

**EVALUATION OF THE FIRST PHASE
OF
'CHOOSE LIFE'

THE EXECUTIVE'S
SUICIDE PREVENTION STRATEGY
2003-06

SCOTTISH EXECUTIVE RESPONSE
29 August 2006**

SECTION A – BACKGROUND AND CONTEXT

1. Background

The Executive commissioned an independent evaluation of the first phase of the implementation of 'Choose Life', the Executive's national strategy and action plan to prevent suicide in Scotland. 'Choose Life' was launched in December 2002 as a ten year plan with the goal of reducing the suicide rate in Scotland by 20% by 2013. The first phase of implementation ran from April 2003 to the end of March 2006.

The first phase of Choose Life was funded as part of the Executive's commitment to health improvement, public health and social inclusion. Funds of £12m were allocated through the Executive's National Programme for Improving Mental Health and Well-Being to support specific national (£3m) and local work (£9m). Following the launch of 'Choose Life' in December 2002, guidance was issued to local areas in July 2003 to help guide local work up to March 2006.

A further £8.4m has been invested for 2006-08 to continue providing support to national and local delivery. Guidance was issued in December 2005 to guide the work during 2006-08.

The expectations of the evaluation work were to review progress towards achieving the milestones set out in Choose Life between 2003-06, provide recommendations to guide the next phases of work on suicide prevention and in making future investment decisions around continuing suicide prevention implementation and delivery.

The evaluation has been carried out by a consortium of agencies involving Edinburgh University's Research Unit in Health and Behaviour Change, Glasgow University's Public Health and Health Policy Unit, The London School of Economics Health and Social Care Research Unit and the Scottish Development Centre for Mental Health. The evaluation team was led by Professor Steve Platt from Edinburgh University.

The evaluation forms a key component of a parallel programme of research and evaluation to support the Executive's work on health improvement, mental health and suicide prevention, commissioned through the Executive's Health Department Analytical Services Division.

2. Choose Life - Progress to Date

Progress has been made in the following key areas:

- A National Implementation Support Team has been established to help support, guide and co-ordinate national work and support local implementation.
- All 32 Community Planning Partners have local suicide prevention action plans in place and there are Suicide Prevention Co-ordinators in each local authority area.
- There are now 168 Applied Suicide Intervention Skills Trainers working across Scotland and to date over 7,000 people have been trained in ASIST.
- Since 2004, Breathing Space (as part of the operation of NHS 24) has been providing a free confidential phone line service for people experiencing low mood or depression. The service is targeted at men. The service has been independently evaluated and is continuing to develop and expand its service. On average, 2,500 - 3,000 calls are received every month.
- A range of national partnerships have been established with key organisations, including the Samaritans in Scotland, Childline Scotland, the Scottish Prison Service, and a range of national voluntary organisations including CRUSE Bereavement Care and the Scottish Association for Mental Health.
- Guidelines for the media on the reporting of suicide have been published and distributed.
- Improvements are being made to the knowledge and evidence base on suicide prevention and improving capacity in suicide prevention research in Scotland.
- A comprehensive public facing information website on suicide prevention in Scotland has been established.
- Good progress has been made in the ability to provide more accurate and timely data and trends analysis on suicide in Scotland.

Suicide prevention work in Scotland is one part of continuing efforts to improve population mental health and well-being, address the stigma and discrimination that people with mental health problems and illness can experience, part of delivery work on improving the quality of life and social inclusion of people experiencing mental illness and a continuing part of the efforts to improve the prevention of mental health problems and illness, particularly depression, and provide appropriate care, treatment and support for people. The work on Suicide Prevention is part of continuing work to help meet the objectives of 'Delivering for Health'.

3. Progress Towards the 20% Reduction Target in Scottish Suicide Rates

The European age standardised suicide rate (deaths by intentional self harm and those of undetermined intent) in 2000/01/02 was 17.5 per 100,000 population and in 2003/04/05 it was 15.7; between these three-year periods there has been a decrease of **12.1%**. These rates since 2000 suggest there *may be* an emerging downtrend in suicides in Scotland, but it is too early to tell if we are starting to see a *significant* or long lasting downward trend and whether we are on track to meet the 20% reduction by 2013.

