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Talk to me 2

Suicide and Self Harm Prevention Strategy for Wales 2015-2020

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MINISTERIAL FOREWORD

Many people know of family, friends, neighbours or colleagues who have experienced the social and emotional consequences of suicide. Prevention of suicide and self harm remains a major public health and community challenge.

Suicide is usually in response to a complex series of factors that are both personal and related to wider social and community influences. Consequently, no one organisation or government department can tackle the issue in isolation. Suicide and self harm prevention needs effective collaboration and joint working across central government departments, between local authorities and health boards, involving the third sector, service users and, of course, clinicians and professionals in a range of settings including schools, workplaces, hospitals and communities. More can be achieved through true partnership than alone. It is for that reason *Talk to Me 2* exemplifies a '3Cs' approach, namely one that is truly cross-governmental, cross-sectoral and collaborative in design and delivery.

This strategy and action plan addresses the period 2015 to 2020, builds on what has already been achieved and will sustain the momentum of recent years by focusing on a smaller number of achievable objectives and priority actions, all specific to suicide and self harm prevention. *Talk to Me 2* acknowledges, but does not duplicate, other strategies and action plans, such as *Together for Mental Health*. The decision to focus on set priorities does not preclude other action being taken at either the national or the local level

It is a defining characteristic of *Talk to Me 2* that it identifies not just the risk and protective factors but also the many settings, services and groups of people that are to be taken into account: priority care providers have been identified to deliver action in priority places to the benefit of specific groups of priority people.

Stigma remains a cause for concern, and an area where improvement is needed. Just as with wider issues of mental health provision and support, stigma can isolate, stopping those in crisis from seeking help and preventing those left behind from accessing appropriate services and post-suicide bereavement support. I was pleased to launch *Help is at Hand Cymru* in 2013 to support those bereaved by suicide. Reducing stigma, improving awareness and understanding of suicidal behaviours amongst the public and those professionals and individuals who frequently come in to contact with people at risk of suicide and self harm, will encourage 'help-seeking' behaviours and increase the chances of earlier, more timely interventions.

The action plan supports the delivery and steps needed to be taken at the national and local levels to implement this strategy. The varied social, cultural and geographical landscape of Wales means that local areas need to adapt and develop strategies according to local circumstances. This national strategy provides the supportive and co-ordinated framework that makes such regional variation possible.

I would like to thank Associate Professor Ann John for her leadership of the National Advisory Group, and its work to develop *Talk to Me 2*. I commend the strategy and action plan and anticipate further improvements in the months and years to come.

Mark Drakeford AM
Minister for Health and Social Services

INTRODUCTION

1. This strategy document and associated action plan builds on *Talk to Me,* the 2009 national action plan to reduce suicide and self harm in Wales[1]. It sets 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.

2. In 2012, Welsh Government launched *Together for Mental Health,* its 10 year strategy to improve mental health and wellbeing in Wales[2]. This recognised that efforts to improve social, economic and environmental wellbeing in Wales are intertwined, and emphasised that improvements in mental health and wellbeing will only be achieved through concerted effort, the commitment of all Welsh Government departments and partner bodies.

3. An effective suicide and self harm prevention strategy would usually identify ways to establish, sustain and enhance mental health and wellbeing and community resilience to alter the life trajectories of people before they become suicidal. *Together for Mental Health* includes measures to develop individual resilience across the life course, and build population resilience and social connectedness within communities; it is for this reason such issues are not covered by *Talk to Me 2*. Similarly, *Together for Mental Health* and the Mental Health (Wales) Measure 2010 (the Measure)[3] address the treatment and management of mental health disorders, and the rights, responsibilities and duties assigned to individuals and to services; both impact on the suicide and self harm agenda and should be read alongside this document. The *Social Services and Wellbeing Act* and related Codes of Practice similarly stress the importance of emotional wellbeing in both adults and children, introduce key duties for local authorities, health boards and other bodies, and ensure greater consideration of issues such as carers' rights, safeguarding and innovative models of social service delivery.

4. Suicide is usually in response to a complex series of factors that are both personal and related to wider social and community influences. There is therefore no single reason why someone may try to take their own life. Suicide is best understood by looking at each individual, their life and circumstances.

5. It is however important to remember suicide and self harm are largely preventable, if risk factors at the individual, group or population level are effectively addressed. This requires a public health approach, broader than focussing on services for mental health service delivery, and which demands collective action by individuals, communities, services, organisations, government and society.

6. This means no single organisation or government department can take sole responsibility: suicide and self harm reduction must be **cross-governmental, cross-sectoral and collaborative**, with shared responsibility at all levels of the community, if it is to have a chance of success. The agenda therefore requires joint working across and between government at all levels, involving health boards, the third sector, and service users and professionals drawn from multiple

settings. Real partnership achieves more than individual action and the development of this strategy and action plan reflects that.

7. People who self harm or people in distress and at risk of suicide may come into contact with statutory or third sector services, in response to their actions or because they are actively asking for help. This strategy promotes the importance of a compassionate response to these individuals, encouraging future help seeking behaviour. Those engaging in suicidal behaviours should be encouraged to be active partners in planning and managing their own care.

SUICIDE AND SELF HARM: DEFINITIONS

8. **Suicide** is death resulting from an intentional self-inflicted act.

9. **Suicidal behaviours** range from suicidal thoughts, planning suicide, attempting suicide to completing suicide.

10. **Self harm** is usually defined as intentional self-poisoning or self-injury. This covers a wide range of behaviours, including isolated and repeated events: self cutting, poisoning, scratching, burning, banging, hitting, hair pulling and interfering with wound healing. It challenges the individual, families and professionals alike.

11. Behaviours associated with substance misuse, risk taking or eating disorders are generally not considered self-harm because usually the harm is an unintentional side effect of the behaviour. However boundaries can be blurred, meanings differ in different contexts and there are often associations.

