Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NCSR

Llywodraeth Cymru
Welsh Government

Suicide and Self-harm in Wales:

National Centre for Suicide Prevention and Self-harm Research

Annual Report 2026

Contents

Scope

This document has been compiled with respect to the National Centre for Suicide Prevention and Self-Harm Research's (NCSR) independent advisory role as set out in the Welsh Government's Suicide Prevention and Self-Harm Strategy for Wales, 2025-2035.

Report Authors

Prof Ann John	NCSR Director
Dr Marcos Del Pozo Banos	NCSR Co-Investigator
Dr Amanda Marchant	NCSR Co-Investigator
Dr A. Jess Williams	Lecturer in Suicide Prevention, Swansea University
Dr Gareth Roderique-Davies	NCSR Co-Investigator
Dr Sinong Chen	NCSR Welsh Government funded Research Officer
Nancy Meligy	Research Assistant, Swansea University
Emily Grimstead	NCSR Project Manager
Elinor Thomas	NCSR Communication and Engagement Officer
Bethanie David	NCSR Project Administrator

Acknowledgements

We thank Rhys Jones and David Tabor from the Office of National Statistics for their report on registration delays and male suicide in Wales.

1 Foreword

Understanding suicide and self-harm is central to responding to those in distress and to suicide prevention. The need is often unseen, the people affected not always known, and the opportunities to intervene can be brief. Those affected may be individuals, families, or whole communities.

Since the launch of the National Centre for Suicide Prevention and Self-Harm Research alongside the Welsh Government's strategy in 2025, we have strengthened our understanding of the scale and nature of these challenges in Wales. This report brings together evidence from data, research and lived experience gathered over the last year to provide a clearer picture of what is happening, who is most at risk, and where we might act.

The findings remind us that suicide and self-harm do not arise from a single cause, but from a complex interaction of factors across a person's life. While patterns can be seen at a population level—such as higher risks among men, those living in deprived areas, or young people experiencing adversity—each person's story is unique and must be understood in context.

Much of what we see in the data reflects only part of the reality. Many people who experience self-harm or suicidal thoughts do not seek help, and many opportunities for support remain missed. At the same time, there are clear points of contact—particularly in primary care and workplaces—where timely, compassionate intervention can make a difference.

Responding effectively requires coordination across sectors, strong leadership, and a commitment to evidence-informed action. It also requires listening—to data, to practitioners, and crucially to people with lived experience, whose insights are essential to shaping meaningful and ethical responses.

More than anything, suicide and self-harm are human experiences that call for compassion. Behind every statistic are individuals, families and communities living with distress, loss, and often silence. Supporting those affected—whether they are at risk, bereaved, or caring for others—must remain at the heart of all prevention efforts.

This report provides an evidence base to guide action across Wales. It is not comprehensive but reflects some of the work of the Centre in it's first year. It highlights progress, identifies challenges, and reinforces the need for a sustained, collective response. Suicide prevention and responding to self-harm are not static; they must evolve as we learn more and patterns change. Our responsibility is to remain attentive to the evidence, responsive to changing needs, and above all, committed to reducing harm and saving lives.

Professor Ann John,
Director of the NCSR

Who we are

The National Centre for Suicide Prevention and Self-Harm Research (NCSR) was launched alongside the new ten-year Suicide Prevention and Self-Harm Strategy for Wales on 1st April 2025, by the Minister for Mental Health and Wellbeing Sarah Murphy, marking a significant milestone in one of the nation's most pressing public health challenges. It is led by Swansea University, in collaboration with Cardiff University, the University of South Wales and the Samaritans, and funded by Health and Care Research Wales and Welsh Government.

Picture: Our Director Ann John and Sarah Murphy MS, Minister for Mental Health and Wellbeing at the Centre launch

The Challenge in Wales

There is rarely one single cause of self-harm, suicidal thoughts and behaviours - with many different factors interacting across a person's lifespan; highlighting the need for cross-sectoral strategies to co-ordinate prevention and action. However, research highlights several key factors that contribute to self-harm, suicidal thoughts and behaviours, including a history of suicide attempts or self-harm, mental health conditions, substance use, unemployment, relationship breakdown and financial struggles. While these factors are important at a whole population level for assessing need and planning pathways and services, each person is best understood by considering their own life and circumstances. Self-harm, suicidal thoughts and behaviours can affect anyone.

Suicide is potentially preventable. Effective prevention involves evidence informed policy and practice. This evidence includes research, evaluation and knowledge from those with lived experience and is the only way to create lasting change. That is why the Centre is made up of researchers and those with lived experience, and is why we work with policy colleagues to independently inform policy.

While tracking suicide and self-harm rates is essential for monitoring trends and informing prevention efforts, official statistics capture only part of the picture (see Figure 1, based on 2014 data). Only just over half of people who have made a suicide attempt seek help even from friends and family. This highlights the substantial proportion of need that remains unrecorded and unsupported.

Exposure to suicide [1] is far more common than many people realise. In fact, one in four adults have thought about taking their own life, and 1 in 13 have made a suicide attempt at some point [1]. For every death by suicide, at least 135 people are exposed and potentially affected [2]. This includes family, friends, colleagues as well as individuals who may have known the person indirectly, such as through receiving a service, being a patient, or witnessing the death.

Addressing suicide prevention and self-harm requires prevention and support efforts that reach well beyond clinical settings.

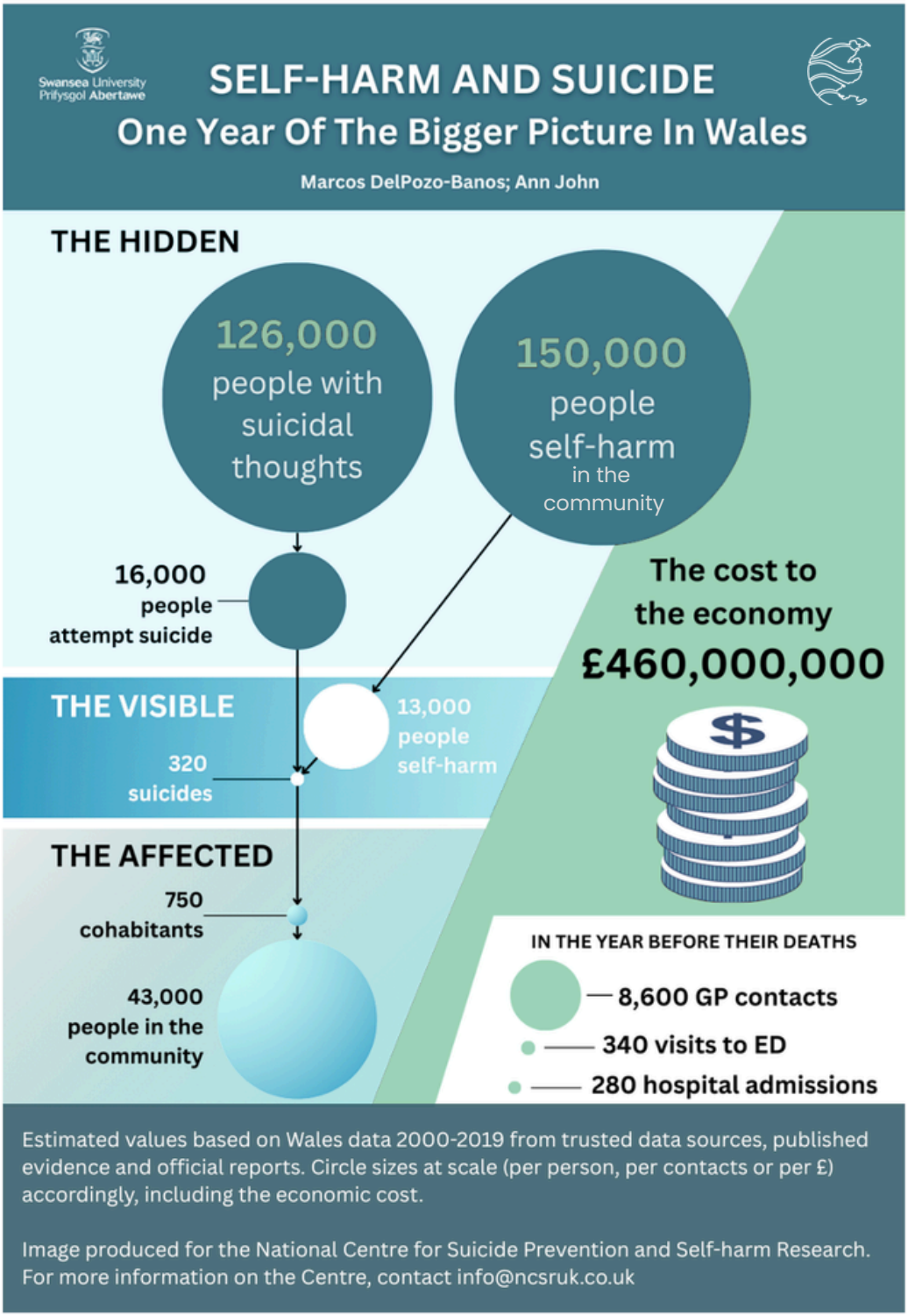


Figure 1. Self-harm and Suicide: One Year of the Bigger Picture in Wales.

Key objectives
To address these challenges the NCSR aims to:

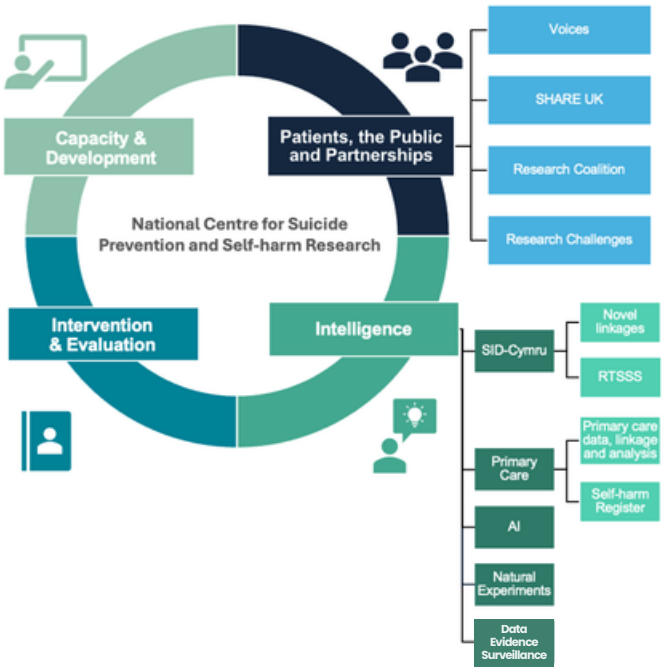
- **Advance research excellence:** conduct studies to better understand the causes of suicide and self-harm and identify and evaluate effective interventions.

- **Involve people with lived experience:** The NCSR has formed a People with Lived Experience Advisory Group, facilitated by the Samaritans and Swansea University, to ensure those with lived experience of suicide and self-harm play a central role in shaping research, policy and interventions in a meaningful and ethical way.

- **Inform policy and practice:** The NCSR is named as the official independent evidence advisory body to the Welsh Government within its Suicide Prevention and Self-harm Strategy, 2025 – 2035.

- **Empower communities:** Equip policymakers, healthcare professionals and communities with practical tools for suicide prevention.

- **Build capacity for future research:** Support early and mid-career researchers in advancing suicide prevention and self-harm intervention research.



The diagram demonstrates the workstreams within the NCSR

The NCSR connects government, public sector agencies, third-sector organisations, researchers, people with lived experience and the public - **putting people at the centre** - to drive evidence-based change in policy and practice, support for those at risk and to save lives.

Purpose of the Annual Report
The purpose of this annual report is to provide an update on the NCSR's delivery against the Welsh Government strategy. It has three elements:

- An update on suicide and self-harm data
- Summaries of current NCSR research
- Strategy relevant policy briefings

2 Key Messages and Advice

1. **Males were around four times more likely to die by suicide than females. Male suicide rates appear to show a longstanding increase over time in Wales. This is particularly evident in males aged 25-44 years.**

Advice

- Suicide prevention activities should continue to prioritise approaches tailored for men, with particular attention to the barriers males face in seeking help alongside training and resources for staff in appropriate responses and signposting.

- The apparent increase in male suicide rates warrants close monitoring.

- When prevention efforts are targeted and resourced, existing and emerging trends should be considered.

2. **Rates of suicide and self-harm were 2-3 times higher in the most deprived areas of Wales compared with the least deprived areas.**

Advice

- Consider developing accessible pathways and outreach in more deprived communities, ensuring that support is accessible and relevant to those in greatest need.

- Consider developing and disseminating resources to support cross sectoral signposting to local, regional and national services addressing wider determinants e.g., debt, financial adversity, housing, domestic abuse, gambling.

3. **Contacts with healthcare settings for self-harm have declined since 2020, particularly for males. This likely reflects a reduction in help-seeking behaviours rather than a decrease in self-harm rates in the community [1]. General Practice was the commonest setting for seeking help.**

Advice

- Consider developing clear care pathways for those who seek help in healthcare settings for self-harm or distress, with specific approaches tailored to males.

- Further research is needed to understand the drivers of declining healthcare contacts and any associated increases in unmet need.

