Right Here Brighton and Hove

# Young People and Self Harm: Perceptions and Understanding

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This research was designed and implemented by Right Here Brighton and Hove Research & Evaluation volunteers:

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## Executive Summary

This research on self-harm was commissioned as a result of the concern of a group of professional organisations in Brighton and Hove around the increase in self-harm by young people in the city. All researchers involved were Right Here volunteers aged between 16-25 years. Focus groups were held with three different population groups – young people, educational and medical staff. An online survey captured the views of young people's supported accommodation staff. Four focus groups were held with young people; two groups held with medical staff and one focus group with educational staff. The online survey was completed by ten members of supported accommodation staff. The main aim was to gather the perception and understanding of young people about self-harm. This research found that communication is a fundamental factor within this subject. Research showed that self-harm was perceived to be a range of things:: a form of communication unto itself to express a need for help and support; a secretive issue for those who are self-harming; and generally found to be a difficult subject to broach. It was also found that professionals would like training or further training to enhance their confidence and self-efficacy with young people that self-harm. This research concluded that an information guide on self-harm would be of great value to respond to the research findings.

## Introduction

Right Here Brighton and Hove is a project led by young people aged 16-25. We promote the mental health and emotional wellbeing of young people in this age group in our city. The Research and Evaluation volunteer team undertakes peer-led research on the issues that are most important to young people in Brighton and Hove.

The Research and Evaluation team were commissioned by the Brighton and Hove Self-Harm Working Group (professionals from services across the city with a common concern about the increasing prevalence of self-harm in Brighton & Hove) to carry out research on self-harm in young people.

## Aim

This research set out to discover the perceptions and understanding about young people and self-harm, through interviewing professionals and young people themselves We also aimed to explore their knowledge and awareness of the current support services available and determine whether professionals felt they were suitably trained and confident to respond to a young person that was at risk of or was self-harming.

# Literature review

As a starting point we undertook a literature review of national and international academic findings on good practice and the most effective interventions for young people who self-harm. The purpose behind this review was to help enhance and broaden the knowledge and understanding around young people and self-harm, and the most useful support currently available, to help guide the planning of our own research and inform local developments in self harm prevention. The summary of our literature review is below.

When looking into self harm and emergency visits it has been shown that mental health disorders are diagnosed in approximately half of emergency visit by young people following an episode of deliberate self harm. It was also established that emergency treatment following deliberate self harm in young people results in 56% Inpatient admission, 29% Outpatient care, 6% Emergency department continuing care, 5% No follow up care, 4% Follow up care unspecified. This suggests that some mental health disorders may be co morbid/co-exist with self harm . Consequently, systematic mental health assessments in the emergency department of young people following an episode of deliberate self-harm may improve detection of mental health disorders (Olfson, Gameroff, Marcus, Greenberg & Shaffer, 2005). Furthermore, it has been revealed that CAMHS staff are more knowledgeable and felt more effective than either A&E staff or teachers toward self harm and adolescents, whereas A&E staff expressed more negative attitudes towards self harm. Additionally, 82% of staff reported having received no specific training in adolescent self-harm behaviour; 48% of CAMHS staff received training, no teachers reported having any training and 96.1% of A&E staff reported having no training. In addition, findings indicated that 95% of all staff reported that they would benefit from further training (Timson, Priest & Clark-Carter, 2012).

Professional staff not having the appropriate training, or indeed any training in relation to self harm, may have huge effects on how young people view services to support self harmers. A recent review has shown that a minority of young people when attending A&E feel they were wasting the nurses and doctors time, this may relate to medical professionals lack of knowledge around the issue of self harm, which resulted in doctors making immediate referrals to the duty psychiatrist, rather than personally providing immediate help and support (Palmer et al, Fortune et al cited in Angela Underdown, NSPCC, 2009). It has been established that young people believe they can cope alone and would choose not to engage with services. Young people are three times more likely to confide in a friend than a professional and the use of phone lines in young self harmers seemed to be a common source of help. In addition, when considering the training and supervision of professionals, young people's views and experiences should be an essential element of the training, and supportive supervision should be made available for staff (Angela Underdown, NSPCC, 2009).

There are a variety of interventions available for helping young people with self harm. However, it needs to be established what type of intervention may be considered most effective for young people. A systematic review of interventions used for self harm in adolescents revealed that Selective Serotonin Reuptake Inhibitors (SSRI-Antidepressant) should be used in conjunction with other therapies. Findings also showed that using SSRI's alone can in fact increase suicidal cognitions and thus, lead to self harming behaviour. This review also indicated that Cognitive Behavioural Therapy (CBT) is more effective when combined with antidepressants (SSRI) than when delivered alone (Fortune and Hawton, 2005).

Additional research has made comparisons with a routine care intervention; which is run by nurses and includes family sessions, counselling and if required psychotropic medication with group therapy; this includes elements of CBT and problem solving therapies. The findings revealed that adolescents (aged 12-16) that received group therapy as well as routine care were less likely to repeat self harm on two or more occasions than adolescents that received routine care alone. It was found that adolescents who received group therapy had better school attendance and lower rates of behavioural disorders than adolescents who received routine care alone. The results from this study strengthen support for the use of group therapy as an intervention method for young people. However, this study does have some limitations. Firstly this has only been implemented in one health district and delivered by experienced therapists, which indicates the validity of this study's findings is weakened/ reduced. Furthermore, the interventions used in this study did not alter depression levels, thus if depression and self harm co-exist for some patients the therapy used in this study would not be effective in the long term. This effect cannot be accounted for as this study only focused on short term effects, consequently it has not been established whether group therapy has long lasting effects as an intervention for self harm. Despite having an under-representative sample, this study's findings are consistent with research findings in older age groups thus strengthening the reliability of this study's results (Wood, Trainor, Rothwell, Moore & Harrington, 2001). However, the evidence from a recent trial does not lend support to the addition of developmental group psychotherapy (Group Therapy) to the current routine care for the child and adolescent mental health services treatment of adolescent self harm (Green, Wood, Kerfoot, Trainor, Roberts, Rothwell, Woodham, Ayodeji, Barrett, Byford & Harrington, 2011).