These figures use three year averages because the data is subject to annual fluctuations. It is advisable, where possible, to use European Age Standardised Rates; this allows account to be taken of different age structures within a given population, eg, if comparisons are to be made over time or by country.

The target in England is a 20% reduction target by 2010. The baseline rate is from 1995/96/97 and was 9.2 per 100,000 population; the target is thus 7.4 per 100,000. The latest available data, for years 2001/02/03, shows a rate of 8.6 deaths per 100,000 – a reduction of 6% from the 1995/96/97 baseline. These are also European age standardised rates.

Health Department HEAT targets

Reducing Suicide Rates by 20% between 2002 and 2013 is part of the current Health Department HEAT Targets for Local Delivery Plans by Health Boards; the suicide prevention target is a health improvement target.

Health Inequalities targets

In terms of health inequalities targets, there is an Executive target to reduce the rate of suicides (for 10-24 year olds) for the most deprived communities by 15% from 10.07 per 100,000 in 2001-03 to 8.56 per 100,000 in 2007-09. Progress to date shows that there was an -8.43% reduction in the suicide rate (10-24 year olds) in the most deprived areas between 2001-03 and 2002-04. There was a further reduction during the 2nd year leading to an overall decrease of -16.38% in the suicide rate in deprived areas since 2001-03. These data are subject to fluctuations and the rate may rise again before the end of the target period.

Between 2001-03 and 2002-04 there was a +21.19% increase on the rate of 4.16 per 100,000 (10-24 year olds) in the most affluent areas. This fell in 2003-2005 but the rate was still above the 2001-03 level representing an increase over the 2 years of 7.84%.

The inequality ratio narrowed considerably over the 1st target year (by 24.44% from 2.42 in 2001-03 to 1.83 in 2002-04) but has increased very slightly over the 2nd year to 1.88. However, this still represents a decrease of 22.46% since 2001-03.

Although there has been an encouraging start in the most deprived areas in the first two years of the target period, these results are based on relatively small numbers and therefore subject to large fluctuations. Data are required from future years to establish whether the changes in trend are genuine or whether they are just showing annual fluctuation in the data.

Age group figures

On age group figures - from 2000 - 2005, there were *reductions* of 32% in the rate for those aged 15-24 years, 18% for 25-34 years, 7% for 35-44 years, 13% for 45-54 years and 3% for 55+ years.

From 2002 - 2005, there were *reductions* of 22% in the rate for those aged 15-24 years, 27% for 25-34 years, 7% for 35-44 years, 7% for 45-54 years and 16% for 55+ years.

Rates by sex

Since 2002, rates of male suicide have been showing a general downward trend. In 2005, the European age standardised rate for males was 21.5 per 100,000, in 2002, the rate was 27.1. This 2005 rate represents a decrease of **21%** on the 2002 rate. In contrast, the female rate (7.8 per 100,000 in 2005), while markedly lower than the male one, has remained quite stable over this time period.

Consideration of male suicide by age over 2000- 2005 indicates a decrease of 30% (from 30.0 to 20.9 per 100,000) for the 15-24 age band, and of 33% (from 54.2 -36.3 per 100,000) for the 25-34 age band.

4. Key Issues For the Next Phase of Work on Suicide Prevention

From the evaluation work and on-going performance management of suicide prevention work, there are a number of issues that are emerging as key for the next stages of work, these include:

- The need to build on the population and community development based approach taken forward in 2003-06 and to balance this with a focus on those groups at highest risk of suicidal behaviour. Highest risk groups include people with a mental illness, the prison population, those who are victims of violence and abuse, those with poor economic and education opportunities and those abusing substances.
- An improved co-ordinated local approach to suicide prevention, linked to other strategic and support activity by CPP agencies while moving away from a project-based approach to a more strategic, mainstreamed and sustainable approach.
- Improved national and local connections with delivery in mental health care and treatment services.
- Improved national and local connections with delivery in primary care around recognition, assessment and response, particularly linked to people with depression.
- Greater focus given to links with alcohol and drug misuse actions in local areas.
- A more strategic and targeted approach to national and local training and greater clarity about which key front line services and practitioners need to be trained in suicide prevention.
- Improved linked and supportive actions from other key policy and implementation areas. Including general health and social care, schools, children and young people, social inclusion, communities, employment, training and criminal justice.
- Continuation of the target to reduce suicide rates in Scotland by 20% by 2013 as a key health improvement target and to carry out further work on identifying and developing other appropriate measures for tracking progress in the prevention of suicide.
- Improvements required (nationally and internationally) in knowledge and evidence as to what constitutes the most effective interventions for suicide prevention at different levels of delivery - individual, organisational, community and population levels.

