Truth Hurts

Report of the National Inquiry into Self-harm among Young People

Camelot Foundation

developing·learning·changing

Mental Health Foundation

This report sets out an **agenda** for **change**. Over and over again, the young people we heard from told us that their **experience** of asking for help often made their situation **worse**. Many of them have met with **ridicule** or *hostility* from the professionals they have turned to. Our intention is that this report will serve as a **turning point** in *understanding* self-harm and be a launch pad for changes in the **prevention** of, and **responses** to, self-harm among young people in the UK.

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FOREWORD

A generation of young people are under the media and political spotlight. From 'A' levels to ASBOs; bullying to binge drinking – young people are under intense scrutiny - almost always to their detriment. It shouldn't surprise us that many of them are finding it hard to cope with some complex and often bewildering issues in their lives.

Ironically, given how closely we scrutinise our young people, few of us have paid attention to the growth of self-harm as a way many of them are coping with, and expressing, their distress. Yet the most recent research suggests that, in the UK, 1 in 15 young people has self-harmed. In other words, on average, in every secondary school classroom there will be two young people who have hurt themselves as a response to the pressures of growing up in an increasingly complex and challenging world. Self-harm among young people is a significant and growing public health problem. But there is almost universal misunderstanding about self-harm amongst those in closest contact with young people. This results in a very poor response when a young person finally finds the courage to tell someone that they need help.

Recognising this huge area of unmet need, in 2004 the Camelot Foundation and the Mental Health Foundation launched a National Inquiry into self-harm among young people. We have worked to draw this hidden problem into the light; to understand it as thoroughly as possible and to identify how young people can be helped and supported to find less damaging ways of dealing with their distress.

The Inquiry Panel has been meeting for two years. Its members deserve huge thanks for the diligence with which they sifted the evidence presented to them, and the insights they have shared on the issues before us. Given the diversity of the membership, we have been very encouraged by the consensus that has developed amongst the Panel about our key findings.

From the outset, we were determined that the voice of young people who have experience of self-harm would be a cornerstone of the Inquiry's work. Our thanks are due to all the young people who contributed so freely and openly – most in the hope that it would lead to better experiences for other young people in the future. We are keenly aware that we must not let them down.

This report sets out an agenda for change. There is no shortage of things that need to be done. We need to know more about the prevalence of self-harm, across the UK as well as in particular population groups; we need to commission services where young people feel listened to, and respected; we need much better evidence of what works, both in relation to preventing self-harm and in intervening once the behaviour is underway; we need to build a better understanding of why young people self-harm, and provide high-quality information for young people, their families, and a whole range of agencies and professionals in contact with young people. Above all, perhaps, we need to develop the confidence of those closest to young people, so that they can hear disclosures of self-harm without panic, revulsion or condemnation.

Over and over again, the young people we heard from told us that their experience of asking for help often made their situation worse. Many of them have met with ridicule or hostility from the professionals they have turned to. The Inquiry has also heard evidence from over 350 agencies and individuals, most of whom were deeply committed to finding a better way of responding to young people who self-harm, but who also felt isolated and under-resourced.

Our intention is that this report will serve as a turning point in understanding self-harm and be a launch pad for changes in the prevention of, and responses to, self-harm among young people in the UK.

I urge you to read the report – hear the voices of the young people – and commit to playing an active part in transforming the experience of the 1 in 15 young people in the UK who are in such pain that they are harming themselves.

Catherine McLoughlin CBE
Chair, National Inquiry Panel

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The young people consultation sites, their project workers and the young people who responded to the Inquiry's website made an enormous and important contribution. Their voices have been an important backbone to this Inquiry.

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EXECUTIVE SUMMARY

Introduction

Self-harm among young people is a major public health issue in the UK. It affects at least one in 15 young people and some evidence suggests that rates of self-harm in the UK are higher than anywhere else in Europe. Self-harm blights the lives of young people and seriously affects their relationships with families and friends. It presents a major challenge to all those in services and organisations that work with young people, from schools through to hospital accident and emergency departments.

Levels of self-harm are one indicator of the mental health and mental well-being of young people in our society in general. Recently there has been a shift in government strategies, across the UK, towards recognising and promoting better mental health and emotional well-being for all children and young people. These initiatives may eventually do a great deal to reduce self-harm among young people but the Inquiry found that implementation to date is patchy and there is not yet an adequate evidence base specific to self-harm.

This Inquiry set out to try and find the definitive answers to the key questions:

- what is self-harm
- how common is it among young people
- can it be prevented
- how can we respond better to young people who self-harm.

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered. Self-harm can involve:

- cutting
- burning
- scalding
- banging or scratching one's own body
- breaking bones
- hair pulling
- ingesting toxic substances or objects.

Young people who self-harm mainly do so because they have no other way of coping with problems and emotional distress in their lives. This can be to do with factors ranging from bullying to family breakdown. But self-harm is not a good way of dealing with such problems. It provides only temporary relief and does not deal with the underlying issues.

Although some very young children are known to self-harm, and some adults too, the Inquiry focused on young people aged between 11 and 25 years because rates of self-harm are much higher among young people, and the average age of onset is 12 years old.

The issue

There is relatively little research or other data on the prevalence of self-harm among young people in the UK or on the reasons why young people self-harm. It became clear to the Inquiry that self-harm is a symptom rather than the core problem. It masks underlying emotional and psychological trauma and a successful strategy for responding to self-harm must be based on this fundamental understanding.

The evidence about reasons why young people self-harm shows that there are a wide range of factors that might contribute. Young people told the Inquiry that there are often multiple triggers for their self-harm, often daily stresses rather than significant changes or events. These include things like feeling isolated, academic pressures, suicide or self-harm by someone close to them, and low self-esteem or poor body image which can make them feel unstable and even hate themselves. Many described how self-harm gets out *'all the hurt, anger and pain'* but that relief is so short-lived they do it many times. Crucially young people talked about having no alternatives: *'I don't know how to release my feelings in any other way'*. Many also explained that their self-harm is about feeling dead inside and that self-harm *'brought them back to life'* and made them feel *'something – alive and real'*. Because young people often find release or even positives from self-harm it can be difficult to envisage coping with life without it: *'I have found the decision to stop harming myself infinitely more difficult than the decision to start.'*

Prevention

School-based work appears to be one of the most promising areas where the prevention of self-harm can be successfully tackled. One of the key findings of the Inquiry, which is backed up by previous research, is that many young people prefer to turn to other young people for support. Young people told the Inquiry that often all they want is to be able to talk to someone who will listen and respect them, not specifically about self-harm but about problems and issues in their daily lives. Many said that had this been available to them they may never have started to self-harm. *'If there had been people to talk to at school then maybe I wouldn't have felt the need to start self-harming then.'*

A number of schools have started to implement peer support schemes and all schools are now required by the Department for Education and Skills to have anti-bullying strategies. The Inquiry found evidence which shows that these are significantly more effective when they are part of a whole school approach to good mental health for all.

A key factor that many young people told the Inquiry exacerbates their self-harm is social isolation. Many young people told the Inquiry that it helps tremendously to know that they are not the only young person in the world who has problems in day to day life and deals with these through self-harm. We were told that the feeling of being alone is hard enough but reaching out is even harder; *'As someone who had self-harmed I found it hard to accept that I wasn't alone as I'd never heard of it - I wanted someone else to clarify what I did, show that they understood and be willing to listen and not judge.'*

Disclosure and immediate response

It was clear to the Inquiry that young people who self-harm can find it very hard to talk about it and are often afraid of how people will react. *'At school my self-harm was treated very badly. It was treated as a piece of gossip throughout the staff and the head teacher asked me to leave as a result, saying that I was a lovely person but he couldn't have it in his school.'* The reaction a young person receives when they disclose their self-harm can have a critical influence on whether they go on to access supportive services. It can be also hard for family, friends, and professionals to handle a young person's disclosure of self-harm.

The key message from young people is that they need preventative measures that are non-judgemental and respectful. Equally importantly, school staff and others must reach out to young people – rather than expect young people to come forward - and provide opportunities for them to discuss problems before they turn to self-harm as a way of coping.

The Inquiry was told that for many young people disclosure of their self-harm was a very bad experience. They told us that they lost control of who else would be told (e.g. parents, other services) and that attitudes changed unhelpfully. *'My doctor looked at me differently once I told her why I was there. It was as if I were being annoying and wasting her time'.*

A strong theme in the evidence presented to the Inquiry was the need for school staff and others who work with young people to have a much better awareness and understanding of self-harm. This includes a basic understanding of what self-harm is, why young people do it, how to respond appropriately, and what other support and services are available. This alone would make it more likely that young people who self-harm get the help that they need.

Support and therapeutic interventions

The Inquiry heard about a wide range of services for young people who self-harm, across the UK. Young people appear to benefit very much from some of these approaches, although to date there is not a strong evidence base to demonstrate their effectiveness. The Inquiry concluded that more comprehensive and targeted research is needed in order to shape the development of effective services, support and therapeutic interventions. A key message from young people is that they want a range of options, a one size fits all approach will not work. *'I tried so many – I found it hard to adapt to something different, when I was used to coping with my own way. Eventually though I found a way of coping which I got on with and it helped me to stop'.*

The Inquiry heard from young people that self-help was critical. They stressed the crucial importance of being able to distract themselves from self-harm even for a short period of time. For some distraction can be a first step towards tackling their self-harm and it should be treated as a positive step. Successful distraction techniques that young people told the Inquiry about included using a red water-soluble felt tip pen to mark - or rubbing ice - instead of cutting, hitting a punch bag to vent anger and frustration, and flicking elastic bands on the wrist. *'I tried holding an ice-cube, elastic band flicking on the wrist, writing down my thoughts, hitting a pillow, listening to music, writing down pros and cons – but the most helpful to my recovery was the five minutes rule, where if you feel like you want to self-harm you wait for five minutes before you do, then see if you can go another five minutes, and so on till eventually the urge is over.'*

Recovery

The Inquiry recognised the need to clarify what is meant by recovery in terms of self-harm. Some young people interpret it as reducing their self-harm as they tackle the underlying issues, using distraction techniques and minimising the damage that self-harm inflicts; others interpret it as completely stopping self-harm. Professionals in particular need to be clear that many young people use this first interpretation.

Some young people find that over time, their needs or circumstances have changed to the point where they do not feel that they need to self-harm. Others manage to learn new coping strategies for dealing with difficult emotions or circumstances, often by adopting successful distraction techniques which help them cope with the immediate urge to self-harm. This may involve some degree of self-harm, at least at the beginning. Recovery is

often a long, slow process and involves changing the circumstances which caused the young person to self-harm in the first place. There is no 'quick fix'.

Conclusion

The research, personal testimony and expert opinion submitted to the Inquiry has demonstrated how far-reaching the issue of self-harm is for young people. The guilt and secrecy associated with self-harm impacts on their daily lives: their relationships; the clothes they wear; their interactions with their friends; and their sense of self-worth. If and when they do tell someone else about their self-harm, the whole issue is frequently taken completely out of their hands, and their previously secretive behaviour becomes common knowledge. They are aware that everyone is watching them closely in case they self-harm again. Most importantly, the focus very often remains on the self-harm, not the underlying causes which means that they feel they have no other option but to continue to self-harm.

Self-harm among young people is a serious public health challenge that everyone in contact with young people must rise to. However, we should be encouraged by the clear direction set out by the young people who contributed to the Inquiry. They have mapped out the way that we should understand self-harm and how everyone involved with young people can work towards prevention and better responses to it. Equally encouragingly the Inquiry has heard evidence about a wide range of services and interventions, many of which hold great promise in tackling this hidden epidemic.

The Inquiry: Method

The Inquiry sought to bring together all the available evidence about self-harm from a range of sources. We reviewed the published research evidence and commissioned new research in areas where little work has been done to date. The Inquiry heard evidence from more than 350 organisations and individuals concerned with young people and self-harm. Most importantly the Inquiry employed a range of ways – consultation groups, an online questionnaire, and direct testimony – to make sure that we heard the voices of young people.

The Inquiry focused on 5 key themes:

- The issue (understanding what self-harm is, the reasons for it, the prevalence of self-harm and differences between particular groups of young people)
- Prevention (existing strategies and interventions, the effectiveness of these, and what factors are associated with good mental health and well-being among young people)
- Disclosure and immediate response (the difficulties for young people telling others that they have self-harmed and in getting help, and the issues for others including professionals, friends and family members)
- Supports and therapeutic interventions (what is currently available, evidence on what works, and what might be more effective)
- Recovery (understanding young people's journeys from starting to self-harm through to it reducing or ceasing completely)

The overall aim of the Inquiry was to provide a thorough, evidence-based platform for changes in how we understand self-harm among young people, and to change and improve both the prevention of, and in particular responses to, self-harm among young people in the UK.

RECOMMENDATIONS

Chapter 1 - The Issue

The evidence that the Inquiry considered clearly shows that self-harm is related to underlying emotional or mental distress. This suggests that much can be done to tackle self-harm within wider strategies to improve young people's mental and emotional well-being. However, an effective response to young people who self-harm also requires that self-harm is understood, and responded to as a specific issue. A comprehensive self-harm strategy requires both a broad, generic focus on promoting positive well-being and behaviour-specific information, training and intervention.

Recommendations	Stakeholders	
United Kingdom Health Departments should give overall leadership for developing policy in respect of self-harm in recognition of the fact that self-harm among young people is a significant public health issue.	England: Scotland: Wales: NI:	Department of Health Health Department NHS Health Scotland Health and Social Care Department Department of Health, Social Care and Public Safety
However, because of its impact on education and youth offending services, UK Health Departments should lead a cross-departmental strategy with their relevant Education and Justice Departments.	England: Scotland: Wales: NI:	Department of Health Department for Education and Skills Home Office NHS Health Scotland Departments for Health, Education and Justice Health and Social Care Department Department for Education Department of Health, Social Care and Public Safety
UK Departments for Education should have lead responsibility for awareness, staff education and training, and mental health promotion strategies in schools and in both higher and further education.	England: Scotland: Wales: NI:	Department for Education and Skills Education Department Department for Education Department for Education
In order to tackle widespread misunderstanding about why young people self-harm the Inquiry calls upon UK Health Departments to develop UK-wide awareness raising campaigns, with the aims of educating the public about why young people self-harm and encouraging non-judgemental, positive responses to young people who do so. The campaigns should be tailored to reach as wide a range of people as possible, but should especially target professionals and others working with young people (such as teachers, youth workers, doctors and nurses), parents, and young people themselves.	England: Scotland: Wales: NI:	Department of Health and CSIP Health Department NHS Health Scotland and the National Programme for Improving Mental Health and Wellbeing Health and Social Care Department Department of Health, Social Care and Public Safety

Recommendations	Stakeholders
It is essential that the public health monitoring agencies in each of the four countries of the UK monitor mental health indicators in young people, including the prevalence of self-harm. Without such data, health and social care agencies cannot respond to the changing mental health needs of the population of young people as a whole. Specifically, the Association of Public Health Observatories should include self-harm data within regular audits of the mental health of young people.	UK-wide: Association of Public Health Observatories
Self-harm remains an under-researched subject. UK Health Departments should plan and commission a targeted programme of research to include epidemiological surveys across different age groups of young people that take into account group differences such as gender, ethnicity and sexuality; a qualitative exploration of different forms of self-harm behaviour including cutting, burning and banging; and robust evaluations of services and interventions for young people who self-harm. This research should aim to establish reliable data on the prevalence of self-harm among young people in the UK and identify which factors place young people at increased risk of self-harm; to develop our understanding of the feelings and meanings that motivate and arise from self-harm; and to provide reliable evidence on the effectiveness of interventions both to prevent self-harm and to intervene effectively when a young person has self-harmed.	England: Department of Health and CSIP Scotland: Health Department NHS Health Scotland Wales: Health and Social Care Department NI: Department of Health, Social Care and Public Safety

Chapter 2 - Prevention

Recommendations	Stakeholders
UK Education Departments should inform local education authorities about good practice that has a strong evidence base; and continue to roll out, and audit, the equivalent of the Healthy Schools Standard (England) which provides a sound framework for promoting positive mental health among young people. Local education authorities must increase their support to schools to implement the standard.	England: Department for Education and Skills Local Education Authorities Scotland: Education Department Health Promoting Schools Wales: Department for Education NI: Department for Education
Head teachers have a pivotal role to play in developing positive mental health strategies in schools. They should recognise the need to develop a whole school awareness of mental and emotional health issues, and be supported to do so. The Healthy Schools Standard (England) and its equivalent in the other UK countries should be extended to the higher and further education sectors, where there is currently no over-arching policy for promoting positive mental health. Given that half of young people are now in post-school education, this is an opportunity to intervene positively with a large section of the population at risk of self-harm. Existing school-based work around anti-bullying strategies should be continued, strengthened and robustly evaluated, as these seem likely to impact on one of the causes that young people cite for their self-harm. Innovative approaches to prevention and intervention should be developed and evaluated across the fields of health, education and social care. Counselling and peer support schemes in schools, exercise on prescription and creative arts approaches all appear to be worth taking further.	England: Department for Education and Skills Scotland: Education Department Wales: Department for Education NI: Department for Education

Chapter 3 - Disclosure and immediate response

Recommendations	Stakeholders
There is an urgent need for many professionals and others working in health, social care and education to reflect on, and update, their practice in relation to young people who self-harm. To do this they need to re-connect to their core professional skills and values: empathy, understanding, non-judgemental listening, and respect for individuals. Professional training curricula and continuing professional development and training for other staff needs to reinforce the fact that young people who self-harm are entitled to a response based on practice of the core skills and values of the caring professions. Accessible guidance for parents on coping with disclosure is also needed. UK Health Departments should commission the development of guidance.	England: CSIP and Department of Health Scotland: Scottish Executive Health Department NHS Health Scotland Wales: Health and Social Care Department NI: Department of Health, Social Care and Public Safety
UK Health Departments should commission the development and effective dissemination of guidance for young people clearly setting out their rights and what they should expect when they disclose their self-harm to education, health, or social care professionals.	England: CSIP and Department of Health Scotland: Scottish Executive Health Department NHS Health Scotland Wales: Health and Social Care Department NI: Department of Health, Social Care and Public Safety

In addition:

The Mental Health Foundation will develop a basic training resource for frontline professionals and other staff working with young people, to enable them to respond appropriately to a young person's disclosure of self-harm. This will cover: awareness and understanding of self-harm; the importance of maintaining a non-judgemental response to disclosure of self-harm; working with the young person to identify what help they need; basic information about signposting onto other services; the implications of religion, race and culture in young people's experience of self-harm; and responding to young people when they disclose their self-harm. The toolkit will be disseminated to training and professional organisations and to service providers. It should be incorporated into pre- and post-qualification training, professional development and life-long learning, and training for non-professionally aligned staff.

The Camelot Foundation will commission a virtual centre of excellence on self-harm. It will act as a national resource, making up-to-date information easily available on self-harm and on services on offer for young people around the UK. The aim will be to create an easy to access, definitive, quality-assured guide for professionals and non-professionally aligned staff, parents and young people on self-harm.