Furthermore, a recent study has compared CBT with TAU (treatment as usual). TAU consists of psychotropic medication, psychotherapy and psychiatric hospitalisations. Patients in CBT and TAU combined condition were found to have significantly greater reductions in Self harm, suicidal cognitions, symptoms of depression and anxiety compared to the control TAU only condition. Patients (consisted of 15-35 year olds) in CBT and TAU combined condition were found to have significantly greater improvements in self esteem and problem solving compared to the control TAU only condition. Although this study lends support to CBT as an intervention for self harm, this study has some serious limitation which should not be overlooked.  This study did not use a validated assessment of self harm, as this was not available at the start of the project. The duration of the follow up period for this study was not sufficient time to understand the long term use of CBT in relation to self harm. Overall the findings extend evidence that the time limited CBT interventions is effective for patients with recurrent and chronic self harm. This study was the first to demonstrate the success of CBT in such short duration.  However, Long term effectiveness has yet to be established (Slee, Garnefski, Leeden, Arensman & Spinhover, 2008).

From reviewing the existing research on best practice and interventions, we wanted to understand further what young people's perception and knowledge of self-harm was, we also wanted to explore if there could be benefits from training or further training for professionals who work closely with young people (e.g. teachers, GPs) who may need to know how to assist and engage with young people who have self-harmed. The existing research showed there were a very high percentage of professionals who felt they would benefit from further training and we wanted to determine whether this was applicable to professionals in Brighton and Hove as well. Following our literature review, we developed our research questions and split these into what we wanted to learn from young people and what we wanted to learn from professionals working with young people.

# Research Questions

**Young People:**

1. What are young people's common perceptions and assumptions about self-harm?

2. What understanding do young people have about self-harm?

3. How would young people feel if someone they knew had or was self-harming?

4. Are young people aware about the help and services available?

**Professionals:**

1. What are the professional's common perceptions and assumptions about self-harm?

2. What knowledge do professionals have about self-harm?

3. Do professionals feel they know how to respond to a young person disclosing their own or a peer's self-harm?

4. How aware are professionals about the help and services available?

# Methodology

**Participants** - The different groups we wanted to target were young people age 16-25, medical professionals and college and young people's supported accommodation project staff.

**Design** - The formulation of the aims and research questions shaped the questions for structured group interviews and an online questionnaire. Focus groups were chosen as the method to gather the information we required to find answers to our questions. As our research topic is quite sensitive and one of our target groups was young people we felt we did not want to use a methodology as indirect as questionnaires or as intense as one to one interviews so we decided that focus groups would be our best option. This method was felt to be appropriate for all our participants and we recognised that focus groups would be a good way to facilitate discussion between professionals as well as with young people. We decided that it was important that we keep the participant's identities anonymous as an ethical consideration. We also felt that due to time constraints we could reach a larger group of people, quicker than holding individual interviews. Although group interviews were our chosen method, due to difficulty in arranging a focus group with supported accommodation project staff around their varying shifts, we converted the questions into an online questionnaire to capture their views.

One of our requirements for participants taking part was for them to provide us with either written or verbal consent to take part in the focus group and with the acknowledgement that the findings would be used within this report. We explained the purpose of our research and how the information would be used before asking for consent.

We set out to invite young people to participate who did not necessarily have personal experience of self-harm; although we are aware the subject of the focus group may have caught the interest of those who did have personal experience.

**Variables** - We then turned our attention to the questions we wanted to ask in our focus groups, whilst we felt we wanted to make sure we asked similar questions to all participants, we also recognised that there were certain questions that would only be relevant for one group e.g. medical staff. There were some limitations with the online questionnaire as we could not encourage further discussion using this medium.

**Materials** – As our research method was qualitative we did not require many materials to conduct our research. The most important equipment we used was a dictaphone, to record the focus groups. We also had a member of our team take notes at each focus group.

**Volunteer training** – Some of the Research and Evaluation volunteers, and their Right Here project coordinator, attended research methods and skills training delivered by researchers from The Tavistock Institute. In order to further prepare the researchers, a training day on young people and self-harm was attended by the volunteers.

**Procedure** – The focus groups were all co-facilitated by two volunteers, with another volunteer taking notes. The team's co-ordinator was always present at our focus groups to ensure that the volunteers felt supported and could deal with any difficult issues should they arise during the focus group. The online questionnaire was sent to a group of Sussex Central YMCA supported accommodation project staff via their managers.

## Findings

We used thematic analysis to review our findings and identify emerging themes. We divided the results into separate categories. These categories were not all the same for young people, college, supported accommodation project and medical staff; however there were more similarities than differences. We have summarised our findings by category below.

### 1. DEMOGRAPHIC

**Young people**

We asked participants at what age they thought young people began to self-harm, the most common age group identified was between 13-15 (early teens). This age was identified as a "transitional" time when young people had moved up to secondary school and became more vulnerable to bullying. It was also noted that this was the time that young people reach puberty.

We also wanted to gauge young people's perception of how many of their peers could potentially be self-harming. We received a wide range from 30%-80%; however the majority felt it could be between 60-80%, only a few participants in one focus group felt it could be as low as 30%.

**College staff**

The two age ranges the college staff identified were 13-14 and 16-17. These ages were identified as an "intense age" and when young people will have "extreme responses" to factors in their lives. College staff agreed with young people about the factors that can affect young people at this age such as secondary school, reaching puberty and becoming an adult.

The college staff had a varied response to how many young people they thought could be self-harming, and it ranged from 6-100%. Those who said100% explained that anything could be seen as self-harm, depending on how you define it.

**Medical staff**

One participant felt that 100% of young people could be considered to be self-harming if binge drinking was included, but only 10% if not.

There was a contrast in prevalence, with the perceived percentage ranging from 15-30% to 40-80%.

