Self-harm: local identification of needs

City of York Council

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EXECUTIVE SUMMARY

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

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

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

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

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

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

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

- To strengthen the identification and recording of self-harm related problems that do not result in a hospital admission. This will establish a baseline measurement of the extent of the issue and help raise the focus on the importance of accurately being able to identify self-harming behaviour. Without being able to accurately identify how much self-harm is happening it is not possible to demonstrate a suitable response to it.

- To develop and enhance a local offer of information, advice and training to key staff groups and people most at risk of self-harm. This will reduce barriers to people who self-harm seeking help and improve the ability of staff to be able to respond to self-harming behaviour and risks effectively.

- To be able to offer evidence based interventions that are effective in reducing self-harming behaviour and clear referral routes into this support. This would also contribute to removing barriers for people to ask for help.

- To seek assurance that appropriate and adequate pathways exist which allow people who self-harm to receive support. This would include clarity that; self-harming behaviour among adults is assessed and risk assessed by service providers; there are clear pathways into support where self-harming behaviour is identified which should include consideration of referral processes for adults and children from Emergency Department and referral from schools into CAMHS.

INTRODUCTION

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

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

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

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

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

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

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

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

Mental Health Foundation (2006).

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

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

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

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

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

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

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

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

NHS Tayside (2011)

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

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

Groups at risk

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

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

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

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

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

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

Local self-harm data

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

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

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

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

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

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

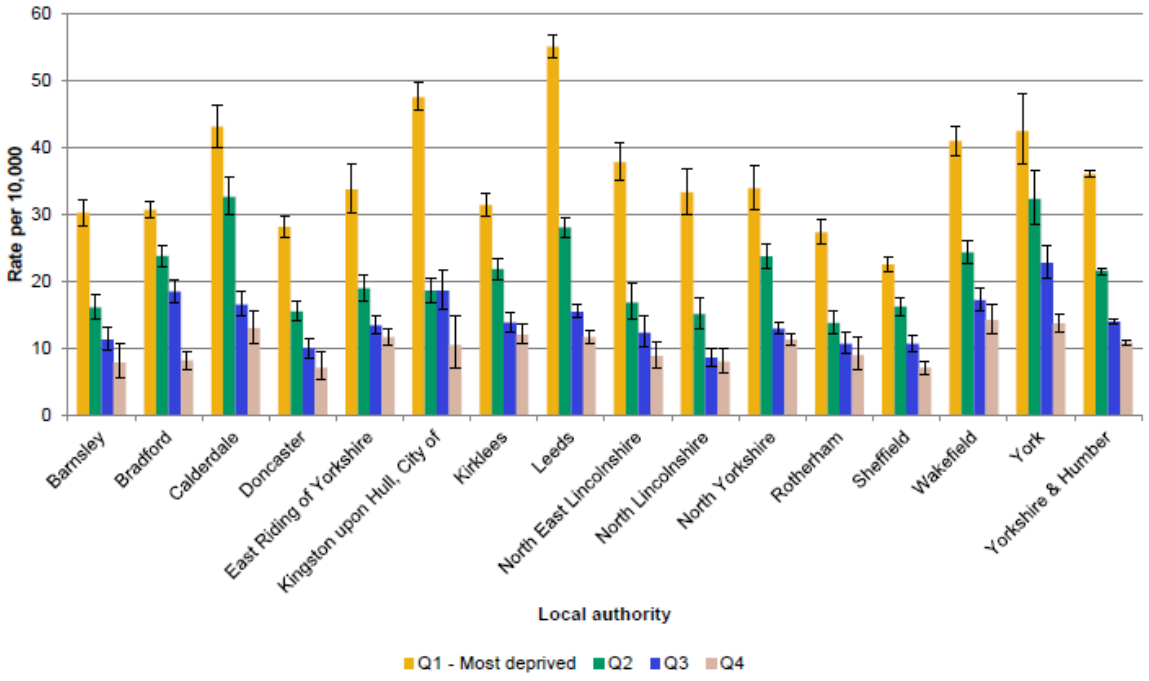
There are groups of people who are identified as being most at risk of self-harming behaviour. These are:

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

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

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

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



Source: Public Health England: Self-harm and suicide

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

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

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

Hospital admissions for self-harm by Local Authority ward area

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

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

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

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

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

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

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

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

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

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

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

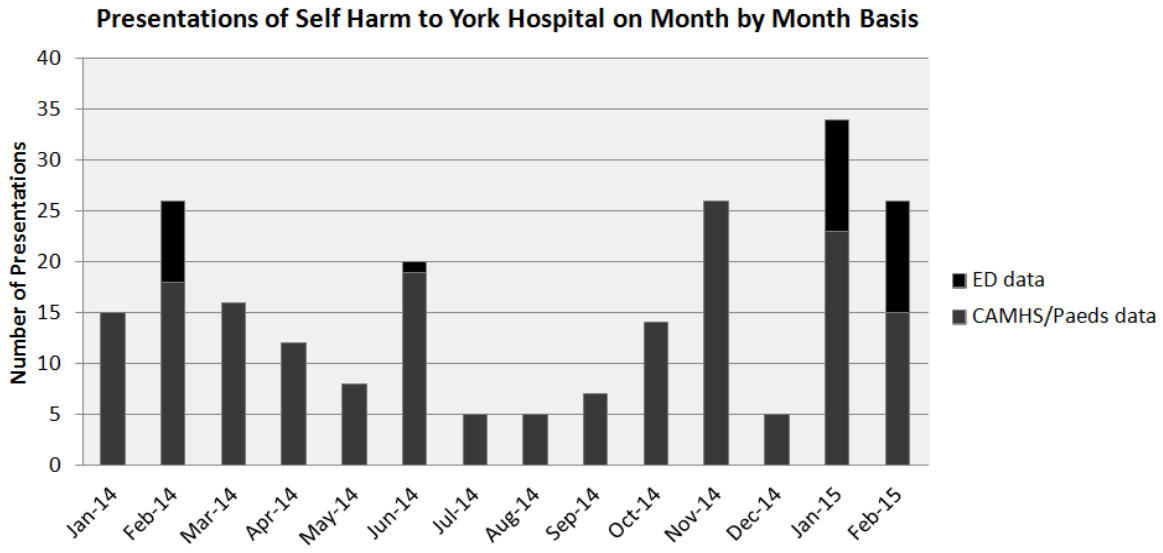
An audit into Child and Adolescent Mental Health Service (CAMHS) completed by Dr. Govenden and Dr. Sykes is summarised below.

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

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

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

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



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

Key findings were as follows:

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

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

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

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