Cardiff and Vale of Glamorgan Suicide and Self Harm Strategy, 2021-24

Equality & Health Impact Assessment

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Cardiff and Vale Suicide and Self Harm Prevention Strategy, 2021-24
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Chris Emmerson, Specialty Registrar in Public Health Dr Suzanne Wood, Consultant in Public Health Medicine
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To reduce suicide and self-harm and their associated impacts in the population of Cardiff and the Vale of Glamorgan • Reduce the number of people who take their own lives, or attempt to do so • Reduce the number of people who self harm and the severity of injury in those who do • Reduce the impact of suicide and self harm on those who care for individuals directly affected by these issues
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	**Data** Population level data were accessed from the Office for National Statistics and Public Health Wales Observatory. These described numbers and age-standardised rates for suicide[1,2] and emergency admissions for self harm[3] over time, for Cardiff, the Vale of Glamorgan, both areas together and Wales as a whole. Figures are broken down by sex, age and deprivation. Other demographic data on key population groups has been accessed directly from the Office for National Statistics or StatsWales, or extrapolated based on census or routinely collected administrative figures. Data on risks/harms related to suicide and self harm were mostly taken from reports or studies specific to the groups whose needs the strategy seeks to understand and address. These are noted in detail in the relevant sections below, but of particular note were the National Confidential Inquiry into Suicide and Safety in Mental Health (known by the legacy acronym NCISH), which collects in depth information on suicides, produces an annual report based on data analysis and interviews with practitioners, and also publishes reports on specific themes related to suicide and self harm9 and the Adult Psychiatric Morbidity Survey, which covers England, but which provides detailed data that can provide insights that may apply to Wales[10].

		Qualitative material In developing the strategy we have engaged with a range of stakeholders, including service users and those with a specific knowledge of mental health issues amongst minority populations in Cardiff and the Vale of Glamorgan. A total of 16 interviews were carried out between November 2020 and January 2021, including representatives from: • Third sector organisations, including Cardiff and Vale Action for Mental Health (CAVAMH) the Amber Project, Samaritans and Papyrus • Cardiff and Vale Adult Mental Health services • Cardiff and Vale Child and Adolescent Mental Health services • Cardiff and Vale Liaison Psychiatry • Cardiff and Vale of Glamorgan Healthy Schools Programme • Her Majesty's Prison and Probation Services (HMPPS) • South Wales Police • Counselling Services for Universities within Cardiff • Cardiff and Vale Recovery and Wellbeing College • Network Rail • Diverse Cymru In addition, we carried out a structured stakeholder engagement exercise between December 2020 and February 2021. This included four workshops (professionals, adult service users, children and young people and carers). This process included: • Understanding the specific needs of service users, including those in minority groups or who evidence suggests may face additional risks or barriers • Identifying existing gaps in services to meet these needs, reduce risks or barriers • Understand the vision that these groups wished the strategy to communicate These findings were integrated into the strategy and action plan.

[2]http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		Guidelines, strategies and frameworks A number of existing guidelines, strategies and frameworks were referred to in order to understand the needs of the population and specific issues relating to equalities. These included: • Cardiff and Vale of Glamorgan population needs assessment (2017)11 • Talk to Me 2, Wales' National Suicide and Self Harm Strategy (2015)12 • Shaping our Future, Cardiff and Vale's ten year strategy, 2015-2513 • Preventing suicide and self harm in community and custodial settings (NICE guideline NG105)14 • Everybody's Business: An inquiry and report on suicide prevention in Wales, Health, Social Care and Sport Committee, National Assembly for Wales [Senedd], 2018
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	**Public engagement** The strategy will be available for public engagement from groups across Cardiff and the Vale of Glamorgan including the Regional Safeguarding Board and the Regional Partnership Board and to service user representative and advocacy groups. Staff involved in the delivery of the strategy, health professionals, individuals who frequently come into contact with people at risk of suicide and self-harm, those who have experienced suicide and self-harm directly or indirectly, and the general public

