Nottinghamshire Health & Wellbeing Board

Topic information	
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Executive summary

Introduction

Within this all ages Self-harm Joint Strategic Needs Assessment (JSNA) chapter the Public Health England Fingertips Health Profile definition is used i.e.

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent.

Self-harm is a behaviour rather than a primary or mental health disorder. It is an indicator of underlying emotional/psychological distress. Self-harm is not necessarily a suicide attempt, it may be a coping mechanism for dealing with intolerable situations. It is more common in children and young people with an estimated prevalence in the UK of between 1 in 12 and 1 in 15 between ages 11 and 25 years. Research shows that the incidence of self-harm in childhood and adolescence has increased in recent years with an increase of 68% in girls aged 13 to 16.

- The UK has the highest self-harm rate in young people of any country in Europe, with a rate of 400 per 100,000 population.
- Self-harm is more common in females than males with a girl to boy ratio of as much as 5 or 6 to 1 between ages 12 to 15 years.
- 22% of 15 year olds reported that they had self-harmed (32% of girls and 11% of boys) in surveys.
- Self-harm results in approximately100,000 admissions to hospital a year (all ages) in England, 99% of which are emergency admissions.

- Those that self-harm have a 1 in 6 chance of repeat emergency department (ED) attendance.
- People who repeat self-harm are at greater (up to approx. 30 fold) risk of suicide.

Self-harm is not limited to children and young people. The analysis in this JSNA chapter gives an indication of the size of the issue in the Nottinghamshire adult population based on numbers who have accessed clinical services and include;

- Between 2011 to 2015, approximately 220 young people between the ages of 12 to 17 years were recorded as actual self-harm hospital events and an estimated 2597 of self-harm in the community
- Between 2013 and 2016, Nottinghamshire Healthcare Foundation Trust recorded 2,141 self-harm adult referrals
- Between 2013 and 2016, self-harm A&E attendances was 6,788 between the ages 10 to 85 years.

The true picture of local needs is likely to be underestimated due to the incompleteness and inconsistency of data and the largely unreported nature of self-harm in the community.

This JSNA explores a range of risk factors contributing to self-harm, analysis of a range of service activity and referral data to estimate the size of the issue locally, evidence of what works from clinical guidance and lived experience of individuals and families.

Unmet need and gaps

Service and knowledge gaps are discussed in-depth in sections 8 and 9. The key themes underpinning the recommendations are:

Promotion, prevention and early intervention gaps

- There is a gap in non-clinical support and prevention, to address the root causes of self-harm.
- NICE guidelines and pathways begin when self-harm has been identified. The prevention element (CG16) focuses on prevention of re-occurrence. There are no system-wide support pathway/s that include health promotion, prevention and early intervention to help to reduce the initial occurrence of self-harm.
- There is a need to ensure continuing Public Health influence in the ICS Mental Health and Social Care Strategy work streams responsible for delivery of Pillar 2: *Increasing Support for Prevention, Self-care and the Wider Determinants of Health and* Pillar 3 *Implementing a Person-centred Approach to Physical and Mental Health* of the Draft Nottingham and Nottinghamshire STP All-age Integrated Mental Health and Social Care Strategy, particularly focusing on Adverse Childhood Experiences (ACE) and trauma informed practice.
- The true picture of local needs relating to promotion, prevention and early intervention is difficult to assess due to the incompleteness of data and largely unreported nature of self-harm.
- There is a gap in support for people of all ages who self-harm or who are at risk of self-harm, but do not meet acceptance criteria for clinical/mental health services.

Treatment and recovery gaps

- The majority of local data used in this document has come from commissioned treatment services and the main knowledge gaps relate to the incompleteness and inconsistency of the data.
- Self-harm is not limited to young people: analysis of hospital statistics shows a significant proportion of adults known to self-harm with a potential unknown proportion across all ages who do not access services or seek support.

Recommendations for consideration by commissioners

	Promotion, prevention and early intervention	**Lead/s**
1	Focus on reducing emotional distress/increasing resilience in children and young people, building on evaluation of current resilience programmes in schools.	ICS Mental Health and Social Care Strategy Pillar 2 work stream, South Yorkshire and Bassetlaw ICS Suicide Prevention Work stream (Bassetlaw CCG)
2	Develop trauma/ACE informed practice across the health, care and education system and youth services.	ICS Mental Health and Social Care Strategy Pillar 3 work stream, South Yorkshire and Bassetlaw ICS Suicide Prevention Work stream (Bassetlaw CCG)
3	Promote a community assets approach to support improved population emotional health and wellbeing, reduce social isolation and other underlying causes of self-harm across the life-course.	Public Health
	Treatment and recovery	
4	Improve data quality and recording in commissioned services to more specifically reflect self-harm and gain a better understanding of self-harm across all ages. This would enable a clearer assessment of need to inform development of interventions for promotion, prevention, early intervention, treatment and recovery.	Clinical Commissioning Groups
5	Develop system wide multi-agency (all ages) co-ordinated pathway/s recognising self-harm as a primary presenting need.	Clinical Commissioning Groups

Nottinghamshire Health & Wellbeing Board

Full JSNA report

What do we know?

Background

"*Working in the field of self-injury is like scuba diving without a mask. You get glimpses of what might be under the surface, but it's difficult to know if what you're seeing is real*"[1].

The wide variation in types of self-harm, the contexts in which it occurs, different motives for self-harming and meaning to individuals makes it difficult to define in a way that is universally recognisable or acceptable. Within this JSNA chapter the Public Health England Fingertips Health Profile definition[2] is used i.e.

***Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent*.**

Self-harm happens when a person intentionally hurts or harms themselves. It covers a wide spectrum of behaviours which include; self-cutting, burning, banging and punching, self-poisoning and hair-pulling (trichotillomania).

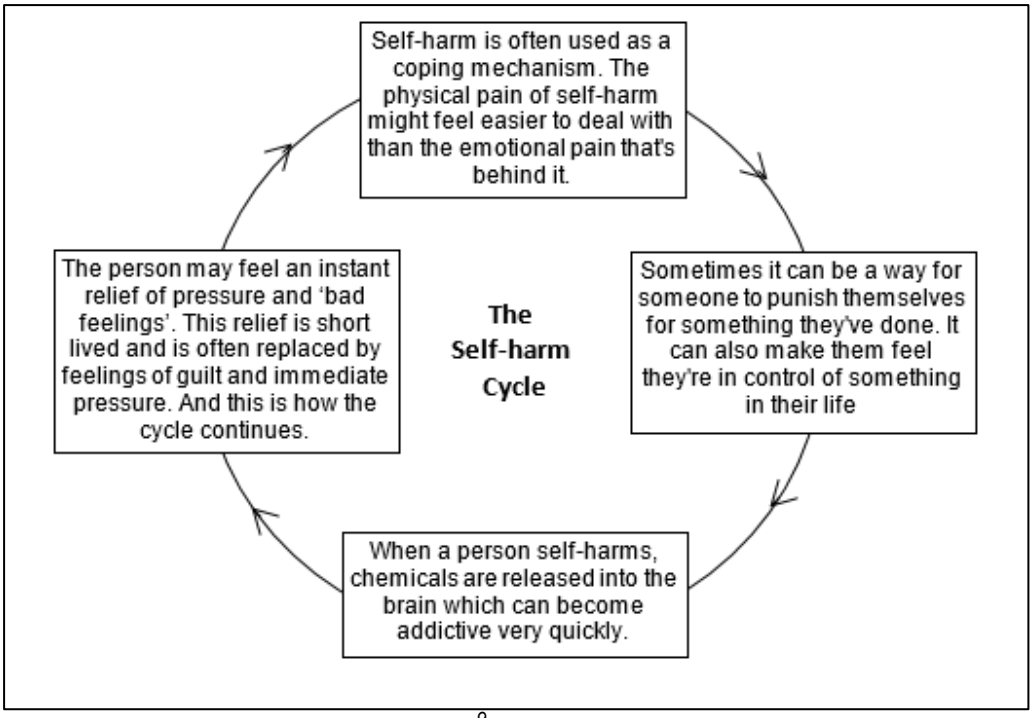
Self-harm is an indicator of underlying emotional/psychological distress rather than a primary disorder. An act of self-harm is not necessarily an attempt of suicide, it may be a coping mechanism for dealing with intolerable situations[3]. People who repeat self-harm are at greater (up to approximately 30-fold) risk of suicide. With suicide rates highest within 6 months of the index self-harm episode - a suicide rate of 370/100,000 in the study cohort compared to a rate of 11/100,000 in the general population[4].

It has been reported that the UK has the highest self-harm rate for young people, of any country in Europe, with estimates of 400 per 100,000 population[5]. Self-harm results in approximately 100,000 admissions to hospital a year (all ages) in England, 99% of which are emergency admissions[6]. Those that self-harm have a 1 in 6 chance of repeated emergency department (ED) attendance.

Self-harm is cyclical in nature shown in Figure 1. It is likely that there are both psychological and physiological processes and factors preceding and following the behaviour that help to mask the pain associated with physical injury. Dissociation[x] ("zoning out") typically comes into play before an act of self-harm, allowing an individual to feel little or no pain[7]. The main characteristic of all dissociative phenomena involves a detachment from reality, as opposed to a loss of reality as experienced in psychosis. Physiologically, neurotransmitters such as endorphins are released when a person is injured or stressed. These neurotransmitters act in a similar way to morphine, reducing the amount of pain experienced when an individual is hurt. Sometimes people who self-harm describe feeling a "rush" or "high" from the act that may be explained by the release of these chemicals[8] and which can become addictive.

[x] Dissociation is one way the mind copes with too much stress, such as during a traumatic event. The word dissociation can be used in different ways but it usually describes an experience where a person feels disconnected in some way from the world around them or from themselves

Figure 1: The self-harm cycle



Source: Adapted from NSPCC self-harm cycle[9]

1. Who is at risk and why?

Table 1 presents potential risk and protective factors for self-harm related to genetics, familial, social, psychological and cultural factors[10,11]. Specific local factors driving self-harm are explored further utilising the interviews with people with lived experience.

Table 1: Description of risk and protective factors of self-harm.

Characteristics	Risk factors	Protective factors
Demographic	Aged under 25 years Female gender Low socio-economic status Homosexual/bisexual orientation	
Social and community environment	Adverse childhood experiences and environment Adolescent interpersonal difficulties Peers who self-harm	Effective social and familial support Religious affiliation Cultural norms
Mental Health	Depression Anxiety/personality disorders Substance abuse	Medication e.g. lithium for bi-polar disorder
Psychological characteristics	Impulsivity Inability to problem solve	Optimistic outlook
Genetics	Inherited vulnerability of serotonin system	
Situational factors	Media Drug/alcohol use	
Physical Health	Epilepsy HIV	

Source: Adapted from Skegg 2005[10]

1.1. Age/gender

Self-harm is not a mental health problem[12] but a behaviour that often indicates unbearable emotional distress[13]. According to a World Health Organisation (WHO) collaborative study[14], there has been a threefold increase in the number of teenagers who self-harm in England in the last decade. Some very young children are known to self-harm but rates are highest in young people between age 11 and 25 years. With an estimated prevalence of 1 in 12 to 1 in 15 young people (6.6-8%). Across the young people in the UK, the estimated average age of onset is 12 years[15], peaking in mid-adolescence. This rate could be higher as self-harm often goes undetected as a result of individuals hiding it. Data from surveys suggest it is more common in females than males[16] with a female to male ratio of as much as five or six to one between ages 12 to 15 years.

In 2014, the Health Behaviour in School-Aged Children study (HBSC)[17], estimated 22% of 15 year olds reported that they had self-harmed (32% of girls and 11% of boys). The sex ratio becomes less with increasing age as the behaviour increases in boys in later teenage years and levels off in girls[18].

Research shows that the incidence of self-harm in childhood and adolescence has increased in recent years, this is particularly marked in girls aged 13 to 16 years, showing an age specific increase of 68%, from 45.9 to 76.9 per 10,000[19].

Self-harm is widely perceived as something that only young people do. As people become adults they may feel that it is something that they are expected to have grown out of. Some people begin to self-harm in adulthood. An adult may have a wider range of drivers that could lead to self-harm and the feeling of shame and need for secrecy can be more burdensome for adults[20].

A study of adults in hospital, admitted with self-harm identified that approximately 80% had overdosed while 15% had cut themselves, although in the community it is likely that cutting is a more common way of self-harming[21].

Older adults, aged 60 years and older, who present to hospital with self-harm are at very high risk of subsequent suicide (see section 1.6 below). Within this age group 12.8% had repeated self-harm episodes within a one year period. Risk factors for non-fatal repetition of self-harm in older adults include previous self-harm, previous psychiatric treatment and aged between 60–74 years[22].

