Llywodraeth Cymru
Welsh Government

Number: WG50719

Welsh Government

Consultation – summary of response

Draft Suicide and Self-harm Prevention Strategy

October 2024

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

 Digital ISBN 978-1-83625-736-3

Overview

The consultation sought views on the Welsh Government's draft ten year Suicide and Self-harm Prevention Strategy. This document provides a summary of consultation responses.

Action Required

This document is for information only.

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

Contact details

For further information:

Mental Health and Primary Care Division
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Email: mentalhealthandvulnerablegroups@gov.wales

Additional copies

This summary of response and copies of all the consultation documentation are published in electronic form only and can be accessed on the Welsh Government's website.

An Easy Read and Children and Young People's Version of this summary are also available. A summary of the engagement carried with children and young people carried out by Co-production Lab Wales is also available.

Link to the consultation documentation: Draft suicide and self-harm prevention strategy | GOV.WALES

Consultation Summary Report on the Draft Suicide and Self-harm Prevention Strategy

Contents

1. Introduction

On 20 February 2024, Welsh Government issued a public consultation for 16 weeks on the draft Suicide and Self-harm Prevention Strategy (the "strategy"), alongside the draft Mental Health and Wellbeing Strategy. The strategy aims to reduce the number and rates of suicide deaths that have endured over recent years. It also aims to establish a pathway to support people who self-harm and to improve support for those bereaved by suicide. This document provides a summary of the 126 consultation responses submitted to Welsh Government, alongside key findings from the engagement carried out with children and young people by Co-production Lab Wales.

We would like to thank everyone who has taken the time to consider the draft strategy and provide their feedback, either by completing the consultation survey or by participating in engagement sessions.

2. Context

The new Suicide and Self-harm Prevention Strategy will replace the previous strategy Talk to me 2: the suicide and self-harm prevention strategy for 2015-2022.

The new draft strategy is set in the context of A Healthier Wales: our Plan for Health and Social Care ("A Healthier Wales") which sets out the vision for a whole system approach to health and social care in Wales. A Healthier Wales lays out the Welsh Government's ambitions for progress and improvement, and describes the core values that underpin the health and social care system in Wales, including:

"Proactively supporting people throughout the whole of their lives, and through the whole of Wales, making an extra effort to reach those most in need to reduce the health and wellbeing inequalities that exist."

The draft strategy is also set in the context of the Well-being of Future Generations (Wales) Act 2014 which aims to improve the social, economic, environmental and cultural wellbeing of Wales. Achieving the wellbeing goals set out in the Act is vital in relation to tackling some of the key drivers of suicide and self-harm in Wales.

The draft strategy published for consultation set out an overarching vision for suicide and self-harm in Wales, alongside six underpinning principles, six high-level objectives and a number of supporting sub-objectives.

3. Pre-Consultation Engagement

With the view to informing the development of the draft Mental Health and Wellbeing Strategy and Suicide and Self-harm Prevention Strategy, Welsh Government commissioned several reviews to engage a range of stakeholders, services, service users and those with lived experience to help shape future priorities. This included the Independent Review of Together for Mental Health and Talk to Me 2 Strategies (2012-2022) which acknowledged that while we had made some important progress over the last ten years "there remains some way to go" – in terms of the outcomes and societal change we are looking to achieve, which are likely to be long-term or even generational. A pre-consultation engagement exercise (which included over 260 responses to an on-line survey) was also carried out in June 2023, which helped inform the development of the objectives and the underlying principles for both strategies.

4. Background to the consultation

The consultation on the draft Suicide and Self-harm Prevention Strategy included the publication of supporting draft impact assessments, as well as an Easy Read and BSL version of the strategy. The full text of the consultation is available at:

Draft suicide and self-harm prevention strategy | GOV.WALES

An online consultation form was available, which could also be submitted via email and hard copy. An Easy Read consultation form was also developed and shared with stakeholders.

During the consultation period, Welsh Government engaged with stakeholders through online and in-person events. This included engagement sessions with the health boards, third sector, local authorities, and key reference groups (for example, the Ethnic Minority Mental Health Task and Finish Group). Links to the consultation were also shared widely with stakeholders, with a specific focus on ensuring information had been shared with stakeholders and those working with under-served groups. In total, 126 responses to the consultation were received (30 respondents selected to remain anonymous). An engagement pack was developed and shared widely – with the view to supporting stakeholder discussions and feedback. The NHS Wales Executive and the Suicide and Self-harm Prevention Programme also led specific engagement sessions, held at a regional level.

Chart 1 below provides a summary of the organisations and individuals that responded to the consultation.

Chart 1:

Your interest in the strategy. Please tick all that apply.				
Answer Choices			**Response Percent**	**Response Total**
1	Lived experience		42.57%	43
2	Carer		6.93%	7
3	Member of the public		11.88%	12
4	Health care staff		23.76%	24
5	Social care staff		14.85%	15
6	Third sector staff		32.67%	33
7	Other professional role		17.82%	18
8	Organisational response		46.53%	47
9	Prefer not to say		0.00%	0
			answered	101
			skipped	25

Welsh Government also commissioned Co-Production Lab Wales to undertake tailored engagement with children and young people. As part of this work, between February and June 2024, 28 young people (aged between 7 and 25) with a diversity of interests, needs and lived experiences, from all parts of Wales, shared their views on the draft Suicide and Self-harm Prevention Strategy 2024-2034. A summary and key themes from their engagement is available – and is published on the Welsh Government website. It should be noted that the responses from the children and young people engagement are not included in the charts and figures in this summary, as they were asked different questions to suit ability and age. However, their comments have been considered in the wider feedback narrative.

5. Summary of consultation responses: Cross-cutting themes

There were a number of cross-cutting themes raised in the 126 responses to the consultation. We have summarised these below, with the view to addressing repetition across our analysis.

Strong support for the draft strategy overall

The consultation included 15 questions where we asked whether people strongly agreed; agreed; neither agreed nor disagreed; disagreed; or strongly disagreed with aspects of the strategy. These questions included a focus on the strategy's overall vision, principles, priority groups and each of the objectives. Of those responding to these questions, 87% either agreed or strongly agreed with our proposals. However detailed and specific suggestions or amendments were also provided.

In terms of the overall vision, there was strong support for addressing stigma and building compassionate, resilient communities. Responses were also supportive of other aspects of the wider strategy, such as the attention given to the social impact of suicide; the emphasis on early prevention, crisis intervention and postvention at both an individual and community level; and the consideration of the social determinants of suicide and self-harm.

There was particularly strong support for objective 5 centred on ensuring an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma – with 96% of responses either agreeing or strongly agreeing with this objective.

Suicide and self-harm: A call for greater parity

An important cross-cutting theme from consultation responses was a strong sense that the strategy was disproportionately weighted towards suicide. In particular, there were calls for separate strategies and delivery plans for suicide and self-harm, as these were considered as very different issues, and that both should be treated independently.

Responses highlighted the need for clear and specific objectives for self-harm (which were considered missing from the strategy), and for these to include a consideration of safe self-harming / harm reduction, as well as a focus on prevention. The definition of self-harm harm needs specific consideration.

This strategy is using a very narrow definition of self-harm which is something we advise against as it excludes so much and will leave a huge number of people unsupported. (Third Sector)

Regarding the overall vision of the strategy, there were specific requests that suicide and self-harm are considered separately and that the vision should include an ambition to reduce rates of suicide and self-harm independently of one another.

Resources and funding

This was a major theme across all of the consultation questions. Regarding the overall vision of the strategy and each of the objectives, responses highlighted how they need to be supported by a realistic and achievable plan with adequate resourcing. Responses talked about gaps in services, the need for training and upskilling, service improvement and the need for a sustainable and equitable funding model across Wales. A “mismatch” between the high-level vision in the strategy and the harsh reality of “what is going on” in the health and social care services was specifically highlighted.

Detail and clarity

Many responses commented that the draft strategy lacked the necessary detail to allow for an understanding about how it could and would be delivered. Some commented that the Welsh Government had missed an opportunity to engage stakeholders on the detail, to understand who would be accountable for what, and to test if those who will ultimately be responsible for delivery, can deliver. Across all of the objectives, responses called for greater clarity and more detail (for example – clear and achievable metrics, actions, outcomes and timelines) to better understand how objectives would be delivered.

Governance and accountability

Linked to the cross-cutting theme on detail and clarity were calls for a greater focus on governance and accountability. Responses called for named leads and assigned individuals to ensure accountability – for example in relation to cross-Government action (objective 2) and responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour (objective 6). Without this, responses highlighted the risk of inaction and “everybody’s business” becoming “nobody’s business”. Linked to this was a theme around monitoring and evaluation**,** recognising that this is a ten year strategy and things will change during that period so systems and processes need to be put into place to ensure that the strategy is relevant and based on the most up-to-date evidence.

Lived experience and co-production

This was another important cross-cutting theme. Responses were concerned that there was an over-reliance on data and called for a greater focus on working with those with lived experience throughout the strategy and supporting delivery plans. There was also a recognition that engagement with children and young people needs to be carefully managed.

The most fundamental of these principles is that the strategy must be driven by lived experience. The most important people in this strategy are the people experiencing either issue. A range of voices from a cross-section of society, including the groups at particularly high-risk, must be listened to. Their voices must help inform the final document. (Anonymous)

A focus on children and young people

Question 10 of the consultation asked for views on whether it was clear that this was an all age strategy. 48% of responses said that it was not clear. The need for a greater focus on children and young people was consistently mentioned, recognising their nuanced risks (e.g. to the influence of social media) and also the opportunities for embedding positive habits at a young age.

