



OFFICIAL REPORT
AITHISG OIFIGEIL

Equalities, Human Rights and Civil Justice Committee

Tuesday 30 April 2024

Session 6



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Pàrlamaid na h-Alba

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EQUALITIES, HUMAN RIGHTS AND CIVIL JUSTICE COMMITTEE

11th 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 Jane Bray (NHS Tayside)

Sam Campbell (Argyll and Bute Health and Social Care Partnership)

Dr Amy Knighton (Royal College of General Practitioners Scotland)

Dr Hazel Marzetti (University of Edinburgh)

Professor Rory O’Connor (University of Glasgow)

Dr Murray Smith (Royal College of Psychiatrists in Scotland)

Shirley-Anne Somerville (Cabinet Secretary for Social Justice)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

Committee Room 4

Scottish Parliament

Equalities, Human Rights and Civil Justice Committee

Tuesday 30 April 2024

[The Convener opened the meeting at 10:00]

United Kingdom Subordinate Legislation

Recognition and Enforcement of Judgments (2019 Hague Convention etc) Regulations 2024 [Draft]

The Convener (Karen Adam): Good morning, and welcome to the 11th meeting in 2024 of the Equalities, Human Rights and Civil Justice Committee. We have no apologies this morning.

There has been a late change in the order of our agenda this morning. Our evidence session on suicide prevention in Scotland will now take place at item 2. Stage 2 proceedings on the Gender Representation on Public Boards (Amendment) (Scotland) Bill will be taken as item 3.

Our first item is consideration of a proposal by the Scottish Government to consent to the United Kingdom Government legislating in a devolved area, as set out in the proposed UK statutory instrument, the Recognition and Enforcement of Judgments (2019 Hague Convention etc) Regulations 2024. I refer members to paper 1.

Members will note that the Minister for Victims and Community Safety first wrote to the committee on 19 March to notify members of the Scottish Government's proposal to consent to the UK SI, which, at that time, the UK Government intended to lay on 6 May. The minister wrote to us last week, on Thursday 25 April, to advise that the laying date is now due to be between 29 April and 2 May but said that that would not affect the process for the UK Government obtaining the consent of the Scottish ministers.

Are members content that the provisions set out in the notification should be made in the proposed UK instrument?

Members *indicated agreement.*

The Convener: Thank you. We are all agreed.

Suicide Prevention

10:02

The Convener: Our next agenda item is an evidence session on suicide prevention in Scotland. Rose Fitzpatrick CBE QPM, chair of the national suicide prevention advisory group, was due to attend this morning but is now unable to do so.

I refer members to papers 2 and 3, and I welcome to our meeting our first panel: Professor Rory O'Connor, from the University of Glasgow, and Dr Hazel Marzetti, from the University of Edinburgh. Welcome, and thank you for attending. I invite each of you to make a brief opening statement before we move to questions from the committee. We will start with Professor O'Connor.

Professor Rory O'Connor (University of Glasgow): Good morning. I will give a bit of context and set out my experience of the work that I have been doing on suicide, and I will say a bit about the model of suicide that I have developed, which underpins or is a framework for the work of the strategy.

I have been working on suicide research or suicide prevention for 30 years. I currently lead the suicidal behaviour research laboratory at the University of Glasgow. Our lab does a range of different sorts of research in an effort to understand the factors that lead to suicide—the psychological, physiological or biological, cultural and social factors—and how we can intervene to reduce the risk of suicide in people who are vulnerable.

In addition to that, we do a lot of policy-related work. Wearing a different hat, I was the president of the International Association for Suicide Prevention, which is the leading global suicide prevention organisation. We work with partners around the world to tackle the fact that more than 700,000 people die by suicide each year and the fact that suicide is still criminalised in at least 20 countries in the world. We also try to promote best practice in research, policy and advocacy, which involves bringing together all partners in suicide research and suicide prevention—everybody from policy makers to researchers to clinicians to people with lived experience.

In touching on that work today, I bring those different hats to the room, so to speak. I am also a past president of the International Academy of Suicide Research.

That brings me on to the integrated motivational-volitional—IMV—model, which is mentioned in the paper and is included in the “Creating Hope Together” strategy. About 15

years ago, in 2011, I tried to bring together into a framework my understanding of the complex set of factors that lead to suicide, to help us to understand and—crucially—prevent suicide. That led me to publish, in 2011, my paper on the integrated motivational–volitional model, which I subsequently updated with my colleague Olivia Kirtley in 2018. I will say a few words about what the model means, which will, I hope, set the context for some of the discussions that we may have this morning.

It begins with the idea that there are two things, at least, that we can do to prevent suicide. First of all, we can prevent people from becoming suicidal; that is the first crucial bit. Secondly, if people become suicidal, we can intervene to make it less likely that they will act on their thoughts of suicide. My IMV model helps us to understand those two questions.

In essence, the underlying premise of the model is that, often, people become suicidal not because they want to die, but because they want unbearable pain to end. That sense of being trapped by mental pain is a key driver in understanding suicidal risk. That sense of entrapment, which we often talk about, is often driven by feelings of defeat and humiliation, which can be triggered by loss, rejection and shame. The question of why people become suicidal is therefore not necessarily about what mental illness the individual has; rather, it is about what factors lead somebody to feel so trapped that they see suicide as a solution—as the way of ending their pain. It is about the tunnel vision of seeing no alternatives.

The work that has been done in Scotland over the past number of years, including by the Scottish Government and the Convention of Scottish Local Authorities—this is the case with the new strategy, in particular—has been about understanding those drivers. We look on a societal level, a community level and an individual level at what the factors are that lead to defeat, humiliation and entrapment. They could be to do with unemployment, sexual identity, bullying, early life adversity, trauma or inequalities.

The first part is about understanding suicide risk and the sense of defeat and entrapment. The second part comes back to the question of what we can do, if we cannot stop people becoming suicidal, to—as I often describe it—interrupt the transition from suicidal thoughts to suicidal acts. The best evidence suggests that about 30 per cent of people who think about suicide cross that precipice and engage in some form of suicidal behaviour.

According to my model, a group of factors that I call “volitional phase factors” influence the likelihood that a person will cross that precipice.

Those factors include things such as having ready access to the means of suicide, being exposed to suicide—in other words, being bereaved by suicide—impulsivity and past behaviours. There is a range of factors, but the key message is that the factors that lead a person to become suicidal—defeat and entrapment—are different from the factors that lead a person to cross the precipice from suicidal thoughts to suicidal acts.

In the work that we are doing in Scotland, we are trying to use the IMV model as a framework to understand and plan and—we hope—prevent suicide. Sadly, we live in a world where 700,000 people die by suicide each year. Last year, sadly, the suicide rate went up by 1 per cent. In England, it went up by 6 per cent in 2023. My concern is that, with the cost of living crisis, we are in a really risky period and that suicide rates might go up again in 2023.

The Convener: Thank you. I invite Dr Marzetti to give her opening statement.

Dr Hazel Marzetti (University of Edinburgh): Good morning, everyone, and thank you for inviting me. I am a senior research fellow at the University of Edinburgh. I work in suicide research and have a specialism in LGBTQ+ suicide and suicide prevention.

“Creating Hope Together” has huge potential to transform the suicide prevention landscape in Scotland. The efforts in the policy to direct care and support towards people living with suicidal feelings, while also stepping back to consider tackling more structural determinants of health, such as poverty, are crucial to reducing suicides in Scotland.

I was really pleased to see in the strategy that LGBTI people are named as a group that might need specialist suicide prevention. I believe that that is really evidence informed, as LGBTQ+ people are consistently and significantly identified as facing systemically higher rates of suicidal thoughts, attempts and deaths across the world. That presents us with a stark picture of why LGBTI people should be prioritised for prevention practices. In my research, I try to build on understandings of why that tragic health inequality exists in the first place.

In my research exploring LGBTQ+ youth suicide in Scotland, young people described to me all the things that one would expect young people to be grappling with, such as challenges with educational assessments, difficulties at home and with friends, and thinking about what to do with their future, but, in addition to that, they also struggled with social attitudes that positioned being LGBTQ+ as somehow different. That, in turn, gave rise to a climate in which homophobic,

biphobic and transphobic bullying became not only possible but somewhat expected.

For some young people, that non-acceptance existed not only at school but at home, with some families finding themselves unable to accept and support a young person's sexual orientation or gender identity. As such, some young people found themselves unable to find a space in their life in which they felt able to exist safely and as a whole person, and they began to experience a sense of what we have called queer entrapment, in which suicide could then become a visible option for escape.

I think that we can all agree that every life lost in that way is a tragedy, so I whole-heartedly hope that, through our work on the strategy and our conversations today, we can find ways to reduce the number of lives that are lost in that way.

The Convener: Thank you for that. We move to questions from the committee. I will kick off with the first question, which is about the creating hope together strategy. Professor O'Connor mentioned that the suicide rate has increased. What impacts do you think that the strategy has had?

Professor O'Connor: It is too early to tell, because it is very early days for that strategy. When we think about the strategies that there have been in Scotland, it is important to look at the worldwide or broader context. From the period of the choose life strategy to the every life matters strategy, there was a marked reduction of about 20 per cent in suicide.

It is always impossible to claim that a strategy reduces suicide—no country in the world can claim that—but if we look at the research evidence, we can say that there seem to be certain elements that are important in tackling suicide. While, sadly, every death from suicide is an absolute tragedy and we should always do whatever we can to reduce any deaths, at the same time suicide is preventable right up until the last moment.

I agree entirely with Hazel Marzetti that the creating hope together strategy is incredibly ambitious, because, for the first time ever—in any strategy ever published in the world, to my knowledge—we are saying that we want to reduce not only suicide but the inequalities that drive suicide. That is a fundamental shift. When I started working in the area, about 30 years ago, suicide was still considered to be a mental health concern. Mental health is, of course, important and we need to tackle it. It is an important driver, but it is only one driver. It is vitally important that we see suicide as a public health challenge, which is what we do now.

