REPORT TO:	Health and Wellbeing Board
DATE:	3 October 2018
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Children, Education and Social Care
SUBJECT:	Health and Wellbeing Board Audit of Self-harm Practice
WARD(S)	Borough-wide

1. PURPOSE OF THE REPORT

1.1 An audit was carried out in response to a serious incident review involving a young person who self-harmed. Following this the Halton Children's Safeguarding Board requested ' A report on the outcome of assurance work undertaken on behalf of the Health and Wellbeing Board regarding health and wellbeing pathway where young people make self-disclosure' (of self-harm).

This report is a compilation of the responses received from the Health and Wellbeing Board members following a self-harm audit, conducted to establish if the children's workforce know what to do and the appropriate response when a young person discloses self-harm. Additionally primary and secondary schools were asked to participate in the audit. The audit also aims to determine if partners have practices in place to help to prevent self-harm, through encouraging positive emotional health and wellbeing.

The audit will also contribute to work taking place across Cheshire and Merseyside through CHAMPs (the Cheshire and Merseyside Public Health Network) to establish the support available to individuals who self-harm.

2.0 RECOMMENDATION: That:

The Board scrutinise the contents of the report and note the suggestions for future work, that include:

- **Prevention of self-harm is critical. Encourage all partners to support emotional health and wellbeing and resilience in their services, and to promote good practice in staff and the public. This should also include recognition of the role of Adverse Childhood Experience on long term health and wellbeing.**
- **For the appropriate agencies to consistently have a clear self-harm pathway for staff to follow that can be evidenced, and to internally audit compliance against the pathway.**
- **Joint consideration of which agencies support individuals who**

self-harm, and if the current provision is adequate. Self-harm is a behaviour and not a mental illness, and therefore not all individuals who self-harm will receive an intervention. Currently universal services, such as GPs/teachers are the main support available. Further consideration is needed of how we support children and young people who self-harm, and how to support young people in emotional crisis but who do not have a mental health diagnosis.

- **Support partners to provide consistent, high quality information and resources to children, young people and their families about self-harm.**
- **To receive evidence of NHS organisations compliance against the NICE guidelines for self-harm.**
- **For agencies to (continue to) utilise available self-harm training, and to monitor ongoing access to self-harm training.**

3.0 SUPPORTING INFORMATION

3.1 What is self-harm?

NICE defines self-harm as "..any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, and excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself." (NICE, 2013). They also emphasise that "self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself" (NICE, 2004).

Self-harm can encompass a range of behaviours such as cutting, biting, scratching and overdoses. Most self-harm happens in the community without presentation to any health services such as Accident and Emergency departments. Cutting is the most common form of self-harm in the community, whilst overdosing or self-poisoning is the most common form of self-harm to lead to hospital admissions (Hawton et al, 2012).

Self-harm is a topic that many find difficult to discuss and understand and can be associated with guilt and shame. While it has historically been misunderstood, there is now a greater understanding that self-harm is a way for some people to deal with difficult or negative emotions and psychological distress and should not be regarded as 'attention seeking'.

3.2 NICE Guidelines

There are currently two NICE guidelines which address self-harm:

- *Self-harm in over 8s: short-term management and prevention of recurrence. Clinical guideline [CG16] Published date: July 2004*

- *Self-harm in over 8s: long-term management. Clinical guideline [CG133] Published date: November 2011*

The NICE quality standard for self-harm (NICE, 2013) consists of 8 statements that outline the key components of high-quality care for people who have self-harmed. These statements would form a framework to assess the quality of care experienced by an individual who has self-harmed.

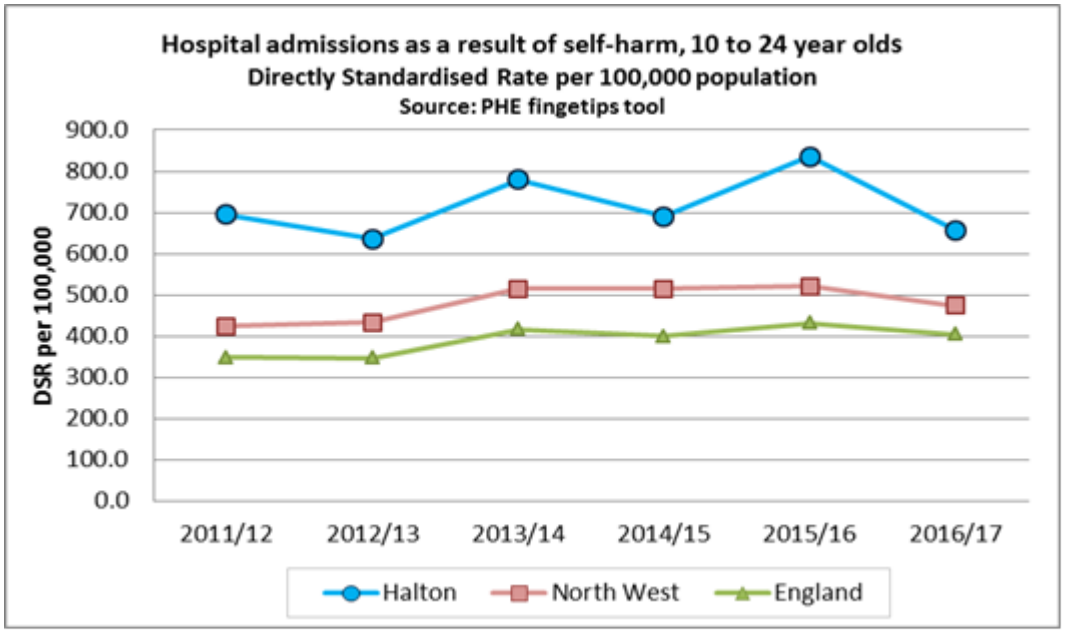
The 8 Key Statements

1. People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.
2. People who have self-harmed have their physical health, mental state, social circumstances and risks of repetition or suicide assessed after an episode of self-harm.
3. People who have self-harmed are offered a comprehensive psychosocial assessment that considers their needs, social situation, psychological state, reasons for harming themselves, feelings of hopelessness, depression or other mental health problems and any thoughts of suicide.
4. People who have self-harmed are checked regularly by healthcare staff, and are accompanied when required, when they are in hospital or another part of the health service, to make sure they are safe
5. People who have self-harmed are cared for in a safe physical environment that reduces the risk of harming themselves further while in hospital or another part of the healthcare service.
6. People who are having long-term support after self-harming have a risk management plan developed with their healthcare professional that helps them reduce their risk of harming themselves again.
7. People who are having long-term support after self-harming discuss the possible benefits of psychological treatments for self-harm with their healthcare professional.
8. People who are having long-term support after self-harming and are moving between mental health services agree a plan with their healthcare professionals that describes how they will be supported while they move from one service to another.

3.3 How big a problem is self-harm in Halton?

In Halton the rates of hospital admission for self-harm are higher than both the national and North West regional average.

Figure 1: Trend in hospital admissions for self-harm (10-24 year olds) per 100,000 population.



Whilst the rate of admissions in 2016/17 appears to have dropped compared to 2015/2016, there are annual fluctuations. The overall trend at present is showing a slight increase, and the gap between the rate in Halton and the North West and England is not closing. A more detailed analysis of the Halton self-harm data can be found in Appendix 1.

3.4 The Audit Process

In order to complete the review the members of the Health and Wellbeing board and primary and secondary schools were asked to complete a series of questions on their current practice in response to self-harm. The details of the questions asked are outlined in the main findings.

We received responses from the following organisations:

- Warrington and Halton NHS Foundation Trust
- St Helens and Knowsley NHS Trust
- North West Boroughs NHS Foundation trust
- Bridgewater Community Healthcare NHS Foundation trust
- Halton Housing
- Cheshire Police
- The Citizens Advice Bureau
- Halton Borough council Adult and Children's Social Services
- Halton Borough Council Health Improvement Team
- A response on behalf of community pharmacies
- 8 schools in the borough, including 6 primary schools, 1 primary and secondary school and 1 high school

At the time of the request there was also work taking place across Cheshire and Merseyside aiming to gain a better understanding on self-harm practice, which Halton public health team had been supporting. It was therefore decided to ask a broader series of questions from providers, to gain greater insight into local practice. The results from this will feed into the audit on self-harm in Cheshire and Merseyside for CHAMPS.