Question 1: The overall vision of the strategy

The vision

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

What we asked you

We asked you if you agreed with this vision and why.

What you told us

To what extent do you agree with this vision? “People in Wales will live in communities which are free from the fear and stigma associated with suicide and self-harm and are empowered and supported to both seek and offer help when it is needed.”

Answer Choices			Response Percent	Response Total
1	Strongly agree		44.32%	39
2	Agree		37.50%	33
3	Neither agree or disagree		10.23%	9
4	Disagree		4.55%	4
5	Strongly disagree		3.41%	3
			answered	88
			skipped	38

Key themes from our analysis of consultation responses

Reframe the focus on stigma

Whilst some responses were in support of tackling the stigma associated with suicide and self-harm, others noted that this could be inadvertently harmful. In some instances, stigma can be a protective factor and reducing it may normalise behaviours. Instead of trying to de-stigmatise suicide and self-harm, the focus should be on addressing stigma for help-seeking, and talking about the behaviours and risk factors that contribute to suicide and self-harm.

Other responses advocated for the complete removal of negative words such as “stigma” and “fear” from the overall vision for the strategy, and instead anchor the statement in a positive, strengths-based approach. The importance of defining what we mean by stigma also came up in responses for other consultation questions (for example, objective 5).

Challenging vision to achieve

Another important theme – was that responses reported multiple challenges in trying to achieve this vision. Changing views and reducing stigma will be time consuming and a difficult action to achieve, which will require a multi-pronged approach. Crucially: the current lack of resource and infrastructure will hinder the achievement of the vision. This is links directly to the cross-cutting theme around needing a realistic and achievable plan for the strategy, with adequate resourcing.

In addition, responses also commented on current “geographical imparity” and how some areas will struggle more than others to meet the strategy’s vision.

Some geographic areas will struggle to more than others to meet this vision, i.e. rural farming communities, isolated small villages and towns. These are areas where everyone knows everyone and there isn’t the same amount of “anonymity” that a larger village or town provides. Seeking help in smaller, remote areas is more difficult, particularly face to face help. (Health Boards, NHS Trusts and Special Health Authorities)

The vision needs to be stronger, clearer and more ambitious

Other responses had strong beliefs that the vision is not ambitious enough and the language used is too passive – in relation to both suicide and self-harm. To strengthen and give more credibility to this vision, responses called for specific and measurable outcomes. A number of questions also arose, including: what are we aiming towards / how will a reduction in stigma be measured?

Responses asked for greater clarity around the terminology used, particularly in terms of defining “communities” and what is meant by “fear”.

Access to equitable services when needed

Responses highlighted the need for the vision to include a focus on investment in services – particularly for those with severe and enduring mental ill health, for at-risk populations, and for people in crisis. Such services need to be timely, relevant and accessible for all, with cultural and geographical parity. There was a particular focus on preventative mental health services and “alternative to admission” models of care for those in crisis.

Holistic and person-centered support

Receiving holistic and person-centered care when required was a key theme, with calls for this to be included in the overall vision for the strategy.

A focus on knowledgeable, compassionate, and trauma informed services

A number of responses noted a lack of compassion, empathy and understanding by staff and society in response to those displaying suicidal behaviours and/or self-harming.

Often, they labelled him as a "waste of space" and invited me to "move on and forget him". (They frequently did the same in the period leading up to his death as he displayed the signs of being deep in crisis). (Lived Experience)

Concerns were also raised about the advice (or lack of advice) currently given to people at risk of self-harm or suicide by community mental health teams and other specialist organisations. There was a strong emphasis on the importance of trauma-informed services to ensure people feel safe and not judged, and the need for improvement in experiences of those accessing support.

An emphasis on education to improve knowledge and awareness

Responses called for the vision to support comprehensive education around suicide and self-harm and mental health more broadly. There is a need for education and information for parents and carers who are supporting a person who is self-harming and/or displaying suicidal behaviours. Responses also noted the importance of education and information sharing of service availability and access, enabling communities to appropriately signpost.

The importance of “inclusivity” was also raised, whereby responses highlighted the need for services to have greater awareness of the diversity in their communities and tailor education to individual need.

A more preventative and proactive approach

Responses called for a more preventative and proactive response in relation to the overarching vision, as the current focus was seen as reactive.

The overall vision as it stands gives the impression that the strategy only comes into effect after a person self-harms, has suicidal ideation or completes suicide. (Networks and Regional Forums)

Responses also noted the need to consider the wider determinants of suicide and self-harm, as part of the overall vision. To reduce incidents of self-harm and suicidal behaviours, it is essential to tackle the inequalities and disparities that may lead to the behaviours.

This aligns with issues raised in relation to the strategy’s focus on priority groups and high-risk groups.

At the opposite end of the intervention spectrum, post suicide support (“postvention”) was also highlighted as being essential, and should form part of the strategy’s overall vision. Services in contact with people coping with completed suicide should ensure that those affected are provided with appropriate support.

Question 2: Principles

To underpin the strategy – we set out six core principles:

- Leadership, ownership and accountability
- Suicide and self-harm are everybody's business
- Focus on inequalities and at risk groups
- Multi-sectoral collaboration
- Person-centred with the involvement of those with lived/living experience
- Evidenced-based and intelligence

What we asked you

We asked you if you agreed that these principles are the right ones.

What you told us

In the strategic vision section there are 6 principles that underpin the strategy. Do you agree these principles are the right ones?				
Answer Choices			**Response Percent**	**Response Total**
1	Strongly agree		31.71%	26
2	Agree		52.44%	43
3	Neither agree or disagree		9.76%	8
4	Disagree		2.44%	2
5	Strongly disagree		3.66%	3
			answered	82
			skipped	44

Key themes from our analysis of consultation responses

Improved alignment needed with the Mental Health and Wellbeing Strategy

A number of responses identified the need for better alignment between the principles underpinning the Suicide and Self-harm Prevention Strategy, and the

Mental Health and Wellbeing Strategy. In particular, there were calls for the Suicide and Self-harm Prevention Strategy to also include principles on a rights-based approach; a trauma-informed approach (with several responses critical of the strategy's lack of reference to the Trauma-Informed Wales framework); no wrong door; free from stigma; equity of access, experience and outcomes; and addressing the wider determinants of health.

Some responses commented that clear definitions are needed for all of the principles, and that they should be more outcomes focussed. Some responses saw the principles as too "generic" (Health Boards, NHS Trusts and Special Health Authorities) or "very high level and broad" (Health Boards, NHS Trusts and Special Health Authorities) and that more specific principles might have been useful. How the principles relate to each other also needs to be clearer – with questions posed around whether leadership, ownership and accountability contradicts the principle that suicide and self-harm is everybody's business.

Support for the evidence-based and intelligence led principle

There was recognition that evidence-based and intelligence-led approaches are effective; that interventions need to be based on what works; and that there is a direct link between this principle and the one focussing on lived experience. Other responses, however, posed questions around what is meant by the evidence-based and intelligence led principle and called for clearer definitions and greater clarity.

There was recognition that data are needed to understand where the focus of the strategy should be, and responses also commented on the need to establish baselines to support the evidence-based principle. Wales specific research is essential to determine exactly who the high-risk groups are, and what inequalities drive suicide and self-harm. Research and reporting on key data and outcomes will also map trends and improvements, with the view to determining the impact the strategy is having (Statutory).

The emphasis on using evidence-based practices and intelligence to inform decision-making reflects a commitment to effectiveness and accountability. By continuously evaluating interventions and monitoring outcomes, the strategy aims to adapt and refine approaches based on what works best in the Welsh context. (Third Sector)

Responses made specific reference to the importance of continuing to draw on data from the RTSSS, and how this had been such a positive development in Wales.

…it is not just the collection of data that is important, but also how this data is then used to identify themes, modify approaches and lead to improved support or identification of risk that matters. This is not often explicit in strategies when talking about data collection. We would recommend including a reference to usage of data and insight in the principle relating to evidence based and intelligence led. (Anonymous)

Support for the leadership, ownership and accountability principle

As highlighted under the cross-cutting themes, there was strong support for this principle, with responses highlighting the need for leadership, ownership and accountability at all levels.

Support for suicide and self-harm being everybody's business principle

There was strong support for the everybody's business principle, and a recognition that not everyone needs access to specialist mental health services. This was echoed in Co- Production Lab engagement which discussed the "missing middle" and a perceived gap in support for those not in crisis with the need for a range of alternative provision.

Support for a focus on inequalities and priority / high-risk groups

There was strong support for a focus on inequalities and high-risk groups (for example, men and boys were seen as particularly vulnerable), and there was particular recognition of the impact of inequalities.

However, a number of responses raised concerns over the priority and high-risk groups that have been identified. Furthermore, an increased focus on high-risk groups takes the focus away from others, and instead, there should be a focus on proportionate universalism.

In contrast, some respondents called for a great focus on inequalities throughout the strategy.

Suicide is a major public health issue, but it is also a major inequality issue. It is impossible to tackle suicide risk in Wales without addressing the inequalities that affect it. (Third Sector)

There was particular support for an increased focus on inclusivity and empowerment, with calls for an explicit reference to the anti-racism agenda in the principle on inequalities.

