Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 2 – The Senedd
Meeting date: 23 May 2018
Meeting time: 09.15

For further information contact:
Claire Morris
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Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Suicide Prevention: Evidence session with Samaritans

(09.30 – 10.15) (Pages 1 – 24)

Sarah Stone, Executive Director for Samaritans in Wales

Emma Harris, Policy and Communications Officer

Susan Francis, Project Officer for Samaritans South Wales Valleys Project

Research brief

Paper 1

Break (10.15 – 10.20)

3 Suicide Prevention: Evidence with Royal College of Psychiatrists in Wales

(10.20 – 11.05) (Pages 25 – 33)

Prof Keith Lloyd, Chair, Royal College of Psychiatrists in Wales

Paper 2

Break (11.05 - 11.10)

4 Suicide Prevention: Evidence session with regional multi-agency suicide forums

(11.10 - 11.55) (Pages 34 - 95)

Dr Gwenllian Parry, Chair, North Wales Suicide and Self-harm Working Group

Avril Bracey, Chair, Mid and South West Wales Regional forum

Paper 3 - North Wales Suicide and Self-harm Working Group

Paper 4 - South East Wales Regional Group

5 Suicide Prevention: Evidence session with Survivors of Bereavement by Suicide (SOBS)

(11.55 - 12.40)

Angela Samata, Ambassador for SOBS

BBC documentary 'Life After Suicide'

6 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

(12.40)

7 Suicide Prevention: Consideration of evidence

(12.40 - 12.50)

Agenda Item 2

Document is Restricted

Suicide Prevention

Samaritans Cymru response

Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress. In Wales, Samaritans work locally and nationally to raise awareness of their service and reach out into local communities to support people who are struggling to cope. They seek to use their expertise and experience to improve policy and practice and are active contributors to the development and implementation of Wales Suicide and Self Harm Prevention Action Plan 'Talk to Me 2'.

1. The extent of the problem of suicide in Wales and evidence for its causes

1.1 Globally, over 800,000 people die by suicide each year.[1] In the United Kingdom and Ireland, more than 6000 people take their own lives each year and in Wales, between 300 and 350 people die by suicide each year. This is about 3 times the number killed in road accidents. In both England and Wales, suicide is the most common cause of death for men aged 20-49. Of the 322 suicides in Wales in 2016, 265 (82%) of these were by men.[2] In 2015, the age groups with the highest suicide rate per 100,000 in Wales were: 30-34 years, for all persons and 30-34 years for males. In reviewing trends over time, there has been a general increase in male suicide in Wales over the last 30 years, with a specific trend of increase since around 2008. Female suicide in Wales has decreased over same period, however, in line with the male trend, there has been a period of general increase since 2008.[3]

1.2 Whilst there is no single reason why people take their own lives, there are a wide range of risk factors and subsequent high-risk groups who are more likely to experience suicidal feelings or completed suicide. These groups include; young and middle-aged men; people in contact with mental health services, people living in areas of socio-economic deprivation; people with a history of self-harm; people experiencing loneliness and isolation, people in contact with the criminal justice system, including prisoners; people with a history of alcohol and substance misuse, asylum seekers and refugees, the Gypsy, Roma and Traveller community, specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; friends and family bereaved by suicide, and lesbian, gay, bisexual, transgender and questioning (LGBTQ).

[1] World Health Organization (WHO). (2014). *Preventing suicide: A global imperative.* Retrieved from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/
[2] ONS. (2016). *Suicides in the United Kingdom, 2015 registrations.* United Kingdom: Office for National Statistics
[3] Scowcroft, E. (2016). *Suicide statistics report 2016: Including data from 2014.* Surrey: Samaritans.

1.3 There must be a concerted and targeted effort from both public and voluntary bodies to identify and reduce the risk of suicide in high-risk groups. Whilst we must maintain an overall population approach to suicide prevention in Wales, it is important that there is cross-governmental and cross-sectoral knowledge of the risk factors for such a prevalent public health problem.

2. The social and economic impact of suicide.

2.1 Every suicide is a tragedy which has a devastating effect on families, friends, colleagues and the wider community. For each of the deaths by suicide in Wales each year, it has been suggested that an average of 6 people are deeply affected and family and friends who have been bereaved by suicide are 1.7 times more likely to attempt suicide.[4] The average cost of a suicide in the general population has been estimated as £1.67m per completed suicide.[5] This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

2.2 We must provide better information and support to those bereaved or affected by suicide. Waiting lists for bereavement support are a major barrier to follow-up care in Wales. Resources such as 'Help is at Hand Cymru' must be more widely disseminated. The stigma around death by suicide can be isolating for the friends and families left behind with survivors of suicide loss experiencing very distinctive bereavement issues surrounding guilt, shame and rejection. We must promote talking as a form of help seeking and early intervention to reduce the stigma of bereavement by suicide.

3. The effectiveness of the Welsh Government's approach to suicide prevention

3.1 As members of the National Advisory Group to Welsh Government on Suicide and Self-harm, we have contributed to the development and implementation of Talk to Me 2. We welcome the 3 C's approach outlined in Talk to Me 2 (Cross-governmental, cross-sectoral and collaborative in design and delivery) and the identification of priority care providers, priority places and priority people. In terms of progress, we believe implementation is still an issue. In the Public Health Wales Midpoint review of the implementation of Talk to Me (2012), it was noted that implementation was difficult due to the *'difficulty in setting up Regional Groups and a lack of high level support in many health boards and local authorities'* We believe the existence of such plans is vital for efforts to reduce suicide and self harm in Wales but this action plan needs a clear

[4] Pitman, A. L., Osborn, D. P., Rantell, K., & King, M. B. (2016). *Bereavement by suicide as a risk factor for suicide attempt: A cross-sectional national UK-wide study of 3432 young bereaved adults.*
[5] McDaid, D., Park, A., & Bonin, E. (2011). *Population level suicide awareness training and intervention. In M. Knapp, D. McDaid & M. Parsonage (Eds.), Mental Health Promotion and Prevention: The Economic Case* (26-28). London: Department of Health.

framework for implementation; one which recognizes the importance of acting locally.

3.2 Many of the top-level objectives in Talk to Me 2 are reliant on effective local partnership working through a cross-collaborative approach. For example, one of the main objectives is to improve awareness, knowledge and understanding of suicide and self harm amongst individuals who frequently come in to contact with people at risk of suicide and self harm and professionals in Wales. This objective is facilitated by frontline training in suicide awareness for public services. However, to achieve this, it is vital that local services, agencies and organisations work in a joined up and collaborative way to effectively manage and target their resources.

3.3 The most effective means of achieving this local and collaborative approach, is the creation and implementation of local suicide prevention plans and ensuring the engagement of Local Health Boards and local authorities in Regional Multi-Agency Suicide Prevention Fora. Local suicide prevention plans are developed and implemented by multi-agency groups and are critical to implementing the national suicide prevention strategies published by Welsh Government.

3.4 We are aware that there is inconsistency surrounding local forums and regional fora in Wales. Whilst there are some groups which champion the strategy and engage in multi-agency working, there are local authority areas in Wales who are not sufficiently engaged. Without a local suicide prevention plan, suicide prevention work is much less effective than it could be.

Through our own collaborative working, there are examples of good practice from public services in reducing access to the means of suicide. We provide a range of public services with Samaritans signs which they install in locations where they have identified a risk or have seen an increase in suicidal behaviour or suicide. We witness good partnership working between public services (such as Police and Fire and Rescue) but this does not necessarily mean they are linked up with local suicide prevention fora. This is for a range of reasons ranging from lack of awareness through to some groups being less focused on operational action.

Reducing Access to Means

3.5 There is evidence to suggest that lives can be saved by the use of a variety of measures including: the installation of Samaritans signs; physical barriers; nets and telephone lines at high risk locations for suicide; and improved surveillance, such as CCTV, at possible, or known, high risk locations.[6] High risk locations could include: bridges, viaducts, high-rise buildings, multi-story car

[6] *Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis Pirkis, Jane et al. The Lancet Psychiatry, Volume 2, Issue 11, 994 - 1001*

parks, cliffs and level crossings. Some services we work with identify the benefits of a preventative approach to reducing access to means at locations which are either known to be high-risk or have the potential to become so. In terms of fulfilling this trajectory, the main barrier is often budget and a lack of shared understanding throughout the sector. Whilst we work with many champions for mental health and suicide prevention, the placement of signs in particular can be a lengthy procedure in terms of budget and approval.

Suicide Prevention Training

3.6 Alongside this, suicide prevention training should form a major part of local suicide prevention. There needs to be greater awareness surrounding the benefits of a preventative approach to suicide, including training of this kind. Training should be provided to frontline workers both in the public sector but also key frontline sectors who are more likely to meet vulnerable groups. Increased awareness of specialist training provided by organisations, including Samaritans and Mind, should also be highlighted. Suicide Prevention Training is particularly important for those identified as 'Priority Care Providers' in Talk to Me 2, such as Job Centre Staff, Emergency Health Staff and teachers.

3.7 A good example of the benefits of suicide prevention training for workplaces and public services is our work with the rail industry in Wales. In 2010, Samaritans began working with Network Rail with the aim of preventing rail suicides and supporting those affected by them. The Rail Industry Suicide Prevention Programme (RISPP) is now a joint partnership between Samaritans, Network Rail and British Transport Police and the wider rail industry.

In Wales, our partnership with Network Rail and work with the wider rail industry focusses on seven key areas: Suicide prevention training, engaging the rail industry in suicide prevention and support activities, reaching out to those most at risk, supporting people affected by a traumatic incident, support at stations following a suicide, working with the media to encourage responsible reporting of rail suicides and working with police and health services. In Wales, the Network Rail suicide prevention team have developed a 12-point plan to push forward the agenda of suicide prevention. Its inclusion in the Wales Route joint suicide prevention plan, as well as adopting recommendations from Talk to me 2, ensures that they are making a difference for Wales and the Route. 1,400 frontline Arriva trains staff members in Wales have now completed a basic level of suicide prevention training, allowing them to act as a preventative force alongside their training for post-incident action.

4. Mental Health Services

4.1 1 in 3 people who die by suicide have been in contact with mental health services in the year before their death.[7] We believe that swift and timely access to psychological therapies can enable and improve recovery, and act as a form of early intervention which can reduce the need for secondary services. Despite the cross-party support and focus on access to psychological therapies in the Together for Children and Young People Programme (T4CYP), Together for Mental Health and the Mental Health (Wales) Measure, access to psychological therapies is still a problematic issue in Wales.

4.2 People's mental health can deteriorate significantly during lengthy waiting times for psychological therapies, which can lead to suicidal feelings or suicide. As members of the Wales Alliance for Mental Health, we believe that an introduction of waiting time measures for psychological therapies across primary and secondary care is crucial. This data should be recorded and published to reduce waiting time

Post-hospital support

4.3 It is also crucial that health boards in Wales collect and publish data for post-hospital support for patients following admissions for self-harm or a mental health crisis. As of April 2017, there is only one health board in Wales that records how many people get timely follow up contact after they've been discharged. The lack of data for post-hospital support in Wales is a major concern. A survey of over 850 people with mental health problems about their experiences after leaving hospital in Wales showed those who weren't followed up appropriately (after seven days or not at all) were twice as likely to attempt suicide and a third more likely to harm themselves compared to respondents who said they were followed up within seven days of being discharged.[8]

4.4 Research by the NSPCC found that 1,193 young people were admitted to A&E departments in Wales because of self-harm in 2015. That number has increased by 41 per cent in the past three years.[9] National suicide prevention strategies recognise that Accident & Emergency services have an important role in treating people who have self-harmed or have made a suicide attempt. At least half of people who die by suicide have a history of self-harm and one in four have attended hospital for self-harm in the preceding year.[10] Given the particularly high suicide risk of people who attend hospital and A&E after harming themselves it is essential that rapid follow-up care is always available. It's

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[7] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). (2016). *Making mental health care safer: Annual report and 20-year review*. University of Manchester.

[8] *Thousands left to cope alone after leaving mental health hospital - putting their lives at risk* Mind Cymru (April 2017)

[9] *Child self-harm figures 'frightening' in Wales, NSPCC says*, BBC Wales (December 2016)

[10] *How local authorities can prevent suicide*, Samaritans (2017)

essential that anyone having self-harmed is treated with respect, given a proper assessment and follow-up care.

Improvements to the accuracy and availability of suicide data.

4.5 We welcome some recent improvements to the availability of suicide data from agencies in the UK such as Office for National Statistics (ONS). Suicide data is now available more quickly and in more useful formats. However, there are still many challenges with suicide data across the UK and Republic of Ireland, which will hinder our understanding of suicide unless they are addressed.

4.6 Ascertaining and recording numbers of attempted and completed suicides, and monitoring them, is an integral component in the development of suicide prevention. Local suicide audits are an effective way for public sector bodies to identify and respond to high risk groups in their areas, as well as reveal sites of concern. It is best practice for public sector organisations, including Health Boards, Local Authorities and the coroner, work to develop and undertake a suicide audit. Learning lessons from the response to a suicide to reduce the number of future suicides and better support bereaved families.

5. Innovative approaches to suicide prevention

Education – Investment in Prevention and Early Intervention

5.1 Many aspects of modern society impact negatively on the mental health and wellbeing of children and young people. The specialist Child and Adolescent Mental Health Services in Wales (CAMHS) is under more pressure than ever before. The last 4 years has seen a 100% increase in demand.[11]

5.2 We must embed a public health approach to mental health and suicide prevention by placing a primary focus on prevention rather than cure alone. Investment in prevention and early intervention can reduce human, social and economic costs. Emotional health programmes in schools should be viewed as a form of promotion, prevention and early intervention which could reduce pressure on CAMHS, reduce specific mental health problems and increase academic achievement.

5.3 To successfully implement and fulfil the potential of the new curriculum, we must provide emotional and mental health awareness training to teaching staff across all schools in Wales to increase confidence in teaching the subject. We must increase confidence in new teaching staff and ensure basic mental health literacy by embedding emotional and mental health awareness in Initial Teacher

[11] National Assembly for Wales, Children, Young People and Education Committee. (2014). *Inquiry into Child and Adolescent Mental Health Services (CAMHS)*

Training (ITT) and make sure the potential of the 'Health and Wellbeing' area of learning is fulfilled; The inclusion of emotional health and wellbeing on the curriculum should be mandatory and not optional.

5.4 We have recently welcomed the announcement of a two-year Welsh Government trial which will allow pupils with mental health problems at more than 200 schools in Wales to access early help from onsite CAMHS practitioners. Whilst this kind of linking up between education and health services is essential, we would like to emphasise that our call for action continues to be placed further downstream and in the primary context of early intervention through building resilience; a skill that can mitigate suicide in the future. It is vital that we realise the potential of the new curriculum.

The Power of Community

5.5 Loneliness and isolation increases the likelihood of suicide and social connection is therefore a protective factor for suicide risk. One intervention which addresses loneliness and isolation is community and outreach group participation. In terms of achieving the protective factor of social connection, the theme or nature of community and outreach groups can be extensive and wide-ranging.

5.6 Organisations such as Men's Sheds Cymru, which cite 'social exclusion as a hidden but persistent problem in many communities', aim to address the problem by creating community groups for men to pursue their interests, develop new ones, belong to a unique group, feel useful, fulfilled and a sense of belonging. Men's Sheds is now established and growing in the United Kingdom but these type of organisations are supported and funded by the Third Sector and their sustainability needs to be safeguarded to protect those who are most vulnerable.

"It gives me a reason to get up in the morning and for two days a week I feel I'm gainfully employed. I feel good working with and helping chaps who often feel isolated in the community. I would need a very good reason not to come." Bill, 67

5.7 It is vital that these types of community or social outreach groups are recognised for their health benefits; social connectedness tackles loneliness and isolation, and can work to reach those who are at the highest risk of being socially excluded and suicidal. This is particularly significant within the current Wales context, following the closure of Communities First and with the lack of a central strategy. Community groups should be given more focus as a form of prevention and early intervention for loneliness and isolation in Wales and policy solutions should be worked up to increase community participation.

