

Self-Harm in Devon A Health Needs Assessment

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Foreword

Why do a health needs assessment focused on self-harm?

The Devon Joint Strategic Needs Assessment highlights that while health outcomes are generally good for people living within Devon, there is a clustering of poor outcomes around mental health and emotional wellbeing for children, young people and adults. Hospital admissions for self-harm, in particular, have been significantly higher than the national average for a number of years.

Self-harm is an important public health issue, due to its prevalence and the impact it has on people's lives and the lives of their families. Also, importantly, self-harm can be, though is not always, one of the first outward signs of mental illness or a mental health crisis. Although self-harm can provide instant relief for emotional distress, there can be longer term physical consequences such as scarring, damage to tendons, nerves, blood vessels and muscles, and damage to liver and kidneys from repeated poisoning.

Self-harm imposes a significant economic cost, both on the health sector and society in general. Self-harm results in approximately 245,000 presentations at Accident and Emergency Units each year in England and is one of the top five causes of acute medical admission. The indirect costs of self-harm in terms of lost productivity, days lost from work, as well as costs to families and carers, are unknown but are likely to be substantial given its prevalence within the UK. Nationally, evidence suggests that rates of hospital admissions for self-harm in England have been increasing since 2007. In Devon, more recently, a convergence of pressures including rising hospital admissions, particularly in paediatric units, increased referrals and higher thresholds for specialist services, has raised the priority of addressing the root cause of self-harm, defining roles and responsibilities and pathways of care.

The Devon Safeguarding Children Board (DSCB) initiated a series of multi-agency case audits in September 2014 and, along with the Children, Young People and Families Alliance has co-ordinated seminars and workshops to gain a greater understanding of the issue and galvanise a co-ordinated response from professionals. An Early Help strategy and implementation plan have been developed to co-ordinate multi-agency support as part of a dynamic response to need, aiming to meet and then reduce need and build the resilience of children and young people and their families. Additionally, Public Health Devon has co-designed a new service and programme with schools and other partners to promote emotional wellbeing, prevent mental illness and provide early identification and intervention. The service aims to support the emotional, psychological and social wellbeing needs of children and young people in Devon through support to schools; direct support for children and young people aged 11-19 years, and targeted parenting support for parents of primary-aged children.

This health needs assessment takes a population perspective and focuses on the needs of children, young people, adults and older adults. It describes levels of need in Devon and compares them to current service provision within the County Council area. In addition, it seeks to identify people's aspirations for better outcomes and their suggestions on assets and resources which may help to achieve a shared vision going forward.

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Self-Harm in Devon: A Health Needs Assessment

1. Executive Summary

Introduction

What is self-harm?

- 1.1 Self-harm has been described as “*any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting.*” NICE Quality Standard QS34 (NICE, 2013).
- 1.2 Self-harm is a symptom of underlying mental or emotional distress. It is a coping mechanism for people who feel they have no other way to deal with extreme negative emotions.
- 1.3 Methods of self-harm can be divided into self-poisoning and self-injury. Studies of attendance at emergency departments show that approximately 80% of people have taken an overdose of prescribed or over the counter medication. However, general population studies have shown that self-injury may be more common than self-poisoning. Of those who self-injure, cutting is the most common method.

Why do people self-harm?

- 1.4 People who self-harm mainly do so because they find it helps relieve distressing feelings and helps them to cope with problems in their lives. It is rarely about trying to end their life. A wide range of factors and multiple triggers may be involved. Once self-harm starts it can be hard to stop because it can fulfil a number of functions, including temporary relief or a feeling of peace. The addictive nature of this feeling can make self-harm difficult to stop.

Repeated self-harm

- 1.5 The individual and societal costs associated with self-harm escalate with repetition. Evidence suggests that those who repeat self-harm are more than twice as likely to die by suicide compared with those who had engaged in self-harm on one occasion only. Risk factors that have been widely studied and demonstrated as having consistent associations with repetition include stepwise increase in the number of previous self-harm episodes and having a greater number of psychiatric disorders.
- 1.6 In Devon, for the year 2013-14, 85% of those with a hospital admission for self-harm were recorded as having one admission, which accounted for 79% of the total admissions. A small group of people (n=16 or 1.16%) had five or more admissions, accounting for 6.55% of total admissions.

Relationship between self-harm and suicide

- 1.7 Following an act of self-harm, the rate of suicide increases to between 50 and 100 times the rate of suicide in the general population. Men who self-harm are more than twice as likely to die by suicide as women and the risk increases greatly with age for both genders. It has been estimated that one quarter of all people who die by suicide would have attended an emergency department in the previous year.
- 1.8 The risk factors for self-harm are similar to those for suicide, with some exceptions; suicide is more common among males rather than females; suicide is more likely to be associated with major depressive disorder, whereas self-harm is more likely to be associated with anxiety disorders. Family dysfunction is more likely to be associated with suicide.

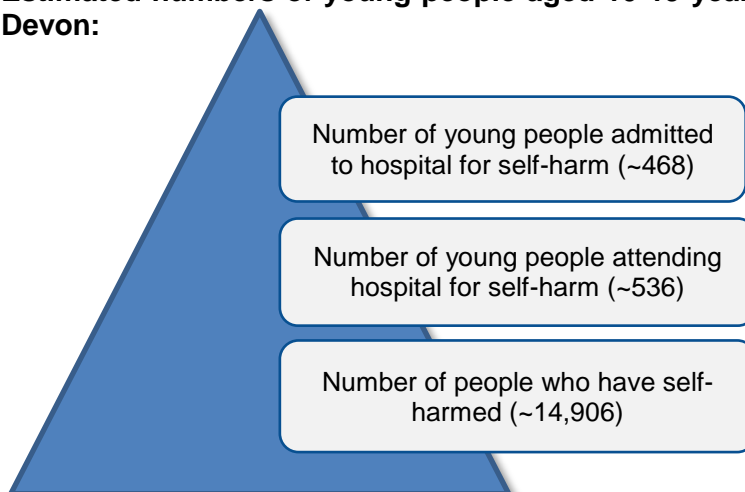
Population estimates of self-harm

- 1.9 The majority of incidences of self-harm are thought to be undisclosed and so invisible to professionals. Population estimates have therefore been undertaken to help understand the burden of unmet need, however, the results of these vary considerably. Although some very young children and some adults are known to self-harm and it often continues from childhood into adulthood, evidence suggests that the majority of people who self-harm are aged between 10 and 25 years.
- 1.10 Findings from a recent international systematic review estimate an average lifetime prevalence of 17.2% among adolescents, 13.4% among young adults, and 5.5% among adults.

Population estimates of self-harm in Devon

- 1.11 To try to understand the size of the issue in Devon, it is possible to use population estimates of self-harm prevalence and apply these to the local population. By considering a range of estimates for school age young people and applying the median rate of 18%, the figure below illustrates that approximately 14,906 young people aged 10-19 are likely to self-harm in Devon, a tiny fraction of whom will be visible to professionals.

Estimated numbers of young people aged 10-19 years who self-harm in Devon:



Source: Public Health, Devon County Council 2015

Demographics

- 1.12 Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support. Self-harm is more common in urban areas for males and females aged between 15 and 64 years, with little difference between urban and rural rates for patients aged 65 years and over.

Age and gender

- 1.13 National data suggests that the age at which self-harm is becoming a concern is changing. The National Society for the Prevention of Cruelty to Children (NSPCC) produces annual reports on outcomes from ChildLine. The reports covering the years 2012-14 highlight that self-harm is becoming a salient issue for younger children over time, with 14 year olds receiving the most counselling sessions about self-harm in 2013-14 and 12 year olds being the age group with the highest increase of counselling about self-harm in 2013-2014.
- 1.14 In Devon, rates for hospital attendance and admissions peak in the 15-19 age group, with higher rates also seen in the 20-49 age groups. In line with national data, admission rates in Devon are three times higher in females than males and the gap has widened in recent years.

Groups at a higher risk of self-harm

- 1.15 Evidence suggests females are up to three to four times more likely to self-harm than males. Self-harm is most prevalent among young people aged 10-25 years and the following groups within society experience higher rates of self-harm compared with others: lesbian, gay and bisexual people, women of Black and South-Asian ethnicity, people with mental health disorders, veterans, prisoners, people with learning disabilities, people who are in or who have been in care, people who have experienced child sexual abuse, physical or domestic abuse and people with alcohol or substance misuse problems.

Deprivation and rurality

- 1.16 In line with national data, hospital admissions in Devon from the most deprived quintile are approximately three times higher than those from the least deprived quintile. In addition, urban rates of hospital admissions due to self-harm are higher than the county average and substantially higher than rates recorded for people from both town and fringe and village and hamlets in Devon.
- 1.17 When examining admission rates for self-harm by town over a five year period between 2009-10 and 2013-14, for all ages, the towns with rates significantly above the Devon average are: Exeter, Exmouth, Bideford, Barnstaple and Honiton.

Sexual, physical and domestic abuse

- 1.18 In line with the literature, higher rates of hospital admission for self-harm coalesce with areas where higher rates of sexual, physical and domestic abuse are recorded. These factors tend to overlap with socio-economic

deprivation. Some Devon towns are notable due to a lack of such alignment, namely Honiton, where age standardised admission rates for self-harm for all ages or those for young people aged 0-19 years have been prominent over a five year period between 2009-10 and 2013-14. However, when examining data on child protection plans with sexual abuse as the primary reason, Honiton town is also unexpectedly prominent in this domain.

Prisoners

- 1.19 Data from the Ministry of Justice show that, nationally, self-harm episodes by female prisoners have decreased from what were very high levels, while episodes in male prisoners have increased.
- 1.20 In line with national data, local data from the three prisons in Devon, all of which accommodate male prisoners, shows that the annual recorded number of incidents has risen over the 10 year recording period in each institution, with a steeper increase observed since 2010.

Trends over time

- 1.21 Hospital admissions rates per 100,000 for self-harm in people aged 10-24 years have risen in Devon from 376.6 in 2007-08 to 419.5 in 2012-13. The rate per 100,000 in Devon is below the South West rate (442.5), but above the local authority comparator group (388.8) and England (346.3) rates.

Patterns in attendance

- 1.22 Hospital attendance in Devon appears to peak on Sundays, Mondays and Tuesdays and, over the 24 hour period, peak between 11pm and 1am.

Service Use

- 1.23 Demand for services supporting children and young people with mental health needs has been rising. Referral rates to Child and Adolescent Mental Health Services have risen over the past five years, as have self-harm alerts recorded across the Devon CAMHS service.
- 1.24 There was increased use of paediatric acute hospital beds for inpatient child and adolescent mental health admissions in Devon over the 12 months between July 2013 and June 2014, and length of stay was shown to extend beyond 72 hours for a quarter of patients in a three month local audit in one hospital. Audit data demonstrated that medical need was usually restricted to the first 24 hours in these cases and that 1:1 mental health nursing was required to safeguard the patient who self-harmed but, also the staff and remaining patients.
- 1.25 Patients who self-harm are a prominent subset of those adults supported by Devon Partnership Trust for mental health problems. Self-harm forms one of the main areas of focus for liaison psychiatry work in emergency departments.

Digital technology as an influencing factor

- 1.26 Digital technology is now a central part of peoples' lives, for information, entertainment and communication. Annual statistics provided by Ofcom indicate that the majority of children aged 5-15 years regularly access the internet via mobile devices such as tablets and phones. Evidence suggests

that there may be both positive and negative influences on self-harming behaviour from the internet. Recent guidance recommended that clinicians should include a detailed enquiry about internet use in clinical assessment of young people at risk of self-harm or suicide.

Policy Context, Clinical and Commissioning Guidance

- 1.27 Over the last five years a range of guidance on self-harm and policy documents focusing more broadly on mental health and wellbeing have been published. Policy highlights the priority of self-harm and calls on agencies to work together to impact positively on the root causes. National guidelines have predominantly focused on crisis care and the clinical end of the self-harm pathway, emphasising the need to treat people who self-harm with the same care, respect and privacy as any patient. Examples of guidance developed at local level take a more integrated and broader community perspective and provide exemplars for practitioners and professionals from a wide range of front-line disciplines.

Engagement and Insight

Schools survey

- 1.28 A survey seeking insight from Devon secondary school staff highlighted that self-harm was a current issue in schools and that students, peers or friends were more likely to highlight the issue than staff. Perceived “seriousness” was understood primarily through relationships with students. Resources used to support students were many and varied, both internal and external. There was confusion around the extent of support schools could offer and what level of expertise was required.

Insight from children and young people

- 1.29 Devon Youth Service conducted a varied programme of engagement with children and young people exploring emotional, psychological and social wellbeing. The engagement provided insight into the main stressors and where people go for support, demonstrating how things change over the different stages between the ages of 11-25 years. Home and school settings were particularly salient as places to ensure appropriate levels of support were made available, with friends providing an important source of support during early teenage years.
- 1.30 Devon Youth Service facilitated a small scale survey with young people who self-harm, which highlighted conflict within families, sexual abuse and bullying as salient triggers and indicated that most young people delayed disclosing their self-harm behaviour. None of the young people planned to disclose their self-harm and did so as a spur of the moment decision, generally to trusted professionals as well as friends. Most had hoped that someone would have noticed that there was something wrong at an earlier stage.
- 1.31 In Made of Rainbows, a video made by young people from the lesbian, gay, bisexual and transgender (LGBT) community in Devon about their experiences of self-harm, similar triggers were highlighted but for this group, issues around coming out and not being able to show who they really are were particularly important. The video illustrates how triggers and functions are different for different individuals and can change over time. The young people wanted professionals to avoid making assumptions around gender

and sexuality and suggested that they would benefit from having someone to talk to at school.

Insight from parents

- 1.32 In a focus group conducted with a group of 10 parents and carers of children and young people who have or were at risk of self-harm, a number of themes emerged. Firstly, parents felt that everyone was too busy to support their child and them as a parent and most had been passed between many busy professionals before finding peer support through their group.
- 1.33 Parents' shared experiences highlighted that some schools did not handle self-harm constructively, with staff confused, scared of the additional responsibility and quick to exclude pupils. GPs had showed willingness but varied in ability to help and understand. An example of good practice was highlighted in which a practice had listed GPs by speciality on their website and so the young person chose to speak to a GP who had a special interest in children and young people or mental health.
- 1.34 Parents felt isolated as friends, family and work colleagues found it hard to understand unless they had personal experience. They expressed frustration that things needed to get to a crisis before meaningful support was provided. Parents felt that they should be regarded as an asset and, if given practical support on how to cope between appointments, they could manage the situation more effectively. They proposed that better use of technology would be helpful in providing parental support and that front-line professionals would benefit from training, particularly learning from those with lived experience.

Insight from professionals

- 1.35 Insight from front-line professionals was gathered through both a semi-structured questionnaire, aiming to highlight key issues and assets, and via attendee feedback at a series of professional development events.
- 1.36 Professionals recognised rising numbers of people affected by self-harm, resulting in pressure in both community and acute settings. They noted that services for adults seemed better designed to cope, contrasting with the lack of out-of-hours care and limited specialist tier 4 inpatient provision for children and young people. They also recognised an over-reliance on specialist services and the need for support for professionals operating in the community.
- 1.37 The need for training and supervision among all front-line staff, both community and acute settings-based, was a dominant theme. There was a preference for multi-agency learning and sharing of skills, incorporating and valuing the input from those with lived experience. They suggested that training should address the lack of confidence and fear which was evident, particularly in community settings.
- 1.38 Working more effectively together, utilising an agreed joint care pathway and local guidelines were highlighted by the majority of respondents. Ideas around how to restructure services to better meet peoples' needs were suggested, including tailored digital information and the use of trusted, neutral venues.

- 1.39 Building on existing trusting relationships and working with parents, possibly through family-based support, were seen as approaches to develop when supporting people within the wider community.

Observations

- 1.40 Based on the qualitative and quantitative intelligence gathered in the process of developing this Health Needs Assessment, a number of observations have been made. These observations should be considered by providers, commissioners and stakeholders when planning to meet the needs of people who self-harm, their parents and or carers, and when developing future services.
- 1.41 Observations are themed around joint working, shared protocols, information and care pathway development; the need for families and communities to build resilience and skill to intervene early and support people within the community; the need for multi-agency training, peer support and supervision for front-line staff; the importance of recognising parents and carers as assets and supporting them to support their loved ones; the need for parity around out-of-hours support for children and young people and appropriate levels of tier 4 in-patient provision. More comprehensive monitoring and suggestions for further research around the needs of older people are proposed.

2. Introduction

- 2.1 A health needs assessment is “a systematic method for reviewing the health needs of a particular population, leading to agreed priorities and resource allocation, which will lead to improved health and reduced health inequalities.” (NICE 2005).
- 2.2 Self-harm has been described as “any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting.” NICE Quality Standard QS34 (NICE, 2013).
- 2.3 In this document, the term self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.
- 2.4 The aim of this health needs assessment is to estimate levels of need and compare them to current service provision within the Devon County Council area. In addition, following the New Economics Foundation report, *Commissioning for outcomes and co-production* (NEF, 2014), this health needs assessment seeks to identify people’s aspirations for better outcomes and to identify assets and resources (as shown in Figure 1) which may help to achieve this vision going forward. This health needs assessment takes a population perspective and focuses on the needs of children, young people, adults and older adults.

Figure 1 Asset Mapping



Source: Adapted from Foot, J. and Hopkins, T. (2011) A glass half-full. How an asset approach can improve community health and wellbeing. London: Improvement and Development Agency (IDeA).

- 2.5 This needs assessment compliments a number of other needs assessments published on www.devonhealthandwellbeing.org.uk including Safeguarding Children Needs Assessment 2014-15, Lesbian, Gay, Bisexual and Transgender Health Needs Assessment 2014, Mental Health and Wellbeing Health Needs Assessment 2013, Domestic and Sexual Violence and Abuse JSNA 2013 and Substance Misuse Health Needs Assessment, 2012.

3. Background

What is self-harm?

- 3.1 Self-harm has been described as “*any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting*”. NICE Quality Standard QS34 (NICE, 2013).
- 3.2 In this document, the term self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.
- 3.3 Self-harm is a symptom of underlying mental or emotional distress. It is a coping mechanism for people who feel they have no other way to deal with extreme negative emotions.

Methods of self-harm

- 3.4 Methods of self-harm can be divided into two broad groups: self-poisoning and self-injury.
- 3.5 Studies of attendance at emergency departments following self-harm show that approximately 80% of people have taken an overdose of prescribed or over the counter medication (Horrocks et al., 2003), most commonly analgesics or antidepressants. However, these figures can be misleading because people who self-poison are more likely to seek help than those who self-injure (Hawton et al., 2002; Meltzer et al., 2002).
- 3.6 General population studies have shown that self-injury may be more common than self-poisoning (Hawton et al., 2002; Meltzer et al., 2001). Of those who self-injure, cutting is the most common method (Hawton & Rodham, 2006, O’Connor et al., 2009, Hawton et al., 2002). Less common methods include: burning, hanging, stabbing, banging or scratching one’s own body, hair pulling, swallowing or inserting objects, shooting, drowning, and jumping from heights or in front of vehicles.

Why do people self-harm?

- 3.7 People who self-harm mainly do so because they find it helps relieve distressing feelings and helps them cope with problems in their lives. It is rarely about trying to end their life. A wide range of factors may be involved. Very often there are multiple triggers or daily stresses rather than one significant change or event. Factors can include:
 - feeling isolated
 - academic pressures
 - suicide or self-harm by someone close to the young person
 - dysfunctional family relationships including parental separation or divorce
 - being bullied

- low self-esteem
- mental illness
- substance misuse
- physical and sexual abuse

Why do people continue to self-harm?

3.8 Once self-harm starts, it can be hard to stop because it can fulfil a number of functions. Horne and Paul's report for SANE published in 2008, reported on survey results gathered from the responses of 827 people with personal experience of self-harm, aged 12 to 59. The report demonstrated the wide ranging functions of self-harm and showed that each individual act of harm can have a number of meanings and functions to each individual. It also demonstrated that these functions were likely to change over time.

3.9 Examples of functions of self-harm include:

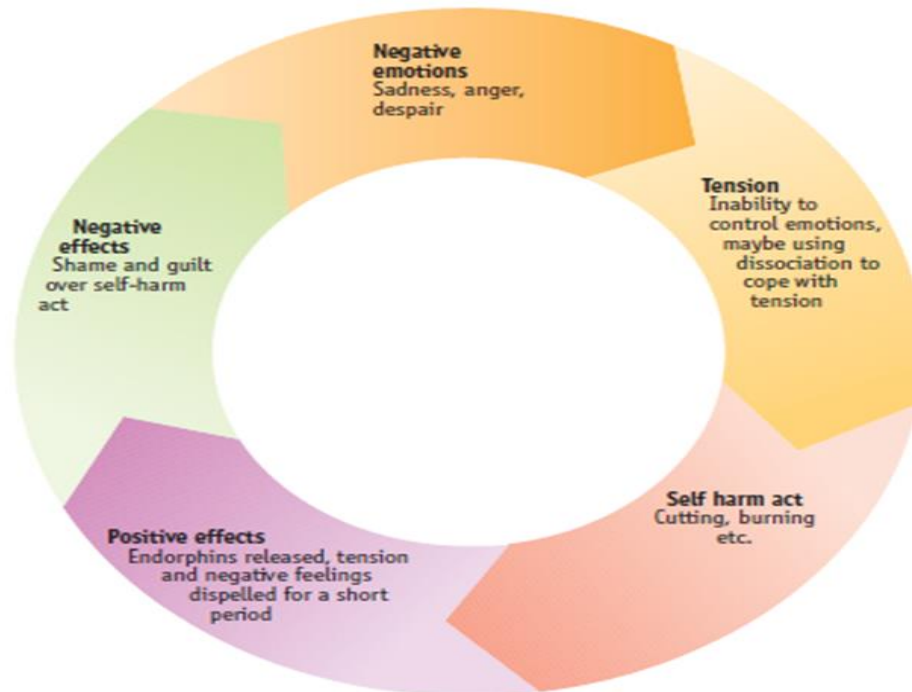
- reduction in tension (safety valve)
- distraction from problems
- form of escape
- outlet for anger and rage
- opportunity to feel physical pain to distract from emotional pain
- way of punishing self or others
- way of taking control
- care-eliciting behaviour
- a means of getting identity with a peer group
- non-verbal communication (e.g. of abusive situation)
- it can also be a suicidal act

The cycle of self-harm

3.10 When a person inflicts pain upon himself or herself the body responds by producing endorphins, a natural pain reliever that gives temporary relief or a feeling of peace.

3.11 The addictive nature of this feeling can make self-harm difficult to stop. People who self-harm still feel pain, but some say the physical pain is easier to stand than the emotional/mental pain that initially led to the self-harm. The Oxfordshire Adolescent Self-Harm Forum created a graphic (figure 2) to illustrate the cyclical nature of self-harm for many people.

Figure 2 The Cycle of Self-harm



Source: Oxfordshire Adolescent Self-Harm Forum (2012) Self-Harm. Guidelines for Staff within School and Residential Settings in *Oxfordshire*

- 3.12 As a coping mechanism, self-harm can become psychologically addictive because to the person who self-harms, it works; it enables him or her to deal with intense stress in the current moment. The patterns sometimes created by it, such as specific time intervals between acts of self-harm, can also create a behavioural pattern that can result in a wanting or craving to fulfill thoughts of self-harm (Nixon et al, 2002)

Repeated self-harm

- 3.13 Repetition of self-harm is common, particularly in the first weeks after the first hospital presentation of self-harm (Gilbody et al, 1997). However a person who self-harms repeatedly might not always do so for the same reason each time or by the same method (Horrocks et al., 2003).
- 3.14 The individual and societal costs associated with self-harm escalate with repetition. Those who repeat self-harm are more than twice as likely to die by suicide compared with those who had engaged in self-harm on one occasion only (Zahl and Hawton, 2004). One systematic review (Owens et al, 2002) reported that a median of 16% of self-harm patients re-present within one year, with the implication that presenting with self-harm in itself is an inadequate predictor of future self-harm.
- 3.15 More recently, Bergen et al (2010) analysed data on self-harm presentations to eight general hospital emergency departments in Oxford, Manchester and Derby between 2000 and 2007 for people aged 15 years or older. Overall, 20.7% of people each year re-presented with self-harm within a year.
- 3.16 In their systematic review, Larkin et al (2014) identified risk factors that have been widely studied and demonstrated consistent associations with repetition. A stepwise increase in the number of previous self-harm episodes and having

a greater number of psychiatric disorders were both associated with a higher risk of repetition in the review. Other factors included impulsivity; comorbidity; problem solving ability; sexual abuse; current psychiatric treatment; stressful life events; work or school problems, family relationship problems; financial problems (protective); attitude towards self-harm episode; and involvement of self-cutting. The study also found that a patient who does not report a wish to die is just as prone to repetition as a patient who does report a wish to die.

Why is self-harm important?

- 3.17 Although self-harm can provide instant relief to emotional distress, there are longer term consequences. Physical implications include scarring, damage to tendons, nerves, blood vessels and muscles, reduction in reaction time and flexibility of thinking after prolonged head banging, damage to liver and kidneys from repeated poisoning.
- 3.18 Self-harming can be, though is not always, one of the first outward signs of mental illness or a mental health crisis, particularly when it is severe enough that the person ends up in an emergency department.

Suicide

- 3.19 The suicide rate in the general population varies across countries. The UK suicide rate was 11.9 deaths per 100,000 population in 2013. The male suicide rate was more than three times higher than the female rate, with 19.0 male deaths per 100,000 compared to 5.1 female deaths. (Office for National Statistics, 2015) There were 6,233 suicides of people aged 15 and over registered in the UK in 2013, a 4% increase compared with 2012. Male rates were the highest since 2001, but female rates remained relatively constant.
- 3.20 Following an act of self-harm the rate of suicide increases to between 50 and 100 times the rate of suicide in the general population (Hawton et al., 2003a; Owens et al., 2002). Men who self-harm are more than twice as likely to die by suicide as women and the risk increases greatly with age for both genders (Hawton et al., 2003b).
- 3.21 It has been estimated that one quarter of all people who die by suicide would have attended an emergency department in the previous year (Gairin et al., 2003). In a large long term study of over 20 years, Runeson et al (2010) found that certain methods of self-harm were associated with increased suicide risk. Hanging, strangulation and suffocation were associated with a six-fold increased risk of future successful suicide compared with self-poisoning (Runeson et al., 2010).
- 3.22 The Royal College of Psychiatrists (2014) state that the risk factors for self-harm are similar to those for suicide, although with some exceptions:
- Suicide is more common among males, whereas self-harm is more common among females.
 - Suicide is more likely to be associated with major depressive disorder, whereas self-harm is more likely to be associated with anxiety disorders.
 - Family dysfunction is more likely to be associated with suicide.

Economic costs of self-harm

- 3.23 In addition to the physical and mental impact of self-harm on service users as well as their families and carers, self-harm imposes a significant economic cost, both on the health sector and society in general.
- 3.24 The assessment and management of self-harm incurs significant NHS resources. Hawton et al (2014) reported that there were 245,000 presentations to A &E in England each year and the Department of Health (2012) noted that self-harm was one of the top five causes of acute medical admission.
- 3.25 Byford et al (2009) estimated the long-term costs, over six years, of a cohort of young people who participated in a randomised controlled trial following an episode of self-poisoning. Lifetime and current (six month) costs were calculated and compared with general population controls to explore costs incurred by the UK general public sector. Resource-use data included inpatient and day patient services for psychiatric reasons, pregnancy or child birth, foster or residential care, supported accommodation, special education, prison and criminal justice, and social security benefits. Over the longer term follow-up, the self-poisoning group used substantially more public sector resources in terms of special education, foster care, residential care or other supported accommodation, and social security benefits. They also spent more time in prison or police custody and had a number of hospital attendances for psychiatric reasons, in comparison with the general population control group. Lifetime differences in the costs of key services were large and statistically significant.
- 3.26 The indirect costs of self-harm in terms of lost productivity, days lost from work, as well as costs to families and carers, are unknown but are likely to be substantial given its prevalence within the UK. (National Collaborating Centre for Mental Health, 2012)

4. Demographics and Risk Factors

Population estimates of self-harm

- 4.1 The majority of incidences of self-harm are thought to be undisclosed, carried out in private and 'invisible' to professionals. To help to understand the burden of unmet need, a wide range of surveys have been undertaken over recent years to estimate prevalence in different age groups.
- 4.2 Estimates of the prevalence of self-harm in the community vary considerably. Although some very young children and some adults are known to self-harm and it often continues from childhood into adulthood, the majority of people who self-harm are aged between 10 and 25 years.
- 4.3 Hawton et al (2002) conducted a questionnaire survey of 6,020 Year 11 pupils in the Oxford, Northamptonshire and Birmingham area. They reported that 13.2% of young people responding had self-harmed at some point in their lives, 6.9% in the previous year. Only 12.6% of those who had harmed themselves had presented to hospital.
- 4.4 Although rates of self-harm vary between countries (Madge et al., 2008), research in England, Canada and Australia between 2002 and 2005 in school age young people indicated an average lifetime prevalence estimate of 17.8% and a 12 month prevalence of 11.5% for deliberate self-harm behaviours.