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Data on admissions to hospitals between 2010 and 2019 from residents in Cardiff and Vale show that younger age groups are more likely to experience emergency admissions for self harm, with age specific rates of 314.8 (confidence intervals 298.1 to 332.1) per 100,000 for those aged 10-17, 378.4 (366.6 to 390.5) for those aged 18-29 and 329.8 (318.4 to 341.6) for those aged 30-44, these are statistically significantly different from those in other age groups and statistically significantly higher than the overall rate of 209.6 per 100,000 over the same period3 Data on suicides in Cardiff and Vale shows that between 2010 and 2019 the age specific rate of suicide per 100,000 was statistically significantly higher than the equivalent rates across Wales (12.1 per 100,000) for those aged 30-44 (14.8 per 100,000, confidence intervals 12.5 to 17.5) and for those aged 45-64 (15.5, 13.3 to 18)2 Evidence from our stakeholder engagement supporting these findings, with projects noting in particular the support needs of those in adolescence in relation to self harm, as they transition to adulthood and in some cases to use of adult social and health services. These groups are identified as being at risk in the Section 3 of the strategy and specific actions are described in the action plan to address these inequalities. Therefore it is anticipated that by targeting these groups in particular, the strategy will have a positive impact.	None	None required

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6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	A 2016 systematic review of relationships between chronic illness and disability with suicide, suicidal ideation and self harm noted consistent associations between a wide variety of categories of specific health issues in this category, including sensory loss, and functional disability[15]. The authors note the difficulties of attempting to summarise very different study populations with a single figure, but studies include: **High functional disability:** an Odds Ratio for experiencing suicidal ideation of 3.22 (CI 2.34 to 4.42) in an unadjusted model compared with those having no functional disability across a population sample of 15,890 from multiple European sites[16] **Vision impairment:** an odds ratio of 14.6 (CI 5.7 37.3) to 9.4 (CI 3.4 26.0) depending on the statistical model chosen for 'having a wish to die' compared with those who have no impairment, in a population sample of Australians aged 70+[17] **Hearing impairment:** an odds ratio of 5.6 (CI 2.3- 13.9) to 5.5 (CI 2.1-14.5) depending on the statistical model chosen for 'having a wish to die' compared with those who have no impairment, in a population sample of Australians aged 70+[17] For **diabetes**, there were typically no associations identified, e.g. OR 1.2 (CI 0.3-4) for suicide amongst a sample of 420 individuals aged 67+[18]	None	None required

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	Research on associations between self harm and long term, chronic illness or physical disability was difficult to locate. One study of the epidemiology of self harm in admissions to a general hospital in Oxford between 1996 and 2010 noted that concerns over physical health were reported by 10.2% of males interviewed, but were not in the top 10 reported issues for females19. A further study of specialist assessments and hospital records across multiple sites in England between 2000 and 2013 for people aged 40-59 examined 24,599 presentations for self harm, finding that 642 men (16.1% of all men recorded as presenting) and 703 women (15.2%) reported a physical health problem. A total of 2,201 (58.1%) of men presenting and 2,706 (60.7%) of women presenting were linked to previous psychiatric treatment under secondary mental health services[20]. As reviewed by the National Confidential Inquiry into Suicide and Safety in Mental Health (known by the legacy acronym NCISH), over 2007-2017 in Wales, 802 deaths (22% of all general population suicides) were identified as patient suicides, i.e. people in contact with mental health services in the 12 months prior to death[9]. This represents an average of 73 patient suicides per year[9]. There are no breakdowns of figures for Cardiff and the Vale of Glamorgan specifically. Work with stakeholders validated the insights that those with disabilities or long term conditions may be at particular risk of suicide and self harm, in particular those who are accessing mental health services. These groups are identified as being at risk in the Section 3 of the strategy and specific actions are described in the action plan to address these inequalities. Therefore it is anticipated that by targeting these groups in particular, the strategy will have a positive impact.	None	None required

