REFRESHING THE NATIONAL STRATEGY AND ACTION PLAN TO PREVENT SUICIDE IN SCOTLAND

REPORT OF THE NATIONAL SUICIDE PREVENTION WORKING GROUP
Background

1. In Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 the Scottish Government made a commitment to: “...take forward a further review of Choose Life in conjunction with key delivery partners...”. This Report is the outcome of that process and proposes 6 new objectives for future suicide prevention work in Scotland, building on previous work and knowledge.

2. The National Suicide Prevention Working Group and Reference Group met to prepare this report between September 2009 and June 2010. The membership of both groups is attached at Annex A.

Definitions

3. For the purposes of this document:

   **Suicide** is death resulting from an intentional, self-inflicted act.

   **Suicidal behaviour** comprises both completed suicide attempts and acts of self-harm that do not have a fatal outcome, but which have suicidal intent.

   **Self-harm** is self-poisoning or self-injury, irrespective of the apparent purpose of the act (excluding accidents, substance misuse and eating disorders).

4. In practice, it can often be difficult to determine intention, making the definitions and distinctions above difficult to sustain. This is reflected in the recording of suicide in Scotland, which includes both death where the intent appears to be clear and deaths where the intent is undetermined. Undetermined deaths are included in the official count of suicide deaths because there is research evidence to suggest that such deaths are more likely to be suicidal than accidental, but we cannot distinguish between undetermined deaths, which have (probable) suicidal intent and those that do not.
5. *Choose Life* made a distinction between suicide and self-harm, while recognising that there are clearly linkages between the two phenomena. This Report maintains that distinction and the Working Group notes that separate work has been commissioned under *Towards a Mentally Flourishing Scotland* to develop policy and practice on self-harm.

**Understanding Suicide**

6. Finding a single intervention, group of interventions or approach which has an evidence base of effectiveness of reducing suicide in the general population is difficult due to the complexities surrounding suicidal behaviour, but a mixture of initiatives that include training of frontline staff and reducing the means available to those showing suicidal behaviour can have desirable outcomes. There is stronger evidence for targeted approaches for particular groups within the population and for improving the general service response to mental illness, including depression and substance misuse, which can also have the effect of reducing suicide.

7. The factor which is most strongly associated with risk of suicide is mental illness (including substance misuse, especially alcohol misuse). Where mental illness and substance misuse co-exist the risk is greatly increased. Affective disorders are the most common psychiatric disorders and patients with bipolar disorder are at particularly high lifetime risk of suicide, perhaps as high as 10-15%. There is an evidence base for reducing suicide by improving the quality of services for people with mental disorder.

8. Suicides associated with psychiatric hospitalisation commonly occur shortly after admission or shortly after discharge, highlighting the importance of safer services and reviewing people soon after discharge. It has also been shown that educating staff in primary care and the voluntary sector in the recognition and treatment of depression can reduce suicide. Indeed, community-based multi-level interventions which include close cooperation with GPs in the treatment of depression offer promise in reducing suicide attempts and completed suicide.
9. A history of self-harm is a consistent and strong risk factor for repeat self-harm and completed suicide, with research suggesting that there is a non-fatal repetition rate of 15-16% at one year slowly rising to 20-25% over the next few years. Risk of later suicide is between 0.5 and 2% after 1 year, rising above 5% after 5 years. The risk of suicide is higher for those who repeat self-harm, for older men and those living alone or misusing alcohol.

10. In addition to the presence of mental illness (including substance misuse) and a history of self-harm it is clear that there are a number of social factors which increase risk of suicide. A consistent link between suicide and socio-economic status, in particular low(er) occupational class and being unemployed, has been identified. Poverty and deprivation are linked to suicide risk with areas of high socio-economic disadvantage having significantly higher suicide rates. In recent decades in Scotland, the number of young people dying by suicide has increased disproportionately in areas of most deprivation relative to those with least deprivation. The absence of an evidence base for general interventions - such as advertising and awareness raising campaigns to support suicide prevention - addressing suicide in these areas makes this evidence challenging.

11. Trauma is a major contributor to suicide risk, with physical and sexual abuse and bullying being recognised as important risk factors, making it important to consider the possibility of abuse as part of any assessment. There is evidence that post-traumatic stress disorder - particularly when complicated by co-morbid depression - is linked to higher levels of suicidal ideation and behaviour.