1.2. High risk groups

The following groups within society experience higher rates of self-harm compared to the general population[23]:

- Lesbian, gay, bisexual and transgender people (LGBT)
- Black and Minority Ethnic (BME) Groups
- People with mental health and/or personality disorders
- Veterans
- Offenders (see section 1.5)
- People with learning disabilities and/or additional needs
- People who have experienced child sexual abuse, physical or domestic abuse
- People with alcohol or substance misuse problems
- Looked after children and young people and care leavers
- Asylum seekers and refugees

Evidence relating to the rates of self-harm in the above groups is variable as there are a number of contributory factors involved, including discrimination, bullying, hate crime and social isolation experienced by minority groups, ethnic minority population density within a geographical area (inverse relationship) and cultural factors. In addition research samples are often small with potential to skew the findings. Also, self-harm is a largely hidden issue making accurate measurement of rates and comparisons with the general population difficult. Where estimated rates have been found in reviewing literature for this JSNA chapter these are shown in Table 2 below.

Table 2: Comparative prevalence of self-harm in high risk population groups where available

High risk group	Indicative rates and characteristics
Lesbian, gay bisexual and transgender people (LGBT)	Trans female age 18-77yrs 26.2%; trans male 57.7% self-harmed (cutting)[24] 8.6% of non-heterosexual people compared to 4.6% of heterosexual people[25] (lifetime self-harm)
Black and Minority Ethnic (BME) Groups	Up to twice as many Black females aged 16–34 years compared with White females are likely to self-harm[26] Asian women Asian women rates of 1.6 times those of white women; Asian females <30yrs 2.5 times those of white women[27].
People with mental health and/or personality disorders	Psychiatric (92.0%) disorders (most commonly depression, substance use and anxiety) and personality (45.9%) disorders are present in people presenting to hospital with self-harm[28]. Self-injury (cutting, burning, and small drug overdoses), and self-cutting in particular, are common in individuals with borderline personality disorder (BPD). Unlike other aggressive and impulsive behaviours self-injury does not "burn out" with increasing age in people with BPD[29].

1.3. Life problems

Self-harm usually occurs in the context of multiple life problems. The 2000-2010 Multi-centre Study of Self-harm in England identified 92.6% of people who self-harm had at least one contributing life problem. This identifies the need for access to appropriate help for underlying causes such as relationship difficulties (the most frequently reported problem at first episode of self-harm) and problems concerning alcohol and mental health issues. Individualised clinical support (e.g. psychological therapy, interventions for alcohol problems and relationship counselling) for people who self-harm whilst facing these life problems may play a crucial role in suicide prevention[30].

Economic hardships, accumulated and seemingly unresolvable problems resulting from recession or austerity measures (including housing, employment, financial difficulties, poverty), often with co-existing or historical damaging life-experiences, have been found to act as a 'final straw' to trigger self-harm, indicating that interventions should include access to practical advice about economic issues before difficulties become insurmountable as well as appropriate psychological support[31].

There is evidence of association between Adverse Childhood Experiences (ACEs) and self-harm. ACEs are exposure to stressful events that occur in childhood and affect a child directly. For example; physical and emotional maltreatment and/or neglect, or the environment in which they live; domestic violence, substance misuse or mental illness in their families[32]. Parental imprisonment and early death are significantly more likely to occur in low-income families. This

means that children from lower income families are at increased risk of exposure to ACEs and have a higher risk of self-harm[33].

1.4. Physical illness

Research[34] has shown that risk of self-harm is significantly elevated in the presence of physical illnesses in adult patients seen in primary care. Specifically raised risk was seen in younger adults and during middle age, but not among older people. There was a dose–response relationship with an increased risk of self-harm associated with an increase in the number of physical illnesses or long term physical conditions. Much of this was explained by the presence of recorded depression. The research suggests a need for tackling psychological distress and reducing self-harm risk in physically ill patients who attend primary healthcare services for non-psychiatric reasons, particularly for women and younger and middle aged adults[34].

1.5. Self-harm in prison custody

Rates of self-harm in prison custody in England and Wales have risen over the 10 years from 2006 to December 2016. In the 12 months to December 2016, there were 40,161 reported incidents of self-harm, a rate of 471 per 1,000 prisoners compared to a rate of 287 per 1,000 in the 12 months ending Dec 2007, shown in Table 3 below[35]. This is a record high, up 24% on the previous year. Those that self-harmed did so, on average, 3.6 times.

The number of self-harm incidents that required hospital attendance increased by 21% on the previous year to 2,740 with the proportion of incidents that required hospital attendance remaining similar at 6.8%. The number of self-harm incidents and those requiring hospital attendance are the highest in the time series (12 months ending December 2007 to 12 months ending December 2016).

Whilst the rate of 399 incidents per 1,000 population in male establishments is less than in female establishments at 1,987 per 1,000 population, the self-harm trends in male establishments show a much higher increase compared to the previous 12 months. With a 30% increase in male compared to a 4% increase in female establishments.

Table 3: Number of self-harm incidents and rate per 1,000 in custody for England and Wales – 2015-2016

Prison establishments	12 months ending	Self-harm incidents	Compared to previous 12 months	Rate per 1,000 prison population	Self-harm individuals	Incidents/ Individuals	Hospital attendances	Proportion of incidents requiring hospital attendances
All	Dec 15	32,313	Up 25%	337	9457	3.4	2,261	7.0%
	Dec 16	40,161	Up 24%	471	11008	3.6	2,740	6.8%
Male	Dec 15	24,977	Up 31%	306	8305	3.0	2,103	8.4%
	Dec 16	32,504	Up 30%	399	9856	3.3	2,605	8.0%
Female	Dec 15	7,336	Up 8%	1888	1152	6.4	158	2.2%
	Dec 16	7,665	Up 4%	1987	1152	6.6	135	1.8%

Source: Gov.uk Safety in Custody Statistics

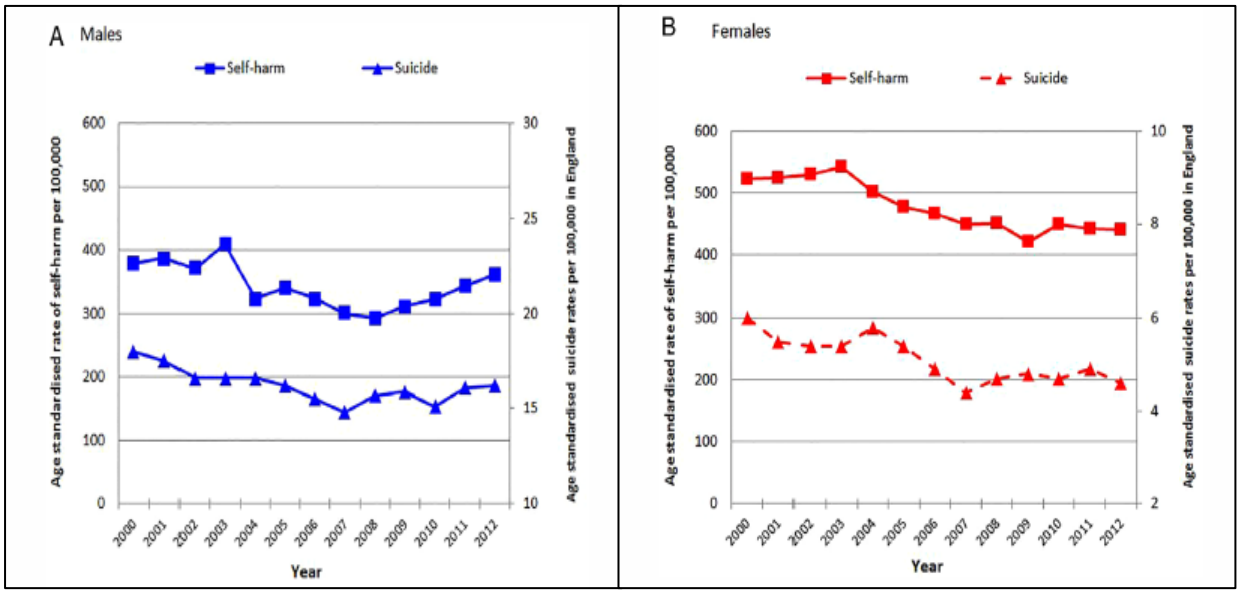
1.6. Links with suicide

There is a wealth of literature to suggest that with repeated self-harm comes an increased risk of suicide[36,37]. Self-harm is the most robust predictor of suicide and research suggests that self-harm increases the probability of someone dying by suicide within 12 months, by between 50 and 100 times above the rest of the population[38]. However, an act of self-harm is not necessarily a suicide attempt. More recently (2017) [39] self-harm was reported in 52% of under 20s and 41% of 20-24 year olds who died from suicide in England and Wales during 2014 and 2015, equating to approximately 200 deaths per year. Evidence suggests that 5% of people who present at hospital for self-harm will have died by suicide within the next 9 years[40].

Not everyone who self-harms will go on to complete suicide - the trends shown in Figure 2 below are based on hospital presentations in five general hospitals across three cities, Oxford, Manchester and Derby and shows that trends in rates of self-harm and suicide are closely related in both males and females[41].

Despite this, evidence[42] suggests that scales and tools that are currently used have poor predictive value, in terms of suicide and that clinical assessment should be based on an individual's needs and circumstances rather than risk. This supports a growing body of evidence that suggests that the motives behind self-harm and attempted suicide are quite different[43]. However, it is clear that there are common risk factors for both suicide and self-harm. This is important when investigating the risk factors of self-harm and potential interventions to prevent it.

Figure 2: Age-standardised rates of self-harm in persons aged 15+ years by gender (2000-2012) presenting to five general hospitals in three cities (Oxford, Manchester and Derby) and age standardised suicide rates in England (ONS)



Source: Geulayov G et al (2015)[44]

A study of 1,177 older adults aged 60 years and over[45] found that within one year of their presentation to hospital for self-harm, 1.5% had subsequently died by suicide. Their risk from suicide was 67 times greater than older adults in the general population and men aged 75 years and older were at greatest risk. This highlights the need for older adults to receive

detailed psycho-social assessment following self-harm in line with National Institute for Health and Care Excellence (NICE) guidance[46].

1.7. Self-harm methods

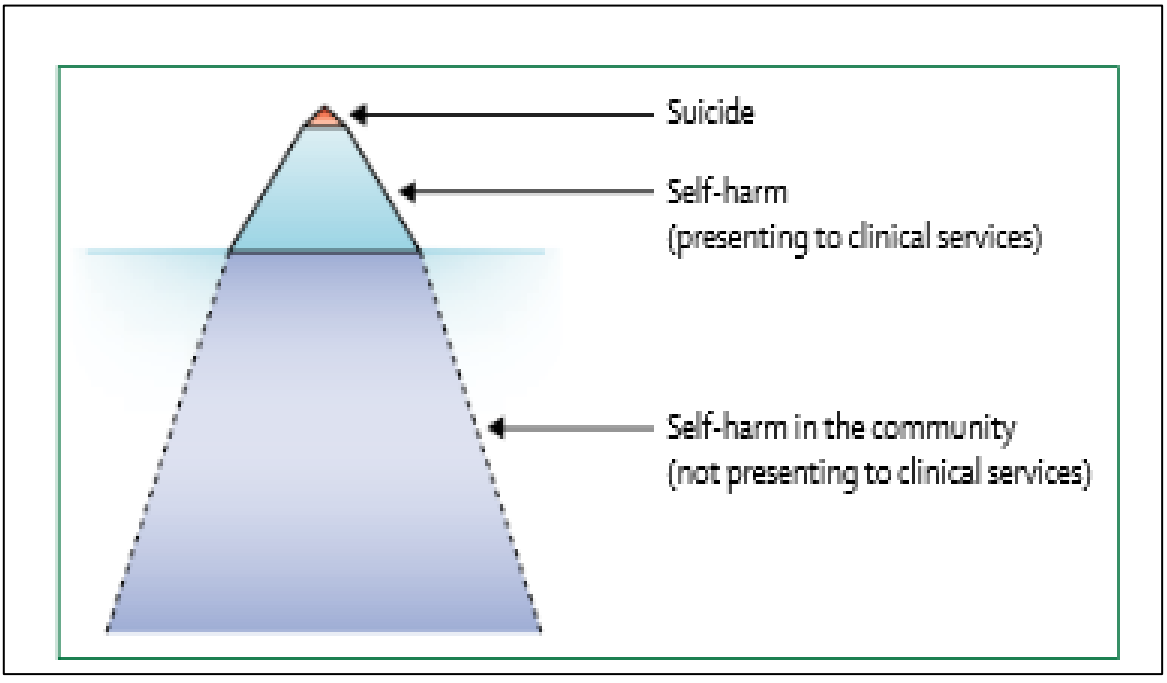
Studies have suggested that people who cut have a higher risk of suicide than those who self-poison[47]. Cutting ranges from superficial wrist cutting to severe and life threatening cutting to areas such as the chest, abdomen and neck. The site of self-injury may be an important indicator of subsequent suicide risk. People who presented with self-cutting to areas other than the wrist/arm were at around four times the risk of suicide than people who self-poisoned. No such increased risk was observed in people presenting with cutting to the wrists/arm.

