East Sussex

Children and Young People Self-Harm Needs Assessment

(Prevention and Early Intervention)

June 2023

Contents

Acknowledgements

We would like to thank members of the JSNA Steering Group (below), as well as the contribution of colleagues from East Sussex Community Voice, Greta Anderson and Ed Peasgood.

Enormous thanks to the young people who helped design our community survey and focus groups. We are very grateful also to the young people who gave up their time to run and participate in the groups.

Finally, many thanks to Miranda Scrambler, Public Health Practitioner for her expertise in reviewing and commenting on the final draft reports.

Self-harm JSNA Steering Group
Ben Brown – Consultant in Public Health (Chair), Public Health, ESCC
Nicola Blake – Health Improvement Specialist, Public Health, ESCC
Clare Brown – Public Health Information Specialist, Public Health, ESCC
Sara Candler - Project Manager (Community Mental Health), ESCC
Sue Davies – Service Manager (CAMHS), SPFT
Hasarali Fernando - Visiting Public Health Trainee, Public Health, ESCC
Simon Hemmings - Professional Lead for Mental Health, East Sussex School Health Service, ESHT
Helen Murtagh - Designated Nurse for Looked after Children, CCGs
Judy Perraton - Schools Mental Health & Emotional Wellbeing Adviser (ISEND), ESCC
Helen Russell - Lead Clinical Quality & Patient Safety manager, Sussex CCGs
Gail Gowland - Named Nurse Safeguarding Children/Acting Head of Safeguarding (ESHT)
Viki Ashby - General Manager East Sussex CAMHS, SPFT
Catherine Dooley - Senior Manager, Safeguarding and Wellbeing (SLES), ESCC
Martin Komen - Senior Commissioner CYP Mental Health, NHS Sussex
Kenny MacKay -Strategic Commissioning Manager for Mental Health, ESCC
Neil Myers - GP (Peacehaven)

ESCC – East Sussex County Council

ESHT – East Sussex Healthcare NHS Trust

KCHT - Kent Community Health NHS Foundation Trust

SPFT – Sussex Partnership NHS Foundation Trust (mental health trust)

List Of Tables

List Of Figures

1. Executive Summary

Levels of Need

Self-harm in children and young people is a significant public health concern. Those who self-harm are at greater risk of poor outcomes such as enduring mental health problems, poor educational attainment, unemployment and suicide.

For most children and young people self-harm is a very private behaviour. This makes it difficult to be certain about current levels of need and to seek the views of those affected. According to the best locally available data, approximately 1 in 20 secondary school age children are self-harming regularly in East Sussex (at least once a week).

Local and national evidence indicates that the prevalence of self-harm has did not increase during the COVID pandemic. Secondary school survey data for school age children in East Sussex suggests the prevalence of regular self-harming behaviours in 2020/21 was similar to 2017 and hospital attendances appear to be fairly stable over this time period.

However East Sussex has experienced an increasing and significantly higher rate of self-harm admissions[1] than England and the South-East, and in the most recent year has the highest rate in Sussex.

It is also clear that the COVID pandemic has had a detrimental effect on the mental health of many children and young people, and that the most vulnerable pre-pandemic have suffered the most. There were record numbers of referrals to mental health services nationally during 2021 and the pressure on local services has not abated.

However, the evidence suggests that we were experiencing a longer-term trend of worsening mental health in children and young people's pre-pandemic, possibly related to issues such as academic pressure, increasing social media use, rising rates of family instability, growing concerns about the environment, and drug dependence.

It is important therefore that a preventative approach to mental health and self-harm addresses factors that were of concern to young people's mental health pre-

1 Admission refers to those young people who have been admitted to hospital following A&E attendance for self-harm

pandemic as well as with major life events that they may have experienced during the pandemic, such as having long COVID, interruption of service provision, spending a long time away from society when shielding, or losing a loved one.

Preventing Self-harm

There is a lack of evidence relating to prevention of self-harm before problems emerge (primary prevention). This is perhaps not surprising because our mental health is influenced by a complex interplay between the wider determinants of health, psychosocial factors, individual behaviours and physical health. Attempting to reducing inequalities in health and preventing self-harm, means understanding this complexity and the need for a multifactorial approach.

Despite this complexity, much is known about the risk factors for self-harm and these present clear and practical opportunities to make a difference. For example, by implementing whole school approaches to mental health prevention, tackling bullying, protecting children from online harms and helping young people with worries around school, relationships and family problems.

Early identification and help with problems should form the core of secondary prevention (as problems emerge). Recently published NICE guidance describes the role that a range of professionals can play, such as mental health workers, youth workers, teachers and GPs. This starts with a psychosocial assessment. A continued training offer is therefore key to ensure that adults who come into contact with young people whom self-harm feel confident and competent to respond positively. Many of the stakeholders we interviewed however felt that it was not always clear what they should be attempting within their role to help a young person or what guidance to follow.

Engagement with professionals

Stakeholders commented upon a wide range of issues relevant to prevention and early intervention, including the need to improve the early identification of children at risk and providing more early intervention support and services. The comments reflected longstanding challenges within the system, including limited funding, unhelpful thresholds for support and a perceived over-reliance on Child and Adolescent Mental Health Services to meet the range and extent of mental health burden in Sussex. The view of many was that there remains a need to address gaps between universal provision (e.g. teachers, GPs) and specialist mental health support.

There are however a number of services highly valued by both professionals and young people, such as iRock and the School Health Service and the growing

presence of Mental Health Support Teams. Partnership working was felt to be working well is some instances, such as developing tools, training, and protocols. However more can be done to work in partnership to reduce gaps and provide a more joined up response to children and young people in need.

Engagement with children and young people

Our engagement with young people as part of this needs assessment tells us that self-harm still carries an unhelpful stigma that can make problems worse and may prevent them from seeking help. For LGBTQ young people, who are at increased risk of self-harm, they may experience the additional burden of societal prejudice and injustice.

Encouragingly, very few young people surveyed viewed social media and influencers/celebrities as a trusted source of information on self-harm. However, young people are exposed to a variety of risks through the internet and social media and the potential for harm cannot be understated. For example, the East Sussex school survey data from 2017 showed that those who reported being bullied online/ smartphone app were 5 times more likely to be self-harming than peers who hadn't.

Young people were more likely to learn about self-harm through friends and were most likely to go to them first with difficulties. In terms of supporting peers, they were more likely to try and help themselves than encourage them to talk to an adult. This emphasises the need to ensure that young people are well equipped to support their peers but also, how and when to get help from professionals. Our survey suggests that awareness of some key (and highly regarded) sources of help could be improved, such as iROCK, School Health, E-motion and E-Wellbeing websites.

2. Recommendations

Our key recommendations are presented in two groups, 'strategic' and those provided by the young people who engaged with us as part of this needs assessment. Those from the young people are summarised below, with the full set presented in Sec 10.

From a strategic point of view, the findings and recommendations from this needs assessment will inform the implementation of 'Foundations for Our Future', the Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027 through its key priorities of,

- Prevention - addressing the issues that impact on mental health

- Early help and access to support
- Specialist and timely support to meet high and complex needs
- Support for life transitions

Together, these priorities should greatly improve our ability to prevent and respond to self-harm.

Strategic Recommendations

1. The multi-agency pan-Sussex Self-harm Learning Network is maintained to 1) co-ordinate the provision of training and health promotion activity to parents and professionals 2) disseminate learning and share good practice 3) review the recommendations of this report

2. Benchmarking work is undertaken by the East Sussex Mental Health and Emotional Wellbeing Partnership group to ensure the recommendations from children and young people are incorporated within local plans, to the satisfaction of children and young people.

3. Pan-Sussex work to enhance Real Time Surveillance for suicide is extended to self-harm, to make best use of ambulance, hospital and other sources of data.

4. The iTHRIVE conceptual framework for system change contained within the Pan-Sussex 'Foundations for Our Future Strategy' is used as the basis for establishing a consistent, responsive, integrated, needs led approach to those who self-harm.

5. The Self-harm and Suicide prevention strategy includes clear actions for pan-Sussex and local plans to prevent self-harm in children and young people, addressing clear risk factors such as bullying.

6. The East Sussex Healthy Schools Programme is widely supported, including participation in the annual 'My Health, My School' pupil survey.

7. The 'My Health, My School' survey data is shared widely to inform planning /commissioning and help schools develop their preventative approach to mental ill health.

Recommendations from Children and Young People

Education and learning

8. Mental health training should continue for all staff.

9. Schools and colleges should proactively explore self-harm behaviours as part of the PSHE curriculum and focus on healthy alternative coping responses. This should commence in schools at a much earlier age, from Year 7 onwards.

10. There is urgent work undertaken to reduce the stigma associated with self-harm through direct and relevant education and engagement with young people (and adults).

Pupil Involvement

11. A greater focus on pupils' voices in schools that see a whole-school commitment to listening to the views, wishes, and experiences of all children and young people. Schools need to place greater value on what young people tell them about their experiences.

12. We recommend lay-testing/mystery shopping of platforms and resources [for self-harm] to support accessibility, especially where focused on children and young people.

Peer support and families

13. There needs to be clear guidance for young people on how to safely support a friend and how to seek professional support. Information and advice needs to be readily available for friends who act as listeners and peer support mechanisms, including how to protect their own well-being and mental health.

14. Families and carers should receive support and targeted advice to boost their knowledge and confidence of how best to support someone who is self-harming (or at risk of self-harm).

Providing information and advice

15. More resources are needed to raise awareness of existing services and support mechanisms, including safe and trusted online resources.

16. Online websites and virtual resources should be more accessible and visually engaging, and to ensure that young people in crisis can easily navigate and interpret what they need to do to seek help depending on their needs.

17. Mental Health and mindfulness apps and self-care techniques should be encouraged to accompany support, but they should not be taken as a 'one-size fits all' cure.

18. Medical and other trained professionals should be the preferred ‘messenger‘ for education, engagement, and communication around self-harm.

Building trust

19. Trust should be cultivated and built upon; young people learning to trust professionals and seeing the opportunities that can be created will be further motivated to trust others within wider networks and support service.

20. Strategies to reduce self-harming should focus on improving transparency and communication with a trusted person or professional, avoiding secrecy and a culture of 'victim-blaming' where a young person then might shy away from talking about their self-harm and getting support.

3. Introduction

What is self-harm?

Due to complexity in its presentation and description (for example, non-suicidal self-harm, self-injury, or deliberate self-harm), self-harm can often be challenging to define. There is currently no single definition of self-harm; the most cited being:

> 'Self-harm is any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.'

National Institute for Health and Care Excellence (NICE)

> 'Self-harm is the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and/or self-neglect'.

The National Self-harm Network

Why do children and young people self-harm?

One of the challenges in the effective prevention and intervention of self-harm is the lack of clear understanding of the for the reasons that children and young people self-harm. A systematic review[1] of research looking at children and young people's non-suicidal reasons for engaging in self-harm, identified several key themes:

Table 1: Commonly reported non-suicidal reasons for self-harm.

Responding to distress	• Managing distress (affect regulation): managing painful, unpleasant emotional states, including making emotional pain physical and blocking bad memories • Interpersonal influence: changing or responding to how other thinks or feel; help seeking • Punishment: usually of self, but occasionally of others

	• Managing dissociation: either switching off or bringing on feelings of numbness and unreality • Averting suicide: non-fatal self-harm to ward off suicidal acts or thoughts
Self-harm as a positive experience	• Gratification: self-harm as comforting or enjoyable • Sensation seeking – through a sense of non-sexual excitement or arousal • Experimenting – trying something new • Protection: of self or others • Developing a sense of personal mastery
Defining the self	• Defining boundaries: self-injury is a means of defining or exploring personal boundaries • Responding to sexuality: through self-harm as creating quasi - sexual feelings and expressing sexuality in a symbolic way • Validation: demonstrating to self, and occasionally to others one's strength or the degree of one's suffering • Self as belonging or fitting into a group or subculture • Having a personal language, including one for remembrance: a means of conjuring up or acknowledging good past feelings or memories

NB: Excluded are psychotic explanations and rarer motives such as self-harm as a political statement

Self-harm as a significant public health issue

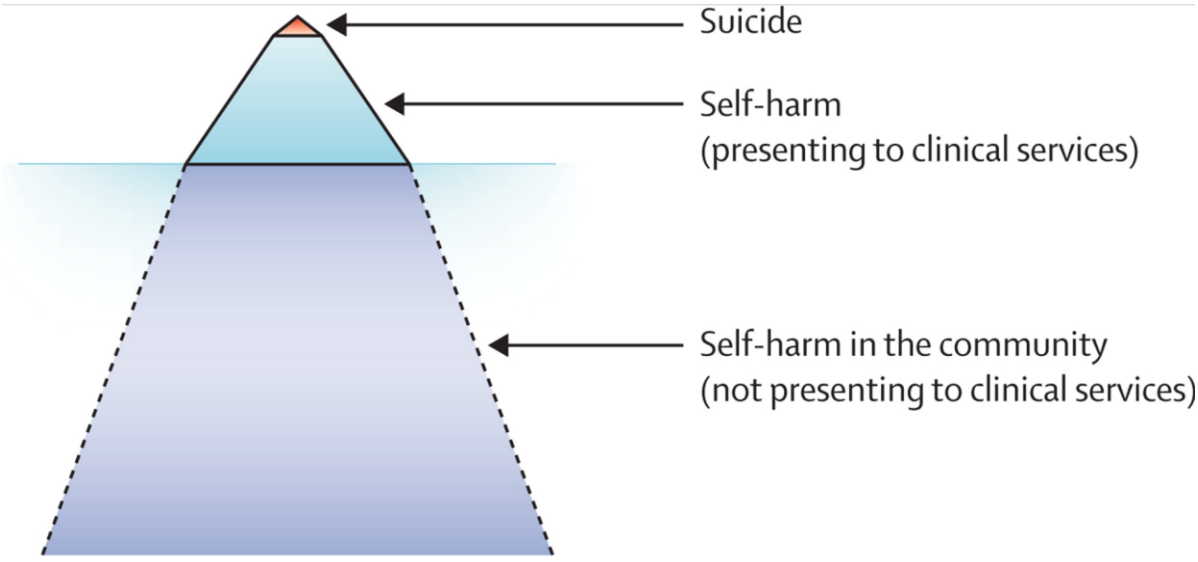
Self-harm can present in a variety of locations (e.g. home, educational, custodial, social care, and healthcare settings) and can result in adverse outcomes, including repetition of self-harm, suicide and mortality, mental health morbidity, poorer education and employment outcomes, and overall decreased quality of life[234]. Those who self-harm in mid to late adolescence potentially face an increased risk of developing mental health issues, as well as higher prevalence rates across a range of health risk behaviours in late adolescence and early adulthood; including increased likelihood of suicidal thoughts.[56]

The Iceberg model of self-harm

The incidence of self-harm in children and young people is often conceptualised in terms of an iceberg model with three levels: fatal self-harm (i.e. suicide), which is

an overt but uncommon behaviour (the tip of the iceberg); self-harm that results in presentation to clinical services (e.g. A&E), which is also overt, but common; and self-harm that occurs in the community, which is common, but largely hidden (the submerged part of the iceberg). Establishing the relative incidence of self-harm at these three levels is important to understanding the extent of the issue and in identifying the challenges for prevention and intervention.

Figure 1: Representation of the relative prevalence of self-harm and suicide in young people



In a retrospective study[7], national mortality statistics, hospital monitoring data and schools survey data were used to estimate the extent of fatal and non-fatal self-harm in adolescents aged 12–17 years in England. The research estimates that every year in England, approximately 21,000 adolescents aged 12–17 years present to hospital following self-harm, with 200,000 engaging in self-harm behaviours within the community and not presenting to clinical services (it is noted that the latter estimation does not take account of young people who reported self-harm in the community and also presented to hospital for self-harm).

4. Aims, objectives and scope

Aims

This overarching aim of this needs assessment is to identify, better understand, and produce a set of recommendations on how best the 'local system' in East Sussex can:

- prevent self-harm in children and young people (including primary and secondary prevention); and
- respond to and provide support for children and young people who are self-harming; specifically in terms of the identification and disclosure of self-harm, as well as the initial support provided by first contact services and professionals (i.e. early intervention).

Objectives

The objectives of this needs assessment are to:

- describe the size/extent of self-harm in children and young people across East Sussex through:
    - analysis of available data sources
    - Identifying the risk factors that increase the likelihood of children and young people self-harming and which children and young people/groups are most at risk
- understand the impact of COVID-19 on:
    - common risk factors for self-harm
    - those children and young people/groups most at risk of self-harm;
    - the need for, and provision of, early intervention support for children and young people who self-harm (or at risk of self-harm)
- understand the protective factors that reduce the risk of children and young people self-harming
- describe what works in preventing self-harm in children and young people
- gain the views of children and young people and professionals in relation to:
    - Their understanding/experience of self-harm prevention in children and young people
    - Their understanding/experience of early intervention support for self-harm (including identification).

Scope

The definition of self-harm agreed by the Children and Young People Self-Harm Improvement Strategy Steering Group for this needs assessment is set out below:

> 'Self-harm is when someone causes harm to themselves either by causing a physical injury, by putting themselves in dangerous situations and/or self-neglect'

However, it is noted that self-harm prevalence and service activity captured as part of this needs assessment does not specifically consider aspects of self-harm related to overeating, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself (e.g. hospital admissions due to eating disorders or referrals to the Children, Young People and Family Eating Disorder Service).

It is not within the scope of this needs assessment to seek the views of children and young people and stakeholders regarding their personal experience of self-harming behaviour or access to specialist mental health services.

Due to the ongoing work to implement the Foundation for Our Future Strategy[8] across Sussex and three local authorities, including adoption of the iTHRIVE framework[9] it was not feasible to undertake mapping of services within this needs assessment. This is partly due to the pace of change in service provision but also the likelihood for duplication. The needs assessment can however inform the way the strategy is implemented.

The scope of the needs assessment will include:

- children and young people (0-24 years) who live in East Sussex, who may identify as
    - currently not engaging in self-harm behaviours (or at risk of self-harm)
    - at risk of engaging in self-harm behaviours
    - currently engaging in self-harm behaviours
    - accessing (or having accessed) early intervention support/services for their self-harm

The needs assessment aligns with the Pan-Sussex iTHRIVE framework to support mental wellbeing, specifically the '*Thriving*', '*Getting Advice*' and '*Getting Help*' categories of need.

This needs assessment will focus on self-harm prevention and intervention, which includes:

- mental health promotion activities and approaches evidenced to prevent self-harm in children and young people
- the identification of self-harm in children and young people
- the initial disclosure of self-harm by a child or young person
- the initial response and early support provided by first contact services and professionals

With regards to the disclosure/identification of self-harm and initial support provided by first contact services and professionals, it is recognised that there are a multitude of different avenues through which this may occur and that a linear pathway does not necessarily exist.

Methodology

To help build a picture of children and young people's self-harm in East Sussex, specifically related to prevention, identification and early intervention, the following methodologies were utilised:

Multi-agency steering group: A Children and Young People Self-Harm Improvement Strategy Steering Group was established in November 2019. The purpose and responsibilities of the Steering Group were to:

- guide the scope, content and completion of the needs assessment
- bring knowledge, expertise and intelligence to inform the project
- ensure that all relevant voices are heard, including those of young people
- take a strategic approach to the issue, identifying strengths and assets, as well as gaps and challenges
- review written drafts of documents
- facilitate agreement on actions and recommendations with their own organisation

Literature review: A review of the evidence of risk and protective factors for self-harm in children and young people was undertaken, alongside a review of the evidence to understand what works in preventing self-harm in children and young people. See Appendix 1 for details of the methodology.

Self-harm prevalence and service activity data analysis: This includes analysis of hospital admission and A&E attendance data relating to self-harm in children and young people, alongside service activity data and data within local surveys completed by children and young people.

Survey and focus groups with children and young people: A self-harm survey for children and young people aged 16 to 24 years was administered by East Sussex Community Voice during February 2022. This survey, co-produced with young people, sought to gain a better understanding of young people's awareness of, and access to self-harm information, the role of support networks, and young people's views and experiences of the initial support they may have received in relation to self-harm. Eight focus groups were also undertaken with children and young people aged 13 to 25 years using a topic guide co-produced with young people.

Stakeholder interviews: Semi structured interviews were conducted with 24 stakeholders from a range of organisations and sectors, to include education settings, the Mental Health Support Team, Early Help, ISEND, Social Care, Clinical Commissioning Group, School Health Service, CAMHS and the Police. These interviews sought views and opinions on the early identification of self-harm, access to and delivery of initial support/first contact services for those who self-harm and what could be improved or done differently to reduce the number of children and young people who start self-harming?

Note: the timescales for the production of this needs assessment are far longer than is usual. This reflects the limited progress that could be made at times during the COVID pandemic. We have endeavoured however to ensure the information presented is as up to date as possible.

5. National And Local Policy Context

National Policy Context

In 2011, the mental health strategy, No Health without Mental Health set out plans to improve mental health outcomes for people of all ages. As part of a commitment to achieving "parity of esteem" between physical and mental health, an implementation framework described how different bodies, such as schools, employers and local authorities, should work together to support people's mental health. It recommended that schools promote children and young people's wellbeing and mental health and pledge to provide early support for mental health problems.

In 2014, the Department of Health published Closing the Gap: priorities for essential change in mental health. This outlined ambitions to improve access to psychological therapies for children and young people and support for schools to identify mental health problems sooner. In July 2014, a taskforce, led by the Department of Health and NHS England, examined how to improve child and adolescent mental health care. They subsequently published the Future in Mind report (March 2015) which highlighted the difficulties experienced by children, young people and their families in accessing mental health support and provided a blueprint for whole systems change. The report set ambitions for improving care over the next five years, including making better links between schools and specialist services. Key objectives included:

- tackling stigma and improving attitudes to mental illness
- introducing more access and waiting time standards for services
- establishing 'one stop shop' support services in the community
- improving access for children and young people who are particularly vulnerable.

In August 2015, it was announced that £75 million would also be allocated to support Clinical Commissioning Groups (CCGs) to work with local partners to develop local transformation plans to overhaul mental health services for children and young people in their areas. Local Transformation Plans covering all 209 CCGs were developed setting out how local agencies would work together to improve children and young people's mental health across the full spectrum of need.

Additionally, the Government committed to implementing the recommendations made in The Five Year Forward View for Mental Health (February 2016). This identified children and young people as a priority group for mental health promotion and prevention, early intervention and timely access to good quality care. In December 2017 the Green paper Transforming children and young people's mental health provision

was published for consultation; this set out measures to improve mental health support, in particular through schools and colleges. Proposals included to:

- incentivise and support all schools and colleges to identify and train a Designated Senior Lead for mental health.
- fund new Mental Health Support Teams, which will be supervised by NHS children and young people's mental health staff.
- pilot a four week waiting time for access to specialist NHS children and young people's mental health services.

The Government's response to the consultation, published in July 2018, committed to taking forward all proposals in the Green Paper, with certain areas trialling the three key proposals in 2019.

The NHS Long Term Plan sets out key priorities for the NHS in England over the next ten years. The Plan (published in January 2019) restated the commitments set out in The Five Year Forward View for Mental Health to improve access to mental health treatment for 70,000 more children and young people and set out further measures to improve the provision of, and access to, mental health services for children and young people, including:

- a commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending
- extra investment over the next 5 years in children and young people's eating disorder services.
- continued investment in expanding access to community-based mental health services to meet the needs of more children and young people; and
- the NHS to work with schools, parents and local councils to embed school and college-based mental health support for children and young people.

In March 2017, the government announced its intentions as part of section 34 of the Children and Social Work Act 2017 to introduce statutory 'Relationships and Sex Education (RSE)' across all secondary schools, including academies and independent schools; and statutory 'Relationships Education' across all primary schools in England. In July 2018, the Government announced the further introduction of statutory Health Education (rather than PSHE education in its entirety), and published draft statutory guidance on RSE and Health Education, with a consultation on the guidance running until November 2018

Following consultation, final statutory guidance on Relationships Education, Relationships and Sex Education (RSE) and Health Education was published by the Department for Education (DfE) in June 2019, with schools able to implement the changes from September 2019 should they wish. Whilst this statutory guidance

came into force on 1st September 2020; due to the disruption caused by the coronavirus pandemic, schools were able to delay the introduction of the new requirements until summer 2021 should they not be ready to begin teaching the revised subjects in the current circumstances. The statutory guidance sets out proposed requirements for health education. The requirements cover physical health and mental wellbeing, and it makes clear that the two are interlinked.

At primary level, pupils are expected to learn:

- that mental wellbeing is a normal part of daily life; that mental ill health is common and can often be addressed effectively.
- that there is a normal range of emotions
- how to recognise and talk about their emotions, judge their own feelings, and where and how to seek support.
- the benefits of things like physical exercise, time outdoors, and how to use simple self-care techniques.
- that bullying has a negative and often lasting impact on mental wellbeing.

At secondary level, pupils should be taught:

- how to talk about their emotions.
- that happiness is linked to being connected to others.
- how to recognise the early signs of mental wellbeing concerns.
- common types of mental ill health (e.g. anxiety and depression).
- how to critically evaluate when something they do or are involved in has
- a positive or negative effect on their own or others' mental health.
- the benefits and importance of things like physical exercise, time outdoors & community participation

In May 2021, the Government announced more than £17 million to improve mental health and wellbeing support in schools and colleges, to help them recover from the challenges of the COVID-19 pandemic. Up to 7,800 schools and colleges in England were offered funding worth £9.5 million to train a senior mental health lead, part of the Government's commitment to offer this training to all state schools and colleges by 2025. Funding also included a new £7 million Wellbeing for Education Recovery programme, to provide training, support and resources for staff dealing with children and young people experiencing additional pressures from the last year – including trauma, anxiety, or grief.

National Suicide Prevention Strategy

In 2012, the Government published the cross-Government National Suicide Prevention Strategy. This strategy set out two overall objectives: (i) a reduction in

the suicide rate in the general population in England; and (ii) better support for those bereaved or affected by suicide. To support delivery of these objectives, the strategy identified six key areas for action, which were subsequently updated in 2017 to expand the scope of the strategy to include addressing self-harm as an issue in its own right.

The National Suicide Prevention Strategy is implemented by partners across Government working individually and collectively to address suicide prevention within their sector and to ensure all partners remain committed to implementing the Strategy's aims to reduce suicides everywhere. Each year a progress report is published detailing activity undertaken to reduce deaths by suicide. The latest progress report (published in March 2021) sets out a refreshed cross-government suicide prevention workplan. This includes a list of new actions agreed specifically in response to the COVID-19 pandemic, as well as existing actions that have either been adapted in response to the pandemic, or continue to be of high importance in the context of COVID-19. The action plan acknowledges the risks exacerbated by the pandemic for specific vulnerable groups (to include children and young people, and those who self-harm), with examples of actions relevant to children and young people detailed below:

- Funding mental health advisers in each local authority to upskill education staff in responses to trauma.
- Ongoing creation of Mental Health Support Teams (MHSTs) for schools/colleges
- The development of implementation guidance for RSHE curriculum content
- Developing the University Mental Health Charter Award Scheme
- Every Mind Matters campaign focused on children and young people
- Establish a new duty of care on how online services should deal with illegal and harmful content (including suicide and self-harm)
- Addressing the lack of LGBT self-harm and suicide data.

Mental Health Policy And COVID-19

The COVID-19 mental health and wellbeing recovery action plan sets out an ambitious, cross-government, whole-person approach to promoting positive mental health and supporting people living with mental illness to recover and live well. It builds on collaboration during the pandemic across government departments, health and care organisations, local government, and voluntary, community and private sector organisations to prevent and mitigate some of the most pressing impacts of COVID-19 on the nation's mental health and wellbeing and support people who are struggling. The plan identifies key commitments for 2021 to 2022, building on the actions taken to date and forms the foundation for future policy development and delivery over the coming months and years, as understanding of the pandemic's impact grows. Many of the actions set out throughout this recovery action plan will also support people at risk of self-harm or suicide and prevent people from reaching this stage.

NICE Guidance

NICE has recently published new guidance Self-harm: assessment, management and preventing recurrence which covers the assessment, management and preventing recurrence for all people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability.

Local Policy Context

Foundations For Our Future

Foundations for our Future[10] was an independently led review of the support available for children and young people's emotional health and wellbeing across Sussex. Commissioned by NHS commissioners, it was undertaken in 2019/20 because organisations and services recognised more needed to be done to improve the emotional health, wellbeing and mental health of our children and young people.

In particular, the services that are available and the experience of children and young people using them needed to improve.

The review identified a number of key themes and recommendations. One key recommendation was the development of a Sussex-wide Emotional Wellbeing and Mental Health Strategy for children and young people 0-25 years. This strategy has a focus on the improvement of services and the experience of children and young people. It also recognises however that this will only be successful if those services are supported by changes in other areas, for example physical health, community improvements, education, and a stronger focus on prevention.

The strategy includes a number of recommendations addressing key risk factors for self-harm such as bullying and parental mental health problems. It also includes a commitment to have a clear pan-Sussex self-harm suicide and prevention strategy. Responsibility for the implementation of the strategy sits with the pan-Sussex Children's Board, and locally through 'mental health and emotional wellbeing partnerships in each of the three local authority areas.

6. Risk And Protective Factors

Introduction

Some children and young people are more likely to self-harm than others because of their life experiences and life circumstances. For example, experience of trauma and relationship difficulties.

A risk factor is a characteristic that precedes and is associated with a higher likelihood of a negative outcome. A protective factor is a characteristic associated with a lower likelihood of a negative outcome or a characteristic that reduces a risk factor's impact. Some risk and protective factors are fixed (such as gender), whilst others are variable and can change over time (such stressful life events).

Some risk factors described below may not be directly causal but are rather positively associated with self-harm (e.g. goth subculture). Others however may be described as causal as they may not be the only cause of the negative outcome but removing them would likely change the outcome.[11] Knowing what the risk factors are help to identify those children and young people most at risk of engaging in self-harm and can inform prevention and early intervention approaches. Risk factors for self-harm involve a complex interplay of genetic, biological, mental disorder, psychological, environmental and cultural factors.[12]

Alongside risk factors, research has sought to better understand under which circumstances a risk factor may result in children and young people being more likely to self-harm, and also the possible internal psychological factors accounting for and explaining the relationships between a risk factor and self-harm behaviour.[13]

Risk Factors

Appendix 2 provides a summary of the evidence identifying the key risk factors associated with self-harm. Most of the study samples included 10–25 year old populations and it is not possible to present these according to smaller age groups.

The highest risks for self-harming are associated with

- family dysfunction
- mental health problems
- child maltreatment
- adverse childhood experiences and bullying

A qualitative study involving 18-25 year olds found similar risk factors including distressing emotions, sense of isolation, exposure to self-harm, relationship difficulties, social comparison, and school/ work difficulties to be related to self-harm in young people[11].

The National Institute for Health and Care Excellence guidelines, 2020[23] highlights a similar set of risk factors, including:

- Socio-economic disadvantage,
- Social isolation
- Stressful life events: relationship difficulties, previous experience in the armed forces, child maltreatment, or domestic violence, bereavement by suicide
- Mental health problems: depression, psychosis or schizophrenia, bipolar disorder, post-traumatic stress disorder, or a personality disorder
- Chronic physical health problems
- Alcohol and/or drug misuse
- Involvement with the criminal justice system (with people in prison being at particular risk)
- Sex related issues: repeated self-harm and physical health problems in men
- Age: peak rates in 16 to 24-year-old women and 25 to 34 year old men

A study completed among LGBTQ young people in England have found that those who had experienced abuse or negative interactions related to their sexual orientation/ gender identity were 1.55 times more likely to plan/ attempt suicide than those in this group who hadn't[24].

In addition to the current evidence review, a literature search undertaken by Brighton and Hove city council (specific timeframe was not mentioned) has captured a number of additional studies/systematic reviews outside of the 5 year time-frame (2017 to 2021) used as part of our evidence search. They have additionally mentioned[25]

- low family educational level
- behavioural disorders
- anxiety
- exposure to self-harm/ suicide in others (family/ friends)
- looked after children/ children in care
- low emotional intelligence
- low self-efficacy (problem solving)
- feelings of entrapment, defeat, lack of belonging, self-blame/ criticism, self-loathing, disgust, and shame also as some of the risk factors.