Minimising the risk of the internet

5.8 The internet is often used by people who self-harm and/or attempt suicide to explore possible methods and read others' personal accounts of suicidal feelings and behaviour. In a population survey of 21 year olds, of the 248 participants who had made suicide attempts (6% of the overall sample), almost three quarters reported suicide-related internet use at some point in their lives. One in five had accessed sites giving information on how to hurt or kill yourself, though most of these had also visited help-sites.[12]

5.9 This research which was undertaken by Samaritans and University of Bristol identified the internet may pose a particular threat to young people. A policy report launched in 2016 set out a range of implications and recommendations for the industry and providers of online help, both of which we believe should be circulated appropriately.

[12] University of Bristol / Samaritans Policy Report (7/2016) *Priorities for suicide prevention: balancing the risks and opportunities of internet use*

Agenda Item 3

Health, Social Care & Sports Committee Inquiry into suicide prevention

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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The Royal College of Psychiatrists in pleased to respond to the Health, Social Care and Sports Committee on their inquiry into suicide prevention. Suicide is preventable if we are given the right training and support, but rates are still high, particularly in certain parts of the population, and growing in others. The Committee recognised through evidence gathered during the inquiry into loneliness and isolation, that these are contributing factor to suicide. We welcome the Committee's in-depth look into this particular area as more can and must be done to prevent deaths and the impact that suicide has on the community.

Main points:

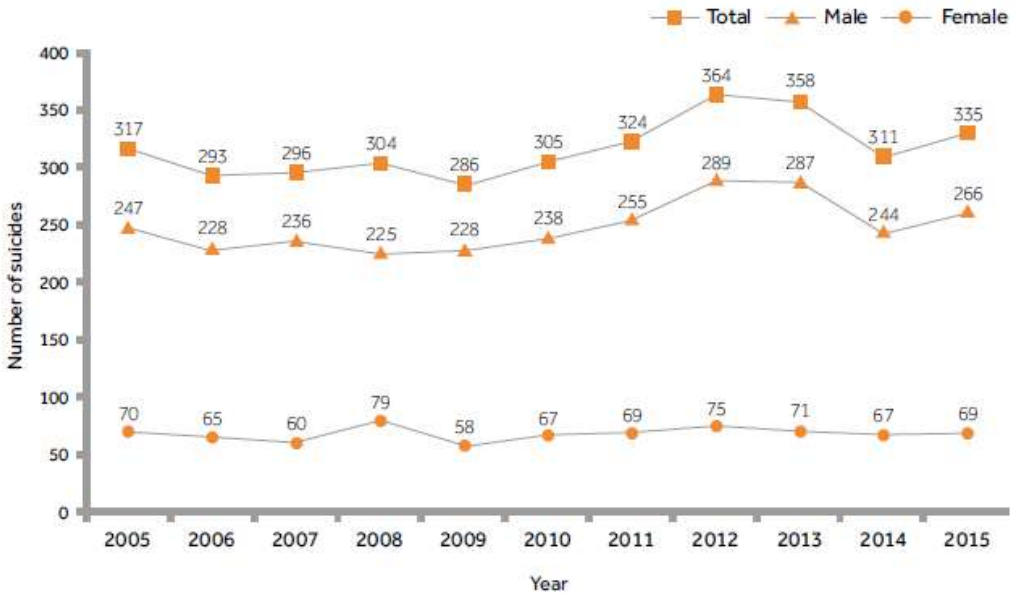
- Suicidal ideation is not a serious mental illness but it is related to poor mental health
- Suicide has a devastating impact on society and is a major public health concern.
- There is still a stigma around suicide and a lack of understanding of, and sometimes willingness to prevent it.
- Most suicides are preventable, so every effort should be made to save lives.
- Once a patient experiences suicidal ideation it is imperative that they are referred to the appropriate services, either in the NHS or third sector, as soon as possible.
- Professionals who are likely to encounter people with suicidal ideation must have training and support.
- Parity of esteem includes staff treating people in distress with respect.
- There must be quicker access to the appropriate psychological therapies, particularly for those in secondary care services.
- Improved liaison services in A&E departments would be able to better manage and care for those who present having self-harmed. These aren't problem people but people with problems who deserve to be treated with respect and dignity.

The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.

Statistics

1. Figures published by the Office for National Statistics in 2017 show that the number of completed suicides in Great Britain fell by 3.4% from 5,870 in 2015 to 5,668 in 2016, which is 10.1 per 100,000 population. Approximately three quarters of all suicides are male with the highest rate amongst the 40 – 44 year age group at 15.1 per 100,000. The age group with the highest rate for women is 50 – 54 at 8.1 per 100,000.
2. Every year, approximately 300 people in Wales die from suicide. This figure peaked to 364 in 2012.

Graph 1: The number of completed suicides in Wales, by male and female



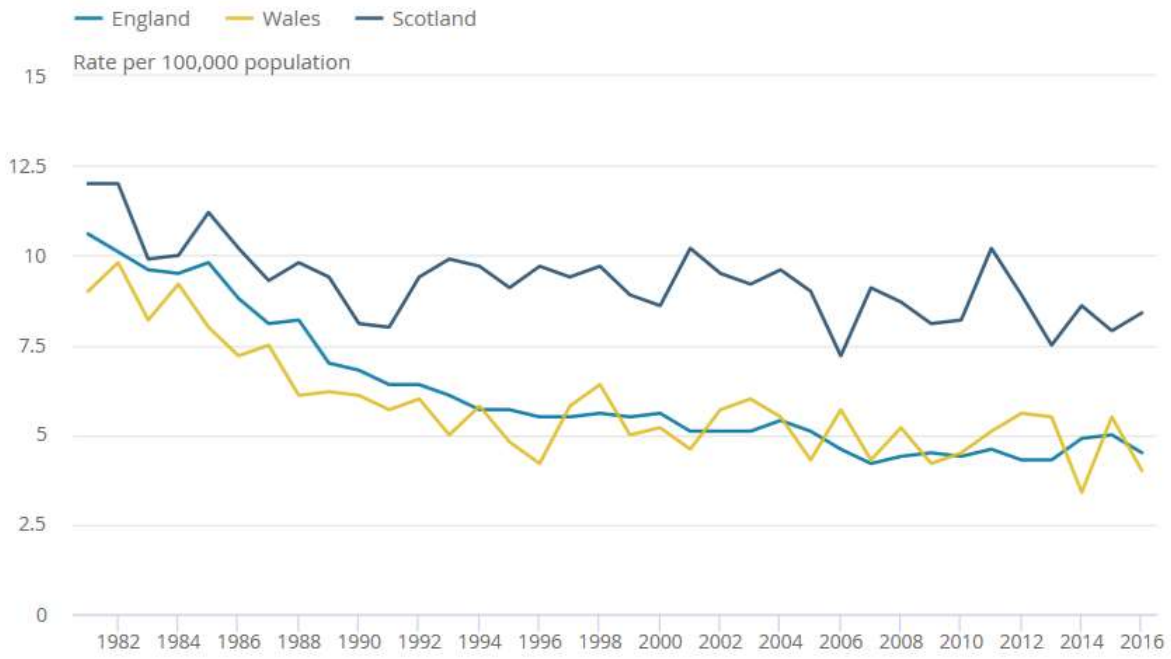
Source: The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

3. The overall rate of suicides has fallen in Wales from 13.0 in 2015 to 11.8 per 100,000 people in 2016; however, this is still higher that the GB average. The lowest rate for Welsh males was in 2008 at 15.1 and the highest was in 2013 at 24.3 suicides per 100,000 males. The figures appear more erratic for Wales and Scotland due to the population size.

Graph 2: The rate of completed suicides in Wales, Scotland and England 1982 – 2016 in men

Source: Office for National Statistics, National Records of Scotland

Graph 3: The rate of completed suicides in Wales, Scotland and England 1982 – 2016 in women



Source: Office for National Statistics, National Records of Scotland

4. During 2005-2015, 28% of suicides in the UK general population were mental health patients, although this figure is slightly higher in Scotland and slightly lower in Wales.[i] This trend has fallen since 2005 and continues to fall but the longstanding downward trend has slowed.
5. Although there is no hard evidence yet to show, there are indications that there could be a rise in completed suicide amongst women between the ages 16 – 34 as they are using more violent means.

Risk Factors

6. There are many reasons why people intentionally take their own lives. Ultimately, suicidal thoughts are triggered by a number of factors that are dependent on an individual's circumstances. However, there are certain factors that increase the risk of attempting or completing suicide.
7. Men are three times more likely than women to complete suicide. This could be attributed to a reluctance to seek help or talk openly about problems that they are experiencing. People suffering from substance and alcohol misuse are much more likely to complete suicide compared with the general population, as are those with psychiatric disorders, particularly those who have recently been discharged from psychiatric inpatient services. (Details of these and other risk factors can be found at Annex A.)
8. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness includes data this year on the less common diagnoses where there is a high prevalence for suicide. These include eating disorders, autism and dementia – all showing a recent rise in rates.

The social and economic impact of suicide.

Social impact

9. Suicide is devastating to those it affects and the impact can be long lasting. Because it is most often preventable, those who are affected by the death of someone through suicide often blame themselves for not having intervened. Their relationship with the suicidal person, their emotional investment in the relationship, often makes it difficult to detect or accept common signs of suicidal behavior.[ii] This impact will resonate within the family and their wider networks, often impacting closer, smaller communities more profoundly. The role of the family in suicide prevention is therefore crucial, albeit very complex.

Economic Impact

10. Suicide has an economic impact as well as a social impact. Depression, which is a major risk factor of suicide, has been identified by the World Health Organisation through the global burden of disease study as one of the leading causes of ill health and economic cost in the developed world. Depression is ranked by WHO as the single largest contributor to global disability (7.5% of all years lived with disability in 2015); anxiety disorders are ranked 6th (3.4%).[iii] The same measures to combat depression will impact on suicide rates.
11. It is important to note that a common factor of suicide is social deprivation. You are at tow to three times increased risk of suicide if unemployed than not. Men in the lowest social class, living in the most deprived areas, are 10 times at greater risk of suicide.[iv]

The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.

Welsh Government

12. Suicide is a major policy issue for Welsh Government in their *Together for Mental Health* strategy, and mental health is one of the five key areas in the Welsh Government's national strategy *Prosperity for All*. There are constructive outcomes in the *Delivery Plan for Together for Mental Health*; however, we would advocate that all individuals discharged from inpatient care to have a first follow up within **three** and not five working days of discharge, given the significant risk of suicide to this group (see Annex A).
13. The Welsh Government has produced guidance on suicide prevention, *Talk to me 2* which uses evidence-based research on suicide prevention, relying on a collaboration of local partnerships. All regions in Wales have developed multi agency suicide prevention forums with agreed local reporting structures, and these report to the National Advisory Group.
14. The College is very supportive of Talk to Me 2 but we are yet to see a strong commitment by some local implementation groups. These groups must take ownership of the Welsh Government's commitment to preventing suicide and it is on the Welsh Government to implement their recommendations, to ensure that local implementation groups are effective.

Public Awareness Campaigns

15. Time to Change Wales has made real strides in reducing the stigma around mental health. We would hope that Phase 3 is continued to be supported particularly as there is a focus on men, the workplace, and developing community hubs across Wales.

Reducing Access to Suicide Means

16. There has been a concerted effort by some organisations to reduce access to suicide means and there are good examples of joint working. The Samaritans have worked with Network Rail on a suicide prevention programme that began in 2010. Since then, they have seen a reduction in the number of suicides to 237, the lowest since the programme began. According the Network Rail 16,000 railway employees have received training to intervene in suicide attempts and in 2016/17 rail employees, the police and public intervened in more than 1,593 suicide attempts on the railway. [v] They, and others, have also put up fencing to reduce access to dangerous areas, such as bridges, and there is the use of the signage with contact details.

The contribution of the range of public services to suicide prevention, and mental health services in particular.

17. Public services have been slow to respond to suicide prevention. Parity of esteem for mental health implies that services treat suicide and the conditions that are predisposed to it with the same attention as they do physical illnesses. Yet we continue to see that some people in distress, who self-harm or threaten suicide can be considered as a nuisance or time and money wasters. What perpetuates this is a lack of understanding around suicide and the stigma that is attached to it. Many, even those working in public services, do not see caring for people in distress as their responsibility.
18. Liaison and mental health crisis services are best equipped to deal with people presenting with suicidal ideation in hospitals and in the community, but these services are not always available. We are pleased that the Welsh Government has invested in liaison psychiatry services across Wales and have developed these in all District General Hospitals, and that the College's Psychiatric Liaison Accreditation Network (PLAN) was adopted in all Emergency Departments. In addition, the College, and others, have signed up to the Crisis Care Concordat to ensure that all public bodies responding to people in crisis work together in the best interest of the individual. Although this is good on paper, we still need to see a commitment from some health boards and more investment in health-based places of safety. We are pleased that the Task and Finish Group that oversees the implementation of local plans will continue to meet and is now an Assurance group.
19. A series of high-profile cases have put suicide on the political agenda and brought it to the forefront of the public's consciousness, which is further helped by a general increase in understanding of mental health and wellbeing.

Education

20. In schools, teachers, counselors, and school nurses should be able to spot early the signs of suicidal ideation. The Samaritans run the DEAL project in schools, providing emotional health lessons in school to increase resilience and improve an individual's ability to cope with difficult situations. We are pleased that it is

now a statutory duty for all secondary schools to have a school counseling service. We are also encouraged that Welsh Government has invested £1.4m in a pilot project in three Health Board Areas to provide dedicated Child and Adolescent Mental Health Support in schools. We would like to see the Donaldson's recommendations taken forward as there is potential for the new curriculum to impact on reducing the risk of suicide in young people and give them the skills that they can take with them into adulthood.

Police

21. The police will come into contact with many people experiencing a mental health crisis requiring immediate support. Although police officers are not mental health professionals per se, in a time of crisis, it may be that the police are the best placed to control a certain situation, in particular where an individual may be violent, aggressive, and a danger to themselves or to others. In other instances, police involvement is unnecessary or even detrimental. The Crisis Care Concordat for Wales was signed by the Local Health Boards and the police to ensure that through collaboration, the use of police cells as a place of safety was reduced. We are concerned that collaboration has not been wholly successful throughout Wales. We also worry that there are no improvements in the provision of health-based places of safety to be used under Section 135 and 136 of the Mental Health Act.

END

Annex A

Factor	Estimated increased risk
Male gender	X 3
Current or ex psychiatric patients	X 10
4 weeks following discharge from psychiatric hospital	X100-200
Prisoners (male and female)	X 5-10
Being a male rather than a female prisoner	X 2
Being married	X 1.5
Accommodated in a single cell	X 9
Life sentence	X 4
Suicidal ideation	X 15
Current psychiatric diagnosis	X 6
Psychotropic medication	X 4
Alcohol misuse	X 3
Self-harm	X 30
In first year following self harm	X 66
Aged over 60 with a more than one episode of self harm requiring hospital treatment	X 49
Those aged over 60	
who have experienced bereavement in the last year	X 3.5
who have life problems associated with accommodation (for example impending move into residential care)	X 5
Socioeconomic deprivation	Not known
Substance misuse	
Drug misuse	X 20
Heroin	X 14
Alcohol	X 6
Prescription drugs	X 20
Prescription drugs and alcohol	X 16
Prescription and illicit drugs	X 44
Schizophrenia	
Previous depressive disorder	X 3
Previous suicide attempts	X 4
Drug misuse	X 3
Agitation or motor restlessness	X 2.5
Fear of mental disintegration	X 12
Poor adherence to treatment	X 4
Recent loss	X 4
Bipolar disorder	X 15
Dysthymia	X 15
Anorexia nervosa	X 23
Anxiety disorders	X 6 -10
Personality disorder	X 7
Physical illness	
Cancer	X1.5 – 4
Neurological disorders	Not known
Renal disease	Not known
Chronic pain	Not known
For men being divorced or separated	X 2
Unemployment	X 2 -3
Family history of suicide	Not known

Source: Public Health Wales (2010) Suicide Prevention – update on the summary of evidence

[i] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester.
[ii] Owens, C. et. al (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study2011;343:d5801
[iii] WHO (2017) Depression and other common mental disorders: Global health estimates.
[iv] Samaritans (2017), Dying by Inequality: Socioeconomic disadvantage and suicidal behaviour, summary report.
[v] https://www.networkrail.co.uk/communities/safety-in-the-community/suicide-prevention-railway/

Agenda Item 4

North Wales Suicide and Self-Harm Prevention Strategic Plan

2018-21

North Wales Suicide and Self-harm Prevention Group

This strategic plan was produced in partnership with:

Contents

Foreword

Every suicide is a tragedy that has a significant impact on family members, friends, colleagues and the wider community long after a person has died. At least ten people are thought to be personally affected by every suicide. There are also large inequalities in suicide and self-harm which should not exist.

