Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar anghydraddoldebau iechyd meddwl

This response was submitted to the Health and Social Care Committee consultation on mental health inequalities

MHI 34

Ymateb gan: | Response from: Samaritans Cymru

Senedd Cymru – Health and Social Care Committee

Mental Health Inequalities Inquiry

Samaritans Cymru response

Samaritans Cymru exists to reduce the number of people who die by suicide. In 2021, 285 people took their own life in Wales. 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. Suicide is a major public health and inequality issue, and it is everybody's business.

Poor mental health and diagnosed mental health conditions increase the risk of suicide for individuals in Wales. We at Samaritans Cymru are committed to helping those who are at most risk of suicide across Wales and strongly focused on the social determinants of mental health; the external factors which make life difficult for individuals and communities.

With this in mind, we are encouraged by this inquiry and look forward to working with the committee where possible in order to explore and advance this agenda. Poor mental health and suicide are both inequality issues and they disproportionately affect certain groups and communities in our Welsh population.

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. Alongside this, it is clear that efforts to improve poor mental health and subsequent suicide risk need to be targeted and applied through an inequality lens. Suicide is not inevitable, it is preventable – we must do all we can, whoever we are, to reduce it

1. Socioeconomic disadvantage

Growing up or living in poverty can have devastating consequences for individuals and communities, affecting education, health, social mobility, child development and life expectancy. 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.[1] Poverty means facing constant insecurity and uncertainty. Its features include inadequate housing, poor mental health, low educational attainment, unemployment and loneliness.

Middle-aged men on low incomes have been the highest risk group for suicide for many years. Based on the latest suicide statistics for Wales, men are 3.9x times more likely to die by suicide than women.[2]

Our own Samaritans UK-wide research report, *Dying from Inequality (2017)*, found that -

- There is a strong association between area-level deprivation and suicidal behaviour: as area-level deprivation increases, so does suicidal behaviour. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent.
- Admissions to hospital following self-harm are two times higher in the most deprived neighbourhoods compared to the most affluent.
- Individuals experiencing socioeconomic disadvantage and adverse experiences, such as unemployment and unmanageable debt, are at increased risk of suicidal behaviour, particularly during periods of economic recession.
- The risk of suicidal behaviour is increased among those experiencing job insecurity and downsizing or those engaged in non-traditional work situations, such as part-time, irregular and short-term contracts with various employers.
- The experience of being declared bankrupt, losing one's home or not being able to repay debts to family and friends is not only stressful but can also feel humiliating. This can lead to an increased risk of suicidal behaviour.
- The risk of suicidal behaviour increases when an individual faces negative life events, such as adversity, relationship breakdown, social isolation, or experiences stigma, emotional distress or poor mental health. Socioeconomically disadvantaged individuals are more likely to experience ongoing stress and negative life events, thus increasing their risk of suicidal behaviour.
- In the UK, socioeconomically disadvantaged individuals are less likely to seek help for mental health problems than the more affluent and are less likely to be referred to specialist mental health services following self-harm by GPs located in deprived areas.

Socioeconomic disadvantage and the coronavirus pandemic

To date, there is no evidence to suggest that national suicide rates have risen during the coronavirus pandemic, either in Wales, the UK or internationally. However, given what we know about the complexity of suicide, and the nature of developing risk based on societal events such as economic disruption and uncertainty, we must not be complacent in thinking that the pandemic will have no impact on suicide. Suicidal thoughts and behaviours are influenced by many factors, including social, psychological and economic factors. Economic disruption and economic recessions have been linked to increased risk of dying by suicide. Worldwide, periods of economic recession appear to increase suicide rates[3] and recessions can result in significant rises in unemployment[4]. People who are unemployed are 2.5 times more likely to die by suicide than those who are employed[5] and, in the UK, every 1 per cent increase in unemployment is associated with a 0.79 per cent rise in suicide for people of working age.[6]

