Equality Impact Assessment

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Describe and explain the impact of the proposal on people with protected characteristics as described in the Equality Act 2010.

Consideration should be given to the following questions. Please consider whether there are possible impacts for subsections of different protected characteristic groups.

How will the proposal promote equality (Please see the general duties)?

The strategy has been written in the context of A Healthier Wales: our Plan for Health and Social Care ("A Healthier Wales") 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:

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.

A refresh of A Healthier Wales was published in December 2024 in response to the Chief Scientific Advisor's report on the NHS in 10 years' time and the projected impact of long-term conditions and risk factors. One of the key priorities in the refreshed actions is "reducing health inequalities by ensuring equality of access to the health and social care system to achieve equity of outcomes" in line with the core principles of services and support being preventative, person centred, sustainable, equitable, and safe and high quality.

It is also set in the context of the Well-being of Future Generations (Wales) Act 2015[1] which aims to improve the social, economic, environment and cultural well-being of Wales. Achieving the Well-being Goals set out in the Act is key in tackling some of the key drivers of suicide and self-harm in Wales.

The strategy recognises suicide and self-harm as inequality issues, linked to social determinants of health such as socioeconomic disadvantage and adverse childhood experiences (ACEs). For this reason, a focus on inequality has been identified as a cross-cutting theme that runs throughout the strategy – and will continue through to the supporting action plan.

Understanding, The Suicide Prevention and Self-Harm Strategy has been developed as a cross-Government strategy identifying the key protected characteristics linked with suicide and self-harm and the identification of multi-departmental actions which address them.

The strategy has been developed following extensive engagement with stakeholders across Wales, including an independent review of the previous (then named) Suicide and Self-Harm Prevention Strategy, Talk to Me 2, pre-consultation engagement (including a stakeholder survey and engagement sessions with mental health stakeholders, which is one of the key drivers linked with suicide and self-harm), and a 16-week public consultation on the draft strategy.

[1] Well-being of Future Generations (Wales) Act 2015

Analysis of the consultation responses identified strong support for the focus on inequalities and high-risk groups, and in particular Welsh Government's recognition of the impact of inequalities on suicide and self-harm. There was support for the increased focus on inclusivity and empowerment, with calls for an explicit reference to the anti-racism agenda in the principle on inequalities.

However, some respondents raised concerns that an increased focus on high-risk groups may inadvertently result in people not classed as 'at-risk' being disregarded and neglected from receiving care and support when required. Instead, respondents called for a focus on proportionate universalism.

In response to the public consultation, the strategy was re-drafted to exclude the list of 'at-risk' groups and instead focus on recognising certain groups as being at heightened risk and placing more emphasis on equity of access for everyone as a core principle. This core principle has not only been considered throughout the re-drafting of strategy but also through the development of the accompanying delivery plan.

Within the strategy, the equalities core principle is written as follows:

*Does this promote **equity of access, experience and outcomes without discrimination**? Services and support should be accessible and appropriate for all. This means understanding the barriers people face and putting necessary systems in place so that when people get support, there is equity in terms of experiences and outcomes. To achieve this, support and services will need to be culturally and age appropriate and meet the needs of Welsh speakers, ethnic minority groups, LGBTQ+ communities, disabled people and people with sensory loss. Services will also need to meet the needs of under-served groups such as people with co-occurring substance misuse, people who are care experienced, neurodivergent people, people who are experiencing poverty and people who are experiencing homelessness.*

The objectives within the strategy provide the opportunity to embed this principle.

The first objective seeks to establish streamlined process for the collection, collation and interpretation of data, evidence and lived experience testimony; and develop a robust infrastructure to ensure the information gathered is used to develop policies, support and services.

This objective provides the opportunity to continue to learn about suicide and self-harm and those affected by it through exploring options to improve data and evidence. We may explore continued improvements to the Real Time Suspected Suicide Surveillance (RTSSS) so that we can better understand how vulnerable groups are affected.

The second objective is about establishing the connections with other parts of Government to influence policies and programmes from a suicide and self-harm perspective. Using the information from the RTSSS and other sources we will be able to identify groups that are potentially at greater risk of harm than others and this objective will allow us to engage with Government officials to ensure that policies and programmes recognise those risks and develop policies and programmes to mitigate risk.

Objective 2 also recognises the role of the internet and media in terms of both being a positive resource for advice and support and an important tool in tackling

stigma, but also a harmful source that can perpetuate stigma if used in the wrong way. There will be certain groups who are more at risk to online abuse which increases their risk of self-harm and suicide. We also know that language can be interpreted in different ways by different people and cultures. Having a focus on data and evidence (as part of Objective 1) will allow us to better understand these issues and how our responses need to be adapted to enhance effectiveness and meet the needs of everyone.

Objectives 3, 4 and 5 aim to ensure that people affected by, or at risk of, suicide and self-harm are always offered a kind and compassionate response no matter where they present. Objective 3 focuses on empowering everyone with the knowledge and awareness to recognise those in need, offer kind and compassionate support; and help them access additional support if needed.

Objective 4 is about providing timely, compassionate and person-centred intervention to those who present to services for support with self-harm and/or suicidal ideation. These services include GPs, accident and emergency services and mental health services. Person-centred intervention means meeting individual need, including language and culture, and will ensure equity of access and needs led services to ensure everyone who seeks help is supported in a relevant and effective way.

Objective 5 is about targeting services where people at-risk of suicide and self-harm may present, including, but not limited to, domestic abuse services, substance use services and unemployment services.

The evidence from Objective 1 will help us to better understand vulnerable groups, the settings they engage with, their individual needs and challenges and how we use all of that to inform how we design our products and services to ensure they are accessible and deliver equitable outcomes.

Objective 6 recognises that those who are affected or bereaved by suicide are at an increased risk of dying by suicide themselves. This objective commits to providing holistic, person-centred support to anyone affected or bereaved by suicide. Through the Strategy we will carry out an evaluation of the current provision for those affected or bereaved by suicide – the National Advisory Liaison Service – and identify if any changes need to be made to the service to ensure equitable access for all.

What are the possible negative impacts on people in protected groups and those living in low-income households and how will you mitigate for these?

We know that suicide and self-harm share a range of underlying contributing factors (also known as 'risk factors'). Risk factors include interpersonal factors (e.g., unemployment, peer victimisation, substance use, a history of trauma or abuse, relationship breakdown[2] [3] [4] [5]), psychological factors (e.g., negative affectivity[6],

[2] The Relationship Between Bullying Victimization and Perpetration and Non-suicidal Self-injury: A Systematic Review | Child Psychiatry & Human Development
[3] Suicide, Self-Harm, & Traumatic Stress Exposure: A Trauma-Informed Approach to the Evaluation and Management of Suicide Risk: Evidence-Based Practice in Child and Adolescent Mental Health: Vol 5, No 4
[4] Substance misuse disorder linked to high risk of self-harm - The Lancet Psychiatry
[5] Gendered experiences of unemployment, suicide and self-harm: a population-level record linkage study - PubMed
[6] Negative affectivity and disinhibition as moderators of an interpersonal pathway to suicidal behavior in borderline personality disorder - PMC

emotional dysregulation[7]) and health factors (e.g., severe and enduring mental health conditions[8], chronic physical health conditions across the life course[9]).

We also know that suicide and self-harm prevalence is associated with sociodemographic inequalities where people, or groups of people, with certain characteristics are at greater risk, through no fault of their own[10] [11] [12]. Examples include living in poverty, a person's ethnicity, age, gender or sexual orientation.

Below is a summary of the evidence we've identified in relation to people with protected characteristics through a rapid evidence review.

Age (including children and young people)

Self-harm

In a study of more than 10,000 young people, using data collected from participants in the Millennium Cohort Study (MCS) in 2018-19, more than a quarter of 17-year-old females (28%) and a fifth of males (20%) reported self-harming in the previous year[13].

Rates of self-harming had increased from 15% to 24% since study members were last surveyed at age 14. The increase was particularly marked for males, with rates more than doubling from 9% at age 14 to 20% at age 17, while females experienced an increase from 23% to 28% over the same period. One in 10 females (10%) and one in 25 (4%) males said they had self-harmed with suicidal intent.

A further study using individual-level linked data across general practice, emergency departments (EDs), outpatients and hospital admissions, found that children and young people were more likely to present to their GP with issues of self-harm than any other healthcare professional. The same study further reports that young women were more likely to be admitted to hospital following emergency department attendance for self-harm. This was most evident in individuals 10–15 years old, where 76% of females were admitted compared with just 49% of males[14].

A number of risk factors for self-harm have been identified in children and young people. For example, pupils who experienced in-person bullying at school were twice as likely to self-harm as those who did[15]. Moreover, high levels of self-harm have been found in individuals diagnosed with eating disorders. The risk of self-harm is estimated at over seven times higher in those with eating disorders compared with the general population. The same study reports that people who self-harm have an increased risk of premature mortality compared with the general population, particularly from

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[7] Emotion Dysregulation and Non-Suicidal Self-Injury: A Systematic Review and Meta-Analysis - PMC
[8] Self-harm and life problems: findings from the Multicentre Study of Self-harm in England | Social Psychiatry and Psychiatric Epidemiology
[9] Major Physical Health Conditions and Risk of Suicide - PMC
[10] Sociodemographic inequalities of suicide: a population-based cohort study of adults in England and Wales 2011–21 | European Journal of Public Health | Oxford Academic
[11] Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf
[12] Socio-economic disparities in patients who present to hospital for self-harm: patients' characteristics and problems in the Multicentre Study of Self-harm in England - PubMed
[13] Mental-ill-health-at-age-17-–-CLS-briefing-paper-–-website.pdf
[14] Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK
[15] 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

unnatural causes, i.e. unintentional injuries (accidental poisoning and other accidents) and intentional injuries (suicide and homicide)[16].

Amongst older adults, self-harm is also more common in women, people with physical and/or mental health conditions and those with previous self-harm history[17]. When compared to younger populations, self-harm rates are less prevalent in older adults. However, self-harm rates might be under-estimated because of shame and perceived or felt stigma[18], lack of disclosure and difficulty working with older adult populations[19].

Several stressors were identified as influencing older adults' self-harm throughout the life-course, including health problems, adverse childhood events, interpersonal problems, loss and loneliness. Self-harm was also associated with a loss of control over their lives and feeling powerless. However, self-harm mostly was a continuation of behaviour from earlier life[20].

Suicide

In 2023, the age-specific suicide rate in Wales, published by Office for National Statistics, was highest for males aged 45 to 49 years (30.8 deaths per 100,000), and for females aged 30 to 34 years (9.7 deaths per 100,000)[21].

According to the Real Time Suspected Suicide Survillence (RTSSS), published by Public Health Wales, in 2022-23, the highest rate of deaths by suspected suicide occurred in males aged 35-44 years (29.4 per 100,000), followed by males aged 25-34 years (29.2 per 100,000)[22].

Amongst children and young people England specific data found that between 1 April 2019 and 31 March 2020, approximately 2 children and young people, aged 17 and under died every week by suicide. Suicides were more common in older groups, with 78% (n=84) of the deaths in those aged between 15 and 17 years and 22% (n=24) in those aged 14 and below[23].

