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What is the role of evidence in shaping suicide prevention policy in Wales?

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Contents

Summary

- This research project aimed to **explore the role of evidence in shaping suicide prevention policy in Wales** through policy analysis and interviews with key policy actors in the field.
- Overall, Welsh suicide prevention policies and policy actors demonstrate a **clear commitment to using evidence** to shape suicide prevention policy in Wales.
- Policy actors believe that suicide prevention policy should be based on a **broad range of evidence,** encompassing epidemiology, academic research, expert advice, and lived experience.
- But while interviewees identified **lived experience evidence** as the most useful type of evidence for the purposes of suicide prevention policymaking, the evidence base of the current Welsh suicide prevention policy – Talk to Me 2 –is dominated by quantitative, epidemiological evidence.
- This report recommends that ahead of the upcoming review of Talk to Me 2, policymakers should:

  1. Establish a lived experience steering group to ensure that lived experience is used effectively.

  2. Gather more evidence on how suicide occurs across the life course – for example, how suicidality manifests and may be prevented in middle-aged men.

  3. Continue to develop real-time suicide surveillance technology to improve the accuracy and reliability of suicide data.

  4. Publish more frequent updates of the implementation of national suicide prevention policy in Wales.

  5. Adopt a broader and more holistic understanding of suicide prevention, beyond the remit of mental health.

Introduction

Suicide is one of the leading causes of death worldwide (World Health Organisation, 2021). Across the globe, 800,000 people die by suicide every year, translating to approximately one suicide death every 40 seconds (WHO, 2021). When considering the number of bereaved family, friends, and communities behind every single one of these deaths, the impact of suicide on our world is monumental.

The World Health Organisation stresses the importance of developing clear and cohesive national suicide prevention strategies as they instil responsibility and accountability among stakeholders, identify gaps in legislation and service provision, and indicate the human and financial resources required for intervention (WHO, 2021). The WHO also states that a national suicide prevention strategy should provide '**authoritative guidance on key evidence-based suicide prevention activities ie. Identify what works and what does not work**' (WHO, 2012).

This guidance highlights the importance of utilising evidence in the generation of national suicide prevention policy. However, suicide is a uniquely challenging context for evidence gathering, as population level data is often delayed and inexact. Moreover, the true reason why each individual life is lost to suicide is - by its very definition – unobtainable. Therefore, a broad range of evidence, guidance, expertise, and research must be drawn upon to answer the unanswerable.

Furthermore, the notion of evidence is not universally defined by policy actors, and the understanding of how this variation manifests in how evidence is used and valued is an empirical blind spot (MacKillop, Quarmby and Downe, 2020). Additionally, suicide prevention policy has been subjected to very limited academic enquiry, and little is known about the process of its production, much less about the role of evidence within that process.

Therefore, by examining the evidence base for Welsh suicide prevention policy, and interviewing key policy actors in the field, this project aims to further knowledge on the role of evidence in suicide prevention policymaking in Wales.

Background

Continuing on from the legacy of the ‘What Works’ regime of the 1990s New Labour government, it is generally accepted throughout the UK public policy sphere that policy should be shaped and informed by evidence (Davies et al. 2004; Cairney 2016). However, many authors in the field of policy studies take a dim view of the belief that there can be an unproblematic, linear link between evidence and policymaking - instead describing evidence-based policymaking (EBPM) as a ‘vague, aspirational term, rather than a good description of the policy process’ (Cairney, 2016 p3).

In reality, public policy is made within the bounded rationality of political environments, where policymakers must navigate constraints of time, agenda, resources, and funding to make policy decisions (Cairney, 2016). Furthermore, within these systems, there are many factors which may facilitate or impede the uptake of research evidence by policymakers, including the characteristics of policy actors themselves, links between users and research, and the nature of the specific policy area (Nutley et al., 2014).

The complex relationship between evidence and policy becomes even more complicated when applying it to the specific context of suicide prevention, which itself occurs ‘within a web of social, moral and political relations that are acknowledged, yet rarely made explicit’ (Fitzpatrick, 2021 p113). Moreover, whilst suicide is far from a new phenomenon, the field of suicide prevention policymaking is in its relative infancy, with the first UK suicide prevention policies having been published just twenty years ago (Marzetti et al, 2022).

One might assume that a phenomenon that is so entrenched in our world would have accrued a similarly ubiquitous understanding and approach by those who seek to study and develop further knowledge on the topic. However, in the literature, almost every aspect of suicide, from its very definition, to the way it should be studied and prevented - if indeed it is considered preventable – is contested (Silverman, 2016; Marsh, 2016). This is further compounded by the reality that the truth about why individuals take their own lives becomes unobtainable at the point of its inception. Therefore, at its best, the evidence base on why people die by suicide is an estimation, or reconstruction of the truth.

Despite the arguably most seminal text on suicide – Durkheim’s ‘On Suicide’ (Durkheim, 1897) – having cemented sociology as an independent field of study (Taylor, 1988), the dominant disciplinary voice within contemporary suicide literature comes from epidemiology, psychology, and the wider medical sciences (Hjelmeland

and Knizek, 2016). This research is characterised by using quantitative, epidemiological data, randomised controlled trials, systematic reviews, and risk modelling to understand who dies by suicide, and what works to prevent suicide at a population level.

