.

Box A Components of an ecological economic evaluation of a maternal health programme in Australia

Event logs: documenting actions and impacts in each of the intervention communities

Diaries kept by and interviews with community development officers on how the programme is evolving

Interviews with other key stakeholders

Documentation of resource costs used and impact of changes in health outcomes on resource use

Focus groups in non study areas to ascertain value other community groups place on changes in health status due to the intervention.

Community based postal survey to elicit community values for project related social outcomes

Organisational survey before and after the intervention to document inter-organisational collaboration and the impact that this has on the collaborations over time

Conclusions

Many methodological papers and policy documents recognise the importance of economic evaluation as one element of the assessment of suicide prevention strategies. Our review of the literature suggests that despite this acknowledgement, there have been very few economic evaluations of national or area-based suicide prevention strategies. This is perhaps unsurprising given that there are few effectiveness evaluations of such strategies. Even when looking at specific individual interventions that have been suggested for suicide prevention such as primary care physician training, there appears to be little economic evaluation.

The human and economic costs of suicide are profound, suggesting that the economic case for investment into effective prevention strategies may be strong. We have illustrated here also how even in the absence of full information, economic methods can play a modest role in informing the policy making process. There do not appear to be any major conceptual reasons as to why a full economic evaluation could not be used; cost benefit analysis may well be the most appropriate approach.

While economic evaluation may be an integral component of future evaluations; there may also be some scope for retrospectively making some assessment of cost effectiveness of a strategy in a particular country or context, if robust information on effectiveness and resources required to deliver this programme are available from effectiveness reviews.

While our analysis would suggest that, even if only moderately effective, investment seems merited because of the many years of life saved, there will also be many other potential benefits gained. In addition to having a potential impact on the number of deliberate self-harm events, other benefits may include the promotion of positive mental well-being and thus improved physical health, as well as the acquisition of new skills by those participating in delivering interventions.

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