In April 2017, Betsi Cadwaladr University Health Board published its mental health strategy which contained a commitment to develop a suicide and self-harm prevention strategic plan. This was followed in July 2017 by national guidance from Welsh Government for local suicide prevention fora which follows in the footsteps of the national strategy *Talk to Me 2*. Our strategic plan for suicide and self-harm prevention has considered national learning, but also builds on practice, experience and expertise within North Wales.

Not only is improving people's mental health a priority for the Together for Mental Health Partnership Board, but it also has a mission to support the whole population's mental wellbeing.

The fact that a majority of people who die by suicide (two thirds) are not in contact with mental health services means that suicide prevention is a shared public health and mental health service priority.

This strategic plan sets out our partnership commitment and action to reduce suicide and self-harm over the next 3 years. No single organisation can do this by themselves; the fact that our strategic plan is endorsed by the NHS, Local Authorities, Police, Network Rail, HM Coroner and Third Sector organisations in North Wales, shows the shared commitment to reduce suicides in the region. This will require a dedicated long-term focus and a commitment to continue to work together so that suicide and self-harm prevention truly becomes everyone's business.

We wish to thank the Betsi Cadwaladr Public Health Directorate for their dedication in leading the partnership in developing this strategic plan, in particular Professor Rob Atenstaedt and Siwan Jones; also Hannah Lloyd and Erica Thomas for their administrative input.

We are all proud to present this strategic plan as the first, important step in reducing suicides and self-harm in North Wales.

Margaret Hanson
Vice Chair, Betsi Cadwaladr University Health Board and Chair of the Together for Mental Health Partnership Board

Teresa Owen
Executive Director of Public Health
Betsi Cadwaladr University Health Board

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Chair of the North Wales Suicide and Self-Harm Prevention Group

2 The wider health and wellbeing agenda around suicide prevention and accountability structure

Suicide and self-harm prevention requires a multi-sectoral approach to ensure joint working across a range of settings. To support the development of this strategic plan the wider health and wellbeing agenda has been considered, seeking to identify the priority placed on mental health, suicide and self-harm prevention.

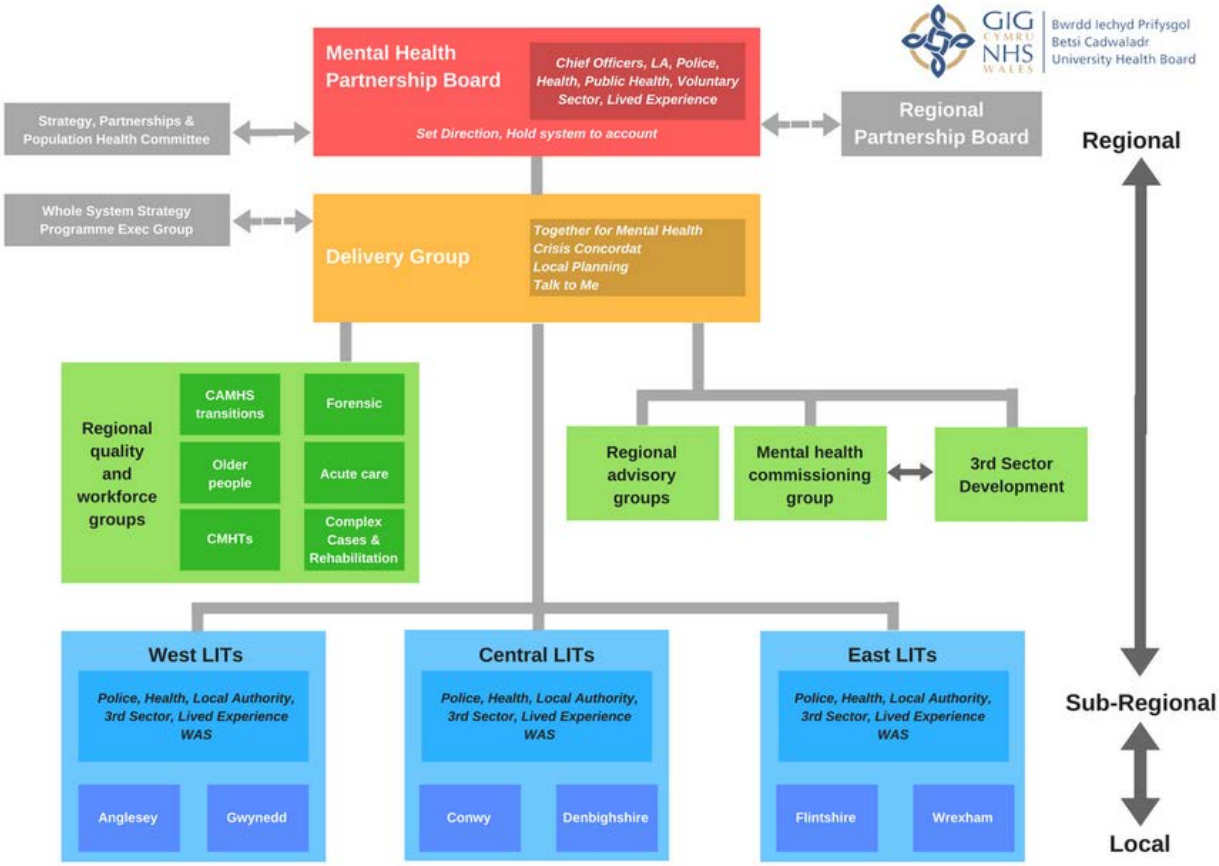
The Mental Health Strategy *Together for Mental Health in North Wales*, ratified by Betsi Cadwaladr University Health Board (BCUHB) in April 2017, is the integrated strategy setting out the direction for mental health and wellbeing services across North Wales encompassing health, social care and the wider partnerships. The strategy confirms the aim to offer a comprehensive range of services which:

- Promote health and wellbeing for everyone, focusing on prevention of mental ill health, and early intervention when required
- Provide evidence based interventions for people with common mental health conditions in the community as early as possible
- Are community-based wherever possible, reducing our reliance on inpatient care
- Identify and provide evidence based care and support for people with serious mental illness as early as possible
- Manage acute and serious episodes of mental illness safely, compassionately, and effectively
- Support people to recovery, to regain and learn the skills they need after mental illness
- Assess and provide effective evidence based interventions for the full range of mental health problems, working alongside services for people with physical health needs.

Figure 1: Together for Mental Health in North Wales – Implementation structure

One of the actions contained in the public mental health section of the strategy is development of a local suicide prevention strategic plan based on national guidance.

The implementation of the action plan to accompany the strategy will be led by a 'Local Implementation Team' (LIT) in each Local Authority area. Figure 1 identifies the implementation and reporting structure around the mental health strategy.



The North Wales Suicide and Self Harm Prevention Group, as one of the Regional Advisory Groups, will report to the Delivery Group which will, in turn, feed up to the Together for Mental Health Partnership Board. The BCUHB *Living Healthier, Staying Well* programme is developing a strategy for health, well-being and healthcare for the Health Board.

There are three overlapping major programmes within the overall portfolio (Figure 2). These are:

- Improving Health and Reducing Inequalities
- Care Closer to Home
- Acute Hospital Care

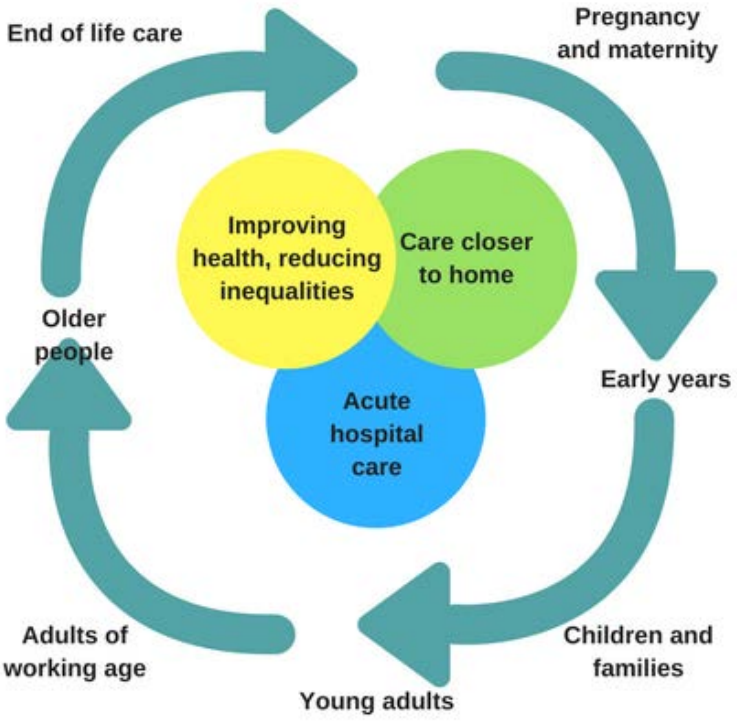
Figure 2: Health and wellbeing – physical, emotional and mental – throughout life

The Social Services and Wellbeing (Wales) Act 2014 emphasises the importance of emotional wellbeing in children and adults and introduces key duties for health boards and local authorities. Furthermore, it aims to ensure greater consideration of issues such as carer's rights, safeguarding and innovative models of social service delivery.

Public Service Boards (PSB) are the key strategic partnership to strengthen joint working and ensure public bodies work collaboratively to improve the economic, social, environmental and cultural well-being of their area. PSB's have been established across North Wales in line with the *Wellbeing of Future Generations Act (Wales) 2015*. The act puts in place a 'sustainable development principle' defined as 'development that meets the needs of the present without compromising the ability of future generations to meet their own needs'. There are five 'ways of working' which public bodies will need to think about to show that the organisation has applied this sustainable development principle.

Each PSB is required to assess the state of well-being across the area as a whole and within its communities to inform the Well-being Plan. The plan must be published by April 2018 and should set out a series of well-being objectives identifying the priorities the PSB has agreed for the area in order to contribute to achieving seven national well-being goals as set out by the Act.

The wellbeing assessment provides an understanding of the assets, challenges and opportunities within each area. Mental health and wellbeing is likely to contribute to the agreed wellbeing objectives, being a fundamental part of our overall wellbeing



3 Suicide and Self-Harm Prevention: Case for Action

3.1 Introduction

In 2015, 64 people died by suicide in North Wales. Suicide is one of the leading causes of preventable death and is the biggest killer of men under 50 years in Wales and England (ONS, 2015).

For every person who dies by suicide, another nine will have attempted suicide. Thus, every suicide reflects underlying levels of poor mental wellbeing in the population of North Wales. Furthermore, every death has a ripple effect within families and communities, resulting in the lives of at least ten others being seriously affected to the extent that they are likely to find it difficult to work, to form relationships and live life to their full potential.

3.2 Policy Drivers for local work on suicide prevention

The Welsh Government Strategy *Talk to Me 2*, sets out the strategic aims and objectives to reduce suicide and self-harm in Wales over the period 2015-2020. It identifies priority care providers to deliver action in priority locations to the benefit of key priority groups, and confirms the national and local action required. The six main objectives of *Talk to Me 2* are:

- Improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self-harm and professionals in Wales
- To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
- Information and support for those bereaved or affected by suicide and self-harm
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
- Reduce access to the means of suicide
- 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

Some of the priority groups that the strategy targets include: men in mid-life; older people over 75 years with depression and co-morbid physical illness; children and young people with a background of vulnerability; people in mental health services; people with a history of self-harm; priority care providers; police; firemen; Welsh Ambulance staff; primary care workers; emergency department staff.

Some of the priority places and settings that the strategy targets include: hospitals, prisons, police custody suites; workplaces, schools, further and higher education establishments, primary care facilities, emergency departments, rural areas and deprived areas.

Together for Mental Health, published in 2012, is a 10-year Welsh Government Strategy to improve the mental health and wellbeing of all people in Wales using mental health services as well as their families. The Strategy is based on the principle of co-production which is the belief that people who use services are experts in their own lives.

The National Institute for Health and Care Excellence (NICE) is currently developing guidance on preventing suicide in community and custodial settings (PHG95) with an expected publication date of September 2018. The guideline will cover children and young people and adults, with specific consideration given to priority groups. Guidance has previously been published on self-harm in over 8 year olds: short-term management and prevention of recurrence (CG16) and long-term management (CG133). There are also a number of pieces of guidance published on related issues such as depression in adults: recognition and management (CG90), looked after children and young people (PH28), and mental health of adults in contact with the criminal justice system (in development).

3.3 Risk factors for suicide

Risk factors for suicide include male gender, those aged 35 – 49 years, a history of self-harm, people in the care of mental health services, being transgender, those with one or more long term physical health conditions, a family history of suicide, a history of childhood abuse and trauma, redundancy and living with material deprivation, those with relationship problems and people in contact with the criminal justice system. However, this list is not exhaustive.

There is a regular review of suicide by people known to mental health services - the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The Inquiry report refers to ‘patient suicides’ as those that occur within 12 months of mental health service contact. The most recent report (Appleby et al, 2016) covers the period 2004-2014.

This reported that across Wales, 23% of all suicides were identified as patient suicides; in total there were 63 in-patient deaths by suicide in Wales in 2004-2014, an average of 6 per year. There was an increase in the number of patient suicides between 2004 and 2013 with a large rise in 2012 and 2013. The most common methods of suicide by patients were hanging (47%), self-poisoning (24%) and jumping (10%). The most common primary diagnoses were affective disorders (42%), schizophrenia (16%) and alcohol dependence/misuse (10%).

At least half of people who die by suicide have a history of self-harm, and one in four have been treated for self-harm in hospital in the past year (Department of Health, 2012). The risk of suicide is highest in people who repeatedly self-harm and who have used violent or dangerous methods. Research has shown that nurses, doctors, farmers/agricultural workers and veterinary workers are all at higher risk of suicide which may be related to their ready access to the means of suicide and knowledge of how to use them (Department of Health, 2012).

Military veterans are another occupational group at risk. Kapur et al (2009) analysed the demographic data of 224 veterans who had died by suicide between 1996 and 2005. The risk of suicide was greatest for males, those who had served in the army, those with a short length of service, and those of lower rank. Although the overall rate of suicide was no greater than in the general population, the risk of suicide in male veterans aged 24 years and younger was about two to three times higher than the risk for the same age group in the general population.

Importantly, the rate of contact with specialist mental health was lowest in the age groups at greatest risk of suicide, suggesting that needs are not being met. The reasons behind this population's vulnerability to suicide are not clear, but the researchers suggested that this might include:

- Finding the transition back to civilian life more difficult
- Being adversely affected by service-related experiences
- Having a pre-service vulnerability which has not been addressed

With males in this age group known to be particularly reluctant to seek help, as well as the fact that they may not even identify themselves as veterans, this sub-group may be particularly vulnerable.

Fear et al (2010) backed up these findings by reporting that the overall suicide rate is no higher in UK ex-service personnel than it is in the UK general population; ex-service men aged 24 years or younger are, however, at an increased risk relative to those in the general population of the same age.

People in contact with the criminal justice system also have a higher risk of suicide than the general population (Suffolk CC, 2016). People are at highest risk in their first week of imprisonment. North Wales has one new prison (HMP Berwyn) and fortunately there have not been any deaths by suicide since it opened. No data was available for suicide in other forms of custody in North Wales. Prison health, including mental health, is the responsibility of BCUHB.

It is widely recognised that other factors and life experiences may place individuals at higher risk of suicide. These can include: chronic pain or disability; job loss and unemployment leading to socio-economic disadvantage; family breakdown and relationship conflict, financial difficulties, and social isolation (Suffolk CC, 2016). Living with a long term physical health condition, including cancer, heart failure, HIV/Aids, Traumatic Brain Injury, COPD, chronic pain, renal disease, diabetes, and sleep disorders, is associated with higher risk of suicide (Ahmed *et al*, 2017).

