Self-harm: local identification of needs

City of York Council

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EXECUTIVE SUMMARY

Self-harm is reported to be a growing concern and issue locally. York does have slightly higher rates of hospital admissions due to self-harm than England average rates and anecdotal and audit information from a range of sources identifies growing concerns about increases in self-harm.

There is a current gap in the availability of comprehensive and robust data to be able to clearly identify the full scope of the issue. There are inconsistent ways of recording, reporting and sharing self-harm related information about risk and prevalence where an incident does not result in a hospital admission. Where self-harming behaviour does result in a hospital admission, there is a good availability of local data but this does not provide a full picture about the scope of self-harm.

A range of services and staff groups identify self-harm as a concern but information about the prevalence of this behaviour is not consistently collected or shared between services.

There is a lack of readily available advice and information for people to access about self-harm, how to identify when self-harming behaviour may be happening, what to do and how to support someone who is self-harming.

There is a reported lack of clear referral options for people who are known to be self-harming. Threshold criteria for access to mental health support services for people who are self harming but have no diagnosed mental health conditions are reported to be too high for people to be eligible to access. However, it should be noted that local child and adolescent mental health services are providing a good level of support to those young people who are accessing hospital services in relation to self-harm. There is also a joint pilot scheme to provide more support into the York Hospital Emergency Department (ED) in order to be better able to support people with mental health needs who are not admitted to hospital. This includes supporting people who are presenting to the ED with self-harm injuries.

There still exists a stigma around self-harm and the local health and social care system might benefit from a focus on training key staffing groups to be able to better support people who are self-harming. By supporting staff to be able to respond effectively to someone who is self-harming, it may make it easier for people to ask for help around self-harm and mental health support needs.

From this paper, there are four areas recommended for local consideration:

- To strengthen the identification and recording of self-harm related problems that do not result in a hospital admission. This will establish a baseline measurement of the extent of the issue and help raise the focus on the importance of accurately being able to identify self-harming behaviour. Without being able to accurately identify how much self-harm is happening it is not possible to demonstrate a suitable response to it.
- To develop and enhance a local offer of information, advice and training to key staff groups and people most at risk of self-harm. This will reduce barriers to people who self-harm seeking help and improve the ability of staff to be able to respond to self-harming behaviour and risks effectively.
- To be able to offer evidence based interventions that are effective in reducing self-harming behaviour and clear referral routes into this support. This would also contribute to removing barriers for people to ask for help.
- To seek assurance that appropriate and adequate pathways exist which allow people who self-harm to receive support. This would include clarity that; self-harming behaviour among adults is assessed and risk assessed by service providers; there are clear pathways into support where self-harming behaviour is identified which should include consideration of referral processes for adults and children from Emergency Department and referral from schools into CAMHS.

INTRODUCTION

Self-harm can be quite difficult to define. There is not one wholly accepted definition but perhaps the most commonly accepted is the NICE (2011) definition:

> Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation.

This definition is stated to exclude harm from excessive consumption of alcohol or recreational drugs, or from starvation through anorexia nervosa, or accidental harm to oneself. However, these sorts of risk taking behaviours are often associated with self-harm. Behaviours such as substance misuse and eating disorders, dangerous driving, dangerous sports, sexual risk taking and self-neglect can be referred to as instances of indirect self harm.

For the purposes of this report the NICE definition as above will be used and the use of self-harm related information will predominantly draw on instances of direct self-harm rather than a wider definition which would include a range of risky behaviours.

In terms of how people self-harm, the most common form is reported to be cutting but there are a range of other ways in which people self-harm. Locally, the cause of admission to hospital in relation to self-harm is overwhelmingly through poisoning by paracetamol. Across the NHS Vale of York Clinical Commissioning Group area, there were 659 admissions to hospital related to self-harm between April 2014 – March 2015. Of these, only 19 were recorded as open wounds i.e. 'cutting' and 581 were related to poisoning – the most common substance used to self-harm through poisoning was Paracetamol.

Some of the other ways to self-harm might include:

- cutting;
- biting self;
- burning, scalding, branding;
- picking at skin, reopening old wounds;
- breaking bones, punching;

- hair pulling;
- head banging;
- ingesting objects or toxic substances;
- Overdosing with a medicine.

Mental Health Foundation (2006).

Self-harm is not the same as suicide or attempted suicide, it is generally used as a way of coping with emotional distress and the majority of people who self-harm do so with no intention towards suicide.

Whilst self-harming behaviour is predominantly a coping strategy which carries with it low immediate risk for suicide, it is not completely separate to suicide. A range of research identifies that future risk of suicide is increased by between 50 – 100 times because of self-harming behaviour (Royal College of Psychiatrists, 2010). In relation specifically to young people aged under 20 years old, 54% of death by suicide between January 2014 and April 2015 were in young people who had previously self-harmed (Healthcare Quality Improvement Partnership, 2016).

An increased level of immediate risk is identified for those aged over 65 who self-harm where the risk of further self-harm and suicide is substantially higher than in other age groups. All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults (NICE, 2011).

For some, self-harming behaviour may only last for a short period of time where for others it might develop into a long-term coping strategy. Some people may stop self-harming but return to this behaviour at times of distress. It is often a secretive and hidden behaviour. This can make it difficult to identify and is not something that can always be changed easily. Even for those people who are receiving support from services, a recovery process can take a long time, particularly where self-harming behaviour has become a normal way of coping for that individual.

A recovery process from self-harm requires finding new coping strategies or using distraction techniques when a person has the urge to

self-harm. Different people find that different techniques work with varying levels of success and these may even vary in how well they work for a person depending on their mood or the situation they are in at that time. Finding the most useful alternative techniques takes time but trying different methods does work to find the most suitable for that person (Mental Health Foundation, 2006).

