August 2022

Suicide Prevention Strategy for Scotland: NSS input

Submitted online: https://consult.gov.scot/mental-health-unit/suicide-prevention-strategy-for-scotland/

This response is made on behalf of the National Secular Society.

The NSS is a not-for-profit, non-governmental organisation founded in 1866, funded by its members and by donations. We advocate for separation of religion and state and promote secularism as the best means of creating a society in which people of all religions and none can live together fairly and cohesively. We seek a diverse society where all are free to practise their faith, change it, or to have no faith at all. We uphold the universality of individual human rights, which should never be overridden on the grounds of religion, tradition or culture.

More information about our organisation can be found here: https://www.secularism.org.uk/about.html

1.1. Do you agree with the proposed vision, described below, for the new Suicide Prevention Strategy:

"Our ambition is a Scotland where everyone works together to prevent suicide.

To achieve this we will work with communities to become safe, resilient and inclusive - where people who have thoughts of taking their own lives, or people affected by suicide, are offered effective, compassionate and timely support, and a sense of hope."

Answer: YES

1.3. To what extent do you agree with the following guiding principle:

Suicide prevention is everyone's business. We will provide opportunities for people across different sectors at local and national levels to come together to connect and play their part in preventing suicide.

Answer: Strongly agree

1.4. To what extent do you agree with the following guiding principle:

We will take action which addresses the suicide prevention needs of the whole population and where there are known risk factors such as poverty, marginalised and minority groups.

Answer: Strongly agree

1.5. To what extent do you agree with the following guiding principle:

All developments and decisions will be informed by lived experience. We will also ensure safeguarding measures are in place across our work.

Answer: Strongly agree

1.6. To what extent do you agree with the following guiding principle:

Effective, timely and compassionate support will be available and accessible to everyone who needs it including people at risk of suicide, their families/carers and the wider community

Answer: Strongly agree

1.7. To what extent do you agree with the following guiding principle:

We will ensure the needs of children and young people are addressed and their voices will be central to any decisions or developments aimed at them

Answer: Strongly agree

1.8. To what extent do you agree with the following guiding principle:

To build the evidence base, quality improvement methodology and testing of new, creative and innovative practice will be embedded in our approach

Answer: Strongly agree

1.9. Please use the box below to share any other comments you have in relation to the principles described above.

RE 1.3: Suicide prevention is, indeed, 'everyone's business'. One group who are often neglected in discussions on suicide are those who are terminally ill and suffering intolerably, too many of whom feel forced to take their own lives in often violent and botched suicide attempts due to the lack of an option of a compassionate, medically-supervised assisted death.

Although not explicitly outlawed in Scotland, assisting someone to end their own life can potentially lead to criminal prosecution for murder or culpable homicide. As of 2021, 86% of Scots think the Scottish Parliament should examine the issue of assisted dying.

RE 1.4: Terminal illness is a known risk factor for suicide. Figures from the Office for National Statistics suggest people with potentially terminal health conditions are more than twice as likely to take their own lives than the general population. People with low survival cancers and chronic obstructive pulmonary disease are at 2.4 times higher risk of suicide. The risk for those with chronic ischemic heart conditions is nearly twice as high than for the general population. Prior to the Covid-19 pandemic, every eight days someone from the UK travelled to Switzerland for help to die, and ten times as many dying people are committing suicide at home.

Three hundred suicides in England each year involve a person with a terminal illness. Although no ONS data was available specifically for Scotland is it highly likely a similar pattern exists here.

RE 1.5: The lived experiences of terminally ill patients who wish to end their own lives, as well as those of their families and friends, must inform suicide prevention strategies and, indeed, legislation to enable the choice of assisted dying.

The current lack of provision for assisted dying in law is widely regarded as cruel and inhumane, as it forces people who are suffering unbearably from a terminal illness to take matters into their own hands, leading to often botched suicides that cause immense pain and distress to both the individual and their family. Furthermore, the current law contains no safeguards to protect dying people who want to control their death and perversely offers fewer protections to people who did not want to die but whose relatives later claim that they did.

