Self-harm needs assessment for children & young people

February 2018

Brighton & Hove City Council

Public Health Intelligence Team

NHS
Brighton and Hove
Clinical Commissioning Group

Brighton & Hove
City Council

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GLOSSARY

A&E	Accident & Emergency Department	
ADHD	Attention Deficit Hyperactivity Disorder	
	Allsorts Youth Project	A local voluntary sector agency supporting children and young people under 26 who are LGBTU. They provide one-to-one support through their 'Talk It Out' sessions.
ATS	Assessment and Treatment Service	Local entry point into specialist mental health service for adults
BHCC	Brighton & Hove City Council	
BSUH	Brighton & Sussex University Hospitals	
CCG	Clinical Commissioning Group	
CIN census	Children in need census	The CIN census collects information on children who have had an assessment to be in need of social care services. Social workers complete an assessment with the family and select from a list of possible factors the family are experiencing, of which self-harm in the child is one option.
CYP IAPT	Children and Young People Improving Access to Psychological Therapies	A programme designed to effect whole system transformation in existing mental health services for children and young people (Section 2.3).
	Community Wellbeing Service	Local service for all ages with mild to moderate mental health needs.
CQUIN	Commissioning for Quality and Innovation	A national framework specifically around transition with the aim of improving the experience and quality of transition from one part of the system to another.
	E-motion	Free online counselling for young people aged 13-25 years who live in Brighton & Hove
	Grassroots suicide prevention	Brighton-based suicide prevention charity.
GP	General Practitioner	
HES	Hospital Episode Statistics	HES contains records of all admissions, appointments and attendances for patients at NHS hospitals in England.
IMD	Index of Multiple Deprivation	A measure of area deprivation measuring aspects of deprivation experienced, such as income, education, employment, health and crime amongst others.
LGBTU	Lesbian, Gay, Bisexual, Trans or Unsure of their sexual orientation and/or gender identity	
LSCB	Local Safeguarding Children's Board	Section 13 of the Children's Act 2004 requires each local authority to establish a LSCB. Their main role is to coordinate what is done locally to protect and promote the welfare of children and young people in the city and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people.
MHRRS	Mental Health Rapid Response Service	A local urgent response service for adults who are experiencing a crisis with their mental health, who think they are at risk of harming themselves or others.
	Mental Health First Aid	Training courses educating people on mental health, empowering them to care for themselves and others.
	MindEd	A free educational resource on children and young people's mental health for all adults

NICE	National Institute of Health & Care Excellence	
PMHLT	Paediatric Mental Health Liaison Team	This supports children and young people who attend hospital with mental health issues including self-harm. They have a one-hour response and refer on to other services if required.
RSCH	Royal Sussex County Hospital	
RACH	Royal Alexandra Children's Hospital	
SAWSS	Safe & Well at School Survey	An anonymous online survey conducted annually by primary and secondary state schools. The 14-16 year olds survey has additional questions not asked of younger children, including self-harm questions in 2012-2015.
	Schools Wellbeing Service	Local service for school-age children with mild to moderate mental health needs.
SFA	Strengthening Families Assessment	The Strengthening Families Programme is one element of the government-funded Troubled Families programme. A SFA is carried out to capture the range of factors a family are experiencing.
Specialist CAMHS	Specialist Children & Adolescent Mental Health Services	Local service for children requiring specialist mental health support.
SPFT	Sussex Partnership Foundation Trust	
	YMCA DownsLink Group	A charity supporting children, young people and families in Brighton & Hove, including supported accommodation and community projects including counselling.
	YMCA Dialogue	Delivers counselling and therapy to children and young people.
YPC	Young People's Centre	A safe and social space in Brighton where young people aged 13-25 can access free advice, support and counselling, affordable food, activities and free access to computers.

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1. Executive summary

This needs assessment identifies the health and wellbeing needs of children and young people (up to age 25) in Brighton & Hove who self-harm or are at risk of self-harming and makes recommendations for action.

For the purposes of this report, self-harm was defined as the following: ***"Self-harm (also known as self-injury or self-mutilation) is the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and/or self-neglect."*** Other definitions were felt to potentially under-report self-harm displayed by males.

A history of self-harm is associated with a significantly increased risk of suicide, and around half of all people who die by suicide have a history of self-harm. Self-harm in adolescents often has a 'contagious' quality.

Prevalence

Routine data on self-harm tends to rely on hospital data, yet only around 1 in 8 who self-harm present to hospital. **Around 20% of 14-16 year olds in Brighton & Hove report that they have self-harmed**, more than half of them 'sometimes' or 'often'. The most common method of self-harm in the community is cutting. Most of the data about self-harm however comes from hospital attendances and admissions, where overdose is the most common method.

The most recent hospital attendance and admission rates for self-harm among 10-24 year olds were higher in Brighton & Hove than England; attendances appear to be falling and admissions rising, though the pattern is unclear and masks what is happening by age group (increases in 10-19 year olds; slight decrease in 20-24 year olds since 2011/12). Many of these are repeat attendances by the same patients; repetition of self-harm is common.

Young people who present to clinical services are the 'tip of the iceberg' of those who self-harm; only around 1 in 8 who self-harm present to hospital.

A&E attendances for self-harm in Brighton & Hove drop substantially in the summer months in 10-18 year olds, which implies a seasonal effect potentially down to a number of factors including the school summer holidays. There is also a rise in A&E attendances in October among 19-24 year olds.

Risk factors

More females than males present to health services for self-harm, however they are also more likely to seek medical support and **self-harm in males may manifest differently**, in ways that often fall outside of self-harm definitions used by services or the community itself; it is therefore likely to be under-reported.

Of all ages, self-harm is most common among adolescents and young adults. Within this age range, hospital admissions for self-harm are **most common in the 15-19 age group** and least frequent among 10-14 year olds. Self-harm in Brighton & Hove is higher among young people from more deprived areas, yet it occurs among people from all parts of the city.

Local data shows that 14-16 year olds who report the following are much more likely to have ever self-harmed:

- **Suicidal thoughts** (28 times greater risk)
- **Have issues with food** (8 times greater risk)
- **Lesbian, gay, bisexual or unsure** (6 times greater risk)
- **Do not identify with gender assigned at birth** (6 times greater risk)
- **Often spend time alone** (5 times greater risk)
- **Bullied** this term (5 times greater risk)
- Worried about friends or **problems with friends/family** (4 times greater risk)

Other important risk factors for self-harm identified in the literature include **mental health issues, stressful or traumatic childhood experiences including neglect or abuse,** and **identifying with 'alternative' subcultures**.

Social media and the internet can provide support but can also be a risk factor for young people who self-harm. Local professionals express particular concern around web pages that promote and encourage self-harm.

Local services in relation to need

There was an extensive **redesign and reorganisation of children and young people's mental health services** in 2017. The Community Wellbeing Service and the Schools Wellbeing Service provide support for low to moderate mental health need and Specialist CAMHS provides support for those with high levels of need.

Young people, parents/ carers and professionals had a range of perspectives regarding services and support for local children and young people who self-harm, including:

- Professionals, young people and parents/carers identified barriers to accessing mental health services, including **long waiting times, inflexible thresholds** and **insufficient focus on the individual needs** of the child or young person. The new/redesigned services are actively working towards addressing these concerns.

- Professionals commented on the **lack of a joined-up approach and common understanding of self-harm across services**, and a need to **improve communication between organisations**. They also identified that more information about what is happening elsewhere in the system would be helpful, in order to facilitate a consistent approach and shared learning.

- Parents/carers and professionals highlighted **inconsistent approaches among services, including conflicting advice and responses**.

- Professionals identified **unhelpful and judgemental attitudes** and responses to self-harm across staff groups, and a **need for training among non-specialist professionals.**

- Professionals commented on the importance of **building young people's resilience** before they consider self-harming, and the important role of schools.

- Parents/carers and professionals highlighted **gaps in support for parents/carers** when a child self-harms.

There is not a 'one-size-fits-all' response or intervention for preventing or managing self-harm. However, there is a **lack of high quality evidence of 'what works' to reduce self-harm**. Therefore, local innovative approaches may be helpful, based on local need/ experience, shared learning and robust evaluation.

Recommendations

The following recommendations were developed and prioritised by the steering group based on the findings of this needs assessment:

1. Develop an action plan and an infrastructure/resource to implement this plan
2. Refresh the citywide definition for self-harm, supported by a common risk assessment and set of supporting resources
3. Explore options for improving communication and information sharing between services
4. Prioritise engagement with children and young people in the development of services
5. Develop a consistent training offer for professionals and families
6. Engage with local organisations/teams working on reducing online harm
7. Improve collection and use of data on self-harm
8. Review the interventions and approaches used by services for young people who self-harm in Brighton & Hove and make recommendations

2. Introduction

The aim of this needs assessment is to identify the health and wellbeing needs of children and young people in Brighton & Hove who self-harm or are at risk of self-harming, and to recommend priorities and action including for commissioners.

Self-harm is a major public health issue and occurs across all age groups. It causes physical injury and can indicate underlying trauma and mental health issues. It puts pressure on health services and leads to avoidable hospital admissions. **This needs assessment focuses on children and young people up to the age of 25**; of all ages, self-harm is generally most common among adolescents and young adults.

This needs assessment is conducted as part of the programme of Joint Strategic Needs Assessments overseen by Brighton & Hove Health & Wellbeing Board. Self-harm among children and young people has been identified as a priority in Brighton & Hove and was approved by the City Needs Assessment Steering Group and the Health & Wellbeing Board in July 2017.

2.1 Methods

A multi-sectoral steering group was established in July 2017 to direct and oversee the project. A range of methods were used to capture data and brought together into this report (More detail of the methodology is in Appendix 2).

Quantitative data analysis: Routine data on self-harm tends to rely on hospital data, yet only around 1 in 8 who self-harm present to hospital. Therefore routine hospital data is supplemented with local 2015 Safe & Well at Schools Survey (SAWSS) data for 14-16 year olds as well as data on self-harm among local service users.

Literature review and mapping existing local services: A literature review was conducted to understand self-harm and what works to prevent/reduce self-harm. A literature search was conducted by the Brighton & Sussex Library and Knowledge Service; peer reviewed and grey literature was gathered from steering group members; and additional searches were conducted on google scholar, NICE and Cochrane.

Surveys to capture the community voice: Two online surveys were designed to capture the views of (a) young people aged 16-25 with experience of self-harm, and (b) their parents/carers. The survey links were distributed via the steering group and local organisations, to promote to the relevant audience via social media, events and mailing lists..

Interviews with local professionals: Semi-structured interviews were conducted with ten professionals from a range of organisations involved in the care of children and young people who self-harm: Specialist CAMHS; Paediatric and Adult Mental Health Liaison Teams at the acute hospitals; Community Wellbeing Service; YMCA DownsLink Group; the University of Sussex; GP; nurse practitioner; Schools Wellbeing Service; and Allsorts.

2.2 The policy context

Action to address self-harm in Brighton & Hove should be considered in the context of national and local policies. Mental health has been placed on an equal footing to physical health in policy through Parity of Esteem. Self-harm can be considered both a physical and mental health issue.

The national *Five Year Forward View for Mental Health* published in 2016 highlights a need for action on mental health for all ages. It identifies children and young people as a priority group for mental health promotion and prevention, early intervention and quick access to good quality care (1).

In 2015 the government published *Future in Mind* to ensure that children and young people's mental health has increased attention and investment. This report highlighted the difficulties children, young people and their families have in accessing mental health support and provided a blueprint for whole systems change (2). In response to this, the *Children and Young People's Mental Health Local Transformation Plan* is produced annually for Brighton & Hove to improve children and young people's mental health support, interventions, services and outcomes (3).

A *National Suicide Prevention Strategy for England* was published in 2012 and committed to tackling suicide in six key areas. In 2017 the scope of the National Strategy was expanded to include a seventh key area for action: "Reducing rates of self-harm as a key indicator of suicide risk" (4). In response to the national strategy, a local suicide prevention strategy and action plan was developed for Brighton & Hove, which included actions aimed at reducing self-harm.

2.3 Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)

As part of the South East learning collaborative, Brighton & Hove are implementing Children and Young People's Improving Access to Psychological Therapies (CYP IAPT), a programme designed to effect whole system transformation in existing mental health services for children and young people though four principles:

- Improving accessibility of services
- Embedding evidence-based approaches and practice within the current workforce across care pathways, to enhance the choice and effectiveness of intervention available
- Ensuring the use of feedback and outcomes tools in clinical practice
- Developing participation as a central tenet in the design and delivery of mental health services across the system.

This is particularly relevant to this project given the value of implementing standardised measures to understand the effectiveness of service for those who self-harm.

3. What is self-harm?

3.1 Definition

There are a number of definitions of self-harm. **The definition chosen by the steering group for this needs assessment is the National Self-Harm Network definition**:

> *"Self-harm can take many different forms and as an individual act is hard to define. However in general self-harm (also known as self-injury or self-mutilation) is the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and/or self-neglect." (5)*

A range of other common definitions were identified but the steering group felt that they did not sufficiently consider an individual's motivation to self-harm, and as such did not take into account **forms of self-harm more commonly displayed by males such as violent and self-destructive behaviour, or alcohol or substance misuse**. For similar reasons, it was not felt appropriate to exclude particular self-harm behaviours such as eating disorders or aggressive behaviour from this needs assessment (though they are not considered individually). The professionals interviewed as part of this needs assessment tended to agree that **there was a wide range of behaviours that could be considered self-harm**.

3.2 Method of self-harm

The most common method of self-harm in the community tends to be cutting, whereas overdoses are the most common method among those who present to hospital (6-8). In Brighton & Hove in 2016/17, self-poisoning accounted for 85% of all hospital admissions for 'intentional self-harm'; 10% were due to a sharp object; 5% by another method. Other forms self-harm can take include burning, biting, substance abuse, head banging and hitting, taking personal risks, picking and scratching, neglecting oneself, pulling out hair and eating disorders (5).

3.3 Why do people self-harm?

Self-harm is generally seen as a coping mechanism by professionals and young people. A 2008 study found that the most commonly reported motivation for self-harm was the desire to relieve mental pain, which highlights that self-harm can be an act of self-preservation, a way to regulate emotion or a coping mechanism. The same study found that overwhelming sadness, self-hate and anger were the most common feelings reported prior to an episode of self-harm, whereas relief/release, calm and peacefulness, guilt/shame/embarrassment and self-hate/anger/disgust were the most common feelings reported afterwards (6). Many elements definitive of addiction are present in self-harm, though views differ as to whether it is an addictive behaviour (6).

