Creating Hope Together: Scotland's Suicide Prevention Strategy 2022 – 2032

Equality Impact Assessment Record

September 2022

Scottish Government
Riaghaltas na h-Alba
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EQUALITY IMPACT ASSESSMENT RECORD

Title of policy/ practice/ strategy/ legislation etc.	**CREATING HOPE TOGETHER: SCOTLAND'S SUICIDE PREVENTION STRATEGY 2022 – 2032**
Minister	Minister for Mental Wellbeing and Social Care - Kevin Stewart MSP
Directorate: Division: Team	Mental Health Directorate: Suicide Prevention Policy and Delivery Team
Is this new policy or revision to an existing policy?	New strategy and action plan (building on current policy as set out in Every Life Matters – Scotland's suicide prevention action plan 2018-2022)

Introduction:

This strategy is being published jointly between the Scottish Government and COSLA, and is a long-term strategy which covers a 10 year period from September 2022. Alongside the strategy there is an initial 3 year action plan which describes what actions will help achieve the vision and long term outcomes as outlined in the strategy. The action plan will be refreshed regularly over the lifetime of the strategy.

Vision, Outcomes, Guiding Principles and Priority Areas:

Our vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide. To achieve this, all sectors must come together in partnership, and we must support our communities so they become safe, compassionate, inclusive, and free of stigma. Our aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope.

We recognise the complex reasons and circumstances which contribute to someone feeling suicidal, and we will adopt the seven guiding principles set out below as our way of working to ensure effective delivery of the strategy and action plan.

The strategy adopts an outcomes approach to describe the changes we need to achieve in order to deliver our vision. Outcomes are changes as a result of this strategy, which include changes in: knowledge, awareness, skills, practice, behaviour, social action, and decision making. Outcomes fall along a continuum from short term, through intermediate, to long term.

To achieve the vision we must deliver across these long term outcomes. Together these outcomes will affect change across our society, services, communities, and individual experiences. We also consider that the suicide prevention long term outcomes will also bring about a positive impact on our National Outcomes, specifically: Human Rights, Poverty, Children and Young People, Health but also Economy and, Fair Work and Business.

Throughout the development of the strategy we asked people what should be prioritised in a new strategy and action plan. The priority areas set out below were identified by people with lived experience and stakeholders as key priorities for suicide prevention, and have therefore shaped the focus of the first action plan, alongside evidence and the outcomes approach.

A summary of the Vision, Outcomes, Guiding Principles and Priority Areas can be found in figure 1.

Vision

Our vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide.

To achieve this, all sectors must come together in partnership, and we must support our communities so they become safe, compassionate, inclusive, and free of stigma.

Our aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope.

Guiding Principles

1. We will consider inequalities and diversity – to ensure we meet the suicide prevention needs of the whole population whilst taking into account key risk factors, such as poverty, and social isolation. We will ensure our work is relevant for urban, rural, remote and island communities.
2. We will co-develop our work alongside people with lived, and living, experience (ensuring that experience reflects the diversity of our communities and suicidal experiences). We will also ensure safeguarding measures are in place across our work.
3. We will ensure the principles of Time, Space, Compassion are central to our work to support people's wellbeing and recovery. This includes people at risk of suicide, their families/carers and the wider community, respectful of their human rights.
4. We will ensure the voices of children and young are central to work to address their needs, and co-develop solutions with them.
5. We will provide opportunities for people across different sectors at local and national levels to come together, learn and connect – inspiring them to play their part in preventing suicide.
6. We will take every opportunity to reduce the stigma of suicide through our work.
7. We will ensure our work is evidence informed, and continue to build the evidence base through evaluation, data and research. We will also use quality improvement approaches, creativity and innovation to drive change – this includes using digital solutions.

Outcomes

Outcome 1:
The environment we live in promotes conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.

Outcome 2:
Our communities have a clear understanding of suicide, risk factors and its prevention – so that people and organisations are more able to respond in helpful and informed ways when they, or others, need support.

Outcome 3:
Everyone affected by suicide is able to access high quality, compassionate, appropriate and timely support – which promotes wellbeing and recovery. This applies to all children, young people and adults who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways.

Outcome 4:
Our approach to suicide prevention is well planned and delivered, through close collaboration between national, local and sectoral partners. Our work is designed with lived experience insight, practice, data, research and intelligence. We improve our approach through regular monitoring, evaluation and review.

Priority Areas

Build a whole of Government and whole society approach to address the social determinants which have the greatest link to suicide risk

Strengthen Scotland's awareness and responsiveness to suicide and people who are suicidal

Promote & provide effective, timely, compassionate support – that promotes wellbeing and recovery

Embed a coordinated, collaborative, and integrated approach

Figure 1

Key aspects of our approach:

The strategy sets out a whole of Government and society approach, which means suicide prevention is embedded across a range of policies to address the social determinants of suicide and to ensure that every opportunity is taken to support someone who is suicidal. Relevant policies include: child poverty, drugs mission, debt and spatial planning.

It considers the whole population and groups at higher risk; both in terms of risk and protective factors.

The strategy emphasises the importance of bringing together individuals, groups and sectors in communities across Scotland, to achieve change. We recognise the value in continuing to engage: across sectors, with new and existing partners and organisations, with people with lived experience of suicide.

We are committed to maintaining this participative approach as the strategy and action plan are implemented. This will help us to continue to learn about the needs of the whole population as well as specific groups at higher risk of suicide, and how we can effectively reach and support all groups effectively through this strategy.

