Scotland's Suicide Prevention Action Plan

National Suicide Prevention Leadership Group
Every Life Matters Suicide Prevention Action Plan

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Actions 5 and 6 Stakeholder Feedback Survey Report

Contents

1. Introduction

The Suicide Prevention Action Plan (SPAP) aims to reduce suicide within Scotland by 20% by 2022. In order to reach this goal, SPAP includes ten composite action points to advance the current understanding of people who experience self-harm distress and to aid the development of new and existing suicide prevention strategies. These action points include evaluating and developing an evidence-based model of crisis support (Action 5) and, in collaboration with stakeholders (i.e. individuals with lived experience, organisational representatives or professionals who support individuals who experience suicidal distress), identify the advantages and barriers around a digitally-based suicide prevention approach (Action 6).
In order to address Actions 5 and 6, a survey was designed to gather experience and insight from key stakeholders with the following aims:

- Learn stakeholders understanding of suicidal crisis
- Understand stakeholders awareness of support services available
- Identify ways to improve services for people experiencing a suicidal crisis
- Identify best approaches for developing digital suicide prevention strategies

2. Methods

Survey content was designed collaboratively between members of the Action 5 and 6 National Suicide Prevention Leadership Group (NSPLG) and Academic Advisory Group (AAG, NSPLG). Survey items comprised of identifying the participants representative stakeholder group, five qualitative items for Action 5, seven qualitative items for Action 6 and participants demographic characteristics (see Appendix 1). Targeted populations were those with lived experience (LE) of suicide (i.e. bereft by suicide), and organisational representatives or professionals (ORP) who work with populations who are known to be at increased risk of suicide (e.g. mental ill health populations, prisons).

The closed survey was placed online using Qualtrics and was available for three weeks across July 2020 with the aim of recruiting 300 participants. Participants were contacted directly using existing professional contacts and approaching organisations directly via email and telephone. Survey results were analysed using NVivo (v. 12) by the AAG. All answers were voluntary, therefore not all survey items were completed by the participants. This is illustrated by the obtained LE demographic data where total participant numbers vary by characteristic (see appendix 2).

2.1 Respondent sample

The survey sample included 31 LE and 180 ORP participants. One participant was excluded from the analysis for their pro-suicide responses. Due to the small number of LE participants within the sample, between group differences should be considered tentatively. Demographic information was collected from LE participants only, with demographic characteristics summarised in appendix 2. In summary, this sample comprised of 14 females and 11 males. The average age of these respondents was 41.88 years (sd. 11.6).

All LE participants who answered at least one Action 5 or 6 question was included in the analysis (n= 29). Due to availability of resources, analysis of the ORP group was limited to 53% (n= 97) of the

sample. Overall 60% (n= 126) of participants who completed at least one question within the survey were included in the current analysis.

2.2 Data analysis and presentation

A summary of the number of participants who answered an Action survey item is provided in Appendix 3. Due to the breadth of topics investigated within this survey, broad themes could not be generalised to the full dataset. Themes pertaining to each survey item clarified within the text of each item discussed. Findings are reported per survey item, beginning with comparisons between ORP and LE participants. Due to the unequal number of participants between the LE and ORP groups, visual presentations of the findings are provided using percentages. Themes within these graphs are listed in order of prevalence in descending order from top to bottom. It is important to note that not every theme is reported here, for example some themes were unique to one participant. Due to the small representation of these themes, they were omitted from the visual illustrations but, where appropriate, are still be addressed in the text.

Further subgroup analysis of LE participant responses has commenced with exploration between Trans and Non-Trans communities in the first instance. Depending on resource availability, further comparisons are planned between i) sex at birth, and ii) between those with a physical or mental health diagnosis and those without. If the means for data analysis is possible, results will be developed into a separate report. Further between-group comparisons of other high-risk populations (e.g. ethnicity, age) could not be explored due to the unequal distribution of characteristics. During the data cleaning stage some comments were removed due to answers being irrelevant, off-topic or explicitly unanswered (e.g. 'I don't know').

3. Results

Key	
LE	Lived Experience
ORP	Organisational Representatives or Professionals

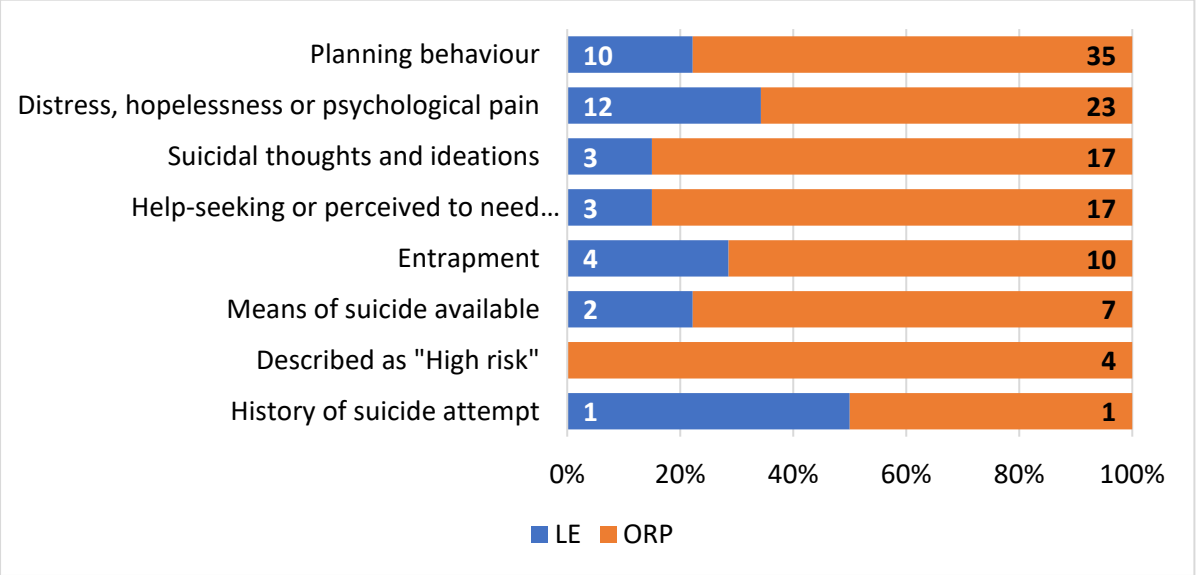
3.1 What does it mean to you when people are described as 'at the point of seriously considering taking their own lives'?

All identified themes are listed in Figure 1. While interpreting these results it is important to stress the significant overlap between a number of these themes. However, without grouping them in the way used here, themes would have become convoluted and vulnerable to misinterpretation.

Planning behaviour was a dominant theme, particularly for ORP participants, accounting for a third of responses for both groups (ORP= 34, LE= 10). For the ORP group, this was followed by psychological pain (caused by thwarted or frustrated psychological needs) and negative affect (e.g. low mood, anxiety) which were reported by less than a quarter of ORP participants (n= 22).

'They have made a plan to take their own life and know how they will do it.' (ORP)

Figure 1. Themes identified for defining someone at the point of taking their own lives



The inverse was true for the LE group. The most common theme within the LE group was psychological pain, reported by over a third of participants (n=12), closely followed by planning behaviour (n=10). This suggests that LE participants were more likely to define someone who is 'at the point of seriously considering taking their own lives' based on affective characteristics and that the individuals emotional state was at least as defining as planning behaviour.

'Losing all hope and thinking that the psychological pain will last forever and genuinely believing that there is no hope of ever feeling any different. Realising that the only way to end the pain is to die and genuinely believing that people would be better off if you were dead.' (LE)

Thoughts of suicide, or suicidal ideation was still a major theme within responses of both groups, however typically not a defining characteristic as this theme was often reported in tandem with other features. The theme of 'help-seeking or perceived to need intervention from others' encapsulates comments of participants' perception that individual should be offered help, though may not be specifically requesting it. This is illustrated in the comments below.