Support for multi-sectoral collaboration

There was strong support for the principle on multi-sectoral collaboration. Responses recognised "that suicide and self-harm are linked to a multiplicity of factors, including poor mental health but also more structural and environmental factors such as social deprivation, isolation, disability" (Third Sector). However, there were also requests that the strategy recognises the work already in place to support this principle (and the others) particularly in terms of partnership working, the strengths of different sectors, and engagement with the voluntary sector.

Responses noted the importance of how the strategy recognises that people who die by suicide are not necessarily in contact with mental health services, and that a multi-sectoral approach to reaching all high-risk groups is particularly welcomed.

Support for the strategy being person-centred with the involvement of those with lived/living experience

There was strong support for taking a person-centred approach, alongside a recognition that everyone is different, and that people may need different types of support, depending on their circumstances. Support should be provided by anyone who works with vulnerable groups.

Person-centred care is crucial because it recognises that we are all individuals with potentially different needs, even in very similar situations. (Networks and Regional Forums)

There were also calls for a greater focus on strengths based empowerment and co-production of care, and needing to ensure that people are not being re-traumatised through co-production, with the need to ensure that support is made available as part of that process.

Support for the principles – BUT they are in the wrong order and prevention is missing

Different responses made different points about the ordering of the principles. A number of responses commented that an additional principle focussing on prevention should come first. Others asked for the person-centred principle or the everybody's business principle to come first. Responses also asked for more information on how the principles would be implemented and put into practice.

Additional principles are needed

Another key theme from the consultation was where responses identified principles that they considered were missing. For example, there were responses which called for additional principles focussing on the following areas:

- Prevention
- Education and training
- Increasing awareness, knowledge and skills
- Increasing awareness access to (and of) access to support
- Role of digital and technology
- Support for those bereaved by suicide
- Reducing stigma and discrimination
- Non-judgemental services
- Compassionate and understanding support
- Trauma-informed services and support being trauma-informed
- No wrong door / people guided to support wherever they present in the system
- Suicide and self-harm as a public health and / or health issue
- People receive treatment/support in their own language

Question 3: Priority and high-risk groups

The strategy identifies a number of priority and high-risk groups.

What we asked you

We asked you if you agreed with the priority and high-risk groups identified, and the reasons for your response.

What you told us

The strategy identifies priority and high-risk groups. Do you agree that these are right?			
Answer Choices		**Response Percent**	**Response Total**
1	Strongly agree	18.60%	16
2	Agree	58.14%	50
3	Neither agree or disagree	13.95%	12
4	Disagree	8.14%	7
5	Strongly disagree	1.16%	1
		answered	86
		skipped	40

Key themes from our analysis of consultation responses

They align with the evidence base and stakeholder experience

A strong theme from the consultation responses was that the priority and high-risk groups identified in the strategy are in line with what the evidence tells about where the focus should be. They align with stakeholder experiences (and lived experience) and highlight how some groups are more vulnerable than others.

Furthermore, responses acknowledged that the identification of priority and high-risk groups will provide a focus for delivery – as well as suicide and self-harm prevention and effective intervention, care and support. The strategy needs to be based on what the evidence from the RTSSS tells us about those age groups most at risk.

Certain groups considered missing

Responses also felt that certain groups were considered missing from the current list of priority and high-risk groups. This included women experiencing the menopause; expectant and new parents; people living in rural communities; and certain occupations – including those working in the emergency services. Multiple responses suggested groups where they felt there was a need for an increased focus on suicide and self-harm prevention. (To note: multiple responses provided detailed evidence for the inclusion of specific groups as either a priority or high-risk group. This evidence will be used to revise supporting impact assessments.)

There are too many priority and high-risk groups

In contrast to the theme above, others commented that the current list of priority and high-risk groups is far too long; there is potential for confusion; and that there is a lack of clarity around which groups the strategy will be prioritising. An increased focus on high-risk groups takes the focus away from others. Instead, there should be a focus on proportionate universalism. Also, the current list of groups potentially captures everyone at some point in their lives, and so becomes meaningless.

Other Key Issues

A number of responses indicated that while they supported the identification of priority and high-risk groups, they flagged specific issues which need further consideration. These are set out below.

- **Support for identifying priority and high-risk groups but the strategy needs to provide greater clarity on how they have been identified:** Responses called for a better explanation of the rationale and evidence for being in a priority or high-risk group**.** Specific calls were made for improved referencing and the inclusion of evidence tables and key data. Some responses stated that the statistics used to identify the priority groups were misleading and confusing and inconsistent across the groups. Several responses also commented on needing to better explain the differences between priority and high-risk groups, and give careful consideration to the language used in the strategy, or alternatively – have just one group descriptor.

- **What does being in a priority or high-risk group mean:** A number of responses commented on what being identified as a priority group / high-risk group means in practice. Questions were posed around whether it would mean increased support for certain groups, or increased funding for specialist services (and if someone was a member of more than one of the groups, would that mean their chances of getting support would be higher).

- **This is a ten year strategy – the priority and high-risk groups may change:** Responses noted that new groups may emerge, and it was unclear how this would be taken into account. Responses highlighted the need for continuous

monitoring and an updating of the strategy to reflect new evidence in relation to which groups are identified as priority and high-risk – for both suicide and self-harm.

- **What about people not in a priority or high-risk group:** It is important to recognise that anyone can have suicidal feelings. Support for priority and high-risk groups should not be at the expense of anyone being able to access support. Focussing on a list of groups risks missing others. Specific reference was made to the importance of being cohort inclusive.

- **Greater support needed for people who attempt to die by suicide:** An important theme from the consultation was that there was too much of a focus around supporting those bereaved by suicide and not enough of a focus on supporting those who have attempted to die by suicide – people who are "near miss" or who would have died without intervention. This is considered further in relation to objective 5. Co-production Lab Wales engagement added to this with the need for greater support for families of young people who self-harm or attempt suicide.

- **Intersectionality and multiple risk factors have not been considered:** Another important theme was that the strategy fails to acknowledge intersectionality, and also fails to adequately address suicide and self-harm amongst those experiencing multiple risk factors. It was noted that the priority and high-risk groups are listed separately – but that "individuals often sit across multiple of these which adds to the complexity and the need for person-centred approaches" (Networks and Regional Forums). Ultimately, suicide is complex and rarely has a single cause.

- **Potential to increase stigma and to increase risk:** Specific concern was raised in responses regarding the potential for a list of priority and high-risk groups to increase labelling and stigma.

  The strategy must be careful not to further stigmatise those who have been identified as high-risk. Many people may fall within the top end of a category and would be considered at increased risk but have no suicidal ideation or self-harm. There is a further worry that people who fit the criteria set out by the strategy may be reluctant to ask for help if they are considered a high suicide risk. (Networks and Regional Forums)

  Stigma was a reoccurring topic in the Co-Production Lab Wales engagement where they spoke about the need to reduce stigma around seeking support and reporting concerns for others. Self-harm is sometimes viewed as being behaviour young people are punished for and they are afraid of escalation or repercussions and therefore less likely to report.

Question 4: Your views on Objective 1

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

What this objective means

There is a range of information and evidence that can inform actions to prevent, predict and respond to suicide and self-harm – including local intelligence, trends and clusters. We have made good progress in Wales, for instance with the implementation of Real Time Suspected Suicide Surveillance, which provides more timely data to inform the response to a suicide and to support preventative action.

Whilst we have made progress, there is an identified need for more robust data, evidence and information in relation to suicide and self-harm in Wales to inform policies and services. We also need a more systematic approach to ensure that we make best use of available research, evidence and surveillance to support cross-sectoral action in Wales and monitor the impact of policy and interventions. This also includes ensuring we have an infrastructure to gather information from services such as the NHS and third sector organisations.

How we will do this

Sub-objective 1a: Develop a robust evidence base for suicide and self-harm in Wales to better understand the causes, the most vulnerable groups, the impact and the most effective interventions and responses.

Sub-objective 1b: Develop more systematic structures and processes for the analysis, synthesis, and presentation of data and research relating to suicide and self-harm, from within Wales, across the UK and wider to inform policy and practice.

What we asked you

We asked you if you agreed with this objective and why. We asked you if you agreed with the sub-objectives and why. We also asked you what you thought should be included in our Delivery Plan so we could achieve the objective.

What you told us

To what extent do you agree with the following high-level objective. Objective 1: Establish a robust evidence base for suicide and self-harm in Wales, drawing on a range of data, research and information; and develop robust infrastructure to facilitate the analysis and sharing of information to focus resources, shape policy and drive action.

Answer Choices		Response Percent	Response Total
1	Strongly agree	52.33%	45
2	Agree	37.21%	32
3	Neither agree or disagree	5.81%	5
4	Disagree	3.49%	3
5	Strongly disagree	1.16%	1
		answered	86
		skipped	40

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

Answer Choices		Response Percent	Response Total
1	Strongly agree	33.80%	24
2	Agree	50.70%	36
3	Neither agree or disagree	12.68%	9
4	Disagree	1.41%	1
5	Strongly disagree	1.41%	1
		answered	71
		skipped	55

Key themes from our analysis of consultation responses

Utilise and build on already-available data and evidence

Respondents highlighted the importance of utilising and building upon the data and evidence we currently have. For example, reviewing the current evidence base to identify research gaps and building on the RTSSS data collection platform to collect additional data on instances of self-harm. (This was also highlighted in responses commenting on the strategy's priority and high-risk groups.)