Appendix 3 provides more detailed summaries of data relating to selected risk factors, including,

- Gender
- family income and socioeconomic adversity
- family variables
- childhood maltreatment/adverse childhood experiences
- psychiatric and psychological factors
- LGBTQ+
- bullying (including cyberbullying)
- internet use and social media
- school absenteeism
- sleep problems
- repeat self-harm
- Parental support
- Mental wellbeing
- Self-compassion
- School connectedness

Protective Factors

Protective factors for behavior outcomes during adolescence typically fall into three categories:

1. individual traits (positive social orientation, high intelligence, and a resilient temperament)

2. social bonding (warmth, affective relationships, and commitment)

3. healthy behavior patterns[14]

There is a consensus that during early childhood, having good affective experiences and bonds, as well as growing in a stable and safe environment, improves emotional development and, consequently, has a positive impact on mental health and behavior during adolescence and adulthood[15]

Appendix 2 provides a summary of protective factors associated with self-harm, established from the literature review. Along with the Brighton and Hove needs assessment literature review[25], key identified protective factors include:

- greater mental wellbeing
- later start of menstruation
- treatment for any mental disorder

- strong social attachments
- positive family relationships
- emotional expressivity
- self-efficacy and optimism

An analysis of the 2017 Health Related Behaviour Questionnaire (Year 10 pupils) in East Sussex highlights a number of risk and protective factors associated with self-harming (defined as sometimes, usually or always hurt or cut myself when worried about a problem or feeling stressed). In alignment with wider evidence, unhappiness with life, bullying, LGBTQ+ identity, anxiety/worry and experience of abuse were identified as significant risk factors. Protective factors include, being non-white British, feeling connected to others, greater mental wellbeing, having trusted sources of support and being able to cope/deal with problems.

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

Risk/protective factor	Odds ratio (95% confidence intervals)
Unhappy with life	10.4 (8.1-13.4)
Been bullied online/smartphone app	4.9 (3.8-6.4)
LGBQ(& other)	4.0 (3.1-5.1)
Bullied in last 12 months at/near school	3.9 (3.1-4.9)
Smoking	3.8 (2.9-4.9)
Physical abuse in relationship	3.6 (2.7-4.8)
Worries about being bullied	3.5 (2.8-4.3)
Afraid to go to school because of bullying	3.4 (2.8-4.3)
Drinks alcohol (occasionally or regularly)	3.0 (2.1-4.1)
Worries about problems with friends	2.9 (2.4-3.7)
Worries about family problems	2.8 (2.3-3.5)
Emotional abuse in relationship	2.8 (2.2-3.4)
Unhappy with weight	2.6 (2.1-3.3)
Not getting enough sleep	2.5 (2.0-3.0)
Used drugs in last month	2.5 (1.9-3.0)
Special needs	2.5 (1.8-3.6)
Worries about money problems/family finances	2.4 (1.9-2.9)
Female	2.2 (1.8-2.8)
Young carer	2.0 (1.4-3.0)
Disabled	2.0 (1.1-3.6)
Parental seperation	1.4 (1.2-1.8)
Worries about schoolwork or tests/exams	1.4 (1.0-1.9)
Non-White British	0.9 (0.7-1.2)
Connecetdness/feeling close to others	0.3 (0.2-0.3)
If worried has trusted adult to talk to	0.2 (0.2-0.3)
Greater mental wellbeing	0.2 (0.2-0.4)
Active coping style/deals with problems well	0.2 (0.1-0.2)

Risk factors (OR>1)

Protective factors (OR<1)

NB: All odds ratios are unadjusted – comparing those self-harming who have the factor to those who don't, with no other adjustments for risk factors made

Pathways to Self-harm

Whilst previous research has identified a multitude of internal and external risk factors for self-harm, it is acknowledged that it is extremely difficult to accurately predict this outcome. There are a number of reasons for this, but much of it relates to the multidimensional nature of self-harm risk and the challenges of conducting research in this area.[16]

However, in a recent UK study[17], researchers used data from participants of the Millennium Cohort Study, (who had reported self-harm at age 14 years) to identify two specific subgroups of adolescents who self-harm. The evidence indicates that it is possible to predict those individuals at greatest risk almost a decade before they begin self-harming.

They found that there were 2 distinct subgroups at age 14 years: a smaller group (n = 379) who reported a long history of psychopathology, and a second, much larger group (n = 905) without. They were similarly characterized by sleep problems and low self-esteem, but there was developmental differentiation. From an early age, the first group had poorer emotion regulation, were bullied, and their caregivers faced emotional challenges. The second group showed less consistency in early childhood, but later reported more willingness to take risks (often linked to impulsivity) and less secure in their relationships with peers/family. Notably, the research found that both groups could be predicted almost a decade before the reported self-harm.

Self-harm and suicide

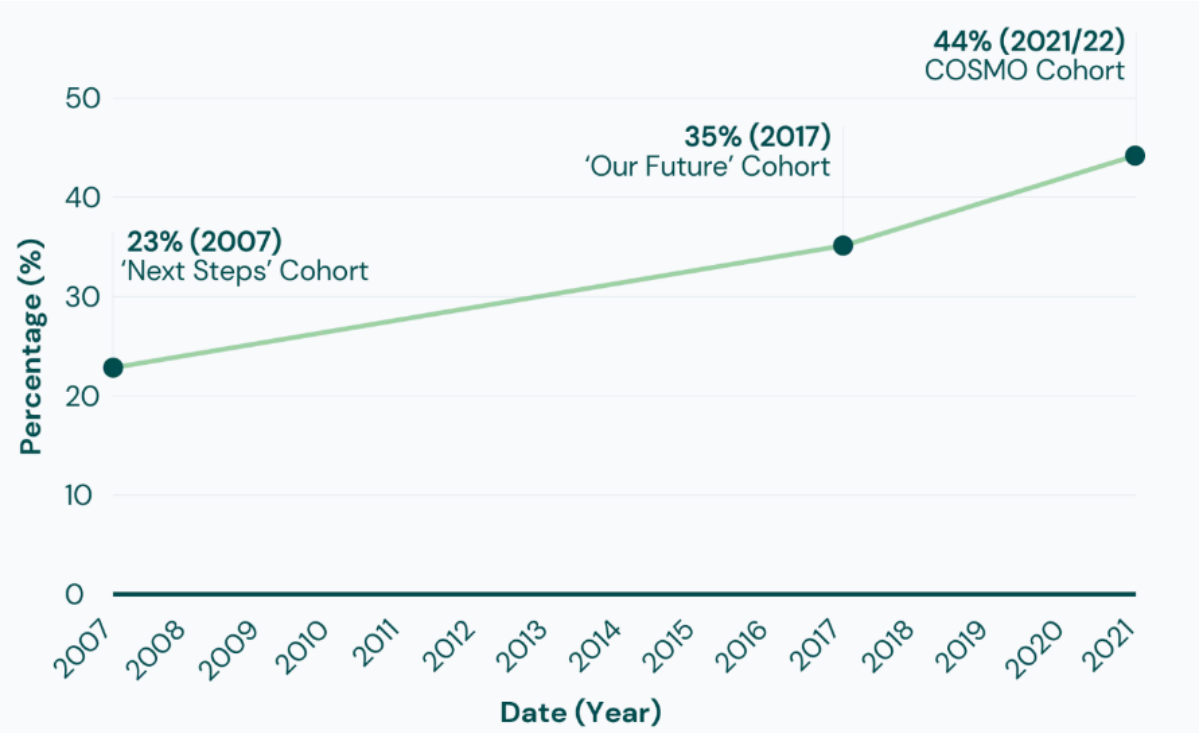
There is a strong association between self-harm and risk of future suicide[1819], with self-harm having been found to significantly predict the transition from suicidal thoughts to suicide attempts[20]. The risk of suicide is increased by between 30 and 100-fold in the year following an episode of self harm (compared to the general population),[21] with approximately 50% of all adolescents who die by suicide having previously self-harmed.[22] Risk of suicide after self-harm is more likely in male adolescents, people who have received psychiatric care, and those who repeatedly self-harm. As part of the Millennium Cohort Study, analysis of data collected during 2018-19 found that one in 10 females (10%) and one in 25 (4%) males reported that they had self-harmed with suicidal intent.

Self-harm and COVID-19

Evidence from the COVID Social Mobility & Opportunities (COSMO), which surveyed Year 11 pupils during the 20121/22 academic year, found that the proportion

reporting levels of high psychological stress has increased considerably since 2007[23].

Figure 2: Levels of high psychological distress amongst young people in England between 2007 and 2021



Notes. Percentage with GHQ-12 scores of 4 and above across three cohort studies. Sources – Next Steps Wave 4 (age 16/17), Our Future Wave 5 (age 17/18) and COSMO Wave 1 (16/17)

Whilst the pandemic is unlikely to solely explain this increase given evidence showing ongoing downward trends in wellbeing among young people over the past, it is likely to have exacerbated the situation for some. The evidence linking experience of the pandemic to mental health is mixed. Evidence gathered during the COVID-19 pandemic suggests that most children and young people have broadly coped well. [24] For example, the Children's Commissioner's 'Big Ask' survey reached over half a million 6 to 17 year olds in April and May 2021, and found that 80% were happy or okay with their mental wellbeing.

However, as with many aspects of the pandemic, the effects have not been felt equally[25]. Throughout the pandemic, children and young people who were female, older (16 to 24 year olds), more disadvantaged, or who had special educational needs and/or disabilities (SEND)have been found to be more likely to report difficulties with mental health and wellbeing[26]. It is acknowledged that the nature of much of this research makes it difficult to determine if these findings are

continuations of pre-pandemic trends or reflect differential experiences between groups of children as a result of the pandemic.

With specific reference to self-harm behaviours, evidence suggests that rates of self-harm across all ages have remained relatively constant during the pandemic, although self-harm has been reported to be higher amongst younger adults (18 to 29 years), people with lower household incomes, and those with a diagnosed mental health condition.[27]

During the first national lockdown, there were initially steep falls in hospital presentations for self-harm.[28] Whilst these have largely recovered to pre-pandemic levels, there remains significant concerns regarding how children and young people who self-harm coped during this time and the impact of the ongoing 'perma-crisis[2]' that many will be experiencing.

Evidence shows the importance, therefore, of a preventative approach to mental health and self-harm addresses factors that were of concern to young people's mental health pre-pandemic[29] as well as with major life events that they may have experienced during the pandemic, such as having long COVID, spending a long time away from society when shielding, or losing a loved one[30].

[2] Statement: The European Region is in a "permacrisis" that stretches well beyond the pandemic, climate change and war (who.int)

7. Level Of Need In East Sussex

Data Summary

- Around a third of secondary school age children report having ever intentionally hurt themselves
- Around 1 in 20 secondary school age children report self-harming regularly
- Self-harm behaviours are higher in females and increase with age. More males are seen with increasing age
- For those attending hospital for self-harm, drug overdose or self-poisoning are the main methods of harm. Other methods of harm are higher in males and also in under 15s
- For those attending hospital, paracetamol is the most common type of overdose followed by antidepressants
- Self-harm increases with increasing levels of deprivation
- Repeat hospital attendance for self-harm has been higher in recent years and is higher in females
- A&E attendances due to self-harm remain fairly stable
- East Sussex has an increasing and significantly higher rate of self-harm admissions than England and the South-East, and the most recent data for 2020/21 shows East Sussex has the highest rate in Sussex
- Within East Sussex, self-harm ambulance call-outs and admissions are highest in Hastings with admissions on an upward trend
- From the local data available we cannot say that the prevalence of self-harm is increasing. Survey data for secondary school age children suggests the prevalence of regular self-harming behaviours in 2020/21 is similar to rates in 2017, and A&E attendances appear to be fairly stable. However, the increase in self-harm admissions and repeat self-harm clearly indicates that the severity of self-harming is getting worse.

National evidence

Self-harm has high levels of underreporting[31]. As a result, accurate prevalence figures are difficult to determine precisely, with statistics largely focused on those who present to hospital or primary care[32]. These statistics show that the rates of self-harm in children and young people have been increasing over recent decades across a number of comparable countries.

An increase in self-harm presentations to hospitals and clinical facilities may be attributable to a number of factors, including changes in the lethality of self-harm methods used by children and young people, the younger age of onset of self-harm

behaviours, increased risk of self-harm repetition in children and young people (relative to young adults), and changes to/improvements in clinical documentation and coding of self-harm presentation (resulting in a higher detection rate).

National prevalence estimates

Estimates for the prevalence of self-harm amongst children and young people in England range between approximately **13% and 20%**.[3334] For example, analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England (2014) found 22% of 15 year olds to report that they had ever self-harmed, with nearly three times as many girls reporting that they had self-harmed (32%) compared to boys (11%).

The majority of young people who were self-harming reported engaging in self-harm once a month or more.[35] Furthermore, a more recent analysis of data[36] collected from participants in the Millennium Cohort Study (MCS) during 2018-19 found that at age 17, 28% of females and 20% of males reported self-harming in the previous year. These rates have increased from those reported by children and young people participating in the study at age 14; with percentages more than doubling for males (9% at age 14 to 20% at age 17), while females experienced an increase from 23% to 28% over the same period. a

Local Data

Introduction

The main sources of data relating to self-harm are through surveys or service data (e.g. hospitals, ambulance) and each have their limitations. See 'Data Caveats' below. This section provides a summary of the local survey and hospital data available.

As previously outlined, the research highlights that much self-harm is hidden and that there are likely to be high levels of under reporting. A dearth of both local and national data and information, and inconsistent recording methods for those who are in contact with services, mean it is impossible to fully understand the local picture of self-harm among children and young people. This needs assessment seeks to provide a picture not only of what we know about self-harm locally, but also to provide a starting point for discussion and actions to improve our knowledge, understanding and support for those experiencing or at risk of self-harm. This section presents the data that is available at a local level, and acknowledges the caveats associated with these.

Data Caveats

Different services define, record and code self-harm in different ways. It is therefore not appropriate to compare data sources and numbers presented may not reconcile with each other, even for the same service (e.g. A&E).

Due to new data systems and resulting data quality for some services, analysis is also limited. Appendix 4 provides a summary of the different data sources used in this section, definitions and issues to be aware of. Generally data on age group, sex and area where patient lives is available, but other known risk/protective factors such as ethnicity and LGBTQ+ are not.

An issue common to analysis of different data sources is the impact of repeat self-harm. For data relating to children and young people seeking urgent care (ambulance call-outs, A&E attendances and emergency admissions) there are two ways of looking at it – either service activity (call-outs/attendances/admissions) or individuals. Where possible, analysis has been done by both. Where this has not been possible it is very important to consider the impact of repeat self-harm and how this may skew analysis due to the extent of repeat self-harm at an individual level. For example, a rise in hospital admissions or attendance may be due to repeat attendance in relatively few individuals.

A&E attendances for 2019/20 and 2020/21 needs to be considered in the context of changes in A&E activity due to the COVID-19 pandemic. For all East Sussex resident A&E attendances, attendances in April 2020 were almost half the monthly average pre-pandemic with children and young people aged under 20 having larger drops compared to older age groups. For all ages, there were 19,558 fewer attendances in April-September 2020 compared to the same period the year before. Attendances appear to have returned to more normal levels in August 2020, but then began to decrease again until they picked up in March 2021.

Please note that small numbers may be suppressed/categories combined for disclosure control purposes.

Prevalence

Local health behaviour surveys of secondary school age children were conducted in 2017 and 2020/21 that included questions around self-harm, and which provide some indication of prevalence among this cohort.

The 2017 Health-Related Behaviour Survey (HRBS) included a section on emotional health and wellbeing and asked: *'when you have a problem that worries you or you are feeling stressed, what do you do about it?'*. Amongst a list of options 'cut

or hurt myself' was included and pupils could select 'never', 'sometimes', 'usually' or 'always'.

- 16% of pupils reported that they cut or hurt themselves sometimes, usually or always (11% for males and 21% for females)
- 6% of pupils reporting usually or always cutting or hurting themselves (3% for males and 7% for females).

During the academic year 2020/21 the *My Health My School* survey was undertaken in some East Sussex schools. Due to low participation to date and different schools undertaking the survey at different times of the year, results must be treated with caution. Over a third of the nearly 2,000 pupils who responded reported having ever hurt themselves, with 6% reporting doing so at least once a week. Self-harming behaviours reported were higher for females and increase with age.

Table 3: Self-reported self-harm behaviours for Year 7, 9 and 11, 2020/21

For those who had ever hurt themselves, statement that best describes them	Year 7	Year 9	Year 11	Total
I used to hurt myself but no longer do it	10%	11%	13%	11%
I have hurt myself once or twice (in the last 12 months)	10%	11%	12%	11%
I sometimes (more than once a month) hurt myself	5%	6%	7%	6%
*often (more than once a week but not every day) or regularly (every day) hurt myself	5%	7%	6%	6%
Total reporting that they had ever hurt themselves	30%	35%	38%	33%
Number of respondants	875	889	212	1976
Percentage of school roll paticipated in the survey	16%	17%	4%	13%

*often and regularly have been combined due to small numbers

Table 4: Self-reported self-harm behaviours for Year 7, 9 and 11 by sex, 2020/21

For those who had ever hurt themselves, statement that best describes themselves	Female	Male
I have hurt myself once or twice (in the last 12 months)	13%	7%
I often (more than once a week but not every day) hurt myself	5%	2%
I regularly (every day) hurt myself	2%	1%
I sometimes (more than once a month) hurt myself	7%	3%
I used to hurt myself but no longer do it	11%	10%
Total reporting that they had ever hurt themselves	38%	24%
Number of respondants	894	956

Both surveys, which were conducted around 3 years apart, show a prevalence of regular self-harm (either usually or always cutting or hurting themselves in response to worry/stress or hurting themselves at least once a week) of 6%. This would equate to around 1,860 secondary school age pupils (12-16 year olds) in East Sussex who are regularly self-harming. A third of secondary school age pupils reported having ever self-harmed which equates to around 10,250 pupils.

Health Service Data

Using the data we have available from the last 10 years, table x shows an estimate of scale of the issue in terms of children and young people seeking urgent care/contact with health services in an emergency situation due to self-harm in East Sussex. Please note any East Sussex Healthcare Trust (ESHT) A&E trend data presented in this section uses different data sources and definitions and is not possible to ascertain the impact of these in relation to the overall picture in East Sussex. This is a particular issue for 2020/21 data.

2020/21 self-harm data for East Sussex residents Under 25s

492 ambulance call-outs

486 A&E attendances at ESHT (Eastbourne or Hastings)

523 admissions (all hospitals)

Table 5: Estimates of children and young people resident in East Sussex seeking urgent care due to self-harm per year.

Activity type	Activity - numbers	Individuals - numbers
Ambulance call-outs	500	Unknown
A&E attendance (ESHT only - Hastings or Eastbourne)	630 - 800	470 – 560
Admission (any hospital)	400 – 530	300 - 400

Age And Sex

Self-harm call-outs/attendances/admissions are higher for females. From an activity (number of overall admissions and attendances) perspective across the different datasets over the last 10 years, it ranges from 60-80% for females. If admissions/attendances are looked at in terms of number of individuals attending or admitted this reduces slightly to between 56-78%. More males are seen with

increasing age. Admissions and ESHT A&E data suggests that the percentage of activity/individuals who are male are on downward trend over the last 10 years with a slight upward trend seen for females.

Figure 3: Percentage of activity/individuals that are male, 2011/12 to 2020/21

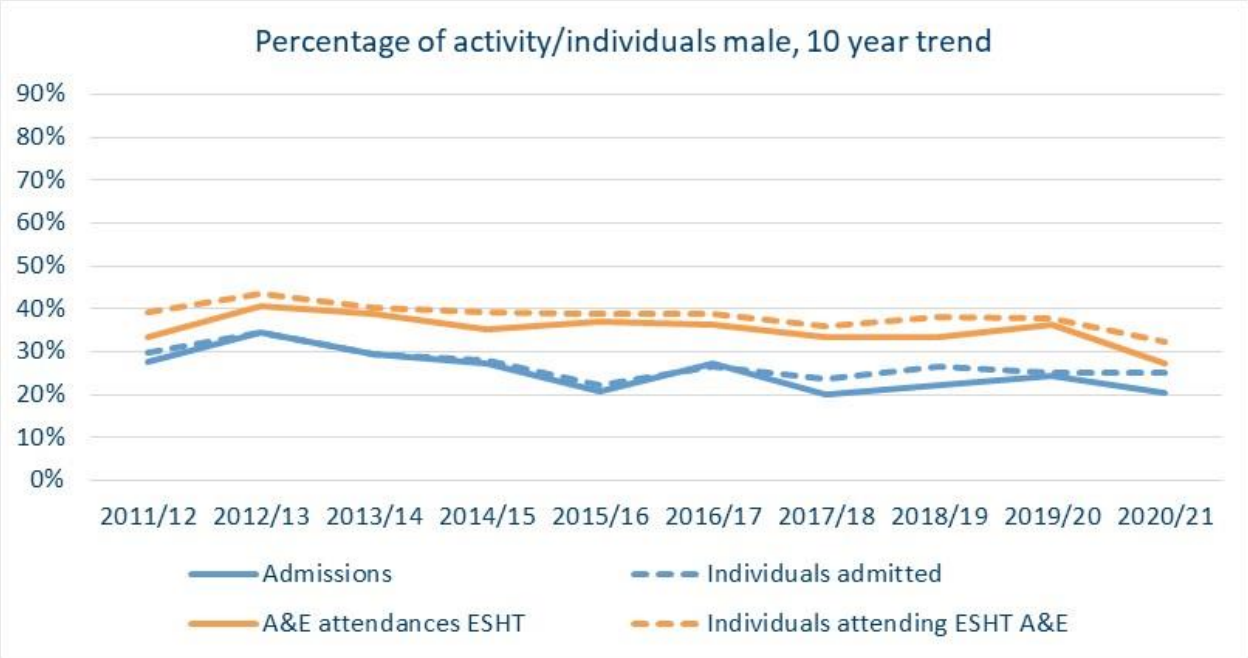
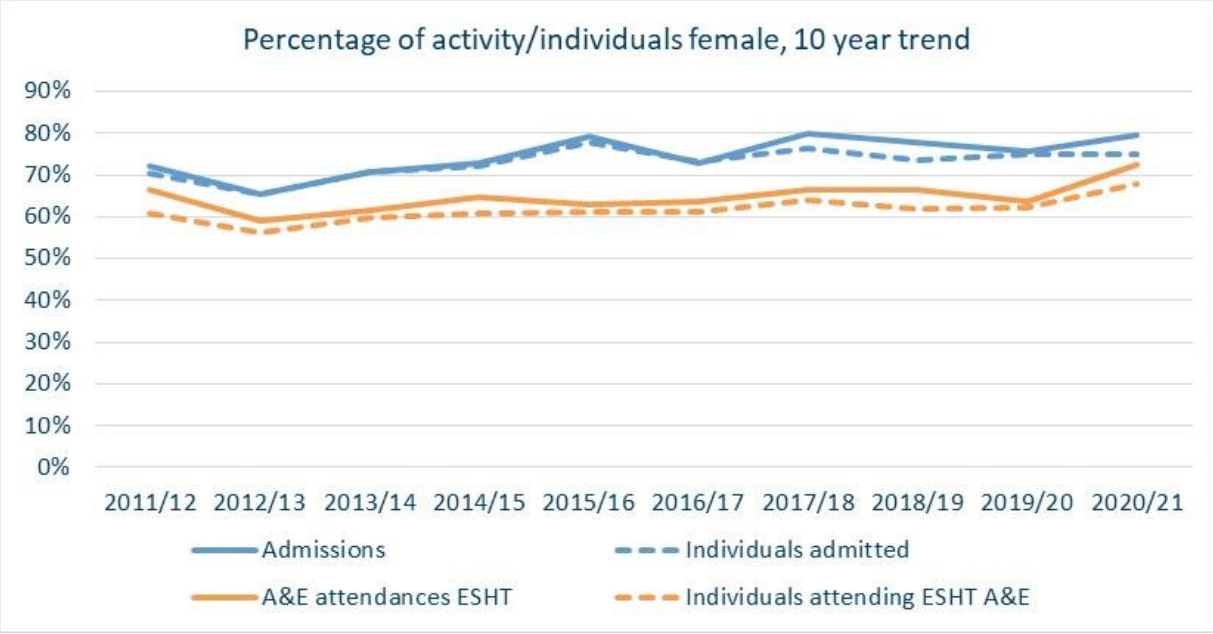


Figure 4: Percentage of activity/individuals that are female, 2011/12 to 2020/21



The majority of self-harm activity for under 25s is for young people aged 18-24 years (table x). Children resident in East Sussex and aged under 15 years account

for 17% individuals who were admitted to a hospital due to self-harm in 2020/21, compared to 31% who were 15-17 and 51% who were 18-24. 5% self-harm related ambulance call-outs were for this age group during the same year, compared to 18% 15-17 year olds and 76% 18-24 year olds.

Table 6: 2020/21 Self-harm activity for East Sussex residents by age and sex

2020/21 activity	Under 15s	15-17s	18-24s	Males	Females
Ambulance call-outs	27 (5%)	90 (18%)	375 (76%)	112 (23%)	376 (77%)
A&E attendances (EHST)	51 (11%)	132 (27%)	302 (62%)	133 (27%)	352 (73%)
Admissions (all hospitals)	91 (17%)	163 (31%)	269 (51%)	106 (20%)	416 (80%)

NB: small numbers of records had no age or sex recorded

Data for 2020/21 indicates that 376 under 25s were admitted to a hospital for self-harm: 20% of whom were under 15 years old. However, when under the 17 age groups are combined, the data indicates that more young people under 17 years (198) were admitted to a hospital for self-harm than 18-24 year olds (178). Of those residents who attended ESHT A&E, 60% were 18-24. Individuals seeking help were 2.5x as likely to be female than male.

Table 7: Individuals seeking help for self-harm during 2020/21 for East Sussex by age and sex (small numbers of records do not have age/sex recorded)

2020/21 individuals	Under 15s	15-17s	18-24s	Males	Females
A&E attendances (EHST)	47 (14%)	93 (28%)	199 (60%)	107 (32%)	226 (68%)
Admissions (all hospitals)	74 (20%)	124 (33%)	178 (46%)	92 (25%)	274 (75%)

Across all age groups there has been a general upward trend in hospital admissions over the last 10 years, particularly amongst 18-24 year olds (figure x). However, Conversely, ESHT A&E attendance data (including historic analysis of self-harm attendances for 2007/08 to 2009/10) shows more year-on-year variation, with attendances generally fairly stable in under 15s (figure x).

For 15-17 year olds and 18-24 year olds attendances were slightly higher during 2008/09 to 2011/12, but then dropped slightly and have since plateaued. Although these data are describing different cohorts of patients (East Sussex residents at any hospital for admissions, and only East Sussex residents at ESHT for A&E attendances), it does suggest that in general there is not an increase in children and young people seeking hospital help for self-harm, but there has been a potential increase in those with more significant self-harm seeking help (i.e. requiring admission). There is insufficient information available to indicate the reasons for this increase.

Figure 5: Admissions and individuals admitted by age group, 2011/12 to 2020/21

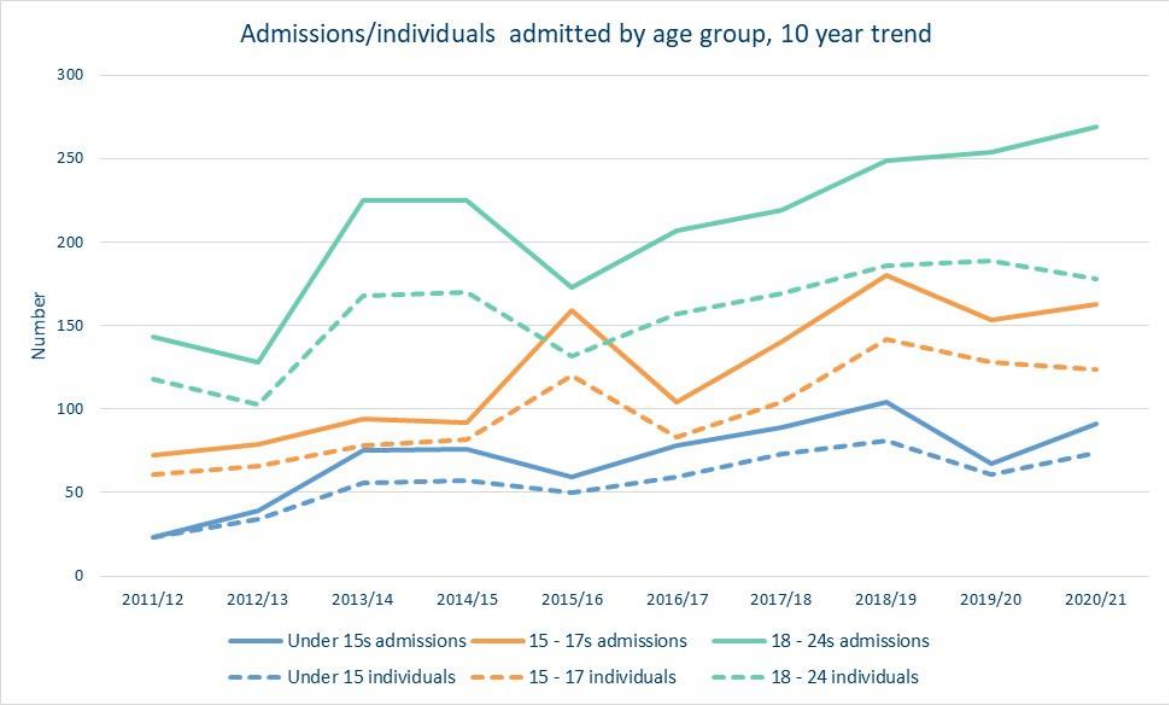
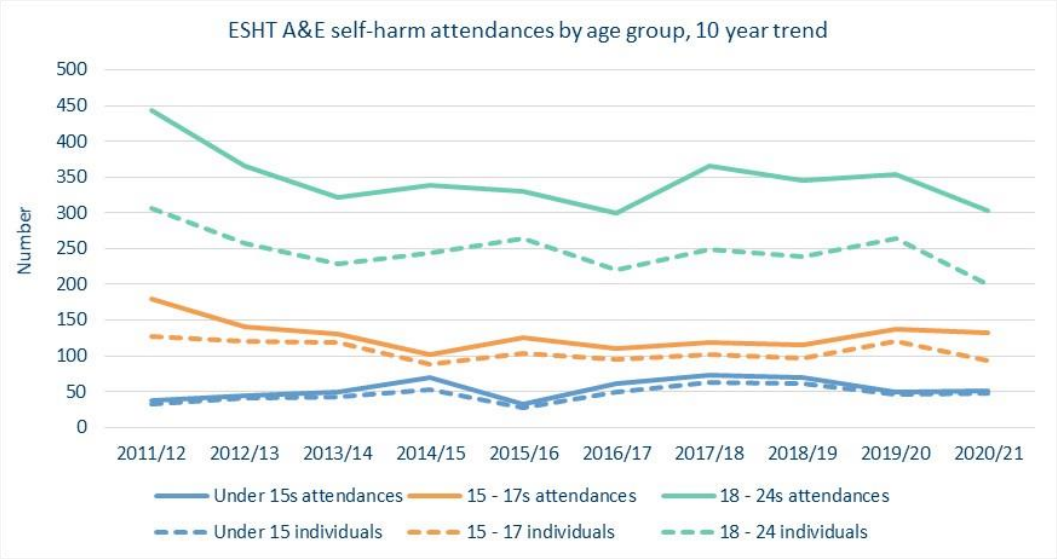


Figure 6: ESHT overall A&E attendances and individuals attending by age group, 2011/12 to 2020/21



Geography

Overall, 1 in 4 self-harm hospital admissions for children and young people residing in East Sussex are for those from Hastings with 1 in 5 from Lewes and a further 1 in 5 from Wealden.

Over the last 3 years Hastings has had a significantly higher rate of overall admissions (one person can be admitted more than once) than the rest of the county. If looking at the rate of individuals admitted, Hastings is not significantly different to the rate for Rother (although is significantly higher than the other areas). Eastbourne has the lowest rate of overall admissions and Wealden the lowest rate of individuals admitted.