Chapter 4 - Support and therapeutic interventions

Recommendations	Stakeholders
The Inquiry has identified the core features of good practice in delivering services to young people who self-harm (set out on p68). Everyone working with young people who self-harm should take account of the Inquiry's good practice guidelines in developing, delivering and evaluating their service and practice. The evidence heard by the Inquiry indicates that effective services for young people who self-harm should be provided across a wide spectrum, from self-management and peer support through to formal psychiatric services. All services should be easy to access, and should be provided in a non-stigmatising environment and way. Local primary health care agencies should commission comprehensive primary mental health care arrangements for young people. Primary care commissioners and the relevant health trusts (depending on local service configurations) need to consider how best to create local primary mental health care for children and young people which can tackle these issues efficiently and effectively. These primary care mental health services will require basic expertise in self-harm issues, as outlined in this report. This should also mean that only a limited number of young people with severe or complex mental health problems will need to be referred to specialist services; in this way. Specialist CAMHS will be able to focus on the young people who really need this level of care.	England: Primary Care Trusts Scotland: Health Boards and Community Health Partnerships Wales: Local Health Boards NI: Health and Social Services Boards/Trusts

Recommendations	Stakeholders
UK Health, Education and Justice Departments should issue guidelines for agencies and organisations working with young people who self-harm on the legal framework that needs to be taken into account in delivering the service. The guidelines should enable those working in the field to: understand the legal context for their practice; develop appropriate self-harm policies, covering their approach to harm minimisation, their obligations of duty of care and the extent of a young person's right to autonomy and confidentiality; and develop a self-harm policy, as part of the organisation's risk assessment process.	England: Department of Health, Department for Education and Skills, and Home Office Scotland: NHS Health Scotland Scottish Executive Departments for Health, Education and Justice Wales: Health and Social Care Department and the Department for Education NI: Department of Health, Social Care and Public Safety
There is a need for robust evaluation of all types of interventions and treatments from self-management and self-help to formal psychiatric interventions. All organisations working with young people who self-harm should put measures in place to track and measure the effectiveness of their work. Service evaluators and regulatory agencies should employ a range of graded outcomes, from a reduction in self-harm behaviour through to cessation. They should also seek to measure young people's experience of, and satisfaction with, their care. In 2004, NICE published guidelines (England and Wales) for the health service on treating people who self-harm. There is an urgent need to evaluate any improvements these guidelines have produced in patients' experience, especially for those young people in contact with A & E services. If necessary the guidelines should be revised. Equivalent guidance should be developed for Scotland and Northern Ireland.	England: NICE Healthcare Commission Scotland: NHS Quality Improvement Scotland and Scottish Intercollegiate Guidelines Network Wales: NICE Healthcare Commission NI: Department of Health, Social Care and Public Safety

INTRODUCTION

Self-harm

'I was glad when I found your website, as I was very confused about my emotions when I was young. It was considered to be attention seeking to cut yourself and I didn't want attention. I just couldn't control my emotions. I needed an outlet. I was ashamed of it. Which really just added to my problems as I already felt ashamed of other things in my life. I think it is very good that this problem is becoming a recognised one and that young people will be able to go to their doctor or seek advice instead of feeling ashamed.'

'We're expected to be good daughters/sons, good siblings, very good students, thin and beautiful, talented, and good friends. Constantly these expectations are far too high for teenagers to meet, and so we come to think it's our own fault, and gradually, begin to hate ourselves for not being able to meet society's expectations.'

Self-harm is a serious public health problem and children and young people are particularly affected by it. It is the reason behind 142,000 admissions to accident and emergency departments in England and Wales every year, mostly as the result of self-poisoning (Hawton and Fagg, 1992)[1].Yet we know these hospital admissions are only a small proportion of the total number of people estimated to self-harm in a variety of different ways every year.

Self-harm has a huge impact on the day-to-day life of those who do it. It is something people often do in secret, about which they almost always feel enormously guilty, and which they go to great lengths to conceal. This can mean that many people who self-harm find it difficult to have close physical relationships. Also, people who self-harm often feel unable to talk either about their self-harm or about the reasons why they are doing it.

There is increasing understanding and acceptance that self-harm is a response to profound emotional pain. It is a way of dealing with distress and of getting release from feelings of self-hatred, anger, sadness, depression and so on. By engaging in self-harm people may alter their state of mind so that they feel better able to cope with the other pain they are feeling.

However, most of the professionals, family and friends who are in contact with a young person who self-harms know very little about the subject. Until relatively recently only very limited research had been carried out in the UK to find out how many young people self-harm, why they do it, and what the most effective and appropriate responses are.

In response to growing concern at apparently increasing rates of self-harm in the UK, and a belief that the available research data do not reflect the full range and extent of this behaviour, in 2004 the Camelot Foundation and the Mental Health Foundation jointly launched a two-year Inquiry into self-harm among young people aged 11 to 25 years old across the UK. The aim was to identify, gather together and evaluate the different pieces of the jigsaw in order to inform and improve responses to young people who self-harm at all levels.

The Inquiry aimed to make recommendations for change in national and local policy, service planning and delivery, and individual practice. It also sought to help young people, their families and friends to understand self-harm better. The Inquiry particularly wanted to hear the voices of young people themselves. This report is the result of that Inquiry.

The Inquiry

The Inquiry took evidence from a range of sources, including personal testimony, expert opinion and research (including new research specifically commissioned by the Inquiry). The experiences and contributions of young people who had self-harmed were central to this.

A Panel of experts chaired by Catherine McLoughlin CBE led the Inquiry. It comprised of young people with experience of self-harm; researchers; policymakers; front-line workers; commissioners of mental health services; and representatives of independent organisations who either worked specifically with the issue of self-harm or ran generic support services for young people. This Panel met every three months over the two-year period to discuss evidence from across the various sectors that involve young people (for example, education, health, and institutional/residential care), as well as specific populations (such as black and minority ethnic groups and lesbian, gay, bisexual and transgender young people).

Five organisations with strong track records in working directly with young people who self-harm from around the UK (located in Derry, Newcastle, Cardiff, Aberdeen and Galashiels) were engaged to consult throughout the life of the Inquiry with groups of young people who have self-harmed. A small consultation group (typically six to eight young people) from each site discussed the same broad themes and questions that the Inquiry Panel considered. Their findings and conclusions fed directly into interim reports, this final report and a further report written specifically for young people.

The Inquiry launched a UK-wide call for evidence which was advertised in newspapers, magazines and other publications. The Inquiry sought out the views, knowledge and experience of a wide range of people and agencies with personal and professional experience of self-harm (including health, education, social care, research and independent organisations) and of those working with young people more generally.

The Inquiry launched its own website in March 2004 (www.selfharmuk.org). The website was constructed and developed to present comprehensive information about all aspects of young people and self-harm, including links to organisations that can offer direct support for those affected by self-harm.

The call for evidence and website elicited such a high volume of responses from young people that the Inquiry decided to develop a questionnaire that young people visiting the website could complete so that we could capture their views and experiences. We also established a sixth 'virtual consultation site' with some150 members via the website.

Inquiry staff undertook a review of literature and practice concerning self-harm among young people which helped identify and clarify areas of agreement and disagreement, and those where policy and practice have not dealt with the issue in sufficient depth. In order to fill some of those gaps the Inquiry commissioned two pieces of research, one from the Centre for Suicide Research at the University of Oxford, the other from the Scottish Development Centre for Mental Health, in partnership with the Research Unit in Health, Behaviour and Change, University of Edinburgh. The Inquiry also commissioned a paper on the legal issues for staff and services dealing with young people who self-harm from a mental health and human rights lawyer.

The report

This report follows the typical journey of young people who self-harm: from the time when they first self-harm; the time when they disclose to someone that they have self-harmed ; through the services and other support or interventions that may be on offer; to, for some, the point when they no longer self-harm. The report cites personal testimonies from young people throughout, as well as the views and experiences of a wide range of individuals and organisations trying to deal with young people who self-harm.

The report looks at:

- The issue: what self-harm is, how prevalent self-harm is amongst young people; the reasons why young people self-harm and whether particular groups of young people are more or less likely to self-harm (and why this might be)
- Preventing self-harm through promoting good mental health and emotional well-being: whether and why this is effective; government and public sector strategies to promote mental health and well-being; examples of work in this field; and other factors associated with good mental health in young people
- Disclosure: the difficulties faced by young people trying to talk about their self-harm and ask for help; and the wide range of issues that professionals, friends and family members have to tackle as well
- Treatments and therapeutic interventions: current interventions and strategies for tackling self-harm and the associated distress across the UK and the evidence for the effectiveness of these
- Recovery: young people's and professional's views on the ways in which the underlying reasons for self-harm can be addressed, in order to reduce self-harm and help young people move on.

'Self-harm used to be a way to get rid of the feelings inside of me. To get out all the hurt, anger and pain that I was feeling. The rush it gave, the sense of feeling better was always so short lived. So short that I was doing it many times. I've been through times when I haven't been able to get up in the morning and function during the day without self-harm. But not now. Now the longer I can manage without it the better. I'm trying to get my life 'normal' though for me self-harm is normal. Something I have always done to mask my feelings. I don't know how to release my feelings in any other way and find talking exceptionally difficult.'

CHAPTER 1: THE ISSUE

What is self-harm?

In its broadest sense, self-harm describes the various things that some young people do to harm themselves in a deliberate and usually hidden way. The most common methods involve repeatedly cutting the skin, but burning, scalding, banging or scratching one's own body, breaking bones, hair pulling and ingesting toxic substances or objects are all done as well. These forms of self-harm were the particular focus of the Inquiry's work.

The Inquiry did *not* look at eating disorders, drug and alcohol misuse, or risk-taking behaviours such as unsafe sex, dangerous driving and getting into fights. The Inquiry decided at the outset that these types of behaviour are already more widely recognised and perhaps better understood, with more research and better services in place to offer the appropriate support and advice; and because they are no longer such taboo issues.

It is widely accepted that self-harm is a response to profound emotional pain that the young person cannot resolve in another, more functional way. It is a way of dealing with distress and feelings that are difficult to cope with and which the young person cannot express in any other way. The self-harm is often a way of releasing feelings of self-hatred, anger, sadness and depression. Through self-harm young people can alter their state of mind and gain some respite from what is troubling them.

Self-harm is a maladaptive coping mechanism and/or way of expressing difficult emotions. People who hurt themselves often feel that the physical pain is easier to deal with than the emotional pain they are experiencing, because it is tangible. However, self-harm provides only temporary relief and does not address the underlying issues.

> *'It dawned on me that continually harming myself was not allowing me to grow; it was just proving that I was still here and I could feel. But it wasn't letting me push things forward, and unless I stopped doing that I would wallow in the wretched situation I was in then forever.'*

> *'Cutting for me releases all the built up anger and frustration and pain I feel inside. There are many things that happen to me in my life which cause the pain I feel and how I release it. Mostly the feelings of isolation like being outcast pretty much from relationships altogether. I don't feel like I am a very stable person and I hate myself a lot of the time. I think body image also has a lot to do with my cutting. School is stressful, home life I can't handle sometimes.'*

Why focus on young people and self-harm?

Whilst there is only a relatively small body of research on self-harm that which does exists shows that rates of self-harm are much higher among young people (National Institute for Clinical Excellence, 2002)[2], with the average age of onset around 12 years old (Fox and Hawton, 2004)[3]. It was for this reason that the Inquiry focused on young people aged between 11 and 25 years old. The earliest reported incidents are in children between five (Inquiry's consultation sessions with young people, 2005) and seven years old (NCH and the Centre for Social Justice, Coventry University, 2002)[4]. It is estimated that approximately 25,000 young people are admitted to hospital in the UK each year after deliberately harming themselves (Hawton et al, 2000)[5]. Most have taken overdoses or cut themselves (Samaritans and The Centre for Suicide Research, University of Oxford, 2002)[6].

There is no such thing as a typical young person who self harms. Whilst the best available evidence indicates that four times as many girls than boys have direct experience of self-harm (Fox and Hawton, 2004)[3] caution is needed in seeing self-harm as a greater problem for young women, not least because young males may well engage in different forms of self-harm, such as hitting and punching themselves or breaking bones, which may be easier to hide or to be explained away as the result of an attack, an accident or a fight.

In the vast majority of cases self-harm remains a hidden and secretive behaviour that can go on for a long time without being discovered. Personal testimony submitted to the Inquiry shows that most young people make great efforts to hide their scars, bruises or other signs of self-harm and are extremely reluctant to talk about their self-harm or what may be troubling them. Most family and friends are likely to be unaware that someone close to them has self-harmed. This may help explain why research – for example that by Meltzer et al (2001)[7] and Green et al (2005)[8] - found that parents were often completely unaware of incidents of self-harm which their children reported to the same study.

The scale of the problem

The statistics on self-harm are unreliable for a number of reasons. Many young people who self-harm will treat themselves or will be treated at home and will not reach the attention of services or professionals. Their self-harm will not therefore be recorded and counted. Young people who self-harm and present at hospital accident and emergency services are predominantly cases of self-poisoning. Substantial anecdotal evidence that the Inquiry heard strongly suggests that this is only a small sub-population of young people who self-harm. Finally, figures on self-harm are confusing as definitions of self-harm used varies across the different research.

However, one survey estimates that 1 in 10 young people self-harms at some point in their teenage years (Samaritans and The Centre for Suicide Research, University of Oxford, 2002)[6]. Another recent survey published by the Priory, which is a private sector provider which treats mental health problems and addictions, found that as many as one in five girls between the ages of 15 and17 had self-harmed and just under one in five adolescents - both boys and girls - has considered self-harm. This survey of 1,000 young people between the ages of 12 to19 also found 'unacceptably high' levels of mental distress, associated for example with bullying and violence in the home (The Priory, 2005)[9]. If extrapolated to the whole UK population this would suggest that more than one million adolescents have considered self-harm and more than 800,000 have actually inflicted injuries on themselves.

Three recent large-scale community-based surveys of self-harm in adolescents in England (Green et al, 2005[8]; Hawton et al, 2002[10]; Meltzer et al, 2001[7]) reinforce the point that the prevalence of self-harm is much higher than is indicated by hospital presentations.

In a study from the Centre for Suicide Research in Oxford, covering more than 6,000 15 and 16 year olds in a representative sample of young people from 41 schools in Oxfordshire, Northamptonshire and Birmingham, 6.9 per cent (11.2 per cent of girls and 3.2 per cent of boys) reported an act of self-harm in the previous year that met with the study criteria (Hawton et al, 2002)[10]. Only 12.6 per cent of these cases had resulted in presentation to hospital.

Further insight into the prevalence of self-harm among young people comes from a national survey of the mental health of children and adolescents in the UK (Meltzer at al, 2001[7]; Green et al, 2005[8]). This survey has now been conducted twice and provides information on prevalence rates for a wide range of emotional, behavioural and hyperkinetic disorders. The first looked at 10,438 individuals aged between five and 15 years old.* In total, 4,249 11 to15 year olds were interviewed, of whom 248 (5.8 per cent) reported having attempted to hurt, harm or kill themselves at some point (Meltzer et al, 2001)[7].

In 2005 the second survey – using slightly different research parameters to the first survey - looked at 7,977 children aged between five and 16 years old and their parents. The prevalence of self-harm reported by young people in this survey was 28 per cent for children with an emotional disorder, with 21 per cent for children with a conduct disorder and 18 per cent for children with a hyperkinetic disorder (Green et al, 2005)[8]. It is important to note that these results are quite specific to the population of children and young people with a diagnosed disorder and they should not be taken to imply that there is a similar level of self-harm in the general population.

* The prevalence rates for self-harm among these children and young people presented here are from the report of the first half of 1999.

The prevalence of self-cutting

Because self-cutting is believed to be a common form of self-harm that is under researched the Inquiry commissioned the Scottish Development Centre for Mental Health (SDC) and the Research Unit in Health, Behaviour and Change (RUHBC), University of Edinburgh, to undertake a review of literature on self-cutting[11]. The remit was to identify and review UK published and 'grey' literature but initial analysis revealed a comparatively small pool of work focusing on self-cutting generally, and little on self-cutting and young people. The main research study that looks at self-cutting (which only covered England) was undertaken by Hawton et al (2002)[10].

Looking beyond the UK the research is similarly sparse with only two studies of note. One by de Leo and Heller (2004)[12], covered Australia and the other, by the National Suicide Research Foundation (2004)[13], covered Ireland. Both provided data in a form which can be used to estimate the incidence and prevalence of self-cutting among young people. However both these studies paid very little attention to the characteristics of the young people involved such as gender, ethnicity, sexual orientation and/or disability. According to the Irish study* the overall lifetime prevalence rate of cutting was 5.7 per cent in both genders; the rate among females (9.1 per cent) was over three times higher than the rate than among males (2.4 per cent).

The researchers commissioned by the Inquiry combined the findings of these three studies. This limited evidence suggests that around four per cent of young people in the community cut themselves over a 12 month period.

Data on the annual incidence of self-cutting which has been treated in hospital are available for Scotland. Figures for a 3 year period (2001/2 – 2003/4) indicate that the annual incidence of *hospital treated* self-cutting is about 31 per 100,000 population aged 15 to 19 years, with a somewhat higher rate among females than males. However, in the 20 to 24 age group, the rate among males is higher than the rate among females with an overall rate of about 38 per 100,000 population (Information Services of National Services Scotland 2004)[14].

The Inquiry concluded that there is a clear and important need for much better data on the prevalence of self-harm among young people in the UK. Caution needs to be exercised in drawing firm conclusions from the research quoted above, not least because of variations in research methodology. However, the Inquiry is satisfied that taking all the available research data together indicates a prevalence rate of between 1 in 12 and 1 in 15 across the UK.

* The Irish study uses a lifetime prevalence measure of self-harm, defined according to similar (but not identical) criteria to those used in English and Australian studies.

Why do young people self-harm?

The Inquiry was interested to know why young people self-harm and whether there are specific individual characteristics that indicate likelihood of self-harm or whether particular groups of young people who self-harm more or less than others.

> *'Pain works. Pain heals. If I had never cut myself, I probably wouldn't still be around today. My parents didn't help me, religion didn't help me, school didn't help me but self-harm did. And I'm doing pretty well for myself these days. Don't get me wrong, not in a heartbeat do I think that self-harm is a good or positive thing, or anything besides a heart-breaking desperate act that saddens me every time I hear about it. But there is a reason why people do it.'*

> *'My emotions can vary rapidly and be very intense. If in an emotionally charged situation, I will either during or shortly after harm myself. I'm not good at dealing with emotions or communicating mine to others.'*

> *'I don't deal with daily stress well, so when extra events occur however big or small, my tension levels rise, resulting in my needing a "release". Self-harm has proven to be most successful in dealing with this.'*

Evidence from the Child and Adolescent Self-harm in Europe (CASE) Study, comprising self-reported information on an overall sample of 30,437 young people from seven countries, clarifies some of the factors associated with self-harm among young people (Madge et al, 2004, NCB)[15]. CASE's work over the past two years has established an international network of experts to design, plan and carry out a European multi-centre study to provide better information on the scale and characteristics of the problem.

The CASE study had two main sources of information. First, participating countries monitored all hospital admissions (inpatient and outpatient) within their study catchment area (with a population of around 250,000 in total in each area) by young people under 20 years of age following an episode of deliberate self-harm. Details on young people's gender, age and method of self-harm are recorded in all instances, along with other available information. Second, around 5,000 pupils aged between 15 and 16 years old in each participating country were given an anonymous self-report questionnaire covering background, life events, deliberate self-harm (occurrence, frequency, context and experiences), and personal characteristics relating to mood, impulsivity, coping, self-esteem and health behaviour.

The likelihood of self-harm was positively associated with a wide range of life experiences and personal characteristics; analyses were conducted to ascertain those *independently* associated with episodes.* Among males, the factors independently associated with self-harm were a family member who had attempted suicide or deliberately harmed themselves at some point during the young person's lifetime (significant in all seven countries); any drug use in past year (significant in five countries); and a low self-image and low self-esteem (significant in four countries). The factors independently associated with self-harm among females were a family member who had attempted suicide or deliberately harmed themselves at some point during the young person's lifetime (significant in all seven countries); a close friend who had attempted suicide or deliberately harmed themselves at some point during the young person's lifetime (significant in all seven countries); a low self-image and low self-esteem (significant in six countries); cigarette smoking in the past week (significant in five countries); drug use in the past year (significant in five countries); worries about sexual orientation (significant in four countries); high impulsivity (significant in four countries); and a high anxiety level (significant in four countries).

* A multiple logistic regression (this is the standard method of data analysis concerned with describing the relationship between one factor and one or more explanatory factors) was conducted separately for each country and each gender, entering 27 variables, relating to healthy living, life events and problems in past year or lifetime, depression score, anxiety score, impulsivity score, self-esteem score, and age. This is the standard method of analysis but it has widely acknowledged weaknesses.

Other factors often linked with self-harm, including bullying, physical or sexual abuse, poor family relationships, and problems with boyfriends or girlfriends, showed significant independent associations with self-harm in fewer countries. The findings overall suggest that the factors most consistently associated with self-harm, across both countries and gender, were attempted suicide or self-harm in a family member, drug use and a low self-image and low self-esteem.