3.5 Main Findings

The following questions were asked of responders. The quality and detail of responses provided varied and a summary of the responses recieved have been provided below:

1) ***Is a Self-Harm Pathway in place and implemented by staff in your organisation. Does the pathway include working across NHS, community, and local authority services, with involvement of young people?***

Warrington and Halton NHS Foundation Trust, St Helens and Knowsley NHS Trust and North West Boroughs all have a self-harm pathway in place. Bridgewater commented that the 0-19 service has contributed to Halton's multi-agency response to developing the Self-Harm Pathway.

Adult social care also described a pathway.

Halton Housing said they had no formal pathway but that they would advise them to see their GP to be referred to mental health services.

Cheshire police also described a pathway relevant to police officers.

Citizens Advice Bureau states that advisers are familiar with the self-harm pathway and where to refer if they come across self-harm.

The Health Improvement Team have formulated a guide to supporting children and young people who self-harm which is part of a training package currently being delivered to staff who work with children and young people.

Community pharmacies said they would sign post as appropriate in accordance with a local pathway developed by service providers. Community pharmacies are not aware of any information currently available to pharmacies.

Of the 8 schools that replied, only 1 said they had a pathway.

In summary: most respondents appeared to have a pathway or a response to self-harm in place, the quality and consistency of these was not able to be ascertained and would require individual organisation level audits.

2) ***Is there provision of self-harm prevention training for***

professionals working with children and young, providing for early recognition of self-harm behaviours and interventions to mitigate ACEs (Adverse Childhood Experiences)?

Warrington and Halton NHS Foundation Trust, St Helens and Knowsley NHS Trust and North West Boroughs currently have training in place. Bridgewater Staff access training provided by CAMHS which includes working across NHS community and local authority services. They have stated that further Health Improvement training will be accessed by the 0-19 service in 2018/19. The 0-19 service itself does not provide self-harm prevention training but engages with and attends multi-agency training and events such as CHAMPs events. Some information with regard to adverse childhood experiences has been shared across the service.

Halton housing is currently working towards getting some training from the council in place.

Adult social care has received training from CAMHs and also receives basic self-harm awareness and managing self-harm training.

Citizens Advice Bureau informed us that advisers have completed suicide awareness and safe talk training which both cover self-harm. The e-learning course provided by HSCB / MindEd called Self-harm and Risky Behaviour that Sure Start advisers will be asked to complete this in future.

The Health Improvement Team provides self-harm awareness training to staff working with children and young people and includes signs and behaviour of which to be aware, however it doesn't include information on adverse childhood experiences (ACEs) or interventions to mitigate against ACEs.

Community pharmacies would sign post as appropriately. They need to be provided with information from the services to enable them to do this. Community pharmacies are not aware of any information currently available to pharmacies.

Of the schools, 50% had received training. This included 3 primary schools and one secondary. In the secondary school all staff had received training.

In summary: Training on self-harm is available in Halton and is being accessed by many agencies. There is more limited awareness of ACEs.

3) What provision is there of self-harm awareness, advice and guidance for young people, families and carers? How can it be accessed? Is this provided in online, digital and printed formats?

There is a great amount of variability in the advice and guidance provided by our acute trusts both in what is provided and in the format in which it is provided, as evident below:

Warrington and Halton NHS Foundation Trust said that *"Each patient is assessed on an individual basis and where appropriate resources have been sourced from the internet and provided to patients and their families. There are little visible resources within Emergency Department or the children's ward. Some posters are displayed for drop in sessions for Warrington. Emergency Department nurses are currently in the process of developing a mental health and wellbeing board which will include support contacts and information."*

St Helens and Knowsley NHS Trust reported *"This information is provided to families and young people by North West Boroughs CAMHS team."*

Bridgewater Community NHS trust responded *"0-19 healthy child service provides self-harm awareness, advice and guidance for young people in a number of settings confidential drop-in service at school / college and at every contact at which a holistic health assessment is undertaken. The 0-19 service will signpost young people , families and carers to Kooth, Papyrus, CAMH ,and other evidenced based services/ guidance (e.g. 5 ways to health and wellbeing model) this includes on-line resources. There is universal access to the 0-19 service. The service is notified via A&E Notifications of self-harm incidents. The 0-19 webpage is currently being refreshed, there is a new 0-19 Facebook page and a Twitter and Instagram account where regular posts and tweets are shared relating to emotional health and well-being. Appropriate evidence based written information is sourced and shared according to need."*

Halton Housing *"Provide information and advice on Mental Health through the medium of social media, on our website and within our customer app. We provide regular updates on local mental health hubs, information on local services and useful contact numbers. Our front line teams also work closely with families to ensure they have appropriate information (leaflets) on how to access further support."*

North West Boroughs say "T*here is CAMHS (children and young people's mental health service) "Who Am I" website which covers self-harm awareness etc available to all. There are printed leaflets for cares, parents and young people so even if signposted externally Halton CAMHS have appropriate literature available. There is also an online counselling service available called Kooth, although not specifically for self-harm this is covered within their remit. This is part of the Halton CAMHS offering. Halton CAMHS have school link workers which have recently been increased to a local college who can provide support and education and advice where needed/ Gaps: Possibly a self-harm pathway across organisations."*

Adult social care have "*leaflets and z cards available for all in a variety of formats and through various links on websites. There is also a monthly MH hub in both Runcorn and Widnes where this information is available as well as people to talk to get advice."*

Citizens Advice Bureau promotes "Hopeline UK" a telephone support

service run by Papyrus, for young people but they don't have access to local literature.

The Health Improvement Team have a communication strategy which includes promoting positive mental health and wellbeing through social media and the press throughout the year. They are also investigating developing an online resource for Halton which would include information regarding local mental health and support services, which would include links to information and advice on self-harm and other relevant topics.

Of the 8 schools, 2 said they provided leaflets and 2 mentioned holding parental meetings. One of the secondary schools mentioned they didn't have any information on their website, however did have displays around the school. Importantly it was mentioned that the students have a 1:1 keyworker who will signpost parents/students to services if required, a dedicated CAMHS link worker, an on-site counsellor 2 times per week and weekly school nurse drop in, as well as Personal Social Health Education (PSHE) sessions which cover self-harm.

In summary: Information provided on self-harm varies between agencies, resources are available, particularly online resources.

4) What steps do you take to improve mental health literacy in parents and Children and young people?

All of the NHS trusts told us that they deferred the role of providing mental health information to CAMHS and North West Boroughs told us anyone can contact CAMHS and that they provided psychotherapy.

Bridgewater emphasised that "*the 0-19 service practitioners provide Universal and Targeted care to children and young people and use the opportunity for face to face contact at drop ins, assessments, immunisation sessions, listening ear visits to provide emotional health and well-being information, advice, guidance and support to provide them with the appropriate information to make an informed choice. Young people are signposted or referred into partner services as required. At home visits parents and carers are also provided with information, advice, guidance and support and either referred or signposted into services. Parents/carers are supported by listening visits according to need".*

Citizens Advice Bureau Advisers are trained in RSPH level 2 award Understanding Health Improvement.

The Health Improvement Team offers all schools a "healthitude" programme for years 6 pupils. The programme consists of education sessions on a variety of topics such as mental health and resilience. The health improvement team provide a Children and young person's mental health agenda aimed at supporting educational settings to improve mental health and wellbeing of their community. However they note that a recent pilot programme (Youth Connect 5) didn't meet local needs and only engaged with low number of parents. In order to improve mental health

literacy of parent's consideration is being given to engaging parents via social media.

7 out of the 8 schools who responded described a range of activities to improve mental health literacy including assemblies PSHE and circle time. 2 schools mentioned that parents are difficult to engage whereas 2 schools mentioned they had parental meetings.

One school mentioned they had daily mindfulness activities and one school mentioned stress management support for staff.

