Draft suicide and self-harm prevention strategy

General information

Your name (optional):

Haleema Khan – Policy and Public Affairs Officer

Organisation (if applicable):

The Welsh NHS Confederation
The Welsh NHS Confederation welcomes the opportunity to respond to the Welsh Government consultation on the Draft suicide and self-harm prevention strategy.

The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts (Velindre University NHS Trust, Welsh Ambulance Services University NHS Trust, and Public Health Wales NHS Trust), and two Special Health Authorities (Digital Health and Care Wales and Health Education and Improvement Wales). The twelve organisations make up our membership. We also host NHS Wales Employers.

Your interest in the strategy. Please tick all that apply.

- Lived experience ☐
- Carer ☐
- Member of the public ☐
- Health care staff ☐
- Social care staff ☐
- Third sector staff ☐
- Other professional role ☐
- Organisational response ☒
- Prefer not to say ☐

Which version of the strategy have you looked at? Please tick all that apply.

- Draft suicide and self-harm prevention strategy ☒
- Easy read version ☐

If you want to receive a receipt of your response, please provide an email address:

Responses to consultations may be made public. To keep your response anonymous (including email addresses) tick the box: ☐

Consultation questions

Question 1

To what extent do you agree with this vision?

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 1a

What are your reasons for your answer to question 1?

Our members agree with this vision, but they have some suggestions to help improve the current draft vision.

Our members suggested that there should be reference to reducing rates of suicide and self-harm within the vision and if the term stigma is used in the vision, then it requires a more comprehensive definition. The definition provided in the document (page 30 - "This is used to describe the negative attitude that can exist in relation to a person’s mental health") is inadequate in that it relates to mental health, not suicide and self-harm, and inaccurately describes what stigma is.

Members understand that suicide clusters may result from ‘contagion’, whereby one or more than one person’s suicide influences another person to engage in suicidal behaviour, and that peer influences can account for some self-harm behaviour. By de-stigmatising suicidal and self-harm behaviour some of our members questioned whether this might potentially normalise these behaviours which could result in an increase in these behaviours. By reducing stigma, would we be making this behaviour acceptable. Whereas talking about the feelings that lead to the behaviour and therefore help seeking behaviour, and support after the behaviour has occurred should be where the de-stigmatisation takes place.

Some of our members also highlighted that ‘fear’ and ‘stigma’ will look different to different people.

Question 2

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 2a

What are your reasons for your answer to question 2?

Members agree with the six principles that underpin the strategy.

Members strongly agree with the principles which focus on ‘inequalities and at-risk groups’, ‘involving those with lived/living experience’, ‘suicide and self-harm is everybody’s business’ and being ‘evidence based/intelligence led’.

Members also welcome the inclusion that ‘suicide prevention is everyone’s business’ and the emphasis that both suicide and self-harm prevention does not always need specialist mental health service input.

Moreover, members agree with the principles of ‘leadership, ownership, and accountability’ and ‘multi-sectoral collaboration’. However, members believe that greater direction and directives from Welsh Government are required for this to be realised equitably across Wales.

Question 3

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 3a

What are your reasons for your answer to question 3?

Our members agree that the strategy address high-risk and priority groups,

However, members stated that there is insufficient information provided about the increased risk of self-harm in women. This is currently included with children and young people, but women are a distinct at-risk group.

Furthermore, there are under 2 pages of information presented about self-harm, but 4 pages presented about suicide. In the 2023 'Review of Together for Mental Health and Talk to Me 2 Strategies' stakeholders repeatedly asked for greater parity between suicide and self-harm in the successor strategy to Talk to me 2. There is a plethora of evidence about self-harm in the literature which needs to be better reflected here.

Also, there is currently no mention of people who have experienced a relationship breakdown or those experiencing financial insecurity, both of which are known drivers of suicide risk.

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

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

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

Objective 1

Question 4

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

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 4a

What are your reasons for your answer to question 4?

Our members agree with the above high-level objective. However, members suggested that the objective should also seek to develop systems to identify and learn from attempted suicides to help strengthen the evidence base and identify areas for action.