In particular, we know there is further work needed to fully understand the needs of children and young people. We will work with the new Youth Advisory Group – and other leading children and young people's organisations and groups – to understand their needs and co-produce approaches with them.

We also know that some groups have suicide prevention needs which are specific to their experiences, such as LGBTI people, racialised groups, and migrants. We are fully committed to engaging with members of these communities – and trusted organisations who work with and for them – to ensure we continue to build our understanding of their needs and take tailored suicide prevention approaches

This strategy builds on a wide programme of suicide prevention in Scotland over the last 20 years, most recently the Suicide Prevention Action Plan 'Every Life Matters' which was published in 2018. Following extensive engagement and evidence gathering the new strategy will continue the following work:

- Reduce stigma and grow awareness of suicide through the social movement and campaigns
- Provide learning opportunities for the workforce
- Embed Time Space and Compassion into the responses people receive when they are suicidal
- Support people bereaved by suicide
- Provide support for local area action planning through Implementation Leads and ensure the local network of suicide prevention leads are well informed, engaged and connected to national work through opportunities to share learning
- Ensure evidence is available to support needs assessments through multi-agency reviews of deaths by suicide and access to more timely data

The new strategy seeks to support anyone affected by suicide (including family and carers) and will be driven by communities and statutory services. It prioritises action on: people with higher risk of suicide, children and young people, and key settings – e.g. prisons.

To ensure this is realised, the strategy focusses on key areas such as:

- Taking a whole of Government and society policy approach – ensuring that we address the factors that lead someone to be suicidal, as well as taking every opportunity to identify and support people who may be suicidal – as early as we possibly can.
- Reaching out to support people who are at particular risk of suicide – better understanding about how we can connect and support marginalised groups.
- Taking a more focussed approach – prioritising key settings, communities, and parts of the workforce – so that we can achieve the biggest difference in preventing suicide.

The governance structure will be revised and will include representatives from poverty and marginalised groups. This revised, and improved, governance will help ensure we deliver on the actions in the action plan and achieve the long term outcomes.

Who will it affect?

The strategy and associated action plan(s), seek to create a positive impact for everyone in Scotland, by preventing death by suicide and supporting anyone affected by suicide. Although no-one is immune from suicide, some individuals are at greater risk. Data from Scottish Suicide Information Database (ScotSID) report profiling suicide deaths between 2011 and 20193 shows:

- Just under three quarters of all suicides in Scotland are male
- Almost half (46%) were aged 35-54
- Death by suicide is approximately three times more likely among those living in the most socio-economically deprived areas than among those living in the least deprived area
- 88% of people that die by suicide are of working age with two-thirds of these in employment at the time of their death.

The strategy – and its long term outcomes – seek to create the conditions needed to prevent suicide – at a society, community and individual level. For people to receive the support they need, when and where they need it, we must continue to review what is working well, and address aspects that need improved. People who are identified as at higher risk of suicide, or the workforce that supports people identified at higher risk, are highlighted across the action plan, and reflected in this EQIA.

We know that suicide prevention needs to be much more than acting at a point of crisis, and we must use our knowledge of risk and protective factors to take early action, and to do that in a way that offers Time, Space and Compassion.

Our approach must respond to the suicidal experiences that people face, recognising that experiences of suicide are personal - varying from one person to another and are unlikely to follow a linear route. As such our efforts will span the following areas: promotion of wellbeing (primary prevention), early intervention, intervention, recovery and postvention.

The strategy and action plan reflect the fact that people have different needs. Equality legislation covers the protected characteristics of: age, disability, gender reassignment, gender including pregnancy and maternity, race, religion and belief, and sexual orientation. The strategy has the potential to affect everyone so the scope of this equality impact assessment (EQIA) is extended beyond the list of protected characteristics to include wider socio-economic considerations.

What might prevent the desired outcomes being achieved?

It is essential to continue meaningful engagement and partnership working to implement the strategy. This includes continuing to deliver a whole of government policy approach, supported by local service delivery, and working across sectors – and communities - to ensure everyone can play their role in preventing suicide. The strategy builds on previous work in Scotland, and the process of developing the strategy has deepened the reach of national and local government to affect change.

The backdrop in which the strategy launches is one of increased uncertainty around the cost of living crisis, as well as the continued recovery from COVID-19 and effects of exiting the EU. Together these are having fiscal impacts.

Crucially, these events have had, and will continue to have, an impact on the mental health of Scotland's population, just as they will globally. It will be even more important in this climate to pursue a whole of Government and society approach to suicide prevention, and to ensure individuals, groups and communities across Scotland are working together to reduce suicide. It will also be important for the Government's suicide prevention budget to be prioritised, and for wider resources to be drawn upon – for example, capitalising on other mental wellbeing funds and using wider policy levers.

Informing Development and Content:

The Suicide Prevention Policy and Delivery Team have led the work, within Scottish Government, on development of the new strategy and action plan. However, this work has been a collaborative exercise with COSLA and with support from Public Health Scotland.

As the strategy and action plan is being published jointly by the Scottish Government and COSLA, a strategy development team was established with a lead from each organisation. This team also included a lead from Public Health Scotland who has significant experience of delivering suicide prevention in Scotland, and wider public mental health approaches.

In recognition that this strategy and action plan will have significant impact on different individuals, groups and communities across Scotland there has been extensive engagement throughout the development of the work. The views, evidence and comments submitted throughout the development process have been very valuable and insightful. They have informed both this EQIA and the approach of the strategy and action plan.