However, the reliability and suitability of these methods for understanding suicide have been widely critiqued in the literature (Hjelmeland and Knizeck, 2016). For example, there are widely acknowledged issues with reliability and timeliness of population level statistics on suicide due to the lengthy processes involved in ruling a death as a suicide (Appelby et al, 2019). It is also difficult to compare suicide death rates across different regions and countries, due to inconsistencies with how coroners define and categorise suicide death (Welsh Government 2015). Additionally, there are issues with suicide deaths being under reported due to stigma (Appelby et al, 2019).

Other forms of academic enquiry, championed by psychology and the wider clinical sciences, have concentrated on identifying risk factors for suicide, and combining those to create conceptual models of suicide risk which aim to help predict which individuals are more likely to act on their suicidal thoughts at a population level (O'Connor and Nock, 2014). However, theoretical, population level models of risk are not always easily translated into applied knowledge that is useful to practitioners working with individual suicidal clients, particularly as suicide risk is entwined with the social milieu, or social-cultural background, of each individual.

Instead of focusing on the level or type of risk posed to a 'homogenous' population such as service users, Hjelmeland and Knizek (2016) advise that sociological suicide research should instead focus on understanding *how* these risk factors manifest for individuals in context, adding to our understanding of why some service users die by suicide, and others do not. To do this effectively, researchers advocate using qualitative methods to study the complex process of suicidality situated within the sociocultural context and life course of the individual (Hjelmeland and Knizek, 2016).

Such qualitative methods may include interviewing those with 'lived experience' of suicidal behaviours, such as a previous suicide attempt, or individuals who have been bereaved by suicide. These methods add nuance to suicide statistics but are limited in terms of their ability to offer generalisable insights. Additionally, Fincham et al. (2011) found that the way relatives construct narratives around suicides post-mortem are primarily concerned with navigating blame and guilt, and therefore suggest that any accounts of the deceased by loved ones were likely to have been selective and performative, to avoid judgement.

This dominance of clinical knowledge in the literature is indicative of wider discourse, which frames suicide as a preventative public health issue (Jacob, 2008). Indeed, suicide has become so synonymous with mental health and psychopathology that suicide rates are often used as a proxy indicator of the wellbeing of the nation (Taylor et al., 1997; Bray and Gunnell, 2006).

With suicide being increasingly framed as a public health issue, is it unsurprising that quantitative research is prioritised, as within the field of public health research and evidence-based medicine, positivist, large scale studies sit firmly atop the hierarchy of knowledge (Parkhurst and Abeysinghe, 2016). Additionally, this dominance of quantitative research is reflective of the wider shift in the research community towards research which is more easily translatable into measurable impact (Smith et al., 1993; Martin, 2011).

Framing suicide as a subsection of mental health, rather than a broad, cross sectoral issue, may also shape how suicide prevention policy is made. According to Kingdon's 'multiple streams model', a problem must simultaneously have a) attention, b) policymakers with motive and opportunity and, crucially, c) an available solution for it to affect a change in policy (Kingdon, 1984). Therefore, thinking about suicide as an intangible societal problem pervading every policy area is much less conducive to policymaking than focusing on those who take their lives in arguably more preventable circumstances – in specific settings and in the context of mental illness.

Indeed, in a recent study of the construction of suicide through the current UK suicide prevention policies, Marzetti et al. (2021) found that this narrow framing of suicide as a preventable public health issue was perpetuated through the policies. They argue that:

> '**Although suicide prevention policies have the potential to think beyond the boundaries of clinical practice, and consider suicide prevention more holistically, the policies […] take a relatively narrow focus, often reducing suicide to a single momentary act and centring death prevention at the expense of considering ways to make individual lives more liveable'.** (Marzetti et al., 2021 p1)

What this research did not consider is how the construction of suicide impacts and interacts with the evidence used to shape and inform policy. Indeed, no study to date has explored the role of evidence within suicide prevention policymaking, which could have important insights for policy, practice, and academia alike. This study seeks to address this empirical blind spot and explore the role of evidence in suicide prevention policy in Wales.

Research questions

The aim of this research project is **to understand the role of evidence in shaping national suicide prevention policy in Wales**. The specific research questions to be addressed in this project are as follows:

1. What is the evidence base for the current national suicide prevention policy in Wales?
2. What types of evidence are(n't) considered useful in the production of suicide prevention policy in Wales - and why?
3. What can be done to encourage the use of under-utilised evidence in suicide prevention policymaking?

Methodology

This is a mixed methods research project, using a combination of documentary analysis and semi-structured interviews. To address research question 1, the current national suicide prevention policies in Wales, England, Northern Ireland, and Scotland were subjected to documentary analysis using NVivo. All implicit and explicit references to evidence use were identified, coded, and analysed to understand what evidence had been used to shape the policies.

To address research questions 2 and 3, semi-structured interviews were conducted with seven key policy actors involved in the production of suicide prevention policy in Wales. Participants' names and specific roles have been omitted for anonymity but they represented a wide range of organisations including Public Health Wales, Welsh Government, public services, and third sector organisations. Throughout the report, the interviewees will be referred to as participants 1-7, corresponding to table 1 below (Table 1).

The interviews explored participants' understanding and experience of the use of evidence in the production of suicide prevention policy. Interviews were conducted

remotely using Microsoft Teams or Zoom, and each lasted approximately 60 minutes. Interview data were then transcribed and thematically analysed using NVivo.

Table 1. Table to show the organisations represented by interview participants. Information is deliberately general in order to protect the anonymity of participants.