- A focus on primary care is warranted, for example developing clinical pathways, staff training, resources.

4. **An increase in healthcare contacts was evident in the year preceding suicide, indicating an escalation of need in the period leading up to crisis. The most common last point of contact prior to death was in primary care.**

Advice

- These contacts represent an important opportunity to identify individuals at risk, initiate appropriate care pathways, and deliver timely preventative interventions.

- Primary care settings in particular should be supported to recognise and respond to those in distress or who are self-harming, ensuring that people in crisis are connected to the right support at the right time.

5. **Individuals under the care of mental health services showed a pattern of disengagement from routine outpatient care in the year preceding their death, while contacts with emergency departments and hospital admissions increased.**

Advice

- Mental health services should consider strengthening processes for identifying and responding to disengagement from care ,such as proactive follow-up and re-engagement protocols, recognising this as a potential indicator of escalating need.

- Improving communication and coordination between mental health services and routine care and emergency settings could support continuity of care during periods of high vulnerability.

6. **Children who spent less time at school had higher rates of self-harm. This included those who were persistently absent and/or excluded from school and those unable to attend mainstream school i.e. those educated other than at school (EOTAS). Children in EOTAS settings had more complex needs. Children excluded from school had higher rates of suicide.**

Advice

- Attendance data is routinely collected and could be used to target assessment and early intervention.

- EOTAS settings such as Pupil Referral Units are a unique opportunity to develop skills and provide more intensive support to children with complex needs. Closer working or integration with mental health services (e.g., in-reach) in these settings would support this.

7. **The Strategy explores conducting a public health media suicide prevention campaign. Public understanding of suicide prevention is somewhat limited. Research indicates that widespread misconceptions about suicide persist, and these misunderstandings can make individuals less likely to intervene when they are concerned about someone. Media campaigns have increasingly been used as broad public-facing interventions to promote suicide prevention by raising awareness, improving understanding, and influencing beliefs, attitudes and behaviours. Recent scientific evidence highlights several key recommendations for effective suicide prevention media campaigns.**

Advice

- Use of positive, hope-orientated and help-seeking messages within all campaign materials
- Follow safe reporting principles and avoid sensationalised language
- Deliver campaigns through traditional media, digital media and social media channels
- Incorporate lived-experience perspectives
- Embed the campaigns within broader suicide prevention services
- Draw on previous successful campaigns to inform design and messaging
- Be aware of the limitations of media campaigns on suicide prevention
- There is little direct evidence of the impact of public health media campaigns focussed on reducing risk factors for suicide and/or self-harm, such as alcohol consumption, and their direct effects on these outcomes. Any such campaigns should be evaluated with outcomes to include measuring suicide and self-harm.

8. **The new British Standards Institution (BSI) Suicide Prevention in the Workplace Standard BS30480 [2], provides clear guidance and practical tools to help workplace organisations strengthen their suicide prevention efforts.**

Advice

- Integrate suicide prevention into existing policies, such as mental health and wellbeing, diversity and inclusion and health and safety
- Inclusion of both ethical considerations and clear intervention protocols
- Provide clear signposting to internal and external mental health and suicide prevention resources
- Offer mental health and suicide awareness training for managers and workers
- Assess the effectiveness of their policies, through self-evaluation and benchmarking questions.
- Consideration should be given to encouraging the adoption of the Standard

Further information can be found within the “Policy Briefings” section of this report.

3 What is happening in Wales? Current Epidemiology

Understanding Suicide and Self-Harm Data

Factors that contribute to suicide are many and complex. However, suicide is potentially preventable. Self-harm is a key risk factor for suicide. Understanding who dies by suicide, who self-harms and where they seek help is essential to prevention efforts. This allows us to identify changes over time, enabling responsive priorities to be set to inform policy and practice and to document the impact of any interventions.

In Wales, there are several sources of information on suicide and self-harm. The two included in this report are:

- From the Office of National Statistics (ONS) (publicly available at https://www.ons.gov.uk).
- Suicide and Self-harm Information Database - Wales (SID-Cymru), based at the NCSR at Swansea University and hosted by the Secure Anonymised Information Linkage (SAIL) Databank.

Another important source is:

- Real Time Suspected Suicide Surveillance system (RTSSS), established in Wales on 1 April 2022 to collect information on deaths by suspected suicide as a central national repository [3]. We are currently working with Public Health Wales to link the RTSSS into SID-Cymru at the SAIL Databank.

There are a number of considerations when thinking about what suicide and self-harm statistics mean.

Definitions

Suicide:

Data analysed in this document refers to the Office for National Statistics (ONS) classification of suicide where the underlying cause of death was:
1) Intentional self-harm (ICD-10 code X60-X84).
2) Event of undetermined intent (Y10-Y34)
In 2016, the National Statistics definition of suicide was modified to include deaths from intentional self-harm in 10 - 14-year-old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.

Self-harm:

Self-harm is defined as any intentional self-poisoning or self-injury, irrespective of intent. In this report, self-harm data were derived from electronic healthcare records across three settings: primary care (general practices), emergency departments (EDs), and hospital admissions, using previously validated lists of diagnostic codes (read codes, emergency department-specific codes, and ICD-10 codes), for individuals aged 10 years and over. Self-harm incidence was defined as a recorded episode with no preceding self-harm in the previous 12 months.

Under-reporting

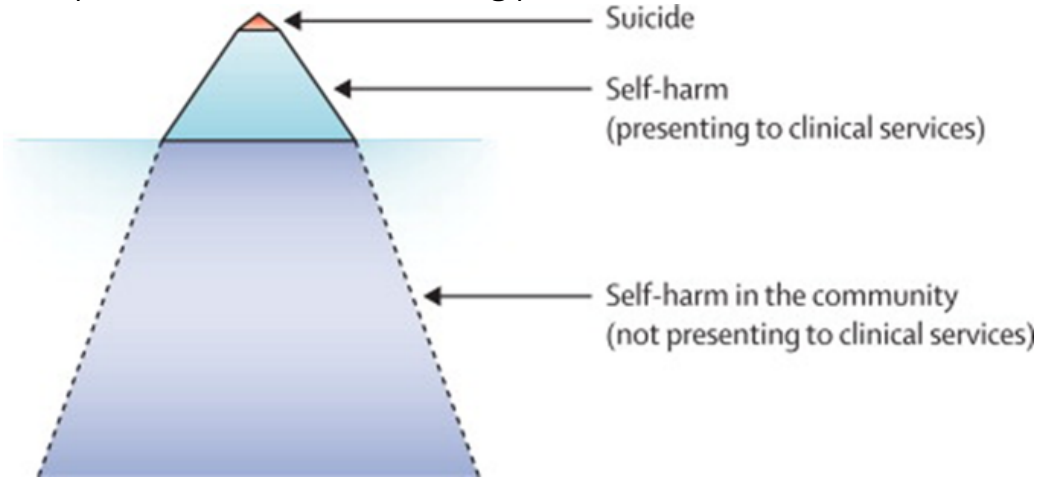
Suicide:

It is widely acknowledged that official statistics may underestimate the 'true' numbers of suicide in the UK and across the world. The classification of a death as suicide depends on the conclusion reached by a coroner, who must determine intent based on the available evidence. For some people, intent cannot be established with sufficient certainty. Where a death is recorded as 'undetermined intent' it will be included in suicide statistics for those aged 15-years and over, but where it is coded as accidental it will not. The latter occurs, for example, in single vehicle road traffic accidents.

Self-harm:

There is broad consensus that data based on clinical presentations substantially underestimate the true prevalence of self-harm in the population. People who self-harm do not always seek support. This phenomenon is often described as the "iceberg phenomenon" (figure 2): suicide deaths represent the visible tip of the iceberg; recorded self-harm episodes capture only those individuals who present to clinical services; and the far larger burden of self-harm occurring in the community remains hidden from routine data sources [5]. The findings in this report therefore reflect contacts with healthcare settings rather than population-level rates in the community and should be interpreted accordingly.

Figure 2: Representation of the "iceberg phenomenon" in self-harm and suicide [5]



Recent findings from the Adult Psychiatric Morbidity Survey [1] reveal that among adults who have self-harmed, fewer than half accessed medical or psychological support (37.9%). This underscores the substantial yet often overlooked proportion of individuals who self-harm without coming into contact with services, as illustrated in Figure 2.

In addition, data completeness in this report was affected by differences in availability and recording practices across health boards. Self-harm presentations to emergency departments were not available from all health boards, and variations in local coding and data entry practices may have affected how events were recorded and captured. As a result, the figures presented here are likely to underestimate actual self-harm rates, particularly in emergency departments.

Changes over time may partly reflect shifts in help-seeking behaviour rather than changes in the underlying level of need. They may also more accurately reflect certain groups, such as females and younger adults, who are more likely to seek support than men or older people, influencing how these patterns appear in the data [1].

Suicide- change in the coroner's burden of proof (2018)

In 2018, a change was introduced to the coroner's standard of proof in England and Wales, moving from a criminal standard ("beyond reasonable doubt") to a civil standard ("on the balance of probabilities"). This change affects how conclusions are reached and has implications for the classification of deaths as suicide or undetermined intent. As a result, suicide registration statistics from 2018 onwards are not directly comparable with those from earlier years. Apparent changes in suicide rates around this period may reflect changes in the burden of proof and hence how deaths were recorded, rather than true changes. Throughout this report, figures that span this period highlight 2018 to support appropriate interpretation.

Delays in registration

Official suicide data are subject to a delay in availability. Before a suicide death can be registered, an inquest must be completed (England and Wales). The length of time required to complete this process varies from case to case, with the median registration delay in Wales in 2024 being 265 days. Registration delays in Wales are longer than in England. Therefore, data for more recent years may be subject to revision, and trends based on registration data should be interpreted with caution, especially at the end of the time series. Data from ONS registrations are provided by year of registration rather than year of death whereas that from SID-Cymru is by year of death. Appendix III is an analysis from ONS assessing the impact of registration delays on male suicide rates in Wales. We note that these delays in inquests and registration have a huge impact on families.

Small numbers and populations

Suicide is a relatively rare event, particularly within smaller population groups, specific age bands, or local areas. Where populations are small, for example where males and females are analysed separately, rates can be unreliable since a small change in the number of suicides will have a large impact on rates. When this occurs it is demonstrated by relatively wide confidence intervals (bars around points in graphs, ranges in brackets). In these analyses any comparisons should be interpreted with caution and particular attention paid to overlapping error bars where differences are then not statistically significant i.e. we cannot really say there is a 'true' difference.

As a result, annual suicide rates can show substantial year-to-year fluctuation that does not necessarily reflect meaningful changes in rates. While self-harm rates are considerably higher than suicide rates, they can still show substantial year-to-year fluctuation that does not necessarily reflect meaningful change over time. To reduce this volatility and support clearer visualisation of longer-term patterns, suicide rates are presented as five-year rolling averages and self-harm as three-year rolling averages. Ninety-five percent confidence intervals are presented alongside rates to indicate the degree of statistical uncertainty and to help convey the extent of variability in the estimates.

Age standardised vs. crude rates

Age standardised rates have been standardised to the European population to allow for comparisons. This is because the age structure of a population affects rates. For example, an area with an older population would naturally show higher rates of many health conditions than an area with a younger population. Age standardisation removes this structural difference and allows for a fairer comparison. Crude rates are not standardised in this way.

Data sources

Suicide:

While ONS suicide registration data provide robust national-level statistics, they do not include detailed information on deprivation. Where analyses require such information, data will be drawn from SID-Cymru hosted within the SAIL Databank. SAIL enables secure deidentified linkage of administrative datasets and supports analyses of suicide in relation to deprivation and other population characteristics that cannot be examined using publicly available ONS suicide registrations data alone. ONS data are presented by year of registration rather than year of death, whereas data from SID-Cymru are presented by year of death. Suicide deaths in SID-Cymru are currently available to 2023 only.

This report includes a total of 4,144 people who died by suicide from 2013-2024 based on ONS registration data, of whom 3,709 died between 2013-2023 (the comparable period for SID-Cymru). This compares with a total of 3,058 people in SID-Cymru who died by suicide over the same period given difference in data coverage and cohort development within the SAIL databank. As such, numbers with SID-Cymru will appear lower than those from ONS registrations.

Self-harm:

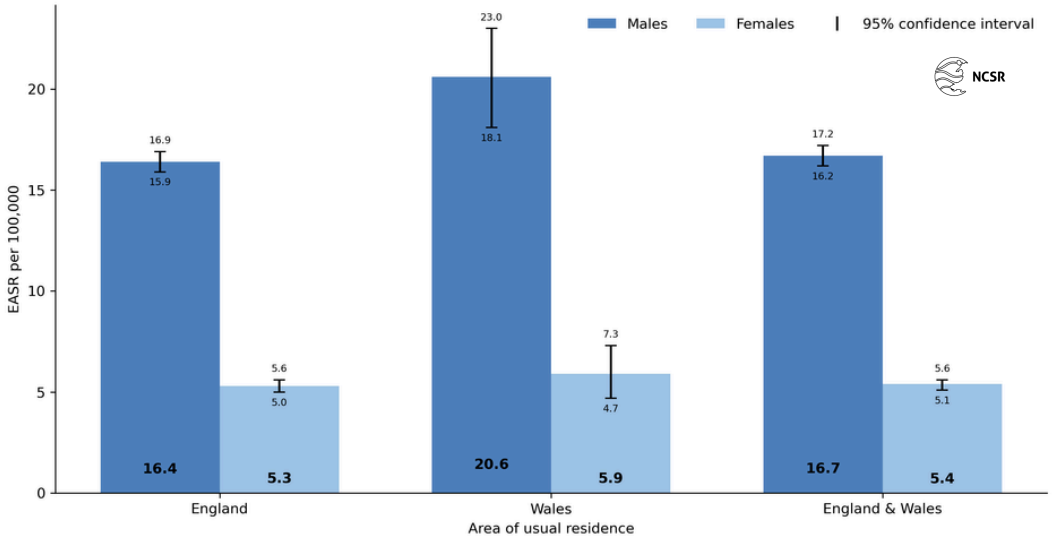
Self-harm data for this report are derived from electronic healthcare records (primary care, emergency departments (EDs), and hospital admissions data) held within SID-Cymru.