Similar rates were demonstrated for young people in a more recent international systematic review by Muehlenkamp et al (2012) who identified lifetime prevalence rates of at least one self-injuring event at around 18%. Swanell et al (2014) built on the work of Muehlenkamp et al (2012) and extended their international systematic review to all ages. Overall, their study revealed that prevalence was 17.2% among adolescents, 13.4% among young adults, and 5.5% among adults. These data reflect findings of the adult psychiatric morbidity survey conducted in England (HSCIC, 2009) which stated that self-harm without suicidal intent was reported by 4.9% of adults (5.4% of women and 4.4% of men) aged 16 or over.

- 4.5 Data from the Avon Longitudinal Study of Parents and Children (ALSPAC) cohort who were surveyed in 2012 (Kidiger et al, 2012) provides similar findings from young people in the South West of England. The survey achieved a high response rate at 52%. Of the 4,810 16-17 year olds who responded, 18.8% of respondents had ever self-harmed. Consistent with other research, the prevalence of lifetime self-harm was higher in females (25.6%) than males (9.1%).

Hospital admissions for self-harm

Trends over time

- 4.6 Evidence suggests that rates of self-harm in England have been increasing since 2007. Between 2002/03 and 2008/09 hospital admissions for self-harm in England rose 49% (from 67,652 to 101,053). In the same period the number of patients rose by 43%. (South West Public Health Observatory, 2011). Some research highlights an association with the economic downturn.

Variation by month, day and hour

- 4.7 There is limited evidence to demonstrate patterns of hospital presentations linked to month of the year or day of the week. However some reports have demonstrated patterns in hospital admissions data, such as increased presentations during May and June, which may suggest a link with exam pressures (Cadogen, 2015).
- 4.8 Over a number of years the National Registry of Deliberate Self-Harm in Ireland (2013) has observed the highest number of self-harm presentations on Mondays and Sundays. This pattern was more pronounced in women than in men. There was also a consistent pattern of association between self-harm increases and public holidays.
- 4.9 Bergen and Hawton (2007) studied time of presentation in 5,348 self-harm patients who presented to a general hospital during a six year period. Their data demonstrated that presentations to the emergency department for self-harm vary markedly during the 24 hour day. Presentations ranged from a peak between 8pm and 3am to a low between 4am and 10am. The majority (72.0%) occurred outside office hours.

Deprivation and socio-economic factors

- 4.10 Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms (Hawton et al 2001) and among those who are single or divorced, live alone, are single parents or have a severe lack of social support (Meltzer et al., 2002).

- 4.11 Data from the adult psychiatric morbidity survey (HSCIC, 2009) stated that of those adults who lived in the most deprived quintile, 10% reported having self-harmed at some point in their lives, whereas only 3% of those who lived in the least deprived quintile reported ever self-harming.
- 4.12 Evidence suggests that periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide and self-harm (Gunnell et al 1999). The global financial crisis of 2008 has been associated with a rise in suicide rates and self-harm in many countries, such as the 12% reported increase in rates of self-harm in Ireland during the period 2007-12 (National Registry of Deliberate Self-Harm in Ireland, 2013).

Rurality

- 4.13 In the UK, people living in urban areas are more likely to suffer poor physical and mental health than rural populations and have increased rates of psychiatric disorder. Harriss and Hawton (2011) investigated rates of self-harm in urban and rural districts of Oxfordshire, and compared characteristics of self-harm patients resident in these two areas. Information was collected on 6,833 self-harm episodes by 4,054 persons aged 15 years and over presenting to the local general hospital between 2001 and 2005. They found that urban self-harm rates were substantially higher than rural rates amongst both males and females aged between 15 and 64 years. This relationship was sustained even when socio-economic deprivation and social fragmentation were taken into account.
- 4.14 There was little difference between urban and rural rates for patients aged 65 years and over. Urban self-harm patients were more likely to be younger, non-white in ethnic origin, unemployed, living alone, to have a criminal record, to have previously engaged in self-harm, and to report problems with housing. Rural self-harm patients were more likely to suffer from physical illness and to have higher suicide intent scores.

Groups at a higher risk of self-harm

Young people

- 4.15 The rate of self-harm is low in early childhood but increases rapidly with the onset of teenage years (Hawton et al., 2002). Hawton and Rodham (2006) conducted a school-based survey of 6,000 young people in Year 11 (aged 15 and 16 years) in Oxfordshire, Northamptonshire and Birmingham. The percentage of participants from the survey who reported having deliberately tried to harm themselves at some point in their lives was 13.2%, with 8.6% in the last year. Rates were higher in girls than boys both for lifetime (20.2 versus 7%) and for previous year (13.4 versus 4.4%). This anonymous survey also examined the factors associated with self-harm, coping strategies used and access to services. Self-harm was associated with interpersonal difficulties: younger teenagers describe family problems and older teenagers cite partner issues. Little is known about the problem of self-harm in younger children; however, there appears to be a difference in the female to male ratio with increasing age, from 8:1 females to males in 10-14 year olds through 3.1:1 in 15-19 year olds, to 1.6:1 in 20-24 year olds (Hawton & Harriss, 2008). An Oxford study comparing trends in self-harm between 1985 and 1995 found that the largest rise was in 15-24 year old males (194.1%) (Hawton et al., 1997).

Young people's relationships within school

- 4.16 There is cross-sectional evidence that young people's relationships within schools are associated with self-harm (Wichstrom, 2009). However, in a more recently published study, Kidger et al, (2015) examined the association of school experiences on self-harm two years into the future by using data collected as part of the prospective Avon Longitudinal Study of Parents and Children (ALSPAC).
- 4.17 Members of the ALSPAC birth cohort completed postal surveys of school experiences aged 14, and self-harm behaviour aged 16 (n=3939). Associations between school experiences, namely feeling connected to school, enjoyment of school and perception of teachers as fair and subsequent self-harm were examined. The authors found that self-harm aged 16 was associated with earlier perceptions of school; specifically not getting on well with or feeling accepted by others, not liking school or the work done in class and feeling that teachers are not clear about behaviour or fail to address misbehaviour consistently.
- 4.18 These associations were partially weakened when current mental health was adjusted for. The authors highlighted that this may be that for young people with concurrent mental health problems, experiencing difficulties at school leads a young person to self-harm as a coping strategy, or that an individual who self-harms increasingly finds him or herself disconnected from school life, either because of the stigma surrounding the behaviour, or because of whatever led to the behaviour in the first place.
- 4.19 In this study, poor school experiences were shown to relate to both suicidal and non-suicidal self-harm, with slightly stronger associations visible for suicidal self-harm.

Sexuality

- 4.20 Lesbian, gay and bisexual people are subject to prejudice, discrimination and social exclusion. A systematic review of mental disorder suicide and self-harm among lesbian, gay and bisexual people found a higher risk of self-harm, mental disorder and substance misuse than in heterosexual people (King *et al*, 2008).
- 4.21 Kidger et al (2012) report from the ALSPAC cohort that one in five lesbian and bisexual women self-reported self-harm in the last year compared to one in 200 of women in general. This study also stated that 53% of trans people reported to have self-harmed at some point, with 11% currently self-harming. Data reported from 'The Gay and Bisexual Men's Health Survey 2012' by Guasp, (2012) estimate that one in 14 gay and bisexual men deliberately harmed themselves in the last year compared to just one in 33 men in general who have ever harmed themselves.

Black and South Asian People

- 4.22 Studies in Britain have found that women of South-Asian ethnicity have a higher than average rate of self-harm compared with White men and women (Bhugra and Desai, 2002). Those under 35 years are at a higher risk than older women. The reasons identified for this difference include isolation and family pressure from husbands demanding a less Westernised form of behaviour; interference from parents-in-law; arranged marriages or the rejection of an arranged marriage; isolation even within the wider community; cultural conflict, and problems at school, including racist bullying. South Asian

women who engage in self-harm have also been found to be less likely than their White counterparts to have a psychiatric disorder (Husain *et al*, 2006) and less likely to attend the accident and emergency (A&E) department with a repeat episode of self-harm. Across all age groups, the rates of self-harm were lower in South Asian men compared with South Asian women.

- 4.23 In a recent systematic review, Al-Sharifi *et al* (2015) found evidence to demonstrate significant differences in the rates of self-harm between ethnic groups in the UK, with Asian males being least likely to self-harm and Black females being most likely to self-harm. Black and South Asian people were less likely to repeat self-harm and White people most likely to repeat self-harm. The authors found that factors that may help protect or predispose individuals to self-harm or attempt suicide (such as religion, mental health and coping styles) also differ between ethnic groups.

People with mental health disorders

- 4.24 A wide range of mental health problems are associated with self-harm, including borderline personality disorder, anxiety, depression, bipolar disorder, schizophrenia, eating disorders, post-traumatic stress disorder (PTSD and drug and alcohol-use disorders, (Klonsky, 2007).
- 4.25 In a study examining a representative sample of 150 self-harm patients who presented to a general hospital in Oxford, Haw *et al* found the prevalence of mental illness and personality disorder to be 90% and 46% respectively, (Haw *et al*, 2001).
- 4.26 In a more recent study of people presenting at general hospitals involving 1108 individuals (a third of whom were assessed by mental health specialists), probable depression was identified in 29%; alcohol or drug misuse in 32% a further 9% were alcohol dependent; anxiety/stress-related disorders in 13%; a severe mental illness in 7%; and a further 4% were diagnosed with personality disorders (Dickson *et al*, 2009). Four per cent were identified as having no psychiatric disorder evident at time of assessment.
- 4.27 In one survey of a sample of the British population, people with current symptoms of a mental disorder were up to 20 times more likely to report having harmed themselves in the past (Meltzer *et al.*, 2002). The association was particularly strong for those diagnosed as having phobic and psychotic disorders. People diagnosed as having schizophrenia are most at risk and approximately half of this group will have harmed themselves at some time.

Veterans

- 4.28 Veterans have been identified as a group of people at particular risk of self-harm (Royal College of Psychiatrists, 2010), due to their life experiences, personal or social circumstances or a combination of these factors. Little has been reported on self-harm among the UK Armed Forces, partly due to the difficulties in recording self-harm, within an often-difficult-to-reach population.
- 4.29 Pinder *et al* (2011) conducted telephone interviews with 821 personnel who had previously participated in the King's Centre for Military Health Research military health study. Within the telephone interview, participants were asked about attempted suicide and episodes of self-harm. A lifetime prevalence of 5.6% for intentional self-harm (self-harm or attempted suicide) was reported. Intentional self-harm was associated with younger age groups (34.4 years vs 39.8 years), psychological morbidity (in particular, post-traumatic stress

disorder) and adverse experiences in childhood. Ex-service personnel reported lifetime prevalence more than double that of serving personnel (10.5% vs 4.2%, respectively).

Prisoners

- 4.30 Self-harming behaviour is widespread in prisons; the rates for both genders being markedly higher than in the general population. The nature of the prison environment is likely to exacerbate a person's previous self-harming behaviour and their vulnerability to starting it. Women prisoners are particularly vulnerable which is thought due to their significant unmet needs that relate to their offending (Corston, 2008). Prison is also said to be harsher for women because prisons and the practices within them have been designed for men. Women prisoners are more likely than men to be primary carers of young children and because there are fewer women's prisons, women are more likely to be located further from home.
- 4.31 A new system for monitoring self-harm was introduced in Prisons in December 2002 and as a result recording of self-harm improved. In prison custody self-harm incidents are more likely to be detected and counted than in the community.
- 4.32 Several measures have been introduced in prisons to try to reduce suicide and self-harm, including safer cells and the Assessment, Care in Custody and Teamwork (ACCT) procedures for prisoners at risk of self-harm. Current initiatives to enable closer working between police and mental health staff may divert some individuals with psychiatric disorders away from prison to more appropriate treatment facilities.

People with a learning disability and learning difficulties

- 4.33 The nature and prevalence of self-harm in people with learning difficulties is not well understood (Royal College of Psychiatrists, 2010). In a prospective cohort study where individual assessments were conducted with people aged 16 and over, Cooper et al., (2008) calculated the overall rate of self-injury as being 4.9%. Deb et al., (2001) interviewed a random sample of 101 adults with learning disabilities (aged 16-64) known to a social services department in Wales, supported by their carer. Overall, 24% were considered to self-injure, the majority of whom (67%) were female. The rate of self-injury varied with the severity of learning disability: 73% of people with severe learning disability self-injured, compared with 19% with moderate self-injury, and 17% of people with mild self-injury.
- 4.34 More recently, Lowe et al., (2007) collected data on 901 adults and children over the age of five using learning disability services in a defined area of Wales. Overall, 9% were considered to self-injure.
- 4.35 Factors recognised as being associated with self-injury in people with learning disability are genetically-determined syndromes, disrupted neurotransmitter pathways, severity of learning disability, developmental delay, autism; those with more severe autism and associated difficulties were more likely to show more self-injury, no speech, pain, the existence of previous self-injury, impoverished environments and oppression (Heslop and Macaulay, 2009).

Children looked after by local authorities and care leavers

- 4.36 People who are in or who have been in care are more likely to report having self-harmed. Various rates have been proposed but, in the Chief Medical Officer's Report 2012, Simkiss stated that looked-after children and care leavers are between four and five times more likely to self-harm in adulthood. The Foresight report on mental capital and well-being noted that 45% of all children in care, and 72% of young people in residential child care, are likely to have a diagnosed mental health problem (Foresight, 2008).
- 4.37 NICE states in its commissioning guide for self-harm (NICE, 2013) that looked-after children and young people may demonstrate far higher levels of mental health diagnoses than children in the general population, and that children and young people are taken into care for many reasons, but the main ones are physical, emotional or sexual abuse, or neglect, which are, themselves, risk factors for self-harm.

Older people

- 4.38 Hawton and Harriss (2006) studied 730 people who were 60 years or older and had presented to hospital following self-harm. The authors found very high suicidal intent among this group and, at follow-up over 20 years, very high suicide rates (4.5%). Dennis et al (2005) studied older people with depression finding that two thirds had significant suicidal intent. Older people with depression who self-harmed were more likely to have a poorly integrated social network; loneliness and lack of support from services were identified as important factors in determining suicidal behaviour in older adults.
- 4.39 Lamprecht et al (2005) examined self-harm in older people presenting to acute hospital services over three years. More males (56%) than females (26%) who presented with self-harm were married. The observations suggested an increase in self-harm in men, and marriage may no longer be a protective factor among older men. Dennis et al (2007) confirmed their previous finding that the majority of older people who harmed themselves had high suicidal intent and a high proportion (69%) were depressed. Individuals were frequently living alone with an isolated lifestyle and poor physical health. Barr et al (2004) described four characteristics that have been shown to be associated with increased vulnerability in older people who self-harm: increased suicidal intent, physical illness, mental illness and social isolation.
- 4.40 Murphy et al 2012 studied 1,177 older adults aged 60 years and over who had presented to hospital with self-harm. The authors found that within one-year of their self-harm presentation, 1.5% of older adults had subsequently died by suicide. Their risk of suicide was 67 times greater than older adults in the general population. Men aged 75 years and over had the highest suicide rate. Of those studied who had presented, 12.8% repeated self-harm within one year.

Risk factors

Life events

- 4.41 Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of his/her life. Second, life events, particularly relationship problems, can precipitate an act of self-harm (Haw & Hawton, 2008; O'Connor et al., 2010). Many people who self-harm have a physical illness at the time and a

substantial proportion of them report this as the factor that precipitated the act (De Leo et al., 1999).

Family history

- 4.42 Some evidence suggests that a family history of self-harm may be a risk factor for repetition of self-harm. A large-scale cross-sectional study with over 6,000 participants conducted among young people in England (Hawton et al., 2002) reported that self-harm in family members was a risk factor for both males and females. Although this was based on students' self-reports resulting in possible ascertainment bias, this finding suggests there is an intergenerational transmission of risk, one explanation for which is genetic susceptibility. This hypothesis is supported by a large twin study with 5,995 participants based in Australia, which found that history of self-harm in a co-twin was strongly predictive of self-harm in monozygotic twin pairs but not in dizygotic twin pairs, suggesting that the heritability of suicidal thoughts and behaviours was in the region of 45% (Statham et al., 1998).

Sexual, physical and domestic abuse

- 4.43 Child sexual abuse is known to be associated with self-harm (Fliege et al., 2009; Hawton et al., 2002; Meltzer et al., 2002), especially among people who repeatedly self-harm, as well as a range of mental health problems particularly in teenage years and adulthood for females and for looked-after children (Meltzer et al., 2002). Physical abuse is also implicated in self-harm (Glassman et al., 2007; O'Connor et al., 2009a). Those who experienced bullying in childhood are at increased risk of future self-harm even after adjustment for the co-occurrence of other risks such as abuse (Meltzer et al., 2011).
- 4.44 Experience of domestic abuse is a significant risk factor for self-harm. Compared with controls, in a retrospective cohort study, people experiencing domestic abuse were more likely to present with self-harm (Boyle et al., 2006). It is suggested that healthcare professionals explore whether self-harm is an issue when there is evidence of domestic abuse (Sansone et al., 2007). It is important to note that socio-economic factors such as unemployment and poverty, childhood experiences of abuse and experiences of domestic violence are all associated with a wide range of mental disorders, as well as self-harm. How these experiences and factors interact needs to be explored and better understood.

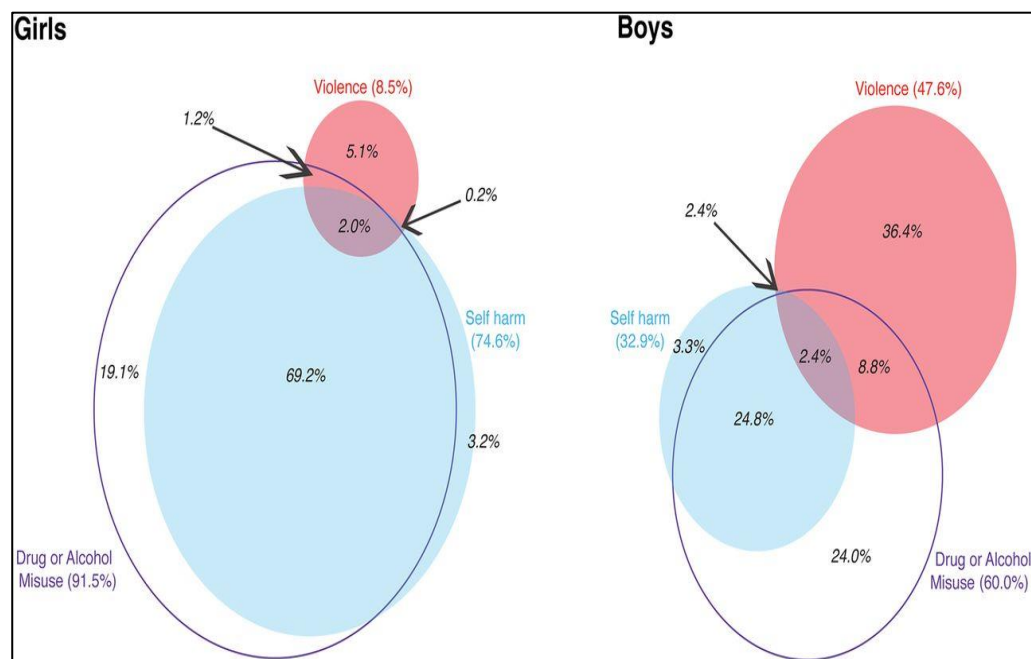
Alcohol and drug use

- 4.45 Approximately half of people who attend an emergency department following self-harm will have consumed alcohol immediately preceding or as part of the self-harm episode (Horrocks et al., 2003). For many, this is a factor that complicates immediate management either by impairing judgement and capacity or by adding to the toxic effects of ingested substances. Approximately one quarter of those who self-harm will have a diagnosis of harmful use of alcohol (Haw et al., 2001). Men are more likely to drink before an episode of self-harm than women (Hawton et al., 2003) and are more likely to be misusing drugs or alcohol, as well as to have higher rates of several risk factors for suicide.
- 4.46 People who have, or are recovering from drug and alcohol problems are at a significantly greater risk of self-harm and suicide than the general population (National Mental Health Development Unit, 2009). In people who have a pre-existing tendency to self-harm or suicide, the risk of self-harm can be

increased if they have alcohol and drug problems, both as a result of intoxication and in the psychological withdrawal phase. In some circumstances the use of alcohol or drugs acts as a form of self-medication and the risk of suicide and self-harm can increase in the short term when people begin to address their substance problem.

4.47 In a recently published study, Herbert et al 2015 demonstrated the overlap between self-harm, drugs/substance misuse and violence related emergency admissions in young people aged 10-19 years. The authors examined longitudinally linked administrative hospital data (Hospital Episode Statistics) for young people aged 10–19 years with emergency admissions for injury in England in 1998–2011. Of the 402,661 records examined one-third of the cohort (141 248) had a record of an emergency admission that the authors classified an “adversity-related injury”, comprising of violence (maltreatment/assault/undetermined causes of injury), self-harm, or drug or alcohol misuse. The graphic (figure 3) below shows the overlap between the reasons for presentation.

Figure 3 Percentage of adolescents with adversity-related injury, by types of adversity between 10-19 years of age and sex.



Source: Herbert et al (2015) Violence, self-harm and drug or alcohol misuse in adolescents admitted to hospitals in England for injury: a retrospective cohort study.

4.48 Girls in the adversity group were most likely to be exposed to multiple types of adversity between 10 and 19 years of age especially self-harm and drug or alcohol misuse (69.2%). Fewer boys in the adversity group were exposed to multiple types of adversity (38.4%), the most common combination also being self-harm and drug or alcohol misuse (24.8%).

4.49 The authors highlighted that although the data demonstrated that adolescents often present with multiple types of adversity (especially in girls), the majority of guidelines exist for managing individual problems.

Influencing factors

Digital technology

- 4.50 Digital technology, particularly social media platforms such as Facebook, Tumblr and Twitter, is now a central part of peoples' lives, for information, entertainment and communication. The use of apps such as WhatsApp, Whisper, Yik Yak and We Heart It and accessing the internet on mobile devices have become a way of life, so people can share, connect and communicate with each other instantly and spontaneously.
- 4.51 People use a range of social media and congregate within an array of online forums. Some of the services offer blogging facilities such as Tumblr. Services like Tumblr allow users to upload images, videos, poems and music, which can be very popular with those who self-harm, as they can share and connect with each other and express themselves creatively.
- 4.52 In a personal communication to contribute to this Health Needs Assessment, the UK Safer Internet Centre (Higgins, 2014), a charity aiming to deliver a wide range of activity to promote safe and responsible use of technology report that the most damaging content around self-harm is not usually hosted on mainstream sites but individually curated blogs. The best of these use a system of moderation and may add a "*sensitive content*", or age rating which has to be read and acknowledged before entering the site. Some of the independent blogs contain graphic images of self-harm and advice on different techniques and hiding strategies.
- 4.53 When people disclose a desire to self-harm on the mainstream sites there is often a redirection to external services. Whisper set up its own helpline and hosts resources, Facebook, Tumblr and Pinterest direct people at risk to either Samaritans or to US based support services. Some charities in the US utilise staff online to reach out to users in distress although this is resource expensive and not a popular option in the UK.
- 4.54 Daine et al 2013 systematically reviewed the literature to determine whether there was evidence that the internet influences the risk of self-harm or suicide in young people. At that stage only 14 studies met the criteria for inclusion in the review demonstrating the limited body of research to that date.
- 4.55 The results indicated both positive and negative influences from the internet. The authors stated that the internet may normalise self-harm, provide access to suicide content and violent imagery and create a communication channel that can be used to bully or harass others. Conversely, the internet is also used as a support network and a coping mechanism, and can connect people who are socially isolated.
- 4.56 The authors recommended that clinicians should include a detailed enquiry about internet use in clinical assessment of young people at risk of self-harm or suicide. This was indicated due to the evidence that exposure to others who are self-harming is a major risk factor for self-harm, the fact that such exposure may occur through the internet and that exposure to self-harm and suicide on the internet may be associated with potentially more dangerous methods of self-harm.

- 4.57 In their recently published guidelines *CR192 Managing self-harm in young people* the Royal College of Psychiatrists (2014) included recommendations for clinicians to include an assessment of a young person's digital life as part of clinical assessments and for parents to be interested and engaged in their children's digital lives as early as possible.

Media use by children and young people

- 4.58 Each year Ofcom provide detailed evidence on trends in media use, attitudes and understanding among children and young people aged 5-15; media access and use among children aged 3-4 and parental attitudes and approaches to mediating children's media use. The report draws on a large-scale quantitative survey based on in-home interviews with children and parents. In the most recent report *Children and Parents: Media Use and Attitudes* 1,660 interviews with parents and children aged 5-15 and 731 interviews with parents of children aged 3-4 were conducted between April and June 2014. Some of the most salient points highlighted by the authors were:

- Seven in ten children aged 5-15 have access to a tablet computer at home. Children's access to a tablet computer at home has increased from 51% to 71% for 5-15s since 2013.
- Children are almost twice as likely to go online using a tablet. Four in ten children aged 5-15 go online using a tablet computer, almost twice as many as in 2013.
- Compared to 2013, it appears that older children are less likely to believe that all the information that they see on websites or apps is true.
- Around three in ten parents of 5-15s who go online are concerned about their child being bullied (30%) or the content of the websites their child visits (28%).
- Parents of 5-15s use a combination of approaches to mediate their child's access and use of online content and services, including: using technical tools; regularly talking to their children about managing online risks; supervising their child; having rules (about access to the internet and/or behaviours while online).
- The majority of parents whose child goes online at home or elsewhere (95%) use at least one of these approaches, and one in three (33%) use all four. A very small minority (5%) do not mediate their child's internet use in any of the ways mentioned above, rising to 11% for parents of 12-15s.
- Parents of girls are more likely to check social media activity (73% vs. 61%) and to say that they usually supervise their child online by asking about what they have been doing online (46% vs. 34%).

5. Policy Context, Clinical and Commissioning Guidance

- 5.1 Over the last five years a range of guidance on self-harm and policy documents focussing more broadly on mental health and wellbeing have been published. Policy highlights the priority of self-harm and calls on agencies to work together to impact positively on the root causes. Key points from these documents have been summarised below in date order. National guidelines have predominantly focussed on the clinical end of the self-harm pathway and crisis care, whereas more local guidance has integrated broader community aspects. Guidance documents have been summarised below, presented from national to local.

Guidelines

National Institute for Health and Care Excellence (NICE) guidelines: Self-harm: short-term management (NICE, 2004), Self-harm: longer-term management (NICE, 2011) and evidence updates

- 5.2 These are evidence-based clinical guidelines for professionals involved in the management of people who self-harm and have a mainly clinical focus, outlining the roles of ambulance staff, acute services and primary care. The guidance states that all staff should have received “*appropriate training*”. It makes it clear that anyone who attends an Emergency Department for self-harm should be offered a comprehensive assessment of their physical, psychological and social needs and risk; including “*identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent*”. Assessments for children and young people should also include “*a full assessment of the family, their social situation, and child protection issues.*”
- 5.3 The particular risks associated with self-harm in later years are highlighted and staff are asked to regard all acts of self-harm in people older than 65 years of age as “*evidence of suicidal intent until proven otherwise*”.
- 5.4 The guidance states that all relevant organisations should jointly plan “*integrated physical and mental healthcare services within emergency departments for people who self-harm in conjunction with local service users and carers wherever possible*”, including “*effective liaison psychiatric services available 24 hours a day*” and consider “*integrating mental health professionals into the emergency department, both to improve the psychosocial assessment and initial treatment for people who self-harm, and to provide routine and regular training to non-mental-health professionals working in the emergency department.*”
- 5.5 There is also an emphasis on treating people who have self-harmed with the same care, respect and privacy as any patient and to enable full involvement in decision making. Staff are expected to be aware of “*the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach*”.
- 5.6 *NICE quality standards and guidance for commissioners* is based on the clinical guidelines; the quality standards identify the key markers of high-quality self-harm services and the accompanying guidance is for those seeking to commission such services.

Royal College of Psychiatrists (RCP, 2014) Managing self-harm in young people

- 5.7 In 2014, the Royal College of Psychiatrists published guidance which focuses on service-level issues, particularly the roles of professionals and inter-service relationships. Within the 14 recommendations, particular focus is given to courage and compassion in asking about self-harm, reduction of stigma and the importance of treating young people who have self-harmed in a non-judgemental and respectful manner, joint working across disciplines, availability of out of hours services and the importance of assessing a young person's digital life as part of high-quality assessment at all levels of service.
- 5.8 One key recommendation relates to admission of 16 and 17 year olds attending acute hospital. The report recommends that routine admission should be restricted to situations where there is doubt about the safety of the young person or where a high quality assessment cannot be performed without an admission.

