

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:



HM Coroner



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North Wales Suicide and Self-Harm Prevention Strategic Plan 2018-2021

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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.



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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:

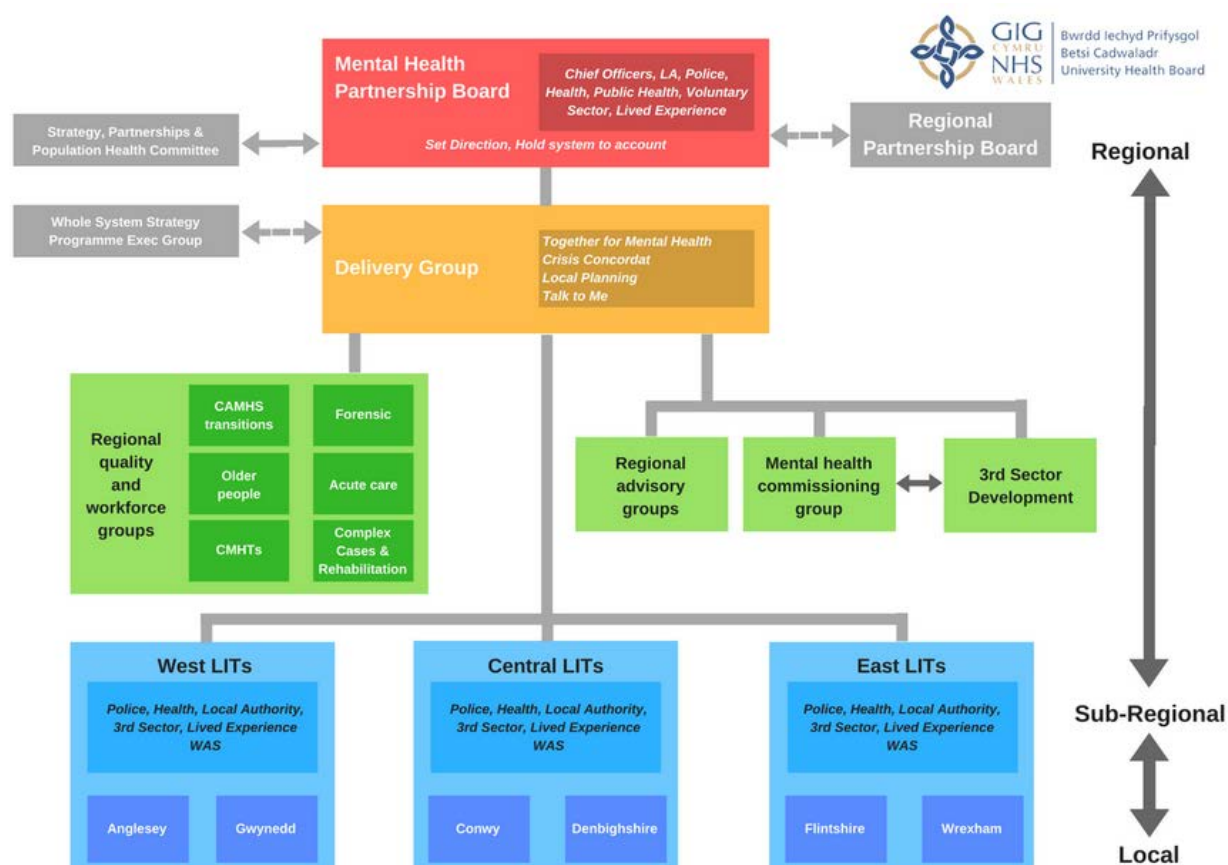
- Promote health and wellbeing for everyone, focusing on prevention of mental ill health, and early intervention when required
- Provide evidence based interventions for people with common mental health conditions in the community as early as possible
- Are community-based wherever possible, reducing 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

