Llywodraeth Cymru
Welsh Government

Number: WG48734

Welsh Government

Consultation Document

Draft Suicide and Self-harm Prevention Strategy 2024-2034

Date of issue: 20 February 2024

Action required: Responses by 11 June 2024

Overview

Welsh Government is publishing a new draft Suicide and Self-harm Prevention Strategy (2024-2034) for public consultation, which will replace the previous strategy **Talk to me 2: the suicide and self-harm prevention strategy for 2015-2022.** We are also consulting on a new draft Mental Health and Wellbeing Strategy, which will replace the previous ten year strategy **Together for Mental Health.**

The Suicide and Self-harm Strategy aims to reduce the number and rates of suicide deaths that have endured over recent years. It also aims to establish a pathway to support people who self-harm and to improve support for those bereaved by suicide.

The strategy sets out an overarching vision for suicide and self-harm in Wales, alongside six underpinning principles, six high-level objectives and a number of supporting objectives.

How to respond

Please respond by completing the online form or completing this questionnaire and sending it to:

Email: mentalhealthandvulnerablegroups@gov.wales

If you intend to respond in writing, please send completed forms to:

Mental Health Policy Team
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

When you reply, it would be useful if you confirm whether you are replying as an individual or submitting an official response on behalf of an organisation and include:

- your name
- your position (if applicable), and
- the name of organisation (if applicable).

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

Having your own discussions

We understand that there are lots of groups that may want to discuss the strategy and respond to the consultation. To support these discussions, we have created an engagement pack with ideas and information on how to feedback.

Engagement with children and young people

We want to make sure that we listen to the views of children and young people on the Suicide and Self-harm Prevention Strategy for Wales (2024-2034). To do this we have created a children and young people friendly version of the strategy. Please contact: mentalhealthandvulnerablegroups@gov.wales

The Co-Production Network for Wales are running focus groups and can support people to run their own consultation sessions with the children and young people they work with. If you are a teacher, clinician, youth or playworker, mentor or anyone else working with children and young people and you would like support to run a session on the Suicide and Self-harm Prevention Strategy for Wales (2024-2034) please contact: MHStrategy@copronet.wales

Help and support for your own mental health

If you need support with your mental health, you can ring the CALL Helpline: 0800 132 737. Or for urgent support please call the NHS on 111 and press 2.

Contact details

For more information:

Mental Health Policy Team
Welsh Government
Cathays Park
Cardiff
CF10 3NQ
mentalhealthandvulnerablegroups@gov.wales

This document is also available in Welsh: https://www.llyw.cymru/strategaeth-atal-hunanladdiad-hunan-niweidio

UK General Data Protection Regulation (UK GDPR)

The Welsh Government will be data controller for Welsh Government consultations and for any personal data you provide as part of your response to the consultation.

Welsh Ministers have statutory powers they will rely on to process this personal data which will enable them to make informed decisions about how they exercise their public functions. The lawful basis for processing information in this data collection exercise is our public task; that is, exercising our official authority to undertake the core role and functions of the Welsh Government. (Art 6(1)(e))

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about or planning future consultations. In the case of joint consultations this may also include other public authorities. Where the Welsh Government undertakes further analysis of consultation responses then this work may be commissioned to be carried out by an accredited third party (e.g. a research organisation or a consultancy company). Any such work will only be undertaken under contract. Welsh Government's standard terms and conditions for such contracts set out strict requirements for the processing and safekeeping of personal data.

In order to show that the consultation was carried out properly, the Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. If you do not want your name or address published, please tell us this in writing when you send your response. We will then redact them before publishing.

You should also be aware of our responsibilities under Freedom of Information legislation and that the Welsh Government may be under a legal obligation to disclose some information.

If your details are published as part of the consultation response then these published reports will be retained indefinitely. Any of your data held otherwise by Welsh Government will be kept for no more than three years.

Your rights

Under the data protection legislation, you have the right:

- to be informed of the personal data held about you and to access it
- to require us to rectify inaccuracies in that data
- to (in certain circumstances) object to or restrict processing
- for (in certain circumstances) your data to be 'erased'
- to (in certain circumstances) data portability
- to lodge a complaint with the Information Commissioner's Office (ICO) who is our independent regulator for data protection

For further details about the information the Welsh Government holds and its use, or if you want to exercise your rights under the UK GDPR, please see the following contact details:

Data Protection Officer:
Welsh Government
Cathays Park
CARDIFF
CF10 3NQ
Email: dataprotectionofficer@gov.wales

The contact details for the Information Commissioner's Office are:

Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
Tel: 0303 123 1113
Website: https://ico.org.uk/

Strategic vision / intent

This strategy sets out our commitment to deliver a reduction in the number and rates of suicide deaths that have endured over recent years. It also aims to establish a pathway to support people who self-harm and to improve support for those bereaved by suicide.

The overarching vision for this strategy is:

People in Wales will live in communities which are free from the fear and stigma associated with suicide and self-harm and are empowered and supported to both seek and offer help when it is needed.

We will do this through multi-sectoral collaboration and ownership across Government, making sure that we have strengthened the governance frameworks that are in place to drive action and monitor effectiveness.

We all have a role to play in preventing suicide and self-harm, which have a disproportionate impact on the most vulnerable people in our society. Suicide and self-harm have a devasting impact on families, loved ones, professionals and communities. Whilst suicide and self-harm are complex, they are preventable and never inevitable. Suicide and self-harm are public health issues, but they are also inequality issues, linked to social determinants of health such as socioeconomic disadvantage, and adverse childhood experiences (ACEs). It is for this reason that suicide prevention does not belong to any one sector and instead requires a cross-sectoral and cross-Government approach.

The following principles run through this strategy:

- Leadership, ownership and accountability
- Suicide and self-harm are everybody's business
- Focus on inequalities and at risk groups
- Multi-sectoral collaboration
- Person-centred with the involvement of those with lived/living experience
- Evidenced-based and intelligence led.

Strategic context

This strategy has been developed following extensive engagement with stakeholders across Wales.

It has been written in the context of **A Healthier Wales: our Plan for Health and Social Care** ("A Healthier Wales")[1] which sets out the vision for a whole system approach to health and social care in Wales. A Healthier Wales lays out the Welsh Government's ambitions for progress and improvement, and describes the core values that underpin the system in Wales, including:

[1] A healthier Wales: long term plan for health and social care | GOV.WALES

Proactively supporting people throughout the whole of their lives, and through the whole of Wales, making an extra effort to reach those most in need to reduce the health and wellbeing inequalities that exist.

It is also set in the context of the **Well-being of Future Generations (Wales) Act 2014** which aims to improve the social, economic, environmental and cultural wellbeing of Wales. Achieving the wellbeing goals set out in the Act is vital in relation to tackling some of the key drivers of suicide and self-harm in Wales.

We have ensured the strategy is supporting delivery of the More than just words Five Year Plan (2022-2027) which is the Welsh Government's strategic framework for promoting the Welsh language in health and social care, and which identified mental health service users as one of the priority groups. Our vision for "More than just words" is for Welsh to belong and be embedded in health and social care services across Wales so that individuals receive care that meets their language needs without having to ask for it, leading to better outcomes. The *More than just words* Framework seeks to drive progress through a focus on the three themes of Welsh language planning and policies including data; supporting and developing the Welsh language skills of the current and future workforce; and sharing best practice and an enabling approach. At the core of the Framework is the principle of the Active Offer which places a responsibility on health and social care providers to offer services in Welsh, rather than the onus being on the patient or service user to have to request them.