About 9% of people with Borderline Personality Disorder (BPD) complete suicide. The most frequent method of suicide in this group is by drug overdose. Self-cutting behaviours double the risk of suicide in people with BPD. The risk of suicide in a person with BPD also increases in the presence of other factors, some but not all of which are treatable. These include, but are not limited to: antisocial personality disorder (higher in males), major depression, substance misuse, impulsive aggression, poor emotional control, hopelessness, history and severity of childhood sexual abuse, age over 30 years, number of previous self-injurious behaviours and suicide attempts and no prior treatment or extensive and unsuccessful treatment history[48].

2. Size of the issue locally

Quantifying self-harm is difficult, as only a small proportion of people present to clinical health services. This means that the behaviour is largely hidden within communities, as illustrated in Figure 3 below for young people, aged 12 to 17 years. It is possible that a similar model would apply for adults.

Figure 3: Self-Harm Iceberg Model - Representation of the relative prevalence of self-harm and suicide in young people aged 12 to 17 years.



Source: Hawton K et al (2012)[49]

Hospital Episode data are available on referrals to Mental Health services, ED attendances and hospital admissions. However, self-harm is coded differently in all three situations. Self-harm is not recorded as a presenting diagnosis for hospital presentations. Therefore, the rate of self-harm is difficult to compare or get a good overview of the number of people in the system that either present and/or have a history of self-harm.

A study of the rates of self-harm presenting to general hospitals indicate variations in self-harm presentations over time and by hospital site[50]. The analysis from hospital episode data within this document therefore is likely to represent a potential underestimate of the true picture and this needs to be taken into account when making commissioning decisions and in planning services.

2.1. Estimated number of 12 to 17 year olds who self-harm in Nottinghamshire

Geulayov et al[51] estimated the incidence of the three levels of self-harm represented in the Iceberg Model (Figure 3) i.e. suicide, hospital presenting non-fatal self-harm and community occurring non-fatal self-harm, in adolescents aged 12 to 17 years in England. The methodology of Geulayov et al has been applied to estimate the number of adolescents aged 12 to 17 years in Nottinghamshire involved in the three levels of self-harm. These are presented in Table 4. and in Figure 4 representing the Iceberg Model. Note: suicides have not been shown due to very low numbers.

The local estimates indicate that there is a significant proportion of unreported adolescent self-harm within the community which does not come to the attention of clinical services. This highlights the need for preventive measures at the community level, for example through school-based programmes, as well as responsive and effective treatment services to meet the needs of those presenting to clinical services following self-harm.

The analysis estimates a girl to boy self-harm ratio in the community of 5 to 1 for 12 to 17 year olds which is in line with estimates from the evidence reported in Section 1.1 above.

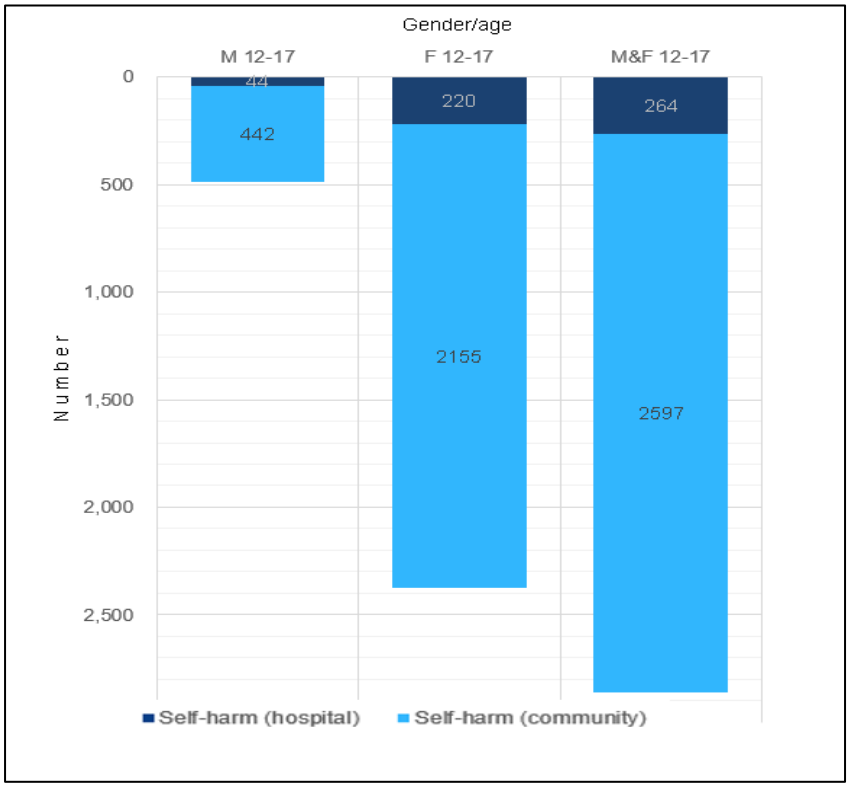
Table 4: Gender/age annualised average (based on five years 2011–2015) actual self-harm hospital events and estimated self-harm in the community for Nottinghamshire age 12-17 years population.

	Gender/age		
	Male (12-17 years)	**Female (12-17 years)**	**Total**
Hospital	44	220	264
Community	442	2155	2597
Gender ratio	1	5	

Source: Public health local analysis and HES data

Note: These figures are estimates calculated using methodology from research and as such should be regarded with caution.

Figure 4: Iceberg Model representation by gender/age annualised average (based on five years 2011 – 2015) actual self-harm hospital events and estimated self-harm in the community for Nottinghamshire age 12-17 years population.



Source: Public health local analysis and HES data

2.2. Child and Adolescent Mental Health Services Nottinghamshire Healthcare Foundation Trust

Data relating to self-harm referrals is collected by the Nottinghamshire Healthcare Foundation Trust (NHFT) Child and Adolescent Mental Health Services (CAMHS) outside of the usual patient record system at the point of referral and referral outcome.

Table 5 shows from a total of 333 self-harm referrals to the CAMHS service in an 8 month period in 2016, the highest proportion were in the age range 12 to 16 years, 64.6%. Of the total 333 self-harm referrals 56 individuals were referred twice, 4 referred 3 times, with two thirds (n=226, 67.9%) of referrals being female.

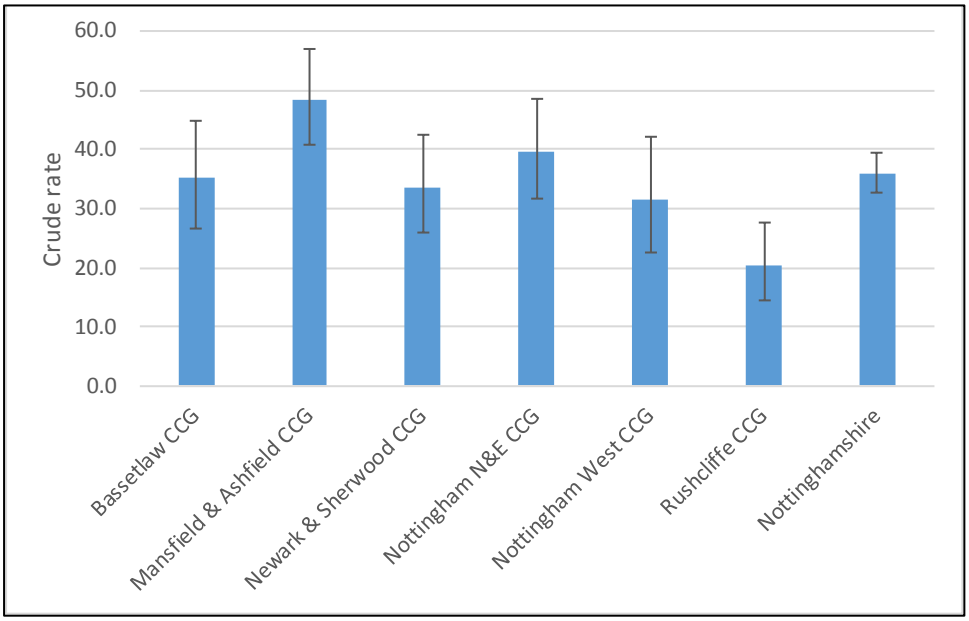
Table 5: Age range of CAMHS self-harm referrals - April 2016 to December 2016

Age	Referrals	*Percent*
11 years	49	*14.7*
12 to 16 years	215	*64.6*
17 to 18 years	69	*20.7*
Total	**333**	***100.0***

Source: CAMHS referral data

Figure 5 shows that for all Nottinghamshire CCGs the self-harm rate was 36.0 per 10,000 population for the age group 5 to 18 years. With Mansfield and Ashfield CCG having the highest rate of self-harm referrals to CAMHS, 49.0 per 10,000 population and Rushcliffe CCG having the lowest rate at 20.0 per 10,000 population.

Figure 5: CAMHS referrals for self-harm by CCG rate per 10,000 - April 2016 to December 2016



Source: CAMHS referral data

, the highest proportion of self-harm referrals to the CAMHS service were from GPs, 59.2% with a further 26% from elsewhere in the NHS, as shown in Table 6.

Table 6: Number and percentage of self-harm referrals to CAMHS services by referral source - April 2016 to December 2016

Referral source	Number	Percentage
General Practitioner	197	*59.2*
Other NHS	51	*15.3*
Community Paediatrician	28	*8.4*
Education Service	18	*5.4*
Other	24	*3.6*
Internal referral	8	*2.4*
Social Services - Other	7	*2.1*
Total	**333**	***100.0***

Source: CAMHS referral data

Other includes:	
	School - Other
	A&E Department (Written)
	School - County Secondary
	Social Services- County
	School - County Primary
	Other (non-NHS [Written])

2.3. Adult Mental Health Services – Nottinghamshire Healthcare NHS Foundation Trust (NHFT)

Only a small number of teams across Nottinghamshire Healthcare Foundation Trust (NHFT) Mental Health Trust (adult's services) use the 'self-harm' referral reason. These are the Department of Psychological Medicine (DPM) and Rapid Response Liaison Psychiatry (RRLP). As the Liaison Psychiatry service provides a liaison function to the Acute Hospital Trusts and are not therefore community-based services. The RRLP teams accept referrals

for any patient over the age of 16 years from either the Emergency Department at each hospital or from the inpatient wards.

Also, there may be a difference in provision and/or access across Nottinghamshire County; as the majority of referrals within the data with self-harm identified are handled by teams located at Queens Medical Centre/Nottingham University Hospitals, hence most are attributed to the South Nottinghamshire CCGs. The analysis below therefore reflects an incomplete "snapshot" as Mid-Nottinghamshire CCG and Bassetlaw CCG Acute Trusts self-harm data is not captured. Therefore, there is an underestimate of self-harm within the adult population who are accessing mental health services in Nottinghamshire during the time period.

The data in Table 7 and Figure 6 shows a higher female to male ratio up to age 50-54 years, after which it evens out. However, it is not possible to draw any conclusions on whether this reflects reality, due to the data recording issues mentioned above.

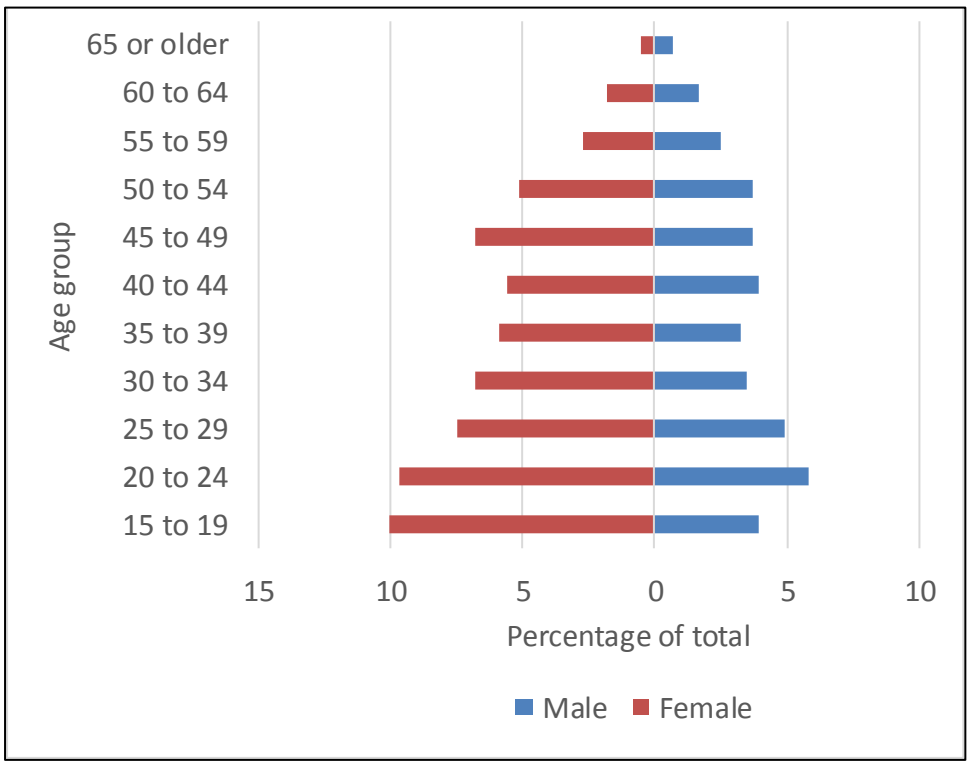
The data does suggest that there are potentially significant numbers of adults within the Nottinghamshire population who self-harm with referrals of 1,510 individuals aged 25 and over with self-harm identified in the referral data.