Different social groups such as minority groups, social classes and girls were identified as the groups who were more likely to self-harm. Although it was noted that it seemed that when boys self-harmed they sometimes would do so in a "more serious" manner (i.e. injury through violence in physical fights).

Teenage years were identified as the age range when young people would start to self-harm; however it was noted that there was an increase in younger ages as well.

**Supported accommodation project staff**

The range was wide when supported accommodation project staff considered what percentage of young people they believed were self-harming, from 10-70%. The most common percentages were 20% and 30%.

When answering at what age they believed young people begin to self harm, participants gave responses that were between the ages of 10 and 20 years.

**Demographic summary**

The majority of participants across all focus groups understood that young people tended to start self harming around the age of 13, as this was a time of transition and change. The online survey also reflected a view that self-harm begins at age 13 years and possibly younger. It was noted that some participants knew of examples of younger people self-harming as well. The percentage of young people participants believed could be self-harming varied between each group, one of the key factors to this difference was how individuals defined self harm.

## 2. TYPES OF SELF-HARM

**Young people**

The types of self-harm identified in our focus groups can be viewed on a spectrum of severity and intention. Cutting was mentioned in almost every focus group and tended to be the first type mentioned. At the other end of the spectrum were tattoos and piercings as whilst they do "harm" the body they are not necessarily intentional self-injury. In the middle of the spectrum was substance and alcohol misuse and participants noted young people's relationships with these can differ and it was identified that there is a difference between going out drinking with friends and sitting in alone drinking.

**College staff**

The college staff had a similar perception of what could be viewed as self-harm, and again this could be viewed on a spectrum of severity. Cutting was mentioned as well as other actions such as over picking spots, burning and making oneself bleed. The college staff also identified actions such as tattoos, eating disorders and excessive drug taking/alcohol consumption, but they did note that these actions are not always about self-harm. Some went so far as to say self-harm could be perceived as "anything that

presents a risk to yourself" and that it was "risk to self and knowledge that it's not good for you".

**Medical staff**

As with both college staff and young people the perceived types can be viewed on a spectrum with cutting, drugs overdose/self-poisoning and burning on one end of the spectrum and behaviours "that put young people in vulnerable situations i.e. runaways" at the other.

**Supported accommodation project staff**

In tune with all of the focus groups, the online survey showed the supported accommodation project staff viewed cutting as the most common type of self-harm. Burning, and starving self was also mentioned. Abuse of medication was noted as a type of self-harm which reflects the types mentioned by medical staff. Drugs and alcohol were also mentioned which came up in all focus groups.

> **Types of self harm summary**
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> All focus groups mentioned a number of different actions and behaviours that could be viewed as self harm. The types mentioned could be put on a spectrum of severity and intention with deliberate self injury at one end and piercings and tattoos at the other.

## 3. REASONS

**Young people**

Young people identified both external and internal reasons as to why someone may self-harm. The external reasons covered factors such as family and relationships, which came up in all of our young people's focus groups. Also other influences such as stress; bullying; people who have experienced abuse; and social media and celebrities were all mentioned in at least half of our focus groups.

The main internal factors identified were to do with self-image and perception of self, including self-loathing and having a negative view of self.  Also the perception that previous emotional trauma or depression were viewed as being part of the reason someone may start to self-harm.

**College staff**

Staff discussed what a difficult time the teenage years can be and that this could be a reason some young people self-harm. Puberty and hormones were identified as well as the teens being a transitional time when friendships are more uncertain and can lead to some being more isolated. It was also perceived as a time when young people have limited choices and are under a lot of pressure to achieve.

The influence that social media can have was discussed by the staff. It was perceived that teenage young people were at the peak of being addicted to Facebook and constantly being in contact with peers through technology. It was identified that this meant it was difficult for young people to "get their equilibrium back" and that social media has changed private time for young people as it was so intrusive (i.e. if something difficult had happened within a young person's peer group during the day at school/college, it may not end when they get home. Instead of having time to be away from situations outside of their home, a young person may have a continuation of the difficulty being present in their room too via social media).

The influence that others can have such as relationships and in particular sexual relationships were discussed as a reason. One participant noted that our society,

"doesn't view the female body in a healthy way, women show disgust at their body by harming".

Also the idea that only those in a sexual relationship are validated and anyone not in a sexual relationship was not, was another perception.

Different feelings such as pleasure, control, rebelling, anxiousness, release and euphoria were all perceived reasons as well.

**Supported accommodation project staff**

Both bullying and low self-esteem were noted as two of the most common views as to why young people may self-harm, which mirrors the focus groups with young people and college staff. Physical pain to deal with emotional pain was also mentioned, along with a cry for help, abuse, bereavement, depression, and mental health issues. Strained relationships was also mentioned which reflects the views of the young people in the focus groups.

**Reasons summary**

Young people and supported accommodation project staff mentioned external reasons as well as internal reasons; whereas college staff mainly focused on the external factors such as social media, society and the difficulties in young people's lives during teenage years. Internal reasons included a sense of control; release; feeling alive; hormonal changes; cry for help along with self-image and self-esteem and self-harm as a coping mechanism.

## 4. COMMUNICATION

**Young people**

There was a contrast in the way that Self-Harm was seen as form of communication, many of the focus groups identified it as a secretive thing, and that may feel like someone's "worst nightmare if someone found out". However, others spoke of how it could be seen as a way of seeking attention.

One of our questions in the focus group was about the difference in use of language and how this could change the meaning, so we asked if participants saw a difference in the following phrases:

*"People who self-harm are attention seeking"*
*"People who self-harm are seeking attention"*

Most agreed that attention seeking had negative connotations and that people who self-harm could more appropriately be viewed to be seeking attention for help. We included this question after discussing our research with a local mental health support group for young people, who brought the importance of language to our attention.

There also seemed uncertainty about how to approach someone if they had been self-harming, some said they didn't want to make people feel worse or others feel uncomfortable. The participants also identified that it would be scary to approach adults with this subject.

In the majority of focus groups the subject of parents was raised, some felt they would inform them where as others said that they would not want to.