12. Sexual orientation is also a risk factor for suicidal behaviour. A recent systematic review highlighted high rates of mental illness and suicidal ideation in lesbian, gay and bisexual people. An implication of this finding is that this higher risk needs to be recognised in the planning of public health and clinical services. Concern about sexual orientation among adolescents in Scotland is also associated with self-harm.
Suicide in Scotland

13. Suicide is not evenly distributed in the community with some age groups having higher rates of suicide and deprived areas having up to twice the rate of suicide than the national average. Men are more likely to complete suicide than women. In 2009 the age groups of highest incidence were 25 through to 60. The chart below shows deaths for which the underlying cause was classified as “intentional self-harm” or “event of undetermined intent” registered in Scotland, 1974 to 2009, with five-year moving average and showing the likely range of values around the moving average.
14. In 2009 there were 746 deaths by suicide in Scotland (14.2 per 100,000 population). This was an 11.5% reduction on the 2008 figure of 843 suicides in 2008 (16.1 per 100,000) which had been a slight increase on the 2007 figure of 838 suicides in 2007 (15.9 per 100,000). The data is provided by the General Register Office for Scotland and relates to calendar years.

15. The Scottish Government is working towards a target of reducing suicide rates by 20% between 2002 and 2012. As annual numbers can tend to fluctuate, three year rolling average rates are used for monitoring purposes. The target requires a reduction from a rate of 17.4 per 100,000 for the average of the three calendar years 2000, 2001 and 2002 to 13.9 per 100,000 for the average of the three calendar years 2011, 2012 and 2013.

16. The suicide rate for the three years 2007-2009 was 15.4 per 100,000. This is a reduction on the figure for 2006-2008 which was 15.6 per 100,000. The [11.5%] reduction between 2000-2002 and 2007-2009, while promising, does not guarantee that the overall 20% reduction target will be achieved; progress to date needs to be sustained over the next few years.

**History: How we got to where we are...**

17. In November 1999 the Centre for Theology and Public Issues at the University of Edinburgh organised a major conference, ‘The Sorrows of Young Men’. The conference raised concerns about suicide in Scotland, particularly trends among young to mid-aged adult men, and proposed possible future directions for practice, policy and research. The Scottish Parliament signalled its concerns in a debate held in April 2000, during which the then Deputy Minister for Community Care articulated the Scottish Executive’s determination to “tackle [the issue] through both general and specific measures that are informed – as is appropriate – by the available research”.
18. This Ministerial commitment was the basis for a development process which continued through 2001 and involved people from a wide range of backgrounds, including health and social care professionals, service providers (from both statutory and voluntary sectors), mental health service users, suicide ‘survivors’ (family members and others directly affected by suicide), and others with an interest in suicide prevention. Participants endorsed the plan to develop a national strategic approach to suicide prevention, highlighting the importance of the goal of reversing the suicide trend in Scotland, but also supporting a broader, integrated approach to tackling the determinants of mental health and well-being in its widest sense.

19. A National Planning Group was established to advise on the development of a draft ‘Framework for the Prevention of Suicide and Deliberate Self-harm’ which was issued for formal consultation. In parallel with this work, the Scottish Development Centre for Mental Health was commissioned to undertake two projects: ‘Exploring Experience’, a series of discussions with the media about the reporting of suicide and with groups and services affected by suicide and self-harm; and ‘Laying the Foundations: Identifying Practice Examples’, a compilation of work carried out by statutory and voluntary agencies with those at risk of suicide and self-harm. Reports based on the two SDC projects were published with the main consultation report.

20. The ten-year Choose Life suicide prevention strategy and action plan was launched in December 2002 by the Scottish Executive as part of the National Programme for Improving Mental Health and Wellbeing. The overarching aim of the Choose Life plan was set as reducing suicide in Scotland by 20% by 2013.

21. The Choose Life strategy reflected the consensus that suicide prevention should not be addressed in isolation, but should be part of a national public health policy to promote and support a positive approach to mental health. It set out a public health, population-based approach designed to raise public awareness and build skills and capacity within communities to recognise suicide risk, and improve knowledge of what works to prevent suicide. It also identified the main actions that were required at national and local levels. Broadly speaking, the responsibility of national actors, the then Scottish Executive and national agencies, was to set the strategic direction, give guidance and provide support while local actors, health
sector, local government and voluntary organisations were tasked with developing and implementing local plans for suicide prevention.