Children's Social Care responded that *"Barnardo's Go4ward offers an emotional health and wellbeing service for children and young people in the care of Halton Borough Council. We work with ages 5-18 (and up to 25 with additional needs) as well as post adoption (again 5-18 yrs and up to 25yrs with additional needs) and care leavers (up to 25yrs). Go4ward also works alongside carers and other professionals as part of a supportive team response, tailored to the individual needs and circumstances of each child and young person. We predominantly offer counselling to children and young people in the form of play, creative arts and expressive, solution focussed and CBT techniques; person centred counselling and integrative counselling. Referrals are usually accepted via the EHWB Panel although referrals can be discussed and submitted directly to the service".*

In summary: The question regarding mental health literacy was interpreted differently by different respondents. It was clear that schools and health improvement teams are working to support children, young people and their families to develop their ability and awareness of the importance of discussing emotional health, and that service are available to support children in care to support their emotional health.

5) In designing local services, what steps do you take locally to seek the views of those young people who have disengaged from services?

Warrington and Halton NHS Foundation Trust said that, "Children and young people who have self-harmed are referred to appropriate services and discharged from WHHFT. The views of young people are captured throughout the admission process. WHHFT would liaise with specialist services when children who self-harm are admitted. Where there are concerns that the young person is not engaging support and guidance is obtained via the hospital safeguarding teams. WHHFT are currently in the process of developing a Children's and Young Persons Strategy which will incorporate the views of the children and young people."

St. Helen's and Knowsley have *a "Paediatric Patient Participation Group who look at ways of engaging and seeking the views of young people, although this subject has not been included as yet, it is likely to be considered in the future."*

CAMHS have a "*SHOUT group fortnightly open to anyone who is open or has previously been open to CAMHS. Manager of team sits on Children's Trust and Child in care board which has representation from young people".*

Bridgewater informed that the *"redesign of the 0-19 service will enable us to reach disengaged young people such as NEET, Educated at Home etc. The 0-19 service has been innovative in developing our Voice of the Child programme which has resulted in ensuring all 0-19 staff are competent in reflecting views and the voice of young people".*

One primary school described the 'Pupil Voice' that is collected from vulnerable pupils who have accessed services. We didn't receive any other responses from school on this question.

The police said that "*informal feedback is taken from members of the 'vulnerable youth' cohort to influence services on an ad-hoc basis."*

Citizens Advice Bureau said that they don't provide direct "self-harm" provision. *"… but we do consult the public on service design issues albeit in a generic way. We have recently been engaging with the Youth Parliament about producing an "employment rights" handbook and their feedback suggests that there is massive demand from young people who want to know their rights to tackle the problems they face (e.g. bullying, exclusion, etc.)"*

In summary: agencies had processes in place to seek the views of service users, with some agencies looking to engage with those who are not directly involved in services. The responses didn't clearly demonstrate that the views of individuals who self-harm who disengage would be captured in all areas, but it appears that some services are working towards achieving broader feedback from users.

6) Do acute hospital/ crisis care services adopt and foster a culture of empathy to those that self-harm and have the appropriate policies and procedures in place?

Warrington and Halton NHS Trust staff have received training from CAMHS which emphasises a culture of empathy.

St Helens and Knowsley's self-harm pathway "ensures young people are managed sensitively, seen in the relevant department and that their safety is maintained. If possible, they are fast tracked to the paediatric unit to avoid unnecessary waits and also to try and limit the number of professionals they need to see and tell about their circumstances."

In summary: There is some evidence of this, but it wasn't evident across all providers.

7) Is 24/7 Psychiatric Liaison Service available for CYP & young adults?

There is not 24/7 on site psych liaison at the two acute trusts; with different arrangements for on call services at the two acute trusts. CAMHS sees referrals up to midnight in Warrington hospital and up to 10pm in Whiston. Outside these hours there is an on call service provided by North West Boroughs.

In summary: No there is not currently a 24/7 psychiatric liason service, but there is some cover in place.

8) Does assessment of a young person's digital life form part of clinical assessments?

Warrington does not currently ask these specific questions and Whiston does only when Child Sexual Exploitation is a concern. It does form part of a CAMHS assessment however. Warrington would welcome feedback on how to incorporate this into assessments.

In summary: The assessment of an individual's digital life could be improved.

9) Is the use of psychological therapies specifically structured for people who self-harm to reduce repetition of self-harm?

North West Boroughs provide Dialectical Behavioural therapy, individualised care plans based on need and individual psychological therapies based on need. The other two trusts refer to this service.

In summary: Yes this is provided by North West Boroughs

10) What data do you collect on primary care/ community services attendances for self-harm?

All three of the NHS trusts collect data on A&E admissions for self-harm and Warrington hospital stated that the source of admission could be captured in this data. Whiston hospital collects data on all attendances for Children and young people with mental health issues. NWBH has information regarding referrals to CART after a young person presents on the self-harm pathway to acute trusts.

11) What percentage of young people under the age of 16 seen in A&E are admitted following acute self-harm?

North West Boroughs does not collect this data, Warrington could provide this data given some time and Whiston hospital is currently unable to provide this data.

12) ***What data do you collect on hospital attendances for self-harm? Please give a contact name to access the data***

The schools were asked some additional questions:

13) Do you promote a whole school/college approach to emotional wellbeing and services with a single-point of access?

There was a wide range of responses to this question with one schools saying they refer to CAMHS to others describing trained counsellors and family support workers. One School is in the process of completing the 5 Ways to Well-Being and actively gets involved with health improvement teams training sessions.

14) How do you encourage parents to engage in their children's digital lives as early as possible and what is in place to keep children safe in the digital world?

All of the schools do some work around this.

One school responded:

"We speak to new parents regarding digital safety at our new parents meetings before they start in September. We provide a wealth of information on our school website and have policies in place. A flier is to be sent out to parents at the end of terms to remind them about digital safety during the summer holidays. Children are regularly taught about internet safety in class along with visits from outside agencies and taking part in Crucial Crew event."

15) Do all your schools and colleges have regular access to on-site support/ electronic communication from a CYP Mental Health Service professional?

Seven out of the eight schools who responded said they had access to either on site or electronic communication from a Mental Health Service professional. In some cases this included promoting KOOTH, in others this meant having the contact details for CAMHS.

3.6 Recommendations and conclusion

The audit identified that the majority of agencies were aware of self-harm, had a pathway in place or common practices for staff when self-harm is disclosed and staff were accessing self-harm training.

Suggestions for future work would include:

- Prevention of self-harm is critical. Encourage all partners to support emotional health and wellbeing and resilience in their services, and to promote good practice in staff and the public. This should also include recognition of the role of Adverse Childhood Experience on long term health and wellbeing.
- For the appropriate agencies to consistently have a clear self-harm pathway for staff to follow that can be evidenced, and to internally audit compliance against the pathway.

- Joint consideration of which agencies supports individuals who self-harm, and if the current provision is adequate. Self-harm is a behaviour and not a mental illness, and therefore not all individuals who self-harm will receive an intervention. Currently universal services, such as GPs/teachers are the main support available. Further consideration is needed of how we support children and young people who self-harm, and how to support young people in emotional crisis but who do not have a mental health diagnosis.
- Support partners to provide consistent, high quality information and resources to children, young people and their families about self-harm.
- To receive evidence of NHS organisations compliance against the NICE guidelines for self-harm.
- For agencies to (continue to) utilise available self-harm training, and to monitor ongoing access to self-harm training

4.0 POLICY IMPLICATIONS

The early identification, support and services available to children and young people that self-harm should be considered across policies and for services that work with children and young people and families. The promotion of positive emotional health and wellbeing should also be prioritised for families and the general population, as a means of preventing self-harm behaviour.

5.0 OTHER/FINANCIAL IMPLICATIONS

No additional funding is requested in this report, however there are financial implications to partners of ensuring the workforce is trained, services are available and positive emotional health and wellbeing is promoted.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton Borough Council

Halton Council want all children and young people to have the opportunity to achieve and develop the skills and character to make a successful transition to adult life. Keeping safe and having good mental health is a vital part of achieving these aspirations.

6.2 Employment, Learning & Skills in Halton

In order to help their pupils succeed, schools and community partners have a role to play in supporting them to be resilient, mentally healthy and to keep them safe. It is important that the children's workforce know what to do and where to go for support for young people who are self-harming.