3.1 What is happening in Wales? Suicide Data

Comparison of Wales and England

Male suicide rates (European age-standardised; EASR) were higher in Wales than in England (Figure 3). Female suicide rates were comparable between the two nations.

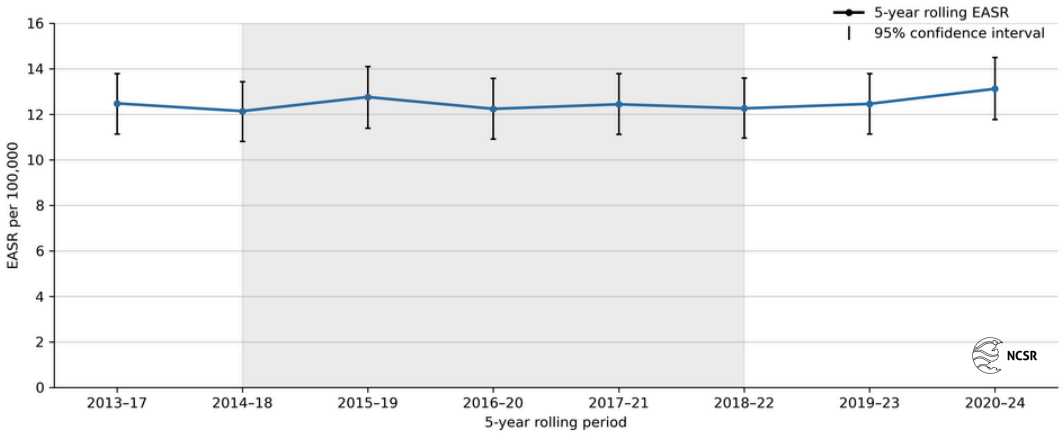
Figure 3: Suicide, European age-standardised rate (EASR) per 100,000 population, males and females aged 10+, England, Wales and England & Wales, 2019-2024 registrations. Produced by NCSR using ONS mortality registration data



Trends in suicide rates over time

Suicide rates (5-year rolling EASR) remained relatively stable between 2013 and 2024 with the confidence intervals overlapping with all previous time periods (Figure 4). On average, one person takes their own life every day in Wales.

Figure 4: 5-year rolling European age-standardised rate (EASR) per 100,000 population, persons (sexes combined), aged 10+, Wales, 2013-2024. Produced by the NCSR using ONS mortality registration data



on average

1

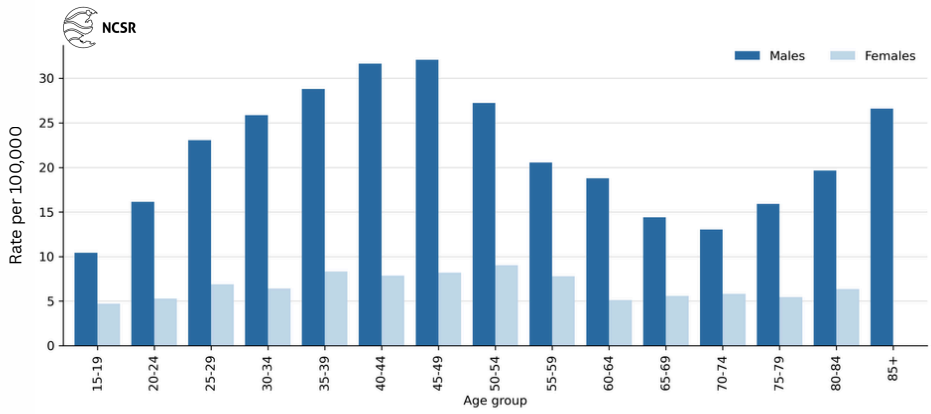
person takes their own life every day in Wales

**Shading to represent change in burden of proof in 2018*

Age-specific suicide rates

Suicide rates (2019-2024 EASR) varied across age groups in males, while they remained relatively stable across ages in females (Figure 5). Male suicide rate was lowest in 15-19-year-olds and highest in those aged between 40 -and 49-years (with rates more than three times greater).

Figure 5: Suicides, age-specific rates per 100,000 population, males and females aged 15+, Wales, 2019-2024 registration. Produced by NCSR using ONS mortality registration data

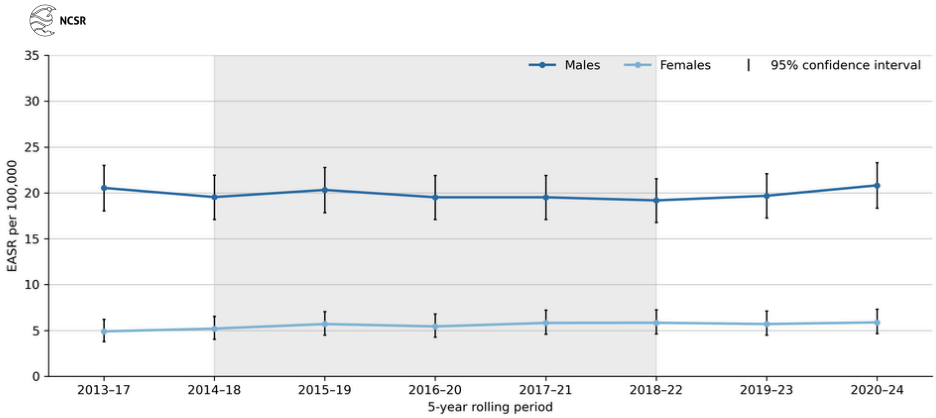


**Rates for females aged 85 years and over are not shown due to small numbers*

Trends in suicide rates by sex

Male suicide rates (5-years rolling EASR) were consistently around four times higher than those of females across the reporting period. Whilst an upward trend in male rates was apparent when reviewing annual rates (please see Figure 7 and Appendix III), the wide overlapping confidence intervals with 5-year rolling averages mean this should be interpreted with caution. No equivalent increase was observed among females.

Figure 6: Suicides, 5-year rolling European age -standardised rate (EASR) per 100,000 population, males and females, aged 10+, Wales, 2013 -2024 registrations. Produced by NCSR using ONS mortality registration data.

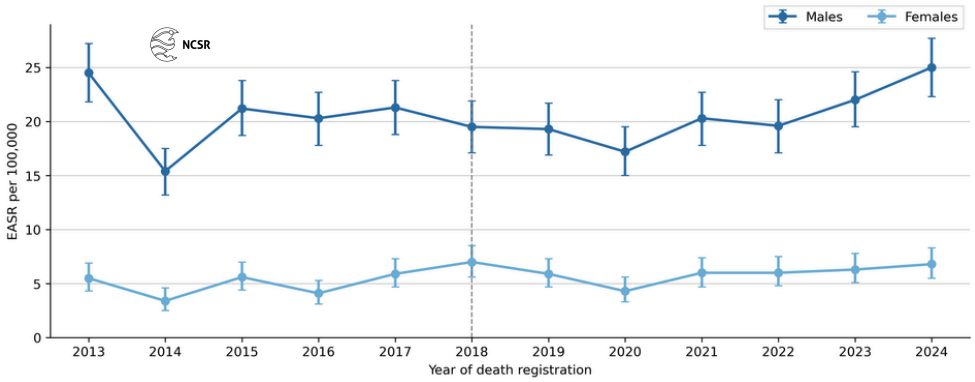


**Shading to represent change in burden of proof in 2018*

Year-to-year variation in suicide rates

Annual suicide rates in Wales year by year are shown in Figure 7, rather than rolling averages, thereby highlighting how rates fluctuate from one year to the next. There appeared to be a long-standing increasing rate in males from 2020, whereas female suicide rates remained relatively stable.

Figure 7: Suicides, annual European age -standardised rate (EASR) per 100,000 population, males and females, aged 10+, Wales, 2013 -2024 registrations, Produced by NCSR using ONS registrations data

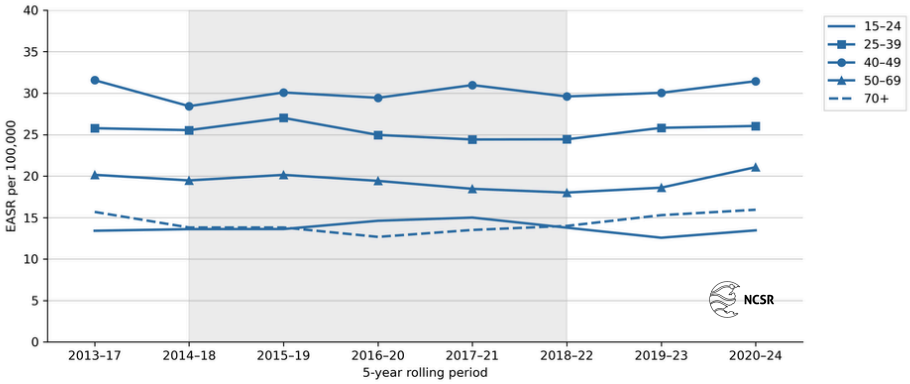


**Dashed line represents change in the burden in proof in 2018*

Trends in suicide rates among males and females by age group

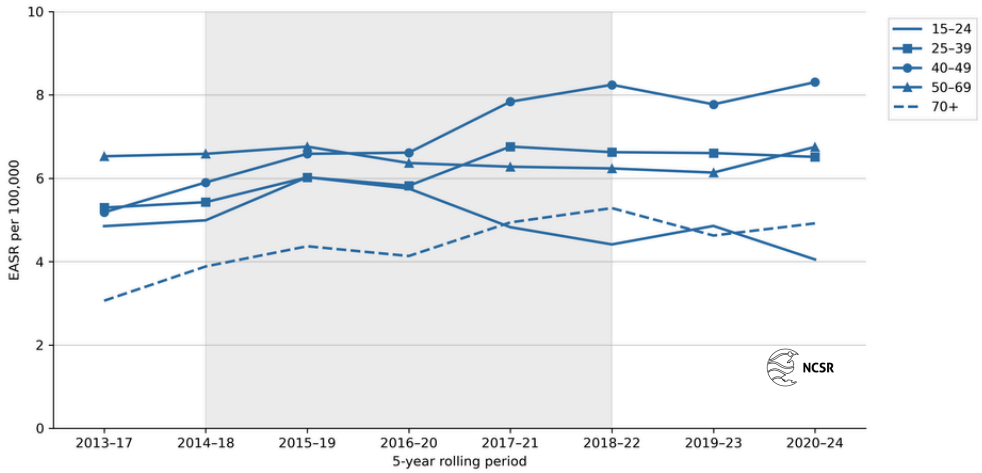
Suicide rates over time across age groups for males and females remained relatively stable (Figures 8 and 9). Small apparent variations over time cannot be interpreted due to wide confidence intervals. Across almost all male age groups, suicide rates (5-year rolling EASR) increased between the 2018-2022 and 2020-2024 periods, the sole exception being the 15-24 age-group (Figure 8). The most marked increase was observed among males aged 50-69 years. No similarly clear pattern was observed among females although the 40-49-year age group has shown a steady increase (Figure 9).