Alcohol or drug abuse is strongly associated with suicide risk, particularly in individuals who also experience poor mental health (known as dual diagnosis).

Other groups of people who may have higher rates of mental ill-health (although detailed data on suicide rates is lacking) include survivors of abuse or violence, members of minority ethnic groups, and children who are especially vulnerable such as looked after children, care leavers, and children in the youth justice system. It is also recognised that members of the LGBT+ community are at increased risk of suicide (Department of Health, 2012).

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. Suicide is a leading cause of death for women during pregnancy and in the year after giving birth (MBRRACE-UK, 2015).

Adverse childhood experiences (ACEs), including exposure to child abuse and neglect, are well documented risk factors for suicidality (Ports et al, 2017). Cymru Well Wales has committed to addressing ACEs and their impact in Wales by making all public services in Wales able to respond effectively to prevent and mitigate the harms from ACEs, and by building protective factors and resilience in the population to cope with ACEs that cannot be prevented.

3.4 Suicide data for BCUHB

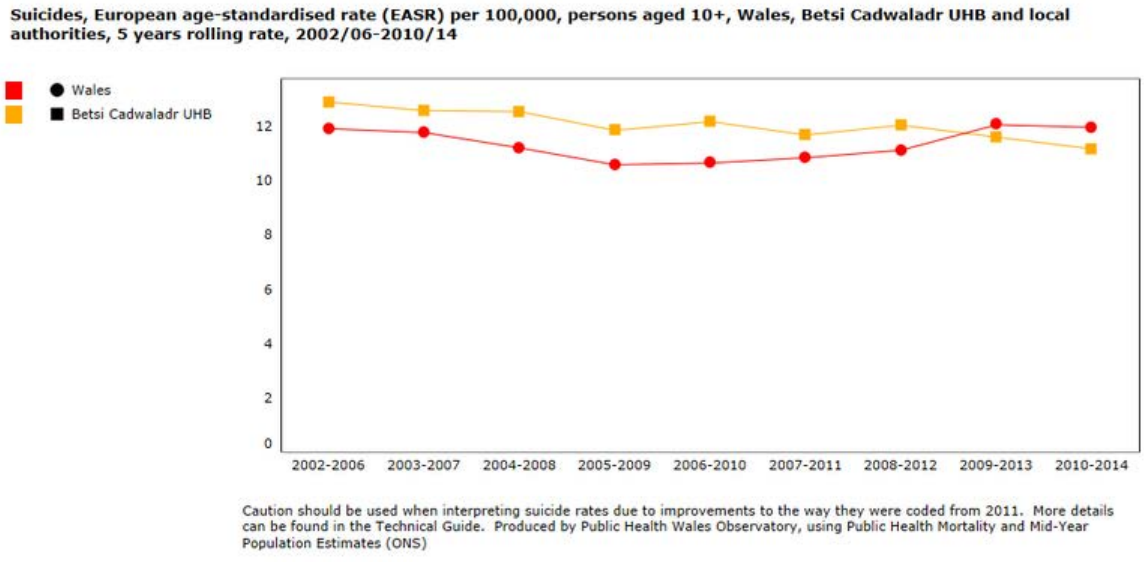
It is commonly acknowledged by those working in the field of suicide research that official statistics underestimate the 'true' number and rate of suicide. For example, a perceived stigma attached to reporting a death as suicide may lead to under-reporting. In the UK, part of the solution to under-reporting has been to include 'deaths of undetermined intent' within the official statistical category of suicide.

This tries to correct for known under-reporting and is thought to produce a more accurate total (and rate) of suicide in a given year. In summary, deaths from suicide are identified from death registrations where the cause is given as from self-harm, or from 'event of undetermined intent'. Fortunately, as we have seen, the number of people in BCUHB each year who die by suicide is relatively low. Due to the low numbers of suicides it is important to:

- Use suicide rates per 100,000 people. Using numbers can give a misleading picture when considered alone.
- Not consider increases or decreases for a year at a time in isolation. Five-year rolling averages have been used for monitoring purposes, in preference to single-year rates, in order to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.
- Due to concerns related to the identification of local individuals, numbers less than 5 are not presented within this document.

Figure 3 shows how rates of suicide in BCUHB compare to Wales rates over time. Suicide rates are presented as number of deaths per 100,000 people of all ages, and are given as five-year averages to 'smooth out' variations in the data given the relatively small number of deaths each year. It can be seen that the suicide rate in BCUHB was higher than the Welsh average between 2002-2006 and 2008-2012, but in 2009-2013, it crossed over and became lower than the Welsh average.

Figure 3: BCUHB and Wales



Similar data for the three areas – West, Central and East is shown in Figures 4, 5 and 6.

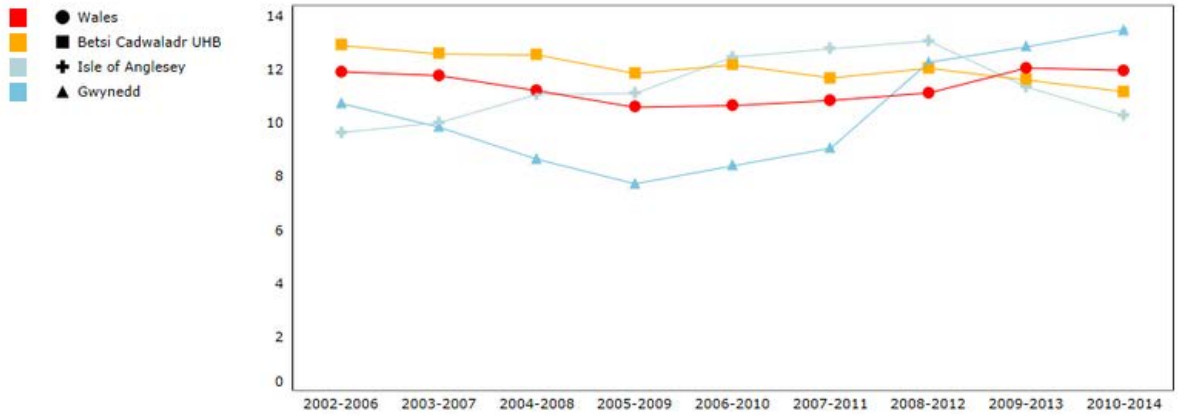
In the West, Anglesey's suicide rate seems to have gradually increased between 2002-2006 and 2008-2012 but since then has fallen back to be lower than BCUHB and Wales. Gwynedd has historically been lower than BCUHB and Wales, but since 2008-2012 has been higher.

In the Central Area, both Conwy and Denbighshire have historically had higher rates of suicide than BCUHB and Wales. However, there has been a decline in the suicide rate in Conwy, which now lies below that of BCUHB and Wales; Denbighshire is now similar to the BCUHB rate.

In the East Area, the suicide rate in Flintshire has declined over the period, and largely remained below the BCUHB and Welsh averages. Wrexham started off below the BCUHB and Wales rates, went above it for a number of years, but has now dropped below again.

Figure 4: West Area

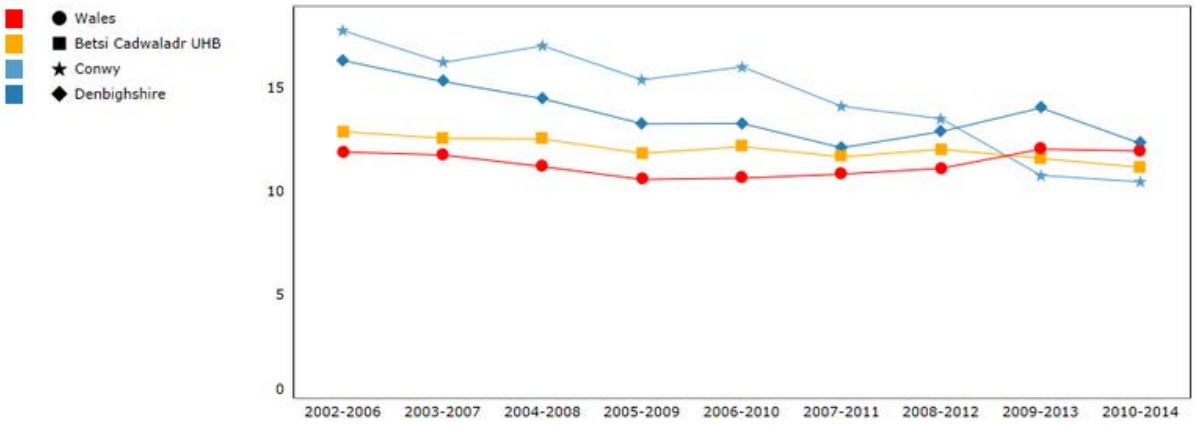
Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales, Betsi Cadwaladr UHB and local authorities, 5 years rolling rate, 2002/06-2010/14



Caution should be used when interpreting suicide rates due to improvements to the way they were coded from 2011. More details can be found in the Technical Guide. Produced by Public Health Wales Observatory, using Public Health Mortality and Mid-Year Population Estimates (ONS)

Figure 5: Central Area

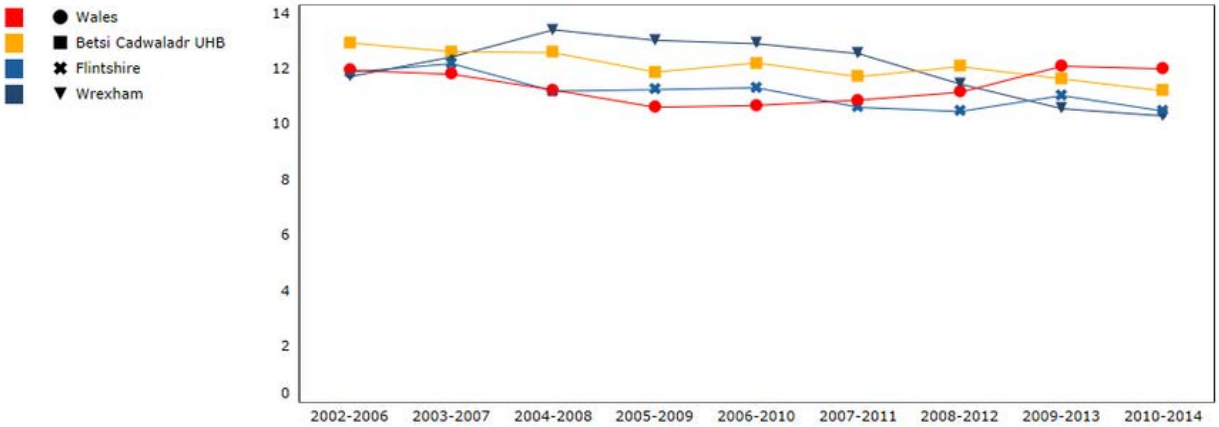
Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales, Betsi Cadwaladr UHB and local authorities, 5 years rolling rate, 2002/06-2010/14



Caution should be used when interpreting suicide rates due to improvements to the way they were coded from 2011. More details can be found in the Technical Guide. Produced by Public Health Wales Observatory, using Public Health Mortality and Mid-Year Population Estimates (ONS)

Figure 6: East Area

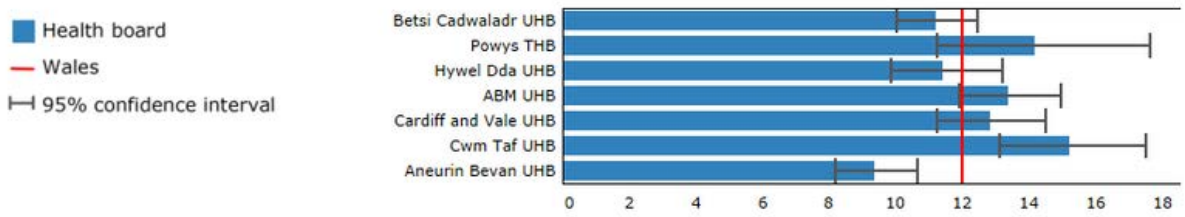
Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales, Betsi Cadwaladr UHB and local authorities, 5 years rolling rate, 2002/06-2010/14



Caution should be used when interpreting suicide rates due to improvements to the way they were coded from 2011. More details can be found in the Technical Guide. Produced by Public Health Wales Observatory, using Public Health Mortality and Mid-Year Population Estimates (ONS)

Figure 7

Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales and health boards, 2010-2014

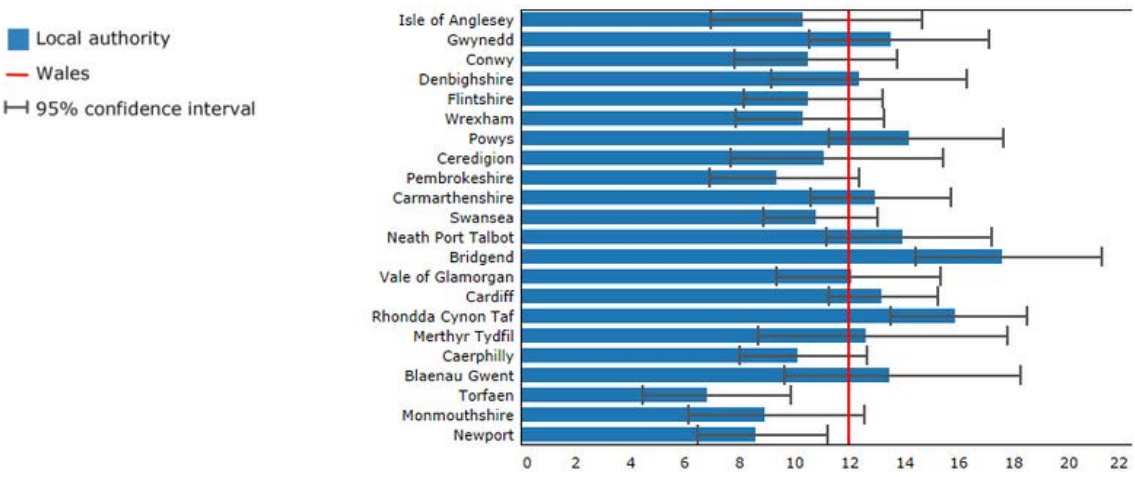


Caution should be used when interpreting suicide rates due to improvements to the way they were coded from 2011. More details can be found in the Technical Guide. Produced by Public Health Wales Observatory, using Public Health Mortality and Mid-Year Population Estimates (ONS)

In the most recent years (the five calendar years 2010-14), Figure 7 shows that the rate of suicide in BCUHB is not statistically significantly different from the Wales rate as a whole. In terms of the individual Unitary Authorities (UAs), Figure 8 shows that none of the North Wales UAs are statistically significantly different from the Welsh average.

Figure 8

Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales and local authorities, 2010-2014



Caution should be used when interpreting suicide rates due to improvements to the way they were coded from 2011. More details can be found in the Technical Guide. Produced by Public Health Wales Observatory, using Public Health Mortality and Mid-Year Population Estimates (ONS)

The overall rate of suicide for all persons hides considerable differences between the rates for men and women in Wales. Male suicide rates are nearly three times higher than female rates, and this has been a consistent pattern. The latest data for 2014 gives a rate of 11.1 deaths by suicide per 100,000 men, and for women the rate is 4.4 per 100,000 in Wales (Appleby et al, 2016).

The gender differences in suicide are important and need to be considered. There have been suggestions that this is due in part to the changing nature of society but records suggest that across England male suicides have been considerably higher than female suicides since the 1860s, with the male to female ratio fluctuating from 4:1 in the 1880s to 1.5:1 in the 1960s (Thomas & Gunnell, 2010).

As part of the preparation in writing this strategic action plan, the BCUHB Public Health Directorate carried out a 'suicide audit' which reviewed ONS data on 741 suicides that were registered between 2006 and 2015 (calendar years) and occurred in BCUHB or were by BCUHB residents elsewhere in the UK. This was compiled using the strict ONS classification for suicide.

In North Wales over the registration period 2006 and 2015 (calendar years), 580 recorded suicides out of 741 (78%) were in males and 162 in females (22%) (Source: ONS). Suicide also varies with age. Figure 9 shows that age distribution of the 741 suicides (Source: ONS). It can be seen that the greatest proportion is in those aged 40-49 years.