Risk factors for suicide and self-harm amongst children and young people include:

- Poverty
- Online harms
- Bullying, victimisation and discrimination
- Additional learning needs and/or neurodivergence
- Homelessness
- Substance misuse
- Experience of care
- Caring responsibilities

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[16] Clinical management and mortality risk in those with eating disorders and self-harm: e-cohort study using the SAIL databank - PMC

[17] Troya, M.I. · Babatunde, O. · Polidano, K. · et al. Self-harm in older adults: a systematic review. *Br J Psychiatry.* 2019; 214:186-200

[18] Long, M. 'We're not monsters… we're just really sad sometimes:' hidden self-injury, stigma and help-seeking. *Health Sociology Review.* 2018; 27:89-103 Jan 2

[19] Geulayov, G. · Casey, D. · McDonald, K.C. · et al. Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study. *Lancet Psychiatry.* 2018; 5:167-174 Feb 1

[20] Understanding self-harm in older adults: A qualitative study - eClinicalMedicine

[21] Suicides in England and Wales - Office for National Statistics

[22] Deaths by suspected suicide 2022-23 - Public Health Wales

[23] NCMD-Suicide-in-Children-and-Young-People-Report.pdf

- Disability and chronic physical health conditions
- Poor mental health
- Academic pressures or worries
- Social isolation
- Non-conducive family environment
- Relationship problems
- Neglect
- Adverse childhood experiences

Suicide is also a concern among older adults and in particular older men. Risk factors for suicide in older adults include the loss of a loved one, loneliness and physical illness[24].

Ageism deteriorates care options for older adults: from normalizing depression in late life to fostering reluctance to intervene clinically, given the fragility of health of older patients and the fear of harmful drug–drug interactions[25].

It is also important to note that suicide attempts may present differently, for example voluntary stopping eating and drinking (VSED) is common amongst older adults.

Disability and chronic physical health conditions

Self-harm

Population-based studies have reported higher rates of self-harm among adults with disabilities when compared with their peers[26] [27].

Studies investigating self-harm among adolescents with disabilities identified that notable risk factors for self-harm (e.g., female sex, other sexual orientation, being bullied, depression at age 14) were similar to those without disabilities and suggest opportunities for targeted (girls) and preventative interventions (bullying reduction, mental health promotion). Among adolescents, after adjusting for sex, ethnicity and poverty, out of nine functional impairments, those related to mental health, learning, and memory were strongly associated with higher rates of self-harm. Functional impairments such as vision and mobility did not show significant association with self-harm behaviours in the last year[28].

Chronic physical ill health has also been associated with greater prevalence of self-harm. For example, a data linkage study of nearly 500,000 adults with rheumatic conditions between 1990 and 2016 found that people with fibromyalgia, rheumatoid arthritis, and osteoarthritis were at increased risk of harming themselves[29].

Suicide

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[24] A systematic review of physical illness, functional disability, and suicidal behaviour among older a
[25] Late-life suicide in an aging world | Nature Aging
[26] Marlow, N. M. , Xie, Z. , Tanner, R. , Jacobs, M. , Hogan, M. K. , Joiner, T. E., Jr , & Kirby, A. V. (2022). Association between functional disability type and suicide-related outcomes among U.S. adults with disabilities in the National Survey on Drug Use and Health, 2015–2019. *Journal of Psychiatric Research*, *153*, 213–222. https://doi.org/10.1016/j.jpsychires.2022.07.014
[27] Khurana, M. , Shoham, N. , Cooper, C. , & Pitman, A. L. (2021). Association between sensory impairment and suicidal ideation and attempt: A cross-sectional analysis of nationally representative English household data. *BMJ Open*, *11*, Article Article e043179. https://doi.org/10.1136/bmjopen-2020-043179
[28] Self-Harm Among 17-Year-Old Adolescents With/Without Disabilities in the United Kingdom | Crisis
[29] Painful rheumatic conditions are linked to self-harm - NIHR Evidence

Disabled people are much more likely to die by suicide than non-disabled people according to the latest data released from the 2021 Census[30]**;** the figure for disabled men was over three times higher; the figure for disabled women was over four times higher.

People with intellectual and learning disabilities have higher rates of mental health difficulties[31] and therefore it could be argued that they are more likely to be at risk of suicide. Indeed, one systematic review concluded that adolescents with intellectual and learning disabilities were more likely to die by suicide and had expressed increased suicidal ideation compared to those without disabilities[32]. However, more robust data is required to fully determine the relationship between suicide and learning and intellectual disabilities.

Mechanisms contributing to suicide risk for this population may be perceived burdensomeness, loneliness, depression symptoms, threat on independence, pain[33], and a perceived lack of usefulness, value, dignity, and/or pleasure with life.

A diagnosis of severe physical illness is also associated with higher suicide risk. Type and number of physical health conditions, in addition to the condition's impact on daily activity, have been suggested to be associated with an increased risk of suicidal ideation and suicide attempts [34] [35] [36].

Ethnicity and race

Self-harm

Some evidence suggests that minority ethnic children and adolescents account for an increased proportion of self-harm presentations to hospital over time compared with white ethnic groups. Minority ethnic groups also tend to be more socioeconomically disadvantaged and less likely to receive a psychosocial assessment[37] [38].

However, other research has demonstrated that self-harm is more prevalent among White teenagers, compared to young people from other ethnic groups. Rates of self-harm with suicidal intent have been found to be similar across all ethnic groups[39].

The reasons for self-harming may differ across cultures, religions and ethnicities. Reasons for self-harm reported by South Asian people, included:

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[30] Sociodemographic inequalities in suicides in England and Wales - Office for National Statistics
[31] Mental health problems in people with learning disabilities: prevention, assessment and management
[32] Disability and suicide: A review. - Record details - EBSCOhost Research Databases
[33] Physical disability and suicide: recent advancements in understanding and future directions for consideration - ScienceDirect
[34] Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people - The Lancet Regional Health – Europe
[35] Does physical ill-health increase the risk of suicide? A census-based follow-up study of over 1 million people - PMC
[36] Scott KM, Hwang I, Chiu WT, Kessler RC, Sampson NA, Angermeyer M, Beautrais A, Borges G, Bruffaerts R, de Graaf R, Florescu S, Fukao A, Haro JM, Hu C, Kovess V, Levinson D, Posada-Villa J, Scocco P and Nock MK (2010) Chronic physical conditions and their association with first onset of suicidal behavior in the world mental health surveys. Psychosomatic Medicine 72, 712–719.
[37] Self-harm in children and adolescents by ethnic group: an observational cohort study from the Multicentre Study of Self-Harm in England - The Lancet Child & Adolescent Health
[38] Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study - PubMed
[39] High levels of serious mental health difficulties among 17-year-olds | CLS

- low self-esteem and worth, with self-harm seen as a punishment ("*I don't know why I can't love myself… I see myself as a disappointment, like the family see me as a disappointment*")
- loneliness, isolation, and having no one to share their difficulties with ("*I was in a world of my own, suffering the hurt in silence*")
- abuse including racism, sexism and domestic violence ("*we're treated differently by our own because we're women, we're treated differently outside because we're Asian*")
- economic and political issues, such as a fear of deportation
- the need to protect the family's honour ("*protecting the honour of the family is another expectation*")[40].

Suicide

Figures of suicide rates, in England and Wales across ethnic groups between 2017 and 2019, published by ONS, found that among males, rates of suicide among the white (14.9 per 100,000) and mixed ethnicity (14.7 per 100,000) groups were similar. Among females, suicide rates in this period were consistently higher among the Mixed ethnicity group than others (7.1 per 100,000)[41].

The RTSSS does not currently collect data in relation to ethnicity, among other information which would add to our understanding. Work is underway to address this as stated in the report published in 2024[42]:

"A list of data fields has been developed for the RTSSS, but we are not yet able to collect all of the data, e.g., religion, disability status, or to establish the level of data quality, e.g. ethnic group, gender identity. For ethnic group we will explore the options for improving data quality, but it remains difficult in the absence of access to GP data. Data on gender identity is not currently readily available from other sources, but when this becomes available from a reliable source, we will explore the feasibility of collecting this information."

There is international evidence that experiences of racism and ethnic discrimination contribute to suicidality, and their impact on mental health is well-established[43]. In Wales, research into race trauma has found that race-based stressed may lead to poor mental health outcomes including depression, anxiety, and a negative outlook on life.[44]

A 2020 study, "Hate: As regular as rain", included Roma people, Showmen, Gypsy people and New Travellers and reports a high prevalence of suicide within these communities. It also highlights a large proportion of those who took their own life or attempted to, had spoken about experiences of hate speech and hate crime prior to the event[45].

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[40] Why do South Asian people self-harm? - NIHR Evidence
[41] Mortality from leading causes of death by ethnic group, England and Wales - Office for National Statistics
[42] Annual Report: Deaths by suspected suicide 2023-24 - Public Health Wales
[43] Ethnicity_and_suicide_July_2022.pdf
[44] Ace Hub Wales - Understanding-and-Responding-to-Racial-Trauma.
[45] Rain-Report-201211.pdf

Religion

Self-harm

Religious affiliation, importance of religion, and belief in God have been associated with lower rates of self-harm[46].

That being said, it is possible that incidences of self-harm are underrepresented in this cohort, due to stigma. Indeed, studies have identified a prevalence of stigmatised beliefs and negative perceptions about mental illness within a Christian setting, with many attributing it exclusively to demonic possession, lack of faith, personal sin, or other negative spiritual influences[47]. Whilst self-harm isn't a mental health condition it is susceptible to stigmatised perceptions.

Suicide

Religion performs a doubled edged role in a suicide crisis. On the one hand this has in the past led to unsympathetic and harsh responses, and a sense of shame for victims and their families, but it has also long been considered a reason why religious people might be less likely to take their own life[48].

Evidence suggests that religion may be a protective factor for suicide, because religion:

- may help people to cope better with life stresses
- reduce the incidence of depression and substance misuse
- facilitate recovery from depression
- enhance social support and
- provide sources of hope and meaning[49].

Although interpretations of such studies are debated and negative findings are also reported, the overall balance of findings is thought by many to reveal a benefit for religious beliefs and practices in relation to mental health and well-being[50].

Sexuality and gender identity

Self-harm

LGBTQ+ young people report significantly higher rates of self-injurious thoughts and behaviours compared to their straight and cisgender peers, including non-suicidal self-injury and suicide attempts[51].

Suicide

National suicide rates for LGBTQ+ communities aren't available in the UK, because sexual orientation and gender identity aren't currently recorded on death certificates. Similarly, the evidence on suicide risk, particularly in children and young people, with gender dysphoria is generally poor. Most studies are methodologically

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[46] The Journal of Nervous and Mental Disease
[47] 'Mad, bad, or possessed'? Perceptions of Self-Harm and Mental Illness in Evangelical Christian Communities | Pastoral Psychology
[48] Religion and Suicide Risk: a systematic review - PMC
[49] Koenig, HG King, DE Carson, VB Handbook of Religion and Health (2nd edn). Oxford University Press, 2012.Google Scholar
[50] Suicide and religion | The British Journal of Psychiatry | Cambridge Core
[51] Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school experience | Journal of Public Health | Oxford Academic

weak, being based on online surveys and self-selected samples and coming from biased sources.

