Report of the Children's Self-Harm Working Group

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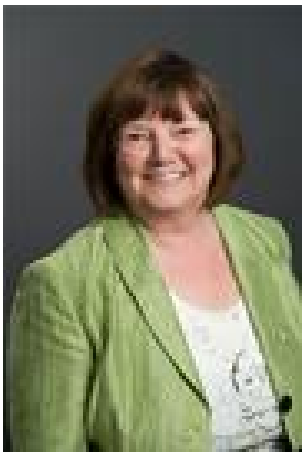
Chairman's Foreword



This Working Group was set up to review, improve, recommend and formalise Hillingdon's arrangements for addressing children's self harm. The Chairman of the External Services Scrutiny Committee, Councillor Mary O'Connor, asked me to chair this Working Group to investigate the issues and to report back to that Committee.

I was glad of the opportunity to investigate such an important issue. It would seem to be a 'hidden' problem as very few children admit self harming and do it in secret. It is difficult to know the extent of the problem and it was difficult to get accurate information on statistics, so we were very reliant on the witnesses that attended our meetings.

This review focused on children/young people up to the age of 18 years old and vulnerable adults up the age of 25 years old. The overall objective of the Working Group was to identify ways that Council could improve the services it offered to children, parents/carers and work better with organisations to provide this service.

We are very grateful to the many witnesses who came to our meetings to provide us with the information needed to make our recommendations and we particularly thank: Joint Director of Public Health, NHS Hillingdon/LBH; Designated Nurse for Looked After Children, Hillingdon Community Health; The Hillingdon Hospital NHS Trust; Headteacher, Hillingdon's Virtual School; Deputy Headteacher, Uxbridge High School; Headteacher, Yeading Junior School; Educational Psychologist, LBH; Domestic Violence Strategic Coordinator, LBH; Asylum Service Manager, LBH; Service Manager, Children in Care Team, LBH; Service Manager Safeguarding Children, LBH; Service Manager Family Support Services, LBH; Team Coordinator, CFACS, CNWL; Chief Executive, Mind; Project Director, selfharm.co.uk; Operations Director, YouthNet.UK; Head of Safeguarding for Children, Action for Children.

A very special 'thank you' goes to the people that gave up their time to talk to us about their personal experiences of self harm and how this impacted them.

All these people have clarified the importance of this review and shown the need for the recommendations that we have made.

Cllr Shirley Harper-O'Neill

Summary of Recommendations

This is a composite list of the recommendations made by the Working Group.

Recommendation 1

That Cabinet endorses the Working Group's view that children's self harm is an issue of great concern and that failure to tackle this will have a significant impact on many families in the Borough. As such, Cabinet agrees that further work needs to be undertaken to establish and collate the support that is currently available in the Borough for children and young people.

Recommendation 2

That Cabinet supports the proposal that the Corporate Director of Social Care, Health and Housing be asked to ensure that Social Services front line staff are trained on the signs of self harm and mental health issues for children. Cabinet also agrees that best practice drawn from the Well Being Project should be incorporated into this training and that progress on training be reported back to the Cabinet Member.

Recommendation 3

That Cabinet agrees that there is a need for a more joined up approach when dealing with issues of self harm and asks the Chief Executive to progress the issue with the Local Strategic Partnership.

Recommendation 4

That Cabinet agrees that clinical coding used in hospitals and A&E departments for self harm needs to be improved and asks the Director of Public Health to progress the matter with The Hillingdon Hospital NHS Trust and report back to the Cabinet Member for Social Services, Health and Housing within 6 months.

Recommendation 5

That Cabinet supports the proposal that the Local Safeguarding Children Board (LSCB) be asked to create a webpage regarding self harm on the Council's website with links to the Samaritans, ChildLine, NSPCC and CFACS/CAMHS. That Cabinet also agrees the LSCB develop together with external agencies an early intervention strategy.

Recommendation 6

That Cabinet agrees that the Deputy Chief Executive and Corporate Director of Planning, Environment, Education and Community Services be asked to ensure that all junior and secondary schools within the Borough are advised of the training that is provided by CFACS/CAMHS with regard to self harm.

Introduction

1. This report presents the findings of the Children's Self Harm Working Group which was established by the External Services Scrutiny Committee to review the Council's arrangements for addressing children's self harm in the Borough.

2. Self-harm (also known as self injury or self mutilation) means deliberately injuring ourselves. Often this leaves a mark, a scar, draws blood or leaves a bruise. The most common ways of doing this are cutting, burning, biting, scratching or pricking to draw blood, picking at old wounds, punching or head-banging a wall. Other ways to self-harm include self-poisoning, pulling your hair out, hitting yourself against objects, taking a drug overdose, and swallowing and putting things inside yourself. Behaviours associated with substance abuse, neglecting yourself and eating disorders can also be considered to some extent as self-harm.

3. Self-harm is more common than is generally realised. It is impossible to say exactly how many people self-harm because many young people hurt themselves secretly before finding the courage to tell someone and many of them never ask for counselling or medical help. There is no 'typical' person who self harms. It can be anyone. An individual who self harms cannot be stereotyped; they can be of all ages, any sex, sexuality or ethnicity and of different employment status, etc.

4. Most people who self-harm have been through difficult experiences as a child or young adult. These experiences may include: separation from someone, being bullied, assaulted or isolated, being put under pressure, homelessness, going into care, bad relationships, hospital or other institutions, neglect, physical violence, emotional abuse or sexual abuse.

5. Someone who self-harms may feel bad about themselves. As pressure builds up, self harm can feel the only way of dealing with it. Sometimes a physical pain provides a relief to the feelings in their head. They may want to punish themselves because they feel guilty or worthless. Or they may feel the cutting acts like a pressure valve, allowing them to relax. It can also be a way to physically express feelings and emotions when individuals struggle to communicate with others. In the majority of cases, self harm is a very private act and individuals can go to great lengths to hide scars and bruises and will often try to address physical injuries themselves rather than seek medical treatment.

6. Although suicide is not the intention of self-harm, the relationship between self-harm and suicide is complex as self-harming behaviour may be potentially life-threatening. There is also an increased risk of suicide in individuals who self-harm to the extent that self-harm is found in 40–60% of suicides.