Respondents named a number of data sources to include in a central repository. These included: hospital admission data, including the number of people who present with poor mental health; data from specialist services; A&E data; NHS 111#2 data; police data; and data collected by third sector organisations.

Continue to collect data and evidence throughout the lifetime of the strategy

Respondents also emphasised the importance of continuing to collect new data and evidence throughout the lifetime of the strategy to ensure the information used to develop policies and practices is up to date.

The importance of systematic structures for data and evidence collection

Responses called for a single, easy-to-use, robust system for recording, analysing and disseminating data and evidence. Responses felt strongly that there is a need to establish systematic structures to ensure greater collaboration, co-production and consistency at local, regional and national levels.

Co-production Lab Wales engagement talked about using impact data to demonstrate how submitting Multi-Agency Referral Forms can make a difference in prevention and to encourage more professionals to submit them.

Challenges

Responses reported multiple challenges of trying to establish more systematic structures and processes for the collection and sharing of data and research. Some responses highlighted a reluctance from some organisations to share intelligence and data. Others commented data privacy policies and the current structures in place make data sharing difficult. Respondents also reported that even when data and evidence is collected and shared, findings may be biased as they will only reflect those who seek help/access services.

We would strongly advise to think about the infrastructure and the implementation of it. Sharing of information is often blocked due to data privacy policies and working in silos across services. Current information and data sharing continues to be a major issue between social, health and community care so an enormous rethink around what strategies need to be implemented to improve efficiency and outcomes. (Networks and Regional Forums)

Improve data/evidence quality, timeliness and applicability

Following on from the previous theme, responses noted a number of ways to improve data quality and timeliness. Delivery plans should focus on collecting Wales-specific qualitative and quantitative data (and data from Wales-commissioned services) at a local and regional level and prioritise the collection of equalities data.

Respondents felt strongly that there should be clear data collection metrics, including baseline data to demonstrate success, and transparent publication timelines. Data should be accessible and useful; and needs to be reviewed regularly.

Engagement, information sharing and collaboration

There was strong emphasis for the development of cross-sector engagement links and partnership working to develop research priorities and obtain data. Specifically, it will be key to collaborate with academics and third sector organisations to develop a robust dataset and conduct collaborative research projects and evaluations of suicide prevention programs and policies.

Research should be outcome focused, for example to inform delivery and services, and result in practical guidance and solutions. The data and evidence collected should be monitored regularly to respond quickly to trends and should be used to evaluate effectiveness of policies/interventions and assess impact. Others stated that a focus on research and data is welcomed as long as too much time isn't allocated to it, and that supporting actions and delivery plans are not in replacement of intervening and supporting those in need. Finally, respondents highlighted that whilst data and evidence may shine light on the right support to provide for people in need, it is important to keep the individual person at the centre of the support.

Additional topic areas where more evidence is required

A number of responses highlighted topic areas of importance, particularly areas where more data and evidence are required. These topic areas included: evaluation of the effectiveness of bereavement services for suicide; the development and/or identification, implementation and evaluation of preventative interventions; a full scoping of support available to identify gaps in service provision; exploration of the reasons for not asking for/accepting support; the effectiveness of informal sources of support; and understanding of what works in supporting different demographic groups and communities. A number of respondents also noted the need to understand the underlying causes of self-harm and suicide, including the identification of influential socio-demographic factors; and greater understanding of people's thoughts and feelings when self-harming and/or engaging in suicidal behaviours.

Language

A small number of responses highlighted concerns about the language used in this objective. A suggestion was made to move away from a deficit model of suicide and self-harm to a strength-based model, with an emphasis on prevention.

Timely support

Although not directly related to this objective a theme emerged around the need for timely, face-to-face support. Specifically, there needs to be specialist services for those who have been affected by suicide, children and young people who self-harm and for their families who support them. Support should be flexible and at a time when needed.

This theme emerged strongly in the Co-production Lab Wales engagement with children and young people citing long waiting lists preventing them getting help at the right time. In addition, young people talked about the need for out of hours support and having options for different types of support both during crisis and in a prevention or step-down space.

The emergence of this theme highlights an important evidence-gathering exercise to firstly identify effective interventions to support those bereaved by suicide and those self-harming and secondly, to identify an optimal service-delivery model.

Question 5: Your views on Objective 2

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

What this objective means

Through the delivery of Talk to Me 2, we have established effective cross-Government and cross-sectoral working to prevent suicide and self-harm in Wales. This has been strengthened through the implementation of the Strategic Cross-Government Suicide and Self-Harm Prevention Board – which will evolve into the National Suicide and Self-Harm Programme Board. Our aim is to build on this work to ensure that relevant policy areas across the Welsh Government work collaboratively with each other, with social services, local government and third sector organisations to prevent suicide and self-harm. This objective focuses on specific current and emerging drivers of suicide and restricting access to means, but it is underpinned by cross-Government and multi-sectoral partnership working and the preventative actions set out in our Mental Health and Wellbeing Strategy. This work recognises the link between socio-economic disadvantages and risk of suicide and self-harm.

How we will do this

Sub-objective 2a: Delivering the Mental Health and Wellbeing Strategy to improve mental health and wellbeing through a preventative approach and tackling the wider determinants of mental health.

Sub-objective 2b: Ensure clear understanding and ownership of wider cross-Government and cross-sector action to tackle key drivers of suicide and establish programmes of work to strengthen and co-ordinate prevention measures.

Sub-objective 2c: Improve how we respond to, and manage, locations of concern to enable local action to be taken with an informed, evidence-based, and consistent approach.

Sub-objective 2d: Identify ways to enhance online safety and limit the encouragement and assistance of self-harm through the provision of legislation and new policy opportunities.

What we asked you

We asked you if you agreed with this objective and why. We asked you if you agreed with the sub-objectives and why. We also asked you what you thought should be included in our Delivery Plan so we could achieve the objective.

What you told us

To what extent do you agree with the following high-level objective. Objective 2: Co-ordinate cross-Government and cross-sectoral action which collectively tackles the drivers of suicide, and reduces access to means to suicide.

Answer Choices			Response Percent	Response Total
1	Strongly agree		41.67%	35
2	Agree		44.05%	37
3	Neither agree or disagree		8.33%	7
4	Disagree		4.76%	4
5	Strongly disagree		1.19%	1
			answered	84
			skipped	42

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

Answer Choices			Response Percent	Response Total
1	Strongly agree		25.71%	18
2	Agree		61.43%	43
3	Neither agree or disagree		10.00%	7
4	Disagree		1.43%	1
5	Strongly disagree		1.43%	1
			answered	70
			skipped	56

Key themes from our analysis of consultation responses

Cross-Government action includes UK Government

A number of responses commented that “cross-Government action” should include UK Government action – and that this should be made clear in the objective. Opportunities for sharing and learning good practice across the UK nations, Europe and elsewhere was also highlighted. There were also calls for collaborative working with the UK Government in relation to non-devolved areas, for example, criminal justice partners on prisoner suicides (Third Sector).

Needs greater clarity

Not all responses were supportive of the focus of this objective and the sub-objectives. Some felt that this was a complex objective, and that working across sectors presents a significant ongoing challenge. There were calls for clear definitions of what is meant by cross-government and cross-sectoral action. Some responses commented that the language used was inaccessible and that there was an inconsistent use of the terms suicide and self-harm. Questions were also posed around the evidence base on reducing access to means, with one response commenting that this was “not well enough researched to know whether it just makes people turn to alternative options” (Anonymous).

Physical and chronic health conditions and links to suicide and self-harm

Some responses felt that objective 2 failed to consider those with physical health conditions and that this objective also neglected to consider withdrawal from life sustaining medication / treatment – as a means to self-harm, or die by suicide.

Links to wider strategies and policies

While the links to the Mental Health and Wellbeing strategy are welcomed, some responses commented that there was already a significant number of policies and strategies in place (and set out at the start of the Suicide and Self-harm Prevention Strategy) and that people could feel overwhelmed – which could in turn hamper meaningful and realistic action. However, responses also stated that accessing mental health services is a huge barrier – particularly for vulnerable groups.

Question 6: Your views on Objective 3

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

What this objective means

Building on our work to deliver the vision in Talk to Me 2, this objective aims to ensure that we provide a more tailored and targeted approach to support those groups that are most vulnerable to suicide and self-harm. It also aims to ensure that we identify and provide appropriate, person-centred support within the settings where individuals who are vulnerable present. We will do this through being led by research and evidence to identify groups and settings, and will develop programmes of work to support individuals and organisations.

How we will do this

Sub-objective 3a: Develop capability and response in key settings where the most vulnerable to self-harm and/or suicide might present.

Sub-objective 3b: Ensure that all policies, actions, services and governance arrangements related to self-harm and suicide in Wales provide the opportunity for people to access services in the language of their choice and are consistent with the Welsh Language Standards and Cymraeg 2050 which sets out our long term approach to achieving a million Welsh speakers.

Sub-objective 3c: Ensure that all policies, actions, services and governance arrangements related to self-harm and suicide in Wales respect and value children's rights.

What we asked you

We asked you if you agreed with this objective and why. We asked you if you agreed with the sub-objectives and why. We also asked you what you thought should be included in our Delivery Plan so we could achieve the objective.

What you told us

To what extent do you agree with the following high-level objective. Objective 3: Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.