12. For the purpose of this strategy self harm is defined as intentional non-fatal self-poisoning or self-injury, irrespective of the degree of suicidal intent or nature / purpose of other types of motive. This definition is necessarily very general because the method, nature of motivation or degree of suicidal intent is complex and may change for any individual over time. It may be ambivalent, dissimulated or concealed and is often considered by the individual as a coping mechanism for the management of distress. Long-term outcome research in adults consistently highlights the association between self-harm and suicide [4 5]. Those who repeat self harm are at significantly greater risk of completing suicide than those who have a single episode. It can be difficult to differentiate behaviours where there is an intent to die (cutting with suicidal intent) from those where there is a pattern of self harm with no suicidal intent (habitual self-cutting). The latter is sometimes called non suicidal self injury (NSSI).

13. There is considerable debate on the usefulness of making this distinction for prevention. People who engage in suicidal and non-suicidal self-harm share a number of risk factors but there may also be distinct groups within these populations. Only a small fraction of those who engage in NSSI go on to make suicide attempts or die by suicide. Self harm is an important public health problem in its own right, regardless of intent. It is one of the top five causes of hospital admissions in the UK. Many actions to prevent and reduce suicide will have benefits for those who self harm. For these reasons the strategy and action

plan in Wales includes self harm but recognises the complexities discussed above.

CURRENT DATA

14. Suicide is rare but globally almost 800,000 die in this way each year [6]. Worldwide it is the 15th leading cause of death accounting for approximately two in every 100 deaths. Suicide is one of the three leading causes of death in the most economically productive age group (15-44 years); the other two being road traffic injuries and inter-personal violence. Notably it is the second leading cause of death among young people in the 15-19 years age group [7]. Suicide is a significant social and public health problem. The World Health Organisation has adopted a global target that suicides will be reduced by 10% by 2020 [8]. Each year in Wales between 300 and 350 people die from suicide. This is about three times the number killed in road accidents.

15. Suicide is a tragedy for all concerned and is a cause of distress for many people - the individual, family, friends, professionals and the community at large. It is estimated that for every person who dies through suicide at least six others are significantly and directly affected. Many others may be indirectly affected. Losing someone through suicide can be particularly traumatic and difficult to cope with; its impacts are psychological, spiritual and economic.

16. Men are around three times more likely to die by suicide than women. Women are more likely to engage in non-fatal suicidal behaviours that require hospital admission. Many people may have thoughts of suicide. Up to 19 people in every 100 will have thoughts of suicide at some point in their life [9]. These thoughts are distressing and can further isolate an individual, creating additional barriers to seeking help. Only a very small number of those who harm themselves or who think about suicide will actually die in this way.

17. Self harm behaviour regardless of intent is a serious public health problem in its own right. It is one of the top five reasons for medical admission in the United Kingdom and results in significant social and economic burden due to the utilisation of health services, particularly with respect to unscheduled hospital care, to treat the injury/ overdose. There is also the psychological and social impact for the individual, friends, family and professionals. The UK has one of the highest rates of self-harm in Europe. This figure may not represent the true scale of the problem, since many people who self harm either do not require medical attention or such attention is not sought. The true scale of self harm is estimated to be 1 in every 130 people. Self harm is more common in females and the risk of repetition is extremely high – up to 40% will go on to repeat including 13% in the first year. A prior suicide attempt (i.e. where intent is known) is the single most important predictor of suicide in the general population. Providing those who self harm with appropriate follow up care and support is an essential component of this strategy.

Suicide as a cause of death in Wales

18. Suicide (intentional self harm and events of undetermined intent) accounted for 27% of external causes of death (transport accident, suicide, other accidental

injury, other external causes) in all ages (15 and over) between 2010 and 2012. This exceeded deaths from road traffic accidents which account for 9.1% (an average of 107 per year) in the same age group and time period.

19. Suicide is a major cause of death amongst the 15 to 44 age group. In Wales over the period 2010 – 2012 it accounted for almost one in five deaths in males aged 15 to 24 years and just over one in ten deaths amongst women of that age.

20. The most common method of suicide in Wales was hanging/suffocation, followed by poisoning. Across the period examined (2001-03 and 2010-12) both the proportion of suicides by hanging/suffocation and the number has increased from 45% (an average of 143 deaths per year) to 58% (an average of 187 deaths per year) while that for poisoning has decreased from 31% (an average of 97 per year) to 22% (an average of 72 per year).