7. Given the cross-cutting nature of the review the Working Group comprised Members who have experience of various Committees across the Council and the Chairman of the parent Committee, the External Services Scrutiny Committee.

Reason for the Review

8. The UK has one of the highest rates of self harm in Europe at 400 per 100,000 population. There are estimates that every 30 minutes a teenager deliberately cuts, burns or scalds themselves. More than 24,000 teenagers are admitted to hospital in the UK each year due to the severity of their injuries after deliberately harming themselves. Most have taken overdoses or cut themselves.

9. It is estimated that 1 in every 12 children or young people deliberately self-harm. There are other estimates that suggest 1 in 10, and some that say as much as 1 in 5. All kinds of people self-harm, but it's most common among girls age 15-19 and men aged 20-24.

10. In 2004, there were 277 suicides amongst children and young people aged between five and 24-years-old in England and Wales. In 2005, 28 children under the age of 14 (10 girls and 18 boys) took their own lives.

11. This review will focus on children/young people up to the age of 18 years old and vulnerable adults up the age of 25 years old. It will look at what the Council is doing currently and also at the extent of children's self harm in the Borough. Physical self-mutilation will be the primary focus of the review, but it will also touch on other related issues such as anorexia and drug and alcohol abuse.

12. Current procedures need to be reviewed to ensure that sufferers are not overlooked. Work is currently being undertaken by various departments within the Council to address the issue of children who self harm.

13. To ensure that Borough residents receive the best possible service, children who self harm and their parents/carers should be made aware of procedures and advice that are available to help them. This would go some way to making sure that those residents who want and need help are not overlooked.

14. This is a sensitive subject and sufferers are often unwilling to speak openly about their situation for a variety of reasons including fear and embarrassment. Raising awareness of children's self harm (and the help and advice that is available to them) may help them to speak up and gain support in dealing with the matter.

Aim of the Review

15. The review sought to answer a series of questions including:

- Are residents' expectations and concerns about children's self harm reflected in the Council's service standards?
- How are instances currently identified and dealt with across the Council and how can this be improved and standardised?
- How have other councils successfully dealt with the issue of children's self harm?
- Training of staff to properly detect and assess cases.
- Balance of the 'nanny state' versus an individual's freedom.

Ultimately the aim of the review was to recommend, review, improve and formalise the Council's arrangements for addressing children's self harm in the Borough.

Terms of Reference

16. The Working Group's Terms of Reference were agreed as follows:

- To consider existing Council services and procedures which address children's suicide and self harm and any improvements that could be made;
- To review whether the Council's processes in tackling this are timely, effective and cost efficient;
- To review the guidance and support that is currently available from the Council to these children and their parents/carers;
- To assess ways of measuring the number of cases of children's self harm and the accuracy of these methods;
- To seek out the views on this subject from Residents and partner organisations using a variety of existing and contemporary consultation mechanisms;
- To examine best practice elsewhere through case studies, policy ideas, witness sessions and visits; and
- After due consideration of the above, to bring forward strategic, innovative and practical recommendations to the Cabinet in relation to the Council's procedure in dealing with cases of children's self harm.

Methodology

17. The main method for collecting evidence for this review was through a series of witness sessions held in January, February and March 2011. In addition to these sessions, the Chairman of the Working Group spoke with people who had a history of self harm as a child or young person. Some organisations who were unable to attend the meetings provided written information on self harm. A self harmer also gave a statement in her own words about her experiences of growing up self harming.

18. In addition, the Working Group attended selfharm.co.uk's official launch at Channel 4 studios on Thursday 3 March 2011. This event showcased four short films produced by the organisation and a group of youths who volunteered their time.

19. This report presents the findings from these meetings and events. It sets out the background to how the review was undertaken and presents the Working Group's findings from the witness sessions. The recommendations contained within this report address the main issues that arose in the discussions.

20. The Working Group is incredibly grateful to the following people who gave up their time to attend the meetings and advise Members on the key issues:

- Dr Ellis Friedman: Joint Director of Public Health
- Erica Rolle: Domestic Violence Strategic Coordinator, Community Safety Team, LBH
- Teresa Chisholm: Named Nurse for Looked After Children, Hillingdon PCT
- Fiona Lyon: Headteacher of Hillingdon's Virtual School, LBH

- Dr Jo Carruth: Paediatrics Lead, Hillingdon Hospital A & E
- Geraldine Evans: Safeguarding Nurse, Hillingdon Hospital
- Karen Andor: Educational Psychology Service, LBH
- Paula Neil: Asylum Service Manager, LBH
- Ann Holmes: Service Manager, Children in Care Team, LBH
- Judith Barton: Deputy Headteacher, Uxbridge High School
- Christine Robson: Team Coordinator, CFACS, CNWL
- Paul Hewitt: Service Manager Safeguarding Children, LBH
- Parmjit Chahal: Service Manager Family Support Services, LBH
- Carole Jones: Headteacher, Yeading Junior School
- Dr Abbas Khakoo: Medical Director, The Hillingdon Hospital NHS Trust
- Rachel Welch: Project Director, Selfharm.co.uk
- Jill Patel: Chief Executive, Mind
- Claire Easterman: Operations Director (or Patrick Daniels), YouthNet.UK
- Shaun Kelly: Head of Safeguarding for Children, Action for Children

21. In addition to those people who attended the meetings, the Working Group is also grateful to the people that gave up their time to discuss their personal issues of self harm with Members.

22. One of the main aims of this Working Group was to review the Council's arrangements for addressing children who self harm in the Borough. The Working Group also sought to clarify the links between the reasons for self harming and the effects it had on the self harmer as well as their family or carers. It is hoped that this work will act as a catalyst to the work that must be undertaken to tackle the issue in Hillingdon. This may be a long process and the impact may not be immediately clear, but the Working Group believes that children's self harm is an issue that must be addressed.

Recommendation 1

That Cabinet endorses the Working Group's view that children's self harm is an issue of great concern and that failure to tackle this will have a significant impact on many families in the Borough. As such, Cabinet agrees that further work needs to be undertaken to establish and collate the support that is currently available in the Borough for children and young people.