Oxfordshire Adolescent Self-Harm Forum Self-Harm. Guidelines for Staff within School and Residential Settings in Oxfordshire.

- 5.9 These guidelines which were first published in 2003, most recently updated in 2012, were developed by the Oxfordshire Adolescent Self-Harm Forum. This forum is a collaboration between the Education Department, Samaritans, Mental Healthcare Trust and the Department of Social and Health Care. They were written by the Oxfordshire Adolescent Self-Harm Steering Group and advised by a number of experts including Professor Keith Hawton, a Consultant Psychiatrist with Oxford Health NHS Foundation Trust who is Professor of Psychiatry at Oxford University and Director of the Oxford University Centre for Suicide Research. Professor Hawton has published extensively in the field of research into suicide and deliberate self-harm.
- 5.10 The Oxfordshire guidelines provide a practical handbook for schools and residential staff, acting both as a resource to understand self-harm but also as a guide for immediate and longer term action, referral and ongoing support.
- 5.11 The Oxfordshire guidelines have been used as a model by a number of local areas in the South West, including Bath and North East Somerset, Wiltshire and Swindon.

National Policy 2011-15

- 5.12 In 2011, HM Government published *No health without mental health* a cross-government mental health outcomes strategy for people of all ages, in which it acknowledged the importance of community and other non-acute care settings having good knowledge of self-harm:

“Self-harming in young people is not uncommon ... only a fraction of cases are seen in hospital settings; therefore, all those in contact with young people should be aware of how, and when, to refer somebody on for further assessment and support.”

Royal College of Psychiatrists College Report CR158 (2010) Self-harm, suicide and risk: helping people who self-harm: Final report of a working group.

- 5.13 This report provides background information on self-harm in the UK, describes some of the public policy issues, and explores the results of a survey and consultations with healthcare professionals and others working with young people who self-harm. Makes a series of recommendations, including development of a common curriculum on self-harm for front-line health professionals, more research funding on relevant therapies, and more recognition of the crucial contribution of the third sector in dealing with self-harm and suicide.
- 5.14 In 2012, *Preventing suicide in England. A cross-government outcomes strategy to save lives* (HM Government, 2012) was published and highlighted knowledge about groups at higher risk of suicide. People with a history of self-harm were identified as one of five high risk groups who were to be prioritised for prevention.
- 5.15 In 2013, Professor Dame Sally Davies focused the advocacy volume of her Annual Report *Public Mental Health Priorities: Investing in the Evidence* (Department of Health 2013) on public mental health and dedicated a chapter to the issue of self-harm. Within the report, Professor Davies made the following recommendations:
- Increase the proportion of self-harm patients receiving a psychosocial assessment in hospital.
 - Services should have ready access to brief psychological therapy following discharge for patients for whom it is suitable.
 - Patients who are multiple repeaters of self-harm require special attention with further development of effective therapies.
 - Screen for alcohol misuse in those who self-harm.
 - Develop training that can help counter the often negative attitudes and understanding of general hospital medical and nursing staff regarding self-harm.
- 5.16 The report also acknowledges that, as most young people do not present to clinical services, there is a key role for prevention in community and school settings.
- 5.17 In *Closing the Gap: Priorities for essential change in mental health* (Department of Health, 2014) published two years after the cross government mental health outcomes strategy, the authors challenge the health and social care community to go further and faster to transform the support and care available to people with mental health problems. They also challenge the public health community, with local government in the lead, to help give mental health and wellbeing promotion and prevention the “*long overdue attention it needs and deserves.*”
- 5.18 The report identified 25 aspects of mental health care and support where they hope and expect to see “*tangible changes*” in the next couple of years. Of particular relevance were challenges 14 and 17:

CHALLENGE 14:

We will change the way frontline health services respond to self-harm

In this challenge, the authors discuss preventing long term mental health conditions and repeat admissions to emergency departments and in some cases, suicide by ensuring that all patients presenting with self-harm are referred for a psychosocial assessment, as set out in the NICE guidelines. There was also an expectation that GPs should refer people who disclose self-harm to psychological therapies.

They also propose a new self-harm indicator to be introduced in the revised Public Health Outcomes Framework, in order to understand the prevalence of self-harm but also how emergency departments are responding:

- Attendances at emergency departments for self-harm per 100,000 population.
- Percentage of attendances at emergency departments for self-harm that received a psychosocial assessment.

CHALLENGE 17:

Schools will be supported to identify mental health problems sooner

In this challenge the authors recognise that many schools want to do more to help children who are, or may be, experiencing mental health problems. It calls for schools to identify mental health problems in their pupils sooner and for health and education professionals to work collaboratively so that the right decisions are made to support each child, referring those who need extra support to the right places sooner.

It mentions the new Special Educational Needs (SEN) Code of Practice, which ensures a child's mental health needs are captured within any assessment of their educational, health and social care needs. It sets the expectation that there should be clear arrangements in place between local health partners, schools, colleges, early years providers and other organisations for making appropriate referrals to Child and Adolescent Mental Health Services (CAMHS). It also mentions how schools can contribute to mental wellbeing in many other ways, such as tackling bullying and addressing discrimination.

- 5.19 Also published in 2014 by the Department of Health and a wide range of signatories was the *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*. The Concordat is a joint statement that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs. It establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. It sets an expectation that in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. Of particular note, the

Concordat introduces the concept of “*parity of esteem*” and challenges the NHS “*put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.*”

5.20 In 2015, prior to the general election, the Department of Health and NHS England published *Future in mind Promoting, protecting and improving our children and young people’s mental health and wellbeing*. The report summarised the work of the Children and Young People’s Mental Health and Wellbeing Taskforce which consisted of education, health and care professionals, charities and community organisations, young people and their families. The taskforce was asked to identify what was blocking the provision of excellent mental health care for young people.

5.21 The resultant report advocates a “*whole system approach ... focusing on prevention of mental ill health, early intervention and recovery*” and sets out 10 Government aspirations to be achieved by 2020. In short, the aspirations include:

- A whole child and whole family approach, where we are promoting good mental health from the earliest ages.
- Improved access to evidence based interventions and support when and where it is needed, in schools, GP practices, hospitals or in crisis care.
- Better use of the voluntary and digital services to fill the gaps in a fragmented system.
- Easier access for a child or young person to seek help and support in non-stigmatised settings.
- A simpler, non-tiered system, built around the needs of children, young people and their families, using some of the innovative practices which are already happening in this country and abroad.

6. Analysis of National and Local Need

Data sources

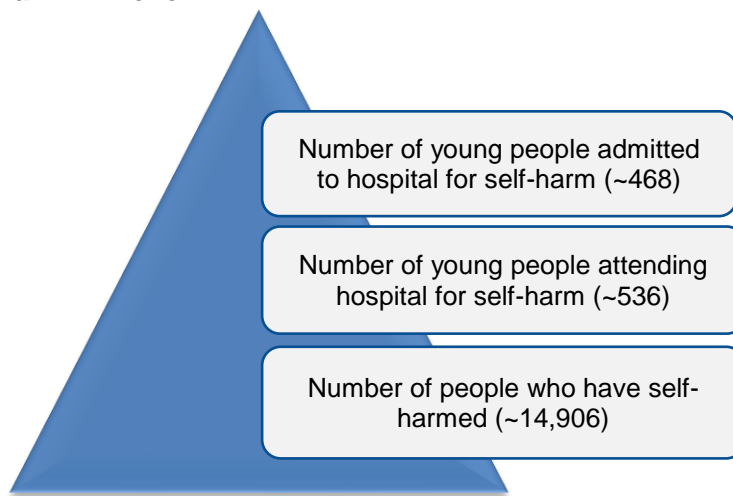
6.1 Definitive data are difficult to obtain because the majority of incidences of self-harm are thought to be undisclosed, carried out in private and do not result in medical attention. As such hospital statistics are widely regarded as presenting the “tip of the iceberg” with the vast majority of acts of self-harm being ‘invisible’ to professionals.

6.2 The information in this needs assessment includes both accident and emergency attendances and hospital admissions which can both give a picture of the people seeking treatment for self-harm. In addition, data from mental health services and those in prison custody are directly collected and so can describe the need within these groups. Survey data offers the best opportunity to estimate the proportion of the population who will self-harm in their lifetime. Service (e.g. counselling services) use can give some indication of trends.

Population estimates of self-harm in Devon

- 6.3 Using population estimates of the prevalence of self-harm it is possible to estimate the scale of the problem in Devon. By considering a range of estimates of prevalence for school age young people for example, including 17.8% reported by Madge et al (2008), 18% reported by Muehlenkamp et al (2012), 18.8% reported by Kidiger et al, (2012) and 17.2% reported by Swanell et al (2014), it is possible to estimate an approximate number of young people who self-harm in Devon.
- 6.4 Choosing a median rate of 18%, figure 4 illustrates the estimation that approximately 14,906 young people aged 10-19 self-harm in Devon, a tiny fraction of which are visible to professionals.

Figure 4 Estimated numbers of young people aged 10-19 years who self-harm in Devon

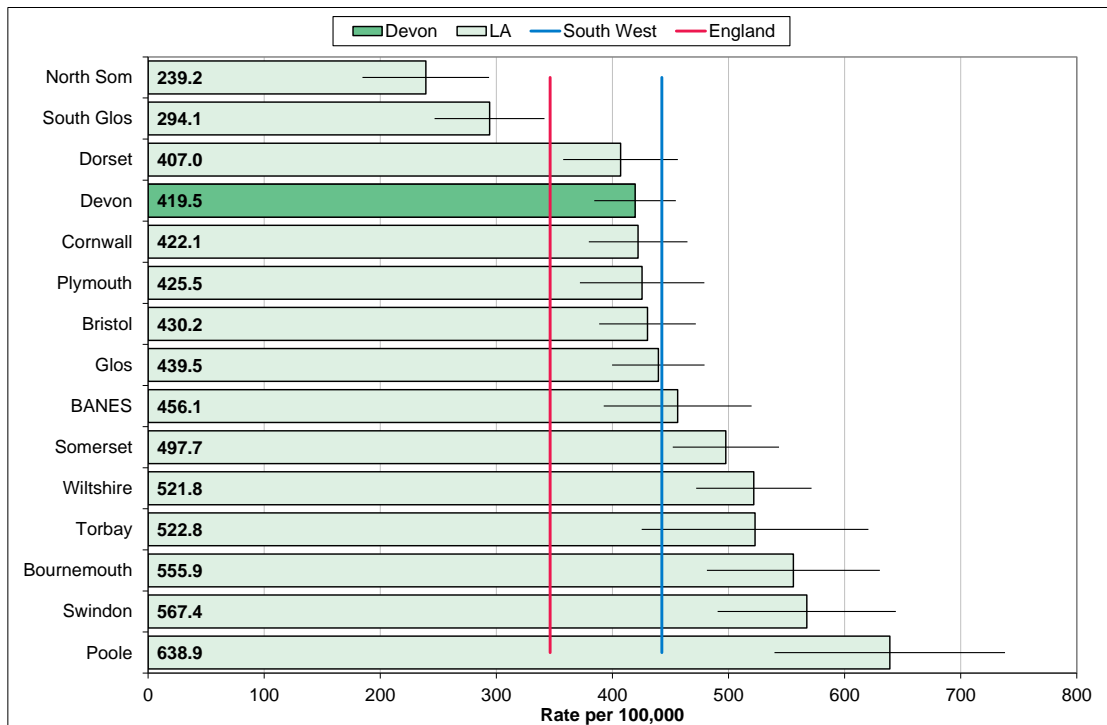


Source: Public Health, Devon County Council 2015

Hospital admissions for self-harm

- 6.5 Self-harm results in approximately 245,000 presentations to A & E each year in England (Hawton et al, 2014), and is one of the top five causes of acute medical admission (Department of Health, 2012).
- 6.6 In the year 2013-14, hospital admissions rates for self-harm in Devon were significantly above the England average but below the South West Average. Only two of the fifteen local authorities in the South West recorded lower admission rates than the England average (346.3).

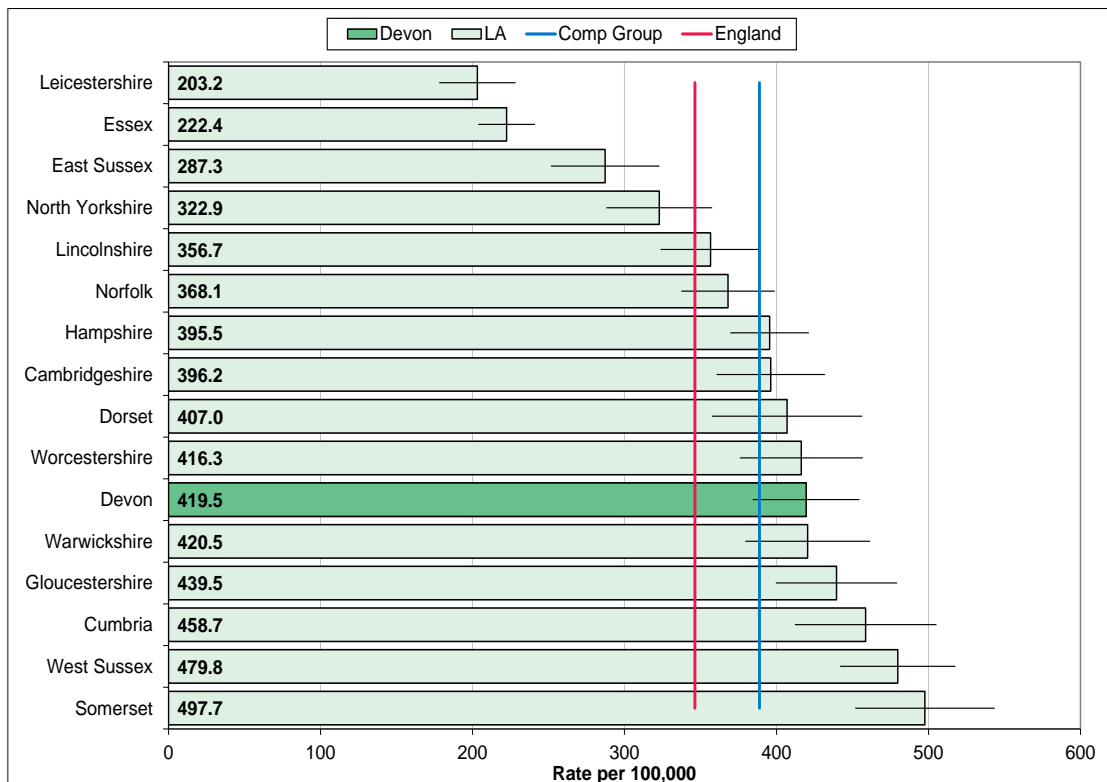
Figure 5 Direct Age Standardised Admission Rate for Self-Harm, Aged 10 to 24, South West Local Authorities, 2012-13



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

6.7 When compared with the local authority comparator group, the rate of hospital admissions for self-harm in Devon is just above the average for the group.

Figure 6 Direct Age Standardised Admission Rate for Self-Harm, Aged 10 to 24, Devon Local Authority Comparator Group, 2012-13



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Age and gender

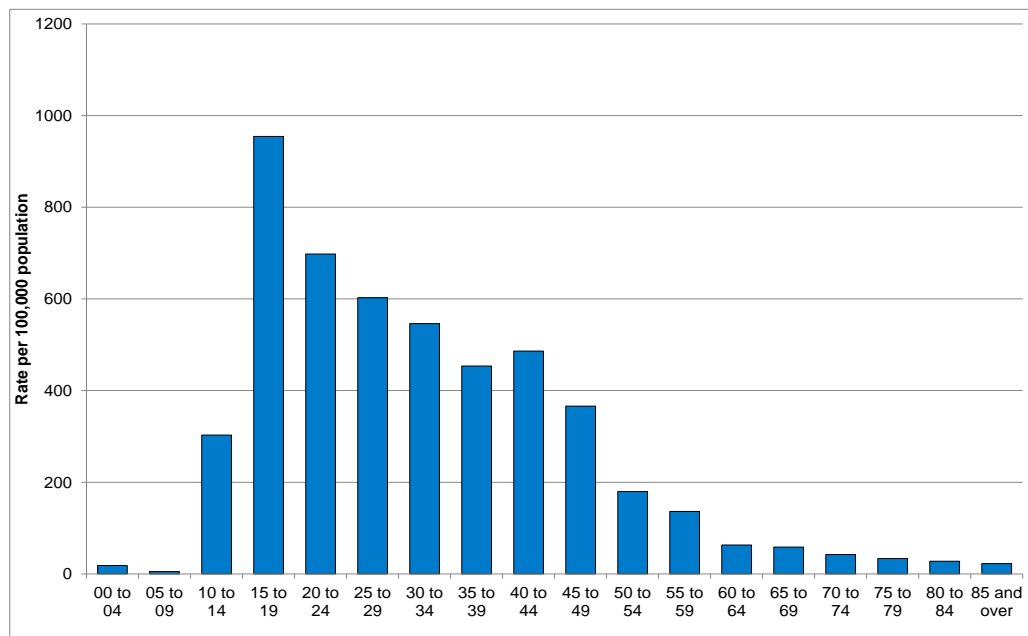
National Society for the Prevention of Cruelty to Children - ChildLine

- 6.8 In their reports detailing service use, the National Society for the Prevention of Cruelty to Children (NSPCC) (2014, 2015) stated that in for 2012-13, girls contacted ChildLine about self-harm 2.3 times more than boys. Self-harm was the fourth most common reason for girls to seek support. Analyses demonstrate that the gap between boys and girls appears to be widening. The ratio of girls to boys concerned about self-harm was 12:1 in 2011-12 and 15:1 in 2012-13.
- 6.9 Data also suggests that the age at which self-harm is becoming a concern is changing. In 2012-13 most counselling sessions about self-harm were with 15 year-olds but in 2013-14, 14 year olds received most counselling sessions about self-harm. The age with the highest increase of counselling about self-harm in 2013-14 was 12 year-olds (44 per cent increase from 2012-13).

Devon hospital episodes by age and gender

- 6.10 In Devon, 2,172 people attended accident and emergency departments as a consequence of self-harm in 2013-14. Attendance rates peaked in the 15-19 age group, as illustrated in the chart below, with higher rates also seen in the 20 and 49 age groups.

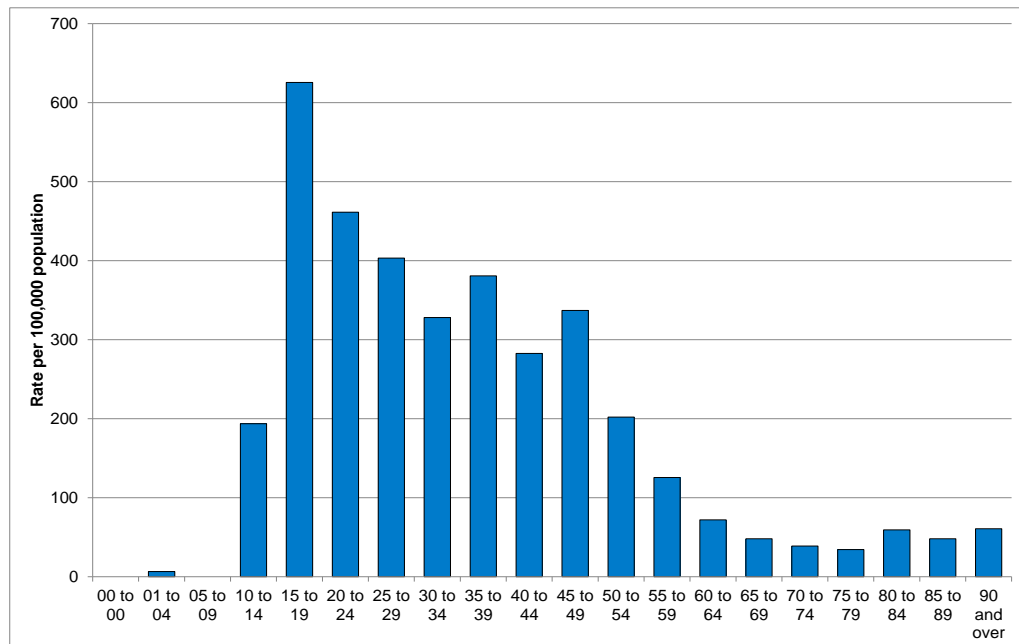
Figure 7 Accident and Emergency and Minor Injury Unit Attendance Rates for Self-Harm by Age Group, Devon, 2013-14



Source: Secondary Uses Service, Commissioning Dataset, Accident and Emergency Table

- 6.11 In 2012-13, 1,591 people from Devon were admitted to a hospital bed due to self-harm, with highest rates of admission in the 15-19 age group. A similar distribution as with accident and emergency attendances is observed with admission rates in the 20-49 years age groups remaining prominent. These data highlight the needs of this age group should feature prominently alongside the needs of those aged under 20 when considering issues around self-harm.

Figure 8 Emergency Hospital Admission Rates for Self-Harm by Age Group, Devon, 2012-13



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Trends over time

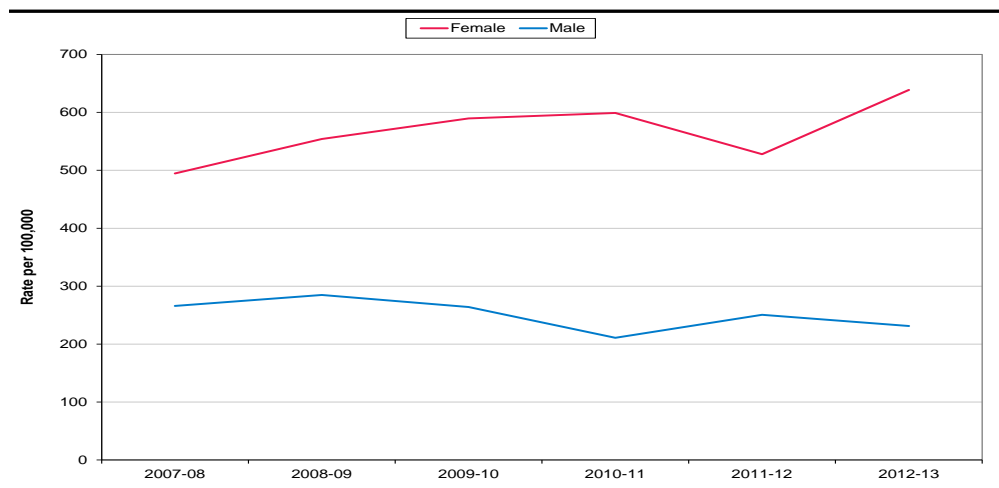
6.12 The NSPCC ChildLine reports that the number of children disclosing self-harm has risen steadily since the mid-1990s. Recent reports demonstrate the increases are continuing with 22,532 young people counselled about self-harm in 2012-13 and 24,308 in 2013-14, an increase of 7.9%

Devon trends in hospital admission rates

6.13 Hospital admissions rates per 100,000 for self-harm in Devon have risen from 376.6 in 2007-08 to 419.5 in 2012-13.

6.14 In line with national data, admission rates in Devon are three times higher in females than males and the gap has widened in recent years.

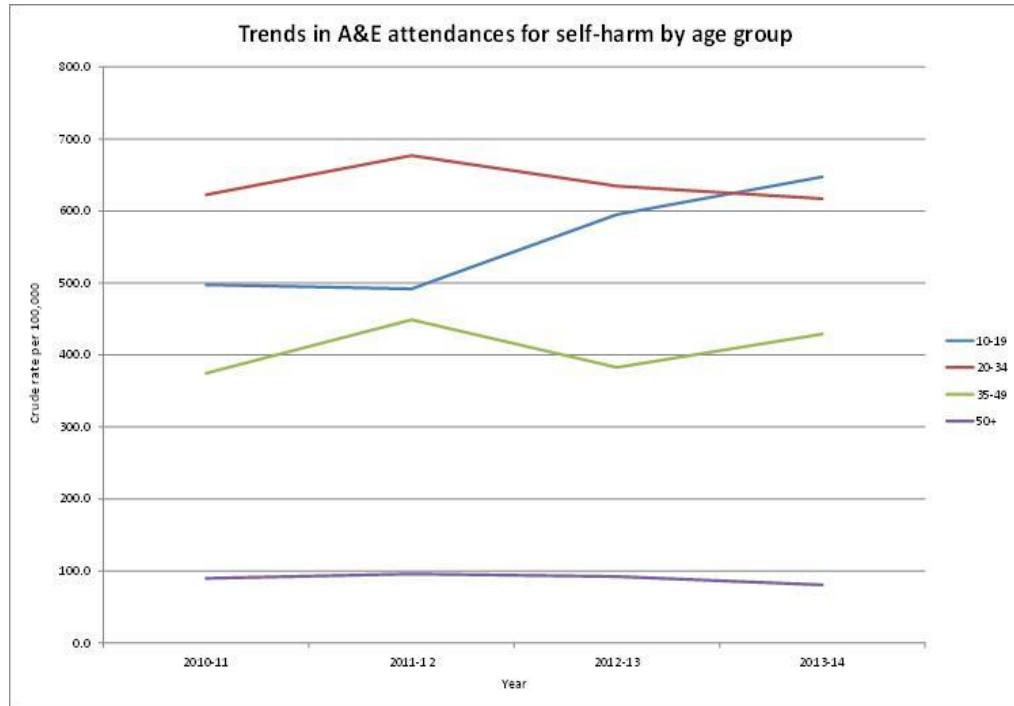
Figure 9 Direct Age Standardised Admission Rate for Self-Harm by Sex Aged 10 to 24, Devon Trend



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

- 6.15 When considering the age of people attending A&E in Devon for self-harm over time, there have been rises in attendance by those in the 10-19 and 35-49 age groups and a small fall in rates for those aged 20-34 and 50+.

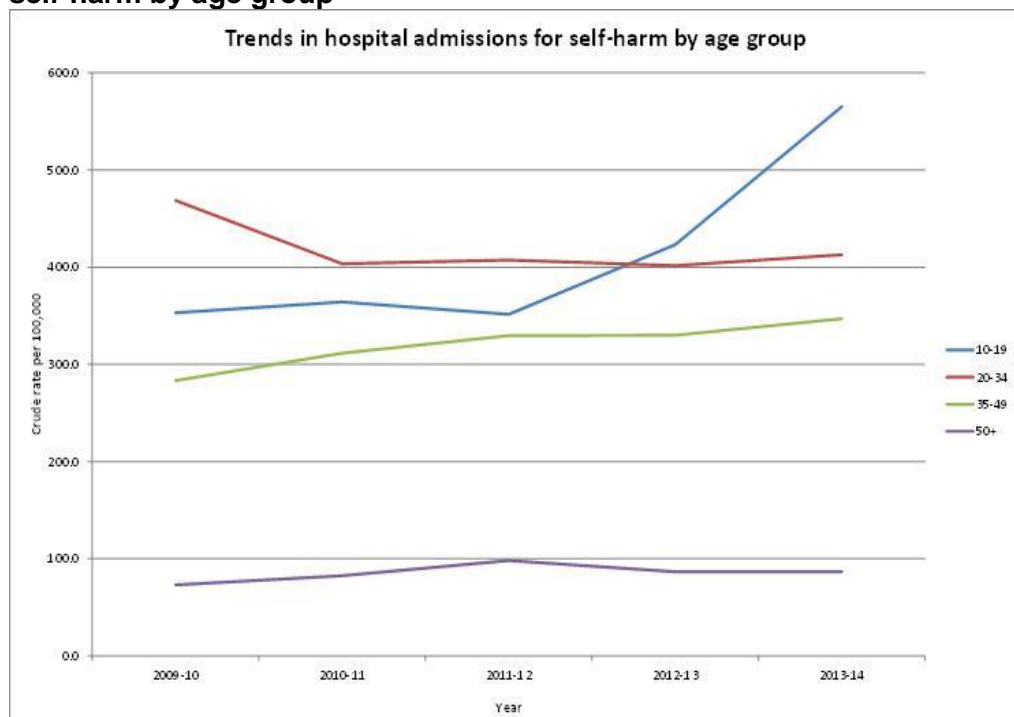
Figure 10 Trends in accident & emergency for self-harm by age group 2010 - 2014



Source: Secondary Uses Service, Commissioning Dataset, Accident and Emergency Table

- 6.16 While there have been relatively stable rates of hospital admissions for those in age groups 20+, there has been an increase in the rates of young people aged 10-19 years being admitted since 2011.