The reasons given by people who self-harm for their self-harm are varied but the most common is because of emotional distress:

- self-harm temporarily relieves intense feelings, pressure or anxiety;
- self-harm provides a sense of being real, being alive - of feeling something other than emotional numbness;
- harming oneself is a way to externalise emotional internal pain - to feel pain on the outside instead of the inside;
- self-harm is a way to control and manage pain - unlike the pain experienced through physical or sexual abuse;
- self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions;
- self-loathing - some people who self-harm are punishing themselves for having strong feelings (which they were usually not allowed to express as children), or for a sense that somehow they are bad and undeserving (for example, an outgrowth of abuse and a belief that it was deserved);
- self-harm followed by tending to wounds is a way to be self-nurturing, for someone who never was shown by an adult to express self-care;
- harming oneself can be a way to draw attention to the need for help, to ask for assistance in an indirect way;
- on rare occasions self-harm is used to manipulate others: make other people feel guilty or bad, make them care, or make them go away;
- self-harm can be influenced by alcohol and drug misuse.

NHS Tayside (2011)

Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself (NICE,

2011). A range of factors may cause a person to start self-harming and these might include: family problems; feeling stressed; relationship problems; exam or school work pressure; low self-esteem; bereavement; loneliness and isolation; feelings of guilt; bullying; difficulties associated with sexuality; feelings of rejection; mental health issues; reaction to trauma or abuse; peer pressure; poor body image; substance misuse (drugs and alcohol). There may be a range of other reasons that lead someone to self-harm and these reasons may differ from person to person or be a combination of several different reasons.

Groups at risk

Self-harming is not restricted to a particular group. People of different ages and gender might self-harm and because much self-harming behaviour goes unidentified, due to its secretive nature and its use as a way of coping, it is difficult to identify a clear picture of how often it happens. However, self-harm is known to be more common in younger people than older people and more common in women than men.

The UK has one of the highest self-harm rates in Europe, reported at about 400 per 100,000 people (Royal College of Psychiatrists, 2010).

The reported rate of people admitted to hospital as a direct result of self-harm is identified to be lower than this estimate and in 2013, was 203 per 100,000 people. This figure only reports people who are admitted to hospital and does not account for those who do not seek medical help for wounds, who manage their own wounds from self-harm or do seek medical help but are not admitted to hospital e.g. in an Emergency Department (ED) setting that does not result in a hospital admission.

Because of the secretive nature of self-harming behaviour and stigma associated with self-harm, much goes unreported and the actual rates of presentation to hospital for treatment are likely to represent only a proportion of self-harming behaviour. It is difficult to accurately identify how much goes unreported.

There is not a consistent way that known self-harming behaviour that does not result in a hospital admission is recorded. Where self-harming behaviour might be known about by a range of support services such as mental health support services or schools, there is no standardised reporting process to identify how many people are affected. Just over 40% of young people who died by suicide during 2014 – 2015 were not known to services and had not expressed ideas of suicide; however, self-harm is known to be a common risk factor (Healthcare Quality Improvement Partnership, 2016). This makes it particularly pertinent to consider how able young people feel to access support when problems exist which make them vulnerable to risk of suicide, and what responses will work best to reduce that risk.

Anecdotally, services report increasing concerns about the amount of young people engaging in self-harming behaviour but it is very difficult to clearly identify how many people might be affected. The one clear measure that is available, hospital admission data, is an under representation of the true level of self-harming behaviour that takes place.

Local self-harm data

Public Health Outcome Framework data published by Public Health England shows that between 2010–2013, York is reported to have slightly higher rates of hospital admissions for self-harm in young people aged 10 – 24 than the England rate. This equates to 368 admitted to hospital per 100,000 people compared to 352 per 100,000 people across England.

Across all age groups for the same period, the rate is still higher than the England average. It is 215 per 100,000 people in York compared to 203 across England.

In North Yorkshire for the same time period, the rate for admission in 10-24 year olds is lower than the England average at 310 per 100,000 people.

In North Yorkshire across all age groups for the same time period, this rate is also lower than the England average at 173 per 100,000 people compared to the England rate of 203.

This shows that self-harm cases presenting to hospitals are higher in York than the England average rate and that the rate of hospital admissions because of self-harm is higher in people aged 10-24 than in the rest of the population.

Survey information reports that among 15-16 year olds, over 10% of girls and 3% of boys reported self-harming in the previous 12 months (NICE, 2011).