Figure 8: Suicides, 5-year rolling European age -standardised rate (EASR) per 100,000 population, males aged 15+, Wales, 2013 -2024 registrations. Produced by NCSR using ONS registration data



**Shading to represent change in burden of proof in 2018*
**Deaths among persons aged 10-14 years are excluded due to small numbers*

Figure 9: Suicides, 5-year rolling rate per 100,000 population, females aged 15+, Wales, 2013-2024 registrations. Produced by NCSR using ONS registrations data



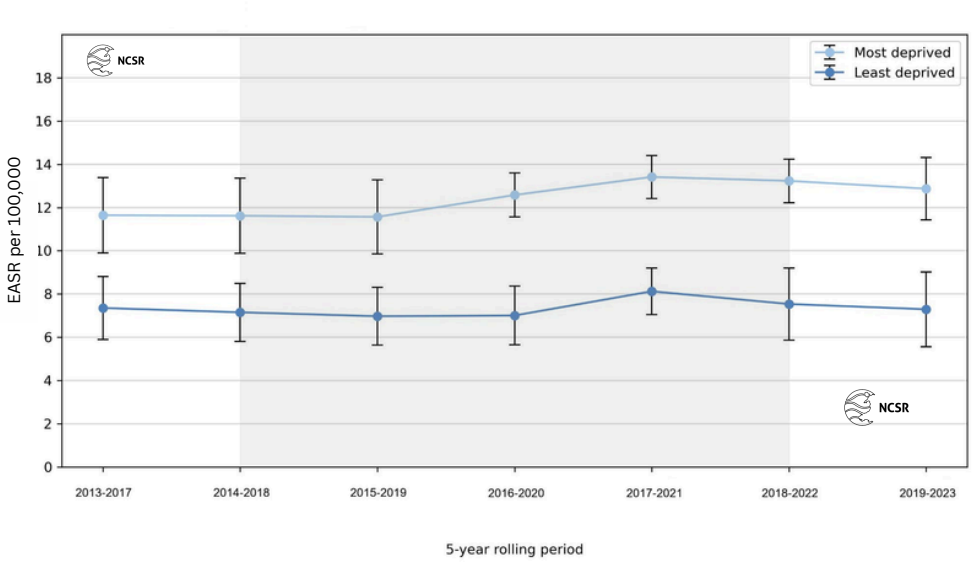
**Shading to represent change in burden of proof in 2018*
**Deaths among persons aged 10-14 years are excluded due to small numbers*

Trends in suicide rates by deprivation

A persistent inequality in suicide rates (5-year rolling EASR) by deprivation level was evident across the reporting period, with the most deprived fifth consistently recording the highest rates of suicide (Figure 10).

This gap appears to widen following the 2018 change in burden of proof. However, it remains unclear whether this reflected a different impact of the change across deprivation groups or a true difference in the deprivation gap.

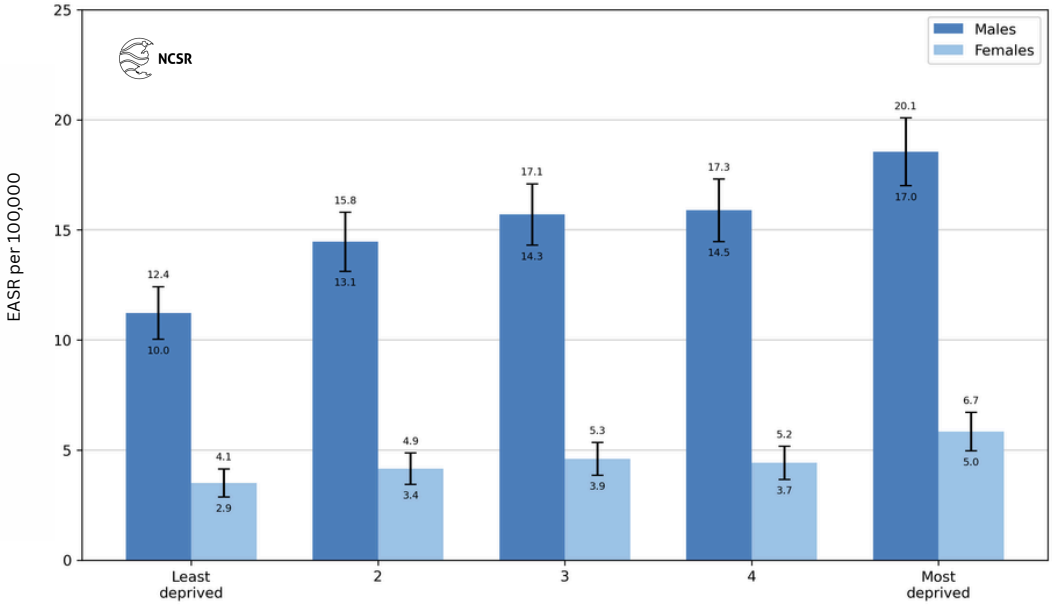
Figure 10: Suicides, 5-year rolling European age-standardised rate (EASR) per 100,000 population, most and least deprivation fifth, males and females aged 10+, Wales, 2013 -2023 occurrences. Produced by NCSR using linked Welsh-Demographic Service and ONS suicide occurrences data held with SID-Cymru



**Shading to represent change in burden of proof in 2018*

A clear and significant deprivation gradient is apparent in males (Figure 11) but not females, although the difference in female suicide rates between the least and most deprived areas seem to be real (non-overlapping confidence intervals).

Figure 11: Suicides, European age-standardised rate (EASR) per 100,000 population, by deprivation fifth, males and females aged 10+, Wales, 2019-2023 occurrences. Produced by NCSR using linked Welsh-Demographic Service and ONS suicide occurrences data held with SID-Cymru

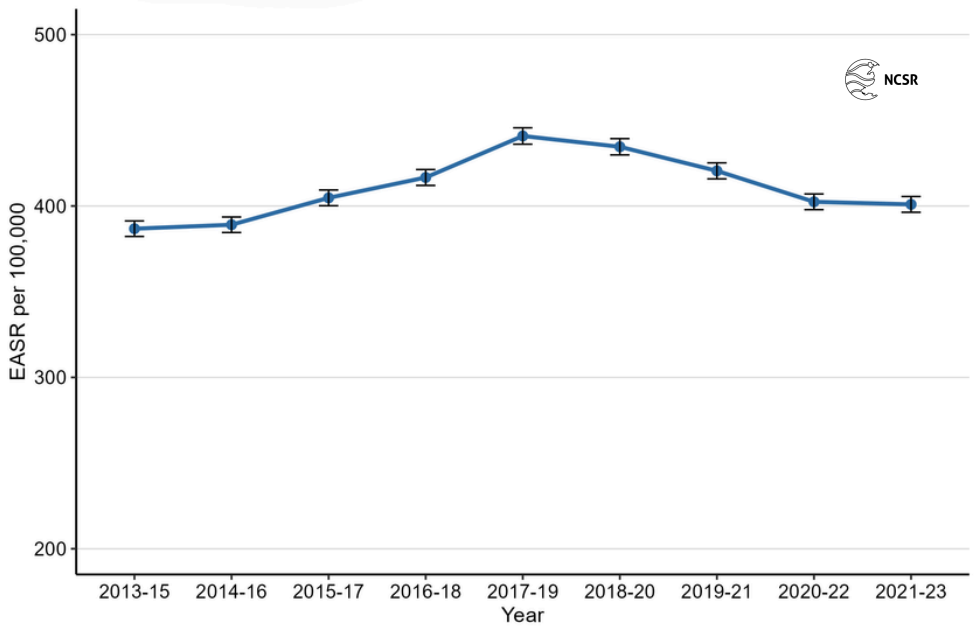


3.2 What is happening in Wales? Self-harm Data

Trends in self-harm

Self-harm rates in Wales increased between 2013 and 2019, before declining in subsequent years from 2020 (Figure 12). This likely reflects a reduction in help-seeking from healthcare settings rather than a decrease in levels of need. There was a marked rise in the proportion of adults who have self-harmed, increasing from 2.4% in 2000 to 10.3% in 2023/24 [1] In 2014 24.6% of adults (29.2% women, 16.2% of men) reported receiving medical attention following self-harm compared with 17.5% of adults (18.6% of women and 15.0% of men) in 2025 [1]. Contacts with healthcare settings do not appear to have returned to pre-pandemic levels [7].

Figure 12: Self-harm, 3 year rolling European age-standardised rate (EASR) per 100,000 population, persons (sexes combined), aged 10+, Wales, 2013-2023. Produced by NCSR using linked Welsh-Demographic Service and health data held within SID-Cymru



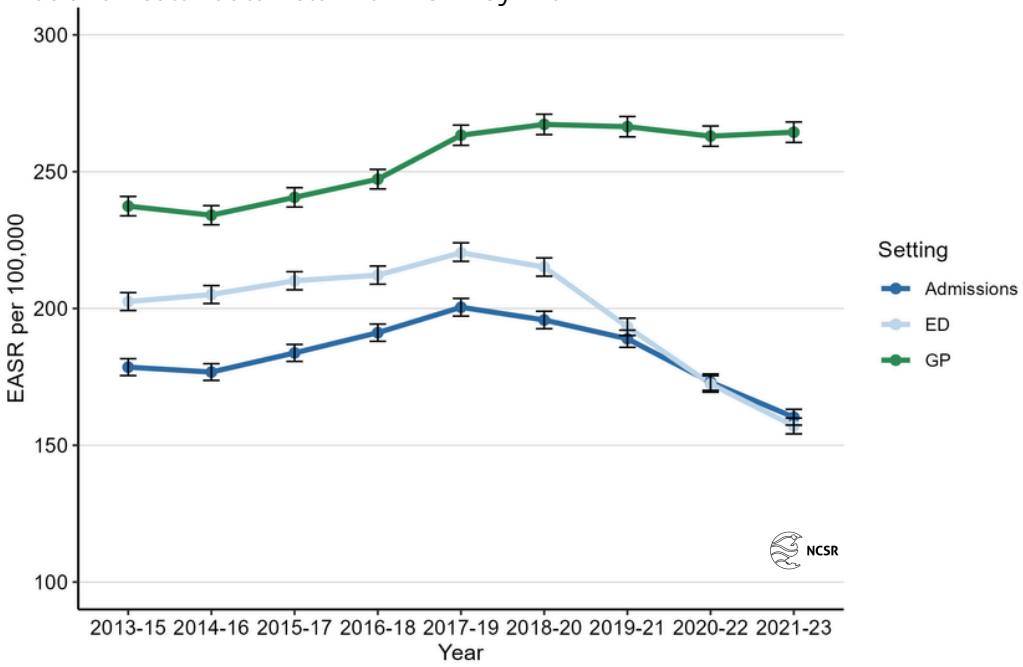
contacts with healthcare settings for self-harm have reduced since 2020

**Includes self-harm contacts from general practices, emergency departments and hospital admissions*
**Patients are counted once a year*

Self-harm by healthcare setting

The highest self-harm rates were observed in general practice (GP) settings, while the lowest rates were recorded in hospital admissions up to 2019–21 (Figure 13). Rates in GP settings showed an overall upward trend between 2013 and 2023, whereas rates in emergency departments and hospital admissions declined after 2019 (Figure 13). This decline is likely due to public health measures during the pandemic and messaging for individuals to avoid attending hospitals. Records of self-harm do not appear to have recovered to pre-pandemic levels. The same decline was not seen for GP attendances with the disparity between primary and secondary care increasing over time.

Figure 13: Self-harm, 3 year rolling European age-standardised rate (EASR) per 100,000 population, by healthcare setting, persons (sexes combined), aged 10+, Wales, 2013-2023. Produced by NCSR using linked Welsh-Demographic Service and health data held within SID-Cymru

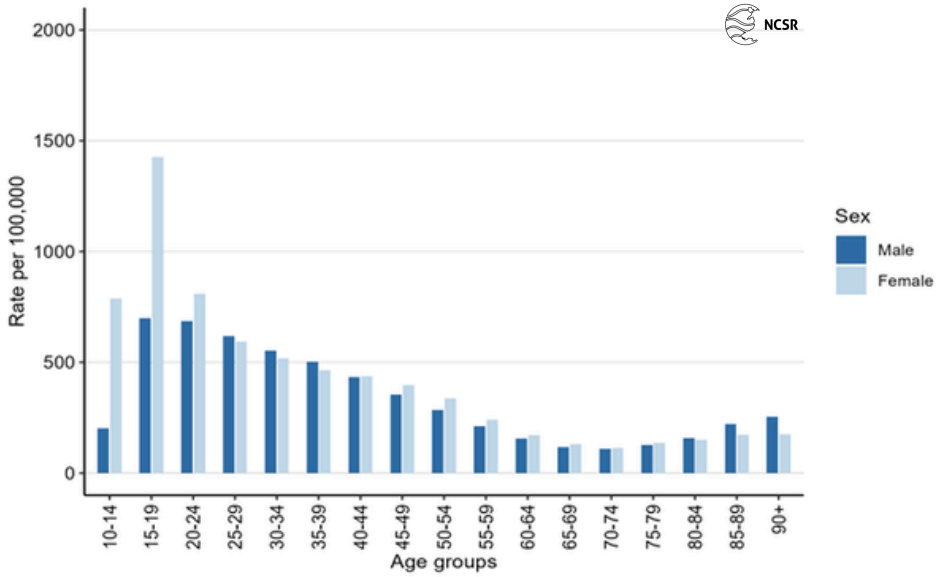


**Includes self-harm contacts from general practices, emergency departments and hospital admissions*
**Patients are counted once a year*

Self-harm by age and sex

Among females, the highest rates were observed in those aged 15–19 years, followed by those aged 10–14 years (Figure 14). Among males, the highest rates occurred in those aged 15–19 years, followed by those aged 20–24 years (Figure 14). Rates are higher in females than males across most age groups, with this disparity greatest in those aged 10-14 years.