3.4 Social contagion of self-harm

Self-harm in adolescence often has a 'contagious' quality with evidence to suggest social contagion of self-harm in a range of settings including inpatient units, prisons, group homes and special education schools, adolescents in the community, and colleges (9). Exposure to peer self-harm may put vulnerable adolescents at particular

risk for perceiving the behaviour as an effective coping strategy, especially because adolescents often identify with similar peers (10). Professionals interviewed as part of this needs assessment discussed self-harm incidents occurring in 'clusters', among groups of friends within a short period of time. The dominance of social media among young people may lead to increased risks of social contagion among younger generations.

3.5 Self-harm and suicide

A history of self-harm is associated with a significantly increased risk of suicide, and around half of all people who die by suicide have a history of self-harm (11, 12). However, **there are important differences between self-harm with suicidal intent** and, for example, self-harm used as a coping strategy; one study found that self-harm might play a protective role in some cases (6, 13, 14).

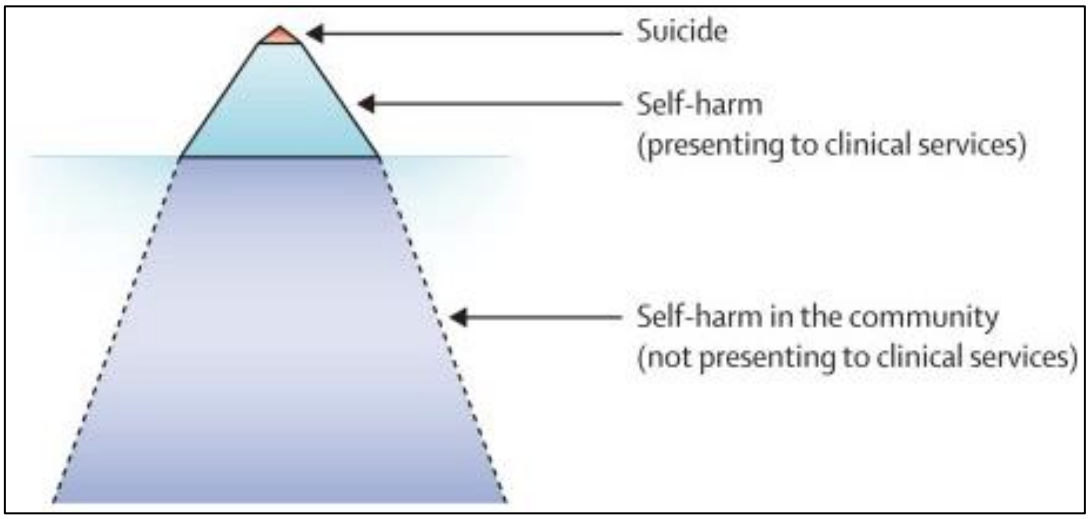
Risk of suicide after self-harm is more likely in male adolescents, people who have had psychiatric care, and those who repeatedly self-harm (15).

4.The level of need in Brighton & Hove

Statistics on self-harm in the UK tend to rely on routine hospital data. However, only a small proportion of individuals who self-harm present to hospital (around one in eight) (15). **Those who present to clinical services are the 'tip of the iceberg' of those who self-harm** (Figure 1).

There are many people who self-harm who do not attend A&E, and many more who do not present to health services at all. It is difficult to estimate the true extent of self-harm in the community; Western countries have found that around 10-20% of adolescents in the community report having self-harmed (this equates to around 6,400-12,800 young people aged 10-24 in Brighton & Hove) (7, 16-20). Further, the way that hospitals and other services define self-harm may not include those young people who self-harm through, e.g. violent and self-destructive behaviour, or alcohol or substance misuse. Chapters 4 and 5 aim to understand the true extent and patterns of need for support for self-harm across Brighton & Hove.

Figure 1: The self-harm iceberg (15)



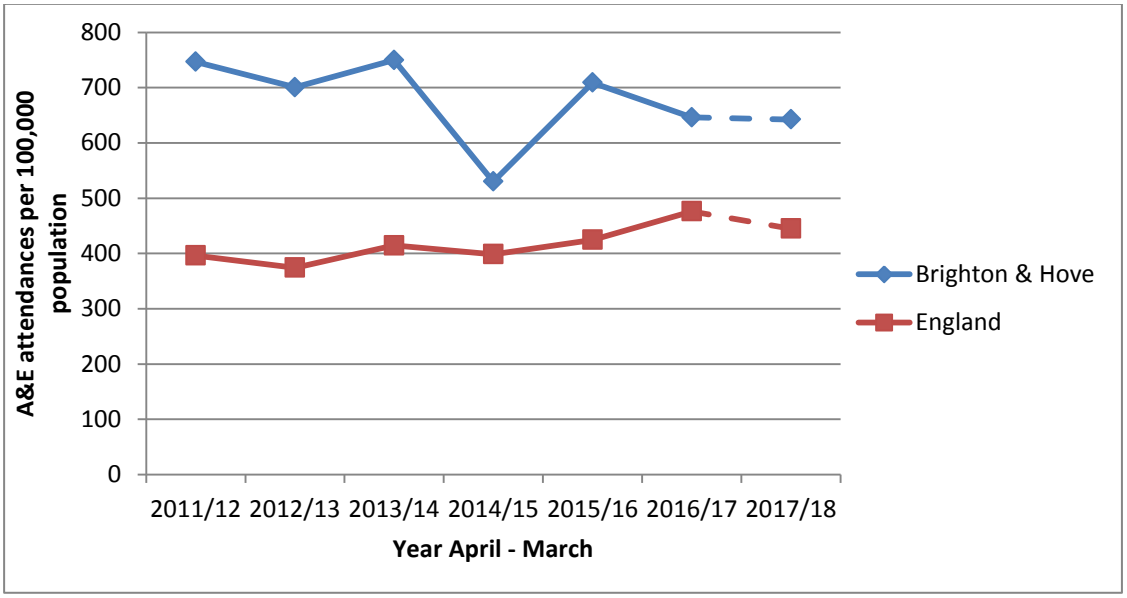
4.1 Prevalence of self-harm

Around 20% of 14-16 year olds in Brighton & Hove report that they have self-harmed and this figure has been fairly consistent year on year (SAWSS 2013-2015). In the 2015 SAWSS, 21.6% (649) students reported that they self-harm, more than half do so 'sometimes' or 'often' (343 students). The proportion of students responding that they ever self-harm is broadly consistent across schools which increases validity of the data; however, the proportion responding that they often self-harm is more variable by school, which may suggest that some schools have a greater number of at-risk students or that some schools have been particularly effective at supporting young people.

The rate of A&E attendance for self-harm among 10-24 year olds in 2016/17 in Brighton & Hove was 646 attendances per 100,000 population, considerably higher than the England rate of 476 per 100,000 population. Figure 2 shows that the local A&E

attendance rate has shown a slight downward trend between 2011/12 and 2017/18, against an increasing national trend.

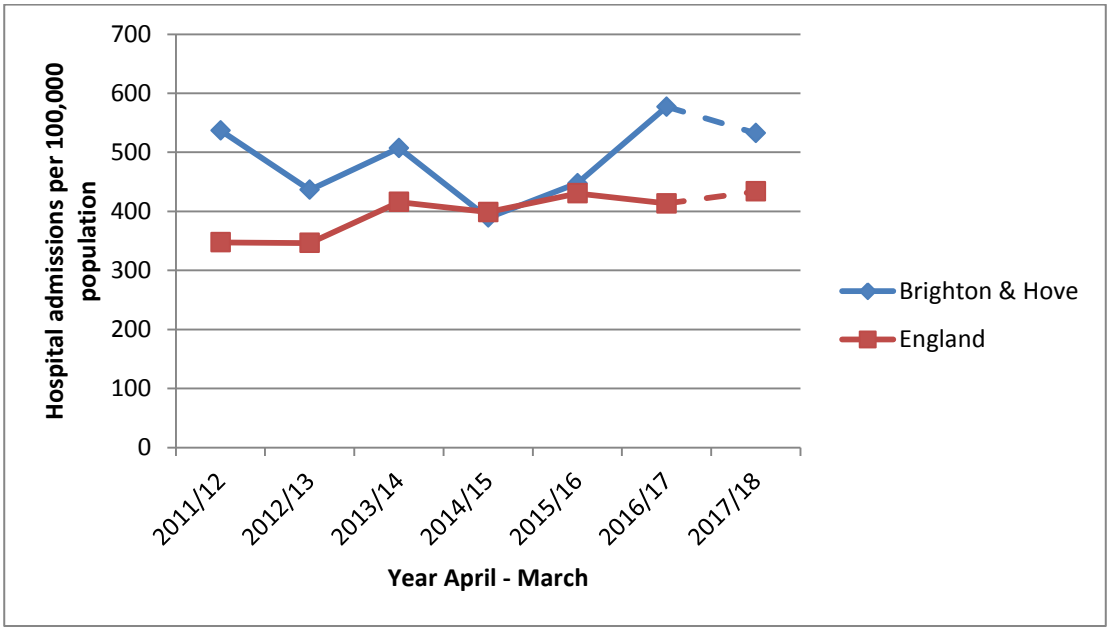
Figure 2: A&E attendance rates for intentional self-harm in 10-24 year olds per 100,000 population in Brighton & Hove, 2011/12-2017/18 (HES data)



* At the time of publication, data was only available for the first seven months of 2017/18, therefore these have been extrapolated to get an estimated annual figure for 2017/18.

Some of the young people who attend A&E require an admission to hospital. Hospital admission rates for self-harm in 10-24 year olds in 2016/17 were also higher in Brighton & Hove (577 per 100,000 population) than England (413 per 100,000 population). Figure 3 shows that the Brighton & Hove rate fell considerably between 2011/12 and 2014/15, before increasing rapidly in 2016/17. Estimates suggest that 2017/18 projected rates are falling but remain considerably higher than England.

Figure 3: Hospital admission rates for intentional self-harm in 10-24 year olds per 100,000 population in Brighton & Hove, 2011/12-2017/18 (HES data)



* At the time of publication, data was only available for the first seven months of 2017/18, therefore these have been extrapolated to get an estimated annual figure for 2017/18.

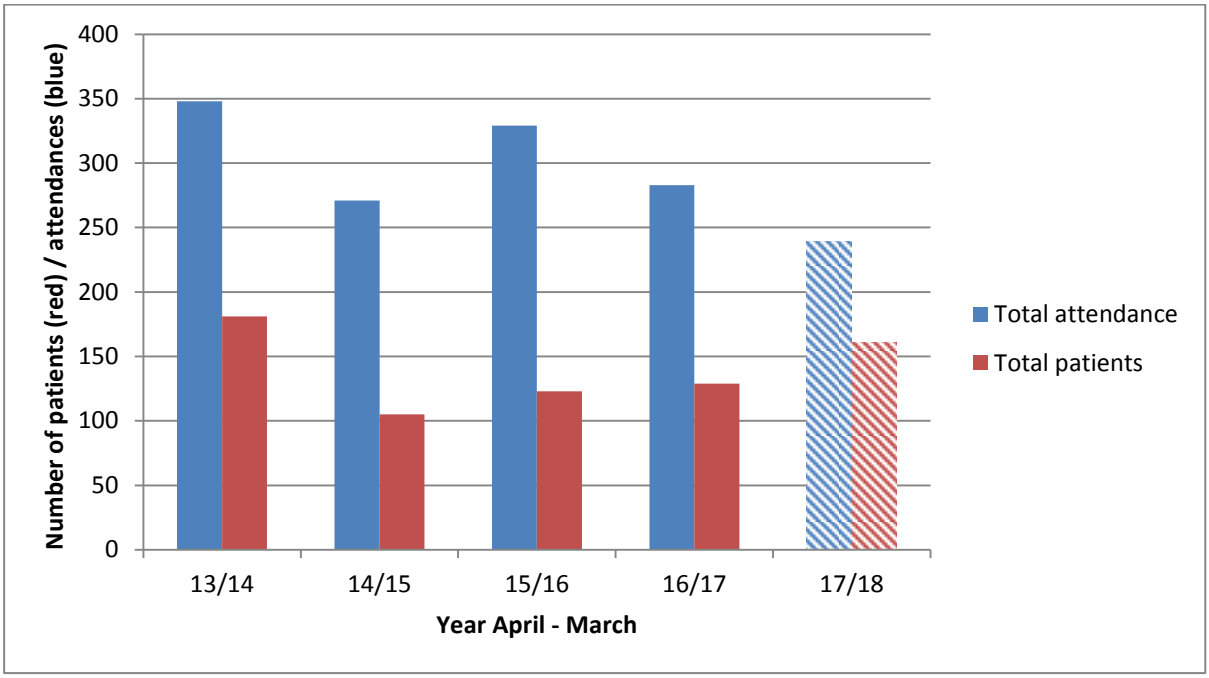
The most recent A&E attendance and hospital admission rates for self-harm among 10-24 year olds were higher in Brighton & Hove than England; attendances appear to be falling and admissions rising, though the pattern is unclear and this masks what is happening by age group (Chapter 5). The fall in attendances might imply that self-harm is reducing in the city, or it might indicate some success among local services intervening earlier and preventing young people reaching the point of attending A&E. Rising admissions may suggest an increase in self-harm incidents using more harmful methods more likely to require hospital admission.

4.2 Repeat self-harm

Figure 2 and 3 represent the total number of admissions/ attendances rather than individual patients. Figure 4 shows that the number of unique people attending A&E in Brighton & Hove is lower than the total number of attendances (averaging around 300 people per year), because many people attend more than once. Over the four years to 2016/17, the number of patients attending represents around 70% of all attendance which implies that **young people who attend A&E for self-harm do so on average 1.4 times a year**. Similarly for admissions: in 2016/17, only 54% admissions for self-harm involved a patient who only attended once that year; ten patients were admitted four or more times, accounting for 24% of all admissions.

Repetition of self-harm is common in adolescents. Studies have found that almost three-quarters of adolescents who present to hospital for self-harm report previous self-harm, and 15-25% of individuals return within the year due to a repeat episode (21-23). Repetition of self-harm is more common among adolescents who do not present to clinical care, and more likely with self-cutting than self-poisoning (24).

Figure 4: Number of unique patients (aged 10-24) attending A&E and total attendance in Brighton & Hove, 2013/14-2016/17



* At the time of publication, data was only available for the first seven months of 2017/18, therefore it only represents part of the year.

