OFFICIAL REPORT
AITHISG OIFIGEIL

Equalities, Human Rights and Civil Justice Committee

Tuesday 23 April 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 23 April 2024

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EQUALITIES, HUMAN RIGHTS AND CIVIL JUSTICE COMMITTEE
10th Meeting 2024, Session 6

CONVENER

*Karen Adam (Banffshire and Buchan Coast) (SNP)

DEPUTY CONVENER

*Maggie Chapman (North East Scotland) (Green)

COMMITTEE MEMBERS

*Meghan Gallacher (Central Scotland) (Con)
*Marie McNair (Clydebank and Milngavie) (SNP)
*Paul O'Kane (West Scotland) (Lab)
*Evelyn Tweed (Stirling) (SNP)
*Annie Wells (Glasgow) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Richmond Davies (Public Health Scotland)
Dan Farthing (Scottish Action for Mental Health)
John Gibson (The Canmore Trust)
Rob Gowans (Health and Social Care Alliance Scotland)
Rebecca Hoffman (LGBT Health and Wellbeing)
Neil Mathers (Samaritans Scotland)
Aidan Mitchell (Change Mental Health)
Jason Schroeder (Scottish Men's Sheds Association)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equalities, Human Rights and Civil Justice Committee

Tuesday 23 April 2024

[The Convener opened the meeting at 10:00]

Petition

Makaton Sign Language (Legal System) (PE1787)

The Convener (Karen Adam): Good morning, and welcome to the 10th meeting in 2024 of the Equalities, Human Rights and Civil Justice Committee. We have no apologies.

Our first agenda item is consideration of a continued petition, PE1787, on the use of Makaton sign language in the legal system. I refer members to paper 1.

At our meeting in late February last year, committee members discussed how much further we could progress the petition, given its narrow scope. We ultimately kept the petition open to seek further information, as is outlined in paragraph 3 of the paper, and that information is summarised in paragraphs 5 and 6. The clerks recently received an update from Scottish Government officials, which is included in full as an annex to the paper and is summarised in paragraphs 8 to 10.

We are invited to consider whether to close the petition at this point. Although there is no specific set guidance on the use of Makaton in the legal system, a number of policies, duties and practices are in place that are designed to ensure that relevant authorities provide as much support as possible for people to communicate in a way that is most accessible to them.

As no member has indicated that they have any thoughts on those points, do we agree to close the petition?

Members *indicated agreement.*

The Convener: We are therefore agreed to close the petition under rule 15.7 of standing orders, on the basis that a number of measures are in place to make communication as accessible as possible. There might be further opportunities for the petitioner and others to highlight consideration of Makaton in future legislation, including the Scottish human rights bill.

I thank petitioner Sandra Docherty for lodging the petition and for helping to raise awareness of Makaton.

10:02

Meeting suspended.

10:03

On resuming—

Suicide Prevention

The Convener: Our next item is an evidence session on suicide prevention in Scotland. I refer members to papers 2 and 3. I welcome to the meeting Rob Gowans, who is policy and public affairs manager at Health and Social Care Alliance Scotland; Neil Mathers, who is the executive director of Samaritans Scotland; John Gibson, who is chief executive officer at the Canmore Trust; Dan Farthing, who is head of suicide prevention at Scottish Action for Mental Health; Jason Schroeder, who is chief executive officer at the Scottish Men's Sheds Association; Rebecca Hoffman, who is national policy lead at LGBT Health and Wellbeing; Aidan Mitchell, who is policy and public affairs officer at Change Mental Health; and Dr Richmond Davies, who is head of public health analytics and intelligence at Public Health Scotland.

We have a large number of witnesses this morning, which is great to see, and we have a lot to cover on this important topic, so I am afraid that we do not have time for opening statements. However, you are all very welcome, and I want to note that we are grateful for your responses to our call for views.

I will open up the questioning. Given the increase in deaths by suicide over the course of the every life matters strategy, what impact has been made by the Scottish Government's previous suicide prevention initiatives?

Rob Gowans (Health and Social Care Alliance Scotland): In relation to some of the previous strategies, quite a few things have been done before—I am reflecting on some of the lived experience work that we did previously. The latest strategy—the creating hope together strategy—is welcome. It contains a lot of really good content, and there is good consideration of equalities and human rights and an engagement with lived experience. In common with other strategies, much of what will determine whether it is successful will be the action that is based on it and the funding that is attached to that, particularly for third sector organisations, which play a huge part in suicide prevention and work with people on an early intervention basis.

Neil Mathers (Samaritans Scotland): Previous suicide prevention initiatives have left a legacy of valuable work over the past couple of decades. I highlight the fact that suicide training is being delivered to a wider network of people. That includes safeTALK, applied suicide intervention skills training—ASIST—and mental health first aid training. The creation of a social movement, particularly through United to Prevent Suicide, has had a particular impact, and the "time, space, compassion" approach has been introduced to embed in a wider range of different organisations and front-line services.

That is a good foundation for beginning to engage people's lived and living experience of suicide in work, but it has to be said that deaths by suicide have not shifted significantly over the past 10 years, so there is much to be done. The suicide rates for people who live in more deprived areas are still 2.6 times higher than those in the least deprived areas, and the rates for men are still three times higher. Those figures have not shifted.

John Gibson (The Canmore Trust): I reiterate what has been said. The previous iterations of our plan for suicide reduction are amazing pieces of work, as is the current one. However, we have to kick off with the elephant in the room, which is that, as Neil Mathers has just said, we are not shifting suicide rates in Scotland or, indeed, across the United Kingdom. We cannot shy away from that.

A huge amount of fantastic work is being done. The new creating hope together strategy, which we will doubtless come to, is an outstanding piece of work, but we cannot but kick off by acknowledging that we are not currently shifting the high rates of suicide in our country.

Dan Farthing (Scottish Action for Mental Health): I will try to avoid simply repeating what has been said. I associate ourselves with the comments that have already been made.

It is important to remember where the every life matters strategy came from. The approach that was taken marked a change in cross-sectoral work in bringing voices from outside Government into the process. There was an additional focus that was lacking before the every life matters strategy. It is important to recognise the work in bringing us together and starting to lay infrastructure in the way that Neil Mathers has described. The lived experience panel, which is now the lived and living experience panel, and some of the other infrastructure that we have built have got us to a point at which, as John Gibson has said, the documents that we are working with are very strong. We have good foundations, but it is really about where we go next and whether we are actually going to tackle the figures that have already been highlighted. That is important.

Jason Schroeder (Scottish Men's Sheds Association): Unfortunately, the level of support that we have had around suicide prevention over the past 10 years has not been substantially good enough, so the delivery—I am talking only about men here—is, unfortunately, lacking. I hope that, today, we can speak about why we have got to

this situation, understanding the psychological differences, and how we can deliver and are delivering but getting no support.

Rebecca Hoffman (LGBT Health and Wellbeing): From an equalities perspective, previous Scottish Government suicide prevention initiatives have had limited impact in reducing suicidal ideation or mental distress within the LGBT community. Previous action plans and strategies have not necessarily made tangible commitments or recognised suicidal ideation within LGBT groups or minoritised communities.

All the while, conditions for LGBT people have worsened. That is reflected in our own internal statistics, taken from our annual service evaluation, which placed suicidal ideation at 40 per cent for LGBT people in 2016, 46 per cent in 2018, 58 per cent in 2021, 61 per cent in 2022 and 64 per cent in 2023. Historically, the responsibility to support the LGBT community has landed with organisations such as LGBT Health and Wellbeing, with kinship networks and with activists within the community, and there has been a lack of prevention-based work.

Aidan Mitchell (Change Mental Health): If we look at the periods from 2002 to 2006 and from 2013 to 2017, we can see that the national rate of deaths from suicide decreased by 20 per cent under previous strategies. However, in recent years, we have seen that improvement stalling. The suicide rate increased to 15 per 100,000 people in 2019 and is now standing at 14.4 per 100,000, as of 2022.

As others have said, the rate of male suicide has consistently been three times that for females and we have not yet been able to break that link. Similarly, we have seen that the difference in mortality rates according to deprivation has been fairly stable since 2001, so that is another link that we have not been able to break.

Some of the impacts of the previous strategies came from funding. The choose life strategy was backed by £20.4 million from 2003 to 2008 and led to a decrease in suicide deaths. We need to see similar levels of funding in future in order to match that.