22. Funding of £4 million per year for 2003/04 to 2005/06 was announced in April 2003, with £1 million to annually support national activity and £3 million allocated for local action through Community Planning Partnerships. A designated National Implementation Support Team (NIST) was established within the Scottish Executive to coordinate and support development and implementation at national level. The core functions of the NIST were awareness raising and campaigning; working with the media; development and dissemination of information and knowledge; and supporting local implementation. Community Planning Partners developed local suicide prevention action plans and developed local delivery structures.

23. An independent evaluation of this work (generally described as Phase One) was commissioned by the Scottish Executive in 2004 and published in late 2006. The purpose of the evaluation was to “assess … infrastructure and early impacts” and to “set the template for the next phase of the Choose Life strategy.” The high level findings of the evaluation were that:

- The approach of embedding suicide prevention work in wider public health, inequalities and social inclusion work made sense;
- The NIST was making progress in establishing momentum for the work and developing infrastructure to support the strategy;
- Work needed to be done to increase NHS and clinical engagement; and
- Suicide prevention training was going well and Community Planning Partnerships had been the best available mechanism for local leadership and co-ordination.

24. The Scottish Executive drew on these findings and issued updated guidance and refined objectives for Choose Life. Further resources were allocated for 2006/07 and 2007/08, with £1 million continuing to be available each year for the national activities taken forward by NIST and £3.2 million being allocated to local authorities to hold on behalf of Community Planning Partnerships. CPPs were encouraged to work with local media in the reporting of suicide; to support local community-based
organisations with a view to building infrastructure and capacity; to make mainstreaming and sustainability a major priority; and to ensure that “suicide prevention and related activities should be increasingly recognised as key elements and embedded within Joint Health Improvement and related local policies and plans”.

25. Within the Scottish Executive, work was taken forward to identify relevant activity that would contribute to suicide prevention, as well as to link suicide prevention into other Executive policies. The target to reduce suicide rates in Scotland by 20% by 2013 was maintained, but augmented by work to identify other appropriate measures for tracking progress in the prevention of suicide. Further research was funded and disseminated, including through the Suicide Information, Research and Evidence Network (SIREN), which was established in 2006.

26. In December 2006, the Scottish Executive published Delivering for Mental Health, its mental health delivery plan, which set targets and commitments for the development of mental health services in Scotland. The plan included an additional suicide reduction target which required that 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency be trained in suicide prevention, with progress on this target being performance managed as part of the national NHS HEAT targets.

27. In April 2008 the relationship between national and local government changed under the Concordat which provided for greater flexibility in the use of resources locally and the introduction of Single Outcome Agreements for each Community Planning Partnership within the context of the Scottish Government’s National Performance Framework. The funds previously provided under Choose Life (£3.2 million in 2007/08) were included with the overall allocation made to local government. A more collaborative approach between national and local government policy development and implementation was encouraged.

28. Many Community Planning Partnerships have established suicide reduction as an element of their local SOA and the evidence is that funding previously
allocated locally for suicide prevention has generally been maintained, reflecting the local importance that has been given to this issue.

29. The National Implementation Support Team moved from the Scottish Government in April 2008 into NHS Health Scotland (HS) and became known as the HS Choose Life Programme. This reflected the principal role that the HS Choose Life Programme has in respect of delivery and implementation rather than policy, a matter that had been raised in the Phase One evaluation.

30. In May 2009 the Scottish Government published *Towards a Mentally Flourishing Scotland* (TAMFS). The focus of TAMFS is on improving mental health and wellbeing. The policy is based on a social model of health which recognises that a range of factors — including lifestyle and social, economic and environmental factors — can have an impact on an individual’s mental health. Reducing the prevalence of suicide is one of the strategic priorities of TAMFS, along with the prevention of common mental health problems and improving the quality of life of those experiencing mental illness.

31. In TAMFS the Scottish Government made the commitment to undertake this review of *Choose Life* with key delivery partners, taking account of the evaluation of Phase Two of *Choose Life* (published in April 2010).