Figure 4 suggests that the number of unique patients (the red bar) has been increasing since 2014/15 compared to a slight downward trend in overall attendance (the blue bar). This suggests that though the numbers of people self-harming may be increasing, there appears to be a reduction in the number of repeat A&E attenders.

4.3 Seasonal effects

Figure 5 shows that **A&E attendances for self-harm in Brighton & Hove in 2016 fell substantially in the summer months (May to August) in 10-18 year olds**, which implies a seasonal effect potentially down to a number of factors including the school summer holidays. A&E attendance data for 2010-2017 (Table 1) shows a peak in 10-18 year olds attending A&E for self-harm in January (compared to April, July and October). It also shows that **19-24 year olds are more likely to attend in October** (out of the four months analysed), which reflects the experience of professionals interviewed for this needs assessment who identified a spike in attendances by university students during their first term.

Figure 5: Seasonal variation in A&E attendance for intentional self-harm in 10-24 year olds in Brighton & Hove, 2016

*Numbers smaller than 5 have been rounded up to 5 for data confidentiality

Table 1: Average number of young people attending A&E in January, April, July and October in Brighton & Hove, average for 2010-2017

	January	*April*	*July*	*October*
10-18 year olds	23.8	14.8	13.6	17.6
19-24 year olds	29.7	23.7	26.4	37.4

4.4 Discharge following A&E attendance

Following attendance at A&E for self-harm in Brighton & Hove in 2016/17, young people aged 10-24 went on to the following locations:

- **70 (17%) admitted to hospital bed**

- **116 (28%) discharged – follow-up treatment to be provided by GP**

There is no standard city-wide protocol agreed by Primary Care so the response to self-harm among children and young people is variable.

- **78 (19%) discharged – did not require any follow-up treatment**

Almost one-fifth of young people attending A&E for self-harm were discharged on the basis that they did not require any follow-up treatment. This appears high given that

self-harm should always be taken seriously (Chapter 6); however, further investigation would need to be done to understand, for example, whether these young people were signposted to further support not falling into any of the other categories, such as local youth services or schools.

- **106 (26%) transferred to other healthcare provider / outpatient clinic**

Patients might be transferred to a healthcare provider considered more appropriate to address the needs of the patient. This might include mental health services such as the Community Wellbeing Service.

- **41 (10%) left department before being treated or having refused treatment**

There are a range of measures in place to reduce the likelihood or impact of patients leaving the department before being treated, including the one-hour response of the mental health liaison teams and the self-harm clinic for adults (Chapter 7) and a leaflet given to patients attending A&E with phone numbers and advice.

4.5 Self-harm reported to services

The numbers of children and young people who have self-harmed presenting or reported to services is variable across services. This is likely to be due in part to those children and young people recognising they need help and knowing where to go, the capacity, eligibility requirements and role of the services. There is also **variation in the ways services record self-harm**: which behaviours are regarded as self-harm; how and when the data is collected; the purpose of collecting the data; and the reliability of coding and recording. Young people may not 'present' with self-harm at the first meeting, but may disclose it at a later point in their engagement with the service, and these are far less likely to be included in the data.

When all this data is viewed together, it provides a picture of the frequency of reported self-harm and the need for services. It also highlights the variety of reporting methods/frequency/reliability which raises questions about what data should be recorded and reported going forwards, and what this data shows.

- **Schools Wellbeing Service**: The Schools Wellbeing Service asks routinely about self-harm in the risk assessment part of their initial assessment with any young person. In the academic year 2016/17, 30 children and young people presented to the Schools Wellbeing Service for self-harm, out of a total of 302 children and young people seen by the service (10% of young service users presented with self-harm). However, it should be noted that the datasets are incomplete due to being a new service, being in transition to new processes, not yet having a database and not all using the same definition or assessment for self-harm.

- **Specialist CAMHS**: In 2016/17 there were 284 referrals to Specialist CAMHS presenting with self-harm, representing 40% of the total number of 719 referrals.

- **YMCA Dialogue/ YMCA East Brighton**: In 2016/17, YMCA Dialogue provided face-to-face counselling for 175 young people aged 13-25, and 48 of the presenting issues were for self-harm (27%) (young people may have more than one presenting issue). In the same period, YMCA East Brighton provided counselling to 26 young people, 9 of the presenting issues were for self-harm (35%).

- **YMCA Youth Advice Centre**: In 2016/17, 46% of new support and advice clients reported self-harm (past or present) on initial presentation, and 17% of housing advice clients disclosed self-harm.

- **Young People's Centre** (YPC): In 2016/17 YPC provided support to 192 young people of whom 30 (16%) presented with self-harm.

- **E-motion**: In 2016/17, 110 young people received counselling and for 22 of them (20%) the main presenting condition was self-harm.

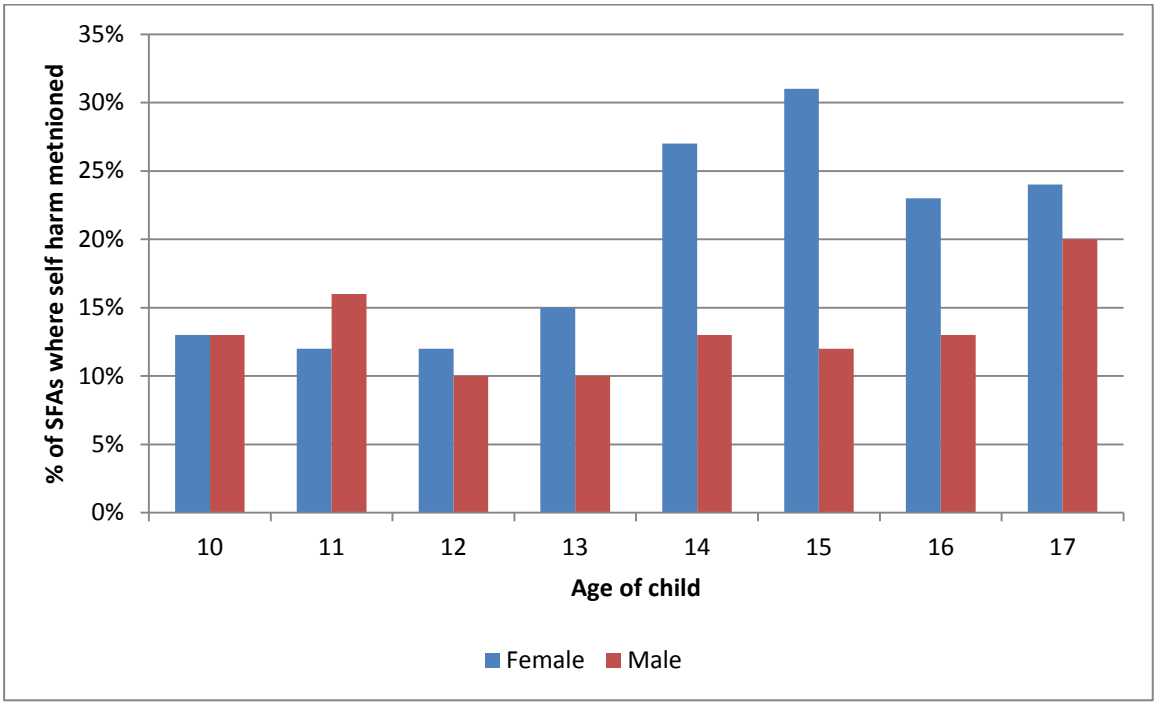
- **Allsorts**: Of the 54 young people aged 11-25 who accessed one-to-one support through their Talk In Out sessions in April-July 2017, 19 spoke about self-harm (35%). All of the 19 stated that they experience mental health issues such as depression, anxiety, low self-esteem and stress.

- **Police incident data**: The police incident database includes any incident reported to the police not initially recorded as a crime. A text search of police records in 2016/17 identified 68 incidents where self-harm was mentioned in relation to young people aged 10-25 (about 27% of police incidents for all ages relating to self-harm). 60% of incidents were regarding self-harm among females, and 40% among males.

- **Children In Need (CIN) Census**: In 2015/16, self-harm was identified as a factor in 0% of CIN assessments (4% in England and 12% in East Sussex). This is not in line with other data on self-harm, particularly given that these children are likely to be at higher risk of self-harm for a range of reasons (Chapter 5). The reason for this figure being so low may be because cases have not met the social worker threshold or because it is not being recorded. Mental health was identified as an issue that affects the child in 61.4% of assessments, above England 36.6%.

- **Strengthening Families Assessments (SFA)**: In 2015/16, there were 198 clients with SFAs aged 10 to 17 and 16% of their assessments mentioned self-harm (though it might relate to any member of the family self-harming). Figure 6 shows the likelihood of self-harm being a factor impacting the family increased over the 10-17 age range from 13% to 22% of all SFAs, and that girls are more likely to be affected by self-harm than boys, particularly at age 14-16 years. At ages 14-16 girls are twice as likely to be affected by self-harm than boys, and further analysis of the narrative of these cases suggests this is due to the girls themselves self-harming rather than another family member.

Figure 6: Strengthening Families Assessments where self-harm is mentioned in children aged 10-17, Brighton & Hove, 2015/16



5. Who is at risk and why?

Self-harm is the result of a complex interplay of factors (15). It is difficult to untangle how these factors interact, what order they occur and to what extent they increase an individual's risk of self-harm. Despite this, there is evidence for relationships between a range of risk/protective factors and self-harm in the literature. Further, local data captured by SAWSS provides further indication of factors which may be associated with self-harm among young people aged 14-16 in Brighton & Hove. This chapter describes the potential demographic and other risk factors for self-harm in children and young people – summarised in Tables 2 and 3.

Table 2: Risk and protective factors associated with self-harm

Characteristic	*Risk/ associated factors*	*Protective factors*
Demographics	– Aged 11- 25 years – Female is reported but males may be as at-risk but not recognised/ expressed differently – Low family socio-economic status – Low family educational level – LGBTU	
Mental health	– Depression – Bi-polar disorder – Behavioural disorders – Substance misuse – Emerging personality disorder – Anxiety	– Treatment for any mental disorder
Childhood experiences, family, relationships and peers	– Trauma in childhood – Parental separation – Emotional neglect – Parental psychological problems – Psychological, physical and sexual abuse – Exposure to self-harm/suicide in others (family/friends) – Looked-after children/ children in care – Part of an 'alternative' subculture	– Strong social attachments – Positive family relationships
Psychological characteristics	– Low emotional intelligence – Low self-efficacy (problem-solving) – Feelings of entrapment, defeat, lack of belonging – Self-blame/derogation/criticism – Self-loathing, disgust and shame – Hopelessness	– Emotional expressivity and self-efficacy – Optimism

Table 3: Factors associated with self-harm in SAWSS 2015

Analysis of the self-reported SAWSS data identified a significant association between ever self-harming and the risk factors in this table. Those factors with a higher odds ratio are more strongly related to self-harm.

Risk factor	*Unadjusted odds ratio* of ever self-harming (95% confidence intervals **)*
Those who have had suicidal thoughts	27.6 (21.3, 35.8)
Often/ sometimes have issues with food	7.9 (6.4, 9.6)
Lesbian, gay, bisexual or unsure	6.4 (4.8, 8.4)
Those who do not identify with gender assigned at birth	5.8 (4.0, 8.4)
Often spend time alone	5.0 (4.0, 6.4)
Have been bullied this term	4.6 (3.6, 5.7)
Worried about friends	4.0 (3.3, 4.9)
Problems with friends	4.0 (2.8, 5.6)
Problems with family	3.9 (3.2, 4.7)
Often/ sometimes drink alcohol	3.1 (2.6, 3.8)
Occasionally/ regularly smoke	2.9 (2.4, 3.6)
Young carer	2.7 (1.9, 3.7)
No adult to talk to in school about worries	2.5 (2.1, 3.1)
Female	2.4 (2.0, 2.8)
Taken drugs	2.3 (1.9, 2.8)
Use social media more than 5 hours on a weekday	2.3 (1.8, 2.9)
Use social media more than 5 hours on a weekend	2.1 (1.8, 2.6)
Receive help from a teaching assistant	2.1 (1.6, 2.7)
Worried about schoolwork	2.0 (1.6, 2.5)
Worried about exams	1.5 (1.2, 2.0)

***** Unadjusted odds ratio: The odds of self-harm among students who reported that they had experience of the risk factor, compared to the odds of those who did not. Not adjusted for any other risk factors.

** Confidence intervals were small as counts were large, and all associations presented here were statistically significant (p≤0.005).

5.1 Demographics

5.1.1 Gender

The relationship between self-harm and gender is complex. In general, **more females than males present to health services** for self-harm and in part this may be due to females being more likely to seek medical support (25, 26). Further, **self-harm in young males may manifest differently** in ways that often fall outside of self-harm definitions used by services or the community itself, for example in self-battery, drinking or drug use, it is therefore likely to be under-reported. Girls responding to the SAWSS were 2.4 times more likely than boys to report ever self-harming; 74% of 2016/17 A&E attendances for self-harm age 10-24 were female.

5.1.2 Age group

Of all ages, self-harm is most common among adolescents and young adults (11-25 years), and the onset of self-harm is associated with puberty (15, 26-29).

Numbers and rates: There is a lack of data for self-harm among children and young people in the community by age, as the SAWSS only measures the age group in which self-harm is most prevalent. Year 10 students in the 2015 SAWSS were more likely to report to never self-harm than year 11 students (but this was not significant). Some variation may be expected year on year due to random fluctuation.

Figure 7 shows that the number of hospital admissions for self-harm in 10-24 year olds in 2016/17 was highest among 20-24 year olds (200 admissions), followed by 15-19 year olds (132 admissions), followed by 10-14 year olds (36 admissions) in Brighton & Hove. However, rates (which take population size into account) in Figure 8 show that hospital admission for self-harm is most common in the 15-19 year old age group (743 per 100,000 population) and least frequent among 10-14 year olds (266 per 100,000 population). This shows that hospital admissions for self-harm are particularly high among 15-19 year olds as there is a greater proportion of this population admitted, despite the absolute figures being greater in the 20-24 year olds. The rate of hospital admission for self-harm is higher in Brighton & Hove for all age groups compared to England according to the most recent two years of data.