Dr Richmond Davies (Public Health Scotland): I echo what has been said. The every life matters strategy laid the foundations for what has happened. The current strategy is outcomes-based and involves expertise in academia and practice and from those with lived experience, so it takes a slightly different approach. We will monitor the outcomes and the direction of travel to see how we are moving forward with that new strategy.

However, based on the previous strategy, Public Health Scotland has been producing guidance on suicide clusters and locations of concern and on how to manage memorials, because those monuments can attract increased numbers of suicides.

We are building on the previous strategy and moving forward to make that even better.

The Convener: Rebecca Hoffman, you said you felt that the needs of the LGBT community were not picked up on in the previous strategy. My question is for all the witnesses. Do you feel that there are any gaps that were not addressed and that the new strategy will address?

Neil Mathers: One of the key differences with this strategy is that it is the first time that we have tried to have a mission not only to reduce deaths by suicide but to tackle inequality. That is vitally important. A key part of delivering on that will be to focus on a whole-Government and whole-society approach. At Samaritans Scotland, we are proud to be part of delivering on that as the strategic outcome lead for outcome 1. We understand that, in order to reduce death by suicide, we also need to understand the link between inequalities and suicide risk, so having a strategy that focuses on addressing those is vitally important.

10:15

Dr Davies: The new strategy has a focus on prevention, and prevention as a public health approach works. The evidence is very clear about how it works. You deal with the building blocks of mental health and wellbeing, which are quite upstream, and that trickles down to have an effect on what is happening downstream. I think that the approach is different this time.

Aidan Mitchell: We welcome the reference to tackling inequality and the vision and guiding principles of the creating hope together strategy. It is unrealistic to expect a strategy to reduce inequalities. There needs to be wider work across Government. Audit Scotland's 2023 report on adult mental health acknowledged that mental health services cannot address those inequalities alone, and that we are not yet working closely enough with other sectors, such as housing, welfare and employability, to address and prevent some of the causes of poor mental health, which leads to higher suicide rates.

Although the strategy commits to a whole-Government and whole-society approach, it specifically draws on non-mental health funding and resources to support suicide prevention—for example, policies on child poverty, substance abuse and use, and debt—and it advises that the Government will continue to develop that approach. We need to see a bit more detail about how non-mental health funding policies are working to support the work.

The Convener: That is important. The panel has mentioned some challenges that the new strategy might face. Aidan Mitchell, you spoke about the need for joined-up thinking across sectors. We are not just firefighting—we are getting to the crux of what is causing the problem in the first instance. Do you see any challenges in the strategy, and are there any weak points that you would like to point out?

John Gibson: In my previous life, I was a biological researcher. One of the things that has challenged me since I came to the suicide community is the lack of research on potential biological models around suicide. It is an international issue, not just a UK or Scottish issue. You will see in Rory O'Connor's integrated motivational volitional model, which is so prominent in the documentation, the word "diathesis". It is a word that everybody talks about but does very little with. Diathesis means is there an underlying biological risk for suicide. If that is true, we can throw all we like by way of strategy at the issue, but if we are not dealing with biological diathesis, we have a problem.

I am delighted to say that, along with a major Scottish university, the Canmore Trust is funding the opening up of research into that diathesis to determine whether there are any biological models for it.

It is an important point, because we deal with families where there have been five or six suicides over two or three generations, and there is very little in the literature about genetic studies or familial studies. It is easy for the psychologist to say that this is clustering because it is about a behavioural model, but until you have a contralateral argument to say that it might be biological, you cannot draw that conclusion. One of the things that we therefore need to address is biological modelling and research funding into biological modelling for suicide diathesis.

The Convener: Thank you, John. Would anyone else like to come in on what they would have hoped to have seen in the strategy, or anything that they think is missing?

Jason Schroeder: I would have hoped to see a conversation that does not seem to happen very much, unfortunately, which is about how we are not all the same. John Gibson was talking about our differences and the biological differences between men and women in this case. We can see that there is a major difference between the masculine and the feminine in the outcomes of suicide. There is clearly something different going on and it cannot be addressed with the same solution, because it is not working.

With our movement, we have delved deeply into the masculine, obviously. The strong, silent type masculine model that has been around in society for the past 200 to 300 years is clearly failing us, and it is why I believe that we are in this situation right now. In relation to the strategy, I had hoped for there to be a discussion point among the different sectors of people in which we would be brave enough to identify and to say that it is okay to be different and to accept that there have to be different strategies for success, because there is no one-size-fits-all approach. However, I did not see that at all.

Rebecca Hoffman: For LGBT people specifically, the factors that contribute to suicide and suicidal ideation are multifaceted and are frequently attributed to minority stress and multiple minority stress, which are experiences of external stressors, such as systemic discrimination, stigma, ostracisation, violence, hate incidents and hate crimes, queerphobia and a lack of access to equitable or timely healthcare. A recognition of the impacts of minority stress and a commitment to a truly intersectional approach that recognises all protective characteristics at risk of suicide as well as at-risk groups in general would have been greatly appreciated.

We recognise that the strategy takes a human rights-based approach, and we commend its commitment to interweaving with the guide "Time Space Compassion" and other on-going pieces of work. However, we would have liked to have seen it do a bit more.

Marie McNair (Clydebank and Milngavie) (SNP): Rebecca Hoffman, how involved has your organisation been in facilitating questions and conversations between the Scottish Government and those with lived and living experience of suicide in order to develop the strategy?

Rebecca Hoffman: Overall, our organisational involvement was pretty limited. We were involved with the mental health and wellbeing strategy, and we hosted a session where the then minister attended our offices to meet with LGBT people who had experience of mental health issues.

We tried to engage with the suicide prevention team in delivering the strategy, but we were not successful in doing so. We submitted a consultation response jointly with the Equality Network to highlight the inequalities that LGBT people experience. We are now working more closely with the suicide prevention team and those at the Convention of Scottish Local Authorities who are responsible for delivering the strategy. Although we are in some ways disappointed by the outcome of the strategy, we also recognise its strengths and we are optimistic that there will, hopefully, be tangible action for our community and other minoritised communities in future.

Marie McNair: Thanks for sharing that. Dan Farthing, could you fill me in on your organisation's involvement?

Dan Farthing: Are you asking about discriminated against groups specifically, or about lived experience more broadly?

Marie McNair: I am asking about lived experience.

Dan Farthing: In relation to the old action plan, we were pleased to be involved in building some of the infrastructure that I mentioned before. As Neil mentioned, the social movement has been very important. That was initiated in the previous action plan, and the lived and living experience panel has really been the heart of the approach to lived experience. There is also a youth advisory group, which was formed shortly after that. The approach to the lived and living experience panel was almost co-designed with the first panel. The principles that it established for lived experience engagement, which have been taken on board across suicide prevention work, have been recognised as best practice by the World Health Organization. We really are indebted to the members of the first panel for the work that they did to establish that. The benefit of that work is being seen already with the new panel. A new panel has been recruited recently and it is just bedding in now. Some of that learning, which was hard-fought for and won by the original panel is really bearing fruit, I think.

One of the things that the first panel established is the value of the voice of lived experience in the work. We were talking earlier about the different points of expertise coming into the panel, and I think that it is unarguable that the lived experience panel has demonstrated the value of the voice of lived experience. However, the challenge that is ahead of us is that the panel has fewer than 20 people, so its ability to deal with some of the diversity and equality issues is naturally limited. We must find a way of bringing in not just the groups that are protected in legislation, but the other groups that are clearly marginalised and discriminated against. We need to talk more overtly about people who face discrimination and that being a driver of suicidal ideation and other suicidation.

We have laid good foundations, and SAMH is very pleased to have been involved in that, but it is the people with lived experience who have pushed that forward. The taking forward of the social movement provides opportunities. We think that there is probably room for some work to be done beyond those people who are regularly engaged through the social movement and to do a slightly deeper layer of engagement to enable us to look specifically at groups whose voices have not been heard loud enough in the work so far, of which there are rather a lot. There are a lot of groups in relation to which there is a powerful case to be made that they are at increased risk and that they face increased challenges that are unique and really need to be understood.

Marie McNair: Rob Gowans, do you want to comment on your organisation's involvement in facilitating conversations with the Scottish Government?