Table 7: Number of Nottinghamshire Healthcare Foundation Trust adult mental health self-harm referrals by age and gender for 2013 to 2016 inclusive

Age group	Female	Male	Total (M+F)	% Male	%Female	% Total (M+F)
15 to 19	215	84	299	*10.0*	*3.9*	*14.0*
20 to 24	207	125	332	*9.7*	*5.8*	*15.5*
25 to 29	160	106	266	*7.5*	*5.0*	*12.4*
30 to 34	146	75	221	*6.8*	*3.5*	*10.3*
35 to 39	126	69	195	*5.9*	*3.2*	*9.1*
40 to 44	119	84	203	*5.6*	*3.9*	*9.5*
45 to 49	146	79	225	*6.8*	*3.7*	*10.5*
50 to 54	110	79	189	*5.1*	*3.7*	*8.8*
55 to 59	59	53	112	*2.8*	*2.5*	*5.2*
60 to 64	38	36	74	*1.8*	*1.7*	*3.5*
65 or older	11	14	25	*0.5*	*0.7*	*1.2*
Total	**1,337**	**804**	**2,141**	***62.4***	***37.6***	***100.0***

(Age not recorded for two individuals)
Source: NHFT referral data

Figure 6: Number of Nottinghamshire Healthcare Foundation Trust adult mental health self-harm referrals by age and gender for 2013 to 2016 combined



Source: NHFT referral data

For the period 2013 to 2016 combined (4 years) there were 2,143 self-harm referrals for NHFT adult mental health services for 1,433 individuals. Of these 320 were referred more than once; 14 individuals were referred more than 8 times over the time period.
In total, 95.3% of referrals within the data were from patients in the south CCGs (Rushcliffe, Nottingham West, Nottingham North and East). The breakdown of referrals by CCG is shown in Table 8.

The differences in the self-harm referral numbers towards the South Nottinghamshire CCGs are likely to be due to inconsistencies in the way that self-harm is recorded by different teams within the Mental Health Trust rather than a reflection of reality, particularly given the relatively high referral rate to CAMHS in Mansfield and Ashfield CCG. The data is therefore of limited value in gauging the use of services by adults who self-harm.

Table 8: Number of Nottinghamshire Healthcare Foundation Trust adult mental health self-harm referrals by age and gender for 2013 to 2016 combined

Clinical commissioning group	Number of referrals	*Percentage*
NHS Bassetlaw CCG	5	*0.2*
NHS Mansfield & Ashfield CCG	42	*2.0*
NHS Newark & Sherwood CCG	54	*2.5*
NHS Nottingham West CCG	547	*25.5*
NHS Nottinghamshire North & East CCG	946	*44.1*
NHS Rushcliffe CCG	549	*25.6*
Total	**2,143**	***100.0***

Source: NHFT referral data

Time trends

It is not possible to identify any trends given that there are only four years of data as well as the lack of data for mid-Nottinghamshire and Bassetlaw. However, in the South CCGs, there was no obvious change in the number of referrals over the 4 year time period 2013 to 2016.

Referral source and teams

From 2013 to 2016, there were1,266 referrals (59.1%) from A&E departments and a further 14.6% from wards at Nottingham University Hospitals NHS Trust. The majority of the referrals, 2,215 referrals (99.1%) was via the DPM – Department for Psychological Medicine. This is the only team listed for the 504 referrals in 2016.

2.4. Accident and Emergency Department (A&E) self-harm attendances

Data were extracted from Hospital Episodes Statistics dataset (HES) for patients registered with Nottinghamshire GPs. Attendances at any A&E facility between 1st January 2013 and 31st December 2016 were included. Self-harm was identified where the field was 'Patient group' =30, denoting self-harm.

Between 2013 and 2016, there were 7,452 attendances recorded as self-harm by individuals registered with Nottinghamshire GPs, an annual average of 1,697 attendances, rate 210.8/100,000 population. There was no clear trend in numbers by CCG over the four years.

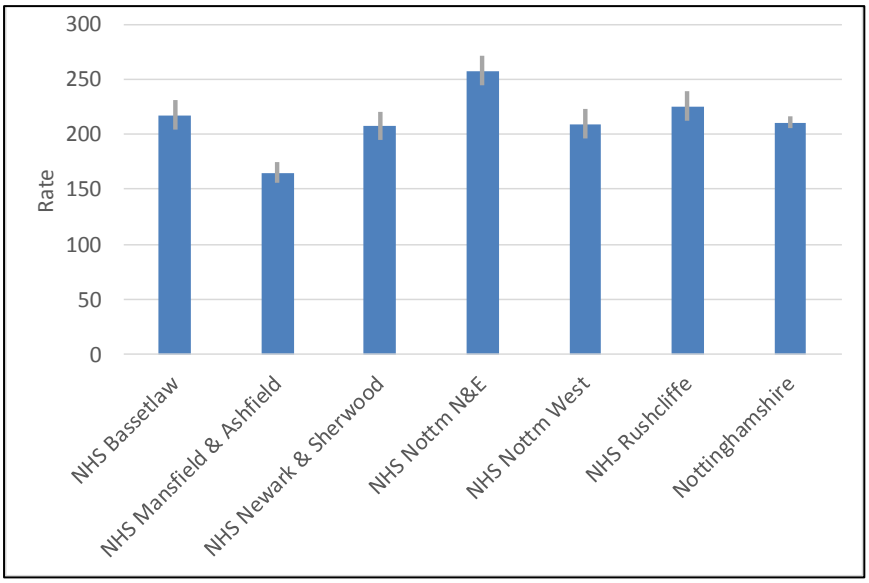
The breakdown of A&E attendances by CCG is shown in Table 9 and Figure 7 which show that NNE has a statistically higher annual average rate of A&E attendance for self-harm at 257.8/100,000; Mansfield and Ashfield has a significantly lower annual average rate of attendance at 165.3/100,000. The other CCGs are not significantly different to Nottinghamshire. The lower rate of attendance for Mansfield and Ashfield may reflect differences and inconsistencies in the recording practices between the different hospitals with Mansfield and Ashfield patients mainly attending A&E at Kings Mill Hospital.

Table 9: Self-harm A&E attendances - average annual numbers and crude rate by CCG, January 2013 to December 2016

CCG	Annual average	Rate per 100,000 population
NHS Bassetlaw	249	217.7
NHS Mansfield & Ashfield	324	165.3
NHS Newark & Sherwood	245	207.2
NHS Nottm N&E	386	257.8
NHS Nottm West	235	209.0
NHS Rushcliffe	258	225.6
Nottinghamshire	**1697**	210.8

Source: HES data

Figure 7: Self-harm A&E attendances - average annual numbers and rate per 100,000 population, by CCG, January 2013 to December 2016



Source: HES data

People of all ages attended A&E for self-harm, with (over the 4 years January 2013 to December 2016) with 33 aged under 10 and 47 people aged over 80 attending. The majority of A&E self-harm attendances, 3,508, 51.7% were among people aged under 30, Table 10. This means that a significant minority of 48.3% were aged 30+, highlighting that self-harm is not confined to the young.

Table 10: Self-harm A&E attendances – number and percentage by age, January 2013 to December 2016

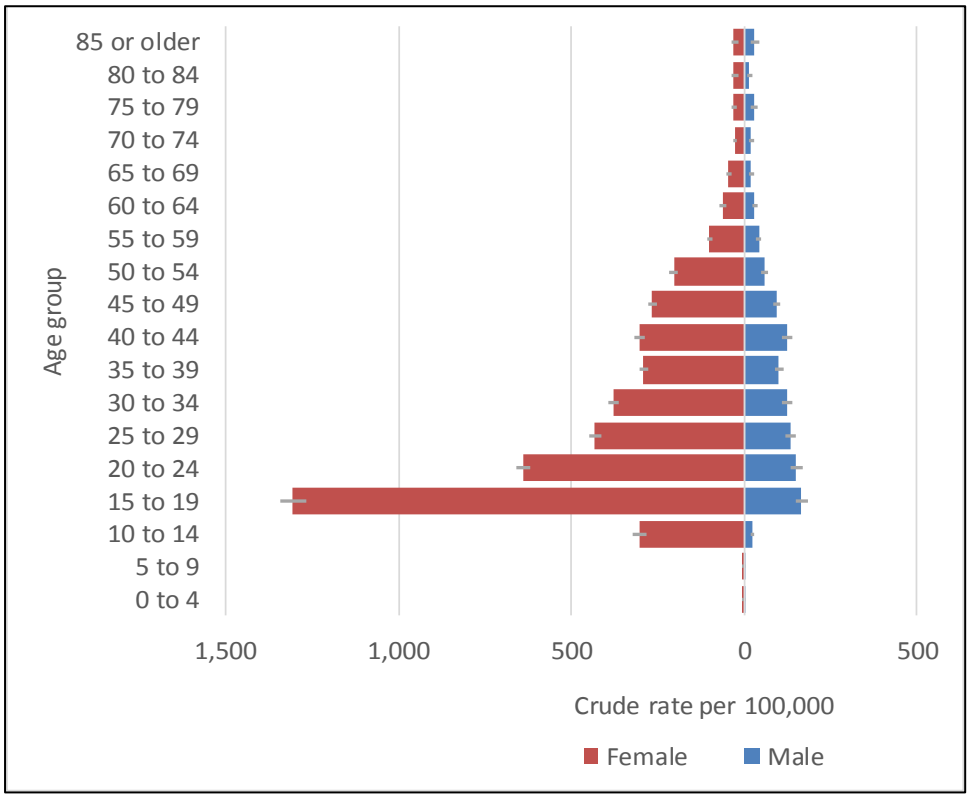
Age group	Number	*Percentage*
Under 10	33	*0.5*
10 to 14	327	*4.8*
15 to 19	1330	*19.6*
20 to 24	1016	*15.0*
25 to 29	802	*11.8*
30 to 34	685	*10.1*
35 to 39	511	*7.5*
40 to 44	568	*8.4*
45 to 49	553	*8.1*
50 to 54	419	*6.2*
55 to 59	217	*3.2*
60 to 64	109	*1.6*
65 to 69	78	*1.1*
70 to 74	42	*0.6*
75 to 79	36	*0.5*
80 to 84	23	*0.3*
85 or older	24	*0.4*

Age group	Number	*Percentage*
Not recorded	15	*0.2*
Total	**6788**	*100.0*

Source: HES data

The rate of self-harm A&E attendance by gender was 244 attendances per 100,000 females and 175 per 100,000 males. The highest rate of attendance was among females aged 15 to 19, with 1,306 attendances per 100,000, more than twice the rate of any other age group, Figure 8.

Figure 8: Self-harm A&E attendances – crude rate per 100,000 by age and gender, January 2013 to December 2016



Source: HES data

The most common self-harm reason for attendance at A&E was for poisoning, which made up 46.4% of all attendances. The pattern of self-harm reason for attendance amongst males and females is similar to the pattern for male and female combined Table 11. The pattern by age group (proportion of poisoning, psychiatric, laceration or social diagnoses within each age group) is also similar.

Table 11: Self-harm A&E attendances – number and percentage by reason for attendance, January 2013 to December 2016

Reason for attendance	Number of attendances	*Percentage*
Poisoning	3,150	*46.4*
Psychiatric	887	*13.1*
Laceration	739	*10.9*
Not classifiable/ not coded	818	*12.1*
Social	296	*4.4*
Contusion	153	*2.3*
Nothing abnormal	153	*2.3*
Dislocation, fracture, amputation	152	*2.2*
Foreign body	103	*1.5*
Soft tissue inflammation	51	*0.8*
Other	286	*4.2*
Total	**6,788**	*100.0*

Source: HES data

2.5. Emergency admissions to hospital for self-harm

Data were extracted from HES (Hospital Episodes Statistics dataset) for patients registered with Nottinghamshire GPs. Emergency admissions to any hospital between 1st January 2012 and 31st December 2016 were included. Self-harm was identified by external cause codes Appendix 1. This definition is the same as that used in the PHOF indicator '2.10ii – Emergency admissions for Intentional Self harm'.