The Inquiry also looked specifically at the English component of the CASE Study outlined above (Hawton et al, Centre for Suicide Research, University of Oxford, 2004)[13] to see if there are any significant differences between this and the European findings. The findings for England were broadly similar to the pan-European findings. For example, school pupils said their most common motive for self-harm was to cope with distress: 'to get relief from a terrible mind state', as one put it. The study also reinforced the point that adolescents who self-harm are more likely than average to have a range of problems, to have maladaptive coping strategies, and to use very little support apart from their friends.

As Fox and Hawton (2004)[3] point out, young people usually start to self-harm as the result of a complex combination of experiences, not one single event or experience. The factors that Fox and Hawton found to be specifically linked to self-harm include mental health problems (such as hopelessness and depression); family circumstances (such as parental criminality and/or family poverty); disrupted upbringing (periods of local authority care, parental marital problems such as separation or divorce); and continuing family relationship problems.

Research additionally indicates a clear link between self-harm and sexual abuse in childhood. For example, Romans et al (1995)[16] interviewed a community sample of 252 women who reported having been sexually abused as children; compared this to a similarly sized group who did not report abuse; and then compared the sub-group of women sexually abused as children who reported subsequent incidents of deliberate self-harm with abused women who did not report self-harm. The authors found a clear statistical association between sexual abuse in childhood and self-harm, and that this was particularly marked in women who had been subjected to more severe and more frequent abuse. Self-harm was also associated with major interpersonal problems in the subject's family and with becoming involved in further abusive relationships as an adult. Two additional studies have attempted to determine whether particular characteristics of childhood sexual abuse place individuals at greater risk for engaging in self-harm as adults, and confirmed that a more severe, more frequent, or a longer duration of sexual abuse was associated with an increased risk of engaging in self-harm in adult years (Boudewyn and Liem, 1995[17]; Turell and Armsworth, 2000[18]).

Reasons cited for self-harm by young people consulted for the Inquiry

Young people consulted for the Inquiry reported a wide range of factors that could trigger self-harm. It is interesting to note that whilst there is some similarity to the research findings previously described there are also some differences. The most frequent reasons mentioned by young people were:

- being bullied at school
- not getting on with parents
- stress and worry around academic performance and examinations
- parental divorce
- bereavement
- unwanted pregnancy
- experience of abuse in earlier childhood (whether sexual, physical, and/or emotional)
- difficulties associated with sexuality
- problems to do with race, culture or religion
- low self-esteem
- feelings of being rejected in their lives.

The biological effects of self-harm

'Why do kids hurt themselves? Because they can't feel anything else. Why can't they feel anything else? Because a previous pain has scarred them, just like scar tissue that you might have now, it doesn't tan in the sun because it's dead! If you hurt inside for whatever reason, your inside will die. And then you don't feel anything. But your brain still works you are still physically alive and the only way to bring those feelings back is to physically feel something.'

'Sometimes when I felt numb and empty, scratching myself helped me to feel emotions again. Brought me back to life in a way.'

Self-harm can also bring its own physical release – and can indeed be 'painless' for some people during and for some time after they self-harm. Smith et al (1998)[19] explain how neurochemicals (the chemicals released in the brain concurrently with every physical and mental activity) can play an important role in self-harm. There is evidence that the group of neurochemicals known as endogenous opioids and another called serotonin may be particularly important. Endogenous opioids (which are similar to the drugs opium and heroin) bring about a very positive feeling of calm and well-being. These chemicals are released when a person feels in danger, experiences fear and particularly when the body is injured in any way. They produce insensitivity to pain that will help the individual survive when having to deal with danger (Smith, Cox and Saradjian, 1998)[19].

'I felt a warm sense of relief, as though all the bad things about me were flowing out of me and it made me feel alive, real.'

'The relief released by it is out of this world.'

'I would just like to mention the adrenalin rush that one experiences with the pain. When I feel numb and like I don't really exist, I cause myself harm and it brings this rush that brings you back to earth.'

While there is no evidence to support the suggestion that people can become addicted to the endogenous opioids released as a result of self-harm, it is likely that as the body begins to "expect" a higher level of endogenous opioids, a greater level of harm may have to be inflicted to achieve the same effect.

'I craved more and more release from the harm, yet I'd cut really deep and it wasn't enough. I needed more to calm, relax…breathe out almost…it sounds awful but I felt I was a nicer person when I cut…balanced, normal.'

'…At the same time as feeling numb I felt extreme pain, so I cut. And it got rid of the feeling. Cutting in small amounts doesn't usually help me to relieve pain, it used to, but I've done it for so long I need to cut a lot to help it now.'

'It can start out as a coping mechanism, and for me still is. However, for me and I am sure others, self-harm can become an addiction. Just like any person who is addicted to drugs, self-harm can become addictive, and like an addict, trying to stop can be a bigger challenge than having no legs and climbing Mount Everest.'

'If your project is to achieve anything, and I pray that it does, I hope that it is to offer ways out for other people like me before they make that first move to harm themselves, because I have found the decision to stop harming myself infinitely so more difficult than the decision to start.'

Self-harm is associated with other biological effects because when an individual is subjected to high levels of stress, they have lowered levels of the neurotransmitter serotonin. Low levels of serotonin are linked with various kinds of impulsive behaviour and lack of constraint; this means that people are more likely to take risks, and that it may be harder for people who already self-harm to resist the urge to do it again (New *et al,* 2005)[20].

It is clear that there may be a biological component to self-harm. However, these bio-chemical reactions have to be considered in relation to the emotional, social and psychological factors that cause young people to self-harm in the first place.

Dissociation

Dissociation is a psychological state or condition in which certain thoughts, emotions, sensations, or memories are separated from the rest of our mental activity. Self-harm can be considered a way to 'go away' or dissociate by separating the mind from the feelings that are causing the emotional pain. For example, the 'LifeSigns – self injury awareness' booklet points out that a person who self-harms can use physical pain as a way to distract themselves from emotional pain (effectively making their pain physical, not emotional). For others it may be a way to feel *something* – even if unpleasant – and 'wake up' in a situation where they have become so detached they are numb and cannot feel anything.

> *'Feeling helpless; stuck inside my head – cutting gives me a release from that; it brings me back to the physical world, it grounds me. It makes me feel part of reality and therefore less alone. It just gives a physical release.'*

Myths and stereotypes

There are a number of myths and negative stereotypes surrounding individuals who self-harm and the self-harm itself, some of which are reinforced in the media.* These mean that professionals, family and friends are much more likely to treat people who self-harm in a hostile and/or negative manner, and that young people are much less likely to be able to get the support and information they need.

The predominant myths are that self-harm is:

- manipulative
- attention seeking
- for pleasure
- a group activity
- only carried out by those who are interested in 'Goth' sub-culture
- a failed suicide attempt
- evidence of borderline personality disorder.

The Inquiry has concluded that if young people self-harmed as a form of manipulating others they would not almost always self-harm in private, on parts of the body that are not visible to others, and they would tell friends and family that they had self-harmed. In practice, young people have told the Inquiry that they have hurt themselves for long periods of time without ever disclosing to friends or family, rarely seek medical attention, and are extremely wary of seeking support from services.

This is shown, for example, in the national survey of mental health of children and adolescents in the UK (Meltzer et al, 2001)[7]. This survey interviewed both parents and young people and found that although 248 of the 4249 young people aged 11 to15 years said they had hurt themselves, only 78 of the parents interviewed stated that their child had attempted to hurt, harm or kill themselves (and were unlikely to be aware that self-harm was happening). Further analysis of the data by gender indicated that 6.5 per cent of girls and 5 per cent of boys reported that they had tried to hurt themselves. Parents reported much lower figures of 2.5 per cent and 1.8 per cent, respectively.

> *'I had to see a children's psychiatrist, who every week I saw him would tell me I had cut myself for the attention, and asked me why I had wanted the attention. And every week I would tell him why I had really done it and he would never listen. This lack of understanding was so frustrating and patronising, it was supposed to help me stop wanting to cut.'*

Self-harm may however, in some cases, be a way of asking for attention in a way that is *not* manipulative; in the same way that other people ask for help and attention by crying. It is quite clear that many of the young people who self-harm do need attention and support.

> *'Some people do it for attention, like I did when I first started. That doesn't mean they should be ignored. There are plenty of ways to get attention, why cause yourself pain? And if someone's crying for help, bloody well give them it, don't stand there and judge the way in which they're asking for it.'*

* The Inquiry has developed media guidelines that are intended to help journalists deal with news reportage and features on young people who self-harm more accurately, sensitively and constructively.

The biochemical effects of self-harm have already been discussed. However, it is very important to stress most forms of self-harm cannot be regarded as a pleasurable activity, as the majority of young people feel ashamed and guilty about their self-harm.

> *'I am of the opinion that current society rejects self-harmers and is mostly repulsed by them - to harm other people is understandable in our culture but to willingly harm oneself is perverted.'*

Self-harm is a personal and private act. It is only extremely rarely carried out as a group activity. When the young people that the Inquiry consulted with were asked if they could estimate what proportion of young people they knew (whether close friends or wider peer group) who self-harmed, they all said this was impossible because the topic was not always openly talked about.

> *'it is a private behaviour, and not always shared.'*

One apparent exception to this, according to expert opinion submitted to the Inquiry (by the Safer Custody Group; YMCA in prison settings; and the Crisis Recovery Unit, Bethlem Hospital) is institutional or residential care settings. The Inquiry was told that young people in these settings may engage in 'copy cat' behaviour. Young people in these settings who self-harm do frequently become aware of each other, acknowledge their mutual tendencies to self-harm and may even discuss this in a group. However, this should not be confused with the stereotyped idea that groups of young people in these settings self-harm together.

The Inquiry could find no evidence to support the belief that this behaviour may be an integral part of a particular youth sub-culture, whether it is 'Goth' (as parts of the media tend to assert) or other. However, this is a question currently interesting some researchers.

Self-harm is usually intended to *harm:* not to kill, or even to inflict serious and/or permanent damage. It is a strategy which (however maladaptive and damaging) makes it possible for the young person to continue with life, not to end it. Some people who self-harm do also try to kill themselves at some point but these are a very small minority. Fox and Hawton (2004)[3] estimate that between 40 to 100 times as many young people have engaged in self-harm than those who have actually ended their own lives.

> *'When I self-harm it is me telling the outside world what I feel inside, which I can't express in words. Often it is an alternative to me attempting to kill myself, and all that I really want is someone to hug me and let me talk to them.'*

> *'Cutting is a release that has in the past saved my life, I do not feel guilty about it and I will not be made to feel guilty and like a timewaster by people who do not understand. All my childhood was full of guilt; I do not need any more.'*

> *'People often link self-harm to suicide but for me it was something very different; it was my alternative to suicide; my way of coping even though sometimes I would wish that my world would end!'*

Some young people who self-harm are given a diagnosis of borderline personality disorder (BPD) by psychiatrists, psychologists or GPs. According to the formal diagnostic classifications BPD is 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts.'

In fact, anyone who is diagnosed with BPD should meet at least five of some quite complex criteria, of which 'recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour' is only one; yet young people have told the Inquiry that they have been given this diagnosis based on having self-harmed alone. The Inquiry concluded it is important to question the usefulness of a diagnosis of BPD to any young person exhibiting self-harm behaviour, and that the term should not be applied to people whose only 'symptom' is self-harm. It is far more important to recognise that self-harm indicates a deeper problem which the individual needs support and advice to address. Equally, of course, a young person who does meet at least five of the formal BPD diagnostic criteria is by definition disturbed and perhaps distressed such that self-harm would not be surprising.

Challenging myths and stereotypes
An approach to reducing the stigma of self-harm

The 'See Me' Campaign was launched in October 2002 to challenge stigma and discrimination around mental ill health in Scotland. It is run by an alliance of five mental health organisations and funded by the Scottish Executive. Its award-winning publicity campaign includes references to self-harm in, for example, personal life histories on its website.

In May 2003, children's charities agreed there was need for work dedicated to young people, concentrating initially on their attitudes towards each other. The campaign consulted extensively with young people and professionals, and eventually developed the characters 'Cloud Girl' and 'Cloud Boy'; Cloud Girl illustrates the issue of eating disorders, while Cloud Boy self-harm and his storyline involves him cutting his arms.

The Young People Campaign was launched in January 2005 with a three week TV ad campaign on Channel 4 (Scotland) and MTV UK. This was supported by mass circulation of sets of materials. (Adult consultees had strongly advised the Campaign to provide a briefing note in advance so that they had basic information to deal with queries.) The media launch featured young people, trained and supported by the campaign, to talk to journalists about their own experiences of stigma.

For further information visit www.justlikeme.org.uk

Groups and populations at particular risk of self-harm

The Inquiry received a range of evidence on 'populations at risk', such as young people in closed and custodial settings; lesbian, gay, bisexual and transgender young people; black and minority ethnic young people; and young people with learning disabilities. Very little formal research comprehensively addresses the issues around self-harm and these populations. This is confirmed by the literature review ('Written on the body: a review of literature on self-cutting') commissioned by the Inquiry and carried out by the Scottish Mental Health Development Centre and the Research Unit in Behaviour, Health and Change, University of Edinburgh (2005)[11].

Closed settings

Self-harm for young people in institutional or residential settings (including the armed forces, prison custody, sheltered housing or foyers and boarding schools) are continually reported, anecdotally, to be higher compared to community settings. Currently only the Prison Service collects data on actual prevalence and incidents of self-harm and this is discussed below.

Custody

The latest figures from the Prison Service Safer Custody Group's Research and Training Unit show that a high proportion of people, and in particular young people under the age of 21, self-harm in custodial settings. Reducing self-harm has been identified by Government ministers as one of the priorities for young offenders' institutions and for the Prison Service as a whole.

In December 2002, the Prison Service introduced a revised system for self-harm data collection that requires all staff to complete a form for every incident of self-harm known to occur within the establishment. This form records details of the method used, together with information on location, treatment, risk status and prisoner details. The new procedures have improved the validity and accuracy of the self-harm data collected although the Safer Custody Group believes that underreporting still continues.

According to the information recorded in this manner, 5,425 individuals harmed themselves during 2003, and 16, 214 incidents of self-harm were recorded. This is the equivalent to a rate of 74 individuals and 222 incidents per 1,000 prisoners. The most common method of self-harm was cutting or scratching (57 per cent of all incidents). Various forms of self-strangulation and suffocation are reported as well: 17 per cent of all incidents were by self-strangulation, eight per cent involved hanging and six per cent were poisoning. Other methods included head banging/wall punching, wound aggravation, ligatures and burning.

Young people (under 21 years) were over-represented in this number, accounting for 25 per cent of prisoners who self-harmed. This was particularly true of young women; 65 per cent of females under 21 harmed themselves and 10 per cent of young males. Although females only account for six per cent of the prison population, they accounted for a quarter of all individuals who self-harmed and nearly half (46 per cent) of all reported self-harm incidents. The female rate of self-harm incidents (1,674 incidents per 1,000) was 13 times higher than the male rate of self-harm (128 incidents per 1,000). Women were also notably more likely to self-harm repetitively. Half of the female prisoners who self-harmed did so more than once, compared with one third of males.

Lesbian, gay, bisexual and transgender young people

Recent research indicates that lesbian, gay, bisexual and transgender young people report higher rates of self-harm than heterosexual young people (they are two to three times more likely to self-harm). Rivers (2000)[21] found that 72 per cent of lesbian, gay, bisexual and transgender adults reported a regular history of absenteeism at school due to homophobic harassment; 50 per cent who had been bullied at school reported they had contemplated self-harm, and 40 per cent had self-harmed at least once. Results from a national survey that looked at mental health problems in gay men, lesbians and bisexuals found that 42 per cent of gay men, 43 per cent of lesbians and 49 per cent of bisexual men and women have planned or committed acts of self-harm. Between September 2000 and July 2002 researchers interviewed 2,430 lesbian women, gay men and bisexual men and women over the age of 16 years in England and Wales and concluded that 'there is a likely link between levels of discrimination and an increased risk of mental health problems' (Warner et al, 2004)[22].

The reasons why young lesbian, gay, bisexual and transgender individuals self-harm are broadly similar to the reasons cited by young people as a whole. For example, 'First Out', a youth service working with lesbian, gay, bisexual and transgender young people in Leicester carried out a small piece of qualitative research into the experiences of young people using the service. These young people cited pressure, isolation, not fitting in, anger and frustration with themselves, panic attacks, the need to take control of something, the need to escape, bereavement and stress caused by examinations and school as reasons why they had self-harmed. This evidence is supported anecdotally by national organisations such as Stonewall and LGBT Youth Scotland and England.

Black and minority ethnic young people

Research has shown that Asian women aged 15 to 35 are two to three times more vulnerable to self-harm than their non-Asian counterparts (Soni-Raleigh, 1996)[23] and the available research suggests the rates of self-harm and eating disorders are believed to be higher among adolescent South Asian girls. However there is little known about the actual experience and needs of young men and women who self-harm from black and minority ethnic groups and communities.

Newham Asian Women's Project (1998)[24] research revealed a complex range of disturbing and familiar issues with accounts of isolation and despair and many forms of abuse within families. There were reported conflicts between generations in families but also additional religious and social pressures with many reporting pressures which include rigidly defined matrimonial roles and the duty of women to maintain the family honour. Many expressed their concern at the unrealistic expectations demanded of them from their families.

All participants in the Newham research felt that the response from services was inadequate and often inappropriate and the women were not aware of the support that was available to them or were distrustful of it. There were also notable examples of professionals who clearly understood very little of mental health issues and even less the about the different culture and self-harm. There were also many breaches of confidentiality - with families often being informed of a disclosure of self-harm.

In 2001 YoungMinds decided to focus a national research study on exploring the awareness and experiences of young people from black and minority ethnic groups who use child and adolescent mental health services (CAMHS*), with a particular emphasis on the barriers preventing these young people from accessing help.

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* Child and Adolescent Mental Health Services (CAMHS) are a comprehensive range of services available which provide help and treatment to children and young people with difficulties or mental health problems. Some of these services are in NHS settings such as Child and Family Consultation Services, in-patient and outpatient departments of hospitals or in GP surgeries. Others are based in educational settings such as schools, colleges and universities or in youth centres, and counselling services.

The YoungMinds research found that although some parts of the country are quite active in developing services for black and minority ethnic young people others have little or no specific provision; and that both young people and staff have a wide range of concerns about existing mental health service provision and problems in accessing services. It concluded that the significant investment in CAMHS in recent years has not yet made a significant impact for many young people from black and minority ethnic communities.

Newham Asian Women's Project: working with minority ethnic communities

NAWP provides a range of support services, mainly for women and children from South Asian communities. It runs four refuges, a training centre, advice surgeries, and a counselling service. Asian women experience multiple pressures, and NAWP is adept at recognising the special needs of its client group; for example, it arranges transport for those who access its youth project, as parents are then happier to allow their daughters to go out without a family member.

Between June 2004 and July 2005, NAWP assisted 35 women who were either suicidal or who self-harmed. One of its projects, Zindaagi (meaning life), aims to promote positive mental health. It liaises with mental heath care providers to ensure access to services and culturally appropriate interventions. NAWP has also undertaken research into the issue of self-harm, published two reports on its manifestation within the Asian community, and provides training to share this knowledge more widely. NAWP is currently updating its research. The latest study will not be quantitative, but it will attempt to highlight issues around the prevalence of self-harm as noted by professionals working with Asian women.

The Department of Health has published data which shows that Asian women are three times more likely to commit suicide than their white counterparts, but there are currently no accepted facts in relation to self-harm.

For further information, please contact Gurpreet Virdee, Zindaagi Development Manager, NAWP, 661 Barking Road, LONDON E13 9EX. Telephone: 020 8472 0528. Email: gvirdee@nawp.org

Young people with learning disabilities

Approximately one-third of a million young people in the UK have learning disabilities (Emerson, Hatton, Felce and Murphy, 2001)[25]. Of those, 40 per cent are likely to develop a diagnosed mental health problem (Emerson, 2003)[26]. In 2001 the Foundation for People with Learning Disabilities convened an inquiry to explore the mental health needs of young people with learning disabilities (Mental Health Foundation, 2002; 2005)[27;28]. The findings from this inquiry and research confirmed that young people with learning disabilities experience the same range of mental health problems as other young people, but found that they are more prone to depression and anxiety disorders and these often go unrecognised and untreated. The report also highlighted the high incidence of self-harm among this group of young people.

