Cafodd yr ymateb hwn ei gyflwyno i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Flaenoriaethau'r Chweched Senedd

This response was submitted to the Health and Social Care Committee consultation on Sixth Senedd Priorities

HSC PSS 44

Ymateb gan: | Response from: Samaritans Cymru

Health and Social Care: Priorities for the Sixth Senedd

Samaritans Cymru exists to reduce the number of people who die by suicide. Each year, between 300 and 350 people die by suicide in Wales, which is around three times the number killed in road accidents. It is a major public health and inequality issue.

Every one of these deaths is a tragedy that devastates families, friends and communities. The causes of suicide are complex. Suicide can be the result of the interaction between many different factors and should not be attributed to one single cause. The complexity of suicide is why suicide prevention requires the involvement of many different sectors, agencies and services. It requires a cross-governmental approach and one which recognises the interaction between suicide and health and social care, education, communities, economy, housing, families and culture. Suicide is everybody's business.

Despite some progress already being made, we have seen no overall reduction in suicide rates over time in Wales and the implementation of suicide prevention measures needs to take place at greater scale and with greater pace. Suicide is not inevitable, it is preventable – we must do all we can, whoever we are, to reduce it

We welcome the opportunity to respond to this consultation on priorities for the Sixth Senedd and look forward to continued working with the committee. We are encouraged by the initial aims and particularly welcome a focus on public health and prevention and access to mental health services.

We would like to set out our organisational priorities which we believe are closely aligned with the work of the Health and Social Care Committee. Suicide prevention requires a cross-sector approach and as such, some of our priorities sit within the work of the Health and Social Care Committee alongside the Children, Young People and Education Committee and the Equality and Social Justice committee. We also have two specific priorities in partnership with external organisations.

We must ensure all schools have a structured and effective approach to emotional health and wellbeing

Though suicide in children and young people is rare, it is the biggest killer of young people (15–24) in the United Kingdom. Suicide rates among young people have been increasing in the United Kingdom in recent years and the rate for young women is now at its highest rate on record. In Wales, the suicide rate for 10–24 year olds is currently at its highest since 2002–2004.

At Samaritans Cymru, we believe that preventative action and reaching high-risk groups is needed to reduce suicide. Investment in prevention and early intervention can reduce human, social and economic costs. As half of all mental health problems begin by the age of 14, school years are a crucial opportunity to equip children and young people with the skills they need and build resilience from an early age.

We must -

• Include mental and emotional health in the delivery of the curriculum systematically so that every child in every school takes part in lessons on emotional wellbeing. Mental health education in schools should be viewed as a form of prevention and early intervention which could reduce pressure on children and adolescent mental health services (CAMHS), reduce specific mental health problems and reduce suicide rates across all age groups.

• Ensure that all schools have a suicide prevention plan which will include:

- Ensuring that all pupils know where they can turn if they are struggling to cope, including the school counselling service and additional support.
- Ensuring that all existing and new staff have access to quality mental health and/or suicide awareness training.
- Ensure that all schools have a proactive suicide response plan which is in place for when a suspected or attempted suicide occurs, and which is informed by expertise in this area.
- They should be aware of sources of advice and support. Samaritans offers a service called Step by Step which works with schools that have been affected by a suspected or attempted suicide. Samaritans offers this service in order to support the school community and reduce the risk of further suicide. Recent research on 'copycat' suicides and suicide 'contagion' suggest that, in young people especially, exposure to suicide can lead to increased risk of suicidal thoughts.

• Focus on minimising the number of children who are excluded from school to break the cycle of lifelong socio-economic disadvantage. Welsh Government should do this by equipping schools and staff with the awareness and knowledge of how to support children who have experienced adverse childhood experiences (ACEs), young carers, children in distress, children with poor mental health or those who may be at an increased risk of exclusion due to disadvantage.

• Explore mechanisms to ensure children and young people between the ages of 16 and 18 years are supported in education, employment or training, which includes work-based training, to minimise the adverse effects of loneliness, social isolation and lack of belongingness that young people who are out of education can experience, all of which contribute to increased suicide risk.

We must mitigate poverty and its impact on individuals and communities

Poverty is a major public health issue in Wales and must be treated with urgency. Growing up or living in poverty can have devastating consequences for individuals and communities, affecting education, health, social mobility, child development and life expectancy4. There is now overwhelming evidence of a strong connection between socioeconomic disadvantage and suicidal behaviour. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent. Middle-aged men on low incomes have been the highest risk group for suicide for many years. Poverty means facing constant insecurity and uncertainty. Its features include inadequate housing, poor mental health, low educational attainment, unemployment and loneliness. Knowing that these are also risk factors for suicide should add urgency and energy to efforts to mitigate both poverty and its impact on individuals and communities.

• We should fund evidence-based services which are built on an understanding of how best to reach middle-aged men on low incomes. Although middle-aged men on low incomes are the group most at risk of dying by suicide, far too little is known about what really works to reach and support this group when they are struggling. Services should be built on an understanding of what this group

actually wants and needs, supporting them to deal with the full range of issues they're facing. All government departments must use every route available to them, for example, through debt advisors, housing associations and substance misuse services to reach this group and other groups of people who are on low incomes and at risk

We must promote cross-sectoral collaboration to mitigate suicides at high frequency locations

Research suggests that around a third of suicides take place outside the home, in a public location. We are aware of many examples of best practice in Wales, where local authorities have worked to reduce the access to these sites for those experiencing distress. With the right help people can get through a suicidal crisis and recover. Limiting access to the means of suicide can interrupt the suicidal intention, buying time and giving individuals the chance to reconsider. It can also increase the chance that help may reach them.