Figure 7: Rates of admissions and individuals admitted by district/borough (with 95% confidence intervals), 2018/19- 2020/21

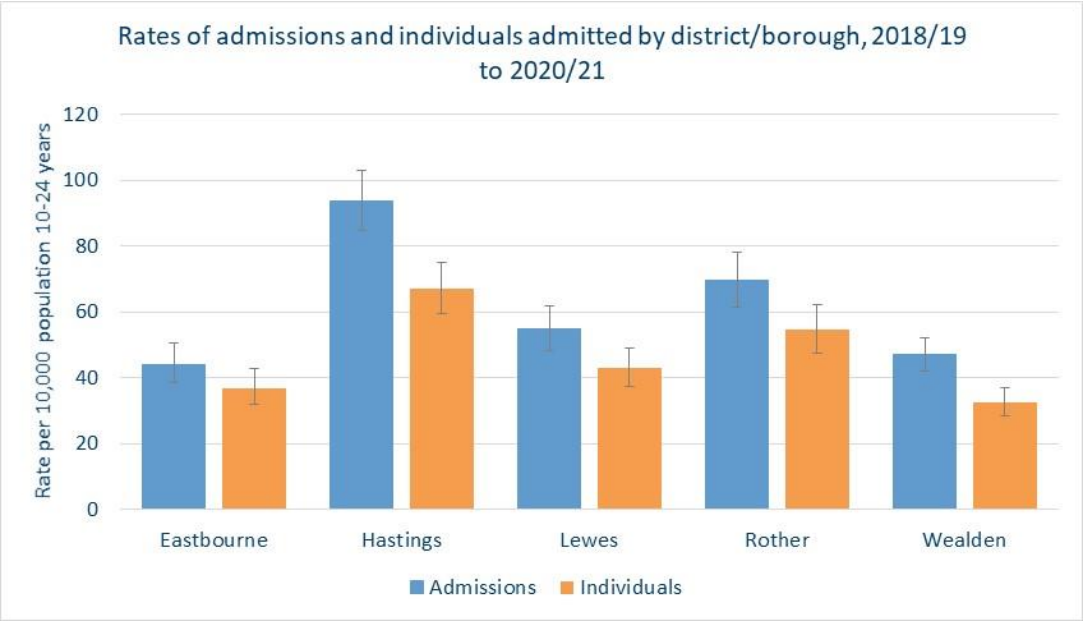
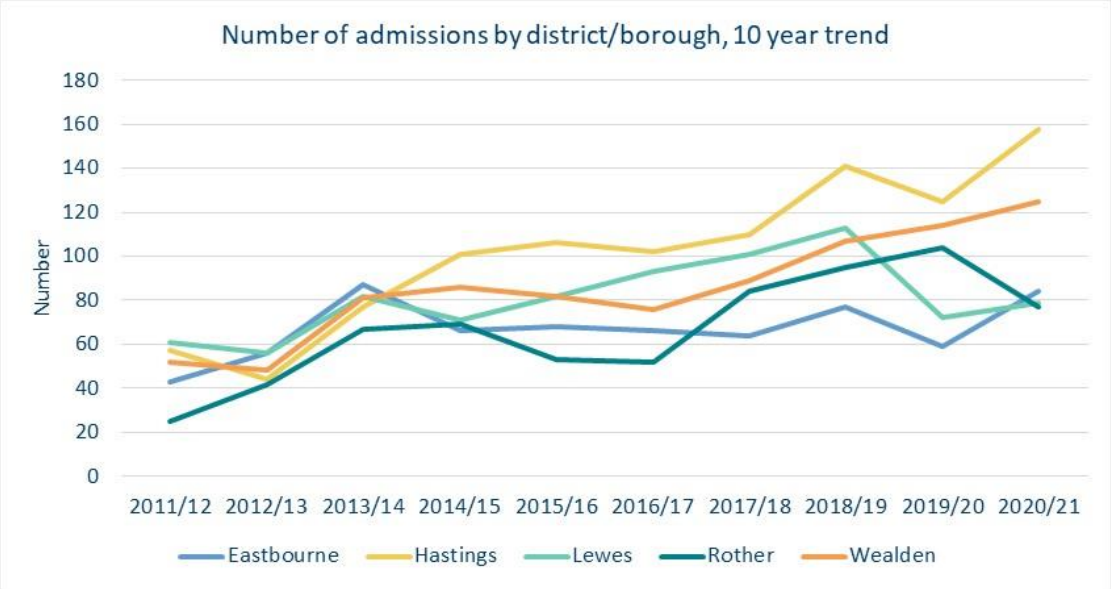


Figure 8: Self-harm admissions (number) by district/borough, 2011/12 to 2020/21



Over the last 5 years there is a clear upward trend in the overall admission rate for Hastings and Wealden which is not reflective of the national trend. In terms of individuals being admitted, the rate in Hastings has increased at a slower rate in the latest year (2020/21) compared to overall admissions, and for Wealden shows a slight drop compared to an increase in the admission rate.

Due to data issues, it is not possible to get an up-to-date view of A&E attendances by district/borough.

Figure 9: Self-harm admission rate by district/borough, 2016/17 to 2020/21

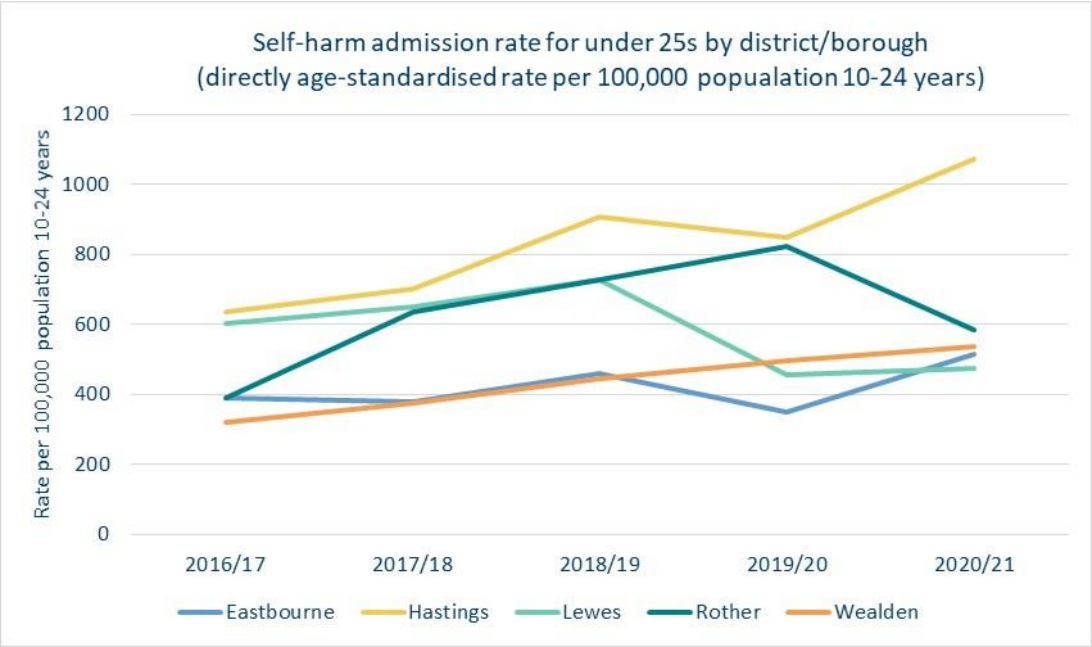
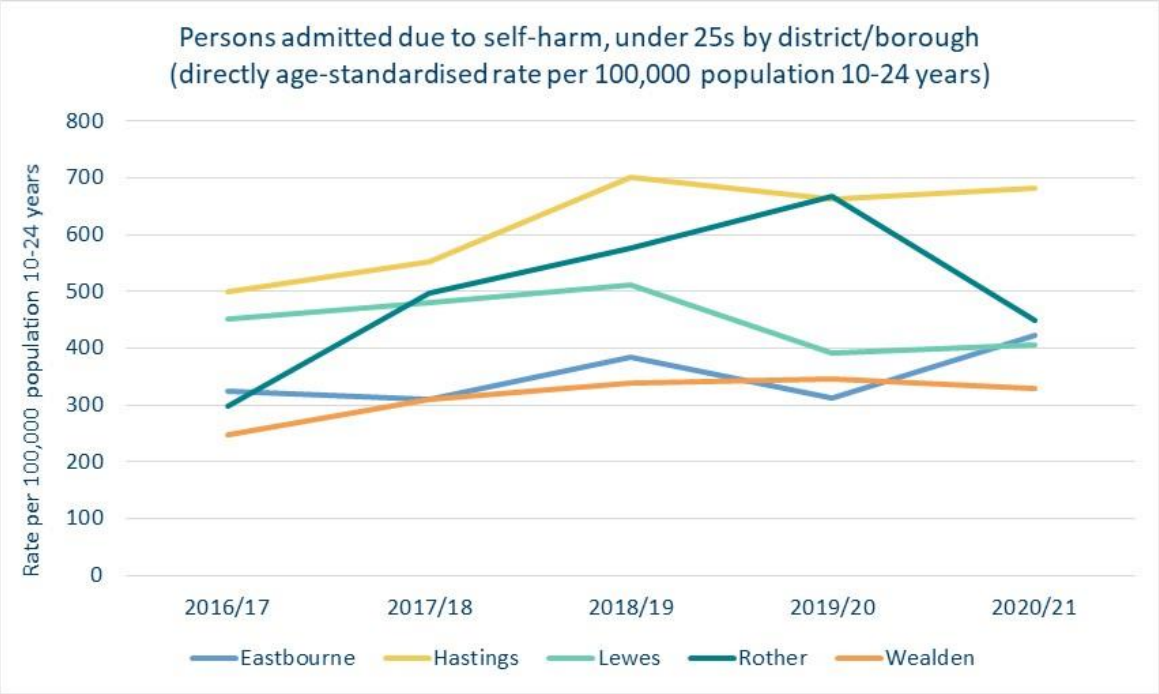
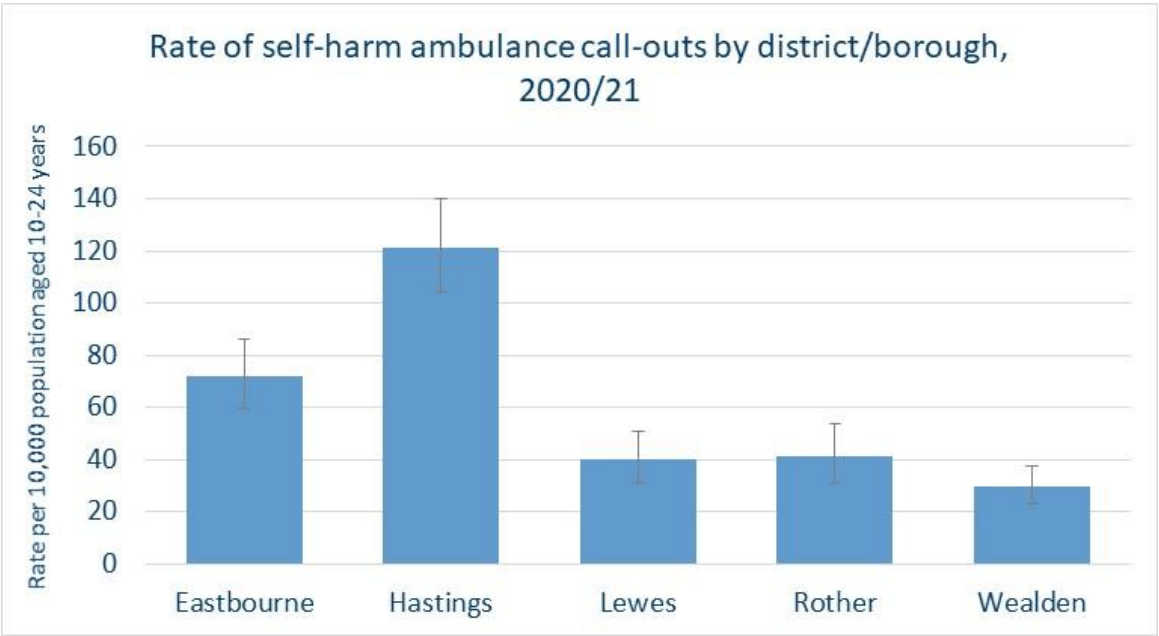


Figure 10: Rate of persons admitted due to self-harm by district/borough, 2016/17 to 2020/21



Ambulance call-outs are significantly higher in Hastings than all other areas (Figure x). Eastbourne also has a significantly higher rate than Lewes, Rother and Wealden (note that ambulance call-outs will include all repeat self-harm, and rates could look very different by individuals).

Figure 11: Rate of self-harm ambulance call-outs by district/borough, 2020/21



Deprivation

Both ambulance and admission data show that self-harm increases with increasing levels of deprivation. Admissions and call-outs from the most deprived areas are significantly higher compared to the rest of East Sussex. Ambulance call-outs to the East Sussex areas that are in the least deprived quintile nationally (quintile 5) are slightly higher than quintile 4, but not significantly so. When considering individuals who are admitted for self-harm, young people living in the East Sussex areas that fall in the 40% most deprived areas nationally (quintile 1 and 2) have significantly higher admission rates than the rest of the county.

Figure 12: Ambulance call-outs by deprivation, 2020/21

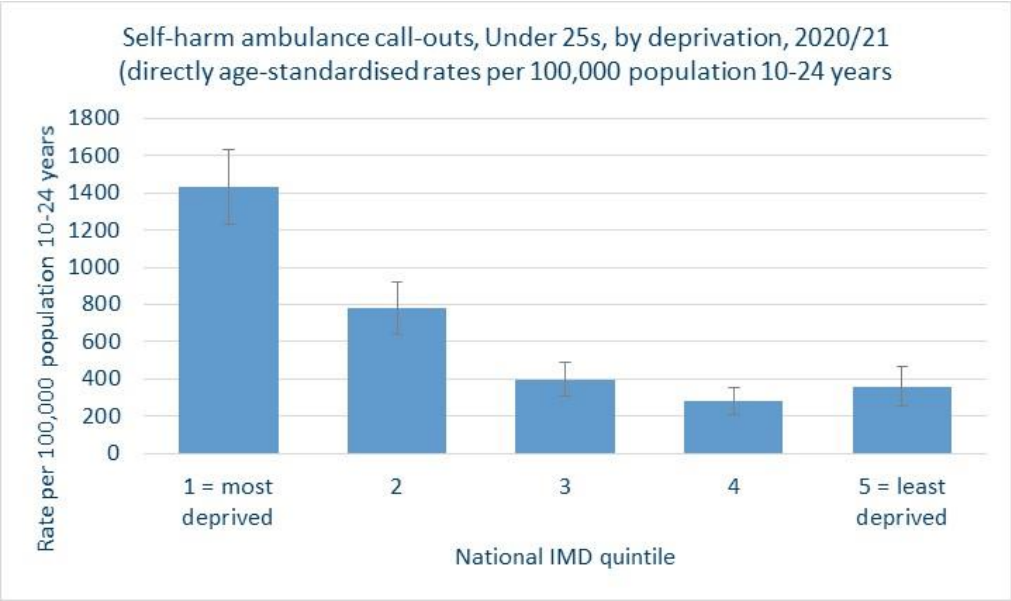
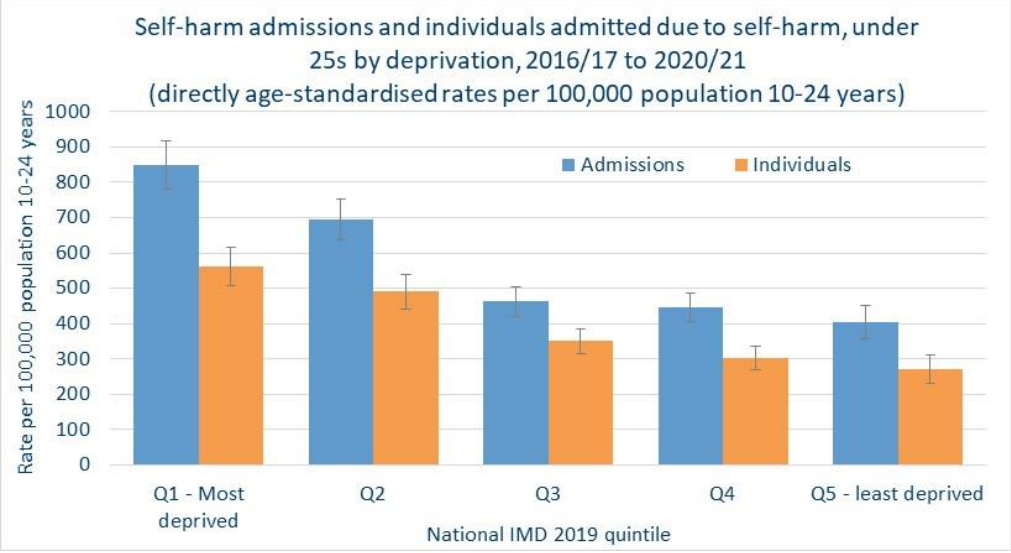


Figure 13: Admissions and individuals admitted by deprivation, 2016/17 to 2020/21



Method Of Harm

Intentional drug overdose/self-poisoning is the main method of harm (72% of ambulance call-outs, 2020/21 (Table x); 84% admissions 2016/17 to 2020/21 (Table x)). Both ambulance and admission data show intentional drug overdose/self-poisoning is higher for females than males. For ambulance call-outs intentional drug overdose/self-poisoning is highest in 15-17 years olds but for admissions it is highest for 18-24 year olds.

Table 8: method of harm by age group, ambulance call-outs, 2020/21

Method	Under 15s	15-17s	18-24s
Intentionally harming self	9	20	104
Intentional drug overdose/self-poisoning	18	70	271
% Intentional drug overdose/self-poisoning	67%	78%	72%

Table 9: method of harm by age group and sex, admissions 2016/17 to 2020/21

Method of harm	Self-harm admissions by method, age and sex, 2016/17 to 2020/21					
	Males			Females		
	Under 15s	15-17s	18-24s	Under 15s	15-17s	18-24s
Self-poisoning	40	100	302	310	494	739
Other method	16	33	45	63	110	112
% self-posioning	71%	75%	87%	83%	82%	87%

A&E data for the calendar year 2021 (for all providers) shows the most common type of overdose was by paracetamol, with over 300 attendances and then anti-depressants with almost 130 attendances (Table x).

NSAIDs[3] have the smallest numbers overall, although are higher in under 18s compared to 18-24 years olds.

Table 10: A&E overdose attendances (any hospital), 2021 (patients can have more than one type of overdose so may be counted more than once)

	U18s	18-24s	Total
Diagnosis Overdose Antidepressant	32	97	129
Diagnosis Overdose Benzodiazepine	11	73	84
Diagnosis Overdose NSAID	33	24	57
Diagnosis Overdose Paracetamol	175	130	305

[3] Non-steroidal anti-inflammatory drugs (NSAIDs) are medicines that are widely used to relieve pain, reduce inflammation, and bring down a high temperature. For example, ibuprofen.

Although very small numbers, admissions due to self-harm by hanging, strangulation and suffocation increased in 2020/21.

Table 11: Method of harm by year, admissions 2016/17 to 2020/21

Number of admissions by method of self-harm, by year						
Method of self-harm	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Self-poisoning	329	376	455	401	426	1987
Use of sharp object	42	53	60	55	64	274
Hanging, strangulation and suffocation	*	*	*	*	13	31
Other specified means	*	*	*	*	10	30
Unspecified means	*	*	*	*	*	20
Use of blunt object	*	*	*	*	*	12
Jumping from a high place	*	*	*	*	*	*
Smoke, fire and flames	*	*	*	*	*	*
Jumping or lying before moving object	*	*	*	*	*	*
Drowning and submersion	*	*	*	*	*	*
Steam, hot vapours and hot objects	*	*	*	*	*	*
Total	389	448	533	474	523	2367

*small numbers have been suppressed due to disclosure control

Time/day Analysis

Both ambulance and A&E attendance data show that incidents/attendances are lowest around 3/4am until noon and pick up around 6pm. Ambulance incidents peak around 10-11pm and in A&E around midnight.

Table 11: time of day analysis – counts by hour for ambulance and ESHT A&E

	Aug 19-Mar21	19/20 & 20/21
Hour	Ambulance	ESHT A&E
0	54	76
1	40	61
2	35	42
3	36	27
4	20	36
5	21	28
6	13	23
7	16	17
8	11	23
9	21	25
10	26	24
11	25	35
12	32	38
13	29	42
14	35	45
15	39	41
16	38	46
17	36	46
18	55	52
19	52	57
20	67	61
21	59	57
22	75	57
23	59	67

Numbers are generally lower Wednesdays to Saturdays (up to midnight on these days) but for ambulance call-outs numbers are highest on a Monday (then Sunday).Attendances are highest for Tuesdays (then Sunday) in A&E.

Table 12: day of the week analysis - counts by day of the week for ambulance and ESHT A&E

	Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Aug 19-Mar21	Ambulance	111	83	104	103	99	101	108
19/20 & 20/21	ESHT A&E	155	158	151	146	122	137	157

Repeat Self-Harm

The majority of children and young people residing in East Sussex who receive hospital care as a result of self-harm have only done so once (80% for A&E attendances at ESHT 2019/20 to 2020/21; 75% of admissions 2016/17 to 2020/21).

Table 13: number of attendances of East Sussex residents aged under 25 at ESHT A&Es due to self-harm, 2019/20 to 2020/21

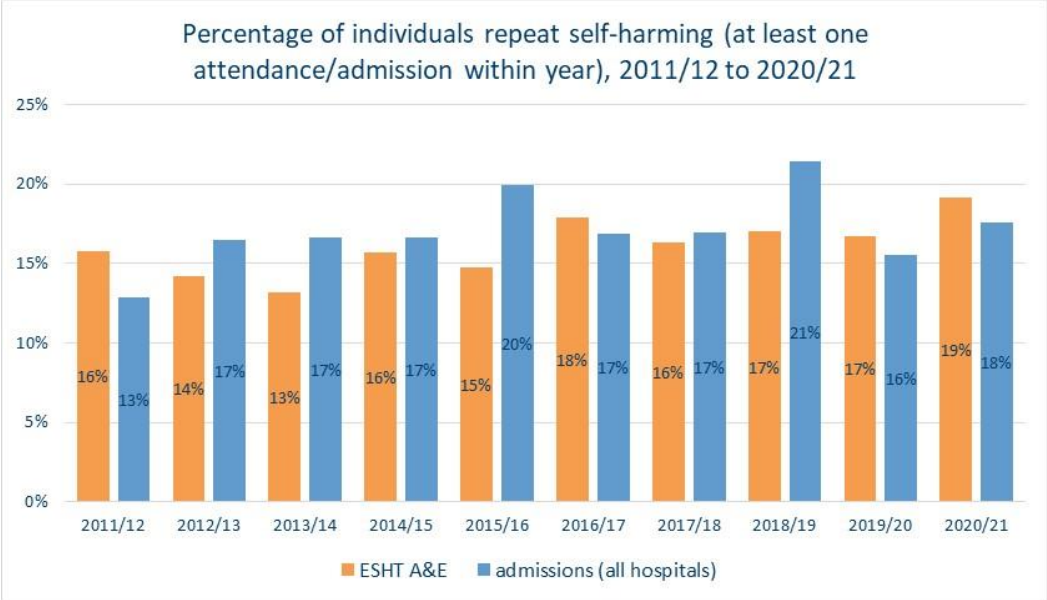
Number of attendances	No of people	% of people
1 attendance	570	80%
2 attendances	82	12%
3 attendances	28	4%
4 attendances	13	2%
5 or more	19	3%
	712	100%

Table 14: number of hospital admissions of East Sussex residents aged under 25 due to self-harm, 2016/17 to 2020/21

Number of admissions	Number of people	% of people
1	1112	75%
2	217	15%
3	70	5%
4	28	2%
5	14	1%
6	15	1%
7	8	1%
8 or 9	15	1%
10 or more	9	1%
	1488	100%

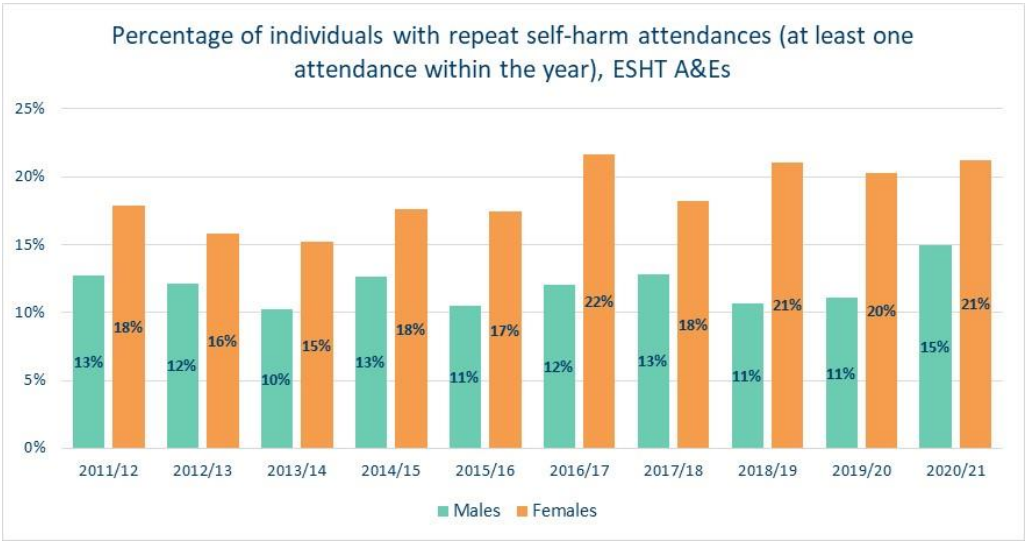
Over the last 10 years individuals who have had more than one attendance within the year at ESHT A&Es ranges from 13% in 2013/14 to 19% in 2020/21 (Figure x). 2020/21 had the highest repeat self-harm as measured by at least 1 attendance within year, with 9 individuals who had at least 5 attendances within the year. From an admissions perspective it ranges from 13% of individuals having at least one admission within year in 2011/12 to 21% in 2018/19.

Figure 14: Percentage of individuals repeat self-harming (at least one attendance/admission within the year) ESHT A&E and all admissions, 2011/12 to 2020/21



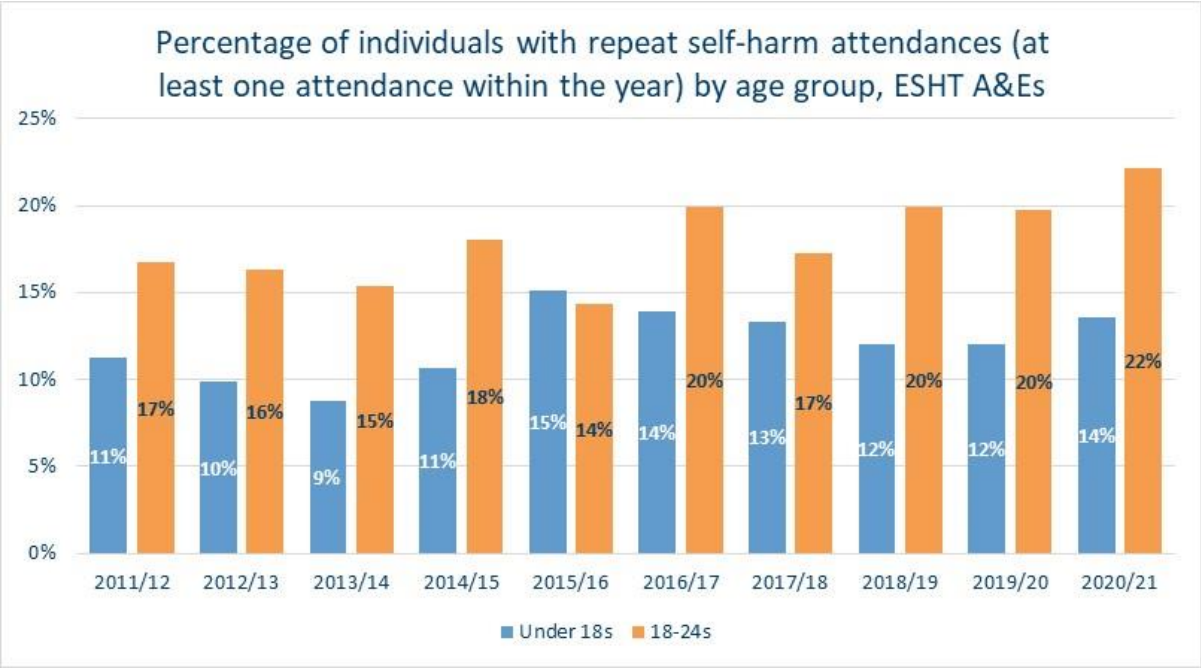
Repeat self-harm is higher in females. For females, attendances at ESHT A&E for repeat self-harm was highest in 2016/17. with attendances since this time remaining consistently higher compared to the 5-year period before (2011/12-2015/16). For males, repeat self-harm in 2020/21 was the highest it has been over the last 10 years. Over this period, 29% of females who were admitted for self-harm were admitted on more than one occasion compared to 20% of males.

Figure 15: percentage of individuals with repeat self-harm (at least one attendance within year) at ESHT, by sex, 2011/12 to 2020/21



Repeat self-harm is higher in young people aged 18-24 years. Over the last 10 years attendances at ESHT A&E for repeat self-harm ranged from 9% in 2013/14 to a peak of 15% in 2015/16 for under 18s and has remained between 12% and 14% in subsequent years; and for 18–24-year-olds it ranged from 15% in 2013/14 to a high of 22% in 2020/21.

Figure 16: percentage of individuals with repeat self-harm (at least one attendance within year) at ESHT, by age group, 2011/12 to 2020/21



Place of Attendance/Admission

Around two-thirds of A&E self-harm attendances for East Sussex Under 25s are at ESHT hospitals and a further 1 in 5 at University Hospitals Sussex – East (attending in Brighton or at Princess Royal in Haywards Heath). It is not possible to break the available data down by hospital site for all attendances. Data from ESHT shows that just over half (54%) of self-harm attendances at the Trust are at Conquest Hospital.

Around half of self-harm admissions for under 25s in East Sussex are to the Conquest Hospital in Hastings (note that there are no beds at Eastbourne District General Hospital (EDGH) for children who need an overnight stay – they would be transferred to Conquest or another suitable hospital if needing to stay overnight. EDGH does have a Short Stay Paediatric Assessment Unit). Almost 1 in 5 admissions are in Brighton (Royal Sussex County Hospital or Royal Alexandra Children's Hospital).

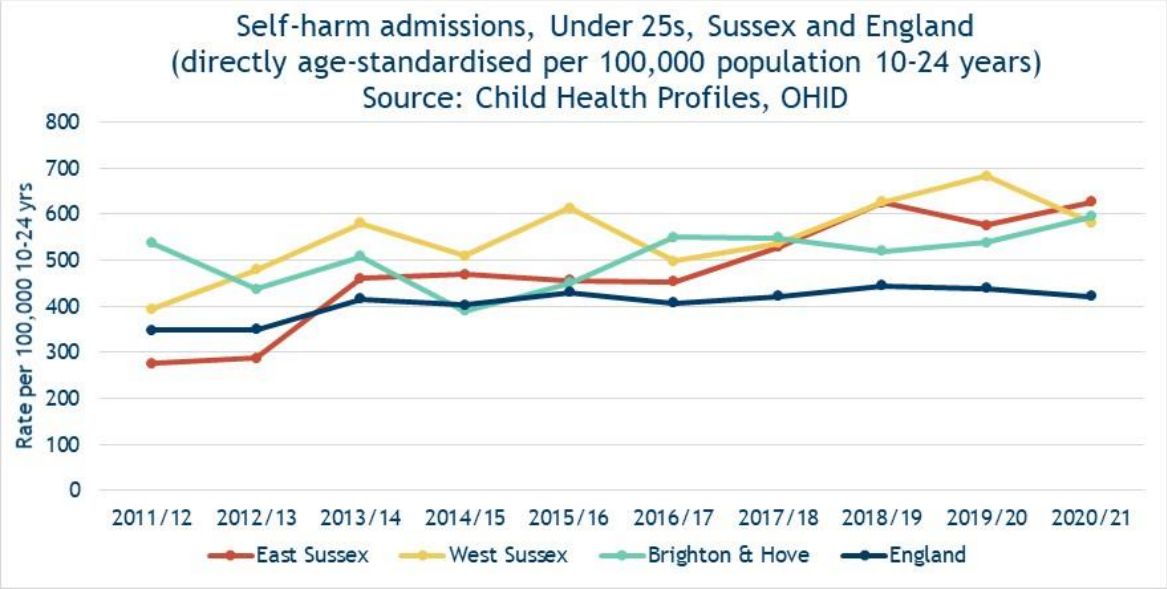
Table 15: Where patients admitted to for self-harm by age group, 2016/17 to 2020/21

Number of admissions by hospital and age group, 2016//17 to 2020/21					
Hospital	Under 15s	15-17s	18-24s	Grand Total	% of total admissions
Conquest Hospital	306	388	508	1202	51%
Eastbourne DGH	19	95	266	380	16%
Royal Sussex County Hospital	0	31	187	218	9%
Royal Alexandra Children's Hospital	84	135	0	219	9%
The Tunbridge Wells Hospital	15	59	121	195	8%
Princess Royal Hospital	*	*	62	74	3%
Queen Victoria Hospital (East Grinstead)	*	*	*	14	1%
East Surrey Hospital	*	*	*	11	0%

Comparisons To England

The only self-harm data for which there is sufficient data to allow comparisons to other areas is for self-harm admissions. The rate of self-harm admissions for under 25s has been on an upward trend over the last 10 years in East Sussex, which is not the case for England where the rate has been more stable since 2013/14. East Sussex has had a significantly higher rate than England and the South East in the most recent years. All Sussex areas have had higher rates than nationally with the latest year (2020/21), which is also the first year East Sussex has seen the highest rate in Sussex (though not significantly higher).