However, a growing amount of global evidence points to a higher risk of suicidal behaviour and self-harm for LGBTQ+ people[52]. Research has also highlighted a number of reasons as to why their risk is high compared to other people[53] [54]:

- Experiencing discrimination or bullying based on your LGBTQ+ identity can cause you to feel trapped or isolated, which may lead to feelings of suicide. Research points to high rates of discrimination and victimisation in LGBTQ+ communities, and has connected homophobic, biphobic or transphobic bullying with suicidal behaviour.
- LGBTQ+ people are at higher risk of experiencing mental ill-health, which is a known risk factor for suicide.
- A strong support network[55] can be an important protective factor against suicide and loneliness. Experiencing rejection from parents or loved ones impacts many people in LGBTQ+ communities and can lead to isolation if no other positive support networks are in place[56].

Importantly, a recent review was conducted in response to claims that there has been a large rise in suicide by current and recent patients of the Gender Identity Development Service (GIDS) service at the Tavistock since an earlier restriction of puberty-blocking drugs. Examination of the figures provided by NHSE on deaths in each year between 2018-19 and 2023-24 did not support the claim[57]. However, it is likely that there has been a rise over a longer period as young people at risk have increasingly presented with gender dysphoria and referrals to GIDS have risen.

Sex and gender

Self-harm

There are higher age-specific rates of emergency hospital admissions for self-harm among ***females*** than males for almost all age bands. However, rates among males are increasing[58].

Suicide

In Wales, in 2023, males accounted for around three-quarters of registered suicide deaths (296 male deaths; 90 female deaths), a trend seen since the mid-1990s[59].

Although suicide rates are lower for females, there are some groups of women who are at an increased risk of suicide. For example, women with infertility problems

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[52] Queer-Futures-Summary-Report-1.pdf
[53] Austin, A., Craig, S.L., D'Souza, S. & McInroy, L.B. (2022) Suicidality among transgender youth: Elucidating the role of interpersonal risk factors. *Journal of Interpersonal Violence*, **37**(5–6), NP2696–NP2718.
[54] Self-harm and suicidality among trans and gender diverse youth from culturally and linguistically diverse backgrounds—A scoping review - Macedo - 2024 - International Journal of Mental Health Nursing - Wiley Online Library
[55] Hsieh, N., & Liu, H. (2021). Social relationships and loneliness in late adulthood: Disparities by sexual orientation. Journal of Marriage and Family, 83(1), 57–74. https://doi.org/10.1111/jomf.12681
[56] LGBTQ+ communities and suicide
[57] Review of suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust: independent report - GOV.UK
[58] Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK - PMC
[59] Suicides in England and Wales - Office for National Statistics

undergoing IVF[60]. Fertility Network UK surveyed 1,300 fertility patients and found 40% had experienced suicidal feelings, with 10% struggling with suicidal thoughts often or all the time[61]. Another study found that suicidal thoughts in women undergoing IVF were more prevalent in women who were childless or had fewer children and experienced higher levels of depressive symptoms. In addition, they reported more frequently on denial, social withdrawal and self-blame coping strategies compared to participants without suicidal risk[62].

Research has also identified the relationship between risk of suicide and hormonal changes. Results of a meta-analysis found that women with premenstrual dysphoric disorder (PMDD) are almost seven times at higher risk of suicide attempt and almost four times as likely to exhibit suicidal ideation[63].

A growing number of studies focusing on suicide rates among middle-aged women, have suggested that the high rate of suicide in women aged 45–54 years may be related to the biological changes associated with the menopause[64]. However, the current evidence on menopause and suicidality is mixed[65]. Moreover, menopause often coincides with what is often a time of wider upheaval in women's lives. These are the emotionally turbulent years of children leaving home, elderly parents getting sick, midlife divorces and transitions at work that can make it harder to disentangle cause from effect. Further research is needed to unravel the relationship between menopause and suicidality.

Pregnancy/maternity

Self-harm

Evidence has shown that thoughts of self-harm can happen during pregnancy and the year after birth (perinatal period)[66]. Although incidents of self-harm during the perinatal period are rare in the general population; in women with severe mental disorders, it is more common with some studies reporting prevalence of up to 20%[67].

There is mounting evidence suggesting a link between parental self-harm and a wide range of adverse outcomes for the child later in life[68]. Perinatal self-harm is likely to be a marker of bonding difficulties and potentially deficits in mother and infant interactions, which mediate childhood mental health problems. Even preconception self-harm has been associated with bonding difficulties in the first year after birth[69].

Suicide

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[60] Suicidal risk among infertile women undergoing in-vitro fertilization: Incidence and risk factors - ScienceDirect
[61] The far-reaching trauma of infertility: Fertility Network UK survey | Fertility Network
[62] Suicidal risk among infertile women undergoing in-vitro fertilization: Incidence and risk factors - ScienceDirect
[63] Suicidal Risk in Women with Premenstrual Syndrome and Premenstrual Dysphoric Disorder: A Systematic Review and Meta-Analysis - PMC
[64] Perimenopausal depression – an under-recognised entity - PMC
[65] Examining suicidality in relation to the menopause: A systematic review | PLOS Mental Health
[66] Lindahl, V · Pearson, JL · Colpe, L. Prevalence of suicidality during pregnancy and the postpartum. *Arch Women Ment Health.* 2005; 8:77-87
[67] Brameld, KJ · Jablensky, A · Griffith, J · et al. Psychotropic medication and substance use during pregnancy by women with severe mental illness. *Front Psychiatry.* 2017; 8:28
[68] Lunde, I · Myhre Reigstad, M · Frisch Moe, K · et al. Systematic literature review of attempted suicide and offspring. *Int J Environ Res Public Health.* 2018; 15:E937
[69] Niederkrotenthaler, T · Floderus, B · Alexanderson, K · et al. Exposure to parental mortality and markers of morbidity, and the risks of attempted and completed suicide in offspring: an analysis of sensitive life periods. *J Epidemiol Community Health.* 2012; 66:233

In general, a protective effect of the perinatal period against suicide has been identified[70], but there is an increased risk of suicide in women with severe postpartum psychiatric disorders, highest in the postnatal year[71].

There is also evidence of an inverse trend between the risk of offspring suicide or attempted suicide and the age of exposure to a parental suicide attempt[72].

Other groups at risk

Below are some additional groups we've identified through a rapid evidence review as being 'at-risk' of engaging in self-harm and/or experiencing suicidal thoughts, feeling and behaviours.

Low-income households

Self-harm

Some research has identified low childhood income as a risk factor for self-harming behaviour in adolescence and young adulthood[73] [74]. Low income can be considered a stressor, which may affect child socio-emotional, behavioural and cognitive development[75] as well as the development of coping strategies[76]. Lack of disposable resources may also affect children indirectly through impaired parenting due to poverty-related stress in parents[77].

Adverse childhood experiences, such as parental mental health or substance abuse problems and family dissolutions, are more common in low-income households[78]. These experiences are known to have an impact on adolescent mental health problems and self-harm, and recent findings also suggest that the consequences of adverse experiences may be more detrimental in low-income households than in others[79] [80].

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[70] Appleby, L. Suicide during pregnancy and in the first postnatal year. *BMJ.* 1991; 302:137-140

[71] Appleby, L · Mortensen, PB · Faragher, EB. Suicide and other causes of mortality after post-partum psychiatric admission. *Br J Psychiatry.* 1998; 173:209-211

[72] Niederkrotenthaler, T · Floderus, B · Alexanderson, K · et al. Exposure to parental mortality and markers of morbidity, and the risks of attempted and completed suicide in offspring: an analysis of sensitive life periods. *J Epidemiol Community Health.* 2012; 66:233

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[74] P.L.H. Mok, S. Antonsen, C.B. Pedersen, M.J. Carr, N. Kapur, J. Nazroo, R.T. Webb. Family income inequalities and trajectories through childhood and self-harm and violence in young adults: A population-based, nested case-control study. The Lancet Public Health, 3 (2018), pp. e498-e507, 10.1016/S2468-2667(18)30164-6

[75] S. Hodgkinson, L. Godoy, L.S. Beers, A. Lewin. Improving mental health access for low-income children and families in the primary care setting. Pediatrics, 139 (2017), 10.1542/peds.2015-1175.

[76] P. Kim, C. Neuendorf, H. Bianco, G.W. Evans. Exposure to childhood poverty and mental health symptomatology in adolescence: A role of coping strategies. Stress and Health, 32 (2016), pp. 494-502, 10.1002/smi.2646

[77] L.M. Berger, C. Paxson, J. Waldfogel. Income and child development. Children and Youth Services Review, 31 (2009), pp. 978-989, 10.1016/j.childyouth.2009.04.013

[78] N. Halfon, K. Larson, J. Son, M. Lu, C. Bethell. Income inequality and the differential effect of adverse childhood experiences in US children. Academic Pediatrics, Child Well-Being and Adverse Childhood Experiences in the US, 17 (2017), pp. S70-S78, 10.1016/j.acap.2016.11.007

[79] P. Lanier, K. Maguire-Jack, B. Lombardi, J. Frey, R.A. Rose. Adverse childhood experiences and child health outcomes: Comparing cumulative risk and latent class Approaches. Maternal and Child Health Journal, 22 (2018), pp. 288-297, 10.1007/s10995-017-2365-1

[80] The effect of low childhood income on self-harm in young adulthood: Mediation by adolescent mental health, behavioural factors and school performance - ScienceDirect

The relationship between poverty and self-harm seems to disproportionately affect women. A fifth of young women reporting 'severe' money problems and one in ten reporting 'definite' problems had self-harmed in the past year. This same pattern was also evident in relation to debt: those seriously behind with payments or who have had utilities disconnected were three times[81] more likely to have self-harmed in the past year than other women.

The areas where young women live appear to matter too. Self-harm in the past year was four times more common among young women who did not feel safe in their neighbourhoods in the day[82].

Suicide

There is a strong association between area-level deprivation and suicidal behaviour: Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent.[83]

Young people from more disadvantaged families, in the lowest 40% of the income distribution, are twice as likely to report having attempted suicide compared to their more advantaged counterparts. The proportion experiencing psychological distress is also higher among those from lower income families[84].

The risk of suicidal behaviour is increased among those experiencing job insecurity and downsizing or those engaged in non-traditional work situations, such as part-time, irregular and short-term contracts with various employers.[85]

The experience of being declared bankrupt, losing one's home or not being able to repay debts to family and friends is not only stressful but can also feel humiliating. This can lead to an increased risk of suicidal behaviour.[86]

Financial hardship can contribute to feelings of entrapment and loss of control, factors that are considered as integral to the development of suicidal behaviours, in the Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour[87].

The risk of suicidal behaviour increases when an individual faces negative life events, such as adversity, relationship breakdown, social isolation, or experiences stigma, emotional distress or poor mental health. Socioeconomically disadvantaged individuals are more likely to experience ongoing stress and negative life events, thus increasing their risk of suicidal behaviour[88].