I want to make a point about mental health. In western countries, suicide usually occurs in the

context of mental illness or mental health problems. There are some statistics that suggest that, for 80 to 90 per cent of people who die by suicide, that happens in the context of mental illness. However, if we flip that question around and ask what percentage of people who have been treated for depression—which is the mental health problem that is most commonly associated with suicide—die by suicide, we find that the figure is about 4 per cent. That highlights the importance of looking at suicide as a public health concern and looking at the drivers of suicide. The statistics, which will be well known to the committee, show that three quarters of all suicides are by men and that people who live in a disadvantaged area are three times more likely to die by suicide.

Therefore, I am really optimistic about the scale of the ambition to tackle inequalities. In the every life matters strategy, we had 10 actions. Although those were really important actions, arguably, we did not look at the inequalities agenda. If we want to be serious about tackling suicide, we need to tackle inequalities. For me, that challenge requires resource and a genuinely cross-Government and cross-community approach.

10:15

Dr Marzetti: I echo what Rory O'Connor has said. The ambition to tackle those social factors, in addition to providing crisis support, is fundamental to long-term change. Recently, we finished a project to look at the policies from 2009 to 2019. When we talked to the public about their perceptions of such policies, they talked about how important crisis intervention is in keeping people safe in an immediate moment of risk. However, one of the participants in the research said that such action is just suicide postponement if we do not tackle the socioeconomic inequalities. That reflection really stuck with me, and it is an important consideration when we are thinking about such policies.

Professor O'Connor: Hazel Marzetti has just triggered a thought about where suicide prevention begins and ends. Of course, suicide prevention is everybody's business—in Scotland, we have been using that as a strapline for many years. Indeed, globally, Scotland has led the way over the past 25 years in our suicide prevention activities.

We think about people with mental health problems and people who die by suicide in the context of mental health problems. Less than 30 per cent of people who die by suicide have been in contact with specialist clinical services in the 12 months before they die. Two questions arise from that. One is: why is that? Why is the number so low? Is it because people do not recognise that

they need help, or is it because the services and supports are not tailored to their needs?

The second question is: what do we do about that? That is partly a case of ensuring that services are tailored to needs and are accessible at the time of need. Suicidal thoughts do not wait for anybody; they do not respect waiting lists. We can try to tackle that.

However, we also need to look at the roles of other gatekeepers. When we look at the data for people who die by suicide, we find that at least 80 per cent have been in contact with primary care services in the 12 months before they die. Those people often present with physical rather than mental health problems. One of the things that we at the International Association for Suicide Prevention have been calling for is better engagement of primary care in suicide prevention, which will involve giving primary care the time, the resource and the skills to work with people who are vulnerable, especially given how stark those statistics are. Nobody has solved that challenge yet.

The Convener: You mentioned that tackling inequalities will be a key component of the new strategy. What will the barriers be?

Dr Marzetti: I was not involved in development of the strategy, so I will bow to Rory O'Connor's expert knowledge on that.

The strategy contains a beautiful puzzle infographic. I wondered, when reading the strategy, about the extent to which the people who work in all the various domains to do with socioeconomic contributors and the various areas of government think about suicide prevention as a central outcome for their work. That is one of the really amazing things in policy in this area that is not the same as what happens in some of our research, which is more practitioner focused. Practitioner-focused work has to focus on the immediate moment and the immediate interaction, whereas policy enables people to think across all the different areas.

A question that I have left over is to ask to what extent do people in areas outside development of suicide prevention see suicide prevention as a core part of what they are doing and a core outcome.

Professor O'Connor: I absolutely agree with Hazel Marzetti. There are so many different angles. It is partly about—as Hazel suggested—tackling inequalities, which we really need to start doing before birth.

We know that early-life adversity is a strong risk factor for suicide. We have done work in our lab recently with people who have been suicidal in their 30s or 40s. We look at how their body

responds to stress and cortisol. We measure using the cortisol and saliva paradigm in our studies. When we do a stress induction to look at how the body responds, we can predict how much cortisol people will release based on how much trauma they have told us they experienced as children, which might have been upwards of 30 years earlier.

That illustrates the vital importance of putting in as much protection and as many mitigation measures as possible early on in life, including before birth and, crucially, in the periods when we know that the brain is developing. The brain develops right up to the age of 25, but I refer to the early years, in particular, because there is evidence that among those who experience trauma very early in life there are what are known as epigenetic effects. Genetic influences can be turned on and off in the context of trauma, and that turning on and off leads to increased vulnerability, which could be in the context of inequality and social disadvantage.

The figures in Scotland have been great—we have been lifting children out of poverty, but we have so much more to do. If we tackle inequality and ensure that people get the support that they need early in life, in terms of promoting social connections and attachments and providing them with money and resources to live lives that, basically, are not mired in stress and trauma, that will save lives. Not only will it save lives—of course, any traumatic death is devastating—but the economic argument is clear. It is awful to put numbers on people's lives because there is trauma and devastation behind every single statistic, but the Samaritans published figures recently that showed the stark reality that the cost of suicide is about £1 billion a year to Scotland, or £1.5 million per death by suicide.

If we make that investment early in life and across the lifespan, the payback on an economic level—never mind the ethical, moral, inequalities and promoting-equality angles—we see that the benefit it is so clear. We must ensure that we invest for the future, because—as I mentioned in my opening statement—I am concerned that suicide rates will go up in Scotland, because there was a 6 per cent increase in 2023 in England. We have not yet released our 2023 statistics, but we know that the cost of living crisis kills and that austerity kills. We know from the previous global recession that the impact of recessions and austerity is devastating.

Dr Marzetti: I will add a tiny bit to that. Sometimes it is useful to flip what we are talking about regarding suicide. We often think about preventing deaths by suicide, which is a direct thing to consider, but what Rory O'Connor has just spoken to—our work echoes this—is how we

support people to live well and to want to continue to live. It helps me to reframe the matter by thinking about what helps people to live rather than about what prevents them from dying.

The Convener: That is very helpful.

Professor O'Connor: Something else has come into my head from what Hazel Marzetti has said. It links to the distress brief intervention work—a real innovation in Scotland—which is also tackling inequalities. I should have said in my opening remarks—I think that I did not—that I am the chair of the academic advisory group to the Scottish Government's suicide prevention advisory group. For members who are not familiar with it, I note that the distress brief intervention work in Scotland is a brief two-stage intervention for people who are in distress. More than 62,000 people have benefited from the intervention since it started in 2017. It is the first in the world: Scotland is leading the way. Anybody who presents in distress, in any part of the country, I hope, will be offered up to 14 days of specialist support with no waiting list, just immediate support. Independent evaluations have been incredibly positive.

We are working now on rolling that out in schools; I am involved in that. We have developed all the intervention materials and, I think, 600 young people have benefited from DBI.

What is really remarkable about DBI is that it is bringing together the voluntary sector, the statutory sector, the police and education services. I have never seen a cross-sectoral intervention like it. When we started talking about it in 2016, people were sceptical, but the benefits are remarkable, and people are getting the help that they need. It grew out of one of the previous suicide prevention strategies and action plans. I hope that, in time, anybody in Scotland who needs it will be able to benefit from it.

It is also remarkable that the DBI process is engaging people who are more socially disadvantaged in support and care. That is one great example of a benefit. The process required funding; the Government funded it and, across the country, people have seen the benefits of it. We need more such innovation.

The Convener: Thank you so much. I move to questions from Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): Thank you for the very full answers that you have given so far—you have already answered a few of my questions. Can you both explain to the committee why the research is so important, why education, too, is important and how we can really help people?

Dr Marzetti: It is all about understanding the nuances. For example, in my population of

interest—LGBTQ+ people—it is about understanding why some LGBTQ+ young people experience stigmatisation, discrimination and harassment then go on to think about or to attempt suicide, but some do not. It is important to me to understand those important nuances and to understand then what we can do to cultivate environments in which none of those young people wants to end their life. However, we are only at the start of that journey and I would say that the evidence is very much in its infancy.

On education, I do not know whether I have understood your question, so please correct me if I do not answer it properly. Education on suicide and suicide prevention often focuses on destigmatising suicide: we do lots of work on that. Something that I have been thinking about a lot, following the project that I mentioned and which I have completed, is how important it is not only that we think about destigmatisation of suicide and focus directly on suicide, but that we think about destigmatising other experiences. I am thinking in particular of people who are living in poverty and are, perhaps, in receipt of benefits, and how to not stigmatise that in the ways that we see now. We are seeing lots of stigmatisation of people who are in receipt of benefits, which makes things really difficult. Destigmatising of being in receipt of benefits is, for me, a core part of destigmatising suicide.

Professor O'Connor: I agree and will add to that. I would say, in response to the important question of why research is important, that suicide prevention begins with understanding, and understanding has to be evidence based, otherwise all we have is guesswork. That approach is so important when we look at interventions, because they have the potential to do harm as well as good.

In the work that we have been doing for many years at the University of Glasgow, we have been trying to build the evidence base. I have touched on the idea that suicidal people are often trapped by mental pain, but the drivers of that pain are unique and depend on one's characteristics, background, who they are and so on. Currently, we are doing work on neurodiversity that includes people with attention deficit hyperactivity disorder and autistic adults in order that we can understand how those individuals view the world and how their views and experiences of the world increase their risk of suicide. That personalised and tailored approach is absolutely fundamental.

As for learning and education, I genuinely believe that suicide prevention is everyone's business. It is a complex issue, but there are universal strategic and broad public health approaches being taken to destigmatisation. We need to educate people about the warning signs of

suicide, alongside having specialised clinical or other psychosocial interventions for high-risk groups. After all, the evidence tells us that even small things can make a difference.

We have, for example, been doing work on safety planning, which is a very brief six-step intervention that we hope will interrupt the transition from suicidal thoughts to suicidal acts. It is not trying to solve what has led someone to become suicidal; instead, it tries to reduce the likelihood of, or to interrupt, that transition.

With funding from NHS Education for Scotland, we have developed four modules that will be available to anybody. They track a lot of our work on understanding and preventing suicide, but they also cover how to do safety planning. Initially, that was done with clinicians, but we are trying to argue that, with a public health approach, any one of us could work with somebody whom we are concerned about on developing a safety plan. In the first year of the strategy, we have been working with the national delivery leads and partners on making safety planning, which is a fairly simple intervention, more widespread and taking it into places of employment, universities, colleges, general practices and beyond.

