Children & young people Who self harm

Why is this issue important?

Self harm among young people is a major public health issue in the UK, it affects at least one in 15 young people and some evidence suggest that rates of self harm in the UK are higher than anywhere else in Europe .[1]

- Over the last ten years inpatient admissions for young people have increased by 68% due to self harm
- Last year alone hospital admissions for under 25s increased by 10% due to self harm
- Amongst females under 25 there has been a 77% increase in the last ten years in inpatient admissions due to self harm

The National Institute for Health and Clinical excellence (NICE) define self harm in clinical guidance as 'self poisoning or self injury irrespective of the purpose of the act" including poisoning, asphyxiation, cutting burning and other self inflicted injuries.

The World Health Organisations defines self harm as "an act with a non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others will cause self harm or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences"

The Royal College of Psychiatrists state that at a wider level self harm "may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem(such as anorexia or bulimia) , being addicted to alcohol or drugs , or someone simply not looking after their own emotional or physical needs"

Self harm and suicide are often considered separate issues as self harm is "usually intended to harm: not to kill or even to inflict serious and/or permanent damage".

Levels of self harm are one of the indicators of the mental health and mental wellbeing of young people in our society

Self harm is a response to profound emotional pain that the young person cannot resolve in another way. It is a way of dealing with distress and feelings that are difficult to cope with

European research [2]showed that the likelihood of self harm was positively associated with a range of life experiences and personal characteristics. Among males the factors associated with self harm were a family member who had attempted suicide or deliberately harmed themselves at some point during the young person's lifetime; any drug use in past year and a low self image and self esteem,. The factors associated with self harm among females were a family member who had attempted suicide or deliberately harmed themselves, a close friend who had attempted suicide or harmed themselves, a low self esteem and low self image; cigarette smoking, drug use in last year, worries about sexual orientation, high impulsivity and a high anxiety level. Other factors often linked with self harm including bullying, physical or sexual abuse, poor family relationships and problems with boyfriend or girlfriends showed independent associations with self harm in fewer countries.

Findings for England were found to be broadly similar to pan European findings. For example school pupils said their most common motivation for self harm was to cope with distress. The study in England also reinforced the point that adolescents who self harm are more likely than average to have a range of problems, to have maladaptive coping strategies and to use very little support apart from their friends.

Research suggests that young people usually start to self harm as the result of a complex combination of experiences. Fox and Hawton (2004) found that factors specifically linked to self harm include mental health problems, family circumstances disrupted upbringing and continuing family relationship problems. Other research also indicates a correlation between sexual abuse in childhood and later self harm

Groups and populations at particular risk of self harm:

Self harm amongst young people in institutional or residential setting (including the armed forces, prison custody, sheltered housing or hostels and boarding schools a) are continually reported anecdotally to be higher than community setting but data is not consistently collated

Custody ; figures from the prison service show that a high proportion of people and particular young people

[1] Truth Hurts Report of the National Inquiry into Self Harm among young people 2006

[2] Child and adolescent self harm in Europe study (CASE) 2005

Children & young people Who self harm

under the age of 21 self harm in custodial settings. Female rate of self harm was significantly higher than for males.
Lesbian, gay, bisexual and transgender young people. Research In Ireland [3] showed that 1 in 4 bisexual young people had made a suicide attempt and 1 in 5 gay/lesbian young people have made a suicide attempt. Bisexual and unsure young people reported an increased % of low self esteem. There was a difference between bisexual young people and heterosexual young people where bisexual young people showed a higher rate of negative avoidant behaviour and poor family support than their heterosexual peers. The mitigating and supporting presence of one good adult in their lives was low for bisexual young people and would therefore increase their risk of self harm/suicide
Black and minority ethnic young people; anecdotal evidence from BME projects suggests that Asian young women have a two to three times greater risk of self harm
Young people with learning disabilities. Of the young people in the UK who have learning disabilities, 40% are likely to develop a diagnosed mental health problem [4] for most young people with learning disabilities their behaviour has been associated with their condition rather than a response to distress and there is little detail in research[5]

A large scale piece of research was conducted in 2012 across young people (aged 12-24), GPs and other health care professionals, teachers and parents (of children 11-24). [6]The methodology included both quantitative and qualitative research, social media discourse analysis and literature review

The words most associated with self harm across the groups were:

Self harm was seen as a hugely concerning issue by all concerned and particularly amongst young people

81% of young people would be very worried if they knew that a friend was self-harming, compared to 53% who would be worried about an eating disorder or 50% if their friend was being bullied.

