Champs Public Health Collaborative

Self-harm: Case for Change

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Working together to improve health and wellbeing in Cheshire and Merseyside

21st November 2017

Self-harm: Case for Change

Definitions: ChiMat refer to self-harm as ‘when someone hurts or harms themselves’ (2011), and in children and adolescents it most often involves overdoses, self-mutilation, scalding, banging head or other body parts against a wall, hair pulling and biting. Self-harm as a result of drug/alcohol use is often not included in the literature

The LJMU Report addresses the following issues;

- Self-harm statistics locally and nationally and trends
- Suicide audit information
- Overview of the links between ACES and self-harm
- Interventions to tackle self-harm: what works.

National statistics on self-harm

- Self-harm is **difficult to measure** as it is not always reported, although rates have **increased in the UK** over the past decade and are among the highest in Europe

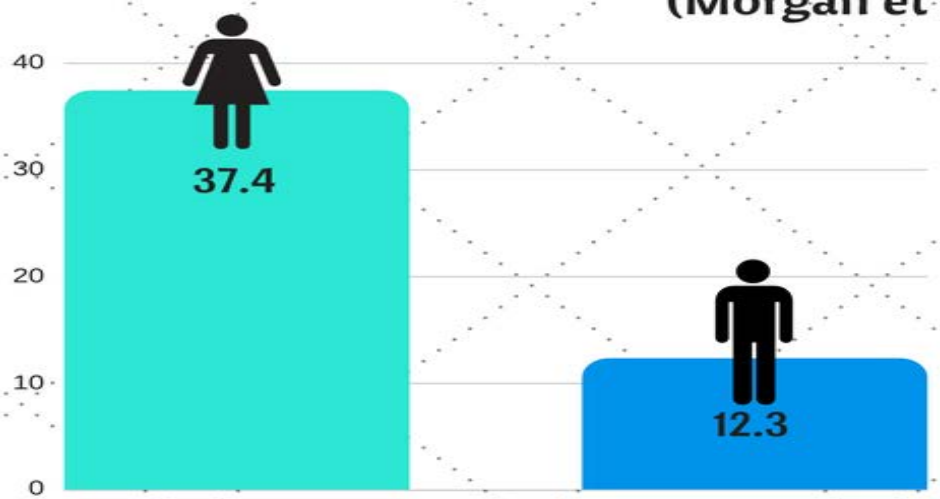
- According to Hospital Episode Statistics 2016 data, there were 430.5 hospital admissions per 100,000 population for self-harm in 2015/16, an increase from 347.4 in 2011/12

- A PHE survey of 5,335 students aged 11-15 found that 22% of 15 year olds had self-harmed - 32% of girls and 11% of boys

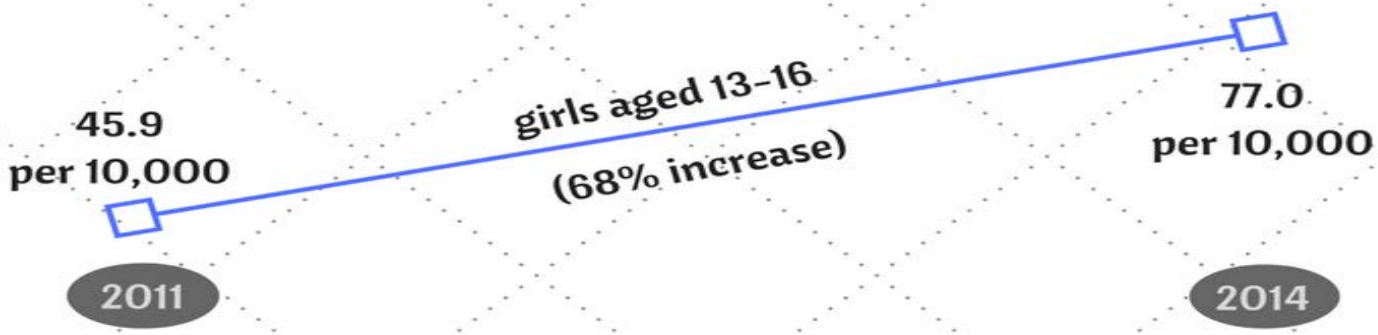
- **Risk factors** for self-harm include mental health problems, family criminality/poverty, disrupted upbringing and being abused.

