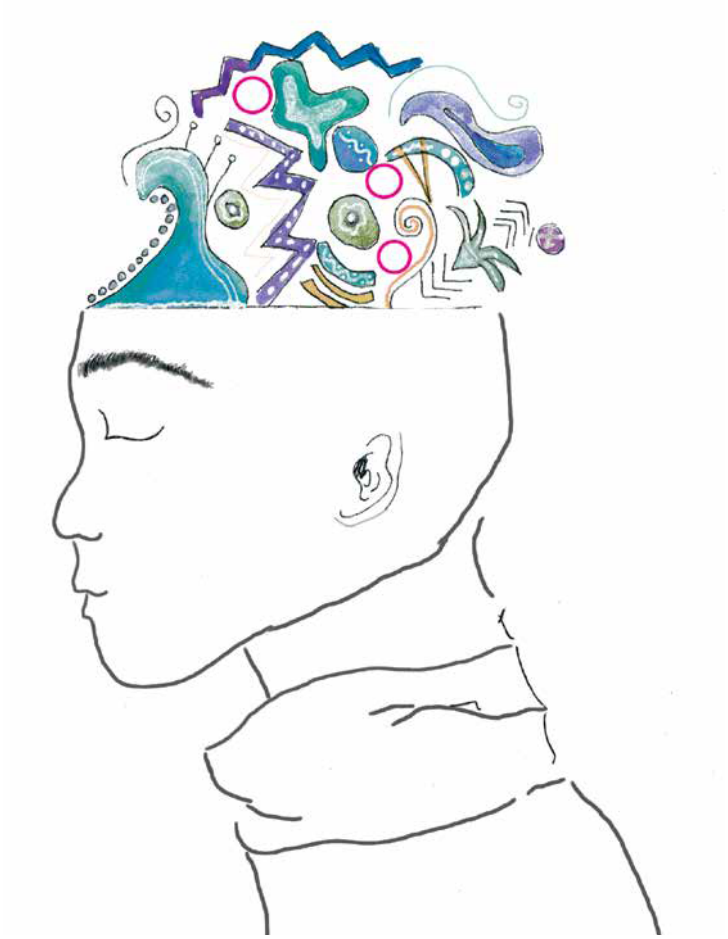
Emotional Health and Wellbeing



Picture with thanks and acknowledgement to the Somerset young people who developed the LifeHacks resource.

Looking through the lens of self-harm

Annual Report of the Director of Public Health for Somerset 2018

Contents

Foreword

The emotional resilience of our population is important to us all. It is particularly important to the development of a young person progressing into adult life. The recent national focus on mental health has been a huge step forward in helping to dispel some of the myths and stigma associated with it, but there is still a significant way to go before mental health, and the services associated with it, are given the same level of attention as physical health.

Many of us can give a good account of what we should be doing to improve our physical health, but there has been far less focus on improving our emotional health and resilience and ensuring we have the skills to cope with the stresses and strains of everyday life and the responsibilities it holds.

One indicator of emotional resilience is the level of self-harm amongst the population. In 2016/17 there were 1,371 emergency admissions to hospital for self-harm across the whole Somerset population, but our understanding of the issue has been limited. Many people have a preconceived idea of what self-harm is and the possible reasons for it, but the issue is far from simple; in fact it's really complex. Because of this, it's important that we try to understand it more, starting with a definition that we could all use. The National Institute for Health and Care Excellence (NICE) uses the following definition:

"Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress."[1]

There are lots of facts and figures in this report and it does help with our understanding of self-harm in a small way, but the figures do not tell the whole story; they merely help us to raise the issue and indicate where there is a need for more work and more understanding.

In short, this is the first chapter of the story. Hopefully, it will capture the attention of the reader sufficiently to want to understand more, to want to help raise the profile of this largely hidden issue and to want to help do their bit to improve emotional resilience, particularly of our young people.

This year, I have used the Annual Public Health Report to try and achieve three things. Firstly, to gain a greater understanding of self-harm; secondly, to raise the profile of this issue in order to help tackle to stigma associated with it; and thirdly, to raise the importance of us all developing and maintaining our skills to cope appropriately with the stressors of everyday life.

The data supplement (APHR statistical annex) that accompanies this report can be found at the following link: http://www.somerset.gov.uk/organisation/departments/public-health/

Trudi Grant, MSc PH, UKPHR, FFPH
Director of Public Health, Somerset County Council

Introduction

Emotional resilience is our ability to adapt to stressful situations and cope with life's ups and downs. The word 'resilience' actually comes from the Latin word 'resilio' which means to 'bounce back'. Resilience does not take away life's difficulties, but it is what helps us to deal with problems and live through challenging times. A resilient person bends rather than breaks under pressure; is flexible and adaptable, rather than rigid and resistant. A resilient group or community also flexes and responds to adversity, supporting and protecting its most vulnerable members.

Positive indicators for community resilience include levels of social connectedness, which these days can include digital connectedness as well as people-to-people connectedness; the amount of support we have or feel we have from others around us, or conversely, how alone or isolated we feel; and levels of acts of kindness to others through formal or spontaneous voluntary actions.

Of course, things do not always turn out well, and there are some less positive measures we can look at to understand how resilient we are as a nation or a community. The most well-known indicator is the rate of death by suicide. Rates of suicide are monitored locally and nationally for just this reason. Whilst each individual death is a personal tragedy, the overall rate or trend of suicide tells a story about the health of our community and the hidden challenges which lie beneath the surface. Self-harm is another such indicator. Levels of self- harm also tell us a story. They tell us about levels of acute distress, about unhappiness and about a desire for things to be different. Each individual act of self-harm tells a story but all of those stories together say something very powerful.

In Somerset we have seen an increase in presentations for self-harm in our hospitals. We also know that levels of emotional distress and self-harm among young people is something which is of increasing concern, to parents, to schools and to young people themselves. This report looks at the issue of emotional health and wellbeing, through the lens of self-harm, as a way of understanding more clearly these needs and experiences and how we might work with young people, their parents, teachers and others to better promote positive emotional health and wellbeing and resilience. What is self-harm? How prevalent is it? And what does this tell us about the emotional health and wellbeing of children and young people in Somerset?

What is self-harm?

The nature and context of self-harm

Self-harm is a significant health issue which impacts not only on the wellbeing of the individual, but also on friends, families and communities, together with an impact on health, education, social care and criminal justice services.

Definitions of self-harm

Definitions of self-harm are numerous and vary but a short definition is provided by the National Institute for Health and Clinical Excellence (NICE) defining self-harm as:

'an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress'

The Royal College of Psychiatrists state that at a wider level, self-harm *"may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs".*

Self-harm is a universal phenomenon which crosses all cultures, ethnicities, creeds and classes.

Self-harm is not usually an attempt to complete suicide (although it is considered a risk factor of suicide) or seek attention, but a way of expressing deep, emotional feelings, such as low self-esteem. It can also be a way to cope with traumatic events or situations, such as the death of a loved one, or an abusive relationship.

Self-harm may include:

- swallowing poisonous substances
- non-lethal overdoses
- cutting your skin
- burning your skin (usually with cigarettes)
- scratching or picking at your skin
- biting, including severe nail biting
- hitting or punching either yourself or an object
- punching and banging against things
- deliberately breaking your bones
- embedding items in the skin
- pulling out your hair

The National Preventing Suicide in England Strategy and the recent Public Health England Suicide Prevention Planning Guidance, highlights that self-harm, including attempted suicide, is the single biggest indicator of suicide risk. Similarly, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness indicated that self-harm was reported in 52% of under 20s who completed suicide[2].

The need to improve knowledge and good practice in supporting children and young people who self-harm needs to be a golden thread through all efforts to improve the mental health and emotional wellbeing of children and young people. This requires a whole system approach to look at self-harm both as a coping mechanism and as a risk factor to suicide.

Within this context, addressing self-harm in children and young people is recognised as a national priority[3]. A recent YoungMinds report on 'Talking self-harm'[4] reports that that:

- 1 in 12 children and young people are said to self-harm
- Over the past 10 years inpatient submissions for young people who self-harm has increased by 68%
- In females under 25 years admissions have increased by 77% in the last 10 years
- 77% of young people feel they don't know who to turn to with questions about self help
- 97% of young people believe that self-harm should be addressed in schools
- UK is thought to have the highest rates in Europe

The Somerset Transformation Plan for Children and Young People's Mental Health and Wellbeing (2015-2020) sets out the strategic direction, vision and principles for the changes to Child and Adolescent Mental Health Services. Self-harm is addressed within this plan as a key area for concern. The plan states that this should be seen within the context of mental health promotion, the emotional health and wellbeing agenda and action to prevent self-harming behaviours in the first place.

'WHY I SELF-HARM'

- STATEMENTS FROM SERVICE USERS

Below are a series of statements provided by young people about why they self-harm:

"To convey feelings difficult to put into words"

"To express experiences as something visible"

"To replace emotional pain with physical pain"

"To escape traumatic memories"

"To stop feeling numb, disconnected or dissociated"

"To express suicidal feelings and thoughts, without completing suicide"

"To communicate severe distress"

Source: Salford University Training Day "Reducing and Identifying the Risk of Self-Harm"

Reasons for self-harming behaviour

It is often difficult to understand why people self-harm, reasons can be complex and individual. Some people have said that by deliberately hurting themselves they are

temporarily able to change their state of mind to better cope with painful feelings. Self-harm in these cases seems to provide a mechanism for dealing with intense emotional pain. Individuals report that the behaviour can help them to cope with negative feelings and to feel more in control. Others report feelings of wanting to punish themselves. Self-harm can be a way of relieving overwhelming feelings that build up inside, when people feel isolated, angry, guilty or desperate. However, acts of self-ham can also lead to a burden of emotional guilt and secrecy which can have a negative effect on a child, young person or adults' ability to build and maintain relationships. This compounds the problems even more. Self-harming can also become a pattern of addictive behaviour.

Some reasons given for self-harm among young people include:

- being bullied
- not getting on with parents
- stress and worry about academic performance and examinations
- parental separation or divorce
- bereavement and loss
- relationship breakdown
- illness or health problems
- unwanted pregnancy
- experience of abuse including sexual abuse
- difficulties with sexuality
- low self-esteem
- feelings of being rejected.
- pressure from social media

A person is more likely to harm themselves if they feel:

- people don’t listen to them
- hopeless
- isolated, alone
- out of control
- powerless – it feels as though there's nothing they can do to change anything.

People who self-harm usually try to keep it a secret from their friends and family. They often injure themselves in places that can be easily hidden by clothing, and they are very careful to hide the damage and scars.

Signs of self-harm include:

- signs of depression, such as low mood, tearfulness, a lack of motivation or interest in anything, or a lack of energy
- signs of low self-esteem, such as blaming themselves for any problems, or thinking they are not good enough for something.
- unexplained cuts, bruises or cigarette burns, usually on the wrists, arms, thighs and chest
- insisting on always keeping covered, even in hot weather

Dispelling the myths

Despite its prevalence and impact, our understanding of self-harm is incomplete and remains surrounded by myths and misconceptions.

