Your Voice Heard: Developing practice guidelines for working with young people aged 18 and under in relation to self-harm, suicide attempts and deaths by suicide

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Your Voice Heard Project:
This research project was funded by the National Institute for Health Research Applied Research Collaboration North East and North Cumbria (NIHR-ARC NENC) and data was collected between March 2021 and October 2022.

The project work included:

- Scoping and review national data in England for 329 local authorities re: policies and procedures for self-harm
- A systematic review (Waller et al., 2023) about the barriers for recording and reporting young peoples' self-harm
- An online national workshop attended by 96 participants from a range of UK organisations
- Interviews with 4 parents whose children had self-harmed
- Interviews with 2 young people and a focus group with 8 young people who had experience of self-harm
- Interviews with 10 multi-agency practitioners

In addition, members of the project team were involved in a parallel research project in the North East funded by the Association of Directors of Public Health and led by Professor Newbury-Birch and Dr Jennifer Ferguson. This sister project used a case study based approach in sites across the North East of England to determine the prevalence of self-harm in young people across the North East and in North Cumbria. Relevant findings from this separate project are incorporated into this document where necessary.

IMPORTANT INFORMATION

Our research identified that most local authorities have published guidance on working with young peoples' self-harm and suicide. **Consequently, this document does not seek to provide full guidance but contains key messages from our research for organisations to use to inform their guidance and policies**. In appendix 1, we have made some recommendations for strategic managers and practitioners based upon the findings from our study. Significantly, the ADPH funded project (Newbury-Birch and Ferguson, 2022) revealed that despite there being policies about recording and reporting of self-harm, **many practitioners did not know about the existence of these policies/guidance**, indicating a gap in how to communicate with multi-agency staff about policies and procedures.

Context/background: Internationally, self-harm and death by suicide is recognised as a significant public health issue and death by suicide is one of the biggest causes of fatality in young people (Abraham and Sher, 2017; Rufino and Patriquin, 2019). In 2020, there were 151 deaths by suicide in England and Wales for young people 10 -24 years (ONS, 2022). In Scotland, of the overall deaths for children/young people in the 5 – 24 year old age range, "probable suicides" accounted for just over 25% of all deaths between 2011 and 2020 (Public Health Scotland, 2022).

Definitions : Self-harm is when there is deliberate injury or poisoning to self, regardless of intended outcome (Royal College of Psychiatrists, 2015; NICE, 2022). Reasons for children and young peoples' self-harm are complex but it does not necessarily mean they want to die (Hawton et al., 2012) although it is important to undertake a holistic assessment to determine the meaning of the behaviour (Hawton et al., 2012) establish level of concern and decide on support needed (NICE, 2012). Self-harm can escalate the risk of suicide (Hawton et al., 2020).

Reasons for self-harm: Young people self-harm for a variety of reasons and causation is complex, including biological, developmental, social, experience of trauma, peer influence and family factors (Hawton et al., 2012).

Themes from the Your Voice Heard project data informed by young people and parents/carers with lived experience and professionals

1. Service provision and interventions

Waiting times and problems accessing services (or lack of services) were a particular problem for young people and their families, particularly when in crisis. However, service interventions were praised when immediate risk to life was identified but it seemed that young people had to reach crisis point before receiving a service.

Cancellations of appointments without informing young people or non-attendance of appointments by practitioners were particular issues which could compound negative feelings.

if you make if somebody makes an appointment, turn up… it's not exactly pleasant if someone doesn't turn up, it's, it feels like you're not really important

Generic interventions such as taking a hot bath were criticised for lack of goodness of fit with the needs of the young person, indicating the need for **personalised interventions** based on an assessment of the young person's needs and preferences. Young people wanted **strategies to cope** and for practitioners to do something (which accords with McLeod's (2008) suggestion that active listening for young people requires doing or action, not simply listening). When information is provided, young people stressed the need for this to be in an accessible format (easy to read and jargon free).

and just giving them some strategies to cope with that kind of thing, because for me, probably the most successful thing

The **content and delivery of interventions/support** is also important emphasising the need for non-judgemental, person-centred approaches. **Worker/practitioner characteristics** of empathy, warmth, caring, non-judgemental and humanity are valued but often not evident in interactions; these are important characteristics in making young people feel valued. **Some interventions were regarded as punitive**, particularly in managing perceived risk, so considering what the service feels like to the recipient is important. Such empathic person-centred approaches are necessary as young people are acutely aware of the stigma around mental health generally and how emergency responses (such as Police intervention) might be perceived by the general public.