Receiving treatment in one's own language can be particularly important for people experiencing self-harm or suicidal thoughts, those around them, and those impacted by suicide. The Welsh Language (Wales) Measure 2011 gives the Welsh language official status in Wales and reinforces the principle that the Welsh language should not be treated less favourably than the English language when providing services. Ensuring that suicide and self-harm services are provided through the medium of Welsh, and that this is actively offered to people receiving support, is crucial.

This strategy is separate from, but connected to, our **Mental Health and Wellbeing Strategy**. It is connected because having a mental health issue is a risk factor for suicide and self-harm. However, a separate strategy for suicide and self-harm prevention in Wales recognises that suicide and self-harm are not diagnosable mental health conditions and most people who die by suicide are not known to NHS mental health services. Suicide and self-harm are behaviours in response to emotional distress caused by factors including mental and physical health conditions, addiction, poverty and financial strain, bereavement, job losses and relationship breakdowns. Many of the risk factors for suicide, self-harm and poor mental health are the same and mental health services have a vital role to play in treating and preventing self-harm and suicide. For example, through the offer of crisis support and establishing a pathway for people who self-harm. However, a broader and more specific set of interventions are required to tackle suicide and self-harm, such as looking at the physical environment (land and buildings), suicide surveillance, rapid response to suspected suicides, and the provision of specialist bereavement support.

As well as the Mental Health and Wellbeing Strategy, the successful delivery of the objectives within this strategy are also reliant, in part, on the successful delivery of other Welsh Government policies which have identified links with suicide and self-harm, namely:

- The new Child Poverty Strategy for Wales
- Connected Communities: A Strategy for tackling loneliness and social isolation and building strong social connections 2020
- The Substance Misuse Delivery Plan 2019 and Substance Misuse Treatment Framework
- The Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy 2022-26
- Challenging Bullying - Rights, respect, equality: Statutory guidance for governing bodies of maintained schools 2019
- A Guide to Fair Work 2022
- The Anti-racist Wales Action Plan 2022
- The LGBTQ+ Action Plan 2023
- The work of the Disability Rights Taskforce

In 2023, the Welsh Government also gave legislative consent to the UK Government to introduce regulations within the **Online Safety Act** (OSA) which received Royal Assent on 26 October 2023. The Act establishes a new regulatory regime to address illegal and harmful content online, with the aim of preventing harm to individuals.

Welsh Government is also working with the UK Government on wider regulatory reforms through the Criminal Justice Bill, which will broaden the scope of self-harm offences to include non-communicable forms of assistance or encouragement (e.g. passing a blade).

Other key achievements

The cross-Government policies and programmes identified above collectively provide a robust response to some of the key drivers of suicide and self-harm in Wales, delivered through effective cross-Government working. Below are some of the other key achievements we have made since the publication of Talk to Me 2 in 2015.[2] Through these previous plans, we have made a step change in our approach to prevent suicide and self-harm in Wales.

However, with enduring rates of suicide and self-harm in Wales, we recognise that more needs to be done. This strategy provides an opportunity to critically review progress and identify what further action is required.

Other key achievements include:

[2] Suicide and self-harm prevention strategy 2015 to 2022

The appointment of a **National Suicide and Self-Harm Programme Lead for Wales** with **Regional Leads** to drive national and local partnership action. We have established effective local partnerships with the aim of preventing and supporting the response to suicide and self-harm. This national programme of work is accessible via a digital platform for suicide and self-harm prevention.[3]

In 2019, we published "**Responding to issues of self-harm and thoughts of suicide in young people: Guidance for teachers, professionals, volunteers and youth services**". The guidance provides information for adults who work with children and young people regarding how to respond to issues of suicide and self-harm. It addresses how to ask questions of children and young people who may have suicidal feelings or be self-harming, and how to respond to disclosure of these feelings and behaviours. It provides guidance on confidentiality, safeguarding and routes of escalation.

In 2022, we established a **Cross-Government Suicide and Self-Harm Prevention Strategic Group**. The Group has been established to drive forward cross-Government and multi-agency work to prevent suicide and self-harm in Wales.

In the same year, we also launched **Real Time Suspected Suicide Surveillance (RTSSS)** in Wales which was developed in partnership with Public Health Wales, all four police forces in Wales and the NHS Wales Executive. The RTSSS collects data directly from police forces relating to sudden or unexplained deaths that are suspected to have been by suicide. The first RTSSS report was published in January 2024. The report identifies that there were 356 deaths by suspected suicide of Welsh residents who died in or outside of Wales, between 1st April 2022 and 31st March 2023, giving a rate of 12.6 per 100,000 people. The launch of RTSSS demonstrates a collective and shared priority to prevent suicide, enabling us to respond much more quickly to any possible changes in rates, to activate preventative measures, and to ensure that immediate support is made available to the individuals and communities most affected.

We have published* guidance entitled "**Responding to people bereaved, exposed or affected by suicide"**. The guidance has been informed by insights into the needs and experiences of people living with bereavement by suicide in Wales. The guidance aims to ensure services provide a more compassionate response.

We have also commissioned* a **National Advisory and Liaison Service** for those impacted by deaths that might be a suicide. This will provide a single point of contact for people across Wales who have been affected by a death by suicide and can be used as a key touch point, and by a wide range of agencies, to signpost people to support. The digitisation of the nationally recognised Help is at Hand Cymru resource[4] also enables its continual improvement as a resource for healthcare and

[3] Welcome to the Suicide and self-harm Prevention Cymru Training Hub
[4] Help is at Hand Pages - NHS SSHP
*The bereavement guidance has not yet been published but will be prior to the publication of the final strategy. The Liaison Service is currently being procured and is anticipated to be operational prior to the publication of the final strategy.

other professionals to help people who have been affected by suicide or unexplained deaths.

Clearly, our wider improvements to mental health support through the delivery of the **Mental Health and Wellbeing Strategy** will continue to contribute to our efforts to reduce suicide and self-harm in Wales. Key services transformation including the establishment of **single points of contact for Child and Adolescent Mental Health Services** (CAMHS) and the all-age **111 press option 2 for mental health support** provide vital and more accessible support. Also, our Joint Ministerial **Whole System Approach** aims to improve the emotional wellbeing of our young people and has **significantly extended support in schools** through the schools counselling programme and CAMHS in-reach service.

What is the current picture? A summary of available evidence

The following evidence has been compiled drawing on a range of sources including Knowledge and Analytical Services (KAS) within Welsh Government, Office for National Statistics (ONS), Digital Health and Care Wales (DHCW), Public Health Wales (PHW) and both Swansea and Cardiff Universities. The objectives and policies have been developed based on this evidence and additional information acquired through knowledge and engagement with service providers and stakeholders across Wales. This has identified the need for a more robust and systematic approach to gather and analyse data, research and evidence in relation to suicide and self-harm in Wales and a specific objective (Objective 1) has been included to deliver this. This process will begin prior to the publication of this strategy and will inform the first iteration of the Suicide and Self-harm Delivery Plan for Wales.