That is why education is vital. On the ground, even small things can make a difference alongside more complex and detailed interventions and work on upstream stuff such as tackling inequalities.

10:30

Evelyn Tweed: What challenges do you both face in your research?

Professor O'Connor: Funding—it would be remiss of me not to highlight the funding issue. I am a trustee of MQ Mental Health Research, which is the only dedicated mental health research charity in the UK. A few years ago, it did what is known as a research landscape survey to look at the funding that was being invested in mental health compared with funding related to other major causes of death, such as cancer. The statistic is really stark. If we compare research funding for every person who is affected by mental health—not suicide specifically—with research funding for every person who is affected by cancer, we see that research funding for cancer research is 25 times what it is for mental health research, and suicide prevention research gets only a small proportion of that.

The landscape has changed; it has definitely got more positive, but we still have a long way to go. No way is there equality or parity of esteem for funding for mental health or suicide prevention research, which is difficult to do, but we are ready and waiting. We do try; thankfully, we have been

very fortunate over many years to secure funding, but it is a more difficult task, as each year passes.

Evelyn Tweed: In previous meetings I was really interested to hear about Professor O'Connor's work on the biological predisposition to suicide. You have also talked about the integrated motivational-volitional model, today. Are there any specific challenges in that research, and will you give us an update on where you are with it?

Professor O'Connor: I see suicide as a biopsychosocial phenomenon. In terms of the causes of suicide, a perfect storm of factors comes together. There might be some biological or genetic vulnerability factors—predisposition or a diathesis—that interact with environment, including the social context and psychological and clinical factors. For me, the cultural, social and biological factors all interact to impact on how you view your world.

I argue that suicide is ultimately a psychological phenomenon. It is a devastating behaviour that people engage in. Basically, the individual feels trapped with their mental pain, which is a psychological process that leads them to think about suicide.

With regard to the biological evidence, in terms of genetic vulnerability there is no one gene for suicide: we will never have a gene for a behaviour. We do genome-wide association studies, which look across the genome, and there is evidence that there is stuff going on; there are areas of vulnerability.

In relation to biological vulnerability, I mentioned the cortisol system. Early-life trauma is important because the cortisol system is our fight-or-flight response. When we encounter a threatening situation, we need cortisol to be released to prepare us either to fight or to flee. However, we think that cortisol is also important in decision making, emotion regulation and problem solving.

If someone comes from a traumatic background—that trauma can take any form—their body has always been “on”; it has been repeatedly stressed. Their production of cortisol has been repeatedly challenged, and over time, they have what is known as dysregulation of the cortisol response—the hypothalamic-pituitary-adrenal axis is the technical term—which becomes completely blunted. As we show in our experimental studies, when people say that they have attempted suicide and we take an experimental look at how their body responds to stress, we see that they release less cortisol, which means that they are less prepared to deal with challenges. If we put on top of that that they feel trapped, have no job, have no relationship, feel isolated or are experiencing bullying and trauma, we can certainly see where that perfect storm of factors, both biological and

psychological, comes together. However, we need to do more such research because there are lots of gaps in our knowledge. That work is difficult to do, but we are trying to do it.

Evelyn Tweed: Professor O'Connor, you said that right now is a particularly risky time. As MSPs, we can see that in our inboxes; the cost of living crisis is really cutting in. What can we do now to interrupt suicidal thoughts?

Professor O'Connor: We need more resources, but we need to target resources so that the people who are most vulnerable are supported.

Many of us in the suicide prevention field were concerned that Covid would lead to an increase in suicide rates, but Governments around the world, including the Scottish Government, responded quickly to provide safety nets for the most vulnerable people. Those safety nets undoubtedly saved lives, and the sense of social connectedness and social cohesion that we all experienced during the early phases of Covid saved people's lives, too. During the cost of living crisis and the financial concerns that it brings, we need to intervene so that people have money to live on and provide for their families.

Work from Brazil showed that use of conditional cash transfers prevents suicide—it showed that providing money to families to stay alive and feed themselves prevents suicide.

We need to consider who is most vulnerable in the cost of living crisis. Three quarters of all suicides are by men, so what is the impact of the cost of living crisis on men—especially middle-aged men, which is the group who are at greatest risk of suicide? We need to ask questions including questions about how we can provide targeted and universal support as we navigate choppy waters.

The suicide rate in the UK went up by about 1 per cent last year. In the United States, it increased by 16 per cent. Suicide is a real challenge in the western world. Nobody has found the right answer to how we solve that, but we know, from the previous economic crisis, that countries that took safety-net approaches saved lives. Those countries had much lower increases in suicide rates.

Lastly, we need to ensure that there is access to services.

Maggie Chapman (North East Scotland) (Green): Good morning, both. Thank you for your comments so far, and for joining us this morning. I will talk a little bit about some of the different groups that are perhaps disproportionately affected.

Hazel Marzetti, you mentioned in your opening comments the very clear recognition in the strategy and in your research of the impacts that LGBTQIA+ communities face. Can you say a little bit more about why it is so important that the strategy recognises the disproportionate effects on different groups? Have we got the strategy right, now?

Dr Marzetti: It is important that LGBTQ+ people, and a variety of other groups that are mentioned in the strategy, are named specifically, because often services and local authority areas look to such strategies to give them an idea of what to do and what to prioritise. Making sure that it is very clear that LGBTQ+ people are a priority for prevention practices is important, because it sends a message to other services and organisations, to say that we need to pay attention to that group.

I am sorry, but could you repeat the second part of your question?

Maggie Chapman: Are we getting it right in the strategy, around not only identifying the most at-risk groups, but understanding how and why they are at risk?

Dr Marzetti: That requires a very complicated answer. Particularly for the LGBTQ+ group—which is the group that I know the most about—we have to think about things more broadly. Today, we have talked a lot about the combination between support at a time of crisis and longer term, more structural support.

In the study that I talked about at the beginning, with LGBTQ+ young people, we talked a lot about the balance of crisis support. A person should be able to go somewhere and have easily accessible support when they do not feel able to keep themselves safe from suicide, but we should also be thinking more broadly about what is happening in wider society. If homophobia, biphobia and transphobia are much more acceptable in wider society—if that is seen as okay—crisis support is going to be limited in its effectiveness.

Making sure that we think about both structural and personal issues is important for at-risk groups, as is considering the broader strategy. We have to think about how we can do that, because it is important. I am not certain that that is in the strategy, because the strategy does not have a tremendous amount of detail. LGBTI people are named as a group that might need prioritisation, but there is not a lot of detail about what that would look like. I wonder whether in future that might be built out a bit, to ensure that it is clear what we are doing.

Maggie Chapman: When you say “built out a bit”, is that about the cross-organisational, cross-

community working that you have both already talked about?

Dr Marzetti: Yes. It also involves thinking about what the details look like. What would a prioritised or tailored approach to LGBTQ+ suicide prevention look like? I am just starting up some research work on that, but it would be fantastic to see that from a policy perspective, too.

Maggie Chapman: You have both talked about poverty and financial and economic inequality as well—it is about being able to track back through all those factors.

Dr Marzetti: Yes—exactly.

Maggie Chapman: I have similar questions for you, Rory O'Connor, about groups that we know, from the data, to be at high risk. Do we necessarily understand why? I am not asking specifically about neurodivergent people, but you mentioned them in particular.

Professor O'Connor: The short answer is that, for many groups, we do not yet know why they are at increased risk. For the neurodiverse populations, that is precisely why we are doing the work. The ADHD UK charity, which was set up in memory of a son lost to his mother through suicide, has funded some of our work in that regard, and we are trying to understand that in the context of the IMV model.

Similarly, we are doing work with autistic individuals to understand the particular factors for them. There seems to be a masking and camouflaging with autistic individuals. Continually living in a world where you are trying to pretend you are something that you are not is so exhausting—it is mentally exhausting. That is one particular factor that is emerging there.

We are also doing work with my colleague Heather Wardle at Glasgow on gambling harms. That work has just started. We know that there is a relationship between gambling and suicide, but we do not quite know who is most at risk. In the context of the IMV model, we are trying to understand that better. We are trying to understand the particular characteristics of people who engage in certain gambling behaviours and those who are in certain demographic or social contexts.

For me, the most important thing is ensuring that we have the data and research evidence in place. One outcome that we are pursuing is to ensure that we get the right data to answer the right questions. Although we have data on suicide, our data on non-fatal suicidal behaviour is very patchy. Some of the national surveys include questions on that, but they are not large enough, in my view, for us to take an intersectional approach to understanding different groups of

people at risk. A few years ago, we did the largest-ever—and only—study on young people in this area, trying to determine the prevalence of suicidal thoughts and behaviours in young adults. Such studies require a lot of investment, but they are so worth while, because they allow us to understand better who is at risk and why.

We should be trying to get more real-time data on suicidal thoughts, self-harm and suicide attempts, which could allow us to consider intersectionality at substantial scales. That would involve more real-time monitoring of data. In England during Covid, near-real-time reporting of suicide was established, and the 2023 data on suicide have just been reported on. We will have to wait until the autumn for ours. If we can do more to understand changes in patterns of people at risk earlier, then we can intervene. That is my hope and aspiration.

Dr Marzetti: I will jump in here on the point about intersectionality. Sometimes we think about particular groups, such as men, LGBTQ+ people, people who gamble and autistic people, as being quite separate, but there are lots of people in the middle of that Venn diagram. Sometimes it is quite difficult to hold that in our minds, and we can forget about it easily when we are working with a specific population, but it is so important to take that intersectional approach and to see the various crossovers. For instance, gay and bisexual men are part of the LGBTQ+ community, but as men, they are also part of another group that is at risk of suicide. It is so important to think about that.