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Evidence & Findings

BACKGROUND

23. It is widely accepted that the term 'self harm' included instances of successful and unsuccessful suicide. There is a stigma attached to suicide, particularly within certain religions, which means that the statistical information available regarding the number of suicides and attempted suicides recorded is not particularly reliable.

24. Although a report published by the London Health Observatory in 2009 indicates that the number of suicides in London each year was decreasing, this does not reflect the increasing number of people that self harm: there were 6.64 suicides recorded between 2005 and 2007 per 100,000 population in Hillingdon compared with 7.49 average for London and 7.89 average for England during the same period. Although the report splits this information by gender, it does not split it by age. It is noted that drugs suicides are more common in London that they are elsewhere in the country.

25. There are often assumptions made when collating information regarding suicides. For instance, it is often assumed that drug overdoses are instances of deliberate self harm. Whilst there are tools available to clinicians to predict suicide, these are often unreliable as a patient that is deemed low risk could then go on to commit suicide.

26. Professor Louis Appleby has undertaken some work on suicide (including the reasons that individuals attempted suicide) for the National Patient Safety Agency in a successful attempt to drive down suicide rates in England. Hillingdon could be compared against this best practice.

Resources available

27. The Working Group believes that it is important to remember that the Council's resources are limited and that any action taken to address children's self harm should not raise residents' expectations too high. Members also maintain that raising awareness of the self harm is vital in tackling the issue.

28. There are currently no additional resources available within the Council to devote to identifying and tackling children's self harm. As such, any work undertaken as a result of this review would have to be fulfilled within the current budgetary constraints and subsumed within the workloads of existing officers.

29. In the future, consideration could be given to how additional resources can be identified to deal with the potential increase in reports of self harm that could result from the recommendations of this review.

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CURRENT WORK

Education & Children's Services, Safeguarding Children

30. The Local Safeguarding Children's Board for Hillingdon includes representations across various agencies. The Board has an independent chairman and there are sub-groups relating to various issues.

31. The Council's Safeguarding Children section does not systematically collect information on children who self-harm. There have been discussions on how best to quantify information on incidents of self harm in Hillingdon. The Council is starting to get information from Hillingdon hospital on young people that have been admitted who have self harmed. Early indicators seemed to show an increase in the number of those admitted to hospital that have self harmed.

32. The Council carried out a management review after a care leaver committed suicide. This was done in order to improve the services provided to service users. There needs to be improvement with the working relations with adult services as the transition is not always a smooth process.

33. Nationally and regionally, it is evident that there is an increase in emotional harm for those children on a child protection plan. There has been a rise in Asian teenage girls who self harm. There needs to be greater awareness and education amongst all communities.

34. There are other issues to consider such as an increase in internet bullying: E-Bullying. This is a further factor which could cause young people to self harm. There is an E-Safety Sub Group which is working with young people around education. A Child Death Overview Panel is also now in existence and the E-Safety Sub Group does a lot of work around bullying and self harm.

35. The reporting of self harm is often done through peer groups. Young people often carry out self harm in secrecy and rarely share this with adults. They are more likely to share this with other young people.

36. Officers are trying to find ways of working with schools to tackle peer group violence. This is another factor which can lead to self harming.

37. It is clear that there should be close collaboration with schools, health, children's services, social care, and other departments and organisations.

38. Having a therapist attached to teams has worked well in the past. This enabled difficulties to be picked up at an earlier stage and therapists could fast track cases. Training children's social workers on children who self harm, and the mental issues around this, could also be very beneficial. There is a lack of confidence in social workers around this area so training is needed for front line children's social workers.

Education & Children's Services, Children in Care Team

39. The Council's Children in Care team identified between 10 and 20 cases of children's deliberate self harm each year, but this figure could be much higher. Officers advised that it was difficult to accurately quantify, monitor and address the number of children using the service that deliberately harmed themselves as it was often hidden.

40. When self harm is identified, it is usually through an assessment process or through discussions with the carers or school staff and is often highlighted by changes in the child's behaviour. Once the issue has been identified, help is sought for the child from other relevant support services such as Child, Family and Adolescent Consultation Service (CFACS) or the Hillingdon Drug and Alcohol Service (HDAS). Although cutting themselves is the most widely publicised form of deliberate self harm, some of these children suffer from eating disorders or substance misuse.

41. The Children in Care team use a strengths and difficulties questionnaire which is completed by the child themselves (if they are older) or by the child's carer. The information on these forms is then analysed and, when appropriate, discussions are undertaken around the child's emotional wellbeing. A clinical psychologist has recently been showing the team how to make more proactive use of the information provided in these questionnaires and schools are now also completing them where appropriate.

42. Improvements could be made to the communication between the Children in Care team, health service and schools to ensure that children that self harm are identified as soon as possible and measures can then be put in place to address the issue. More training could also be given to staff to raise awareness and increase the likelihood that they are able to identify signs of deliberate self harm. A greater awareness and better understanding of the service provided by smaller groups would also be beneficial, particularly if this information is coordinated by one group and held in one place.

Asylum Service

43. The Council's Asylum Service deals with unaccompanied minors and young adults up to the age of 16 in care and care leavers up to the age of 24. It is difficult to identify self harm in the children that the Service deal with as they often arrive in the country with emotional or psychological issues that are not obvious. These issues often result in manifestations such as sleep disturbance and nightmares and it is important for the Service to be aware of this. The more acute manifestations often arise around the time that a child's asylum case is being decided.

44. The Well-Being Project (WBP) was in operation for five years and was funded by the Department of Health until it ended in October 2010. The Project provided a mental health service for looked-after unaccompanied asylum seeking children and offered a range of mental health services to those who suffered with psychological adjustment difficulties or persistent emotional problems. The Project collected information regarding various concerns about each of the several hundred children that been supported by the service. Since the project had ended in October, this information was no longer collected.

45. Although the significance of no longer having the WBP is not yet clear, it is apparent that the level of mental health support to the Service is no longer available. The WBP has also provided training, undertaken consultations and has enabled early intervention to identify children's mental health problems. It is unclear whether these aspects will now be covered elsewhere.

