TALKING TABOOS

# Talking Self-harm

YOUNGMINDS
The voice for young people's mental health and wellbeing

CELLO GROUP

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# Foreword

**For those of you who don't know us, Cello plc is a health focused insight and strategic marketing group. And Talking Taboos is our campaigning brand with a mission to directly tackle health and social issues using Cello's experience and resources in health, insight and communications. Talking Taboos focuses on areas where embarrassment, fear or ignorance prevents sufferers from seeking help, and where tackling the stigma will be a part of the solution.**

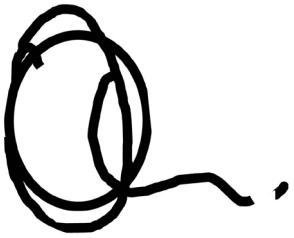
Simply put, we aim to take the 'oo' out of Taboos.

This document contains the results of a ground-breaking, year long research study, working in partnership with teen mental health charity, YoungMinds. The research used a suite of services including advanced qualitative research, professional online community forums and social media discourse research, integrated with a nationally representative quantitative sample of 2,461 people. It explores society's perceptions of young people who self-harm and the current barriers that exist between providing the help they so clearly need.

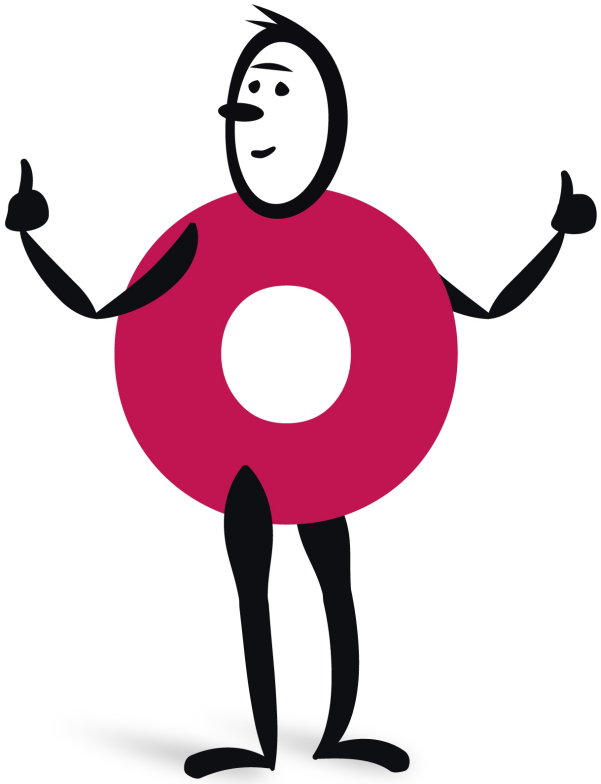
The study is a demonstration of Cello's expertise in the health sector and effectiveness in stimulating discourse around pressing health and social issues. The Group has pooled its extensive knowledge and expertise with specific audiences: healthcare professionals; GPs; young people; teachers and parents to contribute to a 'whole community' view. In conjunction with YoungMinds, it provides a clear set of recommendations on how to relieve the suffering and distress experienced by those affected.

Tapping into our communications teams, we hope to use traditional and digital media to create a national debate that will get people talking about self-harm and how we can better support young people.

Thanks to all those involved within Cello who gave their time and expertise in the development of this program, and to our Board for providing funding. Finally, thanks to YoungMinds for their help and guidance as a partner in this process. We hope that the work we have done will help them in their drive to support young people who suffer the distress caused by mental illness.



**Vincent Nolan**



# Introduction from YoungMinds.

At YoungMinds we deal with self-harm a lot. The ways we do it vary but they include: our Parents' Helpline; our training courses for teachers; youth workers and service providers; our lobbying work with government officials and our work directly with young people.

Mental health problems don't just affect particular groups; they span all races, cultures and classes, and self-harm is no exception. Self-harm is surrounded by myths and misconceptions – while it's often just thought of in terms of cutting, self-harm, or self-injury, describes a wide range of things people deliberately do to themselves that are harmful but usually do not kill them. It's worth noting that while self-harm is usually not an attempt at suicide, it is still highly traumatic for young people and those who care for them.

## THE SYMPTOMS.

The most common form of self-harm is cutting the arms or the back of the legs with a razor or knife, but it takes many forms, including burning, biting, hitting and taking overdoses.

The reasons vary greatly, and are specific to the individual, but a young person may self-harm to help them cope with negative feelings, to feel more in control or to punish themselves. It can be a way of relieving overwhelming feelings that build up inside, when they feel isolated, angry, guilty or desperate.

## THE STATS.

One in twelve children and young people are said to self-harm[1] and over the last ten years inpatient admissions for young people who self-harm have increased by 68%. In the last year alone these hospital admissions for under 25s increased by 10%. And, among females under 25, there has been a 77% increase in the last ten years.

## CAUSES.

Worringly, as the hospital figures are only the tip of the iceberg, the true figure of how many children and young people are self-harming is likely to be far higher, and this is especially so for particular at-risk groups including lesbian and gay, transgender and bisexual young people, looked-after children, and young people in the criminal justice system.

Self-harm is surrounded in guilt, shame and mystery for all parties. Parents often confide in us that they feel it's their fault their child is harming themselves; teachers tell us they see the signs but cannot bring themselves to say anything, and even if they want to, they can't find the words to reach out to young people; and the children and young people we work with say over and over again, "I need help, I am in terrible pain inside".

And it's getting worse. More and more children and young people are using self-harm as a mechanism to cope with the pressures of life. Self-harm is often dismissed as merely attention seeking behaviour but it's a sign that young people are feeling terrible internal pain and are not coping.

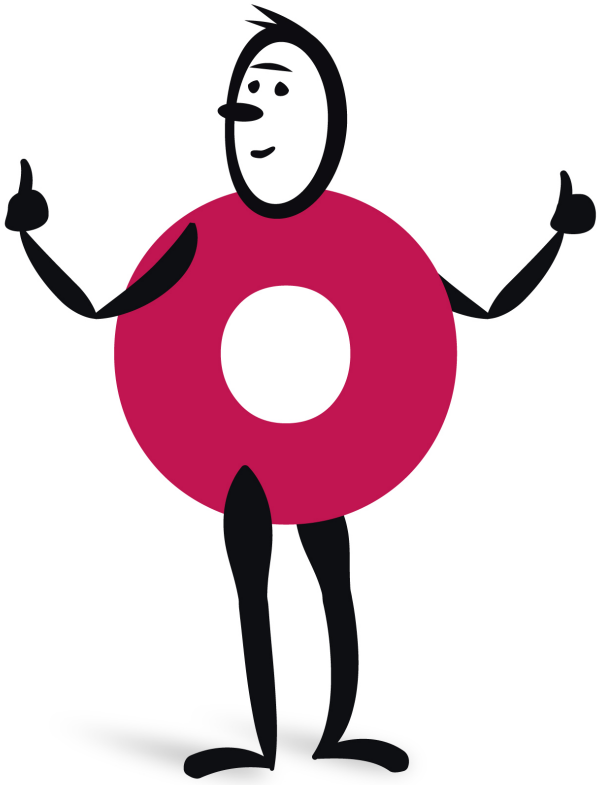
Young people today are growing up in a harsh environment with increasing stress to perform at school, low job prospects and the constant pressure to keep up with the latest consumer trends. And social networking, although creating ever greater circles of 'friends', often leaves young people feeling even more isolated and alone.

[1] Mental Health Foundation (2006). Truth hurts: report of the National Inquiry into self-harm among young people. London: Mental Health Foundation

## MAKING PROGRESS.

When we first met representatives from the Cello group we liked the idea of their Talking Taboos initiative and felt that if there was one thing that really was a taboo and needed talking about it was self-harm. Some cynicism was expressed about corporates just trying to make themselves look good by doing research on a controversial issue. However, our experience of working with the Cello group demonstrated that this couldn't be further from the truth. They have put their hearts and souls and over a quarter of a million pounds worth of their time into researching what parents, teachers, healthcare professionals and young people themselves know and feel about self-harm.

This is a ground-breaking piece of research about public attitudes, and its results highlight a comprehensive range of insights that we need to act on. If we don't we will not only continue to waste millions of pounds in treating entrenched mental illness when we could have intervened early, but we will keep failing the thousands of young people who are crying out for help, and the teachers, GPs and parents who really want to support them but don't know how to.



# Management Summary

1. Self-harm among young people is the number one issue that young people themselves are concerned about among their peers, in a list that includes gangs, bullying, drug use and binge drinking.
   - Normally young people are less concerned than GPs, teachers and parents about issues, but self-harm is the one issue where everyone shares an equally high level of concern.
   - Over 80% of young people would be very worried if they knew that a friend was self-harming, compared to 50% who would be worried about an eating disorder.
2. Self-harm is also the issue that all groups feel least comfortable approaching with young people.
   - Two in three teachers, parents and young people think that they would say the wrong thing if someone turned to them.
3. However, there is a desire for more conversation and action to help young people. The majority of people believe that they need to be able to offer support to young people who self-harm but nobody feels empowered to act.
4. There is not a balanced or complete understanding about self-harm – it can be viewed as too serious or too trivial to prompt action:
   - Over half of GPs, teachers and parents think that young people who self-harm are likely to try and commit suicide;
   - Also, almost half of these groups see self-harm as a way to manipulate others.

- While there is also considerable sympathy towards young people who self-harm, all groups (professionals included) struggle to empathise with young people who are harming themselves.
- Almost half of GPs feel they do not really understand young people who self-harm.

**5.** Currently, there is little open communication and considerable scope for stigma and fear.

- Parents associate a young person self-harming with failed parenting and shame; many are frightened to let the issue 'out of the home' over a third say they would not seek professional help.
- Teachers feel helpless and unsure as to what they can say; 80% want clear practical advice and materials that they can share directly with young people.
- Three in five GPs report they are concerned that they do not know what language to use when talking to a young person about self-harm.
- Nearly four in five young people say they don't know where to turn to with questions relating to self-harm.

**6.** There is a stark difference between the places young people feel comfortable seeking support (online) and the places they believe they should be going (parents, teachers or GPs) when it comes to self-harm.

- The range of information online can vary from supportive to dismissive, from inciting self-harm to mocking and ridiculing those who do it. When a young person looks for information, or information finds a young person, it's a game of chance as to whether that information will be measured and helpful, or part of an extreme negative view.

**7.** There is a strong desire to break the conspiracy of silence around self-harm so people feel more able to seek and provide support.

- The number one reason parents, teachers, young people and GPs think young people who self-harm stop doing so is that they find better ways to cope with the emotions associated with it, principally through getting support.
- As such, the overwhelming majority (between 80% to 90% of all groups) want to open the dialogue so young people know where they can turn to.
- 97% of young people believe that self-harm should be addressed in schools, with two in three feeling that it should be part of lessons. Greater teaching around emotional awareness and literacy appears a strong and obvious platform for raising the topic of self-harm in context.

# IMPLICATIONS FROM THIS RESEARCH

1. There is a need to increase knowledge around self-harm across all groups. This will promote more consistency and empathy in the responses given to those who are self-harming. Resources and interventions need to enable people to both:
   - Talk more openly at a broad conceptual level to combat narrow views that exacerbate stigma;
   - Help all groups provide better support to a young person who is self-harming.
2. The organisations and professionals that can offer support need to be more present in the online spaces that young people feel comfortable going to.
3. There is an overarching need and opportunity to help all audiences play a stronger role in building the emotional resilience of young people.

# RECOMMENDATIONS

## RAISING AWARENESS AND UNDERSTANDING ABOUT SELF-HARM.

Myths, misconceptions and lack of understanding characterise self-harm. More knowledge would lead to more consistency in responses given to young people.

A suite of off- and online resources should be developed by representatives from voluntary and statutory sectors who work with young people and families. These should be created and tested directly with the audience and marketed through awareness campaigns for general and more targeted use (i.e. at teachers/youth workers, parents, healthcare professionals). The resources need to cover the causes of self-harm, spotting it, how to support young people who self-harm, including comprehensive signposting to voluntary and statutory support services.

## ONLINE SUPPORT.

Thousands of young people get emotional support from online communities rather than going to their parents, teachers or GPs. Everyone concerned about the emotional wellbeing of young people needs to acknowledge and accept this and look at why young people are supporting each other online.

The helping organisations are, on the whole, not found in the places young people look online. They need to develop their online presence in a sensitive way that works for young people, respecting what they are already doing online and centrally involving them as experts in the development of all online service provision.