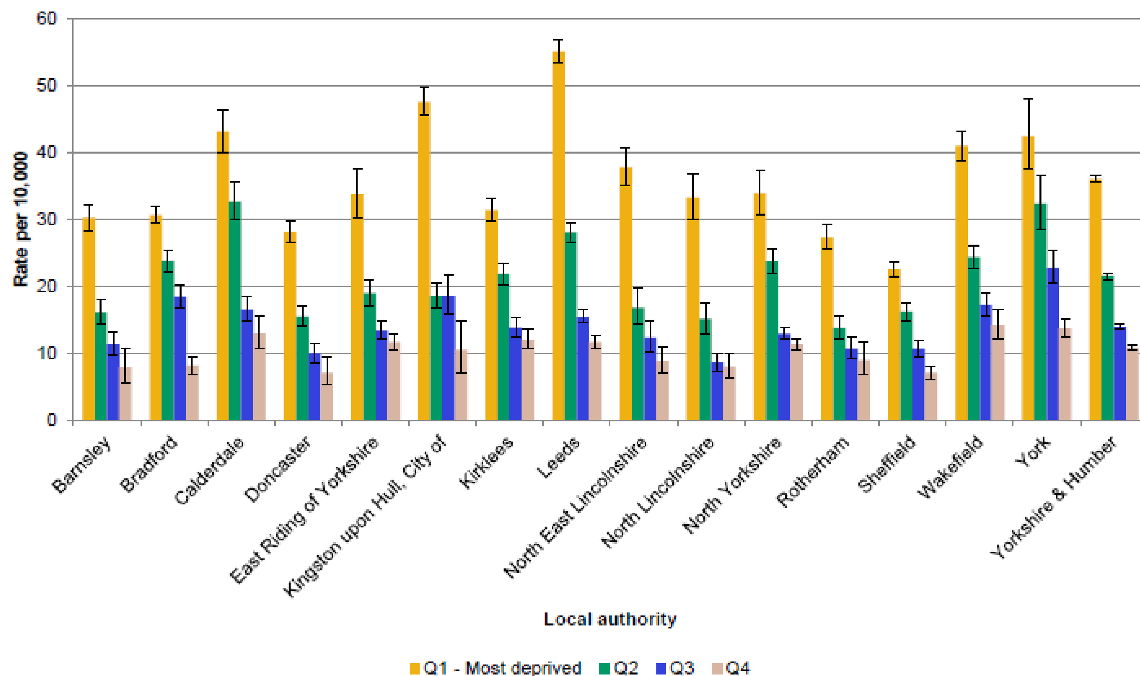
There are groups of people who are identified as being most at risk of self-harming behaviour. These are:

- adolescent females;
- young people in residential care;
- lesbian, gay and bisexual and transgender people;
- women of South-Asian ethnicity;
- prisoners;
- asylum seekers;
- military veterans;
- children and young people in isolated rural settings;
- children and young people who have a friend who self-harms;
- groups of young people in some sub-cultures who self-harm;
- children and young people who have experienced physical, emotional or sexual abuse during childhood;
- people living in financial deprivation or being unemployed
- people who misuse substances
- people who live in areas that are socially fragmented and disconnected
- people who experience adverse life events
- people who have existing mental ill-health problems and / or previous suicide attempts

NHS Tayside (2011); Royal College of Psychiatrists (2010); NHS Health Scotland (2014)

Increased levels of self-harm related admissions are linked to living in areas of deprivation. The graph below highlights how emergency self-harm admission rates are higher in areas of deprivation across all local authority areas in the Yorkshire and Humber region.

Emergency self-harm admission rates for all persons per 10,000 population by deprivation quartiles, 2010/11 - 2012/13



Source: Public Health England: Self-harm and suicide

Local hospital data for the period 2010–2013 for admission because of self-harm has been analysed to identify which wards that people who have been admitted to hospital because of self-harming live in.

This identifies a general trend of higher levels of self-harm related admissions among people who live in wards that have higher levels of deprivation (e.g. Westfield, Guildhall), or have higher proportions of students and people of Asian ethnicity (e.g. Heworth) than the local authority area average.

Three of the five most deprived wards in York have rates of hospital admission for self-harm those are among the 5 highest by ward: Westfield, Clifton and Heworth.

Hospital admissions for self-harm by Local Authority ward area

Admissions for self-harm	Population mid 2013 estimates	% Admissions per population	Ward Name	IMD 2015 (high score = more deprived)
131	13,809	0.95%	Westfield	25.8
94	9,626	0.98%	Guildhall	21.66
94	14,134	0.67%	Clifton	21.01
118	14,217	0.83%	Heworth	16.58
82	12,504	0.66%	Micklegate	15.64
98	11,073	0.89%	Hull Road	14.29
77	13,036	0.59%	Holgate	14.08
46	8,720	0.53%	Acomb	12.95
99	12,206	0.81%	Huntington and New Earswick	12.39
63	11,438	0.55%	Dringhouses and Woodthorpe	9.64
108	10,125	1.07%	Fishergate	9.14
10	3,733	0.27%	Osbaldwick	8.66
44	8,191	0.54%	Strensall	7.85
49	13,375	0.37%	Skelton, Rawcliffe and Clifton Without	7.03
8	2,820	0.28%	Fulford	6.76
9	3,603	0.25%	Heworth Without	5.46
40	5,497	0.73%	Heslington	5.42
12	3,991	0.30%	Bishopthorpe	5.4
6	3,623	0.17%	Derwent	5.08
42	11,972	0.35%	Haxby and Wigginton	4.76
*	4,214	n/a	Wheldrake	4.6
40	10,526	0.38%	Rural West York	4.57

Source: Public Health England; Hospital Episode Statistics; Office for National Statistics IMD

The wards used in this data analysis are old ward profile areas that have since been replaced but because of the data parameters of this data, it has not been possible to use the new ward boundaries.

Locally, hospital admissions among 10-24 year olds can be seen to have fluctuated year by year but that the most recent figures show an increase from 6 years earlier and are at the highest level in this 6 full year period.

These figures clearly show that self-harm admissions for girls and women are higher than in boys and men and are approximately 3 times as high. This reflects national trends in gender differences of self-harm.

Young people aged 10 to 24 years resident in York who were admitted to hospital as a result of self-harm

Financial year	Gender		
	Male	Female	Total
2007/08	43	125	168
2008/09	59	131	190
2009/10	61	132	193
2010/11	41	109	150
2011/12	43	111	154
2012/13	46	147	193

This data also identifies that the highest rates of hospital admission for self-harm are amongst 15-24 year olds.