Suicide

The national suicide rate, published by the Office for National Statistics has remained between 10.0 and 13.0 per 100,000 population over the last five years with the latest numbers broadly in line with the pre-coronavirus (COVID-19) pandemic rates in 2018. Over the last decade there were, on average, approximately 330 registered deaths by suicide (an average rate of 12.4 registered suicides per 100,000 people each year) in Wales.[5]

The following have been identified as *priority groups*:

- ***Middle-aged men***

Men are three times more likely to die by suicide than women, with middle-aged men (40-49) having the highest rates of suicide of any group since 2008.[6]

[5] Suicides in England and Wales Statistical bulletins - Office for National Statistics
[6] Suicides in England and Wales Statistical bulletins - Office for National Statistics

Analysis of the socio-demographic characteristics associated with death by suicide was undertaken using 2011 Census data,[7] and found that in England and Wales, for men aged 40 to 50 years old, the highest rates of suicide were in disabled people, those who have never worked or are in long-term unemployment, or are single (never been married or in a civil partnership).[8]

- ***People who self-harm or have self-harmed***

Self-harm results in 5,500 medical admissions per year in Wales across all ages and is one of the top five causes of admissions. Much of this is unscheduled.

Research has estimated that approximately 8 per cent of 14 to 19 year olds will self-harm. Self-harm is the strongest risk factor for suicide, the second leading cause of death in the 15 to 19 year old population. However, only a very small fraction of those who self-harm go on to make suicide attempts or die by suicide.[9]

- ***People in contact with mental health services***

A longitudinal research study conducted in Wales (2020) found that 31 per cent of people who died by suicide had contacted health services in the week before they died. The last point of contact was most commonly associated with mental health and most often occurred in general practices. Moreover, 16 per cent of people who died by suicide had contact with an emergency department in the month before they died, most often in relation to self-harm, mental health, or substance misuse.[10]

Data collected by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) found that during 2008-2018, 22 per cent of general population suicides in Wales, or an average of 74 suicides per year, were people who had been in contact with mental health services in the 12 months prior to death. The Inquiry also found that whilst there was an increase in the number of patient suicides between 2008 and 2013, this was broadly in line with general population figures. From 2013 onwards the figures have been lower, particularly in male patients.[11]

- ***People in contact with the justice system***

Those in contact with the justice system represent a key suicide risk, with ONS figures showing that between 2011 and 2021 the risk of suicide was six times higher in offenders in the community compared with the general population in England and Wales.[12] This risk was particularly pronounced amongst female offenders, where the risk was 11 times greater than in the general population (compared to a risk four

[7] This exercise has not yet been possible with 2021 Census data due to delays in death registration data, and these associations may have changed in that 10-year period.
[8] Sociodemographic inequalities in suicides in England and Wales: 2011 to 2021 - Office for National Statistics
[9] Guidance - Key Topics - Public Health Wales
[10] Contacts with primary and secondary healthcare prior to suicide: case–control whole-population-based study using person-level linked routine data in Wales, UK, 2000–2017
[11] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual Report: England, Northern Ireland, Scotland and Wales. 2021. University of Manchester. Wales section starts on page 75
[12] Drug-related deaths and suicide in offenders in the community, England and Wales - Office for National Statistics

times greater amongst male offenders). Of the total identified suicides amongst offenders in the community across this time period, 219 were drug-related suicide (representing 17 per cent of suicides).[13]

Data from the Real Time Suspected Suicide Surveillance (RTSSS) report published by Public Health Wales (PHW), found that during 1 April 2022 to 31 March 2023, 74 per cent of the deaths by suspected suicide were in people previously known to the police.[14]

- ***People with substance misuse challenges***

Substance misuse, including alcohol misuse, is a risk factor. Research into alcohol-related emergency hospital admissions in Wales suggests that such admissions also increase the risk of suicide.[15]

- ***People with autism***

Autistic people are at a higher risk of suicide than non-autistic people. Figures show that as many as 11 to 66 per cent of autistic adults had thought about suicide during their lifetime, and up to 35 per cent had planned or attempted suicide.[16] 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[17] and autistic women.[18] Indeed, females with Autism Spectrum Disorder (ASD) were over three times as likely to die from suicide as females without ASD and young people with ASD were at over twice the risk of suicide than young people without ASD.[18]

Just like in the general population, experiencing mental health problems, social isolation and unemployment can increase suicide risk in autistic people. Yet, being autistic in itself is thought to contribute to this risk over and above these other factors.[19]

- ***Victims of domestic abuse***

A review of deaths in domestic settings or following domestic abuse in England and Wales (between 2020 and 2022) found that 24 per cent of these deaths were suspected victim suicides.[20]

---

[13] Drug-related deaths and suicide in offenders in the community, England and Wales - Office for National Statistics
[14] Deaths by suspected suicide 2022-23 - Public Health Wales
[15] Risk of suicide following an alcohol-related emergency hospital admission: An electronic cohort study of 2.8 million people
[16] Hedley, D., & Uljarević, M. (2018). Systematic review of suicide in autism spectrum disorder: current trends and implications. Current Developmental Disorders Reports, 5(1), 65-76.
[17] Hirvikoski, T., Boman, M., Chen, Q., D'Onofrio, B. M., Mittendorfer-Rutz, E., Lichtenstein, P., ... & Larsson, H. (2020). Individual risk and familial liability for suicide attempt and suicide in autism: A population-based study. Psychological Medicine, 50(9), 1463-1474.
[18] Kirby, A. V., Bakian, A. V., Zhang, Y., Bilder, D. A., Keeshin, B. R., & Coon, H. (2019). A 20-year study of suicide death in a statewide autism population. Autism Research, 12(4), 658-666.
[19] Cassidy, S., Bradley, L., Shaw, R., & Baron-Cohen, S. (2018b). Risk markers for suicidality in autistic adults. Molecular Autism, 9(1), 1-14.
[20] Domestic Homicide Project - VKPP Work

- ***By area deprivation***

Further data from the RTSSS report, found that during 1 April 2022 to 31 March 2023, the rates of deaths by suspected suicide in residents in the most deprived and next most deprived areas (13.9 per 100,000 and 13.7 per 100,000) were statistically significantly higher than the rate in residents in the least deprived areas (9.5 per 100,000).[21]

Other high-risk groups

We know that **disabled people** and **neurodivergent people** tend to have lower levels of wellbeing and are at greater risk of experiencing poor mental health.[22] Given the link between poor mental health and suicidality,[23] the risk of suicidal behaviour among these groups is heightened.