Children who are care experienced

Self-harm

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[81] Tomorrow is too late. Suicide prevention support for people with no fixed address
[82] Often-Overlooked-Young-women-poverty-and-self-harm-2.pdf
[83] Samaritans, 2017. Socioeconomic disadvantage and suicidal behaviour. Finding a way forward for Wales. Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf
[84] High levels of serious mental health difficulties among 17-year-olds | CLS
[85] Samaritans, 2017. Socioeconomic disadvantage and suicidal behaviour. Finding a way forward for Wales. Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf
[86] Samaritans, 2017. Socioeconomic disadvantage and suicidal behaviour. Finding a way forward for Wales. Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf
[87] The integrated motivational–volitional model of suicidal behaviour - PMC
[88] Samaritans, 2017. Socioeconomic disadvantage and suicidal behaviour. Finding a way forward for Wales. Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf

Research suggests that children who have experience of care are more likely to hurt themselves compared with their peers due to both their background and circumstances of living in care [89].

Suicide

Children who have experience of care are also at a greater risk of both attempted and completed suicide than their peers[90].

At present self-harm and suicide in looked after children and young people remains under-examined, and more research is required to contribute to preventative efforts and social care improvement.

Homelessness and housing

Self-harm

People experiencing homelessness appear to have high rates of self-harm[91]. A study conducted in Ireland found that age-standardised incidence rates of self-harm were 30 times higher in people experiencing homelessness compared with domiciled people[92].

People who self-harm and experience homelessness have more complex needs and worse outcomes than those who are domiciled. Risk of self-harm repetition has been found to be higher than in domiciled people, as has mortality due to accidental causes[93].

People recorded as experiencing homelessness are predominantly men aged between 25 and 54 years – suggesting a different demographic of people who self-harm compared to the general population[94].

Rates of self-harm amongst the homeless population in Wales remains undetermined, and consequently, more work is required to further understand the relationship.

Suicide

Suicide is the second most common cause of death among people who are homeless in England and Wales[95].

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[89] Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: Systematic review and meta-analysis of prevalence - ScienceDirect

[90] Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: Systematic review and meta-analysis of prevalence - ScienceDirect

[91] Haw, C, Hawton, K, Casey, D. Deliberate self-harm patients of no fixed abode. Soc Psychiatry Psychiatr Epidemiol 2006; 41: 918–25.CrossRefGoogle ScholarPubMed

[92] Barrett, P, Griffin, E, Corcoran, P, Mahony, MTO, Arensman, E, O'Mahony, MT, et al. Self-harm among the homeless population in Ireland: a national registry- based study of incidence and associated factors. J Affect Disord 2018; 229: 523–31.

[93] Self-harm in people experiencing homelessness: investigation of incidence, characteristics and outcomes using data from the Multicentre Study of Self-Harm in England - PMC

[94] Self-harm in people experiencing homelessness: investigation of incidence, characteristics and outcomes using data from the Multicentre Study of Self-Harm in England - PMC

[95] Suicide the second most common cause of death for homeless people, ONS stats show | Samaritans

Research has identified factors that increase risk among youth experiencing homelessness, including childhood abuse, street victimization, substance use, and depression[96] [97].

Prisoners

Self-harm

The 'Safety in Custody Statistics' for England and Wales highlight that in the 12 months to September 2024, the rate of self-harm was 891 incidents per 1,000 prisoners (77,869 incidents), up 11% from the 12 months to September 2023 to a new peak, comprising of a 14% increase in male establishments to a new peak, but a 2% decrease in female establishments.[98] The rates of self-harm between males and females have changed considerably since the previous year, with statistics finding that in the 12 months to June 2023, there was an 8% increase in self-harm in men's jails and a 65% increase in female establishments[99].

Self-harm in prison was associated with current or recent suicidal ideation, lifetime history of suicidal ideation, and previous self-harm. Any current psychiatric diagnosis was also strongly associated with self-harm, particularly major depression and borderline personality disorder.[100]

Prison-specific environmental risk factors for self-harm including solitary confinement, disciplinary infractions, and experiencing sexual or physical victimisation while in prison was associated with self-harm.[101] Sociodemographic and criminological factors were less strongly associated with self-harm in prison[102].

Suicide

The 'Safety in Custody Statistics' for England and Wales highlight that in the 12 months to December 2024, there were 342 deaths in prison custody of which 89 deaths were self-inflicted, a decrease of 7% from the 96 self-inflicted deaths in the previous 12 months. Self-inflicted deaths in prison were highest among prisoners aged 60 to 69 in 2024, followed by the 40 to 49 and 50 to 59 age groups.[103]

For people who have been in prison, their risk of suicide remains higher than other people even once they are back in the community. This is particularly the case in the days and months after their release. In England and Wales, men have been shown to be 8 times and women 36 times more likely to die by suicide than others in the community, in the first year after their release from prison.

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[96] Hadland SE, Wood E, Dong H, Marshall BDL, Kerr T, Montaner JS, & DeBeck K (2015). Suicide attempts and childhood maltreatment among street youth: A prospective cohort study. Pediatrics, 136(3), 440–449
[97] Yoder KA, Whitbeck LB & Hoyt DR (2010). Comparing subgroups of suicidal homeless adolescents: Multiple attempters, single attempters, and ideators. Vulnerable Children and Youth Studies, 5 (2), 151–162.
[98] Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2024 Assaults and Self-harm to September 2024 - GOV.UK
[99] Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to September 2023 Assaults and Self-harm to June 2023 - GOV.UK
[100] Risk factors for self-harm in prison: a systematic review and meta-analysis - PMC
[101] Risk factors for self-harm in prison: a systematic review and meta-analysis - PMC
[102] Risk factors for self-harm in prison: a systematic review and meta-analysis - PMC
[103] Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2024 Assaults and Self-harm to September 2024 - GOV.UK

Some of the factors associated with higher rates of suicide are also associated with higher rates of imprisonment. For instance, economic deprivation, homelessness and specific experiences of financial insecurity, like unemployment.

The prison environment itself also plays a role in higher rates of suicide. Some examples include, lacking control over simple activities, or a lack of purposeful activity[104].

Substance use

Self-harm

Many studies report significant relationships between substance use and self-harm in clinical populations. For instance, Ness and colleagues analysed routinely collected patient data in England between 2000-2009, finding that the proportion of patients who had self-harmed and exhibited alcohol use or misuse increased over the study period, particularly among younger women[105]. A similar study[106], using the Irish register of self-harm presentations at hospital across 2012-13 found that alcohol was present in 43% of patients across Ireland and Northern Ireland. A study of psychiatric inpatients in Finland[107] found more than a 4-fold risk for self-mutilative behaviour in females with a high level of nicotine dependence compared to non-smokers. In a juvenile correctional facility in the USA, those who engaged in self-mutilation were significantly more likely to have a history of illicit drug use than those who did not self-mutilate[108].

The comorbidity of substance use and self-harm in non-clinical samples is also well attested in the literature[109] [110]. In an evidence review by Moller and colleagues[111], 32 of the 36 identified studies found substance use to be significantly associated with self-harm. Among the five community-based studies, alcohol was associated with self-harm in all five and illicit drug use and self-harm were associated in four. Only two of the community-based studies assessed tobacco use; both found strong associations between smoking tobacco and self-harm behaviour.

Additional studies have found that those presenting with both self-harm and substance use are more likely to be older, male, living alone, unemployed, sick, disabled, and have a history of self-harm. They also had higher scores on measures of anger, aggression, and impulsivity[112] [113].

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[104] Policy_position_people_in_prison_and_leaving_prison_England_and_Wales_FINAL_Se_yUdCQIF.pdf
[105] Ness, J., Hawton, K., Bergen, H., Cooper, J., Steeg, S., Kapur, N., et al. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. Emergency Medicine Journal, 32, 793-799.
[106] Griffin, E., Arensman, E., Perry, I.J., Bonner, B., O'Hagan, D., Daly, C., et al. (2018). The involvement of alcohol in hospital-treated self-harm and associated factors: findings from two national registries. Journal of Public Health, 40, e157-e163.
[107] Riala K, Hakko H, Rasanen P. Nicotine dependence is associated with suicide attempts and self-mutilation among adolescent females. Compr Psychiatry 2009;50:293-298.
[108] Penn JV, Esposito CL, Schaeffer LE, et al. Suicide attempts and self-mutilative behavior in a juvenile correctional facility. J Am Acad Child Adolesc Psychiatry 2003;42:762-769.
[109] IAE-y-suicidio-en-adolescentes.pdf (cienciassociales.edu.uy)
[110] Hawton K, Rodham K, Evans E, Weatherall R. Deliberate self-harm in adolescents: self report survey in schools in England. BMJ 2002; 325: 1207–11
[111] Deliberate self-harm, substance use, and negative affect in nonclinical samples: a systematic review - PubMed (nih.gov)
[112] Hawton K, Hall S, Simkin S, et al. Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990–2000. J Child Psychol Psychiatry 2003; 44: 1191–98
[113] Deliberate Self-Harm Patients with Alcohol Disorders: Characteristics, Treatment, and Outcome | Crisis (hogrefe.com)

It has been suggested that the association between self-harm and substance use is due to similar motivations for engaging in self-harmful behaviour and for consuming alcohol and other drugs. The most commonly reported reason for self-harming is to reduce negative or unwanted emotions or feelings[114] [115]. Likewise, the use of alcohol[116], tobacco[117], cannabis[118] and other illicit drugs[119] to manage emotional pain, anxiety and distress is well attested in the literature.

Suicide

Globally, people with substance use disorder (SUD) are at significantly greater risk of suicide compared with the general population[120].

One UK-based study found that people admitted to hospital due to alcohol-related issues had a high risk of subsequent suicide; an alcohol-related admission from any cause was associated with a 27-fold increased risk of death from suicide. Women were at nearly three times a higher risk of suicide after such admissions compared to men. The highest risks were associated with admission for 'toxic effects of alcohol or poisoning by alcohol' where the risk of suicide was 18-times higher than for those not admitted in men and 30-times higher in women, followed by alcohol use disorder at nearly 10-fold and 24-fold, respectively[121].

SUD is also widely recognised as an important modifiable risk factor for suicide[122], with 45% and 33% of those who died by suicide in England whilst in contact with services, having a history of alcohol or other drug misuse respectively[123]. Furthermore, in over half of National Health Service suicide-related compensation claims, the deceased had a history of substance misuse[124].

There are numerous biopsychosocial mechanisms, which may contribute to the increased risk of suicide amongst people with SUD. These include:

1) SUD leading to unemployment, social isolation and marginalisation;

2) substance use influencing cognition and behaviour, which may result in disinhibition and impulsivity; and

3) pain, distress and psychiatric conditions increasing the likelihood of both SUD and suicide[125] [126] [127].