I had like an incident and they'd make me feel bad. Pretty much like they would make me feel guilty about what was happening

Like for me, they just isolated me in the room for two years, because of something

Use of **screening scales**, whilst necessary, could dominate support sessions and leave little room for young people to discuss their needs. Similarly, medication was seen to have a valuable place in treatment packages but young people did not want this to be the first treatment option. **Overuse of questioning** could feel interrogational.

They just bombarded you with questions and useless information.

A particular problem for young people was the **constant re-telling of their experiences** as they moved between services, suggesting the need for improved inter-agency/disciplinary information sharing/communication (an area of practice also noted by practitioners) and joined up service provision to avoid "start again syndrome" (Brandon et al., 2008) (NB: start again syndrome is often used in child safeguarding practice but given it impairs analysis and decision making by discounting relevant practice, this seems relevant here).

sort of repeating yourself to like two services when they should only really be one...It's just not very helpful

The **transition to adult social care** from children's mental health services was also seen as problematic and challenging as the service provision changed.

we'd kind of gone from this twice a week, a lot of support, being able to ring up and speak to people or people get back to you when, you know, it felt a lot more hand holding type situation, a lot more care, more resource, just to go to adult service where it was, we you know, we went and saw a psychiatrist for five minutes

Young people also spoke about not having information and diagnoses/definitions given to them in a clear, **jargon free**, manner and not receiving **easy to read guidance**.

2. Effective service provision and interventions

A number of points were raised about effective service provisions and interventions. Careful use of language is important along with clear, jargon free communication. One parent spoke about the impact of **being spoken about** in professional meetings, so considering how families can be involved and included and how to convey information are important. However, one practitioner noted that there is little evidence about how to involve people with lived experience.

It's not a nice feeling to be sat in a meeting with a, you know, a quite a large number of professionals talking about your child. And to think, what are they actually saying about her?

there is a limited evidence around how you involve people with lived experience

A parent spoke about problems with the phrase 'commit suicide', emphasising that this does not accurately reflect the intention behind the behaviour and reinforces stigma.

The terms that are used, so I don't really know how to word it but I think you know, like if like committing suicide you you're saying that somebody's gonna like they put themselves but the commitment to it they putting themselves forward for it… It was more. I don't want to be going through what I'm going through right now. I'm finding a process to cope, a coping mechanism. I think it's a coping mechanism. Yeah. I don't think it's an attempt. I don't think it's a commitment.

There was recognition that some practitioners are working under immense pressure but also 'go the extra mile' to ensure that young people and families receive support they need, particularly in urgent situations.

The therapist basically saw (YP2) the very next day and did the rapid eye movement type therapy with her. Which was incredible. It fixed her in an hour it was absolutely incredible. But again, that was just somebody managed to squeeze that appointment in.

Young people also spoke about the helpfulness of **online technologies and apps** (e.g. Kooth and Shout) as well as **volunteers** with lived experience of mental health challenges.

3. Families and support networks

Whilst focusing on the needs of individual young people, both parents and young people were keen to have their **needs seen holistically and to include parents/carers/networks as part of the solution.**

…they tell my parents first, without me being in the room

I think it's really important that mental health services, see families as part of the solution. And not always think that they're part of the problem, because genuinely, not all families are part of the problem.

It may also be possible to reconsider and reframe non-compliance, antagonism and complaint as help seeking; a parent spoke about using threats of complaints and refusing to leave a service in order to ensure services were provided.

CAMHS, because they tried to discharge her, it sounds awful, because I threatened to. But I threatened to put a complaint in to PALS.

So you go down there. So it sounds like I'm a psycho. But I mean, in all honesty, they can't the really they can't push you out, they've got to provide care, they've got a duty of care to your child.

4. Training

Training of staff across a broad range of service providers including emergency services and anyone working with young people was identified as a need. Practitioners themselves identified challenges in accessing training, that training may not be current/up to date training and the lack of availability of training. Training all staff, rather than staff in designated roles, is also necessary. Practitioners reported receiving varying levels of training from extensive to none.

we haven't had training in it, I've just kind of, you know, researched it myself found things that work and tried them out and found that they really worked

we have to fight a lot for training, just because of like the limitations

time and time again, what we hear is that they tend to target the training to those services who are frontline, and therefore don't necessarily see it to be relevant for everybody within the organisation. So that is a misunderstanding.