# RECOMMENDATIONS FOR SPECIFIC AUDIENCES

## SCHOOLS.

The lack of clear and defined information sources mean that 77% of young people feel that they don't know who to turn to with questions about self-harm – a view that is shared by parents, teachers and GPs.

**Resilience building.**

There is an urgent imperative to build the emotional resilience of children and young people across society and in particular in school. If young people develop the skills to combat adversity and deal with the emotional rollercoaster of childhood and the teenage years, the rate of self-harm will start to reduce.

Information on the whole-school approach to resilience building recommended can be found here:
http://www.cypmhc.org.uk/media/common/uploads/Final_pdf.pdf

The NICE public health guidance on mental health promotion in schools also needs to be widely implemented.

*"There might be something to be learnt from good models for tackling bullying and loneliness: Just giving words and acknowledging what they might be going through"*

**Teacher**

- As mentioned, consistent language that teachers can use when talking to young people about self-harm would be welcomed by them. Changes to make the Child Protection process more empathetic at the initial point of disclosure/discovery would also be beneficial. Currently, teachers' training focuses more on what they should not say than things they can say.
- Advice on how to respond to individual cases in supportive ways and where to get more information, help and support are also needed.
- Consideration needs to be given to how education on self-harm could be included in the curriculum via PHSE classes and other appropriate curriculum areas.
- Teachers also need to have greater awareness of the links between self-harm and other issues affecting young people in society, i.e. cultural issues, gang membership, sexual exploitation etc.

## PARENTS.

**The need for information.**

Parents need targeted information (off- and online) to help them understand what self-harm is, why young people self-harm, and how they can provide and get additional support. It also needs to address the sense of shame and guilt parents feel.

Parents' networks such as Netmums, Mumsnet and Dadstalk and lifestyle magazines should also be utilised to raise some of the sensitive issues around supporting a child who may be or is self-harming.

## HEALTH CARE PROFESSIONALS (HCPS).

**Training.**

A general increase in education and awareness for HCPs was felt to be key in identifying and thus helping a young person who self-harms. Initial GP training should also cover why young people self-harm and how GPs can support those who do. It should also be available as modules in CPD training.

**Assessment tools.**

GPs also need more guidance on how assessment tools, such as NICE guidelines and Integrated Care Pathways, can support their consultation and referral process. Having more uniformity between front line professionals and mental health teams in how they classify and talk about self-harm would help to simplify the referral process.

**Referral options.**

GPs need comprehensive information on who to refer young people to and how, including information on statutory and voluntary organisations. Furthermore, because of the stigma associated with seeing a medical professional, GPs felt that more voluntary organisations in the community which patients could access without referral would help increase the numbers of patients seeking treatment for self-harm. They also need patient information leaflets on self-harm.

**Access to talking therapies.**

Health Care Professionals need improved access to talking therapies for young people to be provided by both the statutory and voluntary sectors.

**The transition to adulthood.**

Because referral options to services become limited once a patient reaches adulthood and can no longer be referred to CAMHs, mental health services from both children's and adult services need to work together more effectively to support patients through the transition to adulthood.

# Methodology

This groundbreaking piece of research is the first conducted with the UK's general population in order to understand perceptions and misconceptions around self-harm. It has been conducted with the people who may come into contact with a young person who self-harms and seeks to recognise how different groups (teachers, GPs, peers, parents) feel about the issue. It looks to understand what a young person who self-harms can expect in terms of support or otherwise if either they choose to raise the issue, or if someone else spots the symptoms. The questions asked and the analysis of the results have been informed by an extensive review of medical literature, consultation with YoungMinds (who come into contact with young people who self-harm) and talking to other professionals (HCPs and teachers) who have experience with the subject.

Research was conducted with four main audiences: young people (14-24 years old); teachers (including Child Protection Officers (CPOs), Heads and Deputy Heads); parents (with children 11–24 years old), GPs and other HCPs (including psychologists and front line staff).

**The research itself was conducted between March and September 2012 and consisted of four stages:**

## QUALITATIVE RESEARCH.

50 GPs contributed to qualitative discussions, quick polls, private tasks and idea generation tasks on eVillage, Insight Research Group's on-going qualitative online community. 45-minute depth interviews were carried out with 20 HCPs (a mix of psychologists, A&E physicians and nurses, medical students and paediatricians). 20 parents (of children aged 11 to 18) participated in an online qualitative forum, private online diary exercises and depth interviews. Eight focus groups were conducted with secondary school teachers who had some level of pastoral responsibilities. Six school leaders (Heads/Deputy Heads) took part in 90-minute, one-on-one depth interviews.

## QUANTITATIVE RESEARCH.

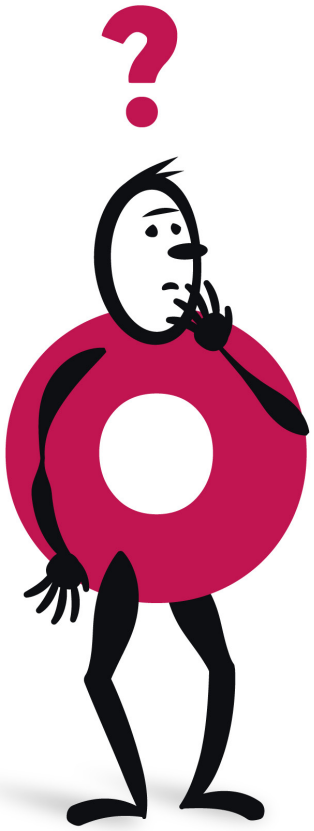
2,461 interviews were conducted with young people, teachers, parents and GPs in August 2012. The survey was online and consisted of: 1,002 young people (aged between 14 and 24, biased towards those under 20 and in full-time education); 265 teachers (all of whom were fully qualified and currently teaching/overseeing pupils of 14+); 994 parents of children between 11 and 24; 200 GPs (from a full range of practice sizes). Across all the surveys, participants were chosen to be representative of all age ranges, ethnicities, socio-economic backgrounds, regions and school types (faith, public, state etc).

## SOCIAL MEDIA DISCOURSE ANALYSIS.

Social media monitoring and netnographies were conducted in March 2012. Facegroup's Pulsar tool tracked real-time mentions and online conversations around self-harm and surrounding areas, based on a lexicon of query terms generated with YoungMinds.

## MEDICAL LITERATURE REVIEW.

An evidence analysis of non-suicidal self-injury (NSSI) in youth/adolescents was conducted using recently published scientific literature. A PubMed search produced 28 relevant articles published within the past year, which were used to inform the further research and recommendations.



# Main Report

## SECTION 1
## THE LEVEL OF CONCERN AROUND SELF-HARM

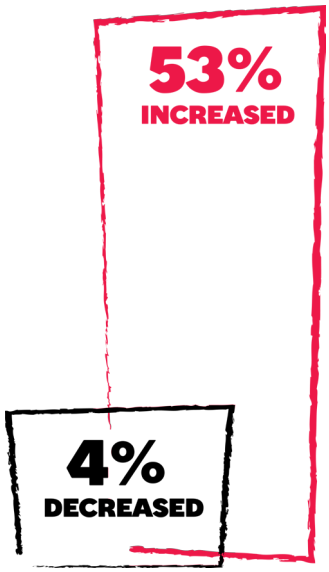
This section discusses society's perceptions towards young people who self-harm and reveals that the UK considers it an extremely important issue - more serious and more common than many more high profile youth issues such as youth gangs, drugs, binge-drinking or eating disorders. We also find the issue is one that evokes sympathy and a need for serious attention.

## SELF-HARM IS PREVALENT AND INCREASING.

Self-harm is thought to be as common among young people as eating disorders and gang membership. Teachers and GPs estimate self-harm to affect around one in ten young people, while estimates are often even higher among parents and young people themselves.

Self-harm among young people is not only a relatively common issue, it's also one that GPs feel is on the increase. Over 10 times as many GPs believe that the number of young people self-harming has increased over the last 10 years as feel it has decreased. Hospital admissions have also increased by over 68%.

**GPs: Over the last 10 years, do you think the number of young people you see who are self-harming has ....?**




It's not just health care professionals who think self-harm is on the increase – teachers can feel that the secrecy surrounding the subject means that what they see is just tip of the iceberg.

*"I'm dealing with more cases of students self-harming than I have done at any other time in my career. Other teachers here wouldn't have any idea of how common it is. We're really careful to prevent that kind of thing leaking out; it's on a 'need to know' basis"*

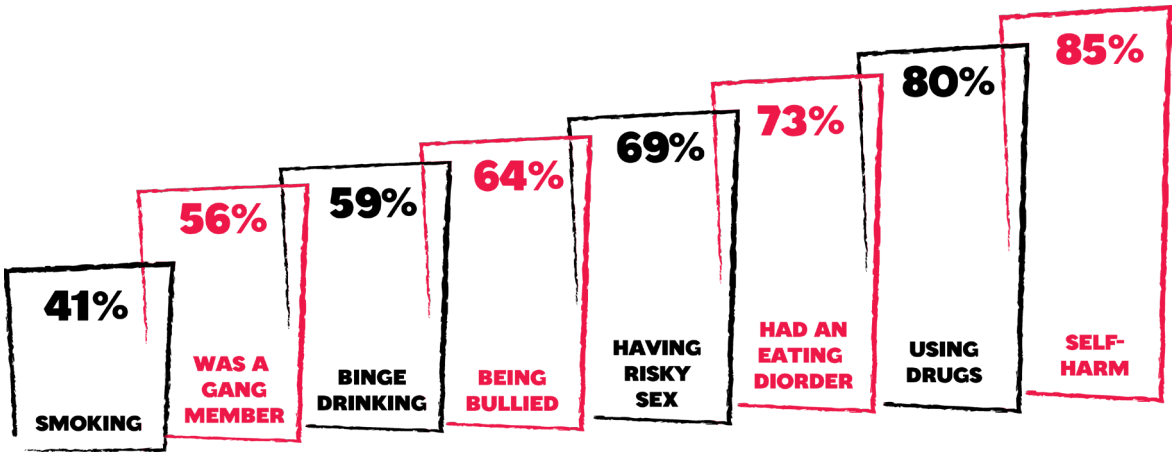
**Deputy Head and Child Protection Officer**

## SELF-HARM IS AN EXTREMELY CONCERNING ISSUE.

Self-harm among young people is the number one issue that young people themselves are concerned about among their peers. 81% of young people would be very worried if they knew that a friend was self-harming, compared to 53% who would be worried about an eating disorder or 50% if their friend was being bullied.

This level of concern about the issue is shared by all groups: parents, teachers and GPs. Across the board, self-harm is the issue that all groups are most concerned about in a list that includes gangs, bullying, drug use and binge drinking. Furthermore, underpinning their concerns is the perception that there are lasting consequences for those who self-harm (held by four out of five people (85%), e.g. lasting stigma from scars.

**Imagine a young person you knew was being affected by the following issues. How worried would you be about them in each scenario?**




**% answered 8-10, where 10 is extremely worried; Average across young people, parents, GPs and teachers:**

## THE MAJORITY OF PEOPLE VIEW SELF-HARM WITH A HIGH DEGREE OF SYMPATHY.

**Across all the groups involved, self-harm is seen as prevalent, increasing and more worrying than other issues facing young people today.**

There is a high level of sympathy towards the feelings that people believe lie beneath self-harming behaviour. These are most commonly thought to be depression, sadness, low self-esteem and bullying. 86% of people view self-harm as a way of young people coping with difficult feelings and situations, while three quarters (76%) see it as a form of self-punishment. This level of sympathy with the underlying causes of self-harm highlights how important all groups believe it is to help young people who find themselves in the situation where they are self-harming. As the diagram on the next page illustrates, while cutting of the skin is what most people associate with self-harm, the majority of associations are with difficult and complex emotions.