GP data on self-harm

(Morgan et al, 2017)



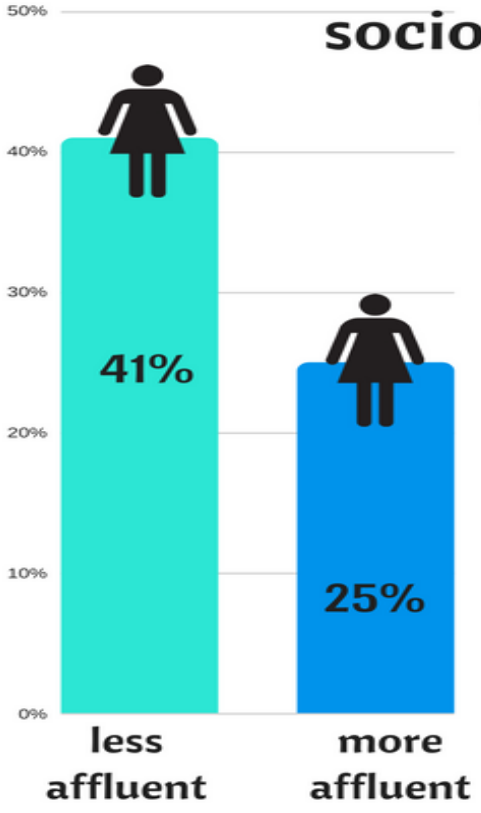
annual incidence of self harm per 10,000 aged 10–19

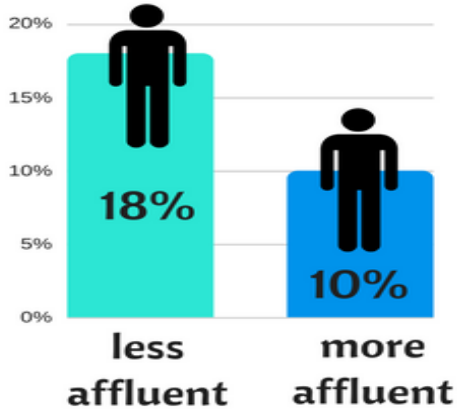


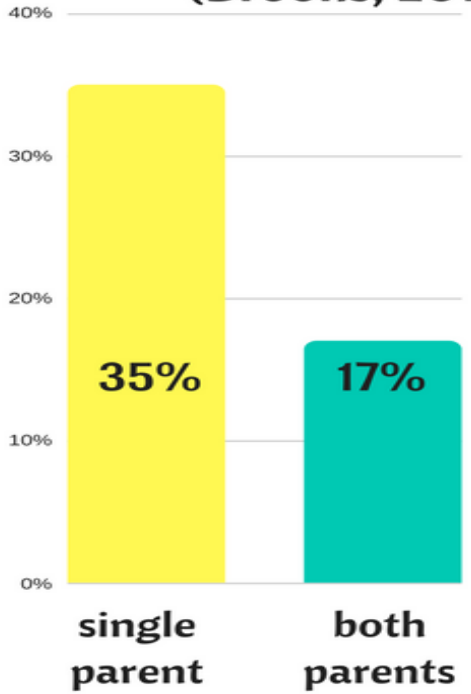
Risk factors for self- harm

socio-economic status, gender and single parent households

(Brooks, 2017)







ages 11-15, % ever self harmed

Other risk factors include bullying (Brooks, 2017) and sexual abuse (Fliege et al, 2008)