All groups felt that it was very important to talk more openly about self harm
While the vast majority of people believe that they need to be able to offer support, they currently don't feel able to. Self-harm is the issue that all groups feel least comfortable approaching with young people. Two in three teachers, parents and young people all think that they would say the wrong thing if someone turned to them.
Crucially, over a third of GPs (38%) say they would like to be able to talk to a young person about self-harm but don't know how.
Over half of GPs, teachers and parents (52%) agree that young people who self-harm are likely to attempt suicide.

For parents, the thought of their own child self-harming rings huge alarm bells as they believe there must be something seriously wrong at home for it to happen, reflecting very poorly on their ability to provide a supportive home.
At the other end of the spectrum from the view that self-harm is too serious to be broached is the perception that it is trivial or 'selfish' behaviour... that it's a fashion, a fad or a way to manipulate people.

The views on the extremes perpetuate the stigmas of both how frighteningly serious it's perceived to be and/or how trivially it can be perceived. While the main view held is that self-harm is to be sympathised with and it is a way of coping with emotions, there is a deep lack of understanding and empathy as to why it happens.

Information and opinions about self-harm can come from anywhere; discussions with friends, what's seen or heard in the media, links from Google, any number of social media sites and forums, schools or other professionals organisations. Across teachers, parents and young people, there is a lack of consistency offered by this broad range of sources in terms of the types of information and opinion expressed within them. Information can vary from supportive to dismissive, from inciting self-harm to mocking those who do it.

[3] My World Survey study of youth mental health in Ireland, Dooley and Fitzgerald 2012)
[4] Emerson 2003
[5] Truth Hurts Report of the National inquiry into self harm among young people
[6] Talking Self Harm
http://www.cellogroup.com/pdfs/talking_self_harm.pdf

Children & young people Who self harm

When a young person looks for information, or information finds a young person, it's really a game of chance as to whether that information will be measured and helpful or part of a negative extreme view.
Conversations with friends are the most common source of information on self-harm for young people (45% of young people say that's what informs their views). Information online, from websites, social media sites, blogs etc, is second most common (33% of young people say these inform their opinions about self-harm). While online peer support can be helpful and positive for young people, when it comes to self-harm, the online landscape is particularly complex: there is a lack of coherent messaging and meaningful conversations around the issue, particularly in the social media space where young people who are self-harming turn to for support. While the authoritative voices of charities are present online, different groups of people are also constructing and shaping their own niches and discourses around self-harm, which gives rise and weight to more extreme associations seen elsewhere in the research. Potentially, this can lead to a very disparate set of narrow views around self-harm.

There are clear differences in opinion between pupils and teachers on how self-harm is dealt with in schools. One in three teachers (34%) believe they are covering self-harm in lessons, but just over half that number of pupils (20%) think that's the case.

The lack of clear and defined information sources mean that 77% of young people feel that they don't know who to turn to with questions about self harm a view that is shared by parents, teachers and GPs. Only around one in ten young people feel comfortable seeking advice from teachers, parents, GPs or the school/health systems in general, whereas around half feel these groups are where they should be able to turn. Conversely, half are comfortable going online (Google or forums where other young people talk about self-harm), but only one in five feel that's where they should be going.
Self-harm's strong association with mental illness and problems with young people's home life can position the behaviour as something beyond teachers' reach. Unlike many issues and behaviours affecting young including gangs, eating disorders, drugs and alcohol, teachers have relatively few anchor points for understanding self-harm.
The study showed that there is considerable variation in support offered in schools and that schools find it increasingly difficult to support young people with issues from outside the school environment including those online
Some questions exist around whether school approaches to self-harm could themselves be exacerbating stigma and fear. For example, in some schools self-harm is treated as a Child Protection issue but eating disorders and persistent heavy smoking are not. The passing of concerns re self harm to Child protection leads in schools was seen to have potential to damage relationships between the young person and the trusted adult they first spoke to.