Professor O'Connor: In addition to that, there is one group that may have been overlooked in recent years: women. According to the suicide statistics in Scotland and, most recently, in England—where there have been larger numbers, so it is easier to see trends—there has been an uptick in female suicides. Three quarters are still men, but real-time monitoring is so important, because we can see where something is going on and where we need to intervene. Five or 10 years ago, we could see that suicide rates among young people were increasing. We can try to intervene in such cases to see what else we can do. That is only one category, but intersectionality just increases the risk.

10:45

Maggie Chapman: There is that challenge to consider between the targeted approach and the whole-society approach that understands that none of us has just one identity and we all have multiple characteristics. Last week, we talked about other groups that are identified as being at risk, such as asylum seekers, refugees and former prisoners. The stats for former prisoner suicide in the first week post-release say something quite

stark about what we need to do in our post-release planning and support. Does how we understand those issues and those at-risk groups all come down to data and therefore tracking through to resource?

Professor O'Connor: I do not know whether this will answer your question, but I will give it a try. The stats that you just mentioned about suicide within seven days from release are stark, and there is the same data for suicide following discharge from psychiatric hospitals, so that seven-day period is crucial.

The National Confidential Inquiry into Suicide and Safety in Mental Health, which covers the whole of the UK—it used to be called the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness—tracks all the suicides of people in contact with mental health services or the justice system. The guidance is really clear—we need to make sure that we have continuity of care at discharge or release. I know that the national delivery lead, Haylis Smith, is working on that with her partners across the outcomes. It is about making sure that the key principles of the NCISH guidance to prevent suicide are implemented. Those principles include that joined-up approach to discharge. It is the same thing with discharge from a hospital after a suicide attempt. If you present to the emergency department, you are more likely to reattempt, if you are going to, within those days and weeks. That continuity of care is absolutely vital, and we need to ensure that it is joined up. I know that that work is being actively considered.

Maggie Chapman: This is my final question, because I know that other people want to come in on monitoring. It is about something a bit less tangible and perhaps harder to quantify and collect data for—the kind of intergenerational risks that are associated with conflict. As more and more of that is experienced not only in our own society but elsewhere, do we have an understanding of people who have lived in conflict societies and the impact that that has on them post-conflict? The impact could be felt decades later.

Professor O'Connor: Yes. I am Northern Irish. We have done work on that in Northern Ireland, and the evidence is clear. Intergenerational trauma has an impact for 20, 30 or 40 years. New members of our society who have experienced that are at increased risk and we have done some work with Scottish Action for Mental Health on trying to understand the situation for asylum seekers and refugees, which is a very important issue. We understand it, but I do not know whether we have done enough yet to ensure that those people are supported during that vulnerable period of time in the immediate period, and then over time.

Marie McNair (Clydebank and Milngavie) (SNP): I do not know whether you are in a position to give the committee your view on this question, but do you feel that people with lived experience of suicide were meaningfully involved in the development of the strategy? If you cannot respond, it is okay; perhaps the next panel will be able to answer.

Professor O'Connor: I can answer that question, and the answer is yes. Scotland leads the way on this, and, with my International Association for Suicide Prevention hat on, I know for certain that we have been one of the first to properly engage people with lived and living experience as equal partners. I am the chair of the academic advisory group, which feeds in evidence, and I am an equal partner to the people who have lived and living experience. I met the new panel very recently to see how we can work together, and I know for certain that the people who have lived experience are fundamental to all the work of developing the strategy.

I speak as somebody who also has lived experience. I have twice been bereaved by suicide, so I bring a number of different hats. Before I was bereaved by suicide, I thought that I had some sense of what it is like to lose somebody to suicide, but I did not. That approach is fundamental to everything that we do in Scotland, it is recognised as an example of excellence by the World Health Organization, and it will only get better and more embedded.

Marie McNair: In what way can people with lived and living experience of suicide be involved in the implementation of the strategy? What challenges do you envisage with that?

Professor O'Connor: Their experiences are fundamental to implementation. For example, we always involve people with lived experience in our research. An example might illustrate that. We are undertaking a safety planning trial and are trying to implement it in a national health service context. We are working with our lived experience partner, Suzy Syrett, who is one of our co-applicants as well. With her experience, she was able to tell us about giving the safety plan to people who are discharged from hospital. When a person is discharged from hospital, they get loads of material and their safety plan gets lost. She told us that, if the colour of the safety plan is changed, people will know where to get it in a moment of crisis. That is just one concrete example of implementation.

When we think about all the work in the strategy, we need to involve people with lived experience to ensure that we know what the barriers to implementation as well as the facilitators are. That is something that we are actively doing. In the academic advisory group,

when we do work on safety planning to improve education, people with lived experience are at the centre of that work. There are lots of other examples.

I cannot remember the last part of your question.

Marie McNair: What do you envisage the challenge to be? You have touched on that a wee bit.

Professor O'Connor: We have to ensure that we keep people safe. Working in suicide prevention is tough work for all of us, especially those with lived and living experience. Obviously, Scottish Action for Mental Health is the lead network at the moment. That is central to everything that we do.

It is also about recognising that lived experience is unique. Trying to get the right breadth of lived experience is always a challenge, and we have been really conscious of that in ensuring that we have intersectional representation. I hope that that will always be reiterated and updated.

Paul O'Kane (West Scotland) (Lab): I want to return to the implementation and resourcing of the current strategy. I appreciate that, in previous answers, there has been a call for more funding for research, which is important. The creating hope together strategy has anticipated that some of the £2.8 million will be used to fund research. Can you expand on the details of where that money or additional resource could be spent, not just in research but on other elements that you think would be helpful to complement that?

Professor O'Connor: I will answer that question broadly initially. On resourcing for the strategy, there is a resourcing target for the specific activities that are included in the strategy. That includes access to mental health services, of course. We need to get to the 10 per cent to ensure that we have any chance of meeting the needs of those who are most vulnerable, because the need will continue to grow.

More broadly, on one of the challenges and one of the most aspirational parts of the strategy, there is a list of the commitments from across Government departments in annex A, I think. We need to ensure that they are funded and supported. There are two bits to that. One bit is about ensuring that people in those different Government departments recognise the role that they can play. That is an important element. The second bit is that, given that we know that resources are tight now and are getting even tighter, do we need to think about whether there are ways of ring fencing funding so that there is funding for suicide prevention activities specifically? I go back to the previous point that

that is money well spent. It not only prevents suicide; economically, it makes sense.

On the research component, once we identify, working with Public Health Scotland, the key gaps in data relating to suicidal ideation, suicide attempts and intersectionality, will funding be available to do the research—quantitative but, crucially, also qualitative—so that we understand better why the risks increase? We need to ensure that that funding is made available.

There are three levels: dedicated crisis support, the public health bit across Government departments and the specific research.

Dr Marzetti: To add to the note about funding, something that participants in the two studies that I have spoken about have found particularly difficult is what happens if suicidal people are encouraged to reach out and share their suicidal feelings but there is not enough resource to catch them. It is hard for them to take what we all agree is the really difficult step of telling somebody what they are feeling, and if there is a long waiting list or a dismissive attitude, or if people feel that they have to wait until they are bad enough to engage with the service, that is a missed opportunity for us to provide care and support to people who really need it. That is what I would add to the conversation on funding.

Professor O'Connor: Something else has just come into my head: we need long-term funding. Short-term funding is too short term; if we are to make a real difference, we need long-term commitment. I understand the constraints around how Government works, but my plea would be for some way of guaranteeing longer-term funding to ensure that we deliver. We can look at intermediate markers, and we have not mentioned the outcomes framework yet, but it has been a real innovation. Most suicide prevention strategies do not have an outcomes framework and then we are surprised when they do not work. It is therefore great that have that outcomes framework, because it indicates for the next period of time whether we are being effective and means that we can guide resources accordingly.

Paul O'Kane: That is interesting. The discussion that we had last week while taking evidence from third sector and voluntary sector organisations came from very much the same space in talking about sufficiency of funding and longer-term funding. We had interesting contributions about being able to test changes, try things and support people in a more informal way. That perhaps comes back to Dr Marzetti's point about people who use informal spaces such as men's sheds or some of the preventative organisations feeling that they can share more openly. Do you recognise the concern that there is

not sufficient long-term funding to allow such organisations to try things?

Dr Marzetti: I will speak to what that is like in the LGBTQ+ space. Those are sometimes the important services that people feel able to access. If they have gone to their GP and are on a waiting list, those services can hold people in the interim. Making sure that funding is available to support such activity is crucial.

Paul O’Kane: Let us move on to talk about what is working in the strategy and measuring success. Professor O’Connor touched on this. A reduction in the overall number of suicide deaths is not sufficient in terms of the measurements that we are trying to make. What further reporting do we need on that? On the financial element, is it important that the Government is willing to put down in black and white exactly where and how money is spent and to report that to Parliament and those who are invested in the strategy?

Professor O’Connor: I will answer the second part of your question first. Transparency is, of course, vital and, when I was on the leadership group for the previous strategy, we did that. I assume that the same will happen with this strategy, because it is important. The tricky bit maybe relates to what I said earlier about ensuring that we have cross-Government funding, support or resources.

On other data, I have already mentioned the importance of trying to monitor the precursors to suicide, such as suicide attempts and suicidal thoughts. The single best predictor of whether someone will die by suicide is whether they have attempted suicide previously, so we need to be able to monitor that, but we just cannot and we do not. We have some data on hospital-treated self-harm, but it looks only at those who present to emergency or clinical services and it needs work to be more robust. We do not have data on suicide attempts.

As I said earlier, we need to look at suicidal thoughts and behaviour in the community. Yes, those are in some of the national surveys, but the surveys are not large enough for us to understand who is particularly vulnerable or to do fine-grained analysis of that. I support a call for that.

On other indicators and outcomes, we need to look at society. Years ago, we used to monitor mental health stigma in Scotland and we could see how the situation was improving and how people’s awareness of suicide prevention and mental health strategies was increasing. It is important that we do that so that there are other indicators that people are engaging with or understanding what we are trying to do at the Government level, especially if our motto—I firmly agree with this—is that suicide prevention is

everyone’s business. We need to get those messages out to more people and understand who those people are and what their needs are.

We also need to understand different populations. What are the needs of people in the workplace versus those of people in a community organisation versus those in the statutory sector?