Local statistics on self-harm

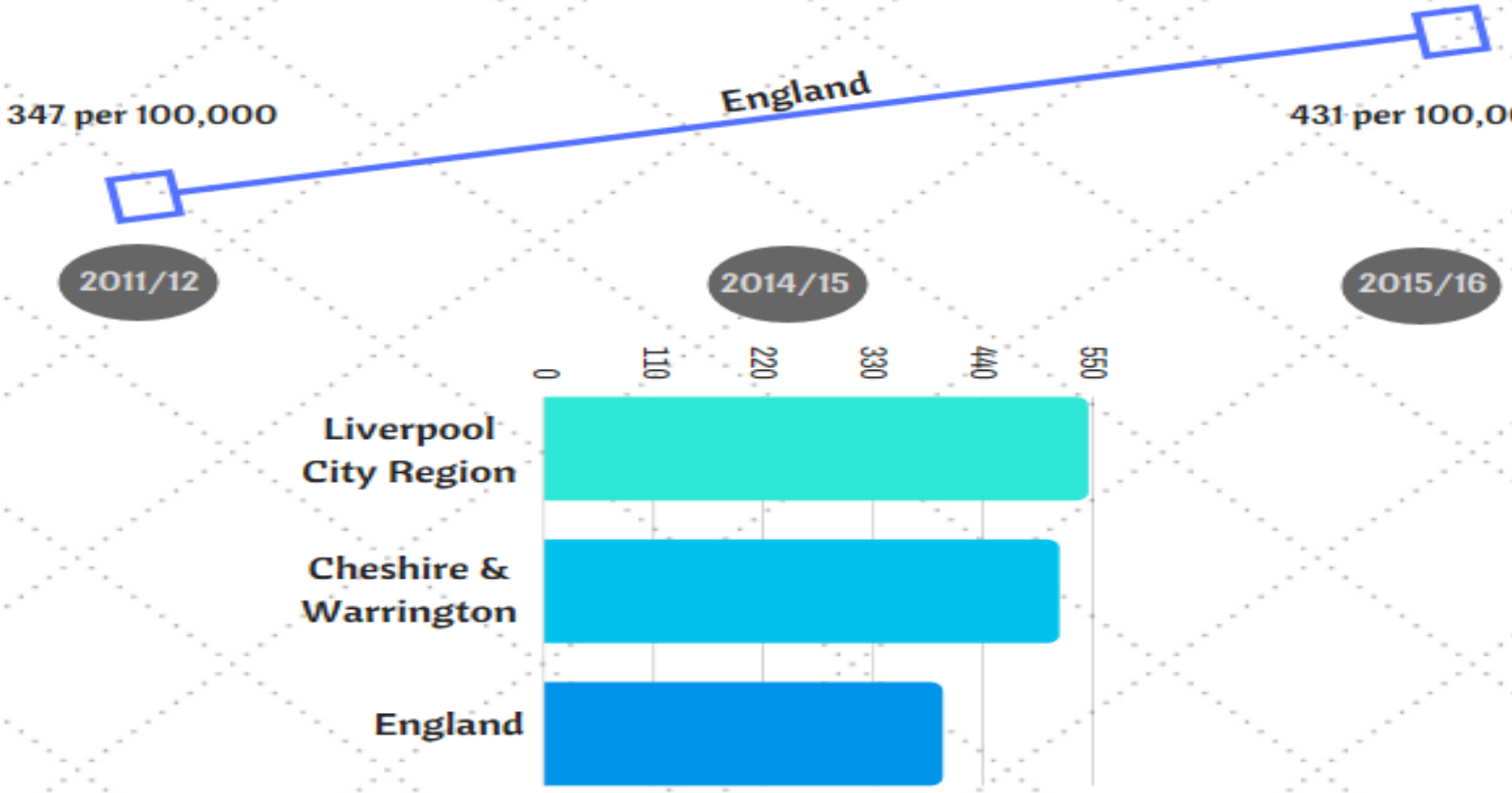
Local statistics were less straightforward to obtain. Data on hospital admissions, NWAS calls-outs for self-harm, and young people in contact with CAMHS are presented in the accompanying report.

Hospital admissions for self-harm

- Rates of hospital admissions for self-harm in 10-24 year olds were higher than the England average in 7 of the 9 C&M local authority areas, ranging from 958.9 in St. Helens to 493.9 in Cheshire East. Only Cheshire West and Chester had rates which were similar to the England average
- Rates for 10-24 year olds for 2015-16 were significantly worse than the England average in the Liverpool City Region overall and Cheshire & Warrington overall and are increasing.