"It means to me that someone has hit rock bottom and are in need of care and advice from professional bodies/charities, family and friends and also being encouraged to do some work on themselves." (LE)

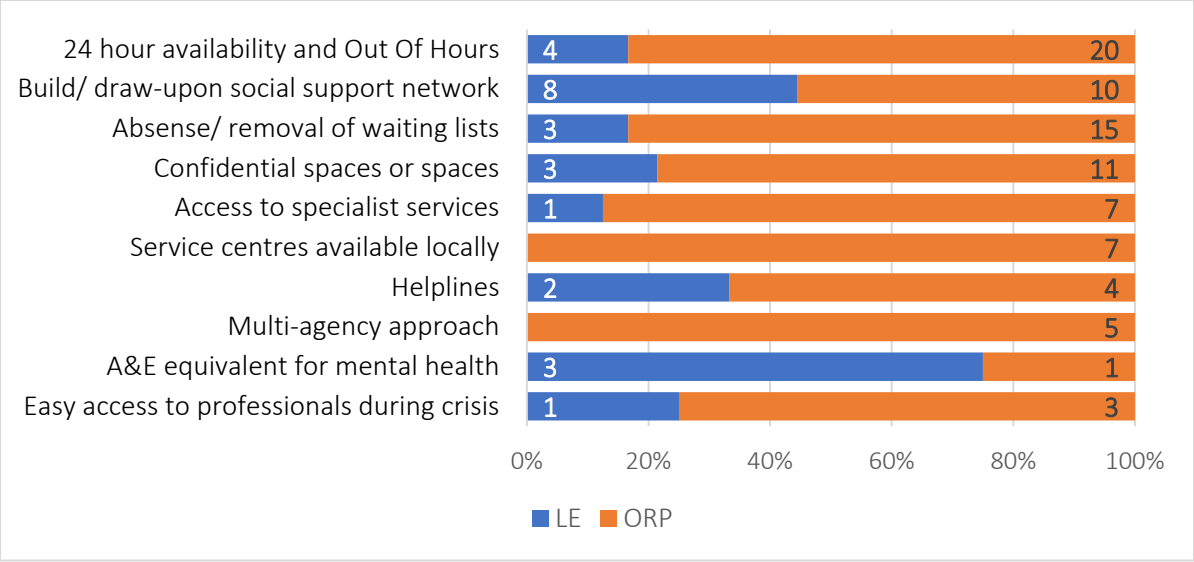
"That they require assistance, be that counselling or just someone to be present with them." (ORP)

Other comments from ORP participants were less clear, with four respondents defining someone experiencing a suicidal crisis as 'high risk' with no further context offered. Only one person from the LE and one from the ORP group considering a history of suicide attempt (or suicide behaviour) to be defining features of an individual experiencing a suicidal crisis. One final participant described their understanding of suicidal crisis based on the negative feelings (i.e. worry) it invoked in themselves, rather that commenting on presentational characteristics of the individual in suicidal distress.

3.2 In your opinion, what help and support should be available for people seriously considering taking their own lives?

Leading recommendations for help and support for people considering suicide were; increased working hours of current services, extended Out of Hours (OOH) services, introduction of further 24-hour supports and improved crisis response. This was predominantly advocated for by ORP participants in the context of mental health. Over a quarter of ORP participants felt crisis support services should be available at all times of day and night, which speaks to a need that the skillset should be that a psychologically supportive nature.

Figure 2 Between-group themes exploring 'What helps should be available for people seriously considering taking their own lives'



"I think the availability of organisations such as Samaritans and Breathing Space is very helpful, however some such organisations are not available 24 hours a day, therefore an organisation which is available around the clock, particularly at weekends and during the Christmas period (a time of heightened risk) would be helpful." (ORP)

"Trained mental health workers available 24/7 to be contactable for support rather than other emergency services who are not best trained to help. A crisis response team who attend calls 24/7" (ORP)

These views were further reflected by the LE, whose most common recommendation was for the availability of immediate crisis response.

"more immediate [correspondence] from mental health professionals" (LE)

Responses from LE participants emphasised the need for crisis supports to be trained or experienced in mental health so as to provide a specialist service. However both LE and ORP groups indicated that more facilities should be available specifically for mental health support, with a strong emphasis on the importance of staff having compassion, understanding and the time to listen to those who contact them.

"After I almost took my own life I was lucky enough to have a flatmate comfort me and I phoned up NHS 24. The woman on the phone was also very comforting and just having these two people engage

with me in such a comforting way immediately helped take some of the weight off my shoulders." (LE)

"Talk to people with lived experience or people who have specific suicide training." (LE)

Only the ORP group explicitly stressed the need for increased professional input (e.g. CPNs, psychologists, psychiatrists), but both groups expressed a need for, and increased availability of, designated mental health hubs as a place individual's could go to share their thoughts. This theme of requiring a dedicated mental health support venue was reinforced by comments on the unsuitability of police and Emergency Department staff for caring for someone considering suicide.

"All too often it falls to the police and we are not trained properly in how to assist someone in coping with this .Our only option is to then take them to A&E which is not the best place for them" (ORP)

"The equivalent of a mental health A&E is required. In reality, normal A&E departments are awful when it comes to mental health, which is why a separate service is needed." (LE)

"There should be a crisis service similar to A&E specific to mental health." (LE)

A further suggestion, from both LE (n=8) and ORP (n=10) participants was the encouragement of using peer supports and building social networks through support groups. This theme, though the second most popular theme, was half has common in the ORP group. Comments argued that the introduction of support groups and building social networks would help to normalise the individual's experiences for them, have better availability, and demonstrate that people can recover from the distress they are experiencing.

"accessible peer to peer support to talk to other people that may be in the same situation. This may show they're not alone" (LE)

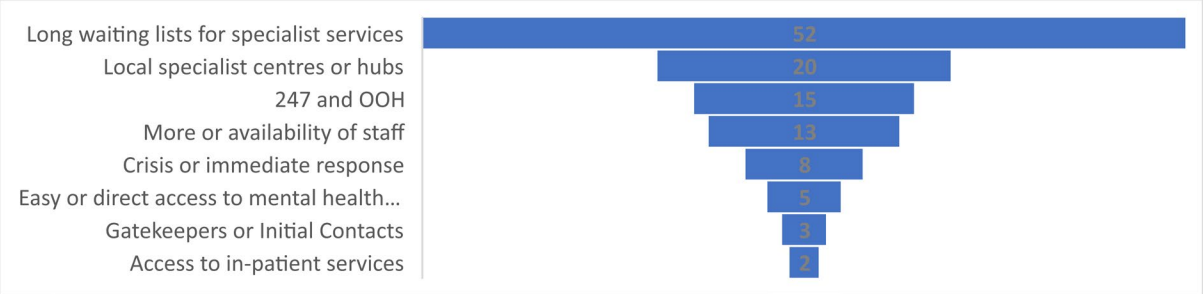
"People need to feel they have a support network who believe their life matters, even if they don't at that moment in time." (LE)

Summary
Comments gathered from both ORP and LE participants in this survey item indicate a dissatisfaction in Emergency Departments caring for individuals presenting with a suicidal crisis. Recommendations were for an equivalent Emergency Department resource to be made available which was specifically designed for mental health care and staffed by mental health specialists. An alternative leading recommendation of the role of lived experience and support groups so individuals felt less alone with the experiences they were having.

3.3 Currently, where do you think there are gaps in support for people seriously considering taking their own lives?

Identified gaps were identical across the LE and ORP groups, with waiting lists being highlighted as a particular issue (see figure 3).

Figure 3 Whole sample comments of gaps identified in support services for people considering taking their own lives



Comments from the LE Group demonstrated recognition and understanding that NHS mental health services were over-burdened with many people waiting to see a mental health clinician. Suggestions from both LE and ORP participants included the introduction of a check-in service offered as an interim support for those on the waiting list to reassure patients of upcoming treatment and ensure the individuals are still safe. Some participants felt this would be a more effective alternative to medication.

"There are huge waiting lists for any type of counselling or therapy and that's understandable, but throwing medication at someone that will take weeks to come into effect and then leaving them to it is killing people" (LE)

"I think many of these people struggle to access appropriate support quick enough. Waiting times for appointments, counselling are often long and delayed and people struggle in the meantime to cope." (ORP)

"The length of time it takes for someone to get help from mental health services as I have heard of so many people having been to their GP and being on a 'waiting list' for psychiatric help and not hearing back anything for over a year. There should be at least regular check-ins and updates for these patients." (ORP)

The theme of waiting lists was pervasive throughout the responses collected here, particularly by ORP participants who were more likely to comment on services being understaffed and underequipped.

"the MH services are underfunded, understaffed and not comprehensive enough to meet [demand]" (ORP)

"Community mental health pathways are underfunded, overworked and do not have the capacity to deal with the daily volume." (ORP)

Beyond access to existing services, and the recommendation for interim support, some participants suggested the upskilling of other professional bodies, especially GPs and Emergency Department staff in order to improve care for people who are help-seeking..

"GP's should also be trained in this area and in MH in general" (LE)

"I feel there needs to be more crisis services for mental health as the normal A&E department are not always prepared or have the training and time to deal with this the way it should be dealt with." (LE)
"I also think there is a training gap for A&E staff" (ORP)

"GP's and mental health teams, they do not have the right amount of staff to deal with the high number of cases and people are made to feel they are wasting their time by asking for help." (ORP)

LE participants also reinforced this theme by expressing that greater understanding and compassion is needed from service providers who engage with self-harm populations.