Lastly the role of social media was discussed in all the focus groups we held for young people. It was viewed as both a positive and a negative form of communication and the influence that social media can have was also widely discussed. Young people discussed how they had seen stories on Facebook of their peer group and relayed how

they disclosed they were "planning to cut themselves". This type of communication was perceived as attempts at gaining attention.

In contrast, the more positive views held about social media in connection with self-harm were noted as young people relaying their stories of not being ashamed of their scars from their previous self-harm and how this had been "inspirational" to those who had read this.

### College staff

This professional group discussed how self-harm was a result of a lack of articulation in young people to convey emotional distress in other ways.

### Medical staff

Self-harm as a form of communication and way of seeking help was identified in both medical focus groups and that "maybe they do want people to know about it".

### Supported accommodation project staff

Young people being "unable to talk about emotions" was mentioned twice by supported accommodation project staff. There was also a comment about how young people may find it difficult seeking support and so use self-harm as a coping mechanism. One member of this staff team noted how self-harm may be a "mental health cry for help dealing with emotions". The communication of self-harm was also noted by one hostel staff member as "a physical expression of an internal emotion".

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**Communication Summary**

All professional groups along with young people, perceived self harm to be a way of communicating, and possibly as a way of asking for help when it was difficult for people to do so directly. When discussed, most participants felt that self harm was a mechanism for seeking help and was not "attention seeking" which was deemed to have negative connotations. In contrast to this it is important to note that for some people self-harm was perceived as very secretive and not something they wanted people to know about. Lastly it was picked up that the subject of self-harm was difficult to talk about both for a young person who was self-harming to tell someone, but also for someone who had noticed someone was self harming and wanting to help but not knowing how to broach the subject.

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## 5. GAINS

### Young people

The most common gain identified by young people was that self-harm could be viewed as a form of release. This was identified in almost all of the focus groups we held with young people. Next to this, the feeling that it could provide a sense of control was identified in half of the focus groups.

Young people perceived that self-harm could be a "cry for help", or a way of someone seeking help. Participants mentioned that "any attention can be good" and "attention seeking can be bad, but they're doing it for a reason, they need help so that's ok". The way in which social media is used was discussed and that in some cases posting pictures of yourself with scars etc. could be viewed as attention seeking; however one participant spoke about someone they knew posting a photo of themselves on the beach, which showed their self-harm scars and they described it as "inspirational and brave". It was mentioned that someone's scars could be a sign that they "got through tough times".

Feelings were mentioned frequently when discussing what someone could gain from self-harm. Perceptions such as "feel alive" and "calm" were identified, as well as the suggestion that any feeling was good. In contrast to this, participants spoke of the different feelings of anger and pain that could arise from self-harm. Participants also noted that it could be part of the process of learning about one self and as a healing process. Lastly there was an idea that self-harm could be seen as a form of distraction.

**College staff**

As with the focus groups for young people the college staff identified the sense of control as being a gain from self-harm and the idea they are "able to do exactly what they want to their body".

Positive feelings such as "pleasure" and "feeling alive" were identified and seen as a way young people relate to themselves. The physical gains such as euphoria from blood release were also discussed, and also the sense of release.

**Medical staff**

The perception that self-harm was a coping mechanism came up in both medical focus groups. As with the college staff and young people the following gains were identified: release; seeking help; sense of control; soothing; and it being a healing process.

**Supported accommodation project staff**

A sense of relief was the most common gain that was noted in the online survey. Control also was mentioned by three of the ten online participants.

> **Gains summary**
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> Providing release and a sense of control were the most common perceived gains. Also providing feelings such as calm, feeling alive or feeling anything at all, were considered to be important gains. Lastly the idea that going through such an experience could make someone stronger was raised in a focus group we held with young people.

## 6. AFFECTS AND CONSEQUENCES

**Young people**

In our focus group questions we asked participants if they thought self-harm was a sign of suicidal behaviour. In 50% our focus groups participants did note that self-harm could be seen as a sign of suicidal behaviour; however this was thought of as dependent on "how bad they are doing it" and only in "some cases".

The other consequence that was mentioned frequently was the affect that self-harming could have on relationships and family as well as the effect relationships and family could have on someone who self-harmed.

Young people expressed concerns around other young people that self-harm, as they felt worried or scared about how far the self-harm may go, linking back to whether people see self-harm as a sign of suicidal behaviour.

The influence of celebrities was mentioned in our focus groups and often spoken about in a negative way. The "cut for Justin Bieber" campaign came up in the majority of groups and would seem to show how far the influence of celebrities and social media can go.

**College staff**

When asked about self-harm leading to suicide, participants did not see a direct correlation and said that it "depends why" a young person is self-harming. They felt it

could be because of feelings that they can't cope with; pleasure - it makes them feel alive; and could also be because it is a pattern. "If it's due to can't cope may lead to suicide, if it's for pleasure it may not".

As with the young people, the influence and negative consequences of social media were identified, and the example of the "cut for Bieber" trend was mentioned again. The college staff also perceived that when a young person was self-harming it could affect their whole life.

**Medical staff**

The perceived consequences discussed involved emotional consequences such as low self-esteem, isolation, feeling shameful and wanting to cover up. Some mentioned that it could lead to suicide as it "could be a build up". It was also discussed that it could affect young people's general health and relationships.

**Supported accommodation project staff**

Physical bruising and embarrassment was mentioned by two of the online participants. Confidence being affected and self-esteem also was noted as it was in the medical staff's focus group.

**Affects and Consequences summary**

One question we asked all focus groups was "Do you think people see self-harm as a sign of suicidal behaviour?" The majority of participants in all focus groups felt that this was dependent on the person, circumstances and reasons for self harming. No one identified a direct correlation, although many acknowledged there could be a build up from self harm to attempts or completion of suicide. The supported accommodation project staff had options of yes, no or not sure on the online questionnaire as to whether people see self-harm as a sign of suicidal behaviour. 80% answered no; 10% answered yes and 10% responded they were not sure. The negative consequences of the influence social media can have was mentioned by both college staff and young people.