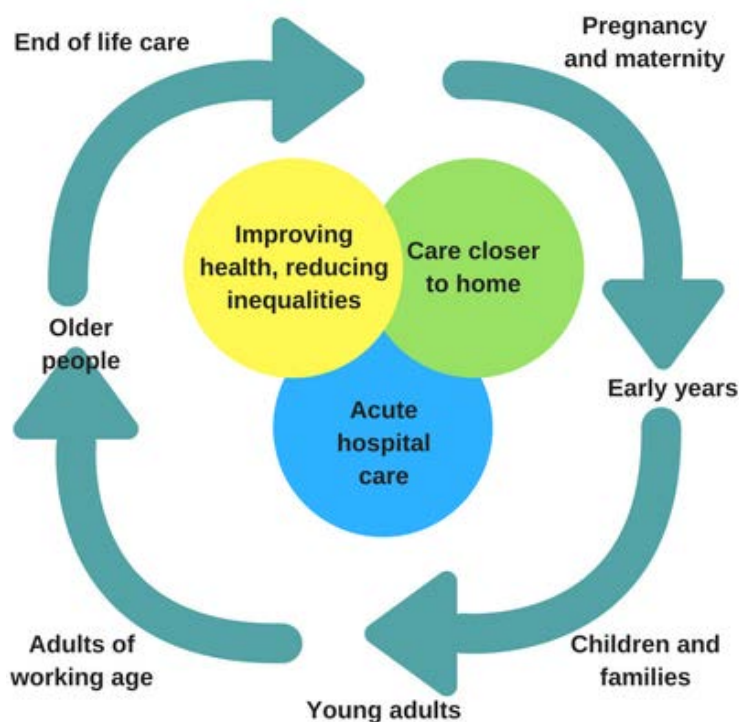
Figure 2: Health and wellbeing – physical, emotional and mental – throughout life

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.

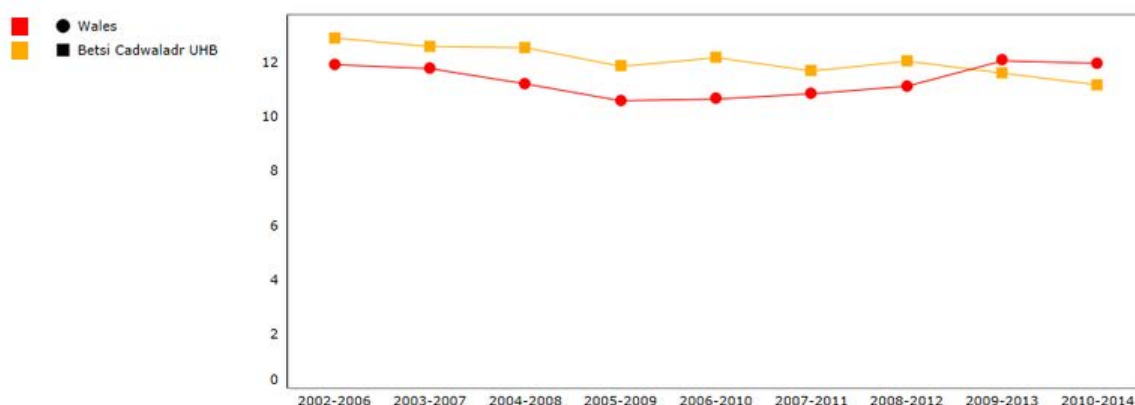
This tries to correct for known under-reporting and is thought to produce a more accurate total (and rate) of suicide in a given year. In summary, deaths from suicide are identified from death registrations where the cause is given as from self-harm, or from 'event of undetermined intent'. Fortunately, 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

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)

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

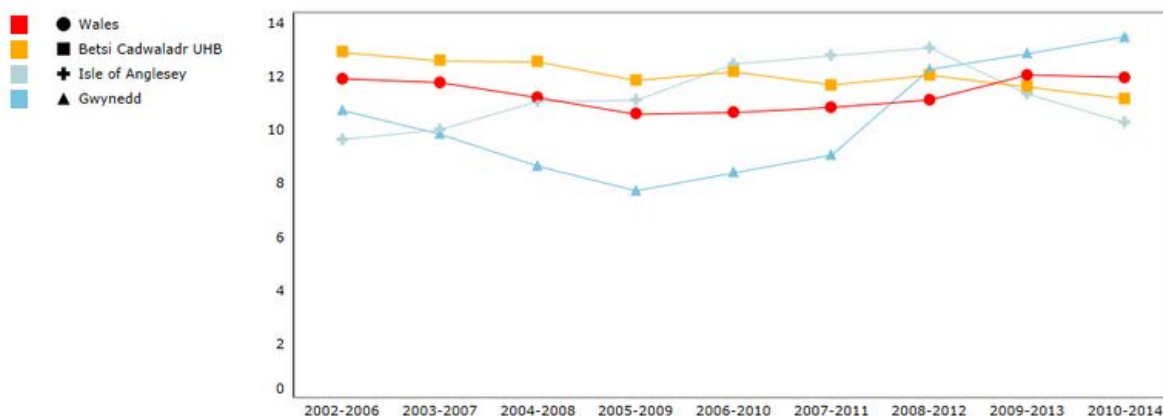
In the West, Anglesey's suicide rate seems to have gradually increased between 2002-2006 and 2008-2012 but since then has fallen back to be lower than BCUHB and Wales. Gwynedd has historically been lower than BCUHB and Wales, but since 2008-2012 has been higher.