LGBTQ+ people are also more likely to suffer from higher rates of psychological distress and lower levels of satisfaction with health services[24]. Additionally, more than half of LGBT pupils in Wales (54 per cent) – including 73 per cent of trans pupils – are bullied for being LGBT at school, which is a further risk factor for suicide. Indeed, two in five trans children and young people (41 per cent) reported to have at some point attempted to take their own life. For lesbian, gay and bi pupils who are not trans, one in four (25 per cent) have tried to take their own life.[25]

An in-depth longitudinal study on suicide among Gypsy, Roma and Travellers in Ireland identified that Travellers experience a 6.6 times higher suicide rate when compared with non-Travellers, accounting for approximately 11 per cent of all Traveller deaths.[26] The most common method was by hanging. When disaggregated by gender and age, this rate was: 7 times higher for men and most common in young Traveller men aged 15-25; and 5 times higher for Traveller women than in the general population. High rates of suicide among Gypsies and Travellers in Britain were also reported in a 2009 Equality and Human Rights Commission (EHRC) review of inequalities experienced by Gypsy and Traveller communities,[27] which confirmed anecdotal evidence of a disproportionately high suicide rate amongst this group. In its December 2017 update the EHRC reported that: “Gypsies, Travellers and Roma were found to suffer poorer mental health than the rest of the population in Britain and they were also more likely to suffer from anxiety and depression.”[28]

---

[21] Deaths by suspected suicide 2022-23 - Public Health Wales
[22] Disability, well-being and loneliness, UK - Office for National Statistics
[23] Too, L. S., Spittal, J., Bugeja, L., Reifels, L., Butterworth, P., & Pirkis, J. (2019). The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies. Journal of Affective Disorders, 259, 302-313.
[24] A review of evidence on socio-economic disadvantage and inequalities of outcome (summary)
[25] School Report Cymru (2017) | Cymru
[26] Selected key findings and recommendations from the All-Ireland Traveller Health Study – Our Geels 2010.
[27] EHRC research report 12: Inequalities experienced by Gypsy and Traveller communities: A review
[28] EHRC, Dec 2017: Race report: Healing a divided Britain, EHRC report on the need for a comprehensive race equality strategy.

Moreover, according to the Equality and Human Rights Commission Report Is Wales Fairer? published in 2018, barriers to accessing health services are a particular issue for **Gypsy, Roma and Traveller families**. Analysis by the ONS of Gypsies' and Travellers' lived experience relating to health found that: "Although participants described mental health challenges affecting Gypsies and Travellers, they suggested this topic is not widely spoken about within communities. Difficulties accessing mental healthcare were also mentioned. These partly linked to apprehension about seeking help and feeling misunderstood or treated unsympathetically by healthcare workers because of their ethnicity, and partly linked to difficulties asking for help at all."

Access to mental health service provision is also a key challenge for **refugees and asylum seekers,**[29] which can further compound people's feelings of loneliness and not belonging, as can social isolation experienced by these groups.[30] Whilst reliable data is lacking in this area, there are indications that the mental strain placed upon displaced people may lead to them being at greater risk of suicidal ideation and behaviour.[31]

The Office for National Statistics' publication Sociodemographic Inequalities in Suicides in England and Wales: 2011 to 2021[32] found that rates of suicide were lower in those who reported being in a partnership (married or civil partnership) than those who reported themselves as single, separated or widowed. They also found that "suicide rates were higher in **white and mixed/multiple ethnic groups** than they were for other ethnicities", but issues related to the quality of the underlying ethnicity data and changing demographics since 2011 should be acknowledged.

Drawing on non-Wales-specific UK-wide evidence and based on advice from the National Advisory Group, the following groups have also been identified as potentially high risk in Wales:

- Children and young people
- Pregnant women and new mothers
- Perpetrators of domestic abuse
- Victims of bullying
- People struggling with academic pressures
- People experiencing problems related to old age
- Members of the armed forces and veterans
- People who have experienced adverse childhood experiences (ACEs)
- People who are in care or care experienced
- People with physical illnesses
- Problem gamblers

[29] Suicide among psychiatric patients who migrated to the UK: a national clinical survey - eClinicalMedicine
[30] Patterns of Suicide and Suicidal Ideation in Relation to Social Isolation and Loneliness in Newcomer Populations: A Review | Journal of Immigrant and Minority Health (springer.com)
[31] Suicide rates and suicidal behaviour in displaced people: A systematic review | PLOS ONE
[32] Sociodemographic inequalities in suicides in England and Wales - Office for National Statistics

- People experiencing social isolation and loneliness
- People with a history of bereavement, especially by suicide
- Victims of rape, sexual abuse and sexual assault

Self-harm

Data from Patient Episode Database for Wales (PEDW) published by Digital Health and Care Wales (DHCW) shows there has been a decline in the number of hospital admissions for self-harm in each year in Wales since 2018/19. There were a third less hospital admissions for self-harm in 2021/22 (4,000 admissions) compared to 2018/19 (6,000 admissions), although this is likely to have been affected by fewer people seeking help in hospital settings during the COVID-19 pandemic.[33] It is important to note that these figures do not account for the numbers of people who self-harm but have not been admitted to hospital as a result. Consequently, the rates of self-harm in Wales are likely higher than the figures reported above.

The identified high **priority groups** are:

- ***Children and Young People, particularly girls and young women***

Though there has been a decline in the overall number of hospital admissions for self-harm in data from PEDW there has been a gradual increase in self-harm admission rates amongst young people in Wales, particularly girls aged 10-14. In 2021/22, the number of hospital admissions due to self-harm for girls aged 10-14 reached a record high of 800, which was 300 more than any other year.[34] Amongst females aged 10-18, these incidences have continued to rise until 2019, with incidences amongst males rising until 2019 before dropping in 2020-21.[35]

Further research suggests that incidence rates of self-harm in the UK amongst 10–24-year-old girls increased between March 2020 and March 2022, primarily driven by increases in the 13-16 age group (with incidences amongst boys being lower than expected).[36] Girls were more likely than boys to be admitted to hospital after attending emergency departments for self-harm. This was true even for those aged under 16, for whom clinical guidance always recommends admission for a full risk assessment.[37]

Prevalence of self-harm amongst children and young people is consistently highest in the most deprived 40 per cent of areas in Wales, although over the past decade there have been increasing incidences of self-harm in more affluent areas.[38]

---

[33] Patient Episode Database for Wales (PEDW), Digital Health and Care Wales (DHCW)
[34] Patient Episode Database for Wales (PEDW), Digital Health and Care Wales (DHCW)
[35] Lohakare, H.S., Marchant A., John A (2023). Self-harm contacts across healthcare settings in Wales. NHS Executive [forthcoming]
[36] Temporal trends in eating disorder and self-harm incidence rates among adolescents and young adults in the UK in the 2 years since onset of the COVID-19 pandemic: a population-based study - The Lancet Child & Adolescent Health
[37] Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK
[38] Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK | Archives of Disease in Childhood

In addition to rising rates of self-harm amongst children and young people in Wales, research using 2017 data from the Schools Health Research Network (SHRN) found that pupils aged 11-16 who had been bullied in person were three times more likely to self-harm than their peers who had not experienced bullying.[39] This risk is particularly clear amongst trans children and young people, with UK-wide research suggesting that those who are transgender report higher levels of self-harm, self-poisoning and suicide attempts,[40] and reports from Wales in 2017 suggesting that over 70% of trans learners were bullied in school for being LGBT.[41]

Further data covering over 400,000 pupils in Wales aged 7-16 between 2009 and 2013 found that school exclusions, or persistent absence from school, could be indicators of current or future self-harm as well as poor mental health.[42]