"Because the symptoms aren't visible, there is an assumption that they are less severe than they are." (LE)

"People who are actively suicidal however are not taken seriously as they are not as vocal about their feelings" (LE)

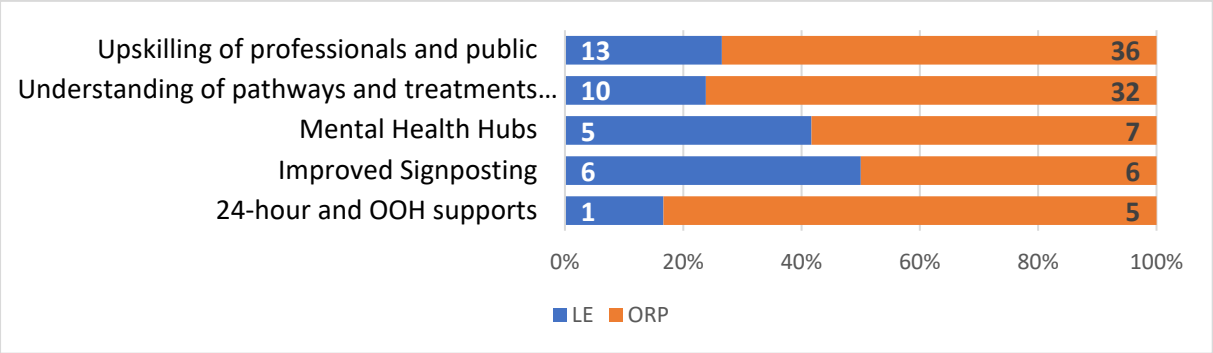
ORP participants frequently suggested stigma prevented people from coming forward about their mental health concerns and so did not engage with supports that are available. No LE participants discussed stigma within their answers to this question.

"I think there is a wide range of support available however, the stigma regarding mental health may prevent people utilizing the support." (ORP)

Summary
Overall, the themes here suggest a pervasive gap in the provision of specialist mental health services, both in emergency response and in after-care treatment. This is illustrated by the leading theme of long waiting lists to see a mental health specialist as well as the availability of a mental health equivalent of an Emergency Department. The recommendations gathered here were consistent that having 24-hour mental health hubs to see skilled mental health staff (i.e. compassionate, patient and non-judgemental) without strict time commitments would be beneficial. This suggestion was followed by the provision of dedicated groups where individuals thoughts and feelings can be normalised.

3.4 What would encourage people to ask for help if they were seriously considering taking their own lives?

Figure 4. Leading themes identified between LE and ORP groups of factors which would encourage people to ask for help



During analysis of survey data, it was identified that a large minority of participants mis-read this question and interpreted the item as 'would you encourage people to ask for help' . Although responses to this mis-interpretation were positive, these answers did not indicate what the help would look like. As such, these responses were removed from the analysis.

Of the remaining data, the themes and answers offered were almost identical between the ORP and LE groups. Both LE and ORP groups suggested that improving the public's understanding of what to expect when engaging with treatment would also encourage people to ask for help.

"More correspondence from professionals, a definite plan of action or treatment and understanding

is needed" (LE)

"I'd like to know who to ask, and ideally have some sense of the person and how they might respond to me." (LE)

"If they knew what is involved, what to expect , that there is help available and that the help will be compassionate and that there is hope." (ORP)

"If they knew they would get a human response, empathy, kindness, someone to listen and help them overcome the difficulties they are facing. If they feel like they have an ally, not necessarily to solve all of their problems for them but someone who can provide support." (ORP)

Similarities between the groups continued in that themes pertained to increased availability to mental health hubs or confidential spaces so individuals would have a dedicated area to discuss their feelings to trained or skilled others.

"I'd like someone kind and friendly, maybe in my GP practice but not my GP. I would like to be able to spend time talking about my problems." (LE)

"Being able to be seen quickly and privately." (LE)

ORP participants indicated that 24-hour availability of mental health services, as well as easier access to these services would encourage people to ask for help.

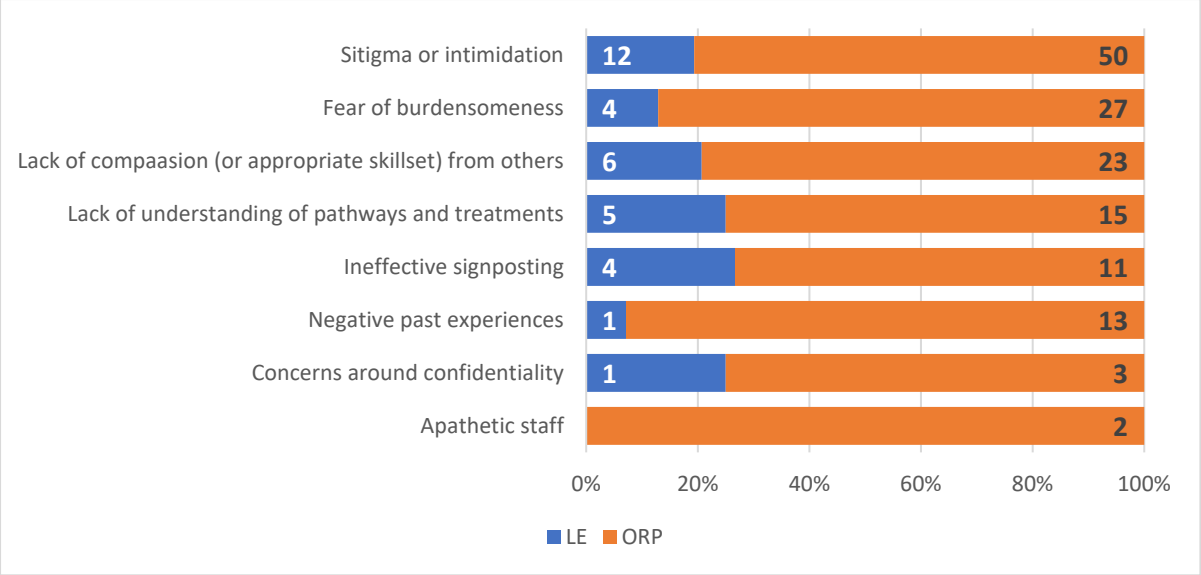
"Low threshold supports- that do not need referrals or technical assessments to access" (ORP)

"Access to a CPN either via a 24hr drop in [centers[at hospitals or via a phone line without having to contact Ambulance/ Police first" (ORP)

Summary
As summarised in earlier survey items, the suggestion for a mental health hub, or mental health Emergency Department was present within the answers gathered here. However, within this answer, knowing that professionals were suitably training to respond to suicidal ideation and behaviour seemed to be the leading theme which would encourage individuals to seek help. This therefore speaks to the lack of suitable mental health support currently available which is reinforced by the themes of recommended increase in availability of mental health specialists out of hours, and improved signposting so as to know where one could access such supports. As there were a number of participants who mis-read this survey item, responses to this answer should be interpreted tentatively.

3.5 What would prevent people from asking for help if they were seriously considering taking their own lives?

Figure 5 LE and ORP group comparisons exploring barriers around asking for help



All responses to this survey item were oriented towards real or perceived societal attitude and how participants have been, or could be, responded to when asking for help. As illustrated by figure 5, almost half of LE participants and over half of ORP participants highlighted stigma or intimidation as a deterrent from asking for help.

"Belief that the person will be treated as inferior, weak, stupid." (LE)

"Embarrassment. Especially for men. In the modern world viewed as weakness by some" (LE)

"Stigma, fear of family, friends or work knowing they are feeling suicidal but want support. Also attitudes of NHS staff if repeated attempts or self harming. Not being taken seriously." (ORP)

"The stigma surrounding suicide, especially for men, I think is a huge reason people do not come forward to speak about their mental health. " (ORP)

Other prevalent themes were more split between the LE and ORP group. LE participants reported barriers in help-seeking included concern of being a burden on services, friends or family by sharing their thoughts of suicide ('fear of burdensomeness'), not knowing what to expect in treatment or anticipating unwanted treatment as a result of asking for help('lack of understanding of pathways and treatments'), as well as ineffective signposting causing people to being unaware of treatment and support options.

"I'd be scared to getting sectioned." (LE)

"not having the knowledge that there are other options" (LE)

"Access to help, not knowing exactly where to go - GP, Hospital etc. " (LE)

"Fear of extremes - you'll be sectioned or you'll just be sent home again. " (LE)

In contrast ORP participants highlighted that feeling burdensome to friends and family following their disclosures of suicide was a common barrier in addition to not getting the emotional support they were looking for.