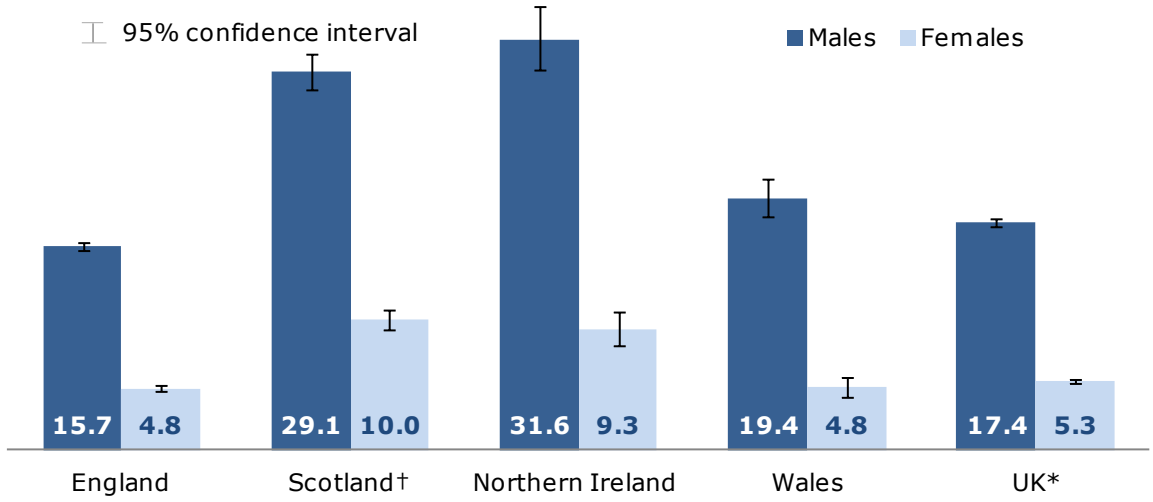
International comparisons

21. Both the UK as a whole and Wales individually are amongst Organisation for Economic Co-operation (OECD) countries with lower suicide rates. The Wales suicide rate for males per 100,000 population in 2009 is 10.2 (2.1 for females) with the OECD average rate being 18.1 (5.1 for females). Comparisons across different countries are difficult to make because of differences in coding and cultural differences in the classification of intent.

Wales compared with other nations

22. There was a small but statistically significant difference in the rate of suicide (2009-2011) between Wales and the UK average in males but not females (Figure 5). Comparisons across different countries are difficult to make because of differences in coding and cultural differences in the classification of intent.

Suicides, European age-standardised rates (EASR) per 100,000, males and females aged 15+, UK Nations, 2009-2011
Produced by Public Health Wales Observatory, using data from ONS, GROS & NISRA

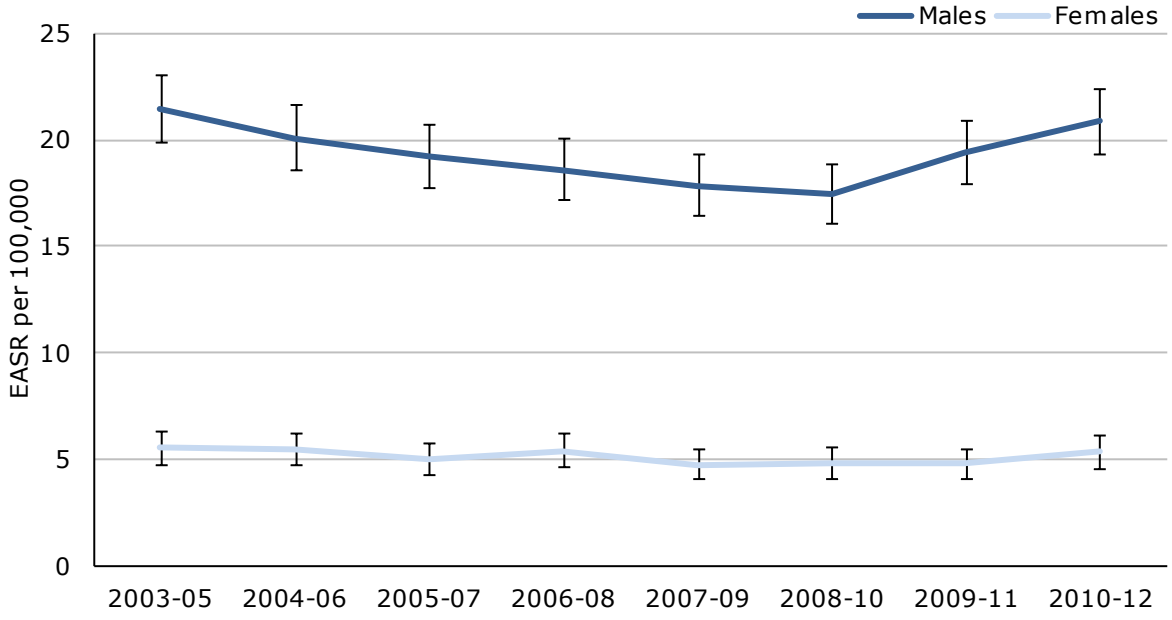


*UK is derived from the sum of England, Scotland, Northern Ireland and Wales and does not include deaths of non-residents
†Denominator used to calculate 2011 rate is based on 2010 MYEs as Scottish MYEs have not been revised to reflect Census 2011 populations

Trends in suicides in Wales

23. There has been significant change in terms of data collection due to changes in Coroners' reporting. As a result of this any change in trends in suicide rates in Wales using 3 year rolling rates should be interpreted with caution. The general downward trend in rates in males between 2004 and 2009 appears to be changing and is cause for concern but this may be due to more accurate recording. Rates for females remained fairly steady between 2001 and 2012.

Suicides, 3-year rolling European age-standardised rate (EASR) per 100,000, males and females aged 15+, Wales, 2003-2012
Produced by Public Health Wales Observatory, using ADDE & MYE (ONS)