11:00

The Convener: Thank you. Do any other members wish to come in?

Annie Wells (Glasgow) (Con): I would like to go back to Professor O’Connor. You spoke about the distress brief intervention programme, and I have just been reading up on it. Can we do more to let people know that it is there? I have lost someone to suicide—not a personal friend but a friend of the family—and it is their funeral today. I do not think that enough was done in their case, and I do not think that the person or their family knew where to go for help and support. Can we do more with that?

Professor O’Connor: Absolutely. The DBI work is phased, and the end of March this year was the end of one phase of that work, which was effectively trying to ensure that DBI is available anywhere in the country. In the next two years, which will be the embedding phase, we will try to do exactly that. We will look at what else we can do to understand the preventative benefits of DBI by working with colleagues in ScotCen—the National Centre for Social Research, led by Joanne McLean—where we have a research project funded by the National Institute for Health and Care Research that is trying to understand whether DBI saves lives, first of all, and the elements that are effective and what else we can do. That is one part of the work.

We are also working with our colleagues in DBI central—the central team in DBI—for the next two years to see whether DBI can be tailored for different populations. We are at the exploratory stage of that work. We are also looking at making it more accessible and we have been developing the digitisation of DBI resources so that more people can understand and access it. As part of that work, we have developed a module on recognising and responding to distress, which was published about a year and a half ago. Again, that is a resource for anybody. That is what we hope to do.

Annie Wells: Thank you.

The Convener: As I see no indications from members that there are more questions, I thank you both for attending today. Your contributions have been invaluable.

I suspend the meeting for five minutes.

11:02

Meeting suspended.

11:13

On resuming—

The Convener: I welcome to the meeting our second panel on suicide prevention in Scotland: Dr Amy Knighton, Royal College of General Practitioners Scotland; Dr Murray Smith, Royal College of Psychiatrists in Scotland; Sam Campbell, health improvement principal, Argyll and Bute health and social care partnership; and Dr Jane Bray, consultant in public health, NHS Tayside. I thank all of you for attending this morning and invite each of you to make a brief opening statement before we move on to the committee's questions. I will start with Dr Knighton.

Dr Amy Knighton (Royal College of General Practitioners Scotland): Good morning and thank you very much for inviting the RCGP to be here this morning. I am a GP partner up in Carnoustie; I am chair of the RCGP's east Scotland faculty, and I was part of the previous iteration of the national suicide prevention leadership group.

Perhaps I can give you a little bit of background. RCGP Scotland represents around 5,000 members of the GP workforce in Scotland. Our purpose as the professional membership body is to encourage, foster and maintain the highest possible standards in general medical practice, supporting GPs from their time as medical students through their training and qualified years to their retirement.

11:15

Every suicide is a tragedy, and GPs do everything that they can to help people in crisis and to prevent anyone from reaching that point. Such a devastating and traumatic event often has repercussions for future generations, too. RCGP Scotland recognises the prime importance of societal and public health factors in preventing suicide and supports efforts to address them.

The college also asks for deeper recognition of the key role played by general practitioners and their teams in the provision of primary care mental healthcare. It also feels that the lack of investment in services and the workforce is a key barrier to the ability to reduce suicides in Scotland and to deliver preventative and upstream action. Access to GPs, primary care team specialists and third sector support is crucial in influencing suicide prevention.

Dr Murray Smith (Royal College of Psychiatrists in Scotland): Good morning, and

thanks for the opportunity to participate in today's session.

I am a consultant liaison psychiatrist at Aberdeen royal infirmary and I also lead the unscheduled care mental health service in Aberdeen. Among other things, I regularly work with people who have self-harmed or have attempted suicide. Today, I am representing the Royal College of Psychiatrists in Scotland, in which I am vice-chair of the liaison psychiatry faculty.

Just by way of background, I point out that the college is a professional medical body for psychiatry in Scotland, representing and supporting psychiatrists and aiming to improve outcomes for people with mental illness and their families and communities. As a devolved nation council of the Royal College of Psychiatrists, we represent more than 1,400 members, fellows, affiliates and pre-membership trainees in Scotland.

I want to make three statements on suicide prevention and the strategy. First, it was published at a very important time in Scotland. In my job as a member of the NHS's front-line staff, I regularly see at first hand the devastation caused by self-harm and suicide, and I regularly discuss the issue with colleagues in my department and at wider college meetings. Like many stakeholders, the college welcomed the strategy's publication, and we were pleased to be represented on the national suicide prevention leadership group, which led to the strategy's development. That said, we think that it will be difficult for the strategy to deliver all of its aims and objectives, what with tightening budgets and the difficult financial state.

That brings me to my second point, which is about funding. The Government has never—or at least not yet—met its commitment to allocate 10 per cent of the total NHS budget to mental health services, and that will have negative ramifications for suicide prevention in the short and long term. Scotland, like the rest of the UK, is facing difficult economic conditions, and such periods bring added stresses to individuals and an increased risk of suicide. It is therefore important that at such times the Government increases—not reduces—funding for the provision of mental health services.

My last point on the strategy is about patients, particularly those in mental health services. The college's overall view is that the strategy's aspirations and approach are sound, and we welcome the whole-system approach and the commitment to extending and developing learning reviews of all deaths by suicide. However, there perhaps needs to be stronger emphasis on people moving and transitioning through the system from, for example, child and adolescent services to adult services and on patients moving from in-patient

services to out-patient follow-ups. In our experience, it is among those groups of patients that death by suicide is most likely.

I am sorry to end my statement on a somewhat morbid note, but I think that my time is probably up.

Sam Campbell (Argyll and Bute Health and Social Care Partnership): Thanks for having me here today. I am the health improvement principal in NHS Highland, covering the health and social care area of Argyll and Bute, which, as you will understand, is a remote, rural and island community.

Although a distinct and beautiful region, Argyll and Bute faces a number of challenges. For such a rural health and social care partnership, the geography and demographics can, at times, be perceived as challenging, but we use that as an opportunity to push boundaries through innovation and by building strong and resilient communities.

The region has one of the lowest population densities in Scotland, with more than 86,000 residents spread across the second-largest local authority area in Scotland—only Highland Council covers a larger land area. Some 17 per cent of the population live on islands and 43 per cent live in remote and rural areas. The economy is mainly service based, with higher levels of employment in areas such as agriculture, fishery, forestry and tourism than elsewhere in Scotland. Due to the seasonal nature of those posts, levels of unemployment fluctuate throughout the year.

One of the region's biggest challenges is changing demographics. Since 2011, the population of Argyll and Bute has decreased by 2.4 per cent and is projected to fall a further 5.9 per cent from 2018 to 2028. More than 25 per cent of the population is aged over 65, and there is a net outmigration alongside a natural decline in the population. It is, therefore, essential that Argyll and Bute strives to be an area where people can live good lives doing well-paid jobs and living in affordable homes.

Argyll and Bute and other remote and island communities require innovative and bespoke solutions to the challenges of addressing suicide. Robust communities with a strong third sector help areas to survive and thrive. Key areas and action that the strategy can support us with include infrastructure, such as housing, transport and support services; a focus on preventative activity and improving the social and economic determinants of health; ensuring capacity in all parts of the system through well-staffed and supported services, including those in the third sector; and the collection of and access to appropriate and robust data that caters for remote, rural and island communities.

Dr Jane Bray (NHS Tayside): Thanks for inviting me to the meeting. I am a consultant in public health in NHS Tayside and I have a remit for mental health and suicide prevention in the Tayside health board area. Also, I sit on Public Health Scotland's public mental health special interest group—a national group that advises the Scottish directors of public health on anything to do with mental health—and have previously served as its co-chair. In the Tayside area, for the past six years, I have chaired the Tayside multi-agency suicide review group and lead strategic suicide prevention work.

I welcome the fact that the suicide prevention strategy includes an upstream focus. That is absolutely crucial if we are to do work on preventing suicide, particularly in relation to socioeconomic deprivation, which, as I am sure that you are all aware, has a strong association with suicide, as we see very much in our local suicide deaths, particularly in the city of Dundee, which is a very disadvantaged city area.

From a public health perspective, we need better data. We have data around suicide deaths—that is improving, and is addressed in the strategy—but, as Rory O'Connor mentioned earlier, we do not have good data around self-harm. Further, we do not have routine data collection in our community mental health services and non-statutory services in the third sector. If we are to evaluate what our services are doing and see what is happening in our population over time and identify trends and changes, we need that data. As well as being used for the evaluation and implementation of services, the data is crucial in terms of research, which we need a lot more of in this area. Unfortunately, there is limited research into public health generally and public mental health in particular. The more funding that we can direct into that important area, the better.

There is no one strategy that can prevent suicide, so I am pleased to see the strategy join up across policy areas. Finally, I highlight that, as my colleagues have said, we see challenges in our local services.

The Convener: Thank you all. We move on to questions from the committee. I will start. What impact was made by the previous strategy, "Every Life Matters"?

Dr Knighton: The previous work, which I was part of through the national suicide prevention leadership group, was invaluable. It helped to increase suicide awareness and training, with the United to Prevent Suicide movement. The awareness of the importance of lived and living experience was a big part of that. It has laid good foundations.

Dr Smith: I agree with my colleague from the Royal College of GPs. Given all the successive strategies, it is clear that suicide prevention has been high on the Government agenda. It is important to keep the momentum going and keep focus and funding on those things, so that the strategy can deliver.

As others have said, the issue cannot be kept in isolation and there are a lot of related strategies. Lots of different issues lead to suicide attempts or death by suicide. In my day-to-day, front-line work, I have not noticed whole-scale change from the previous strategy, but it is still fairly early for us to see the outcomes of the strategies—what is working and what is not working.

Sam Campbell: I agree with the previous speakers on the requirement for momentum on suicide prevention. That has been there, but we need to keep it going and we need to recognise that strong, vibrant and sustainable services and third sector partners are absolutely vital in tackling suicide.

Dr Bray: I, too, agree. It has taken time to build the momentum. We are seeing changes now, and more awareness across local areas. The challenge is around sufficient local and national resource to bring that momentum. The lack of consistent funding to the third sector to drive forward change impacts locally on what can be delivered, sustained, evaluated and moved on over time.