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

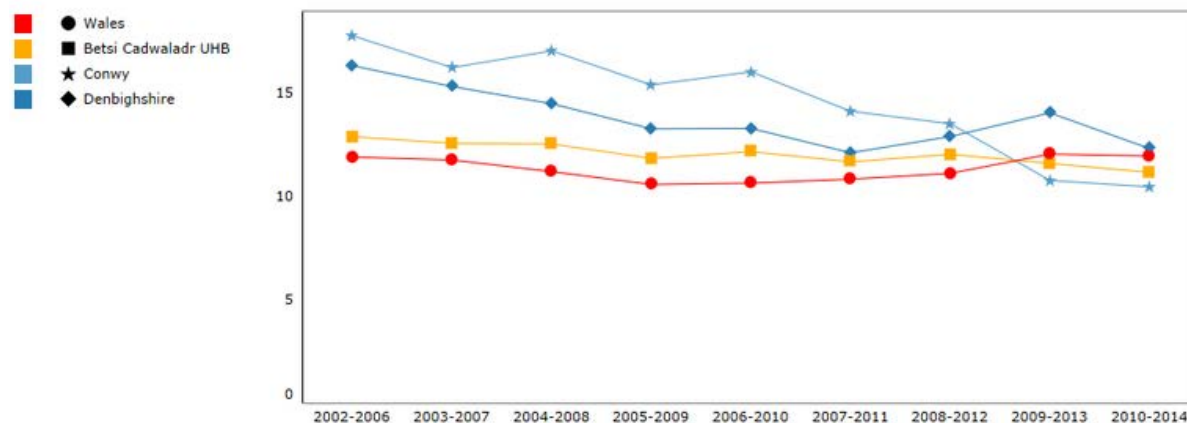
Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales, Betsi Cadwaladr UHB and local authorities, 5 years rolling rate, 2002/06-2010/14



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

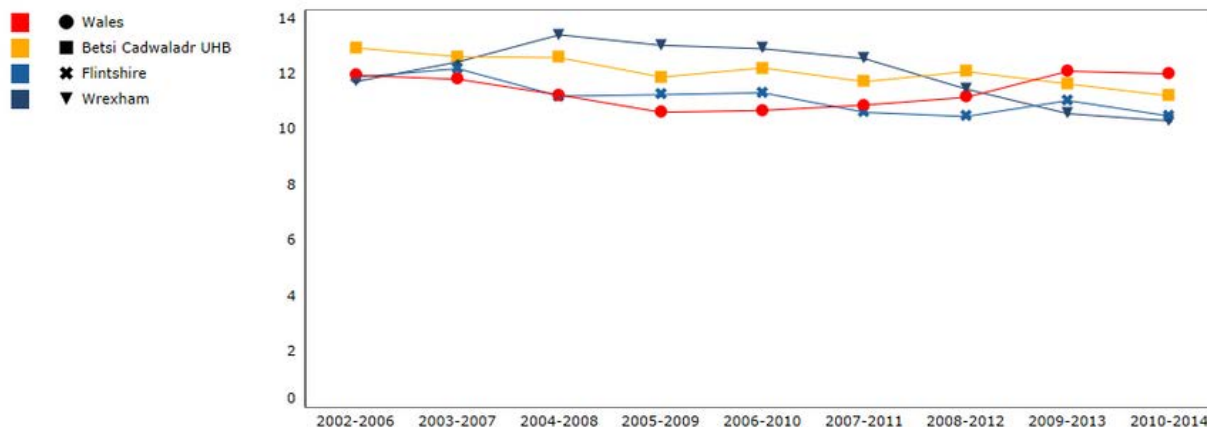
Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales, Betsi Cadwaladr UHB and local authorities, 5 years rolling rate, 2002/06-2010/14



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

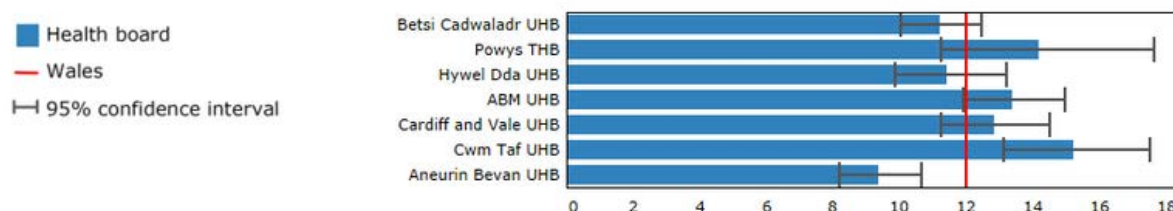
Suicides, European age-standardised rate (EASR) per 100,000, persons aged 10+, Wales, Betsi Cadwaladr UHB and local authorities, 5 years rolling rate, 2002/06-2010/14