A multi-stage approach to engagement was undertaken to develop this strategy and action plan. Each stage has helped inform this impact assessment which has resulted in a richer, more meaningful and considered approach to suicide prevention.

A summary of engagement/development stages and activities is detailed below:

Development Phase and Aim	**Description**
1. Early Engagement Phase September 2021 – January 2022 <u>Aim:</u> Undertake extensive information and evidence gathering exercise to shape ideas on what should be included in a new strategy and action plan – and inform where more intensive engagement required in following phase, for those identified at higher risk.	<u>Actions:</u> ▪ 41 online engagement event – split into regional and national events to allow communities the opportunity to comment on thoughts from their local perspective as well as national perspective. o 684 people registered to attend these events o 264 people registering self-identified as having lived experience of suicide. ▪ Online questionnaire o 189 responses – 32 of which were from organisations. ▪ Direct engagement with known groups and communities at increased risk of suicide ▪ Development of engagement and facilitation packs for organisations – to support conversations with groups and communities who may not engage in 'traditional' ways of consultation. Feedback encouraged in any format, to best suit the needs of those responding. <u>Outputs:</u> ▪ Publication of an 'Early Engagement Summary Report' following independent analysis of data gathered.

2. Targeted Engagement Phase Aims: Build on the extensive early engagement phase to further inform what should be contained in the new strategy and action plan. Undertake in depth engagement with at risk groups and communities to inform drafting. Undertake engagement with specialist organisations and professionals to test thinking around content for draft strategy and action plan.	Actions: ▪ Roundtable discussions with at risk groups and communities/organisations representing at risk groups and communities. ▪ One to one discussions with organisations representing at risk groups and communities. ▪ Discussions with Mental Health Leads in each NHS Board. ▪ Cross-government engagement to ensure 'whole-Government/society approach' reflected in preparation for draft. Outputs: ▪ Draft strategy and action plan produced – informed by phase one and two engagement.
3. Public Consultation Phase Aim: To seek public feedback on draft versions of the strategy and action plan document.	Actions: ▪ Six week public consultation on draft strategy and action plan. Outputs: ▪ Consultation summary

EQIA Process

The process of developing this EQIA has been continuous throughout the stages outlined above. Information and evidence contained within this final EQIA document, being published alongside the strategy and action plan, has informed the content of both the strategy and action plan.

The EQIA process will also be carried out as specific parts of the action plan are scoped and designed, as well as included within evaluation approaches. A full EQIA should be carried out for future versions of action plans which accompany the 10 year strategy.

We have considered published evidence available specific to suicide and gathered under the protected characteristics as listed within the Equality Act 2010: Age, Disability, Sex, Pregnancy and Maternity, Gender Reassignment, Sexual Orientation, Race and Religion or Belief. We recognise there will be additional evidence gathered through the development of the mental health strategy and self-harm strategy which will help understand some of the wider determinants which may also contribute to suicide.

Data and evidence gathering, involvement and consultation

Include here the results of your evidence gathering (including framing exercise), including qualitative and quantitative data and the source of that information, whether national statistics, surveys or consultations with relevant equality groups.

Characteristic	Evidence gathered and Strength/quality of evidence	Data gaps identified and action taken
AGE	National Records of Scotland's annual publication on Probable Suicides provides a key source of data in respect of this and other characteristics. Age is relevant to this EQIA because people at any age can have suicidal thoughts, attempt suicide, or know someone who is experiencing suicidal thoughts or who has attempted suicide. The average age of deaths from suicide has increased over time, with a difference of 3.4 years since 1994 increasing to 46.6 in 2021. There has been a sharp increase in average age in the past three years, increasing by 5%.[1] The rate for suicides in the 25 to 44 age group has fallen in the last ten years, having previously been 1.5 times as high as for age 45 to 64.[2] DBI evaluation /progress reports provide an understanding of people with suicidal ideation and in distress, who access the service. It helps us understand the wider issues of people in suicidal distress which affect all ages.[3]	We will continue to gather and use relevant data relating to age, to help target activity to promote suicide prevention. Through the multi-agency reviews work we will build our understanding of a range of factors including age. We intend to also gather data for suicide attempts.

[1] Probable Suicides, 2021, Report (nrscotland.gov.uk)
[2] Probable Suicides, 2021, Report (nrscotland.gov.uk)
[3] Extended Distress Brief Intervention Programme: evaluation - gov.scot (www.gov.scot)

	Children and Young People: Probable deaths from suicide in those aged 19 and under have fallen for the last three years from 44 in 2018 to 26 in 2021. Although it is difficult to discern a trend in these figures, probable deaths from suicide in those aged 19 and under broadly fell from a high of 65 in 2000 to a low of 20 in the years 2014 and 2015, before rising again to the total of 44 in 2018, and then falling every year since to 26 in 2021. In the years covered by the statistics from NRS, there have only been four years where the total was lower – 1980 (22 probable deaths) and the years 2013-2015 (25, 20 and 20 probable deaths respectively).[4] 2018 research suggests 1 in 9 of Scottish young people aged 18-34 have attempted suicide[5]. The student population are also at a higher risk of dying by suicide, perhaps due to the financial and academic stressors associated with university life[6]. Service response to children and young people experiencing suicidal ideation has been shown to be variable across different locations. In one area 57.2% of children and young people referred to CAMHS with suicidal ideation were rejected compared to 20.6% in a second area.[7]	Our action plan recognises there is a suite of evidence on children and young people (CYP), and includes an action to review and synthesise that evidence to inform our approach to preventing suicidal behaviour in children and young people alongside: • insights from the suicide prevention Youth Advisory Group • ongoing policy and service development to consider effective responses for CYP • learning from reviews of suicide deaths in CYP undertaken through the work of the National Hub for Child Death Reviews and multi-agency reviews.