6.3 A Healthy Halton

An understanding of self-harm and how to support children and young people who self-harm is important across the children's workforce, to provide early intervention and support.

6.4 A Safer Halton

Children who are at risk of harm are identified quickly and services work together to minimise the risk of harm and take action to formally protect

children in a timely way.

6.5 Halton's Urban Renewal
None identified.

7.0 RISK ANALYSIS

7.1 Ensuring that services have an appropriate, compassionate and effective response to children, young people and their families affected by self-harm is important to keep children safe, but also to ensure they can fully participate in their education, society and the opportunities available to them.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Evidence suggests that the risk of self-harm is higher in some marginalised communities. Supporting the children's workforce to understand the risk factors associated with self-harm will equip them to be better prepared to identify where support is needed and provide a more equitable services, based on need.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None.

Appendix 1: Self-harm in Halton Data Report

Summary of findings

- The data presented is for self-harm admissions, data is not available on the rate of self-harm in the community of Halton, or rates of attendance at hospital for self-harm.
- Rates of self-harm in Halton are higher than England and the North West averages for both children and young people and all ages. They appear to be increasing in children and young people.
- The highest number of admissions for self-harm are in the 15-19 age group, closely followed by the 20-24 age group.
- Young people aged 10-24 accounted for a third of the total admissions (34%) whilst making up just 17% of the population.
- There were 143 admissions for self-harm amongst young people aged 10-24 and a total of 421 hospital admissions for people of all ages in Halton
- More females than males are admitted to hospital for self-harm, particularly in children and young people.
- The main method resulting in hospital admissions for self-harm are over the counter non-opioid medications (e.g. paracetamol, ibuprofen, aspirin, co-codamol).

Background

What is self-harm?

NICE defines self-harm as "..any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, and excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself." (NICE, 2013). NICE explicitly state that 'self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself" (NICE, 2004).

Most self-harm happens in the community without presentation to any health services such as Accident and Emergency departments. Research suggests that cutting is the most common form of self-harm in the community, whilst overdosing or self-poisoning is the most common form of self-harm that leads to hospital admissions (Hawton et al, 2012).

Why do some people self-harm?

Self-harm is a way for some people to deal with difficult or negative emotions and psychological distress (Young Minds 2018). Historically people who self-harm have been dismissed as 'attention seeking'; but there is now a greater understanding that this is not the case and self-harm is a behaviour employed that indicates an individual may need additional support to cope.

Risk factors for self-harming

NICE lists the following as risk factors for self-harm (NICE, 2014):

- Socio-economic disadvantage.
- Being socially isolated, single, divorced, living alone, a single parent, from a sexual minority, or an asylum seeker.
- Stressful life events, for example caused by relationship difficulties, or experienced by veterans from the armed forces.
- Mental health problems, such as depression, psychosis or schizophrenia, bipolar disorder, post-traumatic stress disorder, or a personality disorder.
- Chronic physical health problems.
- Alcohol and/or drug misuse.
- Involvement with the criminal justice system, particularly people currently in custody.
- Child maltreatment or domestic violence.

The impact of self-harm

Whilst self-harm is not a mental illness in and of itself, there is agreement that an act of self-harm should flag up that a young person may be having difficulties that require further help and identifies a young person in need (RCPsych, 2010).

The evidence shows that people who self-harm; including previous suicide attempts, are at the highest risk for suicide. One study showed 50% of people who take their own lives have a history of previous self-harm (Foster et al, 1997). In addition to the increased risk of suicide, there is also a risk of further repeated episodes of self-harm, with an estimated 18% of young people going on to self-harm again (Hawton et al, 2012), with adverse outcomes including liver damage, scarring and nerve and tendon damage (NICE, 2014).

There is increasing governmental recognition of the impact that self-harm is having on young people. The Government's National Suicide Prevention Strategy is 'strengthening its focus' on self-harm and identifies self-harm as a 'new key area' in the strategy and the Health Secretary called for expanding the scope of the National Strategy to include self-harm prevention in its own right. (Department of Health, 2017).

Self-harm data

The prevalence of self-harm

The number of individuals who are or have self-harmed in Halton is very difficult to determine accurately. This is because individuals do not always seek help or advice from medical professions, and the only routine data collected is for those individuals who are admitted to hospital as a result of their injuries.

Research indicates that women are more likely to self-harm than men, and this is more pronounced in adolescence (Hawton et al 2002, as quoted in NICE 2004). NICE reported a survey of 15-16 year olds that found more than 10% of girls and 3% of boys had self-harmed in the previous year and a lifetime prevalence of 0.5% across all age groups. Research suggests that self-harm prevalence is between 1 in10 to 1 in 15 in young people (Hawton et al 2002, NICE 2004).

Hospital admissions data

Figure 1: Trend in hospital admissions for self-harm (10-24 year olds) per 100,000 population

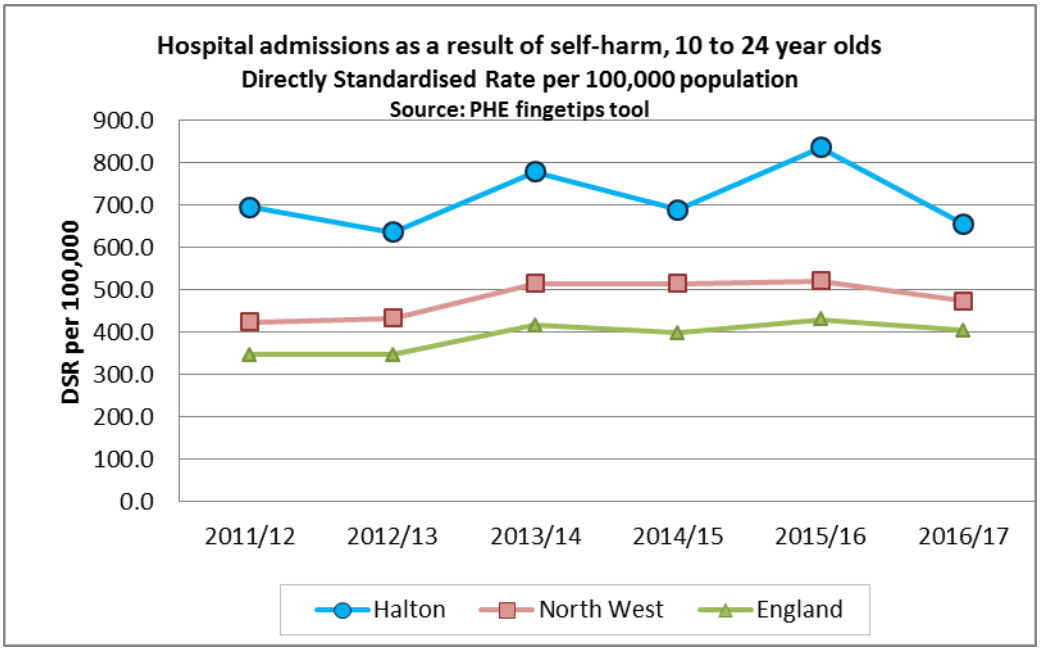
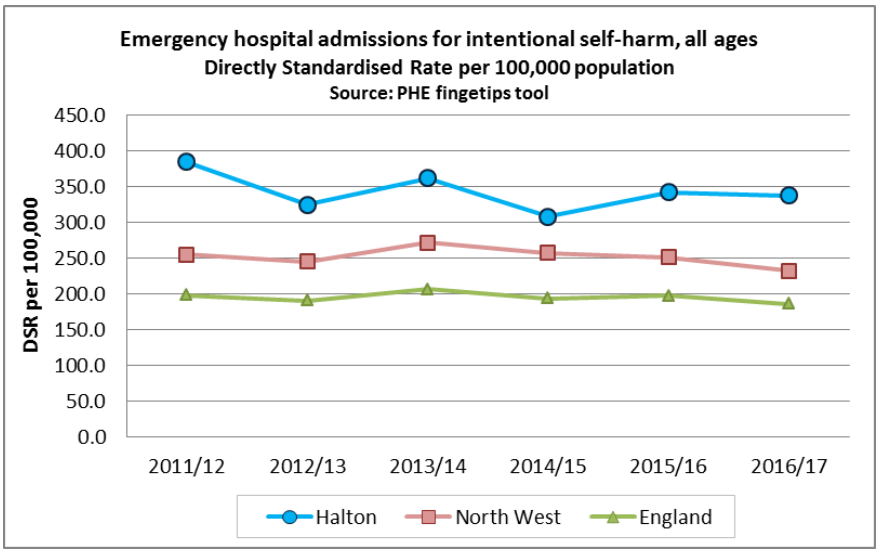