Other high-risk groups

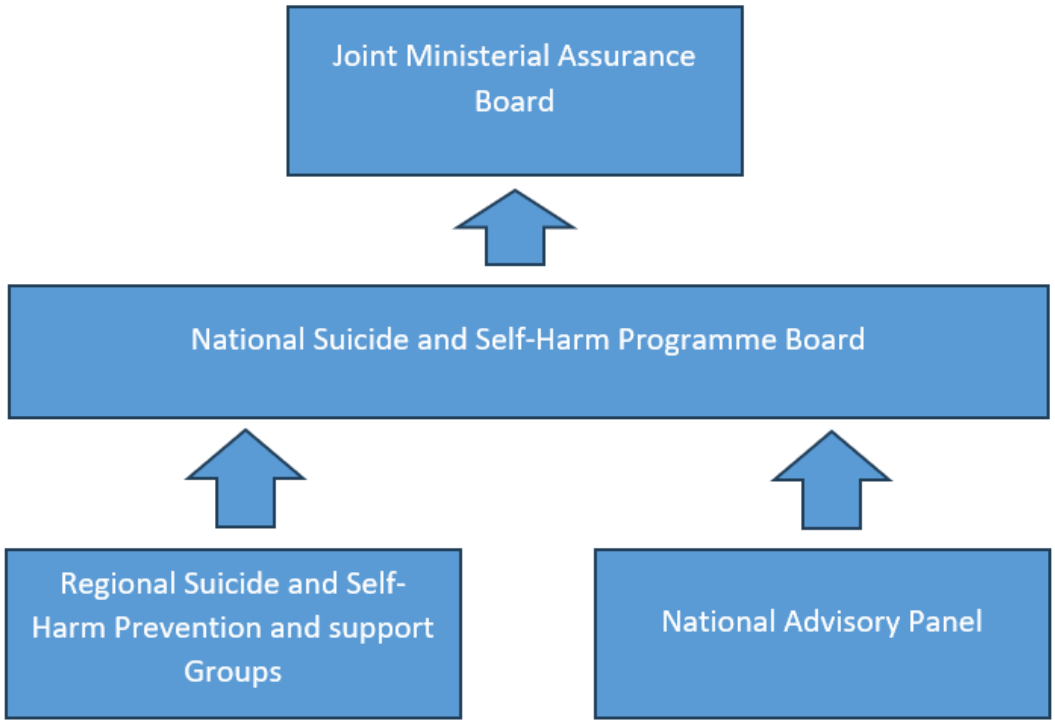
The risk factors for people who self-harm are consistent with other safeguarding risks such as child abuse and neglect, substance misuse, intimate partner violence and sexual exploitation.[43] Other risk factors include having an eating disorder,[44] links with other mental health conditions or contact with the justice system.[45]

A systematic review of studies based in Europe, the USA, Israel and Australia found links between loneliness and suicidal ideation and behaviour, with stronger links seen in the 16-20 and over 65 age groups. It is suggested that these age groups may be particularly affected due to the transitional nature of these time periods – moving out of compulsory education, and from working to retirement age – and the associated shifts in social and emotional ties.[46]

[39] Self-harm, in-person bullying and cyberbullying in secondary school-aged children: A data linkage study in Wales - John - 2023 - Journal of Adolescence - Wiley Online Library
[40] White,J., Trinh, M-H. and Reynolds, C. (2023). Psychological distress, self-harm and suicide attempts in gender minority compared with cisgender adolescents in the UK. The British Journal of Psychiatry 9(5)
[41] School Report Cymru (2017) | Cymru
[42] Association of school absence and exclusion with recorded neurodevelopmental disorders, mental disorders, or self-harm: a nationwide, retrospective, electronic cohort study of children and young people in Wales, UK - The Lancet Psychiatry
[43] Guidance - Key Topics - Public Health Wales
[44] Clinical management and mortality risk in those with eating disorders and self-harm: e-cohort study using the SAIL databank - PMC
[45] Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2022 Assaults and Self-harm to March 2022
[46] Loneliness as a predictor of suicidal ideation and behaviour: a systematic review and meta-analysis of prospective studies - ScienceDirect

How will we deliver the strategy?

Accompanying the strategy will be a series of Delivery Plans which will provide more detailed 'SMART' actions. Using these, the strategy will be delivered through continued multi-sectoral and cross-Government collaboration with strengthened governance in place to drive implementation and monitor progress.



We have established the Joint Ministerial Assurance Board to ensure robust governance arrangements are in place to provide strategic oversight of both the Mental Health and Wellbeing Strategy and the Suicide and Self-Harm Prevention Strategy. The Board is chaired by the Deputy Minister for Mental Health and Wellbeing, with the Deputy Minister for Social Services as the Vice Chair. Progress on the implementation of the Strategies will be reported to the Board on a quarterly basis.

The Strategic Cross-Government Suicide and Self-Harm Prevention Board will be adapted and evolve into the National Suicide and Self-Harm Programme Board. The Board will be responsible for the development and delivery of the Suicide and Self-harm Prevention Strategy and accompanying Delivery Plans. It will drive action across Government and externally, manage risks, provide assurance and monitor impact. The Board will consist of key internal and external partners with responsibility for reporting directly to the Joint Ministerial Assurance Board.

To support the implementation of the Suicide and Self-Harm Prevention Strategy and accompanying Delivery Plans, we will review the role of the National Advisory Group and other forums on Suicide and Self-Harm Prevention as part of our actions to

strengthen the infrastructure to use research, evidence and intelligence. The aim will be to ensure we have a systematic, evidence-based and data driven approach to the development and delivery of our actions.

Local action will be delivered and co-ordinated by the Regional Suicide and Self-Harm Prevention Partnership Groups who will report to the National Coordinator as a member of the Programme Board.

As part of the review of governance arrangements for the Mental Health and Wellbeing Strategy, we will ensure links are made with the governance arrangements for this strategy, given the interconnection between the actions and ambitions.

Funding

This strategy is being developed in a period of financial constraint and as such we have developed it with the understanding that there will need to be a way of setting priorities, ensuring best use of existing resources and an opportunity to be clear about what can realistically be delivered.

The final strategy will be accompanied by a costed delivery plan which over the life of the strategy will be renewed and refreshed.

Objectives

High-level Objective 1

Establish a robust evidence base for suicide and self-harm in Wales, drawing on a range of data, research and information; and develop robust infrastructure to facilitate the analysis and sharing of information to focus resources, shape policy and drive action.

What this objective means

There is a range of information and evidence that can inform actions to prevent, predict and respond to suicide and self-harm – including local intelligence, trends and clusters. We have made good progress in Wales, for instance with the implementation of Real Time Suspected Suicide Surveillance, which provides more timely data to inform the response to a suicide and to support preventative action.

Whilst we have made progress, there is an identified need for more robust data, evidence and information in relation to suicide and self-harm in Wales to inform policies and services. We also need a more systematic approach to ensure that we make best use of available research, evidence and surveillance to support cross-sectoral action in Wales and monitor the impact of policy and interventions. This also includes ensuring we have an infrastructure to gather information from services such as the NHS and third sector organisations.

How we will do this

Sub-objective 1a: Develop a robust evidence base for suicide and self-harm in Wales to better understand the causes, the most vulnerable groups, the impact and the most effective interventions and responses.

Sub-objective 1b: Develop more systematic structures and processes for the analysis, synthesis, and presentation of data and research relating to suicide and self-harm, from within Wales, across the UK and wider to inform policy and practice.

High-Level Objective 2

Co-ordinate cross-Government and cross-sectoral action which collectively tackles the drivers of suicide and reduces access to means to suicide.