Young people aged 10 to 24 years resident in York who were admitted to hospital as a result of self-harm

Financial year	Age group (years)				Total
	10-14	15-17	18-20	21-24	10-24
2007/08	18	42	66	42	168
2008/09	17	40	55	78	190
2009/10	13	50	74	56	193
2010/11	13	28	57	52	150
2011/12	18	32	51	53	154
2012/13	22	61	63	47	193

Source: Public Health England, Child and Maternal Health Intelligence Network; Hospital Episode Statistics (HES).

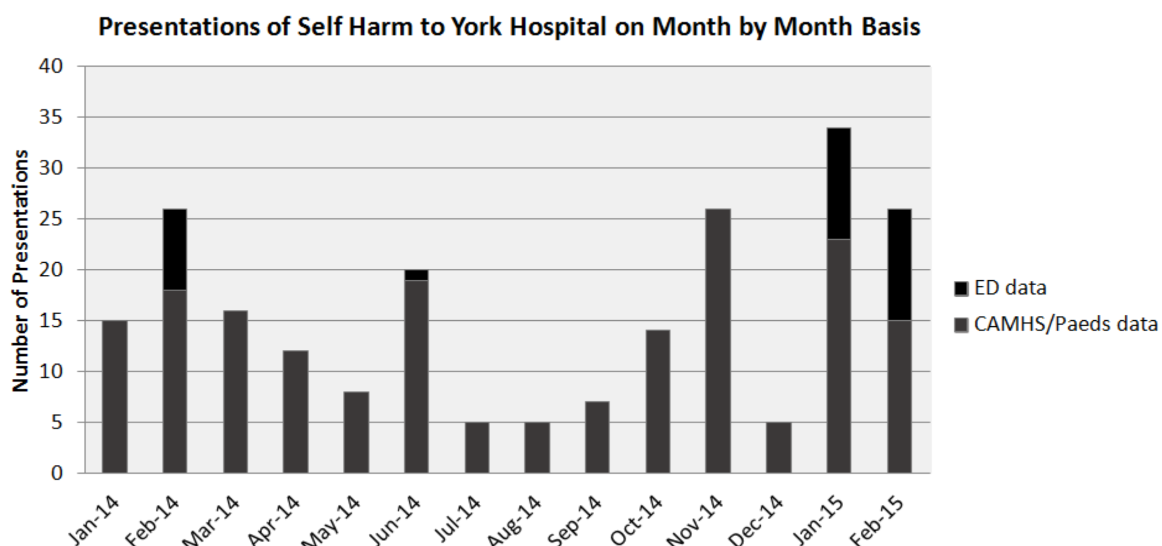
An audit into Child and Adolescent Mental Health Service (CAMHS) completed by Dr. Govenden and Dr. Sykes is summarised below.

Activity data was collected from hospital records of admission to the children's ward and CAMHS documentation of referrals received. Emergency department attendances for all conditions were reviewed for

certain key months between January 2014 and February 2015 for all children aged 10-18 years.

This reported that between January 2014 and February 2015 there were 214 presentations to York Hospital Emergency Department (ED) by 119 children and young people with self-harm and/or suicidal thoughts. Of these children, City of York residents accounted for 91 of 119 children (76%) and 167 (78%) attendances.

The graph below shows the number of children and young people presenting with self-harm. For February 2014, January 2015 and February 2015 data was checked against ED records and additional presentations were found. Shown is the combined total for all records.



The graph shows seasonal variation in presentations with self-harm. There is a rise during the exam period (June) but otherwise the summer months have fewer presentations. In the second half of the study period (July 2014-February 2015) there are more presentations, 117 in total, compared to the first half which saw 102 total presentations.

Key findings were as follows:

- 24 boys (20%) account for 47 (22%) attendances, 95 girls (80%) account for 167 (78%) attendances.
- Young people aged 16 and 17 years accounted for 50% of the total attendances, the youngest child seen was 9 years, the oldest was 18 years.

- Approximately 8% of children in this group are looked after, compared to a city rate of 245 per 10,000 population (2.5%), making them significantly over represented in this group.
- 89% of children seen had a documented risk assessment carried out by medical staff in ED, CAMHS or paediatrics.
- Of 214 presentations: 153 (71%) were admitted; 24 (11%) were discussed with CAMHS and discharged, 4 (2%) self discharged; 25 (12%) were seen and discharged with no risk assessment documented; 8 (4%) had other outcomes.
- 137 (64%) presentations involved overdose of medication or other harmful substances. Of these, 94 included paracetamol. 43 (20%) attendances were due to self injurious behaviour, including one young man found unconscious after an attempted hanging. 34 (16%) presentations were due to increasing thoughts of suicide, self-harm or feeling unsafe.
- Most children stated they felt very low in mood and where a particular trigger was documented, the majority of children and young people cited family issues and arguments as the reason for their self-harm. Issues with relationships, school or work stress, bullying, police visits or court cases and being the victim of sexual assault were also given as reasons for self-harm.
- Many of the children and young people seen in this audit presented only once to ED but a key minority presented over 3 times during the study period.

There were a number of limitations in gathering accurate data for this audit. Only presentations where there was documentation of self-harm intent or suicidal thoughts were included in the audit. Cases of indirect self-harm such as presenting with anxiety, intoxication from alcohol or other substances, or from punching a wall, whilst identified, were not included in the audit. This would indicate that if the criteria for identifying self-harm were broadened, that it would be likely that more children would be identified. The audit only looked at attendances of children and young people under 18.