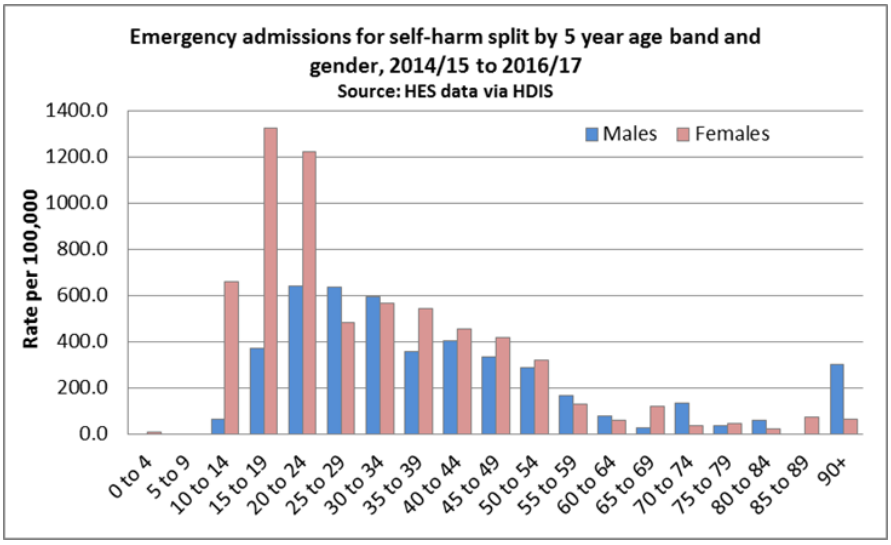
Figure 1 shows that over the period of 2011-2017, hospital admissions for self-harm in Halton have consistently been higher than in both the North West and nationally and the gap has not closed over time. There is annual fluctuation, but overall the trend appears to be increasing.

Figure 2: Trend in hospital admissions for self-harm (all ages) per 100,000 population



The trend for self-harm admissions for all ages has an overall trend of remaining at a similar level since 2011/12.

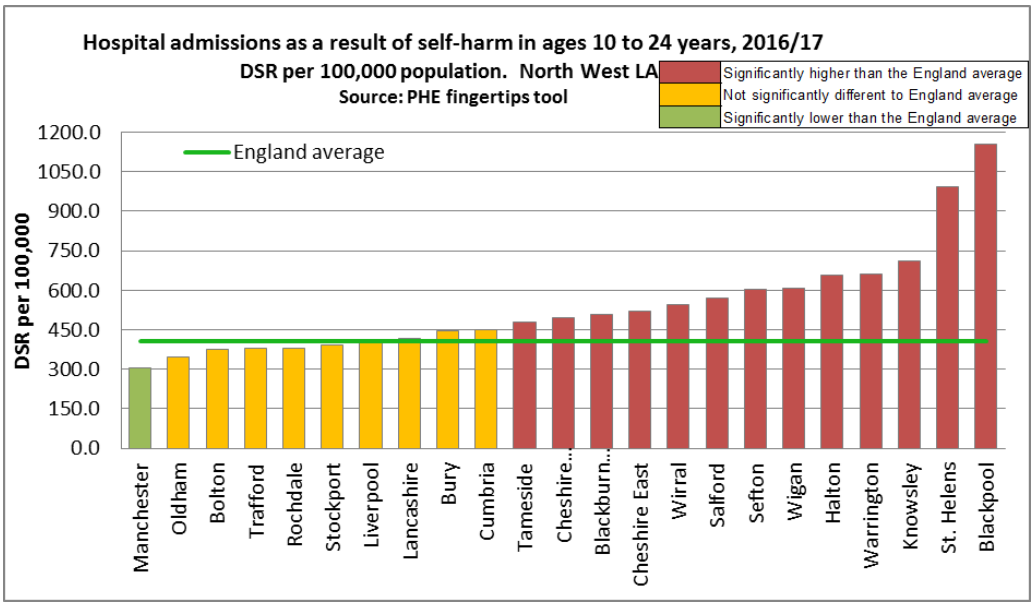
Figure 3: Emergency admissions for self-harm split by 5 year age band and gender, 2014/15 to 2016/17



This bar chart illustrates that the highest proportion of admissions are seen in young people aged 15-19, with the rate of admissions in girls approximately three times higher in this age group. The higher rates of self-harm in girls in this age group were also found nationally (Brooks et al, 2017). The second highest rates are found in the 20-24 age group, suggesting the transition from adolescence to adulthood is also a high risk time for self-harm.

The differences between the rates in boys and girls in Halton reflects the national picture whereby girls are more likely to be admitted for self-harm however boys are more likely to die as a result of suicide.

Figure 4: Rate of hospital admissions for self-harm (10-24 year olds) per 100,000 population in North West local authorities, 2016/17



This bar chart shows how Halton compares to other local authorities in the North West for self-harm admissions. The chart highlights that the rate of self-harm admissions are significantly higher than the England average and that it is the 5th highest in the North West. Figure 5 shows how Halton compares for self-harm admission in all ages, where Halton has the 4th highest rate of admissions. For 2016/17, the Halton self-harm admission rate (10-24 years) was the 11th worst in England (out of 148).

Figure 5: Rate of hospital admissions for self-harm (all ages) per 100,000 population in North West local authorities, 2016/17

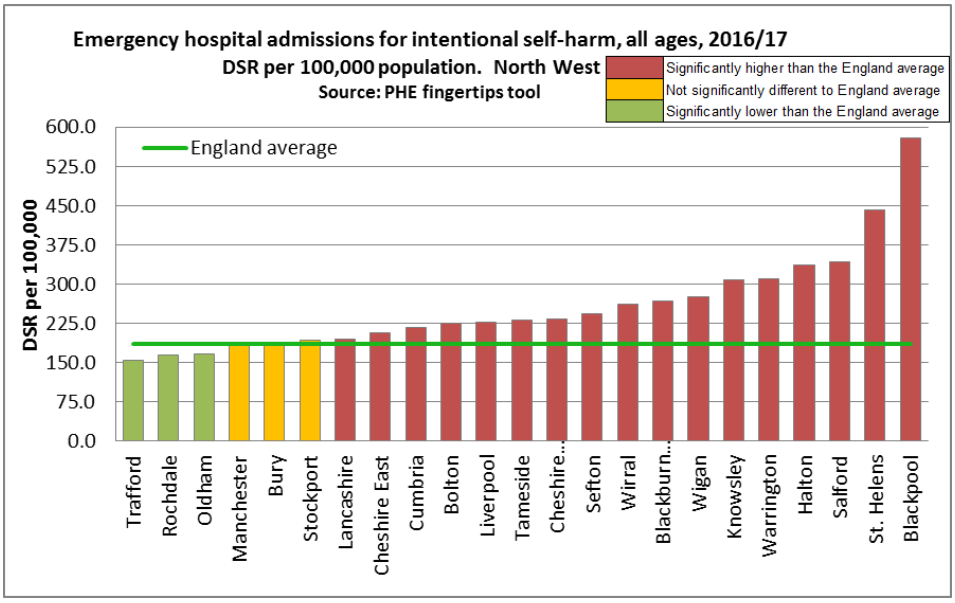


Figure 5 shows how the rate of hospital admissions for residents in Halton of all ages compares to other areas in the North West. Halton has the 4th highest rate. Both figure 4 and Figure 5 show there is large variation between

the different areas of the North West, with Oldham having rates less than the England average and Blackpool significantly higher than the England average. This may be due to variability in practice and policy around whether someone is admitted to hospital following an episode of self-harm or discharged and will also depend on local arrangements for follow up. For 2016/17, the Halton self-harm admission rate (all ages) was the 7th highest in England (out of 148).

