Self-Harm in Devon
A Health Needs Assessment
July 2015

Executive Summary

1. Foreword

Why do a health needs assessment focused on self-harm?

1.1 The Devon Joint Strategic Needs Assessment highlights that while health outcomes are generally good for people living within Devon, there is a clustering of poor outcomes around mental health and emotional wellbeing for children, young people and adults. Hospital admissions for self-harm, in particular, have been significantly higher than the national average for a number of years.

1.2 Self-harm is an important public health issue, due to its prevalence and the impact it has on people's lives and the lives of their families. Also, importantly, self-harm can be, though is not always, one of the first outward signs of mental illness or a mental health crisis. Although self-harm can provide instant relief for emotional distress, there can be longer term physical consequences such as scarring, damage to tendons, nerves, blood vessels and muscles, and damage to liver and kidneys from repeated poisoning.

1.3 Self-harm imposes a significant economic cost, both on the health sector and society in general. Self-harm results in approximately 245,000 presentations at Accident and Emergency Units each year in England and is one of the top five causes of acute medical admission. The indirect costs of self-harm in terms of lost productivity, days lost from work, as well as costs to families and carers, are unknown but are likely to be substantial given its prevalence within the UK. Nationally, evidence suggests that rates of hospital admissions for self-harm in England have been increasing since 2007. In Devon, more recently, a convergence of pressures including rising hospital admissions, particularly in paediatric units, increased referrals and higher thresholds for specialist services, has raised the priority of addressing the root cause of self-harm, defining roles and responsibilities and pathways of care.

1.4 The Devon Safeguarding Children Board (DSCB) initiated a series of multi-agency case audits in September 2014 and, along with the Children, Young People and Families Alliance has co-ordinated seminars and workshops to gain a greater understanding of the issue and galvanise a co-ordinated response from professionals. An Early Help strategy and implementation plan have been developed to co-ordinate multi-agency support as part of a dynamic response to need, aiming to meet and then reduce need and build the resilience of children and young people and their families. Additionally, Public Health Devon has co-designed a new service and programme with schools and other partners to promote emotional wellbeing, prevent mental illness and provide early identification and intervention. The service aims to support the emotional, psychological and social wellbeing needs of children and young people in Devon through support to schools; direct support for

children and young people aged 11-19 years, and targeted parenting support for parents of primary-aged children.

1.5 This health needs assessment takes a population perspective and focuses on the needs of children, young people, adults and older adults. It describes levels of need in Devon and compares them to current service provision within the County Council area. In addition, it seeks to identify people's aspirations for better outcomes and their suggestions on assets and resources which may help to achieve a shared vision going forward.

1.6 This needs assessment compliments a number of other needs assessments that are either completed, planned or underway which consider different aspects of health and wellbeing in Devon. Completed needs assessments are published on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk.The findings in this document should be considered alongside other related needs assessments, the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, to ensure a full picture of need.

2. Introduction

What is self-harm?

2.1 Self-harm has been described as "*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*." NICE Quality Standard QS34 (NICE, 2013).

2.2 Self-harm is a symptom of underlying mental or emotional distress. It is a coping mechanism for people who feel they have no other way to deal with extreme negative emotions.

2.3 Methods of self-harm can be divided into self-poisoning and self-injury. Studies of attendance at emergency departments show that approximately 80% of people have taken an overdose of prescribed or over the counter medication. However, general population studies have shown that self-injury may be more common than self-poisoning. Of those who self-injure, cutting is the most common method.

Why do people self-harm?

2.4 People who self-harm mainly do so because they find it helps relieve distressing feelings and helps them to cope with problems in their lives. It is rarely about trying to end their life. A wide range of factors and multiple triggers may be involved. Once self-harm starts it can be hard to stop because it can fulfil a number of functions, including temporary relief or a feeling of peace. The addictive nature of this feeling can make self-harm difficult to stop.

Repeated self-harm

2.5 The individual and societal costs associated with self-harm escalate with repetition. Evidence suggests that those who repeat self-harm are more than twice as likely to die by suicide compared with those who had engaged in self-harm on one occasion only. Risk factors that have been widely studied

and demonstrated as having consistent associations with repetition include stepwise increase in the number of previous self-harm episodes and having a greater number of psychiatric disorders.

2.6 In Devon, for the year 2013-14, 85% of those with a hospital admission for self-harm were recorded as having one admission, which accounted for 79% of the total admissions. A small group of people (n=16 or 1.16%) had five or more admissions, accounting for 6.55% of total admissions.