## WORDS MOST ASSOCIATED WITH SELF-HARM ACROSS ALL AUDIENCES.

## WHAT DO YOU ASSOCIATE WITH SELF-HARM?

*"A need to find relief... to experience physical pain that can be controlled in order to mask emotional pain and uncontrollable suffering"*

**Young Person**

*"It's high parental expectations, a lack of control over life and a release or reaction to stress and home circumstances... it's also a lack of understanding in teaching staff as students who self-harm are scared of the person they become"*

**Teacher**

*"Self-harm is often connected to stress – being unable to control the world around so it's a way to assert a level of control"*

**Teacher**

*"I think there are ever increasing pressures on young people, both from peers and society as a whole, and self-harm is used as a coping mechanism, where more beneficial forms of support have decreased"*

**GP**

*"Punishing yourself... feel what's bad to make yourself feel better. It's like taking your anger out on yourself because you can't elsewhere."*

**Young Person**

*"The problem normally lies at home. It is a sorry state but it happens and should be sorted out as soon as possible"*

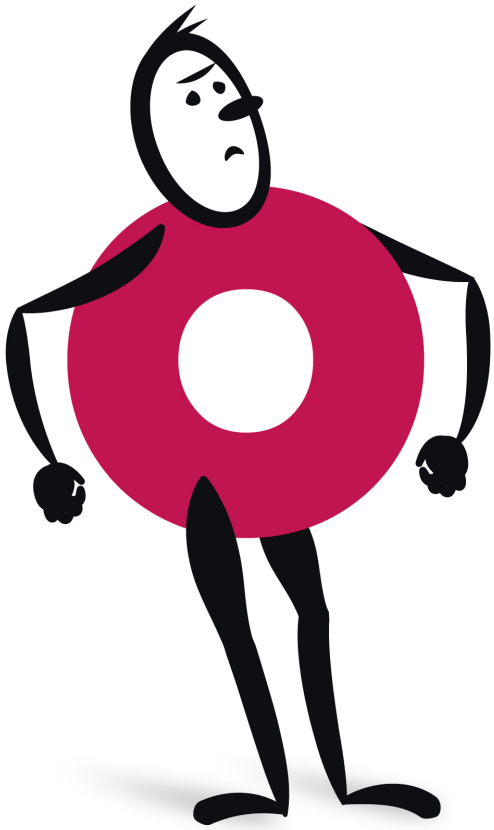
**Parent**

*"People think that it's emos that do self-harming, but that's just bullshit any young person with problems can do self-harming as a way to deal with their problems"*

**Young Person**

*"I have a friend that self-harms. It is an ILLNESS and has to be ADDRESSED"*

**Young Person**



## SECTION 2
## THE DESIRE TO HELP... AND THE FRUSTRATION OF NOT BEING ABLE TO.

**All groups agree that being more open and increasing understanding of self-harm is a good thing.**

Given what we have seen in the section above, it is perhaps no surprise that across all the groups involved, there is strong support for talking more openly about self-harm. Currently, over half of young people (53%) believe that self-harm is on the increase because young people who do it feel stigmatised, and therefore are not accessing support.

The belief in opening a dialogue about self-harm with young people so that they at least know where they can turn to is shared by between 80% to 90% of all groups. Conversely, the belief that a more open dialogue about self-harm would lead to an increase in cases, e.g. due to raising awareness and glamorising or normalising, is only held by a small minority.

**% agree that…**

**Average across young people, parents, teachers and GPs**

**87%**

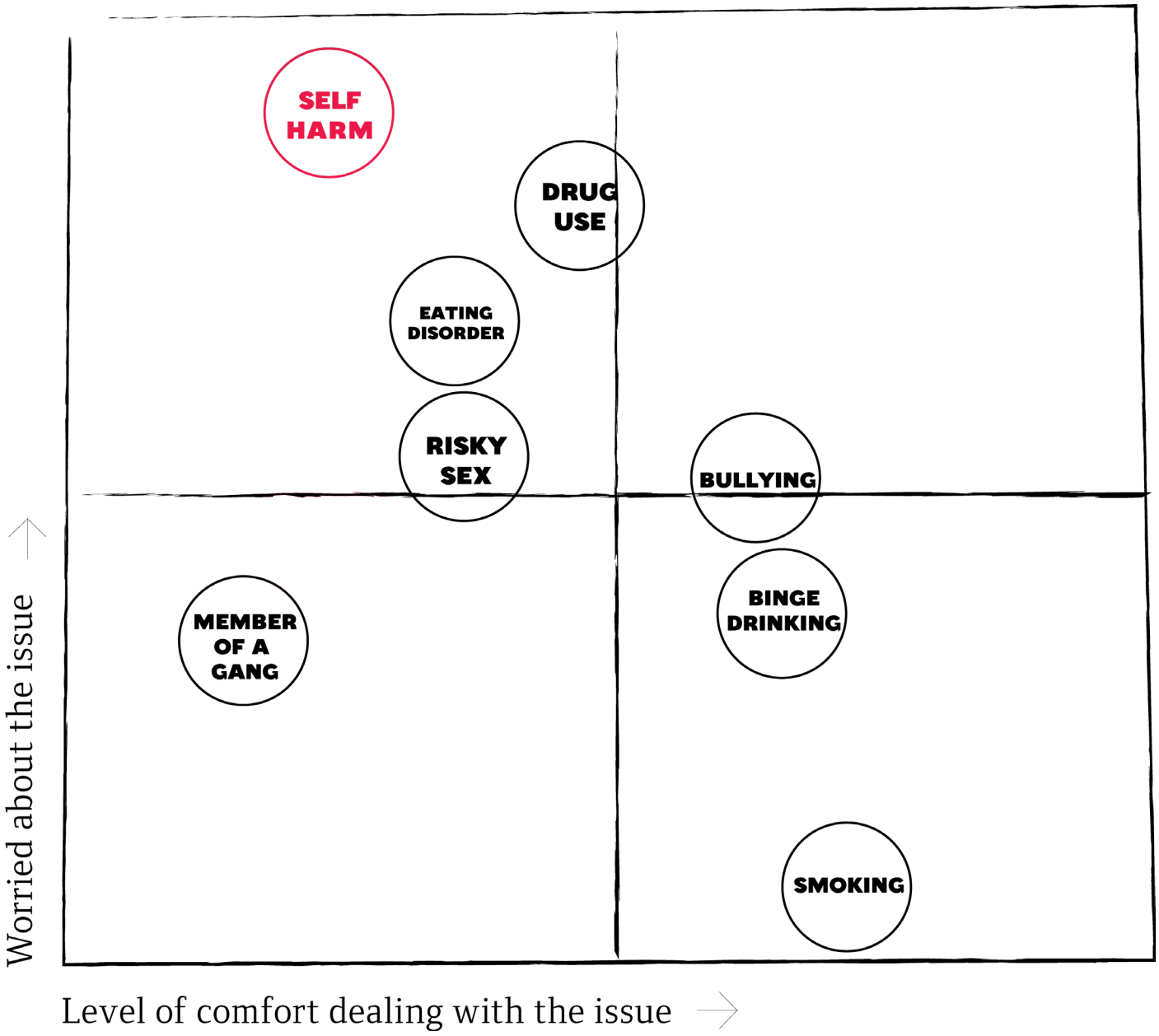
SCHOOLS, THE NHS AND FAMILES NEED TO TALK ABOUT SELF-HARM SO THAT YOUNG PEOPLE FEEL ABLE TO TALK TO THE APPROPRIATE PEOPLE ABOUT IT

**19%**

SELF-HARM WOULD INCREASE IF IT WAS TALKED ABOUT OPENLY

71% of young people, 70% of parents and 60% of teachers say they don't feel able to talk about self-harm, but the vast majority (78%) would like to be equipped to have the conversation if needed.

*Map showing how worried people would be if they saw signs of the issue compared to how comfortable they would be dealing with the issue with a young person*




Average across young people, parents, teachers and GPs

While the vast majority of people believe that they need to be able to offer support, they currently don't feel able to. Self-harm is the issue that all groups feel least comfortable approaching with young people.

Two in three teachers, parents and young people all think that they would say the wrong thing if someone turned to them.

*"You are so worried about handling it badly, that you avoid handling it at all"*
**Teacher**

Teachers want to both be able to talk about self-harm at a broad conceptual level (77%), as well as know what they can say to offer advice and support to individuals who are self-harming (82%). However, they currently feel much less comfortable discussing self-harm than a range of other behaviours including binge drinking, drugs and risky sex.

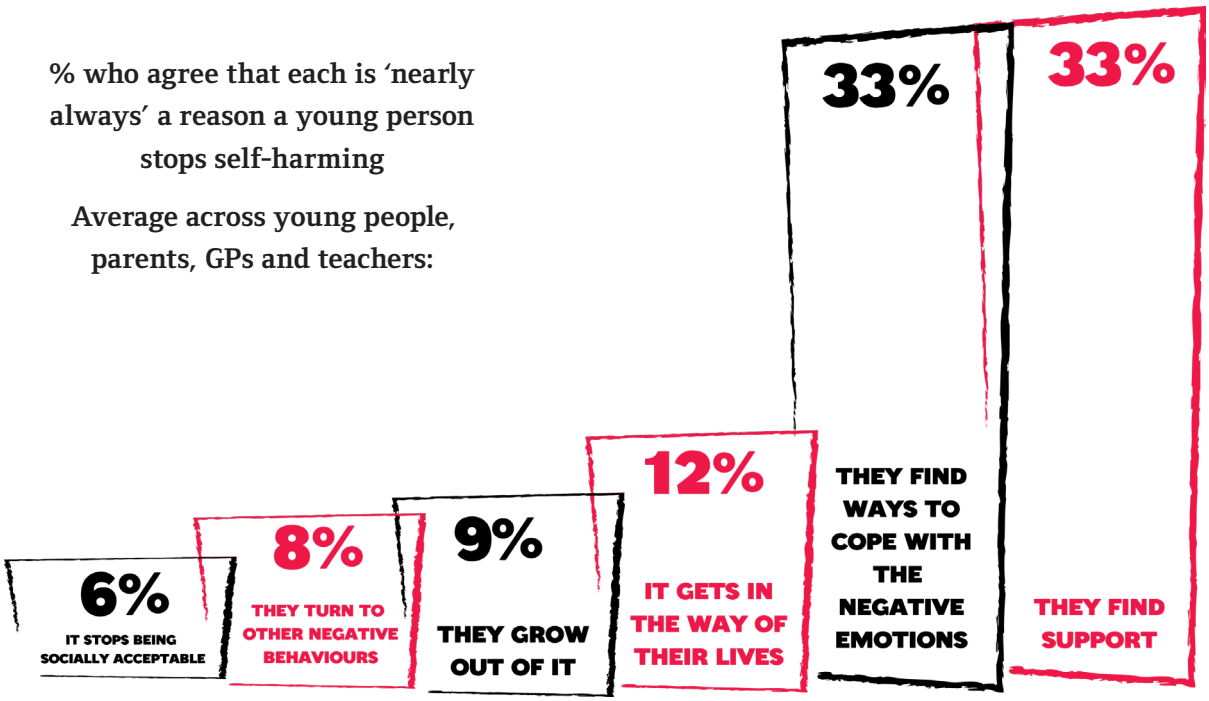
Crucially, over a third of GPs (38%) say they would like to be able to talk to a young person about self-harm but don't know how.

*"When I see young people who are self-harming I feel concerned and also uncomfortable. I am worried that I will not be able to help much"*
**GP**

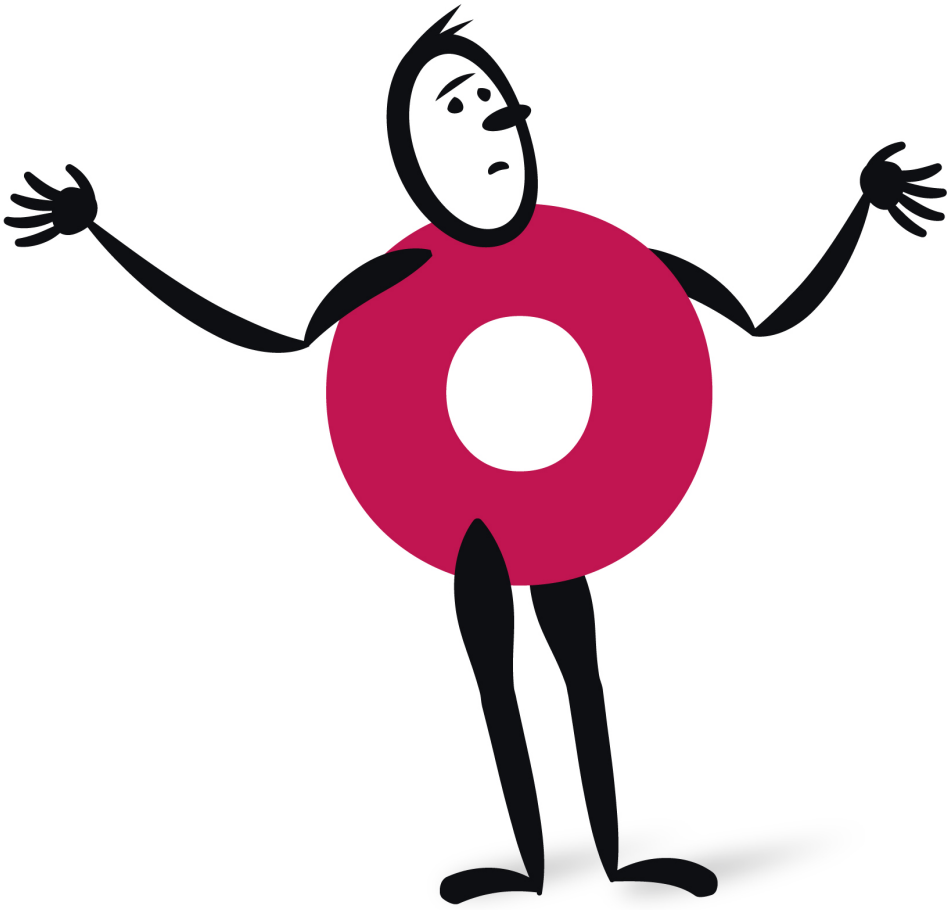
Being able to talk about self-harm is vitally important, as all parties believe that learning to cope with the negative emotions, explicitly through finding support, is the main reason that young people manage to stop harming themselves.