[4] Suicide among young people in Scotland - A report from the Scottish Suicide Information Database 6 September 2022 - Scottish suicide information database - Publications - Public Health Scotland
[5] Suicide attempts and non-suicidal self-harm: national prevalence study of young adults | BJPsych Open | Cambridge Core
[6] Prevalence of mental health issues within the student-aged population - Education Policy Institute (epi.org.uk)
[7] Frontiers | Characteristics and outcomes of referrals to CAMHS for children who are thinking about or attempted suicide: A retrospective cohort study in two Scottish CAMHS (frontiersin.org)

	Adults: (25-65 years) Working age adults are most at risk of dying by suicide[8]. The age group with the highest rate of suicide was 35-44 between 2011 and 2019. Older adults (over 65 years) Research has explored the term 'giving up' in the context of older people[9] Longitudinal data indicates that the suicide rate for people aged 65 plus in Scotland has generally decreased over time, especially among females[10]. A 2012 study of people over age 60 who self-harm found they are at much greater risk of suicide than both the general population and young adults who self-harm. The risk of suicide among those who self-harmed was 67 times greater than the risk among older adults in the general over-60s population – and three times greater than the relative risk of suicide among younger adults who self-harm. The suicide rate was highest among men aged 75 years and above. Those who repeated self-harm were more likely to be single or live alone. Other important risk factors included previous self-harm or contact with mental health services[11].	Our action plan recognises the need to develop new approaches to prevent suicidal behaviour in older adults, which will be informed by • Engaging with people with lived experience • Reviewing and synthesising the evidence around the needs, risk and protective factors and effective responses • Implementing learning from the reviews of suicide deaths in older adults. We are separately developing a self-harm strategy and action plan, and as part of that work will consider how to use data and insights to understand – and address- the needs of older adults who self-harm, including to reduce risk of suicide.

[8] A profile of deaths in Scotland 2011-2019 (publichealthscotland.scot)

[9] Thinking about suicide in later life
[10] Scottish trends - ScotPHO
[11] Suicide risk for older people who self-harm (manchester.ac.uk)

DISABILITY	People with disabilities can be affected by suicide in the same way as non-disabled people. Suicidal ideation is typically higher among people with disabilities. A United States survey in 2021 indicated that adults with disabilities were three times more likely to report suicidal ideation compared to persons without disabilities (US Populations)[12] Within the UK, a recent Citizens Network survey indicated that 93% of disabled respondents considered that the Department of Work and Pensions system for claiming benefits had made their mental health worse, and 61% of respondents disclosed that this caused them to have suicidal thoughts.[13] Autistic people are at a higher risk of suicide than non-autistic people. Figures show that as many as 11-66% of autistic adults had thoughts about suicide during their lifetime, and up to 35% had planned or attempted suicide.[14] Autistic people are also more at risk of dying by suicide than non-autistic people, with the highest risk seen in autistic people without co-occurring intellectual disability, and autistic women.[15]	We will undertake tests of change to understand more about the needs of groups with heightened risk of suicide, which is likely to include working with trusted intermediaries. This work is still to be fully scoped, however there is potential learning to allow for focussed suicide prevention approaches to support people with disabilities.
SEX	Sex is relevant to this EQIA because men and women can have suicidal thoughts, attempt suicide, or know someone who is experiencing suicidal thoughts or who has attempted suicide.	We will continue to build our understanding of the differing needs of men and women through our suicide reviews work. Our work in communities will also help our understanding of

[12] Disparities in Suicide | CDC
[13] Disability Benefits and Suicide (citizen-network.org)

[14] Autistic people and suicidality (autism.org.uk)
[15] Autistic people and suicidality (autism.org.uk)

	Research on risk and protective factors carried out by the Academic Advisory Group on behalf of the National Suicide Prevention Leadership group, has shown that there is a greater risk of suicide attempts for females but a greater risk of death by suicide for males. Stigma also plays a part in help seeking behaviours. In 2021, most of the decrease in suicides was among females which decreased by 42 to 188 (from 230 in 2020). There were 565 male probable suicides (down by 10 on the previous year). The mortality rate for probable suicide in 2021 was 3.2 times as high for males as it was for females[16] The reasons why men are more likely to die by suicide are complex, spanning a wide range of individual-level and broader social factors, and also impact the likelihood of men seeking help for mental health problems. Samaritans' report Suicide risk factors for middle-aged men highlights the key factors associated with male suicides. [17] The report indicates that men living in the most deprived areas are up to ten times more likely to end their lives by suicide than those from the most affluent areas. Those with lower quality housing, lower income, less education and in poor quality or no employment are at most risk of suicide. Unemployed people are 2-3 times more likely to die by suicide than those in work, and suicide is seen to increase in times of economic recession. Men in mid-life are at risk compared to younger and older people. While a history of psychiatric illness, particularly depression, underlies many suicides, only a minority of those who have wider diagnosed mental health problems take their own life. Some personality traits and 'mindsets' are thought	the intersectionality of factors affecting both sexes and how these might be addressed.