Rob Gowans: We had quite a lot of involvement in facilitating the participation of people with lived experience in the development of previous strategies, and we have done a bit of that for the mental health and wellbeing strategy through the diverse experiences advisory panel, which we run with the Mental Health Foundation.

In general, we would strongly recommend that people with lived experience should be engaged not just in relation to the creation of the strategy but throughout the process. As has been alluded to, an equalities lens and an intersectional lens need to be applied so that we can speak to particular groups who are most at risk as actions are developed.

Engaging people with lived experience has huge benefits for our work, and the Scottish Government and others can get a huge amount of really good insight from experience panels. As Dan Farthing mentioned, that takes a lot of work and a lot of engagement, but it is well worth doing across the whole of the strategy, to inform the actions.

Marie McNair: Does anyone else want to come in?

John Gibson: I can speak directly as a member of the lived experience panel. I come at the issue from direct experience, as I lost my son to suicide in 2019 and I made an attempt on my life in 2020, so this is not theoretical stuff for me—it is hard-hitting, appalling stuff.

All that I can say is that I joined the lived experience panel halfway through its previous iteration and I have stayed on as a member of the current panel. As someone who was previously an academic, I was gobsmacked to find, when I came to this process, that the Government was not simply offering academic understanding, but that lived and living experience were equally allowed at the table. Believe me, in the world that I come from, that is dramatic and wonderful.

As an initiative, it is commended by the World Health Organization. The involvement of lived and living experience is a fantastic approach to the work that is being done. Lived and living experience is absolutely at the heart of what is going on. I completely take Rebecca Hoffman's point that representation on the lived and living

experience panel probably needs to be constantly reviewed and updated. However, I am pretty impressed with it, as a model.

Marie McNair: Did you feel that you were fully involved in the development of the strategy?

John Gibson: I felt very involved in the development of the strategy at various levels, at various times and in various encounters. I was deeply involved in individual conversations and group conversations of the panel at various times, so, yes, I felt fully involved.

Marie McNair: Thank you for sharing that, John.

The Convener: We will move on to questions from Paul O'Kane.

10:30

Paul O'Kane (West Scotland) (Lab): Good morning to the panel. My questions will focus on the funding landscape and the funding of suicide prevention work in particular. Yesterday, I read comments from Samaritans Scotland and SAMH on the broader picture of funding for mental health services. Samaritans Scotland has said that, given the challenges,

"There is no indication that the Scottish Government will meet its own target of increasing mental health spend to 10% of the NHS budget".

Samaritans also recognised that "Creating Hope Together" is a very ambitious strategy and said that funding is required to deliver it. I want to give Neil Mathers and Dan Farthing the opportunity to speak to those comments, and then we will have a broader conversation.

Neil Mathers: To reiterate, we feel that the strategy is ambitious. We fed into the strategy and we feel that it reflects many of the priorities that we wanted to see in it. However, ambition needs to be met with the appropriate levels of funding and resource. One thing that we are looking for is sufficient resource and funding in the system to deliver the support that people need, when they need it. The failure to meet the Government's commitment of providing 10 per cent of front-line NHS funding for mental health services is an indication that that aim of having sufficient resources will not be met, and it is not a good sign of where we are going in the next few years.

We would certainly like a greater commitment to funding for the delivery of the strategy. That means making sure that funding is in the system at the front line so that people who need support, whether they are in crisis or before that threshold is met, have the necessary support to deal with what they are struggling with.

Dan Farthing: I agree entirely with Neil Mathers. There is also an issue around security and longevity. We know that we need to make society-wide changes. One of the things that we like about the strategy is that it is ambitious about making society-wide change, but that requires a significant commitment of resource over a sustained period. We are in a year-to-year funding cycle, and it is hard to plan and spend the money effectively if you do not know where you will be in two or three years' time, especially if you want to make longer-term societal changes.

We have talked about the last time that it felt as if suicide prevention work was driving down suicide rates. At that point, there was a much more significant amount of resource, so it seems that we have almost learned in Scotland that the rate of spending needs to be much higher if we want a result. We must remember that it is not just expenditure on suicide prevention that dictates the suicide rates; there are other factors at play. We are concerned about the cost of living crisis and other financial pressures that people face, because we know from academically established and lived experience evidence that those pressures increase suicide rates. If we anticipate that things will get worse or that there will be additional pressures at any point over the next 10 years, additional resource is needed.

Really, it is about how committed we are to getting the figures to come down. As Neil said, the resources need to follow the ambition.

Paul O'Kane: I am interested in what you said, Dan, about the adequacy of funding and the sustainability of funding. Last week, the Scottish Council for Voluntary Organisations was in the Parliament speaking about those issues in a broader context in the voluntary and third sector. I am interested in the third sector work that is going on in this space, which many people round the table are engaged in. Does year-to-year funding present challenges to your ability to test change and test what works, because you need a sense of security to do that? I imagine that, within this ambitious plan, we want to test what works. Is year-to-year funding limiting or holding back initiatives that could move forward?

Rob Gowans: Year-to-year funding is a particular issue—generally, third sector funding is an issue. Probably one of the biggest concerns around successful implementation of the strategy and a successful reduction in suicide is that it needs funding. That applies across the public sector. We are concerned about the cuts that health and social care partnerships are making, and about cuts across different areas, because it will take cross-sector action to challenge poverty, inequality, discrimination and stigma and to reduce rates.

In relation to the third sector specifically, a lot of our members have told us that the unpredictability

of the funding has never been so bad. A survey that we did last year showed that 84 per cent of our member organisations had experienced increased demand for services, partly off the back of the cost of living crisis; however, 61 per cent reported a reduction in grant funding, facing higher bills and being unable to pay uplifts for employees.

The biggest call was for longer-term funding arrangements. Although year-to-year funding is welcome, it does not necessarily give organisations the certainty to continue pieces of work or to progress things beyond piloting them. There is also the issue of their on-going sustainability as organisations—of secure, longer-term funding for the third sector, in line with the fair funding principles that the Scottish Council for Voluntary Organisations has suggested.

Aidan Mitchell: There is a specific issue with year-to-year funding. Another example that we point to is that we are the strategic outcome lead for the suicide bereavement support service. Its final independent evaluation report was published last week and recommended that the service be rolled out nationally, across Scotland, so that everyone is able to access it. The independent report showed how invaluable post-suicide support was for the whole community, so we are really pleased that the Scottish Government and COSLA are committing to rolling the service out further.

The issue is in the funding of that. A sum of £2.5 million was spent last year. Of that, £600,000 has been allocated to the continued funding of the suicide bereavement pilot service and improvement to suicidal crisis responses. If the intention is to roll out the pilot across Scotland—it is currently in two health boards—multiplying that sum sevenfold would mean looking at a budget that is more than the total spend of the suicide prevention work that the Scottish Government is currently doing. We will therefore need additional funding from the Scottish Government in order to finance some of the really important continuing work on suicide bereavement support.

Jason Schroeder: I will fill you in a bit on what is going on with us. In 2009, no men's sheds existed in the country and nobody had heard of them. It took me four years to get the first one open. From 2013 until now, we have used a successful methodology to engage men voluntarily—which is highly unusual, with men, when it does not involve risk—and we now have more than 200 groups across Scotland, engaging more than 10,000 men voluntarily across the whole of Scotland, across all sectors.

I do not understand whether the Government is serious about what we want to implement. Possibly for the very first time in Scotland's history, we have a model of engagement in which men are voluntarily excited about getting together in a safe place and talking about their vulnerabilities. Why has the Scottish Government stopped all our funding this year? We are now at a critical point. In the next eight to nine months, unless the situation is turned around, we could see a collapse of the whole movement. That would be devastating for the people of Scotland—for all of us.

Neil Mathers: I will illustrate my previous point when it comes to Samaritans and the service that we provide across Scotland. As you may know, our volunteers provide a listening service to people across Scotland. We answer 12,000 calls every month. Many of those calls are directed by people who are getting support from mental health services. We receive calls from people on psychiatric wards and people who no longer have mental health support over evenings and weekends but who expect continuity of care. Our service provides that support for them when the system does not provide it. That indicates that there is not enough funding in the system to provide the support and care that people need.