Figure 7: Number of hospital admissions for intentional self-harm by age group, Brighton & Hove, 2016/17

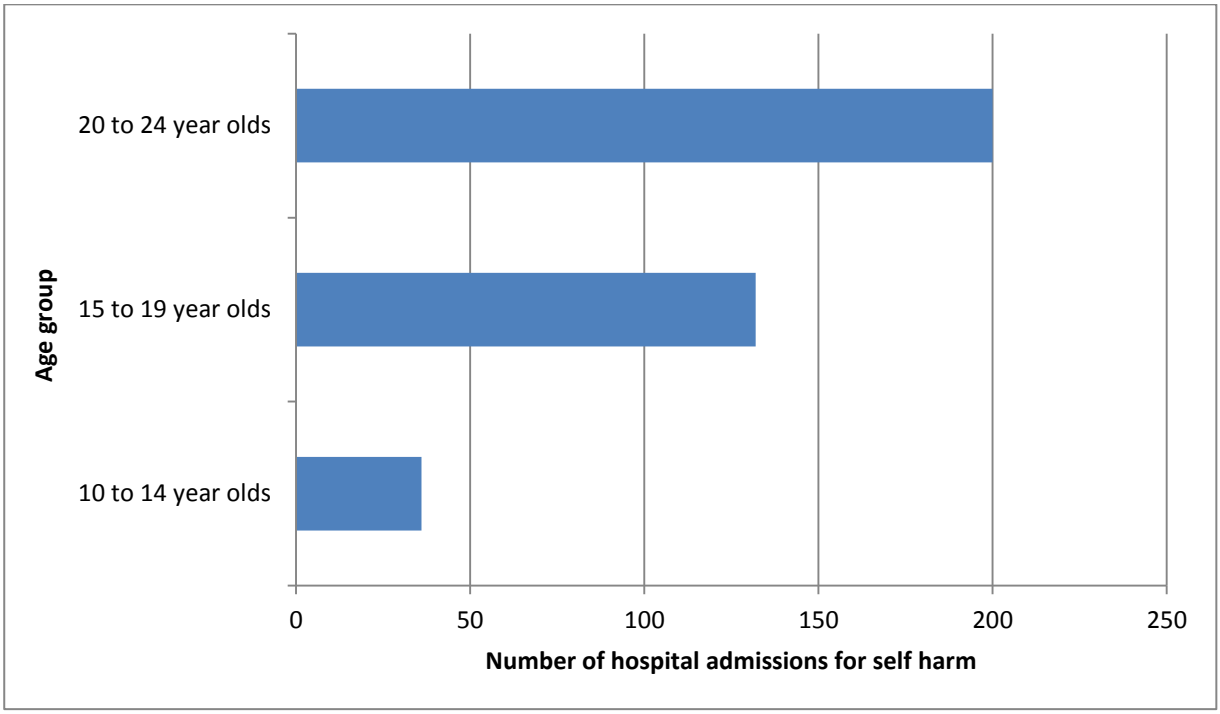
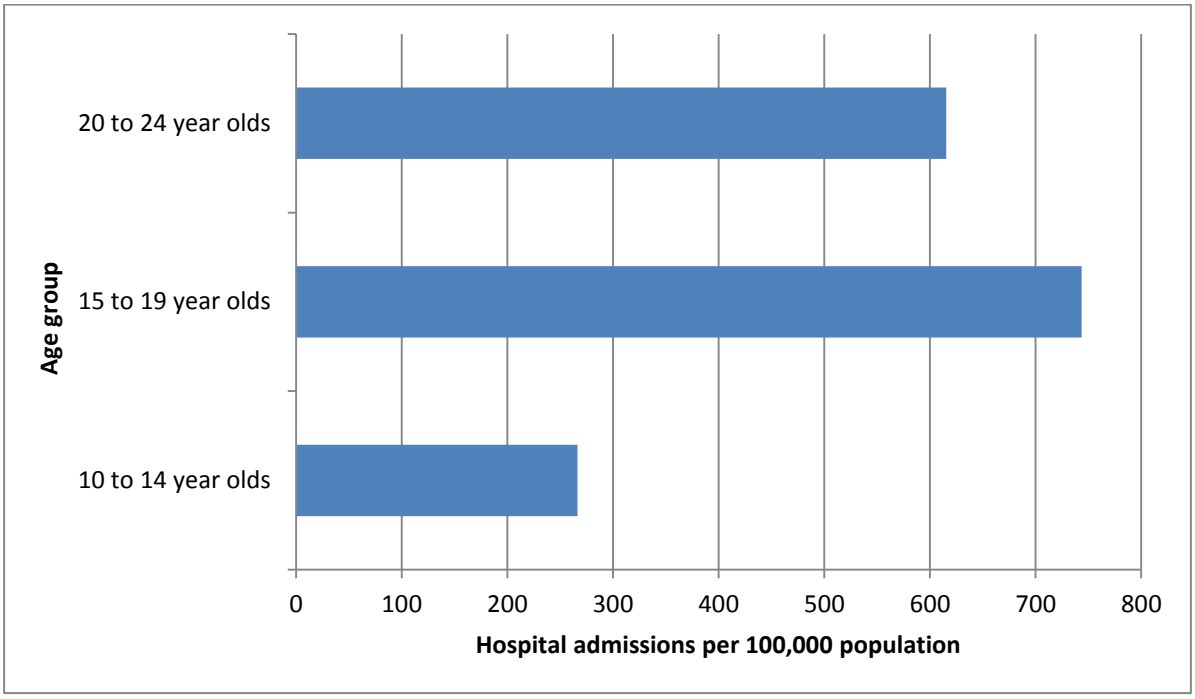
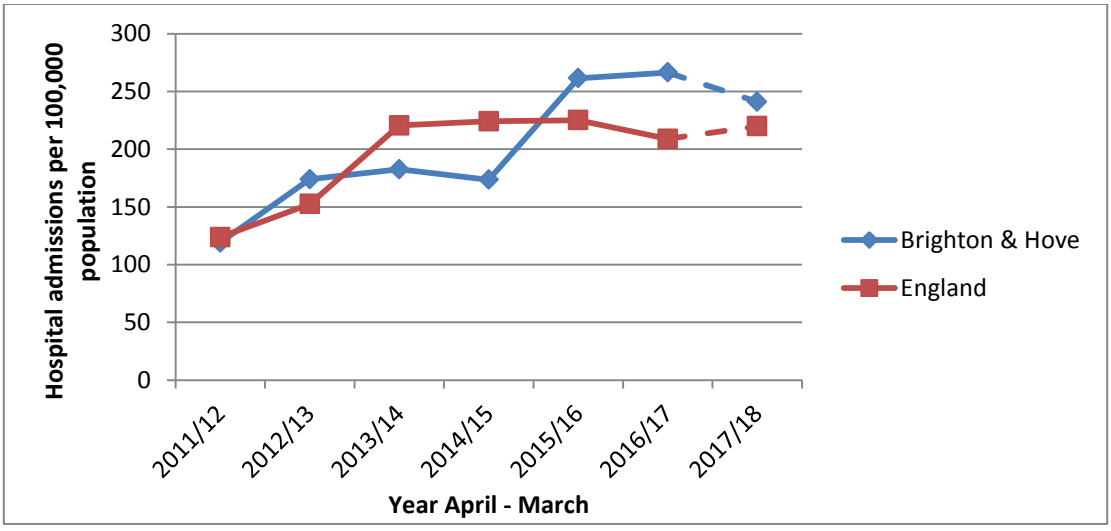


Figure 8: Rates of hospital admissions for intentional self-harm by age group, Brighton & Hove, 2016/17



Trends over time by age show a steady upward trend in hospital admissions for self-harm among 10-14 year olds in Brighton & Hove; rates more than doubled from 2011/12 to 2016/17 from 119 to 266 per 100,000 population (Figure 9). The total numbers of young people in this age group admitted to hospital for self-harm are relatively low (36 admissions in 2016/17); however, this age group is projected to increase in size by 8% over the next decade which may suggest an increasing need for support. The 15-19 and 20-24 year old age groups are projected to remain fairly static in size over this period.

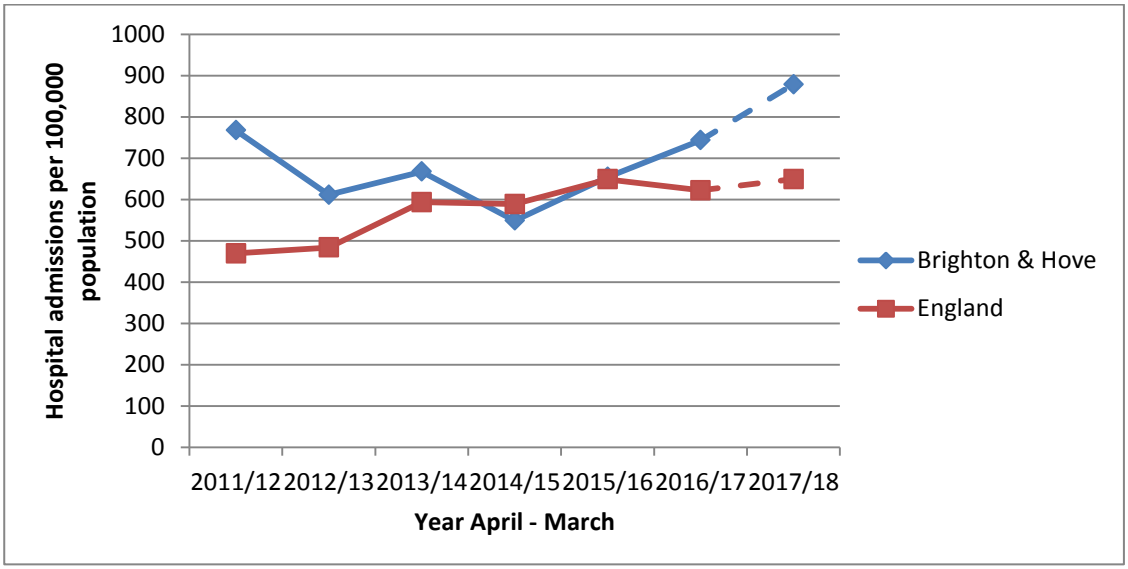
Figure 9: Rates of hospital admissions for intentional self-harm in 10-14 year olds per 100,000 population, 2011/12-2016/17 with estimates for 2017/18, Brighton & Hove and England (HES data)



* Fluctuations in the trend in this age group are likely given that the numbers are small. At the time of publication, data was only available for the first seven months of 2017/18, therefore these have been extrapolated to get an estimated annual figure for 2017/18.

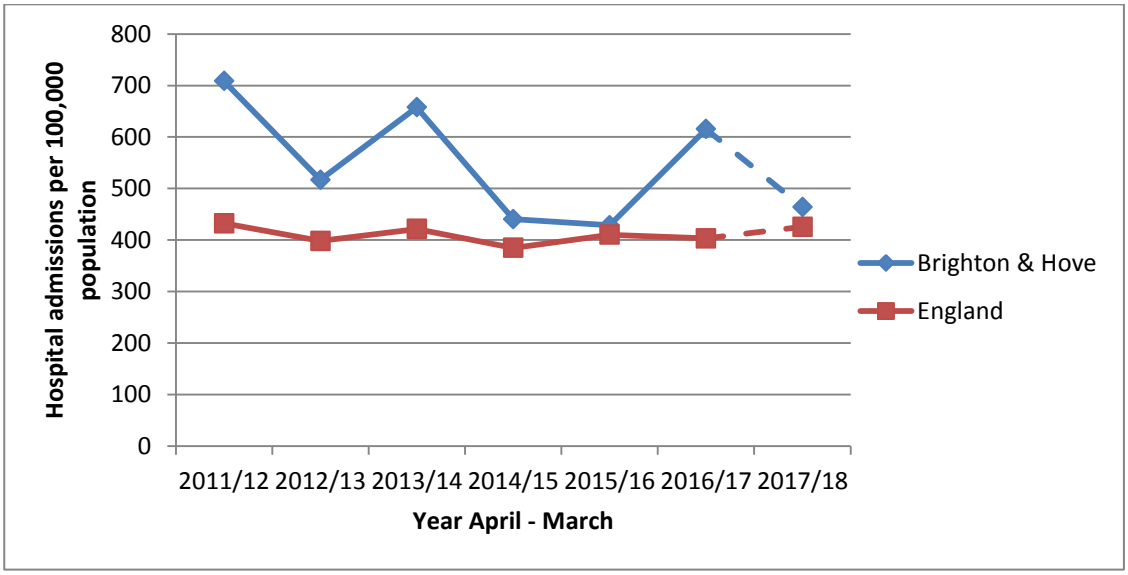
There is greater fluctuation year to year within the other age groups, though 15-19 year olds have seen an upward trend since 2014/15 and 20-24 year olds a small downward trend since 2011/12 (Figures 10 and 11).

Figure 10: Rates of hospital admissions for intentional self-harm in 15-19 year olds per 100,000 population, 2011/12-2016/17 with estimates for 2017/18, Brighton & Hove and England (HES data)



* At the time of publication, data was only available for the first seven months of 2017/18, therefore these have been extrapolated to get an estimated annual figure for 2017/18.

Figure 11: Rates of hospital admissions for intentional self-harm in 20-24 year olds per 100,000 population, 2011/12-2016/17 with estimates for 2017/18, Brighton & Hove and England (HES data)



* At the time of publication, data was only available for the first seven months of 2017/18, therefore these have been extrapolated to get an estimated annual figure for 2017/18.

5.1.3 Ethnicity

A&E attendances for self-harm among 10-24 year olds were predominantly in the white British ethnic group, representing 74% of attendances. This resembles the make-up of the population (83% of 0-24 year olds in Brighton & Hove were classified as white British in the 2011 Census and the general trend for this figure has been downwards) (30). In 11% of attendances, ethnic group was 'not stated'. The numbers are too small to make conclusive comments about whether certain ethnic groups are more likely to self-harm locally. Similarly, SAWSS data on ethnic background is based on small numbers therefore differences are not significant and inferences may be misleading.

5.1.4 Sexual orientation and gender identity

Self-harm is higher in those who report same-sex attraction, in both sexes; one study from New Zealand of young people (aged under 25) who reported having experienced same-sex attraction were 5.5 times more likely to self-harm in men, and almost two times more likely in women (31). This pattern is reported to be related to the increased prevalence of mood disorders, substance misuse, victimisation, bullying, and social stress amongst lesbian, gay and bisexual individuals (32) (33). Consistent with the literature, **self-harm reported in SAWSS is 6.4 times higher among pupils who identify as lesbian, gay, bisexual or unsure** compared to heterosexual/straight.