In 2021, we launched a UK-wide research report, *The impact of economic disruption on young adults*, which was carried out against the backdrop of the coronavirus pandemic. (At the core of the research was an online survey which included all UK nations and the Republic of Ireland). We carried out a quantitative exploration of the relationship between economic disruption and psychological factors related to suicide risk, alongside qualitative exploration into how the relationship impacts young adults (16-24) through interviews with those with lived experience of economic disruption. We found:

- Economic disruption over the past year left young adults experiencing feelings of defeat, entrapment, shame and hopelessness.
- Young adults who experienced some economic disruption in the past 12 months were more likely to report feeling suicidal afterwards, than those who didn't experience any economic disruption. Young adults also described feeling suicidal during the pandemic meant previously relevant, accessible and useful forms of support were not available.

Through our conversations with young adults, we found there were a range of common triggering events, which resulted in them experiencing feelings of defeat, being trapped, shame and hopelessness:

- Drop in income due to a reduction in hours, being placed on furlough or job loss.
- Job loss after a period of uncertainty or not being successful for a job they went for.
- Borrowing money from friends or family or needing to access benefits such as Universal Credit.
- Not being able to pay bills or afford food.
- Forced to make changes to their standards of living.

These events highlight how the impact of economic disruption is not uniform across all young adults. We found access to social support, access to financial support or other sources of income, pre-existing mental health conditions, and the nature of economic disruption itself influenced the extent of impact on the young adults' wellbeing.

Overall, holistic support is needed for young adults to be able to see a way out of difficult economic times and have hope for the future. Although these findings are intertwined with the unprecedented impact of the coronavirus pandemic, the underlying principles throughout this report stand true during times when young adults are knocked back financially.

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. Knowing that poverty is also a risk factor for poor mental health and suicide should add urgency and energy to efforts to mitigate both it 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

- **Mental health and suicide awareness training** are key drivers in mitigating the impact of poverty in communities across Wales. Training was identified as an approach which could hold real strength for Wales, with trauma-informed care and practice, a framework which is responsive to the impact of trauma, being highlighted as integral. Individuals attending job centres, foodbanks, community outreach events and GP surgeries are often identified as having mental health issues or feeling suicidal. These places and the staff that work within them are identified as priority places and priority care providers in Talk to me 2 and therefore staff should be trained effectively. Most significantly, it was felt that being trained to implement intervention and prevention must be made economically viable for organisations and companies.

- **We must prioritise 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. 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.

- **Community groups and outreach as a form of prevention and early intervention** Loneliness and isolation can have a serious impact on physical and mental health and are a risk factor for suicidal behaviour and suicide. Being socially isolated can make an individual more vulnerable to poor mental health and suicidal behaviour. Those who are socioeconomically disadvantaged often experience lower levels of social support which puts them at greater risk of suicidal behaviour. Community groups should be seen as a form of prevention and early intervention and policy solutions should be worked up to increase community participation. The Loneliness and Social Isolation fund is a unique opportunity to embed this measure and should encourage and work with county voluntary councils to reach those who are most at risk in terms of socioeconomic disadvantage.

- **Addressing the cost-of-living crisis.** As a Wales team, we are proud to be part of the Anti-Poverty Alliance and work with partners including Bevan Foundation. The effects of the cost-of-living crisis are set to worsen over the next year and given the way in which the pandemic has widened inequalities, we are very concerned for those who are most vulnerable in terms of suicide risk. Whilst many of the issues involved with the crisis lie with the UK government, we know there are meaningful actions that the Welsh Government can take.

In relation to this specific action area, we support the actions outlined in the recent plan published by Bevan Foundation – The cost of living crisis: a Welsh action plan

We believe the focus on the three areas that are the biggest pinch-points in households' budgets: housing, energy and food, is crucial. We are particularly passionate about measures to improve child poverty, including bringing forward Free School Meals (FSM) provision, in order to safeguard against future suicide risk.

2) LGBTQ+

Suicide statistics on sexuality or gender aren't routinely collected and very few reliable data sources exist on suicide and self-harm rates among LGBTQ+ people. However, individual studies and systematic review suggest rates are higher among LGBTQ+ people compared to heterosexual and/or cisgender people.