In our consultation response, we said that it costs us about £600,000 a year to deliver the listening service in Scotland, and it falls almost entirely on us to raise that money from the general public. It is vital that we reach a settlement with the Scottish Government on a mechanism for third sector funding that provides a bit more stability and a foundation that allows us to leverage additional funding to support a service that is critical to so many people. That will ensure that we can provide the listening service in years to come.

Paul O'Kane: It is very important for us to hear those points. I have heard from other third sector organisations that, when funding is late in being announced or committed to, there is a sense that organisations will bridge the gap somehow or that such services will always exist. However, as Neil Mathers outlined, the challenge is that it takes a lot of resource to have such services funded by public donations or other grants and trusts. Have people experienced that bridging issue when the Government has been late in delivering funding?

Jason Schroeder: We are experiencing that right now in relation to the social isolation and loneliness fund. We were told that it was a three-year fund but, eight months in, when we were about to go into our second year, we were told that there might be no funding for that year. On that second-year funding, two weeks before, we were told that we would have to reduce our budget by 25 per cent. We all rushed around and considered whether we could even employ people with that budget, and we had a meeting with all 56 charities that were part of that £3.2 million fund. Literally 24 hours before the end of the financial year, the Government did a U-turn and said that, actually,

we could have 100 per cent of the funding for the next year only. How can you operate like that?

Paul O'Kane: I am keen to understand whether details of spending on suicide prevention should be included in progress reports on the strategy. Would that give people a better sense of the progress that was or was not being made in budget allocation? Would it be helpful in showing the wider picture and allowing organisations to plan better? Should the committee consider that matter in our conversations with the Government?

Rob Gowans: That would be helpful. We have spoken to the committee previously about human rights budgeting, and one of the key points about that relates to transparency. If you look at Government budgets, such as health and social care partnership budgets, it can be very difficult to identify precisely what is being spent on what—in this case, suicide prevention. Sometimes, there are only top-line figures; the information does not necessarily tell us what has been spent on other initiatives in the third sector.

What you have suggested would be a very welcome measure, because it would give us a lot more detail about what is happening on the ground, where some of the funding gaps are and what has been committed to.

Annie Wells (Glasgow) (Con): Good morning. I will focus on monitoring and evaluation of the strategy. Is the evaluation plan that is detailed in the outcomes framework adequate, or should there be any additions or changes to the plan?

Dan Farthing: I think that we have good news for you, in that the plan is not the full extent of monitoring and evaluation. The published plan is the high-level element of work, but there is on-going work to build in more practical engagement at a lower level.

I might ask Dr Davies to comment on this, because outcome 4 leads the work, but Matter of Focus has been brought on board to take an impact and outcome led approach. It has a system that we are looking at implementing across delivery to enable us to look much more closely at how we can demonstrate with a degree of confidence that the work that is being conducted is actually contributing to the outcomes in the strategy.

I will let Dr Davies come in.

10:45

Dr Davies: Dan Farthing mentioned Matter of Focus. It has been engaged in the issue and will be looking at whether the activities that are set out in the plan will meet the outcomes in the outcomes framework, because it is very important to see whether they are enough or whether there is a need to change tack a bit. That is the methodology that is being used.

We also have to pilot the electronic reporting system that is being worked on. It will be able to determine whether the things that we want to collect exist, and if they do not exist, how will we be able to access data and information that are necessary for us to be much more evidence informed in how to move towards our outcomes.

All those things are happening. What is published in the strategy is high level, and there is a lot of work being done, as we speak, to operationalise the outcomes.

Annie Wells: It is good news that that is being worked through just now. I will follow up on that with my next question. Some respondents to our call for views said that focusing on the reduction in suicide deaths as an overall measure is perhaps not the right way to do it. Should we look at broadening measurement of the strategy's success?

Neil Mathers: Deaths by suicide is an important measure for us, but I do not think that it is sufficient. One thing, which Dr Davies mentioned, to acknowledge about the new strategy is the focus on outcomes, which has not happened in previous strategies. We should recognise and celebrate the fact that we have a focus now on understanding whether we are making significant progress. The work that is being done to understand what data we need to gather in order to understand whether the outcomes are being achieved should make a huge difference.

We do not have access to the data that we need. We certainly encourage having a focus on understanding attempted suicides, because that would give us a better indication, alongside deaths by suicide, of what more we need to do to address suicidality. There is definitely much more that we need to do in gathering data and understanding that data. That does not include just data from academic research; we need also to use service insight and insight from people with lived and living experience to help us and to inform us about what needs to change.

John Gibson: The issue of dying by suicide is not a complete science. I do not know whether the committee understands that. That came as a bit of a shock to me. We meet regularly and for the most part we use postvention, which is work with families in which there has been a suicide. It is not at all unusual for a family to be delivered a death certificate that makes no mention of suicide whatsoever. There is an upstream issue in respect of how the registrar general records suicidality, which I think the country and this committee need to understand. It is not quite as clear as saying, "We found body X in certain circumstances—it

was definitely a suicide." There is an issue of the balance of probabilities that needs to be addressed, which is important.

Although I agree with everyone's comments so far, I still do not want to move away from my position that we need to see a reduction in suicides and suicide numbers in Scotland. We can measure all the other upstream stuff, and it is important that we do so, but the end point—we are talking about a suicide prevention strategy—must be a reduction in suicide. There is no getting away from that. We cannot obfuscate with nicer upstream things—there has to be a reduction in suicide. That has to be the outcome of the strategy.

Dr Davies: That is why Public Health Scotland's publications talk about probable suicide rather than absolute suicide, because there are grey areas where it is not quite known whether a death was actually suicide.

You mentioned gaps. We do not have any data at all on suicidal ideation and suicide attempts. We hope that, as time goes on and as we deal with the strategy, there will be pilots to allow us to understand how that information can be collected. The issue is a bit nuanced. People need to present themselves or say something to someone in a healthcare, social care or third sector support structure so that that information is recorded somewhere. If it is not recorded, we do not know it. There are a number of challenges in that.

Annie Wells: Thanks very much.

Maggie Chapman (North East Scotland) (Green): Good morning panel, and thank you for your contributions so far today, and previously in writing. I will explore a couple of issues around support for marginalised and minoritised groups and how the strategy deals with those. I have a couple of general questions to ask, first.

Is there enough information in the strategy to identify particularly vulnerable groups, or is that a problematic way of viewing the issue in the first place? Given what we know about increases, not only in suicide but in suicidal ideation, in specific groups, does the strategy get to grips with that enough?

Rebecca Hoffman mentioned that issue in her opening remarks. Do you want to come in first?

Rebecca Hoffman: Yes, I am happy to come in.

First, I will say that we welcome the human rights based approach of the strategy and we appreciate the importance of reducing suicide deaths for all in society. We see huge strengths in the strategy. However, on prevalence, specifically in the LGBT community in Scotland, the "Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people", which was published in 2022, found that nearly one in three LGBT people had tried at one time to end their life. At the intersections, that was 49 per cent of trans masculine people, 47 per cent of non-binary people, 36 per cent of trans women and 31 per cent of bisexual women. Those figures are alarmingly higher than the population average, which the Scottish Government reported as being 7 per cent in 2022.

Our internal data confirms that that is the reality for LGBT people. In our 2023 service evaluation, we had a sample of 332 people who accessed our services. Sixty-four per cent of LGBT people using our services said that suicidal ideation is an issue that impacts them. The figure is 80 per cent for trans and non-binary people, 98 per cent for LGBT people seeking asylum and 100 per cent for intersex people and those with variation in sex characteristics. It is important to recognise prevalence—specifically, high rates of prevalence. By adopting a truly intersectional approach to both prevention and intervention, as well as having the strategy, we can get it right for everyone. That is what we believe.

Maggie Chapman: Dan Farthing, I will come to you on the same question. Are there issues that the strategy does not get at when it comes to particularly vulnerable groups?

Dan Farthing: The strategy is very broad and ambitious. Quite often, when you are looking for specific things, there are references, but we are saying that there needs to be a greater degree of intentionality when it comes to individual groups. We understand that, historically, not enough has been done in this area. Through the previous action plan, SAMH was involved in work that was specifically focused on racialised communities and on asylum-related challenges. We are aware—I say that especially because we are here—that there are a large number of groups with very specific challenges and specific drivers of their risk factors, which are not easy to understand unless we properly engage.