Answer Choices			Response Percent	Response Total
1	Strongly agree		47.13%	41
2	Agree		42.53%	37
3	Neither agree or disagree		6.90%	6
4	Disagree		0.00%	0
5	Strongly disagree		3.45%	3
			answered	87
			skipped	39

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

Answer Choices			Response Percent	Response Total
1	Strongly agree		21.33%	16
2	Agree		57.33%	43
3	Neither agree or disagree		17.33%	13
4	Disagree		2.67%	2
5	Strongly disagree		1.33%	1
			answered	75
			skipped	51

Key themes from our analysis of consultation responses

The sub-objectives on children's rights and Welsh Language should be set out as core principles

While there was support for sub-objective 3b and 3c, a number of responses queried whether they should be set out as core principles for the strategy – rather than specific to this objective.

Concerns around those who are not currently engaged with the settings and services listed

Whilst there was strong support and agreement around settings where people currently engage being an effective method of support, a high number of responses were concerned for those who do not engage in the named settings, or any services at all – and called for the objective to be "expanded upon to explore a broader definition of the settings in which they are most engaged" (Health Boards, NHS Trusts and Special Health Authorities).

Many responses asked for clarification on what this would mean for those who do not currently engage in the settings listed, and the links with social isolation amongst groups such as children and young people who are not in school; farming communities; Gypsy, Roma and Traveller communities; and neurodiverse people.

A number of respondents also offered additional and alternative settings to those highlighted under objective 3, such as community spaces (e.g. libraries, community hubs, and places of worship) and those provided by the third sector; social housing or homeless support services; colleges and universities; the criminal justice system; secondary health care settings; social care settings; highways and transportation-related settings; Third sector organisations that provide support around housing / homelessness, drug and alcohol dependency, immigration issues, and legal advice; and perinatal mental health settings. A high number of responses also suggested online settings should also be included.

Children and young people spoke specifically about the key locations for prevention and community based services including: home, schools, youth and community clubs, sports, universities and leisure settings (Co-Production Lab Wales engagement).

High-risk groups

Responses also set out comments and suggestions regarding the vulnerable groups listed under objective 3 – and a more detailed discussion on this can be found in our analysis of responses in relation to priority and high-risk groups. Key issues raised in relation to high-risk groups and objective 3 were calls for a greater focus on intersectionality; services needing to be patient focussed; concerns over the focus on too many at risk groups; and questions around whether people would not be supported if they don't fall into the high-risk groups.

Ensuring person-centred and needs led support

Many responses reflected on the importance of support being person-centred and needs led – in order to be effective and allow individuals to access the care and services they need.

Variety of support – rapid intervention, long-term prevention and include postvention

Respondents also commented on the pace of intervention and prevention. While there was agreement that intervention should be rapid (although there were also calls for this to be better defined) – responses also highlighted that prevention was key, and that this should be longer term and embedded into services.

Participants in the Co-Production Lab Wales engagement spoke about addressing waiting lists being a priority as well as increasing the options for support.

The 16-18 year olds' CAMHS waiting list is too long; so instead of adding a young person to the waiting list the professionals will let them wait for an adult referral (which would happen before coming off the waiting list). As a result there is a two-year gap in provision, and a lot of kids drop off from support and provision then, which is the worst time of life to have a gap (because it's so confusing, with leaving school, college being very different, the lack of a safety net or a structured timetable, etc). (Co-Production Lab Wales)

Responses also suggested postvention action should also be included in the objective.

Collaboration and joined up working

The majority of responses noted that to achieve the objective and sub-objectives, the delivery plan should include a dedicated action around services working collaboratively together to support those in need.

A number of respondents also noted the impact of third sector and community organisations in this area currently and requested that engaging and working with these groups was committed to within the delivery plan.

It was agreed that smaller groups and charities make a profound impact on people's mental health and wellbeing so the strategy should focus more on recognising and encouraging local groups to reconnect communities. People feel a sense of belonging through local groups which can help mitigate potential to having suicidal thoughts and ideation. As a result, it was considered crucial that local grassroots organisations are included in the action plan for this objective. (Networks and Regional Forums)

Mapping exercise and evidence led actions

In order to identify the current position, existing resources and plan future action, some responses suggested a mapping exercise should be undertaken. A number of responses also requested that action should be led by evidence in order to be robust, and that data collection and presentation should be improved.

Role of peer support

A number of respondents noted the importance of peer support and called for this to acknowledged within the strategy. Children and young people spoke about the effectiveness of peer support schemes in schools (Co-Production Lab Wales engagement).

Online and digital focus

Throughout the responses, recognition of concern around online harms, the online space being a key setting and digital platforms providing access to services was evident. Requests for the creation of digital platforms to support individuals, especially children and young people, were received.

There was also a recognition that there is an important link with the focus on children's rights and online safety.

Question 7: Your views on Objective 4

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

What this objective means

This objective builds on the targeted approach set out in Objective 3 to provide population level information aimed at supporting individuals, groups and organisations to understand their role in suicide and self-harm prevention. It also aims to improve the confidence and skills of individuals to identify people at risk and provide appropriate, person-centred support.

How we will do this

Sub-objective 4a: Identify opportunities to enhance the universal offer of training and support.

Sub-objective 4b: Establish continuity and connection between different services that respond to people who are in distress, ensuring consistent approaches are adopted, with shared learning and development programmes for call handlers and front-line responders.

What we asked you

We asked you if you agreed with this objective and why. We asked you if you agreed with the sub-objectives and why. We also asked you what you thought should be included in our Delivery Plan so we could achieve the objective.

What you told us

To what extent do you agree with the following high-level objective. Objective 4: Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm.

Answer Choices			Response Percent	Response Total
1	Strongly agree		65.12%	56
2	Agree		31.40%	27
3	Neither agree or disagree		2.33%	2
4	Disagree		1.16%	1
5	Strongly disagree		0.00%	0
			answered	86
			skipped	40

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

Answer Choices			Response Percent	Response Total
1	Strongly agree		43.06%	31
2	Agree		48.61%	35
3	Neither agree or disagree		6.94%	5
4	Disagree		1.39%	1
5	Strongly disagree		0.00%	0
			answered	72
			skipped	54

Key themes from our analysis of consultation responses

Everyone has a role to play

A number of responses commented that this objective is key to the success of the strategy in terms of preventing suicide and self-harm and reducing stigma – and also reinforces the principle that suicide and self-harm is everybody's business. The two sub-objectives "provide the building blocks in forming a comprehensive service response to suicide and self-harm prevention" (Commissioners). Training will also help to ensure the delivery of compassionate, person-centred, trauma-informed services, and also support the principle of "no wrong door".

There was general consensus about the importance of everyone being able to spot the signs linked with suicide and self-harm and ensuring they are equipped with relevant and proportionate training to be able to offer support to those in need. There was specific recognition in the responses that people in crisis don't always reach out to crisis services, and so we need to provide the support where this is needed, and that this could be in an emergency department, a GP's surgery, a place of work, a gym, or a job centre. Another important theme was that training should be mandatory for certain groups and that people want to see commitments from services to deliver this objective.

Responses also commented that sub-objective 4b should recognise other groups and services as contributing to this objective, and not just reference call handlers and front-line responders. For example, emergency services and bereavement support workers.

Children and young people spoke about the importance of other services having mental health and suicide and self-harm training. They spoke about the need for police and A and E to be better equipped to understand and respond to young people in crisis (Co-Production Lab Wales engagement).

There is a lot of good practice which we can learn from and opportunities to consolidate

Responses were supportive of proposals to enhance the training offer, particularly in terms of identifying at risk groups and offering support when and where it is needed. The responses pointed to a wealth of good work that was already happening in terms of training and support with many suggesting that a mapping exercise should be undertaken to understand what is already out there, learn from best practice, and where possible, consolidate into a universal resource.

Specific reference was made to the importance of applying the learning around increasing skills, awareness, knowledge and understanding amongst the public, professionals and agencies – which has already taken place in other sectors.

Some responses also suggested that the focus of sub-objective 4a should be on the delivery of training and not "enhancing" the offer. There were also responses that identified specific sectors, where there is a need for training.

Participants in the Co-Production Lab Wales engagement were clear that training needs to cover how to talk to children and young people about suicide and self-harm. Including being young person led, non-accusatory and “understanding self-harm as a coping strategy not a choice”.

Training needs to be consistent whilst also relevant to different settings and level of authority

Responses highlighted that consideration needs to be given to how training packages are balanced in terms of being consistent, whist also tailored to audiences with different roles and responsibilities, levels of authority and to people’s needs. A suggestion was made in the Co-Production Lab Wales engagement to create a framework of tiered training (similar to the Trauma-Informed Wales Framework) for suicide and self-harm awareness.

Training needs to consider complex/co-occurring needs

Another challenge was highlighted in terms of considering co-occurring issues such as substance use and how we can equip people with the knowledge and resources to manage these complexities – with resources for sign-posting to relevant services. This was also noted by children and young people with reference to neurodiversity considerations in training (Co-Production Lab Wales engagement). There were also suggestions that the training should bring together other principles such as being trauma informed and mental health first aid. Joint training events could facilitate collaboration and connection.

Services need to be consistent and joined-up with a stronger focus on prevention

Continuity and connection between services was also highlighted as important in terms of adopting a whole system approach and being able to offer a “warm handover”. There was also support for a greater focus on supporting those at risk of suicide and self-harm and establishing a national service. This was also a theme for those who responded to the consultation question on priority and high-risk groups.