Figure 6: Rate of hospital admissions for self-harm (10-24 year olds) per 100,000 population in North West local authorities, 2016/17, split by age bands

LA	10 to 14	15 to 19	20 to 24
Blackburn with Darwen	405.9	761.8	368.3
Blackpool	590.4	1,624.00	1,247.80
Bolton	168	611.8	347.6
Bury	237.3	581.2	509.8
Cheshire East	256.9	827.5	479.5
Cheshire West & Chester	341.2	687.6	465.3
Cumbria	254	674.6	429.2
Halton	317.8	770.6	862.2
Knowsley	490.5	1,190.60	474.8
Lancashire	327.1	586.8	349.3
Liverpool	397.3	489.2	323.6
Manchester	246.5	458.2	212.9
Oldham	120.7	510.3	404.2
Rochdale	219	504.8	415
Salford	263.8	947.7	508
Sefton	323.2	814.2	663
St. Helens	526	1,486.00	964
Stockport	354.8	472.6	349.9
Tameside	277.3	670	490.2
Trafford	145.4	505	474.3
Warrington	284.7	879.1	802.9
Wigan	252.4	866.4	692.8
Wirral	264.7	739.8	624.1
North West	**294.5**	**688.6**	**441.9**
England	**211.6**	**619.9**	**393.2**

significantly higher than the England average

significantly lower than the England average

Figure 6 above shows the rate of hospital admissions for self-harm, split by age group for the North West local authorities. It shows that in particular the rate of hospital admissions in the 20-24 year old age group was the third highest in the North West and is much higher than the England average. The rate of admission amongst 20-24 year olds in Halton was higher than in 15-19 year olds and 10-14 year olds. Halton is the only local authority where the rate in 20-24 year olds is higher than the rate in 15-19 year olds.

Figure 7: Admission rate for self-harm per 100,000 population aged 10 to 24 years, 2014/15 to 2016/17 by Halton wards

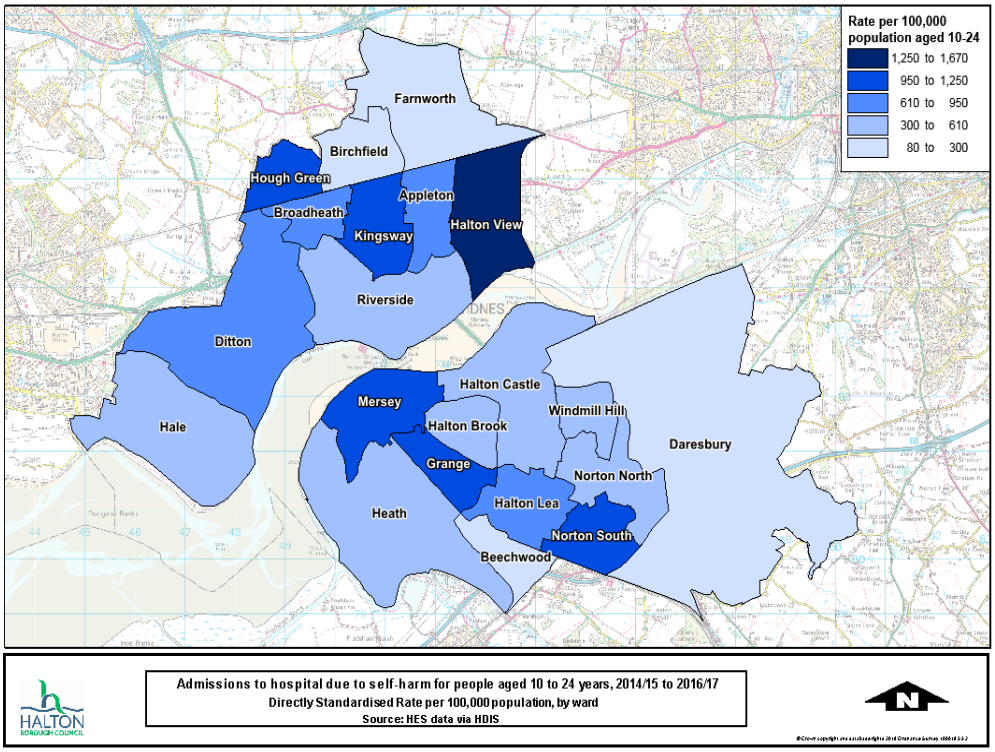


Figure 8: Distribution of deprivation in Halton by LSOA – National Quintiles – Indices of Multiple Deprivation 2015

Figure 7 shows the wards in Halton with a high rate of emergency admissions due to self-harm for 10 to 24 year olds; shown by the dark blue areas. Figure 8 shows which areas in Halton are the most deprived. When comparing these wards with the most deprived areas in Halton (dark red in the figure below), it shows that generally the highest admission rates are seen in the most deprived wards and lower admission rates are seen in the least deprived areas.

Statistically there was a moderate correlation (0.45) between deprivation and levels of self-harm for young people, but this increase to 0.75 for all ages, showing a stronger relationship between admissions due to self-harm and deprivation. This findings is what would be expected as socioeconomic disadvantage is a known risk factor for self- harm (NICE, 2014) and may partially explain this trend, but it is not clear why the relationship is less in young people.

Figure 9: Hospital admissions due to self-harm in 10 to 24 year olds, Directly Standardised Rate per 100,000 population

Ward Name	12/13 to 14/15	13/14 to 15/16	14/15 to 16/17
Appleton	949.6	933.2	830.4
Beechwood	206.4	209.3	138.2
Birchfield	248.6	125.5	88.0
Broadheath	542.0	984.0	710.4
Halton Castle	475.0	691.1	609.6
Daresbury	238.8	237.2	271.0
Ditton	1032.2	1100.9	850.1
Farnworth	149.8	186.5	222.8
Grange	1254.9	1127.4	1233.3
Hale	139.2	290.5	424.4
Halton Brook	638.8	686.2	547.3
Halton Lea	708.8	709.3	710.1
Halton View	791.0	1569.7	1661.1
Heath	616.9	716.0	589.7
Hough Green	864.7	856.6	953.1
Kingsway	981.8	1086.1	1041.8
Mersey	762.4	954.9	1023.1
Norton North	477.4	502.8	522.9
Norton South	1076.3	917.0	1025.9
Riverside	737.5	569.4	338.0
Windmill Hill	557.2	466.5	395.7

Red = significantly higher than the England average

Orange = not significantly different to the England average

Green = significantly lower than the England average

Figure 10: Admission rate for self-harm per 100,000 population, all ages, 2014/15 to 2016/17 by Halton wards

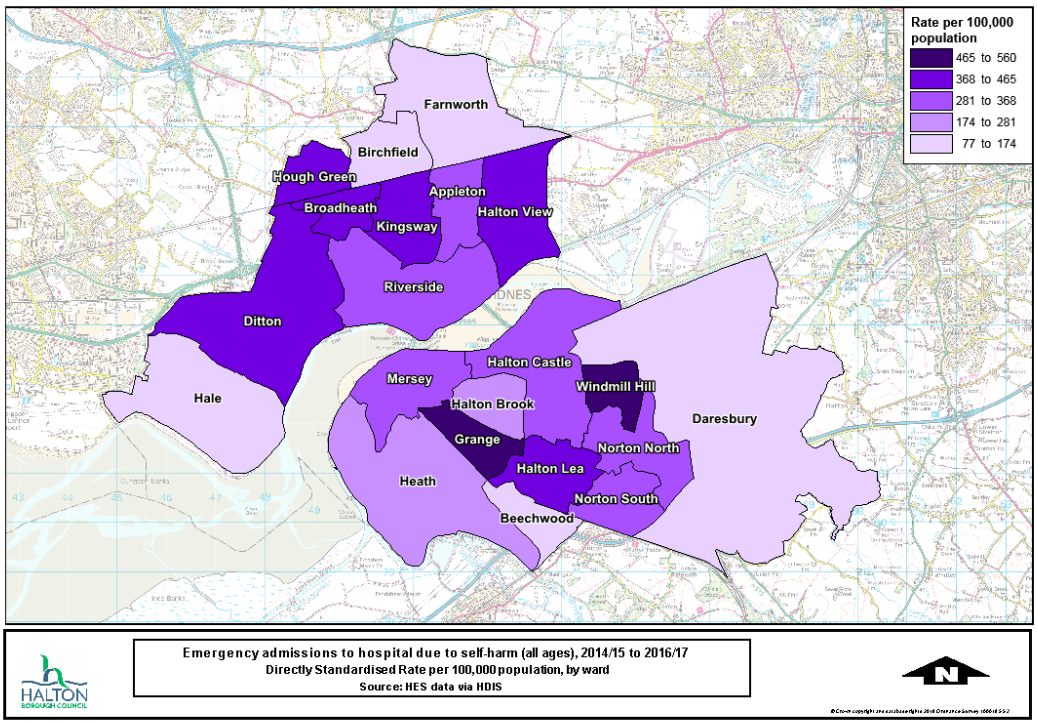


Figure 11: Distribution of deprivation in Halton by LSOA – National Quintiles – Indices of Multiple Deprivation 201