Suicide in Wales by age and sex

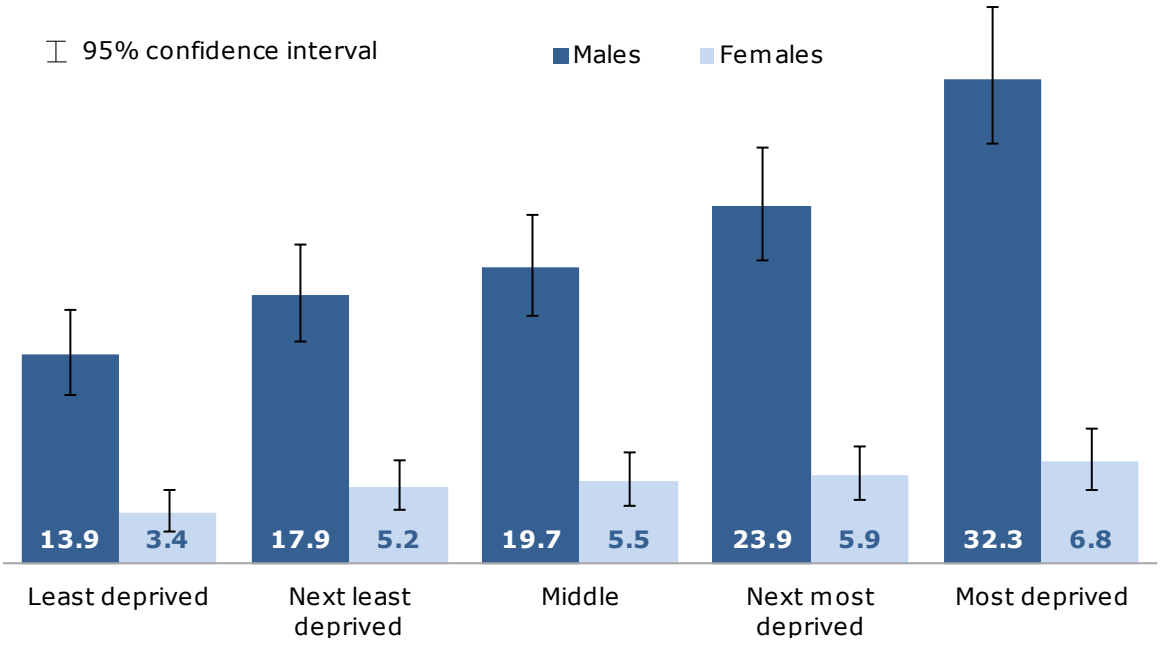
24. In Wales suicide rates were highest in males in the 30 to 49 year old age groups during 2003 to 2012. There is a secondary but lower peak amongst elderly males of 80 years plus. The pattern is different for females, with the highest rate seen in 30 to 34 year olds and 45 to 54 year olds.

Suicide and deprivation

25. Among both males and females there is an association between suicide and area of residence based deprivation. Rates are higher in our more deprived communities and this gap appears to be widening in Wales. This is consistent with existing literature and highlights that suicide prevention should address inequalities that exist in society.

Suicides, European age-standardised rate (EASR) per 100,000, by deprivation fifth (WIMD 2011), males and females aged 15+, Wales, 2010-12

Produced by Public Health Wales Observatory, using ADDE & MYE (ONS), WIMD (WG)



26. It is also important to note the impacts of the prolonged economic downturn and subsequent uncertain recovery. The UK's Faculty of Public Health's 'Better Mental Health for All' (2013) recognised that economic crises increase the risk factors that drive poor mental health, namely poverty and low household income, debt and financial difficulties, poor housing, unemployment and job insecurity. It is consequently not unexpected that Wales and other nations have seen an increase in rates of suicide in recent years.

Self harm data

27. In 2010 there were 4,450 individuals admitted to inpatient care following self harm. Some individuals are admitted more than once in any year. There are approximately 5,500 admissions for self harm in Wales each year. This gives an indication of the burden of self harm on services but does not take into account

those assessed in A&E departments who do not require admission, or the many more who do not attend following an incident of self harm. The age and pattern of self harm shows that young women aged 15-19 have the highest prevalence with some evidence of an increase in males over 85.

28. The patterns of suicide and self harm in Wales have not always been as we see them today and will continue to change. The challenges these changes present for prevention are considerable. There should be ongoing systematic collection of and access to data on suicide and self harm to enable the identification of priority people and places for action and to monitor and evaluate the impact of intervention.

RISK AND PROTECTIVE FACTORS

Risk Factors

29. Risk factors indicate whether an individual, community or population is particularly vulnerable to suicide, and exist at various levels. Factors may relate to the individual, be social or contextual in nature, and can exist at multiple interaction points. Where risk factors are present there is a greater likelihood of suicidal behaviours. Prevention efforts should focus on at risk groups while simultaneously focusing on the entire population in order to mitigate risk at the individual level. The following table – although not exhaustive – lists a number of known risk factors.

INDIVIDUAL	SITUATIONAL	SOCIO-CULTURAL
Male sex Low socio-economic status Restricted educational achievement Previous suicide attempt(s) Mental disorder (including those unrecognised or untreated) Major physical or chronic illnesses including chronic pain Alcohol or substance misuse Family history of suicide History of trauma, abuse or neglect Sense of isolation Hopelessness Impulsiveness Admission to prison / engagement with criminal justice system Victimisation, bullying and stigma.	Job and financial losses Stressful life events (including divorce/ separation) Relational or social losses or discord Easy access to lethal means Clusters of suicide have an element of contagion	Exposure to suicidal behaviours Stigma associated with poor help seeking behaviour Barriers to accessing healthcare, particularly mental health and substance misuse treatment

(Adapted from *WHO Public Health Action for the Prevention of Suicide 2012* [10])

Protective Factors

30. As equally important as risk factors, protective factors help reduce a person's vulnerability to suicidal behaviours and increase an individual's capacity to cope with particularly difficult circumstances.

Protective Factors
Strong connection to family and community support i.e. social connectedness
Skills in problem solving, conflict resolution and non-violent handling of disputes
Restricted access to the means of suicide
Seeking help and easy access to quality care for mental and physical illness
Personal, social, cultural and religious/ spiritual beliefs that support the self

INTERVENTIONS FOR PREVENTION

31. Universal interventions intend to eliminate or attenuate risk factors, strengthen protective factors and are aimed at whole populations across different settings. Approaches include tackling stigma, increasing public and professional awareness and improving community resilience and social connectedness. They also include measures to encourage help seeking behaviour and to restrict access to the means of suicide.

32. Selective / targeted interventions are aimed at individuals or groups within a particular population or setting at increased risk of suicidal behaviours (such as those with mental health issues and the unemployed). These will include training in schools, prisons, healthcare settings and in certain communities; post-suicide bereavement programmes; the identification and management of depression and other mental disorders; and the prevention and treatment of substance misuse. In this context, emergency departments, specialist CAMHS and other mental health in-patient units have a key role to play.