46. As they were unaccompanied, all of the children seen by the Asylum Service do not live with their parents: the younger ones are predominantly in foster care. As such, the Service tries to ensure that these children have contact with others from their own communities through community groups and schools.

47. The Asylum Service is currently in the process of being mainstreamed and it is suggested that this is an opportunity for the best practice drawn from the WBP to be incorporated into training delivered to all teams in Education & Children's Services. This training would help these teams to identify and address the emotional and psychological issues of the children that they have contact with.

48. There has been significant interest in the WBP. The Thomas Coram Foundation undertook extensive research into the achievements of the WBP and it is suggested that the best practice identified should be expanded on and rolled out across the whole of Education & Children's Services, schools and beyond. Although resources and funding are limited, consideration should be given to the continuation of staff consultation and training to ensure that they are confident about what course of action to take when a self harm issue arose.

49. The Service deals with approximately 500 children – this figure had previously been between 1,400 and 1,500. Of those children dealt with by the Service aged 0-18, 60% live outside of Hillingdon. When these children need help or support regarding self harm, the Service approaches the local CAMHS.

50. Officers suggested that the resources and different pockets of activity currently undertaken by different groups in relation to children's self harm should be joined up.

Recommendation 2

That Cabinet supports the proposal that the Corporate Director of Social Care, Health and Housing be asked to ensure that Social Services front line staff are trained on the signs of self harm and mental health issues for children. Cabinet also agrees that best practice drawn from the Well Being Project should be incorporated into this training and that progress on training be reported back to the Cabinet Member.

Educational Psychology Service (EPS)

51. The Council's Educational Psychology Service had undertaken a pilot project regarding self harm in secondary schools (including special schools) in 2008. The project trained teachers in basic risk assessment, taught them how to identify students that were self harming and encouraged them to refer these students to Child and Adolescent Mental Health Services (CAMHS).

52. As approximately 1 in 10 young people are at risk of deliberate self harm, more cross-Borough initiatives would be advantageous. Multi agency work is essential as it is easy to miss things and is thought to be useful to have a team to talk things through.

Hillingdon's Virtual School

53. Hillingdon's Virtual School works with looked after children. As Hillingdon's looked after children live in many different parts of the country (approximately 45 other local authorities has dealings with them), the school is currently investigating the potential to have a more joined up approach. The School's Headteacher questioned how the issue could be moved forward with CAMHS for cross-borough liaison and how the out of borough schools could be supported.

54. With regard to unaccompanied asylum seeking children, once they have finished full time education, suppressed trauma from their lives before they entered the country could lead to them deliberately harming themselves. Those who do not have indefinite leave to remain have been known to harm themselves as a result of the stress of having their cases re-examined once they have finished school. Provisions/support need to be put in place to help these young people before they finish their education - a survey could help with this by establishing what their concerns are. Social Services should be involved in this process so that referrals can then be made to the relevant support services.

Recommendation 3

That Cabinet agrees that there is a need for a more joined up approach when dealing with issues of self harm and asks the Chief Executive to progress the issue with the Local Strategic Partnership.

Hillingdon Community Health (HCH)

55. In addition to physical self harm, consideration also needs to be given to children's risk taking with regard to issues such as sexual health. In the last 6 or 7 years, officers were only aware of one child who had left local authority care and then committed suicide.

56. Every looked after child is given an annual health check. Information from these health checks is returned to the Designated Nurse and Designated Doctor and is included in an annual report. Between July and December 2010, 6 of the 231 health checks completed reported instances of deliberate self harm - these were predominantly girls. It is thought that these figures are an underestimation as the children had not been asked whether or not they were deliberately harming themselves. As such, it is as only when the information is volunteered by the child, or the self harm is apparent, that it is recorded.

57. Officers had recently visited an unaccompanied asylum seeking children's home and were advised by the manager that there were high levels of deliberate self harm at the

unit. The self harm occurs in waves and some of these children are advised to do it as a way to stay in the country. Instances of self harm at the unit include severe cutting and children setting fire to themselves. This information has not been fed back through the health assessment process.

58. Officers recently met with the Liaison Health Visitor and agreed that information will be collated regarding children from local authority care that are admitted to Accident and Emergency (A&E) through self harm. Looked after children are four times more likely to have mental health issues, four times more likely to have problems with drugs and alcohol and four times more likely to become teenage parents. It is therefore likely that these children are also four times more likely to self harm.

59. The Wellbeing Project, which had previously been operational in the Borough, screened the wellbeing of children. The project had originally been Government funded and was later part funded by the Council.

The Hillingdon Hospital NHS Trust

60. The Acute Hospital Trust is a secondary service and, as such, only sees the 'tip of the iceberg' regarding children's self harm. Many of the children that are seen in A&E will not mention that their injuries are as a result of self harm. However, where the injuries or previous scarring indicate that the child is deliberately harming themselves, this is noted. Figures are collated regarding drug abuse, self harm and alcohol abuse and presented to the Safeguarding Children Board. The figures recently collated have changed as a result of improvements in the way that the information is collated.

61. A large proportion of parents that find that their children are harming themselves will take them to their GP or to A&E. There is a different care pathway for children under 16 and those aged 16-18 that present at A&E with evidence of self harm. Those under 16 years old are referred to the paediatricians and, after assessment by them, are referred to CAMHS. Those aged 16 to 18 are seen by A&E doctors and then referred to CAMHS. If the young people under the age of 18 need immediate assessment and CAMHS staff are not able to attend, the assessment is undertaken by the on-call psychiatric Senior House Officer for the adult service. If a patient has been referred to CAMHS by A&E, A&E staff will only follow this up if the young person has repeatedly come in with self harm injuries. Young people who are referred to CAMHS will sometimes not turn up to their appointments. This could then result in the CAMHS team closing their files and no further action being taken.

62. Children admitted to hospital as the result of self harm will not be discharged before they have been seen by CAMHS. This then enables the child's state of mind to be assessed.

63. The A&E Consultant (Paediatric Lead), advised that there are a significant number of asylum seeking children that are brought into A&E – some of whom return time after time.