**% who agree that each is 'nearly always' a reason a young person stops self-harming**

**Average across young people, parents, GPs and teachers:**




**Across all of the constituent groups, there is very clear agreement that being able to talk about self-harm is necessary and beneficial. And yet no one feels equipped to have the conversation.**



## SECTION 3
## WHAT PREVENTS PROFESSIONALS AND PEERS FROM HELPING.

We have seen that across society, there is a desire for more conversation and action to help young people, and yet we've also seen that both professionals and young people themselves often feel powerless to act. There are a number of factors that explain this current impasse...

**SELF-HARM CAN BE VIEWED AS SO SERIOUS THAT PEOPLE ARE AFRAID TO BROACH IT.**

Dear Dr Miriam

I discovered that my 17-year-old daughter has been self-harming. I suspected it and then confirmed it when she fell asleep and I could see the cuts on her arms. What can I do?

**Dr Miriam says:** That is worrying for you but in a study of 17 countries, self-harming turned out to be quite common affecting around three in 100 adults.

A survey in the UK of 15 to 16-year-olds estimated that more than 10% of girls had self-harmed. Self-harm and psychological disturbance are strongly linked so I think you should see your doctor fairly urgently to ask his advice on the support and counselling your daughter can have.

There's always the likelihood that the self-harm might escalate and lead on to something worse.

As a first step could you try to have a low-key chat with your daughter about what's troubling her?

Over half of GPs, teachers and parents (52%) agree that young people who self-harm are likely to attempt suicide.

*"It's about abuse, illness, suicide and no employment future"* **Teacher**

*"This sort of thing, it's hidden. I certainly don't think they'd discuss with their parents, it's something that they're hiding... I think maybe it's a cry for help. Unfortunately... it's just like suicide - a high percentage of those are a cry for help."* Parent

*"[I associate self-harm with] depression, loneliness, disappointment and suicide."* **Parent**

This is reflected in mainstream media where self-harm can be treated as an extremely serious issue. The majority of media articles we analysed over the course of the research talked about self-harm alongside suicide, intertwining it in many people's minds.

*"There's always a likelihood that self-harm might escalate into something worse"* **Dear Dr Miriam advice column**

Some psychologists fear that when Health Care Professionals (HCPs) link self-harm to suicide it can hinder effective treatment, as HCPs can be intimidated by the risk.

*"In my experience, front line staff feel uncomfortable and under-confident when dealing with [self-harm] patients. They assume that self-harm is connected to suicidal feelings and they do not know how to ask questions around this topic. It's obviously uncomfortable to ask someone why they want to die, or just to talk about death generally, and they are nervous about initiating that conversation. If they understood that self-harm and suicidal ideation are not the same thing, they may feel more comfortable themselves and in turn be able to adopt a 'bedside manner' which allows them to get more information out of their patients."* **Psychologist**

While studies have shown that young people who self-harm are more at risk of suicide, people don't necessarily self-harm because they want to commit suicide. The young people YoungMinds work with describe self-harm as a coping mechanism to help manage overwhelming feelings; and young people who took part in the survey describe it as a diversion of painful feelings:

*"Being depressed or down but wanting to feel something other than you're 'stupid' or 'a cry baby.'"* **Young Person**

## A CHILD PROTECTION ISSUE IN SCHOOLS.

The fear of self-harm can often be exacerbated by the school system, where it is typically treated as a child protection issue (even when equally damaging behaviours such as eating disorders and persistent heavy smoking are not). 88% of teachers say that a Child Protection Officer (CPO) is responsible for the issue in their school. Teachers who have built trust and rapport with pupils then find that they are unable to do much to support young people themselves as they are required to send the young person into the child protection procedure.

## A SIGN OF BAD PARENTING.

For parents, the thought of their own child self-harming rings huge alarm bells as they believe there must be something seriously wrong at home for it to happen, reflecting very poorly on their ability to provide a supportive home.

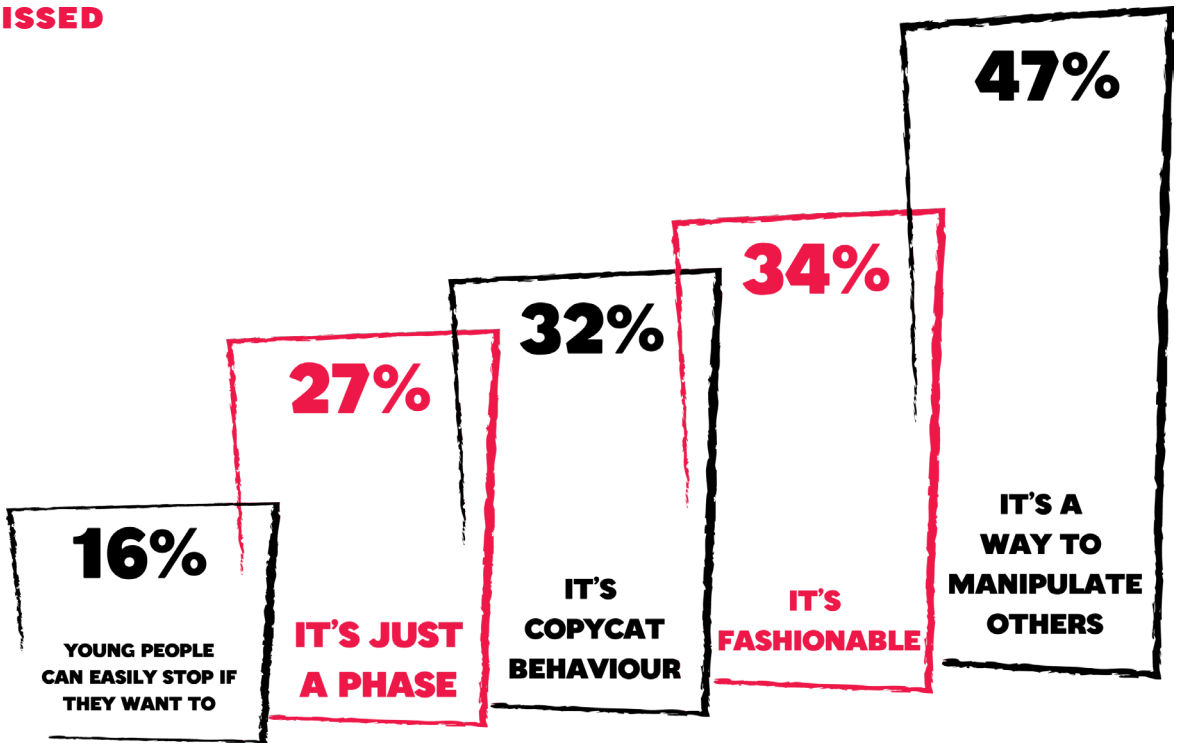
*"I'd feel that it was a breakdown in our relationship that she hadn't felt able to come to me earlier and tell me about the issues that were upsetting and affecting her and I'd feel sad that I hadn't picked up on it and that she'd got to this level of upset and hadn't been able to speak to me, so I'd feel sad on both."* Parent

*"If I found out she was doing it I'd feel dreadful that she was doing something like that, that I hadn't seen the warning signs or been able to support her, and it would make me feel really low, but I would want to support her."* Parent

*"The problem normally lies at home. It is a sorry state but it happens and is very sad and should be sorted out as soon as possible."* Parent

**CONVERSELY, SELF-HARM CAN ALSO BE VERY EASILY DISMISSED BY SOME.**

At the other end of the spectrum from the view that self-harm is too serious to be broached is the perception that it is trivial or 'selfish' behaviour... that it's a fashion, a fad or a way to manipulate people.




**% of parents, teachers and GPs who agree with each statement about self-harm among young people**

*"They think it's cool to have a drama, lots of people at school talking about you."* Teacher

*"Self-harm is part of the drama of the day, it's part of getting attention from friends."* Teacher

*"It's young people being unable to cope with the feelings arising from the hormonal surges of puberty... physically hurting themselves as a way to avoid dealing with any emotional hurt that they are too immature to cope with."* Parent

*"Often it's just a fashion thing."* Teacher

*"It's stupid... It's just kids who are being spoilt and pampered too much then end up finding it hard to cope with the pressures they receive from their environment, so start self-harming."* Young Person

While nearly half of adults can see self-harm as a way to manipulate others, there is a feeling in the GP community that those who are self-harming for non-manipulative/non-attention-seeking reasons do not actively show what they have done or seek help for it. Therefore, they (and potentially others who express these dismissive views) are only seeing the subset of young people who appear more attention seeking in their behaviours.

Equally, teachers and GPs who feel that young people who self-harm for attention-seeking reasons do not necessarily dismiss self-harm as trivial – it can be a way to start a dialogue

*"It is attention-seeking but that just means a young person is in need of attention. It's more of a cry for help."* Teacher

*"Self-harm is a way of expressing very deep distress. Often, people don't know why they self-harm. It's a means of communicating what can't be put into words or even into thoughts and has been described as an inner scream. Afterwards, people feel better able to cope with life again, for a while."* GP

**THE CONTRADICTORY NOTIONS OF SELF-HARM AS TRIVIAL, AND SELF-HARM AS TOO SERIOUS TO BROACH, REFLECT A MORE ESSENTIAL PROBLEM SURROUNDING THE ISSUE: PEOPLE'S LACK OF UNDERSTANDING.**

The views on the extremes perpetuate the stigmas of both how frighteningly serious it's perceived to be and/or how trivially it can be perceived. While the main view held is that self-harm is to be sympathised with and it is a way of coping with emotions, there is a deep lack of understanding and empathy as to why it happens.

Almost half of GPs also feel that they do not really understand young people who self-harm and the motivations behind the behaviour. While they understand that the behaviour is most likely in response to a psychological stressor and is a 'cry for help', they have difficulty rationalising the behaviour.

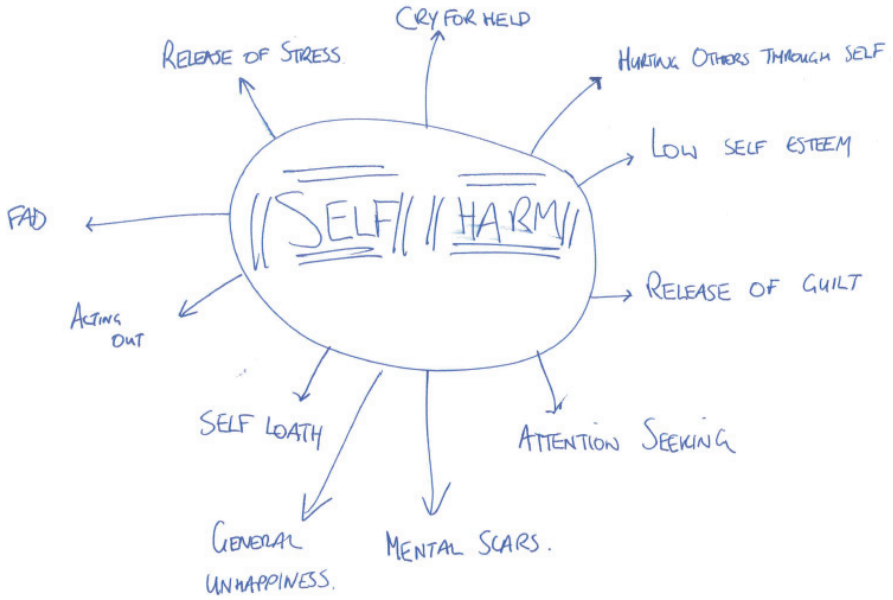
Similarly teachers and parents struggle to grasp how young people would find comfort from choosing to inflict pain on themselves, finding it difficult to isolate or be confident naming the emotional states that would accompany this particular response.