- A systematic review concluded that LGB people are twice as likely to die by suicide compared to heterosexual people, with gay and bisexual men 4 times more likely to die by suicide.[7]
- Research shows that trans people have significantly higher rates of self-harm and suicide than cisgender, with one study finding trans people were at 2x risk of suicide attempts compared to cisgender females and 4x compared to cisgender males.[8]
- Evidence shows that trans people and those with multiple protected characteristics are more likely to attempt suicide compared to the broader LGBT population.[9] Self-harm rates were particularly high among trans men.[10]
- In one recent GB survey, 2% of LGB people and 12% of trans people reported attempting suicide in the last year.[11] Rates were higher among LGBT young people aged 16-24 (13%).
- One UK survey found that 4 in 5 trans people (84%) had experienced suicidal thoughts at some point in their life and almost half (48%) had attempted suicide at some point.[12]

We have welcomed the recent proposed Welsh Government LGBTQ+ action plan and in particular, action point 40. -

40. Ensure any future review of mental health services takes account of the focus on and efficacy for LGBTQ+ people including young people

- Given that suicide risk is higher within the LGBTQ+ community, we believe that this action point is crucial. Primary and secondary services, alongside frontline settings such as schools, should all be provided with a robust understanding of the link between LGBTQ+ and poor mental health, self-harm and suicide risk. This action point would form part of the wider suicide prevention agenda in Wales.

3) Prisoners

People in prison in England and Wales are significantly more likely to take their own lives than those in the general population. Over the last decade the rate of self-inflicted deaths in prison in England and Wales has risen by over a third. Suicide is now the second leading cause of death in prison and male prisoners are 3.7 times more likely to take their own lives compared to men in the community.[13]

As women account for just under 5% of prison population, it is difficult to estimate the risk of suicide in women's prisons reliably.[14] However, there is evidence to suggest that women in prison in England and Wales are up to 20 times more likely to take their own lives than women in the community.[15]

In the 12 months to December 2020 (the most recent data), there were 67 suicides in prisons across England and Wales. Self-harm incidents in prison custody reached a record high of 64,552 incidents in the 12 months to March 2020, up 11% from the previous 12 months. In the most recent quarter, there were 15,390 self-harm incidents, down 6% on the previous quarter. The number of individuals self-harming increased by 5% in the 12 months to March 2020, to 13,180, and the number of self-harm incidents per individual increased by 7% from 4.6 to 4.9 population.[16]

At Samaritans, we see the enormous scale of poor mental health in prisons – we provide emotional support to people in prison through our Listener scheme. We supported people in prison 332,974 times in 2018 and see the wide range of concerns that underpin their distress.[17]

As with all suicides, the reasons that people take their own life are complex, but the increased risk of suicide in prisons is suggested to be due to a unique combination of pre-existing vulnerability and features of prison life. Background and experiences that lead to vulnerability before entering prison includes past self-harm or suicide attempts, mental health problems, socioeconomic deprivation and traumatic life events.

People with a diagnosed mental health disorder are 5-15 times more likely to die by suicide[18] and a third of people who die by suicide are in contact with mental health services in the year before their death. According to the National Audit Office (2017), 23% of prisoners report that they have had contact with mental health services before being imprisoned, although this figure is likely an underestimate. The Prisons and Probation

Ombudsman found that 70% of prisoners who died by suicide between 2012 and 2014 had been identified as having mental health needs.

Concerns related to health were discussed in 32% of all Samaritans prisons contacts in 2018. These concerns include problems related to mental health, physical health and substance misuse. The most frequently discussed concern in face-to-face contacts from prisoners was mental health/illness:

Far fewer people in open prisons (11%) expressed concerns about their mental health than prisoners housed in closed conditions. In closed conditions, mental health was the most commonly discussed concern, and was discussed in, on average 1 in 4 contacts. This reflects multiple studies that have found that mental health problems are associated with increased distress and suicide in prisons. Women in prisons were over 1.6 times more likely to discuss mental health problems and 1.8 times more likely to discuss physical health problems than men. Previous research has found that women enter prison with higher levels of mental health problems, which includes an increased likelihood of having received in-patient psychiatric care. Mental health problems often co-exist with other concerns. Prisoners who discuss mental health problems are 1.6 times more likely to have homelessness concerns. The link between physical and mental health problems is well known. Related to this, those prisoners with a physical health concern are 1.6 times more likely to discuss financial problems. Previous research has highlighted the extra financial burden that having a health problem brings, and this will be no different for those in prison.