Self Harm

hospital admissions ages 10-24



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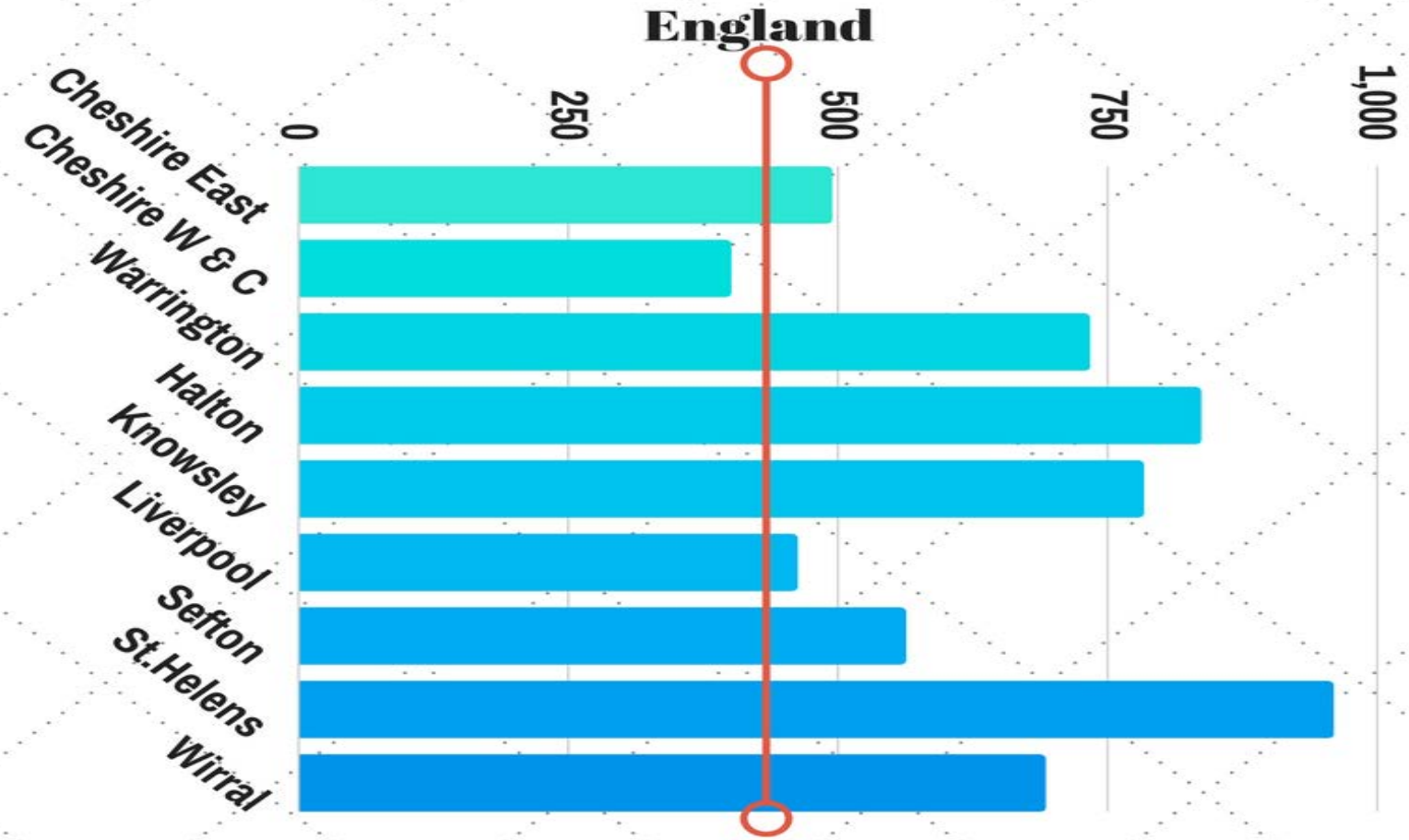
Hospital admissions for self-harm

ages 10-24, 2015/16

(Hospital Episode Statistics, accessed July 2017)