There is a widespread belief that self-harming is a symptom of something deeper, but many people in a position of responsibility cannot empathise with it or understand it.

*"It's very sad and everything but I can't say I completely 'get' it; I mean, I couldn't do it."* Teacher

*"I've got no idea what triggers it, that's in the realm of a psychologist."* Teacher

**A TEACHER'S SPONTANEOUS ASSOCIATIONS WITH SELF-HARM, COVERING EVERYTHING FROM 'FAD' TO 'SELF LOATHE'.**




**This lack of understanding of self-harm reflects the lack of encounters with trustworthy and useful information around self-harm, both among youth and professionals; this is a problem we will explore in the next section.**

## SECTION 4
## CURRENT SOURCES OF INFORMATION AND THEIR DIFFICULTIES.

**In this section we will discuss how nearly four in five young people don't know where to turn to talk about issues of self-harm. Left to seek out information, they will go online where they are most comfortable - even though they feel it's not the place they should be going. What they then find online can be anything from support to ridicule.**

## ‘KNOWLEDGE’ ABOUT SELF-HARM IS BUILT UP FROM AN INCONSISTENT ASSORTMENT OF SOURCES.

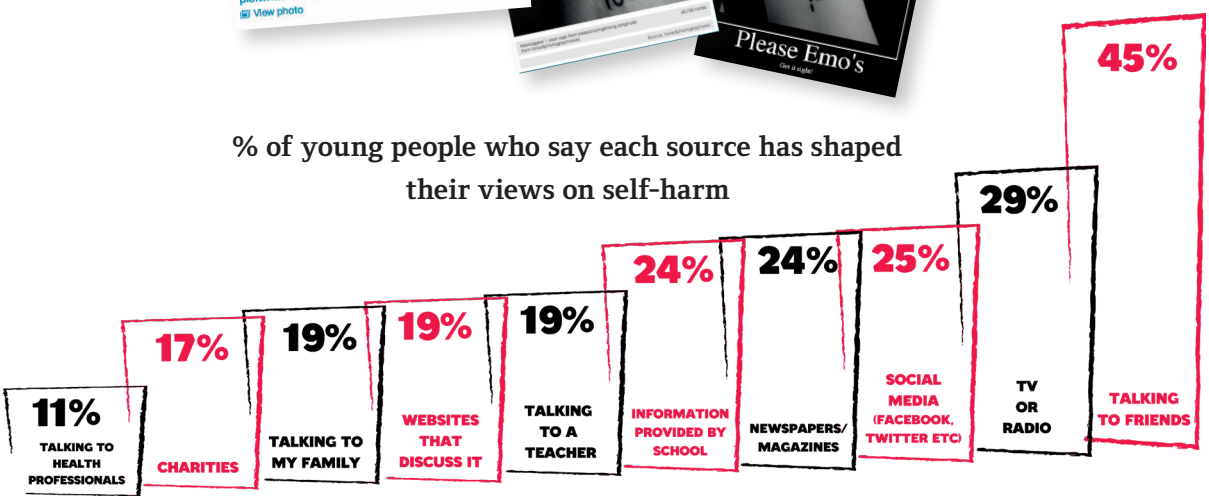
Information and opinions about self-harm can come from anywhere; discussions with friends, what’s seen or heard in the media, links from Google, any number of social media sites and forums, schools or other professionals organisations. Across teachers, parents and young people, there is a lack of consistency offered by this broad range of sources in terms of the types of information and opinion expressed within them. Information can vary from supportive to dismissive, from inciting self-harm to mocking those who do it.

When a young person looks for information, or information finds a young person, it’s really a game of chance as to whether that information will be measured and helpful or part of a negative extreme view.

## YOUNG PEOPLE MOST COMMONLY GET ANY INFORMATION ABOUT SELF-HARM FROM FRIENDS, ONLINE OR THE MEDIA.

Conversations with friends are the most common source of information on self-harm for young people (45% of young people say that’s what informs their views). Information online, from websites, social media sites, blogs etc, is second most common (33% of young people say these inform their opinions about self-harm). While online peer support can be helpful and positive for young people, when it comes to self-harm, the online landscape is particularly complex: there is a lack of coherent messaging and meaningful conversations around the issue, particularly in the social media space where young people who are self-harming turn to for support. While the authoritative voices of charities are present online, different groups of people are also constructing and shaping their own niches and discourses around self-harm, which gives rise and weight to more extreme associations seen elsewhere in the research. Potentially, this can lead to a very disparate set of narrow views around self-harm.

**% of young people who say each source has shaped their views on self-harm**



**Offline media discourse around self-harm also lacks consistent messaging. Associations with self-harm in the media are wide ranging (they include eating disorders, bipolar disorder, depression, domestic abuse and bullying) but often self-harm is only linked to one of these issues at a time, with the implication that self-harm can be seen to have a very specific and niche underlying cause.**

## PARENTS AND TEACHERS HAVE NOT OFTEN MADE THE LINK THAT SELF-HARM CAN BE TALKED ABOUT IN SOCIAL MEDIA.

Focus groups with teachers showed that despite high top-of-mind awareness of social media influences and the associated impact of these on young people's identity and relationships, many teachers haven't naturally connected social media to self-harm yet.

*"I hadn't even thought of that but it makes sense. There are so many opportunities to reinvent yourself online now... I can see how that might bring in a competitive element that might prolong the behaviour."* Deputy Head teacher and CPO

*"Raising awareness of the contribution that technology is making to this issue, now that would be a new area that would really get teachers' attention."* Teacher

## ONLINE SUPPORT.

Many thousands of young people seek and derive emotional support from online communities rather than going to their parents, teachers or GPs. All those who are concerned about the emotional wellbeing of young people need to acknowledge and accept this and look at why young people are supporting each other online.

*"I got all my support via the internet from other young people like me when I was self-harming. They didn't judge me and they understood it was a coping mechanism and not linked to me necessarily wanting to kill myself. There is such a panic about self-harm and other young people understand what it's really about."* Young person

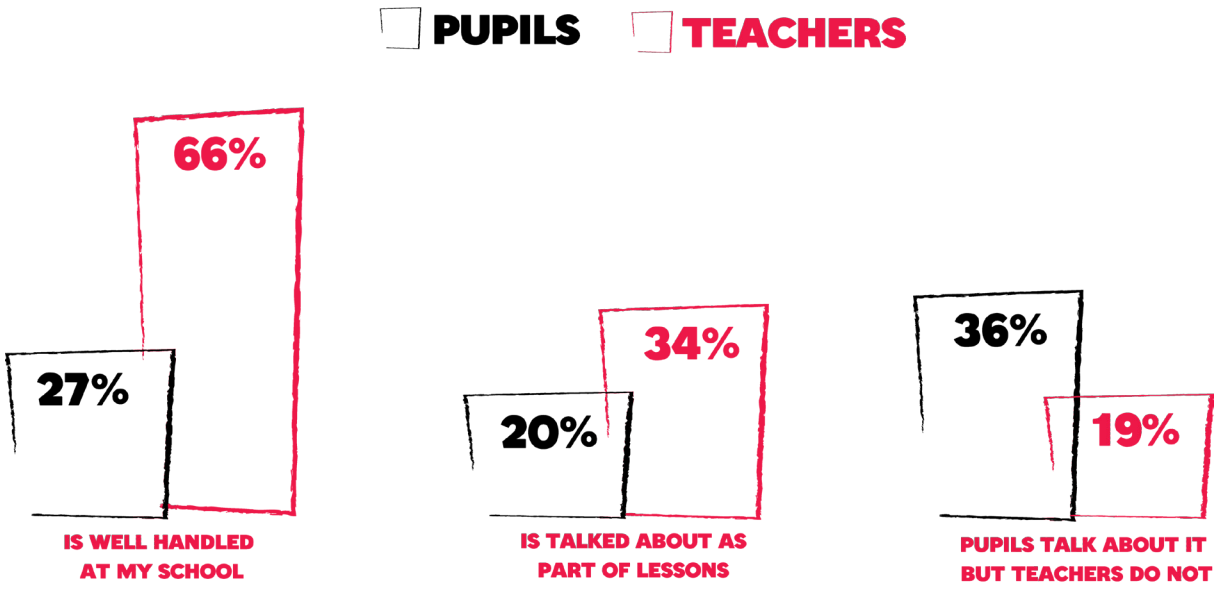
Our research demonstrates that discord between the peer support that young people access online and the helping organisations who are, on the whole, distanced from young people's online activity in relation to self-harm.

Services need to develop their online presence in a sensitive way that works for young people, respecting what they are already doing online and centrally involving them as experts in the development of all online service provision.

## PUPILS AND TEACHERS HAVE VERY DIFFERENT OPINIONS ABOUT WHETHER SELF-HARM IS DISCUSSED IN SCHOOL.

There are clear differences in opinion between pupils and teachers on how self-harm is dealt with in schools. One in three teachers (34%) believe they are covering self-harm in lessons, but just over half that number of pupils (20%) think that's the case. Pupils are twice as likely to say that they talk about self-harm but not to teachers. The disparity between what pupils and teachers think highlights the challenges that exist with open dialogue around these issues; even when staff believe they are putting messages out, they are not being received.

Recent research conducted by Department of Health/2CV highlights the disconnect in how adults and teenagers communicate on issues affecting young people; adults typically talking around issues while young people seek discrete answers to specific questions. Given the high prevalence of self-harm, it would seem important to discuss it specifically and openly, albeit in the context of other issues.



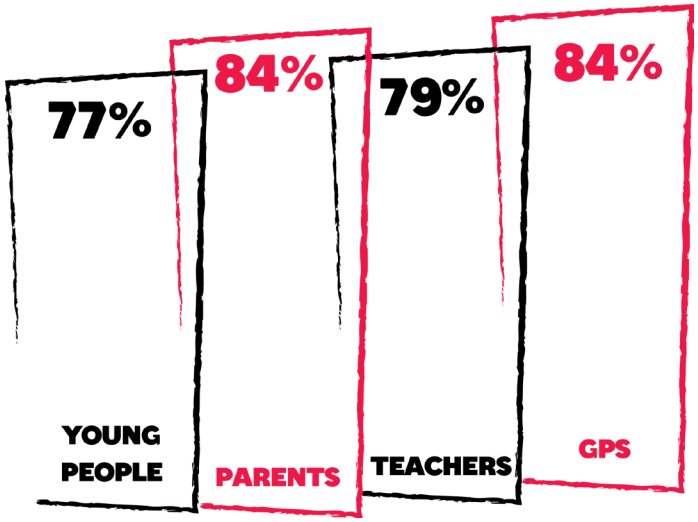

**% of pupils/teachers who agree with each statement about self-harm in their school**

For the majority of teachers (who don't believe self-harm is covered in lessons at their school), perceptions are largely built through direct experiences with self-harm. What they know about it is typically determined by how involved they are in dealing with individual cases and most teaching staff tend to have limited experience of dealing with self-harm. If a case comes to light, their role is usually limited to discovery or a young person's disclosure to them unless they are a dedicated Child Protection Officer (CPO) within the school, as teachers must 'pass on' all incidences of self-harm to the CPO who deals with the case from this point on. This often results in the majority of teachers having a piecemeal understanding of the potential reasons why a young person might choose to harm themselves, and relatively few teaching staff feeling confident in their understanding of the area.

## YOUNG PEOPLE DON'T KNOW WHERE TO TURN TO FOR SUPPORT OR INFORMATION.

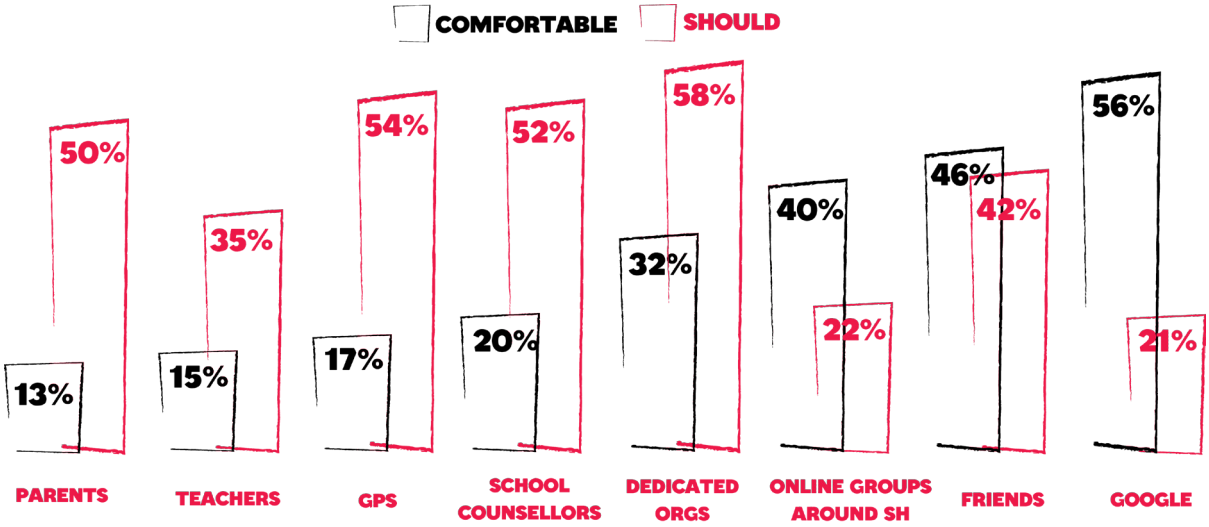
The lack of clear and defined information sources mean that 77% of young people feel that they don't know who to turn to with questions about self-harm – a view that is shared by parents, teachers and GPs.