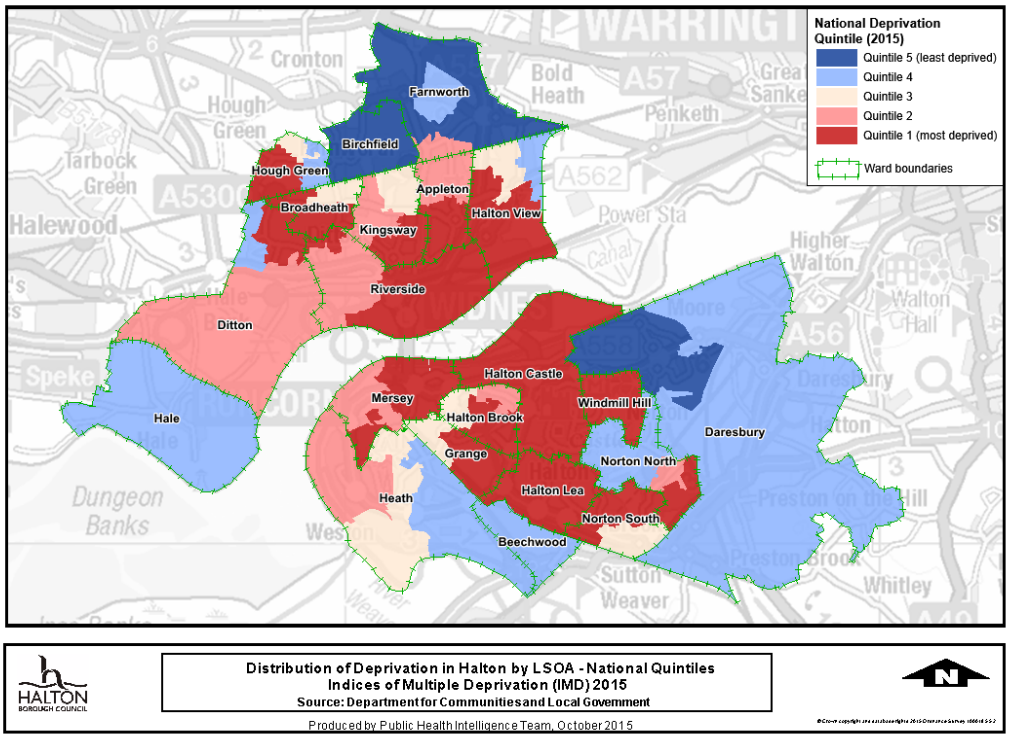


Figure 12: The number of hospital admissions for self-harm (10-24 year

olds) per 100,000 population in 2016/17, split by gender

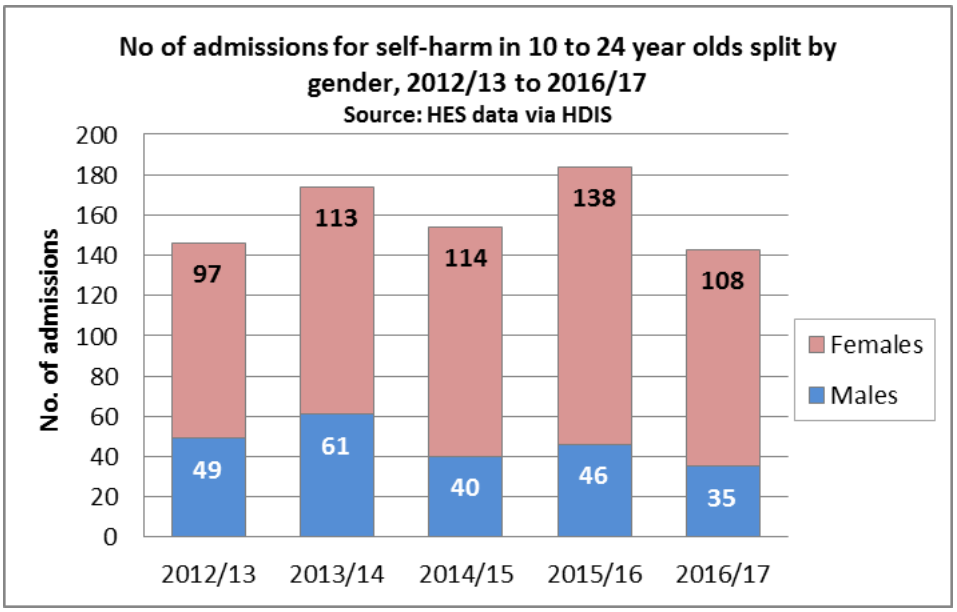


Figure 13: The number of hospital admissions for self-harm (all ages) per 100,000 population in 2016/17, split by gender

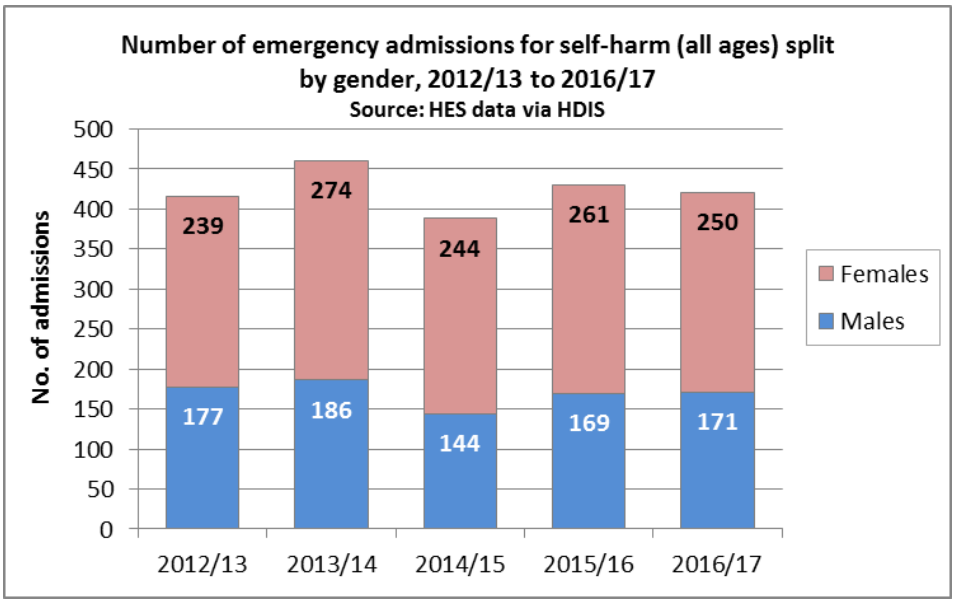


Figure 12 and 13 demonstrate the continuing trend of significantly more admissions amongst females than males in Halton. In 2016/17 females made up over three quarters of admissions for self-harm. This reflects the research conducted nationally (Brooks et al, 2017).

Figure 14: The number of 10 to 24 year olds admitted multiple times:

three year trend

No. of admissions	12/13 to 14/15	13/14 to 15/16	14/15 to 16/17
1 admission	267	296	274
2 admissions	45	40	50
3 admissions	11	13	5
4 admissions	6	8	8
5 admissions	-	-	-
6 admissions	0	-	-
7 admissions	-	-	-
8 admissions	0	-	0
9 admissions	-	0	0
10+ admissions	-	-	-

'-' denotes figures less than 5

Figure 14 shows there are a number of individuals who are admitted to hospital multiple times which warrants further investigation to determine whether these admissions can be avoided with appropriate care.