Work on each of these is progressing and the results of the evaluation give further insights and opportunities to the continuing suicide prevention work across Scotland.

5. Next Stages

Following the publication of the evaluation report and research findings, the Executive will:

- Continue discussions with policy colleagues across relevant Executive Departments and Divisions to identify the work, in hand and planned, that will further contribute to suicide prevention action.(September – December)
- Review local Community Planning Partnership’s annual reports on suicide prevention action. (September - October)
- Consider the commissioning of a further independent evaluation to monitor and review suicide prevention progress up to the end of March 2008.
- Participate in the 4 planned regional Suicide Prevention Evaluation Report Feedback sessions with key stakeholders. (November)
- Receive the final report from the review of Effectiveness of Interventions to Prevent Suicide and Suicidal Behaviour. (January 2007).
- **Produce a finalised plan for the next stages of suicide prevention policy and implementation. This includes the consideration of the future role, function and preferred location of a suicide prevention national co-ordinating body. (March 2007)**

SECTION B - SCOTTISH EXECUTIVE RESPONSE TO THE EVALUATION FINDINGS AND RECOMMENDATIONS

1. General Response and Context

The Executive welcomes the publication of the evaluation.

The evaluation team are to be congratulated for their extensive and detailed work in what is a complex, evolving and challenging area of work.

The Executive is committed to addressing suicide prevention as a key part of its overall policy efforts and particularly as a key continuing component of work on health improvement, public health, health inequalities, social inclusion and mental health promotion, prevention, care and treatment.

Suicide prevention continues to be a key area of challenge for a range of Executive Departments, other Government Departments and for wider public sector, voluntary sector and private sector agencies. Every life lost to suicide is a tragedy for families, friends, communities, and work colleagues.

The results of the evaluation will be used to help inform how suicide prevention policy and delivery will be taken forward and to help guide future investment decisions by the Executive and a range of national and local partner agencies.

Work on suicide prevention in Scotland takes both a universal approach to improving actions at a population level that impact on the prevention of suicide and also a targeted approach to help address those at the highest risk of suicide and suicidal behaviour in our communities.

This requires an integrated and strategic approach at national and local levels that combines raising awareness, promotion, prevention and the provision of a range of service responses for care, support and treatment.

Suicide prevention efforts and prevention of and response to mental health problems are also helped by other linked activity. For example, the Executive funds 'Breathing Space' the national telephone advice and signposting service targeted at young men experiencing low mood or depression.

Work on suicide prevention also links to other work in health improvement, including combating the effects of alcohol, and addressing drug misuse. Linked support work is also provided through efforts to address the stigma and discrimination faced by people with mental ill health, promoting and supporting recovery from mental illness, responding to the mental health needs of children and young people and efforts to combat social exclusion and improve the quality of life of people experiencing mental illness.

Work within mental health care and treatment services also has an impact on suicide prevention. The Executive remains committed to improving mental health care and treatment services and the prevention of mental illness. Work is being taken forward on a mental health delivery plan that we will publish in December this year.

Suicide prevention efforts are also supported by a broad range of work that promotes good mental health and well-being and work that prevents or responds to mental health problems when they arise. This work takes place in a range of settings from schools, to communities to workplaces to prisons and is linked to efforts to improve social inclusion, address poverty, increase employment, training and education opportunities.

We must acknowledge that there are limits to the current knowledge on suicide and its prevention. These limitations are international and not solely confined to Scotland. Our commitment is also to help contribute to a better understanding of suicide and its prevention and we will continue with our efforts on supporting further research and evaluation and contributing to wider UK, European and international work.

2. Evaluation Findings: Work Already in Hand

Work has already begun to address some of the findings and recommendations set out in the evaluation report. The evaluation team reported interim findings and these were used to help guide current national and local work.