% who agree that 'young people don't know who to turn to talk about self-harm'




## YOUNG PEOPLE DON'T FEEL COMFORTABLE SEEKING INFORMATION OR SUPPORT FROM THE PLACES THEY THINK THEY SHOULD BE GETTING INFORMATION FROM.

Low awareness of helpful information sources can drive young people to potentially 'wrong' sources of information. The differences between where young people currently feel comfortable seeking advice and where they believe they should be seeking advice are particularly stark.

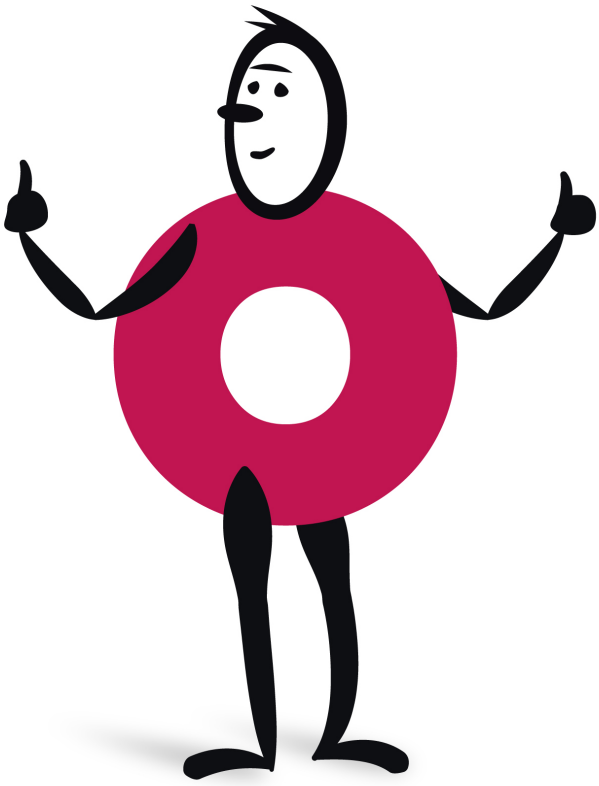



Young people: 'where are you comfortable seeking information or advice on self-harm' compared to 'where do you think you should be getting information/ advice from'.

Only around one in ten young people feel comfortable seeking advice from teachers, parents, GPs or the school/health systems in general, whereas around half feel these groups are where they should be able to turn. Conversely, half are comfortable going online (Google or forums where other young people talk about self-harm), but only one in five feel that's where they should be going.

The right people are in the wrong places. And the wrong people can often be in the right places. There are no channels where young people feel they should be going and also feel comfortable. When they do stray into the internet wilderness, it's a gamble as to what they'll be confronted with.

The organisations and professionals that can offer support therefore need to be more present in the online spaces that young people feel comfortable going.



# SECTION 5
# HELPING THE CONVERSATIONS.

There is an unmet need for the lines of communication and support to be opened, across audiences, to close the gap between where young people feel comfortable seeking advice and where they think they should be going. However, each audience faces challenges in offering the support they think they should be able to provide. In the following sections, we explore in detail the implications for different groups (teachers, parents and healthcare professionals) and the help that they need in order to address self-harm confidently and effectively.

# CHALLENGES AND NEEDS IN SCHOOLS

Focus groups and interviews with teachers provide a deeper understanding of why they feel ill equipped.

**A NARROW VIEW OF THE FACTORS LEADING TO SELF-HARM.**

*"If I was to experience something like that I would immediately think of the broken home types of issues, something happening externally to them."*

*"60% of the behaviours we see are copied from parents and it can be the same for self-harm."*

*"If somebody cuts themselves alarm bells ring."*

Self-harm's strong association with mental illness and problems with young people's home life can position the behaviour as something beyond teachers' reach. Unlike many issues and behaviours affecting young people today, including gangs, eating disorders, drugs and alcohol, teachers have relatively few anchor points for understanding self-harm.

*"With all the eating disorders and obesity too, you can connect them to something. In magazines with all these diets, size zero models... it's more of a natural progression from healthy eating which they get taught in primary school...I wouldn't know where to begin with self-harm."*

*"It's hard to just go straight in there with an issue like self-harm; you need be able to build up to it and talk about the issues that surround it."*

Generally seen to reside 'in the home' or 'in the mind', self-harm shares few apparent touchpoints or connections to other issues that teachers encounter. While some teachers do associate self-harm with bullying behaviour, they do not believe that school events are a major contributor (relative to home life and mental health). The distancing of self-harm from school life appears also to reduce the responsibility they feel. Teachers feel considerable accountability for exam pressure and bullying by comparison.

*"Exam pressure is the effect of school on the kids. You feel bad because it's something you contribute to."*

## A TRIAGE APPROACH TO PROACTIVELY TACKLING ISSUES.

Practically, teachers do not feel they have the time to give an issue as serious as self-harm the attention it requires, and fulfil their other duties.

Many teachers interviewed believe there is a limit to how many issues they personally can be expected to manage, particularly in relation to things that take place outside school. Now more than ever, teachers perceive a multitude of factors affecting school life which they have little control over. New media developments in particular present considerable challenges for schools; the greater range of outside influences on young people; the accelerated speed and intensity of relationships (and bullying behaviour) through social media, and the associated stresses and pressures these can bring are frequently cited by teachers. Even those teachers who take the view that it is the school's role to help in any matter that could affect a child's development while in education (regardless of where it takes place), acknowledge that the age of Facebook, BBM et al make it difficult for teachers to keep up with what goes on in young people's lives. This clearly has implications for whether self-harm falls within their remit.

*"The internet has changed the level of bullying, it becomes a lot bigger a lot quicker."*

*"Kids can go home friends and come back the next day not talking to each other – it all happens overnight and usually on BBM."*

*"Cyber-bullying is big and it's hard to deal with it, especially when it's out of school."*

*"We can't tackle all these issues, especially something that sensitive. PSHE is not a counselling or therapy session, we're just there to deliver the facts."*

The pressures on teachers (notably, increasing amounts of paperwork) stretch them to the limit at times. When there is uncertainty around how common self-harm actually is, and doubts around whether anything they do can guarantee a net benefit, self-harm is not always something they feel they can be on the look out for.

*"Well these others [smoking, drinking, drugs, anti-social behaviour] are more social problems, they can affect anyone. Whereas self-harm, it's not everyone is it? It's going to be a symptom of something much bigger... There's a danger that we could make things a whole lot worse."*

Overall, the teachers interviewed showed little confidence in their understanding of the triggers or the prevalence of self-harm among young people, allowing them to opt-out from needing to do anything around the issue.

*"I've no idea how prevalent it is, that's the problem."*

*"I've got no idea what triggers it, that's in the realm of a psychologist"*

**A more proactive approach to self-harm in schools.**

• *97% of young people believe that self-harm should addressed in school, with two in three feeling that it should be part of lessons.*

Teachers and young people may be able to plug their knowledge gaps around self-harm in tandem, with the provision of appropriate resources that provide the basic facts needed to bust some of the myths, confusion and uncertainty that exist, e.g. regarding the prevalence of self-harm and how it links to other issues and behaviours that are already covered in schools. Consideration needs to be given to how self-harm could be included in the curriculum in PSHE classes and other appropriate curriculum areas.

• *The number one reason teachers say young people stop self-harming is because they learn to better cope with the emotions associated with it.*

There appears to be a particularly big opportunity to educate about the emotional states that can lead to self-harm. Teaching emotional awareness and literacy creates a platform for raising the topic of self-harm in context. This is likely to be more palatable for teachers, parents and pupils (given the fact that all currently struggle and fear tackling the issue head-on). 'Building up' to educating around self-harm in context, e.g. learning to recognise a range of difficult emotions (anger, stress, pressure etc), and discussing positive and negative coping mechanisms, will be important to ensure teachers can find a range of familiar touchpoints to contextualise self-harm. Lessons that build resilience have the power to simultaneously minimise young people from starting to self-harm and de-stigmatise those that do, helping them to feel less isolated and more able to access appropriate support.

**A need to further explore what might be the optimal approaches.**

There is an opportunity for randomised controlled trials in schools not currently providing education around self-harm, whereby teaching on self-harm is introduced in some schools but not others, in order to understand how teaching affects outcomes, e.g. the numbers seeking support, and/or looking at whether and how it prompts more cathartic conversations around the issue.

## SUPPORT AVAILABLE IN SCHOOLS.

For the school to be conducive to pupils feeling comfortable accessing support when they need it, teachers point to the need to create a supportive culture that young people can imitate, e.g. well-supported staff; an effective peer mentoring programme. However, there is considerable variation between schools in the support offered to teachers and pupils.

Increased demands on teaching staff (e.g. large form sizes, little tutor time, high pupil: teacher class ratios and schools that struggle to resource behaviour management) can make the prospect of dealing with self-harm all the more daunting.

*"You don't have time to build bonds with your form; there's a lot to do with 25 kids in 25 minutes"*

Variations in support structures at the school, e.g. availability of school nurses and/or counsellors available for pupils, teachers and parents; separation of pastoral and teaching staff, were seen to affect debate surrounding what everyone's exact role should be in supporting a young person who is self-harming.

*"You can't do both teaching and pastoral stuff. My school has specialist pastoral staff who deal with this stuff on a day to day basis."*

*"We've never been told how to deal with it. We just refer them to the school nurse."*

However, there is agreement that all teachers should have some base level of knowledge and skill to address self-harm when it becomes known to them, or it simply arises in pupil conversations. Every teacher wants to be able to say something positive, even if they don't believe that they alone can be the complete solution.

90% of teachers want to know what they can safely say.

*"Teachers don't talk about it because of confidentiality but it's gone too far that way; it makes it a taboo, like a secret!"*

*"The kid comes to you for your response, whatever that may be, but you have to feel comfortable dealing with it."*

*"All teachers should be able to talk about it in case a pupil asks them about it. Or, if they overhear kids joking about it, they need to be able to step in and say something more constructive than 'don't say that'."* **Deputy Head teacher and Child Protection Officer at the school**

**Resilience building.**

There is an urgent imperative to build the emotional resilience of children and young people across society and in particular in the school setting. The purpose of education must be not only to achieve results but also to nurture and develop emotionally resilient young people. If more young people develop the skills to combat adversity and deal with the emotional rollercoaster of childhood and the teenage years, the rate of self-harm will start to reduce.

Whole school approaches need to be developed to improve the mental health and wellbeing of children and young people. Further information on whole school approaches to resilience building programmes and improving mental health and wellbeing can be obtained here (http://www.cypmhc.org.uk/media/common/uploads/Final_pdf.). NICE public health guidance on mental health promotion in schools also needs to be widely implemented.

## CHILD PROTECTION PROCESS.

The Child Protection process is also believed by teachers to limit how much they can practically help. Among all the teachers interviewed, there was consensus that schools treat self-harm as a serious Child Protection issue and as such, teachers must pass on any incidences to the school's designated Child Protection Officer (typically a pastoral head within the school).

*"As a classroom teacher you break yourself away from the situation, you have to pass it on."*

*"You pass it on if you get a disclosure, it's taken out of your hands."*

*"It's important to keep the relationship, to make them feel a boost; that they trusted you... but information like that has to be passed on to the Head of Year. Then they refer them on to a professional but this takes time."*

## HOW SELF-HARM IS CATEGORISED.

Some questions exist around whether school approaches to self-harm could themselves be exacerbating stigma and fear. For example, in some schools self-harm is treated as a Child Protection issue but eating disorders and persistent heavy smoking are not. This categorisation results in more drastic action and escalation, e.g. immediate involvement of outside agencies, and typically the teacher who passes the case on to the Child Protection Officer no longer stays involved and is not kept up to date. (This is in line with 'need to know' policies which schools operate in such Child Protection matters.)