## 7. RESPONSES

**College staff**

When we discussed how to respond to a disclosure of self-harm or becoming aware of self-harm, staff spoke of the college referrals pathway in place. All staff said that if they think there was a risk of harm they would pass it on and identified that a clearer pathway of referral would make it simpler for the staff as they wouldn't have to decide how to take it further. Teachers spoke of walking their students to student services if they broke down in lesson and that initially they would have a conversation with them.

When we discussed staff's response, some spoke of having a lack of knowledge and understanding around the subject of self-harm: "don't know enough about self-harm" (enough to help) and some were "surprised by my lack of knowledge". Some also discussed that assumptions were easy to make about whether a young person had self-harmed.

Some staff also discussed their uncertainty about the response that students wanted from them when they chose to disclose that they had or were self-harming, "why to me" and "difficulty understanding what to do, do they want someone to listen, do they know what they want?" Some staff felt that if they were not the first person informed and the young person was already accessing services they didn't know "what else to do."

**Medical staff**

When we spoke about responses with medical staff we spoke in a context of how to respond to a patient.

GP staff noted the following points to be aware of when responding to a patient who had self-harmed: "offer your full attention; realise it's a significant problem and address it in the most sympathetic way; don't want to make them self-conscious; it's important to listen." It was also mentioned that it was important to understand what the patient expected of the member of staff.

The policies and referral process that were in place were spoken about, the staff noted there was not a policy to inform others unless there was a safeguarding issue and that they would refer to other services.

The A&E staff identified that they would involve social workers, the duty CAHMS worker and safeguarding team if appropriate.

**Supported accommodation project staff**

The online survey asked the supported accommodation project staff how confident they would be in discussing a disclosure of self-harm with a resident on a scale of 1-10, with most confident being at ten. 40% of the hostel staff rated themselves at 10; 20% at 9; 20% at 8 and 20% at 5 on the scale.

The supported accommodation project staff also mentioned how they would want to offer support, and would feel concerned and sad.

**Response summary**

Overall college staff did not feel very confident responding to a young person who was self harming. They identified feeling unsure about what to do and also about what the young person wanted from them. Medical staff in general seemed more confident about responding to a young person who has self harmed; however they seemed to have clearer referral pathways in place and therefore knew what was expected of them. Some of the college staff mentioned a more clearly defined way of responding and pathway of referral would be extremely helpful. The supported accommodation project staff seemed reasonably confident with 80% of participants placing themselves at 8 or higher on a scale of levels of confidence which may be due to the nature of their work and the relationships they are able to build with residents.

## 8. SERVICE SUPPORT

**Young people**

The services that young people were aware of were the services that were available or promoted at school or college. They also talked about help from within their existing network.

The services that colleges had available or promoted included counselling and services promoted on the back of toilet doors. They also discussed how the internet could be viewed as a useful tool or as a damaging influence. Childline was one of the national services identified as a resource young people were aware of. There were opposing views between students who felt they would approach staff for advice and support and those who wanted to avoid any staff finding out.

There were also differences in opinion about whether close friends would be confided in as some felt it would be "putting negative emotions" onto them. One person suggested

it would be easier to speak with someone you are close to but wasn't immediate family like a Grandparent.

Lastly, it was mentioned that self-harm was not something others could help with and that "you're the only person who can stop it."

**College staff**

The services college staff were aware of and would sign post students to can be divided into 3 categories.

The first was the internet and 'the site.org' was mentioned as a helpful resource, particularly because it was a national site and therefore assumed to be valid and would continue. It was mentioned that one problem with local services is that they could run out of funding and no longer be available. One participant commented, "Brighton and Hove City Council to ensure a service that lasts longer than 2/3 years".

Other internet resources mentioned were "Where to go for" (a Right Here Brighton & Hove website of local youth support services) and the internal college system.

The second category discussed was the services available within the college, such as counselling. Staff spoke of feeling confident that if they referred a student to a counsellor they knew it was going to be followed up. This was contrasted with simply handing out a leaflet that was "hard to follow up from student services". There were different opinions about whether students would involve the college at all whereas some believed students "trust college rather than going to the doctor". Some teachers mentioned they felt pressure having to research services for students to go to and they had "no idea of the services available". It was also thought that getting students involved in sporting activities could help students, as well as specific services.

Lastly local services, external to the college, were mentioned, specifically the Young People's Centre (YPC), CAMHS (Child & Adolescent Mental Health Services) and GPs.

**Medical staff**

Both groups of medical staff were aware of RU-OK (young people's substance misuse service), counselling services and CAHMS.

Local youth services such as Sussex Central YMCA's Youth Advice Centre (YAC) and Right Here were discussed, as was Mind in Brighton & Hove. Online and social websites were mentioned, although it was felt there wasn't enough support online.

**Supported accommodation project staff**

The online survey revealed supported accommodation project staff were aware of a range of services including a self-harm support group at Buckingham Road, TAPA workers (Teen to Adult Personal Advisers), counselling, student services at colleges, CAMHS, MIND, Right Here and GPs.

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**Services summary**

It was mentioned in the college staff focus group that national services or websites were their preferred services to refer young people to as they were assumed to be more reliable and they could guarantee they would still be running. Young people felt quite unsure where to go and there was a difference between those who felt college and adults were the best places to go for advice and those who did not want college involved at all. This would suggest that there is no one support service that exists or model that could be developed that would benefit all young people who may self harm. The supported accommodation project staff were aware of a wider range of services, which may be due to them working in an intensive way with young people who may be particularly vulnerable.

## 9. TRAINING NEED

As part of our focus groups and online survey with staff we wanted to understand the level of training they had received around young people and self-harm, if any, and if they felt they would benefit from further training.