Participant Number	Role within suicide prevention policymaking
1	Welsh Government (Official)
2	Local Authority
3	Third Sector
4	Third Sector
5	Public Health Wales
6	Public Health Wales
7	Senedd (Official)

Policy landscape

Suicide prevention is under the policy remit of health and social care, which is devolved. Therefore, all four UK home nations have their own suicide prevention policy. All four strategies were developed by national advisory groups made up of cross-sector stakeholders, including policymakers, local authorities, emergency services, third sector organisations, and academics. The names, terms, and a brief outline of the evidence base of each of these policies are outlined below in table 2.

Wales

As outlined in Table 2, the current national suicide prevention policy in Wales is 'Talk to Me 2: Strategy for Suicide and Self-Harm Prevention 2015-2020' (Welsh Government, 2015). This policy replaced 'Talk to Me: A National Action Plan to Reduce Suicide and Self-Harm in Wales 2008-2013'.

Talk to Me and Talk to Me 2 were developed by the National Advisory Group (NAG), chaired by Professor Ann John of Swansea University. The policy describes its aim as being:

> **'to set out the strategic aims and objectives to prevent and reduce suicide and self-harm in Wales over the period 2015-2020. It identifies priority care providers to deliver action in certain priority places to**

the benefit of key priority people and confirms the national and local action required (Welsh Government, 2015 p4).

Talk to Me 2 was most recently reviewed in 2018. This midpoint review mainly provided an update on the efforts to implement the strategy but also contained an update on the epidemiological evidence of suicide in Wales. Talk to Me 2 was set to be updated in 2020 but this has now been extended to 2022. No updates or amendments have therefore been made to the strategy since 2018.

In 2018, the Senedd's Health, Sport and Social Care Committee published a report detailing the findings of an inquiry into suicide prevention efforts in Wales, titled 'Everybody's Business'. Whilst this document lies outside the bounds of a national strategy for suicide prevention, it made recommendations for preventing suicides in Wales at a population level. Therefore, this report was included in the policy analysis, mainly to provide a comparison to the national strategy.

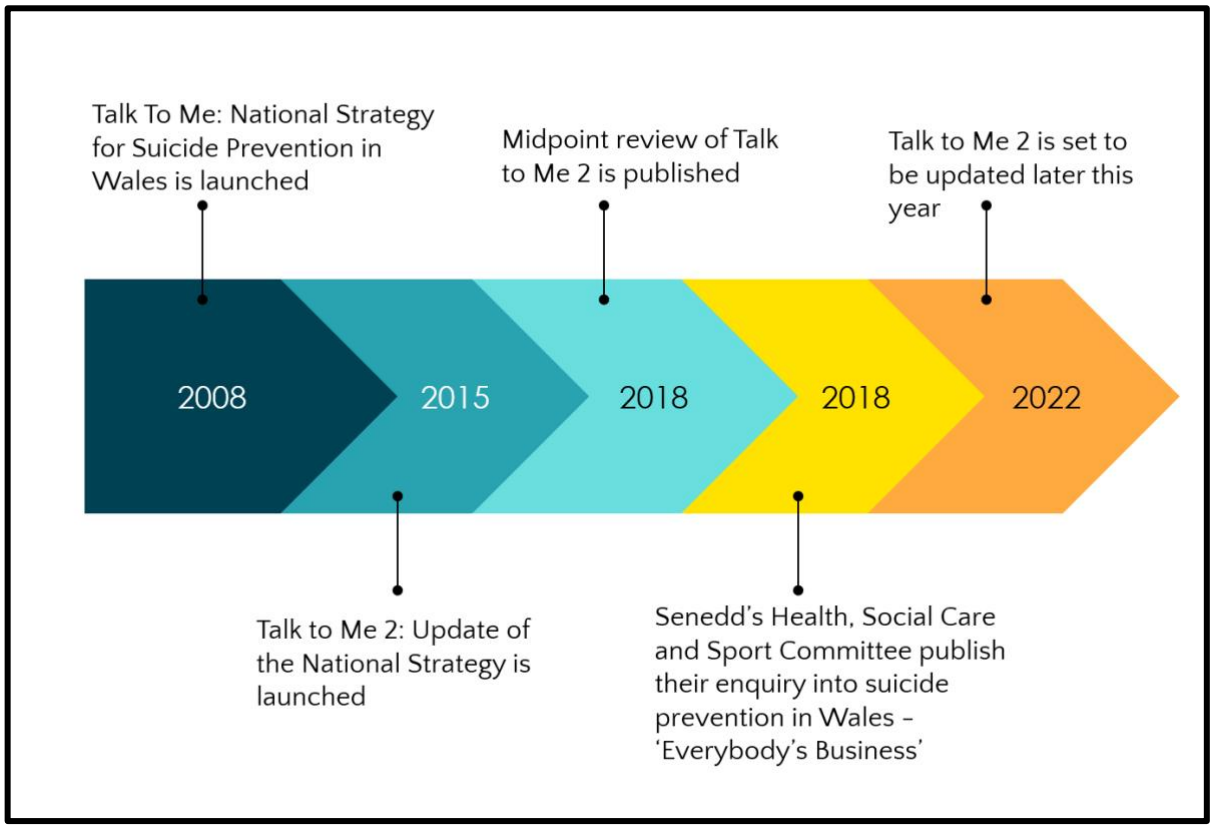

Figure 1. Timeline to show the national suicide prevention strategies of Wales.

Table 2. Table to outline and compare the national suicide prevention strategies of the four UK home nations.