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

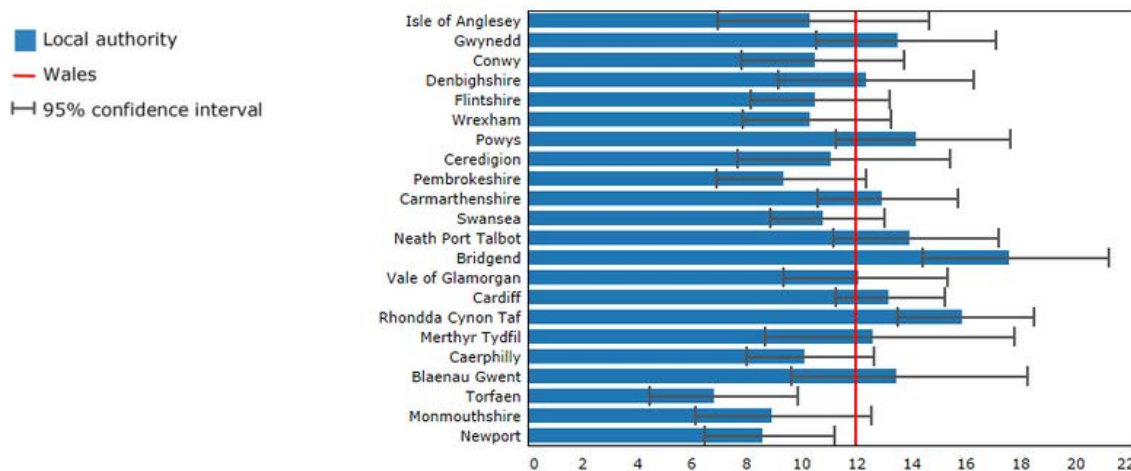


Caution should be used when interpreting suicide rates due to improvements to the way they were coded from 2011. More details can be found in the Technical Guide. Produced by Public Health Wales Observatory, using Public Health Mortality and Mid-Year Population Estimates (ONS)