The existing literature estimates rates of self-harm in people with learning disabilities to be approximately between 8 to15 per cent in institutional settings, and between 2 and12 per cent in community settings (Wisely et al, 2002)[29]. However, most of the research concentrates on people with severe and profound learning disabilities and associated syndromes. This reflects the medical model that associates the behaviour with a syndrome, rather than with response to distress (Collacott et al, 1998[30]; Emerson, 2003[26]; Emberson and Walker, 1990[31]; Hyma and Oliver, 2001[32]). There is also virtually no specific focus on young people in the available research.

One of the few studies solely addressing the views of people with mild to moderate learning disabilities who self-harm was carried out by Duperouzel (2004)[33]. This study attempted to explore some of the subjective experiences of nine people who self-harmed. Participants reported similar views and reasons for their self-harm as the young people that the Inquiry consulted. Most acknowledged that self-harm was not an effective long-term coping strategy, and were concerned about the physical damage they were sometimes inflicting on themselves. Some talked about stopping their self-harm, but did not know how to go about it, or who could help them.

Summary of key findings

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. The particular focus of the Inquiry's work has been on the following types of self-harm: cutting; burning; scalding, banging or scratching one's own body; breaking bones; hair pulling; and ingesting toxic substances or objects to cause discomfort or damage. Self-harm is a maladaptive coping mechanism or way of expressing emotions; it only provides temporary relief and does not deal with the underlying issues.

Rates of self-harm are much higher among young people, and the average age of onset is 12 years old. It affects at least one in 15 young people, making it a serious public health problem. There is a wide range of contributory factors, from bullying to drug use. To date self-poisoning has been researched more fully compared to other forms of self-harm.

There is evidence that the group of neurochemicals known as endogenous opioids and another called serotonin have a role to play in self-harm. These endogenous opioids are released when the body is injured in any way; they are pleasurable in themselves and they produce insensitivity to pain. However, self-harm is not solely a bio-chemical issue; it stems from the individual's thoughts, emotions, and experiences.

A number of myths and negative stereotypes surround individuals who self-harm and the actual act itself. It is frequently taken to be attention seeking and/or manipulation. The stigma associated with self-harm is unhelpful and prevents young people getting the support and information they need to find more positive coping strategies.

The Inquiry concluded that more comprehensive and targeted research is needed in the following areas: epidemiological data collection across various age groups of young people, examining ethnicity, gender, and sexuality; the different types of self-harm behaviour; and the reasons why certain environments like closed residential settings appear to engender higher levels of self-harm, and what can be done to change these environments.

CHAPTER 2: PREVENTING SELF-HARM THROUGH PROMOTING POSITIVE MENTAL HEALTH AND EMOTIONAL WELL-BEING

In the previous chapter we discussed evidence that indicates that self-harm among young people is a widespread, yet hidden and secret behaviour. Very few young people who self-harm seek out or engage with support services. One of the key questions for the Inquiry was to examine whether generic approaches to promoting good mental health and emotional well-being could help prevent young people self-harm. This chapter will examine various government strategies and voluntary organisations' work in this field, as well as other factors such as exercise and diet that are clearly linked to good mental health.

> *'One of the ways of preventing young people from self-harm is to educate them about services that are available for them if they have a problem that is upsetting, and [explaining] that self-harm is not the answer because it never solves the problem. If kids knew the extent and dangers of self-harm they may think twice about doing it and seek a safer method of relieving their problems.'*

> *'It can be difficult to talk to parents and family, similarly with teachers. I believe that in general, mental health education should be made a broader part of the school curriculum, for there are too many misconceptions about it, and programmes whereby young people themselves are made a more integral part of education… information and welfare in educational institutions can only be a positive thing.'*

1. Current research and practice-based evidence

The policy context

Everyone has mental health needs, whether or not they have been diagnosed with a mental illness; good mental health, like good physical health, is important for everyone (Mental Health Foundation, 2005)[34]. The policy and practice we examine in this chapter covers measures which are intended to actively promote good mental health and emotional well-being This includes measures aimed specifically at preventing mental health problems and also those designed to improve the quality of life (and reduce the associated stigma and discrimination) for people who have been diagnosed with a mental illness.

Over the last few years there has been a shift in government strategies, across the UK, towards recognising and promoting better mental health and emotional well-being for all children and young people across various settings, including education and the workplace. However, the Inquiry was concerned to learn that there is still very little support on offer for young people over school leaving age*.

* See appendix 1 for a full list of strategies and policies for England and Wales that affect children and young people.

Anti-bullying strategies

Since September 1999, head teachers of state maintained schools have been under a duty to draw up measures to prevent all forms of bullying among pupils, and must have anti-bullying policies and procedures in place (DfES 2002). Local education authorities have a responsibility to ensure that schools have anti-bullying policies and that these are being implemented in practice.

The National Healthy School Standard provides schools with a framework and support for developing and implementing anti-bullying strategies, based on approaches known to be effective (which usually means involving the whole school, parents and the community).

There is good research evidence to show that a whole-school approach is more effective than specific interventions. For example in their review, Clarke and Kiselica (1997)[35] focused on a systematic, school-wide intervention approach which includes: an attitudinal shift in how bullying is understood and responded to; education for students, teachers, administrators and parents; consistent school policies; close adult supervision; early intervention; school-wide assessment; and supportive training and counselling. Intervention programmes integrating these components have shown significant effects: one study found that that this approach reduced bullying incidents by 20 per cent, and another found a reduction by 50 per cent (Arora, 1994[36]; Olweus, 1991[37]; 1993[38]; 1994[39]).

2. Expert opinion/examples of practice submitted to the Inquiry

Peer support

Many young people prefer to turn to other young people when they have a problem. Peer support approaches are intended to equip school students with the skills to support each other effectively. It is not an alternative to professional counselling and other interventions or treatments, but it is an important intervention in its own right – evidenced by work done by the Place2Be which shows a reduction in bullying where young people are helped to find the support and space to talk about issues that are troubling them.

Structured peer support in schools is still relatively new in the UK – most schools only started peer support schemes in the 1990s. Schools tend to view such schemes as ways to tackle bullying, but there is evidence to suggest that they may also help to create an atmosphere that makes other negative behaviours as well as bullying less acceptable to the student body as a whole (ChildLine, 2005)[40].

There are different models of peer support. Most adhere to Cowie and Wallace's (2000)[41] definition, combining 'peer listening' – a confidential, usually one-to-one listening service; 'peer mentoring' – peer supporters act as 'buddies' or 'befrienders' to individuals or groups; 'peer mediation' – peer supporters are trained in conflict resolution so that they can act as mediators in the playground or in response to bullying; 'peer education' – peer supporters are given information and training skills in a particular subject area such as smoking or sexual behaviour, and train their peers in turn; and 'peer tutoring' – a peer supporter supports an individual with reading or other areas of school work.

As noted earlier, evidence shows that interventions such as peer support are a lot more effective when they are part of a whole school approach rather than run in isolation (Weare and Gray, 2003)[42]. A peer support scheme which is part of a whole school approach may well help schools to meet the demands of the citizenship

curriculum, help them work towards the National Healthy School Standard, and enable the school to demonstrate commitment to students' social and emotional development (Mental Health Foundation, 2002)[43].

The Inquiry heard evidence from a number of voluntary sector organisations that are currently developing or have run peer support schemes.

Childline In Partnership with Schools (CHIPS)

ChildLine receives over 4,000 calls a day to its helpline, but fewer than 50 per cent are able to get through. Its second service, CHIPS, aims to empower children so that they know where they can also go for help, and can tackle some problems independently.

In 2004 CHIPS provided outreach to approximately 82,000 children in schools or youth clubs, offered training to just under 1,000 schools and worked with 8,500 children to become peer supporters. Over half of this work is in secondary schools and most is with young people aged between 14 and 16.

Self-harm is only one aspect of any training provided, although Lindsay Gilbert, the Head of CHIPS, reports that it is something peer counsellors often ask about. Most of the training covers generic counselling skills, such as empathetic listening, as well as principles like confidentiality.

Many peer counsellors ask specifically about self-harm, and one case study in their six-hour training programme tackles the issue – which is still a difficult one for many schools. Participants are asked what the concept means to them, and trainers emphasise that it is not a failed suicide bid but often a way of relieving pressure. A group of young people who self-harm have also planned and provided an advanced training day on the topic for peer counsellors.

For further information, please contact Lindsay Gilbert, Head of CHIPS UK, ChildLine, 45 Folgate Street, London E1 6GL. Telephone: 020 7650 3231. Email: lgilbert@childline.org.uk

Peer Support Project

Before 2002 the Mental Health Foundation funded seven projects in London to develop systems of peer support with young people of secondary school age, in order to promote positive mental health in students and emphasise the importance of mental health in building a positive school atmosphere and promoting achievement. Five projects were in schools, one in a voluntary agency and one in a college of further education; different forms of peer support were developed across the seven sites.

The projects were evaluated by surveys at the beginning and end of the two-year programme. Additionally all projects submitted reports of their own monitoring and evaluation.

The benefits for peer supporters included increased self-confidence; new communication skills; enhanced responsibility; more opportunities to act positively towards the rest of the peer group; and emotional development, as a result of their own growing awareness and their supervision.

The benefits for users included the opportunity to talk to someone who would listen and discuss their problems; help with resolving problems; support from other students; and the knowledge that help was available.

The benefits to the school included an additional support system for young people; lower stress levels in students; fewer incidents of bullying; better communication between staff and students; improvements in students' interpersonal skills; and an enhanced sense that the school was a 'caring community'.

Mental Health Foundation (2002) Peer support: someone to turn to.

Young people's views on preventing self-harm through promoting good mental health and emotional well-being

The research from the Centre for Suicide Research in Oxford University (see chapter 1) included a section commissioned by the Inquiry in which young people were questioned about seeking help and barriers to doing this (Fortune et al, 2005)[44].

Young people were asked: *'What do you think could be done to help prevent young people from feeling that they want to hurt themselves?'* The most common answer (from over a quarter of participants) was someone who would listen to them, and give advice and support. Students from Asian backgrounds were particularly likely to say this would be useful, and girls were more likely than boys to emphasise the importance of talking, listening and advice. Significantly, participants were three times more likely to suggest talking to friends or family members than to mention mental health professionals or drop-in centres; this suggests that potential intervention or prevention strategies might well be directed at involving peers and family members.

Seven per cent, mainly girls, suggested that it would be useful to have someone in school to give advice and support. It is worth noting, in this context, that many pupils described the damaging effects of bullying in their schools, and their wish that schools would deal with this more effectively; and also that girls particularly mentioned the effects of exams, school pressures, and teachers who did not intervene effectively in bullying.

Pupils who had experienced self-harm or knew someone who had self-harmed talked about wanting a support person / counsellor - but ideally not a teacher - who would engage with them on a more regular, hands-on basis and not just when the pupils were facing difficulties.

Fortune, Hawton and colleagues commented on the high number of young people who talked about difficulties in their family situations, with eight per cent expressing a desire to have more active parenting, including more love, attention, time and care from their parents. Similarly, a number of young people commented on serious problems at home such as parents who abused substances, and/or the effects of parental conflict, separation and divorce. However, family members were also considered an important source of support and advice.

Only three per cent specifically mentioned mental illness or psychiatric disorders; only two per cent mentioned the potential role of mental health professionals, or GPs in preventing self-harm among young people. Seven per cent mentioned telephone help lines, which was the most common form of help referred to – and, perhaps surprisingly, only 11 respondents (0.3 per cent) mentioned the internet.

Therapeutic and emotional support in schools: The Place2BE

The Place2Be provides therapeutic and emotional support for children in schools. The charity was established in 1994 and currently works with a school population of 34,000 children in 92 schools in England and Scotland, with the aim of delivering early intervention services to over 100,000 children across the UK by the end of 2006.

Referrals to The Place2Be have come about as the result of abuse, anxiety, bereavement and loss, bullying, changes to family structure, depression, low self-esteem, neglect, relationships with siblings, transfers to new schools, and so on. These are, significantly, very similar to the reasons why children and young people self-harm; accordingly, this scheme could offer a potential model for addressing self-harm.

The Place2Be provides a dedicated team to work with children within the school environment, in a dedicated room (a 'safe space') within the school. Additionally, the organisation provides training for the school workforce in identifying and addressing emotional needs.

The direct service in schools covers The Place2Talk (self-referral); one to one work with children; work in small groups, classes and assemblies; work with parents and carers (including the pilot A Place for Parents); work with school staff, including the dedicated service The Place2Think; and involvement with INSET training days.

The scheme has been particularly successful in working with young males, who are usually unwilling to engage in support services, particularly those concerned with emotional health and well-being.

For further information contact Sarah Konzon, PA to the Chief Executive, The Place2Be, Wapping Telephone Exchange, Royal Mint Street, LONDON E1 8LQ. Telephone: 020 7780 6307.
Email: enquiries@theplace2be.org.uk

The impact of promoting good mental health and emotional well-being on young people who self-harm

Government strategies on mental health promotion and practice examples presented to the Inquiry focused broadly on overall good mental health and emotional well-being. None pay particular attention to self-harm. Nevertheless, anecdotal evidence that the Inquiry heard strongly suggests that this broad focus should benefit children and young people who would otherwise be contemplating self-harm, or who have already self-harmed, and might help them find alternative coping strategies at times of crisis. The work in schools is particularly useful, as so few young people - evidenced by the Inquiry's consultation work - who self-harm engage with support services (such as community projects run by voluntary organisations) of their own accord. The 'whole school' approach should mean that all young people attending school are increasingly receiving the appropriate information and advice, and can expect to be listened to and supported. However, the Inquiry found that practice is patchy and generally has yet to meet the aspirations of the policy.

In July 2005 Ofsted published its 'Healthy Minds' report, looking at the role played by schools in promoting the emotional well-being of pupils, and the impact of the guidance provided to schools four years earlier by the DfES and the National Healthy Schools Standard (NHSS). Ofsted found that the majority of the 72 schools visited were not working towards meeting the NHSS and that nearly half did not even know that such standards existed. Three quarters of the schools had identified unmet staff training needs on mental health difficulties as the main obstacle to meeting the NHSS. (Ofsted, 2005)[45].

Emotional health promotion in secondary schools: Samaritans

Samaritans is embarking on a new project, working with 14 to16 year olds in schools to raise awareness of emotional health, promote healthy coping skills and provide information on the support available for young people. The project will produce materials which support the current secondary school national curriculum, support teachers and other staff (a project officer is training teachers and helping them deliver core material in the Personal, Health and Social Education element of the national curriculum), support local branches of Samaritans' emotional health promotion work in schools, and build capacity so that teachers and branches can add to the programme.

This work is still in its early stages. It will involve an initial mapping exercise to establish what is known to work, and why; consultation with the various stakeholders; consultations with groups of young people; and then a pilot programme of work in four chosen schools. This pilot will help to develop branch guidelines on how to support and work with schools, and high value resources (such as videos and CD-ROMs) to be used within school settings. This will lead to a follow-on pilot in a further 10 schools, before the project is formally evaluated and the results are disseminated.

For further information contact Joe Ferns, Emotional Health Promotion Manager, Samaritans, The Upper Mill, Kingston Road, Ewell, Surrey, KT17 2AF. Email: j.ferns@samaritans.org.

Other factors associated with good mental health and emotional well-being

The Inquiry considered that it was important to examine other factors that are associated with positive mental health and emotional well-being which can affect young people's ability to cope with difficult circumstances and events. In particular we looked at diet and exercise.

Diet

The importance of a healthy and well-balanced diet to mental well-being has become increasingly recognised over the past decade. Low self-esteem, moods swings, depression, anxiety and restlessness - which can be related to diet - are frequently cited by young people as triggering factors in their self-harm.

The Mental Health Foundation recently published a systematic review on food, mental health and well-being highlighting the importance of this link (Mental Health Foundation, 2006)[46]. For example, several studies have established a clear association between a poor balance of omega-3 and 6 fatty acids and depression (Richardson, Cyhlarova and Ross, 2003)[47]. This is reinforced by other studies which show that countries with a high level of fish (which is a source of omega-3) consumption have fewer cases of depression (Hibbeln, 1998)[48]. It is estimated that 85 per cent or more of people in the Western world are deficient in omega-3 fatty acids and most get far too much of the omega-6 fatty acids (Servan-Schreiber, 2004)[49]. Carbohydrates are also important. A diet rich in carbohydrates increases levels of serotonin in the brain, which is thought to improve mood. This may be one reason why people with depression often increase their carbohydrate intakes during bad spells.

Other foods exacerbate depression - including ones that are used as a short-term 'fix'. Many people drink alcohol to cheer themselves up, but subsequent withdrawal from alcohol can precipitate depression. Caffeine can help to increase energy levels and produce a temporary 'high', but in the long term it can lead to sleeping problems, and an over stimulated nervous system which raises anxiety levels (which in turn is linked to depression).

Exercise

The benefits of regular exercise to physical health are well understood and widely accepted. However, the benefits to mental health and emotional well-being (reduced anxiety, decreased depression, enhanced mood, improved cognitive functioning and self-worth) have been less widely reported and are less well-understood and accepted *(*Mental Health Foundation, 2005)[50].

According to the National Institute For Clinical Excellence for patients with depression, in particular those with mild or moderate depressive disorder, structured and supervised exercise can be an effective intervention that has a clinically significant impact on depressive symptoms. (National Institute for Clinical Excellence (2003)[51].

The Mental Health Foundation (2005)[50] has argued that there are several reasons for using exercise therapy as a first-line treatment in primary care. It is a 'holistic care option', addressing both physical and mental health problems. It is a sustainable behaviour change – once people have acquired the habit of exercise, they can integrate this into an overall healthy lifestyle. It does not carry the stigma sometimes associated with medication or counselling and it can also give patients a sense of power over their own recovery, which in itself counteracts the feelings of hopelessness often linked to depression (Mental Health Foundation, 2005)[50]. The Inquiry therefore concluded that providing young people with opportunities and encouragement to participate in a wide range of exercise options was very important.

Safer Custody Group

Psychology and physical education staff at Wetherby young offenders' institute developed the ACCESS programme for vulnerable young offenders, combining sessions teaching skills such as problem solving and assertiveness with sessions putting these skills into practice in the gym. Evaluation showed that the participants increased in self-esteem and assertiveness, became less depressed and hopeless, and reduced their incidence of self-harm.

Carousel, an eight-week course run by a counselling psychologist and psychotherapist at women's prison HMP Brockhill, includes structured group work, one-to-one counselling, art therapy, music and exercise. Interviews with women who have completed the programme so far suggest that their self-esteem and their ability to use a range of coping skills increased, while their violent behaviour and self-harm decreased.

For further details of Carousel contact Julia Rose at HMP Brockhill or Louisa Snow, Suicide and Self-Harm Prevention Consultant to the Women's Estate.

3. Young people's views from the Inquiry consultation sites

Young people's views on the way mental health and emotional well-being are currently promoted in schools

Young people from across the Inquiry's five consultation sites felt schools have no real focus on promoting good mental health and emotional well-being – most of the sessions which fall under this broad heading concentrate more narrowly on drug and alcohol issues, sexual health, peer-pressure and bullying. They expressed particular concerns about needing clear and informed information and advice specific to self-harm. Most said that they had never had any opportunity to discuss or learn about self-harm at school or in any other context.

All 40 young people across the five sites felt strongly that self-harm *should* be tackled in schools and educational settings – one group pointed out that nowhere else gave that degree of access to so many young people. The majority of the young people also talked about the importance of presentations from outside organisations and professionals, discussion groups with peers, peer support/mentoring and information leaflets and posters in schools.

> *'It should be discussed in schools and groups by people who have experienced self-harm, depression, and so on, themselves. They should have people who really know about it to talk to people.'*

Most of the young people consulted by the Inquiry who had been referred to some sort of support (such as a GP, psychologist, 'anti-bullying/peer support' group at school, teacher, counselling service or CAMHS) said that this support had concentrated on the impact on their academic performance. They felt it was important to be able to talk about the things that had triggered their self-harm in a broader sense, and talked about the need for support systems where they could talk openly about their self-harm, be listened to sympathetically, and be helped to explore the reasons why they had self-harmed .