[16] Probable Suicides, 2021, Report (nrscotland.gov.uk)

[17] Suicide risk factors for middle-aged men| Our policy and research | Samaritans

	to contribute to the development of suicidal thoughts, including perfectionism, self-criticism, brooding and having no positive thoughts about the future. Failing to meet perceived expectations for masculinity (such as a perceived role of providing materially for others) contribute to feelings of shame and defeat, which may propel some men towards suicide and as a way of regaining control. Marriage breakdowns are more likely to lead men, rather than women, to suicide, thought to be because of many men's reliance on their partners for emotional support. Divorced or separated men are twice as likely as divorced or separated women to have suicidal thoughts or to have planned suicides. This is thought to be linked to men having fewer supportive peer relationships than women, particularly over the age of 30. A culture of reluctance to talk about emotions can mean men do not recognise or deal with their distress until a point of crisis. Other research suggests males are more likely to die by suicide due to a number of risk factors not limited to: visiting GPs less often[18], a higher tendency towards drug and alcohol misuse[19], and fragmented journeys through care systems[20] Data from ScotSID show that a lower percentage of men who died by suicide between 2011-2017 had been in contact with health services in the period before death than women (65% and 86%, respectively)[21] The 2021 ScotSID report which covered suicide deaths in Scotland between 2011 and 2019 indicated that of the 6,798 people in the cohort, 5,978 (87.9%) were of working age (16-64	

[18] The Gendered Landscape of Suicide
[19] Men and Suicide, Samaritans
[20] Fragmented Pathways to Care: The Experiences of Suicidal Men: Crisis: Vol 27, No 1 (hogrefe.com)
[21] NHS Information Services Division (2018). A profile of deaths by suicide in Scotland 2011-2017. Edinburgh: NHS Information Services Division.

	years). Over a quarter (28.9%) were unemployed, unable to work due to a long-term condition, or of independent means, whilst 3.4% were students. The remaining 67.7% were in employment at the time of their death.[22] Inequalities in relation to middle aged men were also highlighted in the 2017 Samaritans report[23]. For women, victimisation is associated with an increased risk of mental health problems, including suicidal ideation and suicide.[24] The most common forms of violence against women are domestic abuse and sexual violence. The report Hidden hurt: violence, abuse and disadvantage in the lives of women, by Agenda, and based on the 2014 English Adult Psychiatric Morbidity Survey[25], highlights that 53% of women who have mental health problems have experienced abuse and 36% of women who have faced extensive physical and sexual violence in both childhood and adulthood have attempted suicide and 22% have self-harmed.	
PREGNANCY AND MATERNITY	Pregnancy and maternity is relevant to this EQIA as those who are pregnant or have recently undergone pregnancy may experience suicidal ideation and behaviour. 20% of women are estimated to experience a mental health problem during pregnancy or in the first year after the birth of a	Alongside the Perinatal and Infant Mental Health Programme Board, we will seek to extend understanding of suicide prevention approaches in the perinatal period.

[22] A profile of deaths in Scotland 2011-2019 (publichealthscotland.scot)
[23] Samaritans_Dying_from_inequality_report_-_summary.pdf

[24] Scotland's public health priorities and violence against women and girls (publichealthscotland.scot)
[25] Adult Psychiatric Morbidity Survey: Mental Health and Wellbeing, England, 2014 - GOV.UK (www.gov.uk)

	child. Suicide is the leading cause of maternal deaths in the first year post birth.[26] Having recently born children has previously been considered a protective factor against suicidal ideation but the emergence of research into postpartum depression has shown not only that this may not be the case, but the recent arrival of a child can increase likelihood to attempt suicide in male and females, with the highest risk occurring at 9-12 months postpartum[27],[28]. There are a range of suicide risk factors which have been identified for women in the perinatal period. These include having a psychiatric diagnosis but not receiving active treatment, experiencing intimate partner violence, not desiring, or having mixed feeling about the pregnancy and having a psychiatric admission in the first postpartum year.[29]	
GENDER REASSIGNMENT	Gender reassignment is relevant to this EQIA because individuals who have undergone gender reassignment can have suicidal thoughts, attempt suicide, or know someone who is experiencing suicidal thoughts or who has attempted suicide. Transgender young people are four times more likely to think about attempting suicide[30]. 63% of young transgender people have experienced suicidal thoughts or behaviours[31]	Less is known about LGBTI young people's experience of suicidal distress and there is a potential gap in knowledge of risk and protective factors for older transgender individuals. In taking forward the strategy, we will work with relevant groups and people with lived experience to build our understanding of the prevalence, barriers and effective interventions for different communities.

[26] MBRRACE-UK_Maternal_Report_2021
[27] Perinatal Suicide: Highest Risk Occurs at 9 to 12 Months Postpartum - MGH Center for Women's Mental Health (womensmentalhealth.org)
[28] Postpartum Depression in Men - PMC (nih.gov)
[29] Frontiers | Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates (frontiersin.org)

[30] Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review - PubMed (nih.gov)
[31] https://www.lgbtyouth.org.uk/news/2018/february/life-in-scotland-report-launch/