Figure 17: 10-year trend in self-harm admission rates for Under 25s, Sussex and England

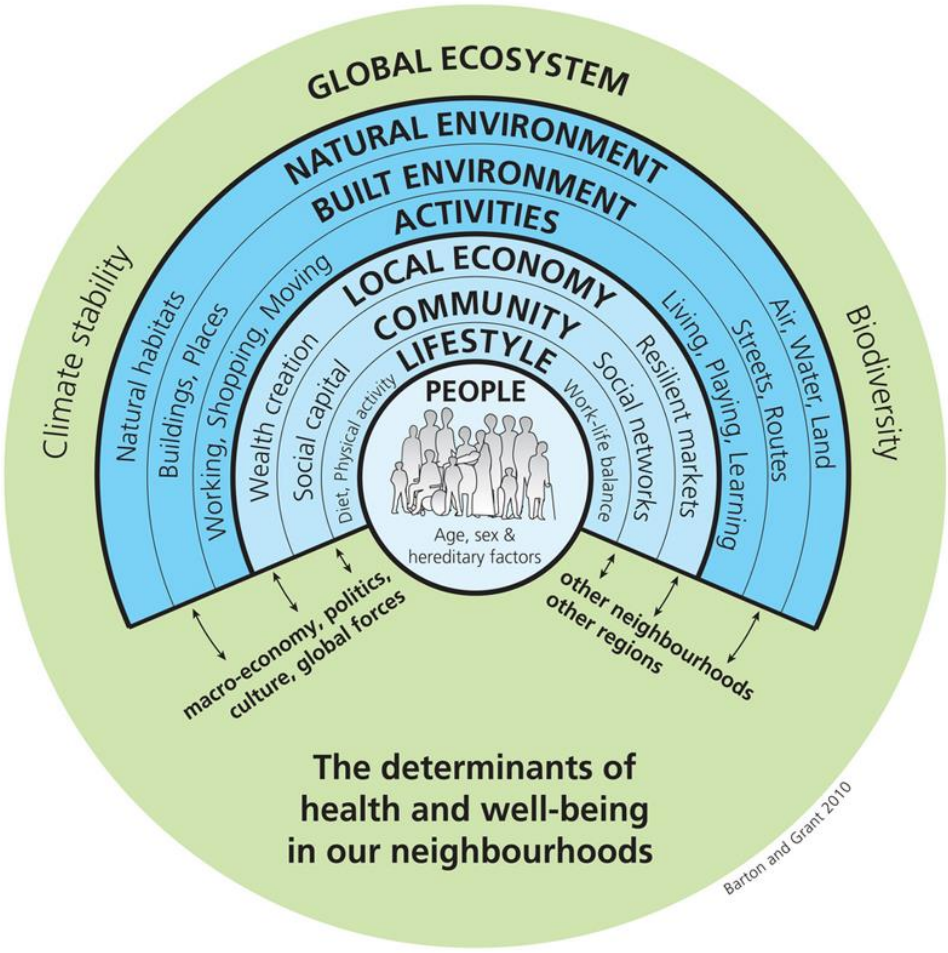


8. Preventing Self-Harm

The Building Blocks of Health

The building blocks of good mental health are wide ranging and include our biology, the environment within which are born, grow, live and work, and other wider determinants of health, such as income, parental education, housing, and the natural and built environment. See Fig X

Figure 18: Determinants of health and wellbeing



Source: Barton, H. and Grant, M. (2006) A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6).

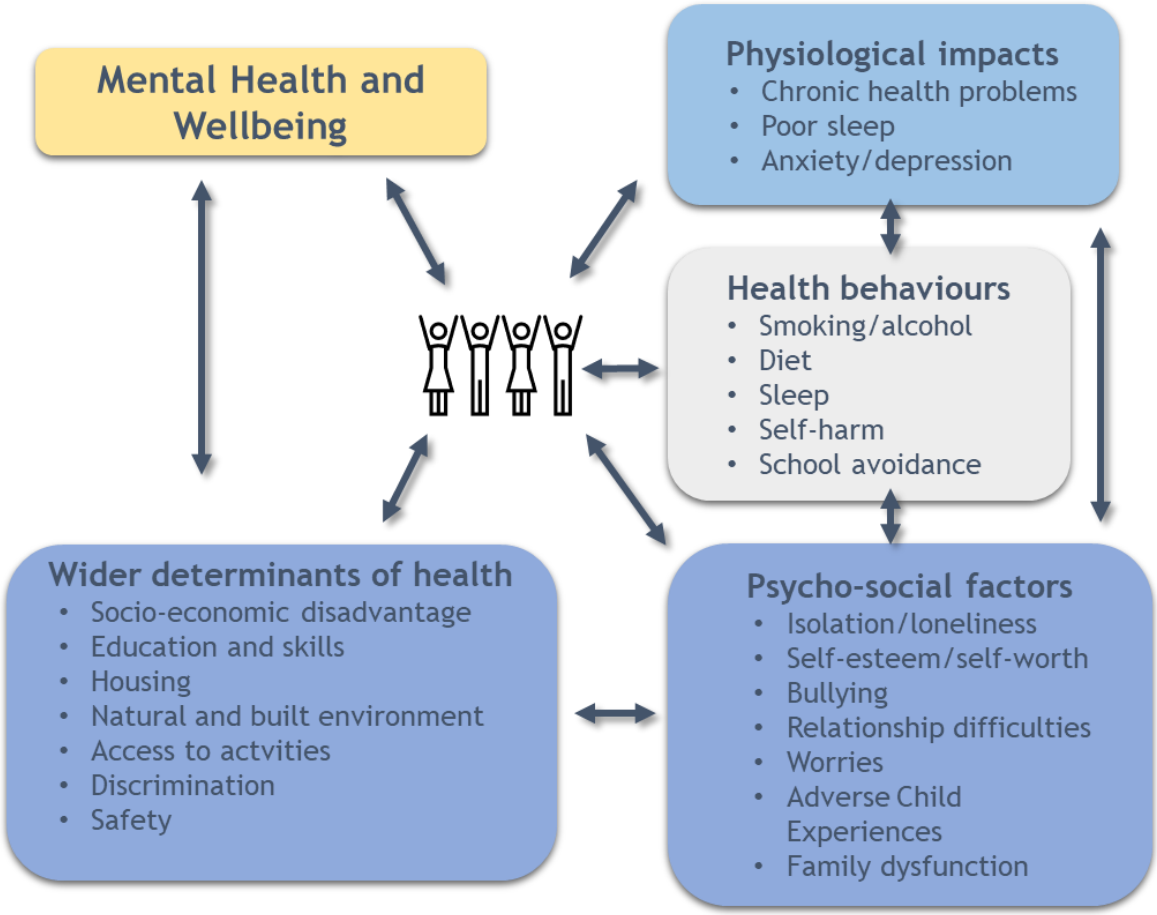
The risk of developing a mental health problem is influenced by multiple factors past and present. This report has highlighted a range of factors that increase or decrease the likelihood that a young person will self-harm. Figure x shows the complex interplay between wider determinants of health and psycho-social factors

(for example, isolation and social support), health behaviours (for example, smoking and drinking) and physiological impacts (for example, high blood pressure and anxiety and depression).

Attempting to reducing inequalities in health and preventing an issue such as self-harm, means understanding this complexity and the need for a multifactorial approach.

The National Institute for Health and Care Research (NIHR) has produced an interactive web-based tool that brings together evidence from academic research, reports, and practitioner and public consultations to map out the factors affecting mental health across all stages of a person's life, including links to key evidence and lived experiences. It is a useful tool for exploring the range of factors that impact on mental health[37].

Figure 19: Patterns of risk affecting mental health and well-being



Adapted from Labonte's health promotion and empowerment practice framework. [38]

Evidence of What Works

Primary Prevention (before problems emerge)

There is a lack of national evidence relating specifically to the primary prevention of self-harm, perhaps reflecting the complex nature of self-harm risk factors.

There is however a strong evidence base supporting interventions aimed at preventing mental illness and promoting good mental health in school aged children and early years. A report outlining this evidence was commissioned in July 2022 by Brighton and Hove Public Health. The methodology followed is provided in Appendix 5. The evidence is summarised below, with more detail provided in Appendix 6.

Table 16: Summary of evidence - Preventing mental illness and promoting good mental health or wellbeing among parents, children and young people

Early Help
• Promote and implement the Healthy Child Programme[4] through a multi-agency approach including, as examples, primary mental health workers, safeguarding, youth workers, counsellors, and public health specialists. • Collaborate with NHS England to support the local implementation of the Early Intervention in Psychosis (EIP) model - to reduce treatment delays at the onset of psychosis and promote recovery by reducing the probability of relapse following a first episode of psychosis. • Implement NICE guidance on preventing psychosis, such as access to pre-emptive CBT for people considered to be at increased risk. • There are significant effects in favour of Wraparound care in improving young people's mental health (wraparound invests in a care coordinator with low caseloads who convenes a team that includes the family's friends and natural supports, as well as professionals). • Early Support Hubs offer a speedy, easy-to-access and non-stigmatising way of getting mental health support for young people. See #FundTheHubs campaign. • implement brief psychological interventions to prevent mental health issues in young people (e.g. group-based CBT resilience and protective factors, coping skills, mindfulness, emotion recognition and management, empathic relationships, self-awareness and efficacy, and help-seeking behaviour).

[4] The Healthy Child Programme is an evidence based universal programme available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. It is primarily delivered through health visiting (ages 0-5) and school nursing (ages 5-19) services.

Whole-school Approaches
• A 'whole-school approach' to mental health is widely acknowledged to have the biggest impact. Supporting your local schools to adopt this approach will boost children's mental health and school achievement. • Implement whole settings-based programmes within local colleges and universities informed by the work of the English Healthy Universities Network, Student Minds and the World Health Organisation's Health Promoting Universities Programme. • Social and Emotional Learning (SEL) programmes that help children and young people to recognise and manage emotions, set and achieve positive goals, appreciate the perspectives of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively. • Intervention to help reduce the incidence of bullying can have positive benefits for mental health of victims and perpetrators. • Target support to children who are out / or at risk of being out of school and who have greater exposure to factors that negatively impact mental health, for example, children who are homeless or those in the criminal justice system
Other

• Adopt a range of prevention strategies for eating disorders:
  • Universal media literacy and using the media to critically look at body ideals.
  • Prevention interventions aimed at children at risk using body image focused cognitive behavioural activities in schools.
  • Cognitive dissonance activities that engage young people in conversation on body image.

• Tackle racism and discrimination. Racial injustice is toxic to young people's mental health.
Consider using digital interventions which have been shown to be effective to reduce depression in young people (e.g. MoodGym).
Reducing Parental Conflict (RPC) has become a government priority through the Department for Work and Pensions, given the detrimental impact this can have on children's mental health. The evidence shows some positive changes in children's mental health from the RPC programme.

Whilst interventions to address the wider determinants of mental health are important, there is limited evidence of their effectiveness. In recognising this limitation, Shah et al (2021) analysed 14 systematic reviews and concluded that there is 'high quality evidence' to suggest that more generous welfare benefits may reduce socioeconomic inequalities in mental health outcomes; and a wide range of 'lower quality evidence' suggesting that social policies were associated with improved mental health outcomes, including paid parental leave, gender equality policies, and community based parenting programmes.

Secondary Prevention (as problems emerge)

Early identification of need and access to early help should form the basis of a preventative response to those who are beginning to show signs of poor mental health and self-harm.

NICE has recently published new guidance Self-harm: assessment, management and preventing recurrence which covers the assessment, management and preventing recurrence for all people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability.

This guidance acknowledges that an initial assessment will need to be undertaken by a range of non-mental health professionals, such as GPs, teachers and social care staff. The nature of this assessment varies by role, but is likely to incorporate concerns around

- Physical health
- Consent and confidentiality
- Involvement of parents/family
- Provision of information and ongoing support
- Getting 'more help' where necessary

Additional guidance for the assessment and care of self-harm is provided for specific non-mental health staff, such as those working in hospital emergency departments, primary care, social care, education, criminal justice and secure settings.

The guidance also states that at the earliest opportunity after an episode of self-harm, a mental health professional should carry out a psychosocial assessment to:

- develop a collaborative therapeutic relationship with the person
- begin to develop a shared understanding of why the person has self-harmed
- ensure that the person receives the care they need
- give the person and their family members or carers (as appropriate)
- information about their condition and diagnosis.

Guidance relating to the treatment and aftercare of young people who self-harm is included, but is not within the scope of this needs assessment.

Local Guidance

There are a number of local resources to help parents and professionals respond in a safe and consistent way to young people who self-harm.

The Self-harm Toolkit, for schools and colleges has been developed by East Sussex County Council to help adults to recognise the signs, identify risks and support children and young people who self-harm, or who are at risk of intentionally harming themselves. Although in many cases a young person may need support from a mental health professional, it is important that a wide range of adults are able to respond confidently and positively to someone who is self-harming and provide early help and advice.

East and West Sussex and Brighton and Hove local authorities have jointly commissioned a series of webinars delivered by Dr Pooky which include tips for parents/carers whose child is self-harming.

Young Minds have produced guidance for anyone finding themselves in the position of wanting to support a young person who is self-harming. This can be difficult due to lack of confidence or uncertainty about what to say or do. The guidance is intended to help take those first steps. No Harm Done

The Charlie Waller Trust has produced guidance specifically for parents. It includes information on the nature and causes of self-harm, how to support a young person when facing this problem and what help is available. Support for parents and carers - Charlie Waller

Our literature search found some further resources to help people respond in a supportive and constructive way to those who have begun to self-harm.

- A document prepared on self-injurious behaviour in children with an intellectual disability presents a summary of research evidence on defining self-injury, causes of self-injury and effective interventions to help parents and carers of such children. It focuses on children with profound to moderate intellectual disability.
- A guide for practitioners in repeating self-harm attempts and prevention prepared in Cambridgeshire gives valuable guidance on how to tackle/ handle an individual, important aspects that needs to be concerned during such events, importance of involving the young person throughout the discussion/ each phase.

- A recently developed online safety plan app "Beyond Now" was evaluated for effectiveness of using in self-harm prevention among a group of 16–42 year old participants in a tertiary medical health service and was found to be user-friendly and easily accessible. Complementing this app, "Blue Ice" app was specifically designed for use which includes a mood diary, a menu of personalized mood lifting activities and automatic routine to delay and preventive strategies when risk of self-harm is reported.

9. Stakeholder/Provider Voice

Stakeholders

Those who work closely to support children and young people (CYP) who self-harm, or are at risk of self-harming, have a unique insight into what is working well in terms of prevention and early intervention, and where there might be room for improvement. Many service providers are East Sussex residents and so they, their families and social networks are also potential users of the services.

Methodology

Semi structured interviews were conducted with key providers and partners to gain a professional perspective of self-harm prevention and early intervention, for residents in East Sussex.

From an initial 39 key partners approached, 24 were interviewed. Key Partners interviewed included: Pastoral managers of colleges; Family support workers; Police officers; Mental Health Support Team SLES; Fellowship of St.Nicholas; Places2Be Area Manager; Practice Educator East Sussex CCG; Holding Space; Elective Home Education; Schools Mental Health and Emotional Wellbeing Adviser ISEND; SENCO; Senior Key worker; Assistant Headteacher for safeguarding and wellbeing; GP; Practice manager; Programme Manager of CCG; CYP mental health and wellbeing lead, NHS Sussex; Social worker ESCC; Specialist mental health practitioner ISEND; E-motion Counselling; School Health Service; CAMHS.

There were 6 key questions asked to all stakeholders interviewed:

1. In your opinion, what, if anything, is working well to support children and young people in relation to:

a) the early identification of self-harm?

b) accessing initial support/first contact services for those who self-harm?

c) the delivery and organisation of initial support/first contact services?

2. In your opinion, what is not working well in relation to:

   a) the early identification of self-harm?

   b) accessing initial support/first contact services for those who self-harm?

   c) the delivery and organisation of initial support/first contact services?

3. In your opinion, what could be improved or done differently to reduce the number of children and young people who start self-harming?

4. What, in your opinion, are the needs of children and young people who self-harm (or who are at risk of self-harm) that are not being met by current approaches to prevention/early intervention?

5. What has been the impact, if anything, of COVID-19 on the need for, and provision of initial support/first contact services for children and young people?

6. In your opinion, what would be the priority for improving/developing the provision of early intervention self-harm support for children and young people in East Sussex?

Results

A summary of the high-level thematic analysis across all participants is provided below. The themes were grouped into four categories,

1. Strategic approach
2. Service provision
3. Access
4. Operational approach

Within each, the tables present sub-categories which are ordered relative to the frequency of mention.

1) Strategic Approach – Summary

(most prevalent theme and key points first for each category)

CATEGORY	THEME	KEY POINTS

Working well	Partnership working	Whole-school approach, Clear pathways, Agencies working together, information sharing
	MH support in every school	Reduce medicalisation, Mental health lead
	Integration of services	Integrated health and social care
	Prevention/Early intervention	Picking up on student behaviour
Not working well	Prevention/Early intervention	Difficult to detect early, asking direct questions, definition of SH vague
	Variation in service provision	Variable access to services and resources
	Partnership working	Lack of communication between services, meetings, joint working, no framework of available services, lack of clearly defined roles
	Lack of resources/funding/services	Services overwhelmed, lack of funding, lack of good quality resources or time
For improvement	Partnership working	Clear evidence-based pathways/guidelines/map of services, regular multi-disciplinary team meetings, collaboration with external agencies, whole school approach
	Resources/funding	Resources for home-schooled, more funding, more resources
	Prevention/Early intervention	Early identification, social media, preventative measures, impact of way of life, clarity of interventions

	Variation in service provision/Equal access to MH support and education	MH part of curriculum in all schools, resources/law change for home schooling
	Prevention/Early intervention	Clear thresholds, early access to interventions, interim services
Needs not being met / gaps	Funding/resources	Consistent resources across schools, the right resources, more funding and time
Priority for improvement	Partnership working	Clear evidence-based pathways/guidelines/map of services, support network of agencies, MDT meetings
	Funding/resources	More money, staff, funded training, resources, increase services
	Variation in service provision/Equal access to MH support and education	Equal access to MH support across regions, comprehensive approach, MH part of curriculum of all schools
COVID-19	Number of MH/SH cases	More or worsening MH in CYP, worse anxiety, more SH (seen by services?), exposure of hidden MH issues, parental anxiety about COVID, lockdown helping anxiety
	Prevention/Early intervention	More difficult to identify
	Funding/resources	stretched services, long waiting lists, delayed or inappropriate management, lack of funding
	Inequality exacerbated	some schools able to cope with COVID better, private vs state school

Strategic Approach: Partnership working

Partnership working was identified as a key theme across a number of interview questions. For example, in terms of what is working well as part of the early identification of self-harm and delivery of initial support/first contact services, a number of stakeholder responses specifically mentioned partnership working, to include information sharing between organisations and how this can help to ensure children and young people receive appropriate support.

> 'I think some of the information sharing there by the A&E departments is important with schools under the safeguarding protocols, so when you've pitched up in A+E your school is likely to find out unless there are very clear reasons not to share information with schools. I think that's beneficial, because the schools will be dealing with that young person the next day.'

The positive impact of partnership working was also highlighted by multiple respondents in in terms of developing pathways and processes, specifically with regards to the development of assessment tools and the dissemination of guidance and joint processes (e.g. flow charts) through the new East Sussex Self-harm reference group.

Finally, a number of stakeholder responses also made reference to the value of utilising a whole school approach, including the value of the relationship between schools (including staff trained in mental health) and parents/carers in the early identification of self-harm.

There are also aspects of partnership working that were highlighted as not working so well. For example, a number of stakeholder responses specifically highlighted that communication between services (and between areas) was not working well, and that there was a lack of clear framework or pathway for mental health services that support children and young people's self-harm.

> 'I think from my perspective, what's not working well is that we don't have a structure where all of the agencies are meeting together and mapping the services so that the young person can have a clear vision of what is available and how they can access that support. It would be good to have a stepping up and stepping down system so that there is this holistic approach.'

A number of stakeholder responses also made reference to roles and responsibilities across different services (with regards to risk) and how this may

not always be conducive to effective partnership working or support for a young person.

> ‘We work closely with the mental health support team. We have a nearly qualified trainee practitioner, and her remit says that once a pupil is self-harming it's not her level of support any longer.’
>
> ‘One of the real problem areas initially is the concerns that are held among some groups around the risk levels that are in play, as a YP you are taking quite a big step/risk in terms of your own wellbeing to discuss this stuff, and if that initial discussion ends up being one where the person you’re speaking to says ‘you’re too risky for us, we’re going to pass you on’, then that’s problematic.’

Stakeholder responses identified partnership working to be the top priority for improving the provision of early intervention self-harm support for children and young people and also an area for improvement. Stakeholders spoke of the importance of partnership working/ bringing multi-disciplinary stakeholders together regularly to support the mapping of services, development of clear pathways, production of guidance, tools and policies and also the importance of strengthening partnerships between organisations, including support agencies and schools.

> ‘I think it's about having a forum to meet consistently and periodically accessing support between and within agencies, mapping services out so we're not duplicating support, and just building relationships so that we can work professionally with other agencies.’
>
> ‘…what really worked well [in response to a major local incident] … was that we had meetings every month where all of the agencies involved will get together and network, but also discuss what was working well, what could be improved, what gaps there were, or other agencies we were not engaging with. That really maximised the impact of what was being done.’

Strategic Approach: Funding/resources

Funding and resources were identified as a key theme across a number of interview questions, including what could be improved or done differently to reduce the number of children and young people who self-harm and what people saw as the top priorities for improving the provision of early intervention self-harm

support. Comments reflected a need for further funding to provide greater volumes of support, particularly at an early intervention stage (e.g. with schools, youth clubs, and parents/carers) as well as the need for funding to support the provision of a trained workforce.

> ‘If you're telling them they've got to wait for that service for three or four weeks, God only knows what's going to happen to them in that time and how they're going to spiral. So I think, unfortunately, what it comes down to is money to put towards increasing services or providing more people for them to speak to or places for them to go to.’

In terms of what is not working well, a lack of resources or funding was and the associated impact on service provision was one of the predominant issues raised. Stakeholders spoke of overstretched services/support systems, with some citing lack of time impacting on their capacity to identify and support children and young people in a timely way or deliver an optimal service.

> ‘As with everything or services have been stretched. For example with our triage nurse, we've had so many calls that on some occasions we've not been able to offer that facility to people because they've been on another job that's been deemed a higher threat/higher risk. So at the time, they've just had to have the police officer, which is something, but it's not the full service that we could be providing.’

Stakeholders described how the COVID-19 pandemic had only served to exacerbate this situation, resulting in long waiting lists, delayed support, and higher risk cases being managed at lower levels.

> ‘In our services – police, mental health, NHS, and social services - we have been so stretched over the last two years that unfortunately unless your case has been quite high on the threat, harm, risk and scale, you've been shifted to one side.’
>
> ‘Now we've got lots and lots of referrals going in for things that perhaps might not have been so obvious or have even been there prior to COVID. Everyone I speak to has got the same number of staff but more and more people being referred to them, and I think that's really hard. I've spoken to social workers who have said that they are only meant to have 16 people on their caseload and now have nearly 40.’

Other themes raised highlighted a lack of funding, specifically relating to early intervention such as counselling in schools, and a lack of resources/support/services for specific groups, such as parents/carers and electively home educated children.

Strategic Approach: Prevention/early intervention

Whilst prevention/early intervention was mentioned on a small number of occasions by stakeholders as something that is working well; a greater number of comments concerned the aspects of prevention/early intervention that were not working so well or could be improved.

For example, stakeholder responses highlighted the difficulties in being able to detect/identify self-harm at an early stage, and the challenges associated with this in terms of defining self-harm, asking young people direct questions, and the often secretive nature of self-harm behaviours themselves.

Stakeholder comments also reflected upon a wide range of issues relevant to prevention and early intervention, including the need to improve the early identification of children at risk and providing more early intervention support and services, as well as tackling some of the issues contributing towards children and young people's anxieties (e.g. trauma during early childhood, children living in chaotic and challenging life circumstances, lack of social connections, bullying, academic pressure, social media).

> 'I mean we were saying that just improving general welfare services, having drop-ins, having people that are available because to catch them when they have those first symptoms that anxiety that you know when they come just feeling really low. That's when it's going to start, isn't it? And it could start and catching them at that stage before it escalates.'
>
> 'More generic provision. Need awareness of provision and how to reach it. If a YP starting to experience anxiety or a traumatic event then that's when we should start our provision before they start to self-harm.'

Other issues raised included the negative impact of the COVID-19 pandemic on self-harm prevention and early intervention, caused as a direct result of increases in demand for mental health support/services.

> ‘People being seen less does mean that there is going to be less early identification.’

Strategic Approach: Variation in service provision

The final strategic theme identified was a perceived variation in service provision. For example a number of stakeholder responses specifically highlighted variation in the early identification of self-harm and delivery of initial support/first contact services across East Sussex and some of the negative impacts of this in terms of awareness of what is available for children of different ages and the support they can subsequently access.

> “So what we see for those that fit the age group for I-rock, that's great, but we're getting younger and younger children who are coming to us who need that support and there is no walk-in triage kind of service for younger children. We can encourage them to go to their GP but for an 11-year-old, for example, or other children who are primary school age, we haven't got anybody to refer to who directly can pick that child up rapidly.”
>
> ‘First contact means school. Mishmash of services available – some services available to some schools…How do you know who you need to contact and the help you’re entitled to? How do you get a referral to the right place at the right time?’

When asked what could be improved or done differently to reduce the number of children and young people who self-harm there appears to be some consensus of a need for equal access to mental health support and education with many comments focused on continuing to strengthen mental health education as part of the curriculum/whole school approach.

> “In the last 20 years, we have done a great job of destigmatising emotional and mental health problems. We’ve equipped a generation with knowledge and a language around mental health that previous generations did not have. What we have massively failed to do is teach young people how to use that information and better understand or control their emotions.”
>
> “Education, education, education! Start talking about mental health early in schools.”

Equal access to mental health support and education was raised by some as a key priority for improving the provision of early intervention self-harm support. Comments centred on the need for a comprehensive approach/offer for all age groups and geographical areas.

2) Service Provision Summary

(most prevalent theme and key points first for each category)

CATEGORY	THEME	KEY POINTS
Working well	Online services	Virtual GP consultations, online resources, iRock (and iRock webinars), text school nurse service, C-zone, websites
	Specialist services/hubs	Drop-ins, triage nurses, youth hubs, workshops, mental health lines, health in mind, young minds
	iRock	good for 14-25, accessible, speeds up referral, self-referral, virtual consultations, responsive
	School services	school health services equipped for SH and MH, text your nurse service,
Not working well	iRock	Lack of communication between iRock and other services, No ongoing care after drop-in
	CAMHS	Clinical/too formal, Identify need but don't take next steps
	Specialist SH service	No specialist self-harm service
	Vague or varying organisation name	vague or varying organisation names, not clear what they do
For improvement	Drop-ins	Have more drop ins/safe environments to talk
	Welfare services	Improve welfare services
Needs not being met/gaps	Inconsistent service	Not all schools giving appropriate service, not all schools have interim services/key workers, lack of resources

	School counselling	Availability of school counselling/talking therapies, therapy for whole family, talking appointments difficult for SEN,
Priority for improvement	Diverse services	More options/diversity of services, online provision, youth workers, no wrong front door
	Online services	individual care packages, variable access
COVID-19	Online services	difficult going from face-to-face to online, difficult to build relationship, not inclusive (some people wont like), don't get full picture, 18+ don't like, innovative/more options, some young people like it, SEN prefer it, access from anywhere, reaching new people
	CAMHS	Not going out to do face to face assessments

Service Provision: Online services

Online services were identified as generally working well. A number of stakeholders spoke positively about online services available, whether this be anonymous reporting apps to aid early identification, information provision online (such as websites targeting young people, professionals, and/or parents and carers), or services developing and enhancing their virtual offer (e.g. via virtual consultations and drop ins, utilising social media channels to deliver interventions with young people, and extending virtual support to additional audiences).

> 'The increase in online support available to young people. I think that extra level of service that's offered, means that some young people are more willing to engage and share.'
>
> 'Recently, we've introduced 'Whisper app' which is a facility on our website, and it means that people can report things anonymously – either about themselves or their friend. We anticipate that that's also going to be another tool to aid that early identification.'

The need to develop and enhance **online services** during COVID-19 was also noted by several respondents as having a positive impact on the provision of initial/early self-harm support for children and young people, and were particularly well received by some groups of young people such as those who are neurodiverse or

with high anxiety, or those who found it more difficult attending a face-to-face service.

Others also spoke about how the increase in online services provision during COVID-19 enabled them to not only offer young people something different, but to also reach a slightly different cohort of young people, whilst also being a way of enabling continuity of support (e.g. when school buildings were closed during the holidays).

> "[We] hadn't previously offered online sessions. [We] began to reach a slightly different cohort of young people. Really good long-term lesson because there is a massive desire from some young people for online sessions – some people simply can't engage face to face e.g. due to anxiety."

Although mentioned less frequently by stakeholders, online services were also mentioned as a negative consequence of the COVID-19 pandemic on the provision of initial/early self-harm support for children and young people. For example, some stakeholders highlighted how it was sometimes difficult to develop relationships and build connections with young people whilst delivering services online, and that it could be difficult to pick up on young people's non-verbal cues or cues from their environment when providing support virtually.

Whilst online services were perceived to be preferred by some children and young people and deemed more accessible, some stakeholders also fed back that online services may automatically preclude some young people from being able to access support and may not suit (or be the preference of) all young people.

> "COVID has stopped that face-to-face interaction, which you need if you're isolated – screen time doesn't work as well….But if you aren't going out to children's houses and picking up on the cues or being able to physically see them, you don't have that protective factor. You can't do any of that through a screen."

A minority of respondents highlighted development of online services as a priority for improving the provision of early intervention self-harm support for children and young people in East Sussex. Responses reflected the need to consider those digitally excluded as well as how services used their online presence to support wellbeing.

Service Provision: Existing local services

With regards to services that support children and young people currently engaging in (or at risk of) self-harm, a number of existing local services were mentioned as working particularly well to meet need, specifically existing drop-in services such as iRock and those provided by the East Sussex School Health Service.

A number of stakeholders also specifically referenced the value of iRock service, particularly in relation to the ease of referral/ability to self-refer, a lack of mental health threshold enabling more young people to be able to access the service, young people being able to access the service quite quickly and in varying formats (e.g. virtual and face to face), and that the service was staffed by both NHS and local authority professionals.

> 'From the health point of view, we have iRock, a mental health drop in, which works well in that it has no thresholds so kids can just drop in and access help straight away.'

Finally, the Single Point of Access (SPoA) was mentioned by several respondents as working well in terms of general awareness of this service/ process, the ability of professionals and carers to access this service for advice (even if this did not result in a young person accessing a further service), and how it was joined up with the 0-19 Early Help Service (i.e. keywork).

A number of stakeholder responses also specifically spoke positively about the School Health Service as part of the interviews, with a number of aspects of the service highlighted. These included the awareness and profile of the service, how they work with the young person and effective communication between the service and referring individual.

> 'With school nursing, we will put those referrals in but and then they will often give us a call back so they do feedback and they will let us know and then come back and talk to us'
>
> 'I suppose that everyone can ring up SPOA e.g. parent/carer/member of staff can ring up for advice and guidance – whether results in a service or not then they can still ring it.'

Other services mentioned by a small number of respondents as working particularly well include CAMHS, School Counsellors (where available), and the support provided through triage nurses (located in ESHT hospitals).