What this objective means

Through the delivery of Talk to Me 2, we have established effective cross-Government and cross-sectoral working to prevent suicide and self-harm in Wales. This has been strengthened through the implementation of the Strategic Cross-Government Suicide and Self-Harm Prevention Board – which will evolve into the National Suicide and Self-Harm Programme Board. Our aim is to build on this work to ensure that relevant policy areas across the Welsh Government work collaboratively with each other, with social services, local government and third sector organisations to prevent suicide and self-harm. This objective focuses on specific current and emerging drivers of suicide and restricting access to means, but it is underpinned by cross-Government and multi-sectoral partnership working and the preventative actions set out in our Mental Health and Wellbeing Strategy. This work recognises the link between socio-economic disadvantages and risk of suicide and self-harm.

How we will do this

Sub-objective 2a: Delivering the Mental Health and Wellbeing Strategy to improve mental health and wellbeing through a preventative approach and tackling the wider determinants of mental health.

Sub-objective 2b: Ensure clear understanding and ownership of wider cross-Government and cross-sector action to tackle key drivers of suicide and establish programmes of work to strengthen and co-ordinate prevention measures.

Sub-objective 2c: Improve how we respond to, and manage, locations of concern to enable local action to be taken with an informed, evidence-based, and consistent approach.

Sub-objective 2d: Identify ways to enhance online safety and limit the encouragement and assistance of self-harm through the provision of legislation and new policy opportunities.

High-level Objective 3

Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.

What this objective means

Building on our work to deliver the vision in Talk to Me 2, this objective aims to ensure that we provide a more tailored and targeted approach to support those groups that are most vulnerable to suicide and self-harm. It also aims to ensure that we identify and provide appropriate, person-centred support within the settings where individuals who are vulnerable present. We will do this through being led by research and evidence to identify groups and settings, and will develop programmes of work to support individuals and organisations.

How we will do this

Sub-objective 3a: Develop capability and response in key settings where the most vulnerable to self-harm and/or suicide might present.

The identified groups include, but are not limited to:

- Children and young people
- Middle-aged men
- People who self-harm or have self-harmed
- People in contact with mental health services
- People in contact with the justice system
- People with substance misuse challenges
- Pregnant women and new mothers
- Disabled people
- Neurodivergent people
- LGBTQ+ people
- Gypsy, Roma and Traveller groups
- White and mixed/multiple ethnic groups
- Migrants and people seeking sanctuary
- Victims and perpetrators of domestic abuse
- Victims of bullying
- People struggling with academic pressures
- People experiencing problems related to old age
- Members of the armed forces and veterans
- People who have experienced adverse childhood experiences (ACEs)
- People who are in care or who are care experienced

- People with physical illnesses
- People with financial difficulties and economic adversity
- Problem gamblers
- People experiencing social isolation and loneliness
- People with a history of bereavement, especially by suicide
- Victims of rape, sexual abuse and sexual assault

The identified key settings are:

- Youth and education settings (including further and higher education)
- Primary care
- Prisons and custodial settings, including Youth Offending Institutions.
- Community services, for instance debt advice, employment centres
- Community drug and alcohol services
- Social care settings
- Mental health services in community, hospital, or acute settings

Sub-objective 3b: Ensure that all policies, actions, services and governance arrangements related to self-harm and suicide in Wales provide the opportunity for people to access services in the language of their choice and are consistent with the Welsh Language Standards and Cymraeg 2050 which sets out our long term approach to achieving a million Welsh speakers.

Sub-objective 3c: Ensure that all policies, actions, services and governance arrangements related to self-harm and suicide in Wales respect and value children's rights.

High-level Objective 4

Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm.

What this objective means

This objective builds on the targeted approach set out in Objective 3 to provide population level information aimed at supporting individuals, groups and organisations to understand their role in suicide and self-harm prevention. It also aims to improve the confidence and skills of individuals to identify people at risk and provide appropriate, person-centred support.

How we will do this

Sub-objective 4a: Identify opportunities to enhance the universal offer of training and support.

Sub-objective 4b: Establish continuity and connection between different services that respond to people who are in distress, ensuring consistent approaches are adopted, with shared learning and development programmes for call handlers and front-line responders.

High-level Objective 5

Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.

What this objective means

This objective recognises the need to improve services and support to provide a more compassionate response when people reach out for help when in distress. It recognises the need to enhance the availability and the quality of support for those who present with self-harming behaviour and to ensure professionals, employers, family and friends have a clear pathway of support to refer to.

The effective implementation of our National Guidance to support organisations to better support those affected or bereaved by suicide will be fundamental to achieving this objective.

The gap in support for those bereaved or affected by suicide and the need to improve support for this group is also recognised. The National Advisory and Liaison Service offers advice and support for those bereaved or affected by suicide and aims to ensure that all those exposed to, affected, or bereaved by a potential suicide receive a proactive offer of support within the first 48-72 hours of the death, and that the offer is compassionate, trauma-informed and responsive to the particular needs of people living with bereavement by suicide (suspected or confirmed).

There is also a need to strengthen and standardise the multi-agency rapid response to a suspected suicide to ensure that appropriate and timely access to support is provided but also to ensure preventative action is taken.

How we will do this

Sub-objective 5a: Through joint working across sectors, establish a clear description of a timely, pro-active, person-centred and compassionate response to all those who present with self-harm or as at risk of suicide to any part of the system, which contributes to reducing stigma and is in line with NICE Guidance (2022), including psycho-social assessment, safety planning, psychological therapies and other evidence-based approaches that help to keep people safe.

Sub-objective 5b: (also contributes to Objective 3): Develop national, regional, and local arrangements to enable rapid response to suspected suicides and cluster recognition, within localities and across borders.

High-level Objective 6

Responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour.

What this objective means

We know that some types of media reporting can perpetuate stigma and lead to imitational or suicide behaviour, but media can also be a powerful means to give people hope or to encourage people to seek help. The Samaritans provide Media Guidelines for reporting on suicide and self-harm. This objective recognises the need to ensure responsible reporting by the media, but also through any form of reporting regarding suicide or self-harm.

How we will do this

Sub-objective 6a: Continue to develop and embed a consistent shared language for suicide and self-harm and the terminology we use.

Sub-objective 6b: Maintain reporting, media and communications policy and guidelines.

Communication

As part of the pre-consultation engagement on the strategies, stakeholders told us:

- We need to be clearer in terms of how we communicate and explain our vision for the Suicide and Self-harm Prevention Strategy for Wales – and how each of the vision statements and underpinning principles will be realised and implemented.
- Specific consideration needs to be given to the language used to describe mental health conditions, mental wellbeing, and mental health / ill-health. Key phrases need clear explanations.
- We need to provide clear and accessible information tailored to needs, including culturally appropriate information for minority ethnic communities; LGBTQ+ communities; neurodivergent people, children and young people; people with sensory loss; and in a person's preferred language.
- We need to develop a standardised approach for services to provide information about services and how to access them (and in so doing, promote the Active Offer for Welsh language and ensure all information complies with the All Wales Standards for Accessible Communication and Information, and where appropriate is children and young people friendly).
- We need better and more accessible information for other professionals on how they can assist their own service users to get access to support.

How will we know?

To ensure that we are delivering a strategy that builds upon the work in this area to date, we will focus on the six key objectives listed above. Accompanying these, we will develop a Delivery Plan (outlining detailed activities that will take place as part of the objectives) and an evaluation framework, which will set out how progress against our objectives will be achieved.