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

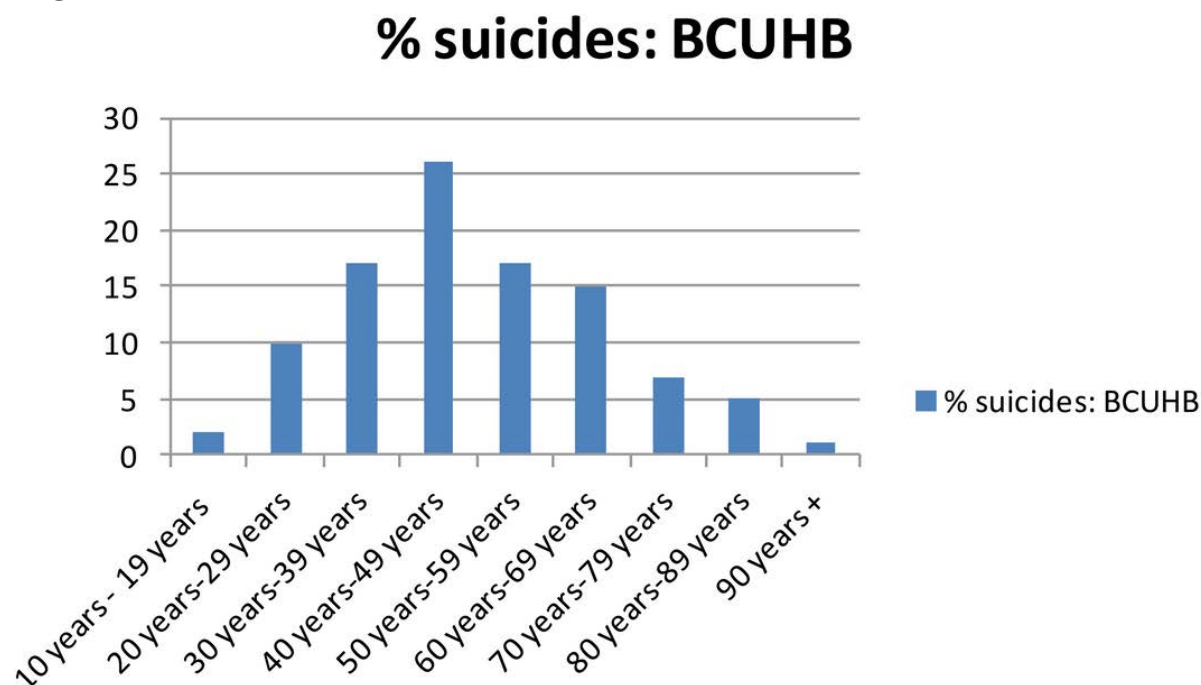
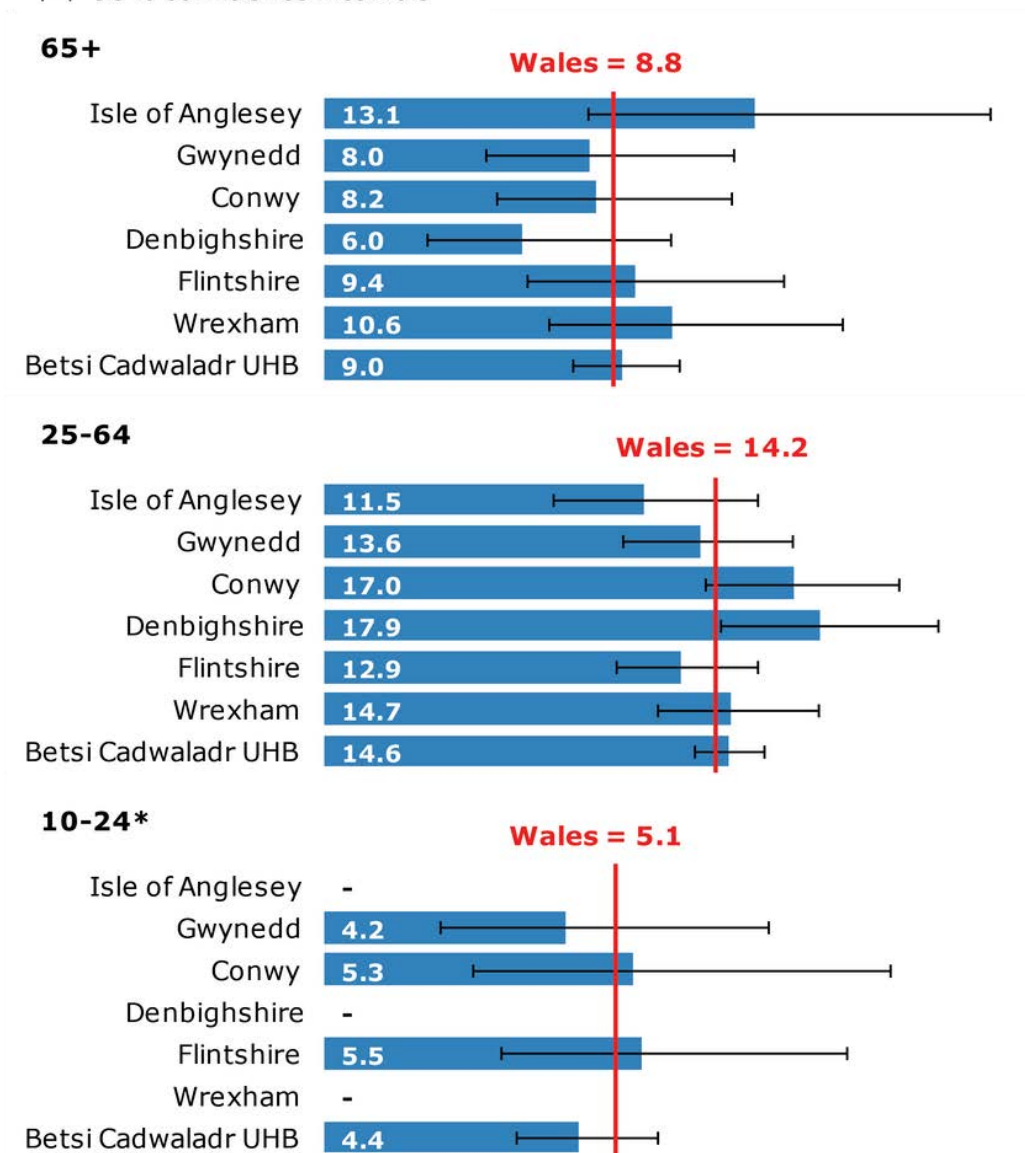


Figure 10

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)

— 95% confidence intervals



* 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.