"Often those closest are the last person someone will share these thoughts with due to feeling like a burden or not being taking seriously" (ORP)

"fear of family, friends or work knowing they are feeling suicidal but want support." (ORP)

"not being taken seriously" (ORP)

"They may feel ashamed so validating their feelings is also important." (ORP)

"Nobody will listen" (ORP)

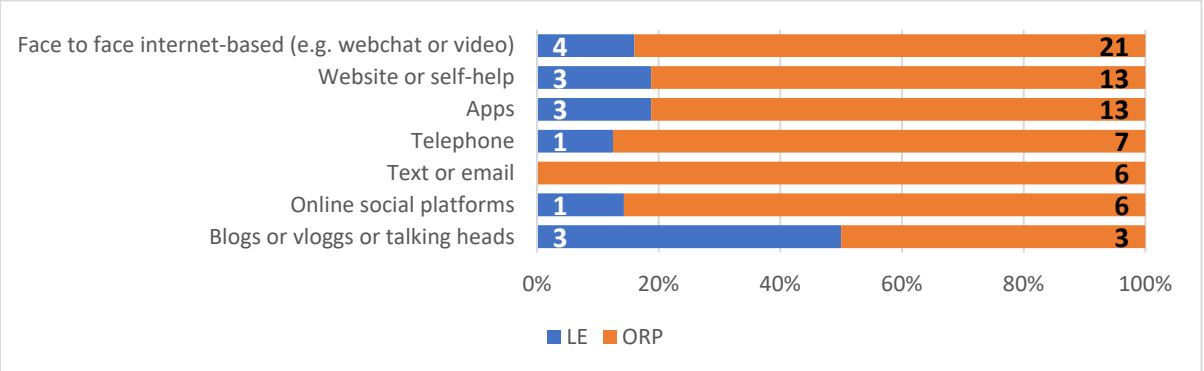
Summary

There was particularly significant overlap within the themes gathered here. Stigma and lack of compassion could be considered similar however in order to maintain homogeneity within the themes, these quotes were developed separately. Leading factors preventing individuals from seeking help were primarily associated with the risk of feeling worse after sharing their thoughts and feelings with others, or having an adverse experience where the individual does not get the care and treatment they are looking for, or their thoughts and feelings are shared with others without their permission. These themes speak to a need for trust in the services offered, where treatments available are clear, transparent and predictable so the individual knows they will have positive experience.

Action 6 questions

3. 6 What digital resources in the context of suicide prevention do you feel is the most effective way for people to access support?

Figure 6. Effective digital resources compared between LE and ORP groups



Views between the LE and ORP groups were split regarding recommendations for digital resources for

suicide prevention. ORP indicated that video conferences or webchat with a therapist would be most helpful.

"video link services, listening service" (ORP)

"web chat and video chat with a real person, with lived experience of suicide." (ORP)

This was followed ORP suggestions of developing Apps and websites. Although the ORP group felt Apps would be helpful, no recommendations were made on what these Apps would feature or how they would function.,

"Phone friendly apps" (ORP)

"An app or website accessible by phone" (ORP)

"informational websites" (ORP)

"links to online resources put in every place a child visits, young adult [too]." (ORP)

In contrast to the recommendations made by ORP, the LE group indicated that the most popular digital aid would be the provision of blogs or vlogs about peoples lived experiences.

"Talking head videos of people who have went through similar issues. Telling their stories honestly and openly. How they felt. What they did. How bad they felt. What helped them. What didn't help them, etc. There are a lot of podcasts last couple of years appearing dealing with men's mental health that I have found really helpful for myself. Similar type of thing from kids, young adults would help others." (LE)

"The most effective digital resource for me is anything visual based. So, a positive suicide survivor story on YouTube works better for me than having to read that same story." (LE)

Similar to the ORPs' leading suggestion, the LE also recommended was webchat or video conferencing with a professional.

"Speaking to someone [on line] when I can be private at home" (LE)

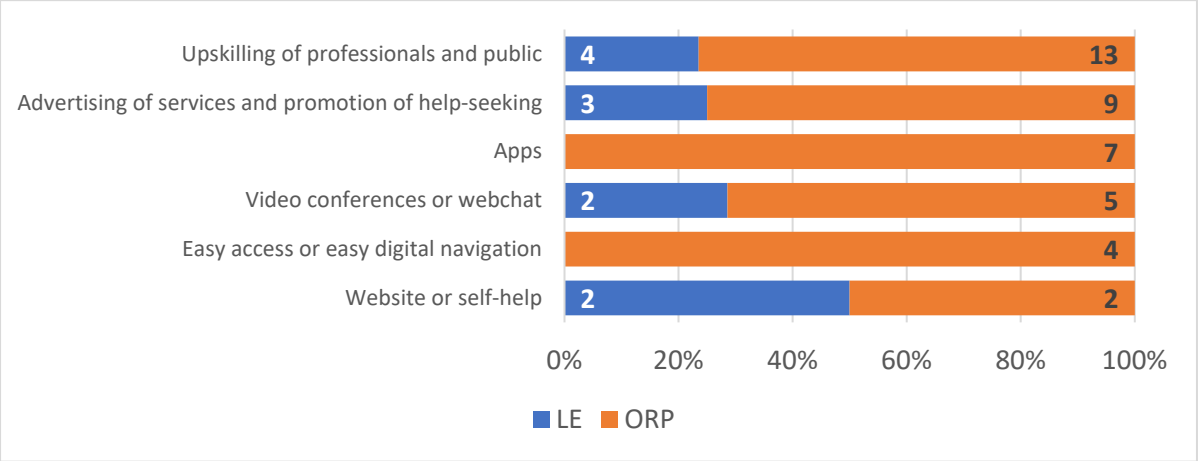
"Forums run by professionals where people know they will be answered by someone who is highly skilled and trained." (LE)

Summary

A strong preference was observed for face-to-face contact through video conferencing software for the ORP group. Although video conferencing was the leading suggestion for LE participants, due to the small sample size digital recommendations from LE participants were more evenly split. The fact that the suggestions were split by LE groups between video conferencing with a mental health professional, blogs or vlogs, and websites for self-help, suggests that the same singular treatment may not be the most effective for all. Only ORP participants felt that email or text would be a helpful way to digitally support individuals experiencing suicidal ideation or crisis, telephone support was also predominantly advocated for by ORP groups.

3.7 What would be the most helpful thing that you would like to see happen developed around online suicide prevention support?

Figure 7 ORP and LE Group comparisons exploring the features online suicide prevention resources could include



The leading theme by ORP participants typically suggested was using digital resources to upskill professionals and the public; to train people in suicide awareness, response and intervention.

"Much more suicide prevention training and safety plan training across all businesses and individuals and not just focussing on practitioners" (ORP)

"Education for children and adults, various methods of assistance across all platforms with one message. Mental Health including Suicide Prevention should be the golden thread running through everything." (ORP)

This was followed by using digital resources to promote such training resources and support services in addition to normalising suicide and self-harm distress and to normalise it. This theme was also the leading theme within LE responses.

"Marketing and promotion of such resources" (ORP)

"More advertising to "[normalize]" we all need someone (a crutch) to lean on at times on our lives and its ok to access support. " (ORP)

"raise awareness of support available will make difference " (ORP)

"Probably have people aware that they can contact online support from mental health professionals via webchats or similar if they are in crisis." (LE)

"Get it talked about, advertise it on the side of buses, and pub toilets, not just in health centres" (LE)

Recommendations of what this digital resource would look like were offered by ORPs with the suggestion of Apps which helped to streamline and signpost existing resources (e.g. helplines, websites) in the geographic area.

"develop a centralised app for people to use across Scotland\UK" (ORP)

"Up to date apps for local authority areas" (ORP)

"disseminate [suicide?help!] app as widely as possible" (ORP)

Suggestions from both LE and ORP participants included the use of video conferencing or online chat feature, with all comments stating this should be with a trained professional

"Immediate ability to access face to face, one to one therapy, by direct access online. e.g. click this link and a human being mental health professional will be there, able to speak to you by video." (LE)

"Anonymous online chats with mental health staff" (LE)

ORP participants also highted the need for the resource to be easy access and easy to navigate so it is available to as many people as possible without complication.

"Easy access and easy read - one click options" (ORP)

"That it was accessible for all" (ORP)

ORP followed these recommendations with the suggestion of developing digital platforms to increase availability to trained mental health professionals

"Cpn services should be available 24/7 to these services to better assess their individual needs" (ORP)

"More support offered 24/7 in various forms like phone support, web chat, emails and texts." (ORP)

Responses from LE participants were more eclectic however some responses mirrored those addressed by ORP above,

"Immediate ability to access face to face, one to one therapy, by direct access online. e.g. click this link and a human being mental health professional will be there, able to speak to you by video." (LE)

However LE also considered the need for advertisement to increase public awareness of these resources

"Get it talked about, advertise it on the side of buses, and pub toilets, not just in health centres" (LE)

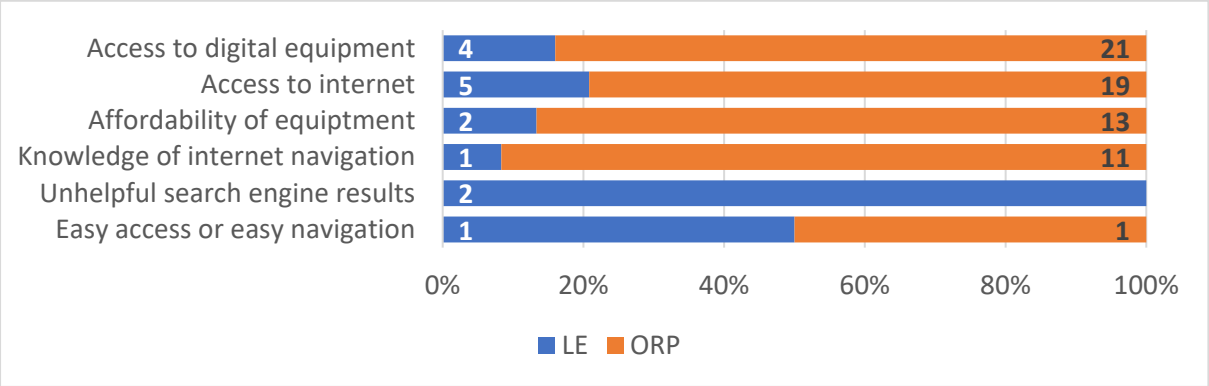
"Probably have people aware that they can contact online support from mental health professionals via webchats or similar if they are in crisis" (LE)

Only two suggestions considered the users ability to utilise digital interventions, one encouraging consideration of the users age, the other considering the users literacy.