The audit reported that the majority of the children and young people presenting with self-harming injuries were appropriately assessed and

referred for treatment. During the period of this audit, CAMHS carried out at 147 assessments on children and young people admitted to the paediatric ward. Comparison is made between this figure and data from the City of York Children's and Young People's mental health strategy 2013-2016 document which states that in 2011-2012 '80 young people were seen in hospital by the CAMHS duty team following an overdose or other serious form of deliberate self harm.'

From the data gathered it is clear that there are high levels of children and young people who self-harm in York. A disproportionate number of these children and young people are looked after and the majority of those seen in hospital cite difficult family relationships as the trigger for their self-harm. It is not surprising that those children and young people who lack robust emotional support appear to be at greater risk of harming themselves. Any actions that can be taken to strengthen vulnerable families and that foster emotional resilience in young people are likely to be of great benefit to the mental health of our community.

The audit identifies a range of suggested actions:

- Clear referral pathways: ED has already implemented a new referral pathway for children presenting with self-harm and they are transferred to paediatrics directly for further assessment.
- Consultant review after multiple presentations: CAMHS may consider that a person presenting for the 3rd time within a given period may need more senior review and possibly be considered for admission.
- Clearer coding: ED is currently planning to update their coding system to try to better capture the number of presentations to the department.
- Crisis team in ED: with additional staff training, the ED-based crisis team may be able to directly assess and manage 16 and 17 year olds presenting with self-harm which could potentially lead to more satisfactory outcomes for those young people and reduce the number of inpatient stays.

- Training: ensure all ED and paediatric staff are adequately trained in conducting risk assessments of children and young people.

It would be useful to replicate this audit assessment within the adult (18+) population to understand how well people in high risk groups for self-harming behaviour based on age e.g. 18-25 year olds and those in high risk groups of immediate risk of suicide e.g. over 65 year olds are being assessed for mental health support needs following identification of self-harm.

An Emergency Department Liaison Service is a year-long joint pilot scheme operating in York which was established in October 2014 in response to difficulties managing presentations involving mental ill-health in the ED, dissatisfaction with the service provided to York Hospital by local mental health services, and an overall national drive to improve the service provided for patients with complex physical and mental health needs.

Since January 2015, the team has provided on demand psychosocial assessments for anyone over 16 years of age, presenting to the ED department at York District Hospital 24 hours a day 7 days a week, with an expected response time of less than 3 hours becoming a 2 hour response time from April 2015.

The aims of this service are to reduce breaches, reduce inappropriate admissions, reduce repeat attendance, and facilitate early identification of mental health issues and appropriate signposting and onward referral to secondary mental health service, voluntary services or primary care. Another function is providing supervision, education and support for the ED staff. The overall goal is to improve the service provided and experience of patients and carers attending the ED, improve collaborative working and links with ambulatory care pathways in ED, with primary care and community mental health services.

This service is limited to the ED so any patients moved on to the medical wards, presenting with mental ill-health on e.g. maternity wards or surgical wards, or presenting with labour and time intensive complex

physical and mental health needs are seen under existing arrangements on an ad hoc basis by the on call psychiatry staff.

A future aim of this provision following the pilot might be to extend the Liaison service in order to support all of York Hospital, working collaboratively with existing services such as psychology, the old age psychiatry team ('MHALT'), the substance misuse liaison team, and developing links between services such as maternity and the proposed perinatal psychiatry service. This would allow expert liaison psychiatry input to improve the psychological care of patients in York District Hospital, promote positive mental health, reduce stigma and ensure parity of esteem between mental and physical health and wellbeing needs.

Due to a recent transfer in service provider of this pilot programme access to activity data is not available for use in this report. This was further complicated by the CQC closure of parts of Bootham Park hospital where this service and its staff are based.

Gaps in data

There is a lack in data around how self-harming behaviour that does not result in presentation to emergency department services or results in a hospital admission is recorded.

A range of services were asked to contribute to the local intelligence about self-harm.

Whilst good practice was described across a number of services in a number of ways that ensured risks for an individual were being identified, it became apparent that self-harm is often not something that is quantified within services.

LOCAL SERVICES

GP Surgeries

GP practices across NHS Vale of York Clinical Commissioning Group were asked to contribute to this report about the scope of self-harm that is identified by GP's. Only one response was received which highlighted some concerns about:

- a lack of consistency in how self-harm is recorded on GP systems
- a lack of confidence in being able to identify those at risk of self-harm
- a lack of effective referral options where self-harm is identified
- a lack of information and support resources available
- attempts to use internet resources but there not being a clearly identified resource

Practices were asked to respond to a brief questionnaire and to supply any other additional information that would contribute to increasing local understanding about self-harming behaviour and its prevalence in the local area. Given the lack of responses to this request, it is difficult to know whether the views highlighted above are shared across all GP's in the clinical commissioning group.

Counselling Services

A number of services offering counselling support were approached to comment on how prevalent self-harm is within the local area. Many of the responses identified a lack of clearly available data around how many people accessing support services were doing so where self-harm was known to be an issue. That is not to say that services didn't feel able to identify self-harm through their assessment processes or through

the development of the therapeutic relationship which allowed the person being counselled to feel comfortable enough to tell their counsellor about their self-harming behaviour.

York St. Johns University Wellbeing Service responded to identify that from August 2015, quantitative information about students who report self-harming behaviour or / and suicidal ideation within their existing risk assessment processes will be recorded to give an overview of the service as a whole in relation to numbers of students presenting with self-harming behaviour. Currently, there are no figures available at a service level; however, risk assessments are routinely carried out with students at appointments using a CORE-34 tool which allows self-harm to be identified and to track changes in this and other risk factors.