Most commonly there is a belief that self-harm is an 'attention seeking behaviour'. Given that most self-harm is carried out in private and over a long period before help is sought, this is an unhelpful myth that often leads to a young person feeling more alone and not listened to.

Another belief is that people who self-harm must enjoy it. There is no evidence that people who self-harm feel pain differently from anyone else. The harming behaviour often causes people great pain. For some, being depressed has left them numb and they want to feel anything to remind them they are alive, even if it hurts. Others have described this pain as punishment.

The secrecy surrounding self-harm has led to a level of stigma that limits understanding and prevents a more open dialogue which would enable young people to access the support they need.

The Young Minds and Cello[5] report highlighted the following challenges:

- A third of parents would not seek professionals help if their child was self-harming
- Half of GPs feel they don't understand young people who self-harm and their motivations
- 1 in 3 teachers don't know what to say to a young person who self-harms

The question we **should** be asking is not

"Why would you do that to yourself?"

but

"What led you to feel the need to hurt yourself?"

"You don't need to understand to listen and try to support me."

(Young Person with experience of self-harming)

What do we know about self-harm in Somerset?

Statistical definition of self-harm

Before moving on to discuss what we know about self-harm locally, it is important that we have a good understanding of what is measured.

In England, emergency hospital admissions are used as proxy for the prevalence of self-harm. It is, however, widely recognised that these hospital admissions do not reflect the true scale of self-harm. As discussed above, self-harm is often a hidden behaviour, which makes estimating the true prevalence difficult. It has been suggested that 'community occurring self-harm' is far more prevalent than self-harm as measured by admissions[6].

In the self-harm statistics, admissions attributed to a different main cause, such as drugs and alcohol, are usually excluded in public health analysis, but there may be a fine line between these presenting issues for admissions.

Self-harm has been highlighted as an issue across the south-west region with only one upper-tier/unitary area, North Somerset, that is not significantly worse than England; this is true of all ages and of young people. Furthermore, it is a Somerset issue; the Somerset statistics for self-harm admissions are significantly higher than both the England and the south west average.

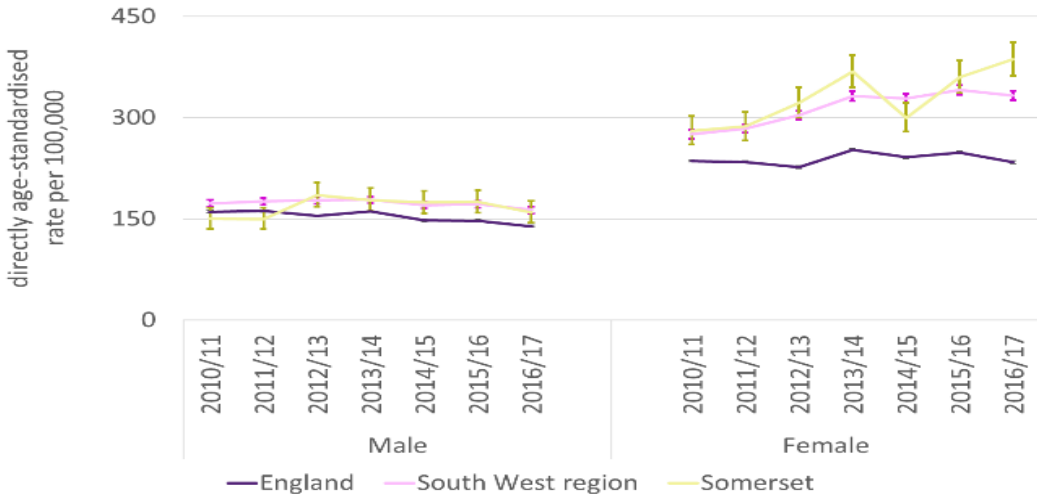
Self-harm admissions in Somerset

As can be seen from the graph below, many of the admissions are of younger age groups and this will be explored in more detail later. Probably as you would expect, almost all admissions for intentional self-harm were emergency admissions. We will focus the rest of this analysis predominantly on emergency admissions unless otherwise stated.

Published data from the Public Health Outcomes Framework (PHOF)[7] allows the Somerset levels of admissions for self-harm to be compared against national and regional data. Figure 1 shows Somerset's emergency self-harm admissions rates for all ages per 100,000 population. Somerset rates are significantly higher than the national rate for both males and females. The female rate is most concerning, being higher than the national and south-west rates and showing an increasing trend over time. Somerset had the 14th highest female rate of all upper tier local authorities in England (152 in total) for 2016/17, with the male rate being 55th.

Figure 1 illustrates that while the issue of self-harm is of concern for both males and females, the numbers and the rates are significantly higher for girls and women. In the next sections we have used other sources of data to investigate further.

Figure 1: Emergency hospital admissions for self-harm trend over time by sex, 2010/11 - 2016/17

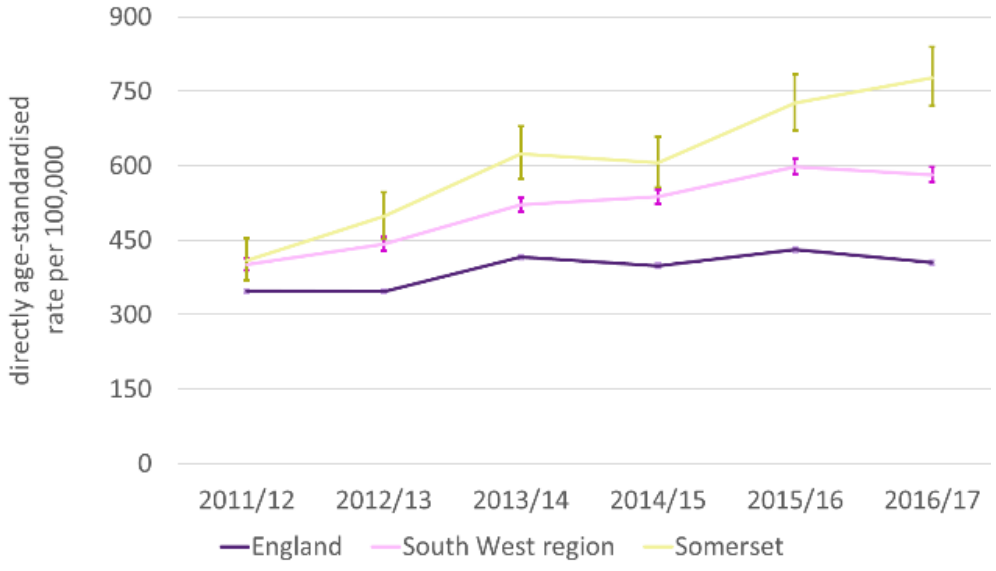


(Source - Public Health England, Public Health Outcomes Framework)

Young people's self-harm admissions

We can use the Public Health England Child Health Profile, for people aged 10-24, to investigate the patterns of admission broken down by age (but not sex) in a little more detail. The definition is similar, but includes all admissions, not just emergencies. As seen in Figure 2, Somerset's rates are consistently higher than the England and regional averages. Somerset has the fourth highest rate of hospital admissions for the 10-24 age group out of the 152 upper tier local authorities.

Figure 2: All hospital admissions for self-harm of young people (aged 10-24) trend over time, 2011/12 - 2016/17

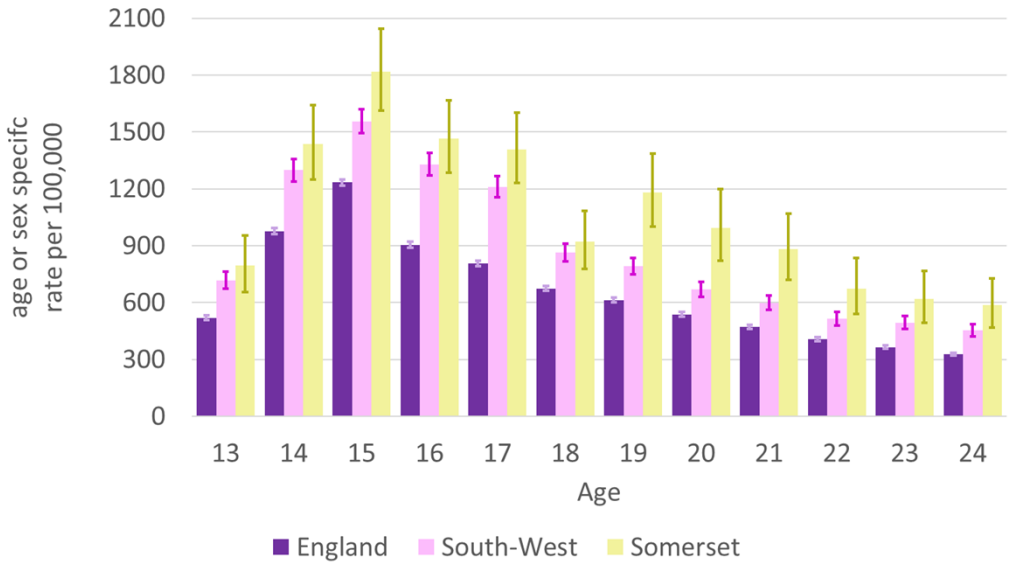


(Source - Public Health England, Child Health Profile)

So far we have only considered the total number of admissions, rather than the number of people admitted. A data source called 'Hospital Episode Statistics' allows us to consider the number of people admitted. We have examined the period 2013/14 and 2017/18 for emergency admissions with a main cause of intentional self-harm.[8] The findings back up the picture we have so far.

Females are around twice as likely to be admitted than males, and young people aged 15-24 are the most likely age group to be admitted. Interestingly, the 45-54 and 55+ Somerset rates are similar to the rates for England and, statistically speaking, significantly lower than the south-west rates. Figure 3, showing the admissions broken down by both age and sex, demonstrates that the difference between the sexes is marked in the younger age groups (10–14 and 15–24). This difference is not seen to the same extent in the older age groups.

Figure 3: Individuals with an emergency self-harm admission per year by ten-year age-sex bands - 2013/14 - 2017/18



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Looking at single years of age (Figure 4) allows a more detailed look at the rates within the 15-24 age band. Emergency self-harm presentations by children under the age of 14 years are fortunately small and therefore have been suppressed for under the age of 13 years.

As can be seen in Figure 4 there is a distinct pattern of presentation for girls. Presentation for girls start to rise at around 13 years. The rates rise to a peak at age 15 and then decline year-on-year. This pattern of presentation is mirrored for England and the south-west. However, the Somerset rates for girls and young women are significantly higher for each year of age than for peers across England. No similar pattern is seen for boys.