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[114] Klonsky ED. The functions of deliberate self-injury: a review of the evidence. Clin Psychol Rev 2007;27:226-39.
[115] Nock MK, Prinstein MJ. A functional approach to the assessment of self-mutilative behavior. J Consult Clin Psychol 2004;72:885-90
[116] Buchmann AF, Schmid B, Blomeyer D, et al. Drinking against unpleasant emotions: Possible outcome of early onset of alcohol use? Alcoholism-Clinical and Experimental Research 2010;34:1052-1057.
[117] Morrell HER, Cohen LM. Cigarette smoking, anxiety, and depression. J Psychopathol Behav Assess 2006;28:283-297.
[118] Hyman SM, Sinha R. Stress-related factors in cannabis use and misuse: Implications for prevention and treatment. J Subst Abuse Treat 2009;36:400-413.
[119] Suh JJ, Ruffins S, Robins CE, et al. Self-medication hypothesis: Connecting affective experience and drug choice. Psychoanal Psychol 2008;25:518-532.
[120] The Burden Attributable to Mental and Substance Use Disorders as Risk Factors for Suicide: Findings from the Global Burden of Disease Study 2010 | PLOS ONE
[121] Risk of suicide following an alcohol-related emergency hospital admission: An electronic cohort study of 2.8 million people | PLOS ONE
[122] [Withdrawn] Preventing suicide in England - A cross-government outcomes strategy to save lives (publishing.service.gov.uk)
[123] National Confidential Inquiry into Suicide and Safety in Mental Health — Research Explorer The University of Manchester
[124] NHS-Resolution_learing_from_suicide_claims_148pp_ONLINE1.pdf
[125] Understanding Links among Opioid Use, Overdose, and Suicide | New England Journal of Medicine (nejm.org)
[126] A Closer Look at Substance Use and Suicide | American Journal of Psychiatry Residents' Journal (psychiatryonline.org)
[127] Suicidal Behavior and Alcohol Abuse (mdpi.com)

Gambling

Suicide

Research has demonstrated that gamblers who report high-risk gambling behaviours are at increased risk of suicidality[128].

Despite the scarcity of data related to the role of gambling in suicides in most countries, available research now shows that the odds ratio for suicide among high-risk gamblers is substantial. A Swedish study, for example, reported a standardised mortality ratio of 15·1 for suicide among a cohort of more than 2000 people with diagnosed gambling disorder compared with the general population[129]. Cowlishaw and Kessler[130]reported odds ratios of 4·2 for suicidal ideation, and 5·5 for suicide attempts, among high-risk gamblers in health-care settings.

Recent activity by groups of experts by experience, such as Gambling with lives, shows the widespread and devastating impact of gambling-related suicides, and the lack of effective responses from government, regulators, and industry[131].

While these findings suggest there is an appreciable relationship between problem gambling and suicide ideation and attempts, well-designed longitudinal research is needed to make more firm conclusions[132] [133], particularly involving coronial records and police reports of suicide.

Veterans

Self-harm

Roughly 16% of Veterans engage in non-suicidal self-injury at some point in their lifetimes, which is approximately three times higher than the rate observed in the general population. In this population, rates of self-harm are similar for men and women, however, it is often overlooked in men[134].

A study investigating self-harm rates in the UK serving and veteran community found that self-harm has increased over time[135]. Lifetime self-harm increased significantly from 1.8% among serving personnel and 3.8% among veterans in 2004/06 to 4.2% and 6.6% in 2014/16. Veterans were consistently significantly more likely to report lifetime self-harm than serving personnel.

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[128] Wardle, H · McManus, S. Suicidality and gambling among young adults in Great Britain: results from a cross-sectional online survey. *Lancet Public Health.* 2021; 6:e39-e49

[129] Karlsson, A · Håkansson, A. Gambling disorder, increased mortality, suicidality, and associated comorbidity: a longitudinal nationwide register study. *J Behav Addict.* 2018; 7:1091-1099

[130] Cowlishaw, S · Kessler, D. Problem gambling in the UK: implications for health, psychosocial adjustment and health care utilization. *Eur Addict Res.* 2016; 22:90-98

[131] Gambling-related suicidality: stigma, shame, and neglect - The Lancet Public Health

[132] Innovative methods needed to understand links between gambling and self-harm - The Lancet Public Health

[133] A meta-analytic investigation of problem gambling and self-harm: A causal inference perspective - PubMed

[134] The Prevalence of Nonsuicidal Self-Injury in Military Personnel: A Systematic Review and Meta-Analysis - PubMed

[135] Suicidal Ideation, Suicidal Attempts, and Self-Harm in the UK Armed Forces - PubMed

Significant determinants of lifetime self-harm included current mental disorder symptoms, stigmatization, poor social support, suicidal ideation, and seeking help from formal medical sources.

Despite these findings, it has been identified that only half of Veterans with non-suicidal self-injury were engaged with mental health services, with few appointments attended, suggesting that these Veterans are not receiving treatment interventions[136].

Suicide

In 2021 in England and Wales, out of 5,175 suicides in those aged 16 years and over, 253 suicides occurred in UK armed forces veterans.[137] Of the 253 UK armed forces veteran suicides occurring in 2021, 93.7% (237) were male and 6.3% (16) were female.[138]

Overall, after accounting for age, there was no evidence of a difference in the rate of suicide between male UK armed forces veterans and the male general population. However, male UK armed forces veterans aged 25 to 44 years had a higher rate of suicide compared with males aged 25 to 44 years in the general population.[139]

A study conducted by NCISH identified high rates of unemployment, homelessness and alcohol and drug misuse all as potential risk factors for veterans following discharge[140].

An older study on the suicide risk of UK armed forces veterans suggests that the stress of transitioning to civilian life, exposure to adverse experiences in the military and pre-existing vulnerabilities to suicide before entering the military may all account for heightened risk among some veteran populations shortly after discharge. It points out that veterans who left after a short length of service and are untrained have a particularly high risk of dying by suicide after leaving the military, suggesting that increased suicide risk may be indicative of a pre-military vulnerability[141].

Unpaid carers

Self-harm

Research carried out by the Me-We Young Carers project[142] found that 14% of all adolescent young carers in the Europe-wide sample said they had thought about harming themselves because of their caring role. But in the UK the figure doubled to

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[136] Nonsuicidal self-injury among veterans is associated with psychosocial impairment, suicidal thoughts and behaviors, and underutilization of mental health services: Death Studies: Vol 48 , No 3 - Get Access

[137] Office for National Statistics (ONS), released 5 April 2024, ONS website, statistical bulletin, Suicides in UK armed forces veterans, England and Wales: 2021

[138] Office for National Statistics (ONS), released 5 April 2024, ONS website, statistical bulletin, Suicides in UK armed forces veterans, England and Wales: 2021

[139] Office for National Statistics (ONS), released 5 April 2024, ONS website, statistical bulletin, Suicides in UK armed forces veterans, England and Wales: 2021

[140] Suicide after leaving the UK Armed Forces 1996-2018: A cohort study - PubMed

[141] Veterans_and_Armed_Forces_policy_position_April_2024.pdf

[142] New research shows three in ten adult UK carers think about self-harming - News & Media - Latest News, Views & Opinions | Carers Trust

28%. 36% of young carers surveyed across the six countries said their mental health had deteriorated as a result of their caring responsibilities. But in the UK alone this figure rose to 56%.

Similar findings were identified through an online survey carried out by Carers UK between June and August 2023[143]. Findings from a total of 11,667 carers and former carers identified:

- A significant proportion of carers said their mental health has been affected by caring. Over three quarters (79%) of carers feel stressed or anxious, half of carers (49%) feel depressed, and half of carers (50%) feel lonely.
- Over a quarter of carers (27%) said their mental health was bad or very bad.
- Over a third of carers (36%) whose mental health was bad or very bad said they had thoughts related to self-harm or suicide.

Suicide

A review of international evidence found that over 45 studies (including 7 from the UK) have reported suicidal thoughts and behaviours in unpaid carers[144]. The number of carers reporting suicidal ideation varies across studies, with some estimates as high as 71% and most likely to be an underestimate.

Among those who have contemplated suicide, the review suggests that 1 in 6 carers are likely to attempt suicide in the future and 1 in 10 have already attempted suicide.

Suicidal ideation in carers can be accompanied by homicidal ideation, and deaths by homicide-suicide have been reported.

Consistent with the general population, depression, anxiety, dysfunctional coping strategies, and limited social support are risk factors for suicidal ideation in carers.

There are also risk factors for suicidal ideation that are unique to carers. These include dissatisfaction with the caring role; wanting a reprieve from caring; experiencing conflict with family or health and social care professionals over the care provision; and, not having an identity or role beyond caring (such as a paid job or volunteering).

Intersectionality

It is important to note that the relationship between discrimination, inequality, self-harm and suicide may be exacerbated for people with multiple minoritised identities/inequalities[145]. For example:

- LGBTQ+ youth from low-income families are at greater risk of suicide ideation and suicide attempts[146].

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[143] soc23-health-report_web.pdf
[144] O'Dwyer, C. (2017). Unpaid carers and their mental health: Policy brief. University of Exeter. Retrieved from https://www.exeter.ac.uk/media/universityofexeter/research/policy/briefs/ODwyer_Un paid_carers_Policy_Brief.pdf
[145] Ethnicity_and_suicide_July_2022.pdf
[146] Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school experience | Journal of Public Health | Oxford Academic

- The risk of suicide and self-harm is elevated in people experiencing work disability, highlighting a relationship between suicide, self-harm, disability, unemployment and poverty[147].
- Previous self-harm was reported by 81% of people experiencing homelessness and often occurred alongside current or previous contact with psychiatric services, as well as problems with substance misuse, finances, legal issues and abuse.

Objective 2 of the strategy commits Welsh Government to work collaboratively with other parts of Government and other sectors to collectively tackle the drivers of suicide and self-harm. This will enable us to limit the impact of different risk factors on those who are vulnerable and prevent escalation.

Objective 5 of this strategy focuses on providing support to services who come into contact with people who are at an elevated risk of suicide and self-harm. Services include but are not limited to debt advice and employment centres, education settings, custodial settings, substance misuse service, mental health services, and services that provide support to women experiencing violence. This approach recognises that people who are vulnerable to suicide and self-harm often have multiple and co-occurring issues and could appear in any part of the system.

The strategy recognises that more needs to be done to better understand the determinants of suicide and self-harm in Wales which will allow us to better understand the risk factors and support required. Objective 1 commits Welsh Government to this.

What if any, barriers do people who share protected characteristics face? Can these barriers be reduced, removed, mitigated?

Men

The suicide rate in middle-aged men in the UK is 3 times higher than women of the same age and 1.5 times greater than men in other age groups[148]. This is of concern because middle-aged men are often thought not to be in contact with health or other support services[149] and are more likely to be affected by economic adversity[150]. At times they report a reluctance to talk about or report mental health problems and may perceive more challenges and barriers to accessing services than women[151].

Ethnic minorities

There is also evidence that people from ethnic minority communities are less likely to access to services involved in suicide prevention, affecting individuals' ability to get support for suicidal thoughts and feelings and their wider mental health[152]. Such inequalities may be partly explained by mistrust of services as well as a fear of being discriminated against, sometimes based on previous negative experiences of

[147] The relationship between work disability and subsequent suicide or self-harm: A scoping review - PMC
[148] Suicides in England and Wales - Office for National Statistics
[149] Inequalities In Men's Health: Why Are They Not Being Addressed? | The King's Fund
[150] The weaker sex? Vulnerable men and women's resilience to socio-economic disadvantage - ScienceDirect
[151] Men and mental health | Mental Health Foundation
[152] What works to support better access to mental health services (from primary care to inpatients) for minority groups to reduce inequalities? A rapid evidence summary | medRxiv

support. Research around suicidality amongst South Asian women found that a fear of experiencing racism, cultural misunderstanding, and oversimplified views of their problems all acted as deterrents to seeking help[153].