The York St. Johns service supported over 700 students in the academic year 2014-15 and estimate that at least half will have presented with some form of self-harming behaviour. The most common self-harming behaviours supported were students who are cutting (usually arms/thighs/stomachs), overdosing (but not with the intent to end their life), head-banging, burning and engaging in damaging eating habits (starving, binging, purging).

The service reported that generally speaking students will either overtly want to discuss/show what they have done, or conversely they will be very reluctant to talk about or acknowledge their self-harm.

The range of support offered in relation to self-harm if students wish to reduce their risk and try to more safely manage their self harm a more detailed risk assessment and safety plan is completed with the student. The service may also do some work with them on how they can make the help-seeking process more accessible for them. For example, this might involve completion of a leaflet which communicates to healthcare professionals what injury they have sustained and how (we use the Indigo project template). This work is done by either our Mental Health Advisors or Counsellors.

The service operates a daily (Mon-Fri) drop-in service which allows staff to routinely assess risk in a prompt manner and take appropriate action.

We also respond to concerns from peers, family, academic staff and any other source who has a significant concern about a student's self-harm. The level of response to these concerns will vary depending on the information provided and any additional knowledge about the student.

The service manager wished to stress that, from her experience in this field, she believes this area to be significantly under-reported, especially in medical statistics, as the majority of people who are self-harming rarely seek support, and very few would actually seek medical intervention.

Castlegate provided a range of information about their counselling services and were also able to identify how many people accessing counselling support reported self-harming. During 2014-2015, 219 people were seen for counselling with an additional 94 expressing an interest in accessing counselling but not accessing it.

Of the 219 clients seen, 77 were people who were self-harming or had self-harmed. Of these, 27 were male and 50 female. 32 were aged 16 – 19 years old and 45 were aged 20 years old or over.

In addition to information about self-harming behaviour, information about suicidal thinking is recorded. Of the 219 clients seen, 87 reported suicidal thinking, 33 of these were male and 54 female. 33 were aged 16 – 19 years old and 54 were aged 20 years old or over.

Of the 219 clients seen, 26 reported having made a suicide attempt, 10 of these were male and 16 female. 9 were aged 16 – 19 years old and 17 were aged 20 years old or over.

Emergency Services

Yorkshire Ambulance Service (YAS) operate the non-emergency medical helpline number – 111 and have provided data about the calls received from people registered to any NHS Vale of York Clinical Commissioning Group GP practice between April 2014 – March 2015 where wound care / self-harm was the reason for calling.

There are some limitations with this data where some of the categories recorded may indicate wound care that is not directly a result of intentional self-harm.

During this period, there were 5,091 calls that were related to wound care or self-harm queries.

Calls to 111 non-emergency helpline in relation to wound care/self-harm

Age band	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Grand Total
under18	153	152	158	150	122	156	159	159	122	138	126	158	1,753
18-64	160	166	156	149	159	151	185	210	202	233	179	226	2,176
over64	74	93	101	79	73	80	99	107	125	124	100	107	1,162
Grand Total	**387**	**411**	**415**	**378**	**354**	**387**	**443**	**476**	**449**	**495**	**405**	**491**	**5,091**

Source: Yorkshire Ambulance Service

Calls made to the emergency 999 number are not specifically coded as self-harm related so it is not possible to extract robust and reliable information about the number of calls to the emergency 999 number about self-harm related incidents. However, there are 7 codes that could be related to self-harm which would account for just under 3,000 out of over 15,000 calls from people registered to NHS Vale of York Clinical Commissioning Group practices.

The most likely codes to indicate self-harm are the ‘overdose/ingestion/poisoning’ and ‘psychiatric/suicide attempt’ codes.

Calls to emergency 999 number which may relate to self-harm

Row Labels	Under 18	18-64	over 64	NULL	Grand Total
Breathing Problems	73	310	447	19	849
Burns/Explosion	10	7	3	10	30

Haemorrhage/Lacerations	23	123	178	11	335
Overdose/Ingestion/Poisoning	51	228	16	24	319
Psychiatric/Suicide Attempt	31	247	15	27	320
Traumatic Injuries, Specific	68	200	67	20	355
Unconscious/Passing Out	44	356	268	41	709
Total (possible self-harm as above)	**300**	**1,471**	**994**	**152**	**2,917**
Grand Total (all reason 999 calls)	**1,139**	**5,796**	**7,085**	**1,631**	**15,651**

Source: Yorkshire Ambulance Service

North Yorkshire Police record known risk factors for the people they interact with. Between 1st April 2012 – 31st March 2015, 335 flags were recorded on the police database to identify self-harm as a known risk factor among children aged under 18.

There are limitations with this data because it is not clear how current and accurate this risk factor data is for all of these individuals and the only time a risk factor is recorded if this is made known to the police officer or PCSO. Risk factors around self-harm are only identified for the people that come into contact with North Yorkshire Police so do not represent a comprehensive prevalence rate across the entire population.

Of the 335 risk factors identified, this represented 251 individuals, 32 of whom were children in the care system. 147 of the risk flags were for males which represented 115 male individuals. 188 risk flags were for females which represented 136 female individuals.

Telephone Support Services

York Nightline is a student listening support service open from 8pm until 8am every night of the University of York term.

The service and organisation is 100% confidential. Nightline does not keep any records of individual callers, they don't ask anyone's name, and everything shared remains completely confidential.