How are you going to educate a whole system when we're bracketed in seven different health boards, 22 different local authorities, hundreds of schools within each local authority. (Networks and Regional Forums)

Staff need support too

A strong theme emerged regarding the need to support staff who come face to face with these challenging issues and can experience vicarious trauma. Co-production Lab Wales engagement added to this, reporting the need to support adults to process their trauma, past experiences and biases so they can support young people effectively.

We need to use existing networks and trusted spaces

Responses highlighted that lots of services already have established networks which could be utilised and helpful in accessing under-served and at risk groups.

There are likely to be opportunities already established within communities through which this information can be shared, such as groups and clubs - spaces which individuals are already accessing and already see as a safe place. (Anonymous)

There were also suggestions that campaigns and social media could be useful for this purpose.

Training needs to be embedded in service delivery

The responses called for a move away from “one off” training and towards a more embedded and sustainable approach with suicide and self-harm training embedded as part of curriculums in schools, higher and further education and in relevant university degrees, including teacher training.

Training on suicide and self-harm needs to be embedded in the curricula of key professional from teachers, to nurses, doctors, social workers and more. (Anonymous)

We need to better define “emotional distress”

The need to better define “emotional distress” was highlighted noting that it might present in different ways in different people (e.g. neurodiverse or transgender). Participants in the Co-Production Lab Wales engagement spoke about: “…a blurred understanding of stress vs anxiety, wellbeing issues vs mental illness, mental health and well-being vs mental health issues. Mental well-being is something that everybody has, vs a mental illness that not everyone has” (Co-Production Lab Wales).

Question 8: Your views on Objective 5

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

How we will do this

Sub-objective 5a: Through joint working across sectors, establish a clear description of a timely, pro-active, person-centred and compassionate response to all those who present with self-harm or as at risk of suicide to any part of the system, which contributes to reducing stigma and is in line with NICE Guidance (2022), including psycho-social assessment, safety planning, psychological therapies and other evidence-based approaches that help to keep people safe.

Sub-objective 5b (also contributes to objective 3): Develop national, regional, and local arrangements to enable rapid response to suspected suicides and cluster recognition, within localities and across borders.

What we asked you

We asked you if you agreed with the objective and why. We asked you if you agreed with the sub-objectives and why. We also asked you what you thought should be included in our Delivery Plan so we could achieve the objective.

What you told us

To what extent do you agree with the following high-level objective. Objective 5: Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.

Answer Choices			Response Percent	Response Total
1	Strongly agree		69.05%	58
2	Agree		27.38%	23
3	Neither agree or disagree		1.19%	1
4	Disagree		1.19%	1
5	Strongly disagree		1.19%	1
			answered	84
			skipped	42

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

Answer Choices			Response Percent	Response Total
1	Strongly agree		38.89%	28
2	Agree		51.39%	37
3	Neither agree or disagree		6.94%	5
4	Disagree		1.39%	1
5	Strongly disagree		1.39%	1
			answered	72
			skipped	54

Key themes from our analysis of consultation responses

Structure and focus of the objective and sub-objectives

Not all responses were supportive of the objective and sub-objectives. There were calls for the objective to be further separated between those who self-harm and have suicidal thoughts, and those that have been affected or bereaved by suicide.

Because the two groups have been put together the objectives are hard to make sense of – which is evidenced by the fact sub-objective 5b also applies to Objective 3. I think this would be more effective if split into two Objectives, especially as it is the main 'intervention' objective. (Anonymous)

Some felt that additional sub-objectives should be included – for example, focussing on: Supporting those that have engaged in suicidal behaviour; outreach (given that not everyone who has suicidal thoughts, or who has attempted suicide, or who is self-harming, will be engaged with existing services and support); children's rights; and evaluation.

Specific reference was made in relation to outreach and supporting those with protected characteristics, along with a focus on transition between child and adult services.

Providing support for key life transitions, for example, changing school, puberty as well as child to adult services was called for by children and young people (Co-Production Lab Wales engagement).

Responses also commented on the wording and language used in the objective and that it was "overly health" focussed.

Whilst the Co-Production Lab Wales engagement criticised physical health indicators being used in mental health. Responses talked negatively about eating disorders being linked to low BMI for treatment. And self-harm and suicide support only being available to those actively self-harming or serious and repeating suicide attempts saying this acted as an incentive to escalate behaviours in order to get help.

Others commented specifically on the reference to NICE Guidance, highlighting that there is no obligation on the part of providers in Wales to follow NICE guidance.

Trauma informed approach and no wrong door

An important theme was that responses highlighted additional principles that should be referenced. In particular, there was strong support for "no wrong door" and "trauma-informed" principles to be included, along with calls for the objective and sub-objectives to specifically reference to the trauma-informed Wales framework. The importance of a no wrong door approach was brought to the fore in the Co-Production Lab Wales engagement where young people spoke about the need for systems to be able to deal with co-existing conditions such as neurodiversity, mental health and suicide and self-harm (Co-Production Lab Wales engagement).

Aligned with this, responses highlighted that supporting environments need to support and facilitate and "do this well" – through for example the provision of

private, quiet, confidential, comfortable, accessible, and non-clinical settings. This was reiterated by children and young people who added the need for schools to also have supportive environments (Co-Production Lab Wales engagement).

Cross sectoral approach and collaborative working

The majority of responses felt that a cross sectoral approach is required to deliver the intended outcomes of the objective and sub-objectives and to achieve success, alongside consistency in the use of language, terminology, and shared culture across organisations involved. Many highlighted the importance of alignment with Trauma-Informed Wales to support a coherent, consistent approach to developing and implementing trauma-informed practice.

There were also calls for guidelines around services working together; collaboration with agencies such as housing and the DWP to reduce stressors; the extension of prevention responsibilities to employers, schools and colleges; and cross-government work that engages with issues such as healthcare waiting times and staffing issues.

Rapid response for those bereaved by suicide

Responses stressed the need to roll out rapid response services for those bereaved by suicide – for people to access immediate support as and when needed, provided locally. They also highlighted that appropriate governance is essential, alongside a delivery plan for strengthening and standardising and evaluating rapid response services. There were also suggestions around exercises to test the rapid response and promote cross-sectoral / multi professional working, and the sharing of best practice among Partnership Boards.

Support for those who attempt suicide and self-harm

Another key theme from the responses was the need to consider specialist provision and rapid response services for people who have suicidal thoughts and who have attempted suicide, as well as support for friends and family. This would be alongside achieving a rapid response to those bereaved by suicide.

It feels like those bereaved by suicide get more urgent support than those who feel they want to end their lives. We need a rapid response to these people as well. It feels like the voices of those who have attempted suicide and survived have not been heard, and that they have been drowned out by the stronger voices of those bereaved. (Anonymous)

Similarly, as highlighted in the cross-cutting theme on self-harm, specialist provision should also be in place for people who self-harm. Co-Production Lab Wales engagement stressed that this support should not be crisis or severity dependant in order to prevent “incentivising” risky behaviours to get support.

There needs to be urgent work on the response to self-harm, which always seems to get lost in this agenda. Until it is seen as part of the core purpose of mental health

services, self-harm prevention and self-harm reduction services will never work. (Anonymous)

Clear pathways

Responses highlighted the need for clear pathways across Wales to support those in need.

In particular, there needs to be a realistic assessment of the care provided in the community of people who have suicidal thoughts with plans developed at a local level, and postvention services available locally. There were calls for an NHS 24 hour helpline, as well as a service that provides longer term support. Co-Production Lab Wales engagement called for more sharing and publicising of existing helplines. Young people also called for automatic support in schools after a death by suicide rather than an opt in approach (Co-Production Lab Wales engagement).

Work in schools to support pupils after a death occurred, support should be automatically offered (not "if you want help come to us", that's not the right approach because the uptake is low even though it's needed). (Co-Production Lab Wales)

Responses also called for more open-door "retreat / sanctuary / safe space" type facilities in the community, and recognised the important role played by community based support groups. Engagement of professional bodies and services delivering psychological therapies in communities across Wales was also highlighted as critical.

Challenges and barriers

Responses also highlighted challenges and barriers to the delivery of the objective and sub-objectives. For example: People can be subjected to a "merry go round" in terms of access to appropriate support. Some commented on mental health services "being stretched", which can be a significant barrier when it comes to accessing prompt responses for individuals in distress.

…the 'service merry go round' which so often included phrases like "This is not our responsibility, you should go to....." This is a significant barrier to prompt responses to individuals in distress. (Third Sector)

Furthermore, in order to genuinely increase the likelihood that people will receive an appropriate, compassionate and person-centred response (if they have self-harmed or attempted suicide), there needs to be a specific focus on taking steps to prevent burnout and compassion fatigue in those individuals working in services.

Multiple examples of current challenges and barriers was set out in one response, which highlighted the "insufficient time in healthcare settings for those with complex health conditions and needs resulting in escalating distress as person-centred care is simply not possible in the time allotted" (Anonymous).

Reducing stigma

Reducing stigma is key to delivering this objective. Responses commented that stigma remains a barrier to accessing support and that there is a need challenge potential stigma within services. Responses commented on the need to create awareness and understanding of self-harm in order to reduce stigma.

Responses highlighted the need to recognise the many different forms of stigma that may be associated with suicide and self-harm, including (but not limited to) internal stigma, professional stigma, provider-based stigma, public stigma and the use of stigmatising language. There were calls for greater clarity on this and for "the reference to stigma in sub-objective 5a needs to be disentangled" (Statutory).

National Advisory and Liaison Service

Many responses welcomed the development of the National Advisory and Liaison Service, although there were also concerns around potential duplication of provision.