Research commissioned by the NHS Race and Health Observatory, and led by The University of Worcester[154], addresses the lack of mental health care provision, despite the significant need, for Gypsy, Roma, and Traveller communities. Factors, both structural and systemic, mean considerable shame and stigma is still associated around the term mental health. Whilst shame, stigma and structural barriers contribute to a number of areas in which Gypsy, Roma, and Traveller communities experience health inequalities, this is worsened by a lack of granular data and tailored health services, as well as healthcare professionals who do not understand the communities' needs or lifestyles.

People who use English as a second language

For patients who use English as a second language (ESL) access to available healthcare services is often delayed; indeed, the fear of not being understood or misunderstanding medical advice can deter individuals from help-seeking[155].

Language barriers also impede effective communication between healthcare providers and clients, leading to misdiagnosis, inappropriate treatments, and/or missed nuances in patient care[156]. This is turn results in suboptimal care and dissatisfaction with the care received[157].

Language barriers interfere with treatment adherence and the use of preventative and screening services, further delaying access to timely care, causing poor chronic disease management, and ultimately resulting in poor health outcomes[158].

The issue of language is particularly important in mental health care as the dialogue between clients and practitioners is central to both diagnostic assessment and treatment[159]. Language barriers have also been found to interfere with the development of a therapeutic relationship between the client and practitioner[160].

The few existing studies on mental health and language barriers have consistently shown that members of linguistic minorities make less use of mental health services than the dominant groups, for comparable levels of distress[161] [162]. Involving untrained interpreters or family members has been found to be problematic due to misinterpretation and confidentiality issues[163]. Although suicide and self-harm aren't mental health conditions, much of the assessment and treatment relies on direct communication rather than objective tests or medication.

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[153] South Asian women, psychological distress and self-harm: lessons for primary care trusts - PubMed
[154] Inequalities-in-mental-health-care-for-Gypsy-Roma-and-Traveller-communities.pdf
[155] Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study - PMC
[156] Language proficiency and adverse events in US hospitals: a pilot study - PubMed
[157] The need for more research on language barriers in health care: a proposed research agenda - PubMed
[158] Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study - PMC
[159] Language_Barriers_in_Mental_Health_Care_20160122-10012-p3kp6y-libre.pdf (d1wqtxts1xzle7.cloudfront.net)
[160] Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study - PMC
[161] Laher N, Sultana A, Aery A, Kumar N. Access to language interpretation services and its impact on clinical and patients outcomes: a scoping review. Toronto: Wellesley Institute: Advancing Urban Health; 2018. p. 1–78.
[162] Delara M. Social determinants of immigrant women's mental health. Adv Public Health. 2016;2016:1–11. https://doi.org/10.1155/2016/9730162.
[163] Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study | BMC Health Services Research | Full Text (biomedcentral.com)

Research specific to the Welsh language has found that although most Welsh speakers in Wales also speak English and are therefore bilingual, in situations of stress and vulnerability many feel more comfortable and confident communicating in Welsh with healthcare professionals[164]. Moreover, even those who are fluent in English may temporarily lose their command of English and revert completely to Welsh when they are tired, ill, or under stress[165], highlighted the need for healthcare services to be available in a patient's preferred language. The Welsh Language Impact Assessment for *Understanding*: the Suicide Prevention and Self-harm Strategy explores this in further detail.

Gender identity

A higher rate of psychological distress and a lower level of satisfaction with health services, as a result of inequalities in healthcare treatment, are observed among LGBTQ+ individuals.

Factors such as homophobia, biphobia and transphobia, fear of judgement and lack of awareness of LGBTQ+ identities can cause people to receive inappropriate care or stop seeking help altogether[166].

Socioeconomic status

In the UK, socioeconomically disadvantaged individuals are less likely to seek help for mental health problems than the more affluent and are less likely to be referred to specialist mental health services following self-harm by GPs located in deprived areas[167].

Unpaid carers

Health and social care professionals are encountering carers at-risk of suicide, but many lack the skills and resources to identify and support them.

There have been no interventions specifically designed to address suicide (or homicide) risk in unpaid carers and, due to the dyadic nature of caring and the need to safeguard vulnerable care recipients, existing suicide prevention initiatives are unlikely to be sufficient[168].

Older adults

Ageism deteriorates care options for older adults: from normalizing depression in late life to fostering reluctance to intervene clinically, given the fragility of health of older patients and the fear of harmful drug–drug interactions[169].

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[164] Roberts, G., 1991. The use of the Welsh language in nurse-patient communication within a bilingual health care setting. Unpublished MN Thesis. University of Wales, Cardiff.
[165] Thomas, G., 1998. The experiences of welsh speaking women in a bilingual maternity service. Unpublished M.Sc. Thesis, University of Wales, Cardiff.
[166] 289_2286_1_PB.pdf
[167] Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf
[168] ODwyer_Unpaid_carers_Policy_Brief.pdf
[169] Late-life suicide in an aging world | Nature Aging

People with substance misuse issues

Research commissioned by Alcohol Change UK in 2020 explored the relationship between self-harm and alcohol use, and the adequacy of services to support people experiencing these co-occurring issues[170].Findings identified that respondents with co-occurring self-harm and substance use are often excluded from mental health support. The most common reason for being unable to access holistic support was the frequent requirement for them to address their use of alcohol (or any other drug) in order to be eligible for mental health support.

Stigma

There are also more general barriers that prevent all groups of people from accessing support for suicide and self-harm, such as feeling of shame and perceived or felt stigma.

For self-harm specifically, research has highlighted that the type of language used can be a barrier for support[171]. This includes:

- Judgemental language
- Dismissive language
- Language that signals a lack of knowledge and understanding

In the first instance people who are self-harming are sometimes accused of having a "self-inflicted" or "invented" problems, of "time wasting", "attention seeking" and not being "real patients", i.e. being morally undeserving of support[172] [173].

Secondly, their self-harm may not be seen as particularly concerning. "Fobbed off", "dismissed" and "not taken seriously" are some of the phrases people have used to describe the ways they have been treated by healthcare services. Injuries have been described by professionals as "low severity" or "superficial" and overdoses as not having involved large enough quantities of drugs[174].

Thirdly, barriers may be created by language that demonstrate a lack of understanding of self-harm. Describing it as a "a cry for help", for example, runs contrary to the reality that much self-harming behaviour is a private coping mechanism that people go to some trouble to hide. Similarly, describing it as "deliberate" is inaccurate, in that suggests a degree of choosing to self-harm, whereas it can be experienced as a compulsive behaviour or driven by intrusive thoughts or dissociative states[175].

There are a number of actions we're taking to mitigate inequitable access to support for suicide and self-harm.

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[170] Alcohol and self-harm: A qualitative study | Alcohol Change UK

[171] Filling in the gaps: a guide to supporting people experiencing co-occurring alcohol use and… | Alcohol Change UK

[172] Chandler, A. (2018) Seeking secrecy: A qualitative study of younger adolescents' accounts of self-harm, online, available at: https://www.research.ed.ac.uk/en/publications/seeking-secrecy-a-qualitative-study-of-younger-adolescents-accoun

[173] Donskoy, A-L., (2011) "Starting from scratch": An exploration of the narratives of the pathways leading up to the first episode of selfwounding, MPhil thesis, University of Bath, online, available at: https://researchportal.

[174] Chandler, A. and Taylor, A. (2021) Alcohol and self-harm: A qualitative study, online, available at: https://alcoholchange.org.uk/publication/alcohol-and-self-harm-a-qualitative-study

[175] Nielsen, E. (2016) Mind your 'C's and 'S's: The language of self-harm and suicide (and why it matters), Institute of Mental Health blog (Nottingham), online, available at: https://imhblog.wordpress.com/2016/01/22/emma-nielsen-mind-your-cs-and-ss-the-language-of-selfharm-and-suicide-and-why-it-matters/op. cit. Nielsen, E. (2016).

Objective 1 of the strategy - Streamlined process are established for the collection, collation and interpretation of data, evidence and lived experience testimony; and a robust infrastructure is developed to ensure the information gathered is used to develop policies, support and services - will allow us to gather more evidence, which will inform our policies and actions and help mitigate and reduce barriers of inequality.

This will include exploring how to improve help-seeking in males; mapping how additional data on protected characteristics can be gathered and included within the Real Time Suspected Suicide Surveillance (RTSSS e.g., ethnicity, gender identity, language Spoken/Preferred Language, immigration status); and establishing a lived experience framework to enable us to learn from those with lived experience and ensure support services are person-centred and needs led.

Objective 2 of the strategy - Co-ordinated cross-Government and multi-agency actions being delivered to tackle the risk factors linked with self-harm and suicide; restrict access or exposure to harmful information online and in the media; limit access to methods which can be used to inflict harm and develop and manage the locations of concern – enables us to limit the impact of risk factors on those who are vulnerable, and offer support to prevent escalation.

As part of this objective, we will continue to:

- Promote emotional and mental well-being through the actions within the “Framework on embedding a whole-school approach to emotional and mental well-being” and tackling bullying through Anti-Bullying Guidance.
- Improve access to services and ensuring equality in support for ethnic minority groups and continuing with our commitment to be an anti-racist Wales, through our Anti Racist Wales Action Plan.
- Implement the Online Safety Act through Ofcom which aims to protect people from online harm, including serious self-harm (including suicide).
- Support carers through the Carers strategy.
- Support students in tertiary education through The Tertiary Education and Research (TER) (Wales) Act 2022 aiming to build on best practice and create a safer and more supportive educational environment.
- Support those living with the impacts of poverty and commit to reduce poverty through the Child Poverty Strategy.
- Support those who have experienced domestic abuse and violence, gender-based violence and sexual violence and abuse and taking action on prevention.
- Address specific challenges in the Gypsy Roma Traveller community in the Enabling Gypsy Roma Travellers Plan.
- Work alongside the Samaritans on their Male Suicide Prevention Campaign, which focuses on increasing help seeking behavior amongst men and promoting better listening.

New actions will explore the opportunity to collaborate on the delivery of the Sound Campaign support system for men, which provides the opportunity to safely

talk about issues such as relationship issues, finances, feelings and emotions to prevent further risk, and scoping potential opportunities to input into the Gambling Levy.

Objective 3 seeks to empower everyone with an enhanced understanding of suicide and self-harm to tackle misconceptions/misunderstanding so that people can reach out without fear of being judged or labelled.

Objective 4 - Timely, compassionate and person-centred intervention is being offered to those who present to services for support with self-harm and/or suicidal ideation – will allow us to improve access to and delivery of services across Wales for those who present with and seek support for self-harm and suicidal ideation.

This will involve co-producing and maintaining accessible, universal and evidence-based training resources, standards and services which are culturally and age appropriate and meet the needs of Welsh speakers, ethnic minority groups, LGBTQ+ communities, the neurodivergent population and people with sensory loss and disabilities. This may require developing bespoke resources for specific demographics.