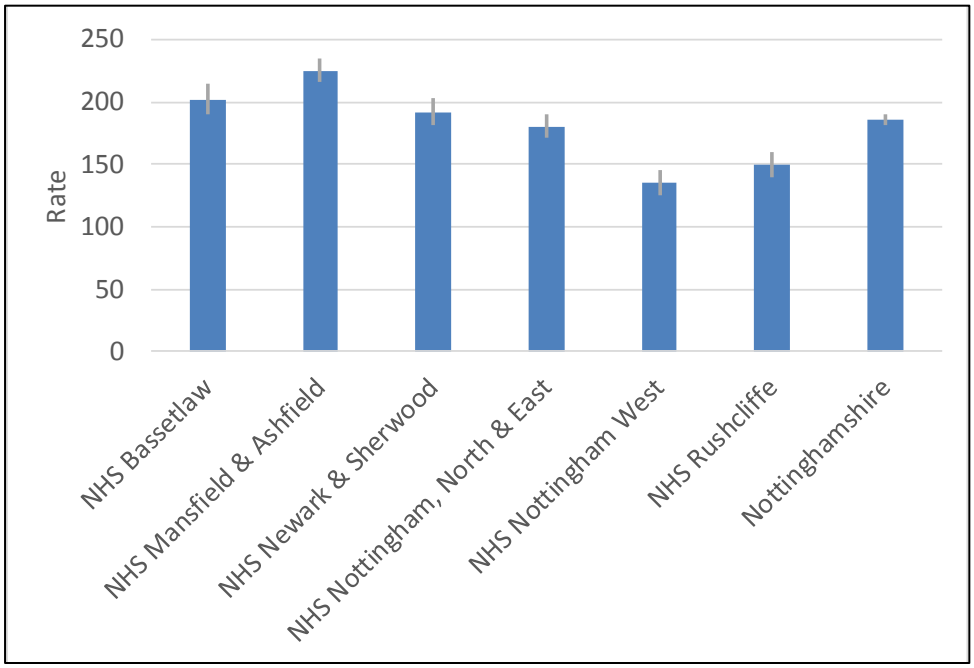
Between 2012 and 2016, there were 7,452 (average 1863 pa) emergency admissions for self-harm by individuals registered with Nottinghamshire GPs. There was no clear trend in numbers by CCG over the five years. In Table 12 and Figure 9 NHS Bassetlaw (202.1 per 100,000) and NHS Mansfield and Ashfield (224.9 per 100,000) show significantly higher rates of emergency admission for self-harm than Nottinghamshire (185.2/100,000).

Rates for NHS Nottingham West (135 per 100,000) and NHS Rushcliffe (149.7/100,000) are significantly lower than Nottinghamshire. This is different to the pattern for A&E attendance rate, where NHS Mansfield and Ashfield was significantly low. This may suggest differences in severity of self-harm incident compared to A&E, or it may be a reflection of more rigorous coding of admissions where higher tariffs can be charged for more complex patients. Further work would be needed to test this.

Table 12: Emergency admissions to hospital for self-harm, crude rates by CCG, January 2012 to December 2016

CCG	Average annual number of admissions	Rate per 100,000
NHS Bassetlaw	289	202.1
NHS Mansfield & Ashfield	550	224.9
NHS Newark & Sherwood	283	191.6
NHS Nottingham, North & East	337	180.4
NHS Nottingham West	190	135.0
NHS Rushcliffe	214	149.7
Nottinghamshire	**1863**	**185.2**

Figure 9: Emergency admissions to hospital for self-harm, crude rates by CCG, January 2012 to December 2016



Source: HES data

Between January 2012 and December 2016 47.9% of emergency admissions for self-harm were to individuals aged under 30. A significant proportion were aged 30 years and over, Table 13. The pattern of admissions by age group is very similar to that for A&E self-harm attendances. Individuals of all ages were admitted for self-harm, with people aged under 10 years and those over 85 being admitted for care.

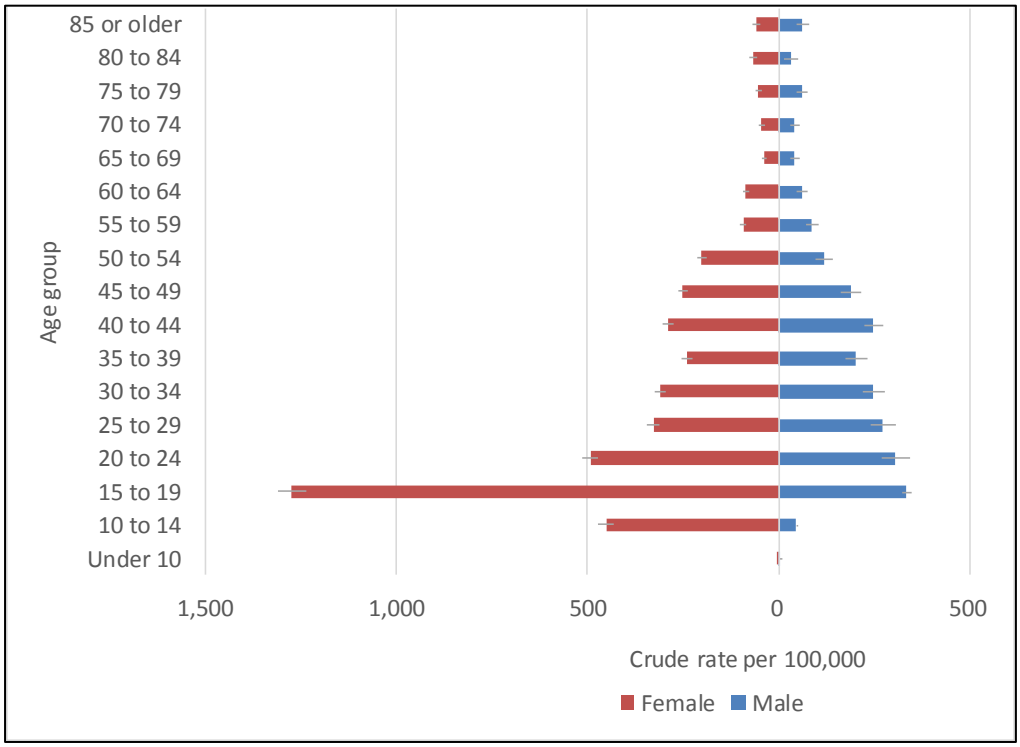
Table 13: Number and percentage of emergency admissions for self-harm, by age, January 2012 to December 2016

Age group	Number	*Percentage*
Under 10	17	*0.2*
10 to 14	529	*7.1*
15 to 19	1,417	*19.0*
20 to 24	877	*11.8*
25 to 29	730	*9.8*
30 to 34	659	*8.8*
35 to 39	529	*7.1*
40 to 44	695	*9.3*
45 to 49	665	*8.9*
50 to 54	496	*6.7*
55 to 59	247	*3.3*
60 to 64	176	*2.4*
65 to 69	103	*1.4*
70 to 74	89	*1.2*
75 to 79	84	*1.1*
80 to 84	56	*0.8*
85 or older	61	*0.8*
Not recorded	22	*0.3*
Total	**7,452**	***100.0***

Source: HES data

The all age rate of emergency admissions for self-harm for females was 232.2 per 100,000; for males the all age rate was 137.9 per 100,000. The rates for males and females was highest on the 15 to 19 age group. The rate for females aged 15 to 19 was particularly high (1,273 per 100,000), more than twice the rates for any age/gender cohort. The pattern of rate of admission by age and gender is very similar to that for attendances to A&E Figure 10.

Figure 10: Self-harm emergency admissions – crude rate per 100,000 by age and gender, January 2012 to December 2016



Source: HES data

Table 14 shows that the method of self-harm identified in over 80% of self-harm emergency admissions was self-poisoning for males and females. Injuries caused by blunt or sharp objects resulted in 8.7% of admissions with self-harm for males and 9.9% of admissions for females.

Table 14: Number and percentage of emergency admissions for self-harm by self-harm method, age, and gender, January 2012 to December 2016

Method	Male number	*Male %*	Female number	*Female %*
Self-poisoning	2274	*83.51*	3991	*84.41*
Object	238	*8.74*	468	*9.90*
Hanging suffocation	34	*1.25*	53	*1.12*
Smoke, fire, flames	10	*0.37*	8	*0.17*
Jump from a high place	7	*0.26*	9	*0.19*
All other means	81	*2.97*	91	*1.92*
Not recorded	79	*2.90*	108	*2.28*
Total	**2723**	***100.00***	**4728**	***100.00***

Source: HES data

The place of self-harm incident is not well recorded in HES self-harm admissions data and was 'unspecified' in over 50% of records for self-harm. Where place of incident was specified, home (over 30% of all admissions) and school or other public institution (3.8% of admissions for males and 6% for females) were the most common recorded places Table 15.

Table 15: Self-harm emergency admissions, number and percentage place of self-harm incident by gender, January 2012 to December 2016

Place of incident	Male Number	*Male %*	Female Number	*Female %*
Unspecified	1551	*56.96*	2436	*51.52*
Home	917	*33.68*	1776	*37.56*
School or public institution	102	*3.75*	291	*6.15*
Residential institution	44	*1.62*	127	*2.69*
Street or highway	26	*0.95*	22	*0.47*
Trade or service area	15	*0.55*	27	*0.57*
Other	68	*2.50*	49	*1.04*
Total	**2723**	***100.00***	**4728**	***100.00***

Source: HES data

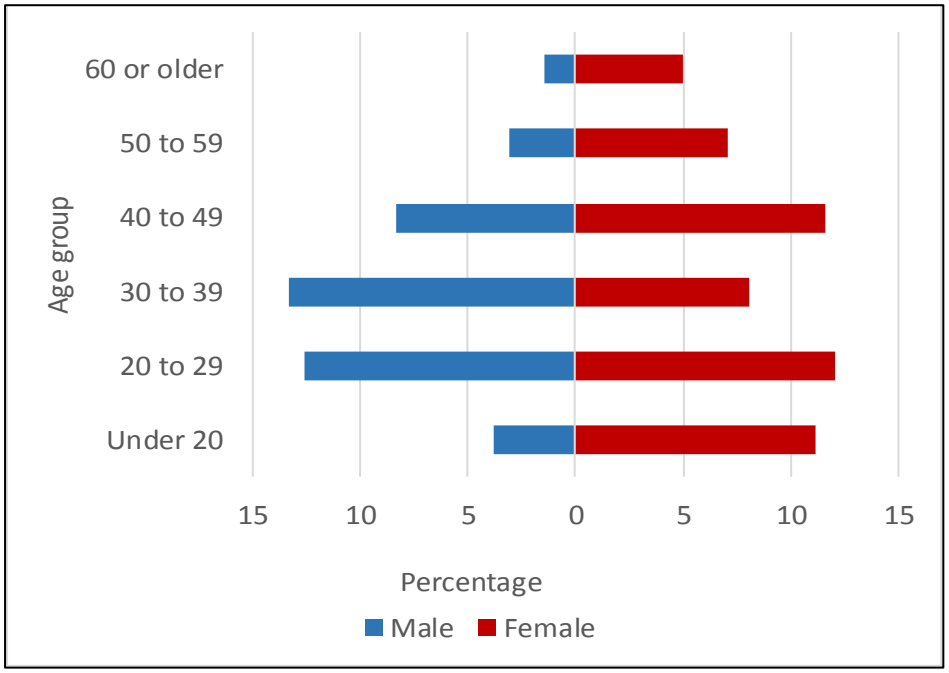
Caveat: Research has found[52] that that routinely collected hospital data, such as Hospital Episode Statistics (HES), varies by hospital site over time and does not accurately capture all hospital presentations for self-harm. It is important to bear in mind when using analysis of such data in making decisions on commissioning and developing services that it is likely be an underestimate of the true picture.

2.6. East Midlands Ambulance Service (EMAS) calls for self-harm

In 2016/17, East Midlands Ambulance Service (EMAS) dealt with 421 calls related to intentional self-harm (as categorised by clinicians) from addresses in Nottinghamshire.

All age groups were represented. Almost a quarter of calls were for patients aged between 20 and 29, with the youngest aged under 10 years and the oldest over 70 years; 56.3%, 237 of the total number of calls were for female patients, Figure 11.

Figure 11: Calls to East Midlands Ambulance Service for intentional self-harm, percentage by gender and age – 2016–2017



The majority; 90.1%, 383 calls, related to overdose, with the remainder attributed to injury resulting in bleeding or haemorrhage, Table 16, Figure 12. Heroin overdose was more common in males (30% of males) compared to females (13% of females).