For example, the guidance for 2006-08 issued by the Executive in December 2005 called for:

- Greater efforts to be made in early identification, intervention and support in health and social care services for people with mental illness who are at risk of suicide.
- More focus to be given to local joint working between suicide prevention and local alcohol and drug misuse work.

Cross-Executive links on policy are already being pursued, in particular in respect of health improvement and public health more generally, alcohol, drug misuse, criminal justice, social inclusion, employability, education and social work and a cross-departmental meeting was held on 9 August where the results of the evaluation were presented and discussed in relation to policy linkages. This work will be followed up with relevant Departments and Divisions across the Executive as the next stage of work is taken forward.

Delivering for Health makes a commitment to produce a mental health services delivery plan. This work is in hand and links and connections to suicide prevention delivery actions are being made.

In addition, further work has been commissioned by the Executive to help inform future decisions around suicide prevention. Key to this is the recently commissioned Effectiveness of Interventions to Prevent Suicide and Suicidal Behaviour Review being undertaken by Liverpool University. This is due to report to the Executive in January 2007.

The results of the evaluation are also being presented to a series of 4 planned stakeholder meetings across the country in November. These are being held to provide feedback on the results and to engage a range of local stakeholders in the process of determining what happens for the next stages of suicide prevention work for 07/08 and beyond 2008.

A finalised plan for the next stages of suicide prevention policy and implementation is planned for March 2007 (this includes the consideration of the future role, function and preferred location of a suicide prevention national co-ordinating body).

3. Report recommendations and responses

A number of recommendations are made in the final evaluation report, relating to future investment in Choose Life, sustainability, targeting of action, the strategic integration of self-harm, the role of the Community Planning Partnership, options for delivering the national coordination function, and outcomes and targets. These recommendations are not staged, as the evaluation team consider them all to be of high and equal priority that require consideration and action for the next stages of work.

3.1 Future investment in suicide prevention

i) Threshold analysis carried out for this report suggests that, if *Choose Life* achieves even a very modest reduction in the rate of suicide, at the current level of investment this is likely to generate costs per life year saved below £30,000. This is the case even if a narrow public sector cost perspective, rather than a societal perspective, is adopted. **Investment in suicide prevention at the current level would appear, therefore, to represent value for money** and the level of success required by the strategy would be modest. With greater success the programme would even be cost saving. However, cost-effectiveness analysis cannot be conducted (even less, cost-effectiveness demonstrated) if there is no evidence of effectiveness – and at present such evidence is not available.

Executive Response

The Executive is pleased to note that current investment appears to represent value for money.

ii) Any future economic evaluation of the Choose Life strategy would almost certainly be one of the first (if not the first) evaluations worldwide to be undertaken of a national strategy. In addition to issues of outcome measurement, it will be critical to collect data on the cost and uptake of different components of a suicide prevention strategy. This should include measurement of all in-kind resources, including the contribution of volunteers. It is also important to link the results of any **economic evaluation** to the context in which interventions are delivered. In the case of Choose Life, the wealth of information emerging from phase one of the evaluation could play an important role in describing this context. (See annex 3 for more discussion of these issues and arguments on the potential use of different economic evaluation techniques, including cost benefit analysis.)

Executive Response

We agree that the next stage of evaluation of suicide prevention in Scotland should consider including an economic evaluation component linked to the delivery of key interventions. The next stages of evaluation work are currently being considered.

iii) Immediate decisions about the allocation of funding for *Choose Life* in the early years of phase two have to be based, therefore, on **what is required in terms of the further development and maintenance of national and local infrastructures so as to maximise successful progress towards the key strategic target (20% reduction in suicide). We have not collected any evidence to suggest that radical changes should be made in the current allocation to local partnerships.** Given the amount of unspent funds at local level, there might be calls for a redistribution from local to national elements, but we believe that

this move would be premature and should be resisted. There were valid reasons for the underspend in the first two years of *Choose Life* and budgets are now moving into balance. In time, **more resources may be required at local level to enhance the integration of clinical and drug/alcohol services into suicide prevention activity.** Consideration might be given to **a modest increase in funds to the national coordinating body**, since NIST has been overwhelmed at times by the support needs of local partnerships.