Summary
Differences between ORP and LE responses here were mixed, in that ORP participants provided similar responses to one-another while LE responses were more variable. Despite this, the leading themes here was using digital technology to improve suicide awareness in schools, workplaces and for medical professionals (e.g. GPs), followed by advertising of available suicide supports. These themes echo the themes gathered from early survey items by speaking to improvement of support for people who currently need access to mental health services, the removal of stigma around suicide by making it part of normal conversation and education and improved signposting so people can access helpful supports. The recommendation of these digital supports being face-to-face video conferencing or improved websites for self-help were also observed here. Only ORP participants were mindful of the need for these resources to be easy to access and navigate.

3.8 What barriers, either now or in the past, prevent you, or the people that you support, from accessing or using digital resources for suicide prevention?

Figure 8. Group comparisons between ORP and LE exploring barriers in using digital resources



As illustrated by figure 8, LE and ORP both highlighted that the utility of digital resources required availability of internet connection and digital technologies would be a significant factor being able to engage with digital suicide prevention resources, with the underlying theme of financial expense to access both. ORP participants were particularly mindful of older generations who may be more averse to internet use.

"Not having access to technology or Internet" (LE)

"No real barriers if you are lucky enough to have access to the internet and a phone ,tablet or computer." (LE)

"Lack of digital resources, lack of IT skill, inability to access areas with free IT. " (ORP)

"Not all patients have access to digital resources - often no credit in phone, no internet" (ORP)

"I think access to online resources has always been an issue. Particularly in older generations. Through lockdown we have seen first-hand that not everyone is digitally connected" (ORP)

Second to accessibility to internet or internet devices, LE participants expressed that concerns about care and treatment after reaching out would prevent people from engaging with digital resources.

"Not feeling the service is right for them, feeling other people need it more or feeling won't be affective" (LE)

"Being passed directly to the police for action." (LE)

In addition to insufficient signposting and streamlining of existing services.

"asking google throws up too many examples and not [directed support to] children, teenagers, types of illness and needs etc" (LE)

." (LE)

"Not knowing where to look. Not knowing what's available." (LE)

This theme of insufficient signposting towards existing services contains a subtext of potential apprehension of which service would be the best to use, and potential distrust of the services provided when looking for support. Of services which were explicitly stated, all were highly established provisions which are promoted by the NHS and mental health campaigns e.g. NHS websites, Samaritans, MoodJuice.

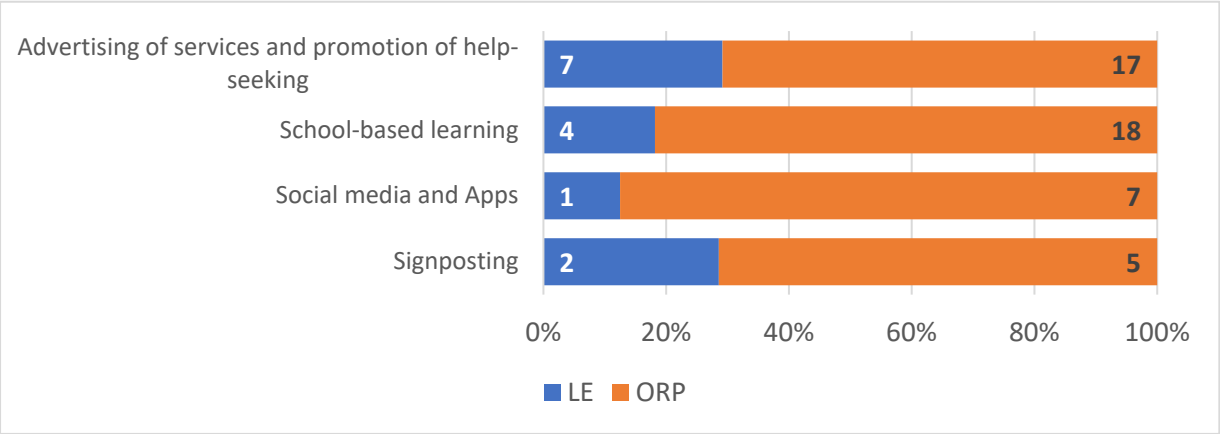
In contrast to the leading themes of the LE group, after barriers to accessing internet more generally, ORP participants reported knowledge of internet navigation was a prevalent theme, demonstrating the ORP group being mindful that the resources may not be accessible to those unfamiliar with internet use, or are illiterate.

Summary
The leading barriers identified by both groups were that of logistics and practicality; the need of internet-enabled devices, and the accessibility (including affordability) of internet use to access the digital resources offered. Similar to earlier themes, ORP participants were particularly mindful of these resources being accessible to everyone, with some populations potentially finding internet navigation and utility more challenging than others. Alternatively LE participants expressed greater concerns about search engines providing too many options and not enough signposting, as well as distrust over what would happen if they engaged with digital treatments.

3.9 How can we encourage children & young people to use online digital suicide prevention services when they need them?

Figure 9. Group Comparison between ORP and LE investigating how to encourage children and

young people to use online digital services



ORP participants suggested promoting the use of the digital supports by introducing them in school and giving psychoeducation more prevalence within the school curriculum, followed by promoting them in other locations children and young people are likely to be.

"Information sessions in schools" (ORP)

"Make it mandatory as part of school curriculum to promote these and continue to talk and educate around cognition, CBT and other functionality of the brain so it becomes. Educate educate educate, promote promote promote" (ORP)

"anywhere young people gather." (ORP)

ORP participants also made recommendation of using celebrities to promote the utility of services and encourage children and young people to reach out.

"The use of high profile role models and peers who have been through similar experiences can assist with this process, although this needs to be closely monitored as it can also have a negative effect on young people." (ORP)

"Utilization of social media platforms to encourage positive conversations around suicide prevention. I.e recognized figures such as celebrities doing live feeds on Facebook, Instagram along with a trained professional who can answer questions. " (ORP)

This theme of promotion was reflected by LE participants however LE recommendations were orientated towards promotion on media platforms.

"Lots and lots of marketing and advertising on social media, YouTube." (LE)

"Adverts on social media" (LE)

"advertising on TV and social media platforms;" (LE)

Within these comments was the sub-theme of making mental health a part of common language and remove the stigma attached to help-seeking or mental health was identified within the ORP responses.

"teach it in school, normalise using them, get them to practice using telephone lines and online resources before they need them." (ORP)

Both groups suggested that promotion could be supported by increasing parental awareness of these resources

"Make parents aware who can thus speak to their children about options available" (LE)

"to up the game with in school presence and learning, by involving parents more and asking for their active cooperation in having conversations about the benefits of online MH resources." (ORP)

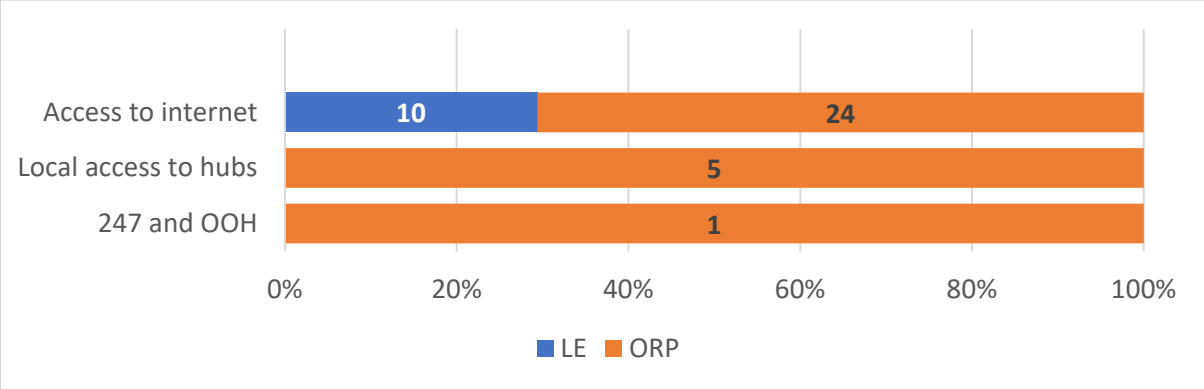
"Awareness in schools and I also feel parents should be made aware of the options to help them support their child." (ORP)

Summary

Overall, ORP participants equally advocated for the promotion of suicide prevention supports through advertising and public exposure, as well as introducing suicide prevention and awareness in education systems. Although the LE participants were most likely to suggest promotion and advertising of suicide prevention supports, due to the small number of LE participants included here, overall views of this group are difficult to interpret. ORP participants also encouraged the involvement of others, including parents, celebrities and social media platforms to maximise children and young person's awareness of suicide awareness and prevention strategies and potentially normalise these conversations for them.