In the section 'what this objective means' it discusses Real Time Suspected Suicide Surveillance (RTSSS) but fails to mention that there was an objective in Talk to me 2 and Talk to Me to also improve self-harm data through the development of a self-harm register. This was as follows:

"*Objective 6 - Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action… Consideration to be given to:*

- *Continuing collaborative work with coroners to improve liaison and information sharing.*
- *RTSSS continuing the collaboration with the Association of Chief Police Officers.*
- *Self-harm surveillance through the creation of a self-harm registers similar to that operated in England or by using routinely available data".*

In the 2023 'Review of Together for Mental Health and Talk to Me 2 Strategies' stakeholders expressed that there was a data gap for self-harm. The objective needs to make it clear that Welsh Government will strive to close the data gap between suicide and self-harm. The effect of this is evident in the introduction, where a lot of evidence is provided about suicide (much of which is from RTSSS), but little is given about self-harm.

Also, there should be co-ordination around the evidence base around interventions for prevention.

Question 4b

Two sub-objectives have been suggested to achieve the objective 1. Do you agree with the sub-objectives identified?

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 4c

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

Members agree with the sub-objectives identified.

However, for data collection 1a, members think it would be beneficial to undertake surveillance of self-harm in addition to suspected suicide as in RTSSS.

Also, members advocate for real-time data sharing which is accompanied by analysis, synthesis, and presentation/visualisation at national level, highlighting local level data which informs national, regional, and local suicide and self-harm prevention plans.

Additionally, members advocate for national and local prevention plans based on a robust evidence base as well as being supported by local knowledge /experience.

Question 4d

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

In terms of actions to include in the plan to deliver against the objectives, members have suggested the development of a self-harm register.

Members also recommend the plan identifies the relevant data sets and sources required, establishing data flow systems, and the infrastructure and resources needed to achieve this. A data driven approach at this level will require dedicated analytical capacity for robust data collection and analysis function. Appropriate support for information sharing processes and information governance will be required. If there is an expectation for organisations to collect data, there should be a clear and consistent methodology shared.

Also, members suggested a rapid review of the current evidence base for suicide and self-harm prevention with a focus on priority groups to enable a greater understanding of the causes/risks for both suicide and self-harm and the most effective interventions. This intelligence should be systematically available, accessible, and applicable at national, regional, and local levels.

Additionally, members suggested identifying evidence gaps and priorities for further prevention interventions.

Objective 2

Question 5

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

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 5a

What are your reasons for your answer to question 5?

Members agree with the above high-level objective.

Members think the areas included in the objective are good as they are areas where changes can be made to potentially improve issues relating to suicide and self-harm. Furthermore, identifying locations of concern is important. Regarding suicides in private residences, it is important to look at people living alone, and implications for people released from mental health services into social housing to live alone.

Tackling wider determinants (such as safe housing, finance) and tackling the multiple drivers of suicide and self-harm (e.g. loneliness, domestic abuse, relationship problems, long term health conditions) require cross Government and cross-organisational solutions. Action should represent a long-term commitment and be responsive to changes in context and factors associated with suicide and self-harm.

Also, cross-government action is vital to deliver primary prevention of suicides, this should include protecting and promoting the mental wellbeing of those in higher risk groups.

Question 5b

Four sub-objectives have been suggested to achieve the objective 2. Do you agree with the sub-objectives identified?

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 5c

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

Our members agree with the sub-objectives identified.

However, our members have enlisted some suggestions to improve the sub-objectives. For example, the sub-objectives do not mention action to “reduce access to means” which forms part of the main objective. There should be a commitment to monitor methods of suicides through RTSSS and to respond to any new methods or emerging patterns of concern.

Also, sub-objective 2c should probably be adapted to reflect that access to means can be locations / poisons/ drugs / facilities (e.g. safe measures in hospital settings as per NCISH) etc.

Question 5d

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

Alongside the strategy, members think reviewing priorities within all other Welsh Government plans and strategies to ‘join the dots’ to maximise the impact and reduce unnecessary duplication.

Objective 3

Question 6

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

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐

- Disagree ☐
- Strongly disagree ☐

Question 6a

What are your reasons for your answer to question 6?

Our members agree with the above high-level objective. On page 20 the background says 22% of suicide cases are known to mental health services 1 year before (in the NCISH data from 2018) and 74% of suicide cases are known to the police (RTSSS data). It is important to explore the reasons they are known to both services is important. Also, for this objective to be effective there will be a need for additional, ring-fenced, and sustainable resources which is equitably shared across Wales based on need.