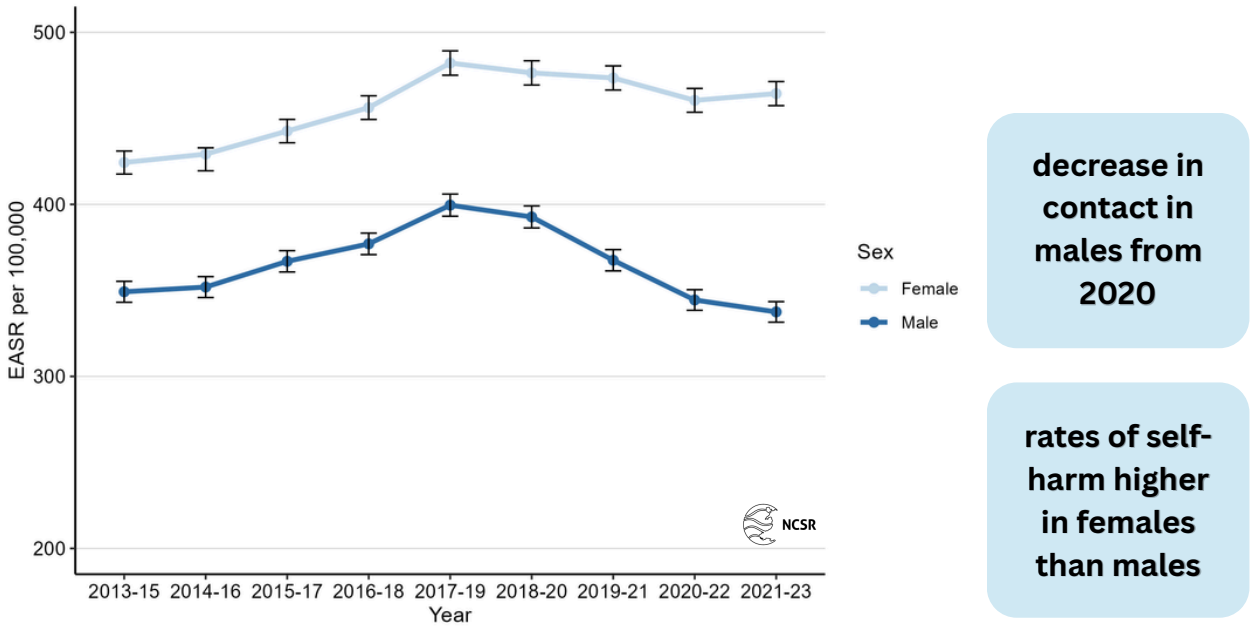
Figure 14: Self-harm, age-specific rates per 100,000 population, males and females, aged 10+, Wales, 2013-2023. Produced by NCSR using linked Welsh-Demographic Service and health data held within SID-Cymru



**Includes self-harm contacts from general practices, emergency departments and hospital admissions*
**Patients are counted once a year*

Between 2013 and 2023, self-harm rates were consistently higher among females than males (Figure 15). There was a decline in self-harm presenting to healthcare settings from 2020 onwards in males but not in females, likely reflecting differences in help-seeking between males and females rather than changes over time in level of need. Females have continued to contact healthcare settings with self-harm overtime however, contacts with healthcare settings in males declined sharply with the introduction of public health measures in 2020 and have continued to decline.

Figure 15: Self-harm, 3-year rolling European age-standardised rate (EASR) per 100,000 population, males and females, aged 10+, Wales, 2013-2023. Produced by NCSR using linked Welsh-Demographic Service and health data held within SID-Cymru

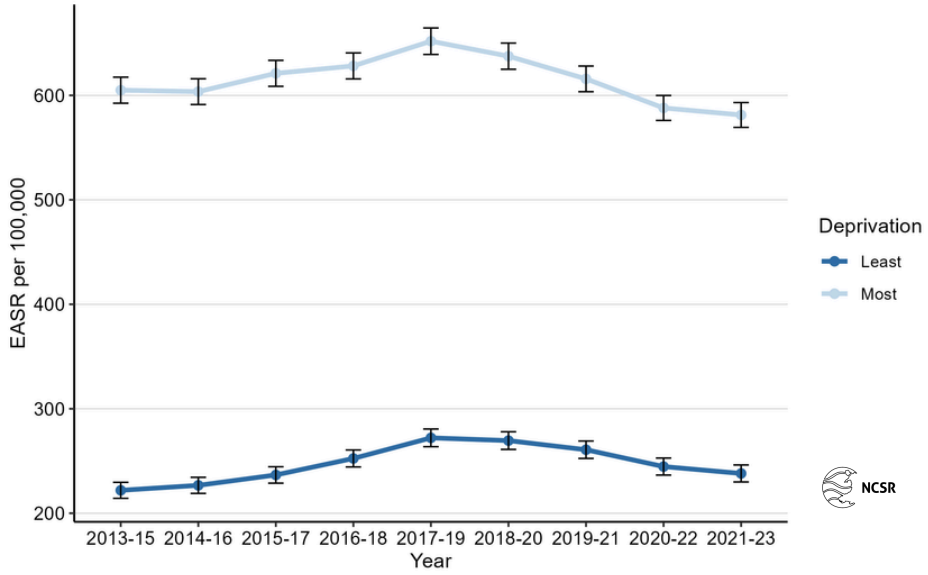


**Includes self-harm contacts from general practices, emergency departments and hospital admissions*
**Patients are counted once a year*

Self-harm by the least and most deprived fifths

Between 2013 and 2023, self-harm rates were consistently higher in the most deprived fifth compared with the least deprived fifth (Figure 16). European age- and sex-standardized three-year rolling rates in the least deprived fifth ranged from 221.9 to 272.0 per 100,000, compared with 581.0 to 651.8 per 100,000 in the most deprived fifth. Rates were increasing overtime prior to 2020 and have decreased since in both the most and least deprived fifths.

Figure 16: Self-harm, 3 year rolling European age-standardised rate (EASR) per 100,000 population, by least and most deprived fifth, persons (sexes combined) aged 10+, Wales, 2013-2023, Produced by NCSR using linked health and demographic data held with SID-Cymru



rates consistently

2-3x higher

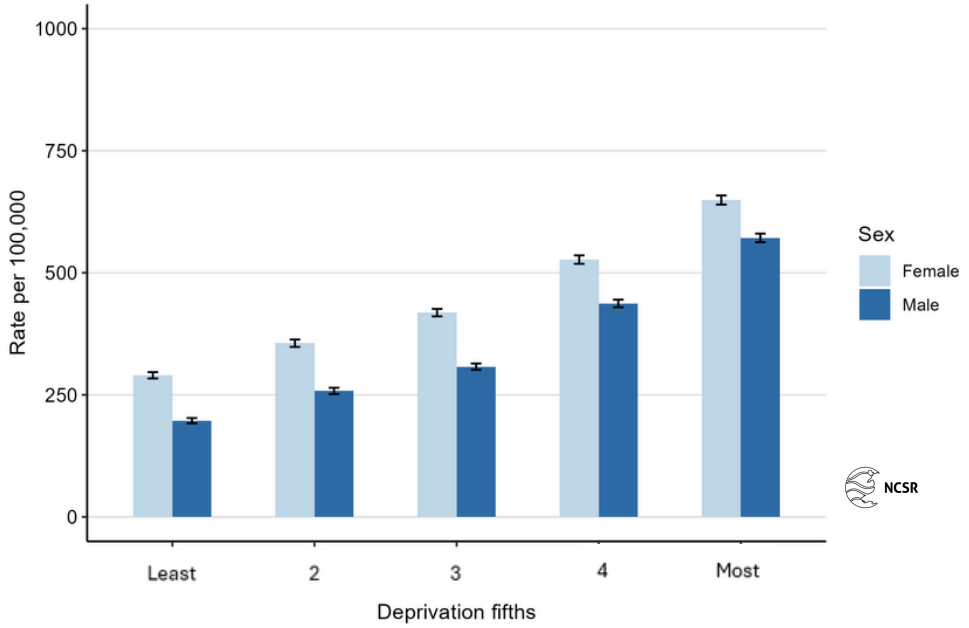
in most deprived than least deprived areas over time

*Includes self-harm contacts from general practices, emergency departments and hospital admissions
*Patients are counted once a year

Self-harm by sex and deprivation

Figure 17 demonstrates a clear deprivation gradient in self-harm rates, with the lowest rates observed in the least deprived fifth and a steady increase across deprivation levels, reaching the highest rates in the most deprived fifth. Rates were consistently higher among females than males across all deprivation groups.

Figure 17: Self-harm, European age-standardised rate (EASR) per 100,000 population, by deprivation fifths, males and females, aged 10+, Wales, 2013-2023. Produced by NCSR using linked Welsh-Demographic Service and health data held within SID-Cymru



rates of self-harm

2-3x higher

in most than least deprived for males and females

*Includes self-harm contacts from general practices, emergency departments and hospital admissions
*Patients are counted once a year

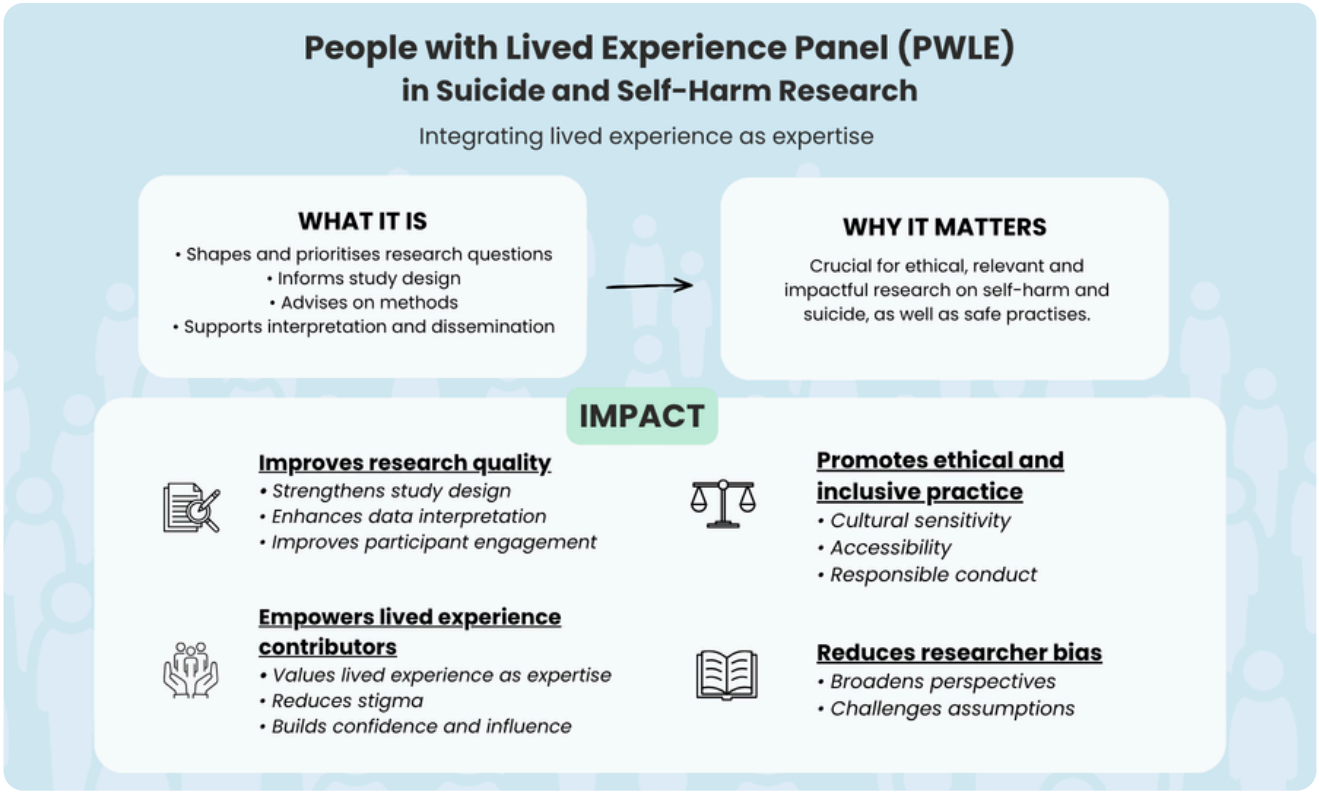
4 NCSR: People with Lived Experience

What is public and patient involvement?

Public and patient involvement (PPI) refers to research carried out “with” or “by” members of the public rather than “to”, “about” or “for” them [6]. While PPI may be described using different terms, such as lay advisors, public contributors or co-designers, leading to variation in definitions across research teams and contexts [8,9,8], it consistently involves people with lived experience of a phenomenon working as members of the research team to help guide, design and conduct research projects.

Through PPI, those with lived experience have a voice in shaping what research is undertaken, how it is carried out, how findings are shared, and how they may be applied in wider contexts. PPI is crucial for ethical, relevant, and impactful research on self-harm and suicide. By involving people with lived experience, PPI improves study design, data interpretation, and participant engagement, while reducing researcher bias. It promotes ethical practice, cultural sensitivity, and accessibility, enhances safety through safeguarding input, and helps ensure research findings are meaningful, actionable, and adopted in real-world settings. PPI also empowers those involved, through valuing lived experience as expertise and contributing to reducing stigma.

In the case of the NCSR, people with lived experience includes people who have a history of self-harm, suicidal thoughts and attempts, or/and have been bereaved by suicide.



The Infographic shows the purpose and breakdown of how the NCSR works with PWLE

NCSR People with Lived Experience (PWLE) Group

A key objective of the NCSR is to embed public involvement across all aspects of its research, governance and communications, to ensure relevance, inclusivity and real-world impact. In partnership with Samaritans Cymru, the NCSR established a People with Lived Experience (PWLE) Advisory Group during its first year of operation and appointed a dedicated PPI Lead, Dr Williams.