3.10 How can we improve access to online digital suicide prevention services in rural areas?

Figure 10. Group comparisons between LE and ORP investigating how to improve access to online digital service in rural areas



Only 14 LE participants responded to this survey item, of which four comments were not suitable for analysis. All remaining LE responses highlighted the need for improved internet coverage or accessing an internet-enabled device in rural areas.

"Better broadband services or better 4G/5G phone coverage so rural communities have better/faster access to online services." (LE)

"People need to have access to technology and Internet access in the first place. " (LE)

Internet accessibility was also the leading consideration for ORP participants, however ORP participants suggested this could be overcome with the use of mental health 'hubs' providing internet access with one ORP participant suggesting these be staffed at all times.

"If individual access not a possibility then Hubs or areas where access is available" (ORP)

Summary

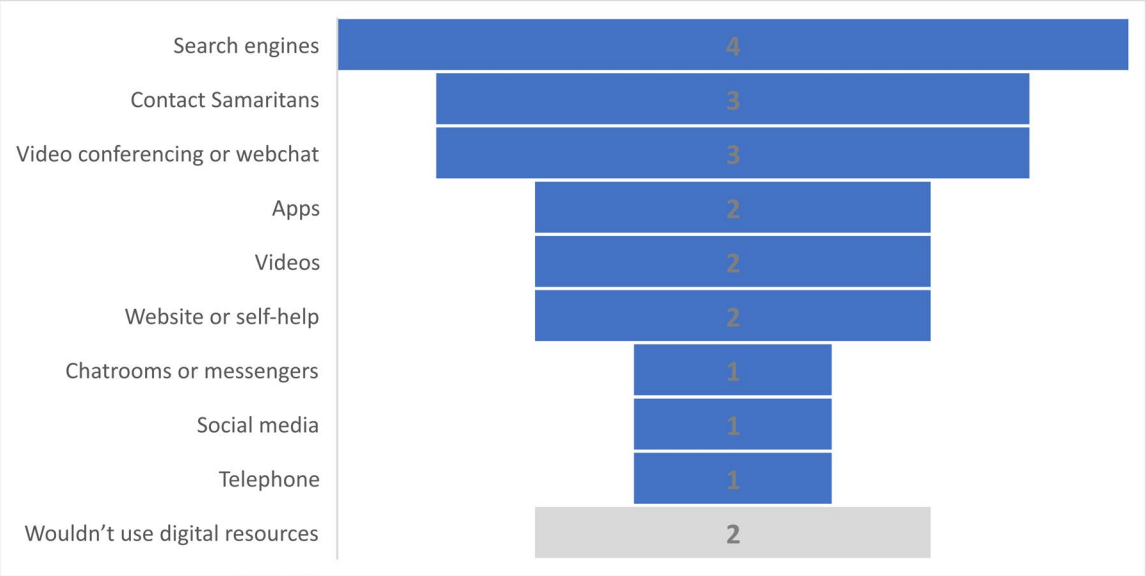
The responses to this survey item was the most homogeneous of all items explored, with all LE participants and most ORP participants who were included in analysis felt that improved internet access would help suicide prevention in rural areas. For the ORP group this was followed by alternative themes of venues providing access to internet-enabled devices and extended operating hours for mental health supports.

3.11 If you were having suicidal thoughts, what digital support would you access, if anything?

LE Group Only

This question was answered by LE participants only with 19 responses included in the analysis.

Figure 11. Tally of digital resources LE participants would use (n=19, LE participants only)



As illustrated by figure 11, the most common digital resource LE participants stated they would engage with was a search engine

"search engine - for any help"

"Just google suicidal thoughts and click the top link"

The second leading theme was contacting Samaritans, however the resources and means in which they contacted this service was not stated, with pro's and con's of contacting this service being highlighted.

"Maybe Samaritans....but the problem is the follow up."

"I would probably access Samaritans if anything, because I remain in control of my decision."

Participants also recommended using video conferencing or webchat as a means to speak to someone about the self-harm thoughts they were experiencing.

"would like to access a human being through the internet. I don't mind a zoom mtg with them but to speak to someone immediately and face to face when suicidal would be the way forward for me."

"People may find it easier with an online chat with these organisations in the first instance instead of a phone call."

Remaining suggestions by participants were brief; responses were limited to one or two words to state the purpose of engaging with digital resources (e.g. "telephone call", "website"). The number of people who referred to these communication means are reflected in figure 11.

Despite the vast majority of respondents indicating they would use digital technology themselves,, or volunteered suggestions of ways others could do so, two participants indicated that they felt digital resources are unhelpful.

"It would be my last resort and unlikely"

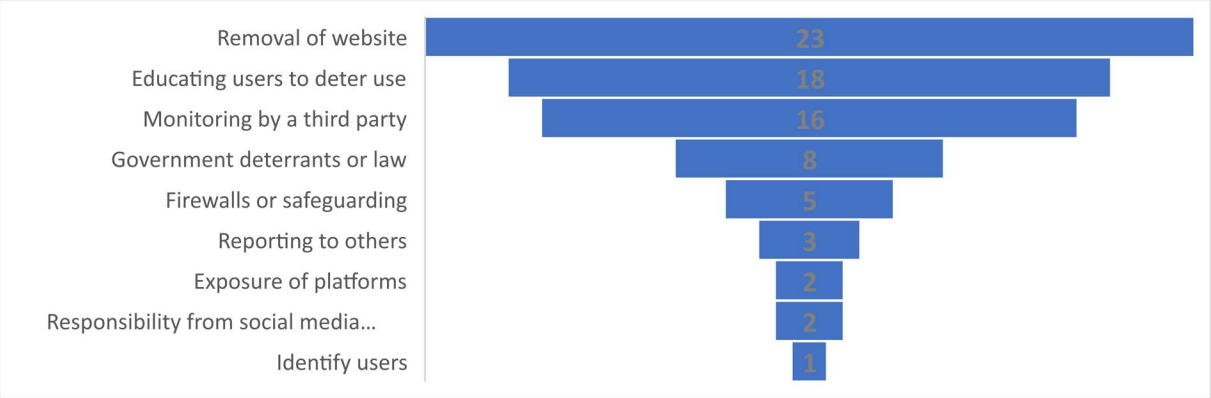
"probably none as I feel they are all a one size fits all model which seems far too impersonal to me."

Summary
Due to the number of LE participants, the results here could be considered to be eclectic, with only one participant distinguishing search engines as the leading digital resource to use during a crisis over calling Samaritans or using video conferencing software. Additionally, comments around search engines were vague with the utility of this being unclear. It may be that those who use search engines may do so to read a blog, obtain a helpline telephone number or any alternative use. It is also important to note that throughout the data collected, other third-sector charities were mentioned by the LE and ORP groups as resources they would use, however these alternative agencies were not mentioned this specific survey item. Overall, these results suggest that individuals would use a variety of resources to suit their individual needs, with no clear preference identified.

3.12 What do you consider as effective ways to manage online harmful content - such as pro-suicide platforms websites?

This survey item was answered only by ORP participants, of which 53 comments were appropriate for data analysis.

Figure 12. ORP views on how to best manage pro-suicide platforms



As illustrated by figure 12 ORP participants indicated that the removal of the websites would be the best way to manage online harmful content.

"blocks on dark webs and sites encouraging people to complete suicide"

"Get the content removed by the host website"

Within the data analysis some participants indicated that removal of a website was not an option, suggested that the participant was not aware that this was possible or that doing so may be unhelpful.

"You can't prevent these and people need to be aware of the harm they can cause."

"I don't think we should try and force them to close or block them, it's about creating awareness around them, in my opinion. "

Further suggestions included educating the general public about why pro-suicide websites exist and how to respond to them.

"Discussion and education for both parents and children, around such matters and the difficulties people might be having and why they find such forums a source of comfort (while being careful not to encourage use of same)."

"I think we could definitely do with more education/awareness raising about being wary of harmful content in general though"

Less common suggestions were to 'make people provide details so we know who is accessing the sites' and encourage online platforms who host this content 'to take more responsibility', monitor the content and deter its use or promotion

"Social media platforms and Search Engines [providors] need to be much more proactive in seeking out these websites and getting the host to shut them shutdown".