Executive Response

Our investment in suicide prevention is continuing for 06-08. With a further £6.2m allocated to support local work, and £2.2m to support national work. Investment has been increased for 06-08 by £200,000 to help with suicide prevention efforts in the Highlands and rural and remote areas.

Guidance has already been issued to local areas for 06-08 and in this guidance it is made clear that enhanced efforts need to be made to achieve improved integration of clinical and drug/alcohol services into local suicide prevention activity.

The evaluation work, and other forthcoming work that has also been commissioned (notably the effectiveness of interventions to prevent suicide and suicidal behaviour, due for final report to the Executive in January 2007), along with further discussions with stakeholders and relevant policy interests across the Executive will help us determine what level of investment the Executive will make beyond 2008. This will be confirmed in the next spending review announcements.

Future investment decisions will be made for post 2008 for both local and national support work on suicide prevention, in light of wider funding priorities. For local work there will be the opportunity to determine (re-determine) how local support funds are to be used. Consideration of using these resources to target and enhance the integration of clinical and drug/alcohol services into suicide prevention activity will be made.

3.2 Sustainability

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

At national level:

- Using opportunities presented by recent developments in national health and social care policy, including *Delivering for Health* and the emergent *Mental Health Delivery Plan*, as well as the *Review of 21st Century Social Work*, to demonstrate the relevance of *Choose Life* to overarching policy goals, such as promoting self help and self management; anticipatory/preventive care
- Involving clinical services in population-based suicide prevention activities
- Strengthening the engagement of national bodies, e.g. COSLA and Communities Scotland, that can promote involvement of key sectors at local level
- Harnessing the energies and skills of national voluntary sector organisations in awareness raising and campaigning
- Promoting the incorporation of *Choose Life* objectives and priorities into other national policy streams and initiatives as an ongoing priority
- Purposive innovation to test out, evaluate, learn and implement, with a view to building knowledge and enhancing capacity to work towards key objectives and priorities.

Executive Response

Work is already in hand to take suicide prevention work forward in the context of 'Delivering for Health'. A Mental Health Delivery Plan will be published by December 2006 and this will include actions for delivery that build on suicide prevention work, and wider work on improving mental health care and treatment services already under way. These include work on promoting self help, self management, anticipatory and preventive work, especially in relation to people with depression by building on the work carried out by Executive's 'Doing Well by People with Depression Programme'.

Further opportunities will also be taken to link with other relevant Executive policies, including the *Review of 21st Century Social Work* to integrate work on suicide prevention into social work training.

The future work of the national co-ordinating body should continue to focus on supporting and promoting integration and sustainability and on improved engagement with clinical services, partnerships with key strategic agencies and the voluntary sector. As we have said before suicide prevention is an agenda for all these agencies and is helped by their wider efforts and actions on health improvement and mental health improvement, addressing social inclusion and health inequalities.

Building knowledge is a key part of improving our response to suicide prevention. Further research and evaluation activity is planned and there will also be a greater impetus given to supporting suicide prevention research and evaluation and for translating this into practice through the activities of the SIREN (Suicide Information Research and Evidence Network). SIREN is supported by the Executive's *Choose Life* strategy.

At local level:

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

Executive Response

Agree, and that is why we are continuing to commission helpful resources that add to knowledge about what works, and why Choose Life has established SIREN.

Local areas should also have in place mechanisms to track and review progress. This is also a key support function of the national co-ordinating body.

3.3 Targeting of action

There should be **more focused targeting of action** in order to maximise the value of the ring-fenced *Choose Life* investment. The following issues should be taken into consideration when addressing this recommendation.

- **Unnecessary duplication of effort at local level should be avoided.** This particularly applies to training initiatives and the implementation of innovative suicide prevention interventions. The possibility of pooled/collaborative initiatives across several local areas should be given serious consideration. The national coordinating body should seek to influence this process.

Executive Response

Agree. Supporting improved pooling of initiatives and promoting more collaborative efforts will be a key future function.

- The **national coordinating body should intervene where important aspects of suicide prevention are being ignored at the local level.** A prime example would be the failure to integrate substance misuse treatment services into *Choose Life* delivery plans. However, the first challenge to the national coordinating body is to ensure better integration of clinical services and *Choose Life* activities at national level. Local areas cannot be expected to follow if the national body is not leading by example.