Country:	Wales	England	Northern Ireland	Scotland
Current policy:	Talk to Me 2: Strategy for Suicide and Self-Harm Prevention	Preventing Suicide in England: A cross-government outcomes strategy to save lives	Protect Life 2: A strategy for preventing suicide and self-harm in Northern Ireland	Suicide Prevention Action Plan: Every Life Matters
Term:	2015-2022	2012-2022	2019-2024	2018-2021
Developed by:	Welsh Government and the National Advisory Group	Department of Health and the National Suicide Prevention Strategy Advisory Group	Department of Health and Suicide Strategy Implementation Body	Scottish Government and key stakeholders – later forming the National Suicide Prevention Leadership Group
Evidence use:	• Epidemiological data heavily cited throughout strategy and midpoint review • Qualitative evidence also used (e.g., child death reviews) • No reference to lived experience data • Reference list mainly comprises studies from psychiatric and clinical sciences	• Epidemiological data heavily cited and prioritised throughout strategy and all subsequent updates • No qualitative data explicitly referenced • Reference list mainly comprises studies from psychiatric and clinical sciences	• Epidemiological data cited • Qualitative evidence also used (e.g., ChildLine call data, lived experience) • Cultural context provided and some local data cited • Economic evidence for the financial burden of suicide included in separate appendix report	• No specific section dedicated to evidence base, but a variety of evidence types discussed throughout strategy • Lived experience quotes used prominently throughout strategy • Holistic, comprehensive language used throughout strategy
Policy updates:	Midpoint review published in 2018.	Five updates published between 2012 and 2021.	Midpoint review published 2022	Two-year review published in 2021

Findings

Q1. What is the evidence base for the current national suicide prevention policy in Wales?

It is evident from the national suicide prevention strategies analysed that all four UK nations demonstrate a commitment to evidence-based policymaking. For example, in Wales, both Talk to Me and Talk to Me 2 frequently refer to the importance of using evidence to understand the issue of suicide and to ascertain what works to prevent suicides.

Epidemiology

The use of evidence within the Welsh suicide prevention policies Talk to Me (2008) and Talk to Me 2 (2015) reflect the wider field of suicidology, in that quantitative, clinical knowledge is privileged over qualitative evidence. In particular, the dominant type of evidence used throughout the Wales suicide prevention policies is epidemiological data on suicide rates and hospital admissions for self-harm, and is often broken down into different categories, such as gender, age, socioeconomic background, location, or type of method used.

This evidence was mainly gathered from the ONS, the Public Health Wales Observatory, and the National Confidential Inquiry into Suicide and Self Harm. These datasets were also commonly used in the wider UK home nations suicide prevention strategies. Additionally, in Wales (SIDCymru), Scotland and Northern Ireland there are dedicated databases for suicide prevention data

Quantitative evidence, and particularly frequencies of suicidal behaviours, are used to convey the scale and urgency of the problem of suicide, and consolidate it as a national priority. Throughout Talk to Me, Talk to Me 2 and Everybody's Business, this was repeatedly done by comparing suicide statistics and prevalence with those of other societal and public health issues which are widely considered to be prevalent or important problems, such as road traffic accidents, cancer, and heart disease:

> **'Suicide is one of the highest causes of death among young people in Wales. There are twice as many deaths in people of all ages each year as a result of suicide than due to road traffic accidents'** (Welsh Government, 2008 p.6)

> **'We know that suicidal thoughts and behaviour are so prevalent that training for public service staff should be given the same focus as other types of training, for example, we heard that GPs are far more likely to have contact with people who are feeling suicidal than to people in need of CPR'** (Senedd, 2018 p21)

Qualitative Evidence

Despite the dominance of quantitative, epidemiological evidence, qualitative evidence was used in the Talk to Me policies in Wales, with a particularly notable inclusion being findings from the Child Death Review programme. This programme carried out a thematic review of all suicide death reviews of children and young people in Wales which generated useful insights - particularly for practice.

A notable omission from the Talk to Me policies was any lived experience evidence, either from individuals who had been bereaved by suicide, or those who have survived self-harm or suicide attempts. In other home nations suicide prevention policies, lived experience evidence was used to convey the tragedy of suicide, to explore the complexity of suicide in more depth.

In particular, the Scottish Government championed the use of lived experience evidence in their suicide prevention policy process, by setting up a lived experience panel. This panel is made up of individuals who had either been bereaved by suicide or had personal experience of suicidality, and the panel acts as a policy steering group alongside their academic advisory and implementation panels. Their use of lived experience evidence is specifically provided as an exemplar within the WHO implementation guidance for suicide prevention policies (WHO, 2021 p87).

In contrast to Talk to Me and Talk to Me 2, the Senedd's 'Everybody's Business' report contained useful insights from bereaved individuals and made a specific recommendation in their report for the NAG to appoint a lived experience member:

> **'All suicide prevention activity should be co-produced with those with lived experience of suicide. This includes clinicians for example with relevant professional experience as well as people who have been personally bereaved through suicide. Importantly, this should also involve those who have themselves experienced suicidal ideation, including survivors of suicide attempts […] It is crucial that their voices are heard at the highest level. The National Advisory Group and regional forums should engage with these groups to ensure that all suicide prevention activity is informed by lived experience.'** (Senedd, 2018 p52)

Additionally, practitioners and other service providers who are at the front line of suicide prevention gave evidence to the Senedd enquiry to provide specific insights on good and bad practice, and issues within their organisations and institutions - explaining how these issues can contribute to suicide deaths.