The Convener: Were there any gaps in the previous strategy that are now covered by the new creating hope together strategy?

Dr Bray: As I said, the upstream prevention and the focus on multiple policy areas are very much welcomed. I would like a bit more detail around how we are going to see that in practice. What will that be? For example, Public Health Scotland recommends health impact assessments. Those can be done for all strategies, policies and new service plans, as a way of looking at health—focusing in particular, for example, on mental health and suicide prevention—as a way of seeing the impacts of different policies and strategies and as a way of driving us forward in the direction that we want to go. I would like to see some of tangible outcomes being looked for in that work.

Dr Smith: The big bits are the focus on the whole-system approach—thinking about the role of everyone, including the third sector and clinical staff—and the development and extension of learning reviews from each death by suicide. Every local area will have its own processes, such as adverse event reviews, but those are not always as joined up as they might be and they apply only to known patients. The focus on

learning from all deaths is therefore welcome and very important.

The Convener: I turn to staff training. From your perspective as healthcare providers, are there areas of development that could help healthcare staff to realise the new strategy?

11:30

Dr Knighton: Part of what RCGP Scotland is pushing for is the return of the protected learning time that general practitioners had, which NHS 24 covered. That gave us time to come together as practice teams in primary care in order to learn together and embed the strategy. The difficulty with day-to-day general practice at the moment is that there is no capacity to take any extra time out for learning because we are too busy, given the workload and the workforce issues. Getting that protected learning time back to allow us to have the space to learn is super important.

Dr Smith: I entirely agree that protected time is needed for learning, to work out who will do reviews and to do them properly. From my experience of having been involved in a few adverse event reviews, I think that it is important that clinicians are involved in them, as well as other members of the team.

The strategy does not always recognise the difference between clinicians and others who are involved. Psychiatrists and mental health nurses have specific training in this sort of thing, and it is our day-to-day job. It is also an important part of the jobs of other members of the team, including GPs and other clinicians; they get training, but they do not always get as much as they want. Training courses on psychiatric emergencies and so on are delivered by health boards, universities and other providers, but there is not always enough time or funding for people to attend them.

Sam Campbell: I agree with what has been said. A number of years ago, I managed the choose life strategy programme in Argyll and Bute when we had the health improvement, efficiency and governance, access and treatment—HEAT—target that was directed at 20 per cent of front-line staff being trained in suicide prevention and intervention skills. That was a valuable way to direct areas to prioritise the training and provision of support. The challenge that we had in implementing that lay in being able to release staff, mostly in health and social care partnerships, to attend.

I highlight the importance of members of the public and third sector partners. Informal services that support our vibrant communities regularly come into contact with people who are in crisis, and it is really important that we upskill them so that they are better able and supported to

intervene and to recognise suicide, and that they are skilled, confident and comfortable with that.

Dr Bray: In the work that I am involved in, training is progressing very well, particularly with regard to third sector staff and non-statutory agencies. That works well locally. However, there are challenges in having the capacity for people to attend training, and there are a lot of competing trainings. We are developing provision locally, and local authorities are looking at how to combine trainings. As with any improvements in efficiency, we need to consider what would be lost as well, so there is no easy answer.

Evelyn Tweed: Good morning, panel, and thanks for all your answers so far. In your experience, what factors contribute to Scotland's suicide rates?

Dr Knighton: RCGP Scotland acknowledges that suicide occurs because of multiple factors. It occurs because of a convergence of genetics, psychological factors, social factors and cultural risk factors, combined with experiences of trauma and loss. We also recognise that access to means and lack of access to support can play a role, and we are aware of the link between major physical illness and mental illness.

Dr Smith: It is complicated and there are lots of different factors. I entirely agree with Dr Knighton. We know that socioeconomic factors such as deprivation, unemployment and isolation are very big factors. I think that the phrase "mental illness" occurs only once in the strategy, but mental illness is a very important factor, too.

There are also those with chronic health problems, including chronic pain. The issue of people with chronic physical illness as well as mental illness is not always recognised as a big area, but those people have reasons to feel despair, as well as the means. There are lots of socioeconomic and medical or clinical factors.

Sam Campbell: I will build on what the previous speakers have said and on the information that earlier witnesses gave the committee. With regard to the Highlands and Islands and remote and rural areas, I will build on the information about stigma that Hazel Marzetti referred to. Research by the University of Edinburgh that is not yet published explores suicide in the Highlands and Islands. It indicates that cultural stereotypes pertaining to masculinity and religious views might also be a factor in the stigma and suicide prevalence in some communities. In addition, in remote, rural and island communities, social isolation and access to appropriate services at the time of need are factors.

Rory O'Connor spoke about the time when people are in distress. Distress does not have a

timescale and it is not willing to wait for services to be available tomorrow.

To answer the question, those are some of the contributing aspects.

Dr Bray: Socioeconomic deprivation is one of the strongest associations, and mental health disorder is equally strongly associated. We have particular challenges in Scotland, where socioeconomic deprivation has had greater impacts on our population than it has had in other areas of the UK. Dr David Walsh of the Glasgow Centre for Population Health highlights that point. In looking at our preventative measures, that is a really important area to focus on.

There are associations with specific population groups, such as transgender or neurodiverse people, and there is obviously a strong association with men.

Evelyn Tweed: Professor O'Connor specifically mentioned the cost of living crisis. Are things worse at present? Dr Bray, you are moving your head, so I will go to you first.

Dr Bray: All our services are seeing the impacts of that in people for whom it is more unexpected. Nurses who work in our hospitals, as well as people who are out in our communities, are seeing people struggle with the day-to-day costs of living. In all third sector and statutory sector services, people are seeing that. It impacts on people's mental health—any stresses exacerbate mental health or physical health challenges. There is a cumulative effect.

We are trying to address the issue locally, by working better together across all preventative factors. Money advice is available, and people can signpost across different agencies, as well as to other health supports.

Dr Smith: The answer is yes—absolutely. Suicide affects people across all socioeconomic demographics and groups, but it is more common among people in the most deprived areas. People frequently speak about stress, their finances and debt, in the absence of mental illness, which is my specialty. Suicide is not only associated with mental illness; there is a lot of distress about the financial situation, so it is a huge factor.

Dr Knighton: Traditionally, approximately one in three general practice consultations were about mental health. That is now thought to be a gross underestimation—probably about 50 per cent of our day-to-day consultations are about mental health. A lot of that is driven by the current climate and difficulties.

Sam Campbell: I will come in on the remote and rural aspect. Household costs in remote and rural areas of Scotland can be 10 to 20 per cent higher than those in rural England; on islands,

costs can be as much as 50 per cent more expensive.

In the context of delivery and the provision of services, we have challenges with staffing NHS services, social care services and our third sector service because of issues such as the cost of living, which is exacerbated by location and the geography of remote and rural areas—that affects the cost of housing, transport, heating and all those sorts of things. Maintaining staffing levels in such areas is really challenging.

Evelyn Tweed: Dr Smith mentioned self-harm and suicide. Will you tell us more about that?

Dr Smith: As Professor O'Connor said, the highest predictor for death by suicide is previous attempts and self-harm. There are lots of people who self-harm for various reasons. Sometimes it is in the context of mental illness; sometimes it is about managing distress. Not all self-harm is with suicidal intent, so different approaches are needed for everyone. We are pleased about the development of the self-harm strategy. That is slightly different, but there are overlapping areas.

Most people—well, not most, but a lot of people—who self-harm end up in hospital emergency departments, and they will be seen, but resources are patchy across the country in terms of which clinicians are available to see people. The aspiration is that, when people who self-harm or attempt suicide come into the emergency department, they should have a mental health assessment and input at the earliest opportunity. That does not really happen anywhere in Scotland, most of the time. Very few places in the country have embedded mental health services in emergency departments. In England, the commitment is that mental health clinicians and liaison psychiatry services should be embedded in emergency departments, 24 hours a day, but that is usually cross-covered by other teams that have other responsibilities.

For example, when I work, my liaison service is a nine-to-five service, but out-of-hours teams that also have other responsibilities come in. Someone who has self-harmed will often have to wait until the next morning to get a psychiatric assessment, which is not ideal. Their physical health is dealt with, but they have to wait until the next morning to see someone. That is far from ideal, so that aspect should be developed.

Evelyn Tweed: In your roles, what challenges do you face? Many of you have said that there are lots of factors at play. Will you tell us a bit more about that, from your point of view?

Dr Knighton: From a general practice perspective, and from my perspective in my clinical experience, it is time and capacity—workload and workforce—that are our big issues.

We would love to be able to give people the time, the space and the compassion that we can give. We are trained in those particular skills of consultation, but we do not have time.

We see upwards of 100 or 200 patient contacts a day, depending on the size of the practice. For example, after a public holiday the week before last, we had 200 emergency calls, and about three of them were from people who were in crisis. You also have people with physical health crises, such as potential heart attacks, and you have to prioritise and use skill with that. Capacity and workforce are the big problems with embedding the strategy; the issue is finding the time to do that.

Dr Smith: I agree that the issue is about workload and capacity. Geographic variation plays a big part, too. The central belt has a bigger population but more resources, while in rural places there is not so much. Aberdeen is fairly urban, but it has a lot fewer resources than other areas. You are probably bored of clinicians saying that we need more resources, but I will say that anyway, because limited resource is an issue.

Having an insufficient psychiatric bed base is also an issue. If someone turns up in the middle of the night, my options include admitting them to hospital, which is not always appropriate or needed, but I have very few alternatives. Services such as distress brief intervention are brilliant and really important, but they are not a huge amount of use to me and my colleagues at 3 o'clock in the morning when we need to do something else.

Resources throughout the country are variable and very different. If I turned up at the Royal infirmary of Edinburgh, the situation would be very different from that if I turned up at the Belford hospital in Fort William.