> *'What they fail to consider is that maybe a young person simply needs someone to talk to, not specifically about self-harm, but about the problems and issues they are facing in their daily lives which makes them turn to self-harm as a way of simply surviving - and I believe that this listening is one of the most fundamental values of good youth work!'*

One group of young people also felt the role of the teachers acting as counsellors was too confusing. The subject should be addressed within the school setting but not led by a teacher but preferably someone independent of the school system.

> *'However self-harm is tackled with schools or anywhere else, if they didn't make it such a dirty subject people would come forward a lot more quickly to get help.'*

> *'If there had been people to talk to at school then maybe I wouldn't have felt the need to start self-harming then.'*

Other strategies for improving mental health

Exercise

Young people from the five consultation sites were asked to discuss the kind of physical activities which they thought could help individuals reduce self-harm. Their suggestions included running, swimming, using a punch bag or cushion, walking, weight lifting, yoga, Pilates, dancing etc. However the young people stressed that everyone needed to find what worked for them, and that different activities might work at different times. Young people also said that they thought the opportunity to choose to do these kinds of activities might be restricted in some situations – for example, the army, looked after children, young offenders' institutions and sheltered accommodation.

> *'I feel the situations given for each example are really different, but the solutions that are being offered are all the same. It doesn't work like that in life, different kinds of solutions need to be provided to fit young people's needs.'*

> *'Exercise. If I feel myself getting tense and wanting to self-harm I would try to get rid of tension by going for a run or going swimming.'*

> *'I can postpone the harming by walking, going to gym…'*

Reducing social isolation

A large number of the young people who submitted their personal testimony to the Inquiry's call for evidence and/or answered the Inquiry's questionnaire talked about their feelings of extreme social isolation. They felt that they were alone in their self-harm. This feeling of social isolation prevented them talking to anyone or asking other people or professionals for help because they felt ashamed and guilty about what they did and worried about how people would react.

> *'I have friends who self-harm and I think that the key to working with young self-harmers is acceptance, care and interest. …having the opportunity to discuss what she does without the other person being embarrassed or shocked. It has helped her tremendously to read articles on self-harm and learn that she is not the only one in the world who does it – I think this is a very common feeling among harmers.'*

It was suggested that this social isolation is compounded for young people in strange or restrictive environments, and this additional stress can make people more likely to self-harm. Some settings, such as prison, the army and sheltered accommodation, limit a lot of the opportunities for choice and control. These can also be very stressful, volatile places which can put people under a lot of pressure.

> *'An unknown environment created feelings of anxiety and fear because you don't know what to expect…'*

> *'I wanted to stop long before I did, but didn't feel I could because I was afraid of what people would say, I didn't have the will power to do it alone. The feeling of being alone is hard enough but reaching out is even harder. As a self-harmer I found it hard to accept that I wasn't alone as I'd never heard of it. So the internet helped me understand the problem, but it didn't feel real, I wanted someone else to clarify what I did, showed that they understood and was willing to listen and not judge.'*

Summary of key findings

Over the last few years there has been a move in government strategies, across the UK, towards recognising and promoting better mental health and emotional well-being for all children and young people. These initiatives may eventually do a great deal to reduce self-harm among young people but implementation to date is patchy and there is not yet an evidence base specific to self-harm.

School-based work appears to be the most effective, for many reasons. One of the key findings of the Inquiry, which is backed up by previous research, is that many young people prefer to turn to other young people for support. A number of schools have started to implement peer support schemes, where student 'mentors' are trained to support other students who are having problems. These schemes (as part of a whole school approach to good mental health for all, and where mentors are adequately supported and able to refer their peers on to specialist support), appear to be successful, although the impact on young people's self-harm are not yet clear.

Other issues associated with positive mental health and emotional well-being are also important – especially if they also have a separate role in tackling the reasons behind a young person's self-harm. Factors such as good diet and regular exercise have been shown to improve people's mood and their outlook on life, and to reduce the incidence of depression. Exercise, in particular, also provides an alternative to self-harm for some and can also help to reduce the social isolation which many young people told the Inquiry exacerbates their tendency to self-harm.

CHAPTER 3: DISCLOSURE AND IMMEDIATE RESPONSE

Self-harm is a difficult issue for many people to understand and deal with – whether they are the person who has self-harmed or the person being told. It is very important that everyone who comes into contact with children and young people has a basic understanding of what self-harm is, why young people do it, and how to respond appropriately. Based on what young people told the Inquiry it is clearly important to avoid being judgemental towards young people who disclose self-harm. Young people want to be treated with care and respect and with an acknowledgement of the emotional distress they are experiencing.

> *'Looking back, I don't think my Mum knew what to do. After she told me that she knew I assured her that I'd stop immediately (as I did my friends, although again, I had no intention of doing so.) She also tried to make me see a doctor, although every time she made an appointment I told her I was busy. With hindsight I realise that I was so deeply in denial that I didn't think I had a problem, and seeing a doctor would be admitting that there was actually something wrong with me – I was terrified!'*

1. Current research and practice-based evidence

Handling disclosure

Many people – family, friends and professional staff - find it hard to deal with being told by a young person that they have self-harmed. This is reinforced by what young people told the Inquiry which is that disclosure can initially make their circumstances worse (for example, relationships may become more strained, worry about what will happen next may increase the young person's self-harm, blowing the whistle on bullying may make things more difficult at school for a short period of time, etc) but that once the initial hurdles are overcome it can also make it possible to draw on support in order to deal with their self-harm – even if the support is informal (from friends and/or family).

Evidence from professional staff – again backed up by what young people told the Inquiry - reinforces the point that it is very important not to focus exclusively on the self-harm itself but on the reasons why the young person has self-harmed. It is very important that professional staff understand that a young person disclosing self-harm needs to know that the fact they have been able to disclose shows strength and courage. It is equally important that people hearing a disclosure allow the young person to take the discussion at their own pace, foster trust and respect the right of the young person to act on their own judgement as to what and how much to say.

Disclosure to friends and family

The majority of young people who have submitted personal testimony to the Inquiry said that they were more likely to speak to close friends about their self-harm than family or any professional or organisation (Fortune et al, 2005)[52]. This highlights the need for greater awareness, information and so on to be developed not just among young people who self-harm but also those friends and family to whom they might disclose.

The Inquiry heard evidence from ParentLine Plus, a national charity offering help and information for parents and families through a range of services including a free 24-hour confidential helpline. The Inquiry was told that (in 2003) self-harm was an issue for three per cent of all calls to the helpline. Typically, parents did not know how to respond or what to do. One mother, for example, discovered from her daughter's diary that she had self-harmed and that, having been sexually abused in the past, she said she wanted to go back 'to a time before the abuse'.

> *'Parents need immediate advice on how to handle the situation and what to do after. They need to learn about listening and what things they can do to support themselves.'*

For examples of information and support available to parents please see Appendix 2.

Disclosure to professionals

Teaching staff

The young people from the Inquiry's consultation sites who had disclosed their self-harm to a member of school staff told the Inquiry that they had only done so because these staff had become aware of their self-harm. These young people described feeling 'under pressure' to raise the issue and ask for support. They also said that they did not feel they had been consulted or informed about the fact that other teaching staff had been told about their self-harm and in some cases parents or professionals from other agencies.

Professor Ron Best, from Roehampton University, presented the Inquiry with interim findings of a continuing project (funded by the Nuffield Foundation). This project is investigating the experiences of teachers and other professionals who work in or with secondary schools in supporting and responding to young people who self-harm. It is already clear from this work that teachers are not adequately trained, supervised or supported in this area. Teachers described their own reactions which included being 'freaked out', 'scared', and 'mystified' by self-harm (Best, 2005)[53].

William Farr CE School, Lincoln: individuality and corporate responsibility

'Every child is known and valued as an individual and every child knows his or her value as an individual,' says Paul Strong, Head Teacher at William Farr Comprehensive in Lincolnshire since 1986. With 1,450 students, 90 teachers and 80 support staff, that is no mean feat. But together, they work within a system called 'Care and Guidance' which – though not specifically a self-harm focused approach - they claim they can pick up some 50 to 60 children who will self-harm within the school community each year (some 50% of the total number likely to self-harm based on the best prevalence data available).

The 'care' part of the package reacts to situations where, for example, a child is being bullied or has recently suffered bereavement; the 'guidance' aims to equip young people with the confidence and tools to deal with problems before they arise. Personal, social and moral education classes as well as the school's peer counselling programme deal with issues such as self-harm. 'We usually find out a child has self-harmed because one of their friends will tell us,' says Mr Strong.

One of the senior management team of eight is an assistant head with responsibility for care and guidance. Heads of year teach fewer classes so that they can devote a good deal of their time to pastoral duties. All staff have a responsibility to identify and report on physical or behavioural changes and all staff have training in such matters. The entire package costs approximately £200,000 a year out of a budget of around £5 million, but Paul Strong believes it is worth every penny to provide a whole-system approach. The school has recently appointed a full-time nurse-counsellor. Previously, a pupil would have been referred outside the school for specialist help. Now there is an on-site professional in whom to confide. As Mr Strong concludes, 'There is nothing worse than a child going to the wrong person and finding someone who is not interested.'

For further information contact Paul Stong, Head Teacher, William Farr Comprehensive School, Lincoln Road, Welton, Lincolnshire, LN2 3JB.

School nurses

The Inquiry heard evidence from the Royal College of Nursing (RCN) who represent school nurses, a group that the Inquiry were told are increasingly aware of the issue of self-harm. School nurses often realise that there is a problem if a young person shows frequent minor illnesses and/or injuries; is clearly anxious; is causing friends to ask for help and support on their behalf; or in some cases, is even requesting 'tools'* that would help them self-harm. The RCN told the Inquiry that many schools are reluctant to acknowledge that self-harm is happening. Even when self-harm is acknowledged the Inquiry was told that there is a reluctance to refer the young people concerned to the appropriate services outside the school. School nurses also told the Inquiry that they lacked clear and practical information about self-harm.†

* The colloquial term for the items that young people use in their self-harm

† Royal College of Nurses told the Inquiry that they had been able to make good use in practice of the information pack produced for the Inquiry launch.

General practitioners

The Royal College of General Practitioners' Adolescent Task Group presented evidence to the Inquiry. The average GP has around 1,800 registered patients registered with them – this means that on average there will be around 10 to 15 young people who self-harm within their practice*. Most young people who do present to their GP as a result of their self-harm come with physical 'symptoms', which are not always attributed to self-harm.

The Inquiry heard that many GPs are not sure how to approach the issue directly with the young person, or where or how to direct them on to the most appropriate services - guidelines on this issue from the National Institute for Clinical Excellence (NICE) are not particularly relevant to GPs as they focus on Accident and Emergency Department procedures. GPs are also often concerned about confidentiality and/or child protection; and what they should do for the young person whilst waiting† for them to be seen by the local child and adolescent mental health services (CAMHS).

> *'My GP is good. She's admitted in the past she doesn't know what to do to help but I think she has the right attitude to self-harm. She thought residential care would be best for me at one stage but has seen how much independent living has helped me. She is honest with me though and refers me for treatment when I need it…'*

The Royal College Task Group recognises the need to seek out and share examples of good practice across the GP community to help fill this current gap in knowledge. They also believe that as well as this GPs should be receiving formal training in responding to young people who self-harm, particularly in terms of disclosure and crisis management.

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* The average young person sees their GP around three times a year, usually for a shorter time than an adult would and the Royal College of GP's Adolescent Task Group believes that GPs should allocate more time for young people.

† Personal testimony from young people and GPs estimate that waiting times are approximately nine months

Accident and Emergency staff

When young people attend A & E departments needing urgent medical attention the Inquiry heard that they will often find themselves in a situation where disclosure of self-harm is a prerequisite for any treatment. The Inquiry has heard a large body of personal testimony from young people around the mostly negative experiences that young people had when attending A & E.

> *'On the occasions I have been admitted to an A & E department they have concentrated on medically patching me up and getting me out. Never have I been asked any questions regarding whether this is the first time I have self-harmed or if I want to again or how I intend to deal with it.'*

> *'A & E isn't usually a positive experience. The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done….Some nurses have tried to offer acceptance and treat me clinically only – that's been a relief. One admission that did lead me to self-harm afterwards was when a nurse insisted on giving me a bath. She wouldn't take no for an answer. I felt great shame at someone seeing my body. The consultants I do see there act as if to say "Not you again". A typical response will be to say just how much I have been in recently and it is crazy for me to be bouncing back and forth into hospital. When I go to A & E I just want appropriate medical care. Sometimes I want to see the duty psychiatrist but this shouldn't be inflicted on me (as often it has been). I feel that hospital staff are just covering their backs rather than actually being concerned about me when they make the referral straight away.'*

Representatives from several hospital A & E departments told the Inquiry that young people who self-harm often return several times which leads to a sense of therapeutic nihilism: professional staff were asking, 'What can we do?' The Inquiry was told that A & E staff did not feel that they had effective models of working to respond well. Nor did they feel they were getting the support they needed themselves – many need debriefing after dealing with self-harm (because the injuries can sometimes be upsetting and it can be difficult to understand why a young person self-harmed).

Guidelines from NICE on the care of people who self-harm, published in 2004[54], were intended to address how young people who have self-harmed are dealt with in A & E (and primary care)*. The Inquiry was told that the guidelines are in part based on the experiences of two focus groups comprising people who had direct experience of self harm. However, the Inquiry was also aware that some of the focus group members were very unhappy with the process and withdrew their involvement.

The NICE guidelines make recommendations for physical, psychological and social assessment and treatment by primary and secondary care services in the first 48 hours after the self-harm has taken place. However, NICE's remit does not include evaluation of the take up or compliance with its guidelines (which apply only to England and Wales) so it is unclear how far service provision in A & E departments has been or will be influenced by the guidelines.

* http://www.nice.org.uk/pdf/CG016NICEguideline.pdf.

Ambulance service staff

Personal testimony from young people in touch with the Inquiry indicates that a number of people have experienced negative and sometimes hostile reactions from ambulance staff. This is backed up by the range of evidence and presentations heard by the Inquiry from ambulance staff which illustrated how self-harm seems to be a difficult and challenging matter for them.

The only official guidance that ambulance staff currently have is a small section in the Clinical Practice Guidelines relating to patient consent. Evidence to the Inquiry from ambulance staff clearly suggests that this needs to be supplemented with a lot more basic training and information. Ambulance staff need to be in a position to react and respond appropriately to a young person whose need for urgent medical attention is often, in effect, the first time that their self-harm has come to light.

Support available to professionals responding to a disclosure of self-harm

Policy and legal advice

In October 2005, the Department of Health published the 'You're Welcome' report[55], which sets out principles that were intended to help health service commissioners and providers (including non-NHS provision) develop services that are more accessible to young people. This report draws on examples of effective local practice and outlines a clear protocol for managing child protection concerns and possible breaches of confidentiality. It stresses young people's entitlement to confidentiality and recommends that all staff (both clinical and non-clinical) become familiar with the service's confidentiality policy; it also recommends that staff receive inter-disciplinary training involving the local Safeguarding Children Boards (formerly the local Area Child Protection Committees) to ensure that there is a common approach to child protection issues.

Legal issues for services and staff dealing with young people who self-harm

In the course of the Inquiry it became clear that there are a number of important legal issues relevant to services (including schools, health and social care providers and others) and individual staff working with young people who self-harm. The Inquiry responded to this by commissioning a detailed legal briefing from an experienced human rights and mental health lawyer. This is available as a separate briefing report on the Inquiry website (www.selfharmuk.org). The Inquiry identified several key questions but the briefing note also has a broader remit.

First, given that the Inquiry has focused on young people between the ages of 11 and 25 we wanted to know how the legal position of services and staff differed depending on the age of the young person who has self-harmed. An example here is in respect of consent to treatment. 'Gillick competence' and the 1989 Children Act are both relevant to the question of whether a young person under the age of 18 years of age can consent to treatment. Overall these provisions will mean that most young people will be able to give informed consent and can expect confidentiality in their dealings with services and staff. The Mental Health Act 1983 is also relevant as is the Mental Capacity Act 2005 (due to come into force in 2007).

Second, the Inquiry was particularly interested in the legal context of the duty of care on services and individual staff. In particular there is a question as to whether services or individuals working with young people who self-harm are vulnerable to being accused of a lack of care. Articles 2, 3, 5, 8 and 14 of the Human Rights Act 1998 are of particular importance.

There is a developing body of both British and European Court of Human Rights rulings that is relevant. The legal advice that the Inquiry commissioned concludes that there is a need in practice to balance a number of rights and to demonstrate defensible practice. Individual practitioners and services should be able to demonstrate that they have acted on any advice from other professionals who might be involved and that they themselves have undertaken an appropriate assessment of the risk to the young person so that they can ascertain the least invasive interventions that will address the identified risks.

The Common Law 'duty of care' is also relevant here. Again there are rulings from the House of Lords and other courts which define and describe when a duty of care will arise. The Inquiry's legal briefing paper covers the general legal context but the Inquiry concluded that it is important for employing services to ensure that appropriate information and training relevant to the service/setting is provided to all staff.

The strong-minded mental health service for young homeless people in foyers: a joined up approach

The transition from being a young person to an adult is hard at the best of times. For those who are homeless, the problems are compounded. In 2003 the Foyer Federation set up a pilot project called 'Strong Minded' to address mental health issues which current services were not covering. Funded by the Gatsby Foundation, it employed five mental health professionals to work on the interface between foyers and existing mental health services. Together, they offered direct one-to-one clinical work, along with education and liaison within a total of 18 foyers.

Anne Marie Lyons, the mental health coordinator based at the Plymouth Foyer, explains: 'My job is about relationship building. I break down the difficulties between the different systems'. One of her first tasks was to carry out a needs analysis. This revealed that self-harm was one of the biggest issues facing residents and staff. She then developed a training package, some which was delivered by the young people themselves. 'There was one young person who was irate at the way people treated her. She said no one would listen. So I asked her to come along with me and tell them. Now I do the textbook, and she does the reality.'

Anne Marie has also helped her foyer introduce clear procedures on dealing with someone who self-harms and improving communication with external agencies. For example, she now follows up any resident who has visited the local A and E department. The local primary care trust has now also set up its own self-harm service. What has been the biggest impact? 'Staff are prepared to talk about self-harm and ask questions without immediately panicking. And young people are more easily able to come forward.'

For more information, please see the Evaluation of the Strong Minded Mental Health Service for Young Homeless People in Foyers on the Foyer Federation website at www.foyer.net

3. Young people's views from the Inquiry consultation sites

The Inquiry heard that many young people still find that disclosing their self-harm is a very bad experience.

> *'I attended an independent school [boarding] and my self-harm was treated very badly. It was treated as a piece of gossip throughout the staff and the head teacher asked me to leave as a result, saying that I was a lovely person but he couldn't have it in his school.'*

> *'I told my guidance teacher and he told me "to do it better next time". I think he was trying to be funny but it stopped me from asking anybody else for help at school, and I wished I hadn't talked to the teacher either, and my teacher never mentioned it again.'*

One of the things that self-harm offers young people is a way to feel in control of something in their lives. Therefore, many fear that by disclosing their self-harm they will lose this control: this previously secretive act becomes effectively 'public property' and the people around them begin to try to stop their self-harm. For example, approximately half of the young people from the Inquiry's consultation sites said that they had confided in friends at school and that their friends had in turn disclosed to teachers. The majority described their sense of lack of control about who else was then told about their self-harm (their parents, other teachers, other staff, and/or other professionals).

Even those young people who spoke directly to an adult said that once they had done this, all decision-making and control were taken from them. They were not being consulted about the services that might be contacted, or about the exact sort of help and information that would support and help them deal with their self-harm. Many were unsure - and felt unable to ask about - who else would be told or involved after they had disclosed private and sensitive information.

Young people told the Inquiry that lack of control exacerbates the self-harm. It is also apparent that many young people who self-harm are afraid that the only coping strategy (even if maladaptive) that has been keeping them functioning might be taken away from them.