That is why have talked about the need to broaden our engagement on lived experience. We must ensure that there is space for those conversations within the social movement and the lived experience panel, as well as finding other forums through which to engage with organisations in a far more open and inclusive way. That would let people who have faced the discrimination that drives suicidal ideation tell us where to go, rather than the Scottish Government or the delivery collective sitting back and assuming that we have the answers. The challenge is how to hand power back to those groups; we recognise that that challenge has not been fully addressed and that there is still a lot to learn.

We must do that within our capacity. I do not want to make everything about resources, but those groups deserve genuine and open conversations and the resources to take ideas and learning forward. If the funding is essentially flat, or is declining in real terms, the ability to innovate in the way that will be necessary if we are to take on the challenges will be curtailed before we even start. I do not want to be involved in getting people to share their lived experiences if we will not genuinely use that lived experience. That is not morally acceptable.

Maggie Chapman: Rebecca, I will come back to you.

Dan Farthing mentioned asylum seekers. You will be aware of the work on asylum seekers that the committee did last year, in which suicide and suicidal ideation came up. You spoke about learning lessons. In many cases, we know what we need to do and just need to get on with it. Do we have the right structures in place? Resource is one thing, but we must also get the resources to the right people—front-line support workers and people beyond them. I am thinking particularly of the vulnerable group of asylum seekers. There are many strings attached to local, Scottish and UK Government agencies, which cut across each other in various ways.

Dan Farthing: There are co-ordination issues. It is challenging to help that group because of the changing nature of the communities whom we work with. We could gear up to become very good at talking to one community but then, a year later, another community might unfortunately have to seek asylum.

I probably disagree with you; the structures are never perfect, but they are workable. There are already some excellent organisations working with people who are seeking asylum. As you say, they know what they need to do and, if resources were made available, they could be doing that now. The nature of this conversation means that we could get tied into process, but we know that real individual people are dying. It is easy to step back and look at statistics, but we must be mindful of the suffering that each death causes. We believe that those deaths are avoidable, so I would not want a restructuring process to delay getting resources to the organisations that can make a difference. The structure is not perfect, but it is probably good enough.

Maggie Chapman: That is really helpful. Rebecca, do you want to come in?

Rebecca Hoffman: I want to come in on Dan Farthing's reference to innovation in funding. A huge part of the issue is that there are organisations that work with minoritised communities that hold expert knowledge of how to support those communities. That is specifically true for the LGBT community, in which people have historically supported each other. Our internal data shows that, for the 62 per cent of people who reported experiencing suicidal ideation, there was a decrease in suicidal thoughts of 57 per cent for trans and non-binary people, 64 per cent for intersex people and 80 per cent for asylum seekers. It is evident that the services exist, but they need to be properly resourced for both prevention work and intervention work. In instances where specialist support organisations are not resourced, those who provide services must be LGBT-affirmed and affirmative, because that makes such a huge difference.

Maggie Chapman: One thing that I picked up from that is the need to retain an intersectional understanding when we use focus groups, because people can fit into more than one group.

Neil—I come to you with the same general question. When we think about particularly vulnerable groups or individuals, are there any gaps in the strategy?

11:00

Neil Mathers: I agree with what Rebecca Hoffman and Dan Farthing said, which I will not reiterate.

Things can work despite structures. The structure is an improvement on what we had previously. It has brought the third sector in to work alongside the Government and the Convention of Scottish Local Authorities in delivery of the strategy. It can feel messy at times, but there is an attempt to broaden and widen the number of stakeholders—the people who can contribute to delivery. That is a good thing.

Rebecca made a point about being able to engage with organisations that already hold relationships with people who experience harmful stigma, discrimination or other forms of inequality—to learn, understand and be guided by their expertise in how we talk about suicide prevention. The model is being built as we speak: those relationships are being formed and networks are being created. We are in a better place with a lot of that.

The other area in which we see hope is the focus on cross-Government work and the recognition that suicide prevention is a small part of the Scottish Government's work. We will tackle inequalities not through the suicide prevention strategy but through its linking up with all the other parts of Government, and with COSLA, to tackle the root causes together. That is a difficult task, but our having that ambition leads the way and keeps the focus on trying to build those

connections across Government. That can be only a good thing.

Maggie Chapman: Richmond Davies, one group that we have not talked about is people who have been released from prison. You may be aware that *The Lancet* recently published multinational research that included Scottish data—Scotland was one of the eight countries covered in that research. It found that suicide was the second-highest cause of death in the first week following their release. Is Public Health Scotland making the connections that Neil Mathers has just been talking about? Are we gathering the right data? That links back to Annie Wells's questions about how we collect and use data and therefore how we feed that into our strategic work.

Dr Davies: There are some data gaps and challenges to drill down into. We know that people who are more deprived are three times as likely to take their own life and that men are three times as likely as women to take their own life. Prisoners fall into both categories. Most of them are men and most of them are from very deprived areas. Therein lies the problem.

We are working with QES, which will pilot a huge data set of about 100 variables in some local areas. We would like to understand whether granular data exists about individuals who have died by suicide, and whether that can be captured quickly, in order to better understand what is going on.

On 7 May, we plan to publish statistics on the services that individuals interacted with prior to their death. We are trying to understand in a more granular form what it was about those individuals that led to their death, and how systems can be put in place and attitudes and thinking can be changed, through all the work that we do, such as training for those who provide care or who interact with people who have suicidal ideation. Lots of resources have been developed collaboratively. NHS Education for Scotland is actively involved. We want to see how those things could be better harnessed and what difference they would make over time.

Maggie Chapman: Thank you for raising NES. It provides some fantastic resources, so the issue is getting those out to the right people.

Dr Davies: Yes, indeed.

Maggie Chapman: I am wondering whether we also need to think about cross-departmental education, training and support. Do people who are supporting prisoners after their release have that training? Can they access exactly the same training that already exists? Let us not reinvent the wheel multiple times across Government.

Dr Davies: Exactly.

Maggie Chapman: I will look out for that report in May.

The Convener: We move to questions from Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): Good morning to the panel, and thank you for all your answers so far. I would like to ask John Gibson about postvention from the Canmore Trust's point of view. Will you explain to the committee what postvention is and why it is so important?

John Gibson: That is a great question. There is no doubt that, up until recently, postvention has been low on the agenda. Postvention is good quality support to individuals, families, communities, schools, colleges, universities and workplaces where there has been a suicide. That reaches out in many different ways. We all grieve differently, and companies and workplaces grieve differently. For some people, it is about getting straight back to work; for others, it is about being off sick for six weeks. Postvention is about balancing all that out, and providing support in the workplace is really important.

Why is postvention important? If you summate the world literature on suicide postvention, you see that there is a suggestion that an individual family member who has lost a first-degree relative to suicide carries a lifetime increased risk of 15 per cent additional suicidality. The important adage that we have in the Canmore Trust is that today's good quality postvention is tomorrow's prevention. As a new charity—we have been going for two years—it is really exciting for us to be around at a time when postvention is coming on to the agenda.

I will say something to the committee that is important and affects all that we are discussing today: many people work in the sector, and we need a much more joined-up approach to all aspects of what we are doing, whether that is through a Government agency, employers or a third sector organisation. When we pull together, we are much more efficient. We stop duplicating effort and, possibly more important, we stop duplicating the spending of donated or public funds. Therefore, we really need to work harder at that.

There is a role for Government in saying, "Here is the initiative that we are kicking off. Who's interested in this? More importantly, who's already working in this area? What expertise can we bring to the table?" It is really important that we build that relationship.

The Scottish Government and COSLA have already done that; they have kicked things off. Two major events—one in February and one in

March—brought together third sector organisations that work in suicide prevention and postvention. Both of the events were great. I was at the first one, not the second one. There was a sense of, "My goodness, you're doing that—we're doing this as well. Let's get together and share our experience and share our approach to this." We must work on enabling that.

Evelyn Tweed: I was interested in your comments about your research on a biological or genetic link to suicide. Where are you with that research? Do you have anything, including timescales, that you can share?

John Gibson: The research has not gone public yet—it is just about to do so.

Evelyn Tweed: Oh, sorry.

John Gibson: It is absolutely fine, because if you want me to go public, I will go public now. This is a great opportunity to do so.