5. Recording and reporting

Our systematic review (Waller et al., 2023) re: recording and reporting self-harm outlines the barriers and facilitators to recording and reporting self-harm across different organisational settings (e.g. schools, health care and criminal justice settings). Facilitators to recording and reporting self harm included staff being able to recognise self-harm, having received training about self-harm. Facilitators also included staff experience and being able to communicate openly and respectfully about self-harm. Barriers to recording and reporting self-harm included concerns about confidentiality and young people's concerns about stigma regarding self-harm and worries about how they would be perceived negatively. Lack of training for staff was also a barrier as was lack of resources to support young people. These findings also accord with another concurrent research project in the North East of England led by Professor Newbury-Birch and Dr Jennifer Ferguson which found that despite there being policies about recording and reporting of self-harm, many practitioners did not know about the existence of these policies.

Undoubtedly, recording and reporting is complex and imperfect. Practitioners with strategic roles outlined the flaws in Real Time Data surveillance (e.g. Real Time Suicide Surveillance does not include self-harm or attempted suicides), the lack of datasets about self-harm and the **absence of a central system** to record data so information was held in different systems across different agencies (although this is being addressed). Reporting of self-harm is challenging with practitioners noting that they referred to **different agencies/people** including children's safeguarding, the school, the designated teacher or not reporting.

Most of the practitioners, including those working in specialist mental health teams spoke of referring to **children's safeguarding** but there were problems with this reporting process as practitioners found the **referral process cumbersome**, **did not see the relevance** of this reporting system or only referred if there were **evident safeguarding issues in the home** (including access to dangerous substances) and **did**

not always refer. Thus, the reporting process often involved **experienced mental health practitioners (with knowledge of self-harm and suicide) referring on to generic children's safeguarding teams who may not have that expertise** unless these are multi-agency safeguarding hubs that include mental health practitioners.

…it seems to me to be a bit of a box ticking exercise, because you're doing it automatically for every self-harm and every overdose

…all of the systems are kind of separate.

…but there's no central, you know, sharing of that yet.

6. Guidance

Our review of national guidance across 329 local authorities in England indicated that there is a plethora of guidance, most often located on websites for Local Safeguarding Partnerships. Most London Boroughs share a policy. We did not find a policy for 6 local authorities, but this does not mean that they do not have one. These policies all pre-date the updated 2022 NICE guidance. However, as indicated above, as North-East based parallel study by Professor Newbury-Birch and Dr Jennifer Ferguson found, many practitioners were **unaware of the existence of policies and procedures.**

Indeed, **levels of awareness of existing guidance amongst practitioners varied** and tended to be role specific, with practitioners in mental health referring to the NICE guidance and practitioners in other settings referring to context specific guidance or not being aware of guidance. The NICE guidance is also not specific to children and young people. A strategic practitioner suggested that branding under the NHS might increase recognition and acceptance of guidance. It was also acknowledged that there may be several pieces of guidance sitting alongside each other and that some guidance (cluster guidance) needed to be updated.

In terms of guidance content, practitioners emphasised the need to develop **safety planning** as part of therapeutic interventions and also the need to **manage high risk locations** such as bridges/cliff tops. As previously outlined, young people wanted intervention strategies to be pertinent to their needs and interests and practitioners acknowledged the need for personalised interventions. In managing locations and places deemed to pose a risk, this may need a broad inter-agency and inter-disciplinary approach beyond services working directly with children and young people (e.g. highways). One strategic manager noted this work was already on the practice agenda.

some more in depth guidance around actually safety planning…

there's so much more evidence now about what works and what doesn't work around the management of certain locations, like bridges, like aqueducts and sort of, you know, so I think, again, you know, probably those need to be updated

Practitioners echoed young peoples' views that **strategies and safety plans needed to be personalised**, should include **reporting processes,** be **evidence based** and should include **lived experience**. Like young people, practitioners also indicated that **digital technologies and apps** have a role in supporting young people.

Messages for practitioners

- If practitioners cannot attend an appointment, they should inform the young person and their family
- Practitioners to avoid cancelling or moving appointments wherever possible
- Suggest strategies that are a good fit for the individual and person-centred
- Active listening is likely to require action/doing something
- Provide information in an accessible format
- Workers characteristics of empathy, warmth, non-judgemental and interest are important
- Careful use of screening tools
- Try to avoid too many questions
- Interventions should not be punitive or judgemental and it might be helpful to use critically reflective supervision to consider how the experience of the service provision might be perceived by the recipient
- Empathic person-centred approaches are important in redressing stigma surrounding mental health
- Medication is a valuable intervention but not necessarily the first response
- Explain mental health definitions in a jargon free way; consider accessibility e.g. language, length, words/pictures.
- Avoid stigmatising language
- Can digital technologies support service delivery? Apps such as BlueIce have have encouraging results alongside traditional service provision for young people who self-harm (Grist et al., 2018)
- Work holistically, engaging family and wider support networks where appropriate
- Consider whether non compliance/antagonism/complaint can be reframed/perceived differently?
- Your local Safeguarding Partnership is likely to have produced specific guidance for you to follow