Nightline was not asked to supply any information towards this piece of work because of their principles:

- Confidential: All calls to Nightline are confidential: we won't divulge anything in your call to anyone outside the service.
- Anonymous: We won't make any attempt to find out who you are – we won't even ask your name. Nightline volunteers are anonymous themselves. The reason that Nightline volunteers remain anonymous is to make clear that they only represent Nightline while on duty and that when not on duty they are just another student. The only exceptions to this rule are our Public Faces. However, they no longer do nights or take calls.
- Non-Judgmental: We have no political, religious, ethnic, cultural, political or moral bias. We accept and respect the views of any caller, and we won't criticise or judge you for anything you've done.
- Non-Directive: We won't try to steer you towards any particular course of action, or try to get you to think about your situation in any particular way.
- Non-Assumptive: We don't make assumptions about our callers; we let our callers explain their situation in their own words and in their own time.

Nightline can be contacted on **01904 323735** every night of term from 8pm - 8am or by dialling 3735 from any campus phone.

The Nightline website provides a range of information about self-harm and links to support for people who self-harm which can be accessed at: http://www.yorknightline.org.uk/new-page-66/

Samaritans are a national charity providing listening support to anyone about whatever is troubling them; you don't need to be suicidal to call. Similar to Nightline, because of their organisational principles of complete anonymity and confidentiality to whatever the caller says, Samaritans were not approached to contribute to this piece of work with any information or data. York Samaritans can be contacted on **01904 655 888** (local call charges apply) or free on **116 123** (this number is free to call). Their website is: http://www.samaritans.org/branches/york-samaritans

Schools

A local pilot programme to place qualified mental health support workers in local schools begun in November 2015. It is too early in this pilot approach to provide any information from this scheme for the purpose of this report. However, it is expected that this programme will bring a number of benefits to the mental wellbeing of local students by providing a visible point of contact for pupils who may be experiencing distress. By making access to support more accessible and safe for students whilst reducing the stigma associated with mental health problems, it is expected that there will be a range of positive outcomes for the schools and the pupils who attend them.

Personal Social Health Education programmes run in every school. No detailed information is given in this report about what elements of these lessons are provided within local schools that may help pupils to build resilience, raise awareness about self-harm risk factors, or to provide information to pupils on how to find alternate methods of coping, or to seek help in relation to mental health or self-harm specific issues.

Exams are identified as particular stress points for young people and local student support services report spikes in need for support and increases in self-harming behaviour at exam times.

Voluntary Sector

A range of support services for people experiencing mental ill health or distress are provided across the local authority and clinical commissioning group area, however, no specific information about the extent of self-harm that these services support has been identified. The type of support offered includes support groups for people, information, advocacy, counselling and training for people to build resilience and skills such as Mindfulness.

RESPONDING TO SELF HARM

Safeguarding

The City of York Safeguarding Children Board Threshold Guidance identifies self-harming behaviour among young people as requiring a level 3 statutory response across all age groups of children up to 18 years of age.

Universal	Level 2 emerging	Level 2 escalating	Level 3
Emotional Health	Good state of emotional health. Good emotional development and responses. Appropriate expression/ recognition of emotions. Appropriate facial expression.	Infrequent, inconsistent emotional problems/responses E.g. expression, recognition, facial expression. Vulnerable to emotional problems e.g. following divorce, separation or bereavement, relationship / friendship breakdown. Unduly anxious, angry, defiant or withdrawn.	Frequent significant emotional problems/responses e.g. expression, recognition, facial expression e.g. arising from divorce, separation, step parenting, bereavement, relationship/friendship breakdown. Emotional health/appearance deteriorating/problems emerging e.g. conduct disorder, Attention Deficit Hyperactivity Disorder, anxiety, eating disorders.

Where self-harming is identified, a level 3 response requires a Child in Need (S17) assessment and intervention. During 2014 – 2015, there were a total of 691 of these assessments completed and self-harm was

identified as the reason in 1.4% of these. For the year date since 1st April 2015, the assessments where self-harm featured equates to 4% of the 363 completed to date (as at 27th November, 2015).

Perceptions around self-harm

In 2006, The Mental Health Foundation published a report into self-harm called 'Truth Hurts' in which they identified how the young people they spoke with to help prepare the report identified negative experiences of asking for help which often made things worse for them. Many were met with ridicule or hostility from the professionals that they turned to.

For the purpose of this report, three people from the local area who have self-harmed were interviewed about their experiences of self-harming, seeking help and recovery in this area. These three people's experiences differed because of their personal circumstances, the routes they explored to get help, the support they received and their recovery proves. All talked directly about experiences of support in York and all had sought and received help and were now in a position where they reported no longer self-harming. However, all identified similar issues of not feeling able to easily ask for help; not knowing who or where to go to for help; of feeling dismissed when talking about their self-harm as identified in the 'Truth Hurts' report.

Other feedback of their local experiences included:

- A lack of awareness amongst health professionals about self-harm. This ranged from:
    - staff using self-reported harming behaviour as a means to assess the stability of depression.
    - being told that the self-harming would never stop
    - never feeling able to go to A&E because of the lack of empathy and compassion experienced
    - never being given any advice about other ways of coping or about harm minimisation or wound care

- feeling that the support offered took too long to be given, particularly if experiencing a crisis;
- that there was a distinct lack of advice given about other ways of coping;
- a lack of harm reduction advice given and an expectation from staff in services supporting these people that they should stop their self-harming behaviour. Examples of situations were given where self-harming behaviour was not tolerated by ward staff in hospitals with a result being to discharge a person who had self-harmed whilst on the ward. Other examples were given where teaching staff were asking to see pupil's arms to make sure that they were not cutting themselves which had the effect of pupils choosing other sites on their bodies to cut and then not wanting to talk to anyone about their self-harming behaviour;
- that ongoing support is crucial to help maintain recovery from self-harming behaviour. This could include having access to a mental health support line to turn to. For one of the people, this resource had been invaluable but was being withdrawn as a resource.
- all had tried accessing support groups, either in person or on-line but predominantly on-line and these were reported to be good supportive groups. However, the risk associated with on-line groups was raised as a concern because some sites can be harmful and it is essential to find a well moderated site that was run with the interests of the safety of the people using it in mind.