A small number of stakeholders, however, mentioned elements of some of these services they perceived as not working so well. For example, for those accessing IRock who may require more support than is possible through a drop-in service, or better communication for those referring to the service in relation to those they refer.

> ‘So when a family is referred to iRock or we suggest they refer their child to iRock we don't necessarily know if that family has gone to iRock and we don't necessarily know unless the family, you know we can do a welfare check up call and we can ask but we don't necessarily know from that service whether provision is being put in place. I understand that capacity doesn't give them time to necessarily come back to us.’

CAMHS was also mentioned by a minority of respondents as being impacted by COVID in terms of a lack of assessments and face-to-face support during the pandemic, and as sometimes being too clinical/formal an environment for a child.

Service Provision: Challenges or gaps in service provision

A number of challenges or gaps were identified by a small number of key stakeholders with regards to current provision for children and young people currently engaging in (or at risk of) self-harm. Key challenges identified included variable quality and consistency of provision leading to CYP not being able to receive the right type of support required at the right time (often associated with available capacity or resources).

The availability of school counselling/talking therapies was also mentioned as not currently sufficient to meet need, as well as the adoption of a whole family approach as part of service provision. Finally, drop in services and earlier engagement/ wider reach of support for children and young people emerged as less prominent themes for areas to be improved.

Service Provision: Diverse services

Stakeholder responses identified diversifying the provision of services to be a priority for improving early intervention self-harm support for children and young people in East Sussex. A wider approach (considering the community offer, such as youth workers), was prioritised to offer more flexibility and diversity in access support, and also in the types/ formats of activities offered. As part of this, a few stakeholder responses specifically spoke about the importance of open access and adopting a ‘no wrong front door’ approach, as well it being priority to ensure that services are promoted and made available where children and young people are, such as via social media and schools.

3) Access – Summary

(most prevalent theme and key points first for each category)

CATEGORY	THEME	KEY POINTS
Working well	No wrong front door	Multiple access points, easily accessible, early intervention
	Low thresholds/open to everyone	Anyone can get help/have conversation, iRock, SPOA, no criteria
	School access	C-zone, increase in school access,
Not working well	High/variable thresholds	CAMHS, iRock, SPOA, overwhelmed, not meeting criteria, age boundaries
	Waiting times	Long waiting list school, GP, CAMHS
	Poor communication	difficult to get in touch with CAMHS, nobody gets back to the parents
	CYP	Not convenient, have to leave lessons, not seeking support
For improvement	Easier access	age limit for iRock, preventative measures, high thresholds, generic access, out of hours contact
Needs not being met/gaps	Poor access/strict thresholds	CAMHS, school counsellors, dismissing as behavioural rather than MH, high thresholds, early intervention
Priority for improvement	Widen access	Phone number, out of hours, flexible options, earlier intervention, lower thresholds, interim services

COVID-19	Poor access	no home visits, cant get full picture of issue, no access to face to face services such as youth groups, school closure

Accessibility of service provision for self-harm support for children and young people was a key theme that emerged across the cohort of stakeholders engaged with. A small number respondents identified improvements in accessibility for some services, particularly in mental health advice in schools, open access to iRock (but this is only available for those over 14) and SPOA. However, the vast majority of those who mentioned accessibility spoke of challenges of high and variable thresholds for support, with a perceived gap in provision particularly between early intervention and CAMHS specialist help. Several respondents suggested that in most circumstances, self-harming behaviour itself would not meet a threshold for acceptance to CAMHS.

> "[Its] all about upping the pressure all the time rather than supporting and soothing and containing. It's hard to access support unless you say there is a significant amount of harm"

Access to specialist advice and support for self-harm outside of CAMHS is also perceived to be limited, with the increasing pressure that services are under meaning that it can be difficult to get a response from other potential front doors for help including GP and SPOA. A number of stakeholders commented that perception of services as being hard to access can persist, such that some may not try to refer.

A number of stakeholders also commented upon the impact of COVID for accessing support, particularly in terms of restrictions on young people's ability to access a range of supportive connections (such as clubs, school, youth groups), rather than mental health services.

Several stakeholders suggested that it is important to understand how young people want to access help, and not making assumptions about what would make it easiest.

> "I think children who self-harm need to be given an opportunity to have a discussion with a professional who is independent and detached from the current environment, and that would include a school."

When asked how support and provision could be improved, there was a broad consensus that central to this would be addressing over-reliance on CAMHS and having a greater range of options for young people at an earlier point. This would enable a greater range of professionals to have a role in helping young people but also address and hopefully resolve problems at an earlier point. It was also identified that generic mental health support should be available at an early point.

4) Operational Approach – Summary

(most prevalent theme and key points first for each category)

CATEGORY	THEME	KEY POINTS
Working well	Training	Self-harm training for schools (Pooky Knightsmith), GPs, workshops, webinars
	Awareness	Increased awareness in schools, open communication, reducing stigma
	Relationships	Trusting relationship with students (Schools), open communication with families
	Referrals	Self-referral (Health in Mind, iRock), signposting to multiple sources
Not working well	Training	Variable training across different staff - social workers, schools undertrained, don't want to promote SH
	Awareness	Lack of awareness of MH and SH in schools, parents, definition of SH, scared to encourage SH, blaming parents, blaming CYP, services available, glamourisation, stigma

	Relationships	Lack of good relationships with students, prevents asking direct questions, teacher/parents
	Support	Lack of MH support in schools, support for parents, correcting misinformation, giving health coping mechanisms
For improvement	Support	MH support in schools, give coping mechanisms, understanding the reason behind it, dedicated time for wellbeing at school, support for parents
	Awareness	Awareness of available support, reduce stigma, give parents support, reduce glamourisation, improve understanding of SH
	Relationships/ Communication	Encourage open communication about MH, speaking to actual person, communication between parents and children, continuity of care, improving how we treat people
	Education	Train teachers about MH, educate CYP about risks and alternative to SH
Needs not being met/gaps	Support	Support for parents, safe space at school, peer support/group counselling, support for teachers
	Staff	People who have time/job is to talk to them, variety of people to talk to
	Education	Lack of trained staff, Lack of health coping mechanisms, lack of sense of self
	Awareness	SEN linked to MH + SH, holistic view of CYP, Stigma, available support, parents understanding, parents feeling judged, needs of families being met, not taking it seriously

Priority for improvement	Awareness	Destigmatisation, better understanding/definition, increased awareness of support and how to access it, taken seriously
	Support	adequate/appropriate/clinical level MH support in schools, support for parents, support groups/peer networks for CYP,
	Education	Education and training for staff - particularly teachers, giving coping mechanisms to CYP
	Opinions of CYP /parents	CYP and parents opinions of what is needed
COVID-19	Communication /relationships	Missing out on social/isolation, barriers to communication/contact, 18+ prefer face to face
	School experience	Missing out on full school experience/academic, struggling coming back to school from lockdown
	Support	Lack of MH support/services stopped, support for families/parents
	Awareness	Increased awareness of MH+SH, decreased stigma, open communication about MH

Another key area of insight from this cohort of providers and other key stakeholders related to the practicalities of service provision (the operational approach to provision). A major theme that emerged related to training opportunities in self-harm support. While the available training was noted to be working well for many (including teachers, and workshops and dedicated webinars, for example the self-harm training delivered by Dr Knightsmith), several others felt that the offer could be more widely available, particularly outside school settings, such as to social workers. Others however commented on the need for clarity and consistency about whether it was appropriate to work with young people who self-harm in their particular role and what level of risk could be 'held' outside mental health services.

> "Our team (…..) were previously taught not to work with children who self-harm (because training involves a low intensity CBT model which is not designed to address self-harm, and people are taught at university that self-harm is not in their remit. But the need is there and CAMHS don't accept referrals unless the CYP is suicidal. Can't respond to a child disclosing self-harm behaviour by saying 'that's not within our remit"

Awareness of mental health issues and self-harm was another major theme emerging across the insights. Many stakeholders felt that the general awareness of mental health issues and self-harm had improved over the years, including better understanding of the factors or difficulties that might lead to this behaviour. Some commented that this has helped reduced the stigma that many young people feel. However, many also commented that fear and anxiety prevented some schools from taking the issue seriously or thinking pro-actively how to support pupils. For example, some felt that parents, teachers and others may be reluctant to ask about self-harm, partly through fear of making things worse but also because there may not be the support available to address the identified need.

The need to support parents in particular to manage self-harm of their children, many of whom may be struggling in other ways, was also raised.

> "Lots of [parents] might have MH issues of their own, difficult relationships, all sorts of complex issues – and then there are so many parents who are in a battle to try to get support for their children. Then the parents' ability to support their child's needs gets worn away slowly"

A key consensus across many stakeholders, was that it is not always clear where to go for help, or rather what each service provides and how they relate to each other.

> "Where do you go? A large number of contacts yp & parents have to make before get to the right service. When you don't work in services, it's very difficult to find out which the right service is for you"

10. Children And Young People's Voice

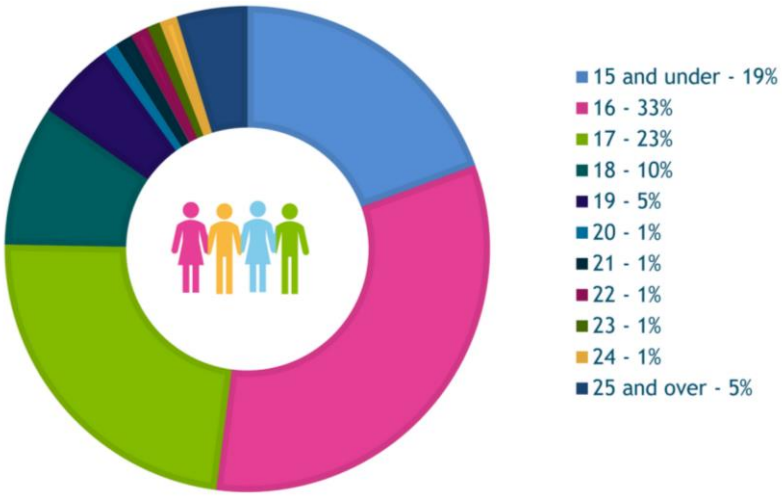
A community survey for children and young people aged 16 to 24 years was administered by East Sussex Community Voice during February 2022. The survey was co-produced with young people and refined with the input of Public Health. The purpose of the survey was to understand more about young people's views and experiences in relation to: awareness of self-harm, their attitudes and opinions, sources of support, helping others and improving mental health.

We did not ask young people about their personal experience of self-harm as this was outside the scope of this work.

Online Survey Results

287 young people took part in the survey which ran from 31st January 2022 until 1st March 2022. The full survey results are available as an addendum to this report.

Age Profile of Participants



Other Characteristics

- 59% of respondents identified as male, 28% as female, 8% as non-binary, 5% preferring not to say or self-describe
- 49% identifying as heterosexual/straight, 23% bisexual, 6% pan-sexual, 5% lesbian/gay woman, 1% gay man, 5% asexual, 8% preferring not to say or self-describe
- 25% of participants considered themselves to be 'disabled', of which 52% specified this as a mental health condition, 15% as a learning disability or difficulty, 6% a physical or mobility impairment, 2% a sensory impairment, 2% a long term condition

- 85% White British, 4% white other background, 3% prefer not to say, 2% mixed/multiple ethnic group

General Awareness

- 80% of respondents had first become aware that some children and young people self-harm before the age of 14yrs. 30% by the age of 12 and 20% by the age of 11yrs.
- Young people became aware that some children and young people self-harm through a friend (32%), by seeing others self-harming (20%), or by self-harming themselves (6%)

Sources of Information

Thinking about what young people might know about self-harm, we asked young people to think about what their main sources of information/influence had been. The top 3 answers were,

Friends	64%
Social media	60%
School	47%

When asked to select up to 3 sources of information about self-harm that they would trust the most, medical and health professionals was the top answer.

Medical / Healthcare Professional	43%
Friends	27%
Websites (including support websites)	26%
School and/or PSHE lessons and/or teachers	31%

The least trusted sources were: movies and TV shows, apps books/magazines and influencers/ celebrity.

When asked whether they had ever actively sought out information about self-harm, 46% of participants said they had. Two thirds sought out information online using websites or via social media. Examples included BBC, NHS, Samaritans, Childline, and Young Minds.

> "I went online , seeking other people who did but had stopped or people who had knowledge of how to stop, so sometimes friends, websites, even some influencers who were spreading awareness"

Far fewer said that they had sought information from specialist services, with 5% saying they had sought information from Child and Adolescent Mental Health Services (CAMHS) and 11% from other NHS services.

Three quarters of those who sought out information found it helpful. The most common reason was that it had educated them and given them the answers they had sought.

> “It helped me understand the topic and how to care for myself around this area”
>
> “It educated me, and the information came from people who have experienced self-harm themselves, not just facts about it but personal experiences”
>
> “It specifically helped me with learning how to talk to a counsellor and rules around confidentiality as parents knowing before I'm ready would make the condition I'm in currently far worse”

The reasons young people gave for information being unhelpful were less defined, however across the responses received, young people told us that the information hadn’t helped with self-harm behaviour and/or was ineffectual or was not pitched at the right level.

> “It was damaging, and I was told I wasn't 'ill' enough or self-harming enough.”
>
> “I was given leaflets containing information I already knew, mostly describing what it was and why people did it. There was no advice or help.”
>
> “Generalisation, typically only refer to self-harm as "cutting”

Attitudes and Opinion

As part of the survey, young people were asked if they agreed or disagreed with a number of statements. In terms of experiences and perceptions of self-harm, over three quarters who answered the question stated that they knew someone who self-harms or has self-harmed, and the majority of respondents were concerned that self-harm was becoming a normalised coping mechanism, and that stigma prevents people talking about it.

> "People tend to normalize self-harm so much as we as society have come to a conclusion that self-harm is what individuals do as a resort to ignore their feelings. This stigma has created an impression on people that it's wrong to seek for help as they may be seen as 'weak'. Moreover, it's the fact that they don't want to worry anyone."

When asked about information and education, only around one in five respondents felt either that they received the right amount of information through education or work, or that social media was a safe source of information.

> "I think people still spread harmful information online especially on apps such as twitter which may be triggering for some who are trying to be clean."

Statement	% agreed / strongly agreed
Most people my age have at least one friend that self-harms/has self-harmed in the past	82%
I am worried that many people my age view self-harm as a 'normal' way of dealing with difficult feelings, situations, or experiences.	69%
Self-harm still carries an unhelpful stigma that prevents people from talking about the issue	87%
Young people receive the right amount of education and support from school/ college/university/ or place of work relating to self-harm	18%
On balance, social media is a safe source of information for someone who may be thinking about self-harming or experiencing self-harm	20%

Sources of Support

For those young people currently self-harming or thinking about self-harming 72% said that they had a person or persons they could turn to for support.

When asked who they would most likely go to as a first source of support, the most common answer was a friend (47%) or a parent or carer (20%). Only 5% would go to a Medical/Healthcare Professional, 4% to a teacher and 3% to a school nurse or staff support.

When asked why they would turn to this person (and were encouraged to select up to three response options), trust was the most common reason selected:

I trust them	74%
They don't judge	38%
They listen	34%
They are likely to understand	32%
They are easy to talk to	30%
I can reach them easily	25%
They keep it confidential	24%

When asked whether there was an organisation they might turn to for support, 75% young people said 'No'.

Of those that said 'Yes', the most frequently mentioned organisations from a total of 48 responses were: i-Rock; Mind; Childline; Samaritans, and Health in Mind. Only 5 (9%) young people said they would turn to their school for support.

When asked to consider the top 3 things which influence their choice of organisation, confidentiality had the greatest influence, closely followed by trust and a lack of judgement:.

It is confidential	31%
I trust them	25%
They don't judge	25%
I can call them	20%
I can reach them online or through an app	20%
They listen	18%
They provide the services I need	18%
They have a good website	16%
They are likely to understand	15%
They have a good reputation	15%

> "They listened, didn't judge and they make it a comfortable environment every time I go so that I feel more comfortable sharing how I'm feeling."

When asked what would make it easier for them to seek professional support or to talk to a professional, the most popular answers were,

It is confidential	55%
Having a comfortable setting or environment	44%
Knowing it's anonymous	44%
It's easy to access	29%
I can text/message them	25%
I can access help online	17%

The survey also looked at young people's awareness of sources of support available for them. From the 200 responses received, national sources of support were by far the most recognised.

Childline	80%
Samaritans	67%
Young Minds	60%
CAMHS	57%
Mind	51%
I-Rock	40%
School health drop-in sessions	25%
Shout Crisis Text Line	19%
Text your school nurse	17%
E-motion	17%
Mental Health Support Teams	16%
Self-Harm UK	13%
E-Wellbeing (YMCA Downslink)	10%

In terms of awareness of self-harm support apps, the greatest awareness by far was 'Calm Harm' with few reporting that they knew of other apps.

Calm Harm	25%
Pacifica	3%

distrACT	5%
BlueIce	4%
ThinkNinja	4%
Self-Heal	6%
Other (please specify)	2%

Accessing Services

63 young people (22% of respondents) answered the question as to what services they had accessed

The four most frequent answers (with the number of mentions in brackets) were:

- CAMHS (20)
- iRock (7)
- Samaritans (5)
- School Teacher / Counsellor (5)

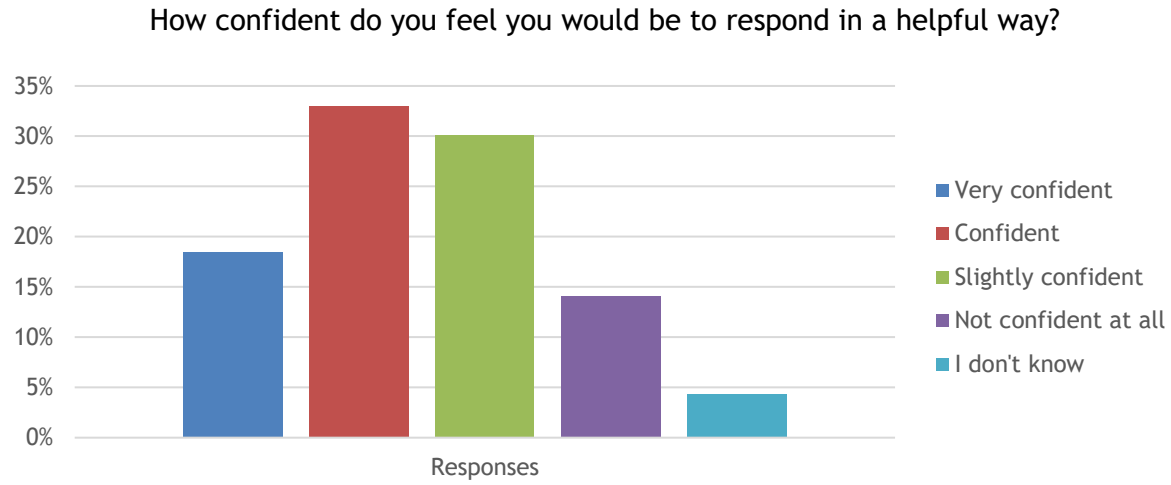
Young people were asked what was most or least helpful about the service they received. Unfortunately the number of responses was too low to draw firm conclusions, but having someone to talk to, having fast and easy access, feeling listened to and being non-judgemental were highlighted as important.

Helping Others

We asked how they would like to be responded to if they were to tell a friend or a trusted person that they were self-harming or thinking about it, the main responses sought were listening and not judging:

To listen	52%
Not judge me	46%
To be calm	39%
Giving me opportunity to talk about how I am feeling	35%
Not push me to change my behaviour	34%
Practical ways to help me cope	25%
To ask how best they can support me	21%
Help me to find support	18%

When asked how confident would they feel in being able to respond in a helpful way if a friend or someone they knew told them that they were self-harming, or thinking about self-harming, the responses were as follows, over half stated they were confident or very confident, while 1 in 7 were not confident at all.



When asked to select the top three types of support/advice they would be most likely to offer if they were concerned about a friend, or someone they knew who was self-harming (or at risk of self-harm), nearly three quarters of young people said they would try to help by talking and listening, and over a third by suggesting distractions in moments of desire to self-harm, or encouraging talking to a professional.

Try to help them myself by talking and listening	73%
Suggest other things they could do in the moment when they feel the urge to self-harm e.g., play music and sing or dance along / hold an ice cube	42%
Encourage them to talk to a doctor or other health professional	35%
Encourage them to talk to a trusted adult	26%
Suggest ways to self-care e.g., mindfulness or enjoying the outdoors	21%
Pass on information that you think would be useful, e.g., books/leaflets/websites/apps	18%
Encourage them to talk to their parents / carer	16%
Suggest they write down their thoughts	15%
Encourage them to talk to a teacher	8%
Encourage them to find a help group	5%

Improving the Mental Health of Young People

We asked young people to tell us what they felt would make the biggest impact to children and young people's mental health in East Sussex?

Free text responses were themed, with the top five answers being:

- Destigmatising self-harm/talking about it
- More Mental Health lessons/awareness in schools
- Easy to access and more approachable services
- More counsellors in schools – that focus on individual support
- Truly confidential services

Focus Group Results

Eight focus groups were also undertaken with 47 children and young people aged 13 to 25 years.

A topic guide was co-produced with a core group of ESCV young volunteers who have past and present lived experiences of issues relating to self-harm, health, and wellbeing, along with experience of community action and co-facilitation. Young volunteers explored a variety of options before selecting and planning the final activities which they deemed appropriate and engaging young participants.

In partnership with local youth workers and recruited through our prior networks and new connections, participants were drawn from:

- Peacehaven Community School
- Peacehaven LGBTQ+ Youth Group and Young Women's Group
- Youth Inspect & Advise Group
- Young Healthwatch East Sussex
- I-Rock Youth Advisory Group
- Sussex Partnership NHS Foundation Trust Expert by Experiences
- Youth PPI Café (16 -25 years)

Young volunteers were supported by project staff to prepare, plan for, and co-facilitate the majority of focus group sessions. Sessions were up to 1.5 hours long, and participants were provided with a briefing before and signposting & support afterward (if needed). Participants were offered a £15 gift voucher to thank them for their time and the value of their contributions. Staff and young volunteers used different activities and participation methods to capture the views and insight of participants. Multiple notetakers were used to improve the reliability of our data.

Scenarios

As part of each focus group we asked young people to consider the following scenario:

- A friend discloses to you that they are self-harming and that they need some extra support and help.
- Where would you 'signpost' them to?
- Who would you recommend that they talk to?
- What information/websites/services do you know of that you would signpost them to?

In responding to the scenario provided, young people recognised the need for appropriate signposting and generally recognised that their role is not to provide clinical guidance or direct advice.

Young people spoke of 'the therapist friend' and acknowledged that it can be damaging to one's own mental health to take on the responsibility of giving advice and support to someone else who is struggling. Some young people told us that they would feel panicked and 'underqualified' to deal with a fellow young person that was in crisis. Many group participants said that for them the priority would be to listen and offer reassurance to the young person, but not to advise or signpost.

Some young people suggested they would talk to the young person's family or someone at school, however others indicated that they would be much more aware of their friend's wishes and would 'go at their pace' and wouldn't want to be seen to betray their friend's trust.

In terms of websites and services, the NHS website was a popular suggestion for support, and likewise, i-Rock and local voluntary sector services were referenced as possible options for signposting and information. Trust and confidentiality were key concerns with some young people reporting that they had found issues surrounding confidentiality in accessing help and that there is a need to keep data safe.

When talking about websites in general, young people fed back that they often found websites contained out-of-date or less reliable information, and that was a concern.

A clear takeaway from this exercise was that many young people recognised this scenario, had experienced this situation were not surprised by the questions, Some were able to discuss the scenario from first-hand experience.

What young people said about stigma and self-harm

The majority (93%) of the 47 young people we spoke to as part of the focus groups agreed that there was still a high level of stigma surrounding self-harm. Young people reported that they were more likely to feel stigma in relation to self-harm from their parents/carers, whereas there was less stigma found amongst friends and peers.

Young people told us that their social groups are more acclimatised to talking about self-harm. They agreed that schools have been making an increasing effort to raise it as an issue but some felt that it's not always done in the right way. Most felt schools were uncomfortable discussing self-harm and that they were reactive rather than proactive - acting only when they hear about instances of self-harm taking place.

> "it's definitely being talked about more but there's defo still a stigma around it, especially older people"

What young people said about schools and self-harm

Young people told us that they value learning about self-harm, self-destructive behaviours, and coping mechanisms and they want to understand why people act in a certain way.

The LGBTQ+ group told us that mental health and self-harm were not discussed in schools – in general. They indicated that they experience a lack of understanding and support from their schools.

For those young people who received some education on self-harm at school, their experiences were on the whole not felt to be positive.

> "it wasn't thoroughly covered it was kinda brushed over and then we moved on - and the attitudes towards Self Harm didn't really change"
>
> "It was viewed as quite trivial and something not serious"

Young people felt that they are sometimes taught by the wrong person which they said made the situation worse. For example, at one school pupils were being taught by a P.E Teacher who it was felt had no interest in self-harm.

There was also a lot of negativity around the support offered in school. Young people fed back that staff in schools and colleges do advise students to come to them about self-harm, but there remains scepticism about the quality of the support, whether it would be truly confidential, and the time it might take to access support.

> "Support from my college has a waitlist of 10 months"
>
> "Staff are in an amazing position to influence our decision making, so it's dangerous when they're teaching with outdated research, with figures from outside the UK."

What young people told us about accessing online information

Young people told us that the key problems with accessing available information online is that it is not always applicable to their needs and potentially harmful. For example, peer groups for those currently self-harming and lists of ways to act on self-harm is very accessible.

Cost was mentioned as a barrier to accessing good support online – often apps will require payment to access full content making it inaccessible for many young people.

Young people fed back that the most useful information they would like to access would be support resources for after self-harm has occurred or after they have recovered and relapsed.

> "I had a brief look at the NHS website. It was quite informative but not helpful."
>
> "Its tricky as you can find loads of things which may not be good but ChildLine is good to talk to even though they do take a while to get back to. I- Rock is great as they are quick to get back."

Support Strategies

The focus group facilitators shared with each focus group several examples of common support strategies; these were taken from the Young Minds website (a UK charity focused on children and young people's mental health). Strategies included the removal of instruments, reducing screen-time/social media time, recovery boxes and green activities.

Young people were asked which of these strategies they thought were appropriate for helping a young person to stop self-harming (in the short term). Most of the suggestions were seen as somewhat helpful, however, the 'No shut door policy' and the 'removal of instruments' were seen as less helpful than the other strategies.

The suggestion of reducing screen time was seen as more useful, but as a compromise only. Instead, explaining how social media could be triggering for self-harm behaviours, and educating young people to use positive social media well were seen as better solutions.

Targeted Youth Support was seen as extremely important by most of the focus groups. The young people participating in the focus groups welcomed any package of support that would be tailored to each young person (with plenty of options),and saw encouraging and motivating a young person to be more supported and use healthier coping strategies as one of the better strategies. In their own words, young people told us …

> "Internet friends can be their support network, so taking a vulnerable young person away from their support network could actually be damaging"
>
> "Distraction can be useful but needs to be clear it is only short term"
>
> "I think the no shut doors policy is very dangerous but that is well-intentioned. If you are destroying someone's privacy it may have an adverse effect on the self-harm."
>
> "Shut door policy - They'll try to become more secretive about self-harm. They'll find another way around it."
>
> "Distractions is great. A walk with friends I think would be nice, with no phones."
>
> "Activities like camping with friends or family is nice to get away for everything."
>
> "Talking to someone or removal of instruments I think isn't for us, it's more about an older person maybe"

Recommendations from Engagement with Young People

The following recommendations were generated in co-production with young volunteers and researchers. They have taken young people's comments and experiences collected during the engagement activities and shaped them into powerful suggestions for change.

Education and learning

1. More resources and support should be directed at schools and colleges to help prevent and address self-harm in children and young people, to include targeted mental health training for staff

The survey findings revealed that most young people became aware that some children and young people self-harm before the age of 14, with 65% aware of self-harm by age 12. Given that for most young people, this awareness stemmed from being made aware of self-harm by a friend (which might not be the most accurately informed source), seeing others' actual self-harm behaviour, or because of their own self-harm behaviours, we are recommending that:

2. Education relating to self-harm and self-harm prevention should commence in schools at a much earlier age, from year 7 onwards

3. A whole-school approach should be embedded in all East Sussex schools and colleges to ensure that mental health is supported, and self-harm is included across the curriculum

4. Schools and colleges should proactively explore self-harm behaviours as part of the PSHE curriculum and focus on healthy coping responses versus self-harm

The survey and focus group findings confirmed that self-harm still carries an unhelpful stigma that prevents young people from talking about the issue (particularly with parents/carers). The focus group findings also revealed that for many young people, self-harm is viewed as a 'normal' way of dealing with difficult feelings, situations, or experiences. This perception, coupled with not feeling able to talk about self-harm with adults due to fear of stigma is a worrying combination that may increase rates of self-harm in young people and limit the ability of young people to seek support. Therefore, we recommend that:

5. There is urgent work undertaken to reduce the stigma associated with self-harm through direct and relevant education and engagement with young people (and adults)

Further recommendations are:

6. Closer relationships should be established (with a focus on information sharing) between schools/colleges and mental health/self-harm support organisations

7. A greater focus on pupils' voices in schools that see a whole-school commitment to listening to the views, wishes, and experiences of all children and young people. Schools need to place greater value on what young people tell them about their experiences

8. We recommend lay-testing/mystery shopping of platforms and resources to support accessibility, especially where focused on children and young people

Peer support and families

The survey and focus group findings highlighted the significant role of peers in not only how young people access self-harm information, but in providing support to young people currently engaged in self-harm behaviours (or at risk of self-harm).

The survey findings revealed that only 50% of young people reported that they would be confident or very confident in responding to a friend if they were to tell them they were self-harming, yet peers were the most likely place young people would go to first for support. Therefore, we recommend that:

9. There needs to be clear guidance for young people on how to support a friend to seek professional support. Information and advice needs to be readily available for friends who act as listeners and peer support mechanisms, including how to protect their own well-being and mental health

10. Young people should receive clarity and reassurance from professionals, guardians, and teachers that there are limits to the support they can be expected to provide to their peers.

11. Families and carers should receive support and targeted advice to boost their knowledge and confidence of how best to support someone who is self-harming (or at risk of self-harm) as early as possible

12. Strategies to reduce self-harming should focus on improving transparency and communication with a trusted person or professional avoiding secrecy and a culture of 'victim-blaming' where a young person then might shy away from talking about their self-harm and getting support

Providing information and advice

The survey findings revealed that young people are not receiving enough information about self-harm and self-harm prevention and have limited awareness of local support services - over 60% of survey participants were not aware of any of the apps listed.

The survey and focus group findings also further highlight the need for young people to receive high quality self-harm education, with young people beingmost likely to find out about self-harm from their friends, more likely to trust their friends that other adults, and more likely to turn to their friends first for support. Therefore, we recommend:

13. To prevent young people from turning to less trusted sources of information, more resource needs to be put into a) highlighting the risks and b) raising awareness of national and local services/websites that young people can access to seek evidence-based information relating to self-harm

14. More resources are needed to raise awareness of existing services and support mechanisms, including what young people can expect from them to ensure that young people understand that they don’t have to manage self-harm by themselves

15. Online websites and virtual resources should be more colourful, visually engaging, and accessible to ensure that young people in crisis can easily navigate and interpret what they need to do to seek help depending on their needsMental Health and mindfulness apps and self-care techniques should be encouraged to accompany support, but they should not be taken as a 'one-size fits all' cure

Building trust

The survey and focus group findings highlighted the important role of trust and confidentiality to young people in accessing support for self-harm. As part of the survey, 75% of young people reported that if they were currently self-harming, thinking about self-harming, or were ever to be in this situation in the future, they did not have an organisation they might turn to for support (compared with 28% who responded that they did not have a person or persons they could turn to for support).