Fourteen people with lived experience were recruited from across Wales to form the PWLE group. Members provide advice and contribute to decision-making throughout all phases of NCSR research activity. This includes, but is not limited to, identifying research priorities, refining research questions, co-producing resources, contributing to project-specific steering groups, and providing insight into NCSR research, governance, and operational processes. All members are aged 18 and over and were purposefully recruited to reflect a diverse range of experiences of self-harm and suicide across all regions of Wales.

The PWLE group meets with the NCSR quarterly via Zoom, facilitated by Samaritans Cymru, to inform and shape suicide prevention and self-harm research. To support different communication styles across such a large PPI group, an online whiteboard (Miro) is used to facilitate written feedback, as well as verbal from across Zoom calls. As the group becomes further embedded, additional ad hoc opportunities for involvement in specific projects will be offered to strengthen the integration of PPI across the NCSR's research portfolio. All PPI activities are remunerated in line with National Institute for Health and Care Research (NIHR) standard PPI payment rates [10].

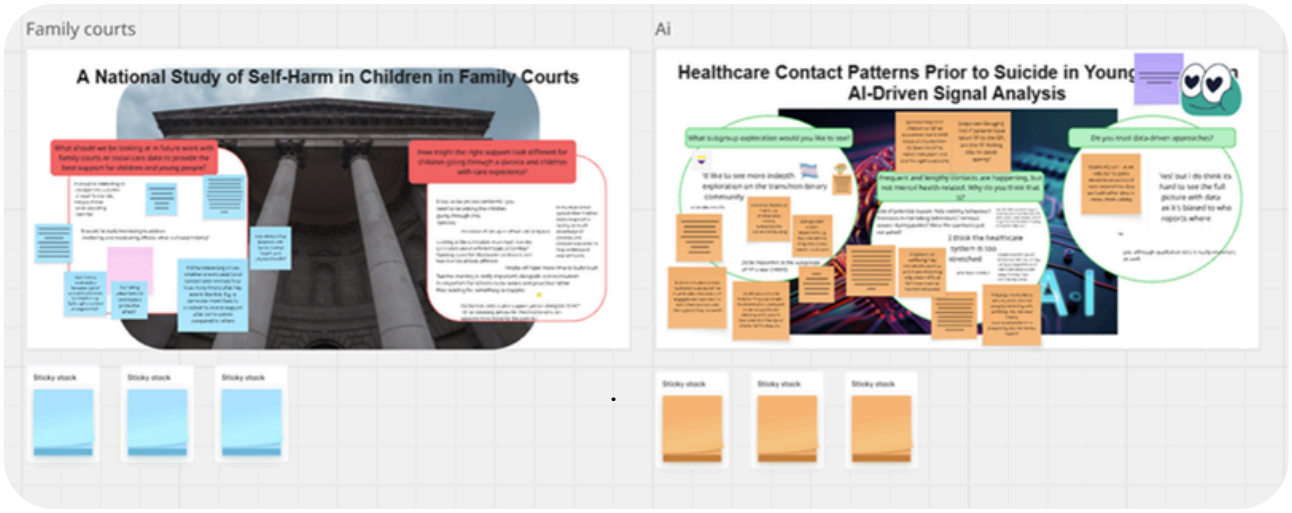
At the National Centre for Suicide Prevention and Self-Harm Research, the voices and experiences of people with lived experience are at the heart of everything we do.

Pictures: Visual representations of PWLE

PWLE Activity to Date

To date, the PWLE group has met twice. An initial introductory meeting in October brought together PWLE members with the NCSR Director (Professor John), the PPI Lead (Dr Williams), and the Project Manager (Ms Grimstead). In January, three NCSR researchers presented projects at different stages of the research cycle to demonstrate how PWLE members can contribute meaningfully across all phases of research. Each researcher sought targeted input from the PWLE group to inform the development of current and forthcoming studies. PWLE members offered invaluable insights that directly influenced study design, recruitment strategies, analytical approaches and the identification of follow-on research opportunities.

To support transparency and demonstrate the impact of PWLE members' feedback and shared experiences, the NCSR provides a "You said, we did" summary after meetings. This approach highlights how PWLE insights are actively embedded across the NCSR's research activity, governance structures, and operational practices, reinforcing the value of lived experience in shaping meaningful and accountable work.



Picture: Miro board of PWLE meetings: Insights into two research projects
The image quality has been deliberately reduced to protect the anonymity of PWLE advisor responses. The use of this image is to illustrate different methods of communication and topics discussed within the meetings.

5 Research Summaries from the NCSR

The NCSR has published thirteen reports and papers within the first year, policy relevant papers have been summarised as infographics for communications and presentation purposes (Appendix I). This is so we can reach different audiences and relay our work in a more digestible way.

Name of Paper	Link to Paper	Page Number
Healthcare use before suicide among mental health patients	https://doi.org/10.1192/bjo.2025.10085	**34**
Covid-19 vaccine uptake among people with a history of self-harm in Wales	https://doi.org/10.1016/j.jiph.2025.103014	**35**
Self-Harm in males before and during imprisonment	https://doi.org/10.1192/bjo.2025.10898	**36**
Cocaethylene and suicidality: an exploratory systematic review	https://doi.org/10.1080/14659891.2025.2494530	**37**
Suicide risk among absent and excluded pupils	https://doi.org/10.1016/j.jad.2025.119394	**38**
Self-harm and mental health conditions in pupils educated other than at school	https://doi.org/10.1192/bjo.2025.10827	**39**
Mental health and self-harm among university students	https://doi.org/10.1192/bjp.2024.90	**40**

6 Policy briefings

1. The use of media campaigns for suicide prevention

Public understanding of suicide prevention is somewhat limited. Research indicates that widespread misconceptions about suicide persist, reducing the liklihood that individuals intervene when they are concerned about someone.

Summary of evidence:

1. Awareness and knowledge

- Across literature reviews [11-13], public media campaigns consistently improve awareness, knowledge, and suicide literacy.

- Campaigns increase recognition of suicide as a public health issue and improve awareness of support services and warning signs.

2. Attitudes and stigma

- Most campaigns show modest positive effects on attitudes, including reduced stigma and more supportive views toward help-seeking.

- Some variation exists depending on message framing and audience.

3. Help-seeking intentions and behaviour

- Evidence is mixed:

    - Some campaigns increase intentions to seek help or awareness of helplines.

    - Actual help-seeking behaviour (e.g. service use, helpline calls) shows inconsistent effects, often limited to specific services or sub-groups.

- Behavioural change is more likely when campaigns are specific, repeated, and linked to accessible services.

4. Suicide and self-harm outcomes

- Few studies are sufficiently powered to assess impacts on suicide rates.

There is little direct evidence on whether public health media campaigns targeting suicide and/or self-harm risk factors, such as alcohol consumption, reduce suicide or self-harm outcomes. Any such campaigns should be evaluated with outcomes to include measuring suicide and self-harm.

Why is this important?

Evidence across reviews suggests campaigns are most effective when they:

- Use positive, hope-oriented, help-seeking messages

- Avoid sensationalism and follow safe reporting principles (e.g. avoiding references to suicide methods or locations associated with suicide such as train stations).

- Incorporate lived-experience perspectives.

- Are embedded within broader suicide prevention systems (services, crisis lines, community supports).

Limitations:

- Heavy reliance on short-term and intermediate outcomes (knowledge, attitudes).

- Limited high-quality evaluation of behavioural and suicide outcomes.

- Variable evaluation quality and inconsistent outcome measures.

- Limited evidence on which specific messages work best and for whom (which remains a significant limitation for policy and practice).

2. Identification of risk and prevention in schools

Summary of evidence:

- Children who are excluded from school were twice as likely to die by suicide as non-excluded peers of the same age and sex after adjusting for other risk factors such as a history of self-harm [14].

- Children who are excluded are more likely to be male, of older ages and to have a history of self-harm and mental health conditions, which are known risk factors for self-harm and suicide.

- Children who self-harm spend less time at school (more than three times as likely to be persistently absent and more than six times as likely to be excluded).

- This is also the case for children with a record of mental health diagnoses, drug or alcohol use and those who are neurodiverse [15].

- Children with a history of self-harm are 3-4-times as likely to be educated other than at school (EOTAS) [16].

- Neurodiverse children and those with a record of mental health diagnoses are also more likely to be educated in EOTAS settings.

- Children who enter EOTAS are more than twice as likely to go on to experience self-harm, drug or alcohol misuse as well as to have a subsequent diagnosis of depression or anxiety.

Why is this important?

- School attendance and exclusion data are routinely collected and could be used to target assessment and early intervention and where to focus resources.

- Preventative measures could focus on factors associated with school exclusion (e.g. deprivation, adverse childhood experiences).

.

- There have been increases in absences from both primary and secondary school since the pandemic.

- Proportion of pupils in EOTAS settings are from the most deprived areas, with complex life trajectories and social, emotional and mental health needs.

- EOTAS settings are a unique opportunity to develop skills and provide intensive support to pupils with complex needs and act as a bridge to mental health services when needed .

- Need for consistent monitoring of outcomes for children who are absent, excluded or not able to attend mainstream school.

Limitations:

- These findings likely underestimate self-harm and mental health diagnoses and levels of need.

- Suicide deaths are a rare outcome in young people which affect statistical power and interpretation.

- There are known limitations of education datasets.

- Pupils who are excluded from classes but remain on the school register are not currently captured in routinely collected exclusions data.

- Not possible to infer cause and effect.

3. Suicide Prevention in the Workplace

Summary of evidence:

- Barriers to help-seeking among the working population include concerns about career impact, stigma and confidentiality [17].

- Many people who self-harm or experience suicidal distress struggle to seek help[3], highlighting the workplace as a key setting for early identification and support.

- Organisational suicide-prevention programmes have been shown to improve attitudes and beliefs about suicide and can contribute to reductions in suicide risk [18].

- To address this, the BSI Standard (BS30480) on Suicide Prevention in the Workplace was launched on 19 November 2025 as the first national standard focused specifically on workplace suicide prevention. It was developed with input from government departments, mental health charities, industry groups and individuals with lived experience, ensuring it is grounded in evidence and real-world practice.

    - The standard is designed for use across public, commercial and third-sector organisations, providing a consistent framework for supporting employees and service users affected by suicidal thoughts or suicide.

- It includes clear explanations addressing common myths about suicide, offering evidence-based corrections to strengthen organisational understanding.

- Since publication, the standard has been downloaded 9,000 times across 100 countries, indicating substantial international interest and uptake.

- The standard outlines practical measures to help organisations:
  - Strengthen awareness and understanding of mental health and suicide across the workforce.

  - Identify and prioritise ethical considerations when responding to suicidal ideation, suicide attempts or deaths by suicide.

  - Recognise and manage suicide risk within the workplace, including identifying warning signs and reducing access to means.

  - Build confidence in having compassionate, consistent conversations about suicide at all organisational levels.

  - Clarify responsibilities across roles such as HR teams, line managers and designated suicide prevention leads.

  - Implement practical suicide prevention and postvention strategies.

  - Establish clear processes for supporting and communicating with staff and families following a death by suicide.

Why is this important?

- Workplaces are key settings for identifying distress, offering support and reducing suicide risk, given the amount of time adults spend in employment.

- A consistent, evidence-based framework helps organisations embed suicide prevention within existing structures such as health and safety, wellbeing, and equality policies.

- The standard encourages employers to consider how organisational culture, working conditions and support systems influence mental health and suicide risk.

- Clear ethical guidance supports safe, compassionate responses to individuals experiencing suicidal thoughts, while also protecting staff from vicarious trauma.

- Training and signposting ensure employees know how to recognise warning signs, initiate supportive conversations and access appropriate help.

- Postvention guidance helps organisations respond safely and sensitively after a death by suicide, reducing the risk of further harm and supporting recovery.

Limitations:

- Uptake of the standard is voluntary, meaning implementation may vary widely across sectors and organisations.

- The effectiveness of the standard will depend on organisational commitment, resources and leadership engagement.

- Data on workplace-related suicide risk is limited, making it difficult to evaluate the full impact of implementing the standard.

- As with all guidance, the standard cannot address every organisational context, and some workplaces may require additional sector-specific adaptations.

7 Update on the NCSR's performance against Welsh Government Strategy deliverables

The NCSR is named within the Welsh Government Suicide Prevention and Self-harm Strategy for Wales, 2025-2035, and has key programme indicators within the strategy (Appendix II).