33. Indicated interventions aim to reduce reoccurrence in those with known suicidal ideation and self harm.

34. Cost effective approaches should be used where a robust evidence base is available. Where evidence is not available or is inconsistent interventions should be implemented within an evaluative framework to inform future providers what does and does not work. The level of evidence underpinning the effectiveness of an implemented intervention should be transparent. For example, surveys of respondent's knowledge and attitudes following training provide lower level evidence than randomised controlled trials for interventions to reduce self harm behaviours.

35. In Wales there are effective local and national policies, interventions and activities which contribute to the prevention of suicide in these groups and for the population as a whole. These are outlined, but not exhaustively listed at Annex 3.

STRATEGIC AIMS AND OBJECTIVES

36. The overall strategic aims of this strategy are to:

- Reduce the suicide and self harm rates in the general population in Wales; and
- Promote, co-ordinate and support plans and programmes for the prevention of suicidal behaviours and self harm at national, regional and local levels.

37. In doing so, *Talk to Me 2* identifies six key strategic objectives.

Objective 1: Further improve awareness, knowledge and understanding of suicide and self harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self harm and professionals in Wales

38. Stigma related to suicide remains a major obstacle to suicide prevention efforts. Those who have lost someone to suicide, as well as, those who have a history of self harm often face considerable stigma within their communities. Stigma isolates and may prevent people from seeking help and can become a barrier to accessing services and support for those who have recently been bereaved through suicide, including families, friends, classmates and colleagues. Stigma may also negatively affect the proper reporting and recording of suicidal behaviours which in turn may impact on our knowledge of emerging trends in these behaviours and thus the targeting of interventions to particular high risk groups. While efforts to reduce the stigma of suicidal behaviours can benefit from being incorporated into the more general processes of de-stigmatising mental illness and promoting mental health literacy additional efforts to reduce the stigma attached to suicidal behaviours are required.

39. Reducing stigma and improving awareness and understanding of suicidal behaviour amongst the public, individuals who frequently come in to contact with people at risk of suicide and self harm usually but not exclusively on account of their professional status or occupation and professionals, would encourage help seeking behaviours, increase the chances of early intervention, enable the recognition of the importance of suicide prevention efforts and improve responses to suicidal behaviour.

Objective 2: To deliver appropriate responses to personal crises, early intervention and management of suicide and self harm

40. While there have been improvements in how services respond to people, too often those who present in distress still feel stigmatised for their self harm and suicidal behaviours. This is particularly important because this contact should be viewed as an opportunity for intervention. In some people who have died through suicide this contact with services has been the last opportunity for intervention. Those who are the first point of contact need to have the necessary knowledge,

skills and attitudes to ensure that compassionate and supportive evidence based care is delivered. This may have a huge impact on future help seeking behaviour. There is NICE guidance on the short and longer term management of self harm [11, 12].

Objective 3: Information and support for those bereaved or affected by suicide and self harm

41. Families and friends bereaved by suicide are at greater risk of mental health and emotional problems and may be at higher risk of suicide themselves. Timely effective support will be facilitated by having effective local responses to the aftermath of suicide in place.

42. The purpose of post-suicide bereavement programmes is to aid the grieving process and reduce the potential for contagion by using counselling and education. Such programmes have been used in school, family and community settings, mainly in the USA, Canada and Australia and a community programme is being developed in Ireland. There is some evidence that these programmes reduce levels of anxiety and depression and encourage help seeking. There is also low level evidence (cross sectional studies) that these programmes are associated with reductions in suicide and self harm. However the National Advisory Group for Suicide and Self Harm Prevention working with partners including Swansea University, Public Health Wales and the Samaritans produced the *Help is at Hand Cymru* [13] booklet to offer practical support and advice to those affected by suicide. Initial dissemination in 2013 included GPs, Coroners, Registrars, funeral directors, Higher and Further Education establishments, Police, Local Health Boards and Third sector organisations.

Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour

43. Media reporting can cause considerable distress to those bereaved through suicide. There is evidence that media reporting and portrayals of self harm and suicide can lead to copycat behaviour especially among young people and those already at risk [14]. This is particularly important in relation to excessive detail regarding method. The 2014 edition of the *Independent Press Standards Organisation Editors' Codebook* [15] commends the inclusion of details of local support organisations and help lines with any coverage of suicide deaths. Adherence to the updated code should continue to be monitored by the Independent Press Standards Organisation balanced with an awareness of tackling stigma in relation to suicide and self-harm, encouraging help seeking behaviour and educating the public both in an understanding of the complexity of reasons why someone may take their own life and in how to respond to person in crisis.

44. Both the National Advisory Group and the Samaritans, which has developed its own media guidelines, will play a part in continuing to stress to editors and others the importance of sensitive reporting and, in doing so, the highlighting of sources of suitable advice and guidance.

Objective 5: Reduce access to the means of suicide

45. Reducing access to certain particularly lethal means of attempting suicide is an effective way to prevent suicide. This is because people may make a suicide attempt impulsively in direct response to a personal crisis. If lethal means are not easily available to them or if they survive the attempt, suicidal thoughts may pass, or there is time to intervene in other ways or to seek help.

46. Suicide prevention by reducing access to the means of suicide is used in:

- Hanging and strangulation in psychiatric in-patient and criminal justice settings
- Self-poisoning
- Those at high risk locations (bridges, tall buildings, cliffs)
- Those on rail and underground networks

47. New methods may emerge where access to the means may be reduced. Media reporting of excessive detail of method may have an impact on people at risk, as can reporting and portraying some methods of suicide. The internet is increasingly becoming a source of detailed information concerning the use of lethal suicide methods.