The disproportionate number of suicides in prison is of great concern.

- We hope that a better understanding of the concerns of prisoners who contact Samaritans can shape and drive positive changes in future. In prisons, suicide risk is a combination of life experiences before imprisonment and the pains of prison life. Many risk factors for suicide are reflected in the conversations we have with prisoners through the emotional support we provide

4) Minority Ethnic Groups

Rates of mental health problems can be higher for some minority ethnic groups than for white people. According to the Mental Health Foundation:

- Black men are more likely to have experienced a psychotic disorder in the last year than white men.
- Black people are four times more likely to be detained under the Mental Health Act than white people.
- Older South Asian women are an at-risk group for suicide
- Refugees and asylum seekers are more likely to experience mental health problems than the general population including higher rates of depression, anxiety and PTSD.

Some of the reasons why there are different rates of mental illness for people from minority ethnic groups are due to discrimination and racism, stigma around mental health and they

are more likely to be living in poverty, where poor mental health and suicide risk is more prevalent.

The final report of the Independent Review of the Mental Health Act 1983 found that "people of black African and Caribbean heritage are more likely than white British people to come into contact with mental health services through the criminal justice system…Adults of black African and Caribbean heritage are more likely than any other ethnic group to be detained under the Mental Health Act". The report also states the link between health inequalities and racism, making it clear that its recommendations should be seen as applicable to public bodies such as the police.

According to Kooth, the digital mental health platform/service across England and Wales, children and young people from minority ethnic backgrounds displayed greater increases in depression, anxiety, self-harm and suicidal thoughts than white peers during the coronavirus pandemic. Kooth service users from minority ethnic groups showed higher levels of self-harm, suicidal thoughts, depression and anxiety than white service users compared to the same time period in 2019.[19]

White C&YP saw a decrease in depression (-16.2%) during the pandemic while minority ethnic users saw a 9% increase

Suicidal thoughts as a presenting issue saw an increase among minority ethnic children and young people of 26.6% on 2019. Among white C&YP, they saw a lower increase (18.1%)

Anxiety/stress was the most prevalent issue for minority ethnic C&YP on Kooth and saw a 11.4% increase on the previous year. Among their white counterparts, the issue saw a lower increase (3%)

In Wales, a Public Health Wales engagement survey on health and wellbeing coronavirus measures found that –

- Coronavirus and the lockdown restrictions are currently having a greater impact on the mental health and wellbeing of minority ethnic residents in Wales.
- A third of minority ethnic respondents report feeling isolated and 1 in 5 are worrying a lot about their finances.
- Minority ethnic respondents are more likely to be feeling very anxious or isolated

It is crucial we tackle the inequalities in access to mental health support for those from minority ethnic communities.

- The pandemic has widened inequalities for these communities and it's crucial everyone is able to access mental health support in a timely and equal way, no matter what their background is. We know cultural factors and language barriers can be an obstacle for those from minority ethnic communities when accessing support and as such, we strongly welcome cultural competency initiatives, such as Diverse Cymru's The BAME Mental Health Cultural Competence Certification Scheme

5) Children and Young People

Though suicide in children and young people is rare, it is the biggest killer of young people (15–24) in the United Kingdom.[20] 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 (ONS) for 10–24-year-olds is currently at its highest since 2002–2004.

With half of all mental health problems beginning by the age of 14[21], we believe that preventative action and early intervention for children and young people is crucial to reduce poor mental health and suicide. Just like the adult population, the causes of poor mental health and suicide in children and young people is complex. However, there are two key factors which are of crucial importance in Wales, given our capacity to effect change as a nation.

