Dear Committee Members,

We are pleased to submit evidence to the inquiry on ‘Children and young people’s mental health.’ Given our expertise and experience in self-harm and suicide prevention research we have focused our response on the question ‘What measures are needed to tackle increasing rates of self-harming and suicide among children and young people?’

Key problems

1) Young people who self-harm struggle with help-seeking. This may be because they struggle to trust people enough to feel comfortable talking to them about the issues that concern them (Townsend, Wadman, 2016) or because they do not want to risk the stigma of accessing mental health services.

2) Access to services and care pathways for self-harm have been problematic among children and young people for many years. GPs are generally the first point of contact in the NHS for young people who struggle with self-harm and have an important role in self-harm management (Mughal et al., 2020). However, there is a lack of resources and services on offer to aid and support GPs in the consultation with young people who self-harm.

In our research, we often encounter young people who simply receive no treatment or support for self-harm and the mental distress associated with it. Instead, they are sent away from services with information leaflets (e.g. about harm minimisation) that are not evidence-based and likely to be harmful when recommended in the absence of other supports and services (Wadman et al., 2020).

In cases where referrals are made to Child & Adolescent Mental Health Services (CAMHS), they face a provision commonly overwhelmed and unable to cope with the volume of need. Moreover, young people are still falling down gaps between services. Those that have self-harmed find they are not eligible for IAPT services; those without a current mental health diagnosis find it difficult or impossible to access tiered NHS services. This is a particular problem for children for whom clinicians would be reluctant to make a formal diagnosis.

3) Unfortunately, even when young people manage to access services and supports for self-harm they often encounter negative, patronising attitudes or feel services offer ‘empty promises’ leaving them feeling that they are not being listened to and let down by services as a result (Wadman et al., 2017; 2018; 2019). Young people from different backgrounds demonstrate differing patterns of access and preferences in relation to services for self-harm and have mixed views about the support they receive from CAMHS (Holland et al., 2020).

4) Key risk factors for self-harm which emerge from our work and that of others are problems with impulsivity (Townsend, Wadman et al., 2016; Lockwood et al., 2017; 2020a; 2020b); emotion regulation and coping with problems (Nielsen et al., 2016; 2017; Townsend, Ness et al., 2016).
5) Certain groups of young people are at especially high risk of self-harm behaviour. In LGBTQ+ young people victimization and mental health issues are a particular problem (Williams et al., 2021). In looked-after young people placement change and anger are highly salient to self-harm, and experiences of clinical services depend on individual relationships with clinicians (Wadman et al., 2017). NICE guidance recognises that autistic people are at particularly high risk of suicide (NICE, 2018) with up to 73% of autistic children and young people experiencing self-harm/suicidality at some point (Olphant et al., 2020). However, research suggests that autistic children and young people are particularly likely to fall through gaps in mental health service provision, and if accepted into services, report lack of understanding and knowledge of autism leading to poor experiences of support and treatment (Crane et al., 2019).

6) It is important to note that increases in self-harm have risen in consort with the growth of the digital environment. We do not yet fully understand risk and resilience in the digital world where vulnerable young people may be especially impacted by social contagion and bullying. The relationship between young people and the digital environment is complex and multi-layered. Online spaces may offer an important, immediate and otherwise unavailable space for information, connection, support-giving and help-seeking, but we need to understand more about these processes and the affordances and risks for those who self-harm.

The solutions

1) Design mental health supports and services for self-harm in collaboration with young people as pioneered by the Orygen model in Melbourne, Australia (www.orygen.org.au). The National Coordinating Centre for Mental Health Clinical Competency Framework for Self-Harm and Suicide Prevention for Children and Adolescents affords a map of the competencies, services and supports that would exist in an ideal care pathway. Ensuring that young people have a say in the design and delivery of services and supports would ensure their acceptability and suitability. Increasing compassion in therapeutic relationships, especially with looked-after young people is important moving forward. We have developed an evidence-based resource, a leaflet called ‘It’s okay to talk about self-harm’ which is designed to support safe conversations about self-harm which could be deployed in a variety of settings. (This leaflet is available for download from the NHS website on self-harm). The top 10 autism community priorities for suicide prevention identified addressing barriers to services as the top priority to address (Cassidy et al., 2020). The leading Autism Research Charity Autistica therefore co-produced guidance commissioned by NHS England for professionals supporting autistic children and young people in crisis (Hughes et al, 2020).

2) Self-harm and suicide prevention should be a core component of evidence-informed education, medical, psychological and nursing curricula with regular opportunities for CPD top-ups throughout the career lifespan.

3) In our Patient and Public Involvement work with young people, they have expressed a desire to see preventative programmes in schools and colleges to help young people develop resilience and tackle key risk factors such as impulsivity, emotion regulation and poor coping. We know from studies in Europe that school-based ‘Youth Awareness of Mental Health’ programmes can be useful in preventing suicide ideation and self-harm (Wasserman et al, 2015) but such programmes require testing and replication in the UK.

4) The literature on adult interventions shows that talking therapies like CBT can be helpful for those who self-harm (Hawton et al., 2016). However, while a range of interventions have been trialed with young people who self-harm, the evidence-base in this group is limited (Hawton et al.,
New interventions are needed in this field and these should include those that focus on key risk factors such as emotion regulation, impulsivity and coping, and in specific settings such as crisis teams, primary care and the digital environment. It is vital that people with lived experience are involved meaningfully in the delivery of new interventions throughout the research and development process i.e. from inception and design to dissemination.

It is important to highlight the costs of not providing effective prevention and intervention programmes for self-harm for young people. Self-harm is the strongest predictor of death by suicide with 50-60% of young people who die by suicide having self-harmed (NCISH, 2017). Self-harm is thus a vital aspect of suicide prevention (Townsend, Ness et al., 2016). Moreover, self-harm is associated with severely compromised health and significantly reduced life expectancy (Bergen et al., 2012). Finally, the economic costs to the NHS are significant, with hospital costs of self-harm estimated to be £128 million in 2013 (Tsiachristas et al., 2020).

In conclusion, we believe; ‘We must act collectively as researchers, clinicians, front-line workers, carers, and people with lived experience to ensure that a clear message is heralded across society, and especially in the health, education, justice, and social care sectors: not only is suicide everyone’s business, but so is self-harm.’ (Townsend, 2019).

Yours faithfully,

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References


young people with and without experience of being looked after in care. *Child and Adolescent Mental Health, 25* (3), 157-164


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