The lack of properly regulated assisted dying causes intrinsic anxiety and mental distress for those suffering intolerably from a terminal illness, as they worry about the increasing pain and discomfort in addition to the decrease in mobility, autonomy and dignity that is likely to occur as their condition deteriorates. No option of assisted dying means they have no control over this process; it is this lack of control that is often a huge source of mental distress.

The knowledge that assisted dying is not an option anywhere in the UK means that they will have no option but to either let the illness run its course (and suffer as a consequence), take their own life, persuade a doctor, family member or loved one to help them die or travel abroad for an assisted death. All of these options are well below ideal, and in most cases will entail pain, distress and suffering for all involved.

Travelling to a country where assisted dying is possible, such as Switzerland's Dignitas clinic, is simply not a viable option for most terminally ill people in the Scotland whose suffering has become so unbearable and unmanageable that they consider their only option is to end their lives. It costs more than £10,000, so it is too expensive for a huge proportion of Scots. Furthermore, the long journey to Dignitas is too much for those already in great pain and distress. Those who do make the journey are often forced to do so earlier than they would choose, so they can have an assisted death before their illness prevents them from travelling. Those who go with loved ones who wish to die and are present during the process face the risk of prosecution when they return to Scotland.

Despite the immense barriers to travelling to Dignitas, its services are clearly in demand for people in the UK. Between 1998 and 2020, 475 British citizens travelled to Dignitas in Zurich for an assisted suicide - more than double the number of Swiss nationals who used Dignitas for assisted suicide within the same period.

It is also widely acknowledged that even with the best available palliative care some people's suffering cannot be alleviated. Whilst most pain can be controlled with good medical care, the suffering that many people who seek an assisted death experience encompasses much more than just pain.

RE 1.6: Assisted dying as an option for those who are terminally ill and suffering unbearably should be legalised. Family members or carers involved in the process of assisted dying should also receive support.

RE 1.8: It is vital that the suicide prevention strategy adopts an evidence-based approach. This will highlight evidence of high suicide rates among the terminally ill. It will also show that in jurisdictions

where assisted dying has been legalised, many terminally ill people are comforted by the fact that the option exists but do not ultimately avail themselves of it.

1.10. To what extent do you agree with the following outcome:

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

Answer: Strongly agree

1.11. To what extent do you agree with the following outcome:

Outcome 2: *Everyone has a clear understanding of suicide, its prevention, and associated risk and protective factors. Everyone is able to respond confidently and appropriately when they, or others, need support*

Answer: Strongly agree

1.12. To what extent do you agree with the following outcome:

Outcome 3: *Everyone affected by suicide is able to access appropriate, high quality, compassionate, and timely support - that promotes recovery. This includes people of all ages who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways*

Answer: Strongly agree

1.13. To what extent do you agree with the following outcome:

Outcome 4: *All suicide prevention activity is designed with lived experience insight. Action will be informed by up-to-date practice, research, intelligence, and improved by regular monitoring, evaluation and review*

Answer: Strongly agree

1.14. Please use the box below to share any other comments you have in relation to the outcomes described.

RE 1.10: There can be no doubt that the legal context in Scotland with regards to assisted dying contributes to suicide risk.

RE 1.11: It is unlikely that it is widely known that terminal illness is associated with higher suicide rates. Possible criminalisation of assisted dying means relatives and friends cannot respond appropriately to the needs of those patients who want to end their own lives but require assistance.

RE 1.12: Terminally ill patients who wish to end their own lives can receive no support in that endeavour without fear that that person might be liable to criminal prosecution.

Currently, anyone who helps a terminally ill patient to end their life will not receive support. Instead, they may be subject to criminal investigation.

RE 1.13: The voices of terminally ill patients who wish to end their own lives and the voices of their families and friends must be represented. Furthermore, the voices of doctors who would, motivated by compassion, want to assist these patients should be heard.