**Evaluation of Phase Two**

32. This evaluation focused on the period 2006 to 2008 and also took account of changes such as those introduced under the Concordat and the move of the NIST team from the Scottish Government to NHS Health Scotland. The main findings were:

   a) There is a continuing need for a strong, visible national lead from the Scottish Government on the policy and strategic direction of suicide prevention. There should be clearer communication about the connections between suicide prevention and other relevant policy areas.
b) A separate Choose Life (suicide-prevention) strategy should continue until 2013. However, the National Suicide Prevention Review Group should review and refocus the current objectives of the strategy to ensure performance can be measured and tracked.

c) At the same time, the utility and relevance of the 20% suicide reduction target should be reviewed.

d) A national support function is still needed to provide leadership and direction for local work, e.g. on targeting, training, evaluation and to facilitate information sharing. However, there may be a case for the purpose and functions of the national support team to be reviewed.

e) At a local level, the role of the Choose Life Co-ordinator should be retained as it seems to be important in ensuring the future sustainability of local suicide-prevention work. However, local areas may wish to revise the role and composition of their Choose Life Steering Groups.

f) Further work is needed, nationally and locally, to link with drug and alcohol services, primary care and clinical mental health services. At the same time, there should be continued investment in training and efforts should continue to focus on increasing the uptake of training among key groups such as GPs, A&E staff and substance misuse workers.

g) The approach to targeting high-risk groups needs to be reviewed. NHS Health Scotland should develop guidance for local areas on how to target high-risk groups.

h) The Scottish Government should continue to support national research on suicide prevention, and, with NHS Health Scotland, should consider how best to take forward the work previously done by SIREN to promote local research, disseminate evidence and support its application in practice.

i) NHS Health Scotland should consider the feasibility and practicality of developing a consistent approach to local evaluation for Choose Life.
Strategic Approach

33. The National Suicide Prevention Working Group considers that the next stage of action for suicide prevention policy and delivery in Scotland should be informed by:

- The available evidence base for effective interventions (this is covered briefly in paragraphs 6 to 12 above);
- The findings from the evaluation of Phase Two (these are set out in paragraph 32);
- International best practice and guidance in developing national suicide prevention strategies (a summary of the UN Guidelines is attached at Annex B, together with the US Institute of Medicine framework for intervention); and
- Data collection and analysis provided by the Information Services Division of the Scottish Health Service and NHS Health Scotland.

34. The Working Group considers that as we move into the final phase of Choose Life it is appropriate and timely to adopt a more focused and streamlined set of objectives to inform work for the remaining 2 to 2.5 years of the Strategy. These are set out below, but this is not to imply that the objectives which informed the programme during phase one and two are no longer relevant (Annex C), but rather, that the programme has matured and moved on sufficiently to allow some of the earlier objectives to be subsumed in the new objectives, thus allowing for a more focused evidence based approach targeting, in particular, high risk groups.

Objective 1: Identify and intervene to reduce suicidal behaviour in high risk groups;
Objective 2: Develop and implement a coordinated approach to reduce suicidal behaviour;
Objective 3: Ensure interventions to reduce suicidal behaviour are informed by evidence from research and evaluated appropriately;
**Objective 4:** Provide support to those affected by suicidal behaviour;

**Objective 5:** Provide education and training about suicidal behaviour and promote awareness about the help available;

**Objective 6:** Reduce availability and lethality of methods used in suicidal behaviour.

35. In considering action to reduce suicide we need to separate out activity which has a broader focus than suicide prevention, but if taken forward effectively and with an understanding of the particular risk issues in respect of suicide, should reduce the overall incidence of suicide. We also need to separate out national and local actions. That suggests that we might think of the following as domains for action:

I. Policy approaches that address structural and general population issues such as work to promote good mental health (e.g. suicide prevention training, Breathing Space, access to CBT and Mental Health 1st Aid), reduce inequality and discrimination (e.g. See Me and Suicide: Don’t Hide It. Talk About It campaigns), promote good early years services (e.g. Child and Adolescent Mental Health Services) and eradicate poverty (e.g. Scottish Government action on social inclusion and employability).

II. The delivery of good quality and where appropriate good joined up mental health and substance misuse services to address crisis, to identify and respond to depression and anxiety, to identify and respond to substance misuse and to provide safe and effective care to those with severe and enduring mental illness.

III. National policy, taken forward by the Scottish Government, to give strategic leadership to the suicide prevention agenda and to monitor and track delivery of the Choose Life strategy and change over time.
IV. National implementation, taken forward by NHS Health Scotland, to support local implementation, improve awareness and understanding and to develop the evidence base for effective interventions.

V. Local implementation led by Community Planning Partnerships and NHS Boards to take forward local action to reduce suicide.

36. In terms of the above objectives of Choose Life, Domain I primarily relates to Objectives 2 and 3; Domain II primarily relates to Objectives 1, 2 and 4; Domain III primarily relates to objectives 2 and 3; Domain IV primarily relates to objectives 2, 3 and 5 while Domain V primarily relates to objectives 1, 4, 5 and 6. These relations are set out in Annex D.