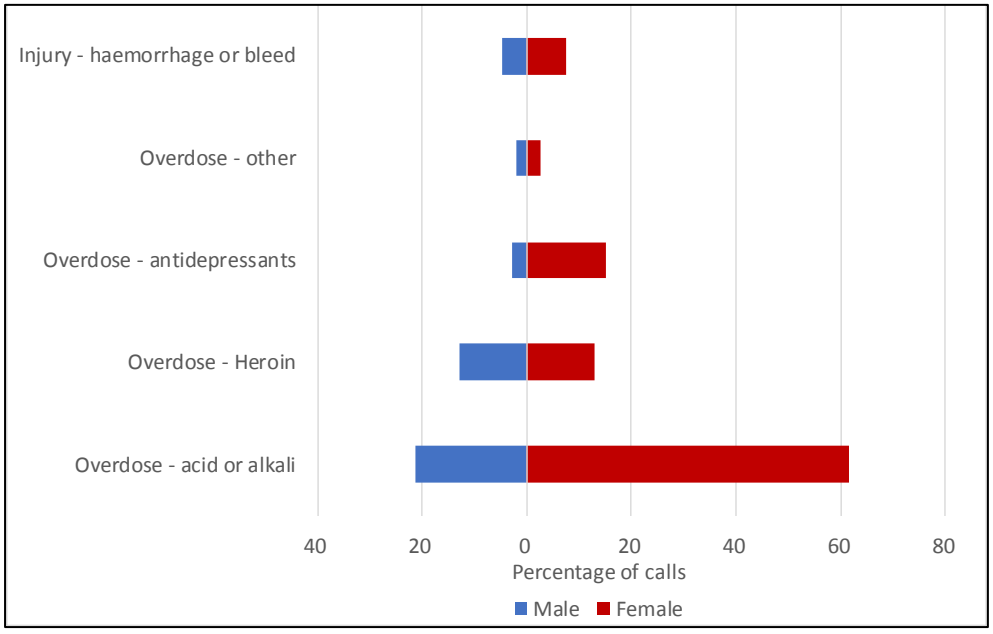
Table 16: East Midlands Ambulance Service – number and percentage of intentional self-harm calls by method and gender – 2016/17

Method	Male number	Male %	Female number	Female %	Unknown	Total
Overdose - acid or alkali	89	49	146	62	<5	**236**
Overdose - Heroin	54	30	31	13	0	**85**
Overdose - antidepressants	12	7	36	15	0	**48**
Overdose - other	8	4	6	3	0	**14**
Injury - haemorrhage or bleed	20	11	18	8	0	**38**
Total	**183**	**100**	**237**	**100**	**<5**	**421**

Source: EMAS Call Centre Data

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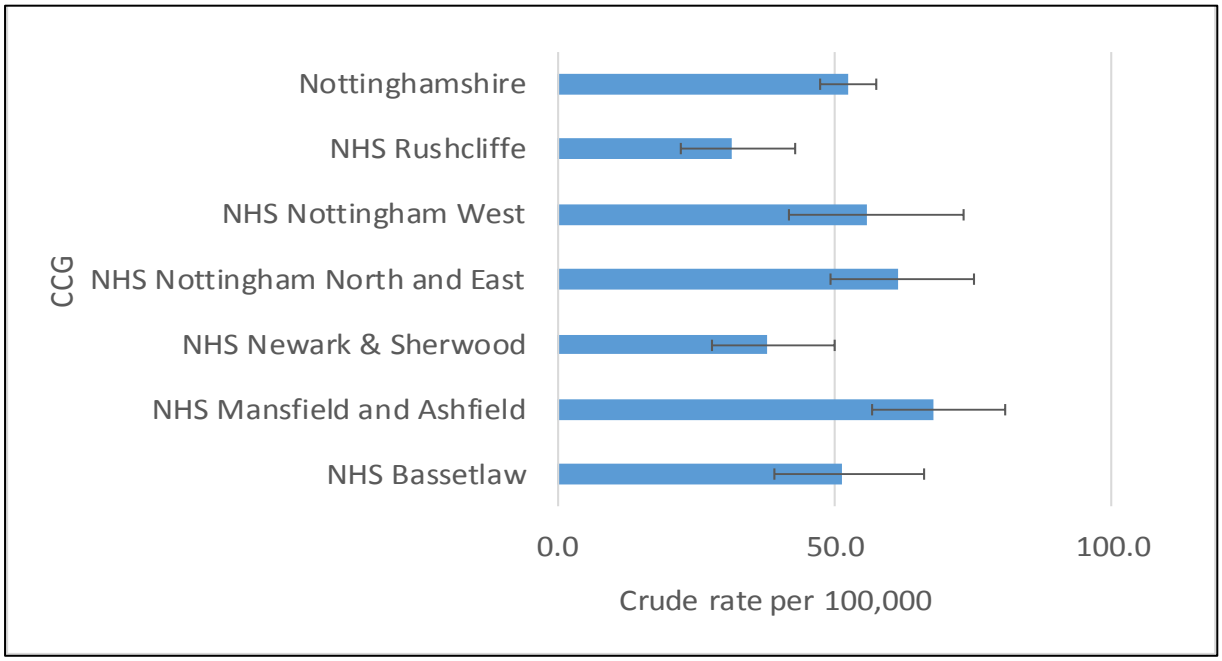
Figure 12: East Midlands Ambulance Service – percentage of intentional self-harm calls by method and gender – 2016/17



Source: EMAS Call Centre Data

Across Nottinghamshire, there were 52 calls related to self-harm per 100,000 population. No CCGs had a significantly higher call rate than the County. Rushcliffe CCG had a significantly lower call rate than Nottinghamshire, Figure 13.

Figure 13: Rate per 100,000 for intentional self-harm calls to East Midlands Ambulance Service by CCG – 2016-2017



Source: EMAS Call Centre Data

3. Targets and performance

Relevant targets within the Mental Health Five Year Forward View[53] relate specifically to suicide rather than self-harm with a 10% reduction in suicide by 2020/21 aligned to the national suicide prevention strategy.

With regard to wider performance on supporting people at risk from poor mental health, there is no current strategy explicitly covering self-harm, but objectives within the Nottinghamshire Sustainability and Transformation Plan are likely to increase the scope of support – including increased access to psychological therapies and more people being able to self-treat through improved information and support.

Broad performance targets are set within the Mental Health Five Year View for 75% of eligible clients to wait a maximum of 6 weeks from referral to treatment. Depending on the service commissioned, eligible clients could have a significantly shorter lead-in for instance with crisis services – e.g. CAMHS crisis referral to community face to face assessment within 4 hours. Repeated self-harm would be one of a multitude of factors which will be taken into account when "clustering" adults of working age and older adults, which will help to determine eligibility and most appropriate treatment route.

3.1. Nottinghamshire benchmarked against East Midlands and England

Performance against the Public Health Outcomes indicators[54] relating to self-harm for Nottinghamshire County and the East Midlands region benchmarked against England are shown in Table 17. These indicate that Nottinghamshire has higher total rates of hospital admissions relating to self-harm compared to England in 2016/17 for 10 to 14 year olds and similar rates for 15 to 19 year olds and 20 to 24 year olds.

Table 17 Public Health Outcomes Indicators for self-harm: Nottinghamshire County LA and East Midlands Region compared to England, rate per 100,000

Indicator	Period	England (rate per 100,000)	East Midlands region	Nottinghamshire
Emergency Hospital Admissions for intentional Self-Harm	2016/17	185.3	200.3[i]	ii
Hospital admissions as a result of self-harm (10-14 yrs)	2016/17	207.2	230.0[iii]	262.8
Hospital admissions as a result of self-harm (15-19 yrs)	2016/17	617.1	658.0[iii]	585.3
Hospital admissions as a result of self-harm (20-24 yrs)	2016/17	397.9	417.2[iii]	399.2

Source: Collated from PHE Public Health Profiles *https://fingertips.phe.org.uk/search/self%20harm#page/0/gid/1/pat/6/par/E12000004/ati/102/are/E10000024 (accessed 16/01/19)*

Key

Compared with benchmark		
Better	Similar	Worse
Lower	Similar	Higher
- could not be calculated		

[i]East Midlands region 200.3 per 100,000. Due to an issue with HES coding in Nottingham University Hospitals Trust in 2016/17, for which over 30% of records did not have a valid geography of residence assigned this value should be treated with caution. In 2015/16, between 10% and 20% of patients that attended hospital from this area were treated at Nottingham University Hospitals Trust.

[ii]Nottinghamshire value is not presented due to an issue with HES coding in Nottingham University Hospitals Trust in 2016/17, for which over 30% of records did not have a valid geography of residence assigned. In 2015/16, over 20% of patients that attended hospital from this area were treated at NUH

[iii]East Midlands region. Aggregated from all known lower geography values

4. Current activity, service provision and assets

4.1. Costs of self-harm (hospital care)

Using cost data from "General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis" [55] the estimated costs of self-harm in 2016 was calculated. These costs represent the financial costs to hospitals, rather than the cost for CCGs under the NHS tariff. The cost values for 'self-poisoning alone' and 'self-injury alone' for admission/non admission were applied to the number of admissions for each CCG and the number of A&E attendances that did not result in admission.

Table18 below shows that highest estimated general hospital cost of self-harm by CCG was Mansfield and Ashfield CCG, £377,688 followed by Nottingham North and East CCG, £229,131.

Table 18: Estimated cost of self-harm based on General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis – 2016, by Nottinghamshire CCG

CCG	Cost of self-harm in 2016 £000k
NHS Bassetlaw	181,650
NHS Mansfield & Ashfield	377,688
NHS Newark & Sherwood	166,962
NHS Nottingham North & East	229,131
NHS Nottingham West	96,045
NHS Rushcliffe	151,212
Nottinghamshire County	**1,202,688**

Source: General Hospital costs in England

4.2. Tariff based costs

Estimates of costs to CCGs using the 2016/17 NHS national tariff are very similar to the estimates above. For these, the non-elective spell tariff (with no adjustment for trim point or market forces factor) was applied to admissions and A&E attendances in 2016. The resultant costs were as shown in Table 19.

Table 19: Estimated cost of self-harm based on tariff by Nottinghamshire CCG

	Estimated tariff based cost (£), activity in 2016		
CCG	**Admissions**	**A&E attendances**	**Total**
	£000k	**£000k**	**£000k**
NHS Bassetlaw	161,629	27,085	188,714
NHS Mansfield & Ashfield	296,986	34,648	331,634
NHS Newark & Sherwood	134,056	24,103	158,159
NHS Nottingham N&E	158,254	42,336	200,590
NHS Nottingham West	76,177	21,971	98,148
NHS Rushcliffe	171,752	32,520	204,272
Total	**998,854**	**182,663**	**1,181,517**

Source: 2016/17 NHS national tariff

4.3. Service provision

Because self-harm is heterogeneous and a sign of unbearable emotional distress used as a coping mechanism by people for dealing with intolerable situations, and not a primary disorder, there are few NHS or Local Authority commissioned services for which self-harm alone is specified as an acceptance criterion. This is reflected in the lack of coding for self-harm as a reason for referral by many commissioned services, so it is not always possible to separate out self-harm from the data management systems, for example in adult mental health services provided by Nottinghamshire Healthcare NHS foundation Trust self-harm, violence and aggression are recorded together so it is not possible to separate out self-harm.

Self-harm may be identified as a coping behaviour in people who are in contact with commissioned mental health services, however self-harm is not always accompanied by a diagnosed mental illness. This often leaves a gap for those who would benefit from support and psychological interventions but do not meet the criteria for access to mental health services, or do not wish to access these services and for whom a clinical model may not be the most appropriate for their needs. This highlights a need for services, experiences and cultures that build and enhance people's self-esteem (community resilience).

People resident in Nottinghamshire who have self-harmed or are at risk of self-harm may have contact with one or more of a range of mental health and other services, including the following (not an exhaustive list) shown in Table 20.

Table 20: Services which may be accessed by people who self-harm in Nottinghamshire

Services	Commissioned by & geographic coverage
Nottinghamshire Healthcare NHS Foundation Trust adult mental health services A wide range of adult community and in-patient mental health services for Nottinghamshire. Settings include, but not limited to, rapid response liaison psychiatry (all ages), Community Mental Health Teams, Psychological Therapies within Primary Care (PCPT) – see below, Mental Health Crisis, Street Triage (all ages – jointly with Nottinghamshire Police), Personality disorder services; Prison Mental Health Services.	**Commissioned by:** All Nottinghamshire CCGs + Bassetlaw CCG **Access via:** referral by GPs, hospital doctors, mental health nurses, self-referral (depends on service)
Psychological (talking) therapies within primary care (PCPT) services • Trent PTS • Insight Healthcare • Let's Talk Wellbeing	**Commissioned by:** All Nottinghamshire CCGs + Bassetlaw (Insight only) **Access:** Referral from any health or social care provider or third sector provider/professional, limited self-referral.
General Practice Provide general medical services to the whole population and often the first port of call for individuals seeking health related advice and interventions and referral on to other services where needed.	**Co-commissioned by NHS England and CCGs:** All Nottinghamshire CCGs + Bassetlaw. **Access:** All individuals, registered with a GP from birth.