The Canmore Trust has fundraised specifically to open up, effectively, a new seam of research in the University of Glasgow, building on Rory O'Connor's psychological research in his major department in Glasgow. Sitting alongside that will be a new seam of biological research.

I would really like to make a point that relates to the tail end of Ms Chapman's questions about affected groups. In the creating hope together strategy, we will have to work hard to identify that there are high-risk professional groups as well. We in the UK will have to work hard to dig that out. It is a freedom of information request issue rather than being something that is actively published.

My son was a veterinary surgeon, and the suicide rate for vets is four times the national average. As much as we can work it out, it would appear that four out of the six highest suicide rates among professional groups are for clinical-facing professions: veterinarians, dentists, medical doctors and nurses. For the first time, in November, we are having a two-day national conference in Glasgow to look specifically at the matter and to consider how we might pool information on that, because it is a really important area.

I will reference Jim Hume, who is sitting behind me in the public gallery and who chairs the Scottish national rural mental health forum, which is hosted by Change Mental Health. Rurality is another aspect that we have not addressed today. I came to the issue of suicide thinking that it must be about poverty in urban areas, but it is not. It might be about poverty, but it is also about rurality. Rurality is a huge factor. The stuff that Jim is doing in pulling together the Scottish national rural mental health forum into a cohesive group is important. The group also does an amazing job in discussing research opportunities.

I hope that that answers your question.

Evelyn Tweed: That was great—thank you.

I want to ask Rob Gowans about gambling and debt. I am also thinking of the cost of living crisis, and I know that other MSPs will have a similar inbox to mine, with messages from people who are struggling. Are we doing enough to look at those issues?

Rob Gowans: A lot more can be done. I am pleased that you mentioned it, because we have been doing quite a bit of work on that over the past few years. We know that there is a strong link between people who have experienced gambling harm and suicide—it is a particular risk.

Our Scotland reducing gambling harms programme puts people who have lived experience of gambling harms at the heart of the policy-making process and enables them to share their experiences. So far, the picture is mixed. There is increased recognition that gambling harms are a public health issue, but, as you alluded to in your question, it can often be a question of priority, and the matter is not necessarily given the attention that it needs. In an elementary sense, that is because some of the powers on gambling and gaming restrictions are reserved. Things might happen at the UK Parliament, but, because some of it is not the direct responsibility of the Scottish Government, the issue can fall off the radar a bit.

People who have experienced gambling harm are an important group to consider, because we know that there is a very strong link to suicide. It is estimated that there are between 250 and 650 gambling-related suicides every year in the UK, so it is very important to consider gambling as part of it.

Evelyn Tweed: Does anybody else want to come in on that?

John Gibson: I will come in on the gambling issue. The research is quite clear that, for the most part, suicide is a multifactorial disorder. It is like pieces of a jigsaw going in. However, the one area that can be a unifactor in suicide is gambling, so gambling debt becomes a unifactor. It can happen very acutely and suddenly, so it is an area that needs further research and understanding.

Dr Davies: For Public Health Scotland, gambling is a significant public health issue, because there is a clear tie with poverty, debt and crime—it just goes on and on. We are exploring possibilities for capturing data that is good enough for us to publish in order to provide more evidence on what is happening with regard to gambling harms in that area.

The Convener: Before we move to questions from Meghan Gallacher, I would like to ask one myself. When we were talking about other groups, it came to mind that we have not discussed postnatal or menopausal women. Have those issues come up for anyone?

11:15

Dr Davies: In preparing our publications on suicide, we normally use information from National Records of Scotland that states how people have died. We have other pieces of information about the maternity system. We try to link those to understand the relationship between pregnancy or birth and suicide. If it is not treated early, postnatal depression could develop into psychotic symptoms. We are working on that aspect.

The Convener: That is great. Thank you.

Meghan Gallacher (Central Scotland) (Con): I thank everyone for their contributions so far. This is a hugely important topic. Our discussion has brought to light how much work needs to be undertaken, by both the committee and the Scottish Government, to consider not only how we prevent suicide but how we ensure that the right support and funding are in place to support everyone who is going through what must be a hugely difficult time.

I will focus more on issues that are affecting men, because the statistics and the facts speak for themselves: 75 per cent of people who died by suicide in 2021 were men. At the start of the meeting, we heard from Neil Mathers the statistic that men are three times more likely than women to die by suicide. Although we need to look across different groups of people, and some will fall into more than one group within society, we must also focus on why that is happening, in particular among men in certain age groups and demographics. We must also ask why that has not been brought more to the forefront of the Scottish Government's strategy and what it needs to do to address that issue.

I will start with a question for Jason Schroeder. Earlier, you mentioned having a strategy and said that we should not be scared to look at different groups on their own. Will you expand on that a little, from your experiences with men's sheds, to re-emphasise not only their importance but the recent difficulties that you have experienced with funding for that vital project?

Jason Schroeder: We have seen that our whole culture is falling short, as far as being a wellbeing economy is concerned. We must examine what we have inherited from our past, through our grandfathers, grandmothers and so on, which is the strong, silent type masculine model. The men's shed movement is now pushing that we want men to be strong, vulnerable, kind and communicative. However, unless we have environments in which to experience that, it will never be experienced.

I am generalising but, when we look across the genders, we find that men tend to be hard wired for isolation. We become solution focused when we think about our problems, with a single focus. Men either find a solution or we do not. If we do not, what can happen is that we internalise the issue—we call it going into the man cave. If we do not then come up with a solution, we can drop into depression. If they still cannot speak about it, or do not have a safe place in which to do so, some men will commit suicide.

We see a difference between men and women in that women are the network communicators of our species. For example, they might pick up the phone and speak to a female friend, but men generally do not do that. We might think, "The solution is for me not to be here." In the cases of both employed and unemployed people, a wife is often the last person to find out about such problems.

What I found fascinating about the men's shed movement is that the first men's shed in Scotland was set up in a wealthy area. We might think that it would be a given for it to happen in areas of deprivation but, according to the report, that is not the case. For example, why do local general practitioners and so on have concerns about wealthy retired oil guys? It is because they have time on their hands.

We find that, whether a person is in a block of flats surrounded by people or is in a croft on the islands, or whether they are a farmer sitting on their tractor hour after hour, because they are more focused on internal, gender-specific and solution-based isolation, they will be proactive in doing something risky. I am talking about gambling and drinking.

We are very proud to have our patron, Sir Harry Burns, standing with us. As he has said, alcohol is one of the biggest issues that we have in Scotland. We have to consider why we are drinking or gambling.

I was a youth worker for 10 years. The Scottish men's shed movement is intergenerational. That is unlike the Australian movement, which it came from; it really looks at retired people. In Scotland, we look at an intergenerational approach. If a man is 18 or older and has time on his hands, he should get himself down to a men's shed.

One of the biggest issues that we have in Scotland is the ageing population. In 15 years or 20 years' time maximum, we could have a mass depopulation of people in the country. In the men's shed movement, that will mean our elders—our

wisdom keepers—who we always had in our villages, will be missing from our culture. Unfortunately, the industrial revolution changed all that for us.

I believe that our culture does not value older people, particularly older men. That is a major issue. The second major issue that I have seen is that older people could not be accessed. That is why I started the movement. I was looking for older men to mentor me to be a better father. I refer to what John Gibson said. In 2009, I nearly took my own life, so that comes from a very personal place.

I am thankful that, in that dark place, I heard about the men's shed movement from a GP from New Zealand who was in Scotland at the time. That GP gave a talk on it. I was in a very dark place as a father in the age group that we are talking about. I was contemplating suicide. I started the movement because I could not see in our culture or the world something outside the betting shop or the pub where men could go, socialise in a healthy way and have a purpose again, in a way that did not lead to risky behaviour. We find with the masculine model that, if we do not have purpose, we drop into depression and suicide very quickly.

I have studied and been trained in suicide prevention as a youth worker. I have worked in two different types of communities—wealthy and poor—and have looked at those kids. I have looked at the boys. With single parenting today, a lot of mothers come to me and ask, "Is there no place where I can send my teenage boy to be mentored by a healthy masculine man? Dad is no longer around." Where are those places? They did not exist, but they do now, thankfully.