The evaluation framework will include, but will not be limited to:

- Initial production of an assessment to identify key components of the framework
- Monitoring and reporting on chosen indicators
- Regular/periodic reflection on the framework to ensure new and emerging evidence and indicators are incorporated where appropriate

The Delivery Plan will set out SMART actions to achieve the objectives. Progress against the timescales set out in the action plan will be monitored and reported via the governance arrangements set out in the *How will we do this* section.

Glossary of terms

Active offer

The Active Offer is providing a service in Welsh without someone having to ask for it.

Adverse Childhood Experiences (ACEs)

Chronic stress on individuals during childhood. Such stress arises from the abuse and neglect of children but also from growing up in households where children are routinely exposed to issues such as domestic violence or individuals with alcohol and other substance use problems. Collectively such childhood stressors are called ACEs (Adverse Childhood Experiences).

Affected by suicide

What someone might experience when they lose someone to suicide, which can include intense sadness, shock, anger, frustration, confusion and isolation.

Anti-racism

Anti-racism is about changing the systems, policies and processes which for so long have embedded a negative view of ethnic minority people.

Bereavement / bereaved

Bereavement is the experience of losing someone important to us. It is characterised by grief, which is the process and the range of emotions we go through as we gradually adjust to the loss. Someone who is bereaved is a person who is experiencing this loss.

Bullying

Behaviour by an individual or group, usually repeated over time, that intentionally hurts others either physically or emotionally.

CAMHS

CAMHS is the name for the NHS services that assess and treat people with emotional, behavioural or mental health difficulties. You might also see CYPMHS used, which stands for Children and Young People's Mental Health Services. They are NHS-provided services that assess and treat children and young people with mental or emotional difficulties.

Care experienced

Care experienced people are those who are either looked after by the state under Wales national legislation, or were previously looked after by the state. In Welsh law, they are defined as Looked After Children or Care Leavers.

Cluster (suicide)

A suicide cluster may be defined as a group of suicides, suicide attempts, or self-harm events that occur closer together in time and space than would normally be expected in a given community.

Co-occurring

This refers to having mental health conditions alongside other issues. For example, the co-occurrence of poor mental health with substance misuse, or neurodivergence.

Crisis support

A mental health crisis often means that someone no longer feels able to cope or be in control of their situation. Crisis support is the help and advice available to someone who needs help.

Custodial setting

Custodial settings include: border custody, court custody, police custody, prison, young offenders institutions, secure training centres, secure children's homes.

Delivery plans

The Mental Health and Wellbeing Strategy and the Suicide and Self-Harm Prevention Strategy will have supporting delivery plans. These will set out the actions that we will take to achieve our vision for mental health and wellbeing in Wales, and suicide and self-harm prevention.

Digital Health and Care Wales (DHCW)

DHCW provide the digital services that are helping to transform health and care delivery.

Disorder

A mental disorder is characterised by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour.

Mental disorder is defined by section 1(2) of the Mental Health Act 1983 (the Act) as "any disorder or disability of the mind".

Emotional Distress

There are times throughout life when we are presented with difficult situations, challenges or a mental health problem, and these may leave us feeling distressed and struggling to cope.

Emotions

These are how we feel about something and how our body reacts. For example, if we experience fear, we might feel our heart beating faster or notice our hands shaking.

Equality

Ensuring everyone is treated equally and fairly and ensuring that everyone's human rights are met.

Fair work

Fair work is the presence of observable conditions at work which means workers are fairly rewarded, heard and represented, secure and able to progress in a healthy, inclusive working environment where rights are respected.

Feelings

These are how we experience our emotions and give meaning to them. They are different for everyone. For example, you might associate your hands shaking with feeling anxious.

Inequality

Inequality of outcome relates to any measurable difference in outcome between those who have experienced disadvantage (for example, socio-economic disadvantage) and the rest of the population.

In-reach service

Services that work in settings outside of their usual location, with the view to improving access to services and outcomes.

Intervention (including early intervention)

The action of becoming intentionally involved in a situation, in order to improve it or prevent it from getting worse.

Legislation

Legislation is law which has been made by a legislature or made by a person authorised by a legislature to make laws. A legislature is a body of persons, usually elected, which is empowered to make, change, or repeal the laws of a country or state.

There are two legislatures which pass laws which apply to Wales: the UK Parliament and Senedd Cymru.

Regulations are an example of laws that can be introduced by the UK Parliament and Senedd Cymru.

LGBTQ+

This refers to lesbian, gay, bisexual/bi, transgender/trans people, queer or questioning. Other letters can be added to the acronym to include other groups, orientations and identities, such as I (intersex) and A (asexual/aromantic). The + (plus) in the acronym is used as a shorthand to include and acknowledge other diverse terms people identify with and use to describe their identities and orientations, including intersex, asexual and aromantic people.

Lived experience

This refers to how people living in Wales experience and articulate the current situation as lived out by them and people they know.

Locations of concern

A location of concern can be broadly defined as a specific, usually public, site that is used as a location for suicide and that provides either means or opportunity for suicide.

One or more incidents of suicidal behaviour at a particular location suggests that action should be considered to address the site in question.

Mental health

This is a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development. People with poor mental health can have a mental health condition but this is not always or necessarily the case.

Mental health conditions

This is a broad term covering conditions that affect emotions, thinking and behaviour, and which substantially interfere with our life. Mental health conditions can significantly impact daily living, including our ability to work, care for ourselves and our family, and our ability to relate and interact with others. This is a term used to cover several conditions (e.g. depression, post-traumatic stress disorder, schizophrenia) with different symptoms and impacts for varying lengths of time, for each person. Mental health conditions can range from mild through to severe and enduring illness. People with mental health conditions are more likely to experience lower levels of physical and mental wellbeing, but this is not always or necessarily the case. Some mental health conditions like eating disorders and schizophrenia are associated with a higher risk of mortality.

Mental wellbeing

This is the internal positive view that we are coping well with the everyday stresses of life.

Multi-sectoral collaboration

Where different organisations and agencies work together to achieve common goals.

Neurodiversity and neurodivergent people

Neurodiversity refers to the different ways the brain can work and interpret information. It highlights that people naturally think about things differently. We have different interests and motivations, and are naturally better at some things and poorer at others.

Most people are neurotypical, meaning that the brain functions and processes information in the way society expects.

For neurodivergent people, the brain functions, learns and processes information differently.

NHS Executive

The NHS Wales Executive is a new, national support function, operational from 1 April 2023.

The key purpose is to drive improvements in the quality and safety of care – resulting in better and more equitable outcomes, access and patient experience, reduced variation, and improvements in population health.

Person-centred

This means treating people as individuals and as equal partners in their healthcare, being mindful and respectful of their individual needs (including a person's preferred language), providing any reasonable adjustments to meet needs and providing compassionate care.

Primary Care

Primary care is about those services which provide the first point of care (day or night) for more than 90per cent of people's contact with the NHS in Wales. General practice (GP) is a core element of primary care, as well as pharmacy, dentistry, and optometry.

Public Health Wales

Public Health Wales is one of the 11 organisations which makes up NHS Wales. They are the national public health agency in Wales.

Public Health Wales work to protect and improve health and wellbeing and reduce health inequalities for the people of Wales.

Real Time Suspected Suicide Surveillance (RTSSS)

The RTSSS collects information relating to sudden or unexplained deaths that are suspected to have been by suicide.