	Suicidal behaviour is highest among trans masculine and non-binary people, with nearly half of survey respondents reporting that they have attempted suicide[32]. Those awaiting treatment from Gender Identity Clinics have reported self-harm and suicide attempts and typically hide these significant issues from others. Research from Stonewall Scotland echoes these findings, indicating that 9% of LGBT people aged 18-24 had attempted to take their own life in the previous year, including 7% of trans people, compared to 2% of non-trans lesbian gay or bi people.[33]	We recognise that we do not know enough about the prevalence of suicidal behaviour among those who are transgender. Given this, we will work with relevant groups and people with lived experience to explore how we can better understand what helps transgender people to seek help and support and reduce the barriers they currently face.
SEXUAL ORIENTATION	Sexual orientation is relevant to this EQIA because individuals of any sexual orientation can have suicidal thoughts, attempt suicide, or know someone who is experiencing suicidal thoughts or who has attempted suicide. LGBTI young people are three times more likely to think about attempting suicide[34] [35] 50% of LGBTI young people have experienced suicidal thoughts or behaviours[36] Perceptions of defeat and feeling trapped is higher in LGBTI youth members compared to control population, and this is a common pathway to suicidal ideation[37]	Less is known about LGBTI young people's experience of suicidal distress. There is also a potential gap in knowledge of risk and effective interventions for older members of LGBTI community. In taking forward the strategy, we will work with relevant groups and people with lived experience to build our understanding of the prevalence, barriers and effective interventions for different communities.

[32] Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people (scot.nhs.uk)
[33] LGBT in Scotland – Health Report (stonewallscotland.org.uk)
[34] Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review - PubMed (nih.gov)
[35] manifesto_for_change_final-1-1.pdf (wordpress.com)
[36] https://www.lgbtyouth.org.uk/news/2018/february/life-in-scotland-report-launch/
[37] Suicidal ideation in lesbian, gay, bisexual and transgender youth in Scotland : the role of defeat and entrapment - Strathprints

	In the UK, LGB adults were around twice as likely to have attempted suicide in their lifetime. Gay and bisexual men are more likely than their heterosexual peers to attempt to complete suicide. 84% of LGBT young people (ages 13-25) have experienced at least one mental health problem or associated behaviour, with the majority experiencing anxiety (78%), stress (72%), or depression (63%). Half of LGBT youth had experienced suicidal thoughts and actions, and 43% had self-harmed[38] LGBTI+ asylum seekers were especially likely to have attempted suicide. Of those who responded to the question in the HNA survey, nearly one in three (31%) said that they had an attempt to end their life.[39]	We recognise that we do not know enough about the prevalence of suicidal behaviour among those who are LGBTI. Given this, we will work with relevant groups and people with lived experience to explore how we can better understand what helps LGBTI people to seek help and support and reduce the barriers they currently face. While we aim to take a pro-active approach to preventing suicide, the work around multi-agency suicide reviews will also build our understanding of risk factors and the intersectionality of these which may contribute to suicide.
RACE	Race is relevant to this EQIA because individuals of any race may experience suicidal thoughts and behaviours, and some races may be affected more than others. Whilst our academic research on risk and protective factors found no association between ethnicity and suicide / self-harm, further qualitative research highlighted that racism can trigger the onset of poor mental health, difficulty processing traumatic events and suicidal ideation and attempts.[40] It is recognised there may be a hidden prevalence due to issues around stigma and difficulties in help seeking. Research commissioned by the National Suicide Prevention Leadership Group (NSPLG) highlights an association between	In taking forward the strategy, we will work with relevant groups and people with lived experience to build our understanding of the prevalence, barriers and effective interventions for different communities. We recognise that we do not know enough about the prevalence of suicidal behaviour among racialised groups whether that be as a result of stigma or wider social, cultural or institutional factors. Given this, we will work with relevant groups and people with lived experience to explore how we can better understand what helps racialised groups to seek

[38] LGBT-Rural-Report.pdf (equality-network.org)
[39] https://www.stor.scot.nhs.uk/bitstream/handle/11289/580332/Final Report %2831 May 2022%29.pdf?sequence=1&isAllowed=y
[40] 4 Findings - Suicide ideation - experiences of adversely racialised people: research - gov.scot (www.gov.scot)

	racism and suicide ideation and attempts in racialised groups. This identifies several factors: racism, immigration, mistrust of services and stigma and lack of knowledge within racialised communities.[41] Mental health issues remain undiscussed in some racialised groups due to stigmatisation towards them and their families[42]. This has been compounded by campaigns only showing white people with mental illness.[43] Lived experience participants have reported experiencing a "constant drip" of micro-aggressions that have impacted their mental health and sense of belonging in Scotland[44] Research in 2018 revealed that the level of suicides among Polish men in Scotland was nearly twice as high as among the general population (96% higher).[45] The follow up report in 2020 Mental Health and Suicides among Polish Men in Scotland reinforced these results by indicating that 66% of those interviewed had suicidal thoughts and 25% had attempted suicide (173 participants).[46] Data from the COVID-19 Social Study indicated that the reported frequency of abuse, self-harm and thoughts of suicide/self-harm was higher among women, Black, Asian and minority ethnic (BAME) groups and people experiencing socioeconomic	help and support and reduce the barriers they currently face.