"greater responsibility taken by social media companies"

Summary

The range of themes gathered here was large, spanning from removal of websites and government imposed fines on the website creators, to educating website users on the negative implications of

these websites or leaving the websites up with no action taken. The leading theme was the removal of the website, followed by educating users of these resources or monitoring these websites should intervention be required. However it was unclear what this monitoring would do or at what threshold would be appropriate for any further action by these third-party monitors. Within the responses it seemed a large number of participants did not know, or feel, it was possible for the websites to be removed, with some suggesting that removal of the websites would be futile as they would be recreated under a different web name, and others advocating that human rights should allow these websites to remain available.

4. Themes

Specific survey questions have been discussed in the context of its component leading themes within sections 3.1-3.12, however exploring these leading themes in a broader context may lend itself to the understanding of stakeholder perceptions and attitudes within the areas explored here. Overall, 20 themes were developed across the survey questions. It is beyond the remit of this report to be able to comment on each of these themes out with the survey items, however a discussion of three key themes across the whole respondent sample may help provide further context to the development of existing support services and the development of digital suicide prevention strategies.

4.1 Frontline staff

Frontline staff (e.g. GPs, paramedics, police and Emergency Department staff) are particularly likely to encounter individuals who report or present with suicidal ideation or self-harm behaviour and are vital in suicide prevention strategies (e.g. Distress Brief Intervention). The prominence of these professions is reflected in that they were frequently mentioned throughout the survey by both the ORP and LE groups. Due to the unique role of each of these professions within the context of caring for those experiencing a suicidal crisis, the professions are discussed individually below.

4.1.1 General Practitioners (GPs)

The role of the GP was discussed by 34 participants (47 comments) across ten survey items between Actions 5 and 6. LE participants discussed that the lack of availability of GPs made contacting a GP during a suicidal crisis unlikely. Leading themes around GPs was frustration towards the time constraints of 10-minute appointments, the limited mental health skillset of GPs, and the gatekeeper role of GPs for getting referred to mental health professionals.

"Going to a GP in the midst of a suicidal crisis is unrealistic"

"When discussing suicidal thoughts with a GP it could be difficult to open up about something so private in the space of a 10 minute appointment"

"There isn't anything out there that has direct access to a mental health professional. I still have to go through my GP where it is hard to get an appointment."

Participants suggested that it would be helpful for GPs to receive training in mental health support, some comments suggested that the use of talking therapy instead of medication would be preferred.

"GP's to receive more mental health focused training and move away from the pharmacology route of treating mental illness."

"The GPs have very little time to spend with the person and are limited to prescribing antidepressants."

"GP's should also be trained in this area and in MH in general- particularly in relation to trauma."

A further suggestion offered was to promote consistency between patients and GPs to develop a rapport where patients feel they can share their experiences, or to bypass the GP all together with a self-referral system.

"They see a different GP each time, so little chance to build up trust and open up."

"online self referral - I think a lot of people are reluctant to visit GP"

4.1.2 Paramedics and ambulance service

Discussions around ambulance service and paramedics were less common, with only 22 comments across 12 participants. These comments primarily pertained to having a mental health equivalent to an ambulance service for physical health emergencies, a mental health professional included within the ambulance service, or having a specific mental health hub where the ambulance could take distressed patients instead of to the Emergency Department.

"Ambulance staff require a place of safety and a referral pathway to take patient [too] or signpost patient [too]."

"A rapid response team to be dispatched almost in terms of an Ambulance but with Mental Health Nurses on board."

"A Full Mental Health type Ambulance Service fully equipped to deal with incidents"

Police

Police were mentioned 115 times from 57 participants between nine questions. The most salient theme around the police was that they were not an appropriate source of support for individuals experiencing a suicidal crisis.

"I do, however, think emergency responses should be available for intervention in critical moments that are not police."

"it often falls to police to deal with these individuals and they are not best equipped in dealing with mental health."

"The last thing someone feeling suicidal thoughts wants is to deal with the police. All they see in the uniform."

This was reinforced by participants stating that they felt that the police did not have the skillset to respond to a suicide crisis appropriately

"Lack of knowledge in how to deal/support/emapthise from police"

"Medical/social care (public sector) too often pass responsibility onto police who don't have the right knowledge or resources to support people with genuine needs"

Similar to responses to paramedics and ambulance service, it was suggested that the police should be able to take individuals experiencing a suicidal crisis to a venue which is designed for supporting mental health or to have mental health specialists integrated into the police force.

"the police should be able to take them to a "crisis/mental health assessment centre", where they can be assessed within an hour or two"

"A MH practitioner who can attend alongside police services to engage with the individual at the point of intervention."

"-Triage cars either through Police or Ambulance with a mental health nurse/ staff on board with a Police officer or paramedic that can respond to Mental health specific calls."

However further suggestions were made towards the upskilling of the police force and increase the availability of police negotiators who could respond to these crises.

"Education provided to Police regarding mental health as current information is minimal. There is also not enough police negotiators available at any one time."

In addition to the above themes, there was also an undertone of the negative connotations associated with police responding to suicidal distress.

"Police attendance can have a negative impact on the reporter."

"The last thing someone feeling suicidal thoughts wants is to deal with the police. All they see in the uniform."

"they may be afraid that if they express their thought someone will notify the police who will kick their door in and drag them to Hospital"

Emergency Department Staff

81 references from 42 participants were made relating to the Emergency Department and/or Emergency Department staff. These particularly related to questions 2—5 of Action 5 (see sections 3.2 to 3.5). For the majority of responses, comments around Emergency Departments were particularly oriented around having a mental health equivalent.

"I think having somewhere to take patients other than A&E would be of great benefit, where staff are trained in mental health and are able to provide the correct level of intervention."

"It would be much more efficient if patients could go to a specific Mental Health Centre of sorts, or an A&E for mental health. This reduces the stigma of having mental health problems, waiting times, and appropriate interventions and support can be provided."

"There should be a crisis service similar to A&E specific to mental health."

These comments, among many others offered by the participants, illustrated that not just the general setting of the Emergency Department (i.e. lack of confidential spaces, quiet place to think or talk without distraction or disruption) was unfavourable in survey respondents views, but also the skillset of the staff they interacted with. The comments highlighted that patients who attended Emergency Departments for suicidal crises were effectively being taking to the 'wrong' place as their ailments were psychological and therefore were not getting the correct treatment.

"Taking a patient to A&E is probably the worst place to take the patient due to a lengthy wait, roughly 5-6 hours."

"A&E staffs training for suicidal people is inadequate and the environment of an impersonal, noisy and busy A&E dept isn't appropriate"

4.2 Third-sector services

Third sector charities were mentioned 65 times from 43 participants spanning all 12 survey questions. The third-sector supports referred to were predominantly Samaritans followed by Breathing Space. The comments around third-sector supports were positive, with comments suggesting that participants felt Samaritans and Breathing Space were reputable, reliable services. Participants reported that third-sector charities were particularly helpful for having someone to speak to during a crisis, as well as allowing the caller to remain autonomous.

"I think the availability of organisations such as Samaritans and Breathing Space is very helpful,"

"Crisis support like the Samaritans, etc are crucial as they can catch people at a critical moment."

"…from my experience as a Samaritan, I find that people often phone because they don't want the option of suicide removed, but as the conversation goes on the feeling of suicidality often (but not always of course) deflates. The control must remain theirs for as long as possible."

Participants recommended that third sector supports needed to be promoted further, online through search engines, on pro-suicide websites and in more general locations like libraries, GPs and in public places.

"Initiatives such as Samaritans popping up on google when you search for anything suicide related."

"Warnings appearing with numbers for people to call for assistance such as Samaritans and breathing space"

"Services like breathing space and the Mental health hub should be widely advertised as a way of accessing support and advice if you are suicidal"

"Further advertisement of this required."

In addition to increased promotion and advertising of these supports, some participants made recommendations of how these services could be improved. These recommendations included the provision of follow-up contact with callers, more staffing to meet caller demand, more modes in

which to communicate with these services (i.e. webchat) and to improve the general perception of what it means to call such helplines.

"I think people still view contacting Samaritans as admitting to serious mental illness and suicidal. In reality if should be viewed as just a safe place to discuss feelings,"

"Maybe Samaritans....but the problem is the follow up."

"Webchat, as used by Breathing Space, I feel is an effective way for individuals to access support."

"Samaritans must be very busy, because I've tried to call a few times but wasn't answered."

"The 3rd sector mental health charities should also have apps, which most currently don't."

4.3 Compassion

92 references to compassion (including empathy and emotional understanding) were identified from 62 participants. These references were mainly made within questions 2-5 of Action 5 (see section 5.2 to 5.5) and question 8 (see section 3.8) though relevant comments were identified across all 12 survey items. After the need for having specialist staff time to listen to patients, the leading characteristic participants reported they needed from support services was compassion (or other clinical listening skills) from the listener. The need for compassion was made in particular reference to professional support but the benefits of individuals with lived experienced was also acknowledged.