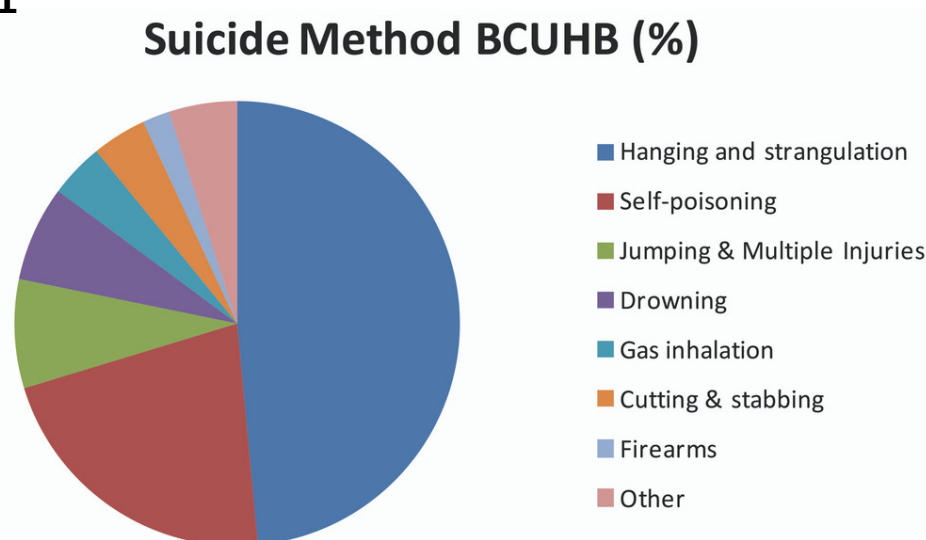
Suicide is a significant equality issue as there are marked differences in the suicide rates according to people’s socio-economic backgrounds (John, Glendenning & Price, 2017). *Talk to Me 2* highlights that improving the mental health of people who are vulnerable due to these circumstances supports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