Services	Commissioned by & geographic coverage
Nottinghamshire Healthcare NHS Foundation Trust Child and Adolescent Mental Health Services (CAMHS) Provide a range of services including primary mental health team, community, specialist multi-disciplinary and crisis services and for children and young people up to age 18 years with emotional, mental health or behavioural difficulties including self-harm.	**Commissioned by:** All Nottinghamshire CCGs + Bassetlaw **Access:** Referral from GPs, healthy families team, hospital doctors, mental health nurses, other professionals e.g. teachers (self-referral planned in near future).
Acute Hospital Emergency Departments • Nottingham University Hospitals NHS Trust • Sherwood Forest Hospitals NHS Foundation Trust • Doncaster and Bassetlaw NHS Foundation Trust	**Commissioned by:** All Nottinghamshire CCGs + Bassetlaw **Access:** Via emergency services EMAS), self-attendance, signposting from e.g. GP out of hours, 111
Public Health Services for children and young people (CYP) 0 – 19 yrs There are a range of services commissioned for children and young people (CYP) by Public Health within Nottinghamshire County Council. These services are not specifically focused on self-harm, however self-harm is something that may fall within their remit, in terms of direct or indirect support to help equip CYP to resist stress and adversity, cope with change and uncertainty and/or to recover faster and more completely from traumatic events or episodes. They include: • 0-19 universal and targeted support (part of the health families service – provides time limited evidence based interventions to children and young people in relation to emotional health and wellbeing which may include self-harm. Also provides enhanced support to any CYP who has been referred to CAMHS but is not yet in receipt of the service. • Resilience in Schools Service – evidence-based resilience programmes that will improve the emotional health and wellbeing and resilience of CYP in schools. The services have recently been commissioned (April 2017) to target schools most in need based on the Income Deprivation Affecting Children Index (IDACI) and with reference to the special education need / prevalence of emotional health and wellbeing data. • Healthforteens – National website with localised elements. Has tab to information specific to self-harm.	**Commissioned by:** Public Health within Nottinghamshire County Council **Access:** Offered to all 0-19 years CYP resident or attending schools in Nottinghamshire including Bassetlaw. **Access:** Targeted to specific school populations according to need in Nottinghamshire and Bassetlaw. **Access:** Via internet, open to all.
CCG Commissioned services for CYP • Kooth – This online counselling service offers emotional and mental health support for children and young people. Staffed by fully trained and qualified counsellors and available Monday to Friday 12:00 to 22:00hrs and weekends from 18:00-22:00hrs. Open 365 days a year.	**Commissioned by:** All Nottinghamshire CCGs + Bassetlaw **Access:** Via internet, open to all Nottinghamshire resident CYP population including Bassetlaw

Services	Commissioned by & geographic coverage
• CASY - a registered charity dedicated to promoting and preserving the mental and emotional health of children and young people. Offers a range of support including counselling.	**Commissioned by:** All Nottinghamshire CCGs **Access:** via CAMHS single point of access (SPA)
• Base 51 – provides holistic health, social care and support services to vulnerable and often chaotic group of young people (YP) aged 12-18 year through individual and group counselling or crisis interventions. Also facilitate access to wider health provision offered by NYG	**Commissioned by:** NHS Nottingham North and East, Nottingham West and Rushcliffe CCGs **Access:** for YP registered with a GP within the commissioning CCG areas. Drop-in ('phone first) or self-referral.
Educational Psychologists – Nottinghamshire County Council • Work with families of schools and link closely with CAMHS primary mental health teams, TETC team and School Health Hub. Have developed Young People and Self-harm Guidance for schools to help staff to understand self-harm, recognise when risks are there and build staff confidence and knowledge of systems and what to do. They have also developed guidance for schools on: ○ Life is for everyone – supporting pupils who present with suicidal feelings: A guide for school staff ○ Suicide prevention guidance for schools: Responding to a pupil suicide.	**Commissioned by:** Nottinghamshire County Council **Access:** Via referral from schools. Guidance available via schools portal
Non-commissioned third sector services include:	Charity funded
• Samaritans – charity providing 24/7 phone contact service which provides a safe, non-judgmental, confidential space for people to talk and explore their emotions	**Access:** via 24/7 telephone line available 365 days/year
• Harmless – a self-harm specific charity that provides short term and long term evidence based interventions for people that self-harm, their friends and families and professionals.	**Access:** Self-referral and signposting by GPs, hospital doctors, mental health nurses, other professionals e.g. teachers
• DASH – Depression and Anxiety Self Help group, Bassetlaw support group for people in the Bassetlaw area living with any form of depression or anxiety. They meet on Tuesday afternoons from 13:30-15:30hrs at the Bassetlaw Museum in Retford.	**Access:** Drop-in
Websites There are a range of local and national resources, help and information available from the Internet, some examples include: • Nottinghamshire Help Yourself website – a comprehensive source of information about a range of services and support in Nottinghamshire County • Royal College of Psychiatrists	**Access:** open to all via internet

Services	Commissioned by & geographic coverage
• MIND • Young Minds • Citizens Advice Bureau – for advice on e.g. debt and money problems • Childline - a free, private and confidential service for children and young people to access help any time online and by phone 0800 1111	

5. Evidence of what works

There is a scarcity of evidence of effective interventions. Psychosocial interventions for adults – Cognitive Behavioural Therapy (CBT)[±] type interventions – can be helpful in reducing the number who repeat self-harm and Dialectical behavior therapy (DBT)[¥] may help with frequency reduction in adults[56] and children and young people[57]. All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm[58,59].

The limited evidence available is inconclusive regarding the effectiveness of pharmacological interventions for people who self-harm[60], in fact NICE guidance CG133 (see below) advises not to offer drug treatment as a specific intervention to reduce self-harm.

5.1. Guidance and standards

There is a range of guidance and standards for best practice from the National Institute of Health and Care Excellence (NICE)[61]:

- **Self-harm Quality standard [QS34]** Published date: June 2013 - covers the initial management of self-harm and the provision of longer-term support for children and young people (aged 8 to 18) and adults (aged 18 and over) who self-harm. It describes high-quality care in priority areas for improvement.
- **Self-harm in over 8s: long-term management Clinical guideline [CG133]** Published date: November 2011 - covers the longer-term psychological treatment and management of self-harm in people aged 8 and over. It aims to improve the quality of care and support for people who self-harm and covers both single and recurrent episodes of self-harm.
- **Self-harm in over 8s: short-term management and prevention of recurrence Clinical guideline [CG16]** Published date: July 2004 - covers the short-term management and prevention of self-harm in people aged 8 and over, regardless of whether accompanied by mental illness. It covers the first 48 hours following an act of

[±] Cognitive behavioural therapy (CBT) is a talking therapy that can help a person manage their problems by changing the way they think and behave. It's most commonly used to treat anxiety and depression , but can be useful for other mental and physical health problems. https://www.nhs.uk/conditions/cognitive-behavioural-therapy-cbt/

[¥] Dialectical behaviour therapy (DBT) is a type of talking therapy. It's based on cognitive behavioural therapy (CBT), but has been adapted to help people who experience emotions very intensely. It's mainly used to treat problems associated with borderline personality disorder (BPD), but it has also been used more recently to treat a number of other different types of mental health problems. https://www.mind.org.uk/information-support/drugs-and-treatments/dialectical-behaviour-therapy-dbt/#.XD9Voe9LGUk

self-harm, but does not address the longer-term psychiatric care of people who self-harm.

5.2. Building resilience

Self-harm is a behaviour that often indicates unbearable emotional distress. It can be difficult to work out the exact reasons why a child or young person harms themselves, but often a child or young person who is self-harming is being bullied, under too much pressure to do well at school, being emotionally abused, grieving or having relationship problems with family or friends[62].

The promotion of resilience, for children and young people, families and communities, places more emphasis on factors that promote wellbeing, not just on the identification and elimination of risk. This is based on the principle that *"A resilient child can resist adversity, cope with uncertainty and recover more successfully from traumatic events or episodes"* [63]. To promote mental wellbeing and reduce self-harm, mental health strategies should include interventions to develop resilience in children and communities and to prevent and mitigate the impact of adverse experiences[64].

5.3. What works from a lived experience perspective

The 2006 report of the National Inquiry into Self-harm among Young People[65] found that social isolation is a key factor in exacerbating a young person's self-harm. Many young people prefer to turn to other young people for support. Often all they want is to be able to talk to someone, not specifically about self-harm but about problems and issues in their daily lives and to be listened to without being judged. Having someone to talk to may even prevent a young person from starting to self-harm in the first place. Supporting a friend who self-harms is a huge responsibility for a young person, they need to know what to do, how to help and get support for themselves.

The Inquiry also found evidence that anti-bullying strategies were significantly more effective when they are part of a whole school approach to good mental health for all and that it is important for school staff and others to reach out to young people rather than relying on young people to reach out to them.

A key message from young people is that a one size fits all approach will not work; a range of options is needed and self-help was critical. Distraction techniques were particularly important and can be a first, positive, step towards recovery. Successful distraction techniques include using a red pen to mark a cut or rubbing ice over a possible cut site instead of cutting. In managing anger hitting a punch bag to vent anger and frustration, or flicking elastic bands on the wrist.

The Inquiry found that it is important to clarify what is meant by recovery in terms of self-harm. For example some young people interpret it as reducing their self-harm, using distraction techniques to minimise the damage from self-harm, while they tackle the underlying issues; others interpret it as completely stopping self-harm. It is important that professionals understand what recovery means to each individual.

Many of the findings of the National Inquiry are reflected in the local views in section 7 of this JSNA chapter.

6. What is on the horizon?

- In July 2018 outcomes of public consultation were published on a Green Paper "Transforming children and young people's mental health provision" published December 2017[66]. The green paper is about what the Government wants to do to help children and young people with their mental health. There is a particular focus on the role of schools. In Nottinghamshire County a lot of important work is being undertaken which will support the recommendations within the Green Paper. This includes online counselling, resilience programmes in schools and projects such as the Public Health Team in collaboration with the School Health Hub and CAMHS, working with a primary school, secondary school and college to develop emotional mental health and wellbeing pathways that school settings can take and adapt to help determine how best to promote and support mental health within their settings and raise awareness of local services who offer support.
- Continuing financial challenge in the health and care sector with potential for dis-investment for commissioned services. The complex financial landscape may present opportunities as well as threats.
- Expected transformation of adult mental health services with additional focus on/support to primary care.
- Development of Social prescribing and strengthening community assets, however social prescribing schemes and community activities often target older age groups.
- There is a growing awareness of adverse childhood experiences (ACEs) and their impact on psychological and emotional distress and resilience across health, care and education systems. The Nottinghamshire County Council Director of Public Health's Report 2017 makes recommendations around prevention of ACEs, developing trauma informed professional practice across a range of agencies and building resilience in young people to reduce the impact of ACEs[67].
- The Draft All-age Nottingham and Nottinghamshire Integrated Care System (ICS) Mental Health and Social Care Strategy, August 2018[68] highlights the need for better wraparound services to enhance self-care, independence and resilience. Stakeholders have been very clear that prevention should be a key priority within the strategy, and that action on prevention should have a particular focus on children and young people, especially those who suffer adverse childhood experience (ACE).

7. Local Views

7.1. Parents/carers – of young people who self-harm

Nottinghamshire Child and Adolescent Mental Health Services (CAMHS) run support groups for local parents/carers of young people who have self-harmed and been supported by CAMHS. Attendees were invited to describe their thoughts, feelings and experiences of self-harm and its impact on families, summarised below:

The parents/carers used the analogy of "the elephant in the room" to describe their young person's self-harm, that they avoided talking about it. They described their feelings of shock, of feeling "scared" and "terrified".

The emotional and physical effects on siblings and the family were huge, for example locking doors, removing everyday items that might be harmful, confusion over whether to remove 'sharps', disciplining their children differently. They described a feeling of "walking on egg

shells", feelings of being "held to ransom" and being scared that Social Services would take their children away. Also feelings of guilt and wondering what they had done wrong.

Parents/carers also described a sense of living in "parallel universes" with changeable moods and behaviours and the conflicts between wanting to allow their young person privacy and space like any adolescent and needing to ensure and monitor their safety.

Parents really valued parent/carers support groups, saying that they helped them with:

- Understanding self-harm
- Finding out what else (support) is out there for parents/siblings
- Feeing less isolated by sharing with and appreciating others in the same situation
- Getting information about different disciplines/professional roles
- Understanding "how we are 'here' – how this happened to us/our family"
- Frustrations about how to get a service – before getting into crisis (and after)
- How to approach/speak to daughter/son.