1.15. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

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

Answer: Strongly agree

1.16. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

Strengthen Scotland's awareness and responsiveness to suicide and suicidal behaviour

Answer: Strongly agree

1.18. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

Promote a coordinated, collaborative and integrated approach

Answer: Strongly agree

1.19. Please use the box below to share any other comments you have in relation to the priority areas described.

RE 1.15: A whole government approach is essential as the government will be integral in implementing legal reform regarding assisted dying.

RE 1.16: Awareness must be raised regarding the high rates of suicide among the seriously or terminally ill. Attention must be also be brought to the current state of the law.

Re 1.18: As previously mentioned, the Suicide Prevention Strategy should collaborate with terminally ill patients, their families and friends, and doctors.

1.20. Do you agree with the proposed approach to delivery and the new Scottish Delivery Collaborative.

To help us deliver the strategy and achieve the actions in our Action Plan we are proposing a new Scottish Delivery Collaborative. A description of this collaborative can be found below:

Scottish Delivery Collaborative: a Scotland wide delivery team on suicide prevention. It will bring together local practitioners with the national implementation team and harness insights from the Academic Advisory Group (AAG), Lived Experience Panel (LEP) and Youth Advisory Group (YAG).

The collaborative will use an agile planning approach and constantly develop and evaluate effective strategies to improve our reach and support for people who are at risk of suicide, including using technology. Public Health Scotland will play a key role in supporting the Collaborative to put knowledge into action and building an active learning approach.

Answer: YES

1.22. Do you agree with the proposed approach to national oversight the adjustments to the role of the National Suicide Prevention Leadership Group?

At a national level, we propose to adjust our existing National Suicide Prevention Leadership Group so that it can champion and drive suicide prevention through a partnership approach; advise SG & COSLA on progress on the strategy and changes needed to direction/ priorities; and, advise the Delivery Collaborative on delivery. We will include new members to ensure our leadership group offers a wider representation of the lived experience of people who are suicidal, organisations focused on poverty and minority groups, and organisations working in key settings, such as justice and education.

Answer: YES

1.25. Is there anything else you want to tell us about the proposed strategy document?

Theme one

Theme One relates to 'Whole Government Policy' and we are seeking your views on the proposed actions contained on pages 6 – 11 of the accompanying action plan document. You can access the document here: Action Plan and Strategy Documents for Consultation.

We know that a number of factors can lead to someone having suicidal thoughts and often these factors cannot be addressed by health and social care services alone.

We want to make sure that suicide prevention is embedded across government policy, in recognition that suicide prevention is everyone's business.

This will help ensure suicide prevention activity is better embedded in all services working with people, on the ground.

2.1. Please use the box below to provide your thoughts about the actions contained under Theme One: Whole Government policy.

In answering this question you may want to consider:

If you agree with the proposed actions outlined.

If there are any proposed actions you disagree with and why.

If there are any actions you think we should consider that haven't been included in the document.

We agree the Plan should promote suicide awareness, especially high rates of suicide in the terminally ill.

We agree the Plan should include campaigns to reduce stigma. This should include reducing stigma around assisted dying by changing the law to allow this as an option for terminally ill people who are suffering intolerably.

2.4. To what extent do you agree with the following proposed actions.

Hold a series of awareness raising events about responsible media reporting (including social media) which begins to support change in media reporting of suicide. Scope to draw on lived experience insight

Answer: Strongly agree

2.5 Please use the box below for any other comments you have in relation to theme three.

RE 2.4: The media should be made aware of high suicide rates among the terminally ill. Lived experience of these groups should be promoted.