**College staff**

Some of the staff spoken to had received training from Sussex Central YMCA's therapeutic services (Dialogue) and others spoke of the benefit gained from Experience in Mind training as they were listening to young people discuss their experiences first hand and staff said they would like to receive more training like this. (Experience in Mind no longer exists, but was a youth participation project where young people used their experiences of service responses to their mental health needs, to develop and deliver training workshops to professionals). Other staff identified that the ASIST (Applied Suicide Intervention Skills Training) training they had received "made me more comfortable to have that kind of conversation with the student", although it was noted that this didn't cover self-harm and only student services received the training, not teachers.

The majority of staff said they felt they would benefit from more training especially around what can cause a young person to start self-harming.

It was noted that within this college that subject teachers make more referrals than tutors to support services, and therefore subject teachers should be offered more training not just tutors. Support staff noted that counselling skills training had been useful to them.

**Medical staff**

Some of the medical staff said they would benefit from further training as "things are changing all the time" so it was important they were kept up to date. Medical staff also felt it was part of their development to receive further training, "generally the more you know the more understanding you could be, rather than criticise".

**Supported accommodation project staff**

In response to whether they had already received some training on young people and self-harm, 70% answered yes; 10% answered no and 20% answered 'a small amount'. A "refresher course" of training already attended was mentioned along with a desire to "gain a greater insight into this common problem". One of the hostel staff answered that "self-harm itself is not too difficult to manage". This member of staff added it is the underlying causes of self-harm and how to better understand changing patterns of behaviour that would be of great benefit.

> **Training need summary**
>
> The majority of college staff were enthusiastic about the idea of receiving further training and many said it would be beneficial. Training that helped staff to understand the experience from a young person's perspective and training that would give them the tools to respond effectively, were felt to be the most important. Medical staff spoke of further training from a slightly different perspective - it was viewed as something that would benefit their professional development, rather than for college staff where the focus was more on being able to assist their students more effectively.

# Discussion

## PREVIOUS RESEARCH

Our literature review of existing research into best practice surrounding self-harm helped to guide our research and determine the key themes we wanted to explore. However there were some key findings in this research which we did not have the opportunity to investigate, given the scope of our research and resources available.

The findings surrounding best practice interventions for young people who were self-harming, were very interesting and it would be beneficial to explore some of these findings further. Several of the reports identified that a combined approach would be the most helpful, and these included the combination of CBT and Selective Serotonin Reuptake Inhibitors (SSRI- Antidepressant), and CBT combined with TAU (treatment as usual).

We believe what can be seen from these findings is there is not one clear intervention that can be used for every young person who self harms, but that a more holistic approach is required. Furthermore the training of those professionals who are likely to have to assist a young person who is self harming has been identified as very important. One research study we looked at noted the effect of professional staff's training on how young people viewed services available to support those who self harm. Lack of training was noted to lead to a young person feeling like they were wasting a nurses and doctors time. The same piece of research showed a young person was three times more likely to confide in a friend rather than a professional and the use of phone lines in self harming young people seemed to be a common source of help.

We suggest this shows that young people are not engaging with professionals or services as much as they could be and this could be because staff are not trained or the services are not offering the type of help that could be most useful for a young person who was self-harming.

Furthermore, a review of the services available and how these could be adapted for young people who self-harm was suggested.

## OUR RESEARCH

Our research showed young people perceived self harm as being a secretive subject that was difficult to communicate. The idea that self harm can be viewed as a 'cry for help' indicates that whilst it is a form of communication, overtly asking for help can be extremely difficult. Many of the young people we spoke to did not view "seeking attention" negatively, but as an acceptable form of communication. Both college and medical staff supported this view. Supported accommodation project staff also supported this view, with comments such as "it makes the pain they are feeling inside visible" and how "a young person may find it difficult to seek support or talk about how they are feeling and use this as a coping mechanism".

We wanted our research to look into any perceived connections people might view between self harm and suicide and whether anyone believed self harm could lead to suicide. The overall perception was that there would be other factors involved and there wasn't a direct correlation. Many participants did identify that self harm could affect all aspects of a young person's life and although some of the consequences may be positive, overall it was perceived it would lead to negative outcomes such as damaging relationships and isolation.

Influence was discussed a lot in all our focus groups, both from the perception of external influences on young people, in particular social media, and the influence young people can have on each other. The college staff seemed to understand the pressures social media can add to young peoples' lives and means they are always connected. Young people did recognise that social media could have a negative effect; however there was also an idea that it could be inspirational and helpful at the same time.

The perceived gains from self harm were similar across all four groups we questioned. Providing release and control were mentioned most often and the idea that it allowed a young person to cope seemed to also be one of the most common perceptions.

Overall the participants all understood the reasons a young person may self harm to be both external and internal factors. The pressures of life for the age group investigated, as well as the changes experienced at this time, were mentioned in most focus groups. Also young people's view of themselves was identified as a reason and feelings such as self-loathing and low self-esteem were mentioned frequently.

Most of the perceptions and understanding all our participants had about self harm were very similar. The main differences were about who or where someone may go for support or help and whether self harm was an indirect form of communication, a "cry for help" or a secretive act that the young person would never want anyone to find out about.

Almost all focus groups we held recognised that self harm could be an action or behaviour outside the most common perception of cutting one's self. The online questionnaire also supported this view. Risky and potentially damaging behaviours were discussed, particularly around drinking alcohol or misuse of substances, but also 'socially acceptable' harm such as piercings or tattoos were also mentioned, although this was always discussed within a context of intention and severity.

Many of our participants, both young people and professionals, were not sure how to respond to noticing or being told someone was self-harming. There was fear of potentially making things worse or not knowing what to say or how to help. Some of the college staff seemed to be most vocal about their uncertainty and many wanted to have a better understanding of why a young person may self harm to help them to discuss the subject. Medical staff and college staff both said they would benefit from further training, as did the supported accommodation project staff.

## Conclusions and Recommendations

There seems to be a need for a universal understanding of self-harm, for both young people and professionals, to help and enable people to talk confidently and appropriately about it.

We conclude that communication is a critical factor to consider:

- Self-harm for some young people is a form of communication in itself and perceived to be an expression of a request for help and support. Therefore knowledge of support services, and how to seek help and talk about self-harm and underlying issues, would be invaluable.