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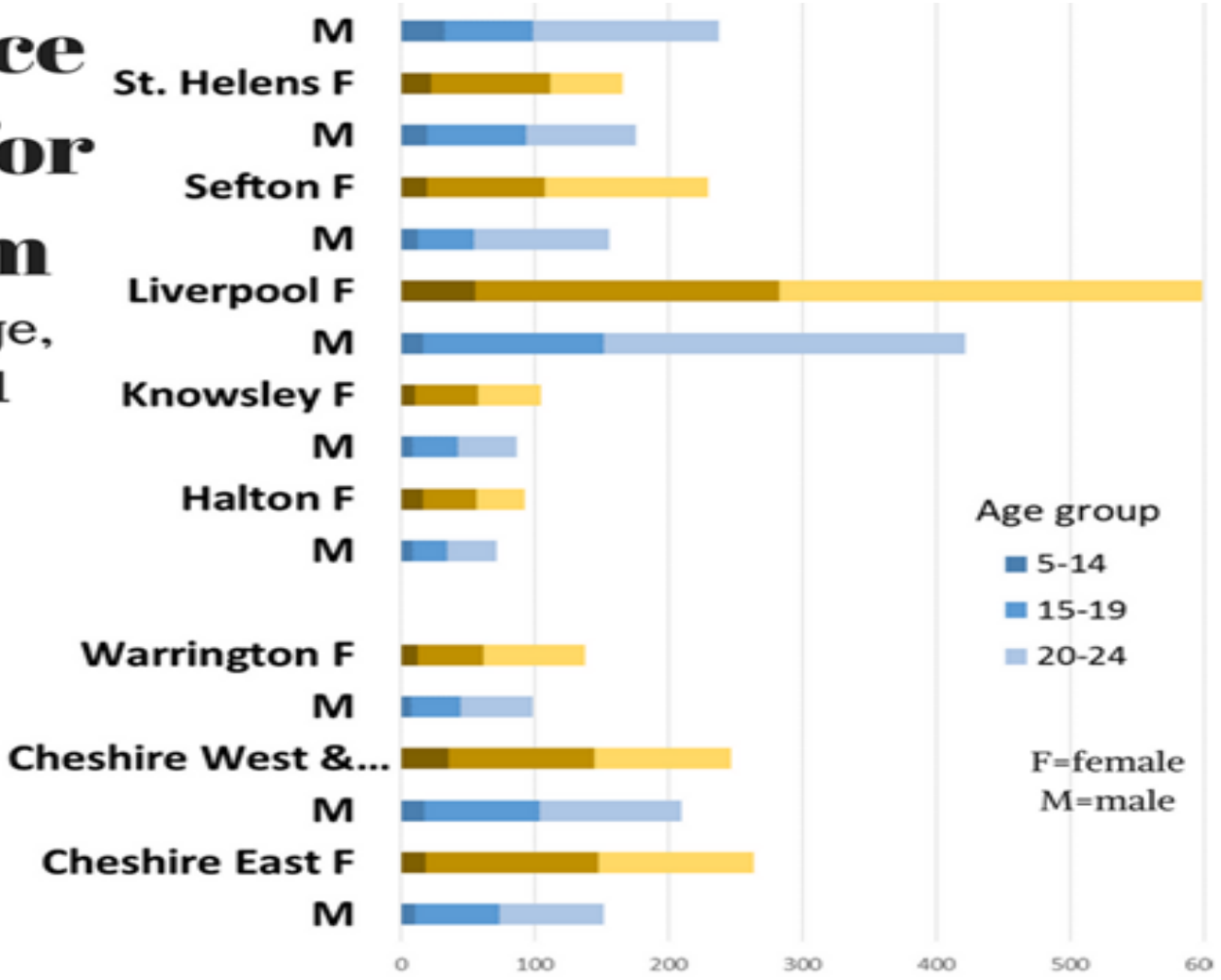
Ambulance call outs for self-harm

numbers by age, sex and local authority, 2016/17



Trauma and Injury Intelligence Group, Public Health Institute, Liverpool John Moores University

Links between self-harm and ACES

- Adverse childhood experiences (ACEs) are stressful events such as maltreatment, or domestic violence, substance misuse or mental illness in their families

- A US study found that the more ACEs adolescents had the greater their risks of self-harm and suicide. ACEs are also strongly related to poor mental wellbeing, and depression, anxiety, PTSD, eating disorders and drug/ alcohol dependence

- In England, half of adults are estimated to have suffered at least one ACE and 9% to have suffered four or more.