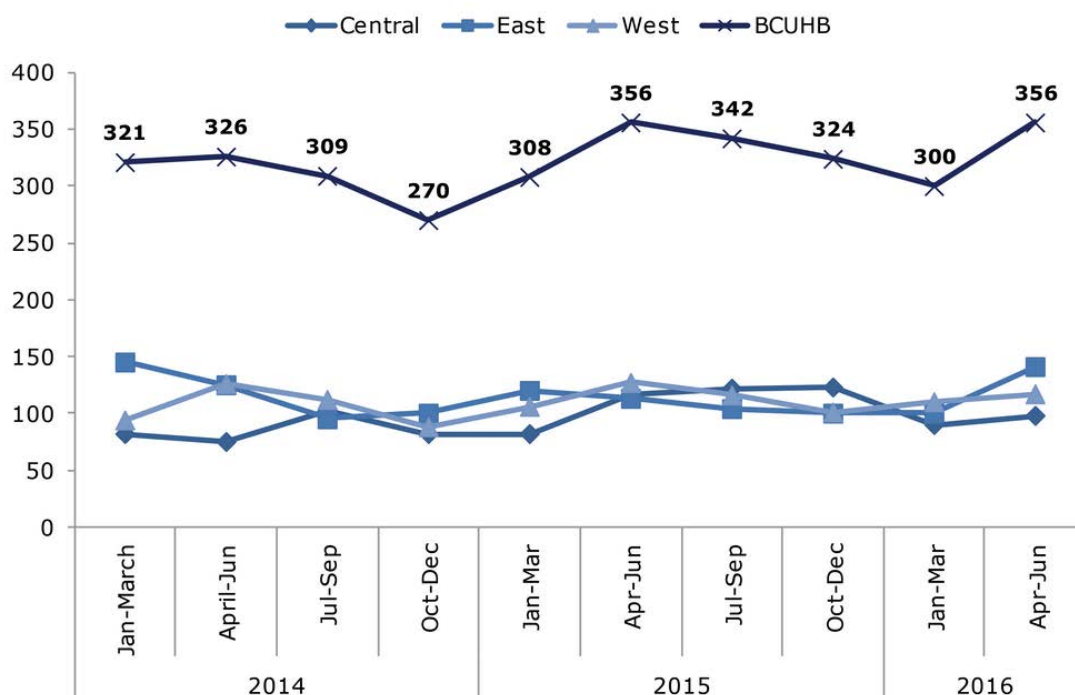


Figure 13

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

Source: NRLS

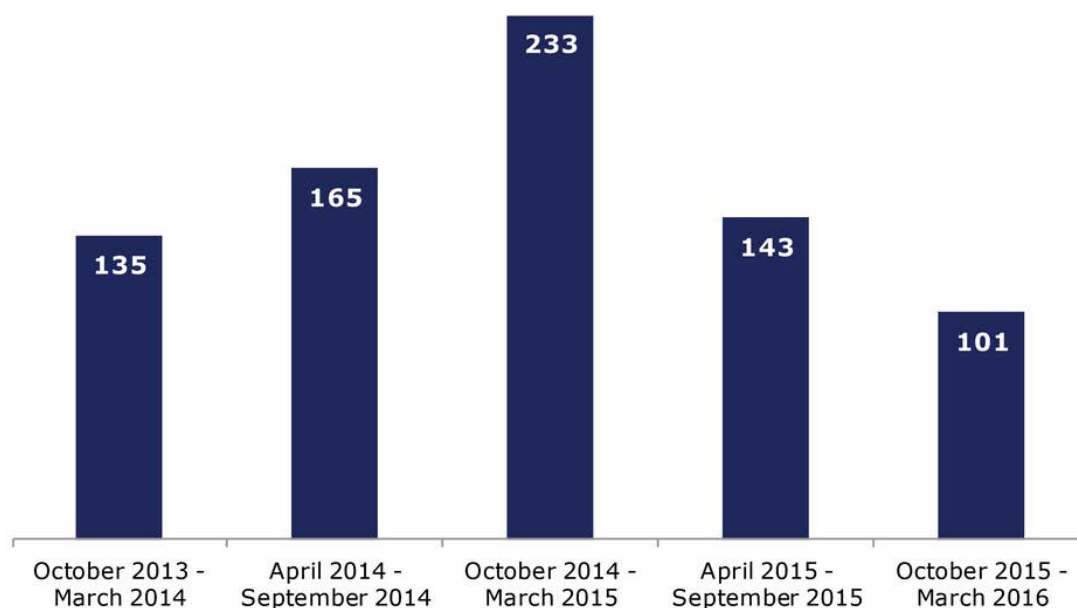
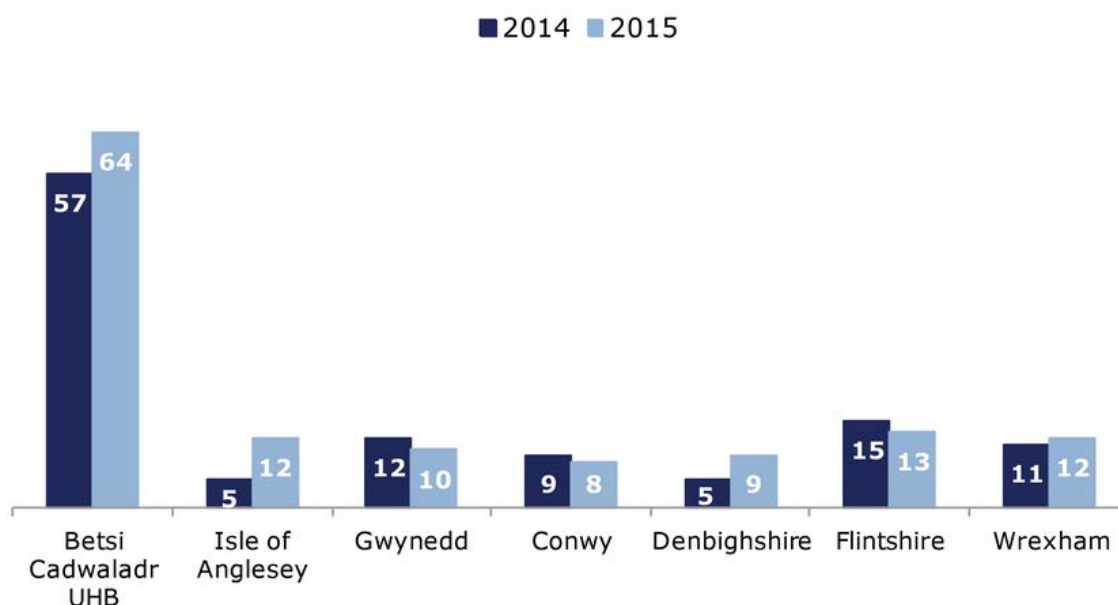