> **'A father of a 17-year-old boy who went to make sense of a very recent death of his son, which looked like suicide, and within a couple of days the GP said to him, 'Now, I can tell you this is his third attempt.' Incredulously, the father said, 'Why couldn't you tell me before?', and the GP, rather apologetically, just simply said, 'Confidentiality.''** (Senedd, 2018 p.34)

Hierarchy of evidence

Throughout the Talk to Me policies there are explicit and implicit references to a hierarchy of evidence, whereby quantitative evidence is privileged over qualitative evidence. For example, in Talk to Me 2:

> **'The level of evidence underpinning the effectiveness of an intervention should be transparent. For example, surveys of respondents' knowledge and attitudes following training provide lower-level evidence than randomized controlled trials for interventions to reduce self-harm behaviours.'** (Welsh Government, 2015 p14)

This hierarchy is also reflected in the semantics present in the report around evidence, suggesting that 'evidence' is understood to be synonymous with 'data', and that 'data' is synonymous with objective truth, or fact. For example, in Talk to Me (2008), the section detailing the epidemiological data around suicide rates is titled 'Suicide and Self-Harm in Wales – The Facts' (Welsh Government, 2008 p6). This is in direct contrast with the call for public consultation at the end of the Talk to Me strategy, where public consultation is referred to as 'views', 'thoughts', and 'opinions' rather than 'data' or 'evidence'.

Interestingly, the notion that statistics on suicide and self-harm rates are hard facts was still maintained, even after the fallibility of this data was explicitly addressed in the policy documents. Talk to Me acknowledges that self-harm figures are most probably an underestimate of the problem because many people who self-harm do not seek help or are treated in outpatients. Despite this admission of inaccuracy, the self-harm rate was given as part of the section, 'Suicide and Self-Harm in Wales – The Facts' (Welsh Government, 2015 p7).

There was no explicit or implicit reference to a hierarchy of evidence in the Senedd's 'Everybody's Business' report. Both quantitative data and written and oral insights submitted by organisations and individuals were all referred to consistently throughout the report as 'evidence'.

This hierarchy of evidence, and the use of epidemiological suicide rate data to monitor progress, is even more pronounced in the national suicide prevention strategy for England. Indeed, the English strategy explicitly referenced that tailored interventions for some particularly vulnerable groups had been omitted from policy, as it was difficult to statistically measure their impact:

> **'Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance.'** (HM Government, 2012 p12)

> **'There are other groups whose risk could be high, such as ethnic minorities, but limits on the data available mean that their risk is hard to estimate or else there is no way of monitoring progress as a result of suicide prevention measures.'** (HM Government, 2012 p13)

Evidence Gathering

In Wales, research evidence appeared to be gathered and brokered by the chair of the NAG, Professor Ann John, who represents a link between policymaking and key locations of data on suicide prevention, through her work with various organisations such as Swansea University and Public Health Wales. Mignone et al (2020) note that this approach of having a hyper expert at the heart of a policy problem is commonplace in health and public health policy – which, as we have seen, is where governments predominantly classify suicide prevention.

The disciplinary voice represented in Wales' Talk to Me policies is distinctly clinical, which, again, is indicative of the current discourse which frames suicide prevention as a mental health issue. This can be seen in its list of references, which are mainly from psychiatric, psychological, and medical journals. Indeed, mental health was mentioned consistently throughout both of the policies. Talk to Me 2 discusses how reducing stigma around suicide will be achieved by improving mental health literacy and destigmatizing mental illness.

This focus on suicide within the context of mental health might be due to the review of Talk to Me recommending that the aims of the policy were too broad and should be stripped back:

> **'The review [of Talk to Me] found that although there had been good progress in some of the commitments the inclusion of a large number of supporting actions in the plan was felt to have reduced focus on delivering actions specific to suicide and self-harm prevention'** (Welsh Government, 2015, annex 1)

RQ2. What types of evidence are(n't) considered useful in the production of suicide prevention policy in Wales - and why?

In this section, findings from the interviews with key policy actors from across the field of suicide prevention policymaking are presented and discussed.

As mentioned above, the Talk to Me 2 strategy for Wales reflects the inherent hierarchy of evidence that exists in the wider literature where quantitative, epidemiological data is privileged above qualitative evidence, such as lived experience data.

In contrast to this, interviewees consistently identified that all forms of evidence available must be considered when making suicide prevention policy - including academic research, expert advice, operational evidence, and lived experience - and that all were equally important in the production of policy. For example:

> **'I think I try anyway as a policy person to try and give equal weight to each bit of the evidence. And I'm using the term evidence to mean our engagement with service users, engagement with stakeholders, looking at operational information and then looking at the published research if you like.'** (Participant 1)

Two interviewees even explicitly reflected on the hierarchy of evidence, and how they deem it not necessarily applicable to the field of suicide prevention policymaking:

> **'You obviously look at systematic reviews first and you see what the evidence is but having said that you can get a really good piece of qualitative research which is actually really informative.'** (Participant 4)

> **'But also, in terms of evidence, case reviews are very useful, which I know is like the 'lower end' of the hierarchy of evidence'** (Participant 6)

Lived Experience

Moreover, in contrast to the policy document itself, almost all participants identified lived experience as the most useful form of evidence for generating suicide prevention policy - particularly in terms of finding out what works regarding intervention and service response:

> **'And actually, the evidence, if I call it evidence from the people with lived experience, what they've told us is something I don't think we could ever get from the published research. […] I think the lived experience information has been far more useful to us than anything that we would probably find in the published literature at the moment. Because it's given us all the touchpoints at where they're impacted.'** (Participant 1)