Relationship between self-harm and suicide

2.7 Following an act of self-harm, the rate of suicide increases to between 50 and 100 times the rate of suicide in the general population. Men who self-harm are more than twice as likely to die by suicide as women and the risk increases greatly with age for both genders. It has been estimated that one quarter of all people who die by suicide would have attended an emergency department in the previous year.

2.8 The risk factors for self-harm are similar to those for suicide, with some exceptions; suicide is more common among males rather than females; suicide is more likely to be associated with major depressive disorder, whereas self-harm is more likely to be associated with anxiety disorders. Family dysfunction is more likely to be associated with suicide.

3. The Findings

Population estimates of self-harm

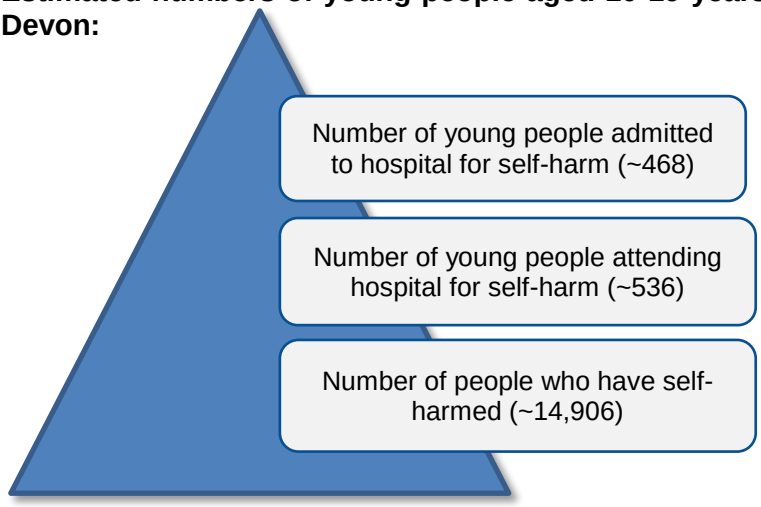
3.1 The majority of incidences of self-harm are thought to be undisclosed and so invisible to professionals. Population estimates have therefore been undertaken to help understand the burden of unmet need, however, the results of these vary considerably. Although some very young children and some adults are known to self-harm and it often continues from childhood into adulthood, evidence suggests that the majority of people who self-harm are aged between 10 and 25 years.

3.2 Findings from a recent international systematic review estimate an average lifetime prevalence of 17.2% among adolescents, 13.4% among young adults, and 5.5% among adults.

Population estimates of self-harm in Devon

3.3 To try to understand the size of the issue in Devon, it is possible to use population estimates of self-harm prevalence and apply these to the local population. By considering a range of estimates for school age young people and applying the median rate of 18%, the figure below illustrates that approximately 14,906 young people aged 10-19 are likely to self-harm in Devon, a tiny fraction of whom will be visible to professionals.

Estimated numbers of young people aged 10-19 years who self-harm in Devon:



Source: Public Health, Devon County Council 2015

Demographics

3.4 Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support. Self-harm is more common in urban areas for males and females aged between 15 and 64 years, with little difference between urban and rural rates for patients aged 65 years and over.

Age and gender

3.5 National data suggests that the age at which self-harm is becoming a concern is changing. The National Society for the Prevention of Cruelty to Children (NSPCC) produces annual reports on outcomes from ChildLine. The reports covering the years 2012-14 highlight that self-harm is becoming a salient issue for younger children over time, with 14 year olds receiving the most counselling sessions about self-harm in 2013-14 and 12 year olds being the age group with the highest increase of counselling about self-harm in 2013-2014.

3.6 In Devon, rates for hospital attendance and admissions peak in the 15-19 age group, with higher rates also seen in the 20-49 age groups. In line with national data, admission rates in Devon are three times higher in females than males and the gap has widened in recent years.

Groups at a higher risk of self-harm

3.7 Evidence suggests females are up to three to four times more likely to self-harm than males. Self-harm is most prevalent among young people aged 10-25 years and the following groups within society experience higher rates of self-harm compared with others: lesbian, gay and bisexual people, women of Black and South-Asian ethnicity, people with mental health disorders, veterans, prisoners, people with learning disabilities, people who are in or who have been in care, people who have experienced child sexual abuse, physical or domestic abuse and people with alcohol or substance misuse problems.

Deprivation and rurality

3.8 In line with national data, hospital admissions in Devon from the most deprived quintile are approximately three times higher than those from the least deprived quintile. In addition, urban rates of hospital admissions due to self-harm are higher than the county average and substantially higher than rates recorded for people from both town and fringe and village and hamlets in Devon.

3.9 When examining admission rates for self-harm by town over a five year period between 2009-10 and 2013-14, for all ages, the towns with rates significantly above the Devon average are: Exeter, Exmouth, Bideford, Barnstaple and Honiton.