The majority of parents reported being wary of discussing self-harm proactively and many didn't feel confident about responding to it if they were to discover it in their own family. Parents typically associated self-harm with failure as a parent. There is a strong underling fear of judgment: self-harm is considered an 'at-home' activity, thereby parents feel the blame will be placed on the home environment and themselves. Indeed, parents spoke negatively of other parents whose children self-harmed.

While 86% of GPs would be comfortable talking about self-harm and what it means with a young person, Health Care Professionals (both GPs and other frontline Health Care professionals) face significant challenges in effectively managing self-harm behaviour.
The biggest challenge for almost all GPs (96%) is unsurprisingly that the consultation time is not long enough to deal with the issue. Significant time pressures on front line A&E staff mean they can only treat the physical trauma and not the underlying cause/issues. Three in five GPs report they are concerned that they do not know what language to use when talking to a young person about self-harm.
88% of GPs feel that referral options within the community are insufficient and three quarters lack the necessary assessment tools and guidelines. Overwhelmingly, referrals centre on CAMHS (95%) and counselling services (72%), where available.
There is limited specific knowledge of or use of self-harm guidelines which means that most Health Care Professionals use their intuition alone when managing self-harm patients. Additionally, 85% of GPs have never had any training specifically related to self-harm, which appears consistent across other front line professionals (e.g. A&E) included in the research.

Relationship between self harm and suicide
Psychological postmortem studies of suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most

Children & young people Who self harm

adolescents who die by suicide. A history of behavioural disturbance, substance misuse, and family, social, and psychological problems is common. There are strong links between suicide and previous self harm: between a quarter and a half of those committing suicide have previously carried out a non-fatal act.[7]
People who self-harm repeatedly are at a high and persistent risk of suicide (Owens *et al*, 2002; Hawton *et al*, 2003). One recent study found an approximately 30-fold increase in risk of suicide, compared with the general population, among those they studied; the rate was substantially higher for female patients than for male patients. Suicide rates were highest within the first 6 months after the index self-harm episode (Cooper *et al*, 2005).[8]

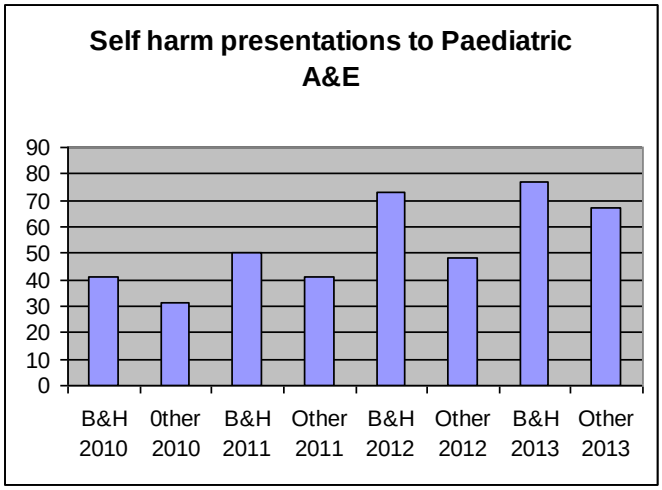
Treatment of self harm
Clinical Guidance for the management of self harm makes recommendations for the assessment and treatment of people in primary and secondary care in the first 48 hours after having self harmed. It reflects that users of services often describe an experience of care that is unacceptable and there is a sense that self harm is poorly understood by many NHS staff. The guidance sets out specific special issues for children and young people (under 16 years). Key points are:

- children should be triaged, assessed and treated by appropriately trained staff in a children's area of the emergency department.
- It recommends that nurses should be trained in the assessment and management of mental health issues and self harm.
- The recommendations suggest that young people should be admitted overnight.
- Emphasis is placed on the issues of confidentiality, consent, child protection, the menial health act and the Children Act.
- Guidance states that a CAMHS team should undertake assessment and that practitioners should have specific training and supervision and support to deal with self harm presentations.
- The guidance proposes that young people who have self harmed would benefit from group psychotherapy.