Poverty and Adverse Childhood Experiences (ACEs) are factors which increase poor mental health and suicide risk in children and young people and adults. Nearly a third of children in Wales are living in poverty which is the highest percentage of any UK nation.[22]

People who have experienced Adverse Childhood Experiences (ACEs) are at much greater risk of mental illness throughout life. Adults who had suffered four or more types of ACEs are almost 10 times more likely to have felt suicidal or self-harmed than those who had experienced none.[23]

These two factors are closely linked. ACEs are often a feature for people who experience socioeconomic disadvantage. Investment in preventing and protecting children and young people from growing up in and living in poverty and experiencing poor mental health and suicidal ideation a major lever required to drive change in Wales. This has been highlighted numerous times during our work with schools and education surrounding the new curriculum.

The new curriculum

Young people are a high-risk group for mental illness and suicide in Wales, and as such, it is crucial that the new curriculum for Wales fulfils its commitment to health and wellbeing in a clear and tangible way. Following our collaborative work with Mind Cymru, we were very encouraged to see mental health on the face of the bill itself.

We believe the possibilities and opportunities of the new curriculum could introduce a new culture of change within mental health reform. The Health and Wellbeing Area of Learning must be harnessed alongside a whole school approach and thorough understanding and distribution of the ‘Responding to issues of self-harm and suicide in young people’ guidance which was initially published late 2019.

The new curriculum provides us with a real opportunity to embed culture change and protect future generations. With increases in referrals for CAMHs and lengthy waiting lists,

we must identify the way in which schools can assist with this, particularly from a preventative downstream perspective.

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. Schools and educational settings need clear stand-alone statutory guidance in order to fulfil this commitment.

- **Focus on minimising the number of children who are excluded from school** to break the cycle of lifelong socio-economic disadvantage and subsequent poor mental health / suicide risk. 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.

- **Schools, local health services, local authorities, public services and the wider public sector must invest and work to reduce ACEs**, their impact on individuals and, most significantly, understand the benefits of intervening in the cycle of ACEs.

Exclusion

Exclusion from school is linked to a much wider set of recurring inequalities, circumstances and consequences, including profound effects on physical and mental health. It is also a risk factor for poor mental health, suicidal behaviour and suicide

- Research shows that exclusion from school is more common among boys, secondary school pupils, and those living in socio-economically deprived communities. There were consistently high levels of psychological distress among those who had experienced exclusion at baseline and follow up.[24]

- Based on surveys during six inspections by the HM Chief Inspector of Prisons for England and Wales in 2017/18, 89% of children reported exclusion from school before they came into detention, 74% reported previous truancy, and 41% said they were 14 or younger when they last attended school.[25]

- A large UK study on exclusion from school found that exclusion was more common among children of lower socio-economic status, boys, and those with language difficulties, lower educational attainment or special educational needs. Family characteristics, such as poor parental mental health and engagement with education, also predicted exclusion. It also found that children who were subsequently excluded were more likely to have a clinically impairing mental health condition or a social communication problem, as well as involvement in bullying as a perpetrator or victim, and poor teacher-pupil relationships.[26]

Exclusion from school is a major inequality issue. Addressing it also represents an opportunity to intervene in the cycle of ACEs. Avoiding exclusion should be understood as part of a wider ambition to intervene in cycles of disadvantage at a formative stage in a young person's life. Intervention to reduce ACEs can have a major effect on mental health and suicide risk.

Young people and self-harm

Self-harm is more common among under 25s and has been rising in recent years across the UK, particularly among young women. While most people who self-harm will not go on take their own life, it is a strong risk factor for suicide.[27] Across the UK, suicide rates (ONS) among young people have also risen in recent years, with rates for young women in England and Wales reaching the highest rate on record for this group. The reasons for suicide are complex, but some of the more common factors among young people are academic pressures and bullying, workplace, housing and financial problems. Young people have been hugely affected by the restrictions resulting from the pandemic. Social lives were curtailed at an important life stage, and work and education opportunities were put on hold for many. We also know that young people, especially young women, experienced the most significant deterioration in mental health in the first month of restrictions and other studies suggest this continued later into 2020.[28]

In our volunteers' conversations with young people during the pandemic there were four key themes: access to mental health and self-harm support, family tensions, lack of peer contact and negativity about the future.