[41] Suicide ideation - experiences of adversely racialised people: research - gov.scot (www.gov.scot)
[42] Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England - PubMed (nih.gov)
[43] Racial-Inequality-Scotland_Report_Sep2021.pdf (mwcscot.org.uk)
[44] Racial-Inequality-Scotland_Report_Sep2021.pdf (mwcscot.org.uk)
[45] A Review of Suicides in Polish People Living in Scotland (scotphn.net)
[46] feniks-polish-men-in-scotland-report-2020.pdf (seemescotland.org)

	disadvantage, unemployment, disability, chronic physical illnesses, mental disorders and COVID-19 diagnosis. [47] Evidence collated in a report by Friends, Families and Travellers relating to Gypsy, Roma and Traveller people across the UK indicates that Gypsies and Travellers have an increased likelihood of experiencing depression and anxiety and are six times more likely to die by suicide than the general population. Between 2005 and 2012, the voluntary sector organisation Roma Support Group reported that 43% of their Roma beneficiaries were suffering from mental health problems including depression, personality disorders, learning disabilities, suicidal tendencies, self-abuse and dependency/misuse of drugs.[48]	
RELIGION OR BELIEF	Religion and beliefs are relevant to this EQIA as members of any religious groups may experience suicidal ideation and behaviours or know people who have experienced suicidal ideation and behaviours. There is mixed evidence around the relationship between religion and mental health, with some indications it correlates with better wellbeing, lower levels of depression, lower rates of suicide and lower drug and alcohol, though possibly increased anxiety. However, these studies are likely to be context-specific, vary widely across different religions and involve significant complexity in measurement criteria. Members of religious groups may experience difficulty in reporting suicidal ideation due to suicidal action being forbidden by their faith.	Many moving parts when considering religion (affiliation, participation, doctrine) and suicide (ideation, attempt), can make research difficult to interpret. We recognise the gap in evidence here and will engage with faith and belief groups when taking forward the strategy which will help us build our understanding of the prevalence, barriers and effective intervention.

[47] Abuse, self-harm and suicidal ideation in the UK during the COVID-19 pandemic - PubMed (nih.gov)
[48] https://www.gypsy-traveller.org/wp-content/uploads/2020/11/SS00-Health-inequalities_FINAL.pdf

	It has previously been asserted that those belonging to religious communities are less likely to die by suicide due to an enhanced sense of connectedness to their community. However a 2020 review suggests that this may not be the case and highlights research that religion may be a risk factor[49].	
MARRIAGE AND CIVIL PARTNERSHIP (the Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example HR policies and practices - refer to Definitions of Protected Characteristics document for details)	This protected characteristic has not been considered as part of this EQIA.	N/A

[49] Religion and Suicide Risk: a systematic review - PMC (nih.gov)

Assessing the impacts and identifying opportunities to promote equality

Having considered the data and evidence you have gathered, this section requires you to consider the potential impacts – negative and positive – that your policy might have on each of the protected characteristics. It is important to remember the duty is also a positive one – that we must explore whether the policy offers the opportunity to promote equality and/or foster good relations.

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	The strategy and action plan consider people in Scotland at all ages. Whilst it does not directly address unlawful discrimination, the strategy seeks to highlight the risk and protective factors around suicide which can occur at any age. It sets out actions to specifically support children and young people, and older people, recognising their needs – and responses – may be different from the others in the adult population.
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good relations among and between different age groups	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations between those of different age groups. The focus on building communities' responses to suicide should also offer indirect benefit between age groups.

Do you think that the policy impacts disabled people?

Disability	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	The strategy and action plan considers people in Scotland who have and who do not have a disability. Whilst it does not directly address unlawful discrimination, the strategy seeks to raise awareness that disabled people may be at higher risk of suicide and lays out actions that will be taken to support someone with a disability.
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good relations among and between disabled and non-disabled people	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations between those of different age groups.

Do you think that the policy impacts on men and women in different ways?

Sex	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	Statistically men are at higher risk of completing suicide whilst women may make more attempts. The strategy and action plan recognise that particular approaches may be needed to support men and women. Whilst it does not directly address unlawful discrimination, the Strategy can help to eliminate any indirect discrimination towards men in accessing the support and services they need.

Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide. The Strategy is promoting equality of opportunity for both men and women to access the support and services they need to reduce their risk of suicide.
Promoting good relations between men and women	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations between men and women.

Do you think that the policy impacts on women because of pregnancy and maternity?

Pregnancy and Maternity	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	This strategy and action plan explore the risk and actions to be taken to mitigate the risk of those who are pregnant or who have just given birth. Including raising awareness of perinatal mental health.
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good relations	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations between those of different age groups.

Do you think your policy impacts on people proposing to undergo, undergoing, or who have undergone a process for the purpose of reassigning their sex? (NB: the Equality Act 2010 uses the term 'transsexual people' but 'trans people' is more commonly used)

Gender reassignment	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	Whilst the strategy does not directly address unlawful discrimination because of gender reassignment, we will work with trusted organisations to build knowledge and implement changes which will aim to have a positive impact..
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good relations	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations.

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	Whilst the strategy does not directly address unlawful discrimination due to sexual orientation, we will work with trusted organisations to build knowledge and implement changes which will aim to have a positive impact.
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good relations	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations.

Do you think the policy impacts on people on the grounds of their race?

Race	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	Racism may have a negative impact on mental health which can contribute to suicidal ideation. Whilst the strategy does not directly address unlawful discrimination because of race we will work with trusted organisations to build knowledge and implement changes which will aim to have a positive impact..
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good race relations	**X**			There may be an indirect effect through work on reducing stigma around suicide that will promote good relations.

Do you think the policy impacts on people because of their religion or belief?