Figure 4: People aged 15-24 with an emergency admission for self-harm per year by sex and single year of age - 2013/14 - 2017/18

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Re-admission ratios (repeat admissions to hospital)

Re-admission ratios allow us to measure repeat admissions and are simply the number of admissions divided by the number of people. A ratio of 1 would mean that everyone who was admitted at all was admitted only once; a ratio of 2 means that everyone was admitted twice in a year, and so on.

Table 1 looks at re-admission ratios amongst those people who have at least one re-admission in the same financial year. This shows that re-admissions for self-harm are lower in Somerset than both the national and regional ratios.

Table 1: Self-harm emergency re-admission ratios for self-harm amongst people with re-admissions

	England	South west	Somerset
Re-admissions ratio amongst people with 1+ re-admission per year	1.25	1.25	1.19

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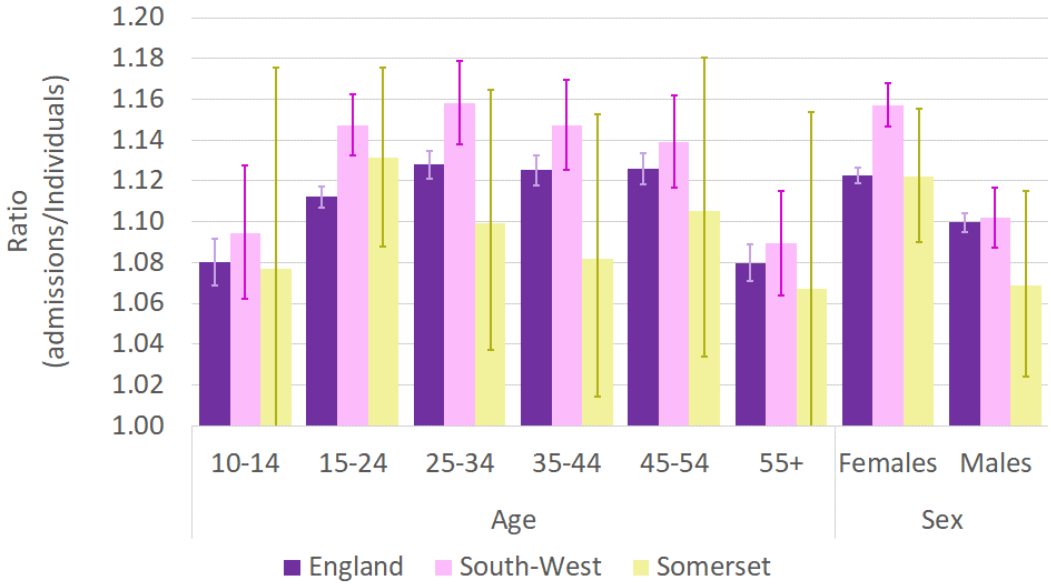
Figure 5 shows that in Somerset, for younger age groups (especially 15-24) more people are admitted to hospital each year for self-harm but on average fewer have a repeat admission in Somerset. This finding goes some way to helping us understand the overall rates of admission for self-harm. It now seems unlikely that the higher rates in Somerset are as a result of more people being admitted more often.

Figure 5: Self-harm emergency re-admission ratios per year by 10 year age bands and by sex, 2013/14 - 2017/18



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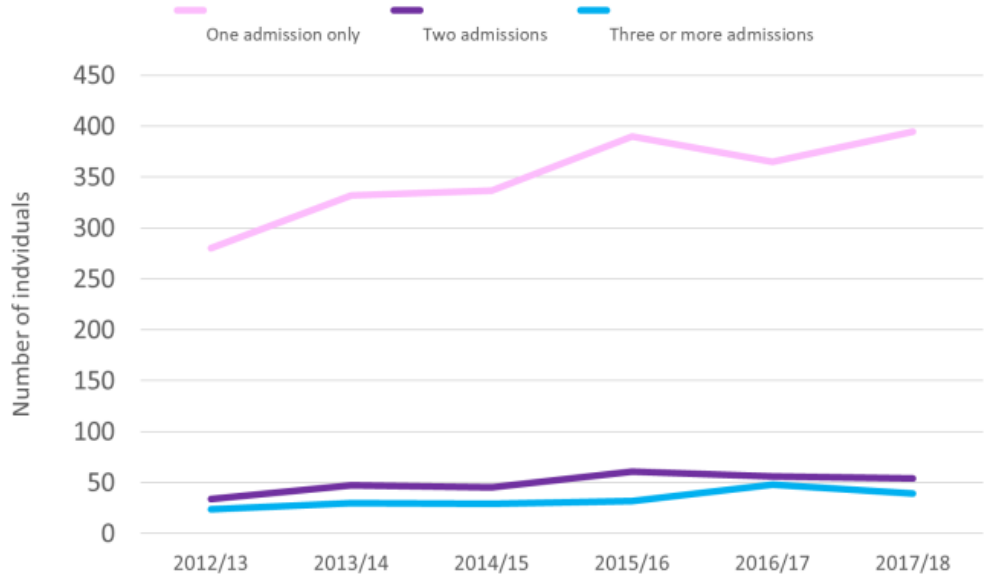
Specifically looking at the number of self-harm admissions for 10-24 year olds, Figure 6 shows a higher and increasing number of young people have one admission only; those with two or more admissions has stayed relatively low and constant over time. It would seem from this evidence that single admissions are driving increased rates in Somerset.

Figure 6: Number of self-harm admissions for young people aged 10 – 24



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Emergency admissions for self-harm - methods

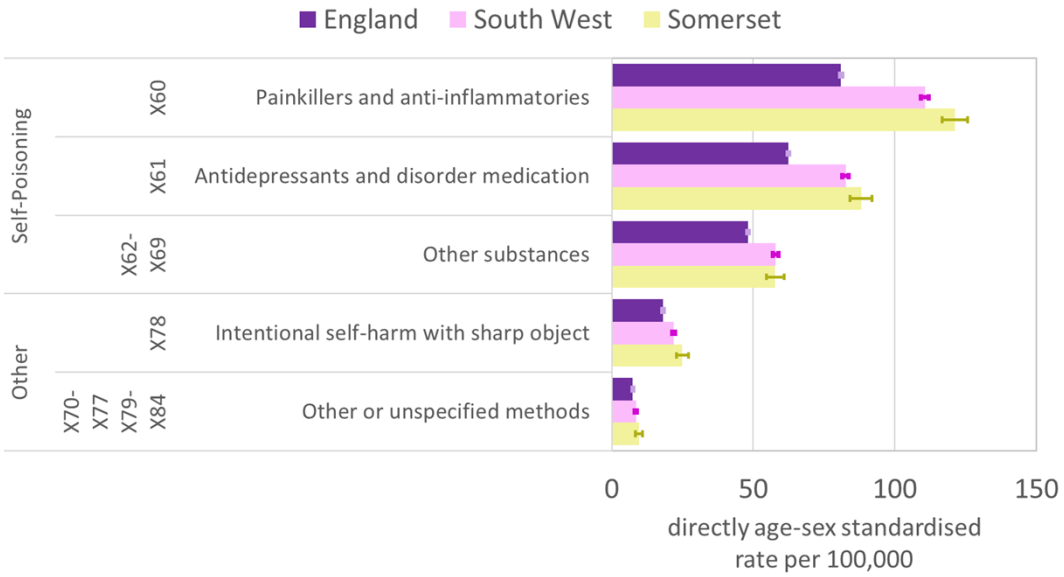
Turning our attention to the types of self-harm that warrant a hospital admission, it is important to understand the main codes used in hospitals that make up the national self-harm indicator.

The analysis of self-harm methods is based on admissions not individuals, because the same people may present with different methods of self-harm at different times. These methods are given different ICD10 (International Clarification of Disease) codes. This allows national and international comparisons to be made.

Figure 7 shows the emergency admissions to hospital by the recorded method of self-harm. Somerset admission rates are significantly higher than England for all methods. In Somerset there are annually about 1,350 emergency admissions against all of the codes for self-harm. The highest, approximately 1,200 emergency self-harm admissions (89% of all presentations in Somerset) are due to self-poisoning, sometimes referred to as overdose.

The ICD-10 codes are very detailed and medical , particularly in the case of some of the poisoning codes. Therefore, although not an official definition, code X60 (intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics) can be thought of as overdoses due to over the counter medications such as paracetamol, ibuprofen and aspirin. Similarly code X61 (intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified) can be thought of as anti-depressants and anti-disorder medication for conditions, such as Parkinson's and Epilepsy. The largest group of presentations for self-harm due to poisoning in Somerset, is coded as x60, those which are over the counter medicines such as paracetamol, aspirin and ibuprofen.

Figure 7: Emergency hospital admissions (all ages) for self-harm by method, 2013/14 - 2017/18



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Emergency admissions for self-harm by all methods are most common for females aged 15-24. In addition, Somerset has significantly higher rates for females in this age group when compared to England across all methods.

Admission due to overdose as a result of painkillers and anti-inflammatories, and admissions as a result of intentional harm with sharp objects, were higher for females aged 15-24. Rates for younger females aged 10-14 are also attributable to these methods. The rate for males aged 15-24 admitted due to overdose as a result of painkillers are also significantly higher than for England. However, the rate for girls of this age locally is still more than three and half times higher than for boys.

It should be noted that the guidance for paracetamol overdoses was changed in 2012 (this is a change to guidance, not coding of admissions, so we do not see a commensurate fall in another type of admission). Bateman et al. (2014) found that:

'There was a significant increase in the number of admissions following the implementation of this guidance estimating an increase from 31.1 per 1,000 to 49.0 per 1,000.'[9]

Naryan et al.[10] found that

'Changes to the management guidelines for paracetamol poisoning in September 2012....have particularly increased paediatric hospital admissions for paracetamol poisoning.'[11]

This change of guidance was applicable nationally and may account for some of the overall upwards trend for this method of self-harm, but it does not explain why Somerset has significantly higher admission rates than nationally.

Although the admission rates of self-harm with sharp objects are smaller, they should not be overlooked: these too are significantly higher in Somerset for 15-24 year olds and for females aged 10-14 than the south-west and England averages.

In Somerset, 40% of individuals with an emergency admission due to intentional self-harm with a sharp object also had one due to self-poisoning in the same year. However, only 4% of those with self-poisoning were also admitted for self-harm with a sharp object. This suggests that two in five people who cut themselves (seriously enough to be admitted) will also take an overdose, while someone with a self-poisoning admission is very unlikely (3 in 100) to also have an admission caused by self-harm with sharp objects[12].

Self-harm and social deprivation

We have already looked at patterns of self-harm admissions by age, gender and method. We can also look at patterns within Somerset by geographical spread and the social deprivation.

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to

measure a broad concept of multiple deprivation, made up of several distinct dimensions, or domains of deprivation.[13] We can investigate admissions for self-harm to see if there is an association with deprivation.