11:45

Sam Campbell: The challenges that I note are the fragility of third sector organisations and our increasing reliance on them to provide preventative activity. I absolutely endorse that activity, which links to what Rory O'Connor said about informal services managing and supporting people in the interim before they can access a formal service. Things such as community link worker programmes could play a greater role in supporting people while they are waiting for treatment—not just for suicide or mental ill health but for a whole variety of services that are provided by health and social care partnerships.

However, we need universal service, and we need provision. The postcode lottery of service, which has been referred to, is unhelpful for people. We need additional support to provide early intervention and support to individuals and

communities, so that they can maintain their own positive wellbeing and be resilient to the challenging circumstances in which they find themselves.

We have challenges with the provision of service. Large third sector organisations are less likely to function in small or remote rural and island areas, which means that provision is limited. We want to build on our community wealth-building programme around emboldening, training and supporting people who live in our communities to provide such services, but there are still benefits to be found from larger-scale third sector organisations functioning in smaller areas.

Dr Bray: I have three things to note, the first of which is that early intervention through our community supports can promote good wellbeing and prevent people from needing to use the services for which money has been reduced over time and of which there are fewer in our communities.

Early intervention by our services is also needed. For example, our child and adolescent mental health services would like to be able to support people at an earlier stage, because interventions and outcomes are better the earlier we intervene. However, because our services are under so much pressure, people tend to be seen only when they are further into crisis. That is beginning to happen with our third sector statutory services, too. They are under pressure to manage much more complex risk, which they do not feel suitably skilled for.

From the suicide reviews that we undertake locally, we see that, if there was better information sharing across organisations and services, that would reduce risk. There are many individuals with many vulnerabilities and complex needs who pop up at a lot of different services over time, but people do not share information about that, so nobody has a full picture of the risk to an individual, which will be higher or lower at different times. Information sharing and working together are important, but it is difficult to find time for that when services are under pressure.

In mental health services, we have a workforce crisis. We are absolutely struggling for skilled psychiatrists. There is no capacity to improve and develop services, because services are so pushed in running the clinical part. The impact on service users and on the wellbeing of staff is perpetuating problems in retention and recruitment. That must be addressed if we are to do anything.

Evelyn Tweed: Thank you all for those answers.

Maggie Chapman: Good morning. Thank you for being with us this morning and for your comments so far.

I want to follow on from Evelyn Tweed's questions about groups of people who might be disproportionately affected by suicide or the experience of suicide. I have a general question to start off with. Do the strategy and the action plans and the thinking around them sufficiently address the needs of people who we know are in high-risk groups?

Dr Knighton: I think that the strategy could probably do more. As we well know, middle-aged men are the highest-risk group.

A research article in the *British Journal of General Practice* last July concluded that clinical factors can be identified in general practice settings that should alert GPs and lead to personalised holistic management, which might play a role in preventing suicide. However—this follows on from Evelyn Tweed's question—time and space will be needed to address that, and adequate funding will need to be provided so that we have the time to learn about those things and to enact them in general practice.

Maggie Chapman: Is there also, then, a question about data collection and data sharing? As the first point of contact, are you able to tell the people who need to know that those indicators are present?

Dr Knighton: Yes, we can, if we have a good enough structure in place. However, in my area of Tayside, we have no locality psychiatrists and our mental health team is struggling to see anybody who is not in crisis. That means that many more enduring mental health problems are coming back to be managed by general practice, which we do not have the time to do, given that we are firefighting ourselves. Having the space and the time to do that would be great, but it all comes back to the issue of capacity.

Maggie Chapman: Thank you. Murray Smith, I want to put the same question to you.

Dr Smith: I agree. In general, I think that the strategy addresses a lot of the issues, but it could go further. As I have said, there is a focus in this strategy and related strategies on distress, but there is not always as much of a focus on mental illness, and I think that both are important.

In particular, as I said in my opening statement, I would like to see more about the transitions between different bits of the system—for example, between child and adult services and between adult and older adult services—because those are tricky periods and people can fall through the cracks. Another high-risk period and difficult transition is when someone gets discharged from hospital to community services. Among the other issues that are identified, substance misuse, intoxication and so on are big areas that make a contribution.

In short, the strategy addresses the areas of risk, but it could do with providing more detail and identifying more actions.

Maggie Chapman: Again, there is a connection between being able to focus resources and being able to target groups of people as they transition or through alcohol dependency support or whatever. Is there a data question in that respect?

Dr Smith: We know a bit about that, but, as everyone else has said, we need more data to measure such things.

Maggie Chapman: Sam Campbell, you have spoken very clearly about rural inequalities. Are those inequalities being acknowledged and addressed in the strategy and action plans, or are there things that we have missed?

Sam Campbell: The challenge is that, in any remote, rural and island area, the data used to identify areas of deprivation does not always provide the texture and detail that we need in order to identify people who are at risk of not just suicide but a number of other things. I am aware that services in our third sector and the health and social care partnership collect data and that there is various information about people, but none of it has been pulled together. If the data was pulled together on to one system instead of being kept on a variety of databases, it could provide a valuable resource and a great opportunity.

I also want to touch on the issue, which the previous panel raised, of data for the benefit of research on and understanding of people who are at risk of suicide. We have bits and pieces of information, but given our very limited resources, we could use that data and information better to target people who are at higher risk of suicide and people who come into contact with them. After all, the data that would be pertinent to the central belt is not the same as the data that would be pertinent to remote and rural areas.

As I mentioned in my opening statement, we recognise that farmers, people who work in forestry and other such groups of people are at greater risk, and we have a greater number of them, given our population demographics. We need to understand who comes into contact with those people and how we get the message across not only to the individuals but to the folk who support them. In that way, we can ensure that they are equipped and supported, and that they know what to do when they come across somebody who could be in distress and considering suicide.

There are a lot of opportunities and there is information there; it is a matter of getting some support to bring that information, in a timely fashion, down to a granular level. That is why I emphasise again that we need bespoke solutions

in those smaller areas in order to identify what is pertinent for us in our area.

Maggie Chapman: I come to Jane Bray with a similar question on targeting groups. Have we identified the right groups, and are we getting that right?

Dr Bray: Yes—I agree with what the others have said. Suicide is a relatively rare event, but a universal approach is important because everybody could be at risk, even though we know that some people are at higher risk. We need to ensure that that approach is in place.

Similarly, with regard to knowing what to do, we need more research evidence and more data around the specific population groups and what works. The strategy has done very well in raising awareness at a universal level, and that has encouraged interest at a local level among communities and in the third sector around suicide prevention. There is good work going on, but data and research are key.

Maggie Chapman: In your opening remarks, you commented on Dundee and the issues of deprivation there. Dundee is Scotland's drug death capital and is closely associated with drug and alcohol misuse and with suicide. Do we adequately understand the socioeconomic causes of that? We have spoken about resources, the cost of living crisis and all those things. Do we need to do more to focus on that aspect?

Dr Bray: Yes, and that is where research is crucial with regard to what interventions we need in those most disadvantaged communities, where we know that people are at high risk of suicide. That is a huge area of work.

Maggie Chapman: My final question is probably for Amy Knighton and Murray Smith again. In your respective roles as members and representatives of your royal colleges, given that you are front-line primary care providers, are you concerned for your fellow workers in this space?

You have talked about additional pressure and not being able to do what you want to do because you do not have the time, the capacity or the resource. Are we not paying enough attention to the consequential impact of that? If any of you or your colleagues are not there, that only exacerbates the problem for everybody else. Are we missing that important aspect? Perhaps Amy Knighton can answer that.

Dr Knighton: To a certain extent, yes. As the workload goes up and workforce numbers go down and become more depleted, GPs—who are not helped by the media pressure and public perception—are becoming more demoralised. They are burning out and struggling to cope, and

they are retiring early and getting out of day-to-day practice because it is just too much.

Maggie Chapman: It is just too hard.

Dr Knighton: Yes—it is too hard.

The difficulty is that a lot of what we deal with in general practice day to day is very emotional and difficult, and we get very little in the way of supervision to discuss those things. I am lucky in that I work in a very supportive practice, where we make sure that we meet each day to allow us the space to offload difficult consultations and problems with one another, but not every practice has that. We carried on doing that all the way through the Covid-19 pandemic, and it was important that we gave ourselves that space.

A recent STV article said that, in the United Kingdom, one nurse in the NHS dies by suicide every week, and one NHS doctor every three weeks. We in Scotland are fortunate that we have a wellbeing service that is particularly directed towards medics. The funding for that needs to continue. Two thirds of the registered users of that service were doctors, of whom half were GPs. Given that we are much smaller in number than our secondary care colleagues, a huge number of GPs are accessing that service.

12:00

Dr Smith: I agree entirely with that. We often feel as though we are firefighting—we are dealing with crises all the time, and that takes quite a toll. There is quite a bit of moral injury as well—we see what we want to do, but we are not able to do it.

In addition, we face a well-publicised workforce crisis, particularly in psychiatry and mental health nursing. That is a national issue, but it particularly affects less urban areas. Locally, in Grampian, I think that 40 per cent of consultant psychiatry posts are either vacant or staffed by people who are not consultants and have not completed their training. Some of those colleagues are very good—some are excellent—but they do not have the same amount of training, and they are very expensive. When we might want to expand services in other places, we are too busy getting bums on seats and paying a lot of money for that variable quality.

Marie McNair: Good afternoon. Following on from my colleague's questions, is there a higher prevalence of suicide in rural areas as opposed to urban areas? Are there any stats on that?

Dr Bray: Yes—rural areas have a higher prevalence of suicide.

Marie McNair: Thank you.

I will move on to my own questions. Do you feel that people with lived and living experience of

suicide have been meaningfully involved in the development of the strategy?

Dr Bray: I have not been directly involved, but we have sent out information on that. I have been at presentations about how people have been engaged. The approach that has been taken has been very good and well recognised as good practice. I think that it has been excellent.

Sam Campbell: I will answer that question from an operational point of view. Although I was not involved in any of the work to develop the strategy, operationally, I sit on the Argyll and Bute suicide prevention group. We absolutely value the input from those with lived and living experience, but it is very challenging work, and it is a very sensitive area. Thankfully, we are dealing with relatively small numbers of people, but managing them in that environment to ensure that we get their valuable input into the work that we do in our area is really difficult to do. It takes time, resource and effort. We receive good support from Jenny Smith at Public Health Scotland, who provides direction and support around what is being done in other areas.