Communication

A clear communication strategy, as well as the need for effective and accessible communication was raised in responses.

Communication was also key in terms of a person's preferred language, with staff needing to be equipped with appropriate training in relation to meeting accessible communication needs.

Question 9: Your views on Objective 6

Responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour.

What this objective means

We know that some types of media reporting can perpetuate stigma and lead to imitational or suicide behaviour, but media can also be a powerful means to give people hope or to encourage people to seek help. The Samaritans provide Media Guidelines for reporting on suicide and self-harm. This objective recognises the need to ensure responsible reporting by the media, but also through any form of reporting regarding suicide or self-harm.

How we will do this

Sub-objective 6a: Continue to develop and embed a consistent shared language for suicide and self-harm and the terminology we use.

Sub-objective 6b: Maintain reporting, media and communications policy and guidelines.

What we asked you

We asked you if you agreed with this objective and why. We asked you if you agreed with the sub-objectives and why. We also asked you what you thought should be included in our Delivery Plan so we could achieve the objective.

What you told us

To what extent do you agree with the following high-level objective. Objective 6: Responsible communication, media reporting, and social media use regarding self harm, suicide and suicidal behaviour.

Answer Choices			Response Percent	Response Total
1	Strongly agree		58.82%	50
2	Agree		30.59%	26
3	Neither agree or disagree		8.24%	7
4	Disagree		1.18%	1
5	Strongly disagree		1.18%	1
			answered	85
			skipped	41

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

Answer Choices			Response Percent	Response Total
1	Strongly agree		36.84%	28
2	Agree		47.37%	36
3	Neither agree or disagree		14.47%	11
4	Disagree		1.32%	1
5	Strongly disagree		0.00%	0
			answered	76
			skipped	50

Key themes from our analysis of consultation responses

Reliable and factual shared language

Responses highlighted that the Welsh Government should collaborate with experts, the third sector and those with lived experience to ensure the shared language for suicide and self-harm is factual, relevant and reliable.

Responses also suggested that information and sources on suicide and self-harm should come from those with lived experience and experts in the area to allow for responsible reporting and appropriate signposting.

Some responses highlighted the impact of reporting on bereaved families and suggested families should have a choice around what is reported and how much detail is shared.

There is a need for transparency respecting those impacted should be the first consideration. Some families may not want information shared and media should be made to respect this. (Health Boards, NHS Trusts and Special Health Authorities)

Recognition of the importance of positive communication in the media

Many responses recognised there have been positive stories and signposting in the media – commenting that by promoting help-seeking behaviour and positive recovery, the media can have great influence. Respondents told us this should be further acknowledged within the strategy and any media guidelines, to encourage further positive communication, along with suggestions of how positive stories could be created.

Participants in the Co-Production Lab Wales engagement talked about the positive opportunities for the media to normalise talking about mental health but felt there was still a “taboo” around talking about suicide and self-harm.

Clear guidelines for media reporting of suicide and self-harm

There was strong support for the Samaritans guidelines and how these should underpin media reporting. Responses also recommended the World Health Organisation (WHO), NICE and Papyrus guidelines on media reporting of suicide and self-harm, suggesting these were more detailed than the Samaritans guidelines. In addition, responses highlighted best practice by Bipolar UK, Time to Change in England and Wales, and the knowledge and expertise of Mind, Adferiad, Platform and Samaritans – with calls for Welsh Government to work collaboratively with these organisations.

Some responses, however, commented that it was unclear which guidelines the strategy would be stating the media should follow, with suggestions that Welsh Government should draw upon the best practice of others to create their own, more detailed guidelines, both for the digital and print media and, the public.

Influence of social media and calls for change

As well as strongly agreeing with the need for this objective and sub-objectives, a high number of responses expressed concern over the influence of social media, in particular how social media trends can glamorise self-harm and suicide. There were strong concerns about the risk of misinformation and the impacts of algorithms on what people see via social media.

A number of the responses called for specific action in this area, including robust monitoring and strong reporting – and for this to be clearly set out in the strategy.

Young people in particular talked about the need for positive communication on social media and a prevention of social media as a "toxic environment" with harmful content algorithms. They asked for new laws, better trigger warnings and more safeguarding against hate and abuse online (Co-Production Lab Wales engagement).

Responsive monitoring and enforcement

A number of suggestions were made around a mechanism for media sign up, for example, in the form of an agreement and clear consequences if the agreement is not followed.

"A written agreement that media outlets to sign up to in a way that protects and promotes online safety. There needs to be mechanisms in place if agreements are broken/not satisfied and assures the accountability is upheld." (Anonymous)

Many responses highlighted the need for rapid responsive monitoring, particularly online, given the fast pace of commenting and the ongoing development of technology and trends – and in order to prevent stigma, to target misinformation, to ensure responsible reporting, and to hold individuals, as well as the media, to account.

A number of responses also called for enforcement to be put in place and potentially legislation to be developed to ensure guidelines and agreements are adhered to.

Collaborative approach to robust media management – on a national and UK basis

Responses acknowledged UK Government / non-devolved responsibilities and requested more information on this issue.

In recognition of the UK Government's powers in this area, there were calls for a collaborative approach both national across Wales and on a UK wide basis to manage and challenge the media.

Responses felt that the UK Online Safety Act could be a key lever in taking action in this area and felt recognition of the Act and its duties should be reflected more strongly in in this objective in the strategy.

Participants in the Co-Production Lab Wales engagement also highlighted the need to raise awareness in specific cultural contexts.

National Public Awareness Campaign

Some respondents highlighted that a national public awareness campaign could be beneficial in meeting this objective – particularly in terms of reducing stigma, educating and raising awareness.

Question 10: All age strategy

The Suicide and Self-harm Prevention Strategy is an all-age strategy. When we talk about our population, we are including babies, children and young people, adults and older adults.

What we asked you

Do you feel the strategy is clear about how it delivers for various age groups?

What you told us

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

Answer Choices			Response Percent	Response Total
1	Yes		53.16%	42
2	No		46.84%	37
			answered	79
			skipped	47

Key themes from our analysis of consultation responses

Greater clarity needed on how the strategy is an all age strategy

As highlighted by the graph above, just under half of responses stated that it was not clear this was an all age strategy. Some responses set out their support for how the strategy includes an all age focus; how it targets the whole population; and how it delivers for various age groups and at risk groups. Others commented that there was a lack of clarity that this was an all age strategy – although there was also recognition that this is "not necessarily a problem if this is remedied at the next stage of planning" (Anonymous).

A key issue highlighted was that while the strategy focusses on at risk groups, there is no alignment with the needs of specific age groups, other than middle aged men, and children and young people (and that even for these groups – there is a lack of detail on key priorities).

The settings and vulnerable / priority groups outline the very different cohorts and needs, and are not clearly aligned to age other than the reference to middle aged men and CYP. (Third Sector)

The nuanced needs of specific age groups are not addressed

A significant theme was that the specific nuanced needs of different age groups is currently missing (particularly for infants, children and young people and for older age groups) and that there was limited focus on priorities for different age groups and implementation. Commitments are needed in the delivery plan to address this gap. Responses commented specifically on how there was no sense of what services and support would look like for different age groups, or what actions would be put in place.

Needs a focus on older people

Responses raised concerns over the lack of focus on older people, with a number of responses highlighting the risks of suicide amongst older groups, relating to mental and physical health, isolation, and the increased likelihood of bereavement. There were calls for the strategy to better reflect this evidence, as well as for including specific action on suicide and self-harm prevention amongst older people in the supporting delivery plan. Suggestions were also put forward around how the strategy could better link with wider initiatives to support older people, including Age Friendly Communities.

Question 11: Impact Assessments

Alongside the draft strategy, we published draft impact assessments to explain our thinking about the impacts of the strategy. They included research we've identified on the possible impacts.

What we asked you

Are there any impacts, positive or negative, that we have not included?

What you told us: Key themes from our analysis of consultation responses

Professionals in contact with people who self-harm and/or engage in suicidal behaviours

Some responses commented that there is a gap in acknowledging the impact and the need for support for professionals who are in contact with people who self-harm and/or engage in suicidal behaviours. There was particular emphasis on the trauma professional staff may experience when some does self-harm or dies by suicide, specifically in relation to the stigma of having "failed".

Carers

Responses noted the impact on carers supporting individuals who self-harm or who are at risk of suicide. It is important to address how to support carers and reduce the stress they may experience.

The negative impact of targeting high-risk groups rather than risk factors

Aligned with feedback on how the strategy identified priority and high-risk groups, responses also commented that services can never be equitable if based on population rather than personal risk. Therefore, it is essential to take a person-centred, holistic approach to suicide and self-harm prevention, considering the wider social determinants, including sociodemographic disadvantage, ACEs and financial stressors.

The equalities impact assessment fails to acknowledge the negative impact of targeting high-risk groups. Taking this approach may exclude some groups of people in need and inadvertently make it more difficult for them to access support. This was highlighted by one respondent who expressed concern that there is only reference to some groups and that the impact on all protected characteristics need to be considered.

Intersectionality – across socioeconomic risk factors as well as protected characteristics

In the equalities impact assessment, respondents would welcome more references to intersectionality in recognition of the fact that certain groups can be more

vulnerable to experiencing multiple inequalities, which in turn, could increase their risk of suicide and self-harm.