- Self-harm (in contrast to the above) also seems to be secretive issue for young people and being able to talk about it would likely be very helpful to addressing the underlying issues that may lead to the act of self-harming. Awareness of, and access to websites, phone-lines and local services, and knowing how to

begin to speak about this, could be greatly beneficial for young people, those who care about them, and professionals.

- Self-harm becoming more generally understood by both young people and those who care about them, work with them, or come into contact with them, would help enable this subject to be spoken about with less judgement and more empathy, and thereby reduce stigma and encourage young people to access support.

We recommend the development of a widely available information guide primarily aimed at young people, to raise awareness and understanding, and get them thinking and talking about self-harm; and be a helpful resource that will include information about local and national support services.

To enhance confidence and self-efficacy in professionals to respond to young people and self-harm, it has been found that training or further training would be of great benefit. Although both the existing and Right Here research have suggested this, it has been particular to Brighton and Hove that young people with personal experience of self-harm being part of the training programme delivery, would be valued. We recommend a training audit across broader professional groups around young people and self-harm; and further investigation into the training content and learning outcomes that would be helpful to professionals, from both the professional's and young person's point of view.

Workforce development has been identified as a priority in the Brighton & Hove Early Help Partnership Strategy 2013-2017 and we recommend that self-harm training is delivered to universal, targeted and specialist services across all sectors, to support the reduction in incidence of self-harm, and ensure young people who do self-harm are identified  and receive  help at the earliest possible opportunity.

When discussing the support available for young people in our focus groups there was varying awareness of local services. Further investment in and promotion of the 'Where to go for…' website may assist young people, their parents and carers, and professionals in identifying the support that is available for young people in Brighton & Hove.

What is also evident is there are no services that are specific to helping young people who self harm. Further study on how effectively existing services can help young people who self harm may be of benefit, and to consider the potential for a service(s) dedicated to this. It may be that existing services could be adapted. An audit of what's available and what is needed would be useful.

We also recommend ensuring there are clear and known referral pathways for professionals across the city to ensure staff are aware of how they can respond to disclosure of self-harm by young people.

## Limitations

There were a number of limitations with our research. Firstly with our participant sample of young people, we only targeted students in 6th form or college. Our results may have been different if we had spoken with a more diverse group of young people. We also asked young people to volunteer to attend the focus groups but we did not specify whether anyone should have experience of self harm, personal or otherwise. Whilst we felt it was important that participants were there voluntarily, we may have limited our responses, as students likely to participate would have potentially had experience of self harm, or had an interest linked to their studies. For example one

focus group we held, the majority of participants were studying health and social care courses.

Secondly we held more focus groups for young people than we did for college staff or medical staff. This was due to time constraints and because we found it easier to engage young people to attend than staff. This could skew the results as we collected more data from young people than staff. Also, it proved difficult for supported accommodation project staff to be able to attend a focus group due to their shift work. This may also have made a difference in the responses we gathered from this group as answering an online survey is markedly different to having the experience of sitting with other professionals and discussing the subject of self-harm.

There were also a few technical issues with our recording equipment, with one focus group the recorder did not work so we did not have the session recorded. We had planned for this and made sure notes were made as well as the recording, but this meant when analysing the data, other volunteers were working from notes that already could have had some bias from the person making them.

Lastly our medical staff sample was fairly diverse; we spoke with a GP surgery (which included all staff from receptionists to GPs) and staff at A&E, whose focus was children up to the age of 18. Although all these participants work in a medical environment, their experiences of young people who self harm were very different. Therefore it is difficult to have one category for "medical staff" when in reality this group was very different and their experience and roles were diverse.

## Acknowledgements

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## FOCUS GROUP FOR YOUNG PEOPLE

**Icebreakers:**
Name, age, what they are studying?
Guess: how many people out of 100 self harm?

**Focus Group Questions:**

1.  What do you think of as self harm?
    **PROMPT**- first three words that come to mind, What's your understanding of the term 'self harm'? What actions would you class as self harm?

2.  At what age do you think the majority of people begin to self harm?
    **PROMPT** – why do you think this age group would be vulnerable? Are there any other social groups you think are more likely to?

3.  Do you think people who self-harm ever influence others to do the same?
    **PROMPT** What makes you think this? Have you read or seen anything on this in the media?

4.  How do you think it could affect someone's life when they self-harm frequently?
    **PROMPT** – Do you think it could affect their relationships with others or what they wear or how they behave?

5.  If you saw someone had self harmed, how would you feel?
    **PROMPT**- this can be a stranger or a friend; how would it vary?

6.  Have you ever felt wary of someone that self harmed? If yes, can you think why that might be?
    **PROMPT**- our research told us a story about a girl at school who used to self harm and the young person providing this story was scared- would you feel scared or worried?

7.  Have you ever thought of someone who self harms as aggressive?
    **PROMPT** - 'If you hurt yourself, you could harm others'- do you think people agree with this?

8.  "People who self harm are attention seeking"
    "People who self harm are seeking attention"
    Do you think there is a difference between the two, and which do you agree with more?

9.  Do you think people see self-harm as a sign of suicidal behaviour?
    **PROMPT** - Can you think why this might be?

10. Can you think of any reasons why someone might self harm?
    **PROMPT** - what do you think people feel they gain from self harm and why.

11. Where do you think young people can get advice about self harm?

12. Would you know who to talk to if you/ a friend self harmed?

## EDUCATIONAL STAFF FOCUS GROUP

**Icebreakers:**
Name, age, what they do.
Guess: how many young people out of 100 self harm?

**Focus Group Questions:**

1. What do you think of as self harm?
   **PROMPT** – first three words that come to mind, What's your understanding of the term 'self harm'? What actions would you class as self-harm?

2. At what age do you think the majority of young people begin to self harm?
   **PROMPT** – why do you think this age group would be vulnerable? Are there any other social groups you think are more likely to?