Figure 8 and Figure 9 show that emergency self-harm admissions are statistically significantly higher in more deprived communities. People living in the most deprived 20% of Somerset (quintile 1) are two and a half times more likely to be admitted for self-harm than people living in in the least deprived 20% (quintile 5).

Figure 8: Self-harm emergency admissions (all ages) by deprivation within Somerset, 2012/13 – 2017/18

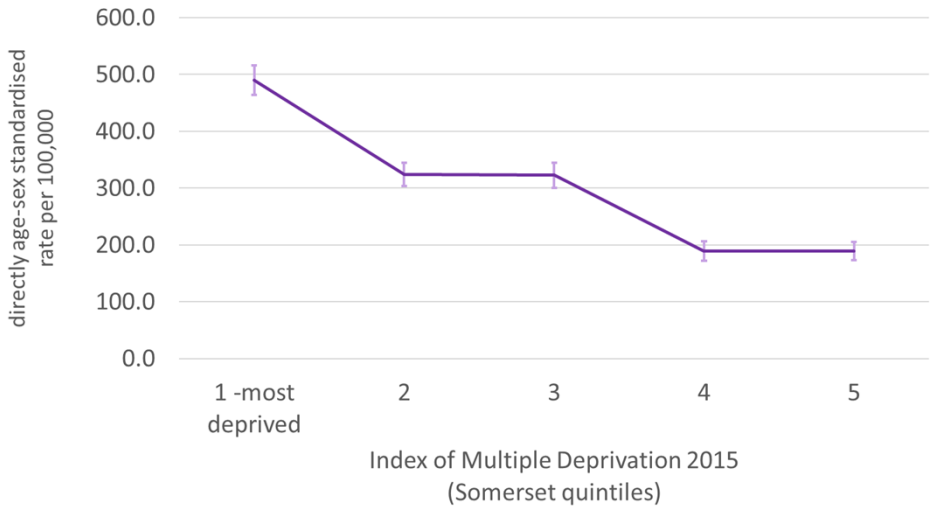

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Figure 9: Self-harm emergency admissions all ages by deprivation within Somerset, 2012/13 – 2017/18

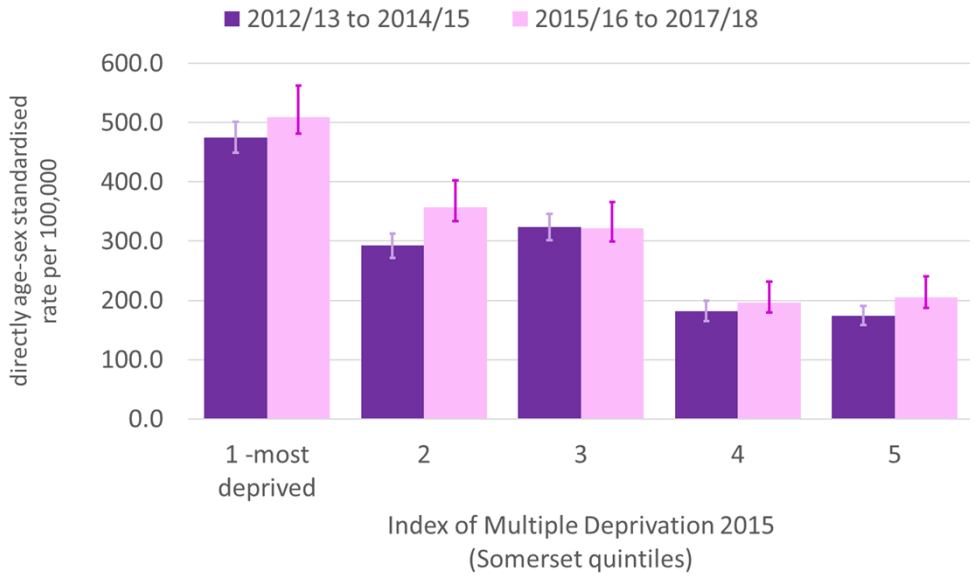

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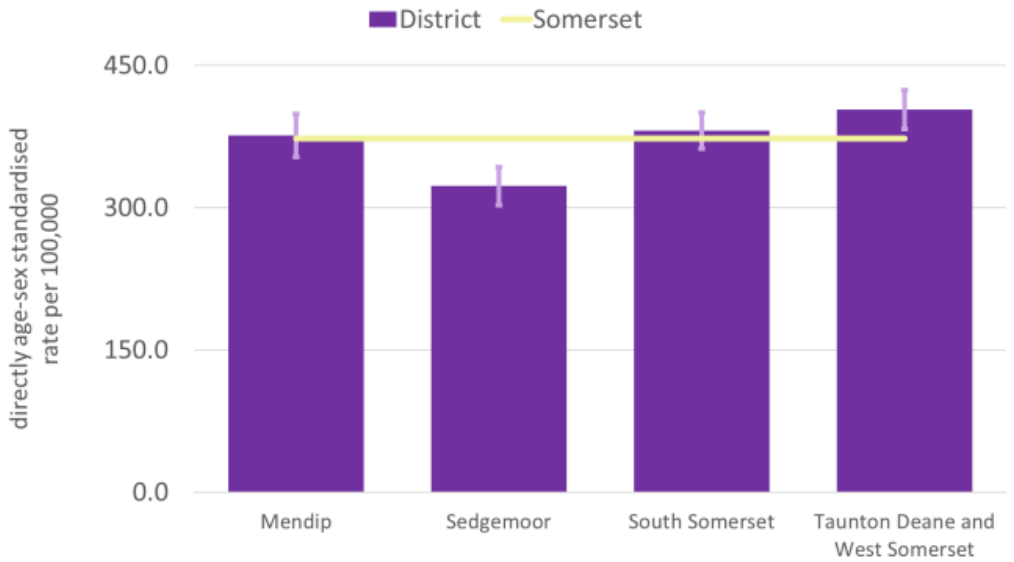
Figure 9 shows how rates for each of the deprivation quintiles have changed between the three-year pooled periods, 2012/13-2014/15 and 2015/16-2017/18. Whilst there is an upward trend between the two time points, for almost all the quintiles, this is only a statistically significant difference in quintile 2.

More detailed analysis[14] which examines the data by age and sex, finds two distinct patterns. There have been statistically significant increases amongst young people aged 15-24 of both sexes in the most deprived quintile and amongst females aged 10-14 and 15-24 in the second-most deprived quintile. However, there have also been statistically significant increases for young women aged 15-24 and 25-34 in the least deprived areas. Self-harm is currently predominantly higher in in more socially deprived areas but it is also increasing in the least deprived areas of the county.

Self-harm emergency admissions by district

We can also look at the differences in rates of hospital admissions between districts. (West Somerset has been combined with Taunton Deane due to small numbers). Figure 10 shows there are significantly lower rates of admissions from Sedgemoor when compared to the Somerset average (this is particularly seen for females aged 15-34); and significantly higher rates for Taunton Deane and West Somerset (the cumulative effect of slightly higher rates in all age-sex groups).

Figure 10: Individuals (all ages) with an emergency hospital admission for self-harm 2013/14 - 2017/18



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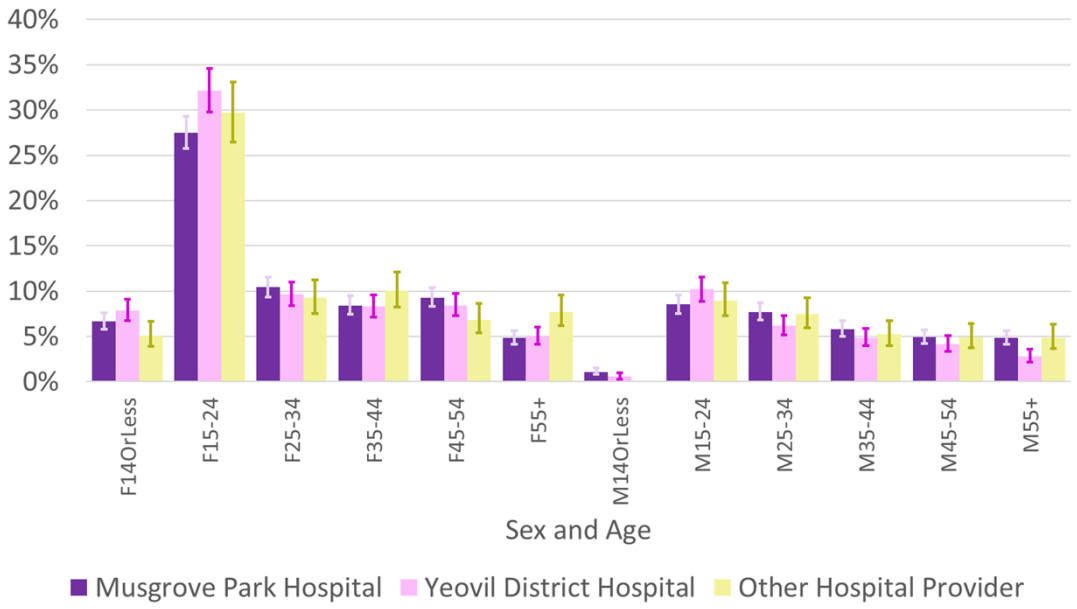
As can be seen in Figure 11, there is little difference in admission rates for self-harm to each of the local NHS hospital trusts, with the highest proportion of admissions to all hospitals being amongst females aged 15-24.

Figure 11: The proportion of emergency hospital admission of Somerset residents for self-harm by age-sex bands and NHS hospital trust 2013/14 - 2017/18



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Gaps in our understanding

This analysis uses information available to us to understand patterns of self-harm. However, we recognise that there are significant gaps in our knowledge, particularly because we cannot link the data held by different organisations. Some areas that we would like to understand further are:

- The overall prevalence of self-harm in the population
- Self-harm amongst vulnerable and protected groups
- The patterns and reasons behind self-harm behaviours
- Links with specialist services such as mental health, substance misuse and domestic abuse services.
- Correlations with other diagnoses
- The links between self-harm and suicide
- Self-harm method and life-course approach.
- Discharge destination
- Multi-method presentations[15],[16]

What are people telling us about self-harm and mental health?

The discussion so far has been based on hospital presentations, which does not give us much information about other types of presentation or need. To get a deeper understanding we need to listen to the people who have experienced self-harm, to parents and to people working in related support services.