> *'My friend went on to tell my head of year who in turn said it was necessary to inform my mother. I felt as though I had no say in what was happening and I felt out of control. Thus the self-harm increased. My mother was shocked and forced me to go to the doctors the next day. My doctor looked at me differently once I told her why I was there. It was as if I were being annoying and wasting her time. She saw my arm and told me that it was only superficial and that she would make enquires as to what should be done with me.'*

> *'The one time I trusted them enough to tell them I had cut myself again, they rang my mother then and there. It made me hate being there even more, and I lied and lied and told them I didn't even consider it whenever I got angry anymore when truthfully it was so much in my mind, and the fact I had been so restricted in cutting myself I was actually now obsessed with it.'*

Fear of losing control and not being consulted with fully and appropriately about decisions in their lives are not the only barriers to disclosure. Evidence to the Inquiry shows that most young people do not have anyone they feel they can talk to about this private and sensitive issue, apart from their immediate friends; they certainly do not know how they might be able to contact more formal support services. In addition, they may be worried that if they do disclose their self-harm, their choices for the future may be compromised: anecdotal evidence from young people shows that they worry that they will not be able to work in professions such as teaching, nursing, or childcare because of the public perception that people who self-harm are 'dangerous' and should not be allowed to work with children.

Those young people consulted for the Inquiry who had disclosed to professionals usually did so either to teaching staff or to a GP. Those who talked to GPs were usually very unhappy with the reaction; many felt that their GPs were simply not interested in them and the underlying factors behind their self-harm. Only a few of the young people talked about positive experiences with their GPs.

> *'The GP and surgery nurse now give me dressings and other things so I can do the cleaning and dressing myself, which I find best for me.'*

Instead of being given different options (which was what they wanted) a lot of young people were given medication (mostly SSRIs) straightaway, with no other follow-up or support. However, NICE guidance (2005)[51] recommends that children and young people under 18 years of age with mild to moderate depression should be offered specific psychological therapy rather than medication and the level of prescribed SSRIs for the under 18's is falling. A smaller number of young people consulted said that they believed their GPs did not understand self-harm. Approximately half of the young people consulted felt pressurised by the GP to show their scars/cuts/burns as evidence of their self-harm, rather than being taken on their word.

However, some young people did find that their disclosure was dealt with in a sympathetic, supportive way which has enabled them to move forward, tackle the issues underlying their self-harm, and find the information and support they need.

> *'I feel a lot more confident within myself, I've learnt to be more open about my feelings and been able to move on, as I felt without them knowing I was being held back. I've been able to come out of myself and explain what I do, and make sense without having to lie and cover up what I did! I no longer feel ashamed with what I did as I know people are supporting me!'*

> *'The close friend was highly skilled - she works in social services. She was an amazing source of strength and support. She was level headed and got me to promise to agree to seek medical treatment and engage with the services because the initial feelings were highly likely to return. Without help things were likely to have ended badly.'*

> *'A lot differently to how I expected; everyone has been supportive, which has given me the confidence to move on and feel stronger to tell more people instead of lying about the scars I've got.'*

Summary of key findings

Young people who engage in self-harm can find it hard to talk about the subject and are often afraid of the reaction they may receive. Almost all of them feel guilty and ashamed.

The reaction a young person receives when they disclose their self-harm can have a critical influence on whether they go on to access supportive services. Young people who have self-harmed want responses that are non-judgemental and which are caring and respectful. Professionals working with young people (youth work, social work, health and education) need to recognise that dealing with disclosure requires them to exercise their existing core professional skills, *not* to have a completely new set of skills.

A range of organisations consulted by the Inquiry emphasised the need for comprehensive, accessible information. It is important that all individuals who come into contact with children and young people have a basic understanding of what self-harm is, why people do it, and how to respond appropriately. This information should cover the support and other services which young people might find useful in dealing with their self-harm and also the needs of people handling disclosure. It can be also hard for family, friends, and professionals to handle a young person's disclosure of self-harm.

CHAPTER 4: SUPPORT AND THERAPEUTIC INTERVENTIONS

This chapter examines the various types of interventions that may currently be available to young people who self-harm; young people's own views on preventing self-harm; and the services young people have engaged with, including their opinions on what services were helpful.

> *'I guess if I were to look at my life over the past five years and ask what I'd change, it would be those very first experiences of harming myself. I wish that, at the age of 15, I had known of other ways to cope with whatever pain or problems I was dealing with. Now I do have other strategies to cope with the urge to harm myself. Sometimes they work and sometimes they don't, but they are there and they help. But at 15 I was too scared to really sit and talk to anyone about it and am only really now beginning to face what it is I do and the ways in which I can help myself.'*

1. Current research and practice-based evidence

Young people's views on getting help

Very little is known about young people's views about getting help and support when they think they may self-harm or once they first start to self-harm. The Inquiry commissioned a further analysis of data collected as part of a school-based research study from Keith Hawton and colleagues at the Centre for Suicide Research in Oxford (see Chapter 1) The commissioned analysis included open-ended questions asking the adolescents' views about their self-harm (see Chapter 2) and about seeking help (including barriers to seeking help).

Q: 'Why didn't you try to get help before you took the overdose or tried to harm yourself?'
The most common reason given was the belief that they could cope on their own, or that they planned to sort matters out themselves and did not need any help. Also respondents were worried that that if they had sought help then services would have tried to stop their self-harm; that they would not be taken seriously and that services would have failed to understand why they self-harmed; and/or that no one could help them. Girls were particularly sensitive about being labelled or dismissed as being an 'attention seeker' or 'stupid' if they asked for help. Those who did not know other people who self-harmed were particularly concerned about being labelled 'crazy'.

Q: 'Why didn't you try to get any help afterwards for the problems that led you to take an overdose or try to harm yourself?'
The reasons for not seeking help afterwards were broadly similar. Nearly 1 in 10 young people felt this was something which they would not repeat, and which they wanted to put to the back of their minds. A smaller number, particularly male respondents, felt that the situation and/or the injury associated with the self-harm was not serious enough to warrant seeking help.

However, the most striking reason was the sense that circumstances had changed after this most recent episode. Some adolescents, particularly girls, described a change in circumstances; sometimes this was a general sense that 'things had moved on'. A smaller group of respondents acknowledged that circumstances might still change for the worse again.

Findings from the Inquiry's questionnaire to young people

Quite separately from the Inquiry's consultation sites, people who visited the Inquiry's website were asked to fill in a detailed multiple choice questionnaire.

A total of 142 young people aged from13 upwards, with an average age of 20 completed questionnaires. There were 137 females and 5 males; the young people were predominantly white; the average age at which self-harm first occurred ranged from six to 23 years old (an average of 14 years old); and they had self-harmed from between two months to 15 years (an average of five years).

TABLE 1: CONTACT AND HELP-SEEKING (N=CONTACT %)

Profession/ individual/ organisation	Contact N (%)	No Contact N (%)
Friend	117 (82.4)	15 (10.6)
GP	87 (61.3)	49 (34.5)
Psychiatric service	86 (60.6)	50 (35.2)
Relative	73 (51.4)	61 (43)
Teacher	56 (39.4)	80 (56.3)
Voluntary/local organisation	44 (31)	95 (66.9)
Other nurse	43 (30.3)	93 (65.5)
School nurse	30 (21.1)	110 (77.5)
Other organisation	36 (25.4)	101 (71.1)
Social worker	23 (16.2)	115 (81)
Police	9 (6.3)	131 (92.3)
Health visitor	8 (5.6)	132 (93)
Prison	2 (1.4)	139 (97.9)

The majority of young people who had sought help reported that they had found it useful; the top four categories of people that young people contacted regarding their self-harm were friends, GPs, psychiatric services and relatives (over 50 per cent in each case). Relatives were felt to be less helpful (although not substantially so) (see Table 1 & 2).

TABLE 2: PERCEIVED HELPFULNESS

Profession/Relationship	Helpful (%)	Not helpful (%)
Voluntary/local organisation (n=44)	88.7	11.4
Friend (n=111)	82	17.9
Health visitor (n=8)	75	25
Other nurse (n =38)	69.7	30.2
Teacher (n=53)	64.3	35.7
GP (n=82)	64.3	35.6
Social worker (n=22)	56.5	43.5
Psychiatric service (n=81)	55.8	44.2
Police (n=8)	55.5	44.4
School nurse (n=29)	50	40
Prison (n=2)	50	50
Relatives (n=68)	42.5	57.5

Respondents were also asked what sort of help they would want on offer (whether or not they had contacted existing sources). Face to face support (such as one to one work and/or counselling) and group support (such as drop-ins and facilitated self-help groups) were most popular, followed by creative initiatives and multimedia/ internet access. (See Table 3 overleaf). These results mirror earlier findings reported in Penumbra's research (Penumbra, 2001)[56].

TABLE 3: WHAT YOUNG PEOPLE THOUGHT WOULD BE HELPFUL

Type of Help	N	%
1:1 support/counselling	121	85.2
Group support/drop-in	101	71.1
Self-help group (facilitated)	86	60.6
Creative Initiatives	85	59.9
Multimedia/internet access	81	57
Information point	72	50.7
Outreach team	64	45.1
Family support	53	37.3
Self-help (no facilitator)	29	20.4

2. Expert opinion/examples of practice submitted to the Inquiry

Self-management

Young people told the Inquiry about the crucial importance of being able to distract themselves from self-harm even for a short period of time. For some distraction can be a first step towards tackling their self-harm and it should be treated as a positive step.

Part of successful self-management is the ability to 'surf the urge', as described by LifeSigns (2005)[57]. In practice this means to wait it out, observing the emotions and how they build up and then diminish and fade away. This can be very difficult for many young people to manage but it is possible.

> *'I use a wide range of things from music and television to relaxation techniques and reading but the one that helps if I'm feeling really bad is to be around someone I trust. I may look bad and not be very talkative – but just to be around someone who doesn't question my odd behaviour and lets me be around them without talking or explanations helps.'*

> *'I tried so many – from holding an ice-cube, elastic band flicking on the wrist, writing down my thoughts, hitting a pillow, listening to music, writing down pros and cons –but the most helpful to my recovery was the five minutes rule, where if you feel like you want to self-harm you wait for five minutes before you do, then see if you can go another five minutes, and so on till eventually the urge is over. Another great help was talking to my friends about my problems. With some of the methods I couldn't last two, three days; I found it hard to adapt to something so different, when I was used to coping with my own way. Eventually though I found a way of coping which I got on with and it helped me to stop.'*

Successful distraction techniques

A majority of the young people consulted by the Inquiry told us that they had found distraction techniques that worked for them. This was confirmed by expert testimony to the Inquiry. However, it is extremely important to recognise the need for individual techniques; a 'one size fits all' approach will not work. Some of the most popular 'tried and tested' distraction techniques used by a range of young people are:

- using a red water-soluble felt tip pen to mark instead of cut
- hitting a punch bag to vent anger and frustration
- rubbing ice instead of cutting
- physical exercise
- making lots of noise, either with a musical instrument or just banging on pots and pans
- writing negative feelings on a piece of paper and then ripping it up
- scribbling on a large piece of paper with a red crayon or pen
- putting elastic bands on wrists and flicking them instead of cutting
- writing a diary or journal
- talking to a friend (not necessarily about self-harm)
- collage or artwork
- going online and looking at self-help websites.

'Most of the time now I can distract myself until the worst of my anger and pain subsides enough for me to deal with things. This is not always the case but nine times out of 10 if I concentrate on other things for long enough I can ride it out.'

'Holding an ice cube until it melts, snapping elastic bands on my wrists, calling a friend, writing poetry, drawing, putting fake blood on my arms and pretending it's real and drawing lines on my arms with red marker pens.'

'I can postpone the harming by walking, going to gym, chatting to friends but ultimately these do not prevent the harming.'

'I took control and responsibility for emotions using flash cards with a statement or quote like "This is a rough patch that I'm going through. I know what this is. I need to take extra care of myself and I know I can get support", or" Don't get caught up in that emotion".'

'I did everything I could to be positive. I knew that if I lifted the depression, I would be able to try and stop self-harming. As I started to feel better, I made the conscious effort to stop the cutting. I would count the days, then weeks and now months and would set myself goals (one week, one month, six months and so on). I started talking to people about it and used distractions to help me through.'

Self-help support groups

The Inquiry heard evidence from several organisations that run self-help support groups specifically for young people who self-harm. Self-help groups offer mutual support which enables people to explore their feelings around self-harm, the reasons behind it, and how they cope with it. They also provide an important opportunity for people to gain trust, find friendships, feel less isolated and alone, and begin to share and explore common experiences and knowledge.

Young people's evidence to the Inquiry confirms the value of self-help groups, and this is supported by research into the effectiveness of self-help groups generally (Young and Williams, 1987[58], Self-help Network, 2002[59]; Hyde, 2001[60]; Adamsen and Rasmussen, 2001[61], Kurtz, 1997[62]). In 2003, the Mental Health Foundation commissioned research into the positive and negative effects of attending a self-harm self-help group (Smith and Clarke, 2003)[63]. The findings from this research suggest that self-help groups offer a safe place to talk openly and honestly without fearing the response from professionals.

However, although many individual testimonies stressed the helpfulness of contact with others who self-harmed and how this is often a turning point in the road to recovery (Clarke, 2003)[64], some professionals are still concerned that talking about self-harm to other people who self-harm may encourage people to continue, and/or self-harm in new ways.

Girls Xpress: campaigning and developing new ways of working

Although it was only established in 2003, the WISH Centre (Women's Integrated Services in Harrow) has already won numerous awards for its GirlsXpress project, a self-help group for those who self-harm between the ages of 13 and 19. Around 15 young women meet regularly, although there are 25 in the wider network and, over 50 who participate in a secure and moderated MSN discussion group. The centre's one member of staff, who trained as a psychotherapist, facilitates their work.

The focus of GirlsXpress is to enable participants to find a voice by developing an understanding of self-harm and campaigning for its wider recognition. Many young women find it difficult to articulate the reasons for their self-harm, so they use the medium of art in order to express the pain they feel. The project employs a sessional artist, who works with participants to use media such as photography to express their feelings. Experimenting with colour and light allows them to explore their psychology, while the creative process also builds confidence and raises self-esteem.

GirlsXpress has also produced a video on self-harm to highlight individual experiences through interview and music. The video won an award at the International Youth Media Festival 2005 and was chosen to be part of the young people's presentation to the World Economic Forum in 2005.

At the suggestion of participants, GirlsXpress also carried out a survey on self-harm in a local secondary school, and used the results to talk to the local education authority and individual heads. Several schools in the area now have self-harm policies that treat young people in the way they prefer. The project has also used the results to highlight issues in the local newspaper, and written articles for the wider youth audience via magazines such as Elle.

For further information contact Rowena Jaber, Centre Developer, The WISH Centre, 51 Sheepcote Road, HARROW, Middlesex HA1 2JL. Telephone: 0208 863 8092. Email: thewishcenter@hotmail.com

Penumbra Aberdeen: listening to young people

Penumbra is a leading Scottish mental health charity with a 10-year track record of working with young people aged 16 to 25 years, mainly in school and community settings. The philosophy underpinning its work is that young people are the experts, and their carers or professionals need to get up to speed on the issues affecting them. It currently has six projects working specifically on self-harm, funded by the Scottish Executive Choose Life Programme.

The longest-running project is the Forum for Action on Self-Harm in Aberdeen, which has been running since 2003 and is made up of young people who self-harm, their carers, and professionals. It employs one development worker whose duties include:

- establishing and supporting self-harm support groups for people who self-harm, parents, carers and professionals
- bringing together the individual support groups around common issues
- establishing links with appropriate planning groups
- facilitating and providing training around self-harm (this includes providing support so that people who self-harm can take on a training role)
- promoting good practice across agencies
- making accessible resources available for organisations and individuals
- liaising with other interested groups locally, nationally and internationally
- collaborating with local press and media to reduce stigma and inform the general population on the needs of this group.

Young people took part in appointing the staff member and she envisages that her role will eventually become that of a facilitator, with the young people themselves taking the lead. Two young people to date have also been employed by the project to deliver the training. Young people have also been involved in work with the media.

Nine young people attend regularly and they have been able to influence good practice by, for example, visiting a range of services to build relationships and provide information and advice about developing guidelines.

For further information, please contact Patrick Little, Young People's Development Manager, Penumbra, Norton Park, 57 Albion Road, Edinburgh EH7 5QY. Telephone: 0131 475 2380 or email: patrick.little@penumbra.org.uk

Websites and internet forums

Websites and internet forums have become increasingly popular, especially with young people, as a way to access information and support for a range of different issues including self-harm. However, some are concerned that some of these forums or websites contain unhelpful and misleading information. It is clear that many young people – especially young men, who tend not to engage in traditional face-to-face services – do find this vehicle for information accessible, especially when trying to deal with a taboo and stigmatised issue such as self-harm. The Inquiry has heard from a number of website and chat forums appropriately run and overseen by voluntary organisations, which provide very useful support and information for young people. It is important that these reputable sites are publicised more widely to young people to ensure that they can access the most appropriate advice (See Appendix 3 for further information).

Telephone help lines

Telephone help lines are another popular and easily accessible source of confidential support and advice for young people, family and friends. They can also direct callers to other organisations that work with young people and issues of self-harm. Many operate only as a 'friendly listening ear' – something many young people told the Inquiry that they value, particularly when they feel they have no-one else that they can turn to. Again it is important that information about reputable phone lines is widely available to young people so that they know where to turn in times of difficulty (See Appendix 3 for further information).

Counselling services

In recent years there has been an increase in the availability of counselling services across the NHS and voluntary sector. The Inquiry could find no evidence (whereas it did for DBT and CBT) to demonstrate the effectiveness of counselling for young people who have self-harmed but found a common – perhaps incorrect – belief that any kind of counselling/therapy, even from an untrained worker, is better than none (Allen, 1995)[65]. It was clear to the Inquiry that 'talking therapies' for young people who self-harm should be carried out by staff who are trained specifically in working with this group, and be focused on the problems or issues that the young people want to address.

Adolescent deliberate self-harm service: rapid intervention and regular reviews

The Deliberate Self-Harm nursing team delivers an assessment and intervention service for 12 to 17 year olds in Glasgow. Although only the equivalent of 6.5 whole time posts it offers seven day a week crisis assessment/intervention to district general hospital and A and E departments, and also accepts routine referrals through area CAMHS teams where the primary presenting problem is deliberate self-harm.

Of the 905 referrals the service has received to date, 84 per cent were female, 96 per cent were white and 22 per cent had had previous contact with mental health services; 585 had overdosed, 238 had been involved in cutting (52 had used both methods), and 103 were abusing alcohol. In 2005, a total of 203 new patients were assessed (175 via hospitals) and offered follow-up. The latter was usually within one week of any incident, and involved the family whenever possible. The initial focus is on crisis planning, and patients are issued with crisis cards with contact details of the nurse therapist and other out of hours emergency assistance.

Patients then receive home based family intervention, starting with a psychosocial risk assessment which usually takes 90 minutes with the young person and an additional 30 minutes with a parent. Four to 10 one-hour sessions follow, typically covering stages in adolescence, problem solving and communication styles. Individual intervention adopts cognitive behavioural therapy techniques, challenging beliefs and assumptions as well as negative or faulty thinking. The whole approach is focused on solutions, and on getting the individual young person to solve his or her own problems.

When therapeutic intervention is complete, the young person is placed on review and offered three appointments within one year. They can also contact the service in crisis at any time within this period for further therapeutic input.

For further information, please contact Eileen McCafferty, Clinical Nurse Specialist, Adolescent Deliberate Self-Harm Service, Old Sandy Road Clinic, 12 Sandy Road, GLASGOW G11 6HE. Telephone: 0141 232 9222 or email: angie.morrison@glacomen.scot.nhs.uk

Therapeutic interventions

Inpatient treatment

The Inquiry heard evidence from the Crisis Recovery Unit at the Bethlem Hospital in London[66], a national specialist residential unit for people of 17 years and above who persistently self-harm (and do so in ways that often result in severe injury). The 12-bed service offers both inpatient and outpatient treatment; it is provided by a multidisciplinary team.

The philosophy of the Unit is that individual young people should retain responsibility for their behaviour, and that – in the short term – self-harm can sometimes be tolerated although not promoted: this is termed 'therapeutic risk'. This approach is based on the view – supported by practice experience – that if staff remove all potentially damaging items and take responsibility for the young person's immediate safety, the young person does not make the choice themselves. In the long term, when they have left the unit, they need to have learned their own strategies for coping with the urge to self-harm.