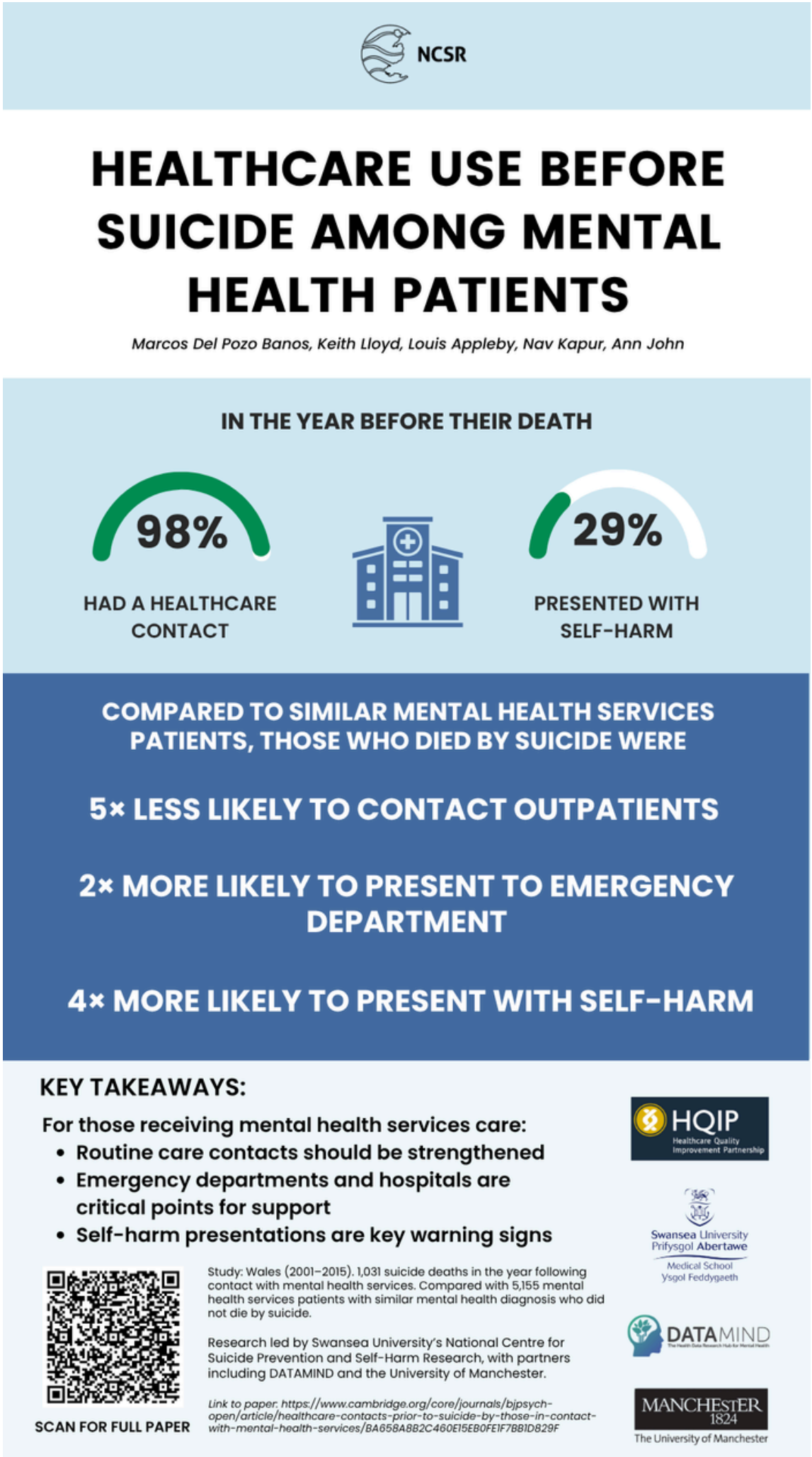
Excellent progress has been made in establishing the terms of reference for the NCSR, which set out the relationships with other structures/organisations. Updates since December 2025:

- The first Data, Evidence and Surveillance Advisory Group Meeting was held on 7th January 2026. The Terms of Reference for this group have been circulated and will be finalised in the next meeting on 7th May 2026.

- The first joint Suicide Prevention, Self-harm, Mental Health and Well-being Research Evidence Network, convened by NHS P&I leadership team, and Directors and Lived Experience partners of National Centre for Mental Health (NCMH) and NCSR, was held on 28th January 2026 in Bangor.

Progress has been made in mapping sources of self-harm data in Wales. The Welsh Government funded Research Officer was appointed in November 2025. An analysis of mapped data resources will be carried out by the Welsh Government Research Officer and is expected to be completed in Summer 2026.

Appendix I: Research Summaries



COVID-19 VACCINE UPTAKE AMONG PEOPLE WITH A HISTORY OF SELF-HARM IN WALES

Olivier Y. Rouquette, Sze Chim Lee, Marcos DelPozo-Banos, David Osborn, Rob Stewart, Ann John

VACCINE UPTAKE ONE YEAR AFTER ROLLOUT

VACCINE UPTAKE GAP

People with a history of self-harm were less likely to be vaccinated

People who self-harm are a vulnerable group and would benefit from targeted approaches for vaccination

Key takeaways:

- People with a history of self-harm were less likely to receive a COVID-19 vaccine than the general population
- Differences in uptake appeared early and persisted throughout the rollout

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2.2 million people living in Wales (aged 16+) were included in this study (2020–2023).

This infographic summarises research by the National Centre for Suicide Prevention and Self-Harm Research, in collaboration with NCMH, ADR Wales and DATAMIND, Swansea University.

Link to paper:
https://www.sciencedirect.com/science/article/pii/S1876034125003636

ADR WALES NCSR

SELF-HARM IN MALES BEFORE AND DURING IMPRISONMENT

HIGH BEFORE, PEAKS AT ENTRY, THEN DECLINES WHILE IN PRISON

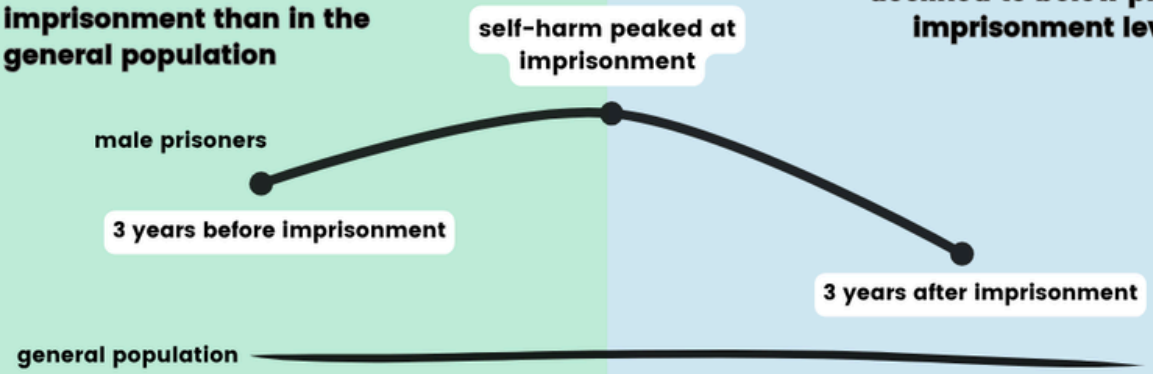
Marcos DelPozo-Baños, Mark D. Atkinson, Sze Chim Lee, Ann John

BEFORE IMPRISONMENT

Self-harm was twice as common before imprisonment than in the general population

DURING IMPRISONMENT

Self-harm then declined to below pre-imprisonment level



4 in 6 prisoners had more than one mental health condition

1 in 10 prisoners self-harmed during imprisonment

Compared with 1 in 6 men in the general population

3 in 5 had a past history

What made a prisoner more likely to self-harm: history of self-harm • drug use • learning difficulties • ADHD

Key Takeaways:

- Early intervention must begin in the community, not just in prison, as many high-risk individuals already have complex needs before imprisonment.
- The first seven months inside are critical for intervention, especially for men with a history of self-harm

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Based on over 4,000 men in Welsh prisons compared with 450,000 men not incarcerated. Using Linked Minister of Justice data and anonymised health records from 2010–2019.

Analyses accounted for age, deprivation, and prior history of self-harm and mental health conditions.

Paper link: https://doi.org/10.1192/bjo.2025.10898

DATAMIND The Health Data Research Hub for Mental Health

Swansea University Prifysgol Abertawe

NCSR

Cocaethylene and suicidality: an exploratory systematic review

Davies, N.H., Tyson, P., Quelch, D., John, B., Lewis, A.S., & Roderique-Davies, G.

Cocaine + Alcohol = Cocaethylene

What Happens When the Two Drugs Mix?

What Is Cocaethylene?:

A chemical created only when cocaine and alcohol are taken together

Known to be harmful to the heart and may also affect the brain
Lasts longer in the body than cocaine on its own

What Did This Researcher Investigate?

A systematic review of published evidence looked at whether using both drugs together increases the risk of suicide beyond the risks already linked to each drug individually.

What the Review Found:

Evidence Reviewed:

- 7 studies looked at cocaine and alcohol being used together
- Only 1 study mentioned cocaethylene specifically
- None focused on cocaethylene's impact on suicide risk

What We Do Know:

- Cocaine alone → linked to higher suicide risk
- Alcohol alone → also linked to higher suicide risk

Why this matters:

- **Use of both substances together is increasing**
- **Evidence is too limited to know if cocaethylene adds extra risk**
- **Understanding its impact on suicide risk is urgently needed**

SCAN FOR PAPER

Link to paper:
https://doi.org/10.1080/14659891.2025.2494530

Wolfson Centre for Young People's Mental Health | ADR WALES | NCSR | MQ

SUICIDE RISK AMONG ABSENT AND EXCLUDED PUPILS

Margaret Ifeoma Diogu, Sze Chim Lee, Marcos Del Pozo-Banos, Olivier Y. Rouquette, Ann John

OVER 580,000 PUPILS, AGED 4–16 YEARS WALES, 2012–2019

18
pupils per year in the study population died by suicide (2012–2019)

1 IN 23
excluded from school

1 IN 12
persistently absent

EXCLUDED PUPILS WERE *2.3 TIMES* MORE LIKELY TO DIE BY SUICIDE

compared to pupils without a record of exclusion

HIGHER RISK IN THOSE WITH A RECORD OF SELF HARM, DRUG USE, MENTAL HEALTH CONDITIONS, AUTISM AND IN MALES COMPARED TO FEMALES

Key takeaways:

Recognising and supporting pupils who are persistently absent or excluded from school may help identify unmet mental health needs and reduce future suicide risk.

SCAN FOR FULL PAPER

Linked education and anonymised health records from the SAIL Databank, including 584,394 pupils in Wales between 2012 and 2019. Analysis adjusted for age, sex, deprivation, self-harm history and mental health conditions.

Paper link:
*https://www.sciencedirect.com/science/article/pii/S0165032725008201?utm_*

DATAMIND

Swansea University Prifysgol Abertawe
Medical School Ysgol Feddygaeth

ADR WALES NCSR

SELF-HARM AND MENTAL HEALTH CONDITIONS IN PUPILS EDUCATED OTHER THAN AT SCHOOL

Ann John, Jo McGregor, Lucy Griffiths, Rhodri Johnson, Karen Broadhurst, Amanda Marchant

*Pupils educated outside mainstream school settings (e.g. alternative provision, due to additional needs or circumstances).

Before education outside school → ***Higher levels of vulnerability***

Into early adulthood → ***Higher risk of self-harm and mental health conditions***

2X **self-harm**

Compared with pupils in mainstream schools.

2X **neurodevelopmental and learning conditions**

HIGHER **risk into early adulthood**

HIGHER RISK WAS ALREADY PRESENT BEFORE ENTERING EDUCATION OUTSIDE SCHOOL AND CONTINUED INTO EARLY ADULTHOOD

(up to age 24)

Key takeaways:

- These settings are a unique opportunity to develop skills and provide intensive support to pupils with complex social, emotional and mental health needs
- Educators in these settings need to be equipped with the knowledge and skills to provide support
- Alternative education settings could act as a bridge to specialist mental health support
- We need to consistently monitor outcomes for children educated in alternative provision

Study of 232,303 pupils in Wales (2010–2019), including 8,056 pupils educated other than at school and 224,247 in mainstream schools.

Data from linked school, GP and hospital records (2010–2019).

Paper link:
https://pubmed.ncbi.nlm.nih.gov/40931724/

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DATAMIND

Swansea University Prifysgol Abertawe
Medical School Ysgol Feddygaeth

Wolfson Centre for Young People's Mental Health | ADR WALES | NCSR | MQ

MENTAL HEALTH AND SELF-HARM AMONG UNIVERSITY STUDENTS

Ann John, Olivier Y. Rouquette, Sze Chim Lee, Jo Smith, Marcos del Pozo-Banos

How university students compare with the general population

95,760 University students studied

VS

151,795 Non-students compared

Individuals aged 18-24 years 2012-2018

- **MENTAL HEALTH ISSUES ARE COMMON AND VARIED AMONG UNIVERSITY STUDENTS**
- **YOUNGER AND FIRST-YEAR STUDENTS ARE MORE AT RISK OF ALCOHOL-RELATED PROBLEMS**
- **STUDENTS STARTING LATER FACE HIGHER RISK OF SELF-HARM AND MENTAL HEALTH DIFFICULTIES**

Based on recorded diagnoses and self-harm presentations in routinely collected health records.