Sexual, physical and domestic abuse

3.10 In line with the literature, higher rates of hospital admission for self-harm coalesce with areas where higher rates of sexual, physical and domestic abuse are recorded. These factors tend to overlap with socio-economic deprivation. Some Devon towns are notable due to a lack of such alignment, namely Honiton, where age standardised admission rates for self-harm for all ages or those for young people aged 0-19 years have been prominent over a five year period between 2009-10 and 2013-14. However, when examining data on child protection plans with sexual abuse as the primary reason, Honiton town is also unexpectedly prominent in this domain.

Prisoners

3.11 Data from the Ministry of Justice show that, nationally, self-harm episodes by female prisoners have decreased from what were very high levels, while episodes in male prisoners have increased.

3.12 In line with national data, local data from the three prisons in Devon, all of which accommodate male prisoners, shows that the annual recorded number of incidents has risen over the 10 year recording period in each institution, with a steeper increase observed since 2010.

Trends over time

3.13 Hospital admissions rates per 100,000 for self-harm in people aged 10-24 years have risen in Devon from 376.6 in 2007-08 to 419.5 in 2012-13. The rate per 100,000 in Devon is below the South West rate (442.5), but above the local authority comparator group (388.8) and England (346.3) rates.

Patterns in attendance

3.14 Hospital attendance in Devon appears to peak on Sundays, Mondays and Tuesdays and, over the 24 hour period, peak between 11pm and 1am.

Service Use

3.15 Demand for services supporting children and young people with mental health needs has been rising. Referral rates to Child and Adolescent Mental Health Services have risen over the past five years, as have self-harm alerts recorded across the Devon CAMHS service.

3.16 There was increased use of paediatric acute hospital beds for inpatient child and adolescent mental health admissions in Devon over the 12 months between July 2013 and June 2014, and length of stay was shown to extend beyond 72 hours for a quarter of patients in a three month local audit in one hospital. Audit data demonstrated that medical need was usually restricted to the first 24 hours in these cases and that 1:1 mental health nursing was required to safeguard the patient who self-harmed but, also the staff and remaining patients.

3.17 Patients who self-harm are a prominent subset of those adults supported by Devon Partnership Trust for mental health problems. Self-harm forms one of the main areas of focus for liaison psychiatry work in emergency departments.

Digital technology as an influencing factor

3.18 Digital technology is now a central part of peoples' lives, for information, entertainment and communication. Annual statistics provided by Ofcom indicate that the majority of children aged 5-15 years regularly access the internet via mobile devices such as tablets and phones. Evidence suggests that there may be both positive and negative influences on self-harming behaviour from the internet. Recent guidance recommended that clinicians should include a detailed enquiry about internet use in clinical assessment of young people at risk of self-harm or suicide.

Policy Context, Clinical and Commissioning Guidance

3.19 Over the last five years a range of guidance on self-harm and policy documents focusing more broadly on mental health and wellbeing have been published. Policy highlights the priority of self-harm and calls on agencies to work together to impact positively on the root causes. National guidelines have predominantly focused on crisis care and the clinical end of the self-harm pathway, emphasising the need to treat people who self-harm with the same care, respect and privacy as any patient. Examples of guidance developed at local level take a more integrated and broader community perspective and provide exemplars for practitioners and professionals from a wide range of front-line disciplines.

Engagement and Insight

Schools survey

3.20 A survey seeking insight from Devon secondary school staff highlighted that self-harm was a current issue in schools and that students, peers or friends were more likely to highlight the issue than staff. Perceived "seriousness" was understood primarily through relationships with students. Resources used to support students were many and varied, both internal and external. There was confusion around the extent of support schools could offer and what level of expertise was required.

Insight from children and young people

3.21 Devon Youth Service conducted a varied programme of engagement with children and young people exploring emotional, psychological and social wellbeing. The engagement provided insight into the main stressors and where people go for support, demonstrating how things change over the different stages between the ages of 11-25 years. Home and school settings

were particularly salient as places to ensure appropriate levels of support were made available, with friends providing an important source of support during early teenage years.

3.22 Devon Youth Service facilitated a small scale survey with young people who self-harm, which highlighted conflict within families, sexual abuse and bullying as salient triggers and indicated that most young people delayed disclosing their self-harm behaviour. None of the young people planned to disclose their self-harm and did so as a spur of the moment decision, generally to trusted professionals as well as friends. Most had hoped that someone would have noticed that there was something wrong at an earlier stage.