Links between self-harm and suicide

- People who self-harm are between 50 and 100 times more likely to die by suicide within a year than people who do not self-harm
- A UK study of 647 GP practices found that young people who had self-harmed were 17 times more likely to die by suicide
- In 2015 in Cheshire & Merseyside 33 children and young people aged 10-24 years died by suicide. Of these seven had a history of self-harm and ten had previously attempted suicide
- Suicide and self-harm share several risk factors, including personality and eating disorders, depression/anxiety, substance misuse, childhood emotional, physical or sexual abuse, and living in deprived areas.

What works (1)

Prevention

- Improve mental health literacy in parents, children, teachers and other professionals
- Promote a whole school & college approach to emotional and mental wellbeing, including social norms and peer behaviour and a single-point of access
- Develop neighbourhoods where young people feel safe

Early detection

- Improve awareness of young people, parents and carers of what help is available and where they can access it.
- Implement screening programmes.

What works (2)

Treatment

- Psychological therapies specifically structured for people who self-harm can be effective, but further research is needed on which interventions are effective
- Professionals and family carers should **respond to any underlying distress**, rather than focusing on stopping the self-harm
- Promote joint working across the interface of NHS, community and local authorities, such as the self-harm pathway
- Assess a person's digital life as part of clinical assessments.
- In assessing services, seek the views of those young people who have disengaged from services, whose views are not currently known, and who are the most vulnerable
- Standardise data collection on hospital and community care attendances for self-harm across C&M in order to facilitate comparisons.

Priority recommendations for Cheshire and Merseyside (1)

Prevention

- Parents should be encouraged to engage in their children's digital lives as early as possible
- Improve mental health literacy in parents, children, teachers and other professionals
- Promote a whole school & college approach to emotional and mental wellbeing, including resilience skills, social norms, services in schools & colleges, single-point of access and screening for self-harm behaviour

Early detection

- Improve awareness of young people, parents and carers of what help is available and where they can access it
- Advice & guidance for young people & families should be available in online, digital and printed formats
- Move towards the THRIVE model of mental wellbeing
- All secondary schools and colleges should have regular access to on-site support from a CAMHS professional
- Improve training for professionals working with children and young people.

Priority recommendations for Cheshire and Merseyside (2)

Treatment

- Use psychological therapies specifically structured for people who self-harm to reduce repetition of self-harm
- Assessment of a young person's digital life should form part of clinical assessments, when there are concerns about self-harm
- Positive mental health should be promoted in the acute hospital setting
- Mental health assessments should be available every day of the year
- Admit those under 16 yrs seen in A&E following acute self-harm
- Promote joint working across boundaries of NHS, community, local authorities with involvement of young people, such as a self-harm pathway
- In designing services, actively seek the views of young people who have disengaged from services, whose views are not known, and who are the most vulnerable
- Standardise data collection on hospital and community care attendances for self-harm across C&M in order to facilitate comparisons
- **Local areas to benchmark current provision against national guidelines**

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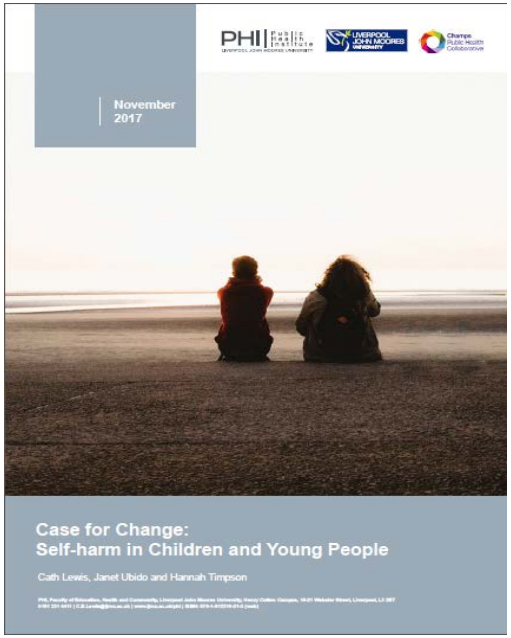
Thank You



Case for Change:
Self-harm in Children and Young People