The experience of children and young people

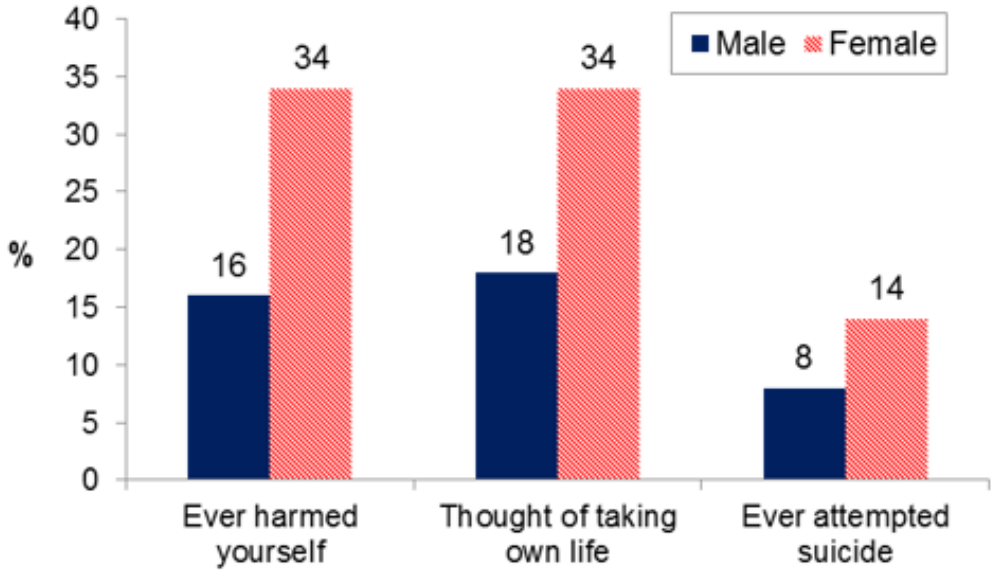
Self-harm is one of the questions included in the Somerset Children and Young People Survey[17] and is probably the best source of information we have about the overall prevalence of self-harming behaviour among Somerset young people. In Spring 2018, this survey found that 28% of secondary school aged girls, and 19% of boys at least sometimes dealt with a worrying problem by hurting themselves (Figure 12).

These figures are similar to findings in the 2016 survey, where a rather differently phrased question gave figures of 34% for girls and 16% of boys having 'ever harmed yourself' (Figure 13). Importantly, these figures are consistent with the view that self-harm is more widespread than is covered by emergency admissions alone.

Figure 12: Percentage of secondary pupils responding that, when they are struggling/ feel bad or stressed/have a problem that worries them, they at least 'sometimes' deal with it by the means described above

	Boys		Girls	
1	Spending time on the computer/ gaming etc.	89	Relaxing (e.g. listening to music, being active etc.)	91
2	Relaxing (e.g. listening to music, being active etc.)	89	Crying	88
3	Speaking to/confronting the person who is causing you to worry	56	Speaking to/confronting the person who is causing you to worry	56
4	Lashing out in anger (verbally or physically)	55	Lashing out in anger (verbally or physically)	52
5	Crying	45	Spending time on the computer/ gaming etc.	52
6	Eating more	37	Eating less	49
7	Eating less	24	Eating more	47
8	Hurting themselves in some way	19	Hurting themselves in some way	28
9	Drinking alcohol	10	Drinking alcohol	15
10	Smoking	8	Smoking	10
11	Taking drugs	6	Taking drugs	6

Figure 13: Self-reported self-harm and suicidal thoughts for Somerset schoolchildren 2016



Source: SCYPS/SHEU

The experience of parents

Parents need access to information and resources to help them to understand and respond to the needs of their children. Seeing your child deeply unhappy or in acute emotional distress is extremely challenging. Fear and stigma associated with mental health problems, and with behaviours such as self-harm, make things even harder. And of course, parents feel a sense of guilt or failure, however misplaced this may be. As the 'Cello' report says:

'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.'[18]

The experience of professionals

In compiling this report, we have talked to a range of professionals, four themes emerged from these discussions. These are outlined below.

Self-harm is a complex – and it has many forms

Whilst self-harm is usually taken to be cutting oneself and self-poisoning, it can also take other forms. The self-harm will inevitably be a symptom of other issues, worries and concerns. It's not an easy subject to talk about and not all professionals feel equipped to respond.

'National research in 2012 found 53% of GPs thought that self-harm had increased, with only 4% thinking it was in decline. 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.'[19]

Having a better understanding of the different needs behind self-harm and the patterns of presentation will be helpful in formulating an appropriate response. We can see, for example, even from this limited analysis that there is a peak of presentation for young women at around 15 years of age, the majority of which do not appear to re-present.

Self-harm as a response to increasing pressure on young people

Anecdotally, teachers, health professionals and others have said that there is increasing evidence of difficulties due to emotional distress and mental health problems among young people in Somerset. Professionals attribute this anecdotally to:

- overall, increased stress and pressure for children and young people from the internal and external expectations of a modern world
- the impact of social media (evidence suggests that social media contributes 25% to the shaping of young people's views on self-harm, albeit significantly less than the 45% from talking to friends)
- the need to perform well academically

The perception of increasing mental health problems may, of course, also reflect the greater willingness to discuss mental health problems and so be, counterintuitively, a 'good thing'.

If stress is indeed a causal factor, there are a range of steps which can be taken to support young people, schools and families to understand and manage stress better and to develop both individual and group resilience.

Furthermore, whilst raised as an issue of concern, it should also be noted that social media can also be source of support and social interaction, particularly in more rural sparsely populated areas. This was a finding from the qualitative research done by the Rural Youth Project to support the 2014-15 Joint Strategic Needs Assessment[20].

The complexity of 'the system' - difficulty finding information and help

Parents, children and teachers have said repeatedly that they find it difficult to know where to turn for help in relation to emotional distress and mental health problems, and more broadly how they support teenagers struggling with the normal challenges of adolescence and guiding them towards appropriate coping mechanisms when in distress. Dr Alex Murray told us that many GPs find a typical appointment slot far too short to deal with self-harm appropriately, and they need more information on where to refer young people who harm themselves, especially those who do not reach the threshold for CAMHS.

For self-harm specifically 'nearly four in five young people say they don't know where to turn'[21].

This is something which, particularly in the digital age, we should certainly be able to do something about.

Thresholds and access to support

Self-harm is for the most part perceived as a mental health problem and there is a general frustration about access to help, and as Dr Alex Murray told us:

'If they find the door is closed they may not ask again.'

The expectation is held, quite widely, that this should come from the Child and Adolescent Service (CAMHS). We have heard some say that, 'you have to attempt suicide to get treatment'. A CQC report in 2018[22] found that 50% of CAMHS referrals were rejected as inappropriate, although usually this involved reference to other, more appropriate services.

CAMHS, however, are services for children and young people who require specialist treatment for a mental health problem and not all young people who are self-harming have a mental health problem. They are experiencing distress, they are hurting, they may be confused, fearful, angry and sad; but the fact that the majority of hospital presentations are single episodes tells us that we should not over-medicalise this issue but understand it and respond more effectively in other ways.

Of course, intervention needs to be appropriate and timely and there are examples where appropriate support could reduce the demand at the higher levels. As an example:

'A troubled young man was harming himself, and was taken to A&E. This environment only added to his distress and his behaviour led to him being arrested and charged. Only after conviction did he get the therapy he needed to deal with the root cause.'

What have we learnt so far?

Self-harm is a complex issue and one which is of concern to young people, their families and their teachers. The profile of CAMHS may lead professionals and parents to think of CAMHS as the provider and may feel that they have missed out on treatment if they are directed elsewhere; even if this redirection is more appropriate for addressing their needs. In conducting the research for this report we heard concerns that people admitted to hospital for self-harm who, after assessment, are judged not to require CAMHS, may not have ready access to the other forms of support. CAMHS reports that the percentage of children who harm themselves and are admitted, that don't meet the tier 3 or enhanced outreach services, is relatively low. While the lack of a clear 'step-down' services from CAMHS is something that we heard expressed strongly. There was a view that services other than CAMHS are patchy in coverage, uncoordinated and often under-resourced. Support for both parents and carers and young people around self-harm, were acknowledged as needing to be more robust.

It seems that overdoses, especially of paracetamol and especially by young women, lie behind both Somerset's higher rates and its recent increase. Most of the presentations

are a single occurrence, and there is a much smaller proportion of individuals who repeatedly harm-themselves to the extent that they need to be admitted to hospital.

The relatively large number of young women who find themselves in such distress that they take an overdose is an issue of concern, and one which needs to be appropriately addressed. We must also not forget that this is an issue for all ages, for some boys and men.

The cohort of regular, frequent and repeated presentations for self-harm is comparatively small and initial analysis suggests that the majority of this group are already known to and receiving help from mental health services, GPs, social workers or schoolteachers.

How can we promote and protect the mental health of children and young people in Somerset?

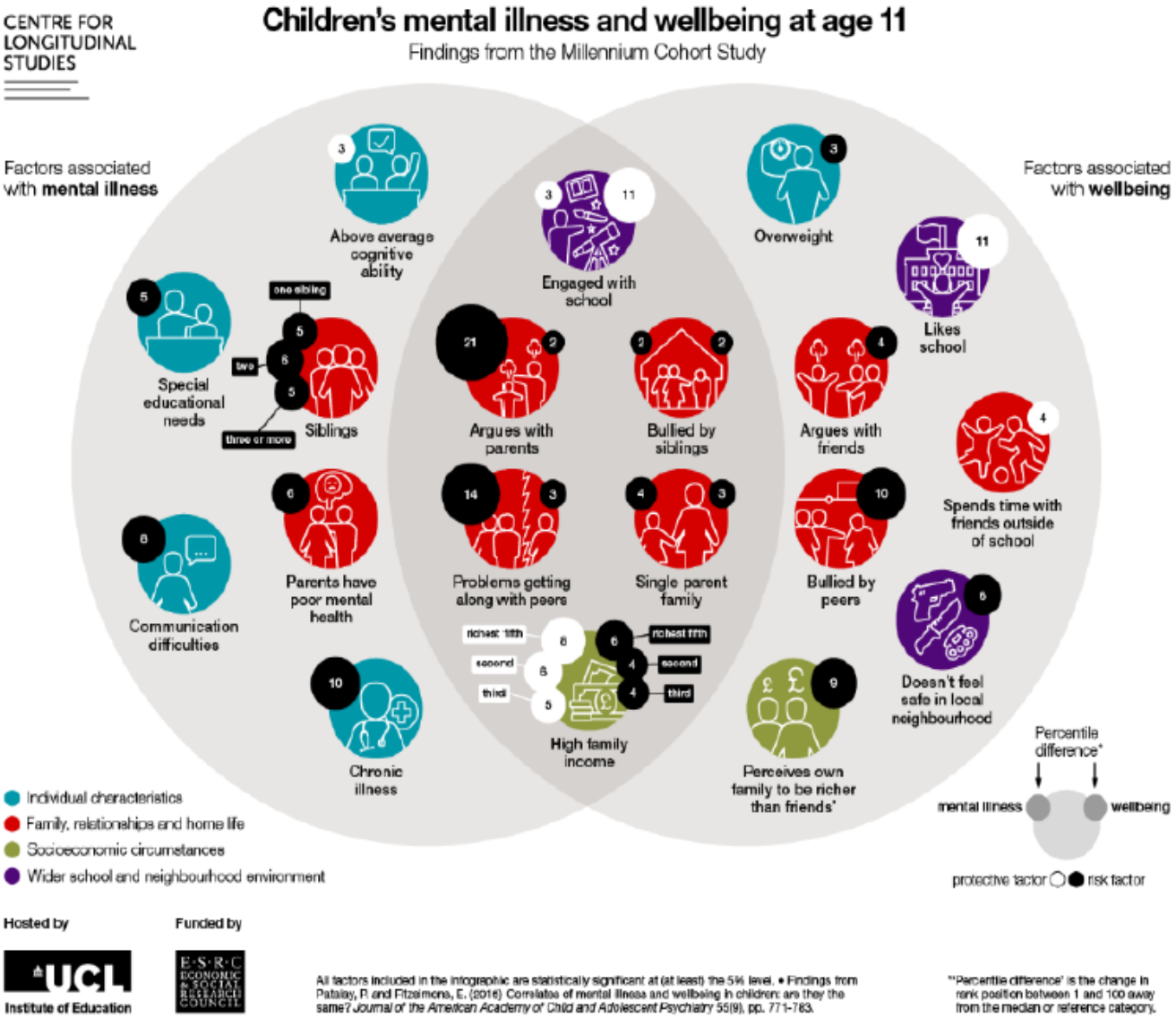
Mental health is central to all health and wellbeing. It is defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, as individuals and as communities. Good mental health is more than the absence of mental illness - it is the foundation for wellbeing. It is something you have to take care of, rather than take for granted. It is based on creating the right conditions for good mental health and wellbeing and on ensuring early interventions are in place when things start to go wrong. Improving mental health goes hand in hand with improving physical health for children and young people. Evidence and action to promote and protect positive mental health is clearly set out the in Positive Mental Health for Somerset Strategy (2014) and the national Prevention Concordat for Better Mental Health (2017).