Whilst the survey findings found that young people regarded healthcare professionals as the most trusted source of self-harm information, they were more likely to access information about self-harm from friends, social media, and their

school. To build trust in accessing a variety of professionals, including medical professionals, we are recommending that:

17. Educational settings or workplaces foster trust between staff and pupils/employees by ensuring a culture of openness, sincerity, and consistency in all its approaches

18. Trust between young people and professionals should be cultivated and built upon; young people learning to trust professionals and seeing the opportunities that can be created will be further motivated to trust others within wider networks and support services

19. Medical and other trained professionals should be the preferred ‘messenger‘ for education, engagement, and communication around self-harm

11. Appendices

Appendix 1 - Literature Review

The aim of the rapid literature review was to identify common risk factors for self-harm and the children and young people most likely to be affected, with the objectives of understanding how to:

1. Reduce the incidence of self-harm in children and young people <25 years
2. Plan primary, secondary and tertiary prevention interventions
3. Use resources, assuming a proportional universalism approach

Prevention of self-harm requires a multi-faceted approach including strategies, direct provision, system approaches, primary to tertiary prevention, wider determinants etc. For this review, the focus will be on risk factors which are feasible to be managed/ prevented by a local public health team with the available resources and finances.

English language articles/ guidelines restricted to the United Kingdom involving children and young people < 25 years were included for this review. Quality assessment was not carried out and mostly abstract reading was done. Three comprehensive online searches were done from 2017 – 2021[1]. Multiple online platforms were searched.

Online sources

Gov.UK, NICE evidence search, PubMed, Knowledge share, Medline, Public Health England, Royal College of Paediatrics and Child Health, Royal College of Psychiatrists, Google, Google site search, British Medical Journal using broad search terms (Annex 1).

Methods

Initially title and abstract screening were done. Selected studies were entered into an Excel data sheet and duplicates were removed. Author, year, title of the article, type of study and risk factors for each study were extracted from the abstracts. Articles on risk factors for self-harm, suicidal ideation/ behaviour, deliberate self-harm, or non-suicidal self-injury were selected. Thirty-two articles including sixteen systematic reviews, ten descriptive cross-sectional studies, three longitudinal studies, one qualitative study and two guidelines were extracted from the evidence review.

Appendix 2 – Risk and Protective Factors for Self-harm – Literature Review Results

An OR is interpreted as how many times more likely a risk factor predisposes a subject to experience self-harm. E.g., Anti-depressants increase the risk of self-harm by 1.4 times in an individual compared to a person who is not taking them. 95% CI indicates that with 95% certainty we can interpret that the risk of self-harm is increased within the range of 1.2 – 1.6 by anti-depressants. A ß value means that for every single unit increase in the risk factor, self-harm will be increased by this value. E.g., ß=0.1 means that for every single unit of unhappiness in school the risk of self-harm is increased by 0.1 times)

Risk factors	OR (95% CI)	Type of study
Ethnic factors		
Mixed ethnic backgrounds	1.2 (0.9 - 1.7)	DCS[2]
Goth identification	2·3 (1·8 – 3.0)	LS [3]
	16.4 (5.1 - 52.9)	LS[4]
Alternative subculture (Goth, Emo, Punk, Mosher)	3.5 - 14.2 (-)	DCS[4]
Family/peer issues		
Family circumstances	1.9 (-)	DCS[5]
History of family dysfunction	3.6 (1.3 - 10.0)	LS[6]
Parental separation	1.1 (0.7 - 1.6)	SR[7]
Financial difficulties	1.2 (1.1 - 1.3)	SR[7]
Socioeconomic adversity	1.2 (1.1 - 1.8)	LS[8]
Low support system from peers/family (ß = 0.2)	Not mentioned	LS[9]
Physiological /Physical issues		
Pain	2.2 (1.6 - 2.8)	DCS[10]
Early menarche (<11.5 years)	1.3 (1.0 - 1.6)	DCS[11]
Psychological issues		
Depression	1.2 (1.1 - 1.2)	DCS[12]

	5.8 (2.4 - 14.4)	LS[6]
Psychosis	1.1 (1.0 - 1.2)	DCS[12]
Posttraumatic stress symptoms	3.2 (1.4 - 7.6)	LS[6]
Current mental health problem	**3.6 (1.0 - 12.8)**	**SR[7]**
	2.7 (1.9 - 3.7)	SR[13]
Borderline personality disorder	3.5 (1.8 - 6.5)	SR[14]
Any personality disorder	2.5 (1.7 - 3.8)	SR[14]
Any mood disorder	2.2 (1.1 - 4.3)	SR[14]
Severity of hopelessness	3.0 (1.7 - 5.0)	SR[14]
Parental mental health problems	**1.7 (1.3 - 2.4)**	**LS[8]**
Low self-esteem (β = 0.6)	Not mentioned	LS[9]
Social issues		
Conflict with peers	2.00	DCS[5]
Having caregivers with self-reported higher extraversion (β = 0.1)	Not mentioned	LS[9]
Sex related issues		
Female sex	**1.4 (1.1 - 1.8)**	**DCS[2]**
	3.1 (1.8 - 5.2)	**DCS[15]**
Sexual-minority adolescents at 16 years	4·2 (2·9 - 6·2)	DCS[16]
Alternative identity	4.2 (1.9 - 9.1)	DCS[15]
School related issues		
Vocational school	2.3 (1.00 - 5.1)	DCS[15]
School absenteeism	**1.3 (1.2 - 1.5)**	**SR[17]**
Occasional school bullying victimization	**1.2 (0.8 - 1.9)**	**SR[18]**
	1.3 (0.7 - 2.6)	SR[18]
Childhood issues		
Adverse childhood experiences	**4.3 (2.0 - 9.2)**	**SR[7]**
Children in the Poor fetal growth	1.9 (1.0 - 3.4)	LS[8]

Abuse and neglect		
Sexual abuse	**3.4 (2.9 - 4.0)**	**SR[19]**
Physical abuse	**2.2 (1.8 - 2.7)**	
Emotional abuse	**2.2 (1.4 - 3.6)**	
Emotional neglect	**1.9 (1.4 - 2.7)**	
Physical neglect	**1.8 (1.3 - 2.5)**	
Combined abuse	**3.4 (2.1 - 5.5)**	
Cyber issues		
Cyberbullying victimization	**5.1 (1.4 - 17.9)**	**SR[20]**
	2.4 (1.6 - 3.3)	
Sleep related issues		
Trouble falling asleep (β = 0.1)	**Not mentioned**	**LS[9]**
Other issues		
Being more willing to take risks (β = 0.1)	Not mentioned	LS[9]
Children with psychopathological issues		
Psychological issues		
Poor emotional control (β = 0.7)	Not mentioned	LS[9]
Low self-esteem (β = 0.5)	Not mentioned	
Sleep related issues		
Waking during sleep (β = 0.2)	**Not mentioned**	**LS[9]**
Trouble falling asleep (β = 0.2)	**Not mentioned**	
Relationship issues		
Quarrels with caregivers (β = 0.1)	Not mentioned	LS[9]
School related issues		
Being unhappy at school (β = 0.1)	Not mentioned	LS[9]
Factors related to repeated self-harm	**OR (95% CI)**	**Type of study**
Being male	**1.1 (1.0 - 1.2)**	**DCS[21]**

10-17 years	**1.3 (1.2 - 1.4)**	
Consuming ≥ 50 tablets	**1.3 (1.1 - 1.5)**	
Taking benzodiazepines	**1.7 (1.4 - 2.0)**	
Antidepressants	**1.4 (1.2 - 1.6)**	

*OR: Odds Ratio, CI: Confidence Interval, DCS: Descriptive Cross-Sectional Study

Protective factor	OR (95% CI)	Type of study
Greater mental wellbeing (within six months)	**0.8 (0.8 - 0.9)**	**DCS[26]**
Black African backgrounds	0.8 (0.7 – 0.9)	DCS[2]
Schoolwork/ career (for suicidal ideation)	0.8	DCS[5]
Late menarche (>13.8 years)	0.7 (0.6 - 0.9)	DCS[11]
Lower symptoms of mania	0.9 (0.8 – 0.9)	LS[12]
Connectedness	Not mentioned	SR[27]
Paternal warmth Self-compassion Having an active coping style (protective against suicide attempts for males, but not for females)	Not mentioned	SR[28]
Isolation reduction and outreach	Not mentioned	SR[27]

References for Appendix 2 – Risk and Protective Factors for Self-harm – Literature Review Results

1. Children and young people who are at risk of self-harm. Frankie Marcelline. (6 May 2021). BRIGHTON, UK: Brighton and Sussex Library and Knowledge Service.
2. Knowles, G., Gayer-Anderson, C., Beards, S., Blakey, R., Davis, S., Lowis, K., Stanyon, D., Ofori, A., Turner, A., Working Group, S., Pinfold, V., Bakolis, I., Reininghaus, U., Harding, S., & Morgan, C. (2021). Mental distress among young people in inner cities: the Resilience, Ethnicity and AdolesCent Mental Health (REACH) study. *Journal of epidemiology and community health*, *75*(6), 515–522. Advance online publication. https://doi.org/10.1136/jech-2020-214315
3. Bowes, L., Carnegie, R., Pearson, R., Mars, B., Biddle, L., Maughan, B., Lewis, G., Fernyhough, C., & Heron, J. (2015). Risk of depression and self-harm in teenagers identifying with goth subculture: a longitudinal cohort study. *The lancet. Psychiatry*, *2*(9), 793–800. https://doi.org/10.1016/S2215-0366(15)00164-9
4. Hughes, M. A., Knowles, S. F., Dhingra, K., Nicholson, H. L., & Taylor, P. J. (2018). This corrosion: A systematic review of the association between alternative subcultures and the risk of self-harm and suicide. *The British journal of clinical psychology*, *57*(4), 491–513. https://doi.org/10.1111/bjc.12179
5. Kim K. M. (2021). What makes adolescents psychologically distressed? Life events as risk factors for depression and suicide. *European child & adolescent psychiatry*, *30*(3), 359–367. https://doi.org/10.1007/s00787-020-01520-9

6. Valencia-Agudo, F., Kramer, T., Clarke, V., Goddard, A., & Khadr, S. (2020). Correlates and predictors of self-harm in a prospective sample of sexually assaulted adolescents. Clinical Child Psychology and Psychiatry, 25(4), 847–859. https://doi.org/10.1177/1359104520920332
7. Sheldon, E., Simmonds-Buckley, M., Bone, C., Mascarenhas, T., Chan, N., Wincott, M., Gleeson, H., Sow, K., Hind, D., & Barkham, M. (2021). Prevalence and risk factors for mental health problems in university undergraduate students: A systematic review with meta-analysis. *Journal of affective disorders*, *287*, 282–292. https://doi.org/10.1016/j.jad.2021.03.054
8. Orri, M., Russell, A. E., Mars, B., Turecki, G., Gunnell, D., Heron, J., Tremblay, R. E., Boivin, M., Nuyt, A. M., Côté, S. M., & Geoffroy, M. C. (2020). Perinatal adversity profiles and suicide attempt in adolescence and young adulthood: longitudinal analyses from two 20-year birth cohort studies. *Psychological medicine*, 1–13. Advance online publication. https://doi.org/10.1017/S0033291720002974
9. Uh, S., Dalmaijer, E., Siugzdaite, R., Ford, T., & Astle, D. (2021). Two Pathways to Self-Harm in Adolescence. *Journal Of the American Academy Of Child & Adolescent Psychiatry*, *0*(0). https://doi.org/10.1016/j.jaac.2021.03.010
10. Hinze, V., Ford, T., Evans, R., Gjelsvik, B., & Crane, C. (2021). Exploring the relationship between pain and self-harm thoughts and behaviours in young people using network analysis. *Psychological Medicine*, 1-10. doi:10.1017/S0033291721000295
11. Roberts, E., Fraser, A., Gunnell, D., Joinson, C., & Mars, B. (2020). Timing of menarche and self-harm in adolescence and adulthood: a population-based cohort study. *Psychological medicine*, *50*(12), 2010–2018. https://doi.org/10.1017/S0033291719002095
12. Akram, U., Ypsilanti, A., Gardani, M., Irvine, K., Allen, S., Akram, A., Drabble, J., Bickle, E., Kaye, L., Lipinski, D., Matuszyk, E., Sarlak, H., Steedman, E., & Lazuras, L. (2020). Prevalence and psychiatric correlates of suicidal ideation in UK university students. *Journal of affective disorders*, *272*, 191–197. https://doi.org/10.1016/j.jad.2020.03.185
13. Williams, A. J., Jones, C., Arcelus, J., Townsend, E., Lazaridou, A., & Michail, M. (2021). A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. *PloS one*, *16*(1), e0245268. https://doi.org/10.1371/journal.pone.0245268
14. Witt, K., Milner, A., Spittal, M. J., Hetrick, S., Robinson, J., Pirkis, J., & Carter, G. (2019). Population attributable risk of factors associated with the repetition of self-harm behaviour in young people presenting to clinical services: a systematic review and meta-analysis. *European child & adolescent psychiatry*, *28*(1), 5–18. https://doi.org/10.1007/s00787-018-1111-6
15. Young, R., Sproeber, N., Groschwitz, R.C. *et al*. Why alternative teenagers' self-harm: exploring the link between non-suicidal self-injury, attempted suicide and adolescent identity. *BMC Psychiatry* 14, 137 (2014). https://doi.org/10.1186/1471-244X-14-137
16. Irish, M., Solmi, F., Mars, B., King, M., Lewis, G., Pearson, R., Pitman, A., Rowe, S., Srinivasan, R. & Lewis, G. (2019). Depression and self-harm from adolescence to young adulthood in sexual minorities compared with heterosexuals in the UK: a population-based cohort study. *The Lancet Child & Adolescent Health*, 3 (2), 91–98. *https://doi.org/10.1016/S2352-4642(18)30343-2*
17. Epstein, S., Roberts, E., Sedgwick, R., Polling, C., Finning, K., Ford, T., Dutta, R., & Downs, J. (2020). School absenteeism as a risk factor for self-harm and suicidal ideation in children and adolescents: a systematic review and meta-analysis. *European child & adolescent psychiatry*, *29*(9), 1175–1194. https://doi.org/10.1007/s00787-019-01327-3
18. Karanikola, M., Lyberg, A., Holm, A. L., & Severinsson, E. (2018). The Association between Deliberate Self-Harm and School Bullying Victimization and the Mediating Effect of Depressive

Symptoms and Self-Stigma: A Systematic Review. *BioMed research international*, *2018*, 4745791. https://doi.org/10.1155/2018/4745791

19. Angelakis, I., Austin, J. L., & Gooding, P. (2020). Association of Childhood Maltreatment with Suicide Behaviors Among Young People: A Systematic Review and Meta-analysis. *JAMA network open*, *3*(8), e2012563. https://doi.org/10.1001/jamanetworkopen.2020.12563
20. Sedgwick, R., Epstein, S., Dutta, R., & Ougrin, D. (2019). Social media, internet use and suicide attempts in adolescents. *Current opinion in psychiatry*, *32*(6), 534–541. https://doi.org/10.1097/YCO.0000000000000547
21. Daly, C., Griffin, E., McMahon, E., Corcoran, P., Webb, R. T., Witt, K., Ashcroft, D. M., & Arensman, E. (2020). Repeat Self-Harm Following Hospital-Presenting Intentional Drug Overdose among Young People-A National Registry Study. *International journal of environmental research and public health*, *17*(17), 6159. https://doi.org/10.3390/ijerph17176159
22. Hetrick, S. E., Subasinghe, A., Anglin, K., Hart, L., Morgan, A., & Robinson, J. (2020). Understanding the Needs of Young People Who Engage in Self-Harm: A Qualitative Investigation. *Frontiers in psychology*, *10*, 2916. https://doi.org/10.3389/fpsyg.2019.02916
23. *Let's Talk about Self harm*. Schools.essex.gov.uk. (2021). Retrieved 9 September 2021, from https://schools.essex.gov.uk/pupils/Emotional_Wellbeing_and_Mental_Health_Information_Portal_for_Schools/Documents/DS17_5950_SelfHarm_Toolkit_Digital.pdf.
24. *Queer futures summary report*. (2021). Retrieved from http://www.queerfutures.co.uk/wp-content/uploads/2016/06/Queer-Futures-Summary-Report.pdf
25. Bloomer, E. (2018). *Self-harm needs assessment for children & young people February 2018* [E-book]. Retrieved 24 September 2021, from http://www.bhconnected.org.uk/sites/bhconnected/files/280318%20Self-harm%20needs%20assessment.pdf.
26. Russell, K., Rasmussen, S., & Hunter, S. C. (2020). Does Mental Well-Being Protect against Self-Harm Thoughts and Behaviors during Adolescence? A Six-Month Prospective Investigation. *International Journal of Environmental Research and Public Health*, *17*(18), 6771. doi:10.3390/ijerph17186771
27. Wilson, C. & Cariola, L.A. (2020). LGBTQI+ Youth and Mental Health: A Systematic Review of Qualitative Research. *Adolescent Res Rev* **5**, 187–211. https://doi.org/10.1007/s40894-019-00118-w
28. Abdelraheem, M., McAloon, J., & Shand, F. (2019). Mediating and moderating variables in the prediction of self-harm in young people: A systematic review of prospective longitudinal studies. *Journal of affective disorders*, *246*, 14–28. https://doi.org/10.1016/j.jad.2018.12.004
29. *Research Summary Self-injurious behaviour in children with an intellectual disability*. Cerebra.org.uk. (2021). Retrieved 9 September 2021, from https://cerebra.org.uk/wp-content/uploads/2020/01/Self-injurious-behaviour-2019-low-res.pdf.
30. *Understanding and responding to children and young people at risk of self-harm and suicide A guide for practitioners in Cambridgeshire*. Keep-your-head.com. (2014). Retrieved 9 September 2021, from http://www.keep-your-head.com/assets/1/cyp-at-risk-self-harm-suicide.pdf.
31. Jeong, Y. W., Chang, H. J., & Kim, J. A. (2020). Development and Feasibility of a Safety Plan Mobile Application for Adolescent Suicide Attempt Survivors. *Computers, informatics, nursing: CIN*, *38*(8), 382–392. https://doi.org/10.1097/CIN.0000000000000592
32. Muscara, F., Ng, O., Crossley, L., Lu, S., Kalisch, L., Melvin, G., Gronow, S., Prakash, C., & Anderson, V. (2020). The feasibility of using smartphone apps to manage self-harm and suicidal acts in adolescents admitted to an inpatient mental health ward. DIGITAL HEALTH. https://doi.org/10.1177/2055207620975315

Appendix 3 – Evidence Summaries for Selected Risk Factors

Gender

The female gender has been identified across several studies[3940] as a risk factor self-harm. For example, in a study to estimate the extent of mental health problems in children and young people aged 11 to 14 years living in inner city London, females were 1.4 times more likely to have ever tried to harm or hurt themselves then males.[41] Furthermore, in a study exploring different youth cultures and self-harm behaviour, 15 year old females were 3 times more likely than males to report having ever harmed themselves on purpose.[42]

In a recent study using data collected from participants of the Millennium Cohort Study (MCS), at age 14, 22.8% of females reported having self-harmed in the prior 12 months compared to 8.5% of males, with the proportions at age 17 being 28.2% and 20.1% respectively. Whilst at both ages more females than males reported having self-harmed; at age 17 the difference between the genders was much smaller, highlighting a much steeper increase in self-harm behaviour for males between these ages[43] This finding is consistent with other research which has found the female to male self-harm ratio to be as high as 6:1 (e.g. in 12 to 14 year olds), before decreasing with increasing age.[44]

It is recognized that the relationship between self-harm and gender is complex. Whilst potential reasons for the differential prevalence of self-harm behaviours in young females compared to young males includes issues related to puberty and the earlier age of onset of psychiatric disorders and sexual activity[4546]; it is acknowledged that in general more females than males present to health services for self-harm[47] and in part this may be due to females being more likely to seek medical support.

A UK study[48] investigating self-harm presentation across healthcare settings in young people found that females were more likely than males to be admitted following A&E attendance for self-harm. This was most evident in those aged 10–15 years, where 76% of females were admitted compared with just 49% of males. Furthermore, self-harm in young males may manifest in behaviours that may fall outside of typical self-harm definitions used by services or the community itself (for example self-battery, excessive alcohol consumption, or drug use) meaning that self-harm in young males is likely to be under-reported.

Family income and socioeconomic adversity

Family income or socio-economic position (SEP) is also a known risk factor for self-harm behaviours in children and young people. For example, in a longitudinal study[49] investigating whether parental SEP during childhood was associated with subsequent self-harm in adolescence, lower parental SEP was found to be associated with an increased risk of offspring self-harm (with stronger associations evident for self-harm with suicidal intent).

In this research, adolescents of parents reporting consistently low income levels during childhood were approximately 1.5 times more likely to engage in self-harm than those never to report being on a low income. Furthermore, in an analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England (2014), the likelihood of self-harm varied by socio-economic status (as measured by the Family Affluence Scale), with 18% of young people categorised in the high family affluence group reporting self-harm behaviour compared to 30% of young people categorised in the low family affluence group.[50]

Findings from a European-based study have also suggested that low parental socioeconomic position is associated with self-harm in adolescence, particularly for girls.[51] Finally, in a study[52] investigating parental income trajectories during childhood and subsequent risks of self-harm in young adulthood, children from families who remained in the least affluent fifth of society over the first 15 years of life were 7 times more likely to harm themselves as young adults compared to the wealthiest fifth.

It is noted however that this association has not been found across all studies. In a recent study using data collected from participants in the Millennium Cohort Study (MCS) in 2018-19, self-harming behaviour was not clearly patterned by family income, with rates of self-harming broadly similar across all quintiles of family income.[53] Low income is often regarded as a stressor, which can affect the socio-emotional, behavioral and cognitive development of children, alongside the development of coping strategies,[54] parenting practices, and access to services/support.[55]

Family variables

A number of stressors originating within family may play an especially important role in relation to self-harming behaviours in children and young people. They include parental separation and divorce, parental mental health, marital or family discord, and interpersonal difficulties.[565758]

In a recent systematic review, family variables (to include family support, family cohesion, parenting behaviours or parental mental health) were found to prospectively predict non-suicidal self-injury (NSSI) in young people[59] (in line with

previous studies[6061]). As part of the Health Behaviours in School-Aged Children survey (2014), young people who reported self-harm were found to be more likely to report difficulties with communicating with their mother and father and less likely to say they had someone in their family they could share their problems with. Furthermore, self-harming behaviour was found to be more prevalent among young people living in one parent households (35% vs 17%); however it is acknowledged that one parent households are more likely to be below the poverty line and that a lower family affluence is also strongly associated with self-harm.[62]

Poor family functioning has also been found to be an important link between childhood adversity and adolescent self-harm, with poorer family functioning at age 14 (and childhood family adversity) found to be positively associated with onset of non-suicidal self-injury (NSSI) between ages 14 and 17 years. Family functioning may influence self-harm behaviours through several risk factors for NSSI such as impulsivity, emotion regulation, self-esteem, interpersonal skills, coping skills, and mental illness. [63]

Childhood maltreatment/ Adverse childhood experiences

Increasing evidence suggests that childhood maltreatment is strongly associated with self-harm, suicide behavior, lower resilience to mental health problems, and greater impulsivity[64]. A number of systematic reviews have explored the association between childhood maltreatment and self-harm and suicide behaviors. Those experiencing sexual abuse, emotional abuse or combined abuse are up to four times more likely to engage in self-harm and suicide behaviours than those not experiencing abuse. However, all forms of abuse are all significantly associated with higher rates of suicide attempts and self-harm. [656667]

Researchers have attempted to identify the potential mechanisms which underlie the association between child maltreatment and self-harm; these include via post-traumatic stress disorder[68], depression[69], and emotion dysregulation[70]. However the association between child maltreatment and self-harm or suicidal behaviors has not been confirmed across all studies.[71]

Adverse Childhood Experiences (ACEs) are “highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person’s safety, security, trust or bodily integrity.”[72]. They include child maltreatment such as verbal, physical and sexual abuse, alongside children living in households experiencing parental separation, domestic violence, mental illness, alcohol abuse, drug use and incarceration.

Exposure to adverse childhood experiences (ACEs) is a well-established risk factor for self-harm.[73] For example, in a study[74] using data from the Avon Longitudinal Study of Parents and Children, higher ACE scores were associated with an increased risk of self-harm at 16 years, such that with each additional ACE, an individual was 11% more likely to report self-harm. The strongest evidence for an association with self-harm was found for emotional abuse and parental separation.

Psychiatric and psychological factors

Evidence shows that psychiatric and psychological factors are strongly associated with self-harm in children and young people; this includes mental disorder, especially depression, anxiety, attention deficit hyperactivity disorder (ADHD), drug and alcohol misuse, impulsivity, low self-esteem, poor social problem-solving, perfectionism and hopelessness.[75][76][77][78]

For example, in a study involving over 30,000 secondary school-aged pupils across seven countries, increased severity of self-harm history was associated with greater depression, anxiety, and impulsivity and lower self-esteem.[79] Furthermore, in one systematic review[80] exploring psychiatric disorders in patients presenting to hospital following self-harm, 8 in 10 young people presenting to hospital with self-harm suffered from at least one mental health issue. Depression, anxiety disorders, and substance misuse were most commonly described, although ADHD and conduct disorder were also common. Finally in a study[81] investigating the association between various aspects of adolescent health and risk of later self-harm requiring hospital admission, several indicators of psychological distress were found to be strongly associated with increased risk of self-harm. Frequently feeling tense and uneasy, or afraid and anxious, was found to increase the risk of self-harm hospitalisation by over four times; whilst symptoms of anxiety/depression, and often feeling lonely were also associated with more than three times the self-harm risk compared to less symptoms and psychological distress.

LGBTQ+

There is significant evidence that young people who identify as lesbian, gay, bisexual, transgender, or gender-queer/questioning (LGBTQ+) are more likely to report engaging in self-harm behaviours compared to their heterosexual peers; with self-harm behaviours among LGBTQ+ young people found to be around 30–50% more likely.[82][83] As part of a research project[84] conducted by Youth Chances into the mental health of LGBTQI+ young people, 52% of LGBTQ+ young people reported having ever self-harmed compared to 35% of heterosexual non-trans young people. Furthermore, research[85] involving 4828 young people participating in the Avon Longitudinal Study of Parents and Children found that sexual-minority young

people were more likely than heterosexual young people to report previous self-harm at both age 16 and 21 years (OR 4·23, CI 2·90 to 6·16). By age 21 years, sexual minorities were over 4 times (OR 4·53, CI 3·02 to 6·78) more likely to report lifetime self-harm (i.e. on at least one previous occasion) with suicidal intent than heterosexuals. Research also suggests that the greatest demographic risk factor for self-harm in LGBTQ+ young people is identifying as a trans or non-binary gender identity. In a national cross sectional survey[86] of LGBT young people aged 11-19 years, 65% of LGBT young people reported having ever self-harmed; with trans young people (compared to non-trans young people) and young people who identify as non-binary (compared to those who identify as male or female) being four times more likely to report having ever self-harmed.

Evidence suggests that LGBTQ+ young people experience different risk factors[87] and that these unique risks, combined with general life stressors, have the outcome of higher levels of self-harm, suicidality and impulsivity.[88] For example, among LGBTQ+ young people, self-harm ideation and behaviors have been linked to high rates of mental health difficulties,[89] victimization and negative responses to being LGBTQ+ (e.g. rejection, peer abuse, bullying, non-acceptance),[90] interpersonal problems, lower self-esteem,[91] struggling with processing/understanding one's own LGBTQ+ identity, difficulties with self-concept integration, and social comparison.[92]

Meyer's minority stress theory[93] provides a possible mechanism to help explain the increased risk of self-harm amongst LGBTQ+ young people. This theory suggests that the stigma, prejudice and discrimination (minority stress) associated with being a sexual minority leads to higher rates of depression, anxiety, psychological distress and mental health issues within this population, which may subsequently account for adverse outcomes such as an increased prevalence of self-harm.[94] The model describes distal (external) and proximal (internal) stressors associated with being LGBTQ+, which include homophobic and biphobic discrimination, prejudice and violence, expectation of rejection, concealment of LGBTQ+ identity and internalized homophobia and biphobia.[95] Research has also suggested that the pre-cursor to self-harm in LGBTQ+ young people may not be discrimination per se, but rather emotional dysregulation. In a study of self-harm among university students, the LGB orientation was associated with increased risk of self-harm with this relationship mediated by self-esteem. This suggests that LGB young people with decreased self-esteem may be at higher risk of harming themselves.[96] Finally, research shows there is a higher prevalence of childhood adversity, such as bullying and childhood sexual abuse, among LGBTQ+ individuals, with such stressors associated with the onset of poor mental health.[97]

Bullying (including cyberbullying)

Bullying is the systematic abuse of power and is defined as aggressive behaviour or intentional harm-doing by peers that is carried out repeatedly and involves an imbalance of power, either actual or perceived, between the victim and the bully.[98] There are many different types of bullying that can be experienced by children and young people; these usually take the form of physical (e.g. assaults), verbal (e.g. insults and threats), relational (e.g. social exclusion and spreading rumours) or more recently, cyber-bullying.[99]

Several studies have found bullying victimisation to be associated with an increased risk of self-harm in children and young people.[100101102] For example, in a systematic review[103] examining the association between cyberbullying involvement and self-harm and suicidal behaviours in children and young people, experience of cybervictimization was found to increase the risk of self-harm by 2.35 times (95% CI 1.65-3.34) compared to those who had not experienced cybervictimization. Furthermore, in a systematic review[104] examining the association between deliberate self-harm and school bullying victimization in young people, a positive association between school bullying victimization and NSSI was found, with the effect size [OR (95%CI)] ranging between 1.33 (0.67-2.64) and 4.75 (2.36-9.54) for occasional school bullying victimization and 11.75 (5.54-24.94) for repetitive school bullying victimization (demonstrating that even occasional school bullying victimization is associated with increased risk for NSSI).

In particular, studies have found a strong association between verbal bullying by peers and self-harm among young people,[105] and when combined with traditional in-person bullying, cyberbullying has been found to have an independent and cumulative effect on self-harm behaviours.[106107] Importantly, studies indicate that it is not only bullying victimisation that is associated with self-harm, but also the experience of being a perpetrator of bullying.[108] For example, in a cross-sectional study[109] involving 16,182 young people aged 12 to 19 years, the risk of self-harm was six times higher (OR 5.97) for those who had experienced both bullying by their peers and had bullied others (compared to those who had not experienced bullying by their peers or bullied others), with the risk five times higher (OR 5.04) for those who had experienced bullying by their peers and three times higher (OR 3.2) for those who had reported bullying others.

It is important to note that not all children and young people who experience bullying will go onto engage in self-harm behaviours. Whilst limited research has been undertaken to date to establish which risk and protective factors may confound the relationship between the different bullying types and self-harm; a recent study found that depression, anxiety and parental conflict accounted for some of the association between being bullied and self-harm, with the relationship

between the being bullied and self-harm significantly moderated by parental support and school well-being.[110]

Internet use and social media

Internet use has been found to have a mixed effect on children and young people's well-being, with evidence of increased self-esteem and perceived social support alongside harmful effects such as increased exposure to graphic content and cyber-bullying[111]

Specifically in relation to self-harm, in a systematic review[112] exploring the relationship between internet use, self-harm and suicidal behaviour in young people, self-harm/suicidal behaviour was particularly associated with internet addiction, high levels of internet use, and websites with self-harm or suicide content. However it was noted that whilst studies showed a significant potential for harm from online behaviour (e.g. normalisation, triggering, competition, contagion), the potential for internet use to reduce isolation, enable outreach and act as a source of help and therapy were also identified. Furthermore, in a systematic review[113] examining associations between social media use and self-injurious thoughts and behaviours (SITB), results largely suggested medium effect sizes for associations between specific social media constructs (cybervictimization, SITB-related social media use, problematic social media use) and SITBs. There was no association between frequency of social media use and SITBs; however, studies on this topic were limited. The majority of studies identified focused on cybervictimization, and results suggested positive associations with all SITBs.