Operationalising the activity that is in the strategy is one of the things on which we could do with additional support and guidance.

Dr Smith: In the college's written submission, we said that the involvement of people with lived experience was excellent. A lived and living experience panel that was linked to the national suicide prevention leadership group was created, and our college had representation on that.

Overall, the approach on that is very good. However, it is always difficult to reach the vulnerable marginalised—those with severe and enduring mental illnesses and substance use. We need to keep trying to reach the most vulnerable ones.

Dr Knighton: I echo Murray Smith's points. I was on the national suicide prevention leadership group, and one of the first things that we did was to create the lived and living experience panel and to recognise the need to involve it in the development of further strategies. I never managed to get to any of the panel meetings, but the reports that we got back were that they were meaningful and really useful for all those involved.

Marie McNair: What do you envision that the challenges will be in implementing the strategy?

Dr Knighton: Do you mean in relation to the strategy in general?

Marie McNair: In relation to lived experience and engagement.

Dr Knighton: As a college, we are passionate about our belief that lived and living experience

should be part of policy decisions. There needs to be adequate support and resource, especially for those who take part. As has been mentioned, the subject is quite an emotional one for many of the people on the panels, so they need to get support. That also applies to the people who deliver those panels and others who are involved in the process.

Paul O’Kane: I return to the subject of implementation of the strategy and resource. I appreciate that some answers have been peppered, or flavoured, with comments about resource. The Scottish Government has allocated £2.5 million to the strategy. In your view, is that an adequate amount of funding? What other areas need a focus? We heard from the first panel about research being a key area. In your experience, where do you think funding needs to be increased?

Dr Knighton: As a college, we support the deep-end group in the call for the Scottish Government to take steps to ensure the long-term funding of our community link workers, who help with so many of the factors that can increase suicides, such as housing, benefits, debt and the lack of investment in all services. We rely so heavily on our third sector colleagues, especially in our practice, where we do not have ready access to a community mental health team. We are very much reliant on those in our third sector, so we would support them in delivering their work. For us and for the Royal College of Psychiatrists, it is also a matter of ensuring that the workforce and infrastructure are there for clinicians.

Dr Smith: It would be hard to say whether the current funding is adequate, as it is fairly early days, but the important thing is that the funding is maintained, as any gaps or cuts to it would have significant adverse effects on what the strategy is trying to achieve.

There are some things where there may need to be additional focus, such as policies and plans that help with mental health, monetary issues, stigma, research or social circumstances. Such policies would be very welcome. As was said earlier, mental health should not be seen in isolation from physical health; they are very much interlinked. There may be gaps in areas where services attend to such groups.

Some of those services are not recurrently funded—services end. Locally, we had a very good drug and alcohol team that worked with people in the Royal infirmary. There has been temporary funding for that and, with all the other funding issues, that funding is going to end, which I think will cause a lot of problems. It is important to fund things recurrently and to keep things going.

Sam Campbell: I agree with the other panel members. Building on that, it is a matter of strengthening our communities and addressing the social and economic determinants of health, especially through financing the third sector, so that community activity, support and information are available. We value the community link working service in Argyll and Bute, and we want to make it universal. However, there is not really a value to increasing link working if there are no third sector organisations to provide services, support and information to people.

Support for third sector partners is absolutely vital. Those partners are not just supporting people to prevent suicide and to address poor mental health; they are reducing isolation and improving people’s outcomes with regard to their physical fitness, too. Providing resource, sustained finance and support is vital to maintaining such services and enabling people to stay in post. In remote and rural island communities, third sector partners might have one or two members of staff in an organisation, and they could be providing sexual health services, drug and alcohol services, counselling services, walking groups, services and support for loneliness and a whole variety of things. If a small chunk of their money is withdrawn, the whole service can collapse, people will be out of work and a whole number of people are then not able to access that support and information. We have some very fragile third sector partners, and they are absolutely vital.

Additional resources would be required within schools, and not only to support children and young people, although we have already heard—and absolutely agree—that early intervention and support are vital for children and young people. I have spoken to colleagues in education and educational psychology, who point to the need for additional support and resources for the parents of pupils who are struggling in school. Young people who experience anxiety, depression or poor mental wellbeing, or who do not attend school, often have parents at home who are experiencing similarly poor mental wellbeing, so it would be beneficial to provide broader support to the whole family.

As I said, we also need to have additional resources directed towards preventative activities—including community link workers, link working, distress brief interventions and work on bereavement by suicide—to ensure that those activities are sustained in the long term, that we can make good long-term decisions and collect good long-term data and that those services feel secure, knowing that their funding will not be cut in six months’ time or next year and that staff knowledge will not be lost if they leave.

Paul O’Kane: Dr Bray, do you want to add anything?

Dr Bray: I reiterate what Sam Campbell said, because I work in a similar environment. From a public health perspective, it is far more cost effective to intervene early to prevent problems later. That begins in early childhood and is about maintaining good mental health. There are pressures on services currently, but we must also invest upstream or nothing will change.

Paul O’Kane: We have heard evidence about challenges with the sustainability of funding to allow the third sector to try things out or make changes and to test what works. It would be interesting to get a sense of that. The amount of money is important, but so is having confidence in funding.

On the NHS side, it was interesting to hear Dr Smith talking about how additional resources or support are used for direct work but are then removed, leaving a gap. Do you feel that we often reinvent the wheel? Do things come in cycles, disappear and then come back? That could be problematic for planning.

Dr Smith: There is a risk that we try things that are not continued or not funded for some reason but then look at the same thing again and do something that is only slightly different. That is why it is important to gather data to measure what works and to make sure that that is available to the right people, so that we are not repeating the same thing over and over again. We should continue funding the things that work.

Paul O’Kane: Dr Knighton, do you want to add anything about the third sector?

Dr Knighton: In my personal practice, we are very fortunate to have Penumbra Mental Health staff in house, but they are not there every day. We used to be able to refer people directly and add them as an appointment, and if we had someone on the phone, we could tell them to follow up with Penumbra. The databases have been changed and we cannot do that now, so we rely on patients making that next step for themselves, which they do not always want to do.

It is important to maintain not only services but the access to those services. As was alluded to earlier, everyone in primary care uses completely different computer systems, which makes data gathering or moving between those systems difficult.

Paul O’Kane: We have already touched on this. We need a sense of what is working within the strategy that goes beyond any overall reduction in the number of deaths by suicide to look at some of the other aspects that were outlined in evidence today and that would work. What should the

Government measure and how should the Government report on spending, which is also of interest to us?

Dr Knighton: From my perspective, in primary care and general practice, it is very difficult to gather any data. We all use slightly different computer systems, and we all code very differently, which, from an informatics point of view, makes pulling that information difficult. It would be great if we magically all coded the same, so that you could pull that data and see whether there has been a reduction not just in people attending in crisis but in overall attendance for mental health provision at other places. However, that might be for very technical computerised people to figure out.

Paul O’Kane: Dr Smith, do you want to add anything from an acute care point of view?

Dr Smith: I agree that focusing only on suicide as the outcome is not enough. The most recent data shows that suicide rates have gone up slightly, for lots of reasons, but that does not necessarily mean that the strategy is not working. As we have all said, none of the systems—those in local authorities and the health service, and even those within the health service, such as GPs and different health boards’ systems—talk to each other, so we cannot learn from each other, because the links are not always there.

As Professor O’Connor said in the earlier evidence session, we do not always get all the data on people who frequently attend. I could look at emergency department data and see how many people have been in in the past six months, but we do not have a systematic way of identifying them. If they turn up in hospital a lot, that is fine, but if they have gone to their GP or a third sector provider a lot, there is no way of identifying those people and trying to intervene before something happens.

Paul O’Kane: That is very helpful.

The Convener: Do members have any questions? No—we are all good.

I thank the panellists for attending. That brings our second panel to a close. I suspend the meeting briefly before we head into the next evidence session.

12:16

Meeting suspended.

12:30

On resuming—

Gender Representation on Public Boards (Amendment) (Scotland) Bill: Stage 2

The Convener: Our next agenda item is stage 2 proceedings on the Gender Representation on Public Boards (Amendment) (Scotland) Bill. I welcome Shirley-Anne Somerville, the Cabinet Secretary for Social Justice, who joins us with her officials. I highlight that officials are not able to speak on the record during these proceedings.

We have no amendments to deal with, but the standing orders oblige us to consider and to formally agree to each section of the bill and the long title. Before we do so, I thank the cabinet secretary for attending and ask whether she wishes to make any comments or whether she is happy for the earlier evidence given to the committee to stand as the official record of the Government's position.

The Cabinet Secretary for Social Justice (Shirley-Anne Somerville): I would like to make brief opening remarks, if I may. As we are all aware and as we have discussed previously, the bill seeks to remove the section 2 definition of "woman" from the original Gender Representation on Public Boards (Scotland) Act 2018. That follows the decisions of the inner house of the Court of Session, which were effective from 19 April 2022. The court decided that the section 2 definition was outwith the legislative competence of the Scottish Parliament and was not law and, accordingly, had no legal effect. At that time, our counsel told the court that we would remove the redundant definition. If the bill is passed, it will provide clarity by removing that redundant definition from the statute book.

I appreciate that introducing a small bill is unusual. As we have discussed previously, we looked to see whether the bill could be attached to planned legislation, but there was not a suitable vehicle. In addition, the change has to be made through primary legislation.

The bill is simply to clear up the statute book to ensure that it is not misleading. Removing the definition from the statute book will eliminate the possibility of any confusion for readers of the 2018 act who are unaware of the court's orders made in 2022.

I was pleased to read the committee's stage 1 report on the bill and that you were satisfied that it is a small, technical fix to clear up the statute book. We are content to recommend that the Parliament agrees to the general principles.

The Convener: No committee member has indicated that they have any questions to put to the cabinet secretary, so we move to the formal stage 2 proceedings.

Sections 1 to 3 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill.

12:32

Meeting continued in private until 12:34.

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