64. The information collected in A&E regarding self harm between April and December 2010 includes suicidal thoughts. During this period, 31 patients up to the age of 16 advised that they had experienced suicidal thoughts. The clinical coding used at the

hospital is not always as accurate as would be liked which means that some self harm might be coded as 'lacerations' and therefore will not show the whole picture. However, there are now prompts on the A&E notes regarding those under 16, to look at whether there is a history/injury fit.

65. Officers advised that asylum seeking young people often claimed to be younger than they actually were, or lied about their name, as they were aware that they would receive a different (and seemingly 'better') service if they were under 16.

66. Patients with mental health issues often deliberately harmed themselves. Whilst assumptions could be made by clinicians about self harm based on scar patterns, the patient could just deny that they had done anything deliberately.

67. The children's area of A&E department is run by the main A&E department. Self harm is often under-coded. For example, there are some people that are admitted due to substance misuse, medication overdose, etc, and these could be called self harm but are not recorded as self harm. Statistics are provided for year 2010/11 in **Appendix 5**.

68. Higher levels of admittances for self harm are recorded between 5pm and 10pm.

69. An example of a recent case of a youth self harming being admitted to A&E at Hillingdon Hospital is a 14/15 year old who came into the A&E department at around 3pm after self harming. He was referred for assessment and was waiting in the children's department with other children, some very young. He was not seen until 10pm - this length of time was unacceptable for the youth. There needs to be a better pathway for children: even though the physical side is ok, the mental side still needs to seen with as much importance. Surgeons are only interested in patching people up from a physical perspective.

70. The lack of communication is a factor of the poor service that was provided. The process was there but elements were not linking into place. The training was good, as was the awareness, but the information on CAD forms was not robust enough. The biggest area of weakness was the communication.

71. For 16 - 18 year olds there is the transition period to consider. The paediatric cut off age is 16 years old, but adult safeguarding does not start until an individual is 18 years old. There is not enough data captured regarding self harm and it is unclear who is responsible for taking this forward. The CAHMS services are very thin on the ground and does not provide an out of office service.

Recommendation 4

That Cabinet agrees that clinical coding used in hospitals and A&E departments for self harm needs to be improved and asks the Director of Public Health to progress the matter with The Hillingdon Hospital NHS Trust and report back to the Cabinet Member for Social Services, Health and Housing within 6 months.

Domestic Violence (DV)

72. Many of the member organisations of the DV Action Forum dealt with clients that deliberately harm themselves. It was suggested that all agencies need to be proactively asking their clients about self harm and for this to be a cross-Borough approach.

73. Although the inaccuracy of the figures appears to dilute the problem of children's self harm, the trends are relatively accurate. There is no doubt that the issue represents real harm and that something could (and should) be done to address it.

74. A significant number of adults in a DV relationship harm themselves. As such, children learn this behaviour and are then more likely to harm themselves.

75. As there are a significant number of independent bodies that provide support and advice to children and young people that self harm, it is suggested that work be undertaken to look at joining these up so that they are more easily accessible to the young people and other organisations. Furthermore, it is suggested that information about self harm (and where to get help) be included in all school prospectuses to make the issue more mainstream.

Uxbridge High School

76. Of the 1,150 pupils at Uxbridge High School, there are currently 20 children that are known to self harm (approximately 2%). Statistics for incidents of self harm in Uxbridge High School can be found in **Appendix 5**.

77. Although the School is ethnically diverse (roughly 50/50), the majority of students that have been identified as self harming there are from white working class families. This might be because non-white self harming children might find individuals other than School staff to confide in.

78. A Common Assessment Framework (CAF) form is completed by School staff when it is felt that a child's needs are not being met by the current level of provision. The School currently has 120 students with CAFs that have been prompted by a range of issues. Some of these CAFs have been started by members of staff that have concerns about a child (before the child mentions anything). The CAF has to be signed off by the parent before a referral can be made to CFACS and, as this is not always possible, there are often delays in securing the help that these children need. A CAF is not required when making a referral to CFACS but a referral form does need to be completed with as much information about the child as possible.

79. Despite trying, very few children from the School have access to the CFACS service and this needs to change. Over the Christmas period, a Year 7 student tried to hang themself. As there was no child psychologist available at the hospital over the holiday period, this pupil had to wait two weeks before they were seen by a child professional. CFACS has been asked to investigate this incident to ensure that it does not happen again.

80. There is a team of Guidance Leaders in place at the School. These individuals are non-teaching Heads of Year who have regular contact with the students and who have

relevant qualifications and experience, e.g., have worked in the mental health sector or have experience of youth work. Each year, the School undertakes a survey of the students to establish how safe they feel at School and the level of trust they have in staff. The results have been very positive.

81. Rather than being identified by PE teachers as might be expected, instances of self harm are often reported by friends to the Guidance Leaders, teachers or to the Deputy Head. Although a significant number of self harm incidents are dealt with through the Welfare Service, the Deputy Head Teacher, on occasion, has driven students to the hospital to ensure that their needs are addressed immediately.

82. A significant amount of training has been undertaken by staff at the School. This training includes at least six child protection sessions per year and several sessions on professionalism and practice for teachers. Those that participate are shown what symptoms and signs they should be looking out for (including changes in a child's eating and sleeping patterns) and what they need to do to report their concerns.

83. The Deputy Head Teacher suggested that a resource is needed for people who don't work in the health service. As this resource does not currently exist, the school often phones social services to ask for advice even though a referral is not actually being made.

84. Worryingly, when a popular soap opera airs a storyline about self harm, there is an upsurge in the number of children at the School that, despite having no previous history of self harm, start to deliberately hurt themselves. These storylines also raise awareness of the issue and result in more children talking about self harm.

85. Parents often don't have very good coping skills and, as such, turn to the School for help and support when their children deliberately harmed themselves. Although staff at the School are able to give these parents their time and support, they are unable to give them solutions to the problem. It is important that support is given to these parents as they often feel guilty and helpless.

86. The Deputy Head Teacher suggested that a self harm support website be set up in Hillingdon that was run by children for children. This type of peer-to-peer support is often very successful.