Those responding to the SAWSS who do not identify with the gender they were assigned at birth were 5.8 times more likely to ever self-harm than those who do. A national survey found gender diverse (trans/ unsure) young people were nearly twice as likely to self-harm (34).

A survey by Allsorts Youth Project of service users (LGBTU aged 11-25) in September 2017 found that 37 of 59 survey respondents (63%) had done something to injure/harm themselves in the last six months; the figure was 10 of 15 (67%) among those aged 11-15. This is not necessarily a representative sample as those who had sought support from Allsorts may be more likely to self-harm than the general LGBTU population, but it may also reflect the increased risk of self-harm among these groups.

5.1.5 Geographical variation

Analysis of four years' data to 2016/17 shows variation in ward of residence of 10-24 year olds attending A&E for self-harm. All wards with higher than average numbers are located close to the hospital; these wards are generally recognised as having higher mental health need, though it may also be that local residents are more likely to visit A&E (as opposed to another health service) than those living further away. There is no clear consistency of self-harm numbers from year to year within wards.

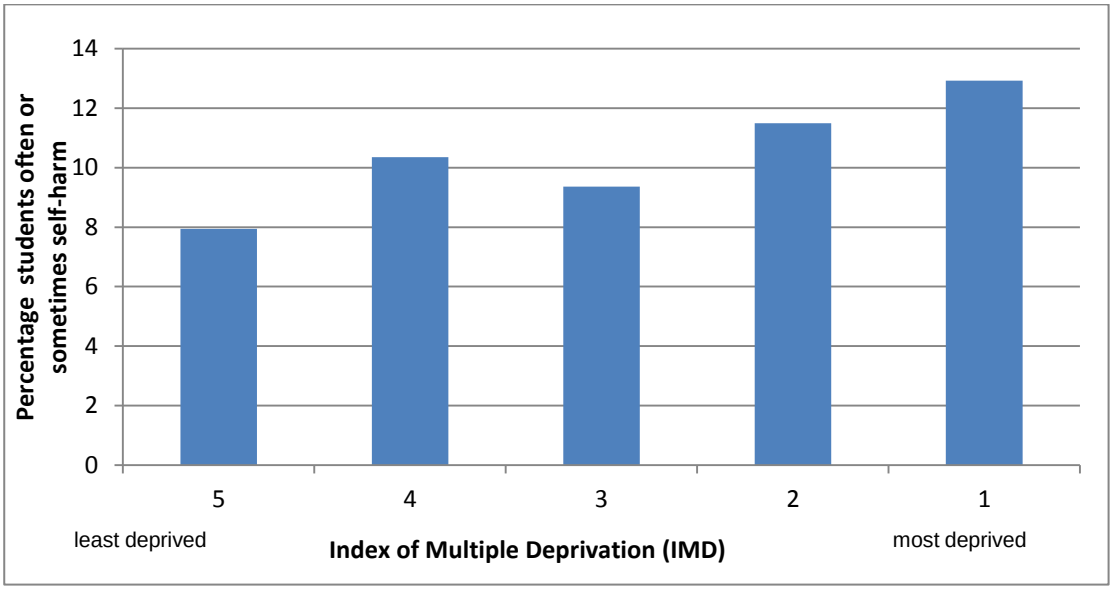
5.1.6 Deprivation

Self-harm has been linked to lower family affluence, socio-economic status and level of education (15, 35, 36). The SAWSS found that students living in the most deprived fifth

of areas in Brighton & Hove[i] have 1.6 times higher risk of reported self-harm compared to students living in the least deprived (Figure 12). A&E unique attendance for self-harm in 10-24 year olds is also higher among those living in more deprived areas of Brighton & Hove, though there is not a clear gradient (Figure 13). There are particularly high rates of A&E attendance for self-harm in some areas that are not high or low on the scale of deprivation locally (deciles 4-6).

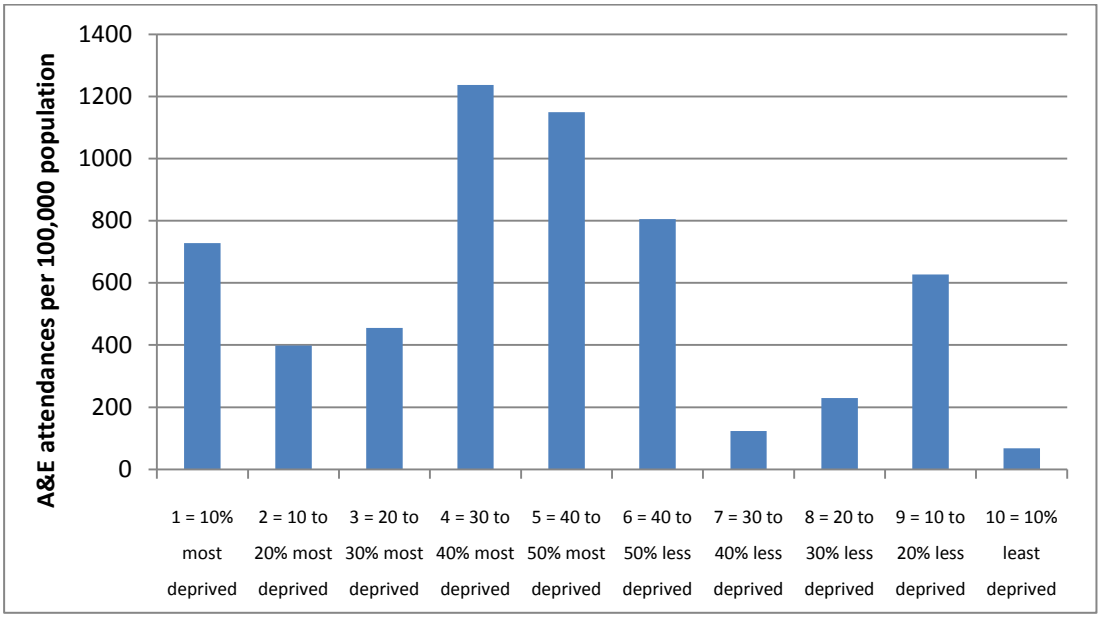
The patterns in Figures 12 and 13 do not correlate closely which suggests different patterns in self-harm in the community compared to hospital presentations. It is evident from both sets of data that **self-harm occurs among residents from advantaged and disadvantaged areas of the city**.

Figure 12: Percentage of students aged 14-16 responding to the SAWSS that often/sometimes self-harm, by English IMD deprivation quintile based on location of residence in Brighton & Hove, 2015



[i] This is based on the Index of Multiple Deprivation (IMD) score for each small area ('lower super output areas' which are based on postcodes and include 400-1,200 households).

Figure 13: A&E unique attendance rates in 10-24 year olds per 100,000 population by IMD rank, Brighton & Hove, 2016/17



5.2 Risk and protective factors for self-harm

5.2.1 Mental health issues

There is good evidence that self-harm is strongly associated with **emotional distress and mental health issues** (37). One study found that nearly 9/10 people presenting to hospital with self-harm suffered from at least one mental health issue (38), including depression, anxiety, bipolar disorder, and substance misuse and behaviour disorders (22, 39-42). Attention Deficit Hyperactivity Disorder (ADHD), eating disorders and emerging personality disorders amongst adolescents presenting with self-harm are also frequent (38). Young people who self-harm are more likely to have lower life satisfaction and experience more frequent negative emotions (35, 43). They are likely to experience more difficulties in identifying, understanding and expressing their emotions (44). Rising academic pressures in young people were mentioned by interviewees as a potential cause for self-harm in young people, and the SAWSS found that students who worry about exams or school work are 1.5-2 times as likely to report self-harm.

Two local professionals interviewed as part of this needs assessment mentioned that **co-morbidity of self-harm and eating disorders** was common, and one said that self-harm was prevalent among young people in recovery with anorexia. In the SAWSS, 20% of young people reported that they sometimes/often have issues with food, and those who did were 7.9 times as likely to self-harm compared to those who did not.

Self-harm is one of the highest indicators for **emotional intensity disorder**. Local professionals have identified this as a priority area and local pathways have been developed by the University of Sussex counselling service and Specialist CAMHS to support young people with emotional intensity disorder (Chapter 7).

5.2.2 Childhood experiences and relationships

Self-harm is also linked to life events or against a background of longer term social and personal difficulties (such as relationship problems, financial difficulties or social isolation) (45). Self-harm is associated with **stressful or traumatic childhood experiences**, most frequently including emotional neglect, psychological or physical abuse, especially sexual abuse (43).

Bullying, including cyberbullying, can also increase the risk of self-harm in young people (46). The proportion of students who ever self-harm in Brighton & Hove is 4.6 times **higher in those that have been bullied in the last term** compared to those who report not having been bullied in the last term. Reported self-harm is also higher among those who report that they have bullied someone else.

Social connectedness and good communication with family, friends and school are likely to be protective against self-harm, whilst difficult family relationships are common among adolescents who self-harm (15, 47-50). Local students who **often spend time alone** have five times higher reported self-harm than those who rarely/never spend time alone. Further, students who often/sometimes report having **problems with friends, or family**, have around four times higher reported self-harm than those who do not.

5.2.3 Social media and the internet

The internet and social media have the potential to support a young person who self-harms; for example web pages designed to support young people to manage or reduce their self-harm, or by promoting social interaction and enabling support from peers.

Nearly half of young people responding to the online survey conducted as part of this needs assessment were aware of the **internet or social media as a source of support** for self-harm (though this might be expected from an online survey). Many considered it helpful; one young person read other people's stories online which they said, "inspired me to find more constructive ways to express my pain". Another young person found blogs of people struggling with their mental health on the Find, Get, Give website (51) useful: *"*It helped me identify other ways of dealing with mental health rather than having to resort to self-harming".

On the other hand, one of the young survey respondents felt that social media perpetuates self-harm: "[social media is] a toxic environment that young people should be actively encouraged to stop using*"*. Research has suggested that social media use may have positive and negative implications on psychological wellbeing; a recent study conducted in the United States has found that adolescents who spend more time on new media (including social media and smartphones) were more likely to report mental health issues, though the reasons behind this are unclear (52). The SAWSS found that **students who use social media for more than five hours on a weekday have 2.3 times higher reported self-harm** than those who use it for less than five hours.

Local professionals have expressed **concern around web pages designed to promote and encourage self-harm**. These include images of self-harm and advice on how to overdose to the extent that you are admitted to A&E but do not cause fatality. One young survey respondent mentioned they had seen Instagram posts encouraging self-harm, and one local professional emphasised that these pages are viewed regularly and in some cases run by young people who self-harm in Brighton & Hove.

5.2.4 Alternative subcultures

Specific adolescent subpopulations identifying as 'alternative' (groups with a strong sense of collective identity and group-specific values and tastes) have been reported as being at higher risk: a 2014 study found around half of alternative adolescents engaging in self-harm (53). There are various proposed explanations for this, including: 'assortive relations' which suggests that teenagers predisposed to self-harm are attracted to subcultures with emotional themes that mirror their own experience; 'direct imitation' (alternative teenagers copy their self-harming friends), indirect imitation or media influence; and confounding risk factors, such as victimisation of alternative groups increasing risk of self-harm (53).

In considering this it is important to be aware of the changing nature of adolescent subcultures and that the increased risk of self-harm identified in 'Goth' or 'Emo' groups may also exist in other/emerging subcultures; for example, recently identified associations between hip-hop and prescription drugs in the United States.

6. Local services in relation to need

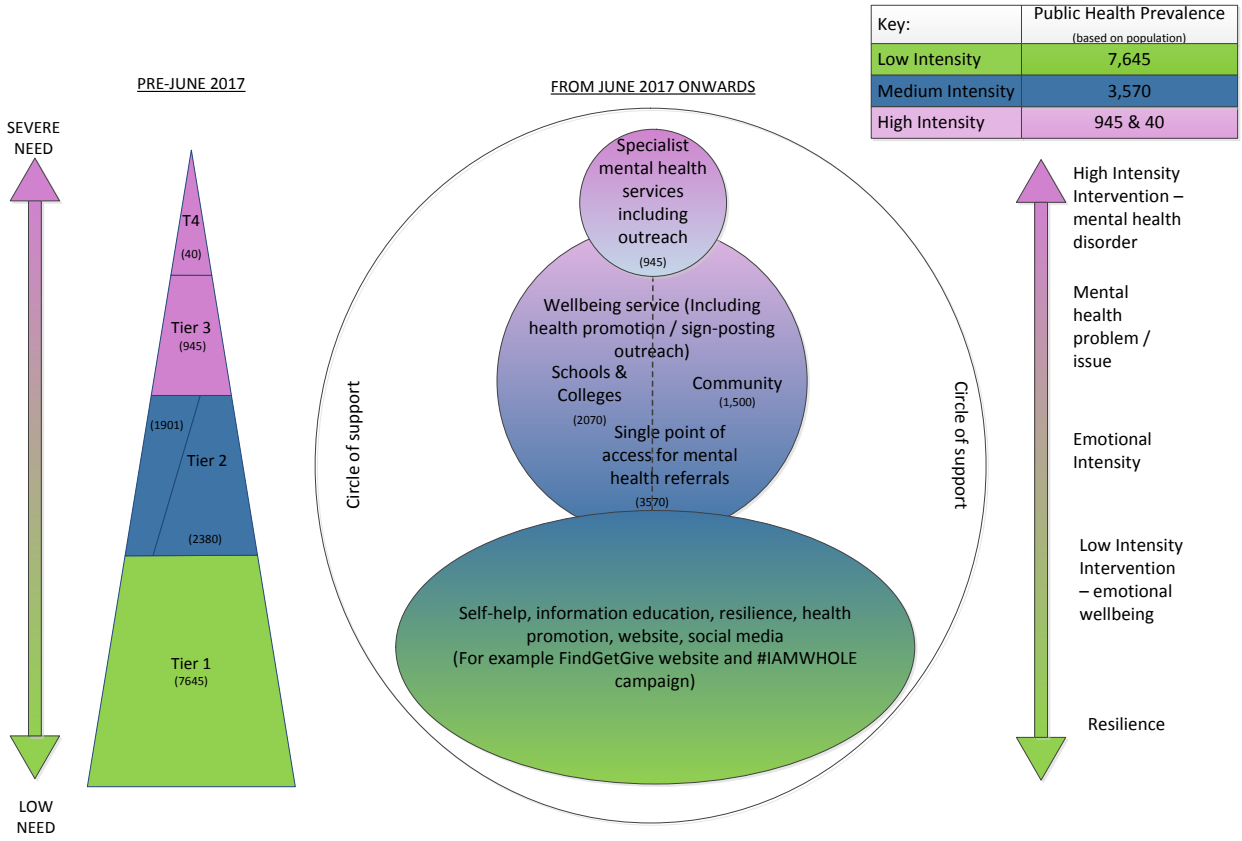
This chapter describes how the main services in Brighton & Hove for children and young people who self-harm are meeting the health needs of this population. The information reflects the views of ten local professionals through one-to-one interviews, online surveys of young people and their parents/carers, and input from the multi-sector steering group. It identifies unmet need and gaps in service provision, and some potential ways to address these.