Objective 6: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self harm in Wales and guide action

48. The epidemiology of suicide and suicidal behaviour changes. Patterns and high risk groups have not always been as they are now and they are likely to change time and again in the future. The therapeutic and preventive challenges of dealing with these changes are considerable. Therefore suicide and self harm prevention require on-going analysis and research. There are a number of ways of accessing information on suicides and self harm through the Suicide Information Database Cymru, the National Confidential Inquiry into Suicide and Homicide, the Child Death Review Programme, the Drug Related Death programme and The Public Health Observatory from which we have identified areas for attention in this strategy.

49. Suicide prevention interventions should be evidenced based or, where that evidence base is not yet available or the programme is developed locally, an evaluative framework should be developed from the onset to identify what works.

IMPLEMENTATION – MAKING IT HAPPEN LOCALLY AND NATIONALLY

50. As previously noted, there is no single reason why someone may take their own life or harm themselves. It is usually in response to a complex series of factors that are both personal and related to wider social and community factors. Given that – and the fact 75% of people who take their own lives are not known to mental health services – the effort to reduce rates of suicide and self harm remains a major public health challenge. Suicide prevention in Wales requires effective, integrated community approaches to address the diversity of

populations, places and individuals, as well as ongoing work to address the inequalities that contribute to the burden of suicide and self harm.

51. Consequently, a truly 3C approach is needed, one that is cross-governmental, cross-sectoral and collaborative. It requires active and explicit support of priority actions, people and places and that links are developed and acknowledged to relevant activity, policy and strategy that form part of suicide prevention efforts in Wales. The delivery plan for *Together for Mental Health* covers suicide prevention, specifically mentioning the National Advisory Group. The focus of suicide prevention should be cross-sectoral with local ownership and implementation supported by national action and leadership.

52. In addition to the suicide prevention actions within the *Together for Mental Health* delivery plan, there is an action plan attached to this strategy. The Welsh Government will provide national leadership and oversight of the implementation and evaluation of the strategy and it will follow up with local agencies the progress they are making in implementing it. High level engagement will be facilitated at health board and local authority level through the Welsh Government. Where actions involve matters that are not devolved, the Welsh Government will engage with the relevant UK Government Departments to ensure a collaborative approach is taken. The National Advisory Group will report annually on progress to the Welsh Government.

53. Public Health Wales will continue to facilitate the implementation of the action plan. It will continue to chair the National Advisory Group which meets on a quarterly basis. Public Health Wales will conduct a mid-point review of the implementation of the strategy.

54. An effective local public health approach is essential to suicide prevention. This in turn is dependent on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and the criminal justice system, transport and the Third sector. Using existing arrangements that drive local partnership is critical to ensure activity on suicide prevention is prioritised and acknowledged. For example, health boards are statutory partners on Safeguarding Boards which offer a significant opportunity to utilise broader experience and knowledge to secure coherent, collaborative and multi-agency approaches to the preventing of suicide and self harm and wider efforts to support well-being. Similarly, the local authority Single Integrated Plan arrangements which encompass Health Social Care and Wellbeing (HSCWB) and Children and Young People's planning structures should support local suicide prevention, and Directors of Public Health should ensure suicide prevention is driven at this level. They should ensure collaboration across sectors is maintained and that suicide prevention remains an acknowledged priority. Health Social Care and Wellbeing Boards are chaired by Directors of Planning who can identify leads for suicide prevention on Local Service Boards.

55. All regions (Mid and West Wales; Cardiff and Vale and Cwm Taf; South East Wales; North Wales) have established multi agency suicide prevention forums which have agreed local reporting structures and which report to the National Advisory Group. These groups aim to improve integration and co-ordination across all sectors and to oversee local implementation. These groups could help

support Directors of Public Health, HSCWBs and the third sector in developing local assessments and strategies, and should build productive relationships with the Local Mental Health Partnership Boards that oversee the delivery of *Together for Mental Health*. It is here that relevant cross-sectoral activity in public mental health and service development could be facilitated for suicide prevention.

PRIORITY PEOPLE AND PRIORITY CARE PROVIDERS

56. Whilst suicide and self harm is not exclusively limited to specific cohorts or groups it is important to note there are groups of people particularly vulnerable to suicide and self harm – priority people - and certain services – priority care providers - specifically well placed to respond to people in crisis.

People at Risk and Priority People

57. Tailored approaches to meet the needs of certain high risk groups (and, more specifically, to improve their mental health) will have an impact on suicide and self harm prevention. Many individuals fall into more than one of these groups:

Looked after children
Care leavers
Children and young people in the Youth Justice System
Bullied or victimised children and young people
Survivors of abuse or violence including sexual abuse and domestic violence
People living with long-term physical health conditions
People with untreated depression
People who are socio-economically deprived
People who misuse drugs or alcohol
People bereaved or affected by suicide
Lesbian, gay, bisexual, and transgender people
Some minority ethnic groups
Asylum seekers (including unaccompanied asylum seeking children)
Rough sleepers, the homeless and those at risk of homelessness
Prisoners and others in contact with the criminal justice system
Certain occupational groups with increased knowledge of and ready access to means (e.g. doctors, nurses, farmers and other agricultural workers)

58. Based on the epidemiology in Wales, particular focus should be given to certain priority people. Measures to address these issues should be actively and explicitly supported as part of suicide prevention efforts although in some cases action may be implemented through the delivery plans for other strategies. The following – for the purposes of this strategy – are considered priority people..

Men in mid life

59. Men are three times more likely to complete suicide than women. Men aged between 30 and 49 are now the group with the highest suicide rate and this appears to be an increasing issue for men in the most deprived areas of Wales.

The current economic climate may exacerbate the risk factors for this group making middle aged men priority people on whom to focus preventative efforts.

60. The action plan recognises the particular challenge of tackling this gender and socio-economic inequality in suicide risk. Measures to strengthen social relationships for men, improve the recognition and management of mental health issues in particular depression, reduce alcohol misuse and support employment and manage debt should be actively and explicitly supported.