Rates of suicide also vary with age in BCUHB and across Wales. Figure 10 shows that the rate of death by suicide climbs from a relatively low rate of deaths in young people aged 10-24 and peaks in the age band 25-64. There are no statistical differences between the UAs in North Wales.

Figure 9

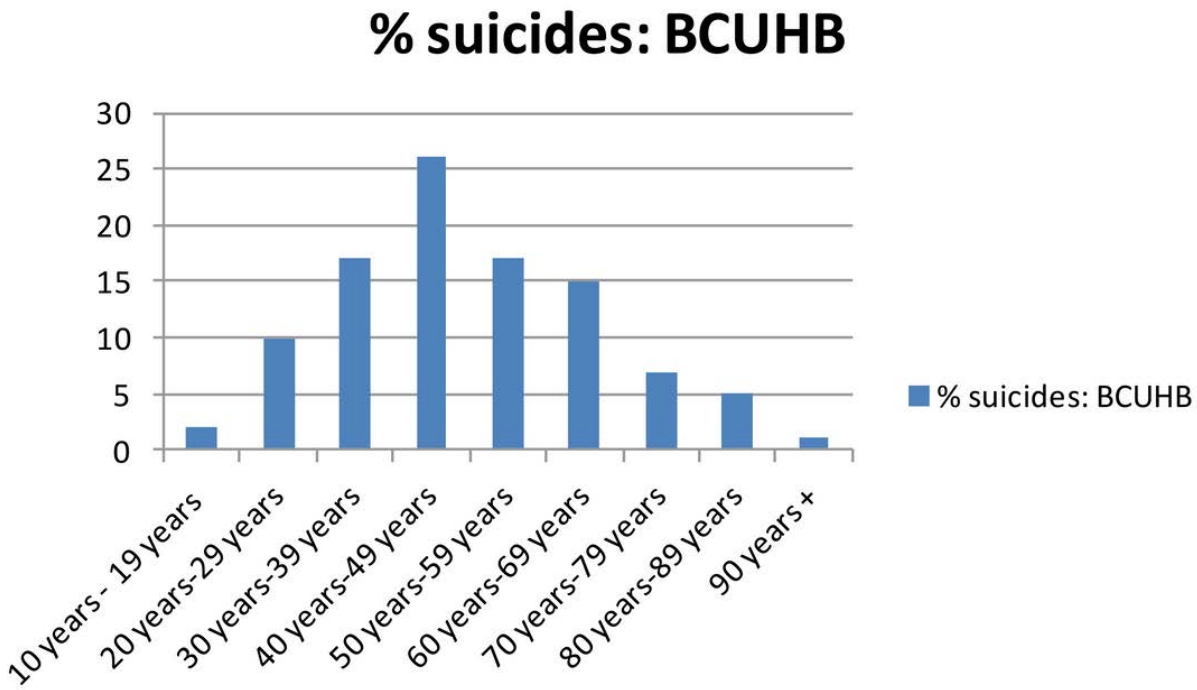
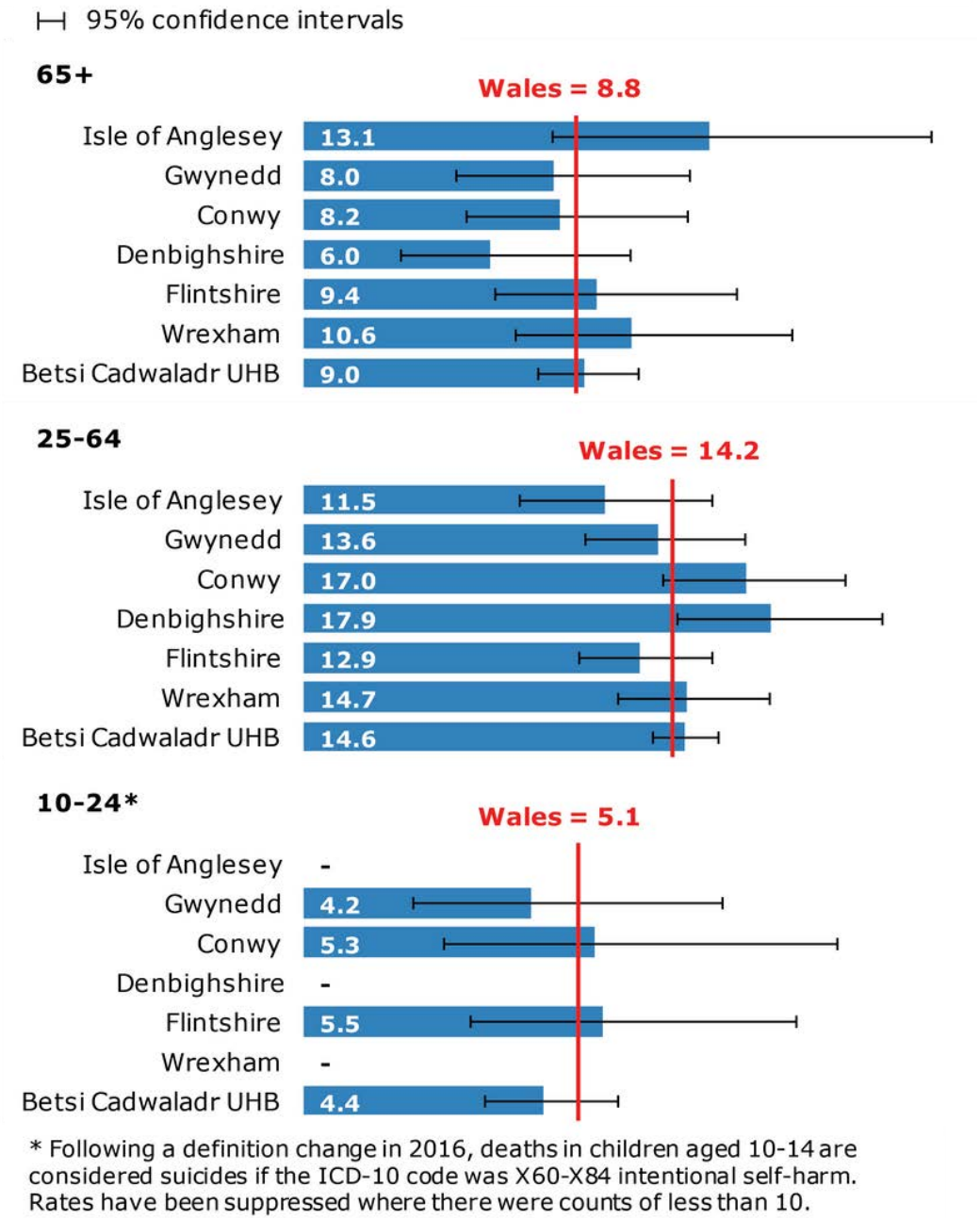


Figure 10

Suicides, age-specific rate per 100,000, persons aged 10 & over, Betsi Cadwaladr UHB and Wales, 2005-14
Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



* Following a definition change in 2016, deaths in children aged 10-14 are considered suicides if the ICD-10 code was X60-X84 intentional self-harm. Rates have been suppressed where there were counts of less than 10.

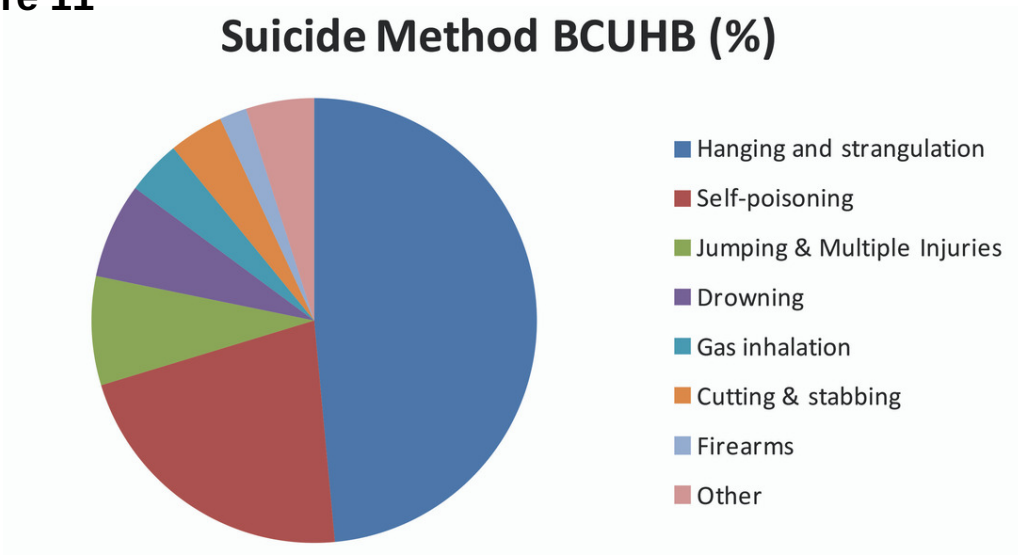
Suicide is a significant equality issue as there are marked differences in the suicide rates according to people's socio-economic backgrounds (John, Glendenning & Price, 2017). *Talk to Me 2* highlights that improving the mental health of people who are vulnerable due to these circumstances supports suicide prevention.

3.5 Suicide Methods in BCUHB and Wales

According to the *National Confidential Inquiry into Suicide*, the most common methods of suicide in Wales in 2004-14 were hanging and strangulation (53%) and self-poisoning/overdose (20%) (Appleby et al, 2016). Less frequent methods were jumping and multiple injuries (mainly jumping from a height or being struck by a train) (7%), drowning (5%), gas inhalation including carbon monoxide poisoning (3%), cutting and stabbing (3%), and firearms (2%).

The equivalent figures for BCUHB based on ONS data are: hanging and strangulation (49%), self-poisoning (22%), jumping and multiple injuries (8%), drowning (7%), gas inhalation (4%), cutting and stabling (4%), firearms (2%) and other (5%), illustrated in Figure 11 below. (Source: ONS)

Figure 11



3.6 Suicide Locations in BCUHB

Most deaths in BCUHB take place at home. However, of the 741 suicides that were registered between 2006 and 2015 (calendar years) and occurred in BCUHB or were by BCUHB residents elsewhere in the UK, four specifically mention the Menai Bridge as a location (Source: ONS). However, there were additional four suicides where the “Menai Straits” were given as a location without reference to a specific landmark, some of which may be associated with the Menai Bridge. Another place in North Wales which stood out as locations for completed suicides was Pontcysyllte Aqueduct with eight suicides recorded in the same time period.

3.7 Suicide and Healthcare in BCUHB

Complete data is not available to identify how many BCUHB residents who took their own lives were mental health service users. There were a number of suicides recorded at the three acute hospitals in North Wales - 63 overall - registered between 2006 and 2015 (calendar years) according to the ONS figures. However, 92% of these were people who died in hospital after being conveyed there after an episode of self-harm or injury elsewhere. More data is available on health care use and suicide from a national perspective, given previously.

3.8 Suicide in Children and Young People

Deaths by suicide in children and young people are thankfully rare in North Wales, although these cases are more likely to receive media coverage. In young people, bullying, family factors, social isolation and academic pressures all increase the risk of suicide. Across Wales, the suicide rate in teenagers is lower than that in the general population, although self-harm is more common.

ONS data on 741 suicides that were registered between 2006 and 2015 (calendar years) and occurred in BCUHB or were by BCUHB residents elsewhere in the UK identified 17 suicides in people aged 14-19 (2.3%) and 35 deaths in people aged 20-24 (4.7%) (Source: ONS). 43 of these 52 deaths were in males (83%).

Improving the mental health of children and young people, including looked after children, care leavers and children and young people in the youth justice system is crucial to reducing deaths by suicide. Evidence shows that suicide is one of the main causes of death in young people and for families its impact is particularly traumatic.

The Thematic Review of Deaths of Children and Young People through Probable Suicide, 2006-2012 (Public Health Wales, 2014) identified a number of key recommendations for Wales.

3.9 Suicide Clusters

Guidance from Public Health England states: ‘The term “suicide cluster” describes a situation in which more suicides than expected occur in terms of time, place, or both. A suicide cluster usually includes three or more deaths; however, two suicides occurring in a specific community or setting and time period should also be taken very seriously in terms of possible links (or contagion), particularly in the case of young people. It is important to establish at a very early stage if there are connections between them.’ (Public Health England, 2015)

The guidance also describes particular groups as being especially vulnerable to clusters/ contagion, namely young people, people with mental health conditions, and prisoners. People who identify psychologically with individuals who have taken their own lives may be affected by contagion, especially if they are already vulnerable. The guidance suggests that the media’s role is very important in prompting the development of suicide clusters (Public Health England, 2015).

It could be considered that suicides by falling from the Menai Bridge and Pontcysyllte Aqueduct form a cluster, given the number of deaths in both these locations, and the public and media perception of these places as high frequency locations for suicide. The Public Health England guidance states that suicide prevention plans should include a suicide surveillance group to identify possible clusters, and a community action plan for responding to clusters (Public Health England, 2015). This needs to be considered in the development of this strategic plan.

3.10 Self-Harm

NICE give a formal definition of self-harm as "..any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself." (NICE, 2013)

On a national level, according to the 2014 *Psychiatric Morbidity Survey*, the proportion of the population who reported having self-harmed increased from 2.4% and 3.8% of 16 to 74 year olds in 2000 and 2007, to 6.4% in 2014 (McManus *et al*, 2014). This increase is evident in both men and women and across age-groups. It notes that greater awareness of self-harming is probably a factor in the increased reporting. In addition, about one in four 16 to 24-year-old women reported having self-harmed at some point; about twice the rate for men in this age group and women aged 25 to 34 years.

The gap between young men and young women has grown over time. Self-harm in young women mostly took the form of self-cutting. The majority reported that they did not seek professional help afterwards.

A recent systematic review and meta-analysis (Carroll, Metcalfe & Gunnell 2014) estimated that 16% of people who present at hospital with deliberate self-harm re-present with self-harm within 12 months. Fatal self-harm occurred within 12 months of the index presentation in 2.7% of males and 1.2% of females.

Older age, first index presentation of non-poisoning self-harm and as well as being male increased the risk of fatal self-harm within 12 months. This information offers indications of whom to target for self-harm reduction interventions.

Primary Care Practice data (Carr *et al*. 2016) indicate that self-harm is more prevalent in Wales, Scotland and Northern Ireland than in England and that deprivation is associated with increased levels of self-harming.

NICE (2013) have produced a list of quality standards that cover the initial management and longer-term support for children (8-18 years) and adults (18 years and over). These can help guide the provision of care aiming to prevent self-harming behaviour. They include the following quality statements:

- People who have self harmed are cared for with compassion and the same respect and dignity as any service user.
- People who have self harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.
- People who have self harmed receive a comprehensive psychosocial assessment.
- People who have self harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self harm.
- People who have self harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self harm.
- People receiving continuing support for self harm have a collaboratively developed risk management plan.
- People receiving continuing support for self harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self harm.
- People receiving continuing support for self harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

3.11 Suicide Attempts

Since 2000 there has been a slight increase in the reporting of suicide attempts, but only among women (0.5% in 2000, 1.0% in 2007). Particular subgroups have experienced more pronounced increases over time. For example, people aged 55 to 64 suicidal thoughts (2.1% in 2000; 4.9% in 2014) and suicide attempts (0.1% in 2000; 0.6% in 2014) at least doubled in rate since 2000. This was evident both in men and women.

Some groups in the population were more likely than others to report these thoughts and behaviours, such as those who lived alone or were out of work (either unemployed or economically inactive). Benefit status identified people at particularly high risk: two-thirds of Employment and Support Allowance (ESA) recipients had suicidal thoughts (66.4%) and approaching half (43.2%) had made a suicide attempt at some point.

Overall, half of people who attempted suicide sought help after their most recent attempt. About a quarter sought help from a GP, a quarter went to a hospital or specialist medical or psychiatric service, and a fifth tried to get help from friends or family. Men and women were equally likely to seek help after a suicide attempt. Older people were more likely to seek help from a hospital or specialist medical or psychiatric service than younger people; the latter were more likely to turn to family and friends. Using GPs as a source of support following a suicide attempt was equally common across age-groups.