6.1 The organisation of mental health services in Brighton & Hove

There is no specific referral pathway for self-harm in Brighton & Hove. The Brighton & Hove Clinical Commissioning Group (CCG) is responsible for commissioning the main mental health services for children and young people in the city. Inpatient psychiatric beds (for children and young people) are the commissioning responsibility of NHS England.

Based largely on the findings of the *Children & Young People's Mental Health & Wellbeing Needs Assessment*, children and young people's mental health services have been reorganised and recommissioned to move away from the four-tiered approach to mental health services to an offer that blurs the organisational lines and criteria and provides support and interventions along a continuum, depending on need (Figure 14). The new model of care is a Thrive-informed approach where 'no door is the wrong door' (3).

Figure 14: Brighton & Hove Children & Young People's Emotional Wellbeing and Mental Health Model, 2017



The *Children & Young People's Mental Health & Wellbeing Needs Assessment* identified that there was insufficient access to mental health services for children and young people with a mild to moderate mental health need. The CCG has commissioned the Community Wellbeing Service (all ages) and Schools Wellbeing Service to address that gap. Children and young people can access counselling in the setting they feel is most appropriate (including an online option). Adults can access the Community Wellbeing Service and the service is able to offer a family approach to need. Table 4 shows that the local waiting time targets for the Community Wellbeing Service were not met in the most recent month for which data is available, though this may be partly due to the need for more time to embed the new services. For the Schools Wellbeing Service in December 2017, 100% of children and young people's need was responded to and advised within ten working days (average first contact date is eight days; average first face-to-face appointment date is 19 days).

Table 4: Community Wellbeing waiting times targets and achievement, November 2017

Waiting time	*Waiting time target*	*Level of achievement*
Referral to assessment	95% within 20 working days	30.3%
Assessment to first treatment	95% within 20 working days	66.7%
Treatment for online	95% within 5 working days of initial assessment	95%

For those who require specialist support, Specialist CAMHS is provided by Sussex Partnership Foundation Trust (SPFT). This service has gone through a process of transformation and redesign including an expansion of assertive outreach, clinical leads in Primary Care, Community and Schools Wellbeing services and Social Care, reduced waiting times and a focus on urgent/ crisis response. Since the redesign, Specialist CAMHS is commissioned to deliver shorter waiting times, and recent figures suggest high levels of achievement against targets (Table 5).

Table 5: Specialist CAMHS waiting times targets and achievement, October 2017

Type of referral	*Waiting time target*	*Level of achievement*
Urgent assessment / treatment	4 / 24 hours from referral	100% / 100%
Priority assessment / treatment	5 days / 2 weeks from referral	89% / 89%
Routine assessment / treatment	4 / 8 weeks from referral	100% / 94%

6.1.1 Crisis support

Children and young people

A Paediatric Mental Health Liaison Team (PMHLT) has been based at the Royal Alexandra Children's Hospital (RACH) since 2015 and supports children and young people who attend with mental health issues including self-harm. The PMHLT have a one-hour response and refer on to other services if required. They support on average 37 young people each month (54).

The Urgent Help Service aims to prevent hospital admissions by providing intensive visits to acutely ill children in their homes over a 4-8 week period. It also supports discharge from inpatient care through a step-down approach. In 2014/15, 40% of referrals to the Urgent Help Service was for self-injury or self-harm (55).

Adults

There is a Mental Health Liaison Team at the Royal Sussex County Hospital (RSCH) A&E to support people who attend with mental health issues including self-harm. They also take referrals from acute medical wards if a patient has been admitted for a physical health problem and self-harm is detected after admission. The team provides a rapid assessment and referral to the appropriate service. The team provides support to 2000 referrals per year and 85% of people receive a response within one hour against the target of 95% (54). The service also incorporates a self-harm follow up clinic (Psychodynamic Interpersonal Therapy) hat successfully supports adults who repeatedly self-harm.

The Mental Health Rapid Response Service (MHRRS) provides 24/7 telephone support for adults in crisis, and it is able to carry out face-to-face assessments 7 days a week within 4 hours until 10pm. Improvements to adult crisis response are underway,

including increased resources at RSCH to ensure a timely response in A&E and other parts of the hospital (54).

6.2 Unmet need and gaps in service provision

There were many positive comments from professionals regarding the effort being made to improve services and remove barriers to access. However, it was generally agreed that changes were still in development as the changes were so new, and that demand remains high for mental health services compared to supply.

Many comments from young people, parents/carers and professionals were consistent with those highlighted in the *Children & Young People's Mental Health & Wellbeing Needs Assessment*, particularly around long waits for assessment and lack of joined up services. It should be noted that many of the respondents are likely to have had experience of Specialist CAMHS prior to the service re-design in June 2017, and it is still early in the change process. However, this does not negate the need to consider these comments.

6.2.1 Barriers to accessing services

6.2.1.1 Long waiting times

Long waiting times for mental health services were frequently mentioned by professionals and by one young person, in relation to Specialist CAMHS, adult mental health services, the Wellbeing Service and University counselling. Professionals identified this was likely due to capacity and that more resources were required, in particular for Specialist CAMHS and University counselling. Though Specialist CAMHS waiting times are improving against targets (Section 6.1), the perception among professionals and young people remains that waits are too long (though this could be because their experience was prior to the redesign). Long waiting times were also identified as a key issue in a recent local YMCA Right Here Young Healthwatch report looking at young people's experience of using A&E during a mental health crisis (56). Professionals commented that being on waiting lists for a long period means young people are unable to access the care they need in a timely way, and this can make them feel that services don't care about them so they choose not to attend.

> "*The doctors put me on a waiting list for therapy but this didn't help as the wait was 6 weeks plus*" *(Young person)*

> "*There is high demand for a fairly small resource" (Professional)*

One professional mentioned that work is being done by Specialist CAMHS on specific clinical pathways involving group work, so that young people are able to access the service sooner rather than waiting for individual therapies.

'Drop-in' groups to support and provide information and access to professionals to young people who self-harm or were considering it were identified as something that

would help fill a gap for young people who are in need of support, for example young people currently waiting for appointments, those receiving less frequent support than needed due to service capacity, and repeat A&E attenders. Some professionals felt that this should be available at the children's A&E whereas others did not consider this environment to be most appropriate to their needs. There were a couple of expressions of concern among professionals fearful that these sorts of groups may lead young people to consider self-harming when they hadn't previously, or that self-harm might be promoted within these groups. This is supported by the evidence on social contagion of self-harm (Section 3.4).

> *"We should have a drop-in/ café for younger people, because they are quite lost and need to feel supported, have somewhere to go; this could be preventive" (Professional)*

6.2.1.2 Meeting thresholds for services and being taken seriously

There was frequent discussion among professionals of young people not meeting thresholds for mental health services (in particular Specialist CAMHS and adult mental health services). This resulted in young people not getting the support they needed, feeling like services were not taking them seriously, and falling through gaps in services. Again this may relate to historical experiences prior to the implementation of Community Wellbeing and Schools Wellbeing Services.

> "*Sometimes they need to be flexible with the thresholds they use, to suit people… children and young people feel that they don't take enough of an individual approach, and that's where their refusing to talk to professionals comes from - they don't want to be another number. Young people fall through the gaps, as they haven't been picked up when they should have been." (Professional)*

CAMHS was perceived by three parents/carers as difficult to access until a young person reaches crisis point. These responses highlighted frustration that their child should have been seen sooner:

> "*It took three hospital admissions and several years of difficulty before she was accepted by CAHMS. This was after 7 mental health assessments, most in A&E." (Parent/ Carer)*

> *"I felt we weren't taken seriously at the beginning and it had to get to a crisis point before we were offered any real help" (Parent/ Carer)*

> *"They [CAMHS] dismiss people who need help very easily, if you aren't in immediate danger they won't help." (Young person)*

The ‘no door is the wrong door’ approach of the services redesign should address this feeling around inflexible thresholds and a lack of support. However, it should be noted that Specialist CAMHS is not intended to be the ‘go to’ for all self-harm/mental health issues and other services should be utilised and may be advised before specialist support is required. It may indicate a need for increased focus on prevention and earlier support including a greater awareness of wellbeing services in the city. This was supported by the findings of a recent local YMCA Right Here Young Healthwatch report, which identified the need for more information about which service is appropriate during a mental health crisis and when, to avoid confusion around who to call (56).

Another issue was identified around those who self-harm but do not have a formal diagnosable mental health problem and therefore are not be eligible for referral to mental health services. One local professional emphasised that self-harm should always be taken seriously as requiring a health response and professionals should be careful not to ‘normalise’ self-harm. This is supported by the pan-Sussex Child Protection & Safeguarding procedures which state that self-harm “must always be taken seriously”. However, in the current system there is a risk that young people who self-harm but are not considered to have a mental health problem may fall through the gaps.

6.2.1.3 Young person-centred support

Two parents/carers highlighted the need for support that is specific to the child, and in particular, to other health conditions notably autism.

> “*My child is autistic and cannot access standard CBT or mindfulness, yet there is no alternative ‘evidence based’ approach apparently.*” *(Parent/ Carer)*

This links to comments from professionals that a ‘child-centred’ and ‘individual approach’ is needed – thinking about how each child can best be supported given their situation and building services around that.

6.2.1.4 Barriers to primary care

General barriers to Primary Care for children and young people were discussed by professionals, including telephone appointments, receptionists asking why an appointment is needed and getting to the surgery at the allotted time. Most self-harm among children and young people seen in Primary Care is identified at the sexual health drop-in clinics rather than specific appointments, and professionals suggested that drop-ins and online sources of support might be preferable to the more traditional forms of support in many cases.

6.2.2 Continuity and consistency of support across the system

6.2.2.1 Lack of continuity and a joined-up approach

Professionals discussed a lack of continuity and a ‘joined-up approach’ between services across the city, though many gave examples of good practice across the system including multi-agency meetings around a young person, and one respondent

noted that a huge amount of work is in progress to join up previously fragmented mental health services across the city.

Professionals suggested that a lack of continuity could be confusing for the service user, as there are many different options. There are multiple statutory and voluntary organisations involved, and it is not always clear what everyone is doing. Two professionals identified that it might be beneficial for one central organisation to organise the different steps in the care pathway - a single point of access joining up *all* mental health support services.

> *"A more joined-up citywide approach [around self-harm] would be really beneficial… There's pockets of good practice… there's not a consistent approach across the city at the moment, but then the services are all very new" (Professional)*

6.2.2.2 Improved communication between organisations

Improved communication between organisations across the city was identified by professionals as one area for improvement, including:

- Better handover/discussion of young people referred into and between mental health services, to ensure the young person receives more informed/prompt care, will not receive the same intervention twice and will not need to repeat themselves.

> *"I didn't like speaking to different counsellors as I felt I ended up repeating myself and my story" (Young person)*

- Follow-up information should be provided to schools after pupils are referred to Specialist CAMHS, so that they can support this.

- Feedback to schools after an overdose or other serious self-harm incident by a pupil should be the norm; each school should have its own confidentiality process to support this. Two parents/carers mentioned the importance of schools being linked in to the support so they could help.

- Professionals identified a need for non-specialists to access support from specialist mental health services. The Assessment and Treatment Service (ATS) was felt to be very accessible for a reassuring conversation about a patient, whereas Specialist CAMHS was more difficult to access by phone.

Work is underway to improve communication between the RACH and schools, to smooth the pathway from hospital back into the community for children who self-harm.

6.2.2.3 Information about what is happening in other teams and organisations

Some professionals expressed a desire for more knowledge and information about what is happening in relation to self-harm in all parts of the system, for example those in specialist services knowing about the education that is being provided in schools. This would enable services to know their role in a citywide approach, and how other services

might fit in with their offer. It would facilitate a consistent approach and smooth pathway for young people who self-harm. Further, services might be able to support each other and share learning. However, one interviewee noted that practitioners are saturated with information about services and you only really take in what you use.

6.2.2.4 Inconsistent approaches among services

Linked to this, professionals spoke of inconsistent approaches of services, including inconsistencies in response including advice given to a young person who self-harms and inconsistencies in training. It was identified that a more consistent approach to self-harm across the city is needed, including a more consistent approach to training (implemented citywide), risk assessment and response throughout the system. However, one interviewee noted that this might be difficult because there are conflicting views as to whether the aim should be to stop/reduce or manage self-harm which may be a substantial barrier to introducing a more consistent approach.

Two parents/carers said that they had received conflicting advice from different services, or to parent and child within the same service, which they felt worsened the self-harm. One said that A&E advised removing all sharp objects for cutting, while Specialist CAMHS advised a different approach. A local professional identified that this may represent conflicting advice, but it might also reflect a change in response based on different information provided at the initial and subsequent assessments. Either way, it is confusing for the service user if not explained to and agreed with them. Consistent advice from professionals was felt to be very important.

> *"Workers gave conflicting advice to me as a parent, and to our daughter. Self-harm worsened and she has since attempted suicide under their care" (Parent/ Carer)*

> *"There isn't a clear narrative right the way through the service, from services down to the population about what self-harm is, and so you can get conflicting bits of training about it… Depending on which part of the system you find yourself in, you might get a very different response" (Professional)*

6.2.2.5 Transitioning to adult services

NICE guidance highlights the importance of smooth transitions from children and young people to adult mental health services. The *Children & Young People's Mental Health & Wellbeing Needs Assessment* identified that the needs of those transitioning between these services were not being met. This is a critical time at which young people are at risk of falling out of services if they are not managed appropriately, and one professional reported that the young person in need of support has the "potential to disappear" at what is a difficult, transitional time.