Messages for policy makers and strategic managers

- Service availability and resource planning should be addressed at a strategic level to ensure young people are able to access services in a timely manner at level suitable to their needs
- Up to date staff training across a broad range of service providers (ambulance staff, Police, schools, CAMHS, children's services, voluntary organisations, health etc) is important and should be provided. Training should be for **all** staff in a setting rather than training key personnel and across a broad range of agencies and organisations, similar to the roll out of safeguarding training which would enable some support to be given whilst waiting for access to specialist services
- Develop inter-agency communication and information sharing protocols for self-harm/concerns re: suicidal ideation to avoid "start again syndrome". Such information sharing protocols are likely to exist in relation to safeguarding as outlined in Working Together to Safeguard Children (H. M. Government, 2018). However, this document whilst mentioning children and young people's mental health and the need for a referral to safeguarding if there is admission to a specialist unit, does not appear to mention self-harm or suicide, despite the processes to report to children's safeguarding teams
- Develop protocols for the transition to adult social care and prepare young people and families for this transition/change
- Include safety planning ideas in guidance but remind practitioners to tailor strategies to the needs of the individual
- Safety planning could also consider the management of high risk locations, requiring a strategic multi-agency response including those who do not work directly with children and young people (e.g. highways)
- Recording and reporting of self-harm is important and guidance should include what/how to record, information sharing protocols and who to refer to
- Suicide prevention networks have a role in multi-agency dissemination and communication of information about existing of policy and guidance, including reporting processes
- Recording and reporting of self-harm and suicide is problematic and complex. Children's safeguarding teams appear to be a central point of referral, but they may not have specific knowledge or expertise about self-harm or suicide unless they have specialist mental health practitioners in a multi-agency safeguarding hub
- Referral processes (usually to children's safeguarding) were seen as cumbersome and strategic managers may be able to streamline the process
- The rationale for automatic onward referral of self-harm should be articulated in guidance (i.e. relating to future risk of death by suicide)
- Different practitioners referred to different agencies (often children's safeguarding) but referral processes are diverse, contributing to a lack of consistency. This is an issue for senior/strategic managers
- A communication strategy for all staff about policy, procedure and guidance is needed, possibly linked to mandatory training
- Guidance should be developed alongside people with lived experience and capture their voices. Ideally have people with lived experience involved in the development and quality assurance of written information
- Guidance should include the use of digital technologies and apps, reflecting the lifestyles of children and young people
- Guidance should be easily accessible by a range of practitioners, young people and families/carers. There may need to be different formats for different audiences

USEFUL DOCUMENTS/INFORMATION

Local Authority Safeguarding Partnerships often contain local guidance.

University of Oxford (2018) *Young people who self-harm: A guide for school staff.* Available at: young-people-who-self-harm-a-guide-for-school-staff.pdf (rcpsych.ac.uk) (Accessed: 21st February 2023).

NICE (2022) *Self-Harm: Assessment, management and preventing recurrence.* Available at: Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE (Accessed: 21st February 2023).

Papyrus (Prevention of Young Suicide): https://www.papyrus-uk.org/

Kooth (online support): https://www.kooth.com/

Young Minds: https://www.youngminds.org.uk/

Childline: https://www.childline.org.uk/

Shout (Text based support): https://giveusashout.org/

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Grist, R., et al. (2018) 'Acceptability, use, and safety of a mobile phone app (BlueIce) for young people who self-harm: Qualitative study of service users' experience,' *JMIR Mental Health,* 5 (1), pp. 1 – 11. Available at**:** doi:10.2196/mental.8779

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Public Health Scotland (2022) *Suicide among young people in Scotland. A report from the Scottish suicide information database.* Available at: https://www.publichealthscotland.scot/media/14883/20220906_scotsid_young_persons_report-final.pdf (Accessed: 24 January 2023).

Royal College of Psychiatrists (2015) *Self-harm in young people: For parents and carers.* Available at: Self-harm for parents | Royal College of Psychiatrists (rcpsych.ac.uk) (Accessed: 31 January 2023).

Rufino, K.A. and Patriquin, M. A. (2019) 'Child and adolescent suicide: contributing risk factors and new evidence-based interventions,' *Children's Health Care*, 48(4), p. 345-350.

Waller, G., et al. (2023) 'The Barriers and Facilitators to the Reporting and Recording of Self-harm in Young People aged 18 and under: A Systematic Review,' *BMC Public Health*, 158. Available at: https://doi.org/10.1186/s12889-023-15046-7