2.6. To what extent do you agree with the following proposed actions.

Implement actions from review of learning approach to suicide prevention to ensure it is fit for purpose and meets the different needs of the workforce and communities alike. This will likely lead to a tailored and targeted learning approach and resources – including to focus on areas where our learning approach can achieve the greatest system-wide impact

Answer: Strongly agree

Develop material for inclusion in the school curriculum which builds understanding on mental health, self-harm and suicide prevention

Answer: Strongly agree

2.8. To what extent do you agree with the following proposed actions.

Increase our understanding and practice around help seeking and help giving (potentially through test of change and sharing of good practice

Answer: Strongly agree

Respond to the diverse needs of communities – we propose at least two tests of change, e.g. to reach particular groups and community setting by working with representative organisations

(1) review the design and delivery of learning approaches to ensure they reflect the communities' experience of suicide, and

(2) test new approaches to supporting people in those communities who are at risk of suicide. As part of this we will seek to understand help seeking behaviours and tailored support for cultural and diversity groups, by working with trusted organisations to develop approaches / interventions that work for groups who are at heighted risk of suicide. We will use the learning to inform our overall approach to supporting communities and groups where suicide risk is high

Answer: Strongly agree

Develop resources to support families, friends and carers, or anyone else, affected by suicidal behaviour – building on existing resources

Answer: Strongly agree

Build new peer support capability to enable further use of peer support models for suicide prevention

Answer: Strongly agree

Consider how primary care settings - including GPs, nurses, and mental health teams - can identify and support people who are at risk of suicide, who may present with low mood or anxiety or self-harm. This could include: safety planning, referrals to DBI, community support (social prescribing), and proactive case management, especially for high risk individuals

Answer: Strongly agree

Statutory services to continuously improve the quality of clinical care and support for people who are suicidal, and share good practice and learning, both individually and by working together across services. To achieve this a first step is for mental health services to adopt the NCISH guidelines into their operating practices, and the relevant Medication Assisted Treatment standards

Answer: Strongly agree

2.10. To what extent do you agree with the following proposed actions.

Ensure all key settings with a higher risk of suicide have a suicide prevention action plan, which connects to local suicide prevention plans (to ensure smooth transition at discharge). Plans should include actions for the people they support as well as their workforce. Key settings include: schools, further & higher education, criminal justice, secure accommodation, and residential care

Answer: Strongly agree

2.12. To what extent do you agree with the following proposed actions.

Continue to embed and enhance our lived experience model, and ensure it is representative of groups experiencing suicidal behaviour. Enhancing the model could include developing resources/toolkit to support people with lived experience sharing their personal stories in safe, meaningful and impactful ways

Answer: Strongly agree

Introduce a horizon scanning function to produce a 6 monthly digest of new evidence, which connections to the mental health Research Advisory Group. Priority areas may include: COVID and cost of living impacts. This insights and evidence will form a core part of our suicide prevention planning, delivery and evaluation, both at a national and local level

Answer: Strongly agree

Roll out multi-agency suicide reviews and learning system (aligning with the serious adverse event reviews process within mental health services.)

Answer: Strongly agree

Host learning events to disseminate information and share learning and good practice between and across sectors on suicide prevention. This will build on the Suicide Information Research Evidence Network (SIREN) model

Answer: Strongly agree

2.13 Please use the box below for any other comments you have in relation to theme seven.

The horizon scanning function should be used to regularly monitor suicide rates in those who are terminally ill.

3.1. Is there anything else you feel you want to tell us about the Strategy and Action Plan that you feel you haven't had the chance to as part of this consultation?

We are very concerned that the lack of a legal framework for properly regulated assisted dying is driving atrociously high numbers of people to suicide. We think allowing the option for people suffering intolerably from a terminal illness to control their death under proper medical supervision will significantly reduce the number of suicides.

Reforming the law on assisted dying is widely supported by the public. The largest poll ever conducted on assisted dying has found that 84% people in Great Britain support a change in the law.

Strong opposition to assisted dying comes from some religious leaders who regard life as sacred and assisted dying as intrinsically harmful. We support the democratic right of all people to contribute to this debate. However, the over-representation of religious groups, and the special status granted to religious groups, currently imposes a disproportionate level of influence. The views of the general public, professionals and relevant organisations should be fairly reflected at policy level.

It is notable that in September last year, the British Medical Association (BMA), which represents about 150,000 medics, voted to change its position on physician-assisted dying from opposition to neutral. Other bodies with a neutral stance on assisted dying include The Royal College of Physicians, The Royal Society of Medicine, The Royal College of Nursing, and the Royal College of Psychiatrists.