A report written by NHS Health Scotland in 2014 also identified a need to improve the experience of care for people who have self-harmed. The experiential evidence provided above and the fact that the issue of improving patient experience around self-harm is still being identified as a need, suggests that people who self-harm are still having negative experiences of seeking help. Whilst this is still the case, it is likely that the numbers of people feeling able to ask for help in connection to their self-harming behaviour will remain low.

NICE CG16 and CG133 (2004; 2011) guidance identifies a number of areas requiring implementation in the care of someone who has self-harmed which includes a focus on developing a supportive relationship

with the person; completing a comprehensive assessment of need and risk; developing a care plan; sharing information with the person's GP and offering an appropriate level of ongoing support which accounts for other mental health support needs and personal circumstances.

The Royal College of Psychiatrists (2010, 2014) recommends that a public health approach towards self-harm should include elements of staff training across a range of sectors; the provision of information and advice; and should identify responses to growing concerns about the internet, social media and social isolation.

Evidence for Interventions

A 2010 evidence review (Wood, S. et al, 2010) report which reviewed a range of interventions effective in preventing, supporting and reducing self-harm and suicide suggests that the following interventions might have some benefits if applied locally:

Developing awareness and skills: School-based education programmes can improve knowledge, attitudes and help-seeking behaviours. Programmes that develop coping skills can improve attitudes towards suicide and reduce suicidal ideation. They have shown promise in reducing both completed and attempted suicides.

Increasing identification and referral: Although findings have been inconsistent, training for health care professionals to improve awareness of suicide has had positive short term effects on suicides and suicide attempts. Training for gatekeepers (other professionals in contact with at-risk groups) can reduce suicide and increase use of mental health services when used as part of wider multi-component interventions.

Supporting and treating those at risk: Help lines can have small effects on levels of suicide when included in services at suicide prevention centres (that also provide outreach and awareness campaigns). There is some evidence that psychotherapy can reduce suicidal ideation, suicide attempts, and repetition of suicidal/self harm behaviour. Among people attempting suicide, professional contact a year after discharge from hospital can reduce the number of reattempts.

Among some high-risk groups (e.g. those with mood disorders), drug treatments can prevent suicide attempts.

Community interventions: At hotspot areas, the use of safety fencing or signposting to support services can reduce suicides. Multicomponent community interventions that combine a variety of initiatives (e.g. education, training for professionals and support) can also reduce rates of suicide.

Societal measures: Restriction of access to lethal means can be effective in reducing suicide rates. Although evidence is limited, the introduction of media guidelines on suicide reporting has been associated with positive changes in reporting as well as decreases in annual suicide levels.

NHS Health Scotland (2014) identifies a range of measures that are recommended to include in local service provision arrangements:

Focus	Actions and interventions
Society	Social protection
	Restricting availability and access to lethal means
	Reducing affordability of alcohol
	Improved media reporting
	Public education campaigns
	National suicide prevention programmes
Community	Building community resilience and connectedness
Individuals	Gatekeeper training
	Screening
	Primary care interventions
	Assistance to family/friends of high-risk individuals
	Postvention
Specific populations	School-based suicide prevention programmes
	Prison-based prevention programmes
	Drug misuse programmes

Source: NHS Health Scotland

Social media is a resource that has potential for benefits and harms to those who use it in relation to self-harm. There is concern over the influence of social media but limited systematic evidence, despite stories

of individuals who have been bullied or encouraged to self-harm. This has to be balanced against the support that vulnerable people may find through social networks. A recent systematic review of the research literature has confirmed that young people who self-harm or are suicidal often make use of the internet. It is most commonly used for constructive reasons such as seeking support and coping strategies, but may exert a negative influence, normalising self-harm and potentially discouraging disclosure or professional help-seeking (Department of Health, 2015).

Locally defined approach

Developing a co-ordinated approach across services which supports increased understanding of the needs of our local population around self-harm, the prevalence of it and an ability to be better able to respond to at risk groups; training and development to more effectively identify and support people who do self-harm along with improved data collection; a defined approach which allows support and services to be developed in line with best practice guidance such as NICE CG16 and CG133 self-harm guidance for short and long term management and prevention of self-harm.

Developing a co-ordinated approach between local suicide prevention plans and self-harm would acknowledge the interconnectedness of these two issues.

Developing a locally relevant training, information and advice offer around self-harm would support recommended approaches to improve the patient journey for someone who self-harms, to be able to offer support based on best practice and to create accessible and high quality resources for a range of people.

Developing local pathways into support services for someone who self-harms would help to more clearly identify how people could access support and to make the offer of support much more visible.

Exploring how technology and resources like social media can be better utilised to allow people who self-harm to be able to support themselves in a safe way and to access information and advice.

To consider how family and friends can be supported where self-harming behaviour is occurring in someone they care about.

The North Yorkshire Police / York University Mental Health Research Project has an objective to produce some locally relevant research into self-harm.

There is a clear need to improve the experience of care for those who have self-harmed.

Self-harm is a complex mix of risk and protective factors which vary across the course of a person's life. It is likely that a range of preventative actions and interventions will be needed.

Consideration could be given to local evaluation of interventions so that clear outcomes can be measured which will contribute to our understanding of what works.

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