Figure 11 Trends in crude rates of emergency hospital admissions for self-harm by age group



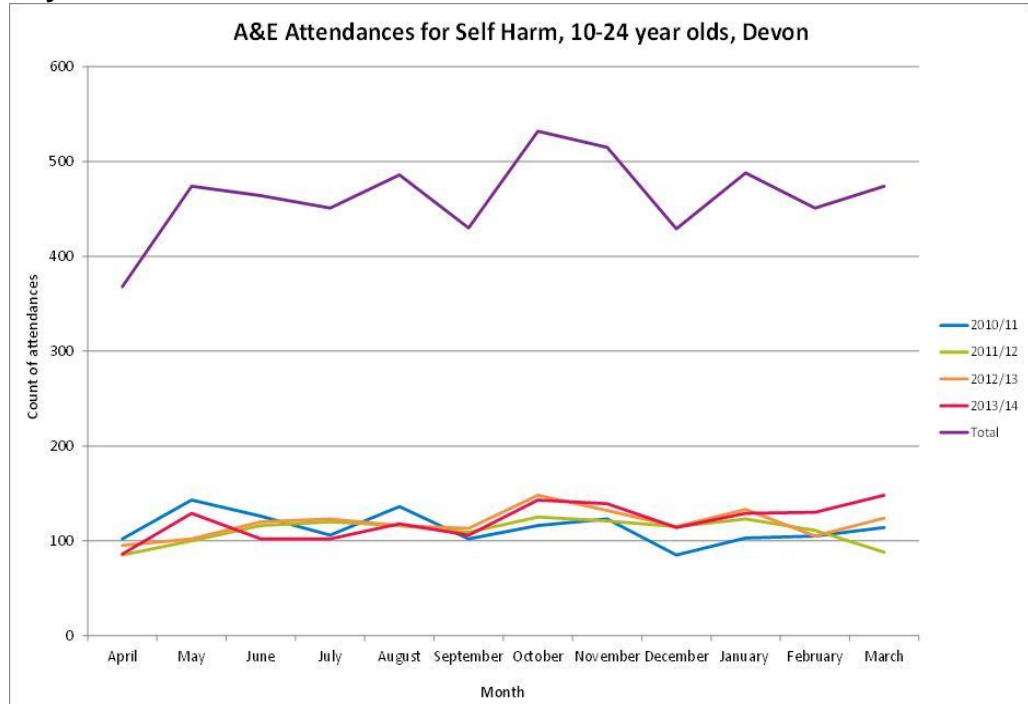
Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

When are people admitted?

Month of year

- 6.17 Data for hospital attendances in Devon for those aged 10-24 years over a four year period do not appear show peaks that could be associated with exam-time pressures as others have shown (Cadogen, 2015). What is observed are a series of smaller rises throughout the year with a clearer peak in the winter months over October and November.

Figure 12 Accident and Emergency attendances for self-harm by month of year

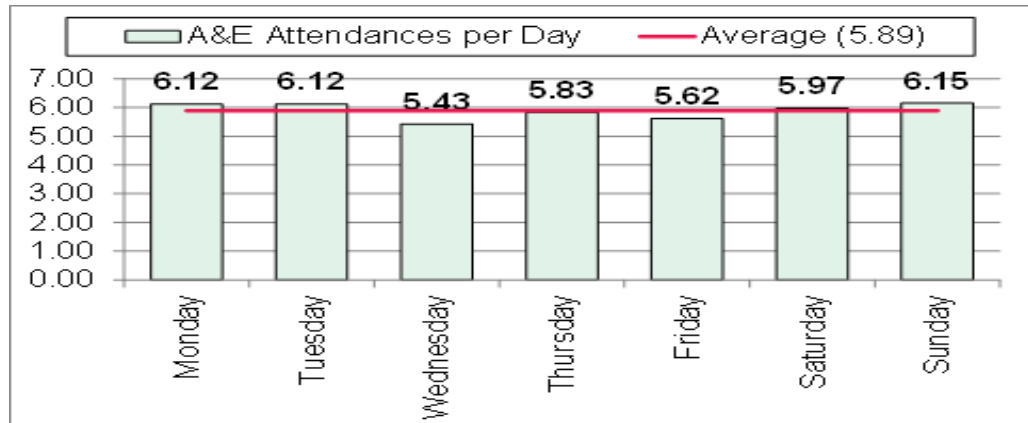


Source: Secondary Uses Service, Commissioning Dataset, Accident and Emergency Table

Day of week

- 6.18 In line with some other studies, data for hospital attendances in Devon are slightly higher on Sundays, Mondays and Tuesdays.

Figure 13 Hospital attendances all ages, by day of the week, Devon 2011-12 to 2013-14

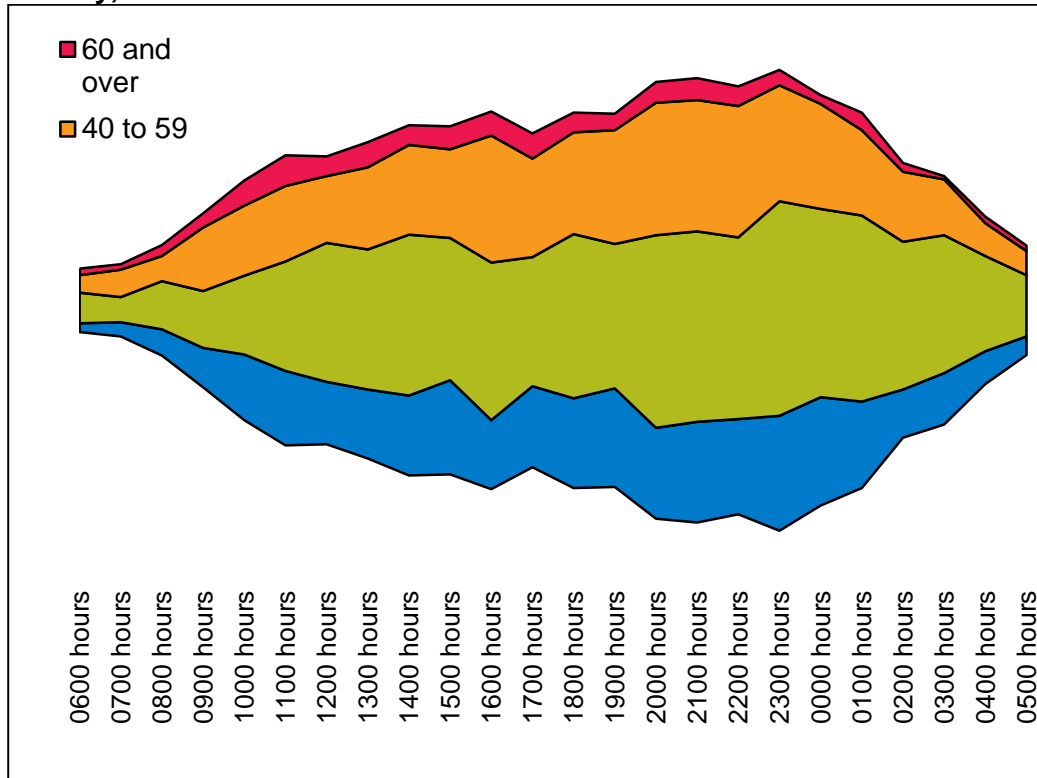


Source: Secondary Uses Service, Commissioning Dataset, Accident and Emergency Table

Time of day

- 6.19 Figure 14 shows the pattern of accident and emergency attendances in Devon by time of day over three years 2011-12 to 2013-14. These data highlight that attendance rates for self-harm rise throughout the day and peak between 11pm and 1am.

Figure 14 Accident and Emergency Attendances for self-harm by hour of the day, 2011-12 to 2013-14



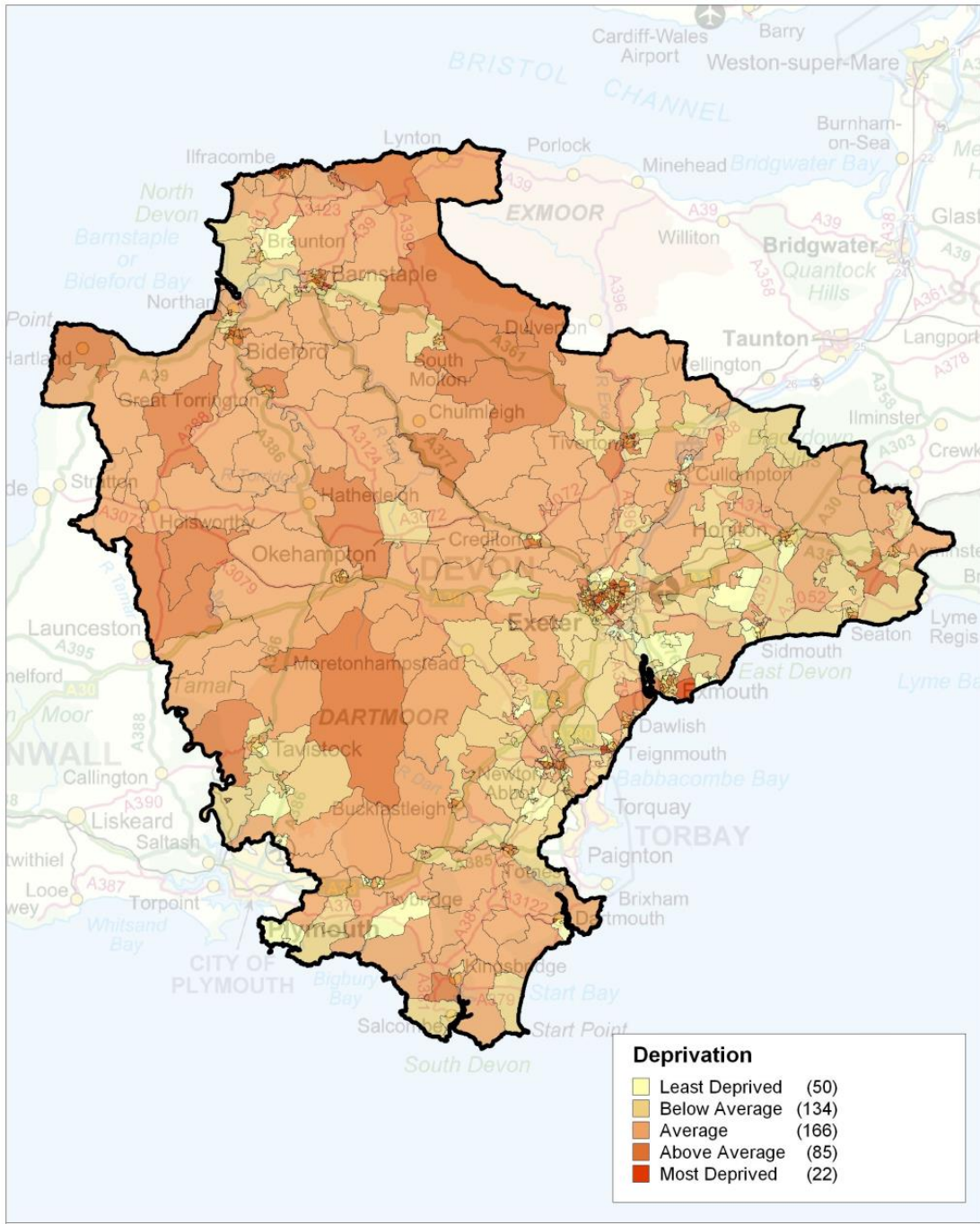
Source: Secondary Uses Service, Commissioning Dataset, Accident and Emergency Table

Deprivation

- 6.20 National survey data from the Adult Psychiatric Morbidity Survey (HSCIC, 2009) which collected data on mental health among adults aged 16-74 years demonstrated a strong relationship between deprivation and self-reported self-harm with 9.0% men and 8.2% women in lowest equivalised household income quintile compared with the highest (2.8% men and 3.3% women).
- 6.21 An updated version of the Index of Multiple Deprivation for 2010 was published in March 2011. Figure 15 shows Index of Multiple Deprivation 2010 figures by Lower Super Output Area (small areas of similar size created by the Office for National Statistics). This suggests that just below 5% of the Devon population live in the most deprived national quintile (one-fifth). These areas include parts of Exeter, Ilfracombe, Barnstaple, Bideford, Dawlish, Dartmouth, Teignmouth, Newton Abbot and Tiverton. Just over 10% of the Devon population were in the least deprived quintile.
- 6.22 While overall levels of deprivation across Devon are lower than the national average, there are issues in relation to rural and urban deprivation which seem to affect Devon differently than is experienced elsewhere. Within Devon rural areas are generally more deprived than rural areas elsewhere in England, whilst urban areas are generally less deprived than urban areas nationally. Whilst urban areas are usually more deprived than rural areas, the

rural areas surrounding a number of towns in Devon are more deprived than the town itself, including Crediton, Great Torrington, Holsworthy, Honiton, Okehampton, South Molton and Tavistock.

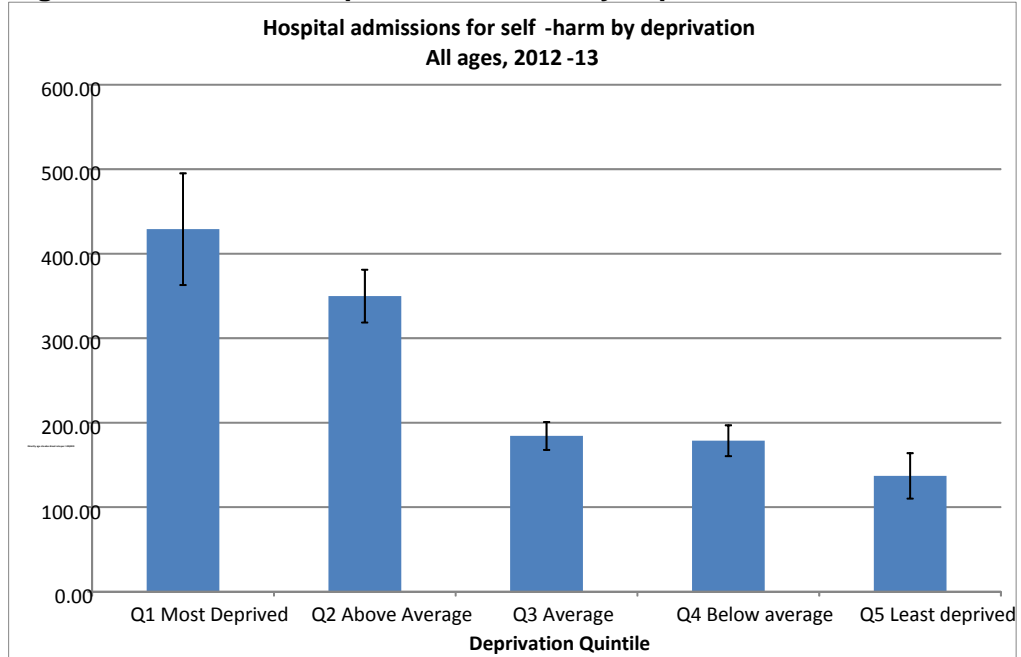
Figure 15 Map of Devon showing Lower Super Output Areas according to Index of Multiple Deprivation, 2010



Source: Public Health Mortality Files, Office for National Statistics, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

6.23 In Devon, hospital admission data for 2012-13 demonstrates a similar pattern as shown in the chart below figure 16, with admission rates in the most deprived quintile approximately three times higher than those from the least deprived quintile.

Figure 16 Self-harm hospital admissions by deprivation, Devon, 2012-13

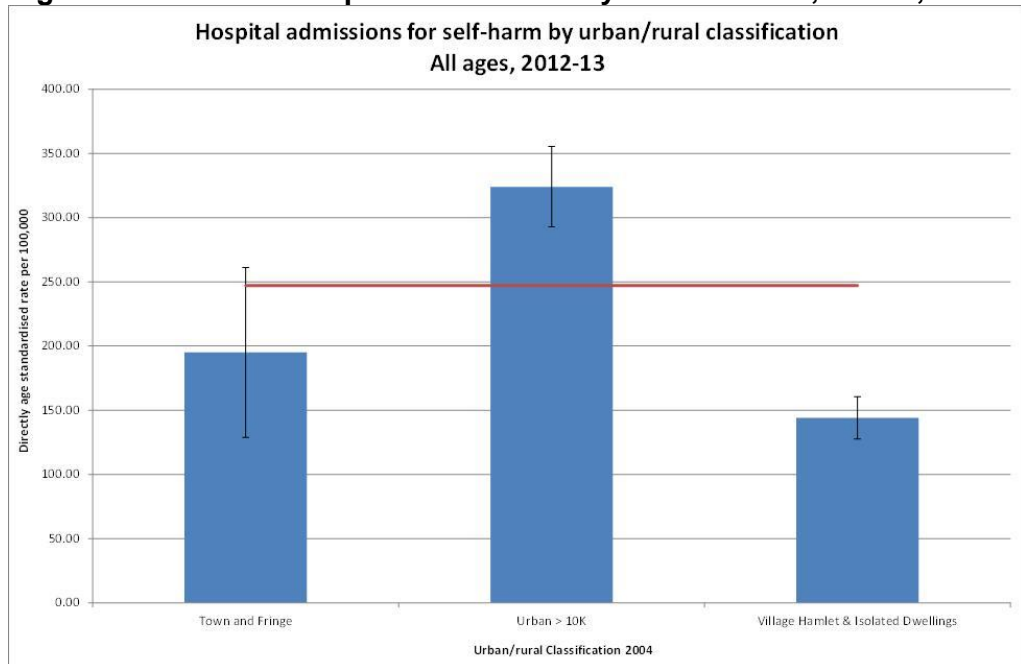


Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Rurality

6.24 Consistent with the literature, urban rates of hospital admissions due to self-harm are higher than the county average and substantially higher than rates recorded for people from both town and fringe and village and hamlets in Devon.

Figure 17 Self-harm hospital admissions by classification, Devon, 2012-13

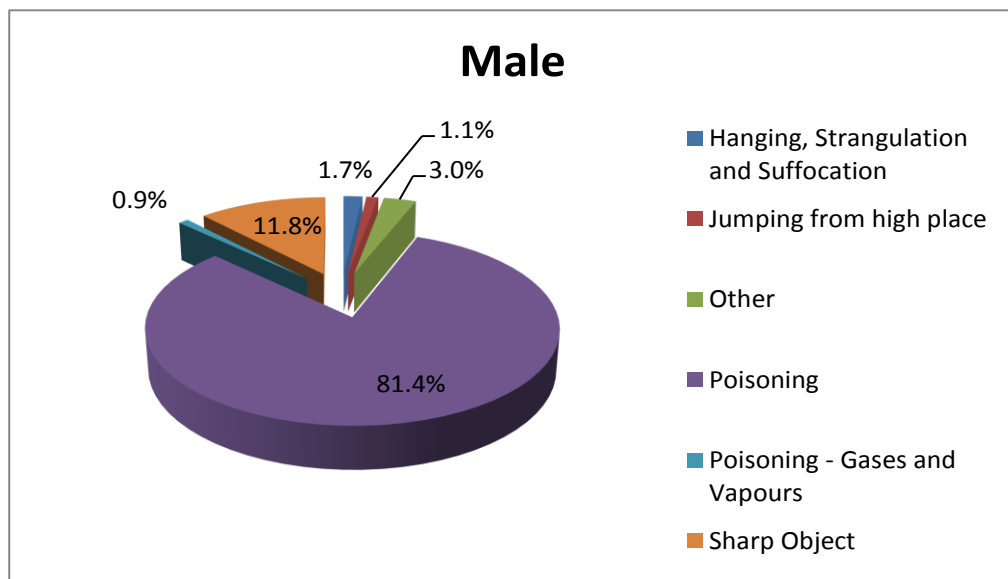
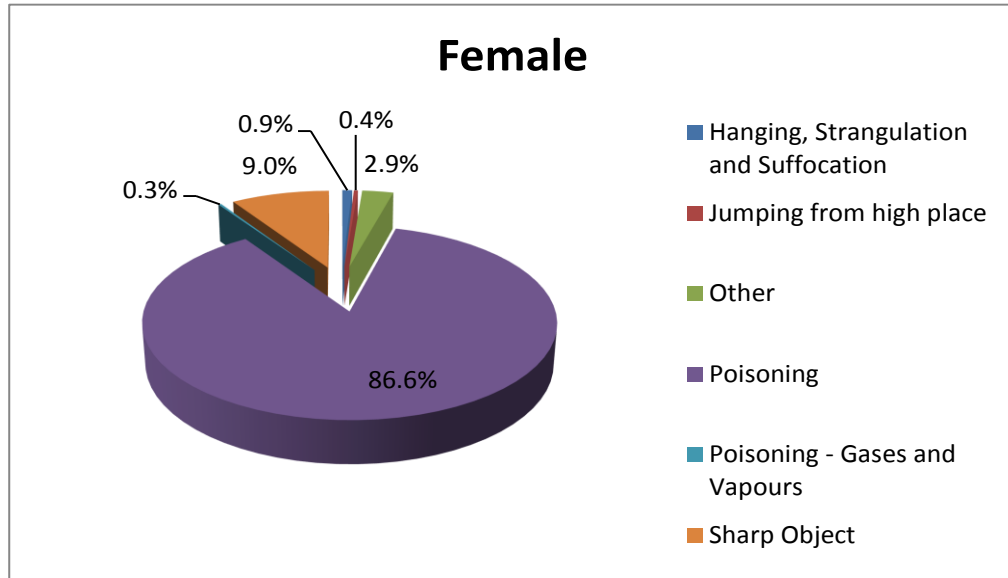


Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Method of Self-Harm

6.25 Devon hospital admissions data show that in 2012-13 both males and females utilised methods in similar proportions, with only minor differences shown in the two pie charts below.

Figures 18 & 19 Self-harm admissions by method and sex, Devon 2013-2014



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

6.26 Hospital admissions data from 2012-13 demonstrate that the use of sharp object as a method is indicated in a higher proportion of the youngest age group 0-19 years at 13.1% and reduces with each age group, with 4.1% of those in the 50+ age group admitted with self-harm by this method. Conversely, the proportion of people admitted for self-harm by self-poisoning is marginally lower at 81% and 82% of people in the youngest two age groups, to 88% and 90% in the older two age groups.

Table 1 Self-harm admissions by age and method, Devon, 2013-14

Method	0-19	20-34	35-49	50+
Hanging, Strangulation and Suffocation	7	6	*	5
Jumping from high place	*	*	*	*
Other	16	21	8	6
Poisoning	382	412	430	262
Poisoning - Gases and Vapours	*	*	*	*
Sharp Object	62	59	43	12
Grand Total	471	503	488	292

*Counts of less than five are suppressed to avoid identification

Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Location

- 6.27 Of those admitted to hospital, the majority of patients state the location where the self-harm took place was home, with a large number unspecified on the medical record. A much smaller proportion is recorded as taking place in a school or other public/residential institution. ta

Table 2 Self-Harm Admissions by Location, Devon, 2013-14

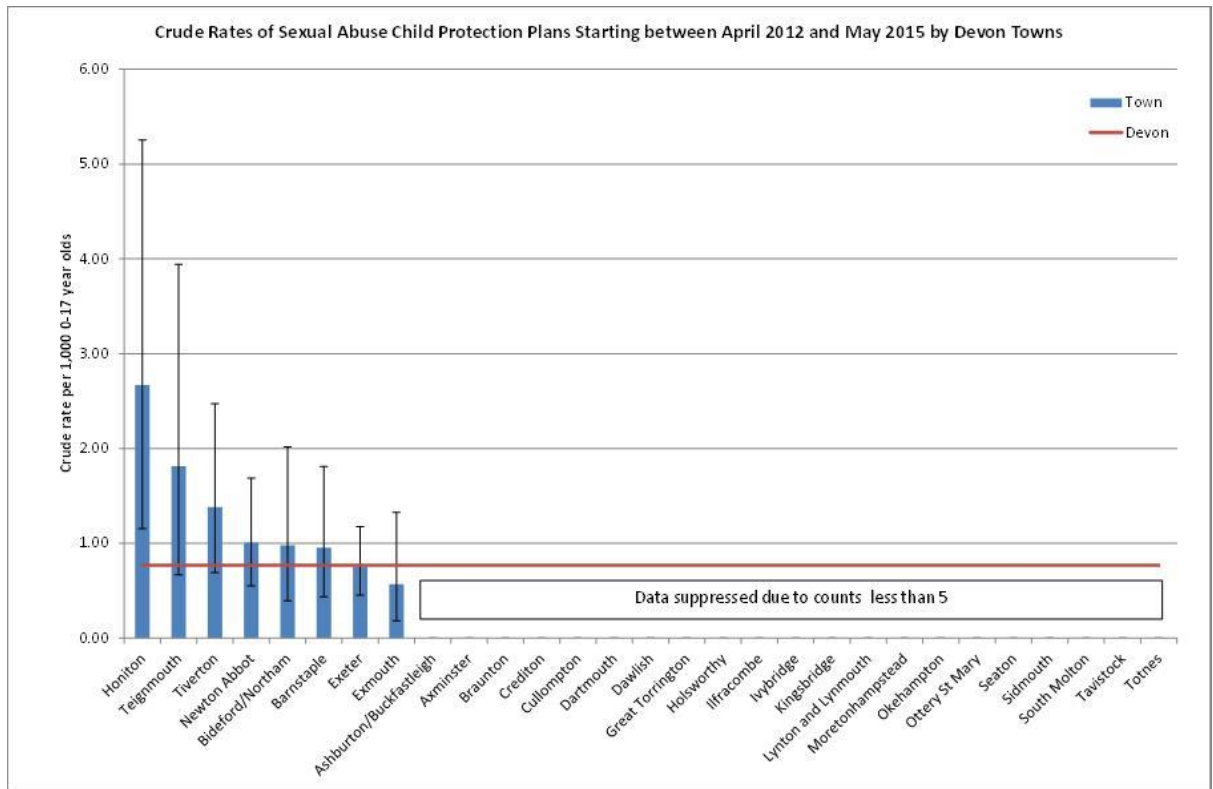
Location	Total
Home	932
School/Public Institution	69
Residential Institution	39
Street and Highway	16
Trade/Service Area	12
Other	59
Unspecified	627
Grand Total	1754

Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Sexual, physical and domestic abuse

- 6.28 In Devon higher rates of domestic abuse incidents were recorded in urban areas compared to rural areas, particularly within areas with higher deprivation in Exeter, Exmouth, Barnstaple, Ilfracome, Okehampton, Newton Abbot and Teignmouth. (Devon & Cornwall Police's Universal Data Set 2012-15)
- 6.29 This pattern is mirrored when police data recording sexual violence is analysed (Devon & Cornwall Police's Universal Data Set, 2011-14), with significantly higher rates recorded in Exeter city centre, and higher than average rates recorded in urban areas with higher deprivation in Exeter, Exmouth, Barnstaple, Ilfracome, Okehampton, Newton Abbot, Teignmouth but additionally Bideford west, Totnes and some rural areas such as Dawlish Rural, Kingsbridge, Braunton rural and Tavistock rural east.
- 6.30 When examining data on Child Protection Plans with sexual abuse as the primary reason, a number of the areas noted for higher deprivation and higher rates of domestic abuse and sexual violence feature prominently at or above the Devon average. However Honiton town stands out as an area that did not demonstrate higher rates in these domains.