3.12 Bereavement by Suicide

The family and friends of someone who dies by suicide are at increased risk of poor mental health and emotional distress. Partners bereaved by suicide are at an increased risk of suicide themselves, as are mothers who lose an adult child to suicide. Children bereaved by a parent's suicide are at increased risk of depression, alcohol or drug misuse, Post Traumatic Stress Disorder, and their own risk of suicide is increased (Penny and Stubbs, 2015; Pitman *et al* 2014). These risks are additional to the risks associated with bereavement from non-suicide deaths.

The evidence suggests that specialist bereavement counselling and support can be helpful for people, although the efficacy has not been well demonstrated to date (Department of Health, 2012). Specialist support for suicide bereavement is offered by the charity SOBS (Survivors of Bereavement by Suicide).

3.13 Effective Prevention of Suicide and Self-harm

An awareness of the evidence around effective suicide and self-harm prevention is important to inform this strategic plan and the development of the action plan.

Evaluating suicide prevention approaches is challenging because suicide is a rare outcome that is affected by many factors, and research often relies on 'proxy' outcomes that are more common, such as suicidal ideation.

The Public Health Wales Observatory Evidence Service has produced an evidence map to inform the development of local suicide and self-harm prevention plans in Wales (Public Health Wales Observatory, 2017). It summarises research evidence that addresses the question: "What interventions might be effective in reducing rates of suicide, self-harm and suicide ideation in Wales"?

Included sources were limited to NICE and NICE accredited guidelines and systematic reviews produced using a robust methodology adhering to systematic review principles. Sources have not been critically appraised by the evidence service. Where evidence included in NICE guidance was duplicated in retrieved systematic reviews only the NICE guidance has been included. Some additional sources that may be useful in informing the development of local suicide prevention plans have also been included.

These include high level sources such as published systematic reviews or evidence syntheses/statements/guidelines from recognised (e.g. expert body) sources. The evidence map covers:

- **Primary prevention**
- **Screening and assessment tools**
- **Management of self-harm and suicide**
- **Mental healthcare**
- **Specific populations**
- **Others**

3.14 Potential Return on Investment for Suicide Prevention Interventions

The economic cost of each death by suicide for those of working age is estimated to be £1.67 million at 2009 prices (John, Glendenning & Price, 2017). This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering. It is estimated that at least ten people are ultimately affected by every suicide.

If we assume that 85% of the 64 suicides (=54) that occurred in BCUHB in 2015 are of working age, this means a potential cost to North Wales of about £90m per annum. If an area-wide suicide prevention intervention were to achieve only a modest 1% reduction rate in the number of suicides, there would be a saving of almost £1m per annum.

There is good evidence that public mental health interventions deliver large economic savings and benefits. Improved mental health leads to both direct and indirect savings in health service costs e.g. reduced use of primary care and mental health services, improved physical health and reduced use of alcohol and tobacco. Improved mental health also leads to savings in other areas: reduced sickness absence and reduced spending in education, welfare and criminal justice, as well as increasing the overall economic benefits of wellbeing for individuals and families.

An influential report (Department of Health, 2011) found that for every £1 invested, the net savings were:

- **£84 saved – school-based social and emotional learning programmes**
- **£44 saved – suicide prevention through GP training**
- **£18 saved – early intervention for psychosis**
- **£14 saved – school-based interventions to reduce bullying**
- **£10 saved – work-based mental health promotion (after 1 year)**
- **£10 saved – early intervention for pre-psychosis**
- **£8 saved – early interventions for parents of children with conduct disorder**
- **£5 saved – early diagnosis and treatment of depression at work**
- **£4 saved – debt advice services**

The London School of Economics (LSE) used the Clifton suspension bridge in Bristol as a case study for an economic model of the impacts of installing a barrier at a cluster location (LSE, 2011). In this case the barrier cost £300,000 to install and halved the number of suicides from eight to four in the 5 years before and after installation. The cost savings were estimated at £44 million over a 10-year period. Even if there had been displacement to other locations or means the cost savings still reached £40 million.

4 Aims and Objectives for the Plan

These follow the aims and objectives of *Talk to Me 2*.

The overall aim of the *North Wales Suicide and Self-Harm Prevention Strategic Plan* is to reduce suicide and self-harm in the general population in North Wales.

The six objectives are as follows:

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

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

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

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

Objective 5: Reduce access to the means of suicide

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

5 Monitoring the Plan

According to guidance issued by the National Advisory Group to Regional Fora on local suicide and self-harm prevention planning (John, Glendenning & Price, 2017), an appropriate monitoring process is required to track the progress of every local plan.

The ultimate aim of these plans is to see a reduction in the number of suicides on a local basis. However, the guidance acknowledges that suicide is a rare enough occurrence to make it difficult to measure a change in rates, particularly at a local area level.

As a result, in addition to the local suicide rate, other proxy indicators can be considered. National guidance notes that there is growing evidence to support using self-harm as an outcome measure for suicide prevention work, such as hospital presentation following self-harm. The caveat around this data source is that admissions at hospital for self-harm will result from a wide range of actions, many of which were not intended to cause death.

In view of this, we propose to monitor three indicators:

- Number of self-harm emergency admissions, Betsi Cadwaladr University Health Board (Figure 12 shows the baseline)
- Reported incidents of self-harm on NHS sites, Betsi Cadwaladr University Health Board (Figure 13 shows the baseline)
- Number of recorded suicides, Betsi Cadwaladr University Health Board (Figure 14 shows the baseline)

It is also important to note that the low numbers of suicides in BCUHB can result in large random fluctuations in the suicide rate without showing a statistically significant change. Small alterations in the way that data is collected and external environmental factors such as economic conditions can also have a large impact on the rate. There are also likely to be long timeframes between implementation of interventions designed to reduce the rate and any impact seen. Figure 14 shows the results chain for the monitoring work required around this strategic action plan.

Figure 12

Number of self-harm emergency admissions, Betsi Cadwaladr University Health Board & Areas, January 2014 to June 2016
Source: BCUHB Information Department

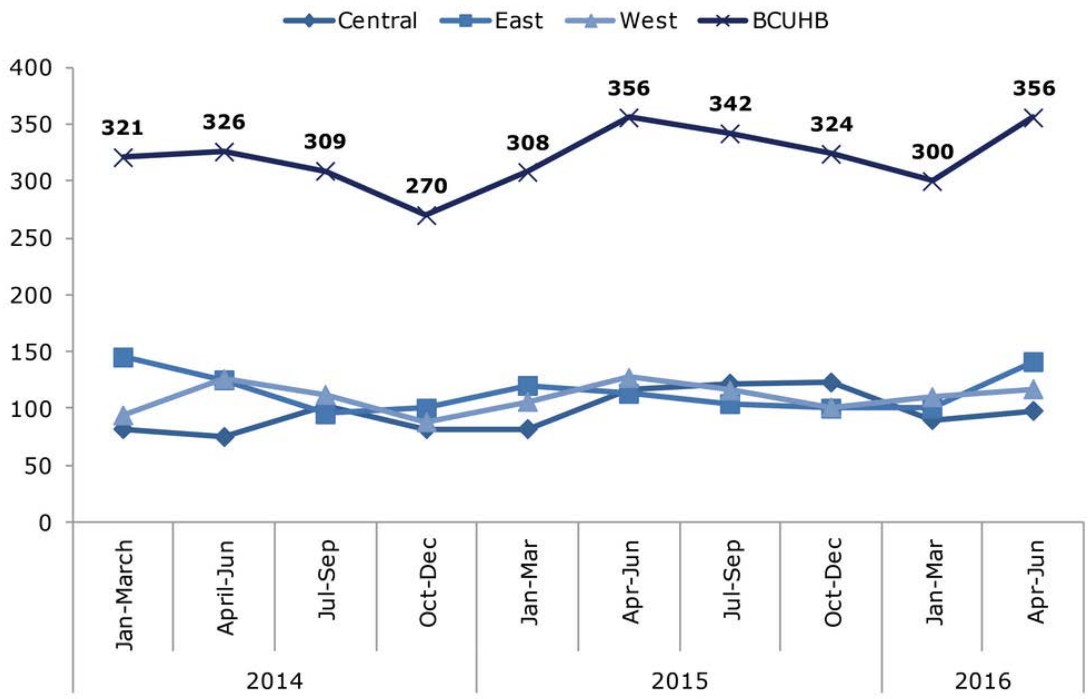


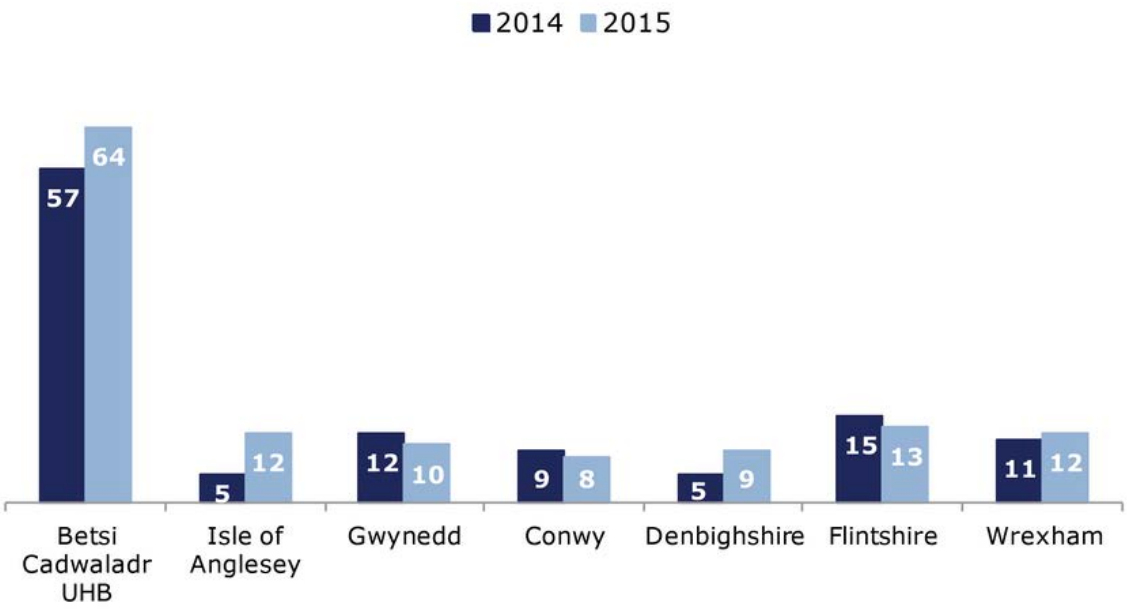
Figure 13

Reported incidents of self-harm (including deaths) on NHS sites, Betsi Cadwaladr University Health Board, October 2013 to March 2016
Source: NRLS

Figure 14

Number of suicides [a], all persons [b], Betsi Cadwaladr University Health Board and local authorities, 2014 - 2015

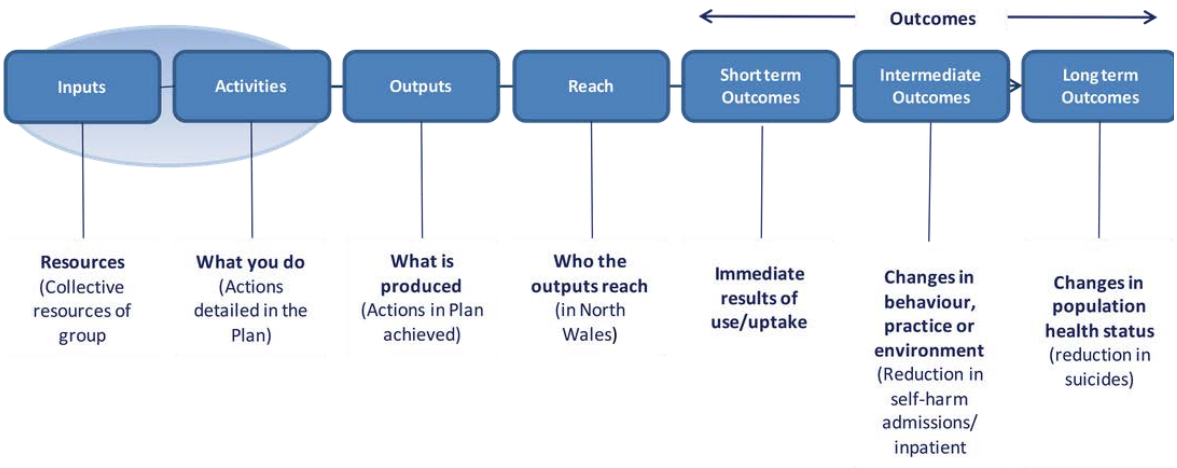
Source: Office for National Statistics



a. Figures are for deaths registered, rather than deaths occurring in each calendar year. Deaths of non-residents are excluded.
b. Persons aged 10 years and over.

Figure 15

Results chain for North Wales Suicide and Self-Harm Prevention Strategic Plan



Adapted from figure produced by NHS Scotland

6 Engagement

We consult or engage when we need or want information from another's perspective, in order to make decisions or plan ahead. But before we jump in and start planning to engage we need to consider:

- Does this particular decision or service change require a consultation or engagement process? Will it make a difference? If the answer is no, then there is no point in doing it.
- Do we or someone we know already have this information, perhaps from another survey or performance indicator? If so, is it available to you to use?
- Is there any other exercise in preparation locally for the same audience and is there an opportunity to pool resources and work together?

There are many different types of consultation / engagement that are often undertaken including a statutory obligation, when organisations have a legal duty to consult or a policy commitment, when a particular service provider has its own clear policy to consult or engage on particular issues.

There is also discretionary engagement, when engagement may be considered by services in order to learn from the experience of others, to confirm stakeholders' priorities, or simply communicate change and collect views. Due to the prescriptive nature of the North Wales Suicide and Self-Harm Strategic Plan (e.g. Welsh Government has set the strategic aims and objectives to prevent and reduce suicide and self-harm in Wales and national guidance has provided the framework for the plan), it has been agreed that the engagement approach should fall under this discretionary level.

The North Wales Suicide and Self-Harm Prevention Strategic Plan sits under the umbrella of the Health Board’s Mental Health Strategy. A substantial amount of stakeholder and service user engagement was carried out as part of the development of this and the feedback from this engagement has informed not only the wider strategy, but also the suicide and self-harm prevention strategic plan. In addition, a detailed review of best practice across the UK has been undertaken, again helping to inform and shape the plan.

Most importantly, the plan has been developed by a multi-agency group working closely with Caniad, who are the combined voice for mental health and substance misuse involvement in North Wales. Taking this into account, once the plan has been signed off by the appropriate bodies in North Wales, a workshop will be held to launch the plan and give an opportunity for key stakeholders and service users to engage with the areas of particular focus and actions being taken forward within the plan.

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Images: Shutterstock and Welsh Ambulance Services NHS Trust

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Appendices

9.1 Delivery Plan

North Wales Suicide and Self-Harm Prevention Delivery Plan

The action plan has been developed by a sub group of the North Wales Suicide and Self Harm Prevention Group in response to the strategic objectives within the *Talk to Me 2* – Suicide and Self Harm Prevention Strategy for Wales 2015-2020. To support its development, the Local Suicide prevention planning document entitled 'Guidance issued by the National Advisory Group to Regional fora on local suicide and self-harm prevention planning' (John, Glendenning & Price, 2017) provided an outline on the requirements of the plan in terms of the national strategic context, ensuring cross-sectoral working and responding to the three main indicators of activity.

People from across all types of local communities die by suicide and most suicides are the result of a wide and complex set of interrelated factors. As a result, suicide prevention requires work across a range of settings with a range of stakeholders. No single agency is likely to be able to deliver suicide prevention alone.

There are already examples of good practice across North Wales in suicide and self-harm prevention. For example, the *Real Steps* report (North Wales & North Powys Recovery Network Sub Group, 2015) involves a piece of work originally commissioned by BCUHB and maps the recovery education opportunities available for people throughout North Wales. The report cites Flintshire's Recovery Education model as an example of best practice, with a wide variety of learning activities available in the county with the aim of enabling people to manage their own emotional wellbeing. The courses are open to anyone who feels that they are experiencing mental health issues, as well as carers, they do not have to be open to formal mental health services. This is to encourage the prevention of reliance on services and to promote personal coping skills.