There are a number of service developments in the city to address this issue. The Community Wellbeing Service is for all ages (previously only 18+) and Specialist

CAMHS is now able to continue to support young people up to 25 years old (previously 18) if clinically indicated, rather than transferring them to a service that does not know them as well. A national Commissioning for Quality and Innovation (CQUIN)[ii] framework specifically around transition has been introduced for SPFT, with the aim of improving the experience and quality of transition from one part of the system to another through joint care planning, joint consultations and planning ahead.

One professional noted that though Specialist CAMHS services are commissioned to work with some young people up to age 25 if felt to be beneficial, working with all young people past the age of 18 might overcome the particular difficulties of this period and negate the need for many of them to transition to adult services at all. The professional reported that one key challenge is that adult mental health services have different thresholds to Specialist CAMHS, therefore some vulnerable patients such as those with early developmental trauma may not meet thresholds for adult services. However, the two services have recently begun discussions around how to address this.

6.2.3 Workforce issues

6.2.3.1 Staff attitudes and responses to young people who self-harm

The treatment young people receive when they first approach a service such as A&E is really important in ensuring they feel comfortable returning to services if they need them in the future. Though local professionals acknowledged that attitudes among staff who work with children and young people are generally much better than in the past, misconceptions around self-harm and judgemental/ stigmatising attitudes in primary and secondary care were identified, creating barriers to help-seeking. It is particularly important to address this because of the shame and stigma around self-harm; compassion is needed in this context. Comments provided by professionals as examples of unhelpful attitudes included:

"You're just doing this because someone else you know does it"

"Why don't you just stop this?"

"You made me a promise last time… you wouldn't do this and you're back here again"

"Attitudes include, 'oh they're just doing it for attention', or the polar opposite… Both are unhelpful viewpoints."

A recent local YMCA Right Here Young Healthwatch report looking at young people's experience of using A&E during a mental health crisis identified similar challenges around attitudes of some staff (56). For example, the following quotes were taken from two of their case studies with young people:

[ii] The CQUIN is a national NHS scheme where NHS funded organisations can earn 2.5% extra income over and above the contracted amount as an incentive to improve the quality of care.

“My most recent experience, I was taken to A&E via ambulance service, and through the whole journey I was told how silly I was to have done what I did, as well as how I “couldn’t really want to die, I’m too young”. Finally arriving at A&E, I was seen and treated within 2 hours, and once deemed fit, I was sent home without any checks or follow-ups.”

“They [paramedics] weren’t horrible or anything but they were really stern and talked down to me, I felt. Made me feel bad saying ‘look at your poor parents’. Just made me want to top myself more in honesty.”

Further, these findings reflect those of a national report by the Care Quality Commission, ‘Right Here, Right Now’, which found that some people who self-harm report they experience a lack of sympathy and other negative experiences when they come into contact with NHS professionals. For example, staff judging people in crisis, not treating them with respect or compassion, or not taking the time to listen to carers’ concerns – and problems with access to services when they need them (57).

6.2.3.2 Training needs of non-specialist professionals

There was a general consensus among professionals that more training was needed for staff without specialist mental health knowledge who may be involved in the care of a child or young person who self-harms. The YMCA Right Here Young Healthwatch report supports this, suggesting that training for paramedics on a few key topics might help to prevent some A&E admissions. “Professionals in emergency services have very little, if any specific mandatory training on mental health issues, despite this being an increasingly large part of their work.”(56)

A training offer for GPs and nurses (primary and secondary care) was identified as desirable, potentially including an opportunity to embed routine enquiry for young people with self-harm risk factors attending their GP. The individual training need would depend on whether they see much self-harm in their role, and training would need to be attractive, applicable and simple. Generally hospital nurses have not had any mental health training at all unless they are mental health nurses.

Professionals report that young people receive variable responses from school staff. This is an important point to get right: a dramatic panic/distress response from an adult can have the result of escalating a young person’s self-harm, and training can help to avoid this. It was felt that more training for schools is needed so that they are confident providing the right response to children who self-harm, and able to provide the correct advice and referral to parents/carers. It was noted that this is improving, however, and that there is training available. Further implementation of Mental Health First Aid training and MindEd were suggested.

Training on self-harm has been provided to acute hospital staff by the Paediatric Mental Health Liaison Team, though this may need to be developed as a regular training event. Grassroots provide suicide awareness and prevention and self-injury training for the

local workforce working with, or for, one or more target group including people who self-harm or have a history of doing so. In 2016/17, Grassroots ran five 'Understanding and working with self-injury' courses with 79 participants. Feedback was positive (immediate and 6-month). 'ASIST' (applied suicide intervention skills training) and 'safeTALK: suicide alertness for everyone' courses were delivered to 29 and 34 participants respectively who work with people who self-harm (though they may not work with children and young people).

> *"There's quite variable responses from staff in schools from quite skilled and able to manage that whereas others become very panicked by it, very anxious" (Professional)*

> *"If you've got the potential to come into contact with a child or young person, then you should have some training around this issue" (Professional)*

6.2.4 Prevention and early intervention

6.2.4.1 Early discussion and education around mental health in schools

Professionals felt that more early discussion of self-harm was needed, particularly in schools. This should be in the context of emotional and mental health and stress management, and general coping mechanisms. It should aim to build resilience among young people, ensuring they know the 'warning signs' and have alternative coping strategies at their disposal. One parent/carer said that there should be more discussion in schools about positive mental health, and support groups for teenagers.

> *"It is important to build young people's emotional intelligence before they consider self-harming" (Professional)*

One professional described it as necessary to be open about the pros and cons of self-harm in the same way as we are about drugs and alcohol. It is also necessary for young people to know what is available to support them if they self-harm. A couple of professionals expressed concern that discussions around self-harm would need to be managed carefully.

There has been increased focus locally on prevention and early intervention, resilience building and awareness-raising in children and young people, including an emphasis on self-help and increased consultation with young people. Central to this approach is the Find Get Give website where young people and parents/ carers can seek help, advice, information and online tools from their peers in a young person-friendly way (51). The #IAMWHOLE mental health anti-stigma campaign was launched in schools in October 2016 to raise awareness, as part of the whole schools approach to emotional and mental wellbeing.

6.2.4.2 Support for parents/carers

As part of the Mental Health Innovation Fund, Safety Net were commissioned by the Council in 2017/18 to provide parenting workshops intended to raise parents' awareness and understanding of self-harm; increase parents' personal resilience and reduce isolation; and develop skills to manage self-harming behaviour.

A number of professionals identified the need for more support for parents/carers at the point they learn their child has self-harmed, as this can be traumatic for them, and they will not necessarily react in the best way to help the situation (and this anxiety might be passed on to their child).

Professionals suggested that after talking to parents/carers about their child self-harming, there should be something to send home with them (existing leaflets were felt to be helpful by three parents/carers) and a referral/support service as standard for any parent/carer. A telephone number for parents/carers to call for information and support to help them to understand the best way to manage their child would be useful. Four parents/carers mentioned that they would value support groups and/or access to professionals.

"I felt very alone whilst dealing with her [daughter] as I was out of my depth and had no understanding of self-harm" (Parent/Carer)

"For parents, when they're told their child is self-harming, they're often just left in the lurch and their anxiety then goes through the roof… they don't know how to respond in an appropriate way, because its really difficult" (Professional)

7. ‘What works’ to prevent or manage self-harm?

Self-harm is often one element or symptom of a more complex underlying need, therefore the risk assessment and response is likely to vary depending on the method and severity of self-harm, motivations behind it and other behaviours exhibited by the young person. This means that there is not a ‘one-size-fits-all’ response or intervention for preventing or managing self-harm, rather a range of possible approaches.

This chapter summarises National Institute of Health & Care Excellent (NICE) guidance for self-harm which is based on the best available evidence of which interventions are most effective for young people who self-harm (39). Having said this, there is a lack of high quality evidence of ‘what works’ to reduce self-harm. Therefore, local innovative approaches may be helpful, based on local need/ experience, shared learning and robust evaluation. For example, local professionals highlighted the following approaches which have shown promising signs of effectiveness in reducing self-harm among young people:

- The STEPPS emotional intensity pathway at the University of Sussex, based on learning from Bristol University, is showing positive signs of reducing self-harm in a cohort with high levels of self-harm.
- The self-harm clinic in A&E provides a small number of frequently attending patients with psychological input based on Psychodynamic Interpersonal Therapy (PIT). During the period December 2016 to October 2017 only two out of 18 patients re-attended A&E, and their self-harm scores reduced considerably over the course of therapy.
- Self-harm z card produced by Right Here
- The FindGetGive website with a self-harm section

7.1 Prevention of self-harm

Most self-harm occurs in the community and most completed suicides occur in individuals not known to mental health services. Therefore, targeting people before they start to self-harm and promoting mental wellbeing across the population (with greater intensity to those groups at high risk of poor mental health or self-harm) may be the most effective approach to reducing self-harm (45). Interventions to prevent self-harm can be population-based (aimed at all young people) or aimed at high risk groups, such as those with a history of abuse (15).

School-based programmes which may be effective include: (15)

- **School-based gatekeeper training** - training peers and adults to better recognise warning signs for suicide.
- **Psychological skills training for school pupils**
- **Whole-school approaches** to change the ethos and culture of a school in relation to psychological wellbeing.
- **Screening in schools to identify those who might be at risk** – including asking adolescents about suicidal ideas

However, there is evidence that such interventions may cause harm as well as benefit, and the possibility of contagion should always be considered (15, 45).

Other evidence-based interventions to prevent self-harm include: (15)

- **Restriction of access to means used for self-harm and suicide** – this is a key suicide prevention strategy in adolescents, especially because of the often impulsive nature of the behaviour. It does not usually result in individuals immediately turning to another method.
- **Improved media reporting and portrayal of suicidal behaviour**
- **Encouragement of help-seeking behaviour**
- **Public awareness campaigns**
- **Help-lines**
- **Internet sources of help** – 22 children/ young people in Brighton & Hove accessed online counselling through E-motion (Section 4.5)
- **Reduction of stigma** associated with mental health problems and help-seeking

As discussed in Section 6.2.4.1, a whole-school approach to addressing mental and emotional wellbeing in schools has been implemented across Brighton & Hove, and the #IAMWHOLE campaign aims to reduce stigma around mental health among children and young people.

7.2 Management of self-harm

NICE guidance on the short- and long-term management of self-harm outlines best practice for the process that children and young people who self-harm should go through once they have accessed primary or secondary care services, including the care they should receive in the longer term (39).

All people who self-harm should be offered **preliminary psychosocial assessment at triage** to determine their mental capacity, willingness to remain for further assessment, level of distress and possible presence of mental illness. They should be offered **treatment** for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment. Interventions for any associated conditions should be provided, including for alcohol-use disorder, drug misuse and depression.

7.2.1 In secondary care

Young people who self-harm managed in secondary care should be offered an integrated and comprehensive **psychosocial assessment of needs** and risks to understand and engage them and to initiate a therapeutic relationship. A **risk assessment** should be conducted to assess the risk of repetition of self-harm or suicide. Risk assessment tools and scales to predict future suicide or repetition of self-harm should *not* be used. A **care plan** should be developed in collaboration with the person who self-harms to identify long-term treatment. Care plans should be multidisciplinary and developed collaboratively with the person who self-harms, and if

agreed by the person in question, with their family, carers or significant others. A **risk management plan** should be a clearly identifiable part of the care plan.

CAMHS professionals who work with children and young people who self-harm should also consider whether the child's or young person's needs should be **assessed according to local safeguarding procedures** and if serious concerns are identified a child protection plan should be developed. This is consistent with what A&E departments are doing in Brighton & Hove.

7.2.2 In Primary Care

Primary care professionals should refer a person presenting with a history of self-harm and a risk of repetition to community mental health services or Specialist CAMHS (if they are aged under 18 years) if: levels of distress are rising, high or sustained in the child or young person or their parents/carers; risk of self-harm is increasing or unresponsive to attempts to help; or they request further help from specialist services. If a person is receiving treatment in primary and secondary care, professionals from both settings should work collaboratively, routinely sharing care and risk management plans.

As mentioned in Section 4.4, response of GPs to a child or young person self-harming is variable across the city; information sharing by professionals is also variable (Section 6.2.2.2).

7.2.3 Transition between services

Transitions from one service to another, or the ending of treatment, services or relationships should be anticipated; plans made (and shared with other professionals and the service user) in advance of these changes; and additional support provided if necessary, including contingency plans should a crisis occur. Specialist CAMHS and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from Specialist CAMHS to adult services. The timing should suit the young person, and treatment in Specialist CAMHS can continue beyond 18 years if there is a realistic possibility that this may avoid the need for transferral to adult mental health services. Mental Health Trusts should work with Specialist CAMHS to develop local protocols to govern arrangements for transition. Locally this has been developed as part of the Transition CQUIN (Section 6.2.2.5).

7.2.4 Harm reduction

If stopping self-harm is unrealistic in the short-term, strategies aimed at harm-reduction should be considered; this includes reinforcing existing strategies and developing new strategies as an alternative to self-harm. This can include discussing less destructive or harmful methods of self-harm with the service user (and their family, carers or significant others, if agreed).

7.3 Reducing repeat self-harm

For long-term management of self-harm, NICE recommends three to twelve sessions of a psychological intervention, including cognitive-behavioural, psychodynamic or problem solving elements. Psychological treatment should be delivered by therapists

trained specifically in self-harm, who work collaboratively with the young person to identify the problems causing distress or leading to self-harm.

NICE recommends that drug treatment alone should not be offered for self-harm. Drug treatments include antidepressants and other pharmacological agents such as benzodiazepines; however, drug treatment is generally less common than treatment with psychosocial interventions, partly due to concerns about the risk of exacerbating suicidality (58).

Adherence to treatment tends to be relatively poor amongst adolescents who self-harm and present to hospital; between 25% and 50% of adolescents will not attend any follow-up sessions (22). Interventions designed to improve adherence to treatment might be considered. Appendix 3 outlines the psychosocial and pharmacological treatments for self-harm, evidence of effectiveness and interventions for adherence to treatment.

Despite the scale of the problem, there is a paucity of quality evidence about which interventions are effective in reducing the reoccurrence of self-harm. One professional interviewed as part of this needs assessment identified that it would be desirable to look at the feedback from patients and review the evidence base for interventions used for people who self-harm, in order to revise the interventions provided by services.

8. Recommendations

This chapter describes a set of recommendations based on the key issues and gaps identified by the needs assessment and developed and prioritised by the steering group. Table 6 outlines the recommendations. The primary recommendation is the development of an action plan and supporting infrastructure/resource, as this will enable delivery of the other recommendations. In developing the action plan, it should be ensured that all groups are reached (e.g. different ages, severity, LGBTU).