Figure 15: The number admitted multiple times, all ages: three year trend

No. of admissions	12/13 to 14/15	13/14 to 15/16	14/15 to 16/17
1 admission	734	739	696
2 admissions	118	112	116
3 admissions	41	34	28
4 admissions	17	17	19
5 admissions	5	8	8
6 admissions	-	-	-
7 admissions	-	5	-
8 admissions	-	-	-
9 admissions	-	0	0
10+ admissions	-	-	-

Figure 15 shows that there are a number of individuals who have been admitted to hospital multiple times with self-harm. This raises the issue of whether their self-harm is being managed appropriately and how we can prevent any further admissions.

Figure 16: The number of 10 to 24 year olds admitted split by age: three

year trend

Age	12/13 to 14/15	13/14 to 15/16	14/15 to 16/17
11 to 12	3.0% (14)	1.4% (7)	2.5% (12)
13 to 14	16.0% (76)	16.2% (83)	14.1% (68)
15 to 16	15.8% (75)	16.8% (86)	20.8% (100)
17 to 18	16.2% (77)	13.1% (67)	11.9% (57)
19 to 20	17.5% (83)	18.4% (94)	17.9% (86)
21 to 22	16.5% (78)	19.9% (102)	19.1% (92)
23 to 24	15.0% (71)	14.3% (73)	13.7% (66)
10 to 24	**100% (474)**	**100% (512)**	**100% (481)**

Figure 16 shows the age groups which make up the highest proportion of admission with the number of admission shown in brackets. It shows that from 2014 -2017 the age group with the highest number of admissions and the highest proportion of admissions are in the age 15-16 age group, who make up one fifth of admissions, closely followed by the age 21-22 group. The proportion of admissions made up by 21 and 22 year olds has been increasing since 2012.

Figure 17: Method of self-harm for hospital admissions for 10-24 year olds 2014/15 to 2016/17

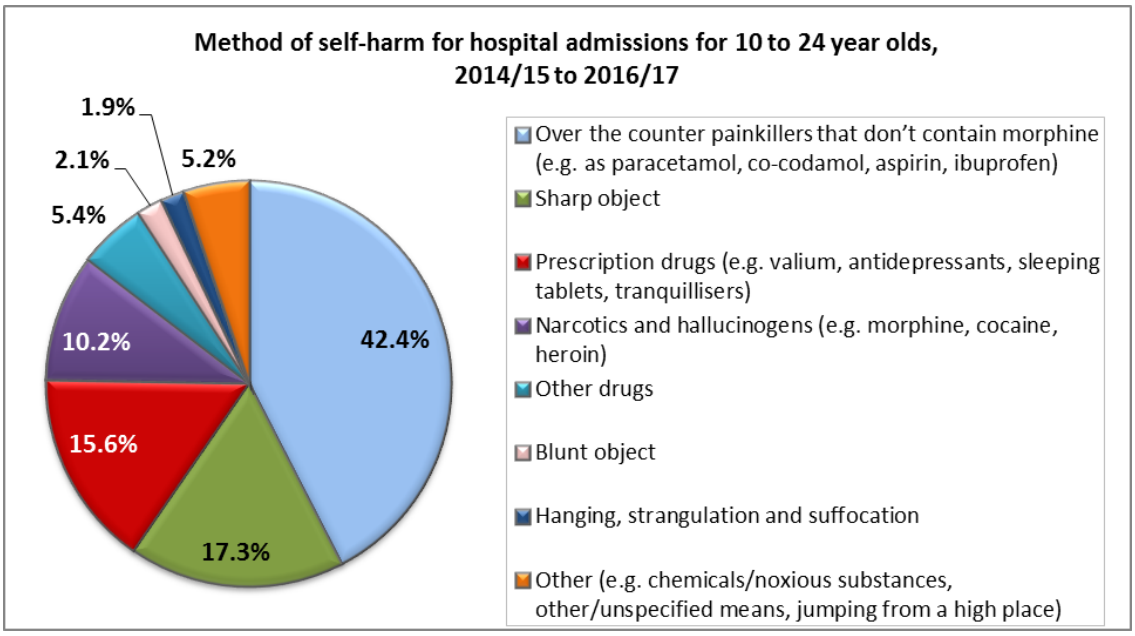
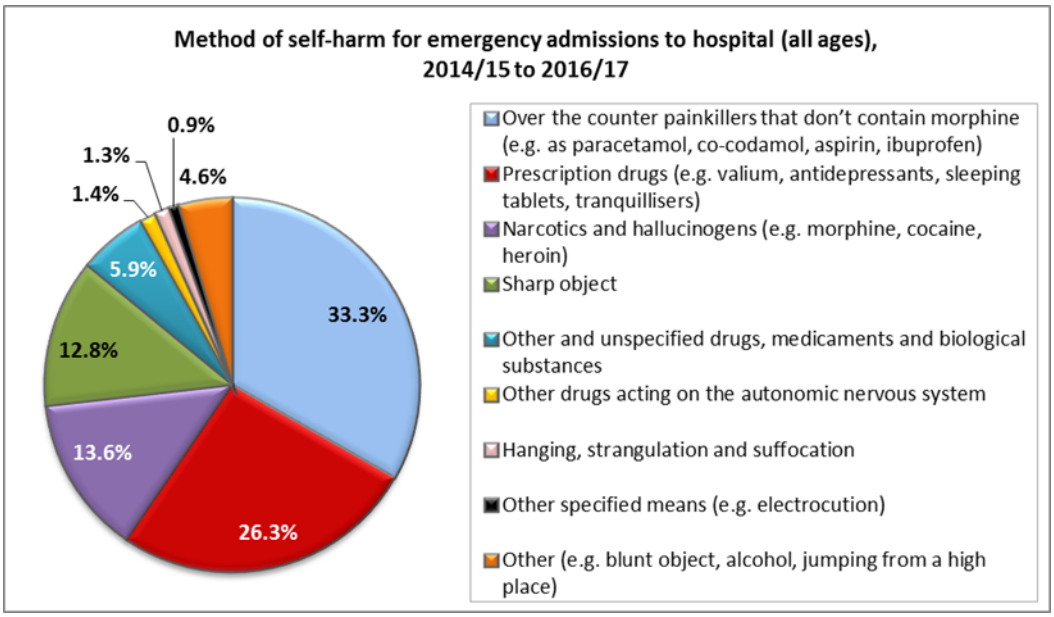


Figure 17 shows the primary method of self-harm in young people and indicates that the choice of methods and proportion choosing those methods of self-harm have stayed broadly similar since 2012. The majority of admissions are as result of overdosing on over the counter painkillers; followed by prescription drugs. Figure 18 shows the methods of self-harm for all ages, which are broadly similar to those of young people.

This data shows that self-poisoning is the most common method of self-harm that results in an admission to hospital, it doesn't indicate that it is the most

common method of self-harm. As mentioned earlier, most self-harm occurs in the community where cutting has found to be the most common method, (Hawton et al, 2012) and it may be the case that some cutting does not warrant an admission to hospital.

Figure 18: Method of self-harm for hospital admissions for all ages 2014/15 to 2016/17



CONCLUSION

This report outlines the prevalence, demographics and methods used for children, young people and people of all ages who are admitted to hospital following self-harm in Halton. The data presented in this report is likely to be a significant underestimate of the problem of self-harm in Halton; as it is only the data for the people who are admitted following self-harm and not the people who attend either A&E or primary care and are not subsequently admitted. There may also be differences between treatment practices and between organisations that contribute to the differences in the number of admissions between Halton and other areas in the North West region.

Rates of self-harm in Halton are high; in young people and for all ages. There are higher rates of admission for females than males, and interestingly significantly higher rates in the 20+ age group compared to the regional and national rates although the proportion of all admissions in Halton is highest in 15-16 year olds.

As in previous years the main method of self-harm continues to be the use of over the counter non-opioid medications (e.g. paracetamol, ibuprofen, aspirin, co-codamol) and the proportion of admissions due to this method has remained static.

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