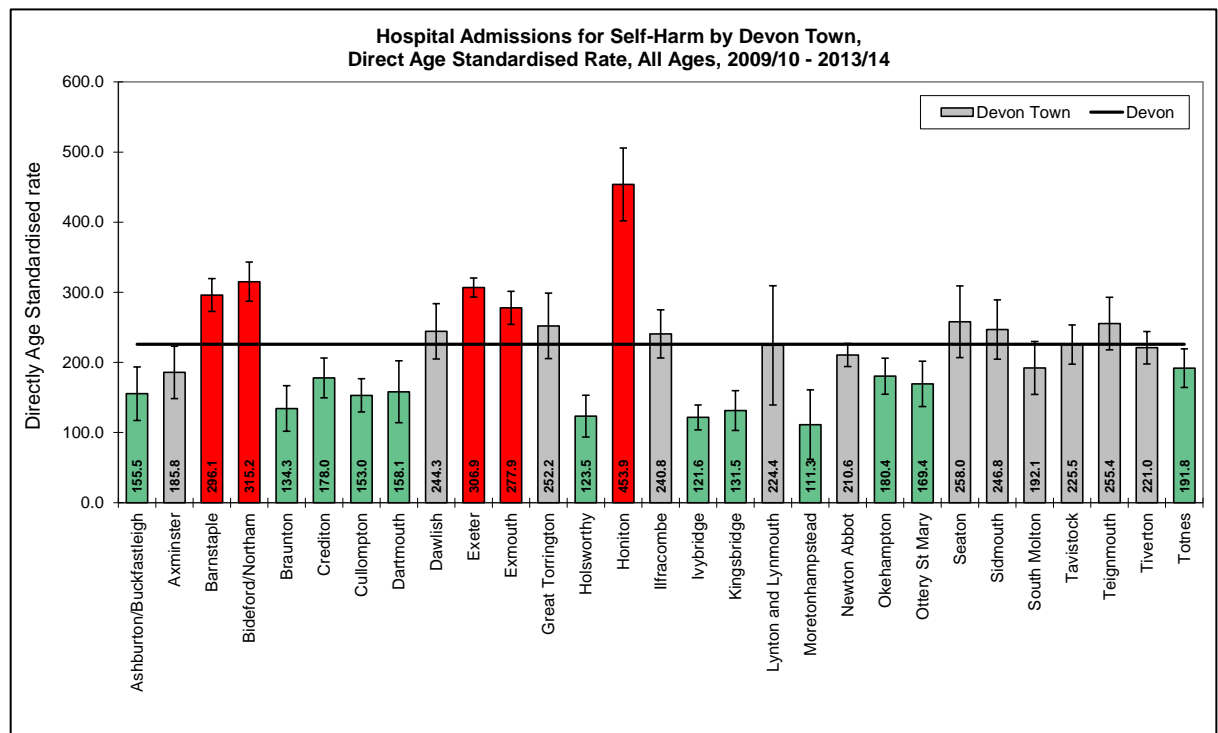
Figure 20 Rates of sexual abuse child protection plans by Devon towns



Source: Devon County Council Social Services

6.31 When considering admission rates for self-harm by town over a five year period between 2009-10 and 2013-14, Honiton is prominent whether looking at directly age standardised rates for all ages (figure 21) or just focussing on young people aged 0-19 years (figure 22)

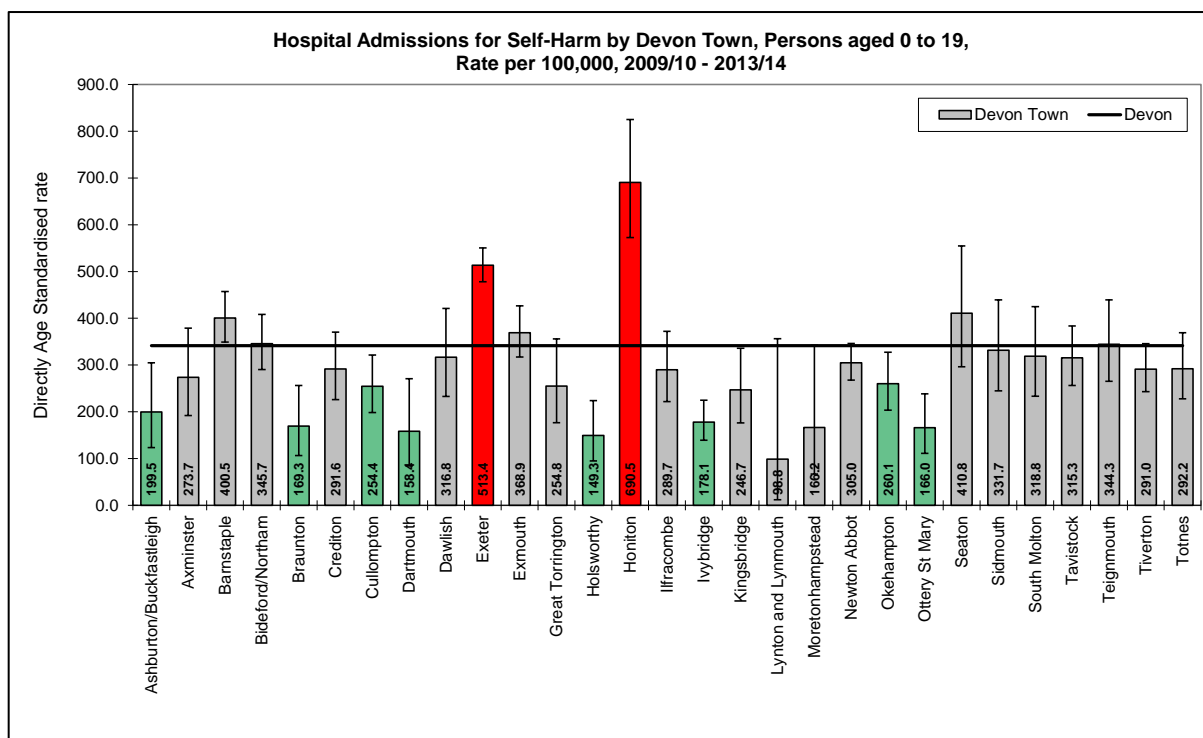
Figure 21 Hospital admissions for self-harm by Devon town, all ages



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

6.32 Other areas which stand out, in line with data on domestic abuse, sexual violence and deprivation when looking at all ages are Exeter, Barnstaple, Bideford and Exmouth. When looking at 0-19 years data, only Exeter and Honiton demonstrate age standardised rates significantly higher than the Devon average.

Figure 22 Hospital admissions for self-harm by Devon town, ages 0-19



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

Sexuality

6.33 In the Devon LGBT Health Needs Assessment 2014, the Integrated Household Survey 2011-12 findings were applied as a crude estimate for the Devon population. This equates to a total gay, lesbian or bisexual population of 14,281 in Devon. Estimates for the proportion of transsexuals vary widely. Using the rate suggested by the Gender Identity Research and Education Society (Reed, 2009) 20 per 100,000 population aged 16 are likely to present for treatment with gender dysphoria in the UK, equating to 127 people in Devon.

Children looked after by local authorities and care leavers

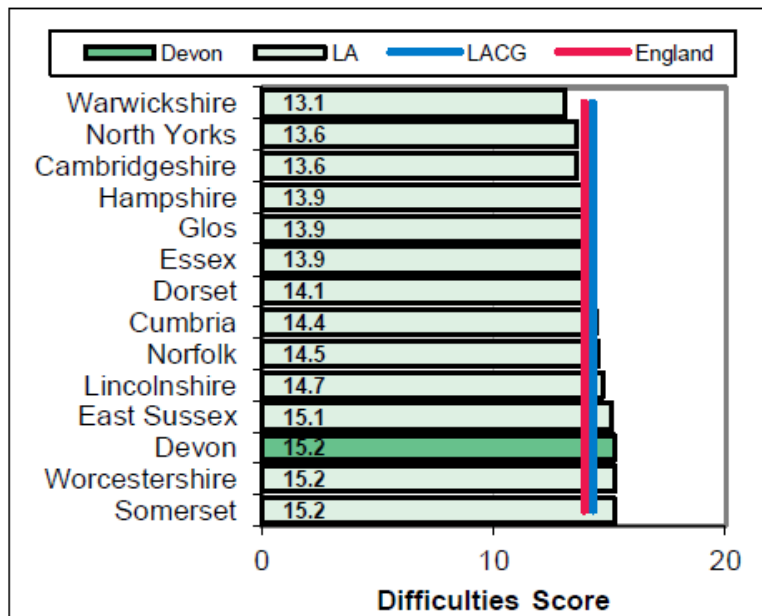
6.34 There are nearly 600 Children in Care in Devon. The proportion of children in foster homes is around 76%, with 5% of Children in Care adopted each year. Children in Devon enter into care at an older age than average, and of these, there is a higher proportion than average of children with statements of special educational need.

6.35 Figure 23 describes the difficulties score which is monitored nationally through the Public Health Outcomes Framework as an indicator of the emotional wellbeing of Looked After children. The difficulties score is collected through a strengths and difficulties questionnaire, with higher scores highlighting greater difficulties. The average difficulty score in Devon was 15.2 which is higher than the South West (14.8), local authority comparator group (14.3) and England (13.8) averages. The average score has decreased since

2011-12 and the gap compared with the regional and national averages has lowered.

- 6.36 Nationally the difficulties score tends to increase with age, with teenagers having higher difficulties scores. The older age profile of children in care in Devon may well influence the higher average scores observed.

Figure 23 Emotional Wellbeing of Looked After Children, 2013-14 Local Authority Comparator Group

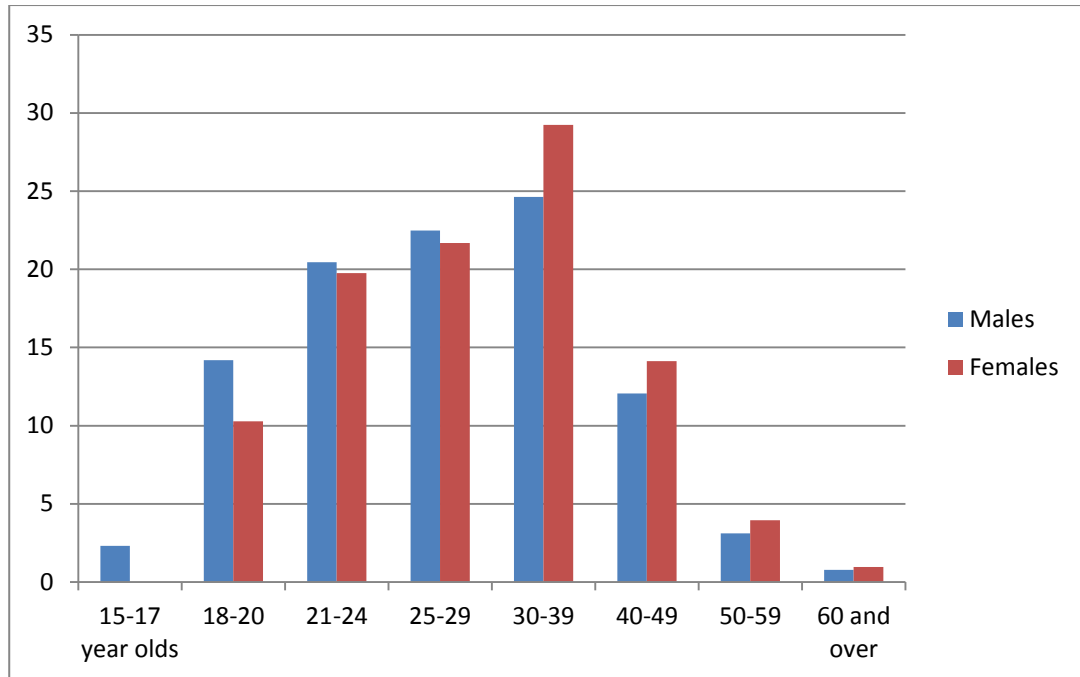


Source: Public Health Devon Outcomes Report March 2015 Devon County Council

Prisoners

- 6.37 Data from the Ministry of Justice (2015) show that nationally, self-harm episodes by female prisoners have decreased from what were very high levels (1736 per 1000 prisoners in 2014 compared with 2991 per 1000 individuals in 2005). This may be related to diversion of individuals who are high repeaters of self-harm to other settings (CMO report, 2013). However, episodes of self-harm in male prisoners nationally have increased (233 per 1000 prisoners in 2014 compared with 146 per 1000 prisoners in 2005).
- 6.38 The average number of self-harm incidents recorded per individual appears to be reducing in women, from a peak of 9.4 in 2010 to 6.1 in 2014. This number has remained fairly level for men demonstrating a small increase from 2.5 in 2004 to 2.9 in 2014.
- 6.39 Nationally, self-harm incidence in prisons is predominantly observed in white populations, with 86% of incidents recorded in white prisoners in 2014.
- 6.40 The age distribution of self-harm incidents in prisons demonstrates a different pattern to the rates recorded in the community. This may be due to a combination of factors, including the environment, levels of mental ill-health and stress, the fact that a higher proportion of incidents can be recorded in prisons compared with limited reporting in the community.
- 6.41 Age profiles demonstrate a broader distribution for both males and females, the highest with a peak for both males and females between 30-39 years.

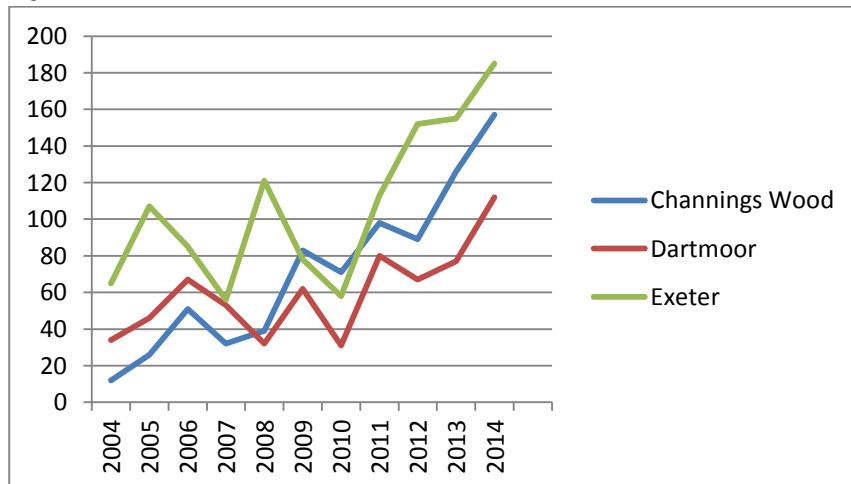
Figure 24 Proportion of individuals who self-harm in UK and Wales prisons by age group in 2014 Source: Safety in Custody Statistics: Self-harm annual tables, 2004 –14



Source: Ministry of Justice (2015)

- 6.42 Method of self-harm varies slightly between men and women. For both sexes, the most frequently recorded method is cutting or scratching, but for women self-strangulation appears to be a more frequently used method when compared to men.
- 6.43 In 2014, only 7% of nationally recorded self-harm incidents resulted in hospital attendance.
- 6.44 Local data from the three prisons in Devon, (figure 25), all of which accommodate male prisoners, show that the annual recorded number of incidents has risen over the ten year recording period in each institution, with a steeper increase observed since 2010.

Figure 25 Self-harm incidents recorded in Devon Prisons 2004-2014. Source: Safety in Custody Statistics: Self-harm annual tables, 2004 - 2014



Source: Ministry of Justice (2015)

6.45 This is in line with the long term national trend of the number of self-harm incidents amongst male prisoners increasing. The number of incidents is affected by changes in the size of the prison population. Nationally prison populations have increased by 41,800 prisoners in the England and Wales prison population between 1993 and 2012 (Ministry of Justice, 2015)

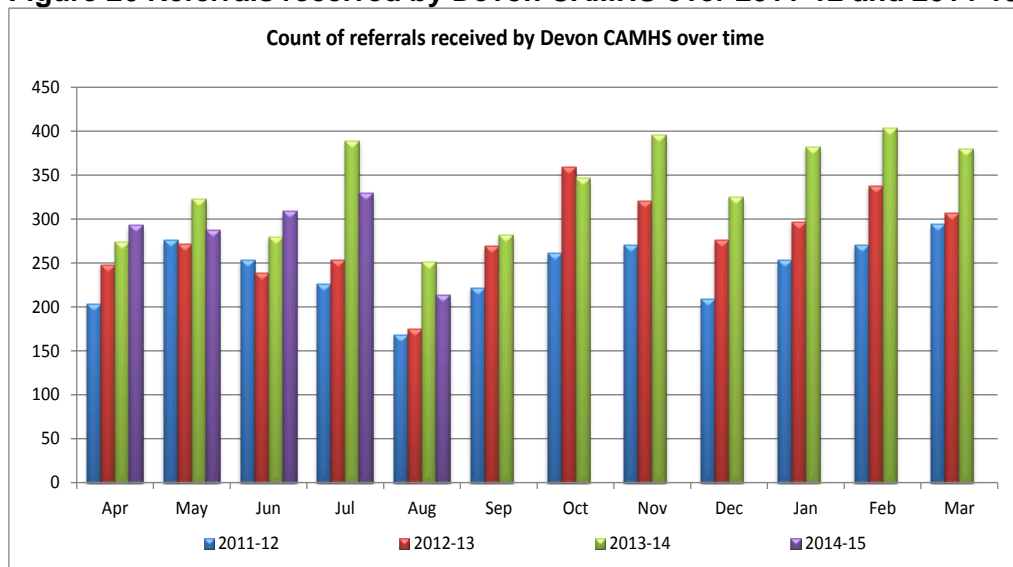
6.46 The rate per 1,000 prisoners accounts for changes in the prison population. The Devon data reflect the national trend in that both the rate and number of incidents has risen steadily over the last 10 years.

Mental Health service users

Child and Adolescent Mental Health Services (CAMHS)

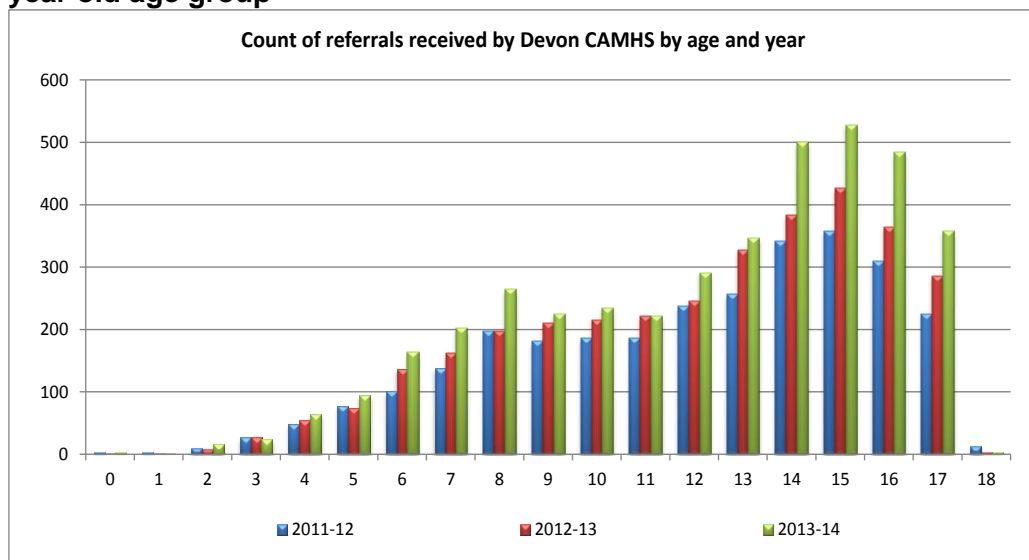
6.47 The number of referrals to Devon CAMHS has increased by more than a third between 2011-12 and 2013-14, around 38.7%:

Figure 26 Referrals received by Devon CAMHS over 2011-12 and 2014-15



Source: Virgin Care Ltd Report to the Integrated Performance and Assurance Meeting, June 2014.

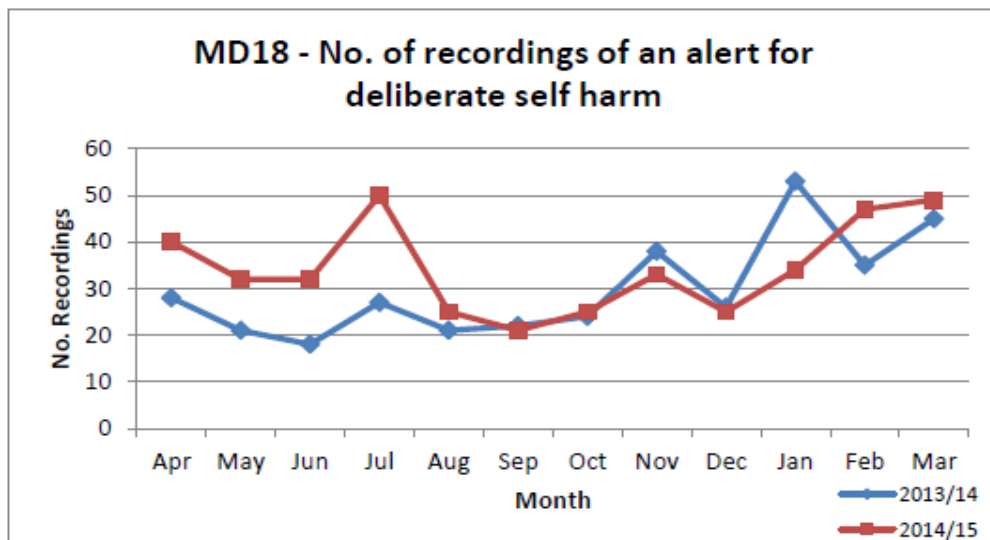
Figure 27 The largest increase in referrals has been through the 14 to 16 year old age group



Source: Virgin Care Ltd Report to the Integrated Performance and Assurance Meeting, June 2014.

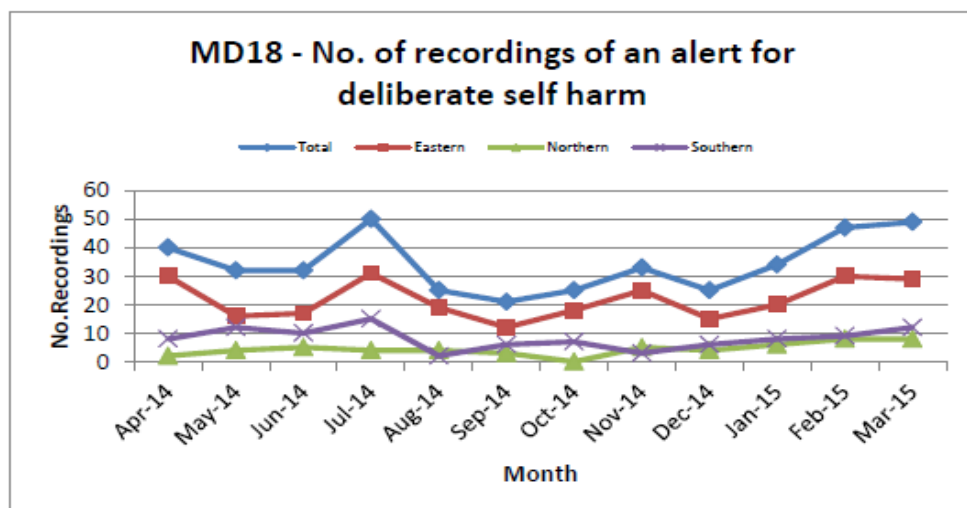
- 6.48 Virgin Care Ltd highlighted an overall increase in CAMHS referrals in their *Report to the Integrated Performance and Assurance Meeting*, June 2014. At that point the authors recognised that the reasons for the increase were complex and likely to be due to several factors including two national trends; firstly, that young people were generally feeling more under pressure (Young Minds 2013) and, secondly, that there were “unprecedented increases in deliberate self-harm”.
- 6.49 Activity in CAMHS is monitored against an agreed contract on a monthly basis and the following information has been taken from the performance reporting process. The graphs (figures 28 and 29) below show the number of self-harm alerts recorded across the Devon CAMHS service, over a two year period, by month and over a one year period by locality. These data include recordings from Core CAMHS, Service Around the Child (SAC) and the Joint Agency Child Abuse Team (JACAT). Peaks in alerts are observed in July, January and February.

Figure 28 Number of recordings of an alert for deliberate self-harm, by year, Devon, 2013-15



Source: Virgin Care Ltd Performance Report

Figure 29 Number of recordings of an alert for deliberate self-harm, by Clinical Commissioning Group locality, by month, Devon, 2014-15

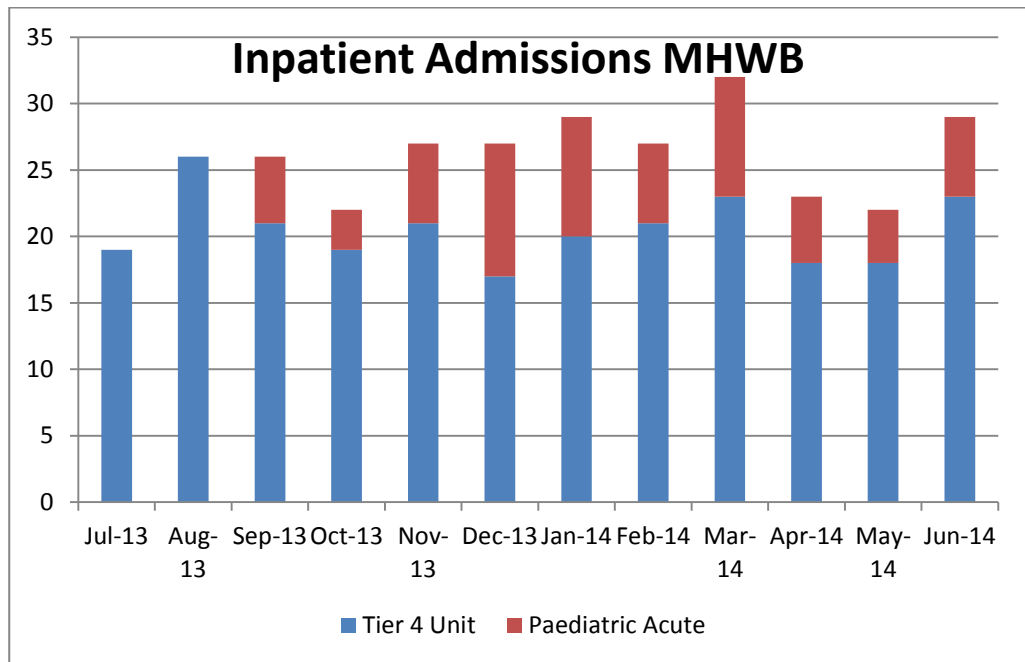


Source: Virgin Care Ltd Performance Report

Inpatient Admissions for Child and Adolescent Mental Health and Wellbeing

6.50 Figure 30 demonstrates the increased use of paediatric acute hospital beds for inpatient admissions in Devon over 12 months between July 2013 - June 2014.

Figure 30 Child and Adolescent Mental Health Inpatient Admissions July 2013 - June 2014



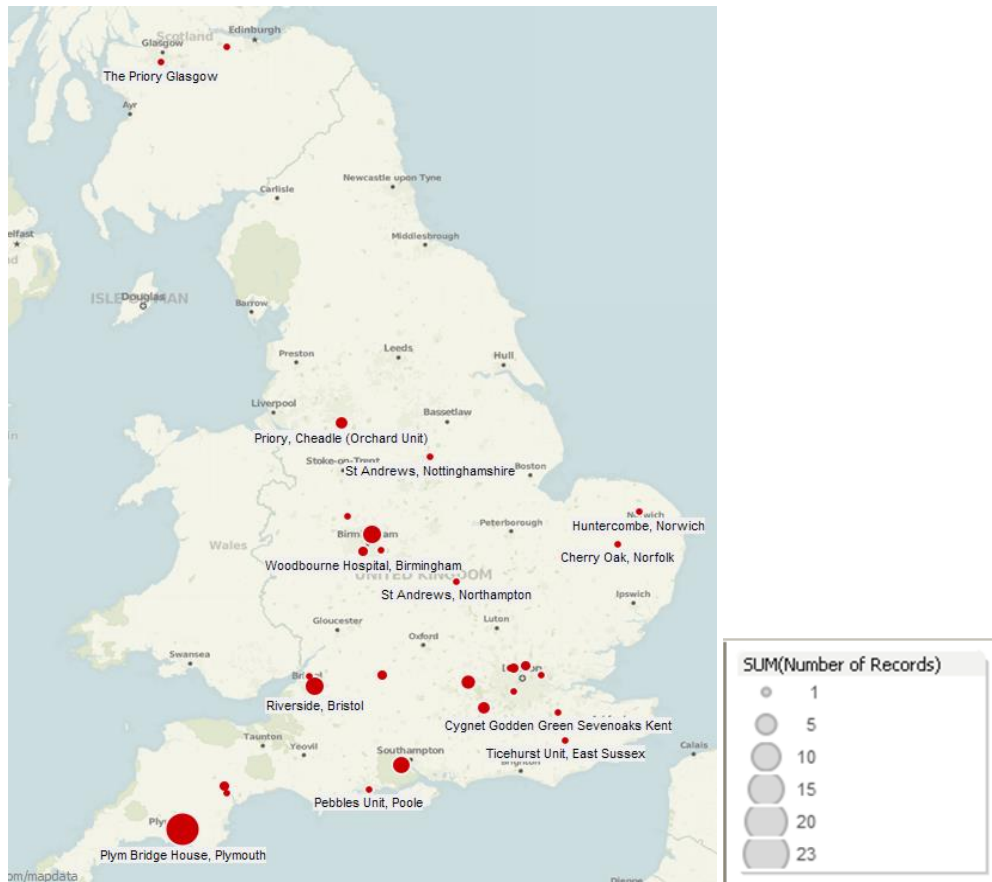
Source: Virgin Care Ltd Report to the Integrated Performance & Assurance Meeting June 14

The geographical spread of tier 4 placements

6.51 Children and young people have been placed across a wide geographical area, for tier 4 in-patient support including some children being placed in Scotland.

6.52 The geographical dispersion of tier 4 placements is shown below.

Figure 31 The geographical spread of tier 4 child and adolescent placements



Source: Virgin care Ltd Report to the Integrated Performance & Assurance Meeting, June 14

Adult Mental Health Services

6.53 Looking at service use data from Devon Partnership Trust for adults 18+ between August 2012 and May 2015, a total of 683 individuals were recorded as having self-harmed. Unlike estimates of prevalence within the community, the gender split is more balanced with similar proportions of men and women recorded (54.5% women, 45.2% men). The age profile of the patients demonstrate a similar proportion of people in each age grouping between 18 and 45 after which proportions reduce and a much lower proportion of 55+ are recorded. This may reflect both the lower known proportions in the community and also a lower number of patients in the older age groups on the Devon Partnership Trust caseload.