It should be noted that 'professionals' or 'services' can relate to all staff who are in contact with children and young people, which may include (but not limited to) mental health services, GPs, social workers, nurses, police, ambulance staff and teachers.

Table 6: Recommendations

Recommendation	*Potential lead(s)*
1. Develop an action plan and an infrastructure/ resource to implement and monitor this plan. a) Develop an action plan; this should include appropriate links to adult services and the City's Suicide Prevention Plan. b) Hold a workshop to engage wider stakeholders, develop the action plan in greater detail and gain commitment to implementing the actions within the existing infrastructure. c) Develop a Task & Finish (T&F) Group out of the project steering group to co-ordinate the delivery of and with responsibility for monitoring the action plan.	Self-harm steering group, Children's Strategic Commissioning Group
2. Refresh the city-wide definition for self-harm, supported by a common risk assessment and set of supporting resources, in consultation with young people and using an equalities framework a) Refresh the Local Safeguarding Children's Board (LSCB) definition of self-harm based on the findings of the needs assessment (ensuring male self-harm is captured) and promote this as a common definition to be used across the city. This should include direct promotion to professionals, parents/carers and children and young people with particular consideration around how to reach boys and young men. b) Develop a common risk assessment for use across services. c) Develop and maintain a guidance document supported by a set	T&F Group, LCSB, Families, Children & Learning and Public Health

of common resources based on the needs assessment findings and the refreshed LSCB definition, for use by children and young people, parents and carers and professionals. This should build on existing resources and developed in consultation with and approved by young people. There should be a clear, visual message, providing advice, information and where to go for help. It will include digital/online resources (including adding more blog content to Find, Get, Give) to which all children and young people should be referred by services while waiting for assessment or treatment. d) A formal commitment/ statement/ concordat across services (children's and adults) at executive level of all stakeholders to use agreed definition and set of resources and promote to parents/carers and children and young people in a consistent way. e) Use revised resources to develop greater awareness of and confidence in alternatives to Specialist CAMHS for children. f) Build awareness around 'drop-in' services available for children and young people, and where they can go for access to a professional support other than A&E. Consider enhancing services if gaps are identified. g) Build on the emotional wellbeing and mental health framework in schools to ensure a common and consistent approach; ensure that improving emotional literacy, mental health and dealing with anxiety are embedded in open, regular discussion.	
3. Explore options for improving communication and information sharing between services a) Review when sharing of information around individuals who self-harm is and is not appropriate: who needs to know and in what circumstances (e.g. level of risk), and ensure necessary confidentiality systems are in place. b) Prioritise which groups/services could better share information. c) Explore options for enabling information sharing, for example through developing a clear information sharing protocol, or specific measures such as allowing young people to share their own care plan. Ensure this links to the Commissioning Framework developed for the main providers of children and	T&F Group, BHCC Public Health

young people's mental health. d) Review and evaluate the A&E-to-schools information sharing pathway	
4. Prioritise engagement with children and young people in development of services that affect them a) Develop a framework for use across the Council and CCG to ensure that we continue to capture the voice of children and young people concerning the development of services that affect them, in particular the younger age groups and within short timescales. b) Consider providing internal training for Council staff on engagement with young people.	Children and Young People Improving Access to Psychological Therapies (CYP IAPT) working group, BHCC
5. Develop a consistent training offer for professionals and families a) Conduct a mapping and gap analysis of training around self-harm. Prioritise which groups should be targeted. b) Identify and develop a consistent training offer for professionals and families based on recommendations 2 and 3a). Consider the inclusion of simulation training and how to involve young people with lived experience in training delivery. c) Consider how to maximise numbers attending, including non-face-to-face options. d) Consider how to implement a training offer specifically for GPs on asking standard questions of children and young people who attend their GP for a wide range of complaints that imply increased risk for self-harm. This should include education about treatment and local referral options.	T&F Group, Specialist CAMHS
6. Engage with organisations/teams working on reducing online harm in Brighton & Hove. This includes engagement with www.saferinternet.org.uk to assist closing down harmful websites and engaging with social media providers.	BHCC community safety team
7. Improve collection and use of data on self-harm in children and young people a) Develop a 'self-harm profile' including: - Hospital data - for benchmarking against other areas and	CYP IAPT working group, T&F Group

identifying trends, while understanding it only reflects the 'tip of the iceberg' of self-harm. - SAWSS data on self-harm - to reflect trends in self-harm in the community. - Self-harm presentations to services – consider how providers can collect and report useful data on self-harm presentations in a consistent way using existing systems. b) Continue to ensure that providers use standardised measures based on CYP IAPT and develop outcomes specifically related to self-harm (either a specific outcome measure for self-harm or one that would need to be adapted). These should be consistent across services and reported regularly to indicate service effectiveness for young people who self-harm.	
8. Review the interventions and approaches used by services for young people who self-harm in Brighton & Hove and make recommendations for improvement a) Conduct a review of current interventions that work successfully for young people who self-harm in Brighton & Hove (including prevention and early identification), including an assessment of their evidence-base. This could include the extension of the self-harm PIT clinic at RSCH to the RACH. b) Capture detail around how the interventions are monitored and evaluated and make recommendations for improved monitoring and evaluation.	CYP IAPT working group

Appendix 1: Self-harm Steering Group members

Ben Glazebrook	Youth Collective/ Impact Initiatives
Burdy Farmer	YMCA Right Here
Elizabeth Freeman	Schools Wellbeing Service, Brighton & Hove City Council (BHCC)
Gill Brooks (Co-Chair)	Brighton & Hove Clinical Commissioning Group (BH CCG)
Greg Burgess / Stella Coomber	Grassroots Suicide Prevention
Helen Arnold Jenkins	Parent & Carer's Council
Jan Szaranek / Lynda Hayes	Prevention Youth Officers, Sussex Police
Jenny Hacker	Public Health Intelligence, BHCC
Jo Tomlinson	Safeguarding Lead, BH CCG
Joanna Bullen	Paediatric Mental Health Liaison Team, Royal Alexandra Children's Hospital
Dr Katie Stead	GP and Clinical Lead for Public Health, BH CCG
Kerry Clarke (Co-Chair)	Public Health Children's Commissioner, BHCC
Mark Cull & Sarah Weston	YMCA Downslink Group
Dr Rebecca Jarvis	GP and Clinical Lead for Mental Health and Children, BH CCG
Ryan Gingell	Allsorts Youth Project

Appendix 2: Methodology

Quantitative data analysis

Data on the prevalence and sociodemographic characteristics of self-harm in Brighton & Hove was identified from publicly-available sources, steering group members and various local services. It was collated and analysed by the Public Health Intelligence Team.

Data sources include:

- Hospital Episode Statistics (HES) – data containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. It includes age of patient and other socio-demographic characteristics, lower super output area and associated Index of Multiple Deprivation decile group as well as discharge and other hospital information.
- Brighton & Sussex University Hospital (BSUH) Accident & Emergency (A&E) data – monthly data recording everyone attending the hospital including those who do not reside in Brighton & Hove.
- Brighton & Hove Safe & Well at School Survey (SAWSS) - Anonymous online survey conducted annually by primary and secondary state schools during lesson time. There was a question on self-harm every year between 2012 and 2015 in the survey for 14-16 year olds (there was no question about self-harm in the 2016 survey). Whilst the questions differ slightly each year, the 2013 to 2015 questions are somewhat comparable, though the 2012 is completely different.
- Data gathered from local services on the numbers of clients presenting with self-harm
- Police incident database – This includes anything which has been reported to the police (usually phone calls) but has not been initially recorded as a crime. A text search for the words “self harm” was performed.
- Children in need census – collects information on any child under 18 referred to children’s social care services within the year, and any cases open at the beginning of the year for whom local authorities were providing a service.

Literature review and mapping existing local services

A literature review was conducted to understand self-harm and what works to prevent/reduce self-harm.

A literature search was conducted by the Brighton & Sussex Library and Knowledge Service on 02/08/2017 using the following search criteria:

- Sources searched: Citation Tracking; Departmeny of Psychiatry, Warneford Hospital, Oxford; Google; Gov.UK; HMIC; NICE Evidence Search; PsycInfo; PubMed; Public Health England.
- Date range used: None
- Search terms: self-harm, adolescen*, young people, child

Relevant publications were reviewed and further publications were identified from the references in those articles. In addition, peer reviewed and grey literature was gathered from steering group members; and further searches were conducted on google scholar, NICE and Cochrane. A desktop review and conversations with commissioners, providers and steering group members provided the intelligence needed to map relevant services in Brighton & Hove.

Surveys to capture the community voice

Two online surveys were designed to capture the views of (a) young people aged 16-25 with experience of self-harm, and (b) parents/carers of children or young people who have self-harmed. Children younger than 16 years were not surveyed due to consent being required. These surveys were designed to meet the objectives of the project, while only asking questions that had not been answered by other research; therefore the focus was on local services and support.

The survey questions were designed in consultation with the steering group, young people (YMCA Right Here), the Parents and Carers Council and the public health team. The surveys were piloted in the public health team.

The survey links were distributed via the steering group and a range of other local organisations, to promote to the relevant audience via social media, events and mailing lists. Safety Net distributed some leaflets including the parent/carers survey link at their training events. The following organisations that were sent the surveys to promote:

- Right Here
- Allsorts Youth
- Universities of Brighton & Sussex
- The Carer's Centre
- Brighton & Hove Faith in Action
- One Church
- Mosaic
- Friends, Families & Travellers
- Safety Net
- Mind
- Parents & Carers Council
- Homewood College
- Sussex Partnership Foundation Trust
- RUok?
- Pavillions
- SHAC (sexual health services)
- Schools
- Brighton & Hove City Council
- Grassroots
- Brighton College
- Brighton Oasis Project
- BH Inclusion Support Service
- Impact Initiatives
- MindOut
- Amaze
- Charlie Waller Memorial Trust
- Police
- Youth Offending Service
- Sussex Community Foundation Trust
- Safespace
- Schools Wellbeing Service
- YMCA Downslink Group

The survey responses were analysed by two members of the public health team and quotes were extracted for use in the report.

Interviews with local professionals

Semi-structured interviews were conducted by telephone or face-to-face with ten professionals from a range of organisations involved in the care of children and young people who self-harm: Specialist CAMHS; Paediatric and Adult Mental Health Liaison Teams at the acute hospitals; Community Wellbeing Service; YMCA DownsLink Group; the University of Sussex; GP; nurse practitioner; Schools Wellbeing Service; and Allsorts.

The interviews were based around the following questions:

1. In your experience, to what extent is self-harm a problem among local children and young people and why?
2. How could we work with young people earlier and more effectively?
3. What are the gaps in current services for children and young people who self-harm?
4. Do you feel that you and others receive adequate training to support children and young people who self-harm and what additional training might be helpful?

Interviewees were provided with information in advance of the interview, including information about the purpose of the needs assessment and what the interviews and resulting data would be used for. They were required to give informed consent via paper form or email. The interviews were recorded and all information was stored and transferred securely.

The interviews were conducted by members of the public health team and a summary of the interview was written up and agreed with the interviewee. The interviews were analysed by the report author and quotes selected to represent what was said. All interviewees were given sight of the final report and asked for their agreement for anonymised quotes to be included.

Appendix 3: Interventions to reduce the repetition of self-harm

A 2015 Cochrane review of psychosocial interventions to reduce the repetition of self-harm in children and adolescents concluded that therapeutic assessment, mentalisation and dialectical behaviour therapy warrant further investigation, yet there was little support for the effectiveness of group-based psychotherapy, cognitive behaviour therapy or home-based family interventions (22). A 2016 Cochrane review of psychosocial interventions for self-harm in adults concluded that the quality of evidence was generally low (results are of limited use as it looked at all adults) (59).

Evidence-based psychosocial interventions for self-harm:

- **Cognitive behavioural therapy** – helps patients identify and critically evaluate the ways they interpret and evaluate disturbing emotional experiences and change the way they deal with problems.
- **Problem solving therapy** – an integral part of CBT, it assumes that ineffective coping behaviours might be overcome by helping patients learn new skills to actively and constructively solve the problems of daily life.
- **Dialectical Behavioural Therapy** – aims to help patients better regulate their emotions, achieve a sense of interpersonal effectiveness, become more tolerant of distressing thoughts or feelings and become better at managing their own thoughts and behaviours.
- **Mentalisation** – aims to improve the patient's ability to empathise with others by developing an understanding of how their own behaviours may impact on the feelings of others, and to regulate their own emotions more effectively. There is a clinical programme specifically for adolescents with severe personality difficulties and co-morbid mental health problems.
- **Group-based psychotherapy** – includes the integration of techniques from several therapies and works on skills related to developing interpersonal relationships and problem solving.
- **Home-based family interventions** – involves therapy sessions with the child or adolescent and family members, and is based on the understanding that self-harm in young people may be related to family dysfunction.

Pharmacological treatments for self-harm include antidepressants (to address the prevalence of depression in children and adolescents who present to hospital following an episode of self-harm (38)) and other pharmacological agents such as benzodiazepines and other anxiolytics. However, treatment with pharmacological agents is generally less common than treatment with psychosocial interventions, partly due to concerns about the risk of exacerbating suicidality (58).

Pharmacological interventions for self-harm:

- **Antidepressants** may reduce self-harm by improving mood in young people with depression, though here are concerns that SSRA (other than fluoxetine) may increase suicidality in young people.
- **Antipsychotics** may act on self-harm by reducing heightened arousal.
- **Mood stabilisers** may reduce the risk of suicidal behaviour among children and adolescents with bipolar or unipolar disorder (to date an effect has only been found for lithium).
- There is mixed evidence for many **other pharmacological agents** including benzodiazepines.

Adherence to treatment tends to be relatively poor amongst adolescents who self-harm and present to hospital; between 25% and 50% of adolescents will not attend any follow-up sessions (22). Interventions designed to improve adherence to treatment include:

- **Enhanced assessment approaches**: adolescents learn to identify psychological pain and their connection to problem behaviours such as self-harm, and identify ways to break the cycle.
- **Compliance enhancement approaches**, such as following up patients in the community or efforts to assess factors likely to impede attendance at treatment.
- **Remote contact interventions** aim to facilitate rapid access to care, by encouraging patients to seek help when they feel distressed and offering on-demand emergency contact with psychiatric services.

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