It appears this categorisation of self-harm, and the due processes attached to it, could be fuelling why some teachers view self-harm as a very serious issue that they are not equipped to deal with. 'Need to know policies' in particular might explain why teachers are uncertain about how common the behaviour actually is: in the absence of other information about self-harm among young people, they rely on personal experiences.

Removing a teacher whom a pupil trusts and went to for advice from a young person's on-going support plan is arguably not always in the pupil's best interests. Teachers express concerns that the Child Protection process can directly conflict with how the child would like things handled, particularly where the child is looking for some instant reassurance from the teacher that they will help.[2]

*"There's a missed opportunity there... That pupil came to you because they trusted you but then you're out of the picture and they might be talking to someone they hardly know."*

*"If a child disclosed to you then it's because you have a relationship with them... To be out of the picture from that point on must be quite unsettling for them."*

*"They confide in one person and then find they are being asked to confide in lots of people."*

**Supporting teachers to stay involved.**

There is an opportunity to further explore how a trusted teacher could be empowered and supported to be the on-going point of contact for a pupil who disclosed to them, or where a strong relationship exists. For example, could professional supervisors (Child Protection Officers, school nurse or an external professional) work with a teacher behind the scenes to help them to feel confident and comfortable supporting a child, and thereby enable greater continuity of care and support for the young person?

Clearly, teachers would need to be able to 'opt-out' of such an arrangement if this issue was unsettling for them, but there are indications from our research that some teachers would like to be able to do more, provided they received adequate support themselves.

Randomised controlled trials in schools could be used to explore the impact of teachers playing a bigger role in supporting young people who self-harm, where a strong relationship exists and the teacher is willing. It will be important to understand the impact on individual teachers and pupils affected by any shift in policy, as well as on the wider school community.

[2] Previous research with school staff has also highlighted this issue - Self-harm: a challenge for pastoral care. Ron Best. PASTORAL CARE – SEPTEMBER 2005

## THE 'PROFESSIONAL' REACTION.

There are strict regulations around how a teacher can react during a disclosure, e.g. they cannot say or do anything that could influence what the child says, such as asking any leading questions; they must try to keep a neutral face; commend the pupil for coming to them but tell them that they have to pass this on now.

Teachers with experience of either discovering self-harm, or of pupils disclosing the behaviour to them, told us how they find this 'professional' reaction very hard to do:

*"Young people tell you as a grown up and they expect you to make it better and you know you can't – it's a real strain on teachers... That's why you don't encourage disclosures because you feel you wouldn't be able to cope with them, you feel helpless."*

*"It's really hard to do it by the book – you're supposed to just sit there with a neutral face."*

*"You feel that you come over very cold."*

*"It's hard to follow that advice; you've got your own emotional response to deal with."*

*"You're not meant to show any emotions if they disclose but it's hard... When a girl came to me I just had to give her a hug. .... I asked her 'why, why are you doing this to yourself?' I know it's wrong but it was just the natural thing to do."*

**Pupil facing resources to help teachers better support young people.**

• *80% of teachers say they want clear, practical advice and materials that they can share directly with young people.*

Teachers overwhelmingly ask for specific messages and examples for how to talk about the self-harm that they can share directly with young people. This applies to both broader education around the issue and individual cases.

For individual cases, there is an apparent need for the Child Protection process to have more empathy running right the way through it, especially at the initial point of disclosure/discovery. For example, teachers would like to be given more accessible and comforting language for talking about self-harm with pupils when they encounter individual cases of it. Currently, they are focused more on what they should not say than things they can say.

*"There might be something to be learnt from good models for tackling bullying and loneliness: just giving words and acknowledging what they might be going through."*

## TEACHER PROTECTION.

However, there is a recognised need for teachers to protect themselves emotionally and professionally, and 'passing on' individual cases of self-harm to dedicated Child Protection Officers within the school allows them this.

*"We're accountable to the children... but it will come back to bite us."*

*"I'd be comfortable listening but I wouldn't be comfortable giving advice."*

In particular, teachers believe they lack the training required to help a young person.

*"I prefer to pass these more mental issues on to a professional who has the right training."*

*"We're a kind of Jack of all trades but there are certain things we're not trained to deal with."*

Against this backdrop, it is perhaps unsurprising that teachers report taking a reactive approach to suspected cases of self-harm.

*"You are so worried about handling it badly, that you avoid handling it at all."*

However, the findings detailed above give strong indications that schools not proactively managing and talking openly about self-harm may be creating unnecessary fear around the issue, which could result in young people seeking support in the potentially damaging social media environment, or suffering in silence.

### Teacher training and support.

*"I would like to know more what you can do to help someone going through it. To know what it's like to be in their shoes" Teacher*

Incomplete knowledge and lack of confidence and the appropriate language required to manage self-harm appears to currently prevent teachers from doing more around this issue.

Training (where feasible) could also help teachers to find more accessible and comforting language for talking about self-harm with pupils when they encounter individual cases.

• *72% of teachers surveyed want more training around the issue of self-harm and how to better support young people in the situation.*

Teachers will of course need adequate support to share the emotional burden that may come from taking a more proactive approach. Given the prevalence of self-harm in the population, it is inevitable that some teachers will have self-harmed at some point (just as they may have a history of eating disorders, family alcoholism or drug abuse), and as such, there is a need to be sensitive and ensure support is in place for them.

# CHALLENGES AND NEEDS AMONG PARENTS

The majority of parents are wary of discussing self-harm proactively and many don't feel confident about responding to it if they were to discover it in their own family. A combination of four factors are at work. These are:

## TALKING IS GOOD BUT PARENTS WOULD PREFER OTHERS RAISED IT.

While 78% of parents believe we need to talk about self-harm more as a society, the majority don't feel confident doing so with their own children. Many feel that it is not their role to deliver the news, believing that they don't have the expertise to deal with such a complex subject.

*"You need an awareness without raising the issue and triggering behaviours, does increasing awareness in youngsters make them want to try it out? It may have never crossed their minds before. Or, is it out there anyway and in one way or another they will get exposed to it and is it better that the carers are informed?"*

**SELF-HARM IS SOMETHING THAT HAPPENS TO OTHER PEOPLE'S CHILDREN.**

The idea that one's own child might intentionally injure their own bodies is abhorrent to parents. It is indicative of something so seriously wrong that it almost doesn't bear thinking about. This means there is little proactive discussion of it between young people and their parents, with two thirds stating that there is no need to talk to their children about it.

*"The girls are busy doing their sporting activities so these issues are not something that they are likely to face and because they have not arisen, they haven't been discussed."*

While parents taking part in interviews hoped their children would be comfortable enough to discuss this issue if it was troubling them, it is not something that they would discuss with them as a matter of course.

*"It is well beyond the standard repertoire of parenting issues."*

### Helping parents to feel more confident talking.

The majority of parents are reluctant to raise self-harm proactively with their children, and currently there seems limited interest in help to stimulate these discussions.

However, parents would appreciate reassurance of how to deal with self-harm were it to present itself. They would appreciate simple guidelines about how to discuss self-harm – including specific things they can say, and ways to initiate and respond in conversations, to allay their fear of saying the wrong thing, or making the problem worse.

### An important role for schools.

94% of parents think that self-harm should be discussed in school, however only 18% believe that it is. Parents believe that talking about self-harm in school should be a preventative measure, feeling that it is something that could be more openly discussed and talked about in the curriculum. They also feel that school can be a place to advertise access to support and an opportunity for teachers to identify any occurrence and communicate it to parents.

## SELF-HARM IS ASSOCIATED WITH FAILED PARENTING AND SHAME.

Parents typically associated self-harm with failure as a parent. There is a strong underling fear of judgment: self-harm is considered an 'at-home' activity, thereby parents feel the blame will be placed on the home environment and themselves. Indeed, parents spoke negatively of other parents whose children self-harmed.

*"Is it bad parenting? If your child's doing that why is it? Is it something in the family? There must be an underlying problem for it to be happening."*

*"It happens to kids with Mums and Dads who are working all the time and have no time for their kids."*

*"[I associate self-harm with] broken homes, a lack of love and bad parenting."*

A mother who had experienced self-harm within her family told of her tremendous guilt that a teacher was the one to notice and not her.

*"Unfortunately I didn't notice, it was a teacher at school who noticed it. She was cutting her thighs so obviously I didn't see it... Her sister said some catty things I think to try and make me notice my daughter's thigh, it was her trying to say something without grassing her up... I did feel really guilty and appalled that I hadn't noticed that she was at that stage. I didn't speak to anyone, I think because I felt inadequate as a parent I kept it quiet. I felt sort of that I'd failed... it's only in the last year that we talk about feelings."*

### Tackling stigma and shame associated with self-harm.

There is scope to reduce the sense of stigma and shame that many parents associate with having a child who self-harms, by challenging the assumption that there is usually a link with problems at home. (A systematic review found no evidence for a relationship between adolescent self-harm and negativity in the home climate[1])

This message is potentially reassuring for parents whose children are engaging in self-harm – and may encourage parents to feel more confident about seeking outside help.

### On- and offline resources to equip parents to understand and discuss the issue.

Parents need targeted information on understanding self-harm, addressing the sense of shame and guilt associated with it and how to support young people who are self-harming. Parents need off- and online resources to turn to which provide clarity on what self-harm is, why young people self-harm, and how they can provide and get additional support.

The internet is often a first port of call for information about self-harm or how to deal with it and is often the only means by which parents gather information. They need to be offered reassurance and practical advice online, to help their child manage the emotions and any other issues associated with the self-harming behaviour.

Parents networks such as Netmums, Mumsnet, Dadstalk and lifestyle magazines should also be utilised to raise some of the sensitive issues around supporting a child who may be or is self-harming.

[1](Michelson D, et al. Int Rev Psychiatry. 2012; 24(2):106-14)

## FEAR ATTACHED TO GETTING HELP.

While nine out of ten parents recognise the best way to recover from self-harm is by getting outside support, many are frightened to let the issue 'out of the home' - over a third saying they would not seek professional help. Their reluctance stems from a fear that it could make things worse for their child, either because of social stigma (particularly around going to the school for support), a belief that it could 'tip the child over the edge', and for some parents, it would signal their failure as a parent.

*"I don't know if you'd want too many people to find out about it, it might affect the thought process of your child."*

*'I didn't speak to anyone, I think because I felt inadequate as a parent I kept it quiet, so I felt sort of that I'd failed so I kept it quiet'*

These findings suggest uncertainty around the effectiveness of health care professionals and schools to support their child and themselves, further compounding the fear parents feel regarding their child doing it.

*"There's nothing out there for help, even from your GP. Even if you went to your GP they would probably say it's depression or there's an issue at home, so where do you go from there, you're stuck, you just have to deal with it and I imagine that's really hard to deal with."*

However, those that had experience of seeking outside support for self-harm reported positive experiences of getting professional help:

*"I don't think we would have got where we are without outside help. I don't think you can deal with it by yourself."*

Clearly, parents need support too if they find their child is self-harming.

*"It would be good to have support groups or blogs so that you feel, it's not just me. So you don't think, is it something I've done? If you are listening to other people you realise there are people in worse situations - which gives you a little bit of a boost"*

# CHALLENGES AND NEEDS AMONG GPS/HCPS

While 86% of GPs would be comfortable talking about self-harm and what it means with a young person, Health Care Professionals (both GPs and other frontline Health Care professionals) face significant challenges in effectively managing self-harm behaviour.

## LIMITED TIME.

The biggest challenge for almost all GPs (96%) is unsurprisingly that the consultation time is not long enough to deal with the issue. Significant time pressures on front line A&E staff mean they can only treat the physical trauma and not the underlying cause/issues.

*"The physical injury they present with is usually very easy to treat during the consultation, but getting to the root of the problem is often much harder to do." A&E Physician*

## YOUNG PEOPLE'S RELUCTANCE TO TALK.

94% of GPs also find that young people not wanting to talk about self-harm is a challenge. This is naturally a greater challenge in instances where the young person who self-harms has not presented themselves, but has been brought in by a concerned relative/friend or referred from A&E.

A major challenge for both GPs and other non-mental-health professionals is to build rapport as young people who self-harm are felt to be defensive and reluctant to share, which is hugely compounded by the limited time of consultations.