Figure 14

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

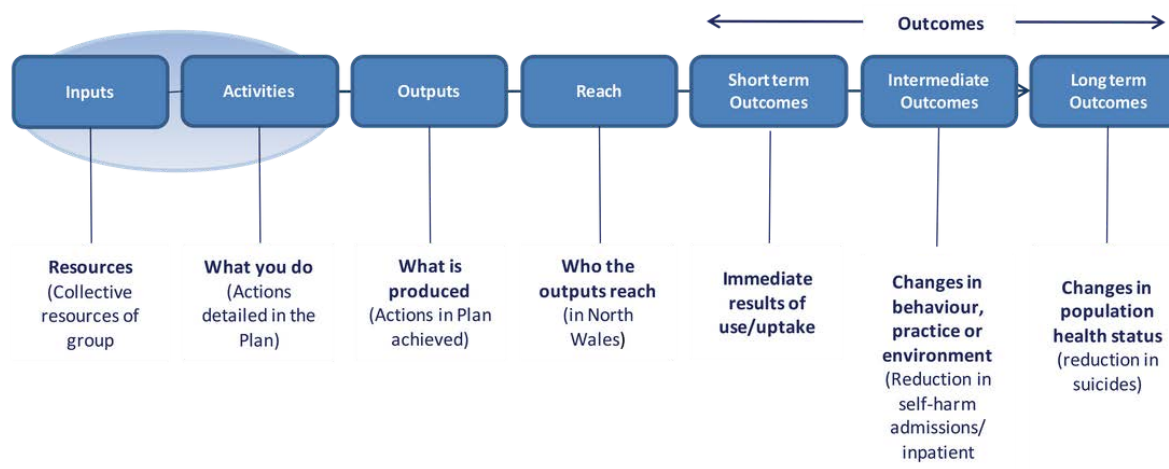
Source: Office for National Statistics



- 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.

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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

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	<p>Priority groups/individuals that the training should target –</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - Police - Welsh Ambulance - Primary Care workers - Emergency department staff - Fire fighters • Network Rail • Healthcare and Community staff 						
	<p>1.3 Review implementation programme of 'Time to Change' in BCUHB; with particular reference to suicide and self harm</p> <p>https://www.time-to-change.org.uk/</p>	<p>BCUHB Employees</p>	<p>BCUHB Public Health Directorate</p>		<p>Group members</p>	<p>Yr 1</p>	<p>Review completed</p>
	<p>1.4 Support and encourage Suicide and Self harm group member organisations to sign up to 'Time to Change' and develop accompanying implementation plan</p>	<p>Organisations represented at the group</p>	<p>BCUHB Public Health Directorate lead agenda item at group meeting</p>	<p>✓</p>	<p>Group members</p>	<p>Yr1</p>	<p>Implementation plan developed</p>

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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

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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

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	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

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							work with this group
Reduce the risk of suicide in children and young people	<p>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:</p> <ul style="list-style-type: none"> • 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	<p>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 tackling cyber bullying and reducing bullying around the protected characteristics</p>	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 <i>Help is at Hand (Wales)</i> 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

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							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

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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

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			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

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- **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.	<p>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 <i>Talk to Me 2</i>. Our strategic plan has considered national learning, but also builds on practice, experience and expertise within North Wales.</p> <p>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.</p> <p>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.</p> <p>The six objectives are as follows:</p> <p>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</p> <p>Objective 2: To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm</p> <p>Objective 3: Information and support for those bereaved or affected by suicide and self-harm</p> <p>Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour</p> <p>Objective 5: Reduce access to the means of suicide</p>

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		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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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.

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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 inequalities where they may exist and improve access to interventions to reduce suicide and self-harm across North Wales.

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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

- 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.

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.

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Form 3: Assessing Impact Against the General Equality Duty

<p>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:-</p> <ul style="list-style-type: none"> • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups 	
<p>1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise</p>	<p>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.</p>
<p>2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)</p>	<p>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.</p>
<p>3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)</p>	<p>Opportunities for on-going stakeholder engagement will include meeting with specific community and special interest groups regarding specific initiatives</p>

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed? (Copy from Form 1)	North Wales Suicide and Self-Harm Prevention Strategic Plan
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>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 <i>Talk to Me 2</i>. Our strategic plan has considered national learning, but also builds on practice, experience and expertise within North Wales.</p> <p>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.</p> <p>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.</p> <p>The six objectives are as follows:</p> <p>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</p> <p>Objective 2: To deliver appropriate responses to personal crises, early intervention and management of suicide and self harm</p>
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	<p>Objective 3: Information and support for those bereaved or affected by suicide and self harm</p> <p>Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour</p> <p>Objective 5: Reduce access to the means of suicide</p> <p>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</p>
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3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
3c. Is your decision or policy of high significance?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>

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	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
	<p>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?</p> <p>As there has been potentially limited impact identified and it is predominantly positive, it is unnecessary to undertake a more detailed equality impact assessment.</p>			
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
	<p>Record Details:</p> <ol style="list-style-type: none"> 1. People who communicate using the Welsh language should be taken into account when any communication approach is planned 			

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	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 <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	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	

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8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Engagement Undertaken:- <ul style="list-style-type: none"> • 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
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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 Cadwaladr 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		

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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.		