Question 6b

Three sub-objectives have been suggested to achieve objective 3. Do you agree with the sub-objectives identified?

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 6c

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

Our members agree with the sub-objectives suggested to achieve objective 3.

However, the key settings in sub-objective 3a does not include Emergency Departments, or Welsh Ambulance Services University NHS Trust services. Members believe that people who self-harm can form a significant proportion of frequent attenders (ED)/ callers (Welsh Ambulance). These are the only services that vulnerable groups can access 24 hours a day 7 days a week. Developing capability and response in these settings would also be important.

Members are concerned that some people don't fall into a priority group/setting and might be missed such as people experiencing relationship breakdowns. Members believe that self-help skills taught at an early age should be prioritised so that prevention is everyone's business including our own.

Additionally, whilst members support the inclusion of neurodivergent people but stress the need to understand the needs, alternative perspectives and experiences of neurodivergent people when considering suicide and self-harm prevention training.

Whilst members strongly agree that a wide range of appropriate and accessible training is essential to achieve this objective, members recognise the resource need required. This resource should be ring fenced and sustainable.

Question 6d

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

The actions members suggested to include on the plan to deliver against the objectives include mapping exercise to identify current resources, conduct a training needs assessment to identify appropriate training at right level for all individuals working within organisations who interact with people most vulnerable to self-harm and/or suicide, make recommendations for appropriate training at the right level and resources easily available to encourage consistency across Wales and set measurements/monitoring evaluation framework to be implemented across Wales.

Objective 4

Question 7

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

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

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 7a

What are your reasons for your answer to question 7?

Members agree with the above high-level objective.

Members agree that the public, professionals, and agencies who may be in contact with people at risk of suicide and self-harm should have skills, awareness, knowledge and understanding of suicide and self-harm. Members also believe that they should feel confident and motivated to have conversations, which can sometimes be difficult. However, for this objective to be achieved there will be a requirement for strong leadership and accountability at national and local level, which is adequately resourced.

Question 7b

Two sub-objectives have been suggested to achieve objective 4. Do you agree with the sub-objectives identified?

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 7c

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

Members agree with the two sub-objectives suggested to achieve objective 4.

However, for 4b, members would include the Emergency Department as one of the key areas for this.

Question 7d

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

Members suggested the following actions to include in the plan to deliver against objectives: Review of current training over across Wales (mapping and gapping exercise), listening exercise with services who currently respond to people in distress to identify training need, easy access to approved and quality assured resources and free resources and courses for professionals and members of the public to increase their knowledge, skills and confidence and signposting to support services.

Objective 5

Question 8

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

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

- Strongly agree ☐
- Agree ☒

- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 8a

What are your reasons for your answer to question 8?

Members agree with the above high-level objective.

However, members suggested that this objective needs to be split into two objectives:

1) those who self-harm or have suicidal thoughts

2) those who have been affected or bereaved by suicide or self-harm

Moreover, the objective discusses providing an 'appropriate, compassionate, person-centred response', but members think this doesn't emphasise enough the need for a timely, high-quality, evidence informed service to improve outcomes for individuals who have self-harmed. It must not be overlooked that many people who self-harm will require services from primary care, ambulance service, or secondary care. People who have self-harmed will require medical assessment before they can be seen by a mental health professional.

RTSSS could be used to support monitoring of use of bereavement services, if an acceptable method of reporting this information can be determined.

Question 8b

Two sub-objectives have been suggested to achieve objective 5. Do you agree with the sub-objectives identified?

- Strongly agree ☐
- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 8c

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

Members agree with the two sub-objectives suggested to achieve objective 5.

Additionally, members have suggested some improvements to the objective. For example, the reference to stigma in sub-objective 5a needs to be disentangled. As it stands, members are unsure what type of stigma they envisage being reduced. The assumption is they are referring to provider-based stigma (e.g. reducing stigmatisation by hospital staff), but it is unclear. It is unclear how it is intended to measure change in (provider based) stigma. There are some standardised stigma measurement scales for suicide stigma. Many stigma intervention evaluations focus on measurement of reduction in stigmatising attitudes, which may not necessarily lead to a reduction in stigmatising behaviours. Therefore, the Welsh Government may wish to consider how stigmatising behaviours could be assessed.