This system has been developed due to the delay between an unexpected death and the death being recorded as a suicide following a coroner's inquest. This makes it difficult to implement an immediate response and support. The RTSSS in Wales will provide information without this delay, enabling services to respond much sooner.

The information from the new system will support services to develop preventative approaches and to ensure support is made available to individuals and communities directly affected. This can include providing bereavement support.

Safeguarding

Safeguarding means keeping people safe from abuse, neglect and harm. Abuse is when someone hurts you or treats you badly. Neglect is also a type of abuse. It means not giving someone the care they need.

Secondary health care

Health care provided by hospitals. Testing, diagnostics and treatment usually overseen by a specialist.

Self-harm

Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress. Self-harm includes suicide attempts as well as acts where little or no suicidal intent is involved (for example, where people harm themselves to reduce internal tension, communicate distress, or obtain relief from an otherwise overwhelming situation).

Sensory loss

People who are d/Deaf, deafened or hard of hearing; or people who are Blind or partially sighted; or people who are Deafblind (those whose combined sight and hearing impairment cause difficulties with communication, access to information and mobility).

Social determinants

The broad social and economic circumstances that together influence health throughout a person’s life course.

Socio-economic disadvantage

Living in less favourable social and economic circumstances than others in the same society.

Stigma

This is used to describe the negative attitude that can exist in relation to a person’s mental health.

Substance misuse

Substance misuse is formally defined as the continued use of any psychoactive substance that substantially affects a person's physical and mental health, social situation and responsibilities. The most severe forms of substance misuse are normally treated by specialist drug and alcohol rehabilitation services. Substance misuse covers misuse of a range of psychoactive substances including alcohol, illicit drugs and licit drugs including prescribed medications taken in a way not recommended by a GP or the manufacturer.

Suicide

The intentional act of taking one's own life.

Suspected suicide

When a person is suspected to have taken their own life intentionally, but this has not been confirmed by a medical professional (a Coroner).

Therapy

Psychotherapy, also called talk therapy or usually just "therapy" is a form of treatment aimed at relieving emotional distress and mental health problems. Provided by any of a variety of trained professionals — psychiatrists, psychologists, social workers, or licensed counsellors — it involves examining and gaining insight into life choices and difficulties faced by individuals, couples, or families.

Third sector

The third sector encompasses the full range of non-public, not-for-profit organisations that are non-governmental and "value driven". This means motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

Timely

Having access to something at the appropriate time. For example: Part 1 of the Mental Health (Wales) Measure 2010 aims to improve access to mental health services within primary care settings, with the view to improving the outcomes for individuals accessing these services. The Measure also looks to achieve "timely referrals" to secondary mental health services and support for patients discharged from secondary mental health services.

Trauma-informed

Trauma-informed is about understanding that lots of people have adversity and trauma that affects them in all kinds of ways.

Unexplained death

Deaths for which the cause remains unascertained after a full investigation.

Universal offer

Where everyone is offered the same service, support or training.

Whole System Approach

Mental health and wellbeing support is provided in lots of different ways by lots of different services. These services can include health, social care, housing, education, youth and playwork, sports and leisure and the voluntary sector. A "whole system approach" means that all these services work together to provide a joined up service that is easy to access and easy to navigate.

Consultation questions

Question 1

To what extent do you agree with this vision?

“People in Wales will live in communities which are free from the fear and stigma associated with suicide and self-harm and are empowered and supported to both seek and offer help when it is needed.”

Question 1a

What are your reasons for your answer to question 1?

Question 2

In the strategic vision section there are 6 principles that underpin the strategy. Do you agree these principles are the right ones?

Question 2a

What are your reasons for your answer to question 2?

Question 3

The strategy identifies priority and high-risk groups. Do you agree that these are right?

Question 3a

What are your reasons for your answer to question 3?

In the strategy there are six high-level objectives. We have also suggested some sub-objectives to deliver each one. We will be publishing 3–5-year delivery plans which will sit alongside the strategy. The delivery plan will include more detailed actions to deliver our objectives. We would like to know:

- what you think of the objectives
- if you think the sub-objectives will deliver the high-level objectives
- what actions you think we could include in the delivery plan to deliver the objectives

You can answer questions about as many of the statements that are of interest to you.

Question 4

To what extent do you agree with the following high-level objective.

Objective 1: Establish a robust evidence base for suicide and self-harm in Wales, drawing on a range of data, research and information; and develop robust infrastructure to facilitate the analysis and sharing of information to focus resources, shape policy and drive action.

Question 4a

What are your reasons for your answer to question 4?

Question 4b

Two sub-objectives have been suggested to achieve the objective 1.

Do you agree with the sub-objectives identified?

Question 4c

What are your reasons for your answer to question 4b?

Question 4d

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Question 5

To what extent do you agree with the following high-level objective.

Objective 2: Co-ordinate cross-Government and cross-sectoral action which collectively tackles the drivers of suicide, and reduces access to means to suicide.

Question 5a

What are your reasons for your answer to question 5?

Question 5b

Four sub-objectives have been suggested to achieve the objective 2.

Do you agree with the sub-objectives identified?

Question 5c

What are your reasons for your answer to question 5b?

Question 5d

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Question 6

To what extent do you agree with the following high-level objective.

Objective 3: Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.

Question 6a

What are your reasons for your answer to question 6?

Question 6b

Three sub-objectives have been suggested to achieve objective 3.

Do you agree with the sub-objectives identified?

Question 6c

What are your reasons for your answer to question 6b?

Question 6d

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Question 7

To what extent do you agree with the following high-level objective.

Objective 4: Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm.

Question 7a

What are your reasons for your answer to question 7?

Question 7b

Two sub-objectives have been suggested to achieve objective 4.

Do you agree with the sub-objectives identified?

Question 7c

What are your reasons for your answer to question 7b?

Question 7d

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Question 8

To what extent do you agree with the following high-level objective.

Objective 5: Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide promoting effective recovery and reduced stigma.

Question 8a

What are your reasons for your answer to question 8?

Question 8b

Two sub-objectives have been suggested to achieve objective 5.

Do you agree with the sub-objectives identified?

Question 8c

What are your reasons for your answer to question 8b?

Question 8d

Alongside the Strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Question 9

To what extent do you agree with the following high-level objective.

Objective 6: Responsible communication, media reporting, and social media use regarding self harm, suicide and suicidal behaviour.

Question 9a

What are your reasons for your answer to question 9?

Question 9b

Two sub-objectives have been suggested to achieve objective 6.

Do you agree with the sub-objectives identified?

Question 9c

What are your reasons for your answer to question 9b?

Question 9d

Alongside the Strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Question 10

This is an all-age strategy. When we talk about our population we are including babies, children and young people, adults and older adults. Do you feel the strategy is clear about how it delivers for various age groups?

Question 10a

If you have answered “no”, please tell us why.

Question 11

We have prepared impact assessments to explain our thinking about the impacts of the strategy. This includes our research on the possible impacts. Are there any impacts, positive or negative, that we have not included?

Question 12

We would like to know your views on the effects that the Strategy would have on the Welsh language. Is there anything we could change to give people greater opportunities to use the Welsh language? Or, can we do more to make sure that the Welsh language is treated no less favourably than the English language?

Question 13

We have asked a number of specific questions. If you have any comments which we have not addressed, please use this space to make them.