37. In making recommendations for the next stage of action the Working Group has focused on Domains II to V where particular action directly related to suicide reduction is required.

Domain II: Improving Mental Health and Substance Misuse Services

38. The Working Group proposes the following particular actions should be taken forward by the Scottish Government:

(a) Reporting of suicide should be taken account of in the work on patient safety in mental health, and in particular in the context of work to refresh the arrangements for conducting and learning from Critical Incident Reviews (noting the importance of learning from the work of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and the Scottish Suicide Information Database which will report from 2011).

(b) The work on risk assessment as part of the development of Integrated Care Pathways should take account of the particular risk of suicide or self-harming behaviour.
(c) There should be a continuing focus on building links between substance misuse, primary care and mental health services with a particular focus on suicide prevention.

39. These actions are in addition to the continuing work on improving crisis services, discharge planning for those admitted to inpatient care, and improving diagnosis and response to substance misuse, anxiety and depression.

Domain III: National Leadership and Policy

40. The Working Group agrees with the Evaluation recommendation that suicide reduction requires a “strong, visible, national lead from the Scottish Government” and proposes:

(a) The Scottish Government creates a National Suicide and Self-Harm Monitoring and Implementation Group (this recommendation is also contained within the recommendations from the Self-Harm Review Group and recognises that suicide and self-harm, while different phenomena, have clear policy and delivery connections).

(b) That the Annual Choose Life Stakeholder Forum (Choose Life “Summit”) should continue, but be supported by suitable ministerial input, including chairing the annual event and act as a forum for wider discussion of suicide reduction and the delivery of the Choose Life strategy.

(c) That the Scottish Government develop a framework for monitoring delivery of the Choose Life strategy as well as progress in reducing suicide with tracking of change to extend beyond the 20% reduction target; and which takes account of data from existing sources (such as the GROS figures, data on training; etc.); which is valid nationally and locally; and which is agreed and overseen by the National Suicide and Self-Harm Monitoring and Implementation Group.
41. The Working Group recommends there be a clear plan for delivery, to be developed by NHS Health Scotland and agreed by the National Suicide and Self-Harm Monitoring and Implementation Group. The Working Group proposes that:

(a) The plan should at least address Objectives 2, 3 and 5 of the refreshed Choose Life Strategy, noting that in respect of objectives 1, 4 and 6 the role of NHS Health Scotland will be primarily in offering guidance to local partners, not in direct service delivery.

(b) In considering objective 5, NHS Health Scotland should bring forward proposals for increasing the number of General Practitioners who have had suicide prevention training; and proposals for extending the training, as appropriate, to other staff groups such as those working for the Scottish Ambulance Service and the Scottish Prison Service.

(c) In considering objective 6, NHS Health Scotland should bring forward proposals to continue action to reduce access to methods of suicide; and proposals in respect of locations of concern and ‘hot spots’.

(d) The plan should include arrangements for co-ordinating and disseminating national and local monitoring information as agreed under the monitoring framework agreed by the National Suicide and Self-Harm Monitoring and Implementation Group.

(e) The Plan should include an offer for NHS Health Scotland to assist Community Planning Partnerships in delivering locally agreed commitments on suicide prevention.
Domain V: Local Implementation

42. The Working Group recommends that at CPP level:

(a) There should be clearly identified leadership and co-ordination for work on suicide reduction.

(b) That action plans should be in place to address Objectives 1, 4, 5, and 6 of the refreshed Choose Life Strategy.

(c) That the CPP should have a clear monitoring strategy to track progress in delivering locally agreed commitments and should track change using the monitoring framework agreed by the National Suicide and Self-Harm Monitoring and Implementation Group.
## ANNEX A

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ANNEX B – GUIDELINES ON NATIONAL SUICIDE PREVENTION STRATEGIES

A. Scotland is one of several countries to have developed a national strategy on suicide prevention. These strategies are heavily influenced by guidelines published by the United Nations in 1996 and share many common elements:

• Coordination of a range of integrated, multi-component activities to promote, support and link inter-sectoral programmes at local, regional and national levels, undertaken by an identified coordinating body;

• High-level political support for strategic aims, to lay the foundation for the strategy and its implementation. This is of particular importance in view of the need for cross cutting, interdepartmental support;