"Adequately trained staff who have the time, skills and compassion to support such individuals. "

"Somebody to talk to who had insight and understanding into their issues and challenges, and who has an understanding of suicide and suicidal ideation."

"the availability of approachable, understanding clinicians/others whom that person feels comfortable in speaking about such a personal issue with"

Some comments around compassion were made in the context of the fear there would be none if an individual was to share their thoughts, or that they have had experience of asking for help where no or little compassion was offered. Thereby the anticipated lack of compassion was a barrier for them to communicate their thoughts and feelings to others.

"Previous experience leading to a lack of trust in services - e.g. feeling like they have not been taken seriously or treated with compassion, fears of being detained"

"I want to speak to someone kind who will just listen to me and try to really understand. I don't want to be patronised or made to feel stupid."

5. Conclusions

Responses between ORP and LE participants were more congruous within Action 5 survey items than Action 6 items. LE participants were more likely to encourage the development of a variety of support treatments and modes to access them so that the service user can have a choice of how to engage with supports. Conversely ORP responses were relatively homogenous within the survey items and considered participant demographics and logistics with regard to suicide prevention strategies. The theme of stigma was more common within ORP responses (see section 3.3) than LE stakeholders who were more likely to report concerns around having a compassionate response from those they seek help from. Although these two themes do at times overlap, and were mentioned by both groups, this illustrates a divergence of opinion between these group perspectives.

Overarching themes from Action 5 included the need for mental health hubs or mental health equivalent of an Emergency Department. This was followed by themes of needing dedicated mental health specialists available within 24-hour services (e.g. mental health crisis helplines). Overarching themes for Action 6 was the need for practical provisions for engaging in digital resources; access to free Wifi and access to internet-enabled technology, most commonly to use video conferencing to speak to a mental health professional.

Limitations of the current report was that only 60% of the data was analysed and sub-group comparisons were not made within either of the LE (e.g. age, sex) or ORP (e.g. third sector vs private sector) groups. The data reported here is based on a closed survey, with groups and organisations approached to participate. This approach may explain the high proportion of participants representing vulnerable groups known to be at a statistically increased risk of suicidal ideation or behaviour (e.g. physical or mental health diagnoses, trans populations). Some targeted groups may have been more receptive to participating in the survey than others, as reflected by representatives of the trans populations being high, and non-heterosexual population being low. Finally, one of the survey items was widely mis-read by participants of both groups (see section 3.4) which could have led to unrepresentative results to this topic area, especially from the LE group.

Following analysis of the survey results, three key themes were discussed more broadly, out with the confines of a survey item. These key themes were third sector organisations (e.g. Samaritans), frontline staff (e.g. police) and compassion. There was significant overlap between these themes, with participants indicating the need for dedicated mental health professionals to be available either to attend a crisis, or for individuals to present themselves to these professionals. Participants indicated that third-sector resources were helpful, especially during a crisis, however frustrations in skillset were seen in all front-line supports discussed. Compassion seemed to be the most important skill needed from others when experiencing a suicidal crisis; the need for understanding from others and the time to talk about their feelings without concern over having their conversation interrupted or being responded to negatively in some way. Recommendations included increased availability of face-to-face web chats with mental health professionals or third-sector workers, as well as a dedicated mental health emergency response assimilated into existing emergency response services.

Future surveys would benefit from using an open survey approach to capture more nationally representative norms from a larger participant group, as well as exploring responses between demographics and professional sectors of work.

Appendix 1. Survey items

1. Stakeholder group

Do you live in Scotland?

Are you aged 16 or older?
This survey is designed to be answered by both those people with lived experience and by organisations and professionals which provide support or services relating to suicide prevention in Scotland. From which perspective are you answering questions?
Options

- Individual with lived experience
- Representative of an organisation or a professional

Do you work for a
Options:

- Public Sector Organisation
- Private Sector Organisation
- Third Sector Organisation

Which of the following sectors do you work in? Please tick all that apply. - Selected Choice

Which of the following sectors do you work in? Please tick all that apply. - Other (please specify) – Text

Who do you, or does your organisation, mainly work with?

2. Action 5 questions

What does it mean to you when people are described as 'at the point of seriously considering taking their own lives'?
In your opinion, what help and support should be available for people seriously considering taking their own lives?

Currently, where do you think there are gaps in support for people seriously considering taking their own lives?

What would encourage people to ask for help if they were seriously considering taking their own lives?

What would prevent people from asking for help if they were seriously considering taking their own lives?

3. Action 6 questions

What digital resource/s in the context of suicide prevention do you feel is the most effective way for people to access support?

What would be the most helpful thing that you would like to see happen/developed around online suicide prevention support?

What barriers, either now or in the past, prevent you, or the people that you support, from accessing or using digital resources for suicide prevention?

How can we encourage children & young people to use online/digital suicide prevention services when they need them?

How can we improve access to online/digital suicide prevention services in rural areas?

If you were having suicidal thoughts, what digital support would you access, if anything?

What do you consider as effective ways to manage online harmful content - such as pro-suicide platforms/websites?

4. Demographics (LE only)

What is your sex?

Do you consider yourself to be trans, or have a trans history?
(Trans is a term used to describe people whose gender is not the same as the sex they were registered at birth) - Selected Choice
Do you consider yourself to be trans, or have a trans history?

(Trans is a term used to describe people whose gender is not the same as the sex they were registered at birth) - Yes - (Pease describe your trans status, for example, non-binary, trans man, trans woman) - Text

Please tell us how old you are in years

Which of the following best describes your sexual orientation? - Selected Choice

Which of the following best describes your sexual orientation? - Other (Please provide the term you prefer) - Text

Do you have a physical or mental health condition or disability that has a substantial effect on your ability to carry out day to day activities? AND/OR has lasted or is expected to last 12 months or more?

What is your current nationality?

What was your nationality at birth?

What is the first part of your postcode in Scotland?

What is your ethnic group? - Selected Choice

What is your ethnic group? - Other (please specify) - Text

To which religion, religious denomination or body do you actively belong? - Selected Choice

To which religion, religious denomination or body do you actively belong? - Other faith/belief (please specify) - Text

What is your employment status? - Selected Choice

What is your employment status? - Other (please specify) - Text

Appendix 2. Lived Experience (LE) demographic summary table

Demographic		Mean (sd)/ N
Sex (n= 25)	Male	11
	Female	14
Age (n= 24)		41.5 (12.3)
Trans-sexual (n= 25)	Yes	10
	No	15
Sexuality (n= 25)	Heterosexual	21
	Bi/ Bisexual	2
	Lesbian	1
	Prefer not to say	1
Physical or mental health condition (n= 25)	Yes	10
	No	13
	Prefer not to say	2
Nationality (n= 25)	British	12
	French	2
	Scottish	11
Ethnicity (n= 25)	White British	1
	White Scottish	21
	Any other White Background	1
	Other (please specify)	1
	Prefer not to say	1
Religion (n= 25)	Church of Scotland (Christianity)	3
	Roman Catholic (Christianity)	4
	No religion (none)	17
	Prefer not to say	1
Employment status (n= 25)	Full time education	1
	Full-time paid employee (30+ hrs per week)	15
	Full-time self-employed (30+ hrs per week)	2
	Part-time paid employee (<30 hrs per week)	1
	Permanently sick/disabled (6+ months)	2
	Temporarily sick/disabled (<6 months)	1
	Wholly retired	2
	Prefer not to say	1

Frequencies are reported for categorical variables, means and standard deviation are used to report continuous variables.

Appendix 3. Number of responses per survey item

	Number of comments		
Item	**ORP**	**LE**	**Total**
What does it mean to you when people are described as 'at the point of seriously considering taking their own lives'	93	30	123
In your opinion, what help and support should be available for people seriously considering taking their own lives	91	30	121
Currently, where do you think there are gaps in support for people seriously considering taking their own lives	89	30	119
What would encourage people to ask for help if they were seriously considering taking their own lives	90	30	120
What would prevent people from asking for help if they were seriously considering taking their own lives?	93	30	123
What digital resources in the context of suicide prevention do you feel is the most effective way for people to access support	63	23	96
What would be the most helpful thing that you would like to see happen developed around online suicide prevention support	70	22	92
What barriers, either now or in the past, prevent you, or the people that you support, from accessing or using digital resources for suicide prevention	76	22	98
How can we encourage children & young people to use online digital suicide prevention services when they need them	76	22	98
How can we improve access to online digital suicide prevention services in rural areas	72	22	94
Q24 (Action 6) - If you were having suicidal thoughts, what digital support would you access, if anything	0	21	21
What do you consider as effective ways to manage online harmful content - such as pro-suicide platforms websites	74	0	74