Protective and risk factors

It is important to focus both on the factors that help promote mental health, as well as to reduce the risk factors that damage mental health. Good mental health allows children and young people to develop the resilience, referred to earlier in this report, to cope with whatever life throws at them and grow into well-rounded, healthy adults.

Figure 14 illustrates the interplay between intrinsic factors such as 'enjoying school'; external factors such as being bullied; biological factors such as being overweight; development factors such special educational needs; social factors such friends and family; and socioeconomic factors such as poverty. It is important to note that whilst there is considerable overlap, there is also significant difference between the absence of mental ill-health and positive wellbeing.

Figure 14: Protective and Risk Factors for Children



Prevention

Professor Sir Michael Rutter, renowned Child Psychiatrist, suggests we should think about resilience in the same way that we think about biology. If you want to protect people against infections, you don't put them in a cocoon and stop them ever having contact with bacteria and viruses - you expose them. But you expose them in ways that they can cope with, either through natural exposure or through vaccination. So the psychological equivalent is to say: what could we do to enable children to cope successfully with hazards? Because challenges, stress – that's part of growing up and you have to learn to cope, and the only way you learn is through exposure, but in small 'safe' doses.

Evidence from a series of reports examining the prevalence of Adverse Childhood Experiences (ACEs)[23] in the Welsh adult population and their impact on health and wellbeing across the life course shows that there are key resilience assets that **every** child benefits from. These include experience of: *adult availability*, *a range of opportunities, being treated fairly, culturally engaged, having supportive friends and having good role models.*

This research is echoed in the work developed by The Centre of Resilience for Social Justice at the University of Brighton, where they have developed the Boing Boing Resilience Framework for schools and educational settings, which identifies similar assets that promote resilience such as *having a sense belonging* and *being valued*. This also chimes with the work developed in 2017 by Reading University's Andy Research Clinic around the Pillars of Wellbeing: *Purpose, Relationships and Lifestyle.*

Work undertaken in Somerset in partnership with primary, middle, secondary and special schools, as well as pupil referral units, has taken this approach, resulting in the Somerset Wellbeing Framework.[20]

The framework has been developed to support schools to promote a whole-school approach to mental health and wellbeing, based on resilience and community building for staff, pupils and families. What this translates to is a conscious and fundamental shift in how schools respond to the children and young people in their setting with much greater emphasis, at a universal level, on building resilience.

Somerset County Council's Public Health Team has worked with schools to pull together the key findings from this work and to develop the framework as a whole-school approach. The key features of the framework are:

- Developing a sense of belonging and connectedness with the place you go to school; where you feel safe, valued and where you are enabled to develop a sense of purpose
- Building positive and caring relationships where children and young people have a voice, are heard and listened to by the adults around them and are given the opportunity to develop and practice emotional literacy
- Development of individual skills around self-care and a deeper understanding of how to promote/support wellbeing for yourself and others
- Access to the right information at the right time which is appropriately aimed at young people and includes ways to enhance wellbeing, prepare for times of stress and organisations that young people can contact
- Availability of suitable/relevant/expert services and resources when they are needed including staff with good levels of awareness and understanding around mental health, promoting resilience and managing young people's mental health behaviours including self-harm
- All of the above linked to wider community of the schools including parents and adults within children and young people's services

The main reason teachers say young people *stop* self-harming is that they learn to cope better with the emotions associated with it. There is an 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.

The framework also includes targeted support with access to help for those that need more:

- Skilled staff and wellbeing leads
- Prompt identification of children and young people that need more
- Appropriate school-based intervention
- Links to local specialist provision
- Reviewing and monitoring mechanisms.[24]

The Somerset Wellbeing Framework uses the 'eight principles' model developed by Public Health England (Figure 15) to achieve a holistic approach to wellbeing. The principles underpin an effective whole-school approach and provide the scaffolding needed to cover every aspect of school life.

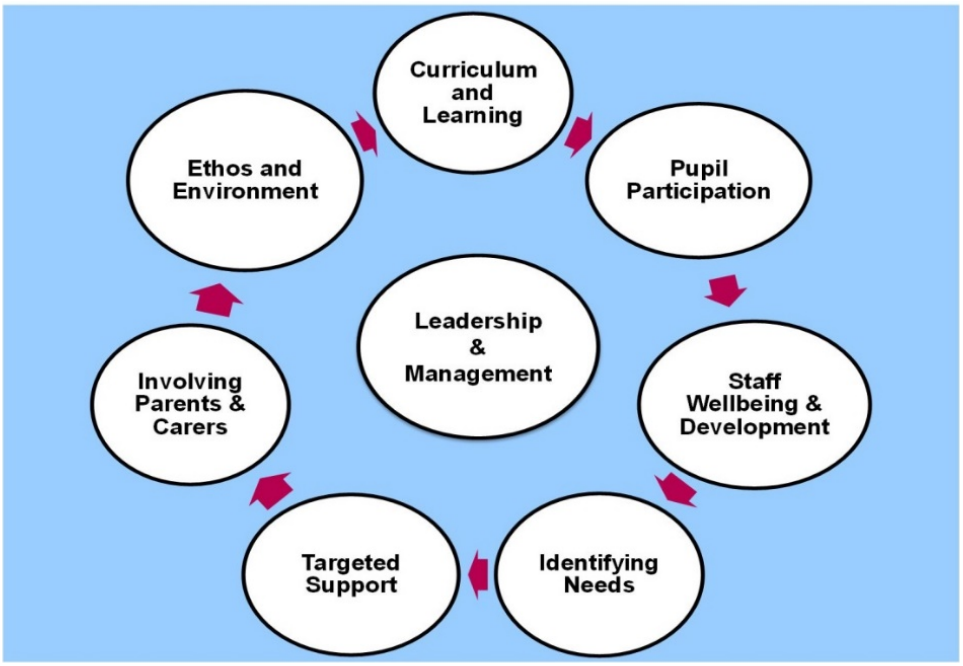
'I feel positive about this work and difference it will make to the children and families in my school. It provides a great framework for improving what we do and there seems to be much more join up and clarity about where we can get additional support.'

Head Teacher - Primary School

'Mental and emotional health has become a real issue in recent years and we know it is something we have to prioritise if we want the best out of young people. This framework will help us to gauge where we are and what more we can do.'

Deputy Head – Secondary School

Figure 15: Eight principles of a whole school approach



The latest research about promoting wellbeing suggests that there are some basic building blocks that have a real impact and - practiced from an early age - will provide a strong foundation for children and young people's emotional health. The pillars (Figure 16) are framed around three areas that coincide with the school year:

- developing a sense of belonging
- forming and sustaining positive relationships
- adopting healthy lifestyles.

Schools, alongside families, are well placed to provide the support children and young people need to explore and develop these pillars and the public health team, alongside partner organisations and children services, will support schools in this approach to improving young people's mental health.

The importance of schools as a setting within which to promote and protect mental health has been identified nationally and additional resources are being made available for schools through the NHS; these will focus on early intervention and whole school approaches for positive mental health.

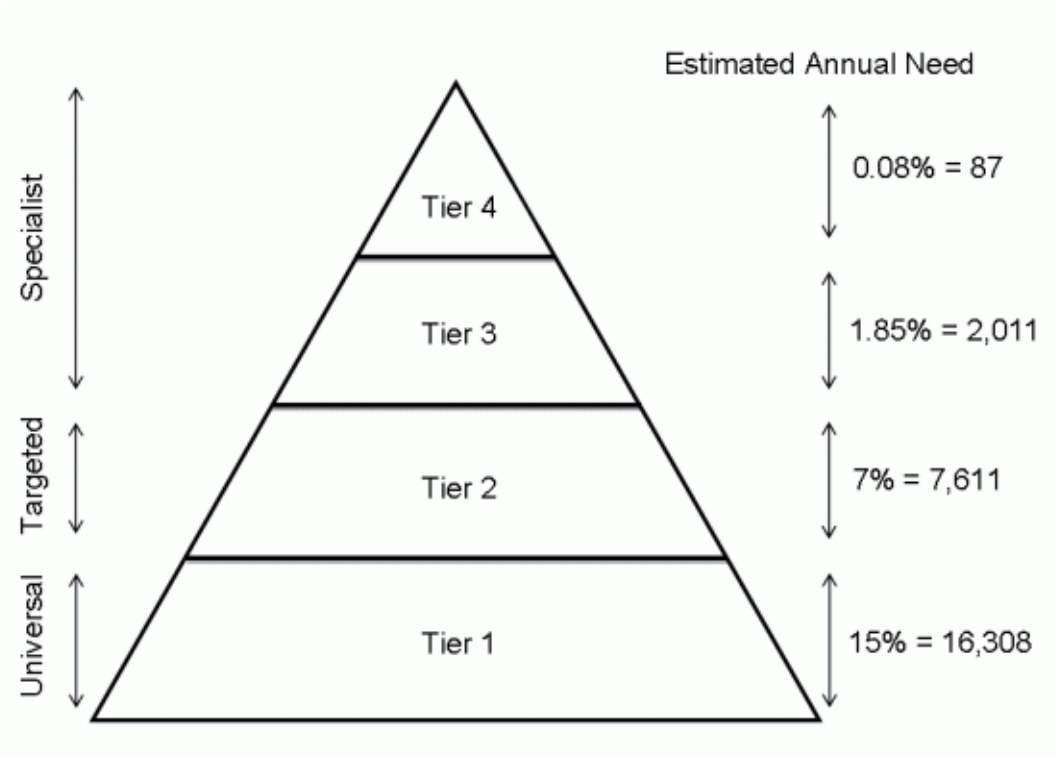
Figure 16: Three Pillars of Wellbeing

Sources of support

Whilst prevention is extremely important, so is access to timely and appropriate help and support. As we have seen, children and young people's mental health is everybody's business – not just the business of specialist services. Help and support can be found in many forms and settings; in schools and communities, as well as health, social care and voluntary settings. Sometimes the most effective help and support comes informally from family and friends. The most common activity amongst secondary pupils when they have a problem that worried them is 'playing computer games' (boys) and 'playing music' (girls). 'Talking to someone about it' comes third. As Dr Alex Murray told us, having the time and opportunity for such self-management may be enough for some to make it through a difficult patch and of course, increasingly help and support is sought on line: indeed, often only the most serious and recurrent self-harm is ever seen by GPs.