Many young people who self harm do not attend hospital departments or seek medical attention. Incidents of self harm presenting in A&E are predominantly for self poisoning

Impact in Brighton and Hove

Over the last 4 years, the number of children and young people presenting at the Paediatric Accident and Emergency (A&E) department of the Royal Alexandra Children's Hospital with serious self harm has increased significantly. The figures are taken from the social work team who assess all those young people presenting with self harm. The Paediatric A&E sees all young people up until their 17th birthday after which time they would be treated in adult A&E and would access the adult mental health liaison team.



Not only have the numbers presenting been increasing, the social work team in the hospital have also recorded increase in severity and potential for long term impact on the health of the child/young person.

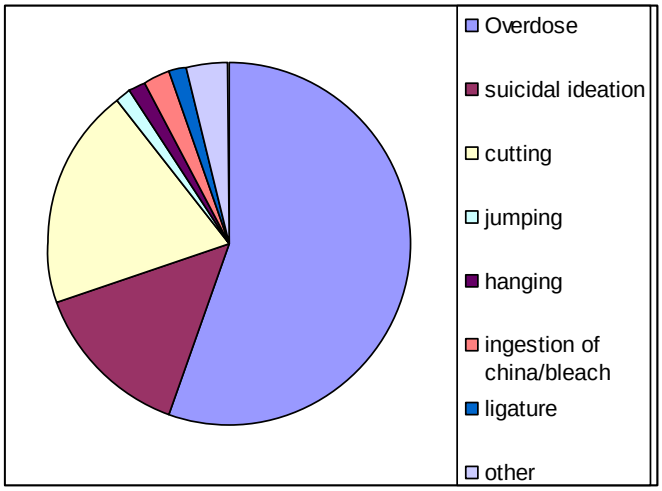
Of the total numbers in 2013:
74% were girls
81% were 14- 16 years of age
52% were first time attendees
48% were repeat attendees

The nature of the self harm varied and could be categorised as follows (B&H data only):

[7] **Suicide and deliberate self harm in young people***BMJ 2005; 330 doi: http://dx.doi.org/10.1136/bmj.330.7496.891 (Published 14 April 2005)*

[8] Self-harm, suicide and risk: helping people who self-harm Final report of a working group RCpsych report 2010

Children & young people Who self harm



Whilst anecdotal, other services for children and young people-both statutory and community and voluntary sector are reporting significant numbers of children and young people they work with to be self harming.

National data re emergency hospital admissions (2007/08 -2009/10) shows the England average to be 137.8 per 100,000. For the period 2007-2009, figures for Brighton and Hove indicate a rate of 181.9 thus well above the England average. [9]

Allsorts survey the attendees at their drop-ins and ask specific questions about mental health, self harm and suicide. In the quarter October – Dec 2012 38 LGBT young people responded of whom;
38 LGBT young people undertook survey at drop-in reporting on their last three months:
18% self harmed
21% contemplated suicide
11% attempted suicide (4 individuals) (none attended A&E as a result)
9 trans young people at Trans youth group (Transformers) (i.e. separate survey):
33% self-harmed
66% contemplated suicide
22% attempted suicide (2 individuals) (none attended A&E as a result)

CAMHS reported the following data from all currently actively worked upon cases as of Friday 6th July 2012

Total

	Number	Percentage of all open cases	Estimated percentage of over 13 yrs open cases
Number with current self harming	11	5.50%	17.00%
Number with historical self harming	4	2.00%	6.00%
Number with historical overdoses/suicide attempts	2	1.00%	3.00%
Number with reported suicidal ideation	6	3.00%	9.00%
Number of cases being referred to t3 due to above issues	2	1.00%	3.00%
Number of cases with substance misuse reported	7	3.50%	10.50%
Cases with no self harm risk identified	172	84.00%	51.50%
Total number of cases open	204	100%	100.00%