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender.	The rate of suicide amongst males aged 10 and over in 2017-19 was 16.6 per 100,000 (13.9 to 20.9) compared to a rate of 4.78 amongst females aged 10 and over (3.3 to 6.9). In Stonewall's 2018 study into LGBT health, which sampled 5,375 individuals across England, Scotland and Wales, 46% of those who identified as 'trans' reported considering taking their own life in the past 12 months, with 12% reporting an attempt to take their own life[21]. These figures were higher than for those identifying as lesbian, gay or bisexual[21] (see below). A thematic report by NCISH on younger people reported that of 316 deaths by suicide of those under 20 in England and Wales over 2014-15, 4 (1%) were reported to be uncertain about their sexual orientation[22]. A meta-analysis of 51 studies into non-suicidal self injury reported a past year prevalence of 46.7% for 'gender minority individuals' (i.e. those reporting some form of gender re-alignment process) compared to a prevalence of 10.6% amongst cisgender individuals[23]. Our work with stakeholders validated this epidemiological evidence in relation to the population of Cardiff and the Vale of Glamorgan, with services supporting young people noting in particular that those in these groups who identified as LGBTQ+ were more likely to have support needs in relation to suicide and self harm. These groups are identified as being at risk in the Section 3 of the strategy and specific actions are described in the action plan to address these inequalities. Therefore it is anticipated that by targeting these groups in particular, the strategy will have a positive impact.	None	None required

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6.4 People who are married or who have a civil partner	The Office for National Statistics reports a long standing finding of lower rates of suicide amongst those who are married or in a civil partnership[24]. In 2015, the rate of suicide for men in England and Wales who were married or in a civil partnership was 9.6 per 100,000 compared with a rate of 11.2 in men who were single, 27.4 in men who were divorced and 25.5 in men who were widowed[24]. For women, the rates were 3.2 per 100,000 in those married in a civil partnership, 3.1 for those who were single, 9.6 for those who were divorced and 6 for those who were widowed[24]. Research self harm in relation to marital status is harder to locate. However, one case control study of risk factors with 9,873 cases and 186,092 controls, all Norwegian adults aged 18-35 found that those who had never been married were 2.26 times more likely to have self harmed (CI 2.06-2.47) and those previously married were 3,38 times more likely to have self harmed (CI 3.37-4.36) than those who were married, also suggesting that marriage is a protective factor[25]. We do not believe the strategy will have a positive or negative impact on this group.	None	None required
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Evidence suggests that risks of suicide and self harm are lower than for the general population during pregnancy and breastfeeding[26]. No evidence specific to self harm during pregnancy or breastfeeding was located. We do not believe the strategy will have a positive or negative impact on this group.		

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6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/ travellers, migrant workers	There are identified issues in relation to gathering evidence on the impact and risks related to suicide and self harm on those of different race, nationality, colour or ethnic origin, with gaps in routine reporting of ethnicity in relation to suicide noted in particular[27]. The Adult Psychiatric Morbidity Survey for England in 2014 found that the age standardised proportion of white adults reporting suicidal thoughts in their lifetime was 19.6%, reporting an attempt at suicide was 5.3% and for self harm was 5.8%[10]. The comparable figures for those identifying as 'black/black British' were 21.4% (thoughts of suicide), 8.9% (suicide attempts) and 5.5% (self harm)[10]. For those identifying as 'Asian/Asian British' the figures were 12% (thoughts of suicide), 5.1% (suicide attempts) and 6.1% (self harm)[10]. For white British women, the age standardised proportion reporting thoughts of suicide was 23.5%, 6.9% reporting a suicide attempt and 8.1% reporting self harm10. The comparable figures for those identifying as 'black/black British' were 20.7% (thoughts of suicide), 3.9% (suicide attempts) and 4.2% (self harm)10. For those identifying as 'Asian/Asian British' the figures were 14.3% (thoughts of suicide), 5.6% (suicide attempts) and 4.7% (self harm)[10]. A 2010 study carried out amongst the Irish traveller community in Ireland suggested that amongst male travellers the rate of suicide was 6.6 times that of non-travellers, although there was no difference between women from the different backgrounds[28]. These insights were validated by work with stakeholders in Cardiff and the Vale of Glamorgan, with those in statutory and non-statutory services noting that the population of Cardiff is notably diverse in terms of ethnicity and the strategy should ensure that this diversity is recognised in strategic work on suicide and self harm.	None	None required