The idea of a 'pyramid of need' is a way of understanding the level and frequency of need and demand. It reflects the fact that most people are healthy, most of the time, and that numbers affected by increasingly serious conditions decline in rough proportion to their seriousness: more people have colds than pneumonia, for example. Recently, national guidance has moved away from this 'tiered' approach to looking at the emotional and mental health needs of young people, as it is considered that it supports a rather 'silo'd' view of need, which is, of course, more fluid than a fixed diagram can describe. However, we have included it here to illustrate the very different levels of need and demand, which increase in intensity as they decrease in number.

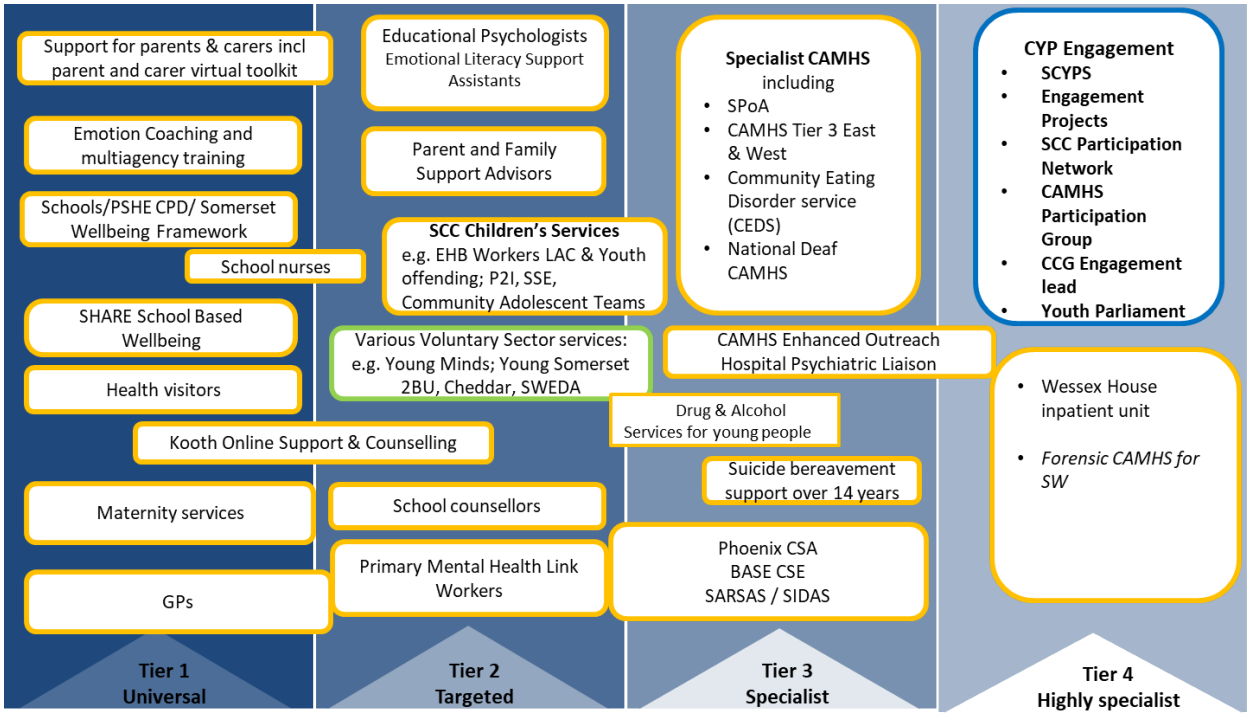
Figure 17: Mental health need in Somerset (0 – 18 years)



Source: http://www.somersetintelligence.org.uk/mental-health-cyp/

Figure 18, below, describes a range of different interventions, resources and support services which are available in Somerset to meet these different levels of need. This is by no means all that is available, but it serves to illustrate both the range of provision and something of the complexity which makes it difficult for young people, parents and teachers to work out where to go for help.

Figure 18: Emotional health and wellbeing support services for children and young people in Somerset



Some other important sources of help

Emotion coaching

Emotion Coaching is a programme which teaches pupils and their teachers the principles of resilience and stress management. Year 8 students in schools who received Emotion Coaching are more likely to be able to say 'no' to someone who is asking them to do something that they don't want to do (66% vs. 59%). Teachers who have engaged with the programme have reported more effective management of emotional and behavioural issues at school.

LifeHacks

Young people in Somerset have helped developed 'lifehacks' to support themselves and each other.

"We've been thinking about how to help ourselves manage our mental health and how to help our friends when they're struggling too. So we've come

'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.'

up with a set of LifeHacks to help you and your friends to keep mentally healthy!"[25]

Online support

Social media has become a space in which we form and build relationships, shape self-identity, express ourselves and learn about the world around us. We must therefore strive to understand its impact on mental health. Social media is often cited as adding pressure on young people, but the internet can be a support as well. Social media platforms can promote a sense of community and facilitate the provision of emotional support.

'Kooth' is an online programme commissioned in Somerset to provide online support and counselling for young people.

Kooth demonstrates how services have to 'be where the young people are' – especially in times of difficulty.

Facebook's suicide prevention tool launched in the UK in January 2016. If users believe a friend's post indicates self-harm or is suicidal in nature, as well as reaching out to them directly, users are able to anonymously report the post to Facebook. The post will be reviewed by Facebook's support team, and if appropriate, the author of the post will be offered a series of options via a private message screen, including access to support lines, resources or a prompt to reach out to their friends and family for help.

Harm Reduction

Unfortunately, for some troubled young people 'self-management' may actually mean harming themselves. The evidence suggests that this is typically cutting the body, rather than the overdoses identified as typical of emergency hospital admissions. Indeed, we know that some charities teach young people how to cut themselves safely – cleanly and hygienically – to reduce the physical danger. (Needle exchange is a similar type of harm-reduction initiative.) Self-harm can be a way for (mostly) young people to cope with pressures at school or work, bullying, breakdown of relationships or sexual physical or emotional abuse.

'I "needed" to harm to punish myself for being what I believed to be a terrible person and to clear the fog in my head. As soon as I did, I'd feel in control, calm and as through a reset button had been pressed in my head."[26]

It is a difficult paradox that deliberately harming yourself is something that you do to try to help yourself with things that feel unmanageable. However, this underlying intention of taking care of yourself is exactly what can be harnessed to help people find a more constructive way forward. Although it takes time, courage and determination, there are ways to learn to manage difficult feelings differently and to be freed from the painful burden of self-harming urges

Children and Adolescent Mental Health Services (CAMHS)

CAMHS is both the main, formal provider of mental health services for children and young people and the best known. CAMHS are commissioned to provide specialist community and inpatient provision for 0-18 years olds with severe, complex and persistent mental health conditions. They offer a number of different treatments by a range of professionals. Annex One provides an outline of the present CAMHS self-harm pathway between CAMHS and the acute hospital provision. Following discharge from hospital all children and young people will receive a follow up contact.

In summary

The evidence around the case for prevention is clear. Prevention is cheaper, more effective and it is everyone's business. Prevention is not all about services, although services are important. It is also about communities, families and individuals. Firstly, we need to work with our most challenged families and neighbourhoods to reduce the impacts of poverty and other adverse circumstances which put children at risk of poor mental and emotional health. Secondly, we need to work with parents and children and schools and just as we work to teach children how to eat healthily, cross the road and the dangers of drugs and alcohol, we need to teach children, especially before they go into adolescence, how to manage stress, cope with difficulties and develop resilience.

Our research suggests that there is in fact a range of information support available, to support positive mental health and to support in times of emotional distress and difficulty but there does not seem to be a quick or easy way to navigate 'the system', and access to some types of help is experienced as patchy.

And finally, while the existence of 'tiers' and thresholds is helpful to organisations, we have heard suggestions that people can feel that they need to 'get worse before they get treated' creating perverse incentives and frustration.

Conclusion and Recommendations

This year, I have devoted my report to looking at self-harm, and emotional wellbeing and mental health amongst children and young people because these are issues of importance in the county.

The analysis undertaken for this report suggests that the higher rates of presentations at hospital for self-harm may be partially explained by higher rates of single presentations by young women for self-poisoning than is seen elsewhere. While changes to treatment pathways and guidance around admissions, especially around paracetamol, may contribute to these high observed rates, the more important message is that the pattern of self-harm we are seeing in Somerset is telling us something about the emotional distress which young people are experiencing.

Whilst the numbers admitted in an emergency are high, the repeat admissions are relatively low, which suggests that when children and young people receive treatment – principally from CAMHS - it is effective.

The fact that the majority of presentations are single episodes suggests that service provision will only ever address part of the problem. While appropriate resources, services and sources of help are vitally important, we clearly need to shift the system towards one in which we actively protect mental health and in which we understand and promote emotional resilience.

Of concern is the fact that too often people simply do not know where to turn for help, or worse, feel that they won't get help until they get more ill or the situation reaches a crisis point. We cannot ignore the fact that many, including GPs, feel frustrated and concerned about lack of access to appropriate support for young people experiencing personal emotional distress.

The gains from promoting and protecting the emotional health and wellbeing of children and young people are known to be lifelong. The economic case for investing in prevention is clear. We need to understand that while prevention is about the provision of services, it is also about protecting children and young people from adverse experiences, about building resilience and about developing a culture of emotional literacy. If we are to reduce admission rates for self-harm and reduce the frequency and scale of self-harming behaviour in our young people, we will need to mobilise a whole system approach with all stakeholders and partners working together to bring about change.