Table 3 Devon Partnership Trust Self-harm referrals by gender and locality 08/12 - 05/15

Gender	Unknown	Mid Devon	SH&WD	WEB	Wakley	Exeter	Newton Abbot	North Devon	Moor To Sea	Total	Percentage of Total
F	50	39	19	20	27	100	8	101	10	374	54.8%
M	45	31	9	15	20	82	12	83	12	309	45.2%
Total	95	70	28	35	47	182	20	184	22	683	100.0%

Source: Devon Partnership Trust

**Table 4 Devon Partnership Trust Self-harm referrals by age and locality
08/12 - 05/15**

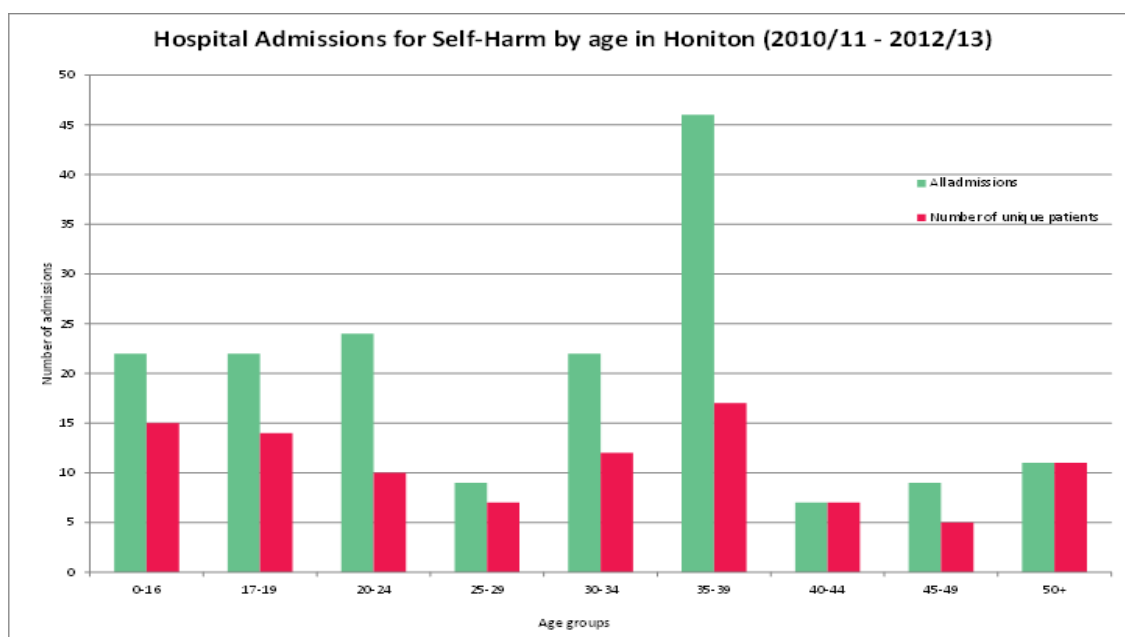
Age Group	Unknown	Mid Devon	SH&WD	WEB	Wakley	Exeter	Newton Abbot	North Devon	Moor To Sea	Total	Percentage of Total
Under 18	0	0	0	0	0	0	1	0	0	1	0.1%
18-24	24	14	4	5	6	38	7	40	0	138	20.2%
25-34	28	11	7	7	5	55	4	29	4	150	22.0%
35-44	18	14	2	9	14	36	4	51	1	149	21.8%
45-54	12	19	5	6	10	31	2	30	3	118	17.3%
55-64	7	6	7	2	3	10	0	15	3	53	7.8%
65-74	4	4	0	2	6	5	0	11	8	40	5.9%
75+	2	2	3	4	3	7	2	8	3	34	5.0%
Total	95	70	28	35	47	182	20	184	22	683	100.0%

Source: Devon Partnership Trust

Repeated self-harm

- 6.54 Analysis of 2011-12 national Hospital Episode Statistics inpatient data showed that 12.6% of people aged 15 years or older admitted for self-harm were readmitted for self-harm within 30 days, and 17.5% were admitted for self-harm within 90 days.
- 6.55 When examining the Devon data for 2013-14 (source: Secondary Uses Service, Commissioning Dataset, Inpatient Table), there were a total of 1,755 hospital admissions. The majority of people (85%) were recorded as having one admission, which accounted for 1381 admissions (79% of the total).
- 212 people had two or more admissions, accounting for 586 admissions in total (15.35% of people accounted for 33.39% of admissions).
 - 77 people had three or more admissions, accounting for 316 admissions in total (5.58% of people accounted for 18.01% of admissions).
 - 34 people had four or more admissions, accounting for 187 admissions in total (2.46% of people accounted for 10.66% of admissions).
 - 16 people had five or more admissions, accounting for 115 admissions in total (1.16% of people accounted for 6.55% of admissions).
- 6.56 Looking more closely at one town as an example, over a two year period, it is evident that for some age groups, specifically those aged 20-24 years and 30-40 years, repeat admissions for self-harm is a driving factor for incidence rates and as such is an important service planning consideration.

Figure 32 Self-harm hospital admissions in Honiton by age



Source: Secondary Uses Service, Commissioning Dataset, Inpatient Table

School Survey, Summer Term, 2014

Method

- 6.57 A school survey was conducted by Babcock International in July 2014 to inform the Devon Safeguarding Children Board Review into self-harm in September 2014. The survey was sent to all secondary schools in Devon. 27 out of 39 schools (69%) responded.

Numbers of Students self-harming

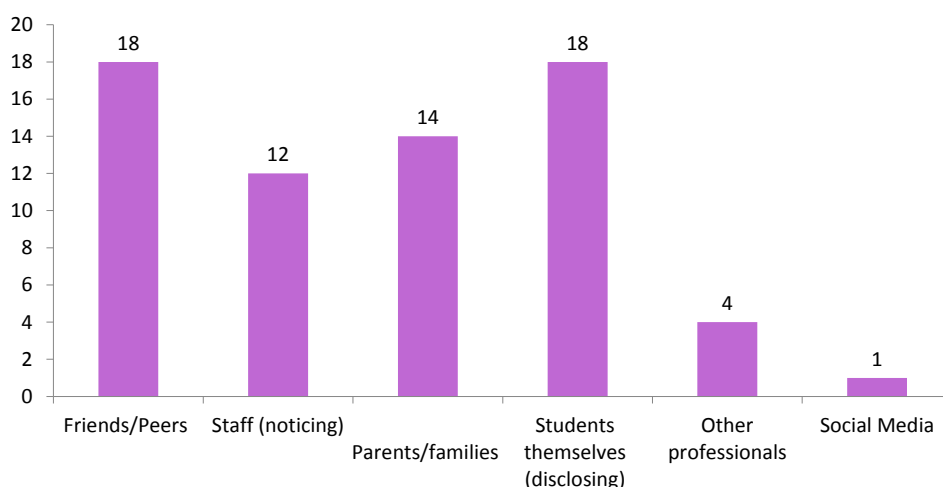
- 6.58 Responding schools were aware of 489 young people who were self-harming. Staff were aware of students from Year 7 onwards, boys and girls, although a greater proportion of those known to staff were girls. One school highlighted the difficulty in knowing numbers *“I believe there to be a far greater number of cases than actually present, based on the fact the level of secrecy associated with this type of behaviour is intense.”*

Schools becoming aware of self-harm

- 6.59 Schools were asked how they became aware of self-harm in the schools. Responses to this question are in line with responses from other surveys, including the Devon Youth Service survey conducted in Autumn 2014. Figure 33 demonstrates that peers and friends, in addition to parents and families are more likely to notice than staff. Often young people will disclose self-harm to school staff themselves.

Figure 33 Response to Survey Question 2

Q: How do you become aware that pupils are self-harming?

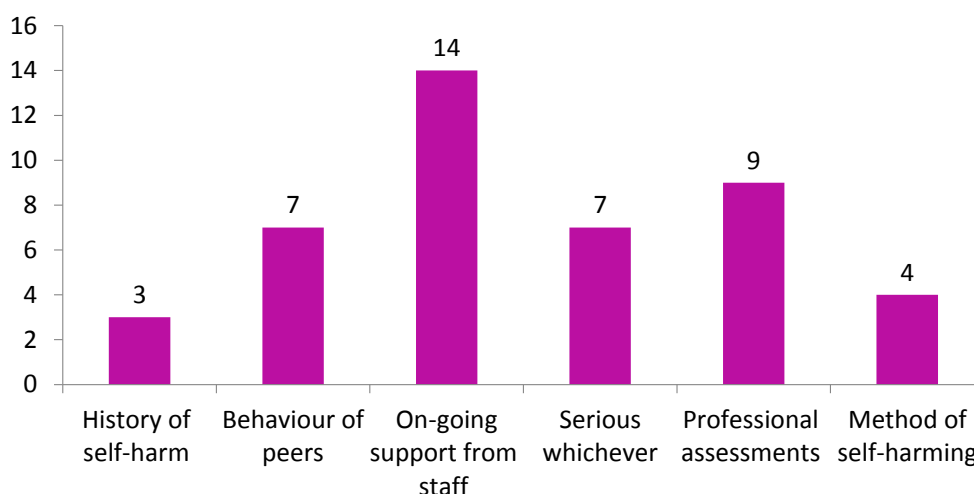


Understanding the seriousness of the situation

6.60 There is debate about whether school staff should try to differentiate between those young people who self-harm due to peer influence and those who do so due to underlying mental health concerns, which relates to how school staff may take further steps to support the young person. Figure 34 demonstrates that the majority of schools responding to this question about differentiating demonstrate that they gain understanding around the motivations for the self-harming behaviour through ongoing contact, with some professional assessments and awareness of peer behaviour.

Figure 34 Response to Survey Question 3

Q: How do you differentiate those pupils who self-harm as a result of peer influence and those who are exhibiting symptoms of an underlying serious mental health concern?

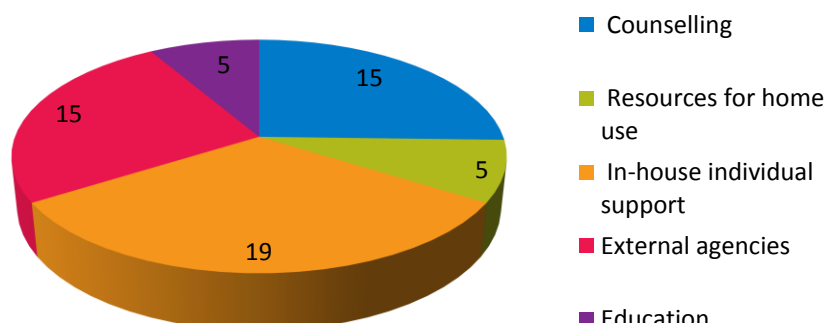


How do schools support young people who self-harm?

6.61 Support provided by schools is many and varied and can be grouped into the categories shown in figure 35. The majority of schools responding reported that they supported young people in-house individually, but with a high number involving external agencies.

Figure 35 Response to Survey Question 4.

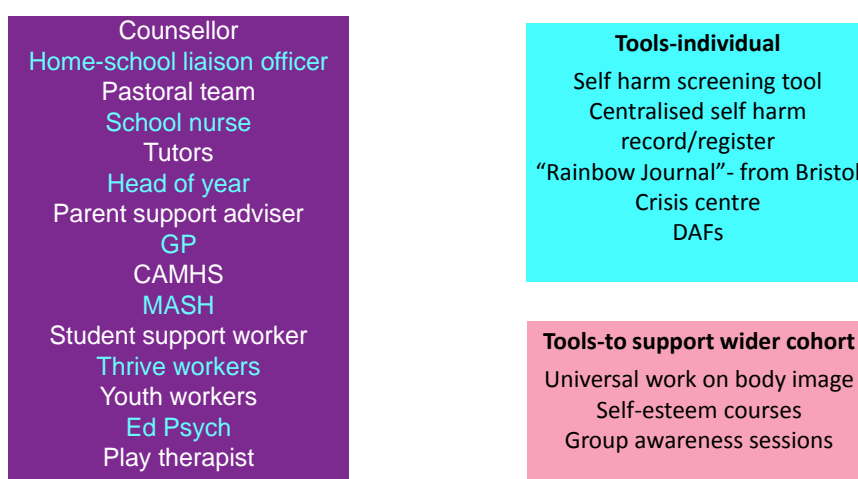
Q: What support do you provide for the pupils?



Resources used in schools to support young people who self-harm

6.62 A wide array of staff, both internal and external were identified by schools as being involved in the support of young people who self-harm. Approximately half of respondents mentioned the strong networks in place with local professionals who could support them. Packages of support were bought in by some schools and what was striking was how this differed between schools, with some being quite clear about packages of external support commissioned and how this could be linked with internal resources and others very unsure of what resources were available to them.

Figure 36 Response to question 4. What support do you provide for the pupils? Range of resources used by schools.



6.63 One school which was particularly clear about their approach commented:

"We provide school nurse, counsellor, pastoral team, referral to CAMHS, liaison with GP where GP will engage with school, liaison with parents, possible Parent Support Advisor. We follow the Devon guidelines/policy for Self Injury and use the Frazer Guidelines to decide whether we tell parents when students do not want us to. We forward information to parents regarding self-injury. We offer information via our Personal Development curriculum on Self Injury. We provide 'Rainbow Journals' to students via the Bristol Crisis Centre. Have a Risk Assessment in place

for one student who has more serious self-injury issues. Attend multi agency meetings when invited or instigate them when we feel necessary. We have provided for uniform differences so that students can cover up any scars should they wish to.”

Training and Fears around roles of school staff

6.64 The need for training was highlighted by a number of schools although there was not a direct question asking about this. Some had already accessed training through the Bristol Crisis Centre for Women and The Project in East Devon.

6.65 Concerns about how far staff in schools could be expected to go in supporting young people were raised by a few respondents, demonstrating the inherent fear that poorly judged action could cause further harm. One school voiced a concern highlighted in local forums in Autumn 2014:

“we are teachers and support staff not experts in the field of mental health – neither should we pretend that going on a day course will make us so. Trained psychologists or mental health nurses takes years to train. We are all in school very aware that this is such a specialist field and getting it wrong can be disastrous”

6.66 One school raised the issue of what level of support should be permitted in school and commented that *“We do not support the practice of ‘safe cutting’ in school”*, highlighting the potential for guidance in this area.

Royal Devon and Exeter Foundation Trust Paediatric Unit 3 Month Audit (June-Aug 2014)

6.67 The Royal Devon and Exeter Foundation Trust Paediatric Unit undertook a three-month internal audit between June and August 2014, led by Consultant Paediatrician Dr Karen Street. The following results were shared at the Devon Safeguarding Board Review (December 2014) and the NEW Devon CCG Clinical Summit (January, 2015)

Description of patients

6.68 There were 44 patients in total, 5 male and 39 female. Of these 21 (48 %) were aged 16-18 years and 23 (52 %) were aged <16 years.

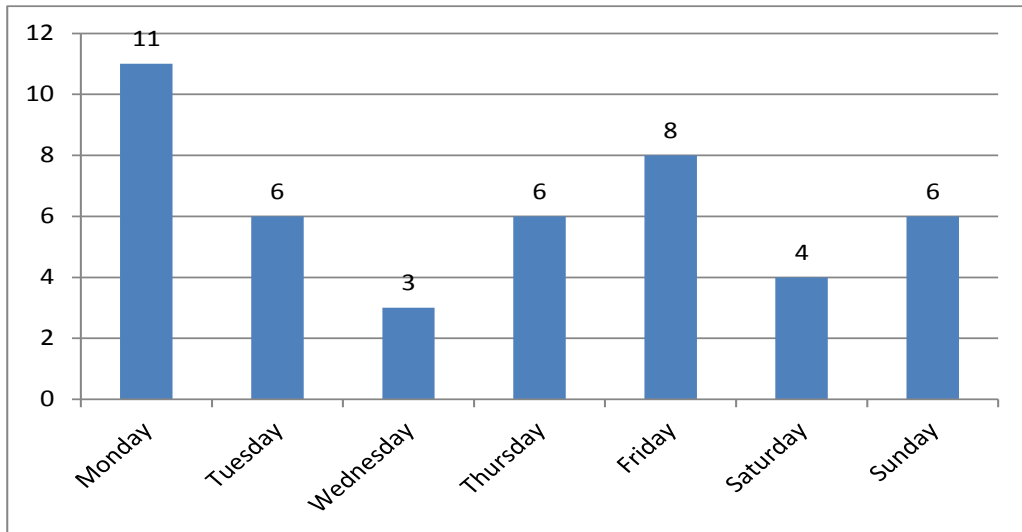
Presentation frequency

6.69 In this time period, 3 patients presented twice and 1 patient presented four times. A small proportion of patients required medical treatment; 5 (24 %) aged <16yrs and 7 (30%) of those aged 16-18 years . None of the patients required medical treatment after 24 hours in the paediatric unit.

Day and time of admission

6.70 In line with county data, admissions to the paediatric unit peaked on Mondays following the weekend. Figure 37 shows the distribution across the week.

Figure 37 Admissions to RDEFT paediatric unit by day of week, June-August 2014



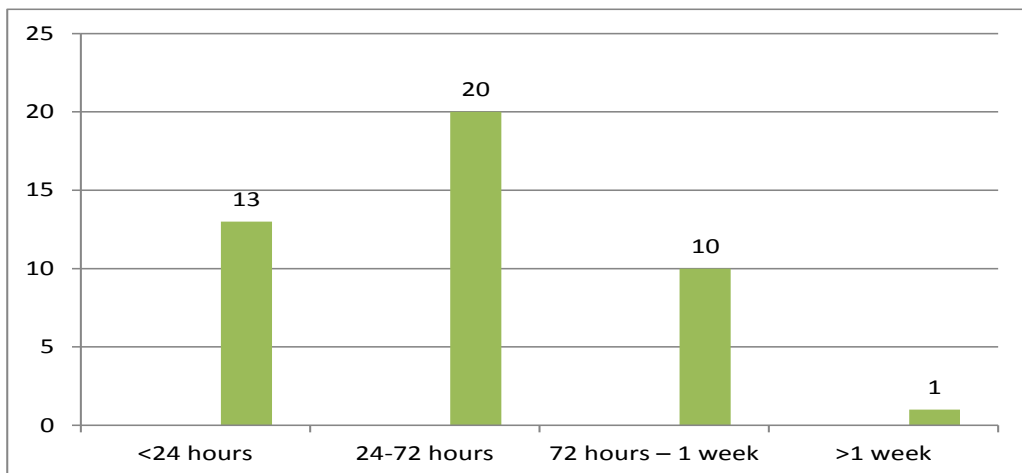
Source: Dr Karen Street, RDEFT

6.71 The majority of admissions were in the early hours, between 10pm and 9am, 19 (43 %) young people were admitted, with a lower proportion admitted in daytime hours 9am and 5pm, 13 (30 %) and early/late evening 5pm-10pm, 12 (27%) .

Length of stay

6.72 Over three months, patients who self-harmed were in the paediatric unit for a total of 115 bed days. Extrapolated to a year, this would represent 460 bed days per year. Figure 38 shows that in a three month period, twenty patients were on the ward for 24-72 hours many of these were awaiting assessments from CAMHS. Of the eleven patients on the ward for longer than 72 hours, many were waiting for a social care placement.

Figure 38 Length of Stay



Source: Dr Karen Street, RDEFT

Medical treatment and 1:1 nursing

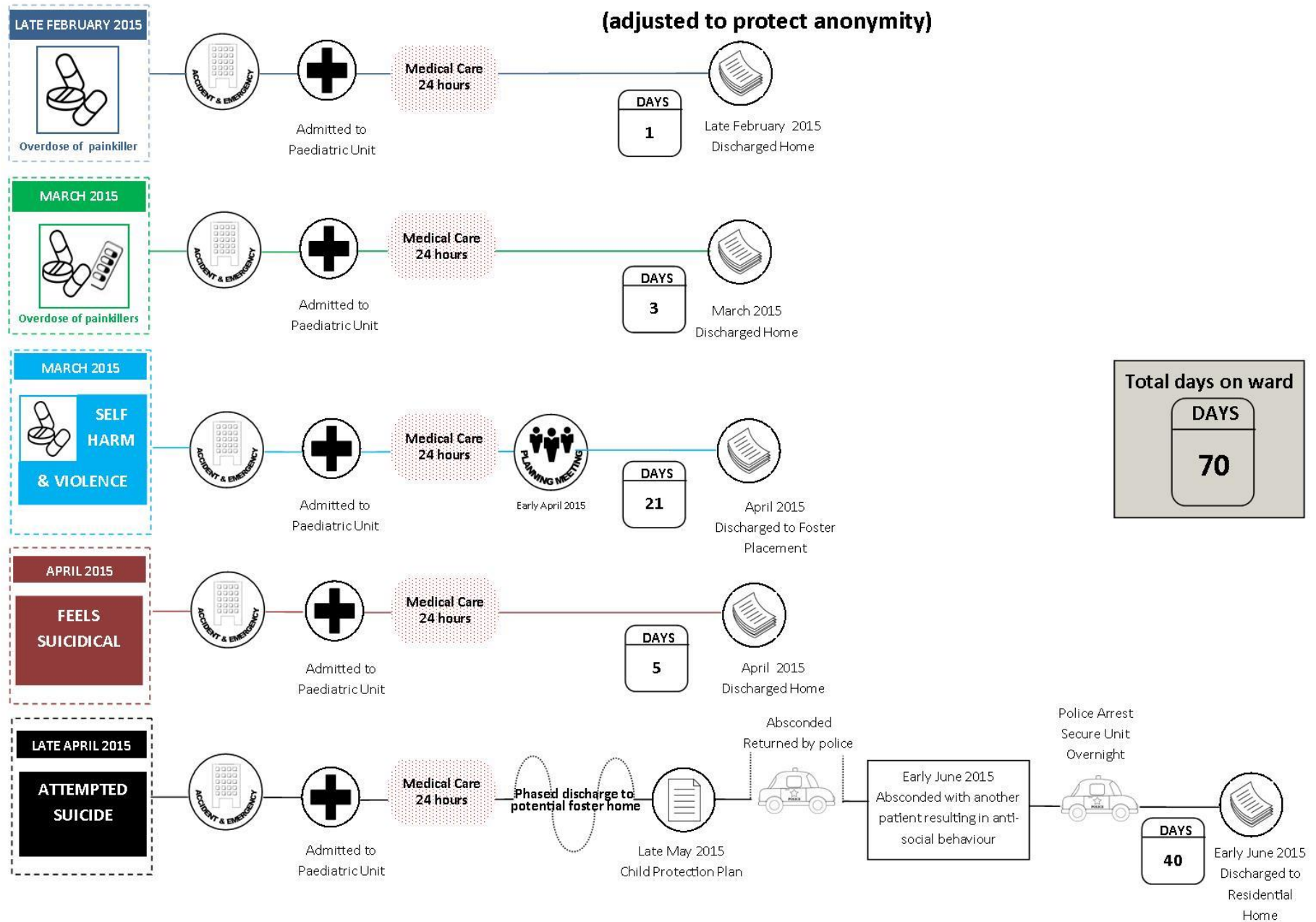
- 6.73 In the three month period there were 14 critical incidents. Four young people engaged in further self-harm on ward, seven absconded and one had to be restrained physically on the ward by police. Of the 115 bed days, 42 days of 1:1 nursing were required, which involved commissioning specialist mental health trained bank nursing staff.

Case example

- 6.74 As part of the Health Needs Assessment process, hospital trusts across Devon were asked to provide case examples to illustrate how services were accessed by patients. The path through services, of one young patient with complex needs from Devon, has been graphically represented in figure 39, but adjusted to protect anonymity. This example demonstrates:
- The proportion of overall days of admission required to meet medical need.
 - The inter-relationships between services.
 - The impact of delays in connecting support services together.
 - The need to find effective solutions to ensure more appropriate support arrangements for young people who self-harm.

Figure 39 Path Through Local Services for a Selected Individual with Complex Needs (2015)

(adjusted to protect anonymity)



7. Engagement Summary

- 7.1 A range of engagement has taken place over the last 12 months which has provided important insights from people who self-harm professionals, parents and carers involved in the support of people both in the community and in acute settings. Links and reports from each are detailed in the appendices with key points and themes summarised below:

Devon Youth Service (2014) Small Scale Survey of young people's experiences of self-harming and interactions with support services

- 7.2 Method and scope of the survey: one-to-one interviews conducted by Service Development Manager, Devon Youth Service, with 18 young people (2 male, 16 female); age range: 14-17 years; locations: Exeter, Bideford, Barnstaple, Okehampton and Ivybridge.
- 7.3 Key triggers to self-harming: the 18 young people interviewed were able to identify specific incidents that triggered their self-harming. These incidents included: family break up or conflict within the family (10); traumatic early sexual experience (4); parental pressure to achieve (1); being bullied or excluded from friendship groups (3). 14 of the young people chose self-harming as a method of dealing with their stress and anxiety because they knew or had heard about other young people self-harming.
- 7.4 How long after starting to self-harm did you feel able to ask for help? Less than six months (0); 6 to 9 months (5); 10 to 12 months (9); 14 months (2); 18 months (2). The two who took 18 months to ask for help were males. Both indicated that they felt unable to ask for help because they believed that self-harming was a 'girl thing to do'.
- 7.5 Who did you go to for Help? School Nurse (5); Youth Worker (6); Teacher (4); Friend (3). None of the 18 young people interviewed had planned to disclose their self-harming behaviour. All indicated that their decision to disclose was a 'spur of the moment decision'. All 18 indicated that they were able to hide the indicators of their self-harming. The four young people who disclosed to a teacher selected a teacher in a subject area that they felt they were achieving in. The six who disclosed to a youth worker indicated that the youth worker was someone they could trust not to overreact. The three young people who disclosed to a friend were then supported to get help from a school nurse (2) and a youth worker (1). Twelve of the young people indicated that they had hoped that someone would have noticed that there was something wrong with them at an earlier stage.
- 7.6 How effective was the support that young people received? 18 young people indicated that the initial support they received was positive, supportive and purposeful. CAMHS referral (8); admitted to hospital (2); Sectioned (1). Six of the young people who received support from CAMHS indicated that this was a good quality service that helped them to develop coping strategies. Five of this group felt that the intensive one-to-one work was initially effective but later became too intense and they would have preferred group work after initial one-to-one sessions. The 10 young people who did not get a CAMHS referral felt that having the opportunity and time to talk with someone that they could trust helped them to deal more effectively with their stress and anxiety.

Devon Youth Service, (2014) Hearing the Voice of Children and Young People and Valuing their Experience. Emotional, Psychological and Social Wellbeing Engagement with Children, Young People and Parents and Carers

- 7.7 The Devon Youth Service was commissioned by Public Health Devon to undertake engagement with children, young people, parents and carers to understand their views on what support would make a difference to their emotional, psychological and social wellbeing, to inform the commissioning of a new service. They used a mixed methods approach using an online survey, group activities and ideas generating workshops: 364 full responses were made to an online survey; 305 responses were from young people ranging in age between 11 and 25 years. A small number of questions in the survey were relevant for this health needs assessment:

Question: "When you were feeling unhappy due to one of these issues, did you share your feelings with anyone? If so, who?"

- 7.8 Family and friends received the highest response. Youth workers and school-based support (teacher, teaching assistant, school or college counsellor) were also salient.

Question: "For you to have a happy and healthy life, which of the following things are important to you?"

- 7.9 To get on well with family and feel safe at home was salient to young people of all ages, with feeling happy at school and not being bullied relevant to younger age groups. Not feeling stressed was relevant to 13-25 year olds and having own life choices to the 19 25's.

- 7.10 Qualitative insight was gained through "Balloon" (worries and concerns) and "Film Strip" (barriers and solutions) exercises.

- 7.11 Primary and the first year of secondary school children: in order of significance to the young people, the following worries and concerns were mentioned:

1. The ability to **switch off, relax and sleep well**.
2. **School worries**, including home-work, keeping up with others, getting things wrong and meeting deadlines and Standard Assessment Tests (SATs) tests.
3. **Social capabilities and peer friendships**. These fears were also projected to the fear of being bullied when they move into secondary school.
4. **Family relationships**, including anxiety regarding parents arguing, fear of parents leaving them or getting divorced and fractious relationships with siblings.

- 7.12 To get help and support, children aged 8-12 years relied predominately on their parents and family members as the people they trust and would go to for help and support. Mothers were the most frequently named significant supporter but fathers, grandparents and siblings also featured. The second group of supportive adults (for those aged 11-12) was teachers and teaching support workers, including teaching assistants and family support workers in

school. The third highest category was friends as someone that they could talk to and trust.