The delivery of the plan will be overseen by the North Wales Suicide and Self-Harm Prevention Group, reporting to the Delivery Group (see Figure 1 on page 5), which will, in turn, feed up to the North Wales Together for Mental Health Partnership Board. The North Wales Suicide and Self-Harm group has established opportunities via the local implementation structure of the Together for Mental Health in North Wales Strategy, called Local Implementation teams (LITs), to share knowledge, address broader issues and support collective action towards the implementation programme of the strategy.

Objective 1: Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales							
Objective	**Key task in achieving the objective**	**Target audience for the intervention**	**Delivery lead**	**LIT role**	**Implementation partners**	**Timing**	**Monitoring**
Develop a training framework for the training of professionals and individuals who frequently come into contact with people at risk of suicide & self-harm including the general public	1.1 Undertake a training needs assessment relating to suicide and self-harm to ensure training matches local needs and expectations. The training should be focussed on: gatekeeper training, general awareness and skills based training to improve the knowledge, skills and attitudes of professionals, community members and friends who may have close proximity to those with a history of self-harm and those with suicidal ideation to improve their ability to intervene and offer support. This should also consider the use of recovery education programs being developed throughout North Wales to deliver training to carers and others who come into contact with people who may be likely to self-harm or take their own lives	Stakeholders identified according to the 3 tiers of training	**LITs** Sub group of the North Wales Suicide and Self harm Prevention group established to develop template for **LITs** to assess training needs and opportunities	✓	Training sub group of Suicide and Self Harm Prevention Group to be established to assist LITs	Yr 1	Training needs assessments completed
	1.2 Produce training plan relating to suicide and self - harm that includes identification of self-harm behaviour (recognising that people who self-harm are a high risk group for suicide) and refer appropriately. Disseminate the plan widely amongst relevant stakeholders. Monitor training implementation and in what service area.	Identify stakeholders requiring various tiers of training	**LITs** develop training plan for their local area; dependent on local need	✓	Local stakeholders	Yr 2	Training plans developed

	Priority groups/individuals that the training should target – • Men in mid life • Older people over 75 with depression and co-morbid physical illness • Children and Young People with a background of vulnerability e.g. looked after children • People in mental health services • People with a history of self-harm • Veterans • People with an autistic spectrum disorder • People living with long-term physical conditions • First responders - Police - Welsh Ambulance - Primary Care workers - Emergency department staff - Fire fighters • Network Rail • Healthcare and Community staff						
	1.3 Review implementation programme of 'Time to Change' in BCUHB; with particular reference to suicide and self harm https://www.time-to-change.org.uk/	BCUHB Employees	**BCUHB Public Health Directorate**		Group members	Yr 1	Review completed
	1.4 Support and encourage Suicide and Self harm group member organisations to sign up to 'Time to Change' and develop accompanying implementation plan	Organisations represented at the group	**BCUHB Public Health Directorate** lead agenda item at group meeting	✓	Group members	Yr1	Implementation plan developed

Provision of better information for the general public on suicide and self-harm	1.5 Develop a local multi-agency suicide and self-harm communications plan with particular focus on recognised campaigns e.g. Mental Health awareness week (February), World Suicide Prevention Day (September), World Mental Health day (October)	Population	**BCUHB Communications (Mental health)**	√	Stakeholder plan developed	Yr 1	Suicide and Self harm awareness campaign plan developed and agreed by all agencies
	1.6 Understand the support provided by helplines across North Wales and target the promotion accordingly e.g. C.A.L.L., Samaritans, Papyrus, Childline, and the local assessment team number	Service providers/General public – link to Communications plan	**BCUHB Public Health Directorate** collate information on helplines. Develop plan to ensure front line agencies are aware of services	√	Group members	Yr 1	Promotion targeted
To promote staff awareness and improve staff knowledge of where to go for health and support through workplaces	1.7 Develop workplace related guidance to aid staff and managers to respond confidently and effectively to situations where there is concern about the immediate wellbeing of an employee, for example in the event of emotional distress and concern about suicide or self - harm.	Workplaces participating in the Health at Work: Corporate Health Standard	**BCUHB Public Health Directorate** work with Principal Workplace Health Officer, Public Health Wales develop guidance		Workplaces/employees	Yr 1	Guidance developed

Objective 2: To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm							
Improve outcomes for people experiencing a mental health crisis	2.1 Deliver the Mental Health Transformation plan (a joint piece work to develop Crisis Care models which includes working with services on prevention and education). (This action is in response to the Mental Health Crisis Care Concordat within North Wales)	Mental health patients	**Service leads BCUHB jointly with Protecting Vulnerable Police Unit (PVPU)**		BCUHB and North Wales Police	Yr 1	Mental Health Transformation plan developed

	http://gov.wales/docs/dhss/publications/161109concordaten.pdf						
Reduce the risk of suicide in people with mental health problems	2.2 Ensure the early identification and treatment of depression	People with untreated depression	**LITs**	√		Yr 1, Yr 2, Yr 3	Raised awareness of increased risk of suicide and pathways to support among key front line professional who work with this group
Reduce the risk of suicide in people with mental health problems	2.3 Ensure the identification and support of women with a possible mental disorder during pregnancy or the postnatal period	Women during pregnancy or the postnatal period	**Perinatal mental health service**			Yr 1, Yr 2, Yr 3	Raised awareness of increased risk of suicide and pathways to support among key front line professional who work with this group
Reduce the risk of suicide in people with a history of self-harm	2.4 Support the implementation of NICE clinical practice guidelines on self-harm	Those at risk of self-harm	**Adult Mental Health Services / BCUHB Children's Services**	√		Yr 1	Raised awareness of increased risk of suicide and pathways to support among key front line professional who

							work with this group
Reduce the risk of suicide in children and young people	2.5 Develop North Wales Suicide and Self-Harm Community Response Plan for children and young people (including those who are vulnerable such as looked after children, care leavers and children and young people in the Youth Justice system) to include the following: • Out of hours support and information • Management of severe self-harm behaviour • Letter, web based public information leaflet for use in schools and colleges • School policy for dealing with suicide or sudden death • Peer support programmes	Children and young people at risk of self-harm/suicide	**BCUHB Children's Services**	√	LA Education Services/Youth Justice	Yr 1	Response Plan Completed
Reduce the risk of suicide in children and young people	2.6 Develop school and college based approaches to promote self-harm and suicide awareness among staff, pupils and parents to recognise the warning signs of suicide and increase knowledge of referral routes into specialist support, as well as tacking cyber bullying and reducing bullying around the protected characteristics	Staff, pupils and parents	**BCUHB Children's Services**	√	LA Education Services/ BCUHB Engagement team	Yr 2	Raised awareness of increased risk of suicide and pathways to support among key front line professional

Objective 3: Information and support for those bereaved or affected by suicide and self							
Provide better information and support to those bereaved or affected by suicide	3.1 Map current provision of bereavement support services and develop 'pathway' which identifies the support process for those bereaved or affected by suicide, use this mapping to increase awareness among staff and public of available support. Include opportunities to raise awareness and target distribution of the *Help is at Hand (Wales)* booklet.	Those bereaved by suicide	**North Wales Suicide and Self-Harm Prevention Group**	√	Group members	Yr 1	Mapping completed.
Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour							
Promote responsible reporting of suicide	4.1 Provide NW media outlets with access to designated suicide prevention lead from Samaritans (Wales) so that they can speak to them prior to 'running a story'	NW media outlets	**Samaritans**		Media outlets	Yr 1	Media outlets provided with relevant information
	4.2 Disseminate Samaritans Guidelines on responsible reporting of suicide to N Wales media outlets	NW media outlets	**Samaritans**		Media outlets	Yr 1	Updated guidelines produced and

							distributed to local media outlets
Objective 5: Reduce access to the means of suicide							
Reduce the number of suicides and suicide attempts at high risk locations	5.1 Develop action plan to maintain best practice related to reducing the risk of suicide at the Menai Bridge and Pontcysyllte Aqueduct (installation of physical barriers, placement of signs and telephones) within available resources	Those at risk of suicide	**North Wales Suicide Prevention Group**		Welsh Government/ Canal and River Trust/ Samaritans	Yr 1, Yr 2, Yr 3	Best practice evidence reviewed
Reducing hanging and strangulation in psychiatric inpatient and criminal justice settings	5.2 Ensure regular assessment of ward areas to identify and remove potential risks e.g. ligatures and ligature points, access to medications, access to windows e.t.c	Mental Health inpatients	**Adult Mental Health Services**			Yr 1, Yr 2, Yr 3	Evidence of regular ward assessments
	5.3 Ensure safer environment for at risk prisoners e.g. safer cells and provide care for at risk prisoners	Prisoners	**HMP Berwyn**			Yr 1, Yr 2, Yr 3	Evidence of regular ward assessments

Reduce the number of suicides and suicide attempts on the rail network	5.4 Ensure staff working on the rail network are trained to recognise the warning signs of suicide and help individuals access appropriate support	Network Rail staff/ customers	**Network Rail**		Samaritans	Yr 1	Network Rail staff trained in North Wales
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							
Monitor Local suicide trends	6.1 Produce an annual data report to ensure that local data relevant to suicide prevention activity is collected, shared between partners and used to monitor suicide trend, progress and inform local activity	Group members. Data presented to group	**BCUHB Public Health Directorate**		ONS/BCUHB Information Team	Yr 1, Yr 2, Yr 3	Data report produced
	6.2 Set up monitoring system of suicide attempts at high frequency locations	Those who use high frequency locations	**North Wales Police**			Yr 1	System established
Review regional and local evidence of best practice	6.3 Maintain an active role in the national suicide reduction programme	Chair of group represents North Wales at the national group meetings	**Chairperson of North Wales Suicide and Self-harm**			Yr 1, Yr 2, Yr 3	North Wales plays an active role in the National programme

			prevention Group				
	6.4 Assess the suitability of effective national suicide prevention interventions for local implementation	Group members	**BCUHB Public Health Directorate**			Yr 1, Yr 2, Yr 3	North Wales plays active role in National programme

9.2 Equality Impact Assessment

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	North Wales Suicide and Self-Harm Prevention Strategic Plan
2.	Provide a brief description, including the aims and objectives of what you are assessing.	In April 2017, Betsi Cadwaladr University Health Board published its mental health strategy which contained a commitment to develop a suicide prevention strategic plan. This was followed in July 2017 by national guidance from Welsh Government for local suicide prevention fora which follows in the footsteps of the national strategy *Talk to Me 2.* Our strategic plan has considered national learning, but also builds on practice, experience and expertise within North Wales. This strategic plan sets out our partnership commitment and action to reduce suicide and self-harm over the next 3 years. No single organisation can do this by themselves; the fact that our strategic plan is endorsed by the NHS, Local Authorities, Police, Network Rail and the Third Sector organisations in North Wales, shows the shared commitment to reduce suicides in the region. This will require a dedicated long-term focus and a commitment to continue to work together. The strategic plan has also been developed through engaging and involving North Wales residents. The overall aim of the North Wales Suicide and Self-harm prevention strategic action plan is to reduce suicide and self-harm in the general population in North Wales. The six objectives are as follows: **Objective 1**: Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in North Wales **Objective 2**: To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm **Objective 3**: Information and support for those bereaved or affected by suicide and self-harm **Objective 4**: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour **Objective 5**: Reduce access to the means of suicide

		Objective 6: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in North Wales and guide action
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	The strategic plan is being produced by a Task and Finish group chaired by Prof Rob Atenstaedt. This will then be approved by the North Wales Suicide and Self-Harm Prevention Group, chaired by Dr Gwenllian Parry, before going to the Together for Mental Health Partnership Board for approval The strategic plan will be going to the Health Board's SPPH committee for sign-off
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCU Mental Health Strategy
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	The key stakeholders who will be affected by this project include: • Patients, carers, service users and their representatives • Staff involved in the delivery of the strategic plan • Individuals who frequently come into contact with people at risk of suicide and self-harm • Those who have experienced suicide and self-harm directly or indirectly • Communities within North Wales that are affected by suicide/self-harm • Visitors/holiday makers to the area • Partner organisations including the local authority and third sector • Police • Network Rail • Welsh Ambulance Services Trust • Media
6.	What might help/hinder the success of whatever you are doing, for example communication, training e.tc.?	The following factors will hinder the outcome of the project: • Key stakeholders not accepting the process and/or recommendations • A lack of funding • Capacity of partner organisations

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	(+)	Medium	Men in mid-life and those aged >65 years are particularly at risk of suicide and are priority groups for suicide prevention in this strategic plan. The highest rates of self-harm are found in children and young people, particularly females aged 11-19 years. These are also highlighted as priority groups for suicide and self-harm prevention in the strategic plan.
Disability	(+)	Medium	Those with mental ill-health and co-morbid physical illness are particularly at risk of suicide and are priority groups for suicide prevention in this strategic plan. Evidence suggests rates are lower among those with severe learning disabilities.
Gender Reassignment	(+)	Low	There are indications that transgender people may have higher rates of self-harm. Education of children and young people about protected characteristics is highlighted as a priority in the strategic plan
Marriage & Civil Partnership	(N)	Low	There is evidence to support that those who are married are at lower risk of suicide than those who are not. There is a higher risk among gay men in a civil partnership than those in heterosexual couples. However, this may be associated with sexual orientation rather than civil partnership status as the risk of suicide is not higher among women in civil partnerships.

Pregnancy & Maternity	(+)	Low	The risk of suicide is low for pregnant women and new mothers. However, the strategic plan includes an action around ensuring the identification and support of women with a possible mental disorder during pregnancy or the postnatal period
Race / Ethnicity	(N)	Low	The evidence base is limited as information on ethnicity is not currently collected. Therefore, we are unable to accurately assess the ethnic background of people who die by suicide, or whether this strategic plan will have an adverse impact. There is evidence to suggest the rates of severe mental illness are higher amongst some ethnic groups. However, it is not known whether this automatically implies there are higher rates of suicide.
Religion or Belief	(N)	Low	It is not clear from the evidence whether there is an impact according to a particular religion or belief. It is possible that religious participation may be a protective factor against suicidal behaviour.
Sex	(+)	Medium	Men are more than 3 times more likely to die by suicide compared with women. Men in mid-life are particularly at risk of suicide and are priority groups for suicide prevention in this strategic plan. The highest rates of self-harm are found in females aged 11-19 years. They are also a priority groups in the strategic plan
Sexual Orientation	(+)	Medium	The evidence suggests that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm. The strategic plan includes an action around educating children around the protected characteristics
Welsh Language	(N)	Low	No change – there is no evidence that the strategic plan will have an impact. However, there may be an impact if this group are not taken into account in the planning of communication approaches.
Human Rights	(+)	Medium	Evidence includes: How fair is Britain? (Equality and Human Rights Commission 2010); On the right track? A progress review of the human rights of older people in health and social care (Age Concern 2007); The Human Rights Act – Changing Lives (The British Institute of Human Rights – no date); Human Rights Inquiry (Equality and Human Rights Commission 2009) The project to develop the North Wales Suicide and Self-harm prevention strategic plan has been conducted in line with local and national policy. It aims to actively eliminate equalities where they may exist and improve access to interventions to reduce suicide and self-harm across North Wales.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide: Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The suicide and self-harm prevention strategic plan has been developed observing the principles contained in the BCUHB Equality, Diversity & Human Rights Policy. The EqIA process itself helps to screen the strategic plan for unlawful discrimination. Overall there appears to be positive impacts on some of the protected characteristics with no impact on others as a result of the strategic plan.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The suicide and self-harm prevention strategic plan contains a number of actions designed at reducing inequalities such as poorer mental health outcomes in some of the protected groups.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Opportunities for on-going stakeholder engagement will include meeting with specific community and special interest groups regarding specific initiatives

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	North Wales Suicide and Self-Harm Prevention Strategic Plan