This reflects a growing recognition in the wider literature of the importance of lived experience in research and policymaking (Mcintosh and Wright 2018). However, whilst lived experience is often posed as an exercise in human rights and advocacy for marginalised communities, policy actors here identified that hearing from those directly affected by suicide is crucial not just from a social justice perspective, but as a way of generating pragmatic, useful insight for policymaking that could not be achieved by traditional academic enquiry alone:

> **'If we don't listen to people in receipt of our services and their experiences then how do we know that we're getting it right? How do we know that we've got the right services or the right response? How do we know that we're making a difference? How do we know where the gaps are unless we actually talk to people? […] years ago, we had this very paternalistic approach you know, we thought we knew best didn't we – and we didn't! So, I think finally now we're getting around to seeing that if we talk to people with lived experience that's the best way to inform our strategic plans and that's the best way to learn lessons.'** (Participant 2)

Furthermore, participant 4 posed that hearing the stories of individuals who had been directly affected by suicide – either through their own struggles with suicidal behaviours or through bereavement – provided rich nuance that complemented the epidemiological data we have on suicide:

> **'if you're doing a painting, the broad strokes, that would be your quantitative background and then when you're putting in people's eyes and the little details on their faces, that would be your qualitative because it adds that extra quality and detail. […]**

You can't talk to dead people, and you can't hear their stories, but you can talk to people who experience thoughts of suicide and who have survived it and who are surviving it. So, to hear those voices and to have that insight would really be able to help shape intervention and policy as well.' (Participant 4)

Epidemiology

Every participant identified that epidemiological data was a necessary and important part of the evidence base on suicide prevention, as it helps to illustrate the scale of suicide and ascertain where to target intervention. Additionally, participant 2 explained that statistics on vulnerable populations and numbers of referrals were necessary, as they are used by Welsh Government to allocate funding and resource:

'We know that post pandemic we've seen a greater rise in our mental health referrals but for me to get additional resource I had to show that, I had to show the number of referrals, I had to show where the most vulnerable risk population groups were to be able to get that resource, and to actually plan strategies for intervention.' (Participant 2)

However, it was noted by almost all participants that the statistics on suicide in their current form are not as useful as they could be, due to the problems in accuracy, timing, and accessibility of the data. The development of 'real-time surveillance' data on suicide was welcomed by many participants, and they were optimistic that the ability to understand the epidemiology of suicide in Wales in real-time would make a positive impact on the effectiveness of policy and practice:

'It's the data issue. It's the timing of receiving information. I think that's what makes it really difficult. Because, you know, the ONS data is a year or so out of date by the time it's published. […] So, it isn't like in any other area of policy, we would have very live data […] So, a big step for us at the moment is developing the real time surveillance system in Wales.' (Participant 1)

Beyond the issues with the reliability, some participants also deemed epidemiology as a less useful component of the evidence base, as it cannot provide information on why suicide deaths occur. Statistics were described as an important 'jumping off point' (Participant 4), but that assumptions about what works to prevent suicides cannot be drawn from the data alone:

I think there are limitations in the data as well that's available, in official data. I don't think it's something that you can draw assumptions

from. I think you need to hear it, really, from people. As much money as might be put in, or as many services are developed, if they don't actually work for the people who need them, if they can't access them, or it's not appropriate care for them, if it doesn't work, […] But I think with suicide, you can't get a full picture from the figures. […] I think you need the data, but you need to really understand how people's lives are affected, I think, and you can't get that from the data.' (Participant 7)

Operational Evidence

Policy actors interviewed expressed concern that there was a disconnect between the national suicide prevention policy, and the front-line activity to prevent suicides in Wales. Therefore, they highlighted the importance of gathering evidence from practitioners themselves about what is working 'on the ground', to establish a more effective feedback loop between suicide prevention policy and practice in Wales:

'One of the things that we quite consistently hear is that there's often a gap between strategy and policy, and what actually happens on the ground. So, it's never enough to just hear from the policy end of it, "Well, yes, we have this, and this is our strategy, and what we do." You need to hear how that's translating down to the ground'. (Participant 7)

'I don't think we've got the evidence that the evidence is getting to the right places. So, if you asked a clinician about the NICE guidance would they all know that they should be following the NICE guidance and doing a psychological assessment on this young person or is it that they know and they haven't got the time, or the young person has already left by the time they go back to do it you know we just don't know'. (Participant 4)

Several participants identified that suicide death reviews are a valuable source of evidence on suicide prevention practice across different sectors and agencies, and could help to fill the gap in the feedback loop between policy and practice. However, it was noted that currently in Wales, only death reviews concerning children and young people are regularly reviewed and thematically analysed, and that adult suicide death reviews are an overlooked source of evidence:

'I just don't think that if you looked at the theory of what one should do, you would never understand the failings in the practice except by looking at an individual case […] So the value of looking at real instances and trying to, in a constructive way, construct learning points

from reviews, that is massive, and I think that is a very valuable research thing to do as well.' (Participant 3)

'So, I think, particularly for child death reviews, I would say that we do try to use death reviews as evidence to formulate recommendations or opportunities for prevention. I'm not aware of anything that goes on in terms of learning from adult suicide deaths, in terms of the reviews that have been done.' (Participant 6)

This is indicative of a wider admission by participants that evidence around children and young people was more useful and even more important than evidence about suicide in adults. This is surprising, given the evidence that suicide is most prevalent in middle aged men (Samaritans 2019). Participant 5 explains that this belief is based on the number of life years lost:

'if you looked at the impact in terms of the years of life lost, it [suicide] had a really big impact, whereas if you look at cancers, or whatever, then it does tend to be people towards the end of their lives. […] It's quite a difficult one, but I'm almost saying that a death in a 75-year-old is not as bad as a death in a 35-year-old. The potential of good life that you're losing is much greater in somebody younger.'