Recommendation 5

That Cabinet supports the proposal that the Local Safeguarding Children Board (LSCB) be asked to create a webpage regarding self harm on the Council's website with links to the Samaritans, ChildLine, NSPCC and CFACS/CAMHS. That Cabinet also agrees the LSCB develop together with external agencies an early intervention strategy.

Yeading Junior School

87. Yeading Junior School, located in Hayes, is a cultural and diverse school where 95% of the school come from a minority background. 83% of the students do not speak English as their first language.

88. The School has an open-door policy for all children and parents. The staff are aware of children's vulnerability and have had training on this to help them look for signs of distress. A group has been set up for this area.

89. The language barrier can often make it difficult for children to explain things to teachers and the School. The School has different sessions set up to encourage the children to discuss issues. These sessions include: 'Seasons for Growth - which deals with loss and bereavement; and 'Circle Time' - which lets children discuss issues.

90. There is a community resource next to the School for parents which offers counselling services. The School has volunteers from a number of social work students from Bucks and Brunel University. These provide key workers and adult buddies for the children.

91. The Headteacher stressed that joint working was key. The School works with a range of professionals across boroughs. This gives teachers a better understanding of the issues regarding self harm. Training on safeguarding is done in the Borough. There were concerns regarding bullying over the Internet which was an ongoing problem in all primary schools.

92. A 'fast' programme has been set up which enables families to meet and understand parents and children and get them to play together. The School tries to empower parents to enable them to see what resources are available to them.

93. The number of children at Yeading Junior School that are known to self harm is very low. The Headteacher hopes that this is as a result of early intervention.

Child, Family and Adolescent Consultation Service (CFACS)

94. CFACS is the dedicated Hillingdon Child and Adolescent Mental Health Service (CAMHS) provided by Central & North West London NHS Foundation Trust (CNWL). Although the service provision is for Hillingdon residents, the team will deal with visiting child emergency referrals.

95. Whilst the majority of CFACS' funding comes from CNWL, a small amount is provided by the Council. Contact is usually first made over the telephone and this is subsequently followed up with a referral form being completed and submitted. It is important that this form includes as much information as possible.

96. The CFACS team, which comprises 15 members, has delivered a significant amount of training to staff in schools over the last 12 years. This training is available to all services that deal with children and has recently been delivered to staff at a Children's Centre. More work needs to be undertaken in schools so that CFACS is not seen as a last resort and instead is involved with self harming children at an earlier stage. In addition

to the service it provides, CFACS can also refer children to other specialist services provided by CNWL (or other providers).

97. Approximately one third of the work undertaken by CFACS is in relation to children's self harm. The team receives approximately 1,200 referrals per year (20-30 each week), about 100 of which are serious acts of deliberate self harm that have been referred by A&E. In total, CFACS receives approximately 300 self harm referrals per year. Every referral received by the team is screened on the day that it arrives and is awarded a level of clinical need/priority. Immediate action is taken on the urgent cases and the remainder are considered at one of two referral meetings held every Monday. If self harm has not been the reason for the referral but is later identified, the team will talk to the young person/their family about the issue. Risk assessment forms are also regularly completed for each child every time their risk levels change.

Recommendation 6

That Cabinet agrees that the Deputy Chief Executive and Corporate Director of Planning, Environment, Education and Community Services be asked to ensure that all junior and secondary schools within the Borough are advised of the training that is provided by CFACS/CAMHS with regard to self harm.

Hillingdon Mind

98. Mind works with a wide range of parents of children. The organisation collects a lot of information about children through the counselling service that it provides. A lot of single mothers ask for help with their children. The service deals with children and young people aged 13 to 25 years old and there is a long waiting list for help. It should be noted that the counselling service is losing money.

99. Workers in the Hayes area speak various Asian languages which is very helpful when communicating within the community. There is some stigma attached in some communities with regard to self harm.

100. Some staff are trained in mental health and first aid. Funding for this two day course is provided by NHS Hillingdon and there has been positive feedback from those that have attended. It is important to make people realise that mental health and wellbeing is as important as physical health. Mind is increasingly being asked to go to schools and colleges.

Selfharm.co.uk

101. The Project Director of selfharm.co.uk explained that selfharm.co.uk was a very young organisation. It started from a local project and is now a national project. The Luton Therapeutic Programme (LTP) proved to be a very successful programme locally so they wanted to make it available nationally.

102. The staff team consists of the Project director and a part time worker who works 1 day a week. The website, which is designed for those aged 13 to 19 years old, has a moderator who works on voluntary basis. However, the site is not specific to age and there are no restrictions on the age of those that are permitted to access the site. As well as providing a service for those that self harm, the organisation is passionate about supporting the parents and siblings, etc, of those that harm themselves.

103. Selfharm.co.uk provides training packages to schools to equip teachers to deal with the issue of self harm. The teaching role has changed vastly over the years, so that it is not just about teaching any more. The training provided by the organisation helps teachers by de-stigmatising the issue of self harm. The organisation also helps teachers to support the siblings of self harmers.

104. Services offered for self harmers are scarce and it even scarcer for the parent, carers, etc, of self harmers. Selfharm.co.uk will be focussing its efforts over the next twelve months on de-stigmatising self harm. With regard to the meaning and timing of recovery, there are many different interpretations. Overall, one of the most important factors is to help young people understand the reasons behind why they self harm.

105. The Project Director at selfharm.co.uk was interviewed about self harm on the ITV programme, This Morning, on Tuesday 1 March 2011 which was National Self Injury Awareness Day. Since the programme aired, the website received more than 2,000 hits in one day and received 350 emails. The message the organisation received from the public was that self harm was not talked about enough and that people need to acknowledge that self harm exists. Empowerment is needed so that people are better equipped to support themselves. It is important to acknowledge that a lot of young people use the Internet and this is often the first place that they will turn to when they want help.

YouthNet.UK

106. YouthNet UK works specifically with 16-25 year olds. The website was developed because it was recognised that the Internet is often the first place young people will go to for guidance on any issue. Specific self harm Internet pages were set up by the organisation as there was a demand for this information.