2. Brief Aims and Objectives: (Copy from Form 1)	In April 2017, Betsi Cadwaladr University Health Board published its mental health strategy which contained a commitment to develop a suicide prevention strategic plan. This was followed in July 2017 by national guidance from Welsh Government for local suicide prevention fora which follows in the footsteps of the national strategy *Talk to Me 2.* Our strategic plan has considered national learning, but also builds on practice, experience and expertise within North Wales. This strategic plan sets out our partnership commitment and action to reduce suicide and self-harm over the next 3 years. No single organisation can do this by themselves; the fact that our strategic plan is endorsed by the NHS, Local Authorities, Police, Network Rail and the Third Sector organisations in North Wales, shows the shared commitment to reduce suicides in the region. This will require a dedicated long-term focus and a commitment to continue to work together. The strategic plan has also been developed through engaging and involving North Wales residents. The overall aim of the North Wales Suicide and Self-harm prevention strategic action plan is to reduce suicide and self harm in the general population in North Wales. The six objectives are as follows: **Objective 1**: Further improve awareness, knowledge and understanding of suicide and self harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self harm and professionals in North Wales **Objective 2**: To deliver appropriate responses to personal crises, early intervention and management of suicide and self harm

	Objective 3: Information and support for those bereaved or affected by suicide and self harm **Objective 4**: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour **Objective 5**: Reduce access to the means of suicide **Objective 6**: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self harm in North Wales and guide action

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No X
3b. Could any of the protected groups be negatively affected?	Yes	No X
3c. Is your decision or policy of high significance?	Yes X	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No X
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? As there has been potentially limited impact identified and it is predominantly positive, it is unnecessary to undertake a more detailed equality impact assessment.	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes X	
	Record Details: 1. People who communicate using the Welsh language should be taken into account when any communication approach is planned	

	2. Inequalities in suicide rates related to deprivation should be taken into consideration when implementing the strategic plan. 3. Other risk factors for suicide and self-harm outside of the identified priority groups should be taken into consideration when implementing the strategic plan. 4. Social and community influences should be taken into consideration when implementing the strategic plan. 5. All other identified actions are already incorporated into the Action Plan	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes X	No
	How is it being monitored?	North Wales Suicide and Self-Harm Prevention group which reports to the Together for Mental Health Partnership Board
	Who is responsible?	This group is chaired by Dr Gwenllian Parry
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Existing data/reports
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	This EHIA will undergo full review at the time the 3-year review of the strategic plan

7. Where will your decision or policy be forwarded for approval?	Together for Mental Health Partnership Board followed by SPPH Committee of Health Board

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Engagement Undertaken:- • North Wales Suicide and Self-Harm Prevention Group which is multi-agency. Close engagement with Caniad, service users group. • Stakeholder workshops will be held to engage with the priorities for action within the operational plan

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Prof Rob Atenstaedt	Consultant in Public Health Medicine, BCUHB Public Health Directorate
	Siwan Jones	Principal Practitioner, BCUHB Public Health Directorate
	Rosemary Howell	Samaritans
	Sean Clarke	Adult Mental Health, Betsi Cadwaladr University Health Board
	Jacqueline Vaughan Thomas	Flintshire County Council
	Sara Owen	Caniad
	Rob Callow	Head of Engagement, Betsi Cadwalar University Health Board
	Andrew Rogers	Head of Corporate Communications, Betsi Cadwaladr University Health Board
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Not applicable		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	The strategic plan remains unchanged as there are no significant negative impacts. The Action Plan will be continuously monitored and adapted as and when any new issues arise. The strategic plan will be circulated to the North Wales Suicide and Self-harm Prevention Group with this impact assessment included as well as other groups for sign-off	R Atenstaedt	October 2017
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	Not applicable		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	Not applicable		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	It is recommended that the plan and EQIA screening are considered by Strategy & Planning Equality Scrutiny Group.		

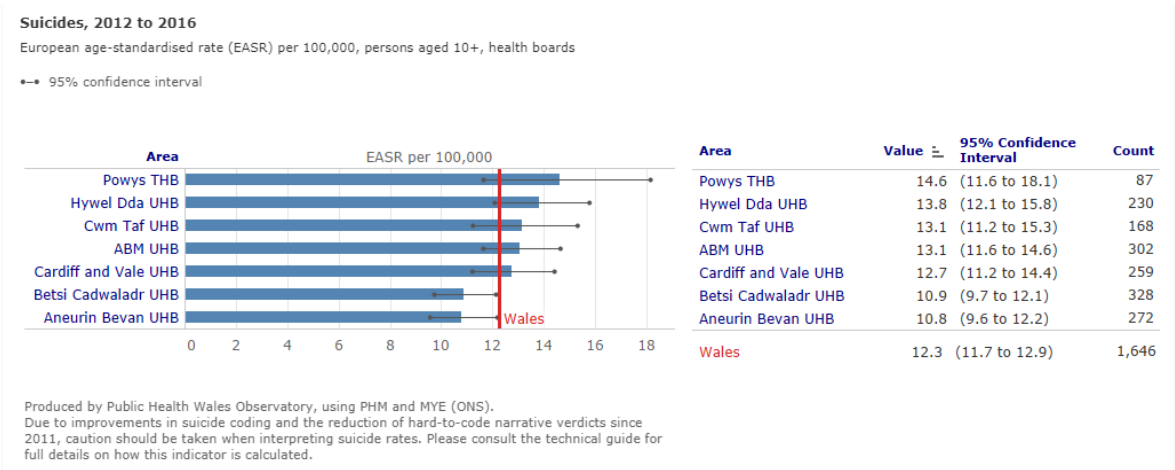
HEALTH, SOCIAL CARE AND SPORT COMMITTEE CONSULTATION: INQUIRY INTO SUICIDE PREVENTION

Evidence from South East Wales Regional Group

1. The South East Wales Regional Multi-Agency Suicide Prevention Forum (SEWRMASPF) promotes the sharing of learning and good practice, highlights current issues and supports collaborative work across the Cardiff and Vale, Cwm Taf and Aneurin Bevan University Health Board areas.

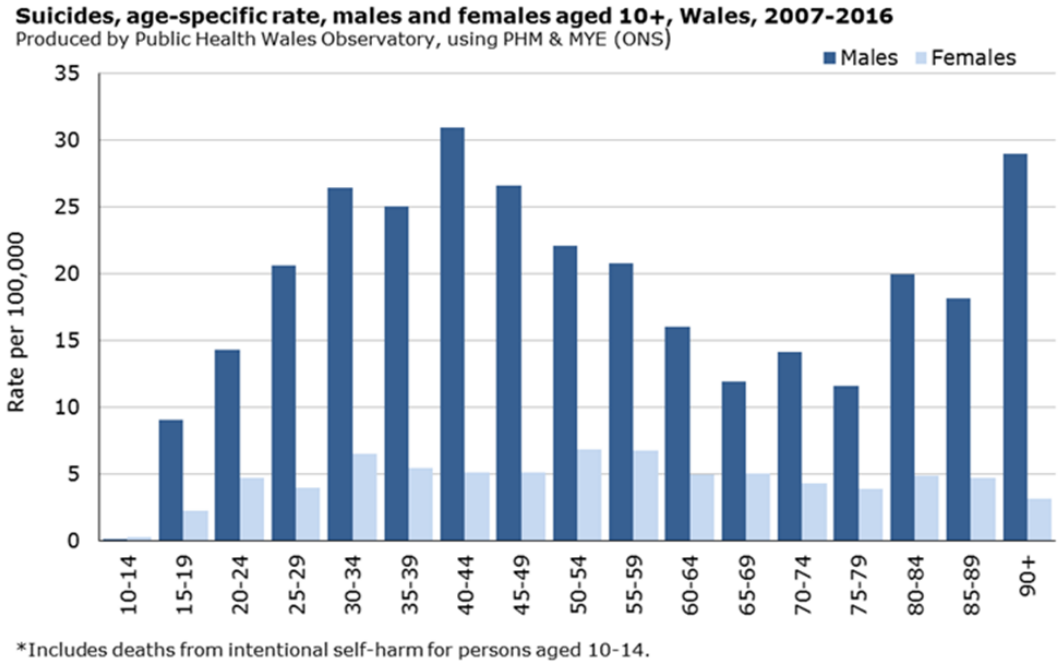
The extent of the problem of suicide in Wales and evidence of its causes

2. The combined populations of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf UHB in total account for 44% of the population of Wales. The total number of suicides in these three health board areas for the period 2012-2016 is 42% of the Wales figure. Cardiff and Vale and Cwm Taf have suicide rates higher than the Wales average, while Aneurin Bevan's is lower, and is the lowest in Wales.



Area	Value	95% Confidence Interval	Count
Powys THB	14.6	(11.6 to 18.1)	87
Hywel Dda UHB	13.8	(12.1 to 15.8)	230
Cwm Taf UHB	13.1	(11.2 to 15.3)	168
ABM UHB	13.1	(11.6 to 14.6)	302
Cardiff and Vale UHB	12.7	(11.2 to 14.4)	259
Betsi Cadwaladr UHB	10.9	(9.7 to 12.1)	328
Aneurin Bevan UHB	10.8	(9.6 to 12.2)	272
Wales	12.3	(11.7 to 12.9)	1,646

3. Suicide rates across Wales are four times higher in men than in women. Half of all the suicides in men occur in the 30-50 age range, with the highest proportion (13%) happening in men aged 40-44. Suicide rates fall in late middle age, but there is a further increase after the age of 80.



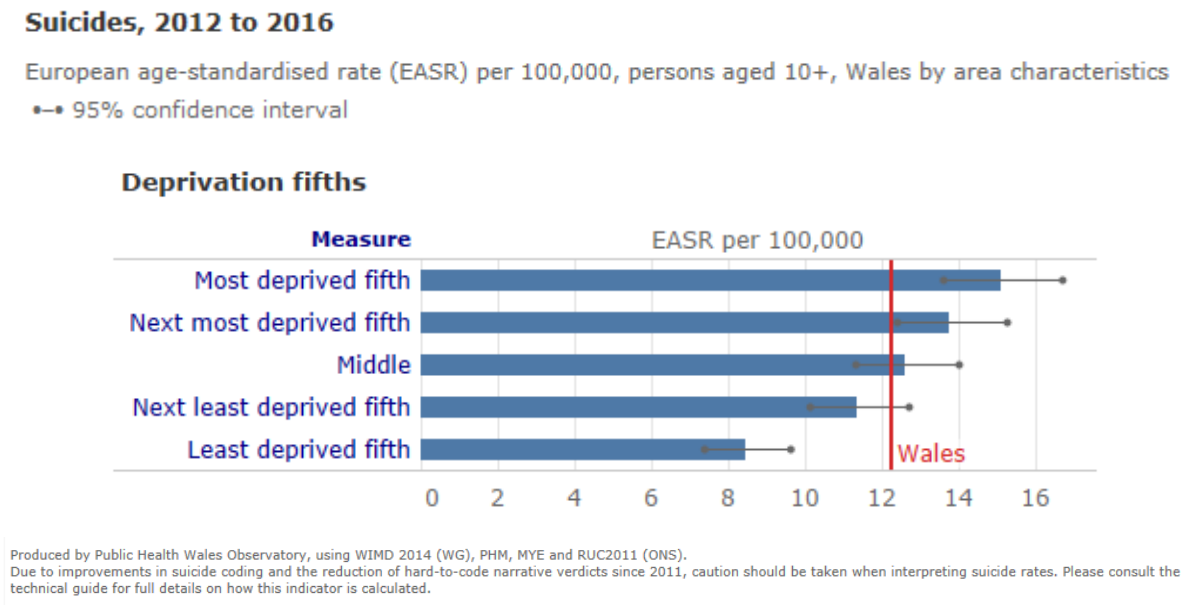
4. There isn't any further evidence for regional statistics on risk factors for specific groups. However, the *Talk to me 2* Strategy does outline priority people, places and care providers in the context of suicide prevention, see Table below.

Priority People	**Priority Places**	**Priority Care Providers**
Men in mid life Older people over 65 with depression and co-morbid physical illness Adult Prisoners Children and young people with a background of vulnerability People in the care of mental health services including inpatients People with a history of self-harm	Hospitals Prisons Police custody suites Workplaces Schools, Further and Higher Education establishments Primary care facilities Emergency departments Rural areas Deprived areas	People who are first point of contact or first responders, including: Police Fire fighters Welsh Ambulance staff Primary care staff Emergency department staff

The social and economic impact of suicide

5. There were 332 deaths from suicide registered in Wales in 2016 (Source: ONS), and for every person who dies at least 10 people are directly affected[1]. The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering[2].

6. The Welsh Index of Multiple Deprivation (WIMD) can be categorised by fifths of deprivation. Suicide rates are two to three times higher in the most deprived neighbourhoods compared with the most affluent, see Figure below.



7. The size of populations needs to be considered when looking at suicide rates. There is more variance in rates at a Local Authority level, due in part to the relatively small numbers involved, and so there is a need to exercise caution in the interpretation of suicide data. The limitations of the data presents challenges for planning suicide prevention and responding to community needs at a local level.

[1] Pitman A, Krysinska K, Osborn D, King M. Suicide in young men. *Lancet*. 2012 Jun 23;379 9834:2383 –2392.

[2] McDaid D, Park A, Bonin E-M. Population level suicide awareness training and intervention. In Knapp D, McDaid D, Parsonage M, editors. Mental health promotion and prevention: the economic case. London: Department of Health; 2011. p.26-28

The effectiveness of the Welsh Government's approach to suicide prevention

8. The Talk to Me 2 Strategy and Action Plan has provided a structure and guidance for the development of local suicide prevention planning. The National Advisory Group (NAG) oversees the implementation of this strategy. There are three Regional Fora in Wales to support the implementation of the National Suicide and Self-harm Action Plan. Regional Fora report to and share minutes with the National Advisory Group to Welsh Government and chairs of the Regional Fora attend NAG quarterly meetings.

9. The South East Wales Regional Multi-Agency Suicide Prevention Forum (SEWRMASPF) promotes the sharing of learning and good practice, highlights current issues and supports collaborative work across the Cardiff and Vale, Cwm Taf and Aneurin Bevan University Health Board areas. The regional group provides leadership, influence and support to ensure successful regional and local delivery of the strategy and the action plan.

10. The South East Wales Group took the decision for the Chair of the group to be rotated. In this way, each health board area takes turns to Chair the regional meeting and also be responsible for reporting to the following NAG meeting on behalf of the Region. This was felt to be a more efficient use of resources, given the time pressures on members of the regional group, who are also responsible for leading suicide prevention work locally.

11. Local groups are responsible for the development and implementation of action plans which are based on the national objectives set out in Talk to Me 2, taking into account local evidence, needs and priorities. As well as reporting to their regional group and to the NAG, local groups are also accountable to the Mental Health Partnership Board in their area. Local Partnership Boards are responsible for reporting to Welsh Government on progress with local suicide and self-harm actions via the monitoring for Together for Mental Health.

The contribution of the range of public services to suicide prevention, and mental health services in particular

12. Some areas of suicide prevention work, for example, reducing access to means, lend themselves to discussion at a regional level due to the operational footprint of some key stakeholders such as:
    - South Wales Police/Gwent Police
    - South Wales Fire and Rescue Service
    - Welsh Ambulance Services Trust
    - Network Rail

13. Information sharing and learning from each other on this broader scale is helpful at the regional level. Regionally, we have agreed to use the same definition for suicide clusters, and have made contact with South Wales Fire and Rescue Service to obtain data on 'persons in distress'.

The contribution of local communities and civil society to suicide prevention

14. Whist it is clear that communities and civil society have a definite role to play in suicide prevention; much of this work occurs at a local as opposed to regional level in South East Wales currently.

Other relevant Welsh Government strategies and initiatives

15. The Well-being of Future Generations (Wales) Act 2015 provides a unique opportunity for all public services to work differently together, involving communities in shaping their long term future and improving well-being for all.

16. The Social Services and Well-being (Wales) Act (2014) provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales. This Act requires local authorities and health boards to look at the care and support needs of the following groups of people in particular:
    - Carers;
    - Children and young people;
    - People with learning disabilities;
    - People with mental health problems/illness;
    - Older people;
    - People with physical disabilities;
    - People with sensory impairments and;
    - Violence against women, domestic abuse and sexual violence.

17. Some of these groups are among the most vulnerable in our communities and may be at increased risk of suicidal or self-harming behaviours.

Innovative approaches to suicide prevention

18. Regionally, we share learning and best practice regarding locally innovative approaches, in order to see whether these can be scaled up to a regional level. One example is the work to identify suicide clusters on a regional footprint.