RQ3. What can be done to encourage the use of under-utilised evidence in suicide prevention policymaking?

Lived Experience

Policy actors identified that there had been a concerted effort in recent years to involve individuals with lived experience in policymaking in ways that were more meaningful than they had been in the past:

'Having been involved with this work for a long time it's far less tokenistic than it was. I can think back to us inviting someone with lived experience to a strategic meeting and it was almost like well 'we've done our bit now, we've invited them''. (Participant 5)

Indeed, since the release of 'Everybody's Business' and the midpoint review of Talk to Me 2, individuals with experience of bereavement by suicide have been recruited to the NAG. However, some participants expressed concern with this current way of

working, and advised that developing a separate lived experience panel or steering group may allow lived experience to be used more effectively:

> **'On the National Advisory Group we do have some people with lived experience who are there from that perspective but I think then we have to be very careful […] I think quite often people are coming from a place of such deep grief that it's really hard for them to see the bigger picture sometimes, so whilst obviously those voices are really important we have to be careful that we don't kowtow to one person's idea of what would help because it might have helped in their situation but […] I think if you had a steering group then you might be able to get five or six or maybe more people and then they would be coming from different perspectives but they could work together but if you've just got one or two that have their own – not agenda because that's not fair – but you know what I mean, their own experience and maybe that isn't very broad and so, yeah that can be sometimes a little bit difficult.'** (Participant 4)

Additionally, practical recommendations made by participants included developing an induction for all new members of NAG, including those recruited in a lived experience capacity, in order that all evidence may be shared constructively, appropriately, and safely. Moreover, participant 2 passionately advocated for perceptions around lived experience evidence to shift away from regarding it as a separate piece of the evidence base towards a model of coproduction, underpinning every level of suicide prevention policymaking.

Synergy in Welsh evidence

During the interviews, policy actors unanimously expressed frustrations with the fragmented nature of evidence on suicide prevention in Wales. It was noted that as suicide prevention is such a broad, cross-sectoral issue that there are multiple agencies in Wales who routinely collect useful data on suicide, but this is not being disseminated effectively:

> **'We know there is delayed information coming from the coroner, we know the police have some information, so there's information all over the place but do we have a clear picture of the situation in Wales, the numbers, the profile of those individuals? Not yet, I don't think'.** (Participant 2)

Participants called for a Welsh repository of evidence on suicide prevention to be developed, that would be accessible to policymakers, practitioners, and those directly affected by suicide prevention in Wales. Participant 4 described the evidence base

for suicide prevention as 'overwhelming' and believed that having a centrally accessible website or database would enable practitioners and policymakers alike to identify the most useful and relevant evidence for their needs:

> **'In a way that feels like it's too hidden for people to be able to access the evidence, you know if you have a regional manager who is working with a multi-agency group in one of the three areas of Wales and they're able to say there is this new piece of research that's come out that is really relevant then I think that would be really useful.'** (Participant 4)

> **'I think there should be some sort of repository where there is evidence, where there's a go-to place where people can find things easier. I think there are different people doing different things. There is not just one place where it's easy to find stuff. I think that's the difficulty as well.** (Participant 6)

Additionally, many of the policy actors interviewed identified that uniting and disseminating routinely collected data in Wales and evidence on Welsh suicide deaths would be useful in making the national policy more culturally relevant. The challenges of analysing Wales specific data were attributed to the lower population, leading to lower sample sizes:

> **'They are quite challenging to research, often because of the relatively low levels of people who take their own lives at any one particular site. So, it is easier to research how well barriers work on the Golden Gate Bridge, because so many people take their own lives from there, than it is to understand how important that is on a motorway bridge over a motorway in Wales, but I do think there is more work we should do about that'.** (Participant 6)

There was recognition among all policy actors interviewed that the gathering and dissemination of evidence in Wales had been improved considerably since the appointment of Professor Ann John as chair of the NAG, and all participants commended her for her efforts to ensure Welsh suicide prevention is evidence-based:

> **'I think we're better, I think Professor Ann John has made a massive difference, she's fantastic. She's seen as this leading light not just in Wales but across the UK. She's invited to international conferences to speak. I think she's done a huge amount for us.'** (Participant 2)

Broadening the definition

The way that policy actors discussed, defined, and situated suicide prevention as an area of policy was indicative of the wider discourse that suicide is primarily a mental health issue. For example, when asked about their role in suicide prevention policy nearly all participants discussed their current or prior involvement with mental health policy. Additionally, the representative from Welsh Government described suicide prevention as being held within the policy remit of mental health:

> **'So, it is very much in a mental health policy brief […] There are all sort of factors that lead to somebody being in that situation. It's much broader than mental health. It's social, welfare, all of those sorts of issues. But, I think it's, kind of held in mental health.'** (Participant 1)

This view seemed to be held most strongly by participant 2 whose remit was implementation of public service provision and responding to suicide:

> **'For me it's about where's the best place to actually respond to this, that's what's critical. Where is the skillset where is the knowledge and the experience and the…where are people most likely to get a proper response which will prevent them taking their own life – that's mental health services I would argue.'** (Participant 2)