107. Figures on self harm are very varied. Some sources suggest that 1 in 10 young people have self harmed, whilst others state as many as 1 in 5. There are some researchers that state that 40% of their service users have indicated self harm.

108. 144,000 users contact YouthNet every month and approximately 10,000 users access the self harm pages on the website every month. There are ongoing discussions on the online discussion board regarding self harm – the discussion board was created as a safe place that was moderated. There are still people who do not know about self harm or recognise it as a condition. The website provides support, advice and next steps for people including parents and carers and youth workers who also go to the organisation for support.

109. There are limitations to what the website can provide as it was originally developed as the first step for a young person and face to face care is not provided. The services that

YouthNet provides are 24/7 so can be accessed anytime they are needed. The organisation also assists users by telling them where they can get further help. In terms of costs, YouthNet estimates that every £10 it spends helps 5 young people to get advice on the first steps to getting help.

110. A safe environment needs to be established for young people that self harm so that they feel safe and respected. It is important that the issue of self harm is not seen in isolation, as often there are other issues involved in self harm. Perceptions of self harm need to change amongst practitioners.

111. YouthNet provides training for all its staff with regard to child protection and safeguarding. Training regarding how to write web content is also provided for the organisation's many volunteers and support staff. These people provide an online counselling service as well as a text service.

Action for Children

112. Action for Children has 400-450 projects across the country in a range of settings including residential care, children's centres, homeless centres, etc. Action for Children has a presence in Hillingdon through the Borough's children's centres.

113. In 2009-2010, Action for Children had 62 notifications, of which 7 were regarding suicide. The organisation has a varied staff group who come from different professional backgrounds. Training opportunities are provided for all of the staff.

114. Not all people who self harm actually go on to commit suicide. For some young people, self harm is a coping mechanism, and they have another type of vulnerability. The team have a consistent approach but need to work on reducing the risk areas.

115. There are national strategies in place to deal with self harm and suicide in Scotland and Wales: 'Talk to me' in Wales; and 'Choose Life' in Scotland.

116. There needs to be clear preventative measures. The issue of self harm needs to stop being a taboo subject – there is a need for a culture where self harm is talked about openly. Clear signposting to where individuals can get help is needed and the effects on the self harmers, their carers and other young people also needs to be considered. Access to good and appropriate mental health for young people and workers is key.

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PERSONAL EXPERIENCE

Situation 1 – Kirstie[1]

117. The Chairman of the Working Group met with Kirstie about her experiences of growing up as a self harmer. This lady started self harming when she was bullied at school. She decided that she could hurt herself much harder that anyone else so felt untouched by the bullies.

118. Kirstie went on to alcohol and violent attachments. She only really got help after her boyfriend tried to cut her throat.

119. Kirstie had very little self esteem and self worth, and felt like she lived on the outside of life.

Situation 2 – Janine[1]

120. The Chairman of the Working Group met with Janine who started self harming as a young girl. She was sexually abused but didn't tell anyone.

121. Janine continued her self harm with bulimia, alcohol, drugs and sleeping around. She never got too close to anyone and pushed people away with her behaviour. She felt that if there was more information on self harm and how to access help, she might have tried.

Situation 3 – In her own words Amanda[1]

122. Amanda wrote about her experiences growing up as a self harmer.

123. My self harm started when I was around 12-13 - it started from hitting my door out of frustration and it escalated from there.

124. When I first started, I would punch things such as doors, mirrors, picture frames and walls. As I got older, I would sometimes take things such as paracetemol, aspirin and even vitamin tablets to make myself feel ill or induce being sick.

125. I would self harm whenever I felt low or an incident occurred. I would probably say that I self harmed on average two to three times a week.

126. I often used to feel very angry and upset by events that happened at the time. I would feel angry to the point where I wanted to explode and just destroy anything in my path. I couldn't take my frustration out the people causing me the pain so I would explode on

[1] These names are not the real names

materialistic things that couldn't respond back. I felt in control hitting things as I could do this without anyone knowing.

127. I did not tell anyone.

128. When I got older (16), my mum made me go to the doctors over the fact that she thought I had depression. I remember having one appointment with my doctor and I remember thinking beforehand I can maybe explain the other stuff that is going on in my head. When I had my appointment, the doctor asked me what seemed to be the problem? I told him what I felt and within 15 seconds of me talking I could see he wasn't listening and was writing a prescription, he then cut me off and told me that the best course of action was medication. Not once did he probe me for any information or elaborate on what I said. It was like he made his decision before I had even opened my mouth. I myself, at 16, probed him for other alternatives but he kept on insisting medication was the best route. Personally, my doctor put me off telling anyone else about what was going on as he made me feel like I was wasting his time and he also infuriated me even more as he didn't want to listen.

129. It impacted my teenage years as for me it just reiterated the fact that no one actually gave a damn and that I was just a problem that needed to be treated with meds.

130. It has impacted me in the sense that I find it very difficult to trust people in my day to day life I also don't think very much of the medical profession and I would never want to approach a doctor with problems of this nature.

131. My self harming did lead me to attempt suicide on 3 occasions and I constantly thought about committing suicide also.

132. To help me when I was growing up, it would have helped by having teachers that could notice the signs, having a more sympathetic doctor, having people come into schools and giving advice and workshops.

133. People did notice marks and scars but it wasn't at all hard to lie about. I covered up marks and scars with make up, long sleeve tops, sweat bands and tubi-grip bandages.

134. Before self harming, I felt anger and I felt upset and a need to get rid of the tension that I had built up in me. During the process, I would not think or feel anything: I had a sort of blind of rage and I couldn't see, feel or hear anything. Afterwards I would feel a sense of relief and look at the damage that I had caused both on what I hit and on myself. If I was bleeding or had caused bruising or swelling, I felt a sense of accomplishment.

135. When I got into my later teens (17-19), I would drink alcohol knowing that whilst drunk it would take a lot more to hurt myself and it would make me push myself further to reach my desired outcome. I would also drink on top of medication to make myself sick.

136. I don't know what would have made me stop. I honestly could not answer that as me dealing with things in this way seems like the only option. I have no faith in the medical profession what so ever.