Executive Response

Agree. Performance management of local areas actions is a key function of the national coordinating body.

- A more ‘experimental’ approach to assessing the merit and worth of local suicide prevention interventions should be adopted, especially at early stage of phase 2. Developmental work still remains to be done in order to test the transferability to the Scottish context of interventions which have shown promise elsewhere and also to evaluate promising innovative practice. Rather than take a *laissez faire* attitude towards this vitally important work, the national coordinating body should seek to ensure that the whole of Scotland becomes a laboratory for a rigorous assessment and evaluation of potential suicide prevention interventions. The achievement of successful outcomes in one (or several) local areas should then be followed by roll-out across the rest of the country.

Executive Response

Agree. Future action and interventions should build on a growing evidence base.

- In considering candidate activities/interventions for suicide prevention, it is important to distinguish between what is best done at local level (e.g. identify and respond to local need) and what is best done at national level (e.g. awareness raising). The national coordinating body should engage in a dialogue with national partners and local areas in order to reach consensus on the appropriate division of responsibility.

Executive Response

Agree.

- In taking forward action in phase two, a balance should be struck between the application of ‘established’ suicide prevention interventions (recognising that these may still be to some degree unproven in the Scottish context – evidence of positive impact may not be transferable from another country/health system/policy context) and innovative practice. At this stage in the evolution of *Choose Life*, both approaches are required. The expectation of appropriate and adequate evaluation of innovative practice should be built into performance review

Executive Response

Agree. We must continue to develop the evidence base.

- The limitations of the priority group approach should be recognised. Priorities tend to be rather general and to depend heavily on the international research literature or the epidemiological picture at national level. The epidemiology of suicide at the local level, however, may be crucially different in many respects. The assessment of local priorities should be encouraged and taken into account in local action plans, even if the priorities differ from those identified at national level. Additionally, the number of priority groups should be as small as possible. When there are too many, it is inevitable that there will be further differentiation or rank ordering among them. Lower order priorities will tend to be overlooked.

Executive Response

Agree. And this is why it is important, and has already been communicated to local areas to be clear about local needs. This is helped by ensuring a local needs assessment.

- The national coordinating body should reinforce the equity focus of current priorities. In particular, it is surprising that socio-economic deprivation and low socio-economic status, which are known to be highly associated with the incidence of suicidal behaviour, are not highlighted in the strategy.

Executive Response

Agree. There needs to be an enhanced focus on inequalities and this will be a focus for the next stages of work. This will combine universal population approaches with targeted action for those at highest risk.

- The national coordinating body should ensure that all participating organisations and players, both national and local, adopt an evidence-based approach, drawing on findings from research (especially primary evaluated intervention studies and systematic reviews of effectiveness), local needs assessment and intelligence, and practitioner expertise, when drawing up plans for suicide prevention interventions. This expectation should be built into performance review processes.

Executive Response

Agree. Action should be based on evidence of effectiveness.

- The national coordinating body should ensure that evidence about effective interventions accruing at local level is collated and disseminated to relevant *Choose Life* organisations and beyond, and that this evidence has an impact on practice.

Executive Response

Agree. This will be considerably enhanced following the publication of the effectiveness of interventions to prevent suicide and suicidal behaviour; the review of effective interventions is due to submit an agreed final report to the Executive in January 2007.

Summary of Executive Response to targeting of action

The recommendations around targeting of action are well made and are helpful for future policy, the future work of the national co-ordinating body and local areas. Work will be taken forward in consultation with key stakeholders to help improve the targeting of action, avoiding any unnecessary duplication and ensuring that local priorities and action are focused where they are needed most and by using the best available evidence on interventions. The function of providing an effective performance management support role will be a key issue for the future national co-ordinating body.

3.4 Strategic integration of self-harm (and its prevention)

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

- The national coordinating body needs to provide guidance about how to identify and reach the subgroup of people whose self-harming behaviour puts them at high risk of future suicide. An operational ‘case’ definition of the subgroup might be all those who are admitted to hospital following an episode of self-harm. However, there is no perfect correlation between hospital treatment and the (medical or psychosocial) ‘seriousness’ of the behaviour: many (perhaps even the majority) of those treated in hospital will not represent a high suicide risk and a small, but significant, minority of those who do not attend hospital (not referred or refusing to attend) will be high risk (and will go on to commit suicide). Whether an alternative approach to ‘case’ finding can be devised, which offers better sensitivity and specificity and is practical and feasible, remains to be seen.