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. (Third Sector)

More data and evidence

Finally, it was highlighted that although we have an awareness of what groups may be disproportionally impacted by suicide and self-harm, we have very little knowledge of the measures and interventions needed to support them. More data and evidence is needed to support this.

Specifically, there needs to be accessible, transparent self-harm data in Wales to improve our knowledge and understanding of what works to support this group; identification of how best to support carers in their role to reduce the stress they experience; better understanding of the effectiveness of informal support; and a wider knowledge of what works in supporting different demographic groups and communities, including Black, Asian and minority ethnic communities, LGBTQ+ communities and people from socioeconomically disadvantaged households in Wales.

Question 12: Welsh Language

What we asked you

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

Key themes from our analysis of consultation responses

Issues with the question

Some responses spoke about being unsure about what the question was asking. Some didn't understand the question, and some thought we are asking the wrong thing. For example, there was support for exploring the impacts of the strategy on people who speak Welsh rather than the Welsh language.

The strategy will have little or no impact on the Welsh language

Some responses commented that the strategy will have little or no impact on the Welsh language. Some commented that the strategy is not relevant at all to the Welsh language, so the question was not needed.

The strategy will have a positive impact

In contrast to the themes above, other responses thought that the strategy will have a positive impact on the Welsh language. Responses were positive that the Welsh language has been considered within the strategy, and that it could supporting the Welsh speaking community in Wales.

Being able to speak about your experiences in your preferred language was seen as especially important, in relation to suicide and self-harm. The positive impacts of being able to receive services in Welsh were highlighted.

More Than Just Words

Many responses welcomed the links made in the strategy to the More Than Just Words 5 year plan. It will be important for the delivery plans for the new strategy to "align with and contribute to the Welsh Government's wider strategic framework for the Welsh language in the field of health and care" (Commissioners).

The importance of other organisations and stakeholders committing to the ambition of having a million Welsh speakers in Wales by 2050 was also highlighted.

Suicide and self-harm are, at best incredibly difficult topics to cover in one's own mother tongue so provision to make this easier for people is a positive thing. For this to be successful all agencies and organisations operating in the health/mental health space need to be signed up to stepping up to the 2050 ambition with clear

accountability lines linked to this. It cannot reside solely within WG and a few others to drive this forward. (Third Sector)

Access to services in a person's preferred language / Active Offer

People wanted to see a focus on Welsh language and people accessing services and support in their preferred language, reflecting people's individual rights.

There was a common consensus around needing to better promote how people can access support in Welsh, supported by actions in the delivery plans, alongside actions that give "greater opportunities to use the Welsh language" (Commissioners). There was also an expectation that the strategy would meet Welsh Language Standards requirements.

A key issue raised, however, was that while there was support for how the Impact Assessment specifically referenced the active offer, the objectives of the strategy do not provide assurance that services and support for suicide and self-harm will be in Welsh. In essence, it is not enough to just promote the active offer: services need to be made available in Welsh.

Linked to this – some responses suggested that the strategy does not convey the need for people to receive support, care and treatment in their first language (Welsh) well enough.

Lack of fluent Welsh speakers impacts ability to offer timely services

Workforce / services are not currently meeting the objectives of the strategy in relation to bi-lingual provision and/or access to services in a person's preferred language. Recruitment would need to be expanded in order to reach more fluent Welsh speakers to meet people's needs. Responses especially wanted to see the commitments made in the Mental Health and Wellbeing Strategy for the Welsh language carried into this strategy.

Calls were made for a detailed plan on how to increase the availability of Welsh speaking staff.

Training in Welsh for staff and students

Another major theme was to ensure staff at health boards and students have the opportunity to undertake training in Welsh. Responses commented that the strategy could be used to promote and encourage the use of Welsh by staff. Respondents thought that English was mainly the default language as that is the language professionals are generally taught in. So even if a staff member is able to speak Welsh, they tend to default to English. Encouraging the use of Welsh could make staff feel more comfortable speaking in Welsh about suicide and self-harm to patients.

Most services default to using the English language as this is the language that most are taught their profession in. More could be done to promote or encourage professionals to learn in Welsh, which would make it easier to use Welsh when talking to Welsh speaking service users. (Health Boards, NHS Trusts and Special Health Authorities)

Need to consider other languages and BSL

Another important theme raised was the importance of considering other languages alongside Welsh (including BSL).

Need to make the most of technology in addressing barriers

There were a number of suggestions in the responses about making better use of technology to try and address the barriers seen in accessing mental health services in Welsh. There were mentions of using AI, online interactive materials and animation, amongst other things. A few suggested using online technology to link patients in one health board with services in other health boards without the need to travel. A number of responses suggested that making the most of modern technology would help provide mental health services and support to a wider range of people.

Access to mental health services in Welsh

Responses noted that access to services and support in Welsh might be difficult in some cases. However, clear efforts should be made to try and ensure as many people as possible can access mental health services in Welsh. Some pointed out that the Impact Assessment mentions it is up to the mental health service to offer services in Welsh rather than the patient to request services in Welsh (in line with the Active Offer). However, they also commented that the objectives in the strategy do not reflect this commitment.

Crisis / early intervention

It is critical that those in crisis / seeking early intervention can access support in the language of their choice, whether that be English, Welsh or another language.

Rise in social media support pages in Welsh from individuals/charities

Responses commented on the rise in mental health social media pages that are available in Welsh. These pages appear to be created by charities or individuals with lived experience and help provide support and information in Welsh.

NHS Wales Executive has an important role play in supporting change in relation to the Welsh language

Responses commented on the role that the NHS Executive will play in supporting “culture change” in relation to Welsh language, and through the implementation of the strategy.

Welcome the concept of ‘language choice’ but need to be aware this choice may change

Another theme raised in consultation responses – was the importance of choice, and a recognition that a person’s preferred language may change.

The language in the strategy does not translate well and is difficult to understand

Some Welsh speakers who responded to the question highlighted that some of the language in the Welsh version of the strategy was difficult to understand and was “too technical” – and there had been too much of literal translation from the English version. Responses called for different vocabulary and for the strategy to be drafted using “daily language” rather than complex words. Responses commented on the importance of ensuring that language and terminology in the resources given to individuals is correctly and appropriately translated. Incorrectly translated resources could potentially cause confusion or even delays in receiving the correct treatment. These resources should meet the Welsh Language Standards.

Question 13: Additional points

What we asked you

We asked you if you had any comments on things which we had not addressed within the strategy.

Key themes from our analysis of consultation responses

Responses to this question informed the cross-cutting themes identified at the start of the summary. A range of data and evidence were also set out which will help to inform supporting impact assessments. In addition, responses commented on:

- **Relationship between the Suicide and Self-harm Prevention Strategy and the Mental Health and Well-being Strategy (and other strategies).** While most people supported having a standalone suicide and self-harm strategy, there were also suggestions that a single strategy covering both would strengthen the relationship and governance arrangements. On the basis of having separate strategies, the relationships between the two documents could have been better defined. There were also calls for the Suicide and Self-harm Prevention Strategy to better explain the expectations of specialist mental health services in relation to suicide.

- **Gaps in services:** Responses commented on the complexities of providing services to vulnerable groups, which requires effective coordination across multiple services. Responses also highlighted flaws in what they identified as the "medical model" of suicide, where people needing support are being referred to A+E, with responses highlighting the importance of alternative support (less clinical / sanctuary model).

- **Definitions:** There were concerns raised about how we have defined suicide and self-harm in the strategy and issues around what they included. For example, questions were raised in relation to whether self-harm included eating disorders and substance use, and whether refusal to take life sustaining medicine would constitute suicide. Responses also highlighted concerns over how the strategy's definition of self-harm includes suicide attempts as well as acts where little or no suicidal intent is involved, and how this could potentially create and increase stigma. Specific calls were made around needing to consider the self-harm strategy in Scotland, and needing to distinguish between acts of suicide / harm from suicidal intention and self-harm.

- **Assisted dying:** This was raised specifically in relation to older people, alongside criticism that older people have not been identified as a specific priority group.

  This is an important omission given the high rate of suicide in those aged 90 years and over. As part of this, it would be helpful to reference the need to consider how the suicide strategy considers the role of the assisted dying bill. (Health Boards, NHS Trusts and Special Health Authorities)

- **Strategic section of the strategy:** Some responses also commented on the strategic section of the strategy, with comments made on how this needs to better capture and reflect on the needs of Wales' diverse population, and include a greater focus on children's rights, the anti-racism agenda and tackling inequalities. Given that this is a ten year strategy, responses also highlighted the need to consider wider developments and their potential impacts – for example, Artificial Intelligence.

6. Next Steps

This document provides a summary of the key themes arising from the analysis of the responses received. Most notable – was the theme relating to how we consider the relationship between suicide and self-harm and present this in a way that gives self-harm greater prominence, with bespoke objectives and actions to meet the needs of those affected.

In addition to the themes outlined in this report, a significant amount of additional detail has been captured from the responses received is being used to inform the next iteration of the Suicide and Self-harm Prevention Strategy and Delivery Plan.

In terms of next steps:

- We will be using consultation responses to inform the development of the final version of the Suicide and Self-harm Prevention Strategy and its supporting delivery plan.

- We will be carrying out further, targeted engagement with stakeholders to ensure the strategic objectives are fit for purpose and that they are supported by SMART actions – that will deliver positive and sustainable outcomes for all.

- We will publish the final version of the strategy and its supporting Delivery Plan by the end of the year.

Suicide and Self-harm Prevention Team

Welsh Government

October 2024