3.23 In Made of Rainbows, a video made by young people from the lesbian, gay, bisexual and transgender (LGBT) community in Devon about their experiences of self-harm, similar triggers were highlighted but for this group, issues around coming out and not being able to show who they really are were particularly important. The video illustrates how triggers and functions are different for different individuals and can change over time. The young people wanted professionals to avoid making assumptions around gender and sexuality and suggested that they would benefit from having someone to talk to at school.

Insight from parents

3.24 In a focus group conducted with a group of 10 parents and carers of children and young people who have or were at risk of self-harm, a number of themes emerged. Firstly, parents felt that everyone was too busy to support their child and them as a parent and most had been passed between many busy professionals before finding peer support through their group.

3.25 Parents' shared experiences highlighted that some schools did not handle self-harm constructively, with staff confused, scared of the additional responsibility and quick to exclude pupils. GPs had showed willingness but varied in ability to help and understand. An example of good practice was highlighted in which a practice had listed GPs by speciality on their website and so the young person chose to speak to a GP who had a special interest in children and young people or mental health.

3.26 Parents felt isolated as friends, family and work colleagues found it hard to understand unless they had personal experience. They expressed frustration that things needed to get to a crisis before meaningful support was provided. Parents felt that they should be regarded as an asset and, if given practical support on how to cope between appointments, they could manage the situation more effectively. They proposed that better use of technology would be helpful in providing parental support and that front-line professionals would benefit from training, particularly learning from those with lived experience.

Insight from professionals

3.27 Insight from front-line professionals was gathered through both a semi-structured questionnaire, aiming to highlight key issues and assets, and via attendee feedback at a series of professional development events.

3.28 Professionals recognised rising numbers of people affected by self-harm, resulting in pressure in both community and acute settings. They noted that services for adults seemed better designed to cope, contrasting with the lack

of out-of-hours care and limited specialist tier 4 inpatient provision for children and young people. They also recognised an over-reliance on specialist services and the need for support for professionals operating in the community.

3.29 The need for training and supervision among all front-line staff, both community and acute settings-based, was a dominant theme. There was a preference for multi-agency learning and sharing of skills, incorporating and valuing the input from those with lived experience. They suggested that training should address the lack of confidence and fear which was evident, particularly in community settings.

3.30 Working more effectively together, utilising an agreed joint care pathway and local guidelines were highlighted by the majority of respondents. Ideas around how to restructure services to better meet peoples' needs were suggested, including tailored digital information and the use of trusted, neutral venues.

3.31 Building on existing trusting relationships and working with parents, possibly through family-based support, were seen as approaches to develop when supporting people within the wider community.

4. Observations

4.1 Based on the qualitative and quantitative intelligence gathered in the process of developing this Health Needs Assessment, a number of observations have been made. These observations should be considered by providers, commissioners and stakeholders when planning to meet the needs of people who self-harm, their parents and or carers, and when developing future services.

4.2 Observations are themed around joint working, shared protocols, information and care pathway development; the need for families and communities to build resilience and skill to intervene early and support people within the community; the need for multi-agency training, peer support and supervision for front-line staff; the importance of recognising parents and carers as assets and supporting them to support their loved ones; the need for parity around out-of-hours support for children and young people and appropriate levels of tier 4 in-patient provision. More comprehensive monitoring and suggestions for further research around the needs of older people are proposed.

5. Acknowledgements

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Christy Thurlow	Service Design & Delivery Manager	NEW Devon CCG
Catriona Cunningham	Safeguarding Nurse	NEW Devon CCG
Francesca Brinicombe	Safeguarding Champion/ Headteacher	St David's Primary School, Exeter
Gary Gates	Youth Intervention Officer	Devon & Cornwall Police
Georgina Howes	Primary Mental Health Worker	Virgin Care
Gerry Cadogan	Public Health Principal	Torbay Council - Public Health
Jane Lake	Education Safeguarding Officer	Babcock LDP
Jenny Lindow	Honiton and Axminster Area Youth Worker	Youth Service
Juliet Jones	Team Manager Permanence and Transition	Children's Social Services
Kirsty Priestley	Public Health Intelligence Analyst	Public Health Devon County Council
Kristine Brayford-West	Named Nurse for Safeguarding and Young People	Northern Devon Healthcare NHS Trust
Laura Grimshaw	Public Health Nurse Team Leader, Northern Locality	Virgin Care
Laura Higgins	Manager	Safer Internet Charity
Mark Ogden	Practice Manager CAMHS (Northern Locality)	Virgin Care
Matthew Daniel	Training and Consultancy Manager	Young Minds
Michelle Thornberry	Nurse Consultant Safeguarding Children and Adults	The Royal Devon & Exeter NHS Foundation Trust
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