Consequently it is recognised that GPs may need to take a challenging/questioning tone too quickly and then fail to elicit a 'helpful' (to them) response.

*"There are always complex underlying issues and within a 10 minute consultation it is difficult to even begin to unravel the problems. Discomfort stems from the lack of time and resources to help there and then, it will need a lot more input than I can immediately manage." GP*

*"Direct questioning is a bit difficult, time consuming; there is not enough time in surgery." GP*

65% of GPs say they want patient information leaflets for them to disseminate. These could be used to support conversations in sometimes difficult consultations with young people who self-harm.

## DIFFICULT TO IDENTIFY WITH A YOUNG PERSON WHO SELF-HARMS.

While specialist Health Care Professionals, both mental health and non-mental health professionals, have a better understanding of young people who self-harm and the reasons behind it than the average GP, understanding between individuals is still variable (especially for non-mental health professionals) and they still find developing a rapport challenging.

In spite of empathy towards young people who self-harms, a lack of understanding can make it difficult to build relationships and get to the root or issues.

*"I think it's difficult because sometimes you can't, on a personal level, fully understand why somebody did it to themselves." Psychologist*

*"I think GPs get very anxious very quickly when they see a young person self-harming... I think they feel uncomfortable in terms of their knowledge and understanding of it, which is why we tend to get referrals quite quickly and they tend to be posted as 'urgent'." Psychologist*

**Greater emphasis on GP / A&E education to differentiate self-harm and suicidal intent.**

While physicians need to be aware of the risks associated with self-harm behaviour, creating greater distance and differentiation between the two issues, or better equipping physicians to identify those truly at suicide risk, is likely to facilitate better conversation and encourage physicians to uncover underlying motivations (fostering greater understanding), without the fear of opening up a discussion about suicide which they do not feel equipped to handle.

## LACK OF COMMON LANGUAGE.

Three in five GPs report they are concerned that they do not know what language to use when talking to a young person about self-harm. It is also difficult for the Health Care Professionals in A&E to engage with a young person who self-harms as they lack a common language, which makes broaching a sensitive topic challenging, with the possibility of further alienation rather than engagement if there is miscommunication.

*"I often feel out of touch with the 'language' of what young people talk about these days." GP*

*"I am not always sure how I should pitch the chat with them, in terms of trying to find out what's causing them to be so upset or hurt." GP*

## LIMITED REFERRING OPTIONS.

88% of GPs feel that referral options within the community are insufficient and three quarters lack the necessary assessment tools and guidelines. Overwhelmingly, referrals centre on CAMHS (95%) and counselling services (72%), where available.

Referral options become especially limited once a patient reaches adulthood and can no longer be referred to CAMHs. In this instance, only patients with a co-morbid mental health condition can be referred to adult services.

A&E physicians (and other hospital based Health Care Professionals) also have the option to refer 'internally' as appropriate, e.g. younger patients (under 16) can be referred to paediatric inpatient services for follow up, or adult patients requiring supervision can be held in hospital and seen by psychiatric staff more quickly.

However, GPs and other front line staff are aware that the referral process within the community is often lengthy (sometimes several months) and this can lead to them selecting what are deemed to be more 'urgent' cases for referral to inappropriate acute resources where they know they will be seen more quickly (rather than following the appropriate community referrals. i.e. to CAMHS or counselling services). It is acknowledged that not all patients over 16 years of age presenting for self-harm will be offered a referral due to strains on available services, or lack of clarity as to where to refer, and even once a patient has been referred, follow up visits are very often infrequent.

## Better referral options.

GPs need comprehensive information on who to refer young people to and how, including information on both statutory and voluntary organisations.

• *79% would like to know which voluntary organisations they could refer to.*

GPs felt that more voluntary organisations in the community which patients could access without referral would help increase the numbers of patients seeking treatment for self-harm, without the stigma associated with seeing a medical professional.

*"I would develop a service that isn't set within a mental-health environment, is in the community, that young people can access without having to worry about the stigma attached to coming to a mental-health service." Psychologist*

## Access to talking therapies.

GPs also need improved access to talking therapies for young people, provided by both the statutory and voluntary sectors.

• *77% would like better access to talking therapies (counselling, CBT).*

## The transition to adulthood.

Referral options to services become especially limited once a patient reaches adulthood and can no longer be referred to CAMHs. This is part of a broader issue where young people with mental health problems can get lost in the transition from CAMHS to AMHS services. Mental health services from both children's and adult services should create joint assessment teams to develop joint transition plans for young people. To ensure smooth transitions to adult support services, the young people they work with should be centrally involved in this process.

## LACK OF RELEVANT INFORMATION, TRAINING AND RESOURCES.

There is limited specific knowledge of or use of self-harm guidelines which means that most Health Care Professionals use their intuition alone when managing self-harm patients.

- 45% of GPs never use NICE guidelines.
- 75% of GPs have never used an Integrated Care Pathway for Self-harm decision making chart.

DSM and ICD type criteria are familiar to mental-health professionals who took part in interviews (and much of the content is agreed with), but there is little familiarity with these types of criteria in primary care.

Differences between front line professionals and mental health teams in how they classify and talk about self-harm can serve to further complicate the referral process as mental-health teams sometimes feel patients are referred to them inappropriately, based on the guidelines referenced in tertiary care. For example, psychiatric professionals receiving referrals for isolated incidences of self-harm (rather than the multiple times the incident is required to have occurred by DSM criteria); different classifications in primary care as to what constitutes minor or moderate self-injury.

Where GPs are aware of or have access to guidelines, only 38% of them find these resources useful. The more commonly used resources among primary care (the PHQ-9 and baseline suicide risk assessment screen) are not specifically tailored towards self-harm, which may limit their applicability.

*"Each patient is different and sometimes the questions and guidelines fail to serve their purpose." GP*

*"Very often the PHQ9 is completed as a box ticking exercise which interferes with the consultation process." GP*

Additionally, 85% of GPs have never had any training specifically related to self-harm, which appears consistent across other front line professionals (e.g. A&E) included in the research. Training offered is non-compulsory and requires a proactive psychologist/mental-health professional to set up and offer the training course. Medical students reported only receiving training as part of a psychiatric rotation. There was firm belief across all non-mental health professionals that they would benefit from further training on self-harm issues.

## VALUABLE RESOURCES TO AID HEALTH CARE PROFESSIONALS IN MANAGING SELF-HARM.

### Training.

A general increase in education and awareness for the public and Health Care Professionals alike is felt by HCPs to be key in identifying and thus helping young people who self-harm.

*"Ensuring that professionals who come across young people who self-harm in the Health Service have at least a minimum education on this [would help], I'm sure there's room for improvement there." Paediatrician*

Increasing understanding of why young people self-harm, and how GPs can support young people who do, should be covered in initial GP training and should also be available as modules in CPD training.

- 74% would welcome online Continuous Professional Development modules focusing on self-harm.

### Assessment tools.

GPs also need more guidance on how to use assessment tools, NICE guidelines and Integrated Care Pathways. 60% want improved guidelines (more tailored towards self-harm) and more generally, GPs want better education on the guidelines and tools that are currently available, and assistance in implementing these pathways.

They also need more support with how these assessment tools can support the consultation, support and referral process. Having more uniformity between front-line professionals and mental health teams in how they classify and talk about self-harm would help to simplify the referral process.

## AREAS FOR FUTURE RESEARCH.

1. Understanding in greater depth and detail what practical measures and resources currently available to front line staff are actually proven to drive success in reducing/stopping self-harm among young people. (This would provide a good benchmark or starting point for development of new services and resources.)
2. What would be the real life impact on the availability of more voluntary/charitable support services (e.g. drop-in centres) for young people in terms of:

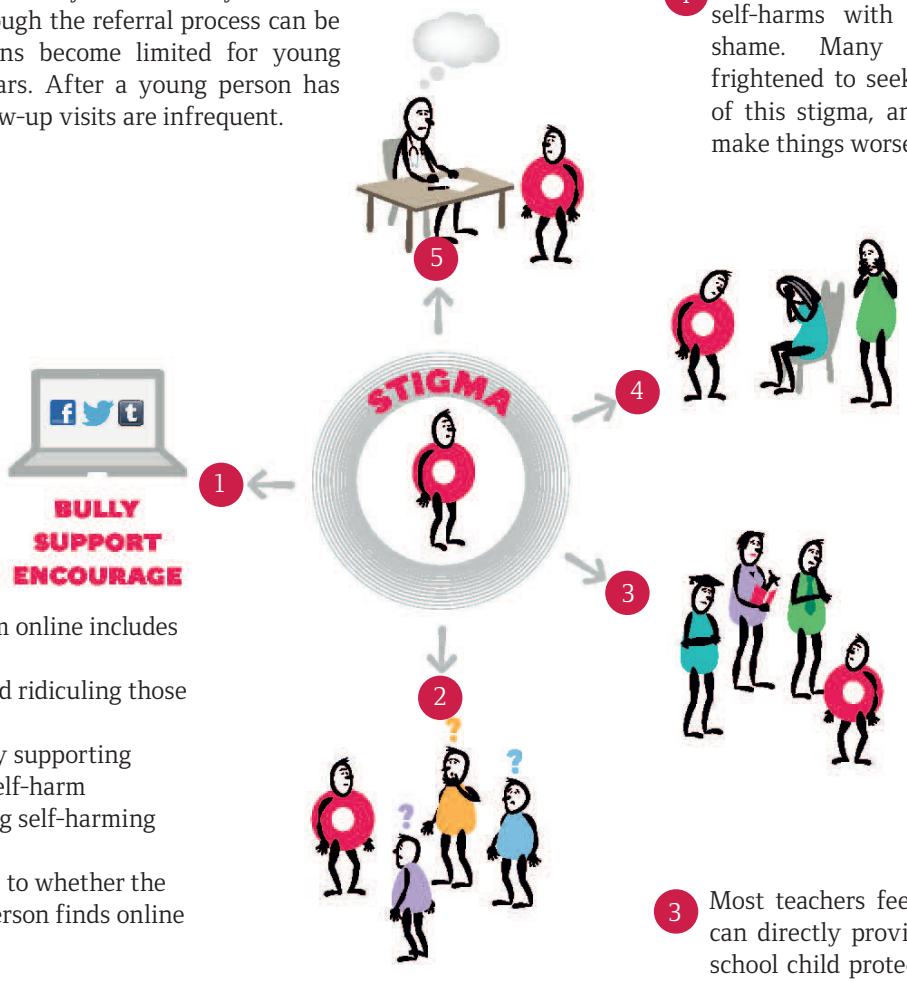
   **a.** Number of patient presentations for help

   **b.** Physicians' attitudes towards managing self-harm.

# SUMMARY OF THE CURRENT SITUATION

5 GPs struggle to build rapport with young people who self-harm and the majority feel concerned that they do not know what language to use during consultations. They will normally refer the young person although the referral process can be lengthy and options become limited for young people post 16 years. After a young person has been referred, follow-up visits are infrequent.

4 Parents associate having a child who self-harms with failed parenting and shame. Many are reluctant and frightened to seek outside help because of this stigma, and a fear that it could make things worse for their child.




1 The picture of self-harm online includes information that can;

- Bully – mocking and ridiculing those who self-harm
- Support – genuinely supporting young people who self-harm

Encourage – inciting self-harming behaviour

It's a game of chance as to whether the information a young person finds online is helpful or harmful.

2 A young person's friends find their peers self-harming very concerning but don't feel equipped to help. They feel that it's the school's role to prepare them better.

3 Most teachers feel limited in how they can directly provide support because of school child protection policies, and due to a lack of knowledge and skills. The designated Child Protection Officer within the school will typically contact parents and outside agencies if a pupil is known to be self-harming.

## CONCLUDING REMARKS:

All the key groups in this research – GPs, parents, teachers and young people - overwhelmingly believe that learning to cope with the negative emotions, explicitly through finding support, is the main reason that young people manage to stop harming themselves. However, only 1 in 10 young people feel comfortable seeking advice from professionals or family, although half actually feel this is where they should be going.

The vast majority of people in our research are in favour of schools, the NHS and families talking more about self-harm so that young people feel able to talk to them about it. Parents, teachers, GPs and young people also want to be equipped to have conversations if needed. Conversely, the belief that a more open dialogue about self-harm would lead to an increase in cases, e.g. due to raising awareness glamorising the behaviour and those who do it, is only held by a tiny minority.

Our research has shown that there is an unmet need and appetite for the lines of communication and support to be opened, to close the gap between where young people feel comfortable seeking advice and where they think they should be going. People need the permission, knowledge, and the tools and language to provide support.

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