Lower recorded mental health and self-harm rates

Before starting university

Higher incidence of new alcohol use, mental health and self-harm records

During university years

KEY TAKEAWAYS:

- Opportunity to provide Flexible, personalised student support
- Diversity and complexity of students needs in line with calls for scaling up of integrated mental health services for students
- Support to include well-being support, counselling and referall pathways to mental health services

SCAN FOR FULL PAPER

Study: Wales (2012–2018) 95,760 students compared with 151,795 non-students. Linked education and health records (HESA and SAIL Databank) **Research led by** Swansea University's National Centre for Suicide Prevention and Self-Harm Research with partners including DATAMIND, ESRC and the Wolfson Centre

Link to paper. https://www.cambridge.org/core/journals/bjpsych-open/article/healthcare-contacts-prior-to-suicide-by-those-in-contact-with-mental-health-services/BA658A8B2C460E15EB0FE1F7BB1D829F

Swansea University Prifysgol Abertawe
Medical School Ysgol Feddygaeth

DATAMIND

Appendix II: Welsh Government Strategy NCSR Relevent Key Programme Indicators

Canolfan Genedlaethol ar gyfer Ymchwil ar Atal Hunanladdiad a Hunan-niweidio
National Centre for Suicide Prevention and Self-Harm Research

NCSR-led Key Programme Indictors

Welsh Government Strategy: Objective 1: Listening and Learning

	Action	When will we do this by?
Better understanding self-harm	Map Sources of self-harm data in Wales	End of Year one
	Review processes for collecting and interpreting data and evidence for self-harm	End of Year three
Better understanding suicide	Establish infrastructure to link data sources (e.g. RTSSS and SAIL) which will provide more comprehensive data relating to deaths by suicide	End of Year two
Improve the processes for information to be shared, analysed and put in practices	Establish terms of reference for the NCSR which sets out the relationship with other structures/organisations	End of Year one

Other Relevant Key Programme Indictors that NCSR is not leading on

Objective 1: Listening and Learning

	Action	When will we do this by?	Who is leading?
Better understanding self-harm	Establish a protocol for consistently identifying and recording self-harm incidents through coding and training	End of Year three	Suicide and Self-harm Programme, NHS Wales Executive
Better understanding suicide	Map how additional data can be gathered and included within RTSSS around: · Ethnicity · Gender identity · Those bereaved by suicide · Language spoken/ Preferred Language · Immigration Status · Learning Disability	End of Year one	Public Health Wales
	Where possible, include new data elements within the RTSSS reporting	End of Year three	Public Health Wales
	Explore the possibility of all Mental Health teams within Health Boards notifying RTSSS of suspected suicide by inpatients or those recently discharged	End of Year two	Public Health Wales

	Action	When will we do this by?	Who is leading?
Improve the processes for information to be shared, analysed and put in practices	Publish a closure report outlining the achievements against the Talk to me 2, Suicide and Self-Harm Prevention Strategy for Wales 2015 to 2022 to set the baseline for the strategy	End of Year one	Suicide Prevention and Self-harm Policy Team, Welsh Government
	Developing a reporting framework and procedure linked with the Strategy Board and Ministerial Assurance Board	End of Year one	Suicide Prevention and Self-harm Policy Team, Welsh Government
	Create and publish an outcomes framework	End of Year one	Suicide Prevention and Self-harm Policy Team, Welsh Government
	Develop a lived experience framework	End of Year one	Suicide Prevention and Self-harm Policy Team, Welsh Government
	Develop Communities of Practice	End of Year three	Suicide Prevention and Self-harm Policy Team, Welsh Government

Objective 2: Preventing

	Action	When will we do this by?	Who is leading?
Inform and Influence Welsh Government policies and programmes	Establish processes for the inclusion of suicide and self-harm consideration into public bodies' assessment of mental health impacts through the Health Impact Assessment	End of Year one	Suicide Prevention and Self-harm Policy Team, Welsh Government

Objective 4: Supporting

	Action	When will we do this by?	Who is leading?
Enhance the offer of support in other services including primary care, mental health, urgent and emergency care and third sector services	Increase our understanding and better communicate the needs of those who seek to engage with services for support around suicide and self-harm, as well as the needs of the workforces who deliver these services	Ongoing	Suicide and Self-harm Programme, NHS Wales Executive

Objective 5: Equipping

	Action	When will we do this by?	Who is leading?
Increase understanding of current provision in other support services and identify gaps in support	*Map services where people with co-occurring issues may present in Wales*	End of Year one	Suicide and Self-harm Programme & Strategic Programme for Mental Health, NHS Wales Executive and Welsh Government
	Increase our understanding and better communicate the complexity of needs of service users, and what needs to be in place to meet those needs	End of Year one	Suicide and Self-harm Programme, NHS Wales Executive
Enhance the offer available	*Directing services to available resources to enhance understanding and skills, in particular:* *· Ensure the basic Suicide and Self-harm awareness modules are available and promoted* *· Ensure frontline workers across sectors, (e.g. Local authorities, housing, DWP, teachers) receive suicide awareness and suicide prevention training to develop listening skills and suicidal conversation skills, so they can hold effective compassionate conversations*	Ongoing	Suicide and Self-harm Programme, NHS Wales Executive

Objective 5: Equipping

	Action	When will we do this by?	Who is leading?
Enhance the offer available	*Ensure the "Treating people with mental health and substance misuse problems" co-occuring framework considers suiicde prevention, self-harm and other health harming behaviours, as well as scoping the provision of support for those who are intoxicated*	Ongoing	Mental Health Policy Team, Welsh Government

Objective 6: Responding

	Action	When will we do this by?	Who is leading?
To ensure timely trauma informed, compassionate and person-centred support is available for those affected by suicide	*Evaluate the impact of the national response to people bereaved or affected by suicide guidance*	End of Year two	Suicide and Self-harm Programme, NHS Wales Executive
	Scope if further provision under the National Advisory Liaison Service (NALS) is required around such elements as being trauma informed, accessibility and language provision	End of Year two	Suicide Prevention and Self-harm Policy Team, Welsh Government

Appendix III: Overall Male Suicide Rates in Wales vs England - Registrations

Authors: Rhys Jones and David Tabor, Office of National Statistics

Is the 2023–2024 rise in Welsh male suicide registrations the start of a real trend? No—this spike reflects registration delays, not a new inflection in risk. The registrations series continues to show an **upward path from 2020,** reaching a **new high in 2024** that exceeds the prior 2017 peak. However, this pattern is strongly shaped by **lengthening registration delays in Wales,** which push deaths into later calendar years and **inflate recent registration totals.**

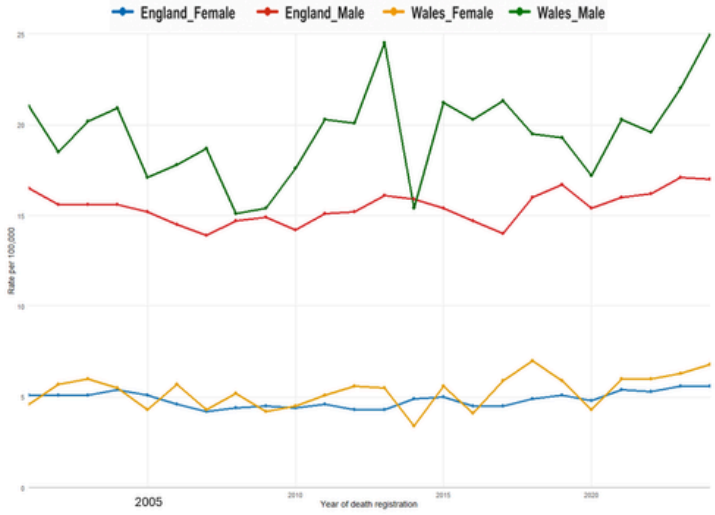
While the registration chart looks persuasive, it is not a reliable indicator of short-term change. The more appropriate lens for trend detection is **occurrence-year data,** and those data clarify two points at once:

(1) the **2023–2024 registration increase is not special** in itself—it's an artefact of timing—and

(2) **separately from registration effects,** Wales has experienced a **gradual, underlying rise in male suicide occurrences since around 2009.**

In short, **don't read the 2023–2024 registration jump as a new signal;** instead, use occurrence-year trends to understand the longer-run movement.

Supplementary Figure 1. Suicide rate per 100,000 England vs Wales
Registrations-based (Age-standardised rate per rates per 100,000, aged 10+)



Overall Male Suicide Rates in Wales vs England – Occurrences

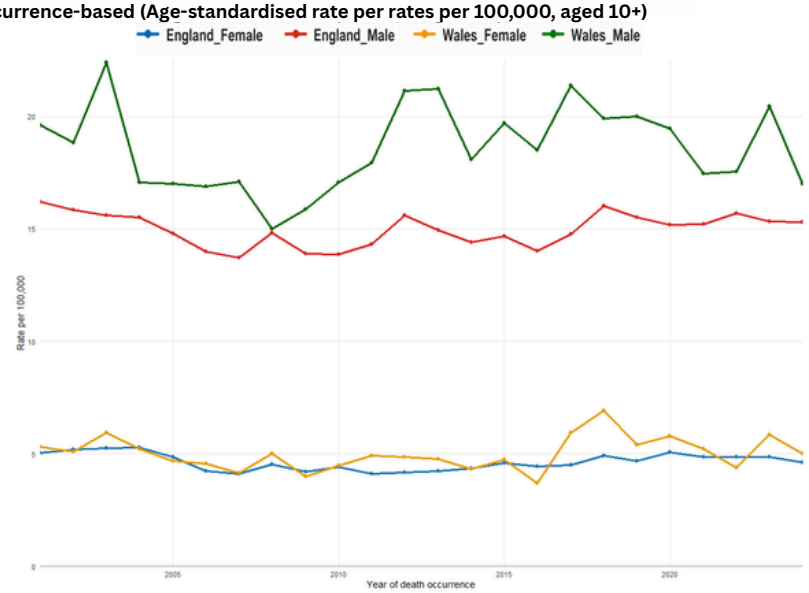
Answering the central question: the 2023–2024 rise in registrations is not evidence of a new surge—yet occurrence data do show a steady increase in Welsh male suicide rates since ~2009. Historically, registrations acted as a reasonable proxy, but **in recent years they have diverged from reality** in Wales due to increasing registration delays. To account for this, we have adjusted the data below, so that each occurrence year is limited to a follow up registration period of 2 years (i.e., deaths occurring in 2021 are limited to those registered by 31 December 2022).This allows for valid comparisons between occurrence years. The occurrence series—assigning deaths to the year they happened—shows a gradual, persistent climb from around 2009 for Wales, whereas England's overall male trend remains flatter over the same period.

The **drop and fluctuation between 2022-2024** on the occurrence series is **not meaningful** at this stage; it reflects outstanding cases yet to be registered and is expected to correct as registrations complete. The key interpretation is twofold:

(a) the recent registration-year spike does not signal a distinct new upswing in 2023–2024, but

(b) Wales has nevertheless seen a **long-run upward trajectory** in male suicide **occurrences** since the late 2000s, which warrants attention beyond the registration-year optics.

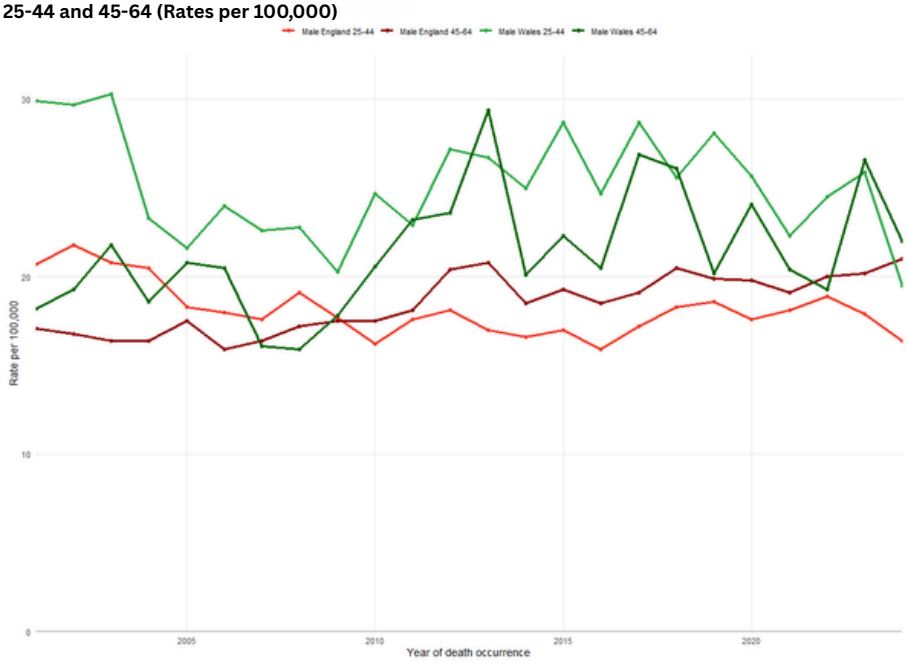
Supplementary Figure 2. Suicide rate per 100,000 England vs Wales
Occurrence-based (Age-standardised rate per rates per 100,000, aged 10+)



Age Bracket Specific Male Suicide Rates in Wales vs England – Occurrences

Age-specific occurrence data reinforce the longer-run finding: Wales shows **sustained increases** since ~2009 in **males 25–44** (with **England males 45–64** showing a **similar** rise), while **England's overall male pattern is comparatively flatter.** Overall, the age-group lens confirms that the **2023–2024 registration spike isn't special,** but that **Wales has experienced a steady, underlying rise in male suicide occurrences since around 2009.**

Supplementary Figure 3. Male Suicide rate per 100,000 England vs Wales
25-44 and 45-64 (Rates per 100,000)



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