We will also improve access to and delivery of Mental Health Services across Wales for those who present with and seek support for self-harm and suicidal ideation. This involves ensuring risk-assessments are person-centred, that they consider the wider determinants of suicide and self-harm (e.g., socioeconomic risk factors, discrimination) and results in the co-development of a holistic safety plan.

Objective 5 - Services who support people with other challenges are identifying people at risk of suicide and self-harm and working with partner agencies to offer holistic, person-centred and compassionate support – will ensure services that may encounter people who self-harm and/or have suicidal ideation and behaviours are equipped to support them.

This will also involve the co-production of mandatory, accessible, universal and evidence-based training resources and standards which are suitable for all populations and demographics.

We will also meet the needs of people with co-occurring substance misuse by ensuring that the “Treating people with mental health and substance misuse problems” co-occurring framework considers suicide prevention, self-harm and other health harming behaviours (OHHBs), as well as scoping the provision of support for those who are intoxicated.

Objectives 2, 3, 4 and 5 of the strategy all aim to increase awareness and understanding of suicide and self-harm amongst professionals and the public and in turn, reduce stigma for those who self-harm and experience suicidal thoughts and behaviours.

Engagement with stakeholders

With the view to informing the development of the vision statements for the Mental Health and Wellbeing Strategy (2025-2035) and the (then called) Suicide and Self-Harm Prevention Strategy, and their supporting principles, Welsh Government carried out pre-consultation engagement with stakeholders in Wales. This involved administering an online survey, which was completed by over 250 individual and organisations. Those who participated in the pre-consultation engagement highlighted

potential barriers for those with protected characteristics – particularly in terms of access to services / tackling stigma – and highlighted how these should be reduced, removed, and mitigated.

Feedback included the need to take an equalities-based approach to suicide and self-harm. Specifically, respondents asked for drivers of suicide and self-harm, such as trauma, life circumstances, living situations and relationships, to be considered throughout the strategy. This feedback was taken into account when re-drafting. For example, a principle committing to focus on inequalities and at-risk groups, which will guide every objective and aim was incorporated into the strategy.

As part of the formal consultation on the draft Mental Health and Wellbeing Strategy and the draft Suicide and Self-Harm Prevention Strategy, we engaged specifically with stakeholders with protected characteristics and under-served groups. We developed a resource pack which was shared with stakeholders to support their engagement with partners and those with lived experience. Specific work was also carried out with children and young people – see the Children's Rights Impact Assessment for further detail. We published the draft Equalities Impact Assessment, the draft Children's Rights Impact Assessment and the draft Welsh Language Impact Assessment as part of both consultations and asked a specific consultation question to gather stakeholder views on our assessment of impacts and other evidence that we should consider. We engaged directly with the following groups to share consultation resources:

- Ethnic Minorities Mental Health Task and Finish Group
- Disability Rights Taskforce
- Disability Wales
- Advocacy Matters Wales
- Papyrus
- Scope
- TGP Cymru
- The Traveller Movement
- Men's Sheds Cymru

The resource pack was also shared with the NHS Executive, Local Health Boards and the National Coordinator for Suicide and Self-harm and was disseminated through regional leads to engage with local partners. Additionally, it was made available to anyone who requested it through our consultation webpages.

Analysis of the formal consultation responses identified a number of themes and subsequent changes to the strategy. These included:

- Greater parity between suicide and self-harm
- Inclusion of additional principles, including being trauma-informed
- Greater emphasis on the all-age approach of the strategy
- More emphasis on incorporating lived experience into policy and service development, implementation and evaluation.
- Less of a focus on high-risk groups and more focus on proportionate universalism to reduce the risk of inadvertently excluding people from support for suicide and self-harm.

During the re-drafting process of the strategy and development of the delivery plan we arranged a series of workshops and meetings with policy colleagues whose policies and strategies could contribute towards the prevention of suicide and self-harm. For example, links have been made with officials leading on the new Child Poverty Strategy for Wales and the challenging bullying guidance. Discussions during workshops and meetings have enabled others to consider the impact of their policies and strategies on suicide and self-harm risk, and us to consider the impact of our strategy on theirs.

We also conducted workshops with external stakeholders, including third sector organisations; academics; and representatives from the national suicide and self-harm prevention programme based in the NHS Wales Executive, during which extensive conversations took place around the definitions of suicide and self-harm and their impacts on different population groups.

Share your EIA wider within Welsh Government, ask colleagues to consider unintended impacts.

The strategy and supporting impact assessments have been shared with relevant Welsh Government departments who have contributed.

How have you/will you use the information you have obtained from research to identify impacts?

The information we have obtained to identify impact has informed the development of the strategy objectives and delivery plan actions.

Record of Impacts by protected characteristic:

This impact assessment, along with the integrated, children's rights, Welsh language, biodiversity, socioeconomic and rural proofing impact assessments detail the available evidence relating to suicide and self-harm in Wales. Reviewing the available evidence and data has highlighted that the development of a more robust evidence base is required. Objective 1 of the Strategy commits Welsh Government to this. Delivery plan actions under Objective 1 include the establishment of a formal relationship with the National Centre for Suicide Prevention and Self-harm. Through collation and interpretation of data, evidence, and lived experience testimony the National Centre will advise Welsh Government on which actions for which groups need to be taken via an annual report.

The other objectives have been developed to use both the available and emerging evidence to deliver effective interventions and support for people affected by suicide and self-harm in Wales as follows:

- Co-ordinated cross-Government and multi-agency actions being delivered to
    - Tackle the risk factors linked with self-harm and suicide;
    - Restrict access or exposure to harmful information online and in the media;

    - Limit access to methods which can be used to inflict harm;
    - Develop and manage the locations of concern.
- Everyone is empowered with the knowledge and awareness to recognise those in need, offer kind and compassionate support; and help them access additional support if needed.
- Timely, compassionate and person-centred support is being offered to those who present to services with self-harm and/or suicidal ideation.
- Services who support people with other challenges are identifying people at risk of suicide and self-harm and working with partner agencies to offer holistic, person-centred and compassionate support**.**
- Timely responses are being provided to suspected suicides and compassionate and person-centred support is available to those affected by suspected suicide.

Accompanying the strategy, delivery plan and impact assessments, an outcomes framework will also be published which will set out how progress against our objectives will be achieved.

Below is an analysis on the impact based on the evidence currently available:

Age

- **Positive** impact on all ages.

This Strategy is an all-age strategy and is relevant to, and supportive of, everyone in Wales without restriction. Objective 1 of the Strategy will help better inform actions to prevent, predict and respond to suicide and self-harm, whilst through objectives 2, 4 and 5 we will ensure that we provide a more tailored and targeted approach to support those groups that are most vulnerable to suicide and self-harm. Through these objectives we will also ensure that we identify and provide appropriate 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 develop programmes of work to support individuals and organisations. The groups identified include.

- Men aged 40-50
- Young people, particularly girls aged 10-14 who are susceptible to self-harm
- Older adults

Disability (think about different types of disability)

- **Positive.**

The strategy identifies, through research undertaken, that people with a range of disabilities have higher rates of suicide and self-harm than non-disabled people. This includes people with chronic physical health conditions, neurodivergent

people and people with mental health conditions (noting that enduring mental health conditions are classified as disabled as defined by the Equality Act 2010[176]).

Through the objectives in this strategy, we will continue to explore the impact of disability on suicide and self-harm, identify effective interventions (objective 1) and work collaboratively with others to implement accessible support (objectives 2, 4 and 5). A core principle within the strategy - promote **equity of access, experience and outcomes without discrimination** – recommends that all services adopt an approach consistent with the social model of disability focussed on the removal of barriers - structural, cultural, and ableist - which hinder disabled people's access and participation.

Race

- **Positive.**

Rates of suicide and self-harm don't appear to be more prevalent amongst ethnic minority groups compared with White groups – albeit noting that improvements to the collection of ethnicity data (e.g., via the RTSSS) may alter this. However, evidence suggests that suicidality may be expressed or developed in different ways in different cultural contexts and ethnic groups, and that clinicians' approaches may not always capture this diversity or recognise expressions of mental distress from people with different cultural backgrounds to them[177]. It may also suggest that existing models of suicidal behaviour and risk assessment are biased towards White groups, resulting in worse aptitude for recognising suicidal behaviour among minoritised ethnicity individuals. In support of this, a study on self-harm in children and youth[178] found that minority ethnic groups were less likely to receive a specialist psychosocial assessment and mental health care. The authors concluded that this could reflect ethnic and cultural differences in help-seeking, self-reliance, and the relevance of mainstream services in meeting the needs of minority ethnic groups.

The suicide rate within Gypsy, Roma, Traveller communities is estimated to be up to seven times higher than all other communities. Structural and systemic factors mean that there is still considerable shame and stigma associated with mental health in some Gypsy, Roma, and Traveller communities. Low literacy levels act as a barrier to being able to access mental health support, and services find it hard to engage men, with some men remaining reluctant to acknowledge mental health problems because these are traditionally seen as signs of weakness. There is also a lack of cultural awareness and training among mainstream mental health staff. The absence of basic understanding about the different norms and mores within the different Gypsy, Roma, and Traveller cultures prevents services being effectively utilised[179].

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[176] Equality Act 2010
[177] Hunt, I., et al. (2021). 'Suicide rates by ethnic group among patients in contact with mental health services: an observational cohort study in England and Wales', The Lancet Psychiatry, 8(12), 1083-1093.
[178] Farooq, B., Clements, C., Hawton, K., Geulayov, G., Casey, D., Waters, K., Ness, J., Patel, A., Kelly, S., Townsend, E., Appleby, L., & Kapur, N. (2021). Self-harm in children and adolescents by ethnic group: an observational cohort study from the Multicentre Study of Self-Harm in England. Lancet Child Adolesc Health, 5(11):782-791. doi: 10.1016/S2352-4642(21)00239-X. Epub 2021 Sep 21. PMID: 34555352; PMCID: PMC9766885.
[179] Inequalities-in-mental-health-care-for-Gypsy-Roma-and-Traveller-communities.pdf

In 2024 the Mental Health and Vulnerable Groups policy team at Welsh Government commissioned Health Care Research Wales to conduct a rapid evidence review to identify what works in increasing access to mental health support for people from ethnic minority groups[180]. Recommendations to improve equality in mental health care included language and cultural adaptations and different sectors working together in collaboration - actions that we will be taking forward (from a suicide and self-harm perspective) through objective 4. However, the effectiveness of interventions to enhance access to mental health services varied across studies and consequently more rigorous research is required. Objective 1 of the Strategy seeks to enhance our understanding of self-harm and suicide, providing the opportunity to explore this, among other issues in greater detail.

Religion/Belief and non-belief

- **Positive**

Some research shows that religious affiliation has been associated with lower rates of self-harm[181] and suicide[182]. Other research suggests that disclosing suicidal ideation or self-harm to people with religious beliefs has led to unsympathetic and harsh responses, and a sense of shame for victims and their families. Objective 1 will allow for greater and continued monitoring/exploration of potential links between suicide and self-harm and religion - and allow us to respond accordingly through successive action plans.