Older people over 65 with depression and co-morbid physical illness

61. In Wales and the rest of the UK there is a secondary but lower peak in suicide rates in those aged over 65. This is particularly evident in men and may reflect unrecognised or unmanaged depression, physical illness, bereavement or social isolation.

62. For older people measures to strengthen social relationships, support the bereaved, improve the recognition and management of mental health issues particularly depression, and improve the recognition and management of physical illness should be actively and explicitly supported. Measures should value physical and mental health equally.

Adult Prisoners

63. Prisoners, particularly those admitted to custody for the first time as an adult and who present with behaviour associated with problematic mental health are widely recognised as being vulnerable to personal self-injury and / or suicide. It is to be acknowledged the custodial environment, despite substantial efforts by HM Prison Service, remains a foreboding experience for many. Consequently, there is an increased risk of suicide or self harm in these environments.

Children and young people with a background of vulnerability

64. The highest rates of self harm are in children and young people, particularly, females aged 11-19. Suicide is uncommon in comparison to self harm. Children and young people with limited employment prospects and a background of vulnerability including adverse childhood experiences, socio-economic deprivation, low educational attainment, drugs and alcohol misuse and mental health issues are particularly at risk. Looked after children, care leavers, children and young people in the contact with the youth offending system, and others – such as those who might find themselves not in education, employment or training - may also be exposed to many of these risk factors.

65. There is an association between suicide and self harm and the reporting and portrayal of suicidal behaviour in the media, particularly where reporting is dramatic and includes details of methods used [14]. An important issue in children and young people is the potential effect of new media in both supporting prevention efforts and the possible detrimental effects of social media, chat rooms and websites that may encourage self harm or suicidal behaviours.

66. Efforts to support and promote the wellbeing of children and young people with limited employment prospects and a background of vulnerability should be actively and explicitly supported. This is consistent with Welsh Government's commitment to the United Nations Convention on the Rights of the Child, specifically Articles 6 and 24, which confirm the right to life, to the highest attainable standards of health and to the importance of preventative care.

People in the care of mental health services including inpatients

67. Approximately a quarter of those who complete suicide are known to mental health services. Although much is being done in Wales to improve quality and access for mental health services, people with mental health problems remain a group at high risk. People with severe mental illness, are at particular risk. Inpatients, people recently discharged from psychiatric hospital and those who refuse treatment in the community are at highest risk. At least a quarter of those known to mental health services have been in contact with services in the week prior to their death, this provides a window of opportunity for intervention.

68. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) reviews all deaths through suicide in those known to mental health services to identify approaches to prevention. It has produced a checklist *Twelve points to a safer service* [16] which provides key guidance for mental health services for suicide prevention.

69. The provision of high quality mental health services across primary, secondary and tertiary care in collaboration with the Third sector that are equally accessible to all according to need is vital to the prevention of suicide across the life course.

People with a history of self harm

70. There are approximately 5,500 admissions for self harm in Wales each year. However many people who self harm do not seek help from services (primary or secondary care) or attend emergency departments but leave before they are seen.

71. Approximately half of those who complete suicide have a history of self harm and approximately one in four have been treated in hospital for self harm in the preceding year. Those who repeat self harm or who have used violent and/or dangerous methods are at a particularly increased risk for suicide.

72. Services need to address how they respond to, assess and follow up people who present with self harm particularly where alcohol is involved. Similarly stigma in relation to self harm and suicide needs to be tackled to encourage help seeking behaviour.

Services and Priority Care Providers

73. There are individuals who come into frequent contact with members of the community on a regular basis such as those with self harm and suicidal behaviours, usually but not exclusively on account of their professional status or occupation. These individuals are:

Primary care staff Mental health staff Social services/social care staff Fostering and adoption agencies / staff Emergency health staff Community pharmacists Teachers, other school, school nursing and further and higher education staff Counsellors for children and young people Community, spiritual and religious leaders Police officers Prison officers Ambulance staff Fire fighters Armed Forces personnel Job Centre staff Sports organisations Third sector organisations

74. For the purpose of this strategy we will focus on priority care providers, those who are often the first point of contact / first responders for someone with suicidal behaviours or who self harms. They have a key role in the care of those at risk of suicide and those self harming and include the following (non-exhaustive list):

Police, fire fighters and Welsh Ambulance staff

75. The police, fire fighters and Welsh Ambulance staff have an important role to play in providing support to, and dealing sympathetically with extremely distressed people, including the families and friends of those who have either attempted suicide or taken their own lives.

Primary care staff

76. These include doctors, nurses, reception staff, district nurses and health visitors. General Practitioners (GPs) have a key role in the care of people who self harm. Appropriate suicide prevention education for GPs can have an impact on preventing suicide at a population level.

Emergency department staff

77. Emergency departments have an important role in managing people who self harm or who engage in suicidal behaviours. The Suicide Information Database (SID) Cymru has demonstrated this is the most common place of last contact with health services in the year prior to suicide. There are still problems in staff attitudes towards and knowledge of self harm. A high proportion of people who self harm who come into contact with emergency departments do not receive a psycho-social assessment- this is a missed opportunity to assess their needs and risks and consider their longer term care.

78. Emergency staff must have the necessary knowledge, skills and attitudes to recognise, assess, signpost, manage and initiate appropriate follow up for those with whom they come into contact and who are in distress. A positive initial contact may alter future help seeking behaviour. Good communication across services is vital to ensure appropriate follow up.