Over 10 years, we have had accessibility to older men who meet in a masculine, mature and grounded way. We have not often seen that before in our culture. If we can change the culture to say that our elders are valuable resources, they have lived through hell and high water, and younger men are probably going through the same thing, those younger men can learn from the learned experience of those men in a safe place.

A nurse from Kinross recently told me that there is an adage that Scottish men in particular are very difficult to talk to, or that they just do not talk. She said, "Jason, my experience with working with the men's shed in Kinross is that we need to change that. The difference that I see now as a nurse for the NHS is that, if we create a place or there is a place where men feel safe, they will open up and speak about their deepest, darkest shameful secrets."

I have been involved with the weird thing called men's sheds for 10 or 15 years now. Of all the models, why did the men's shed model get men excited? I do not know, but the movement has become a global health movement. It is now the biggest health movement in Scotland for men, who voluntarily engage across all ages. That is fantastic. I am, of course, very proud to be a part of that, but I am also very concerned that it is about to disappear again.

Maybe that answers some questions about this deep topic.

Meghan Gallacher: It definitely does. I am hugely concerned about the situation, for the reasons that you have articulated so well. As you said, it is so important for there to be safe places for men to talk. As women, we will congregate to get all the weight off our shoulders, but men will not automatically do that. You highlighted an excellent point about the need for role models to bring up the next generation of men who can be confident in themselves, and it is hugely important that men have somewhere to go where they know for a fact that they will be welcome and able to be open and that will not be an alien place to them.

On funding for men's sheds, I am terribly concerned about the impact that the closure of men's sheds would have on already concerning statistics for men in general. What is the timeframe? You mentioned eight to nine months. What happens? Do men's sheds in rural areas close first, or is it those in urban areas? How could that be condensed? I am pretty certain that every men's shed across Scotland has a worth and a purpose and serves many men—I think that you have 3,000 members.

Jason Schroeder: Our charity has nearly 4,000 members now, and the movement engages more than 10,000 men every week. I believe that it is now the biggest charity in Scotland. I do not know why the Government chooses not to fund it.

We can look at the example of Australia. Thirty years on, it has more than 1,000 men's sheds, which receive $4.5 million of funding a year. The Government in Ireland, whose demographics and rural population are very similar to Scotland's, provided €1.3 million of funding last year.

At the moment, the biggest impact on Scottish sheds is the cost of electricity. Unfortunately, like Ireland, we do not have fantastic weather, so the cost of electricity has a major impact. The Irish Government recognised that and provided €800,000 over winter so that each men's shed could have €2,000 to keep the lights and the heating on in order to meet people's basic need to get together during dark times. Unfortunately, in Scotland, following Covid, there has been an impact on a lot of the elders, who are the nuts and bolts of the movement and have the life experience. They are the trustees.

You need to understand that the movement is unique. Why is it that men are being engaged in this way and not in other models? It is because our ethos is about engaging and empowering men—it is for the men by the men. As the support hub, we are not the umbrella organisation that runs every shed. That does not engage men; what engages men is giving them self-governance over their actions. As the support hub for Scotland, we provide them with policies so that they do not have to reinvent the wheel, because men generally hate paperwork. They just want to get into a shed to socialise and help their communities in relation to, for example, their green footprint or carbon footprint—all the good stuff that happens in the sheds.

However, the main thing is about purpose—the men need a purpose to get out the house. In the shed world, we say that men communicate shoulder to shoulder, whereas women communicate face to face. Unless they have a purpose, the men will not leave the house. In the shed world, wives call it the underfoot syndrome. Husbands, for whatever reason—they might be unemployed or underemployed, have had an accident, have lost their job, be retired or have been affected by sickness—get under their wives' feet. Wives no longer have their own independent space, because the men just sit there. Hundreds of wives have said to me, "My husband is becoming a child. I am losing my partner." When that man has a place to go that eliminates risk—a men's shed—he comes back with a spring in his step and brings back conversation to the marriage. He has given his wife her personal space again, the marriage stays intact and the wife keeps her husband.

We say that every man who goes to a men's shed will have a positive impact on a minimum of five people that day. If the man does not leave the house, those five people will miss out on his interactions—big and small—in his community. Now we are talking about hundreds of thousands of people being impacted. I strongly believe that this is something that has been missed. We did a £150,000 four-year research project with Glasgow Caledonian University that shows that our model works. What has been done in Ireland proves that. Ireland has double the number of sheds that we had.

11:30

Post-Covid, we are finding that the trustees are suffering from fatigue, and we do not have a legacy. My big concern is that our charity will close in eight to nine months. We have no more funding. We do not have enough to cover it. All our men are volunteers. We are the central hub that they go to. We are their go-to for questions from, "How do I start a shed?" to, "How do I keep the shed running?"

We have developed a strategy that is unique to Scotland, with its devolved laws. I am very proud to say that we have exported our development strategy to America and Canada. Our little Scottish development model is now running across the world, yet we are about to close. I am devastated.

Meghan Gallacher: If that does not tell us how important men's sheds are, I do not know what will. We can link men's sheds to other issues. We have veterans groups for a purpose, we have Women's Aid groups for a purpose, and I whole-heartedly believe that we have men's sheds for a purpose.

Thank you very much, Jason. I am sorry that I did not widen my question, but I believe that we need to emphasise one of the biggest groups who are impacted by suicide. I understand that the same issue will affect all the groups who are covered by charities that are represented here today, but I felt that that needed to be put on the record. I do not know whether anyone else wants to come in on that point.

Neil Mathers: I will build on that. It is important that we look at the role of sport and culture and those spaces where men meet. We need to look at how we can provide training and support in those areas so that men have spaces where they can talk more openly.

There is also a need for training of people in front-line services—not just those in mental health services, but those in education, jobcentres, housing support and other customer-facing people on the front line, so that they can recognise distress and the signs of it in men in particular, provide the "Time Space Compassion" principles and signpost men to the support that might make a difference. That is another thing that it is important that we focus on.

An aspect of the strategy that we are leading on is the work to look at reducing and restricting access to means. Some of the evidence suggests that men might seek to use more lethal means, so reducing access to those means could make a massive difference in helping to disrupt someone's plan and to create a space where intervention can be brought in and support can be provided.

Meghan Gallacher: Would anyone else like to comment?

John Gibson: I agree with what my colleagues have said. I have now walked with thousands of men who have been in crisis, and I come back to the issue of addiction. A major factor that comes out in discussion is pornography. Pornography has become a major addictive issue for men. If we want to speak about addiction and the complete

range of factors that are involved in suicidality, we must put pornography on the table. It is a hugely addictive process for men. As they become more disconnected from their families, their jobs and their communities, it is something that many men dip into and sink into, and it becomes a mire that they have great difficulty in getting out of. It influences a host of things, including their relationships. Pornography needs to be included as a major factor in our thinking on suicidality.

Meghan Gallacher: It is one that we do not speak of at all.

John Gibson: We do not.

Meghan Gallacher: That is definitely a point that we should address.

Dr Davies: Another consideration is the fact that most of the men who have taken their lives have been in employment—they have been working. However, we do not have information on the quality of the jobs that they have been involved in or how risky or stressful some of those jobs have been. The majority of the men concerned have been in employment.

Meghan Gallacher: It is about data harnessing to create prevention. If we do not know what the causes are, we cannot prevent it. It is a cycle and we need to get it right. There are a lot of factors. Although we have a strategy, there are still links missing from the chain, so there is a lot more work to do.

Aidan Mitchell: We need to get better at talking about suicide with men in a safe way so that people know what to do when someone tells them that they are struggling and how to break down the stigma and feelings of shame and embarrassment.

What John Gibson pointed out earlier about rural areas is very important. We are a charity and 80 per cent of the people who we support are in rural Scotland. We know from the latest statistics that the Highlands, Tayside, and Ayrshire and Arran have some of the highest suicide mortality rates.

Rural Scotland has some specific issues. It is not just about a lack of access to services because of remoteness. People are also emotionally isolated, with two thirds of the respondents to our 2017 study saying that they could not be open about their mental health within their community in a rural area. It is a double-edged sword of being physically isolated from services and being emotionally isolated. That has to be put on the record.

Jason Schroeder: Something that is very dear to my heart, which we have not spoken about today, is the military and suicides in our military. I am a veteran myself. I am a marine. I have been to war. A lot of my colleagues have committed suicide. I am not sure about this but, from what I hear, the Ministry of Defence does not release too much information about suicides. I would like that to be recognised, spoken about and changed, for sure.