Volunteers told us that access to mental health support was the most common concern among young people and the majority of volunteers regularly spoke to young people about this. Similarly, young people's reduced access to community support services or networks, such as support provided in schools, social activities, or physical activity groups, was a

common cause of distress. Our volunteers suggested that young people saw the loss of these support structures or coping mechanisms as a key driver for the decline in their mental health.

Our volunteers reported that, as the restrictions tightened into the winter, they were hearing from more young adults with worries relating to managing or resisting self-harm. Samaritans' volunteers suggested there had been an increase in contacts with young people about using self-harm as a coping mechanism. Volunteers also spoke of a rise in callers who had returned to self-harm as a way of trying to cope, or who were struggling to resist self-harm in the absence of other support. During the past year, in 22 per cent of contacts where self-harm was discussed, the caller was resisting self-harm.

As our service data doesn't capture specific ages, we cannot track how this has changed over time. However, we do know that discussion of self-harm was much higher among under 18s. In the past year, a third (35%) of callers aged under 18 discussed self-harm compared to 7 per cent of adults.

Volunteers told us that uncertainty and negativity about the future, relating to economic factors, were also key themes in contacts from young people. For younger callers who were just starting out in work, volunteers described concerns from callers about whether they would keep their job. Among those seeking employment, concerns centred on whether they would find a new role in a very competitive job market. Volunteers reported that these concerns extended to those still in education, either school or university. For these callers, looking ahead brought uncertainty both about whether their qualifications would be affected by their reduced time in school, and how they would fare when they did enter the job market. Beyond employment, some callers discussed concerns that they would not achieve the appropriate qualifications, which would then impact their future career choices or employment prospects. Volunteers noted that a few young callers expressed "fear of being a lost generation" and concerns about the impact on their futures.

> '*Several were students who literally felt they could die in their rooms, and no-one would know for days.' – Samaritans volunteer*

> *'The younger people I have spoken to… don't want to be tagged as 'the covid generation' as they see this will impact their ability to get a job. Some have said they don't feel they will get the results they expected prior to covid, and now feel like they will miss out on so much in the future'. – Samaritans volunteer*

6) Women

Self-harm is a complex behaviour that is not always easy to define as suicidal or not, and a person's reasons and intentions when self-harming can change over time. Regardless of intent, self-harm is a serious public health issue and is one of the top five reasons for medical admission in the UK.[29] For many, non-suicidal self-harm is a way of coping with emotional distress or poor mental health, and this is distinct from suicide attempts. Due to

limited self-harm data and evidence in Wales, self-harm remains an issue that is often hidden and poorly understood.

In 2020, we conducted a survey of over 900 adults in Wales to explore current understanding and perceptions of self-harm among the general public. Overall, understanding of the underlying factors that contribute to self-harm were good, with 8 in 10 (84%) of adults in Wales agreeing that people use self-harm as a way of coping when they are dealing with difficult emotions or experiences.[30] Whilst it's clear the majority of Welsh adults understand some of the causes of self-harming behaviour, a fifth of adults in Wales think that self-harm is a passing phase. Women and respondents between 18-34 were less likely to agree with this statement

The most reliable data for self-harm available in Wales is derived from hospital admission data, with approximately 5,500 admissions for self-harm, regardless of suicidal intent, in Wales each year.[31] Self-harm can affect people of all ages and genders, but we know it is more common in females across all age groups. Our data at Samaritans also supports this. Self-harm is discussed in twice as many calls from women than men (12% vs 6%). For the period 2007-2016, age specific self-harm admissions regardless of suicidal intent in Wales showed the highest rate among females aged 15-19 years.[32] For males in Wales, the highest age- specific rate is in the 25–29-year age group between 2007 and 2016.[33] There has also been an increase in self-harm rates amongst those aged 10-17 in Wales. There is no conclusive evidence to explain why self-harm is increasing. It could be attributed to reduced stigma and improved management of self-harm in young people, but this is unlikely to explain all the increase