7.2. Feedback from users of voluntary sector support services – aged up to 50+

The themes captured in 7.1 above were also reflected in testimonials from people who self-harm across a broad age range up to age 50+ years, their partners and families who have accessed support from voluntary sector organisations in Nottinghamshire e.g. Harmless. Additional themes identified are summarised in Table 21 below:

Table 21: Summary of themes identified in testimonials from people up to age 50+ years who self-harm and their partners and families who have accessed support from voluntary sector organisations in Nottinghamshire.

Themes
Reason for self-harm commencing
• Way of coping with traumatic bereavement • Parental divorce • Sibling self-harming • History of mental health problems exacerbated by stress and bereavement • Anxiety and a low sense of worthwhileness
Impact on the person who self-harms when timely and appropriate support or interventions are not available
• Increases the length of time a person self-harms • Referred onward around the health system • Increases ED attendance • Leads to social isolation
Self-harm health service delivery
• Inadequate supply to meet the demand • Inadequate access to crisis support • Lack of awareness on what services were available for preventing/support for self-harm behaviour • Some Health professionals lacking in empathy • Long gaps between health care appointments, suggested need to be weekly • Self-harm behaviour viewed by the ambulance service as non-urgent • Long waiting lists for mental health interventions • Treatment limited to medication mostly • Lack of specialist health and education staff trained staff in the management of self- harm • Clear treatment plans

Themes
Psychological impact on the person who is self-harming
• Feeling of emotional distance leading to social isolation which then worsened the mental health condition • Once recovered from self-harming behaviour, there is fear of relapsing when exposed to any emotional stressors • Recovery was assisted by the knowledge that individualised structured support was available if required
Effect of self-harm on the family
Impact on the families daily life (in addition to those identified in 7.1): • Siblings not self-harming take on the role of watching over their sibling to make sure the sibling is safe. • Can impact on the sibling not self-harming educational attainment, feelings of anger and resentment, and can lead to social isolation. • All family members are hyper–vigilant looking out for the possible self-harming episodes. • Access to parental support to gain an understanding of the self-harming behaviour and an opportunity to express their fears, concerns and worries not easily available. • Impacts on the physical and mental health of other family members.
Support for self-harming behaviour that was described as being effective.
• Able to express to health professional their feelings. • Adequate time to talk about their feelings. • All members of the family being listened to. • Peer support. • Someone to talk to who can be trusted and not be judgemental. • Having strategies can help e.g. get out of the situation you are in by going outside or using distraction techniques. • Animals (pets) can help. • Gaining insight that the future will not always be like it is at the moment. • Support to regain independence and a sense of worthwhileness. • Treated with respect, dignity and honesty. • A place to feel safe. • Family work together to normalise and accept the self-harming behaviour brings the problem out into the open. • Need to raise awareness and reduce self-harm stigma. • Training police to recognise when someone has a mental health problem (rather than assuming under influence of drugs/alcohol) increases confidence in calling emergency services.

7.3. Experience and views in seeking support during a mental health crisis

In March 2016 Healthwatch Nottinghamshire and Healthwatch Nottingham undertook engagement activity to support the development of a local action plan in response to the national Crisis Care Concordat, on behalf of the Nottingham and Nottinghamshire Crisis Concordat Partnership Board. The objective was to target five specified groups to improve understanding of the issues faced by these groups in accessing mental health crisis services. The groups were:

- Black and minority ethnic (BME) communities (including asylum seekers and refugees)
- Students
- Carers of people with a mental health illness
- Veterans/ex-military personnel
- People who are homeless or at risk of homelessness

Self-harm was mentioned by many respondents as a factor in them seeking crisis support. The conclusions and recommendations from the subsequent report[69] are summarised in Table 22. The Nottingham City and Nottinghamshire County Crisis Concordat Partnership Board have produced an action plan to address these recommendations.

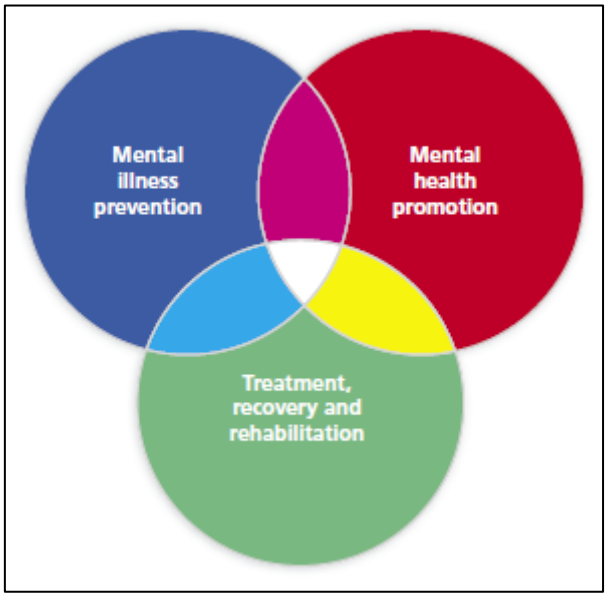
Table 22: Summary of conclusions and recommendations from Healthwatch Nottingham & Healthwatch Nottinghamshire; Experience and views in seeking support during a mental health crisis: Engagement activity report, August 2016

	Conclusion		Recommendation
1	Some people are not getting the support that they need when they need it to prevent the escalation of a crisis episode, or to access crisis services.	1	Ensure greater promotion of services and sources of support so that people are aware of where they can seek help before they reach crisis.
		2	Review the eligibility criteria that are in place for people to gain access to crisis services and include additional support for people who have alcohol and substance misuse problems.
		3	Provide mental health support through locations attended by the community.
2	When people are discharged from the crisis services, they do not always recover and may experience further crises.	4	Implement an open-ended follow-up programme with service users that includes a “step down” service that addresses the specific needs of the community.
3	The majority of people spoke to with a previous experience of crisis services had not had a positive experience	5	Further work on the quality of crisis services is undertaken.
4	Arrangements made when patients are discharged from patient care are not always perceived as satisfactory	6	Further work on discharge arrangements is undertaken.
		7	The Crisis Resolution Home Treatment team should consider ways in which staff can avoid having to ask the service user to tell her/his ‘story’ more than once.

What does this tell us?

Whilst self-harm is not a mental health problem or illness as such is is helpful to use the structure of the Public Mental Health conceptual model[70], Figure 14 to categorise the unmet needs and gaps and recommendations arising from this JSNA. In practice promotion and prevention approaches are closely interlinked[71], so these have been considered together, with early intervention

Figure 14: Public Mental Health conceptual model



Source: Annual Report of the Chief Medical Officer 2013
Public Mental Health Priorities, Investing in the evidence

8. Unmet needs and service gaps

8.1. Promotion, prevention and early intervention

- There is a gap in non-clinical support and prevention, to address the root causes of self-harm, enabling people to be able to ask for help and to develop trusting relationships.
- NICE guidelines and pathways begin when self-harm has been identified in an individual and are focussed primarily on specific services and/or interventions. The prevention element in the NICE guidelines (CG16) focuses on prevention of re-occurrence. There are no system-wide multi-agency (all age) integrated support pathway/s that include health promotion, prevention and early intervention to help to reduce the initial occurrence of self-harm and provide timely access to appropriate support.
- There is a need to ensure continuing Public Health influence in the ICS Mental Health and Social Care Strategy work streams responsible for delivery of Pillar 2: *Increasing Support for Prevention, Self-care and the Wider Determinants of Health and* Pillar 3 *Implementing a Person-centred Approach to Physical and Mental Health* of the STP Draft Nottingham and Nottinghamshire STP All-age Integrated Mental Health and Social Care Strategy, specifically…

- Pillar 2 highlights that action on prevention and early intervention should have a particular focus on children and young people, especially those who suffer ACE and the need for a systemic culture change – moving to a system that takes a longer-term view and thinks about prevention and early intervention to mitigate the impact of ACE rather than treatment alone. In this system, there would be empowered communities with resilience in individuals, families and communities.
- Pillar 3: highlights the development of trauma informed practice. This would help to prevent and mitigate the impact of adverse experiences.

8.2. Treatment and recovery

- The majority of commissioned services are clinical, mainly mental health treatment services. Self-harm alone is not treated as a presenting issue – this leaves a gap in support for people of all ages who self-harm or who are at risk of self-harm, but do not meet acceptance criteria for clinical/mental health services.

9. Knowledge gaps

9.1. Promotion, prevention and early intervention

- The true picture of local needs relating to promotion, prevention and early intervention is difficult to assess due to the incompleteness of data and largely unreported nature of self-harm. An attempt has been made to establish the proportion of unreported adolescent self-harm within the community in section 2.1 above. The figures are estimates calculated using methodology from research and as such should be regarded with caution.

9.2. Treatment and recovery

- The majority of local data used in this document has come from commissioned treatment services and the main knowledge gaps relate to the incompleteness and inconsistency of the data, for example:
  - Research shows that incidence of self-harm in childhood and adolescence has increased in recent years (section 1.1), however it has not been possible to demonstrate this from local data.
  - Hospital Episode data are available on referrals to Mental Health services, ED attendances and hospital admissions. However, self-harm is coded differently in all three situations. Self-harm is not recorded as a presenting diagnosis for hospital presentations and different recording practices add to the incomplete picture. There are similar issues with Adult Mental Health services and CAMHS data. Therefore, it is difficult to compare the rate of self-harm or get a good overview of the number of people in the system that either present and/or have a history of self-harm.
  - For Public Health outcomes indicator 2.10ii (Section 3.1) Emergency Hospital Admissions for intentional Self-Harm, the Nottinghamshire value is not presented and the East Midlands Region value should be treated with caution, due to an issue with HES coding in Nottingham University Hospitals Trust in 2016/17.



  - Due to the data quality issues it is not possible to track what support people presenting to acute services with self-harm receive following attendance or what proportion receive psychosocial assessment in line with NICE guidance.

- Self-harm is not limited to young people: analysis of hospital statistics in section 2 shows a significant proportion of adults known to self-harm with a potential unknown proportion across all ages who do not access services or seek support.

What should we do next?

10. Recommendations for consideration by commissioners

	Promotion, prevention and early intervention	**Lead/s**
1	Focus on reducing emotional distress/increasing resilience in children and young people, building on evaluation of current resilience programmes in schools.	ICS Mental Health and Social Care Strategy Pillar 2 work stream, South Yorkshire and Bassetlaw ICS Suicide Prevention Work stream (Bassetlaw CCG)
2	Develop trauma/ACE informed practice across the health, care and education system and youth services.	ICS Mental Health and Social Care Strategy Pillar 3 work stream, South Yorkshire and Bassetlaw ICS Suicide Prevention Work stream (Bassetlaw CCG)
3	Promote a community assets approach to support improved population emotional health and wellbeing, reduce social isolation and other underlying causes of self-harm across the life-course.	Public Health
	Treatment and recovery	
4	Improve data quality and recording in commissioned services to more specifically reflect self-harm and gain a better understanding of self-harm across all ages. This would enable a clearer assessment of need to inform development of interventions for promotion, prevention, early intervention, treatment and recovery.	Clinical Commissioning Groups
5	Develop system wide multi-agency (all ages) co-ordinated pathway/s recognising self-harm as a primary presenting need.	Clinical Commissioning Groups

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Appendices:

Appendix 1: Admissions to hospital with codes X60 to X84 in any diagnosis field

ICD 10 code	Intentional self harm by:	Cause group
X60	nonopioid analgesics, antipyretics and antirheumatics	Self poisoning
X61	antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs	Self poisoning
X62	narcotics and psychodysleptics [hallucinogens]	Self poisoning
X63	other drugs acting on the autonomic nervous system	Self poisoning
X64	other and unspecified drugs, medicaments and biological substances	Self poisoning
X65	alcohol	Self poisoning
X66	organic solvents and halogenated hydrocarbons and their vapours	Self poisoning
X67	other gases and vapours	Self poisoning
X68	exposure to pesticides	Self poisoning
X69	other and unspecified chemicals and noxious substances	Self poisoning
X70	hanging, strangulation and suffocation	Hanging suffocation
X71	drowning and submersion	Drowning
X72	handgun discharge	Firearm or explosive
X73	rifle, shotgun and larger firearm discharge	Firearm or explosive
X74	other and unspecified firearm discharge	Firearm or explosive
X75	explosive material	Firearm or explosive
X76	smoke, fire and flames	Smoke, fire, flames
X77	steam, hot vapours and hot objects	Steam
X78	sharp object	Object
X79	blunt object	Object
X80	jumping from a high place	Jump high place
X81	jumping or lying before moving object	Jump, lie moving object
X82	crashing of motor vehicle	Crash vehicle
X83	other specified means	Other means
X84	unspecified means	Other means

Source: HES data