This report refers to a number of important resources: the Positive Mental Health for Somerset Strategy (2014) which was developed by a range of Somerset Partners, the Somerset Wellbeing Framework, a resource developed in Somerset by Public Health with schools; and the *Prevention concordat for better mental health* published (2017), endorsed by range of national and local bodies to promote a 'prevention focused approach to improving the public's mental health'.

Recommendations

I have set out below some recommendations for action in Somerset which I urge all partners to support

The task of addressing the issue of self-harm and promoting positive mental health needs to be everyone's business and will require concerted action on a number of fronts. Specialist expertise and strong leadership will be needed from strategic partners and the multi-agency Self-harm steering group that sits under the Children's Trust Commissioning Group for Children and Young People's Mental Health and Psychological Wellbeing.

There is an urgent need to develop accessible guidance and information about self-harm among organisations, professionals, parents and young people . This needs to be supported by an increase in knowledge, confidence and skill and skill in responding to a situation of self-harm and to ensure a consistent and empathetic response with appropriate support .

We need to hear loud and clear the fact that the system is difficult to navigate, and that young people, parents, carers and teachers often do not know where to get information, advice and help.

All schools should adopt the Somerset Wellbeing framework to support and promote positive emotional health and wellbeing and where appropriate could consider developing school based self-harm policies.

The Health and Care Sustainable Transformation Partnership (STP) and Fit for My Future Strategy will need to work closely with all partners to ensure that due prominence is given to the mental health of children, young people and adults, ensuring that prevention and early intervention is addressed as well as treatment.

The Somerset Clinical Commissioning Group has a particular and immediate opportunity working with local authorities and schools to maximise the impact of early intervention investments, including a special self-harm project being undertaken as a result of an additional NHS investment. This project will produce and implement a self-harm protocol and resource toolkit to improve the quality of support, advice and guidance available.

Ongoing audit and data analysis is needed to make sure that we continue to deepen our understanding of self-harm practices and impact and what it is telling us about emotional and mental health in Somerset. Organisations need to work together on this and to develop a better shared understanding.

Finally, and above all, we need to continue to listen to what children and young people are telling us about their experiences and to work with them in designing the solutions. If past experience is anything to go by, we may be very surprised and inspired by what they come up with.

Acknowledgements

I would like to thank all those who have contributed to this report, those who have supplied data and those who have supplied advice and information both directly and indirectly. I hope this is the beginning of a much deeper and longer conversation in Somerset.

Alison Bell; Kerry Allen and CAMHS team members; LifeHacks Young Peoples Group; Fiona Moir; Louise Finnis; Christina Gray; Jack Layton; Dr Alex Murray, Pip Tucker; Young Somerset and the multi-agency Self-Harm Steering Group; Jacqueline Burns

Appendix 1

Prevention Concordat for Better Mental Health

https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

The Concordat advocates:

- Needs and assets assessment, with the effective use of data and intelligence (*such as http://www.somersetintelligence.org.uk/mental-health/*)

- Partnership and alignment
  Upstream prevention (stopping people developing issues in the first place) – to save the pressure on emergency services and the police

- Translating need into deliverable commitments
  Somerset's emerging Improving lives and Fit for my future strategies both cover mental health. When these strategies are complete we should use them to improve the services we provide.

- Define success outcomes
  Commissioning mental health services jointly or in alignment requires shared success and performance measures

- Leadership and Accountability
  The Somerset Health and Wellbeing Board is committed to promoting good mental health and prevention of mental ill-health, and stands ready to lead improvements.

Appendix 2

Positive Mental Health - Joint Strategy for Somerset 2014-19

This strategy advocates the following:

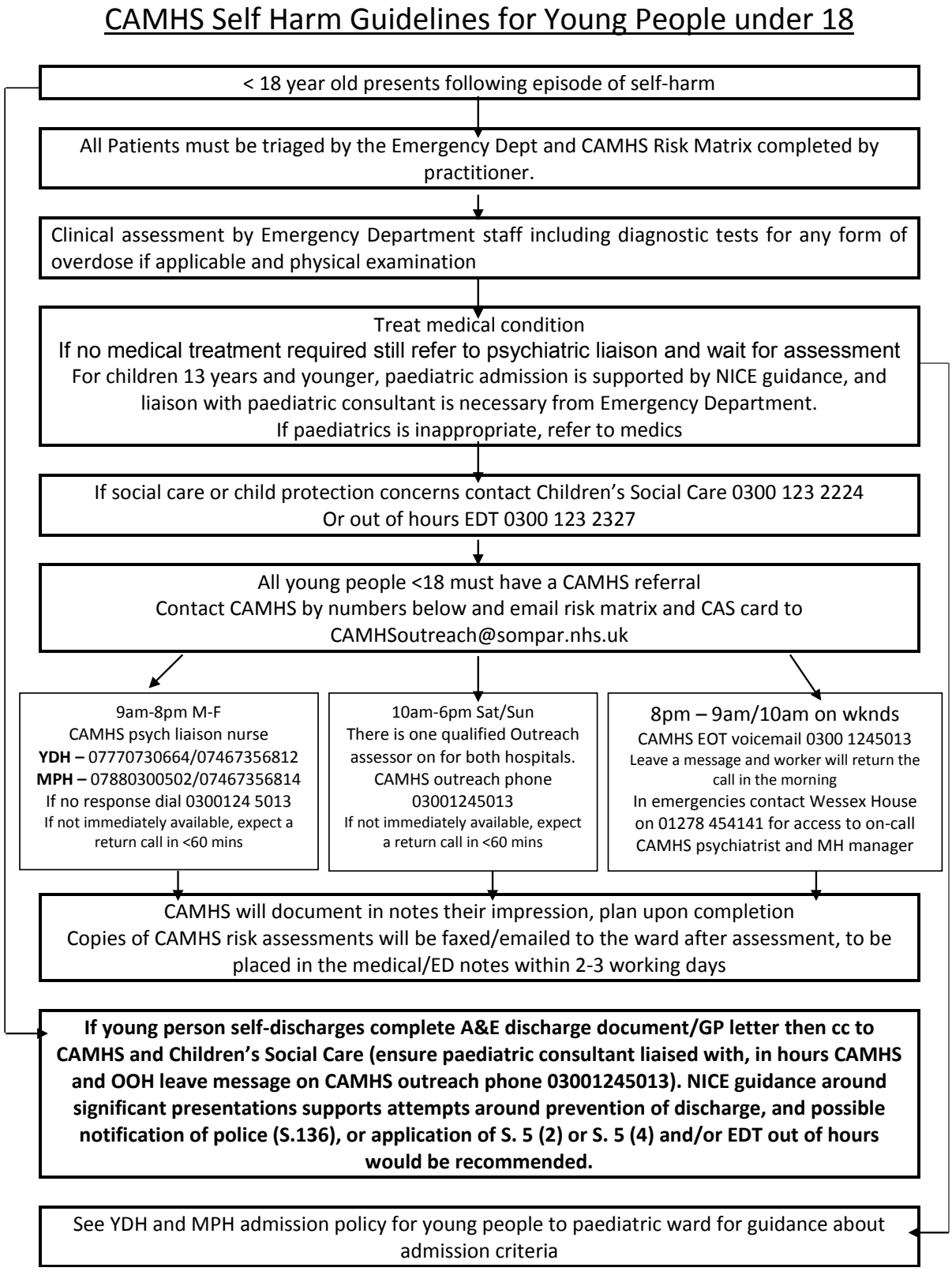
- Involve young people and their families in the co-design, co-production and co-delivery of services to support their health and wellbeing
- Make sure that everyone in the children and young people's workforce is well informed about emotional and mental health
- Invest in parenting programmes which are low cost, high value interventions which can be developed and delivered in a flexible and inclusive way
- Protect children, young people and families from risks such as exposure to bullying, violence, discrimination and from the effects of harmful drinking and substance misuse
- Invest in interventions for behaviour and for conduct disorder which have been identified as a 'best buy for mental health' with potential savings from each case through early intervention estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems

Consideration needs to be given to how education on self-harm could be included in the curriculum via Personal, Health, Social and Education (PHSE) classes and other appropriate curriculum areas. As mentioned, consistent language that teachers, GPs and others can use when talking to young people about self-harm would be welcomed by them[27].

The report suggests there is an urgent need to develop new policies and procedures that clearly provide guidance and information regarding self-harm to all key stakeholders. This needs to be supported by an increase in knowledge around self-harm across all groups to ensure a more consistent and empathetic response is given and all groups provide better support to a young person who is self-harming.

Annex 1

CAMHS Self-harm pathways



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[5] https://cellohealthplc.com/new-research-talking-self-harm-lifts-lid-on-hidden-despair/

[6] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2817%2930478-9

[7] These are 'directly age-standardised' meaning that that differences in the population size and age structure are accounted for in the calculation. The definition is the number of finished first consultant episodes where the patient was admitted via an emergency method and where the main external cause recorded is given an appropriate code International Classification of Disease 10 (ICD-10) code:

- X60-X69 (intentional self-poisoning); X70-84 (intentional self-harm by other and unspecified means).

[8] Rates are calculated using Office for National Statistics (ONS) mid-year population estimates for relevant years and a simple line of best fit trend has been extended for the most recent year (2017) without published data using Microsoft Excel's Forecast function. Individuals are identified by unique identifier and either CCG of residence for Somerset or the ONS Government Offices for the Regions Code for the South-West. The England calculation simply include everyone in the dataset and represents activity in English hospitals; this does mean there may be small numbers of admissions of people from other countries and admissions where the residency was unknown. The calculation uses First Admissions Episodes rather than First Consultant Episodes. However, the number of admissions for self-harm where the patient was in the care of more than one consultant during their hospital stay is negligible.

[9] https://bpspubs.onlinelibrary.wiley.com/doi/pdf/10.1111/bcp.12362

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693484/

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693484/

[12] Please note that this does not account for any admission which might be caused by multiple self-harm methods, as only the main cause is considered. It also does not account for multiple admission across different years. It may also be affected by people's age and sex.

[13] English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

[14] Analysis undertaken by Somerset Public Health

[15] https://www.bmj.com/content/342/bmj.d2218

[16] https://www.nice.org.uk/guidance/cg16/chapter/1-guidance

[17] http://www.somersetintelligence.org.uk/scyps/

[18] https://cellohealthplc.com/pdfs/talking_self_harm.pdf

19 https://cellohealthplc.com/pdfs/talking_self_harm.pdf

[20] http://www.somersetintelligence.org.uk/jsna/

[21] https://cellohealthplc.com/pdfs/talking_self_harm.pdf

[22] https://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services

[23] https://www.publichealthnetwork.cymru/en/news/welsh-adverse-childhood-experiences-ace-study/

[24] https://www.cypsomersethealth.org/wellbeing_framework:_intro

[25] https://www.cypsomersethealth.org/?page=new_lifehacks

[26] MIND, Understanding self-harm, 2013

[27] https://cellohealthplc.com/pdfs/talking_self_harm._pdf