Acknowledging their self-harm also makes it possible to discuss it, because young people are not forced into a position where they are continually denying their self-harm behaviour. Instead, the work focuses on helping young people reach a point where they realise for themselves that self-harm is not an effective long-term strategy for dealing with their problems. The aim is to help young people start to explore alternative coping strategies (as well as strategies for dealing with the urge to self-harm).

Systematic reviews of intervention models – a medical approach

A number of systematic reviews evaluating the effectiveness of interventions after incidents of self-harm have been published relatively recently (Van der Sande, Buskens, Allart et al, 1997[67]; Hawton, Arensman, Townsend et al, 1998[68]; NHS Centre for Reviews and Dissemination, 1998[69]; Fox and Hawton, 2004[3]).

The main interventions that have been evaluated are:

- brief psychological therapy (problem-solving therapy)
- more intensive but conventional psychiatric care (special clinics, outreach, continuity of therapist, routine general hospital admission, longer-term contact)
- crisis cards
- intensive psychological therapy (dialectic behaviour therapy, inpatient therapy)
- drug therapy (antidepressants, flupenthixol).

This literature is however limited. It is largely based on studies on people attending hospital accident and emergency services which, as previously noted, is only a proportion of young people who self-harm. Most of the literature focuses on self-poisoning rather than other forms of self-harm such as cutting, burning or bruising. Although there is some overlap between these behaviours they are not identical. The Inquiry commissioned the Scottish Development Centre for Mental Health and the Research Unit in Health, Behaviour and Change to review the literature on self-cutting. This review found that there is remarkably little on effective therapeutic interventions; Derouin and Bravender (2004)[70], in their review of the phenomenon of self-mutilation among adolescents, comment that evidence-based treatment approaches for people who repeatedly cut themselves have not been documented, while Fox and Hawton (2004)[3] also found no UK-based controlled intervention studies of people who engaged solely in self-cutting.

It is also extremely difficult to reach any conclusions about effective interventions from these studies. For one thing, they examine different types of intervention, with widely varying study populations (typically small numbers from selected sub-populations rather than community based normative populations). For another, different studies focus on different issues (for instance: reducing depressive symptoms, enhancing problem-solving skills, controlling self-harm or encouraging of individuals to use services during a crisis). In addition, the majority concentrated on reductions in incidents of self-harm (and in fact no intervention produced a statistically significant reduction in repetition) rather than mood, or quality of life, or what the people involved themselves wanted to achieve. Despite the limited evidence base, the three forms of intervention described below seem promising:

Crisis cards

In a Bristol-based study (Morgan, Jones and Owen, 1993)[71] - which focused on people who had taken a first drug overdose - people were given cards which enabled the holder to speak to a psychiatrist at short notice and to request psychiatric admission in a crisis. Although the majority did not take up the services on offer on the card, there was some evidence to suggest that the cards reduced the repetition of the behaviour. It is possible that a similar approach might be effective for people who have self-harmed for the first time. It should be noted however that the average age for this group was 30, and one attempt to copy this scheme has not had such good results (*Evans, Evans, Morgan, Hayward and Gunnell, 2005*)[72]. However, it is clearly a good idea to give people who attend hospital after an episode of self-harm advice about local services that they can use either in a crisis or when they are contemplating self-harm

Problem-solving therapy

This is a brief treatment aimed at helping the individual to acquire basic problem-solving skills, by taking him or her through a series of steps: identifying personal problems; constructing a problem list which clarifies and prioritises them; reviewing possible solutions for a target problem; implementing the chosen solution; reappraising the problem; reiterating the process; and learning problem-solving skills for the future (D'Zurilla, 1986)[73]. This usually involves about six one-hour sessions, with some reading and other work between sessions. It can be delivered by any experienced mental health professional, with suitable training and supervision.

Problem-solving therapy has been shown to be an effective treatment for improving depression, hopelessness and poor problem-solving in other settings (D'Zurilla, 1986[73]; Salkovskis, Atha and Storer, 1990[74]; Townsend et al, 2001[75]) and in self-harm studies it has led to improvement in other relevant outcomes such as mood and social adjustment (House, Owens & Storer, 1992)[76]. It may therefore be suitable for some individuals, although the existing evidence does not make it completely clear how widely it could be applied, and further work is needed to build up an evidence base around this type of therapy generally.

Dialectic behaviour therapy

This particular therapy was introduced as a method of helping those who engage in chronic repetitive self-harm, particularly when they have associated borderline personality characteristics (Linehan, 1993)[77]. It is intensive: the full form involves a year of individual therapy, group sessions, social skills training and access to crisis contact. It has provoked a lot of interest, as there is some evidence to suggest that it reduces self-harm in a group of people for whom services generally have little or nothing else to offer; but this evidence does not at the moment demonstrate that it is both widely applicable and cost effective.

Case study: ZEST

ZEST's philosophy is that all self-harm can be traced back to tensions within family relationships. The organisation does not concentrate on the self-harm, but what lies beneath it. It operates on the basis that young people need to talk about family dynamics and that all parties need to change if the self-harm is to stop. Before anyone starts therapy, their levels of distress are measured and their progress is checked three months later.

In 2004, ZEST counselled 560 individuals through its team of clinically supervised 18 volunteer psychotherapists. It also assisted some 800 professionals and ran information sessions for an additional 600 children (its schools pack was developed in consultation with young people and is produced by the local Department of Youth and Community Work). The organisation works closely with other agencies, including schools, and takes part in case conferences.

ZEST has now expanded to three members of staff in response to increasing demand for its counselling and training services, both in Derry and beyond. A project worker has begun to run clinics in three other locations in Northern Ireland and ZEST is seeking to address the needs of people in more isolated communities through an email service. In the longer term, it hopes to develop a family group work project that will include residential weekends.

For further information, please contact Noella McConnellogue, ZEST, 15 Queen's Street, Derry, DT48 7EQ. Telephone: 028 7126 6999 or email: zestni@yahoo.co.uk

Other medical treatments and interventions

A number of other treatments and interventions have been used in work with young people who self-harm. However, although there is a substantial amount of literature on these various forms of treatment in relation to other conditions they have not been sufficiently evaluated in relation to self-harm.

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy is based on the assumption that the way an individual interprets events and experiences affects the way they feel and behave. Individuals develop automatic patterns of thinking which can be distortions of reality, which in turn can lead to maladaptive coping mechanisms, such as self-harm. The therapist aims to change the individual's cognitive processes using techniques that are similar to those used in problem-solving therapy but may also include behavioural techniques.

Family therapy

Family therapy is a branch of psychotherapy that treats family problems. Family therapists consider the family as a system of interacting members; the problems in the family are the result of the interactions in the system rather than the 'faults' or psychological problems of individual members, and the focus is on resolving conflict and improving communication within the whole family. Anecdotal evidence to the Inquiry suggests that family therapy may be a useful intervention for some young people who self-harm. Again, however, there is not an evidence base at this time to support this.

Harrington et al (1998)[78] carried out a randomly controlled case study on adolescents under 17 who had self-poisoned and been admitted to four hospitals in Manchester. Unfortunately, no significant differences were found in those who were allocated a intensive intervention rather than standard aftercare. The authors conclude that brief forms of intervention are only likely to be effective in subjects without major depression. More intensive forms of family intervention may be more effective, but this has yet to be rigorously assessed (Harrington et al, 2000)[179].

Core values

The evidence and testimony submitted to the Inquiry demonstrate a number of good practice and learning points which the Inquiry thinks all services working in this area should consider adopting. These include:

- Full involvement and consultation with clients/residents to ensure that service delivery is well-grounded in the views of young people who self-harm
- A clear underpinning approach or philosophy: that is, a working definition of what self-harm means and of the reasons why young people self-harm, and services based on this thinking
- Clear and consistent service provision goals/objectives – including short term plans and long term goals, and a clear knowledge of what the service can offer
- Comprehensive training for all members of staff specifically on self-harm, with appropriate debriefing/supervision procedures built into day-to-day work and clinical supervision where appropriate
- Outputs and outcomes that are collected and monitored – in other words, an ethos of action research and self-reflection. These data makes it possible to see what works and why, and modify or enhance the service
- Integration with a very broad range of other services that are relevant to young people and families .

3. Young people's views from the Inquiry consultation sites

Personal testimonies

A fundamental element of the Inquiry was young people's own thoughts and experiences of interventions – what works or does not work.

'People who listen and respond in a natural way – showing concern and wanting to support you. Long-term relationships with workers rather than offers of time-limited work provide continuity and the chance to build rapport. I'd also like to see more voluntary sector crisis houses so there is an alternative to hospital when self-harm becomes unmanageable. At these times I want someone to talk to on a daily basis, sometimes to have 24-hour access. Cutting or overdosing and needing to go through A & E can be traumatic and I'd ideally have someone like an advocate or my support worker to go with me. I want workers to be more concerned about me – genuinely – than to only be thinking about risks.'

'The key to working with young people who self-harm is acceptance, care and interest. …having the opportunity to discuss what she does without the other person being embarrassed or shocked. It has helped her tremendously to read articles on self-harm and learn that she is not the only one in the world who does it – I think this is a very common feeling among harmers.'

'I've received the following: medication (paroxetine, olanzapine); cognitive behavioural therapy (dialectic behaviour therapy); hospitalisation; and help from Samaritans….I'm one of the highly fortunate ones. I've stopped hurting myself. This was only achieved through a lot of help from a psychiatrist and a chartered clinical psychologist. More of them are needed in the NHS. Waiting lists are long to gain access to their services.'

The only staff who helped were those that knew self-harm was a positive thing – a way of staying alive… A mental health liaison nurse or team is vital for A & E – I think the attitudes of the nurses in my local hospital arise from ignorance, fear and being overwhelmed with a situation they would do little about….A quiet 10 minutes, decent out of hours help – not anonymous phone lines but shifts of staff you can get to know. Un-judgmental, well taught by informed people who have met survivors of the system and known research centres which tailor treatment to individuals …Learning to recognise when you are vulnerable, what your triggers are – and have people – nurses, social workers, doctors, whatever – whoever just care and not giving up.'

Harm minimisation

Professionals who have presented to the Inquiry and the young people involved in the Inquiry's consultation sites have frequently discussed the issue of tolerating self-harm while young people are engaged in services. For many young people wanting to stop, or significantly reduce their self-harm, it is a long and slow process, even when they are using services. Their self-harm has often become an entrenched maladaptive coping mechanism that requires to be replaced with more positive mechanisms –young people need time to learn and become used to using these alternative strategies for dealing with difficult life circumstances and emotions.

Professionals who gave evidence to the Inquiry had mixed, but usually strong, feelings around self-harm. Testimony from nurse specialists working in psychiatric services, evidence from the Prison Service, and from organisations offering sheltered accommodation highlighted the point that some young people will continue to use self-harm as a coping mechanism and/or a way of expressing their emotions. These professionals do not condone self-harm but appreciate that the young people need time and appropriate support to be able to move towards more positive coping strategies.

Clearly this raises legal issues for services and individual practitioners (see section on legal issues in Chapter 3 and the full legal advice commissioned by the Inquiry on it's website www.selfharmuk.org) and issues around professional codes of practice. Essentially the legal advice commissioned by the Inquiry is that services and individual practitioners should be able to demonstrate defensible practice. This means that they have acted on any advice from other professionals who might be involved and that they themselves have undertaken an appropriate assessment of the risk to the young person so that they can ascertain the least invasive interventions that will address the identified risks.

> *'The most important thing is not to tell people to stop, but to listen to them, find out what they need to stop and help them find ways of achieving that. This way people heal in their own time. Telling people to stop makes them more secretive, more dangerous, and more dishonest about it. People need to not feel threatened by people that are ultimately trying to help them.'*

A wide range of testimonies to the Inquiry – especially those from residential or institutional settings - made it clear that removing the usual means of self-harm (whether physically removing the 'tools' or through a contract between the young person and the professional to abstain from self-harm while they are engaged with the service) only makes the self-harm worse. People who are determined to self-harm invariably find alternatives, which will quite possibly be more dangerous and possibly lethal (which is particularly evident from the experience in prison settings). The issue of 'duty of care' is important for the Inquiry. There is likely to be a direct conflict between the professionals' legal duty to protect and minimise harm towards the young people they look after versus the individuals' perception that they have the right to hurt themselves, as either a form of control or expression in their lives, and that by removing the normal 'tools' they use may intensify their behaviour.

The Prison Service has recently won a case against an individual adult male who wanted the service to provide him with sterile razor blades. He asserted that he had the right to engage in self-harm as he used self-harm for a number of years as a means of coping with stress, and argued that if the service prevented him from doing so it was in effect creating a set of circumstances in which he was more likely to commit suicide. Although this prisoner's argument is consistent with a harm minimisation approach, the judgment in this case was that 'his best protection from his illness, consistent with the policy of protection which must be given to him, is that he should not be provided with razor blades and that there should be a measure of supervision to prevent him self-harming in any other way that he might, by ingenuity, devise….it flies in the face of civilised standards of behaviour'.

Summary of key findings

Fortune et al's (2005)[44] research indicates the difficulty faced by services and individuals in delivering services that young people who self-harm will engage with. The vast majority of the adolescents surveyed felt that they could cope on their own, and therefore did not need to engage in services; or that services would not understand and respond appropriately.

The Inquiry's own questionnaire findings highlight the fact that if young people do seek help and/or advice, they predominantly talk to their friends, although they also sought out a wide range of individuals and organisations for advice and/or support. On the whole the respondents felt that the contact had been helpful: relatives were the least helpful and voluntary organisations the most. The type of support they found most helpful was face-to-face contact.

The Inquiry heard evidence from various organisations that deliver different types of services for young people who self-harm, across the UK. These projects and services offer a number of different approaches, and illustrate how a 'one size fits all' model of working is not appropriate or helpful. Young people appear to benefit very much from some of these approaches, although to date there is not a strong evidence base to support them.

A number of different approaches have been taken in an attempt to intervene and/or 'treat' individuals who self-harm. Systematic reviews evaluating the effectiveness of various interventions after incidents of self-harm have been published, but are limited in several ways: data are based mainly on hospital presentations; the majority of research has investigated self-poisoning alone; most of the literature covers late adolescence through to middle adulthood, with no specific focus on younger people; and none of the literature examines different approaches or treatments for different populations (such as black and minority ethnic young people, or lesbian, gay, bisexual or transgender young people). Further research is needed to fill these gap.

Out of those few interventions which have been evaluated to date, three appear be promising: crisis cards (or green cards), problem-solving therapy, and dialectical behaviour therapy.

Research carried out by Fortune et al (2005)[44] highlights the particular importance of peers, family and the school environment. The young people surveyed suggested that having someone to talk to, who would listen to their problems and who was accessible at home or school, was the best way to prevent young people from feeling that they wanted to hurt themselves.

CHAPTER 5: RECOVERY

Many professionals and organisations working with young people who self-harm equate recovery with ending self-harm. Evidence to the Inquiry however indicates that many young people equate recovery with finding the appropriate support and advice to move forward, positively, in their lives and away from points of crisis and difficult life circumstances. This final chapter explores the recovery process from young people's perspectives, in order to establish how services can best engage with young people and help them deal with (and ideally reduce or cease) their self-harm.

> *'Young people want quotes or advice from people who have suffered from self-harm (especially people who have beaten it for encouragement) because it makes the advice more valid to know they've experienced it all and know what they're talking about.'*

> *'Self-harm is a substitute, short lived relief always ending in pain of every kind. Yet the fear of the long haul, the tiresome journey towards inner peace is enough to, more frequently than not, make you cling to it. I am hopeful that I will complete the trek, that there will be a positive conclusion. I am also aware that I may stumble…..on that perilous path. But, I feel, as long as my direction is forward I am content.'*

Self-harm which stops as the young person grows up

Some young people appear to reduce, and then finally stop, their self-harm gradually over time – without any formal interventions or prevention strategies from professionals or organisations. This may reflect changes in the young person's environment – as the result of moving home, changing schools, finishing examinations, going to university, changing jobs and/or changed financial circumstances – which have the effect of alleviating the underlying problem that caused them to self-harm. This is particularly relevant to the young people whose self-harm stems from multiple, interlinked causes: once one or two of the original factors (such as their family situation, or bullying at school) are removed, they may be in a position where they do not feel they have to use self-harm as a coping strategy.

Chapter 4 has already described how a striking number of young people responded to the question *'Why didn't you try to get any help afterwards for the problems that led you to take an overdose or try to harm yourself?'* by explaining that they felt that things had changed following their self-harm (see Fortune et al, 2005)[44]. Some young people, particularly girls, described a change in circumstances which could include a general sense of 'things moving on'. This narrative of change may also reflect a process of growing out of self-harm (Sinclair and Green, 2005)[80].

> *'My self-harm had been gradually slowing down after I turned 18, and when I left home to go to university I eventually stopped altogether. It was a very gradual process, and not one that I think I was even aware of at the time. It took a long time for me to come out of my denial and actually accept that cutting myself was not something "normal" people did when they were stressed or depressed. I don't think you can force somebody to stop: they have to do it of their own accord. You also have to look at what is going on behind the injury – I was depressed, and it was only when my depression lifted and I cheered up that I didn't want to do it any more! Going to university completely changed my life for the better, and opened my eyes to the world – there's no point sitting in your room on your own, being depressed, when there's new people to meet, things to do, places to go. I think just being out of the environment that triggered my self –harm, away from my family, also helped.'*

'Realising that time passes and that in time things do get better. However, it did take me five years to realise this.'

'Recognising that the moment will pass, that not everything is locked up in that moment and that it will be all right.'

'I gradually realised that it did not solve any of my problems. Also my mood lifted slightly and I no longer felt the compulsion so strongly.'

'The first few months were extremely difficult; I had to train myself out of turning to self-injury whenever I felt I was in a situation that was out of my control, or that my feelings were out of control. With practice, this grew much easier. I stopped thinking about it all the time. After a year, I had no particular problem with overcoming the occasional urge to self-injure and thought about it rarely. Now, after three years, although I feel I could still do it in extreme circumstances, I am confident that I can find another way to cope. However, I do still very occasionally get extremely strong "triggery" episodes – almost like a craving, which can be very difficult to get through. I do not normally think about it, and when I do, it is usually in a dispassionate way. I am no longer affected by things that would formerly cause me to want to hurt myself.'

Learning new coping strategies/distraction techniques

For many of young people that the Inquiry consulted, the recovery process began with learning new coping strategies or implementing successful distraction techniques when they felt the urge to hurt themselves. This is an individual solution - different people need different distraction techniques, and individuals may need different techniques for different moods or situations. Finding the most useful and helpful technique/s takes time, but young people emphasise that trial and error *will* find something that works.

Giving it time

As Chapter 4 explained, many young people who do want to stop, or significantly reduce, their self-harm still find this is a long and slow process, even if they are engaged with services. Their self-harm has become an entrenched maladaptive coping mechanism that needs to be replaced with more positive mechanisms – it takes time to learn and absorb these alternatives to the point where they are automatically the first option when the young person is faced with difficult life circumstances and/or emotions.

'Writing down how I feel can sometimes help – I just write and write until the feeling of pain is less – it's like it is in the paper instead and then I keep re-reading what I have written. Sometimes I try ringing someone who doesn't know that I self-harm and just talking about anything, but I often find that when I need to self-harm, although I know I need to be with someone, I just want to be on my own. Sometimes it just distracts me for the length of time that I am doing something else. Recently I have found that if I put off doing it I can go a couple of days but then I often end up doing it anyway and I have got myself so upset by then that is worse than if I had just cut myself and let all of the feelings and badness out in the first place.'

'I have tried at various points in my life to stop self-harming and with varying degrees of success. I have found that self-harm can be quite addictive and consciously trying to stop completely can be self-defeating, as it increases the urges (like wanting a cigarette). I have found it more successful just to downplay the significance of self- harm in your life and try to find ways of focusing more intently on other (positive) things in your life – relationships, study, work. This has definitely been more successful for me than distraction techniques at the time that I actually want to harm, which I have never found to work. However even when I have successfully not harmed for a long period – up to 12 months – there have always come times in my life when the urges and ultimately the behaviour have returned, which I have not yet found triggers for (other than an increase in depressive symptoms – but again without obvious triggers).'