Through Objective 4 of the strategy, we will ensure risk formulations for suicide and self-harm are person-centred; they will consider a person's current and future influences, and strengths and protective factors, including faith and beliefs.

All actions set out in the accompanying delivery plan will acknowledge that people with the characteristics protected through the Equality Act 2010 may present with particular needs and preferences, including requirements relating to faith or beliefs.

Sex/Gender

- **Positive**.

The suicide rate in middle-aged men in the UK is 3 times higher than women of the same age and 1.5 times greater than men in other age groups[183]. Men also report a reluctance to talk about or report mental health problems and may perceive more challenges and barriers to accessing services than women[184]. Through objective 1 of the strategy, we aim to identify how to increase help-seeking behaviour amongst males to prevent further risk. Through objectives 3, 4 and 5 we will tailor support and resources to ensure it meets the needs of men.

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[180] A rapid review of the effectiveness of interventions to enhance equitable or overall access to mental health services by ethnic minority groups | medRxiv
[181] The Journal of Nervous and Mental Disease
[182] Religion and Suicide Risk: a systematic review - PMC
[183] Suicides in England and Wales - Office for National Statistics
[184] Men and mental health | Mental Health Foundation

The highest rates age-specific emergency hospital admissions for self-harm are among young females, between the ages of 15 and 19[185]. Through objective 2, this strategy aims to continue to work across Government and other sectors to reduce the risk of suicide and self-harm for children and young people. This will include continuing to influence emotional and mental well-being through the actions within the "Framework on embedding a whole-school approach to emotional and mental well-being", tackling bullying through Anti-Bullying Guidance; and increasing online safety through collaborations with UK Government.

Research has indicated that young people may not seek support out of fear of being labelled an 'attention seeker', by both peers and professionals[186] [187]. Objective 4 aims to address this by ensuring that specialist services, where people may turn to for support for suicide and self-harm, offer safe, compassionate and effective support.

Objectives 2, 3, 4 and 5 of the strategy all aim to increase awareness and understanding of suicide and self-harm amongst professionals and the public and in turn, reduce stigma for those who self-harm and experience suicidal thoughts and behaviours, including middle-aged men and young girls.

Pregnancy and maternity

- **Positive.**

The Mental Health and Wellbeing Strategy and accompanying equalities impact assessment recognises that certain population groups and protected characteristic groups, including Pregnancy and maternity, may require additional support in protecting their mental health, and also in accessing services. Objective 2 of *Understanding*: the Suicide Prevention and Self-Harm Strategy – Co-ordinated cross-Government and multi-agency actions being delivered to tackle the risk factors linked with self-harm and suicide; restrict access or exposure to harmful information online and in the media; limit access to methods which can be used to inflict harm; and develop and manage the locations of concern - commits the SSH team to work across government to influence strategic priorities, frameworks and guidance which tackle the wider risk factors for suicide and self-harm. This includes supporting **Mental Health** conditions and concerns and promoting well-being through the Mental Health and Well-being Strategy.

Children

- **Positive.**

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[185] 2012-16_MaSH_rpt_finalv4

[186] Fortune S, Sinclair J, Hawton K. Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. BMC Public Health. 2008;8(1):1–13.

[187] Lewis C, Ubido J, Timpson H. Case for Change: Self-harm in Children and Young People. November 2017. Available at https://www.ljmu.ac.uk/~/media/phi-reports/pdf/2018_01_case_for_change_self_harm_in_children_and_young_people.pdf.

Like its predecessor, this current Suicide Prevention and Self-harm Strategy is an all-age strategy. However, it includes specific priorities and actions that will directly impact children and young people. One of the core principles of the strategy is a focus on prevention. This means targeting the wider determinants associated with suicide and self-harm, such as poverty, discrimination, trauma, abuse, substance misuse and mental ill health. Children who grow up in environments where they are not exposed to these factors will have a substantially reduced risk of suicide and self-harm.

Objective 6 of the strategy also recognises the impact of suicide and self-harm on those affected e.g. family members and friends. Children and young people could be particularly vulnerable to such impact given that men aged between 40 and 49 have consistently had the highest rates of suicide of any age group since 2008 – and many of this age group could have young children. It is widely known that Adverse Childhood Experiences (ACEs) such as death of a parent can significantly increase the risk of the development of mental health problems later in life. Not only does the strategy provide the basis for reducing such incidences through a range of actions but it, and the accompanying mental health strategy, seek to enhance of the timely offer of support for young people who are affected by suicide and self-harm.

The strategy also commits the Welsh Government to identifying further opportunities to enhance online safety. With so much of children and young people's lives on the internet and social media this is particularly relevant. As part of this, the Welsh Government has been and continues to work with the UK Government to bring forward the Online Safety Act which places a duty on internet providers to enhance online safety with a particular focus on children and young people.

Low-income households

- **Positive.**

The Suicide and Self-harm Prevention Strategy for Wales (2015-2020), 'Talk to me 2', presents a clear gradient between the rates of suicide, and residence-based deprivation, with rates of suicide being highest in the most deprived communities. In 2017 Samaritans UK commissioned a report 'dying from inequality'[188], followed by the commissioning of 'socioeconomic disadvantage and suicidal behaviour: finding a way forward for Wales' by Samaritans Cymru[189]. Both reports recognise that people living in the most disadvantaged communities face the highest risk of dying by suicide with income, unmanageable debt, unemployment, poor housing conditions, and other socioeconomic factors contributing to risk.

Self-harming behaviour in adolescence and young adulthood has also been associated with low household income. Low income can be considered a stressor, which may affect child socio-emotional, behavioural and cognitive development[190]

[188] Samaritans_Dying_from_inequality_report_-_summary.pdf
[189] Socioeconomic disadvantage and suicidal behaviour | Samaritans
[190] S. Hodgkinson, L. Godoy, L.S. Beers, A. Lewin. Improving mental health access for low-income children and families in the primary care setting. Pediatrics, 139 (2017), 10.1542/peds.2015-1175.

as well as the development of coping strategies[191]. Lack of disposable resources may also affect children indirectly through impaired parenting due to poverty-related stress in parents[192]. Adverse childhood experiences, such as parental mental health or substance abuse problems and family dissolutions, are more common in low-income households[193]. These experiences are known to have an impact on adolescent mental health problems and self-harm, and recent findings also suggest that the consequences of adverse experiences may be more detrimental in low-income households than in others[194] [195].

The current strategy continues to recognise financial strain and poverty as high-risk factors, and we have already identified, through working with policy teams, possible actions for the supporting action plan. Actions include co-producing and maintaining mandatory, accessible, universal and evidence-based training resources and standards to generate consistent skills across services which people at-risk of suicide and self-harm frequent e.g., job centres, debt management services, housing services. This will allow people working in these services to identify someone at risk of suicide and self-harm, provide an appropriate, compassionate response and signpost to relevant services if required. It also makes links with the Child Poverty Strategy and policies which address those other risk factors linked with low income, such as problem gambling and drinking.

Human Rights and UN Conventions

Do you think that this policy will have a positive or negative impact on people's human rights?

[191] P. Kim, C. Neuendorf, H. Bianco, G.W. Evans. Exposure to childhood poverty and mental health symptomatology in adolescence: A role of coping strategies. Stress and Health, 32 (2016), pp. 494-502, 10.1002/smi.2646
[192] L.M. Berger, C. Paxson, J. Waldfogel. Income and child development. Children and Youth Services Review, 31 (2009), pp. 978-989, 10.1016/j.childyouth.2009.04.013
[193] N. Halfon, K. Larson, J. Son, M. Lu, C. Bethell. Income inequality and the differential effect of adverse childhood experiences in US children. Academic Pediatrics, Child Well-Being and Adverse Childhood Experiences in the US, 17 (2017), pp. S70-S78, 10.1016/j.acap.2016.11.007
[194] P. Lanier, K. Maguire-Jack, B. Lombardi, J. Frey, R.A. Rose. Adverse childhood experiences and child health outcomes: Comparing cumulative risk and latent class Approaches. Maternal and Child Health Journal, 22 (2018), pp. 288-297, 10.1007/s10995-017-2365-1
[195] The effect of low childhood income on self-harm in young adulthood: Mediation by adolescent mental health, behavioural factors and school performance - ScienceDirect

Human Rights	What are the positive or negative impacts of the proposal?	Reasons for your decision (including evidence)	How will you mitigate negative Impacts?
	Positive impact. This strategy sets out our commitment to deliver a reduction in the number of suicide deaths and the rates 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.	Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information. Articles that may apply: • article 8 - the right to respect for private and family life.	N/A

EU/EEA and Swiss Citizens' Rights

Part 2 of the EU-UK Withdrawal Agreement, along with the EEA EFTA Separation Agreement and Swiss Citizens Rights Agreement ("Citizens Rights Agreements") give EU, EEA[196] and Swiss citizens who were lawfully resident in the UK by 31 December 2020 certainty that their citizens' rights will be protected.

The Citizens Rights Agreements are implemented in domestic law by the European Union (Withdrawal Agreement) Act 2020 (EUWAA)[197]

Eligible individuals falling within scope of the Citizens Rights Agreements will have broadly the same continued entitlements to work, study and access public services and benefits, in as far as these entitlements have derived from UK membership of the EU as well as its participation in the EEA Agreement and the EU-Swiss Free Movement of Persons Agreement.

[196] The EAA includes the EU countries as well as Iceland, Liechtenstein and Norway.
[197] Sections 5 and 6 of EUWAA.

Subject to certain limited exceptions[198], individuals will need to have applied for a new residence status (either pre-settled or settled status) through the EU Settlement Scheme. The deadline for making such an application expired on 30 June 2021.

Policy considerations to take into account:

- Have you considered if your policy proposal will impact EU, EEA, or Swiss citizens whose rights are protected by the Citizens Rights Agreements?
- If there is the potential for any negative impact on such EU EEA or Swiss citizens, how will any such impacts be eliminated or managed if management is deemed appropriate?
- Is legal advice required?

Please consider the impacts of your policy on the areas below, indicating whether the impact is positive or negative and any action required to eliminate potential negative impact. Please note the basis for your answer, including where legal advice has been sought and please also indicate where a right is not relevant for your policy:

Residency – the right to reside and other rights related to residence: rights of exit and entry, applications for residency, restrictions of rights of entry and residence.

Mutual recognition of professional qualifications –the continued recognition of professional qualifications obtained by EU/EEA/Swiss citizens in their countries (and already recognised in the UK).

Access to social security systems – these include benefits, access to education, housing, and access to healthcare.

Equal treatment – this covers non-discrimination, equal treatment, and rights of workers.

Workers' rights - Workers and self-employed persons who are covered under the Citizens Rights Agreements are guaranteed broadly the same rights as they enjoyed when the UK was a Member State. They have a right to not be discriminated against due to nationality, and the right to equal treatment with UK nationals.

(Frontier workers (those citizens who reside in one state and regularly work in another) can continue working in the UK if they did so by the 31 December 2020).

Understanding, the Suicide Prevention and Self-Harm Strategy will not impact EU, EEA, or Swiss citizens whose rights are protected by the Citizens Rights Agreements.

[198] E.g., where an individual has Irish citizenship (including dual British and Irish citizenship) or where they had indefinite leave to enter or remain in the UK)