Meeting the needs of Welsh Speakers

79. Receiving services and interventions through the medium of Welsh is a matter of need for many Welsh speakers and impacts on the effectiveness of interventions. It is important this need is met and those that deliver suicide prevention interventions and services should act in accordance with the strategic framework *More than just words* [17]*.*

PRIORITY PLACES

80. There are certain priority places and settings where suicide prevention efforts should be focussed. Key priority places are:

Hospitals
Prisons
Police custody suites
Workplaces
Schools, Further and Higher Education establishments
Primary care facilities
Emergency departments
Rural areas
Deprived areas

81. Measures to address the issues in these priority places should be actively and explicitly supported as part of suicide prevention efforts in Wales although they may be delivered through the implementation plans of other strategies. This does not preclude other action being taken either nationally and locally in other priority places. Particular focus will be given to:

Rural areas

82. Around 85% of Welsh land is used for agriculture or forestry or is common land. Around 20% of the population of Wales is classified as broadly rural whereas

about 65% of the Welsh population live in settlements of over 10,000 people. This compares to 80% in England and just under 70% in Scotland.

83. Rural areas have experienced significant changes over recent years in terms of aging populations, decline in farm incomes and economic pressures to diversify; increased environmental pressures and associated legislation; depopulation of some areas; changing labour markets; and increased competition for local products.

84. Certain factors have been identified as particularly creating risk and stress to people living in rural areas over and above the suicide risk factors affecting general populations: isolation, declining incomes, being different within the rural context; heightened stigma associated with mental health issues; barriers to accessing appropriate care (culture of self reliance, poor service provision) poor social networks; social fragmentation; availability of some means of suicide (firearm ownership); and high risk occupational groups such as farmers and vets.

85. Local suicide prevention plans should take into account the particular issues for remote and rural areas when selecting types of suicide prevention interventions [18].

Workplaces

86. The workplace is an important setting to focus suicide and self harm prevention efforts. Adults may spend a third or more of their waking hours at work. Suicide prevention at work is best addressed through a combination of:

- Improving knowledge, raising awareness and de-stigmatising mental health problems, suicide and self harm (to encourage help seeking behaviour and the ability to respond to colleagues in distress);
- Measures to recognise, prevent and reduce occupational stress;
- Recognition and early detection of mental health, substance misuse and emotional difficulties; and
- Appropriate intervention, support and management being made available through employee health and wellbeing services.

87. Companies of all sizes can have programmes that promote a mentally healthy workforce and prevent self harm and suicidal behaviours. Corporate policies, plans and pathways should be in place to deal with employee mental health issues, self harm or suicidal crises and encourage colleagues to engage with those in distress.

Schools, Further and Higher Education establishments

88. The majority of children and young people up to the age of 16 receive or are entitled to formal education in schools or alternative settings. Up to the age of 18 many are in further education. Given that children and young people are priority people for suicide prevention in Wales these settings are priority places.

89. School based prevention programmes are designed to either reduce risk, and or increase protective factors. They aim to increase knowledge and understanding of suicide, change attitudes towards suicide, increase awareness of risk factors and encourage help seeking behaviour. Within Wales, school based prevention programmes are not in routine use. There is some evidence from randomised controlled trials that such interventions have a short term impact, particularly on knowledge and attitudes. It is not known if these changes persist in the longer term or whether they have an impact on suicidal behaviour and help seeking. There is evidence that training for individuals who frequently come in to contact with people at risk of suicide and self harm, including teachers, increases confidence in recognising those who may be at risk of suicide and referring them appropriately for help. Whether or not such training has an impact on suicidal behaviour has however not yet been established.

90. From 2008-09 to 2012-13 the Welsh Government invested over £13 million grant funding in school based counselling, with the result that counselling was being delivered in all maintained secondary schools from September 2010. The evaluation of the Welsh School-based Counselling strategy in 2011 indicated that 80% of school heads and link teachers surveyed felt that behaviour of pupils had improved as a result of counselling. From April 2013 local authorities have been required, under the School Standards and Organisation (Wales) Act 2013 to make reasonable provision of counselling services for children and young people aged between 11 and 18 in their area and pupils in year 6 of primary school. At the same time £4.5m was transferred to the Revenue Support Grant for the continued support of this service. The school nursing service is also frequently seen as a source of advice and support for pupils and teachers.

91. By supporting children and young people with emotional and behavioural difficulties, this counselling provision can not only help them engage with their learning, but it might also contribute to suicide and self harm prevention efforts, being suitably placed and accessible to children and young people in crisis. The importance of emotional support is also acknowledged by colleges of further and higher education. In terms of higher education for example, the Higher Education Funding Council for Wales (HEFCW) supports the availability of appropriate support services, as confirmed in HEFCW circulars and the body's 2013-14 fee plan guidance.

Prisons and Police Custody Suites

92. Prisons and Police custody suites are priority places for focussing suicide prevention efforts. People at all stages within the criminal justice system, including people on remand and those recently discharged from custody are at increased risk of suicide (although the greatest risk is during the first week of imprisonment). A high proportion of offenders are young men, already at increased risk for suicide. The vast majority (up to 90%) of all prisoners have a mental health issue and/or substance misuse issues. Prisoners are separated from their family and friends and thus isolated.

93. Samaritans runs a prisoner *Listener* scheme which operates in every prison in Wales. This is a peer support scheme where prisoners are trained and supported by Samaritans, using their same guidelines, to listen in complete

confidence to their fellow prisoners. The objectives of the scheme are to assist in reducing the number of self-inflicted deaths, reducing self-harm and helping to alleviate the feelings of those in distress. The first *Listener* scheme started in HMP Swansea in 1991 and Swansea Samaritans continue this work. Samaritans also provides a presence in bail hostels for example in Swansea and in Bangor.

94. The Welsh Government has issued policy implementation guidance: *Mental Health Services for Prisoners in Wales*. The focus of this guidance is designed to ensure that prison and healthcare staff to adopt measures which are designed to identify need, risk and potential of those admitted to custody to take their own life. The emphasis placed on reception screening, immediate follow-up of risk indications and the adoption of decent prison care standards, delivered through staff and other inmates, is stressed. The policy also sets out the duties laid down via the Mental Health (Wales) Measure 2010 on LHBs and the importance placed on the care and treatment of those with particular needs.