7.13 Young people aged 11–19 years: in order of significance to the young people, the following worries and concerns were mentioned:

1. **Formal education experience:** One third struggled with the “*pressure*” of school. Anxieties centred on issues around managing deadlines, worrying about tests, achieving grades, general ability to keep up and to understand subject matter. Young people in alternative curriculum programmes worried about the stigma attached to them, worried more about their future prospects, distrusted teachers and mentioned breaks in confidentiality.
2. **Relationships:** Concerns centred on their capability to build and maintain friendships. Not being understood was a key concern. Young people recorded their concerns about ‘being left out’, ‘unloved’, ‘depressed’, ‘lonely’, ‘no-one caring’, and getting angry with others’.
3. **Emotional health** most readily defined as the ability to understand and cope with emotions ‘feeling sad’, ‘no-one cares about me’ and feeling constantly ‘*worried*’ also featured highly. The majority, who cited emotional health as their primary concern, were young women.
4. **Relaxation and sleep:** Sleeping difficulties were balanced between males and females. Switching off and the ability to feel relaxed also featured highly. ‘Waking up feeling tired’– in particular, ‘worried I’m not awake enough for school’.

7.14 Where to get help and support: Friends were a source of support with 22% of the returns for the younger age range but by teen years reliance on friends rises to nearly 40%. By the age of 12, stigma for seeking support is a major barrier. Turning to teachers and school support workers dips in the 13-15 age range. By the time young people are 16-18 friends become a less important source of support with parents regaining status as the most trusted confident. Turning to teachers and school staff also rises above friends with those in their later teenage years.

Made of Rainbows

<http://www.standupspeakup.org.uk/watch/>

7.15 Made of Rainbows is a 14 minute video made by children and young people from the lesbian, gay, bisexual and transgender (LGBT) community in Devon about their experiences of self-harm.

7.16 The piece provides a powerful insight into the triggers to harming behaviour, highlighting “*bullying*”, “*stress*”, “*feeling different*”, “*scared*” and particularly for this group, issues around coming out. Those involved explain that most of thinking about coming out occurs around about the ages of 12-14 years.

7.17 The video illustrates how triggers and functions are different for different individuals and can change over time for any individual. One young person describes how the initial function for him was “*To stop people hurting me if I hurt myself*”, but that over time, this has changed and the function is now more about self-hate and guilt, “*to hurt myself, because I feel like I have to*”.

- 7.18 One young person describes it as “*overwhelming*” not being able to show who they really are. Strong emotions that need to be overcome include feelings of being shunned by friends and family. One young person describes this using a poignant analogy “*I feel like a broken toy*”.
- 7.19 Feelings associated with the act of self-harm mirror the cycle of self-harm illustrated in section 2 and show how it becomes a “*coping mechanism*”. One young person describes how everything feels a bit “*blurry*” but that it in the moment, “*it is just you and the knife*” and then feelings move to “*relief*”, then “*guilt, ashamed, judged*”.
- 7.20 Young people agree in that self-harm adds to the stigma they already face.
- 7.21 Young people in the video highlight that they wanted all professionals to avoid making assumptions around gender and sexuality and that having someone to talk to at school would be helpful.

Public Health (2015) Focus Group with parents of children and young people who have self-harmed or are at risk of self-harm

- 7.22 In March 2015, a focus group was conducted with a group of 10 parents and carers who attended a support group for parents of children and young people with emotional and mental health problems. The focus group was facilitated by Lucy O’Loughlin, Public Health Specialist, Devon County Council, who has experience of facilitating focus groups. The subject for discussion was circulated a month beforehand and all attendees participated voluntarily. All felt they had experiences to share and contributed to the discussion. A discussion of the key themes with verbatim quotes is included in Appendix 1. Key points to emerge from the focus group were that parents felt that:

- Everyone was too busy to support their child and them as a parent.

“It’s hearing, there is not much funding, there is a waiting list, they are very busy. I hear it all the time....they are very busy all the time. I know. You know, I’m busy, they’re busy. It just makes you feel...it belittles you because I have to be eternally grateful you are putting me on the waiting list.”

- Schools did not handle self-harm constructively, with staff confused, scared of the additional responsibility and quick to exclude pupils.

“They said he was actually “poisoning the school” and asked us to take him out or they would exclude him permanently.”

- GPs showed willingness to help but varied in ability to help and understand.

“My impression with my daughter when I first took her to the doctor first time, was the doctor, she just didn’t seem to know what to say! And it was embarrassing sitting there, where [daughter] isn’t a chatty person anyway and this female doctors is just looking at [daughter] in embarrassment really because she didn’t know what to do or how to go about things.”

- Friends, family and work colleagues found it hard to understand unless they had personal experience, leaving parents feeling isolated.

“I haven’t shared with my family and a lot of people say their friends back off and suddenly nobody gets it, or they are afraid of it, or they are embarrassed.”

- Things needed to get to a crisis before meaningful support was provided.

“It is like “low risk” you have to wait for something really bad to happen before you are a “high risk.”

- They needed practical support in how to cope between appointments with professionals.

“This was at the start of the summer holidays and we had a seven or eight weeks wait to see CAMHS and we had no instructions on what to do at all in that time.”

- There were high expectations of and long waits for CAMHS.

“When we had our CAMHS appointment, it was like, oh my God, it’s like, we’re going to see the Wizard Of Oz.....I was expecting some like, throne, cos it was all like, “ooh, if you get a CAMHS appointment”, I was thinking “Thank God.”

- Assertive parents could navigate the CAMHS system, others felt they needed “*permission*” to do so.

*“I think **permission**, I know it seems ridiculous.... , but actually knowing you actually have **permission** to call these services up and see what is going on, cos often you leave and you’ve got an appointment or somebody will be in touch . But actually you need to know that it’s OK to ring up and say “it has been three weeks, I haven’t heard anything, can you tell me what is going on?”.*

- They were not seen as an asset.

“I don’t want people to think I am a useless person and that I need help because I don’t, I need them to help me help my son”

- Parents could be better supported through use of technology, ongoing contacts (e.g. phone or text) between appointments and peer support either face to face or online.

“If we get a text saying “just checking if everything is alright and you know where we are and if you need us...”.(you think) Oh good... probably won’t phone you, so don’t worry, but just to know someone else is there..(sighs).....Cos if you’re in the middle of a really bad time and you just get that text and you just, “oh...there’s someone else there.”

- Training for front-line professionals should integrate stories told by those with lived experience to ensure sufficient impact.

*“they were sitting there almost in tears, and they **actually hear it** for what it **actually means** to be a parent of a child that is going through this, rather than a statistic or facts on a fact sheet.”*

Public Health (2015) Devon Self-Harm Advisory Group and Linked Professionals Perspectives on Self-Harm Needs and Assets in 2015

Method

- 7.23 Professionals and service leads from a range of relevant disciplines were contacted and asked to complete a pro-forma which outlined their thoughts around self-harm. An example of the pro-forma is included in appendix 2. Professionals were asked to highlight key issues from their perspective and assets that should be utilised better in future. If time allowed, they were also asked to comment on constitutional factors, guidance or pathways, training needs, community networks, demographic trends over time, felt needs of client group, expressed needs of client group and carers, comparative need.
- 7.24 Pro-formas were completed by 17 professionals/service leads consisting of an Area Youth Worker, Consultant Liaison Psychiatrist, Lead Nurse in a Minor Injuries Unit, Primary School Head Teacher, Consultant Paediatrician (x 4), Targeted Family Support Co-ordinator, GP, Internet Charity Worker, Named Safeguarding Lead Nurse Acute Trust, Vice Principal of a Secondary School, Primary Mental Health Worker (CAMHS), Practice Manager (CAMHS) and a Public Health Nurse Team Leader.

Summary of Responses

Trends in Prevalence

- 7.25 There was a general awareness among professionals that low mental well-being and self-esteem is affecting many more people than before. Self-harm and issues associated with mental health appeared to be growing. This was felt among both specialist clinicians and front-line community staff. It was felt by one Primary Head Teacher that many primary-aged children were also “*on cusp of it*”. Children considered at risk were those with lower academic achievement and less secure friendships or no strong friendship groups.
- 7.26 Some felt that the increase could be due to a more open culture of discussion on the topic, which has resulted in more awareness and more people discussing feelings of suicide.
- 7.27 There was also a reference made to higher thresholds for specialist support. One professional raised a concern however, that the rise in prevalence could lead to de-sensitising amongst professionals “*Because it is so common, there’s a temptation to be dismissive of the issue as just another teenage fad*”.
- 7.28 Repeat self-harm was considered much less common but worthy of serious concern as was a new sub-group of young men who were “legal high” users.

Services are well set-up for adults

- 7.29 It was highlighted that there was a contrast in the services in place for adults when compared to children and young people. Adults were able to access liaison psychiatry and so benefitted from a “*thorough 90 minute bio-psychosocial needs assessment*”. Conversely, systems were considered slow to support the under 18s, particularly when identifying social care placements.

Staff attitudes

- 7.30 Some staff with poor attitudes were highlighted, including people “*who are unsympathetic, dismissive, lack understanding, and don’t know how to respond or talk to young people*”. An isolated instance of a frustrated member of staff on a paediatric unit highlighting how to take a more effective poisoning dose, to a young patient who had been admitted for self-poisoning was recounted to illustrate how frustrations due to work-load do spill over.
- 7.31 Conversely, respondents described success when an atmosphere of safety and trust pervaded, where staff “*work hard to ensure people feel safe and not judged*” and disclosure was not met with judgement, panic or shock.

Strengths of Community Health Staff

- 7.32 One respondent felt that some of the community health staff have a wealth of skills and knowledge and that they should be seen as a resource. It was mentioned that all Senior Youth Workers are now Mental Health First Aid trained. Minor Injury Unit Staff were also considered to be well prepared and competent as they study mental health and the welfare needs around mental health as part of their core training; however this was highlighted by a team leader who was themselves very well trained in mental health and may have enhanced staff skills as a result.

Internet/online environment

- 7.33 Some responses mentioned dangerous or irresponsible internet and media resources, including violent games accessed at too early a stage, such as primary aged children playing Grand Theft Auto which is rated 18. Professionals needed to become aware of emerging issues such as “*electronic self-harm*” where young people abused themselves using blogs and posts. Others mentioned their concerns about damaging and dangerous resources such as “*competitive forums on Instagram where young people share photos of self-harm*”. The positive aspects of social media were also mentioned such as “*helping people find support groups*” that offered support.

Lack of an 'appropriate place of safety' and lack of out of hours care from CAMHS

- 7.34 The issue of a lack of an appropriate place of safety for CAMHS patients, either at high risk of committing suicide or with significant behavioural issues, was strongly felt and frequently raised. The inability of acute hospitals to meet young patients’ needs and the fact that their behaviour often frightens other patients and parents around them was a particular concern. “*There is no out of hours for children and young people. Young people are put on the ward with an overdose on a Friday and have to stay ‘til Monday*”. One clinician highlighted instances when they called CAMHS for advice but due to the lack of staff on call, it was not possible to gain answers to their questions.
- 7.35 Suggested solutions included “*closer places of safety*” and “*increased availability of tier 4 beds*”, “*more out of hours care*”, more “*joint working with key agencies.*”
- 7.36 Experience of CAMHS was variable. Services were viewed as fragmented at times, with the perception that many CAMHS staff worked very part time shifts. Others noted that local guidance is “*clear and easily followed i.e. ring CAMHS before 10am Monday to Friday. They will assess same day.*”

Future Needs

The Need for Training

- 7.37 The majority of professionals highlighted a need and a keenness for training. Professionals highlighted the nervousness and fear amongst colleagues *“People are terrified they are going to say or do the wrong thing.”* And the risk that as a result they may provide unhelpful responses when young people disclose the issue or *“back off”* and lose the trust of those who had placed their trust in them. This was exacerbated by having *“no clear procedures to follow”*
- 7.38 General education for frontline professionals working in the community was highlighted, for example health visitors, GPs, school nurses, school staff, college staff, pastoral care, on identifying and supporting young people with self-harm issues. One professional highlighted that staff needed to know what to look for; *“behaviour IS communication- we need to ask, what are they trying to communicate...notice and name it and normalise it”*
- 7.39 Training needed to cover what self-harm is, how to manage self-harm, managing anxiety around self-harm and how to promote emotional resilience and utilise expertise from those with lived experience.
- 7.40 One professional highlighted an *“excellent”* comprehensive programme of multi-agency training which they had personally experienced elsewhere. This was delivered by primary mental health workers, psychologists, family workers and others and was worked through by front-line professionals from a basic level upwards. A contrast was made between this and the current provision in Devon which depended on motivated individuals in particular areas and was therefore considered *“piecemeal”* and patchy. What was offered was invariably full and others had not been aware of it at all.

GP’s training needs

- 7.41 It was suggested that GPs need training as registrars and also post registration, given that they currently have limited or no training in children and adolescent mental health. Dialectical behaviour therapy training to support patients with Personality Disorders was suggested as the most useful approach to focus on.

Schools staff training needs

- 7.42 Respondents highlighted that the issue was relevant in primary and secondary phases and for all staff including *“dinner ladies, first aiders, or a cleaner”*. It was noted that there was a need for staff to notice and act on self-harm earlier, particularly due to the raised thresholds for external services *“We have to skill ourselves as services are not out there”*. One respondent said that school-staff need professional supervision, in both group and 1:1 formats. *“Thrive”* training and similar were highlighted as good examples, which provided a good foundation for staff.

Acute hospital staff training needs

- 7.43 There was unanimous agreement from acute hospital personnel that training for paediatric unit ward staff in hospitals was required. It was felt that staff had received introductory training *“but not sufficient to overcome their lack of*

confidence dealing with these young people.” In addition, the rotation of junior staff means that lack of continuity contributed to this.

- 7.44 There were fears around what the patients might do and skills were required around assessment of suicidal risk, how they could be managed to avoid further suicide attempts whilst on the ward, how to calm situations down and what to do if situations escalated so that the security of staff and other patients was safeguarded. Responses indicated that staff were keen and willing to receive training *“at least 3 paediatric nurses now interested in mental health issues, they are desperate for training and cross working”*
- 7.45 Issues around sharing skills were highlighted and the importance of recognising the different contexts within which different disciplines operate. One respondent said that training needed to be able to cross settings and gave the example of how mental health nurses do not necessarily feel confident in A&E settings, where there is less time to think and reflect. Examples were given of experiential scenario-based models of training being developed in London for both mental health staff and ambulance workers which could address this issue (e.g. Mental Health Facilitator unit).

Ways to support young people

- 7.46 Responses highlighted the aspiration that emotionally distressed people should be helped sooner, to build resilience. Solutions were required around how to fund more group and one to one sessions for young people and how to support young people after being discharged after self-harm admission. Ideas for effective or new ways of working included strengthening youth networks, services for 14-24 year olds, use of linked services such as YES projects, *“Tic/Tac style support”*. The idea of using a youth work approach and using enjoyable pursuits was mentioned more than once, to build self-esteem. Examples included the targeted youth work which involved trips *“helping them feel special”* and protected time where space is given while pursuing an activity *“working alongside and doing is more productive, particularly for boys”*

Information for parents and families to help manage self-harm

- 7.47 Respondents highlighted that there was a *“lack of support for supporters”* and that more educational resources were needed to support *“distressed”* parents and carers to enable them to support the children in their care. A *“do’s and don’ts for parents and carers”* was one suggestion. It was thought that parents and families need to understand what the local offer looks like, possibly via a standardised information leaflet. Listing services on a local database was another suggestion.

Family support

- 7.48 Family support, which tackled a range of complex issues such as family communication was highlighted as an important approach in supporting those who self-harm. The Targeted Family Support programme was mentioned as an important asset in this respect. Parental mental health was highlighted as a significant factor, with young children being exposed to for example *“adult self-harm and also threats of suicide from mother”*. One Child and adolescent mental health practitioner described it as follows:

“From a systemic family practice viewpoint: self-harm can be viewed as a solution to a problem, simplistically, it is not felt to be safe to verbalise difficult emotions, words in the family for a whole host of

reasons. Therefore we need to be mindful of what is helping/ hindering family communication and not just tackle the young person's self-harm behaviour."

The value of joined up working

- 7.49 There was a consensus view that much could be achieved by better joint working between agencies and more effective targeting of resources, for example; schools and GPs or for front-line professionals to access specialist advice. It was suggested that schools should work with others to provide sessions for young people on sexual exploitation, sexual health and self-esteem. It was pointed out however that this kind of work requires time:

"The health teams in localities know their communities extremely well and need time and further resource to support other practitioners as well as complete their client work. They are stretched and this area needs quality time to resolve issues and support families effectively."

- 7.50 There were examples of where Primary Mental Health Workers gave schools staff supervision every month. The role of the Primary Mental Health Worker type-role providing advice and supervision was mentioned a number of times. Support from Primary Mental Health Workers could help to *"make everyone more confident and calm and able to cope"* It was suggested that this should be made more systematic and not just left to develop in an ad-hoc way.
- 7.51 The need to develop networking with all key agencies was highlighted; CAMHS, social care, public health nursing, schools, inpatient staff, youth/vol sector. Joint agency meetings, lead roles within each agency and prompt information sharing was suggested as important. The value of particular close working arrangements were proposed for social care and Primary Mental Health Workers, health professionals and youth workers.
- 7.52 Joint working was also suggested between community and acute service provision, with paediatric units linking more effectively with Integrated Childrens Services, CAMHS advising acute paediatric units on risks in the ward environment as well as management strategies. Additionally, one clinician suggested the need to have more *"information sharing between agencies on historic self-harm to prevent recurrences or identify clients as vulnerable"*.

Support for professionals

- 7.53 Specialist advice and support, particularly out of hours was highlighted as an important requirement, succinctly described by one respondent from an acute hospital:

"We need a tiered consultation service which is flexible and available both to families at the point they are experiencing difficulties and also to professionals who may be the first point of contact for families. Children who self-harm will not fall neatly into 9-5 hrs so consideration needs to be given, for example, to having web-site info on self-harm readily available and signposting and advice for families if they are ringing for advice out of hours. Not enough available in the way of support for professionals who deal with these cases. Better educational material for both victims and professionals".

Multi-agency care pathway

- 7.54 Most respondents highlighted the need for a consistent pathway of managing self-harm across all acute trusts. There was a need for agreed outcome frameworks, utilising the same measures. Currently it seemed that *“everyone is waiting for someone else”*

Assets/strengths to make more of going forward

Use of schools and the voluntary and community sector

- 7.55 Using community centres and schools who access large numbers of people to highlight this area and sign post families for support was one suggestion. These could also offer more acceptable and *“safe-ground”* venues for CAMHS who it was felt sometimes *“use strange places as settings which are not familiar”*. Voluntary sector services that were mentioned as assets include The Project in Axminster and Young Devon.

Parents

- 7.56 It was highlighted frequently that parents should be seen as *“an asset and a strength.”* Developing the skills of all parents to be aware of self-harm issues, was suggested as an important preventative way forward. One respondent said *“Don’t underestimate their capacity. Give them information and help them manage, it may reap dividends”*.

Building on trusting relationships

- 7.57 Relationships people have with the people that they trust, for example, children with schools staff, was seen as an asset to build on. Professionals need to *“believe in themselves”* as their relationships provided an *“important foundation of trust”*. However there was also a caution that professionals needed to accept that sometimes you can’t make a difference and were *“responsible towards but not responsible for”* their people in their care.

Devon Safeguarding Children Board (2015) Professionals Best Practice Seminar Series Feedback

- 7.58 Following a programme of multi-agency case audits undertaken in September 2014 based on the theme of self-harm, the Board held three events across Devon to disseminate key findings from the audits and also to discuss what is our understanding of self-harm in Devon: why do young people self-harm and what can we do to help? The events were held in spring 2015 in North Devon, Exeter and South Devon, and were open to all practitioners working with children and families. In total, 168 practitioners attended the seminars from a wide variety of agencies including: children social care; education – Babcock and schools; Y-SMART; CAMHS; Virgin Care; SAFE; NHS trusts; children centres; registered charities and councils.
- 7.59 Some general themes that arose from the seminars included:
- The need to focus on the cause of self-harm not just the self-harming behaviour.
 - The lack of a pathway in Devon for dealing with children and young people who self-harm.

- Lack of knowledge of what support is out there for children who self-harm; over reliance on CAMHS; request for a tool kit for practitioners.
- Lack of confidence in how to support a young person who is self-harming; this was an issue for school staff in particular, although we also heard from one specific school which was very proactive and confident in supporting young people who self-harm.
- A request for more training on the subject of self-harm and direct work with young people around this issue.

8. Current Service Provision

Commissioning arrangements

- 8.1 NHS England is responsible for commissioning inpatient psychiatric beds (tier 4).
- 8.2 Across Devon, two Clinical Commissioning Groups Northern, Eastern and Western Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group are responsible for commissioning multi-disciplinary specialist tier 3 services across the life course, including Child and Adolescent Mental Health Services “CAMHS”; perinatal mental health services; community mental health services and older people’s mental health services.
- 8.3 Commissioning responsibility for services at tier 2 and below are shared by a range of agencies including clinical commissioning groups, local authorities, schools, police and others.
- 8.4 Local planning is channelled through the Devon Health and Wellbeing Board. Safeguarding procedures are overseen by the Devon Children’s Safeguarding Board and the Devon Adult Safeguarding Board.

Service provision

- 8.5 In order to consider local service provision against national guidance, a summary of NICE guidance and quality standards 2004-2014 and Royal College of Psychiatrists guidance *Managing Self-harm in Young People* (RCP, 2014) is summarised in appendix 3.

Collaborative working around self-harm

- 8.6 From September 2014 the Devon Safeguarding Children Board initiated a series of multi-agency case audits into self-harm, engagement with young people and teachers, a conference for multi-agency professionals in December 2014 and a set of briefings for front-line practitioners in Spring 2015. A Clinical Summit on Self-harm was delivered by the New Devon Clinical Commissioning Group in January 2015. These events involved staff from acute hospitals, mental health services, local authorities, schools, youth services and voluntary sector agencies. A Clinical Pathway Group for Self-Harm is due to meet for the first time in June 2015.

Care pathways

- 8.7 There are currently no locally derived multi-agency guidelines or care pathways in place for self-harm for adults of children and young people in Devon, but a Clinical Pathway Group has been identified.

Community/front-line support/services

- 8.8 A wide variety of professionals and volunteers promote and support good mental health in their front-line roles. As trusted professionals and service leaders they are also likely to be in a position to offer initial support to a person who discloses self-harm. Such professionals include GPs, schools nurses, work-place supervisors, youth workers, school staff, social workers, sports club leaders etc.
- 8.9 Across Devon there is currently no strategically planned, multiagency comprehensive training programme that meets the requirements outlined by NICE and RCP guidance, which aims to equip front line professionals with the appropriate skills and competencies around self-harm. Such training should be planned by and involve people with lived experience and could utilise the expertise of specialist practitioners in the local area.

Voluntary and community sector support

- 8.10 There are a small number of Devon-based voluntary and community sector support services in Devon, but finding these services is not easy using regular internet search engines. Local directories, such as the Devon Community Directory list some, but not others and for a person searching "*Self-harm support in Devon*" the community directory does not appear and the services listed would have limited use.

Early Intervention - children and families

- 8.11 The findings of Ofsted's inspection of Devon's child protection arrangements in 2013 and the publication of the Munro report *Working Together to Safeguard Children 2013* highlighted the need to strengthen Early Help, resulting in the *Devon Early Help Strategy for Children and Families*. The Devon Early Help strategy was signed off by the Devon Safeguarding Children Board in December 2013 and the implementation plan is underway across the county.
- 8.12 Early Help in Devon is an approach which aims to provide support as soon as a problem emerges, at any point in a child's life, beginning with the health and wellbeing of the mother and her partner, and extending through adolescence to life as an adult.
- 8.13 The Devon Early Help approach requires professionals from all agencies to take a family focus, which requires attention to the needs of both the child as well as those of the adults as parent/carers. Professionals across the county are to use the same assessment tools, co-ordinate support through a single key worker and utilise a combination of support which may vary from very low level practical support to more intensive therapeutic help.
- 8.14 The Devon Early Help vision, once fully implemented, could meet many of the requirements of the NICE and RCP guidelines which refer to initial assessment and ongoing support in the community for children, young people and families, if sufficient alignment can be secured.

Tier 2 Emotional, Psychological and social wellbeing services for children and young people

- 8.15 The Devon Early Help Strategy for Children and Families identified a gap in service provision for children and young people with emotional and behavioural problems who do not meet the threshold criteria for the Child and Adolescent Mental Health Service (CAMHS). Objective 11 of the implementation plan for the strategy recommended: “*Co-commission Tier 2 mental health and emotional wellbeing services in schools, according to local need*”. In response to this, Devon County Council, through Public Health Devon and schools, is commissioning a new service to promote and support the emotional, psychological and social wellbeing of children and young people in Devon.
- 8.16 The rationale for the new service is to promote and support emotional, psychological and social wellbeing in all children and young people, to prevent problems from occurring and when they do occur, to identify and intervene appropriately as early as possible. This will reduce the risk of problems escalating and potentially reduce the demand for more intrusive interventions by statutory agencies.
- 8.17 Once implemented, the service model has the capacity to meet many of the recommendations from NICE and the Royal College of Psychiatrists including improving knowledge, awareness and skills around self-harm, access to specialist advice and resources and clinical support for front-line education staff, targeted support for parents with children aged 5-11 and direct support for children and young people aged 11-19. The service is due to start in Devon in September 2015.

Child and Adolescent Mental Health Services (CAMHS)

- 8.18 Child and Adolescent Mental Health Services work with children and young people who have difficulties with their emotional or psychological wellbeing. In Devon, these services are delivered by Virgin Care Ltd and aim to support families, children, young people and their carers.
- 8.19 Core CAMHS services see children for an initial assessment “choice appointment” and then for treatment “partnership appointments”. In addition, there are a number of specialist pathways for children and young people with more complex problems, including one for children who self-harm.

CAMHS assertive outreach

- 8.20 Due to the increase in young people with severe and complex mental health problems, Assertive Outreach (AO) services were introduced in autumn 2014. The AO services aim to provide intensive community based treatment over extended hours for children and young people at risk of admission to tier 4 placement or who need this level of support to enable an earlier discharge.
- 8.21 Out of hours liaison services for child and adolescent mental health are not yet available across Devon 24 hours a day, covering all evenings, weekends and bank holidays.

Children and young people improving access to psychological therapies (CYP-IAPT)

- 8.22 CYP-IAPT is a service transformation programme delivered by NHS England that aims to improve existing CAMHS services working in the community. It is different from adult IAPT as it does not create a standalone service. The key components of CYP-IAPT are:
- Use of routine outcome monitoring measure involving young people and their families feeding back during therapy sessions.
 - Involving children and young people in its service design and throughout their treatment.
 - University training for therapists in Cognitive Behavioural Therapy (CBT), parenting and systemic family practice including leadership training.
 - Improving access.
- 8.23 Devon CAMHS is part of the South West learning collaborative and joined the programme in year 2012. Exeter University has been commissioned to provide the training component.
- 8.24 By November 2014, 28 staff from Devon CAMHS undertook a postgraduate diploma at Exeter University in core CYP-IAPT principles and one of the following: cognitive behaviour therapy (CBT) for anxiety and depression, parenting training for behaviour and conduct (3-10 year olds), systemic family practice (SFP) for conduct disorder (over 10s) for depression, self-harm and eating disorders. Supervision and leadership training has also taken place.
- 8.25 A certificate level training was launched for one year in January 2015 aimed at training less experienced staff in CYP-IAPT principles.

Tier 4 beds

- 8.26 When a child or young person's needs are particularly complex, they require admission to a tier 4 inpatient unit. RCP guidance states the importance of commissioning sufficient and readily accessible tier 4 bed capacity. In recent years national and local tier 4 bed capacity has decreased. There has also been increased usage of paediatric in-patient beds for young people who self-harm or require a tier 4 bed when a bed is not available.
- 8.27 NHS England recognised insufficient capacity in the South West in their *Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report* on the issue in July 2014 and committed to increase the number of specialised beds for young patients and the number of case managers working across the country responsible for ensuring that young people receive appropriate levels of care.

Section 136 place of safety

- 8.28 Until recently, Devon lacked a formal commissioned Place of Safety for young people detained under the Mental Health Act who were awaiting a Mental Health Act assessment. In recent years, children and young people have been looked after in police cells, on acute wards or in their homes while they wait for a bed to become available. In Spring 2015, North East and West Devon Clinical Commissioning Group commissioned an Interim section 136

Place of Safety situated in Plym Bridge House, Plymouth, with capacity for one child /young person at any one time.

Adults

Targeted services-tier 2

Improving access to psychological therapies (IAPT)

- 8.29 Improving Access to Psychological Therapies (IAPT) is an NHS programme that has rolled out services nationally offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. In Devon, patients can either self-refer to the depression and anxiety service or can be referred in by their GP or a range of other services.

Specialist mental health services - tier 3

- 8.30 Devon Partnership Trust are commissioned to deliver a wide range of specialist mental health services for adults and older people, including services for depression and anxiety, eating disorders, learning disability and personality disorder.