We can see from our research that about 15 to 16 per cent of the men's sheds that we have done research on have ex-police, fire or military men going to them. We hear from veterans that they miss the camaraderie and they sometimes miss the dark humour used to deal with incredibly traumatic situations and post-traumatic stress disorder. They find it again, in some shape and form not in civilian life but in the camaraderie and the shoulder-to-shoulder banter that happens in the men's sheds—in this place that is protective of male characteristics. I do not think that the MOD is doing justice to our men, and that impacts on our families and the homelessness that our veteran community is faced with in Scotland.

Meghan Gallacher: Thank you very much for that. That is another issue that is close to my heart, so thank you very much again for raising those points. Convener, I am conscious of time, but thank you very much for that.

The Convener: No problem at all.

John Gibson: There is something that we have not talked about today, although we touched on it with NES and Aidan Mitchell touched on it. It is about educating people on how to deal with men who are feeling suicidal. Education is a major part of this and something that we have not talked about today. The strategy talks about children and young people coming on board with benefits from it. I feel very strongly about that and I think that we are in danger of jumping over or hedging around the issue. We need to educate the young people in our schools on how to deal with suicidality and suicidal thinking. I hear that from parents all the time.

Rory O'Connor's work has shown that one in five, or 20 per cent, of young Scottish men and women under the age of 35 will experience significant suicidal ideation. We do not know who they are and we cannot do a blood test for it. We therefore need to identify a way of educating the whole community on how to react in a suicidal crisis situation. We cannot skip that any longer.

I am aware that we are waiting for major evidence to say what we need to do, but we are going to wait a long, long time for that. We need to be bold in Scotland and take a stance on educating our young people in schools, colleges and universities about suicidal thinking and, importantly, suicidal safety planning. That is really important.

The Convener: Thank you for that important contribution, John. Following on from that, we

have also not touched on neurodivergent people, autistic people and those with ADHD. We know that studies have been done and there is data on the mortality rates of individuals in that community and that group. From what we are hearing today, there is a vast amount of data out there, although some still needs to be gathered. Nevertheless, this sort of thing needs to be streamlined in some way.

All of the committee members have asked their questions, but I just want to ensure that everybody has said everything that they want to get on the record. If anyone would like to raise anything before we close the session, they should indicate as much.

Dan Farthing: We have not really talked about the importance of the link between the Scottish Government and local government. We have referenced COSLA a few times, but we need to recognise the vast value in the work that goes on across Scotland through the local delivery leads and other local initiatives.

We at SAMH are very proud of the work that we do in Grampian, where we co-ordinate between several local authorities, the local police, the Scottish Fire and Rescue Service and the NHS on an approach that embeds suicide prevention work in locally generated real-time data and that network of supports. We have talked a lot about the importance of people getting appropriate support for the issues that they face, being able to understand the communities and so on, but the fact is that a lot of that work has to be done locally. After all, everything is local eventually.

When we talked about funding, particularly the importance of secure funding and funding being preserved for suicide prevention, we quickly started to talk about the third sector. However, we need to understand that a lot of that work is done through local government funding, too. If we are thinking about having a more secure funding structure for suicide prevention and working together in the cross-sectoral way that we all believe in, we need to recognise that protecting some of the funding within local government will be very important in achieving that.

John Gibson: I always like to end on a positive note. Given the 762 suicides a year in Scotland, there is a massive number—I would say an army—of people with lived and living experience out there. They come from all kinds of backgrounds—neurodiverse, LGBT, the military and a whole host of others—and we need to bring those individuals on board so that they can share their stories and experiences, because that will be a preventive mechanism in itself. Sharing stories is helpful for those who share but, for those who hear the stories, it is not only absolutely helpful—it saves lives. Therefore, we need to involve the lived and living-experience folks in that community. We call it the suicide community or the suicide family, but we need to use those people much more. They are just sitting there waiting to be used, and we need to use them as part of an army as we go forward.

The Convener: I appreciate those comments.

Aidan Mitchell: As far as the strategy is concerned, a sufficient measure of success will be the building of a wide network of community-based mental health supports that are able to provide support to those in need across Scotland. We know that people want to be supported in the pre-crisis period and in their local community.

Great work is on-going in that respect. The Scottish Government has committed to rolling out the suicide bereavement support service to break the link in people experiencing a suicide and their close family, and there is also the distress brief intervention programme, which is being rolled out across Scotland and has direct benefits with regard to breaking the link in people who are considering suicide. We just have to think about the wider network of support that we are providing to people all across Scotland.

Dr Davies: Just to follow up on what Jason Schroeder was saying, I would point out that prevention works; the evidence is very clear that it is a very cost-effective intervention, but it involves collaboration and people coming together to change attitudes. It is not just about money; yes, money is absolutely important, but a lot of other things are involved in changing attitudes. We need to provide learning and training resources to make people more resilient and able to cope with all the vagaries and inconstancies of life, and we must have the correct type of data and research to build on the evidence and ensure that we are seeing a clear picture or pattern of what is going on. That will allow us to understand and learn from every single death that happens. Moreover, I suggest that there be a guaranteed review of the death, no matter who the person is, with the learning that arises from the death taken on board, too.

11:45

Rebecca Hoffman: I just want to talk about looking forward to the action plan phase and the next stages of development of the suicide prevention strategy, and thinking about ways in which people such as those in minoritised communities and those at risk and with prevalence of suicidal ideation and completion can be involved.

I want to say on the record that we welcome the fact that the Scottish Government has said in the strategy that it is willing to invite new members to join the national suicide prevention leadership group and subsequent boards, and we encourage

it to ensure that the group is diverse and representative with regard to the prevalence of suicidal ideation. We hope that the invitation will be extended to all minoritised groups who experience prevalence of suicide, including LGBT people, asylum seekers and neurodivergent folk.

Jason Schroeder: I would like to draw attention to something that I experienced the other day with Fathers Network Scotland. A lady gave a presentation on pre-natal and post-natal depression among fathers and their suicides; I had never heard about that issue before, and I just wanted to put it on the record today. The lady's husband committed suicide, and she is now running a campaign around the world to raise awareness of the impact of this depression in fathers and the fact that, with our silent and strong mentality, we do not speak about that sort of thing at all. That presentation was very deep and moving.

Secondly, we have mentioned the impact of menopause. Something that I talk about in the movement is andropause, which very few people have heard of. It is the male menopause, which generally happens to men 10 years after the given 50-year-old menopause for women. Men's testosterone and oestrogen levels change, too, and the change impacts on marriages, on men, and on our ability to move or not.

The issue is not really talked about, and it brings us back to the issue of education, education, education about the biological differences between the two genders, and how we can support our partners through understanding and education. Moreover, kids need to understand that dad is now in a very different place; where he used to be the go-to firefighting hero, he now just wants to sit around and do nothing, while mum has moved into a "Let's get up and go" phase. This sort of thing is not talked about at all across our nation, and again, I think that it requires education. It desperately needs to be talked about and understood by families.

Neil Mathers: I will make two or three points that I do not think have been mentioned yet. First of all, though, I want to emphasise Dan Farthing's point about funding to front-line services on the ground and looking at how we support local councils in delivery. I think that that is critical.

We have not talked about the role of the media. There is the potential of increased risk to people in how the media reports on and talks about suicide and the environment that it creates in that respect. As a result, the strategy is looking at how suicide can be reported more responsibly, and I think that more of a focus on stories of hope and recovery would be really good. We often send out the Samaritans media guidelines to media companies to guide their reporting of such issues.

We have not talked about the role of the private sector either. Private sector companies, particularly financial institutions and energy providers, are dealing every day with vulnerable customers, and we need to think about the training and support that those companies could be building into their workforces to ensure that the people in customer-facing roles have the skills and the confidence to support people who are vulnerable and who are dealing with cost of living issues, pressures on their finances and so forth. We should be paying more attention to that area, because the private sector could play a big role in alleviating distress for many people, particularly those under financial pressure.

The Convener: That completes today's evidence taking, and I once again thank everyone for their participation. It has been quite a thorough session, and your contributions have been noted and recorded.

We will now move into private session.

11:49

Meeting continued in private until 12:12.

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