'On my first attempt to stop, I did not completely want to give it up, which in hindsight is why I feel I failed. At the urging of my boyfriend, I saw a (university) counsellor about it for a short time, which helped me understand why I harmed myself, but I did not take any further. Eventually, I decided to see how long I could go without it to try and see if my life was better not doing it I effectively went "cold turkey". This was unpleasant, but I succeeded. It required a lot of self-discipline and sheer stubborn will. This turned into an attempt to stop completely after about six months.'

'When I first decided to stop it was hard I was trying to do it without anyone knowing; this was before all my friends found out. So many times I longed to stop because I knew it wasn't the right way of coping – I was trying to stop my way of coping without replacing it with a new way. But I didn't know any other ways of coping: all I had learnt was to hurt myself. With my friends behind me I eventually got onto the path of recovery, though it wasn't easy! I had to keep explaining to different people what was wrong… my teacher, then a doctor, then a mental health nurse and eventually my counsellor. It was hard work because I'd never told anyone before, and to have to kept telling everyone was very hard and made things a lot worse. I never stopped the self-harming until I was at the end of my counselling. The counselling was tough stuff. I talked about the past, why I was hurting and had to come up with different ways of coping, I had to talk about myself which again I'd never done before. It made the self-harming worse but in the long run helped me to stop, and I still haven't harmed myself for eight months.'

The challenge for professionals

This testimony from young people demonstrates that their first priority is often a sense of general well-being – indeed, *managed* self-harm may well remain one of their coping strategies for some time. The whole process of stopping self-harm is often very long and difficult. It is important to identify, and acknowledge, other positive outcomes along the way.

This also means that young people urgently need the skills and support necessary to maintain positive mental health and emotional well-being (see chapter 2) and also to develop their own personal strategies for recovery if they have begun to self-harm. This could be provided by a combination of accessible information presented in a way that young people find sympathetic (such as through websites, posters, TV and radio advertisements, and campaigns in young people's magazines) backed up by school-based programmes of emotional support.

Summary of key findings

There is a need to clarify what is meant by 'recovery' in terms of self-harm. Some young people interpret it as *reducing* their self-harm as they tackle the underlying issues, using distraction techniques and minimising the damage that self-harm inflicts; others interpret it as completely *stopping* self-harm. Professionals need to be clear that many young people use this first interpretation: and that in any case recovery is a long, slow process and involves changing the circumstances which caused the young person to self-harm in the first place.

Some young people find that over time, their needs and/or circumstances have changed to the point where they do not feel that they need to use this maladaptive coping strategy. Others manage to learn new coping strategies for dealing with difficult emotions and/or circumstances, often by adopting successful distraction techniques which help them cope with the immediate urge to self-harm. This may involve some degree of self-harm, at least at the beginning. Again, all moves towards recovery usually take a long time. There is no 'quick fix'.

CONCLUSION

The Inquiry calls on government and service providers to affirm their commitment to putting the voices of young people who self-harm at the centre of policy and of service delivery. Some very good work is already going on in this field (this report has highlighted examples that the Inquiry looked at); but responses to young people who self-harm are still patchy, and many services and projects do not have the support and the resources that they should.

The research, personal testimony and expert opinion submitted to the Inquiry has demonstrated how far-reaching the issue of self-harm is for young people. The guilt and secrecy associated with self-harm impacts on their daily lives: their relationships; the clothes they wear; their interactions with their friends; and their sense of self-worth. If and when they do tell someone else about their self-harm, the whole issue is frequently taken completely out of their hands, and their previously secretive behaviour becomes common knowledge; at any point when they appear even slightly stressed, they are aware that everyone is watching them closely in case they self-harm again; and at worst their self-harm may cause them to be diagnosed with a mental health condition such as borderline personality disorder. Most importantly, the focus very often remains on the self-harm, not the underlying causes which have meant they feel they have no other option but to adopt this maladaptive coping strategy.

The Inquiry has established what the barriers are that prevent young people who self-harm from seeking support. The most fundamental one is the fact that many young people do not feel that the professionals they deal with, and/or the services on offer, are meeting their needs (or indeed even recognising what they need, if they are focusing solely on the self-harm). Services and individual practitioners need to become a lot more appropriate, accessible, and effective; and young people also need to be equipped with the skills to maintain their own good mental health, and to tackle self-harm as early as possible.

The voices of young people who self-harm have been the backbone of this report. Some of those young people have moved on from self-harm. Some of them, however, are still at a point where they feel that the only way they can negotiate crises and difficulties is through self-harm. At the same time, almost all those young people very much want to be able to move on, and stop their self-harm. They need, and they deserve, the best opportunities for making that happen.

Extract from Colchester Rape Crisis Line website

'Many people stop hurting themselves when the time is right for them. Everyone is different and if they feel the need to self-harm at the moment, they should not feel guilty about it - it is a way of surviving, and doing it now does NOT mean that they will need to do it forever. It is a huge step towards stopping when they begin to talk about it, because it means that they are starting to think about what might take its place eventually.' For further information, visit www.crcl.org.uk.

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Dr. John Coleman	Chief Executive, Trust for Study of Adolescence
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Katie Foulser	Founder & Director, Self-harm Alliance
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Dr. Mark Hamilton	A&E Physician, Hope Hospital, Manchester & Presenter, Sunday Surgery, Radio One
Nigel Henderson	Chief Executive, Penumbra
John Leaver	Association for Directors of Social Services, Mental Health Representative
Dr. Nicola Madge	National Children's Bureau, Research Unit
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Dr. Andrew McCulloch	Chief Executive, Mental Health Foundation
Graeme Sandell	Programme Director - Service & Practice Development, Mental Health Foundation

EVIDENCE PRESENTED TO THE INQUIRY PANEL

Evidence from meetings

Throughout the course of the Panel Meetings the Inquiry heard evidence from the following individuals and organisations:

Risk Factors & Models of Intervention

Lindsay Gilbert, Head of CHIPS UK, Childline
Angie Conroy, Colchester Rape Crisis Line

Prevalence & Correlates of Self-harm

Dr. Nicola Madge, National Children's Bureau
Prof. Keith Hawton, Centre for Suicide Research, University of Oxford

Educational Settings

Prof. Ron Best, Roehampton University
Sian Davies, NUS Students' with Disabilities (SWD) Officer
Chris Etherington, Royal College of Nurses Forum
Lindsay Gilbert, Head of CHIPS UK, ChildLine.
Joe Ferns, Emotional Health Promotion Manager, Samaritans
Benita Refson – Chief Executive, The Place2Be

Closed Settings (Prisons, Sheltered Accommodation, Secure Hospitals)

Anita Dockley, Assistant Director, Howard League for Penal Reform
Pat McAllister, Head of Network Service, The Foyer Federation & Anne Marie Lyons, Mental Health Co-ordinator for the Foyers in the South West of England
Steven Fox, National Development and Policy Officer, YMCA England.
Justin Hill, Deputy Chief Executive, YMCA Derbyshire & Jackie Callinan, Support Worker, YMCA Derby.
Bill Kerslake, Head of Policy for Health and Substance Misuse, Youth Justice Board
Sarah Day, Independent Schools Nurse, Chair, Royal College of Nursing
Dr. Anne Braidwood, Ministry of Defence, Director, Service Personnel Policy, Medical
Laila Namdarkhan, Director, Women In Secure Hospitals (WISH)

Medical Settings

Jane Blunclark, Clinical Nurse Leader, Crisis Recovery Unit, Bethlem Hospital, London
Dr. Gemma Trainer, Nurse Consultant, Adolescent Psychiatry Service, Bolton, Salford & Trafford Mental Health NHS Trust
Eileen McCafferty, Nurse Specialist, Adolescent Deliberate Self-Harm Team, Glasgow
Dr. Dick Churchill, Vice Chair, Royal College of General Practitioners, Adolescent Task Group & Lecturer in the Division of General Practice at the University of Nottingham Medical School
Tim McDougall, Nurse Adviser for CAMHS, Department of Health
Lord Victor Adebowale, Chief Executive, Turning Point
Dr. Tim Kendall, Deputy Director of the Royal College of Psychiatrists' Research Unit & Co-Director of the National Collaborative Centre for Mental Health
Prof. Sue Bailey, Chair of Children & Adolescent Psychiatry Faculty, Royal College of Psychiatry

Work from the independent sector – groups at risk

Gurpreet Virdee & Kamna Muralidharan, Newham Asian Women's Project
Gail Cunningham, Associate Consultant, Scottish Development Centre for Mental Health – BME Communities Project
Brian Houston and Margaret Johnson, Quarriers, Scotland
Kevin Head, LGBT Youth Scotland
Valerie Howard-Outram, Area Manager, Parentline Plus

Scottish initiatives

Anne-Marie Ward, Self-harm Development Manager, Penumbra
Pat Graham, parent
Gregor Henderson – Head of Mental Health Division, Scottish Executive
Linda Dunion (Director) – 'See Me' Campaign
Caroline Falkner, (Director) – Choose Life
Anne Clarke (Director) – Heads Up Scotland
Patrick Little, Co-ordinator, Self-harm projects, Penumbra

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Parentline Plus at http://www.parentlineplus.org.uk/

Julia Rose at HMP Brockhill – Hewell Lane, Redditch, Worcestershire, B97 6RD. Telephone: 01527 552 650 or
Louisa Snow, Suicide and Self-harm Prevention Consultant to the Women's Estate, Parliamentary, Correspondence & Briefing Unit, HM Prison Service Headquarters, Cleveland House, Page Street, London, SW1P 4LN.
E-mail: public.enquiries@hmps.gsi.gov.uk.

SIARI (Self Injury And Related Issues) at http://www.siari.co.uk/

Sarah Smith, Caterpillar Service, Barnardo's, Marlborough Road Partnership, Cardiff. Telephone: 029 204 97531.
Email: sarah.smith@barnardos.org.uk

Strong Minded Mental Health Service for Young Homeless People in Foyers on the
Foyer Federation website @ www.foyer.net

Gurpeet Virdee, Zindaagi Development Manager, NAWP, 661 Barking Road, London, E13 9EX.
Telephone: 020 8472 0528. Email: Gvirdee@nawp.org

Anne-Marie Ward, Penumbra's North Ayrshire Project, Self-Harm Development Worker, Ardrossan Youth Centre, Stanley Hut, Stanley Road, Ardrossan, KA22 7DH. Telephone: 01294 471 934
Email: anne-marie.ward@penumbra.org.uk

William Farr CE School, Lincoln Road , Welton, Lincolnshire, LN2 3JB
Telephone: (01673) 866900 E-Mail: wfarr@williamfarr.lincs.sch.uk Headteacher: Mr P. Strong BSc (Hons)

YMCA in Prisons at YMCA England, 640 Forest Road, London E17 3DZ Website: www.ymca.org.uk.
Email: enquiries@ymca.org.uk

Young Minds. (2005) Minority Voices at http://www.youngminds.org.uk/minorityvoices/index.php
Young Minds, 48-50 St John Street, London EC1M 4DG. Telephone: 020 7336 8445.
Email: enquiries@youngminds.org.uk

APPENDIX 1

The main government strategies and policies for England and Wales affecting children and young people

Every Child Matters: inspection, assessment and review of services for children and young people (Ofsted, 2004)
This is the cross-government strategy for ensuring that all children are healthy and safe; enjoy and achieve; make a positive contribution; and achieve economic well-being.

Children Act 2004 (DfES, 2004)
The Act provides the legislative underpinning for the wider strategy for improving children's lives. It covers universal services which every child accesses, and more targeted services for children with additional needs. The overall aim is to encourage integrated service planning, commissioning and deliver; improve multi-disciplinary working; remove duplication; increase accountability; and improve the coordination of individual and joint inspections in local authorities.

National Service Framework for Children, Young People and Maternity Services (DH, 2004)
This is a structured programme of interventions to support parents and meet the needs of all children from birth to adulthood. Standard 9 covers the mental health and psychological well-being of children and young people.

Youth Matters (DfES, 2005)
The green paper outlining a strategy for providing young people with opportunities, challenges and support and helping them achieve the five Every Child Matters outcomes. It also sets out the government's intention that all schools offering extended services, and reaffirms the commitment to develop up to 240 full service extended schools – at least one in each local education authority – by 2006. An extended school is likely to be open to pupils, families and the wider community throughout the school day, before and after school hours, at weekends and during school holidays. The services on offer could include childcare, learning, recreation and also health and social care.

Choosing Health: Making Healthy Choices (2004)
This report talks about underpinning principles and overarching priorities across the board for everyone stating that good mental health is crucial to good physical health and making healthy choices.

Healthy Living Blueprint for Schools (DfES, 2004)
This has five key objectives including promoting a school ethos and environment which encourages a healthy lifestyle; provides high quality physical education and school sport; promotes physical activity as part of a lifelong healthy lifestyle; and to promote an understanding of the full range of issues and behaviours which impact upon lifelong health.

Promoting Emotional Health and Well-being through the National Healthy School Standard (HDA/DfES/DH, 2004)
Promoting emotional health [is now an essential criterion for healthy school

Personal, Social and Health Education (PSHE) (DfES, 2004)
This aspect of the National Curriculum aims to give children and young people the knowledge, skills and understanding they need to lead confident, healthy and independent lives, by helping them to understand how they are developing personally and socially and tackling many of the moral, social and cultural issues that are part of growing up. However, individual schools decide their own topics and ways of delivering PSHE.

Health and Safety Executive Management Standards for Work-related Stress
These standards are currently recommended, rather than mandatory, although a strong business case is made for adopting them.

Pathways to work: helping people into employment (DWP, 2002)
This outlines the targeted assistance on offer for supporting people on incapacity benefit back into work.

Mental health and employment in the NHS (DH, 2002)
The framework for ensuring that the NHS adopts a positive approach to employing people with mental health problems.

The main government strategies and policies for Scotland affecting children and young people:

Integrated Community Schools (ICS)
This policy is an integral part of the Scottish Executive's wider Social Inclusion Strategy. A range of professionals including teachers, social workers, health professionals and others work together in a single team in integrated community schools, with the interests of the individual child at the centre.

The National Project for Children and Young People's Mental Health: HeadsUp Scotland
This is part of the national programme for improving mental health and well-being. It was established by the Scottish Executive in April 2004 to contribute to the range of activity already underway in Scotland to improve the mental health and well-being of children and young people. It is intended to ensure that children, young people, parents and carers are involved; develop and deliver guidance to support local work on this issue; and develop and strengthen partnerships to improve the infrastructure for children and young people's mental health.

APPENDIX 2

Information available to parents

A number of organisations have developed appropriate information for parents/carers of young people who self-harm to try and help them deal with this issue (e.g. SIARI, Bristol Crisis Service for Women, Rethink, Young Minds). See below for a particular example from SIARI's website:

Introduction
From a bystander's viewpoint self-injury can seem incomprehensible and pointless. It's a complex phenomenon, and it's not unheard of for people who engage in the act to feel confused about why they do it. Self-injury serves many different functions, and often there is an overlap. However, in a nutshell, one of the primary reasons people self-injure is to alleviate acute emotional pain. The reason they choose this method is because they lack the skills to express their emotions in a healthier way. In other words, self-injury is a maladaptive coping mechanism which temporarily makes people 'feel better' and more able to cope with life.

Safety Issues
If you discover your daughter or son is self-injuring, first and foremost, try to remain calm (even if you don't feel calm). Getting angry, shouting, or being judgemental is likely to aggravate the situation. If his or her wounds are fairly minor, provide a sterile gauze bandage or plaster, and a dose of 'tender love and care'. If the wounds are deeper, or won't stop bleeding, they may need stitching and should be seen by a health care professional. It's also important to recognise that even though your son or daughter's wounds are self-inflicted, he or she may well be in a state of shock. Apply firm, direct pressure to the cut with a sterile bandage, clean cloth or paper towel to stem the flow of blood, and seek advice from your GP, take your daughter or son to casualty or, if necessary, call an ambulance.

Generally
Strive to be accepting and open-minded, let your daughter or son know you are there for them, and reassure them that they are loved. Provide an ear to listen, a shoulder to cry on, a hand to hold, and focus on the person not the injury. Assure them that it's okay to talk about their need to self-injure, and reassure them that they have your support even if you don't understand why they are doing it or what they are going through. Offer to assist them in seeking professional help; e.g., GP, counsellor, therapist, or community psychiatric nurse, but avoid taking control—many self-injurers struggle with control issues. Endeavour not to take it as a personal affront if your son or daughter cannot talk to you because you are too close.

Avoid giving ultimatums; e.g., 'stop or else . . . ' as they rarely work, and may well drive the behaviour underground, or prompt your daughter or son to turn to more dangerous methods to hurt themselves. Self-injury has a highly addictive quality about it, and if a person feels the need to self-injure they will normally find a way, come what may. It is important that the decision to stop comes from the person themselves.

Educate yourself
There are a growing number of useful books on the topic of self-injury as well as some informative websites. Educating yourself on the subject can go a long way towards helping you become a more understanding and productive support person.

Dealing with your own feelings
Be honest with yourself about how your daughter or son's self-injury is affecting you. It's not unusual to feel hurt, devastated, heartbroken, shocked, angry, sad, frightened, guilty, responsible, hopeless, or powerless. It's not easy knowing that a loved one is hurting him or herself, and it might be worth considering seeing a counsellor or therapist for yourself if you are struggling to cope with strong emotions or feel in need of support.
(extracts taken from www.siari.co.uk, June 2005).

APPENDIX 3

What support is available?

42nd Street
2nd Floor, Swan Buildings, 20 Swan Street,
Manchester M4 5JW
Helpline: 0161 832 0169

Basement Project
PO Box 5, Abergavenny, NP7 5XW
Tel: 01873 856 524
Website: www.freespace.virgin.net/basementproject

Bristol Crisis Service for Women
P.O. Box 654, Bristol BS99 1XH
National Helpline: 0117 925 1119
Website: www.users.zetnet.co.uk/bcsw/

Childline
Tel: 0800 1111
Website: www.childline.org.uk

Colchester Rape Crisis Line
P.O. Box 548, Colchester, Essex, CO3 3JX
Helpline: 01206 769795
Website: www.crcl.org.uk

LifeSigns
Website: www.lifesigns.org.uk

Mind
Tel: 08457 660 163
Website: www.mind.org.uk

National Children's Bureau
8 Wakley Street, London, EC1V 7QE
Tel: +44 (0)20 7843 6000
Email: selfharm@ncb.org.uk
Website: www.selfharm.org.uk/database

National Self-Harm Network
P.O. Box 7246, Nottingham NG1 6WJ
Email: info@nshn.co.uk
Website: www.nshn.co.uk

NHS Direct
Tel: 0845 4647
Website: www.nhsdirect.nhs.uk

Penumbra
Norton Park, 57 Albion Road, Edinburgh, EH7 5QY
Tel: 0131 475 2380
Email: enquiries@penumbra.org.uk
Website: www.penumbra.org.uk

Samaritans
Tel: 08457 90 90 90
Email: jo@samaritans.org
Website: www.samaritans.org.uk

YoungMinds
Tel: 0207 336 8445
Parents Information Service: 0800 018 2138
Website: www.youngminds.org.uk/selfharm

Zest
15 Queen Street, Derry, Northern Ireland, BT48 7EQ
Tel: 028 7126 6999
Email: zestni@yahoo.co.uk
Website: www.zestni.tk

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About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services.

If you would like to find out more about our work, please contact us.

Mental Health Foundation
Sea Containers House
20 Upper Ground
London, SE1 9QB
020 78031100
www.mentalhealth.org.uk

Registered charity number 801130

Mental Health Foundation

About the Camelot Foundation

The Camelot Foundation is one of the UK's most imaginative grant making foundations. With an annual donation of £2 million from Camelot Group plc, the Foundation works to support marginalised young people across the UK.

Using a combination of grant giving and direct programme development, the Foundation aims to make a real difference to the lives of the most disadvantaged young people and to show that they have a positive role to play in shaping their own futures and the future of their communities.

Camelot Foundation
University House
11-13 Lower Grosvenor Place
London, SW1W 0EX
020 7828 6085
www.camelotfoundation.org.uk

Registered charity number 1060606

Camelot Foundation
developing•learning•changing

For more information about the National Inquiry into Self-harm among Young People visit:

www.selfharmuk.org

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