Executive Response

Agree. We will consider developing an alternative approach to case finding.

- The less ‘serious’ component of self-harm cannot be ignored, even if it is not included in the scope of *Choose Life*. The majority of people who self-harm are probably not at high risk of suicide but nonetheless constitute a group with a high level of unmet psychosocial need and extensive experience of stigmatised and hostile responses from both the public and professionals. The Scottish Executive/NHSScotland should ensure that health and social care professionals in Scotland adopt the NICE guidelines on the treatment of self-harm (NICE, 2004), pay attention to recommendations of the National Inquiry into Self-harm among Young People (2006) and continue to focus anti-stigma campaigns on this behaviour.

Executive Response

Agree.

- If self-harm remains a focus of *Choose Life*, there should be guidance about how incidence is to be measured (which depends in turn on the operational definition – see above) and what target for its reduction is to be set (see below).

Executive Response

Agree.

Summary of Executive Response to strategic integration of self harm and its prevention

A meeting has been arranged for November 2006 between a range of relevant policy areas across the Executive and a number of external bodies with an interest in the issue of self harm, following the March 2006 Report of the National Enquiry into Self Harm Among

Young People, which we contributed to. Prior to this meeting, policy areas will be discussing a draft Executive response.

The Executive also encourages use of the NICE guidelines on the treatment of self harm and the use of other resources and evidence.

3.5 The role of the Community Planning Partnership

The limitations of the community planning partnership (CPP) as the key *Choose Life* coordinating body at local level need to be recognised. In particular, CPPs have been less effective in engaging proactively with clinical services and planning structures (both primary and secondary health care, in particular drug and alcohol services and mental health services). How can these and other currently excluded partners be integrated into the *Choose Life* effort and be encouraged to 'own' the *Choose Life* agenda?

- CPPs need to review progress and examine the partners and partnerships that have yet to be put in place in order to achieve their CL objectives. Priority should be given to establishing effective links with clinical and drug/alcohol services where these are found to be absent to inadequately developed.
- In order to counterbalance the limitations of using CPP mechanisms, the Scottish Executive might adopt a more directive approach in relation to key priorities, using other policy implementation mechanisms to ensure engagement of key partners in clinical services and following through the proposed integration of clinical perspectives within national *Choose Life* support capacity.
- Despite the above, the CPP remains the most appropriate vehicle for developing strategy and overseeing delivery in relation to *Choose Life* at the local level. However, NIST, on behalf of the National Programme, should continue to work closely with CPPs in order to ensure that *Choose Life* budgets are fully spent on suicide prevention activities, reducing the risk of claw back of unspent allocations by parent local authorities.
- The coordination function is crucial, but that does not necessarily imply that there has to be a dedicated coordinator post. The task of the CPP is to devise the most appropriate arrangement for delivering the function.

Executive Response

Our December 2005 guidance to CPPs highlighted these points and we are also now in the process of reviewing CPPs response to our request for a formal annual report of their suicide prevention activities. Annual reports were to be submitted by 31 July and will be reviewed by the end of September.

We will explore how we can improve links between CPPs and clinical services in the context of Community Health Partnerships.

The role of the national co-ordinating body in supporting CPPs is very important. This role will continue for the next stages of work.

3.6 Options for delivering the national coordination function

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

- A key question is whether this function should remain as a separate section/department within population mental health policy. Currently Mental Health Division is the policy and delivery home for suicide prevention. However, because core Scottish Executive Departments focus on the making of policy, the delivery of policy is more usually carried out by Scottish Executive agencies, local authorities and other bodies. Awareness raising, working with media, improving information capture/dissemination and supporting implementation are functions that relate to mental health improvement work more generally. Thus, some of these functions could also be taken on by organisations which already have delivery responsibilities in these areas, e.g. NHS Health Scotland and the Scottish Public Health Observatory. Such changes could improve opportunities for mainstreaming suicide prevention.
- However, suicide prevention is by no means secure. There is a danger that the momentum and progress gained over the past few years will be quickly dissipated. Another consequence of the dilution of a dedicated coordinating body might be the withering away of a public health perspective and privileging of a clinical, high risk approach. This could be counteracted if the policy home for suicide prevention were moved to Health Improvement Strategy and Support. But (assuming that some of the functions of the national coordinating body were still taken on by other organisations) this might be a similarly unbalanced solution, leading to the continued marginalisation of clinical services.