School absenteeism

It is widely recognized that poor school attendance is associated with a range of negative outcomes across the life course, including poor educational attainment, unemployment, and poverty[114][115], as well as violence, injury, substance misuse and a number of mental health problems.[116] Specifically, school absence has a been identified as a risk factor for self-harm and suicidal ideation in children and young people. In a systematic review[117] of observational studies exploring the association between school absenteeism (including school refusal, school phobia, truancy or long-term absence due to ill health) and self-harm; school absenteeism was found to be associated with an increased risk of self-harm [OR 1.37, 95% CI 1.20–1.57, P = 0.01] in children and young people. Whilst this association was not found in all studies reviewed (with some studies reporting an inverse association); the combined analysis detected a 37% increase in odds of self-harm for those with school absenteeism. Furthermore, in a retrospective cohort study[118] to explore whether adolescents with Autistic Spectrum Disorder (ASD) are at higher risk than

the general population of presenting to emergency care with self-harm, poor attendance at school was found to be associated with self-harm in both boys and girls with and without ASD. Specifically, for those young people with less than 80 per cent attendance, the likelihood of presenting to emergency care with self-harm was three times greater. Whilst such findings do not show that absenteeism causes self-harm, they do suggest that is an important behaviour to target for preventive interventions. The possible mechanisms which could explain the relationship between school absenteeism and self-harm include the presence of a mental disorder (with depression, anxiety and externalising disorders known to be associated with both poor school attendance[119] and self-harm, alongside bullying).[120]

Sleep problems

In recent years, there has been growing evidence that sleep problems are risk factors for self-harm in young people that this relationship is independent of any psychiatric disorder.[121122123124] For example, in a large population based study[125] surveying over 10,000 young people aged 16-19 years, young people with sleep problems were significantly more likely to report self-harm than those without sleep problems. For example, a significantly ($P<0.001$) larger proportion of young people reporting self-harm slept less than 5 h compared with those young people who did not engage in self-harm. Insomnia, short sleep duration, long sleep onset latency, wake after sleep on set as well as large differences between weekdays versus weekends, yielded higher odds of self-harm consistent with a dose–response relationship. Whilst depression did account for some of the association between sleep and self-harm, neither perfectionism nor symptoms of ADHD had any impact on the sleep-self-harm association. This findings were also replicated in a more recent systematic review[126] of sleep problems and self-injury. Findings indicated that sleep problems such as short sleep duration, sleep disturbances, and poor sleep quality were all associated with non-suicidal self-injury, with adolescents and young adults with sleep disruptions found to be at a higher risk of non-suicidal self-injury. In this review, emotional dysregulation, depression, and post-traumatic stress disorder appeared to mediate this relationship. Finally, in a study[127] seeking to identify subgroups of young people who self-harm and longitudinal risk factors leading to self-harm, sleep difficulties (i.e. waking during sleep and trouble falling asleep) age 14 years were commonly associated with self-harm behavior, irrespective of subgroup.

Repeat self-harm

Evidence shows that self-harm is associated with future risk of suicide, and in particular, repeated self-harm.[128][129] Risk factors associated with an increased risk of repeat self-harm in children and young people include psychological factors (e.g. psychiatric morbidity, features of previous self-harm, specifically use of the cutting method, psychological distress, and depression), psychosocial factors (e.g. alcohol and drug misuse, poor family and peer relationships, and social isolation), sociodemographic factors (e.g. age, gender and ethnicity) and a poor school record.[130][131]

For example, in a study[132] involving over 30,000 secondary school aged pupils across seven countries, the female gender, higher depression, lower self-esteem, experiencing the suicide or self-harm of others, and trouble with the police independently distinguished multiple from single-episode self-harmers. In addition, in a systematic review[133] of factors associated with the repetition of self-harm behaviour in young people presenting to clinical services, borderline personality disorder (OR 3.47, 95% CI 1.84–6.53), any personality disorder (OR 2.54, 95% CI 1.71–3.78), any mood disorder (OR 2.16, 95% CI 1.09–4.29), severity of hopelessness (OR 2.95, 95% CI 1.74–5.01), suicidal ideation (OR 2.01, 95% CI 1.43–2.81), and previous sexual abuse (OR 1.52, 95% CI 1.02–2.28) were all associated with repetition of self-harm. Finally, with specific reference to young people presenting to hospital with intentional drug overdose, factors associated with risk of repeat self-harm included being male (HR = 1.13, 95% CI: 1.03–1.24), aged 10–17 years (HR = 1.29, 95% CI: 1.18–1.41), consuming ≥ 50 tablets (HR = 1.27, 95% CI: 1.07–1.49) and taking benzodiazepines (HR = 1.67, 95% CI: 1.40–1.98) or antidepressants (HR = 1.36, 95% CI: 1.18–1.56).[134]

Parental support

Positive attachment or ‘closeness’ to at least one adult during childhood is a protective factor against mental illness, self-harm and suicide. Where no such relationship exists, or there is insecure parent/carer or peer attachment, the risk of self-harm and particularly repetition of these behaviours, is significantly increased.[135]

Despite the role of parental support being complex, a number of large, well-conducted studies concur that factors such as perceived parental warmth, connectedness to parents and parenting behaviours may be protective of self-harm in children and young people.[136][137][138] [139] For example, in a cross-sectional study[140] of youth in an urban area to examine the prevalence and psychosocial correlates associated with reporting self-harm and suicide attempts, youth who had parental support was less likely to report both self-harm and suicidal behaviours (Adjusted OR = 0.50; 95% CI: 0.33, 0.76). Furthermore, in a study[141] to evaluate the time-

lagged associations between both peer and parent relationship characteristics and new onset of NSSI in a large, urban community sample of adolescent girls, positive parenting behaviours were found to have a protective effect in reducing the odds of NSSI onset over the following year (OR = 0.94, 95% CI [0.89, 0.99], p = 0.01). Finally, in a study[142] examining the association between bullying perpetration and victimization and NSSI and suicidal ideation among young males, parental warmth was negatively related to NSSI and suicidal ideation. Specifically, the association between bullying victimization and non-suicidal self-harm was weaker at higher levels of parental warmth, highlighting the important role of parents in mitigating the negative effects associated with bullying perpetration and victimization.

Finally, in a cross-sectional study[143], examining the relationships between perceived family expressed emotion and shame, emotional involvement, depression, anxiety, stress and non-suicidal self-injury; emotional involvement and overall shame were the only significant predictors of self-injury status. For example, individuals with no history of self-injury reported significantly more emotional involvement from family members than self-injurers overall ($t(258) = 2.96$, $p = 0.003$) and past self-injurers reported significantly more emotional involvement from family members than current self-injurers ($t(258) = -3.98$, $p < 0.001$). Furthermore, for every one-unit increase in emotional involvement, the odds of currently engaging in self-injury decreased by a factor of 0.860.

Mental wellbeing

A number of studies have found mental wellbeing to be a protective factor associated with self-harm in children and young people. For example, in a study[144] exploring whether mental well-being protects against subsequent self-harm thoughts and behaviours, researchers found that young people who reported greater mental well-being at baseline were less likely report having thought about harming themselves (OR: 0.876, 95% CI: 0.820,.936, $p < 0.001$) or engaging in self-harm (OR: 0.913, 95% CI: 0.838,.995, $p = 0.032$) during the subsequent six month period. Importantly, these relationships persisted when controlling for gender and depressive symptomology. This study also found that young people with better mental well-being were more likely to report lower perceptions of defeat and entrapment (negative appraisals that have been shown to be proximal predictors of intention to harm oneself). Furthermore, in a study[145] exploring risk and protective factors associated with suicidality and self-harm among traditional bullying and cyberbullying victims, positive mental health/resilience (alongside adequate sleep) were found be significantly ($p < 0.05$) associated with decreased self-harm in both types of bullying victims.

Self-compassion

Self-compassion is a process through which an individual has the intention and motivation to adopt and apply a compassionate mindset to themselves.[146] For example, accepting personal short-comings rather than being critical of oneself. Neff [147] describes self-compassion as a balancing of six integrally connected elements: 'self-kindness' – extending kindness and understanding to oneself in instances of perceived inadequacy or suffering rather than harsh judgment and self-criticism, 'common humanity' – seeing one's experiences as part of the larger human experience rather than seeing them as separating and isolating, and 'mindfulness' – holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them in an exaggerated manner.[148]

Several studies[149][150] have found self-compassion to be a protective factor associated with self-harm in children and young people. For example, in a systematic review[151] exploring the nature and extent of the relationship between self-compassion and self-harm/suicidal ideation, individuals with no history of self-harm reported higher self-compassion. Higher self-compassion was also repeatedly associated with lower levels of risk factors for self-harm (including lower depressive symptoms) and was associated with better peer and familial relationships, including greater feelings of maternal (B= .20, SE= .05, $p<0.001$) and paternal closeness (B=.18, SE. 04, $p<0.001$). Greater closeness was in turn associated with lower NSSI (e.g. maternal, OR= -1.22, $p<0.001$). Furthermore, in a study[152] exploring whether self-compassion mitigated the impact of daily peer hassles and depressive symptoms on NSSI, analysis showed that self- compassion had a moderator effect on the association between depressive symptoms and NSSI. In other words, the impact of depressive symptoms on NSSI was diminished in adolescents who had the ability to be kind and compassionate towards themselves.

School connectedness

Positive orientation to school, teacher support, school engagement, school attachment, school bonding, school climate, school involvement are all terms that refer to the attachment individual pupils have to the school[153]. Although there are differences in how these concepts are measured, most questionnaires arguably are associated with an underlying construct known as 'school connectedness'. Research has found school connectedness to be associated with many health behaviours, with a number of studies showing higher levels of school connectedness to be associated with lower rates of depression[154], self-harm, and suicidality in young people.[155][156][157] For example, in a systematic meta analysis[158], higher school connectedness was found to be associated with reduced reports of suicidal thoughts and behaviors across both general (OR = 0.536), high-risk (OR = 0.603), and sexual minority (OR = 0.608) adolescents.

There is also some evidence to show that school connectedness may act as a buffer against the negative impact of adverse events. For example, in a study[159] aiming to better understand the association between bullying behaviour and self-harm, a significant ($p<0.001$) interaction effect between school well-being and bullying behaviour was found. School well-being (including support from teacher) was found to be more protective of self-harm for those who had experienced bullying (plus those who were bullies as well as bully-victims) than it was for those who had not experience bullying or been a bully.

Appendix 4 – Data Sources

Data	Source	Time period	Self-harm definition	Activity and/or individuals	Other information to note
Prevalence of self-harm in year 10 pupils	East Sussex Health-Related Behaviour Survey (HRBS)	2017	Self-reported 'cut or hurt myself' when worried/stressed	n/a	Survey had 65% participation (n=3,089 Year 10 pupils)
Prevalence of self-harm in Year 7, Year 9 and Year 11 pupils	My Health My School Survey	2020/21 academic year	Self-reported hurting themselves on purpose	n/a	Low participation: Year 7 16% coverage; Year 9 17% coverage and Year 11 4% coverage of school roll. Different schools undertook survey at different times of the year
Self-harm incidents attended by ambulance service	South East Coast Ambulance Service (SECAmb)	January 2018-March 2021 provided – only used August 2019-March 2021	Incidents attended in East Sussex where crew condition code is O07 – Intentionally harming self, O08 – Intentional drug overdose or O14 Intentional self-poisoning	Activity – incidents attended only. Cannot look at repeat self-harm	Due to changes made to data systems only data from August 2019 onwards has been used. Crew condition codes for suicide attempt, suicidal thoughts and death by hanging are excluded
A&E attendances due to self-	Hospital Episode Statistics	2011/12 to 2018/19	Where patient group (reason for A&E	Attendances and individuals	Due to a change to national A&E data systems data is only available up to and

Data	Source	Time period	Self-harm definition	Activity and/or individuals	Other information to note
harm – East Sussex residents	accessed by East Sussex Public Health Intelligence team		episode) = 30 Deliberate self-harm		including 2018/19 via Hospital Episode Statistics
A&E attendances due to self-harm at East Sussex Healthcare Trust	Emergency Department data provided by East Sussex Healthcare Trust (ESHT)	2019/20 and 2020/21	01/04/2019 to 09/12/20 Incident type code 30 = deliberate self-harm. For period 10/12/20 to 31/03/21 chief complaint SNOMED Description of 'self-harm' (Snomed code 248062006) or presenting complaint of 'self-harm'	Attendances and individuals	Attendances at ESHT only account for around two-thirds of self-harm attendances in children and young people in East Sussex
A&E attendances due to self-harm – East Sussex residents	Emergency Care Data Set data provided by Performance and Intelligence Team, Sussex NHS Commissioners	2021	Self-harm: combination of Chief Complaint: Self-harm, Injury Intent: Self-inflicted injury and Comorbitities: History of deliberate self-harm Overdose: Includes an overdose diagnosis code in any position (Overdose of angiotensin-converting-enzyme inhibitors,Antidepressant overdose,Benzodiazepine overdose,Iron product overdose,NSAID overdose,Paracetamol overdose)	Attendances only. Cannot look at repeat self-harm	Due to the variation in coding practices of different providers for self-harm, only overdose data has been presented. Age groups can only split into Under 18s and 18-24s and is not available by sex.

Data	Source	Time period	Self-harm definition	Activity and/or individuals	Other information to note
Emergency admissions due to self-harm	Hospital Episode Statistics accessed by East Sussex Public Health Intelligence team	2011/12 to 2020/21	Where external cause code is ICD10 X60-X84 (Intentional self-harm)	Admissions and individuals	

Appendix 5 - Public mental health areas across the life course that have the potential to prevent mental illness and promote good mental health or wellbeing - methodology

The evidence review was undertaken by Dr Lester Coleman, Coleman Research & Evaluation Services during June/July 2022. The aims were to,

1. To identify public mental health areas across the life course that have the potential to prevent mental illness and promote good mental health or wellbeing. To source evidence from reviews of reviews and meta-analyses.

2. To summarise where there is evidence of effective preventative interventions based on these reviews. Organise by life course stage.

The focus of this review was to examine evidence, mainly sourced from reviews, reviews of reviews, and meta-analyses to identify public health interventions that can prevent mental illness and promote good mental health or wellbeing.

The literature has been used to identify evidence-based activities or services that can help prevent mental illness and promote good mental health during various stages of the life course. These were summarised in a series of tables,

Popular search terms to identify the literature (mainly from Google Scholar, PubMed and JSTOR) were: ‘mental health’, ‘wellbeing’, ‘intervention’, ‘prevention’, ‘life course’, ‘perinatal’, ‘early years’, ‘workplace’, ‘loneliness’ and ‘long-term conditions’. The search revealed 20 reviews and several other relevant

primary data studies. Further works were identified from the references within these studies.

Appendix 6 - Public mental health areas across the life course that have the potential to prevent mental illness and promote good mental health or wellbeing -results

Perinatal and infant mental health - Evidence for mental health prevention – what works?

a) Mental Health Foundation Strategy 2020-2025 Making Prevention Happen (2020):

An indication of the potential for preventative approaches can be seen by examining the priority areas for the Mental Health Foundation from 2020 -2022. These are being evaluated from 2022. Although they are yet to be evaluated, their inclusion in their Strategy suggests they have some level of effectiveness. Of their priorities, three are relevant for the perinatal period through to school age:

- Best start in life – focus on parenting, nurseries and home.
- Mentally healthy schools, colleges and universities – focus on peer education and addressing stress.
- Address Adverse Childhood Experiences (a range of stressful or traumatic events that children and young people can be exposed to) – focus on schools, vulnerable parents, care leavers, youth violence, trauma-informed approaches.

b) Royal College of Psychiatrists (2022) Summary of evidence on public mental health interventions:

There is strong evidence ('showing the strongest evidence of effectiveness') for perinatal interventions targeting parent tobacco, alcohol and substance use during pregnancy; interventions during pregnancy and immediately after birth to prevent child mental disorder; and home visiting and parenting programmes to improve child-parent attachment and prevent child adversity.

c) Mental Health Foundation (2016) Mental health and prevention: Taking local action for better mental health:

There is a need to develop Integrated Care Pathway approaches across local areas that take in to account the physical needs of pregnancy and child development

alongside the potential challenges to mental health and the significant opportunities in the perinatal period to improve mental health outcomes for families.

There is an evidence-base to invest in health visiting and home and family-based interventions to support maternal mental health improvement.

d) McDaid, D. and Park. A. (2022) The economic case for investing in the prevention of mental health conditions in the UK. Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science:

A number of economic evaluations now indicate the cost effectiveness of some measures to prevent and/or intervene early in perinatal depression, including health visitor provided counselling and/or psychological therapies, primary care screening and treatment for depression and telephone peer support.

e) Knapp, M., McDaid, D and Parsonage, M. (2011). Mental health promotion and mental illness prevention: The economic case London School of Economics and Political Science:

Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions. A range of UK trials with interventions provided by health visitors have been positive: women were more likely to recover fully after 3 months; targeted antenatal intervention with high risk groups was shown to reduce the average time mothers spent in a depressed state; and a combination of screening and psychologically informed sessions with health visitors was clinically effective 6 and 12 months after childbirth.

f) Mental Health Foundation (2016) Mental health and prevention: Taking local action for better mental health:

Producing prevention plans that address suicide within the perinatal period following the Joint Commissioning Panel for Mental

Health's three steps:

1. Identify those at increased risk of developing perinatal conditions.
2. Develop a personalised care plan for each woman at increased risk.
3. Ensure that women with a history of serious illness are prepared for pregnancy and receive preventative management when pregnant.

Ensure that perinatal and infant mental health pathways include opportunities, for those that need it, to access appropriate support prior to conception and that every woman (where clinically appropriate) has access to mother and baby units.

Where appropriate, implement national improvement initiatives locally, including:

- developing local Health Visitor Champions;
- implementing the Family Nurse Partnership Programme for young first-time mothers;
- ensuring that midwives have access to Perinatal Mental Health Training; and
- implementing guidelines for GPs and primary care from NICE and the Royal College of General Practitioners (RCGP).

g) Mental Health Foundation (2016) Better Mental Health For All: A public health approach to mental health improvement:

The Maternal Mental Health Pathway sets out guidance for healthcare professionals supporting mothers during pregnancy and after birth to prevent the development or exacerbation of mental health problems during this period and to manage existing conditions. The overarching rationale for the pathway is to strengthen consistent and seamless support and care and to recognise that enhanced partnership working will support the delivery of the Healthy Child Programme and achieve quality outcomes for children and parents.

There are also several national training initiatives available including the Health Visitor Champions training and the Perinatal Mental Health Training for midwives.

h) Perinatal mental health services: Recommendations for the provision of services for childbearing women (2021):

Mother and baby units and community perinatal mental health teams should aim to be accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). Also, see the Royal College of Psychiatrists (2018) 'Perinatal specialist community mental health team service specification template' at https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/perinatal/nccmh-perinatal-specialist-community-mental-health-team-service-spec-template-may2018.pdf?sfvrsn=aa70cd14_4

i) McDaid, D. and Park. A. (2022) The economic case for investing in the prevention of mental health conditions in the UK. Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science:

More work is needed to look at interventions for fathers, as well as interventions addressing anxiety in new parents.

j) Royal College of Psychiatrists (2022) Summary of evidence on public mental health interventions:

There is a moderate evidence rating (showing some evidence of effectiveness) as regards:

- Perinatal interventions targeting birth outcomes
- Breastfeeding support.

k) Mental Health Foundation (2016) Better Mental Health For All: A public health approach to mental health improvement:

Universal infant programmes, which include programmes offered in the context of antenatal care and programmes offered at birth to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant. They show parents what infants are capable of, help them to identify temperamental differences, provide them with knowledge of child development, and help them manage infant behaviours like sleep and crying. More progressive, targeted

interventions to address specific needs among more vulnerable and at risk groups can complement these universal programmes.

Promotional interviewing, an approach which focuses on the positive and aims to empower and support parents as well as to identify needs, is recommended in the English Child Health Promotion Programme during pregnancy and the postnatal period.

Programmes to address both antenatal and postnatal depression cover prevention in high-risk groups and intervention in mothers with established depression. They include cognitive behavioural and person-based counselling, both of which are equally effective if the practitioner can establish a trusting relationship with the mother.

Effective universal approaches to prevention have not yet been developed and programmes for fathers are still relatively new.

Parenting and protecting mental health in early years - evidence for mental health prevention – what works?

a) Royal College of Psychiatrists (2022) Summary of evidence on public mental health interventions:

There is a strong evidence base for the effectiveness ('showing the strongest evidence of effectiveness') of how parenting and home visiting programmes can prevent child mental disorder, substance use, antisocial behaviours and unintentional injury and improve child behavioural outcomes, parenting and parental mental health.

Home visiting programmes can also improve attachment-related outcomes in preschool children including among children with existing severe attachment problems.

b) Mental Health Foundation (2016) Better Mental Health For All: A public health approach to mental health improvement:

The evidence base for parenting programmes is very large and demonstrates an impact on a wide range of outcomes including child conduct disorder and parental mental health. Most parenting programmes are strengths-based; identifying and building on what parents are getting right rather than on problems.

c) Mental Health Foundation (2016) Mental health and prevention: Taking local action for better mental health:

Ensuring families at greater risk for mental health can access evidence-based mental health support, including:

- Triple P; the Solihull Approach; Mellow Parenting; Strengthening Families Strengthening Communities; and Incredible Years.
- A family-systems approach to consider the care giving relationship between the parent and the child as well as the relationship between parents.
- Video Interaction Guidance (VIG), as this is currently considered to be the best evidenced therapy for developing mother-child interactions.

d) McDaid, D. and Park. A. (2022) The economic case for investing in the prevention of mental health conditions in the UK. Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science:

There is good evidence for parenting programmes. Parenting programmes can help promote positive mental health and reduce the risk of poor emotional development. Universal programmes for all the relevant population, as well as targeted programmes for parents and their children at risk of mental health problems, or for those already experiencing behavioural difficulties, have been

shown to be effective. These programmes are often delivered within or around school settings, with teachers and teaching assistants trained to deliver the programmes.

e) Knapp, M., McDaid, D and Parsonage, M. (2011). Mental health promotion and mental illness prevention: The economic case London School of Economics and Political Science:

Parenting programmes can be targeted at parents of children with, or at risk of, developing conduct disorder, and are designed to improve parenting styles and parent-child relationships. Reviews have found parent training to have positive effects on children's behaviour, and that benefits remain one year later.

f) Centre for Mental Health (2002) Mentally healthier council areas: Manifesto ideas for the 2022 local authority elections. Centre for Mental Health:

Effective support with parenting has been shown to be especially valuable, yet access is not universally available and is a postcode lottery.

g) Mental Health Foundation (2016) Better Mental Health For All: A public health approach to mental health improvement:

Parental mental health has been mostly studied in the context of the perinatal period. The impact of parental mental health problems on children's mental health in later childhood has been much neglected. Programmes to support parents, children and parenting in families where a parent has a mental health problem which have been thoroughly evaluated and disseminated internationally are: The William Beardslee programme, a family-based approach for prevention in children at risk; Lets Talk About Children, a manual for a two session discussion with parents who are living with a mental health problem; and Parenting under Pressure, a promising programme for supporting parenting in families where parents abuse drugs or alcohol.

12. References

[1] Edmondson, A.J., Brennan, C.A., & House, A.O. (2016) Non-suicidal reasons for self-harm: A systematic review of self-reported accounts, Journal of Affective Disorders, 191, 109-117

[2] Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S., et al. (2012). Premature death after self-harm: a multicentre cohort study. Lancet 380, 1568–1574. doi: 10.1016/S0140-6736(12)61141-6

[3] Mars, B., Heron, J., Crane, C., Hawton, K., Lewis, G., Macleod, J., et al. (2014). Clinical and social outcomes of adolescent self harm: population based birth cohort study. Br. Med. J. 349:g5954. doi: 10.1136/bmj.g5954

[4] Robinson, J. (2016). Repeated self harm in young people: a review. Aust. Psychiatry 25, 105–107. doi: 10.1177/1039856216679542

[5] Kidger J, Heron J, Lewis G, Evans J, and Gunnell D. Adolescent self-harm and suicidal thoughts in the ALSPAC cohort: a self-report survey in England. BMC Psychiatry. 2012; 12(69): 1-12.

[6] Public Health England (2017) Intentional self-harm in adolescence: An analysis of data from the Health

Behaviour in School-aged Children (HBSC) survey for England, 2014, accessed 15/03/22 at https://www.gov.uk/government/publications/health-behaviour-in-school-age-children-hbsc-data-analysis

[7] Geulayov G, Casey D, McDonald KC, Foster P, Pritchard K, Wells C, Clements C, Kapur N, Ness J, Waters K, Hawton K. Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study. Lancet Psychiatry. 2018 Feb;5(2):167–74. doi: 10.1016/s2215-0366(17)30478-9.

[8] https://www.sussex.ics.nhs.uk/our-vision/priorities-and-programmes/improving-health-services/mental-health/improving-children-and-young-peoples-mental-health/foundations-for-our-future/

[9] http://implementingthrive.org/

[10] https://www.sussex.ics.nhs.uk/our-vision/priorities-and-programmes/improving-health-services/mental-health/improving-children-and-young-peoples-mental-health/foundations-for-our-future/

[11] Offord DR, Kraemer HC (2000) Risk factors and preventionEvidence-Based Mental Health 2000;3:70-71.

[12] Hawton K, Saunders KEA, O'Connor RC. Self-harm and suicide in adolescents. Lancet. 2012;379(9834):2373–82.

[13] Kraemer HC, Stice E, Kazdin A, Offord D, Kupfer D. How do risk factors work together? Mediators, moderators, and independent, overlapping, and proxy risk factors. Am J Psychiatry. 2001 Jun;158(6):848-56. doi: 10.1176/appi.ajp.158.6.848. PMID: 11384888.

[14]Bozzini AB, Bauer A, Maruyama J, Simões R, Matijasevich A. Factors associated with risk behaviors in adolescence: a systematic review. Braz J Psychiatry. 2021 Mar-Apr;43(2):210-221. doi: 10.1590/1516-4446-2019-0835. PMID: 32756805; PMCID: PMC8023154.

[15] Conti G, Heckman JJ, Pinto R. The effects of two influential early childhood interventions on health and healthy behaviour. Econ J. 2016;126:F28-65.

[16] Stepheni Uh, Edwin S. Dalmaijer, Roma Siugzdaite, Tamsin J. Ford, Duncan E. Astle, Two Pathways to Self-Harm in Adolescence, Journal of the American Academy of Child & Adolescent Psychiatry, Volume 60, Issue 12,

2021, Pages 1491-1500, https://doi.org/10.1016/j.jaac.2021.03.010.

[17] Stepheni Uh, Edwin S. Dalmaijer, Roma Siugzdaite, Tamsin J. Ford, Duncan E. Astle, Two Pathways to Self-Harm in Adolescence, Journal of the American Academy of Child & Adolescent Psychiatry, Volume 60, Issue 12,

2021, Pages 1491-1500, https://doi.org/10.1016/j.jaac.2021.03.010.

[18] Hawton K. Suicide following self-harm: findings from the multicentre study of self-harm in England, 2000-2012. J Affect Disord. 2015;175:147–52.

[19] Hawton, K., Bale, L., Brand, F., Townsend, E., Ness, J., Waters, K., Clements, C., Kapur, N., & Geulayov, G. (2020). Mortality in children and adolescents following presentation to hospital after non-fatal self-harm in the Multicentre Study of Self-harm: a prospective observational cohort study. Lancet Child Adolesc Health., 4(2), 111– 120. https://doi.org/10.1016/S2352-4642(19)30373-6

[20] Mars B, Heron J, Klonsky ED, et al. Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population-based birth cohort study. Lancet Psychiatr. 2019;6(4):327–337

[21] Chan M, Bhatti H, Meader N, Stockton S, Evans J, O'Connor R and Kendall T (2016) Predicting suicide following self-harm: Systematic review of risk factors and risk scales. British Journal of Psychiatry, 209(4): 277–83

[22] Rodway, C., Tham, S.-G., Ibrahim, S., Turnbull, P., Windfuhr, K., Shaw, J., … & Appleby, L. (2016). Suicide in children and young people in England: A consecutive case series. Lancet Psychiatry, 3, 751–759.

[23] Holt-White, E., De Gennaro, A., Anders, J., Cullinane, C., Early, E., Montacute, R., Shao, X., & Yarde, J. (2022). Wave 1 Initial Findings – Mental Health and Wellbeing. COVID Social Mobility & Opportunities (COSMO) study Briefing No. 4. London: UCL Centre for Education Policy and Equalising Opportunities & Sutton Trust. Available at: https://cosmostudy.uk/publications/mental-health-and-wellbeing

[24] Good Childhood Report 2021

[25] Theberath M, Bauer D, Chen W, Salinas M, Mohabbat AB, Yang J, Chon TY, Bauer BA, Wahner-Roedler DL. Effects of COVID-19 pandemic on mental health of children and adolescents: A systematic review of survey studies. SAGE Open Med. 2022 Mar 30;10:20503121221086712. doi: 10.1177/20503121221086712. PMID: 35371484; PMCID: PMC8972920.

[26] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/09/the_big_ask_big_answers_09_21.pdf

[27] Covid-19 Social Study Results release 40 5 November 2021, available at https://www.covidsocialstudy.org/_files/ugd/064c8b_86930bad37754dc9ac0553ef44caa902.pdf

[28] Hawton, K. et al. (2021). 'Self-harm during the early period of the COVID-19 pandemic in England:

Comparative trend analysis of hospital presentations', Journal of affective disorders, 282, 991-995.

[29] HM Government. Preventing suicide in England: Fifth progress report of the cross government outcomes strategy to save lives. Published 27 March 2021

[30] Holt-White, E., De Gennaro, A., Anders, J., Cullinane, C., Early, E., Montacute, R., Shao, X., & Yarde, J. (2022). *Wave 1 Initial Findings – Mental Health and Wellbeing*.

COVID Social Mobility & Opportunities (COSMO) study Briefing No. 4. London: UCL Centre for Education Policy and Equalising Opportunities & Sutton Trust. Available at: https://cosmostudy.uk/publications/mental-health-and-wellbeing

[31] Hawton K, Saunders KEA, and O'Connor RC. Self-harm and suicide in adolescents. The Lancet. 2012 379(9834): 2373-2382.

[32] Witt K.G., Hetrick S.E., Rajaram G., Hazell P., Taylor Salisbury T.L., Townsend E., Hawton K. Interventions for self-harm in children and adolescents. Cochrane Database Syst. Rev. 2021;3:Cd013667.

[33] McManus S, Gunnell D, Cooper C, et al. Prevalence of non-suicidal self-harm and service

contact in England, 2000-14: repeated cross-sectional surveys of the general population. Lancet Psychiatry. 2019;0:573-581. https://doi.org/10.1016/S2215-0366(19)30188-9.

[34] Muehlenkamp JJ, Claes L, Havertape L, Plener PL. International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. Child Adolesc Psychiatry Mental Health. 2012;6:10. https://doi.org/10.1186/1753-2000-6-10

[35] Public Health England (2017) Intentional self-harm in adolescence: An analysis of data from the Health

Behaviour in School-aged Children (HBSC) survey for England, 2014, Public Health England, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/621068/Health_behaviour_in_school_age_children_self-harm.pdf

[36] Patalay, P. and Fitzsimons, E. (2020). Mental ill-health at age 17 in the UK: Prevalence of and inequalities in psychological distress, self-harm and attempted suicide. London: Centre for Longitudinal Studies

[37] https://www.publicmentalhealth.co.uk/home

[38] Labonte R. Health promotion and empowerment practice frameworks. 1993. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf

[39] Hawton K, Saunders KEA, O'Connor RC. Self-harm and suicide in adolescents. Lancet. 2012;379(9834):2373–82.

[40] Valencia-Agudo F, Burcher GC, Ezpeleta L, Kramer T. Nonsuicidal self-injury in community adolescents: A systematic review of prospective predictors, mediators and

moderators. J Adolesc. 2018 Jun;65:25-38. doi: 10.1016/j.adolescence.2018.02.012. Epub 2018 Mar 6. PMID: 29522914.

[41] 2. Knowles, G., Gayer-Anderson, C., Beards, S., Blakey, R., Davis, S., Lowis, K., Stanyon, D., Ofori, A., Turner, A., Working Group, S., Pinfold, V., Bakolis, I., Reininghaus, U., Harding, S., & Morgan, C. (2021). Mental distress among young people in inner cities: the Resilience, Ethnicity and AdolesCent Mental Health (REACH) study. Journal of epidemiology and community health, 75(6), 515–522. Advance online publication. https://doi.org/10.1136/jech-2020-214315

[42] Young, R., Sproeber, N., Groschwitz, R.C. et al. Why alternative teenagers' self-harm: exploring the link between non-suicidal self-injury, attempted suicide and adolescent identity. BMC Psychiatry 14, 137 (2014). https://doi.org/10.1186/1471-244X-14-137

[43] Patalay, P. and Fitzsimons, E. (2020). Mental ill-health at age 17 in the UK: Prevalence of and inequalities in psychological distress, self-harm and attempted suicide. London: Centre for Longitudinal Studies

[44] Diggins E, Kelley R, Cottrell D, House A, Owens D. Age-related differences in self-harm presentations and subsequent management of adolescents and young adults at the emergency department. J Affect Disord. 2017 Jan 15;208:399-405. doi: 10.1016/j.jad.2016.10.014. Epub 2016 Oct 21. PMID: 27810724..