3. How do you think it affects a young person's day to day life when they self-harm frequently?
   **PROMPT** – Do you think it could affect their relationships with others or what they wear or how they behave?

4. Do you think people see self-harm as a sign of suicidal behaviour?
   **PROMPT**- Can you think why this might be?

5. If you saw a student had self harmed, how would you feel?

6. How confident would you feel discussing a disclosure of self-harm with a student?
   **PROMPT** – on a scale of 1-10 (ten being confident)
   (N.B. the disclosure can be of their own self harm or a peer)

7. If a student disclosed their own or a peer's self-harm would you inform anyone else? If yes, who would that be and why?
   **PROMPT** –Does the college's policy obligate you to pass on such disclosures?

8. Have you had training or any experience regarding young people and self-harm?

9. Do you feel you would benefit from further training about young people and self-harm? Why is this? What would you like to gain from it?
   **PROMPT** – Do you think that staff would take the time to participate in training about young people and self-harm if it was available?

10. "People who self harm are attention seeking"
    "People who self harm are seeking attention"
    Do you think that people see a difference between the two?

11. Can you think of any reasons why a young person might self harm?
    **PROMPT**- what do you think young people feel they gain from self-harm and why?

12. Where do you think young people can get advice about self-harm?
    What local services would you tell them about (if any)?

## MEDICAL STAFF FOCUS GROUP (MEDICAL CENTRE)

**Icebreakers:**
Name, age, what they do.
Guess: how many young people out of 100 self harm?

**Focus Group Questions:**

1. What do you think of as self harm?
   **PROMPT** – first three words that come to mind, What's your understanding of the term 'self harm'? What actions would you class as self-harm?

2. At what age do you think the majority of young people begin to self harm?
   **PROMPT** – why do you think this age group would be vulnerable? Are there any other social groups you think are more likely to?

3. How do you think it affects a young person's day to day life when they self-harm frequently?
   **PROMPT** – Do you think it could affect their relationships with others or what they wear or how they behave?

4. Do you think people see self-harm as a sign of suicidal behaviour?
   **PROMPT** - Can you think why this might be?

5. If you saw a patient (young person) had self harmed, how would you feel?

6. How confident would you feel discussing a disclosure of self-harm with a patient (young person)?
   **PROMPT** – on a scale of 1-10 (ten being confident)

7. If a patient disclosed their self-harm would you inform anyone else? If yes, who would that be and why?
   **PROMPT** – Does the practice's policy obligate you to pass on such disclosures?

8. Have you had training or any experience regarding young people and self-harm?

9. Do you feel you would benefit from further training about young people and self-harm? Why is this? What would you like to gain from it?
   **PROMPT** – Do you think that staff would take the time to participate in training about young people and self-harm if it was available?

10. "People who self harm are attention seeking"
    "People who self harm are seeking attention"
    Do you think that people see a difference between the two?

11. Can you think of any reasons why a young person might self harm?
    **PROMPT** - What do you think young people feel they gain from self-harm and why?

12. Where do you think young people can get advice about self-harm?
    What local services would you tell them about (if any)?

# MEDICAL STAFF FOCUS GROUP (HOSPITAL STAFF)

**Icebreakers:**
Name, age, what they do.
Guess: how many young people out of 100 self harm?

**Focus Group Questions:**

1. What do you think of as self harm?
   **PROMPT** – first three words that come to mind, What's your understanding of the term 'self harm'? What actions would you class as self-harm?

2. At what age do you think the majority of young people begin to self harm?
   **PROMPT** – why do you think this age group would be vulnerable? Are there any other social groups you think are more likely to?

3. How do you think it affects a young person's day to day life when they self-harm frequently?
   **PROMPT** – Do you think it could affect their relationships with others or what they wear or how they behave?

4. Do you think people see self-harm as a sign of suicidal behaviour?
   **PROMPT**- Can you think why this might be?

5. How often do you treat patients who have self-harmed? (in a week, month) What are the most common self-inflicted injuries you treat?

6. Do you have a procedure for dealing with patients who disclose that they have or are self-harming? If so what is it?  Are you obligated to pass on such disclosures?

7. What would you do if you had a patient you believed had or was self-harming but did not disclose this to you? Would you pass on your suspicions to anyone?

8. Do you have a different procedure for young people who come in with an accidental injury?

9. Have you had training regarding how to treat young people who self-harm, if so what did this training entail?

10. Do you feel you would benefit from further training about young people and self harm? Why is this? What would you like to gain from it?
    **PROMPT** – Do you think that staff would take the time to participate in training about young people and self-harm if it was available?

11. "People who self harm are attention seeking"
    "People who self harm are seeking attention"
    Do you think that people see a difference between the two?

12. Can you think of any reasons why a young person might self harm?
    **PROMPT** - what do you think young people feel they gain from self-harm and why?

13. Where can young people can get advice about self-harm?
    What local services would you tell them about (if any)

1. How many young people do you think self-harm out of 100?

2. What do you think of as self harm? Note the first three words that come to mind.

3. At what age do you think the majority of young people begin to self harm?

4. How do you think it affects a young person's day to day life when they self-harm frequently?

5. Do you think people see self-harm as a sign of suicidal behaviour?

6. If you saw a resident had self harmed, how would you feel?

7. How confident would you feel discussing a disclosure of self-harm with a resident? (10 being very confident).

8. If a resident disclosed their own or a peer's self-harm would you inform anyone else? If yes, who would that be?

9. Have you had training or any experience regarding young people and self-harm?

10. Do you feel you would benefit from further training about young people and self-harm? Why is this? What would you like to gain from it?

11. Do you think that staff would take the time to participate in training about young people and self-harm if it was available?

12. Do you think that people see a difference between the two statements below?
"People who self harm are attention seeking"
"People who self harm are seeking attention"

13. Can you think of any reasons why a young person might self harm?

14. What do you think young people feel they gain from self-harm and why?

15. Where do you think young people can get advice about self-harm? (What local services would you tell them about - if any)?

16. Do you have any further comments?