Liaison psychiatry

- 8.31 Liaison psychiatry is the medical specialty concerned with the care of people presenting with both mental and physical health symptoms regardless of presumed cause. The specialty employs the biopsychosocial model being concerned with the interrelationship between the physiology, psychology and sociology of human ill health.
- 8.32 Liaison psychiatry services are designed to operate away from traditional mental health settings, in the main in general hospital emergency departments and wards, and medical and surgical outpatients. Liaison psychiatry teams are multidisciplinary, clinically led by a Consultant Liaison Psychiatrist. The multidisciplinary liaison psychiatry team will typically include specialist mental health nurses, psychological therapists, occupational therapists and social workers.
- 8.33 Self-harm forms one of the main areas of focus for liaison psychiatry work in emergency departments. Early findings from the National Survey of Liaison Psychiatry (Lee, in press) demonstrate that all 4 acute hospitals in Devon offer a service led by a consultant liaison psychiatrist, but with varying numbers of multi-disciplinary personnel. Since April 2015, contracts have been in place to enable all four teams to offer rapid response for assessment in emergency departments for people who have self-harmed 24 hours per day, covering evenings and weekends. Providers are currently working to achieve this.

9. Observations

- 9.1 Based on the qualitative and quantitative intelligence gathered in the process of developing this Health Needs Assessment and NICE guidance, a number of observations have been made. These observations should be considered by providers, commissioners and stakeholders when planning to meet the needs of people who self-harm, their parents and or carers and when developing future services.
- 9.2 Much can be achieved through collective commitment and collaboration. Many assets exist in Devon which can be built upon to achieve a downward trend in self-harm, reflecting a more confident, connected and resilient community.

Observations

Clear pathways and joint working protocols

- 9.3 Consideration should be given to developing:
- A multi-agency care pathway for self-harm in Devon, which meets the complex and often overlapping needs of people of all ages.
 - Multi-agency guidelines for community/front-line professionals supporting people who self-harm, their parents and/or carers. All relevant organisations should be involved and roles and responsibilities of partner agencies should be clearly defined. Guidelines should be developed to meet the requirements of people all ages.
 - A clear agreed joint working protocol which sets out the responsibility for all partner agencies in respect to young people who are placed on children's wards for self-harming behaviour. This should clearly state the roles and responsibilities of partner agencies in the process.
 - A multi-agency system to share information between agencies on historic and repeat self-harm to identify the most vulnerable clients and prevent recurrences where possible.

Prevention and early intervention

- 9.4 Ensure the tier 1-2 emotional, psychological and social wellbeing services for children and young people provides support for:
- Schools to identify and recognise key stressors to children and young people in both the primary and secondary phases.
 - Parents and schools to develop effective ways to help young people build resilience and coping skills.
- 9.5 The impact of poor parental mental health has been highlighted as an important factor for consideration. Family support approaches, such as those utilised by the Early Help strategy and Targeted Family Support, which emphasise meeting the needs of the child, young person and parent/carers, should be considered as part of an action plan to address self-harm in the county.

- 9.6 The needs assessment identified a need for centrally collated, local information for people who self-harm their parents and carers. Such information should be easily accessible in a range of formats. Online resources could be made easy to find through search engine optimisation.
- 9.7 Young people have identified that they want to be able to talk to people they respect, who understand their point of view and who will not over-react. Consideration should be given to training young people to act as peer supporters for other young people who self-harm, utilising evidence-based approaches.
- 9.8 Parents and carers as well as professionals recognised that parents could be seen more as an asset in supporting the emotional health and wellbeing of children and young people who self-harm. In line with NICE guidance, consideration should be given to how parents and carer's needs are assessed and met. Examples of support could include:
- Standardised written information readily available to all front-line professionals.
 - Use of SMS messages or brief telephone calls to monitor wellbeing between support appointments.
 - Practical advice in how to manage between support appointments.
 - Peer group support via virtual or face-face forums.

Support for professionals

- 9.9 Professionals, parents and young people identified a training need around self-harm for all staff, including front-line professionals, those working in acute and specialist settings and people from the voluntary sector. Consideration should be given to the collaborative development of multi-agency training, utilising the insight of people with lived experience. A model of training that has been cited as a good example involves local professionals sharing in both the delivery and learning. A strengths-focussed approach, which enables professionals to notice self-harm earlier and communicate and support people in a confident, calm and non-judgemental manner should be considered. Among other components, this training would benefit from including a section on understanding the role of digital media in relation to self-harm.
- 9.10 The needs assessment identified patchy and inconsistent availability of specialist advice and guidance to schools, acute hospitals and other staff, to enable them to fulfil their duties around the emotional health and wellbeing needs of young people. Consideration should be given to the systematic delivery of professional supervision and advice to those staff who need it, including school pastoral staff, in the form of group and 1:1 sessions.

Out of hours and tier 4

- 9.11 NICE guidance states that out of hours liaison psychiatry services, enabling appropriate psychosocial needs and risk assessments should be available over evenings, weekends and bank holidays for children, young people and adults. Consideration should be given to ensuring this is the case in Devon.

- 9.12 Section 136 places of safety and tier 4 in-patient beds need to meet the needs of local people and respond to the requirement to remain closer to home.

Monitoring of data and further research

- 9.13 A comprehensive data-set would be beneficial to enable monitoring of self-harm indicators across Devon, similar to the National Registry of Deliberate Self-Harm in Ireland and prisons data-set, to enable closer monitoring and assessment of progress year on year.
- 9.14 Further research is needed to understand the needs and risks presented by older people who self-harm and how community professionals can be involved in noticing and supporting those most at risk.

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Public Health (2015) Focus Group with Parents of Children and Young People Who Have Self-Harmed or Are at Risk of Self-Harm

Methodology

A focus group was conducted in March 2015 with a group of ten parents and carers who attended a support group for parents of children and young people with emotional and mental health problems. The focus group was facilitated by Lucy O'Loughlin, Public Health Specialist, Devon County Council, who has experience of facilitating focus groups. The subject for discussion was circulated a month beforehand and all attendees participated voluntarily. The focus group was recorded and transcribed verbatim. The focus group guide was based on the following questions:

The Focus Group Guide

1. When did you first seek help for self-harm and whom did you contact?
 - What helped or did not help you gain access to services?
 - Did a friend or family member help you gain access to these services?
2. In what ways has the self-harm affected your everyday life (such as education, employment and making relationships) and the lives of those close to you?
3. What support was available to you on and off line? (e.g. support group)
4. Were these supports helpful? If not why not?
5. What was the most useful online support?
6. Did family and friends close to you or people in your community help and support you?
7. What further support do families need?

Key themes from the focus group

There was a strong sense from the group that **everyone was too busy** to help them and their child. School nurses had long waiting lists and waits for CAMHS assessment were a matter of five to six months rather than weeks. Parents expressed a sense of being passed from one professional to another but still feeling alone in their struggle.

The following day I got straight onto the GP and booked an appointment. I got told there was nothing they could do so he would have to see the school nurse. So I phoned the school nurse and they said there is nothing the school nurse can do as she has a really long waiting list and they told us to go back to the GP.....As a parent, I was thinking "I don't know how to deal with this, I don't know why he is doing this, and he isn't talking to me. What actually do I do and who do I turn to". So he went on the waiting list for the school nurse and the appointment never materialized. He then started to hear voices and then he was referred onto CAMHS by his GP for an urgent appointment, but

before his appointment with CAMHS he took an overdose. So it wasn't until then we actually got the help.

Parents understood the pressures on the system but expressed a sense of powerlessness and belittlement in the face of stretched resources, having to feel thankful for even being put on a waiting list.

Its hearing, there is not much funding, there is a waiting list, they are very busy. I hear it all the time....they are very busy all the time. I know. You know, I'm busy, they're busy. It just makes you feel...it belittles you because I have to be eternally grateful you are putting me on the waiting list, you know, because they're busy. You just feel permanently like, you are either apologising, or you are thanking them, eternally for helping you...that's what I feel like.

The **management of self-harm by schools** was discussed at length. Two parents were first alerted to their child's self-harm by schools and the shocking disclosure, although not necessarily delivered in the right setting (such as a parents evening) was approached supportively. However, it was generally felt that schools did not always handle self-harm over time in a constructive way. Initial supportive gestures were followed by withdrawal of support:

I just felt completely useless, I didn't have a clue where to go, what to do. So from the school being very supportive saying, we will do anything we can, to sorry actually we can't.

Some schools chose to send the young person home, in an attempt to protect the remaining pupils.

The school didn't want her there... when they found out my daughter was self-harming, they didn't want her there. They said they had a duty of care and I'm not sure whether that was to her or to the other children who they thought might be at risk from her, but fundamentally they didn't want her there. So they'd just send her home.

Over time, in some cases exclusion was considered for the same reason. Parents expressed frustration that the only service with which their child had constant contact was being withdrawn and that they had to accept a poor level of empathy and support as this was their only option.

*At [my son's] school, they were better to a certain point and then they just seemed to label my son as a "naughty kid", they didn't want him there. They said he was actually "poisoning the school" and asked us to take him out or they would exclude him permanently..... and he then decided that he wasn't going to permanently exclude him., so then we were left with a head teacher who said your son's poisoning the school and the pastoral support worker saying she couldn't work with him and "there was no hope" and we **had** to send him back there*

The parents shared a number of stories where teachers and staff at all levels showed willing but seemed confused about how to act, either scared or afraid of the responsibility. One parent had attended a multiagency training group as a professional and had been shocked at the attitudes witnessed

I was on a self-harming training day yesterday actually; for key stage 3 and 4,the head of the pastoral team is like, "well I'm just not going to do anything about it, because we just don't deal with that, and that is the end of

it” and they were talking about.. “if I told a parent there child was self-harming, then I would be breaching that child’s confidentiality but then if I didn’t tell them it is my duty of care.”..... even the first aider at school was worried about going on training because she didn’t want the responsibility ‘cause once you are trained you’ve got that level of knowledge and she was afraid of the responsibility, if they self- harm at school they are going have to come to you, to get help,”

Other schools which showed more confidence in handling self-harm were interpreted as being too blasé , by failing to explain to parents why they took that particular approach.

*My daughter’s friend at school, she’s 15 and so her friend is 14 and she came and said I’m just letting you know that I’ve noticed she’s self-harming and I think I asked for some advice actually, I said “is there anything at school that you could provide,” cos I know there is a counsellor, but is there anything you could do to just to help boost her self-esteem or **something**. And they said, “yeh, there is a group of 12 of them that we are aware of”, but that was it, they were just watching them. There was a little gang of them, that 1 or 2 of them had done it for one reason and then others done it, you knowsort of....she (daughter) was part of that group and some of them had stopped and then carried on and sort of like “oh yeh, we’re aware of it”*

Experiences of clinicians from **Primary Care** were that they were **generally willing but not always able to help**, through lack of confidence or knowledge.

My impression with my daughter when I first took her to the doctor first time, was the doctor, she just didn’t seem to know what to say! And it was embarrassing sitting there, where [daughter] isn’t a chatty person anyway and this female doctors is just looking at [daughter] in embarrassment really because she didn’t know what to do or how to go about things.

However there were some examples of GPs trying to help with pragmatic advice around medication and sleeping for parents and trying to learn alongside parents if they were not particularly knowledgeable about self-harm in the first place.

I was lucky with my daughter because our GP, he was prepared to have a go at understanding it, I’m not saying that everyone..... it’s not an easy thing to understand but, I think GP’s should be equipped with information even to sign-post or at least have something constructive to say.

Attitudes and experience in working with young people and some subject knowledge was highlighted as particularly important if they were to be in a position to help the young person directly.

*You know, people don’t seem to get **why** people self-harm and if they don’t understand why they are doing it then they can’t help them because they are just saying things that are just irrelevant, if you see what I mean.....you know what kids are like...they will just decide within the first minute of speaking to you whether they like you or not. I think they just switch off. As soon as they realise that they don’t understand, why they’re doing it, what they’re doing, or what it is even, their impression is “well, you can’t help me”*

One parent described a positive experience gained through choosing a GP who highlighted their skills with young people on the practice website. Other parents agreed that this would have been extremely helpful for them and perhaps an approach which could be adopted by other practices.

*We decided to get my daughter her own GP as she was with our GP. We got her to have a look through the website at doctors and choose the one she wanted, and she actually picked the one that specialised in teenagers. So that was a **really good thing** as we had a good GP at the time.*

In discussing support available to parents in their own lives, there was general agreement that **friend, family and work colleagues found it hard to understand** and so consequently offered little support, leaving parents feeling isolated. Many relationships became strained or lost or the issues were glossed over and ignored.

I haven't shared with my family and a lot of people say their friends back off and suddenly nobody gets it, or they are afraid of it, or they are embarrassed.

The acceptance that children could suffer from conditions more usually experienced by adults was identified as part of the block in people's understanding;

*I think also I find that, it's that thing "well, they're kids, how could they possibly have things like that wrong with their children", it is like with depression and things like that, well they are more capable of having things like that, just because, like.... There's like no **legal age** for you to have mental health problems which I think a lot of people think!*

One parent reflected that the sense of isolation was the same for her child given that their close friends did not understand and her child did not want them to know.

It was agreed that friends or family who had experience were in the best place to understand, but only one in the group had benefitted from this;

I must admit I have been really lucky because I have got friends that have been supportive of me and a lot of them have had serious mental health issues themselves or with children you know, so I have been very lucky that way cause they have been there, you know, to help and to listen and to support, try to help, so I feel lucky.

A strongly shared view was that **things needed to get to a crisis before anything happens**. Early attempts to gain help from GPs, schools and school nurses were either ineffective or not prioritised. There was a general frustration that early intervention and prevention were under-resourced.

Parents felt that they were in the best position to know if things were serious or not, but were unable to make professionals understand.

It is like "low risk" you have to wait for something really bad to happen before you are a "high risk" and then you will get some help. If they were low risk and they got sorted and advised and managed them, then surely the high risk people wouldn't be so high risk then.

Parents reflected that the only way to gain support quickly was to go to A&E and one parent had actually been advised to do so by a clinician.

I got told by a CAMHS worker that we should take our child to A&E when the self-harming took place because you'd be treated more as a priority at CAMHS once you have been through A&E.

Recently when she self-harmed, I phoned the doctors and they said they would phone back and I think they did but it went to answer phone and I thought I can't deal with it so we went to A&E and we waited. Eventually by

the time she was seen it was too late for CAMHS to come out, so she stayed in and she actually ended up in the hospital for two nights before they would let her go home. But yeh, we got seen straight away that way whereas the time before it was five months and that was with phoning them up and going to the MP and trying my upmost to get something done about it.

Parents need practical support in how to cope in-between appointments with clinicians and link workers. There were numerous examples of parents having no resources or support network to turn to and being left to their own devices to manage the immediate environment for weeks, either before assessment or between appointments.

We alerted our GP that day and she referred us to CAMHS immediately. This was at the start of the summer holidays and we had a seven or eight weeks wait to see CAMHS and we had no instructions on what to do at all in that time, I just looked after her and was with her 24/7, but we had no idea what to do because we had never come across it before.

Practical support such as how to manage and what to say to younger siblings, how much space to give to the young person or whether to supervise them constantly and issues such as what to do with blades and sharp objects

One of the hardest things I found was we were told by CAMHS to lock everything away that was sharp or medicines or cleaning materials, all that sort of thing. But my daughter actually used pencil sharpener blades, which I had never thought of. But its knowing or I think, not knowing when you know, she has got one of those in her room..., do we take it away? Or do we leave it? What is worse, if we take it away she might find something far worse but if you leave it there you know she has got it and she will do it.....Initially.... we took it away, but she just found other pencil sharpeners. So then we decided to leave it in there because we knew where it was, but no one told us that at any stage.....we had to find our own way.

Parents expressed the desire to be enabled as a carer, with knowledge and arms-length support so that they could manage between appointments with professionals. The emphasis of all the support they discussed had been on the child and they felt there was a gap for parental support.

I don't want people to think I am a useless person and that I need help because I don't, I need them to help me help my son.

Parents did not feel that they are seen as an asset. Parents felt that they are viewed as part of the problem rather than part of the solution. They saw the potential in strengthening them in a situation where resources were restricted, because they provided the “*back bone*” and were the ones holding it all together,

*I think it is so frustrating that health professionals don't see parents as part of the solutions they see us as part of the problem and I think they actually, they forget that actually your child might see them for an hour every two weeks but the rest of the time it's **you**, you are the one who's having to deal with it, day in, day out. Day or night, every single day, it doesn't go away, it goes on and on and on. It's not like it's a quick fix.*

On the whole there was a **variable experience of CAMHS.** In the absence of other support, parents described how CAMHS appointments were built up to be a panacea and that their expectations before their involvement with CAMHS were incredibly

high. One parent describes how she felt when they were finally given an appointment.

When we had our CAMHS appointment, it was like, oh my God, it's like, we're going to see the Wizard Of Oz.....I was expecting some like, throne, cos it was all like, "ooh, if you get a CAMHS appointment", I was thinking "Thank God" and then this link worker said well I'm gonna take him on straight away, cos I do really feel that he does really needs some help, and I went out there and I said to my husband, "I feel physically sick, I feel so relieved, It's like this huge weight....", but just it was, it was just...you find out that that's it, you get a link worker comes around once every fortnight and she comes around and says "how is everything?" and you think, that's only another hurdle you've got to get over, cos you've gotta get past her yet, boot her out the way, ready for the next person...it does feel like that doesn't it, feels like you're doing the hurdles..

Link workers were often seen as ineffective, for example using old facts and figures and providing very little in the way of meaningful support. Some felt that it was easy for both children and young people to learn say the right thing to link workers to make them feel everything was OK.

The woman then said to her "well do you think you might do something or hurt yourself?", and she said "no I won't" and that was that then, it was almost like as if, well that was that solved and sorted, she won't do it.

Some had expected CAMHS to offer support for parents and the whole family but this had not been their experience.

I don't feel like in 18 months we've had any parent support.

Others found that a reliance on part-time staff meant that they were not able to address things at the right time as the staff member was not working on that day and that too many people seemed to be involved in their child's care, with "no one in charge".

One parent felt that the only way they could break through and feel in control with CAMHS was by being quite assertive and demanding to speak to a more senior person when they felt that insufficient progress was being made. In addition they sent weekly progress emails in attempt to retain sufficient focus on their daughter's progress. The rest of the group were not confident enough to do this. Parents felt they needed to be more empowered in their relationships with CAMHS. One parent described it as needing "permission" to follow up and ensure they gained sufficient support:

*I think **permission**, I know it seems ridiculous...., but actually knowing you actually have **permission** to call these services up and see what is going on, cos often you leave and you've got an appointment or somebody will be in touch. But actually you need to know that it's OK to ring up and say "it has been three weeks, I haven't heard anything, can you tell me what is going on?" That actually...you're not being difficult, you're checking what is happening, and I think someone like me, I know it sounds ridiculous, but I do need that permission. I would benefit from professionals saying "actually it is ok...you might wonder what's going on so please do call us, if you want to check" and just feeling like that's OK.*

A strong theme in the discussion was **how parents could be better supported**. Most attending the support group had found information about it via the internet and only one had been signposted to the group via a school-based family support worker.

It may be that a better use of phone messages, texts or emails in between scheduled appointments with CAMHs would help to support parents and maintain their capacity to help their child/young person. Parents spoke of countering feelings of being “alone” or “living in a different world” to everyone else and recognised that even if the messages were generated centrally by a computer, they would still feel it was sufficiently personalised that “a particular person has personally contacted me” and they had been personally targeted by the message.

When you are living it you don't always consciously think Oh, I need to ring them for some help, it would be nice if they just spontaneously rang you and said, “how's it is going, what's happening” just somebody that you've always got...you know that you know that person's gonna ring you regularly just check in.

If we get a text saying “just checking if everything is alright and you know where we are and if you need us...”(you think) Oh good... probably won't phone you, so don't worry, but just to know someone else is there..(sighs).....Cos if you're in the middle of a really bad time and you just get that text and you just, “oh...there's someone else there”.

Parents need to feel understood. Support groups or online forums could provide an opportunity to feel less isolated and more “normal”.

*But just coming here is..... you know is....and a couple of my friends I've said.. “Just come “ because honestly, you think, you're not normal, believe me, you'll find, you're more normal than you think, when you get here and you see that there's so many other people, I always get home and I am exhausted when I have been here because I feel like, “ah, someone understands” and it is **such a nice feeling**. So I don't know where I'd be without you.*

That [online forum] would be brilliant cos actually it is nice to be able to talk to people who understand what it is like and it often is at 11 o'clock at night when everything is fine and is still and you need to type something out and maybe someone else will be there, or they could get up the next day and it's nice to have that reassurance that you're not on our own.

Parents in the group felt that professionals need to develop their skills through training to ensure a better outcome for all. They felt that without understanding the experience of people who lived through the experience they may not properly understand what it was like. **Training should utilise real people with lived experience** to provide the powerful messages and make the right impact.

*It is so frightening to be faced....for six months... I used to go into my daughters room not knowing whether to find her alive or dead, it is as basic as that. It's exhausting to be faced with that every single day.....and I think, when I go out and do talks, the response I get, when I spoke at this training on Friday to teachers they were sitting there almost in tears, and they **actually hear it** for what it **actually means** to be a parent of a child that is going through this, rather than a statistic or facts on a fact sheet.*

APPENDIX 2

Health Needs Assessment Self-Harm in Devon

Professional View of Health Needs of Client Group and the System Currently Available To Support Them

Stakeholder Organisation: Royal Devon and Exeter Hospital	
Client Group: children and young people	Professional Role: Consultant Paediatrician

Headline issues: (please complete the highlighted fields if at all possible)

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Issues around.....	Please write as little or as much as you like ...
The “systems” or “set-up”, constitutional factors:	
National or local guidance/ pathways or absence of:	
Staff training, confidence, competence.	
Society, social and community networks:	.
Age, sex (gender), other protected characteristics ¹	
Pattern changes/ trends over time.	
Felt needs of client group and carers: <i>What is wanted or desired?</i>	
Expressed needs of client group and carers: <i>What is asked for?</i>	
Comparative need: <i>What do others get?</i>	
Assets/strengths to make more of going forward:	
Anything else to add?	
Any anonymised case histories to share which may help illustrate points made?	

Thank you for adding your perspective into this Health Needs Assessment

Please return by Tues April 7th to lucy.oloughlin@devon.gov.uk

¹ disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sexual orientation

Summary of Relevant National Guidance

This summary identifies the key components of the following guidance as they pertain to service planning, commissioning and provision around self-harm; *National Institute for Health and Care Excellence (NICE) guidelines: Self-harm: short-term management (NICE, 2004), Self-harm: longer-term management (NICE, 2011) and evidence updates* and Royal College of Psychiatrists guidance *Managing Self-harm in Young People* (RCP, 2014)

NB: NICE guidance is in black and RCP guidance is in blue

Planning and Commissioning

NICE guidance states that all relevant organisations should jointly plan:

- integrated physical and mental healthcare services within emergency departments for people who self-harm in conjunction with local service users and carers wherever possible
- *consider* integrating mental health professionals into the emergency department, both to improve the psychosocial assessment and initial treatment for people who self-harm, and to provide routine and regular training to non-mental-health professionals working in the emergency department.”

RCP Recommendation 1: For self-harm presenting to the acute hospital, commissioners need to be mindful that multiple services are involved. Therefore, service specifications for all relevant services should include recognition of the importance of self-harm in young people.

RCP Recommendation 2: Commissioners need to stress the importance of collaborative working between the acute hospital, mental health services and the local authority in responding to a young person’s self-harm. Commissioners need to prevent fault lines developing between services, where possible. Pressing for joint protocols and agreed pathways is a good way of promoting collaborative working.

Specifically: adequate in-patient psychiatric beds for children and adolescents commissioned, readily accessible to prevent young people staying on acute medical wards for long periods. Pathways promoting strong community links and facilitating early return to the community should be set down.

RCP Recommendation 10: It is recommended that a consultant paediatrician (local lead) and a consultant child and adolescent psychiatrist be nominated as the joint service leaders. They should work together to ensure that protocols for assessing, caring for and treating young people who harm themselves are negotiated with and agreed between their employing trusts or directorates, where they are different. Additionally, they should press for the resolution of operational difficulties and delivery of appropriate training to paediatric ward and emergency department staff.

Improving knowledge, awareness and skills around self-harm

People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

To enable this statement, all staff (clinical and non-clinical) who come into contact with people who self-harm are expected to receive dedicated training which is regularly reviewed.

- Training should equip staff to understand and care for people who have self-harmed
- People who self-harm should be involved in the planning and delivery of training for staff.
- Emergency departments should make training available in the assessment of mental health needs and the preliminary management of mental health problems, for all healthcare staff working in that environment.
- Mental health services and emergency department services should jointly develop regular training programmes in the psychosocial assessment and early management of self-harm, to be undertaken by all healthcare professionals who may assess or treat people who have self-harmed.
- Providers should offer staff appropriate training on consent and confidentiality in relation to self-harm.
- Health and social care professionals who work with people who self-harm (including children and young people) should be: trained in the assessment, treatment and management of self-harm, and educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgmental attitudes.
- staff responsible for assessing and treating children and young people who have self-harmed should have age-appropriate training and experience
- Providers should regularly review these training requirements, and update them when appropriate.
- Training should be implemented as part of existing continuing professional development arrangements.

RCP Recommendation 5: Many school staff feel unskilled and unsupported in dealing with pupils' self-harm, so it is important that schools prioritise the self-harm training needs of their staff along with other mandatory training. This support is crucial for staff to feel confident in supporting young people in an effective, non-judgemental manner.

RCP Recommendation 6: Young people who self-harm should be involved in the planning and delivery of training.

Access to specialist advice and resources

- Providers working with children and young people or older people who self-harm should have arrangements in place to enable their staff to access specialist advice about mental capacity and consent, when needed.
- Health and social care professionals who work with people who self-harm should be familiar with local and national resources, as well as organisations and websites that offer information and/or support for people who self-harm, and able to discuss and provide advice about access to these resources.
- Commissioners are asked to consider should consider developing information on the services available locally and how these services can be accessed, possibly developing a local directory of services that details eligibility criteria and referral processes.

The role of all front-line professionals

RCP Recommendation 3: Asking about self-harm does not increase the behaviour. It is important that all front-line professionals become familiar with asking about self-harm when talking with young people who are struggling with changes in their lives.

RCP Recommendation 11: All professionals involved in the assessment and management of young people who self-harm, should ensure that good-quality care is provided in a non-judgemental, confidential manner, respecting the young person and their family with a view to emotionally supporting recovery and treatment. At all stages, unhelpful critical comments can raise barriers to future help-seeking and should be strictly avoided

Preliminary Assessment

People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

This is relevant to ambulance, primary care and emergency department services. This should be age-appropriate and determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

RCP Recommendation 4: Front-line professionals should be able to carry out the basics of a mental health risk assessment.

Treatment

People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.

People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.

Children and young people under 16 who have self-harmed should be assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

People who have self-harmed receive a comprehensive psychosocial assessment. This should include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness and full mental health and social needs assessment.

People receiving continuing support for self-harm have a collaboratively developed risk management plan.

This should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Effective liaison psychiatric services

Effective liaison psychiatric services should be available 24 hours a day

RCP Recommendation 12: An essential component of liaison provision is for arrangements to be in place for young people to be assessed on all days of the year, including weekends and Bank Holidays.

Admission of children under 16

All children or young people under 16 who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day

RCP Recommendation 7: In line with NICE guidance, young people under the age of 16 seen in the emergency department following acute self-harm presentations should be admitted. Admission should be to a paediatric, adolescent or medical ward

or to a designated unit. This is indicated regardless of the individual's toxicological state so that comprehensive physical and psychosocial assessments can occur and management/crisis intervention can be planned and initiated.

RCP Recommendation 8: For 16- to 17-year-olds, a developmentally sensitive and risk-proportionate approach should be taken. The objectives continue to be detection of difficulties and high-quality mental health assessment and planning, focused on the most vulnerable young people. If these objectives can be met and safe discharge planned, then it is suggested that a young person aged 16–17 seen in the emergency department following an acute self-harm presentation does not always need to stay overnight. However, if in any doubt, admission should follow.

People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

This should involve offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm.

Longer Term Management

People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

This should be developed with the person who self-harms. This should be revised annually as a minimum and shared with the person's GP

RCP Recommendation 9: Where concerns arise about care quality or significant harm, joint assessment by social care and health services staff should be arranged, with local procedures to reflect this.

Professional and parental engagement in Digital Lives

RCP Recommendation 13: It is critical for professionals to include an assessment of a young person's digital life as part of clinical assessments, especially when there are concerns about self-harm.

RCP Recommendation 14: It is important for parents to be interested and engaged in their children's digital lives as early as possible.

Family and carer support

Providers should routinely involve families, carers and significant others in the care of a person who self-harms, when there is consent to do so. More specifically, they should:

- offer written and verbal information on self-harm and its management, including how families, carers and significant others can support the person
- offer contact numbers and information about what to do and who to contact in a crisis
- offer information, including contact details, about family and carer support groups and voluntary organisations, and help families, carers and/or significant others to access these
- inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.