Executive Response

The Executive is committed to continuing support for a national co-ordinating function until March 2008.

The results of the evaluation along with the views of key stakeholders will be taken into account in reviewing the future role, functions and location of the current National Implementation Support Team and the future role of any national co-ordinating body.

It is planned to have an options paper for consideration by December 2007.

The points made about awareness raising, working with the media and the improving information capture/dissemination and supporting implementation functions are indeed ones that relate to mental health improvement work more generally. Work will take place with NHS Health Scotland and the Scottish Public Health Observatory about their role in supporting these functions in the future. Initial discussions have already taken place.

As to the ‘policy home’ for suicide prevention, this is something that will be considered, but the most important aspect of any policy and implementation is that the work that needs to take place happens and happens effectively. If this can be shown to be more likely by moving the policy home for suicide prevention, then this will be considered.

3.7 Outcomes and targets

Although this is not an area which was explored in great detail in the course of the evaluation, we draw on a wider literature to offer some recommendations concerning the development and operationalisation of outcomes and targets for the second phase of *Choose Life*. Many issues need to be addressed, including:

- At the national level, the definition (and therefore measurement) of suicide should be clarified (we recommend that undetermined deaths are ‘counted’ as suicide for the purposes of tracking progress towards the strategic target), an appropriate measure of high suicide risk self-harm should be established (see above), and a target for reduction of self-harm should be adopted (assuming that targets for *Choose Life* continue to be set – see below)

Executive Response

Agree with undetermined deaths being counted.

It will be helpful to have further consideration of how an appropriate measure of high risk self harm could actually be established and monitored. If this is possible, this may be an appropriate target to consider.

- At local level, there are very large ‘natural’ major fluctuations in suicide incidence and small numbers of deaths (therefore wide ‘confidence intervals’ around ‘average’ trends). As a consequence, it makes no sense to translate the 20% suicide reduction target at national level into a similar target at local level. It will be virtually impossible in the majority of areas to demonstrate that such a target has been reached or, if reached, that the reduction in suicide is attributable to *Choose Life* interventions. We suggest that, if targets are to remain, consideration should be given to the identification of a ‘proxy’ measure that is more robust in terms of establishing and monitoring trends. Hospital-treated self-harm is probably the best candidate, but the problems with this measure have been noted above.

Executive Response

Suicide rates will remain as a target for the national level. Local areas are requested to continue their efforts on suicide prevention to contribute to meeting the nationally set target. Consideration of ‘proxy’ measures will form part of the next stages of work by the national co-ordinating body working with ISD and others.

- In view of the difficulties of establishing trends at the local level, more attention should be paid to the collection of data on measures of process (implementation) and output, ensuring that: (a) the measures are few in number and, as far as possible, agreed through negotiation with local *Choose Life* planning teams; (b) the measures are logical intermediate steps towards the ultimate outcomes (reduction of suicidal behaviour); and (c) relevant data can be collected routinely through existing datasets. Evidence of positive change in these measures (e.g. more professionals and public receiving suicide intervention training) would help to establish a plausible case of progress towards ultimate (but difficult to measure) suicidal behaviour outcomes.

Executive Response

Agree, this is a key function of the national co-ordinating body.

- While targets can be helpful in ‘concentrating the mind’ and galvanising action, disadvantages also have to be recognised. Not all national strategies have adopted targets (Ireland is a recent example). If *Choose Life* is to continue in its use of a target, care needs to be taken to ensure that this is set at a level, and presented in such a way, that it inspires (rather than de-motivates) key national and local actors. This suggests the need to consider the appropriateness of setting the intended reduction at 20% (which is exceptionally ambitious, given the trends during the previous three decades) and the possible replacement of it with a lower quantitative target or even a directional (i.e. non-quantitative) target.

Executive Response

The target will remain at the level of a 20% reduction between 2002 and 2013. There is no compelling evidence to change this goal.

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29 August 2006