Religion or belief	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	This policy does not set out to eliminate unlawful discrimination because of religion or belief. There are no positive or negative impacts identified but religion and belief is considered in the strategy in the context of support and community which can be a risk or protective factor in relation to suicide.
Advancing equality of opportunity	**X**			Our strategy aims to build equality of response and access to support, across equalities groups who may be affected by suicide.
Promoting good relations	**X**			There are no positive or negative impacts identified but religion and belief is considered in the strategy in the context of support and community which can be a risk or protective factor in relation to suicide.

Do you think the policy impacts on people because of their marriage or civil partnership?

Marriage and Civil Partnership[50]	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			**X**	This has not been considered as part of this EQIA.

[50] In respect of this protected characteristic, a body subject to the Public Sector Equality Duty (which includes Scottish Government) only needs to comply with the first need of the duty (to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010) and only in relation to work. This is because the parts of the Act covering services and public functions, premises, education etc. do not apply to that protected characteristic. Equality impact assessment within the Scottish Government does not require assessment against the protected characteristic of Marriage and Civil Partnership unless the policy or practice relates to work, for example HR policies and practices.

Decision making and monitoring

Identifying and establishing any required mitigating action

Have positive or negative impacts been identified for any of the equality groups?	Yes
Is the policy directly or indirectly discriminatory under the Equality Act 2010?	No
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	N/A
If not justified, what mitigating action will be undertaken?	N/A

Describing how Equality Impact analysis has shaped the policy making process

Our approach to developing the suicide prevention strategy and action plan has been dynamic, in response to what people have told us at each stage of the development process outlined earlier in this document.

By undertaking an Equality Impact Assessment we have identified actions where work can be taken forward to address issues and promote equality.

Examples of some of the actions included in the strategy and action plan, which have been influenced by the evidence gathered as part of this process can be found below:

- Respond to the diverse needs of communities. To support this we propose at least two tests of change to reach groups / communities where there is a heightened risk of suicide. Further detail is provided in the action plan document, but in summary we will:
    - Review the design and delivery of learning approaches to ensure they reflect the communities' experience of suicide, and

    - Test new approaches to reaching and supporting people in those communities who are at risk of suicide.

- Ensure relevant staff such as pastoral / guidance staff, school nurses and counsellors in education settings are skilled and responsive to signs of suicidal concerns, whilst ensuring proactive approaches to supporting children and young people at key transitional stages, as part of a continuum of care.

- We know lack of accessible information acts as a barrier to minority ethnic groups and those with learning disability accessing information and support. Therefore, we will provide reliable and easily digestible information in different formats about suicide and suicide prevention to communities, including to community-based organisations and locations, such as sports and youth organisations, libraries, welfare agencies and community centres. This includes providing accessible information for everyone, including people who do not have English as their first language, or those with learning disabilities.

- We will work with our partners across the Violence Against Women sector to ensure that suicide prevention is embedded within the refreshed Equally Safe Strategy, and within the approach of individual partner organisations.

- We will prioritise third sector front line staff in organisations working in violence against women and girls services for suicide prevention training

- We will work with Perinatal and Early Years Mental Health – including the Perinatal and Infant Mental Health Programme Board – to develop approaches and mental health support to ensure suicide prevention is considered during the perinatal period.

Details on funding can be found in the strategy document – the above actions, and the rest in the action plan document will be funded as laid out there.

Given the trends of suicide deaths in Scotland and the evidence on risk and protective factors developed by the Academic Advisory Group, has informed our approach to the outcomes framework which will sit alongside the strategy - specifically how our short, intermediate, and long term outcomes can help reduce suicide, which will only be achieved by addressing inequalities.

Monitoring and Review

Equalities and human rights will continue to be considered proactively as we move into the next stages of our work – creating a prioritised work plan to ensure the actions we have laid out are taken forward, with a focus on inequalities given it underpins suicide trends. Equalities & Human Rights will also be considered, as individual actions are scoped, designed and delivered – with Equalities Impact Assessments carried out so that we promote equality and eliminate inequality in the work that we do.

The action plan document will be refreshed in 3 years, at which time this EQIA should be reconsidered to ensure it reflects all available evidence.

Our approach to implementation has built in horizon scanning and as we develop our workplan(s) we will continue to monitor and engage with the emerging evidence for suicide prevention. Any refreshment of the EQIA will also take account of this. We will also take account of evidence gathered for other relevant strategies such as the self-harm and mental health and wellbeing.

We will consider equalities as we finalise the outcomes framework which will include a set of indicators which will help to measure progress. We will also include equalities data as part of our evaluation of individual actions.

Authorisation of EQIA

Please confirm that:

- ♦ This Equality Impact Assessment has informed the development of this policy:

  Yes ☒ No ☐

- ♦ Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:

  - ○ Eliminating unlawful discrimination, harassment, victimisation;
  - ○ Removing or minimising any barriers and/or disadvantages;
  - ○ Taking steps which assist with promoting equality and meeting people's different needs;
  - ○ Encouraging participation (e.g. in public life)
  - ○ Fostering good relations, tackling prejudice and promoting understanding.

  Yes ☒ No ☐

- ♦ If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination, harassment and victimisation in respect of this protected characteristic:

  Yes ☐ No ☐ Not applicable ☒

Declaration

I am satisfied with the equality impact assessment that has been undertaken for '*CREATING HOPE TOGETHER: SCOTLAND'S SUICIDE PREVENTION STRATEGY 2022 – 2032'* and give my authorisation for the results of this assessment to be published on the Scottish Government's website.

Name: Angela Davidson
Position: Deputy Director – Improving Mental Health and Wellbeing
Authorisation date: 28 September 2022

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