[45] Rhodes AE, Boyle MH, Bridge JA, Sinyor M, Links TS, Tonmyr L, et al. Antecedents and sex/gender differences in youth suicidal behavior. World Journal of Psychiatry 2014;4:120-32

[46] Patton GC Hemphill SA Beyers JM et al. Pubertal stage and deliberate self-harm in adolescents. J Am Acad Child Adolesc Psychiatry. 2007; 46: 508-514

[47] McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., Jenkins, R., Hassiotis, A., Weich, S., & Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000-14: repeated cross-sectional surveys of the general population. Lancet Psychiatry, 6(7), 573-581. https://doi.org/10.1016/S2215-0366(19)30188-9

[48] Marchant, A., Turner, S., Balbuena, L., Peters, E., Williams, D., Lloyd, K., . . . John, A. (2020). Self-harm presentation across healthcare settings by sex in young people: An e-cohort study using routinely collected linked healthcare data in Wales, UK. Archives of Disease in Childhood, 105(4), pp. 347-354. doi:10.1136/archdischild-2019-317248

[49] Page A, Lewis G, Kidger J, Heron J, Chittleborough C, Evans J, Gunnell D. Parental socio-economic position during childhood as a determinant of self-harm in adolescence.

Soc Psychiatry Psychiatr Epidemiol. 2014 Feb;49(2):193-203. doi: 10.1007/s00127-013-0722-y. Epub 2013 Jun 7. PMID: 23744444.

[50] Public Health England (2017) Intentional self-harm in adolescence: An analysis of data from the Health

Behaviour in School-aged Children (HBSC) survey for England, 2014, Public Health England, available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/621068/Health_behaviour_in_school_age_children_self-harm.pdf

[51] Lodebo BT, Möller J, Larsson JO, Engström K. Socioeconomic position and self-harm among adolescents: a population-based cohort study in Stockholm, Sweden. Child Adolesc Psychiatry Ment Health. 2017 Sep 6;11:46. doi: 10.1186/s13034-017-0184-1. PMID: 28878818; PMCID: PMC5585967.

[52] Mok PLH, Antonsen S, Pedersen CB, Carr MJ, Kapur N, Nazroo J, Webb RT. Family income inequalities and trajectories through childhood and self-harm and violence in young adults: a population-based, nested case-control study. Lancet Public Health. 2018 Oct;3(10):e498-e507. doi: 10.1016/S2468-2667(18)30164-6. PMID: 30314594.

[53] Patalay, P. and Fitzsimons, E. (2020). Mental ill-health at age 17 in the UK: Prevalence of and inequalities in psychological distress, self-harm and attempted suicide. London: Centre for Longitudinal Studies

[54] Kim P, Neuendorf C, Bianco H, Evans GW. Exposure to Childhood Poverty and Mental Health Symptomatology in Adolescence: A Role of Coping Strategies. Stress Health. 2016 Dec;32(5):494-502. doi: 10.1002/smi.2646. Epub 2015 Aug 3. PMID: 26234956.

[55] Kim P, Neuendorf C, Bianco H, Evans GW. Exposure to Childhood Poverty and Mental Health Symptomatology in Adolescence: A Role of Coping Strategies. Stress Health. 2016 Dec;32(5):494-502. doi: 10.1002/smi.2646. Epub 2015 Aug 3. PMID: 26234956.

[56] Hawton K, Saunders KE, O'Connor RC. Self-harm and suicide in adolescents. Lancet. 2012 Jun 23;379(9834):2373-82. doi: 10.1016/S0140-6736(12)60322-5. PMID: 22726518.

[57] Valencia-Agudo, F., Kramer, T., Clarke, V., Goddard, A., & Khadr, S. (2020). Correlates and predictors of self-harm in a prospective sample of sexually assaulted adolescents. Clinical Child Psychology and Psychiatry, 25(4), 847–859.
https://doi.org/10.1177/1359104520920332

[58] Emma Björkenstam, Kyriaki Kosidou, Charlotte Björkenstam, Childhood household dysfunction and risk of self-harm: a cohort study of 107 518 young adults in Stockholm

County, International Journal of Epidemiology, Volume 45, Issue 2, April 2016, Pages 501–511

[59] Valencia-Agudo F, Burcher GC, Ezpeleta L, Kramer T. Nonsuicidal self-injury in community adolescents: A systematic review of prospective predictors, mediators and moderators. J Adolesc. 2018 Jun;65:25-38. doi: 10.1016/j.adolescence.2018.02.012. Epub 2018 Mar 6. PMID: 29522914.

[60] Plener, P. L., Schumacher, T. S., Munz, L. M., & Groschwitz, R. C. (2015). The longitudinal course of non-suicidal self-injury and deliberate self-harm: a systematic review of the literature. Borderline Personal Disord Emot Dysregul, 2(1), 2.

[61] Fliege, H., Lee, J.-R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. J Psychosom Res, 66(6), 477 - 493.

[62] Public Health England (2017) Intentional self-harm in adolescence: An analysis of data from the Health

Behaviour in School-aged Children (HBSC) survey for England, 2014, accessed 15/03/22 at https://www.gov.uk/government/publications/health-behaviour-in-school-age-children-hbsc-data-analysis

[63] Cassels M, van Harmelen AL, Neufeld S, Goodyer I, Jones PB, Wilkinson P. Poor family functioning mediates the link between childhood adversity and adolescent nonsuicidal self-injury. J Child Psychol Psychiatry. 2018 Aug;59(8):881-887. doi: 10.1111/jcpp.12866. Epub 2018 Jan 24. PMID: 29363128; PMCID: PMC6055861.

[64] Angelakis I, Gillespie EL, Panagioti M. Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis. Psychol Med. 2019;49(7):1057-1078. doi:10.1017/S0033291718003823

[65] Angelakis I, Austin JL, Gooding P. Association of Childhood Maltreatment with Suicide Behaviors Among Young People: A Systematic Review and Meta-analysis. JAMA Netw Open. 2020 Aug 3;3(8):e2012563. doi: 10.1001/jamanetworkopen.2020.12563. PMID: 32756929; PMCID: PMC7407092.

[66] Serafini G, Canepa G, Adavastro G, Nebbia J, Belvederi Murri M, Erbuto D, Pocai B, Fiorillo A, Pompili M, Flouri E, Amore M. The Relationship between Childhood Maltreatment and Non-Suicidal Self-Injury: A Systematic Review. Front Psychiatry. 2017 Aug 24;8:149. doi: 10.3389/fpsyt.2017.00149. PMID: 28970807; PMCID: PMC5609590.

[67] Liu RT, Scopelliti KM, Pittman SK, Zamora AS. Childhood maltreatment and non-suicidal self-injury: a systematic review and meta-analysis. Lancet Psychiatry. 2018 Jan;5(1):51-

64. doi: 10.1016/S2215-0366(17)30469-8. Epub 2017 Nov 28. PMID: 29196062; PMCID: PMC5743605.

[68] Weierich MR, Nock MK. Posttraumatic stress symptoms mediate the relation between childhood sexual abuse and nonsuicidal self-injury. J Consult Clin Psychol (2008) 76:39–44. doi:10.1037/0022-006X.76.1.39

[69] 44. Cicchetti D, Toth SL. Child maltreatment. Ann Rev Clin Psychol (2005) 1:409–38. doi:10.1146/annurev.clinpsy.1.102803.144029

[70] Shipman K, Zeman J, Penza S, Champion K. Emotion management skills in sexually maltreated and nonmaltreated girls: a developmental psychopathology perspective. Dev Psychopathol (2000) 12:47–62. doi:10.1017/S0954579400001036

[71] Serafini G, Canepa G, Adavastro G, Nebbia J, Belvederi Murri M, Erbuto D, Pocai B, Fiorillo A, Pompili M, Flouri E, Amore M. The Relationship between Childhood Maltreatment and Non-Suicidal Self-Injury: A Systematic Review. Front Psychiatry. 2017 Aug 24;8:149. doi: 10.3389/fpsyt.2017.00149. PMID: 28970807; PMCID: PMC5609590.

[72] https://www.youngminds.org.uk/professional/resources/understanding-trauma-and-adversity/#:~:text=Adverse%20childhood%20experiences%20(ACEs)%20are,security%2C%20trust%20or%20bodily%20integrity.

[73] Wang YJ, Li X, Ng CH, Xu DW, Hu S, Yuan TF. Risk factors for non-suicidal self-injury (NSSI) in adolescents: A meta-analysis. EClinicalMedicine. 2022 Mar 21;46:101350. doi: 10.1016/j.eclinm.2022.101350. PMID: 35330803; PMCID: PMC8938878.

[74] Russell AE, Heron J, Gunnell D, Ford T, Hemani G, Joinson C, Moran P, Relton C, Suderman M, Mars B. Pathways between early-life adversity and adolescent self-harm: the mediating role of inflammation in the Avon Longitudinal Study of Parents and Children. J Child Psychol Psychiatry. 2019 Oct;60(10):1094-1103. doi: 10.1111/jcpp.13100. Epub 2019 Sep 4. PMID: 31486089; PMCID: PMC6771906.

[75] Hawton K, Saunders KE, O'Connor RC. Self-harm and suicide in adolescents. Lancet. 2012 Jun 23;379(9834):2373-82. doi: 10.1016/S0140-6736(12)60322-5. PMID: 22726518.

[76] Fliege H, Lee JR, Grimm A, Klapp BF. Risk factors and correlates of deliberate self-harm behavior: a systematic review. J Psychosom Res. 2009 Jun;66(6):477-93. doi: 10.1016/j.jpsychores.2008.10.013. Epub 2009 Jan 16. PMID: 19446707

[77] Wang YJ, Li X, Ng CH, Xu DW, Hu S, Yuan TF. Risk factors for non-suicidal self-injury (NSSI) in adolescents: A meta-analysis. EClinicalMedicine. 2022 Mar 21;46:101350. doi: 10.1016/j.eclinm.2022.101350. PMID: 35330803; PMCID: PMC8938878.

[78] Sheldon E, Simmonds-Buckley M, Bone C, Mascarenhas T, Chan N, Wincott M, Gleeson H, Sow K, Hind D, Barkham M. Prevalence and risk factors for mental health problems in university undergraduate students: A systematic review with meta-analysis. J Affect Disord. 2021 May 15;287:282-292. doi: 10.1016/j.jad.2021.03.054. Epub 2021 Mar 26. PMID: 33812241.

[79] Madge N, Hawton K, McMahon EM, Corcoran P, De Leo D, de Wilde EJ, Fekete S, van Heeringen K, Ystgaard M, Arensman E. Psychological characteristics, stressful life events and deliberate self-harm: findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Eur Child Adolesc Psychiatry. 2011 Oct;20(10):499-508. doi: 10.1007/s00787-011-0210-4. Epub 2011 Aug 17. PMID: 21847620.

[80] Hawton K, Saunders K, Topiwala A, Haw C. Psychiatric disorders in patients presenting to hospital following self-harm: a systematic review. J Affect Disord. 2013 Dec;151(3):821-30. doi: 10.1016/j.jad.2013.08.020. Epub 2013 Sep 7. PMID: 24091302.

[81] Junker A, Bjørngaard JH, Bjerkeset O. Adolescent health and subsequent risk of self-harm hospitalisation: a 15-year follow-up of the Young-HUNT cohort. Child Adolesc Psychiatry Ment Health. 2017;11:25. Published 2017 May 1. doi:10.1186/s13034-017-0161-8

[82] Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., … Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. Journal of Adolescent Health, 49(2), 115–123. doi: https://doi.org/10.1016/j.jadohealth.2011.02.005

[83] Liu, R. T., Sheehan, A. E., Walsh, R. F., Sanzari, C. M., Cheek, S. M., & Hernandez, E. M. (2019). Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: A systematic review and meta-analysis. *Clinical Psychology Review*, *74*, 101783. doi:https://doi.org/10.1016/j.cpr.2019.101783

[84] Metro Charity (2016) Youth chances: integrated report, available at https://metrocharity.org.uk/sites/default/files/2017-04/National%20Youth%20Chances%20Intergrated%20Report%202016.pdf

[85] Irish, M., Solmi, F., Mars, B., King, M., Lewis, G., Pearson, R., Pitman, A., Rowe, S., Srinivasan, R. & Lewis, G. (2019). Depression and self-harm from adolescence to young adulthood in sexual minorities compared with heterosexuals in the UK: a population-based cohort study. The Lancet Child & Adolescent Health, 3 (2), 91–98. https://doi.org/10.1016/S2352-4642(18)30343-2

[86] V Jadva, A Guasp, J H Bradlow, S Bower-Brown, S Foley (2021) Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school experience, Journal of Public Health, fdab383, https://doi.org/10.1093/pubmed/fdab383

[87] Silenzio, V. M. B., Pena, J. B., Duberstein, P. R., Cerel, J., & Knox, K. L. (2007). Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. American Journal of Public Health,97(11), 2017–2019.

[88] Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. American Journal of Preventive Medicine,42(3), 221–228. https://doi.org/10.1016/j.amepre.2011.10.023.

[89] Williams, A. J., Jones, C., Arcelus, J., Townsend, E., Lazaridou, A., & Michail, M. (2021). A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. PLoS One, 16(1), e0245268. doi:https://doi.org/10.1371/journal.pone.0245268

[90] A. Jess Williams, Jon Arcelus, Ellen Townsend & Maria Michail (2021) Understanding the processes underlying self-harm ideation and behaviors within LGBTQ+ young people: A qualitative study, Archives of Suicide Research, DOI: 10.1080/13811118.2021.2003273

[91] Arcelus, J., Claes, L., Witcomb, G. L., Marshall, E., & Bouman, W. P. (2016). Risk factors for non-suicidal self-injury among trans youth. The Journal of Sexual Medicine, 13(3), 402–412. doi:https://doi.org/10.1016/j.jsxm.2016.01.003

[92] Taylor, P. J., Dhingra, K., Dickson, J. M., & McDermott, E. (2020). Psychological correlates of self-harm within gay, lesbian and bisexual UK university students. Archives of Suicide Research , 24(sup1), 41–56. doi:https://doi.org/10.1080/13811118.2018.1515136

[93] Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin, 129, 674-697. doi:10.1037/0033-2909.129.5.674

[94] Muehlenkamp, J. J., Hilt, L. M., Ehlinger, P. P., & McMillan, T. (2015). Nonsuicidal self-injury in sexual minority college students: A test of theoretical integration. Child and Adolescent Psychiatry and Mental Health, 9, Article 16. https://doi.org/10.1186/s13034-015-0050-y

[95]V Jadva, A Guasp, J H Bradlow, S Bower-Brown, S Foley (2021) Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school experience, Journal of Public Health, fdab383, https://doi.org/10.1093/pubmed/fdab383

[96] Zaqia Rehman, Barbara Lopes, Rusi Jaspal (2020). Predicting self-harm in an ethnically diverse sample of lesbian, gay and bisexual people in the United Kingdom, International Jounral of Social Psychiatry, vol 66(4), 349-360

[97] Warbelow, S., Cobb, T. (2014). Bullying of LGBT youth in America: Prevalence, effects, and government responses. In Peterson, D., Panfil, V. (Eds.), Handbook of LGBT communities, crime, and justice (pp. 405–427). Springer.

[98] lweus D. Bullying at school: What we know and what we can do. Wiley-Blackwell, 1993.

[99] Khaki, Z., El-Salahi, S., & Cooper, M. (2022) Moderators and mediators of the association between bullying victimisation and self-harm and suicide in adolescents: A systematic review, Psychiatry Research Communications, Vol 2 (2), available at https://www.sciencedirect.com/science/article/pii/S2772598722000113

[100] Fisher HL, Moffitt TE, Houts RM, Belsky DW, Arseneault L, Caspi A. Bullying victimisation and risk of self harm in early adolescence: longitudinal cohort study. BMJ Br Med J. 2012;344:e2683.

[101] McMahon EM, Reulbach U, Keeley H, Perry IJ, Arensman E. Reprint of: bullying victimisation, self-harm and associated factors in Irish adolescent boys. Soc Sci Med. 2012;74(4):490–7.

[102] Hay C, Meldrum R. Bullying victimization and adolescent self-harm: testing hypotheses from general strain theory. J Youth Adolesc. 2010;39(5):446–59

[103] A. John, A.C. Glendenning, A. Marchant, P. Montgomery, A. Stewart, S. Wood, K. Lloyd, K. Hawton

Self-harm, suicidal behaviours, and cyberbullying in children and young people: systematic review, Journal of Medical Internet Research, vol 20, No 4, available at https://www.jmir.org/2018/4/e129/

J. Med. Internet Res., 20 (4) (2018), Article e129, 10.2196/jmir.9044

[104] Maria N. K. Karanikola ,1 Anne Lyberg,2 Anne-Lise Holm,3 and Elisabeth Severinsson (2018) The Association between Deliberate Self-Harm and School Bullying Victimization and the Mediating Effect of Depressive

Symptoms and Self-Stigma: A Systematic Review, BioMed Research International

Volume 2018, Article ID 4745791, 36 pages https://doi.org/10.1155/2018/4745791

[105] Mossige S, Huang L, Straiton M, Roen K. Suicidal ideation and self-harm among youths in Norway: associations with verbal, physical and sexual abuse. Child Fam Soc Work. 2016;21(2):166–75.

[106] S. Hinduja, J.W. Patchin Connecting adolescent suicide to the severity of bullying and cyberbullying

J. Sch. Violence, 18 (3) (2018), pp. 333-346, 10.1080/15388220.2018.1492417

[107] A. Zaborskis, G. Ilionsky, R. Tesler, A. Heinz The association between cyberbullying, school bullying, and suicidality among adolescents Crisis, 40 (2) (2019), pp. 100-114

[108] Heerde JA, Hemphill SA. Are bullying perpetration and victimization associated with adolescent deliberate self-harm? a meta-analysis. Arch Suicide Res. 2019;23(3):353–81.

[109] Ingri Myklestad* and Melanie Straiton (2021) The relationship between self-harm and bullying behaviour: results from a population based study of adolescents, BMC Public Health, 21:254,

https://doi.org/10.1186/s12889-021-10555-9

[110] Ingri Myklestad* and Melanie Straiton (2021) The relationship between self-harm and bullying behaviour: results from a population based study of adolescents, BMC Public Health, 21:254,

https://doi.org/10.1186/s12889-021-10555-9

[111] Best, P., Manktelow, R., & Taylor, B. (2014). Online communication, social media and adolescent wellbeing: A systematic narrative review. Children and Youth Services Review, 41, 27–36. https://doi.org/10.1016/j.childyouth.2014.03.001

[112] Marchant A, Hawton K, Stewart A, Montgomery P, Singaravelu V, Lloyd K, et al. (2017) A systematic review of the relationship between internet use, self-harm and suicidal behaviour in young people: The good, the bad and the unknown. PLoS ONE 12(8): e0181722. https://doi.org/10.1371/journal.pone.0181722

[113][113] Jacqueline Nesi, Taylor A. Burke, Alexandra H. Bettis, Anastacia Y. Kudinova, Elizabeth C. Thompson, Heather A. MacPherson, Kara A. Fox, Hannah R. Lawrence, Sarah A. Thomas, Jennifer C. Wolff, Melanie K. Altemus, Sheiry Soriano, Richard T. Liu, Social media use and self-injurious thoughts and behaviors: A systematic review and meta-analysis, Clinical Psychology Review, Volume 87, 2021, https://doi.org/10.1016/j.cpr.2021.102038.

[114] Aucejo EM, Romano TF. Assessing the effect of school days and absences on test score performance. Econ Educ Rev. 2016;55:70–87. [Google Scholar]

[115] Hancock KJ, Lawrence D, Shepherd CCJ, Mitrou F, Zubrick SR. Associations between school absence and academic achievement: do socioeconomics matter? Br Educ Res J. 2017;43:415–440

[116] Kearney CA. School absenteeism and school refusal behavior in youth: a contemporary review. Clin Psychol Rev. 2008;28(3):451–471. doi: 10.1016/j.cpr.2007.07.012.

[117] Epstein S, Roberts E, Sedgwick R, et al. School absenteeism as a risk factor for self-harm and suicidal ideation in children and adolescents: a systematic review and meta-analysis. Eur Child Adolesc Psychiatry. 2020;29(9):1175-1194. doi:10.1007/s00787-019-01327-3

[118] Widnall, E., Epstein, S., Polling, C. et al. Autism spectrum disorders as a risk factor for adolescent self-harm: a retrospective cohort study of 113,286 young people in the UK. BMC Med 20, 137 (2022). https://doi.org/10.1186/s12916-022-02329-w

[119] Kearney CA. School absenteeism and school refusal behavior in youth: a contemporary review. Clin Psychol Rev. 2008;28(3):451–471. doi: 10.1016/j.cpr.2007.07.012

[120] Epstein S, Roberts E, Sedgwick R, et al. School absenteeism as a risk factor for self-harm and suicidal ideation in children and adolescents: a systematic review and meta-analysis. Eur Child Adolesc Psychiatry. 2020;29(9):1175-1194. doi:10.1007/s00787-019-01327-3

[121] Wong, MM, Brower, KJ. The prospective relationship between sleep problems and suicidal behavior in the National Longitudinal Study of Adolescent Health. J Psychiatr Res 2012; 46: 953–9.

[122] Singareddy, R, Krishnamurthy, VB, Vgontzas, AN, Fernandez-Mendoza, J, Calhoun, SL, Shaffer, ML, et al. Subjective and objective sleep and self-harm behaviors in young children: a general population study. Psychiatry Res 2013; 209: 549–53

[123] Russell, K., Allan, S., Beattie, L., Bohan, J., MacMahon, K. and Rasmussen, S. (2019) Sleep problem, suicide and self-harm in university students: a systematic review. Sleep Medicine Reviews, 44, pp. 58-69.

[124] McGlinchey EL, Courtney-Seidler EA, German M, Miller AL. The Role of Sleep Disturbance in Suicidal and Nonsuicidal Self-Injurious Behavior among Adolescents. Suicide Life Threat Behav. 2017 Feb;47(1):103-111. doi: 10.1111/sltb.12268. Epub 2016 Jun 7. PMID: 27273654.

[125] Hysing M, Sivertsen B, Stormark KM, O'Connor RC. Sleep problems and self-harm in adolescence. Br J Psychiatry. 2015 Oct;207(4):306-12. doi: 10.1192/bjp.bp.114.146514. Epub 2015 Jul 23. PMID: 26206862.

[126] Habibolah Khazaie, Ali Zakiei, William Vaughn McCall, Khadijeh Noori, Masoumeh Rostampour, Dena Sadeghi Bahmani & Serge Brand (2021) Relationship between Sleep Problems and Self-Injury: A Systematic Review, Behavioral Sleep Medicine, 19:5, 689-704, DOI: 10.1080/15402002.2020.1822360

[127] Uh S, Dalmaijer ES, Siugzdaite R, Ford TJ, Astle DE. Two Pathways to Self-Harm in Adolescence. J Am Acad Child Adolesc Psychiatry. 2021 Dec;60(12):1491-1500. doi: 10.1016/j.jaac.2021.03.010. Epub 2021 May 7. PMID: 34130904; PMCID: PMC8661039.

[128] Carroll R, Metcalfe C, Gunnell D. Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. PLoS One. 2014 Feb 28;9(2):e89944. doi: 10.1371/journal.pone.0089944. PMID: 24587141; PMCID: PMC3938547.

[129] Zahl DL, Hawton K. Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients. Br J Psychiatry. 2004 Jul;185:70-5. doi: 10.1192/bjp.185.1.70. PMID: 15231558.

[130] Hawton K, Bergen H, Kapur N, Cooper J, Steeg S, Ness J, Waters K. Repetition of self-harm and suicide following self-harm in children and adolescents: findings from the Multicentre Study of Self-harm in England. J Child Psychol Psychiatry. 2012;53(12):1212–9.

[131] Rahman F, Webb RT, Wittkowski A. Risk factors for self-harm repetition in adolescents: A systematic review. Clin Psychol Rev. 2021 Aug;88:102048. doi: 10.1016/j.cpr.2021.102048. Epub 2021 May 29. PMID: 34119893.

[132] Madge N, Hawton K, McMahon EM, Corcoran P, De Leo D, de Wilde EJ, Fekete S, van Heeringen K, Ystgaard M, Arensman E. Psychological characteristics, stressful life events and deliberate self-harm: findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Eur Child Adolesc Psychiatry. 2011 Oct;20(10):499-508. doi: 10.1007/s00787-011-0210-4. Epub 2011 Aug 17. PMID: 21847620.

[133] Witt K, Milner A, Spittal MJ, Hetrick S, Robinson J, Pirkis J, Carter G. Population attributable risk of factors associated with the repetition of self-harm behaviour in young people presenting to clinical services: a systematic review and meta-analysis. Eur Child Adolesc Psychiatry. 2019 Jan;28(1):5-18. doi: 10.1007/s00787-018-1111-6. Epub 2018 Feb 3. PMID: 29397445.

[134] 21. Daly, C., Griffin, E., McMahon, E., Corcoran, P., Webb, R. T., Witt, K., Ashcroft, D. M., & Arensman, E. (2020). Repeat Self-Harm Following Hospital-Presenting Intentional

Drug Overdose among Young People-A National Registry Study. International journal of environmental research and public health, 17(17), 6159. https://doi.org/10.3390/ijerph17176159

[135] Glazebrook K, Townsend E, Sayal K. The Role of Attachment Style in Predicting Repetition of Adolescent Self-Harm: A Longitudinal Study. Suicide Life Threat Behav. 2015 Dec;45(6):664-78. doi: 10.1111/sltb.12159. Epub 2015 Apr 6. PMID: 25845416; PMCID: PMC6680138.

[136] Fortune, S, Cottrell, D orcid.org/0000-0001-8674-0955 and Fife, S (2016) Family factors associated with adolescent self-harm: a narrative review. Journal of Family Therapy, 38 (2). pp. 226-256. ISSN 0163-4445

[137] Myklestad I, Straiton M. The relationship between self-harm and bullying behaviour: results from a population based study of adolescents. BMC Public Health. 2021 Mar 31;21(1):524. doi: 10.1186/s12889-021-10555-9. PMID: 33785014; PMCID: PMC8011108.

[138] Taliaferro LA, Muehlenkamp JJ. Nonsuicidal Self-Injury and Suicidality Among Sexual Minority Youth: Risk Factors and Protective Connectedness Factors. Acad Pediatr. 2017 Sep-Oct;17(7):715-722. doi: 10.1016/j.acap.2016.11.002. Erratum in: Acad Pediatr. 2017 Nov - Dec;17 (8):917. PMID: 28865597.

[139] Abdelraheem, M., McAloon, J., & Shand, F. (2019). Mediating and moderating variables in the prediction of self-harm in young people: A systematic review of prospective longitudinal studies. Journal of affective disorders, 246, 14–28. https://doi.org/10.1016/j.jad.2018.12.004

[140] Swahn MH, Ali B, Bossarte RM, et al. Self-harm and suicide attempts among high-risk, urban youth in the U.S.: shared and unique risk and protective factors. Int J Environ Res Public Health. 2012;9(1):178-191. doi:10.3390/ijerph9010178

[141] Victor, S.E., Hipwell, A.E., Stepp, S.D. et al. Parent and peer relationships as longitudinal predictors of adolescent non-suicidal self-injury onset. Child Adolesc Psychiatry Ment Health 13, 1 (2019). https://doi.org/10.1186/s13034-018-0261-0

[142] Wright, M.F. (2016), "The roles of bullying involvement and parental warmth in non-suicidal self-harm and suicidal ideation among adolescents from residential program", Journal of Criminal Psychology, Vol. 6 No. 4, pp. 202-213. https://doi.org/10.1108/JCP-04-2016-0014

[143] Hack J, Martin G. Expressed Emotion, Shame, and Non-Suicidal Self-Injury. Int J Environ Res Public Health. 2018;15(5):890. Published 2018 Apr 30. doi:10.3390/ijerph15050890

[144] Russell K, Rasmussen S, Hunter SC. Does Mental Well-Being Protect against Self-Harm Thoughts and Behaviors during Adolescence? A Six-Month Prospective Investigation. Int J Environ Res Public Health. 2020;17(18):6771. Published 2020 Sep 17. doi:10.3390/ijerph17186771

[145] Islam MI, Yunus FM, Kabir E, Khanam R. Evaluating Risk and Protective Factors for Suicidality and Self-Harm in Australian Adolescents With Traditional Bullying and Cyberbullying Victimizations. Am J Health Promot. 2022 Jan;36(1):73-83. doi: 10.1177/08901171211034105. Epub 2021 Jul 26. PMID: 34308672.

[146] Jazaieri, H., McGonigal, K., Jinpa, T., Doty, J. R., Gross, J. J., & Goldin, P. R. (2014). A randomized controlled trial of compassion cultivation training : Effects on mindfulness , affect , and emotion regulation. Motivation and Emotion, 38(1), 23–35. doi.org/10.1007/s11031-013-9368-z

[147] Neff, K., & Lamb, L. (2009). Self Compassion. In S. Lopez (Ed.), The Encyclopedia of Positive Psychology (pp. 864–867). Hoboken, NJ: Wiley Blackwell

[148] Cleare S, Gumley A, O'Connor RC. Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. Clin Psychol Psychother. 2019 Sep;26(5):511-530. doi: 10.1002/cpp.2372. Epub 2019 Jun 13. PMID: 31046164.

[149] Abdelraheem, M., McAloon, J., & Shand, F. (2019). Mediating and moderating variables in the prediction of self-harm in young people: A systematic review of prospective longitudinal studies. Journal of affective disorders, 246, 14–28. https://doi.org/10.1016/j.jad.2018.12.004

[150] Cleare S, Gumley A, O'Connor RC. Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. Clin Psychol Psychother. 2019 Sep;26(5):511-530. doi: 10.1002/cpp.2372. Epub 2019 Jun 13. PMID: 31046164.

[151] Cleare S, Gumley A, O'Connor RC. Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. Clin Psychol Psychother. 2019 Sep;26(5):511-530. doi: 10.1002/cpp.2372. Epub 2019 Jun 13. PMID: 31046164.

[152] Ana Xavier, José Pinto-Gouveia, & Marina Cunha (2016). The protective role of selfcompassion on risk factors for non-suicidal self-injury in adolescence. School Mental

Health, 8, 476-485. doi:10.1007/s12310-016-9197-9

[153] Young R, Sweeting H, Ellaway A. Do schools differ in suicide risk? The influence of school and neighbourhood on attempted suicide, suicidal ideation and self-harm among

secondary school pupils. BMC Public Health. 2011 Nov 17;11:874. doi: 10.1186/1471-2458-11-874. PMID: 22093491; PMCID: PMC3280202.

[154] Joyce, H. D., & Early, T. J. (2014). The Impact of School Connectedness and Teacher Support on Depressive Symptoms in Adolescents: A Multilevel Analysis. Children and Youth Services Review, 39, 101–107.

http://doi.org/10.1016/j.childyouth.2014.02.005

[155] Dorol-Beauroy-Eustache O, Mishara BL. Systematic review of risk and protective factors for suicidal and self-harm behaviors among children and adolescents involved with cyberbullying. Prev Med. 2021 Nov;152(Pt 1):106684. doi: 10.1016/j.ypmed.2021.106684. Epub 2021 Sep 16. PMID: 34538376.

[156] Whitlock J, Wyman PA, Moore SR. Connectedness and suicide prevention in adolescents: pathways and implications. Suicide Life Threat Behav. 2014 Jun;44(3):246-72. doi: 10.1111/sltb.12071. Epub 2014 Jan 20. PMID: 24444252.

[157] Taliaferro LA, Muehlenkamp JJ. Nonsuicidal Self-Injury and Suicidality Among Sexual Minority Youth: Risk Factors and Protective Connectedness Factors. Acad Pediatr. 2017 Sep-Oct;17(7):715-722. doi: 10.1016/j.acap.2016.11.002. Erratum in: Acad Pediatr. 2017 Nov - Dec;17 (8):917. PMID: 28865597.

[158] Marraccini ME, Brier ZMF. School connectedness and suicidal thoughts and behaviors: A systematic meta-analysis. Sch Psychol Q. 2017 Mar;32(1):5-21. doi: 10.1037/spq0000192. Epub 2017 Jan 12. PMID: 28080099; PMCID: PMC5359058.

[159] Myklestad I, Straiton M. The relationship between self-harm and bullying behaviour: results from a population based study of adolescents. BMC Public Health. 2021 Mar 31;21(1):524. doi: 10.1186/s12889-021-10555-9. PMID: 33785014; PMCID: PMC8011108.