We must -

• Make incorporating suicide prevention measures into designs for all new public buildings a condition of planning consent. This means that local authorities would have to assess suicide risk in designs for all new public buildings. These include bridges, infrastructure projects, multi-storey car parks, schools, hospitals and care homes. This method of assessing suicide risk and preventing suicides locally should encourage effective working between frontline services, public health and local authority teams. This measure could reduce human, social and economic cost; installing suicide prevention measures in public places and sites is far more cost effective when they are embedded at design stage rather than when they are added on to an existing site or structure.

• Ensure the 'access to means' action in the national strategy is reviewed so that those responsible for mitigating suicide risk nationally and locally are held to account for the effective implementation of this area of action. Reviewing this action will help ensure the continuation of cross-sectoral collaboration (local authorities, local health boards [LHBs], third sector organisations and regional multi-agency suicide prevention fora) to reduce access to the means of suicide where the evidence exists. Restricting access to the site and the means of suicide can be achieved by

i) closing all or part of the site
ii) installing physical barriers to prevent jumping
iii) introducing other deterrents, for example, boundary markings or lighting.

• Increase opportunities for help seeking by the suicidal individual through signs with helpline numbers. These can include Samaritans signs and/or free emergency telephones.

• Check and review existing public buildings and identify locations used for suicide. This will require improved data collection and analysis at a national level. Information on suicide deaths at high frequency locations should be collated nationally so that opportunities to implement safety measures are not missed and that any changing patterns in suicide deaths involving these locations can be quickly identified. This data should be used to ensure ongoing implementation and assessment of initiatives at high frequency locations.

We must should prioritise self-harm

Self-harm is a growing problem in Wales with approximately 5,500 emergency admissions to hospital each year. Although most people who self-harm don't go on to take their own lives, it is a strong predictor of future suicide; many people who take their own life have self-harmed in the past.

Self-harm is a sign of severe emotional distress, and everyone who self-harms should have access to support to help them identify and address the reasons for their distress and find alternative coping mechanisms.

- Thresholds for therapies and other sources of help for people need to be set at a level which means they are available as an early intervention, rather than depending on the level of self-harm itself. Thresholds for help are widely experienced and understood to be too high. People need to be able to access therapies such as DBT early on and not have to wait until their self-harming becomes serious enough to meet current thresholds. This alone would make a significant difference
- There needs to be proactive follow up of people who have been discharged from A&E following self-harm. People presenting at A&E with self-harm represents opportunity for positive intervention. There is currently insufficient systematic follow up of individuals after discharge
- Support services need to be trauma informed. All support services for people who self-harm, whether NHS provided, or community based, should provide trauma-informed support, which acknowledges and supports the underlying issues driving self-harm. Simply stopping self-harming behaviour may be stopping a needed coping mechanism. Helping someone to address the underlying issues to find other ways through is key.
- We must improve data collection practices and present population level self-harm data in an accessible and transparent way. This would enable government departments, local authorities and third sector organisations to evaluate the impact/success of different services/interventions and would lead to evidence-based interventions. It would also make it easier to achieve funding in this area.

- For more detailed information on our key recommendations on self-harm, please access our latest report online *The Right Support At The Right Time? - Improving the availability and quality of support after self-harm in Wales*

We must ensure the continuation of a resourced national strategy and action plan for suicide and self-harm prevention for Wales

• Suicide prevention actions must be well aligned with the wider direction of travel to prevent mental ill health and respond effectively to crisis. There must be an ongoing commitment to the implementation of a strategic and co-ordinated approach. This means ensuring its successor is in place by the end of the current strategy, Talk to me 2, and that it sets out the suicide and self-harm prevention priorities for the following five years.

• There must be a continued commitment to local and regional resourcing of suicide and self-harm prevention strategies and investment in the implementation of the national strategy. It is vital that local and national suicide and self-harm prevention strategies continue to be resourced at least at existing levels, to improve awareness of suicide and self-harm to tackle stigma, to provide training for frontline staff and to fund support programmes

Tackling Health Inequalities in Wales

As part of the Health and Wellbeing Alliance, we are calling for an inquiry across all Senedd Committees on tackling health inequalities in Wales. Meaningful progress will require coherent efforts across all sectors to close the gap and an inquiry undertaken by all Senedd Committees will enable

Committees to consider what action each Welsh Government department is doing to tackle the root cause of health inequalities and put forward recommendations around where improvements are needed.

Prioritising the Mental Health Core Dataset (MHCDS)

As part of the Wales Alliance for Mental Health (WAMH) and through our ongoing collaboration with Mind Cymru, we are concerned with the ongoing delays in delivering the Mental Health Core Dataset (MHCDS). We understand the Welsh Government is committed to developing the MHCDS for implementation in 2022; however, we are concerned with the lack of urgency. In order to understand the way in which mental health services are operating across Wales, and crucially, how services are faring in response to Covid-19, it is vital that this goal is met.

In addition to this, we believe the MHCDS demographics reports should include a means of reporting on mental health services in relation to socioeconomic disadvantage. Suicide rates are higher in areas of socioeconomic disadvantage, and we need to make sure we support those who are most vulnerable; linking postcode data to the wider Welsh index of multiple deprivation would provide us with a much clearer picture.