• A coherent conceptual framework that provides a model for understanding suicidal behaviour; to generate programmes of activity directed towards prevention; and to foster research programmes;

• Community involvement and engagement in formulating, implementing and evaluating programmes, recognising the important contribution of local and community based organisations and networks in implementation and review;

• Objectives that are achievable and measurable, some of which may be expressed as targets for change;

• Monitoring and evaluation to inform implementation and review of strategy.
B. The US Institute of Medicine framework for intervention makes the following proposal for actions in respect of different population groups:

- **Universal, population level public health interventions** e.g. to reduce risk conditions such as high unemployment, or to equip families, communities and organisations with skills and knowledge that promote mental health and well being and foster resilience (e.g. *Mental Health 1st Aid*, Breathing Space, access to CBT). Core components include public awareness campaigns (e.g. *Suicide: Don’t Hide It. Talk About It, & See Me*), media education, means restriction (e.g. guidance on locations of concern);

- **Selective interventions to address high risk sub groups within the general population** e.g. to improve access to mental health care; to enhance the self esteem and coping capacity of high risk school students. Core components include training and access to services;

- **Indicated programmes targeted at groups at high risk** e.g. pharmacological and behavioural treatments for people with specific mental illnesses. The core component is access to services.
ANNEX C – OBJECTIVES IN ORIGINAL CHOOSE LIFE STRATEGY AND THOSE ADDED FOLLOWING EVALUATION OF PHASE ONE.

The Working Group considers that the seven objectives set in the original Choose Life strategy and the four additional objectives added following the evaluation of Phase One remain valid. The original objectives were:

A. **Early Prevention and Intervention**: providing earlier intervention and support to prevent problems and reduce the risks that might lead to suicidal behaviour.

B. **Responding to Immediate Crisis**: providing support and services to people at risk and people in crisis, to provide an immediate crisis response and to help reduce the severity of any immediate problem.

C. **Longer-Term Work to Provide Hope and Support Recovery**: providing ongoing support and services to enable people to recover and deal with the issues that may be contributing to their suicidal behaviour.

D. **Coping with Suicidal Behaviour and Completed Suicide**: providing effective support to those who are affected by suicidal behaviour or a completed suicide.

E. **Promoting Greater Public Awareness and Encouraging People to Seek Help Early**: ensuring greater public awareness of positive mental health and well-being, suicidal behaviour, potential problems and risks amongst all age group and encouraging people to seek help early.

F. **Supporting the Media**: ensuring that any depiction or reporting by any section of the media of a completed suicide or suicidal behaviour is undertaken sensitively and appropriately and with due respect for confidentiality.

G. **Knowing What Works**: improving the quality, collection, availability and dissemination of information on issues relating to suicide and suicidal behaviour and on effective interventions to ensure the better design and implementation of responses and services and use of resources.
The objectives added following the review of Phase One were:

H. **Improving national and local co-ordination** and emphasising the CPP’s role in linking suicide prevention to strategic and support activity by other agencies and partners.

I. **More targeting of high risk groups**, such as people with a mental illness, victims of violence and abuse, problem substance users and the prison population, while maintaining an overall population approach.

J. **Making better connections with key services**: mental health care and treatment services, primary care, substance misuse services and health and social care services more generally, to improve identification, intervention and follow-up with patients and clients at risk of suicide.

K. **Developing a more strategic approach to training**, including the identification and training of frontline workers and practitioners.
### ANNEX D – TABLE SHOWING OBJECTIVES BY DOMAIN

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<tr>
<th>Domain I</th>
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**KEY**

**Objective 1:** Identify and intervene to reduce suicidal behaviour in high risk groups;

**Objective 2:** Develop and implement a coordinated approach to reduce suicidal behaviour;

**Objective 3:** Ensure interventions to reduce suicidal behaviour are informed by evidence from research and evaluated appropriately;

**Objective 4:** Provide support to those affected by suicidal behaviour;

**Objective 5:** Provide education and training about suicidal behaviour and promote awareness about the help available;

**Objective 6:** Reduce availability and lethality of methods used in suicidal behaviour.

**Domain I** Policy approaches that address structural and general population issues…

**Domain II** The delivery of good quality and where appropriate good joined up mental health and substance misuse services…

**Domain III** National policy, taken forward by the Scottish Government…

**Domain IV** National implementation, taken forward by NHS Health Scotland…

**Domain V** Local implementation led by Community Planning Partnerships and NHS Boards to take forward local action to reduce suicide.
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