While most people who have self-harmed will not go on to take their own life, it is a strong risk factor for future suicide.[34] Self-harm can lead to suicidal thoughts developing and, among young people, it is one of the strongest predictors of transition from suicidal thoughts to behaviours. In calls to Samaritans, as expression of suicidal thoughts rises, so too does discussion of self-harm. On an individual level, callers who discuss self-harm with Samaritans were 2.5 times more likely to express suicidal thoughts than other callers. Self-harm can also reduce a person's fear of pain or death and therefore lead to an ability to self-harm more severely over time. More generally, self-harm is often a sign of complex underlying mental health problems and serious emotional distress, yet research shows that long term self-harm does not help reduce that emotional distress.

According to our report, seeking support appeared to be associated with changes in people's mental health in the day, week and month after the self-harm.[35] People who sought support were more likely to say their mental health worsened the day after they self-harmed, compared to those who didn't seek support (41% vs 27%), suggesting that people whose mental health deteriorates following self-harming are more likely to seek support. However, by a month after the self-harm, our data indicates that this changes, with people who sought support appearing to be more likely to report improved mental health, compared to those who didn't seek support (42% vs 33%). This demonstrates the value of help-seeking, and the importance of tackling stigma and increasing awareness in the community and within services to ensure more people access timely and effective support.

Self-harm can be linked to mental health conditions such as depression, anxiety, borderline personality disorder and post-traumatic stress disorder. Mental health services provided by the NHS in Wales have the potential to support people who have self-harmed both to address the underlying causes of self-harm and to understand the triggers of the behaviour. However, our discussions with people with lived experience of self-harm and research experts highlighted that there are many barriers to people accessing support through mental health services, including support being guarded by high thresholds. They told us that as their needs are seen as less serious, people who have self-harmed without wanting to take their own life are being excluded from this support. In a survey of Samaritans volunteers, over a third (32%) said callers who are concerned about their mental health most frequently talk about NHS mental health treatment not being effective.[36] Volunteers spoke of a number of barriers to help-seeking faced by callers, including long waiting lists and a lack of appropriate services, as well as concerns around the attitude/judgement of frontline workers.

A quarter (24%) of the general public in Wales said they would not feel comfortable talking to a GP or another healthcare professional about self-harm. Women were less likely than men to feel comfortable (67% vs 56%). Less than a quarter (23%) of survey respondents with lived experience of self-harm in Wales found support from a GP, doctor or medical professional at least moderately useful after self-harming. Over half (53%) of respondents in Wales who didn't seek support from a GP after recent self-harm thought their GP wouldn't or couldn't help. This compares to less than a quarter (22)% of respondents across the UK and Ireland. Similarly, almost half (47%) of respondents in Wales didn't think their self-harm was serious enough to seek support from a GP, compared to just over a quarter (26%) of respondents from across the UK and Ireland.[37]

We must prioritise self-harm

- 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 wider recognition of the importance of a compassionate response to self-harm. Underpinning all our discussions and recommendations was the need to adopt a compassionate approach to those who have self-harmed. Responding with compassion to someone experiencing poor mental health and distress can help ensure better outcomes and future help-seeking

- 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

(We outline further recommendations on this matter in our report - The right support at the right time. Our focus on self-harm and women is also outlined in the *Women & Girls' Health Plan and Quality Statement for Wales (*Fair Treatment for the Women of Wales)

Finally, as we have supported and emphasised as co-chairs of the Welsh NHS Confederation Health and Wellbeing Alliance's Mental Health Subgroup, it is clear that the policy changes needed to tackle mental health inequalities do not belong to any one sector, government department or Senedd committee. Mental health inequalities are strongly linked to social justice, welfare, early years and education. As such, we call for a cross-governmental approach to tackling mental health inequalities.

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