Research undertaken by Right Here indicated that the perception of self harm is that it is very prevalent particularly amongst those in the early teenage years.[10] The study findings echoed those of the national research with GPs and schools. Predominant issues of lack of confidence and awareness amongst staff about how to tackle concerns re self harm dominated. It was also clear that the issue is of great concern to local students and staff. Similarly the study reflected national findings that sources of help are not always clear for young people and/or professionals or family members.

9.3% of respondents in the KS4 safe and well in school survey (SAWSS) 2012 responded to the question 'how do your feelings affect how you live your life?' indicated that they would hurt/harm themselves.

[9] Hospital admission rate for self harm Chi Mat emergency hospital admission rate for self harm age 0-18 years (2007-2009)

[10] Right Here Brighton and Hove Young People and Self Harm; perceptions and understanding February 2014

Children & young people Who self harm

Review of cases presenting in paediatric A&E with self harm also reflected national findings about the reasons for self harm. Of the 8 cases randomly selected and considered in detail (Carefirst records):
5 had been reported as a missing person on at least one occasion
6 had a family history of contact with social care
4 had parents with known substance misuse or mental health issues
4 had very poor school attendance
2 were excluded from school
2 were known to the police for shoplifitng
4 had reported substance misuse issues (alcohol and drugs including cannabis, ketamine and MDMA)
3 had identified concerns about sexual vulnerability
5 had witnessed or experienced domestic violence
4 had historic contact with CAMHS
1 had a diagnosed mental health condition
1 had a recorded history of sexual abuse

Strikingly most of the young people had multiple and complex histories and a number were part of an identified 'gang' of young people displaying anti-social and criminal behaviour within their community.

Local treatment of self harm
Brighton and Hove has a specific paediatric A&E within the Children's hospital staffed by trained children's nurses and doctors. The A&E treats young people up to their 17th birthday. Young people presenting with self harm are triaged and treated for the presenting medical issue. Once medically fit they are assessed by a social worker who undertakes a risk assessment and determines whether a mental health assessment is indicated. Where appropriate a CAMHS duty worker will attend A&E to assess and decide the plan of care. Where a young person is known to CAMHS and the risk is deemed low they may be referred for a CAMHS appointment either the next day or shortly afterwards. Where a social worker can identify the immediate need for CAMHS they will alert the team and undertake joint assessment. If a young person presents out of office hours they may be admitted to a paediatric ward overnight and a CAMHS assessment planned the next day. The Urgent Help service operates until 8pm and at weekends and can support the hospital in deciding level of risk and need for admission. 24/7 psychiatric access is available where there are serious concerns for a young person's mental health. Where necessary a mental health act assessment can be undertaken and a specialist CAMHS inpatient bed sought. This does not happen often and where it is deemed necessary for a young person to have a period of inpatient treatment this is done in a planned way.

The social work team at the hospital report that anecdotally the young people often state that they access sites such as Facebook and tumblr and also in some cases more extreme sites promoting self harm.

Conclusions
Brighton and Hove is reflecting the national picture in relation to increased numbers of young people presenting with self harm. Young people see it as a major issue amongst their peers and almost something that has been 'normalised'. Locally treatment of self harm in secondary care meets NICE guidance.
There is still significant stigma despite high profile individuals being prepared to talk about their own self harm
Locally and nationally professionals in education and medical settings describe their anxiety about talking with young people about self harm and where to seek help
Social media and online resources can be helpful but there are also sites and online behaviours that are worrying
Young people presenting in Brighton and Hove A&E have complex histories, often over many years. Many have been of concern to their school or social care for some time and participating in risky behaviours before and alongside any incidents of self harm
Numbers self harming in the city are indefinable due to the secretive nature of self harm and those presenting to A&E are the tip of the iceberg

Children & young people Who self harm