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	These groups are identified as being at risk in the Section 3 of the strategy and specific actions are described in the action plan to address these inequalities. Therefore it is anticipated that by targeting these groups in particular, the strategy will have a positive impact.	None	None required
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	A systematic review from 2010 reviewed 12 papers exploring associations between religious belief and suicide. They found no papers reporting a significant difference between those of religious faith and those who reported no faith29. A study of 617 students recruited from universities in London found no association between reported religious faith (Christian, Muslim, Hindu, Sikh and no religion) and self harm. A subgroup analysis of Christians and non-religious individuals who were UK nationals found a statistically significant higher proportion reporting any instance of self harm for those with no religion but the researchers caution that the small numbers and specificity of sampling make it difficult to extrapolate these results[30]. We do not believe the strategy will have a positive or negative impact on this group.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Stonewall's Health in Britain report of 2018 reported that 31 per cent of LGB people who aren't trans had thought about taking their own life in the last year[21]. NICSH reported that 6% of those under 20 and 3% of those aged 20-24 who took their own lives in 2014 or 2015 were reported to be lesbian, gay, bisexual, or transgender (LGBT) or uncertain of their sexuality[22]. A meta-analysis of 51 studies into non-suicidal self injury reported a past year prevalence of 24.7% for 'sexual minority individuals' (i.e. those self describing as gay, lesbian or bisexual) compared to 10.6% for those identifying as heterosexual[23].		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	Our work with stakeholders validated this epidemiological evidence in relation to the population of Cardiff and the Vale of Glamorgan, with services supporting young people noting in particular that those in these groups who identified as LGBTQ+ were more likely to have support needs in relation to suicide and self harm. These groups are identified as being at risk in the Section 3 of the strategy and specific actions are described in the action plan to address these inequalities. Therefore it is anticipated that by targeting these groups in particular, the strategy will have a positive impact.	None	None required
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is no evidence that we could locate that identifies rates of suicide or self harm in those who communicate in Welsh. However, it is important that those experiencing these issues are able to communicate in Welsh if that is their preference, in line with 'More than just words', Welsh Government's Strategic Framework for Welsh language services in health and social care[31]. Statutory services report that they operate in line with Welsh Government policies. Third sector services offering services available to the general public (e.g. Samaritans, Papyrus) report Welsh language capability. The strategy will be translated and made available in Welsh. We do not believe the strategy will have a positive or negative impact on this group.		

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6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/ workless, people who are unable to work due to ill-health	There is evidence that those who are unemployed are at higher risk of suicide. One study found that the relative risk of suicide associated with unemployment was elevated by about 20–30% between 2000-11 globally[32]. A longitudinal study of young adults not in education, employment or training and including clinical interviews suggested that economic inactivity was associated with a threefold increase in lifetime suicide attempts compared to those who are economically active[33]. NCISH, specifically considering those with a mental health diagnosis, found that of 802 suicides in Wales 2007-17, 45% were unemployed and 17% were on long term sick leave. A case control study of risk factors with 9,873 cases and 186,092 controls, all Norwegian adults aged 18-35 found that those currently on sick leave from work were 2.22 times more likely to have self harmed (CI 2.12-2.33) than those currently working[25]. A recent study of specialist assessments and hospital records across multiple sites in England between 2000 and 2013 for people aged 40-59 examined 24,599 presentations for self harm. A total of 1,492 men (39.2% of all men presenting) were unemployed, with a further 668 (17.6%) registered for sickness or incapacity benefits. For women the figures were 1,366 (31.3%) and 712 (16.3%). These proportions are higher than in the general population, suggesting that self harm is more prevalent amongst these groups[20]. In identifying these groups as at increased risk relative to the general population, and by identifying specific actions in relation to these groups, it is anticipated that strategy will have a positive impact.	None	None required

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Those living the most deprived quintile of areas in Cardiff and Vale had an age-standardised rate of 17.6 suicides per 100,000 (Cis 14.9-20.8) over 2010-19, a statistically significant difference to the rate of 13.7 across Wales. Although it is beyond the scope of the strategy to address issues of deprivation directly, in identifying these groups as at increased risk relative to the general population it is anticipated that strategy will have a positive impact.	None	None required
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	In addition to the main groups, we also specifically considered prisoners. Including provisional data for 2020, when two individuals were recorded as taking their own lives, a total of 12 suicides have been recorded at HMP Cardiff in the past ten years[34]. There were 829 incidents of self harm in 2019, a substantial rise on the 459 recorded in the previous year[34]. In identifying this group as at increased risk relative to the general population, and by identifying specific actions in relation to this group, it is anticipated that strategy will have a positive impact.	None	None required

7. References

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