Additionally, the forthcoming update of Talk to Me 2 was often spoken about by participants synonymously with the update of the national mental health strategy 'Together for Mental Health'. Participant 4 expressed deep concern about this, and worried that this narrow definition of suicide may lead policymakers to overlook evidence which is outside the remit of mental health but relevant to suicide prevention:

> **'I'm a little bit worried about this next iteration because the evaluation has been lumped together with the Together for Mental Health strategy as well, so I'm worried that suicide prevention is going to be marginalized within that as well. It's really important that we have our own strategy around suicide prevention because there are key things that are sort of peculiar to suicide prevention and not to mental health. […] Most suicides happen outside of the mental health system for a start, so we have to be careful that you know mental health is so massive that it doesn't take over and then suicide prevention is a little thing on the side because it is separate and different, and we have to hold onto that.'** (Participant 4)

Additionally, participant 4 stressed that how we define suicide prevention itself may affect how the success of suicide prevention policies are understood – advocating for policymakers to broaden their definition of success in suicide prevention:

> **'…We have to be careful that the suicide prevention strategy Talk to Me 2 doesn't get looked at as a failed policy because the suicide rate has gone up. You know you can't prove that we haven't stopped x number of people dying by suicide because of the policies we put in. […] How many people in Wales have [a] helpline number in their phones - that's a measure of success. Do they know where they can go to for help - that's a measure of success. Do they know that they can get counselling and they can get it online and there are lots of organizations who can help. Yeah, so those are measures of success.'** (Participant 4)

Timeliness

Finally, participants identified that a major reason that evidence on suicide prevention is often excluded from policy is timing. When asked about the evidence base for the forthcoming update of Talk to Me 2, participant 1 said:

> **'So, we've already agreed to two or three bits of research that they're doing now, that would directly influence policy because of the topic and the timing, I guess. Because that's always really difficult for us. The policy cycle is over a number of years, isn't it? So, it's critical timing now because we're going to be developing a new strategy. So, evidence information is really important for us now.'** (Participant 1)

Therefore, it was suggested that if Wales adopted a similar model to England and published more frequent reviews of the evidence base for suicide prevention between updates of the national policy, then there would be more scope for the national policy to reflect the evidence around current challenges.

Indeed, the most recent review of England's suicide prevention strategy reflects on the impact of COVID-19 on suicide prevention, an area which is not covered by Talk to Me 2 or its review, as they were published before the pandemic. However, participants identified that evidence of the impact of COVID-19 had already been discussed by the NAG, and that therefore the national strategy did not reflect the timeliness of evidence gathering in Wales.

Conclusion

Evidence clearly plays a very important role in shaping national suicide prevention policy for Wales. Both the policy documents themselves and key policy actors in the field demonstrate a commitment to using a broad range of evidence to ascertain what works, in terms of preventing suicides and using this to inform and shape national policy. This is in part due to the work of individuals who sit on the National Advisory Group, the newly appointed national coordinators and - in particular – Professor Ann John, whose actions to generate, gather, and disseminate evidence for suicide prevention was highly commended by all policy actors interviewed.

However, despite this good work, more could be done to use a broader range of evidence in future suicide prevention policy in Wales, including the forthcoming iteration of Talk to Me 2. A particular area that could be improved is the use of lived experience evidence. It is recommended that the NAG reflect on how individuals with lived experience are currently involved in the policymaking process, and potentially recruit a separate, more representative **lived experience steering group** to oversee future policy updates, following the success of Scotland's lived experience panel (WHO, 2021). Additionally, **induction or training** could be incorporated into the NAG model, to better assimilate those with lived experience with the aims, objectives, and terms of reference of NAG meetings, allowing for more constructive, useful evidence input from all parties.

There was a recognition that lived experience evidence has improved significantly in recent years, and that the inclusion of those voices is now far less tokenistic. However, participants advocated for a culture shift in policymaking towards a model of co-production, so that lived experience is not seen as a separate form of evidence but a perspective that should underpin the entire process at every level.

Policy actors also identified significant issues with the epidemiological data around suicide and suicide prevention, including the significant time delay due to processes around coroners' rulings. It was encouraging to hear of the development of **real-time suicide surveillance** which will provide more accurate and useful suicide statistics. Participants indicated that this surveillance system would be implemented by April 2022 and be an integral part of the forthcoming update of Talk to Me 2.

It is noted that Welsh suicide prevention policy has prioritised evidence on suicide deaths of children and young people. It is recommended that **more evidence is gathered from across the life-course**, for example, to address the prevalence of suicide in middle aged men. More could be done in the forthcoming update of Talk to Me 2 to incorporate learning from adult death reviews, such as multi-agency Adult

Practice Reviews (APRs), alongside the extensive insights from the Child Death Review Programme.

Additionally, improvements could be made to ensure that current, Wales specific evidence on suicide prevention is available and accessible to all stakeholders. Welsh Government should follow the example of England and **publish more frequent, publicly available updates on the implementation of the national strategy** and current challenges. It is also recommended that evidence and data collected across Wales by academics and front-line agencies is gathered and stored in a central location, such as a website or database so that it may be disseminated more effectively.

Finally, it is recommended that Welsh Government and the NAG **adopt a broader understanding of suicide and suicide prevention** and for that to be reflected in the forthcoming update of Talk to Me 2. Suicide prevention is a broad, complex, and nuanced area of policy, with its own specific challenges which must not be eclipsed by the broader umbrella of mental health.

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