Question 8d

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

Alongside the strategy, members have suggested the following actions:

- Ensure consistent approach, language, terminology, and shared culture across organisations involved,
- governance and monitoring systems established and exercises to test rapid response;
- promote cross-sectoral / multi professional working

Objective 6

Question 9

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

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

- Strongly agree ☐

- Agree ☒
- Neither agree or disagree ☐
- Disagree ☐
- Strongly disagree ☐

Question 9a

What are your reasons for your answer to question 9?

Members agree with the above high-level objective. Members agree that social media use about self-harm and suicide between young people is particularly important.

Question 9b

Two sub-objectives have been suggested to achieve objective 6. Do you agree with the sub-objectives identified?

- Strongly agree ☐
- Agree ☐
- Neither agree or disagree ☒
- Disagree ☐
- Strongly disagree ☐

Question 9c

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

Members neither agree or disagree with the two sub-objectives suggested to achieve objective 6. The reasoning for this answer includes the reference to stigma needs to be clarified. This is one of the simpler ones to rectify because media reporting relates to addressing public stigma. The Samaritans media guidelines are from 2020. There are WHO media reporting guidelines from 2023 (Preventing suicide: a resource for media professionals (who.int)) that are more detailed.

Question 9d

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

Alongside the strategy, members have suggested the following actions: - Nationally agreed appropriate language developed and shared, which is regularly reviewed to ensure it is up to date and appropriate and - consider acknowledging sensitive and good practice in media reporting/use

The strategy overall

Question 10

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

- Yes ☒
- No ☐

Question 10a

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

Question 11

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

For some people, self-harming, or attempting suicide is an indicator that something has gone wrong for them & they need some help. This isn't necessarily true of all people, and in some cases, people who use self-harm find that engaging in self-harm is preventative for them and stops them doing something riskier. There is also sometimes an assumption that when someone self-harms, or dies by suicide, that services have let the person down. Sometimes this is true, but not all the time. This is an impact that is hard to measure, but key in proportionality of service response, and in the stigma and management of risk of suicide and self-harm in responders.

Question 12

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

Members stated that the Welsh language and the opportunities provided to use the Welsh language is covered well in the document.

Question 13

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

Members have many comments which they would like to be addressed in the document.

On page 2 and page 6: It states: "This strategy sets out our commitment to deliver a reduction in the number and rates of suicide deaths that have endured over recent years. It also aims to establish a pathway to support people who self-harm and to improve support for those bereaved by suicide." Members think this should be changed so that it also discusses reduction in rates of self-harm.

On page 6, members would remove the word intent from the title because this is confusing in the context of a suicide and self-harm strategy. For example, unintentional injury vs self-harm vs. assault are types of intent in the injury literature.

On page 11 and 15, data on admissions for self-harm [PEDW data] is presented and suggest that admissions are reducing from 2018/19 to 2021/22. However, pressures on Emergency Departments (EDs) have increased since 2018/19 and psychiatric liaison services in EDs have improved, so it may just be that fewer people are being admitted rather than fewer people presenting to hospital. It does acknowledge that the figures don't include people who have not been admitted and thus are an underestimate. However, a study of 10–24-year-olds in Wales for 2003-2015 found that ED attendance is increasing over time and that less than half of ED attendees for self-harm are admitted. There is no equivalent study looking at people of all ages. There is no freely available public data on ED presentations to check whether ED attendances for self-harm are increasing. It will be important that hospital admissions are not used as a key outcome indicator for self-harm. ED attendances may be appropriate as an outcome indicator providing these data can be collated nationally.

On page 15, the study from reference 37 is for data from 2003-2015. It does not relate to study 36. The sentence for reference 37 needs to be rewritten so that it is clear that the evidence is not related to that quoted for reference 36.

Furthermore, more emphasis needed on engagement and support available particularly in secondary mental health services, not always inpatient. Also, more emphasis needed on suicide bereavement support for all affected and long-term funding.

Also, members suggested that the strategies should be separate i.e., a strategy for self-harm and a different one for suicide. There was a strong feeling that linking self-harm and suicide increases stigma and creates a false link between the two in the general population.

The strategy defines self-harm as: “Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress. Self-harm includes suicide attempts as well as acts where little or no suicidal intent is involved”. There was a feeling this could contribute to stigma. There were discussions around intention being key to understanding a person’s actions and therefore society’s and “the system’s” response. Ultimately, there is a clear need to distinguish between acts of suicide/ harm from suicidal intention and self-harm.