137. I didn't receive any counselling. I did not have contact with other people that I knew self harmed.

138. **Situation 4 – Questions answered by Kay[1]**

- How did your self harm start?

After I developed an eating disorder, I started to self-harm.

- What did you used to do to harm yourself?

Razor blades

- How often did you self harm?

Varied, sometimes a few times a week at the hardest times.

- Why do you think you self harmed?

It was a stress release in some sense, but also was a cry for a help as I hated myself so much.

- Did you tell anyone?

Family members

- What support did you get from family members?

They gave me a lot of support and were really upset whenever I self-harmed.

- Did you get any other support? (e.g., school, doctors, friends)

Was in a private eating disorder hospital so was given individual counselling and family therapy, but this was geared more towards me eating disorder and not self-harming.

- How did this impact your childhood?

Isolated, very lonely and missed a lot of schooling.

- What effect does it have on you now, if any, and are you getting any support for this?

I have learnt to live with my scars but still feel vulnerable when I meet new people or start a new job.

- Did you know where/who to go to for help?

I was in hospital so help was there if I needed it.

- Did your family receive any support?

Yes, we had family therapy but again this was for my eating disorder and not self harming.

- Did your self harming ever lead you to attempt or think about suicide?

Yes, I attempted suicide once by taking an overdose on anti-depressants.

- How did other people react if/when they found out and how did this make you feel?

They made fun of me and joked about doing it to themselves. This made me feel very stupid, crazy and isolated.

- What do you think would have helped you when you were growing up?

Talking to others who had self-harmed and had managed to stop.

- Do you think you, and your family, received enough support?

Yes for my eating disorder but not really for my self harming.

- Can you explain the process you went through when you sought medical help?

Once when I self-harmed very badly I was taken to a general hospital where the staff were awful, not very supportive and threatened that they would stitch my wound without an anaesthetic.

- Did anyone ever notice your marks/scars while you were self-harming?

Yes most people

- Did you make an effort to cover up any marks/scars?

Yes, I would not wear short sleeves even in the summer and wore long sleeved tops all the time.

- How did you feel before/during/after self harming?

Upset and ashamed.

- Were you ever under the influence of anything whilst self-harming (e.g., alcohol)?

No

- What made you stop?

My Mum

- What do you think would make you stop?

Nothing

- Did you receive any counselling?

Not specifically for my self harming.

- Did you have any contact with others that self harmed?

Yes other girls in the hospital where I was staying self harmed. One of the girls even gave me razor blades to use.

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FUTURE WORK

139. Having researched work done in other boroughs, there are very limited solutions or experiences that we found that Hillingdon could follow. We hope that our work at Hillingdon can help raise the awareness of the importance of the issue of Children's Self Harm within Hillingdon and beyond the Borough.

140. The issue of self harm is a problem and has always been a problem but is talked about more now. In the future, how self harming could be prevented needs to be looked at so that signs are spotted before it becomes regular behaviour.

141. Further work also needs to be undertaken regarding what action the Council can take to improve the services it offers. How the Council can link in with other organisations to meet the needs of those who self harm and their families, and to look at early intervention strategies so that potential self harmers be given the appropriate support they require.

142. It is stressed that sign-posting and multi agency working is crucial. It is understood that Internet bullying is increasing and that cultural issues can be a problem when dealing with self harm. The Council needs to look at ways that sign-posting and multi agency work can improve to ensure a much better service is provided.

143. There are children and young people who are not getting the treatment they require for self harm as the injuries they arrive with at A & E are not recorded correctly. Data collection and the use of clinical coding in hospitals is important to ensure that accurate information is recorded and, therefore, appropriate treatment is provided.

144. All organisations are under pressure to perform with fewer resources and they have to be innovative with what they have available. Other avenues have to be considered if resources are not available including coordination, communication and multi agency working.

145. It was noted at the witness sessions that front line staff may not always be able to recognise the mental health signs that are related to self harm. Training for staff so that they can recognise the signs of self harm is key in improving the services offered.

Closing word

146. Clearly, the effect of children's self harm is a complex issue. Children's self harm has always been an issue and greater awareness is required to assist those children and young people in need. The Working Group believes strongly that more information needs to be put into the public domain to assist children and families to get the support they need.

147. From the several witness sessions held, a key point that came out from each was communication. It is hoped that the recommendations in this report have highlighted the need for a more joined up approach when dealing with issues of self harm. Signposting and knowing where to go for help is crucial in providing the help that is required.

148. Parents play a key role in the development of their children and the relationship between them is vital in getting services across to children who self harm. Support provided to parents, siblings and carers of those children that self harm is also an important issue and needs to be considered.

149. The Well Being Project , which was part funded by the Council, was in operation for 5 years before coming to an end in October 2010. This project offered a range of mental health services and collected information regarding the children it offered the service to. The project also provided training and enabled early intervention to identify children's mental health problems. It is vital for the Council to use the learning from the Project and continue to provide best practice to its residents.

150. Training key front line staff to deal with the issues regarding children's self harm is important. This resultant early intervention will ensure that staff feel confident in recognising and acknowledging the signs of self harm and know where to get additional information and advice.

151. Although it is difficult to measure the number of children and young people that self harm, the Working Group feel that this an area that could improve. Better data collection should help to show the scale of the issue and highlight the need for better services in this area.

152. The Working Group would like to highlight the excellent work that has been done by organisations such as selfharm.co.uk, YouthNet, Action for Children and National Self Harm Network. These organisations, along with many others, have showed that young people do want to be helped, but do not necessarily know where to access help or have the emotional stability that is required to ask directly for help.

153. It is appreciated that the implementation of the recommendations contained within this report will not be something that can be completed overnight. The approach to implementing change is likely to be slow to ensure that we get it right first time and to manage the expectations of those affected by children's self harm.

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Comments of the External Services Scrutiny Committee

154. The External Services Scrutiny Committee established this Working Group to examine the issue of children's self harm in the Borough. We, the Committee, have considered the Working Group's findings outlined in this report and are delighted to present these to Cabinet and the Council's partners. The report clearly outlines the seriousness of the situation in Hillingdon and the importance of providing a coordinated response to the needs of children that self harm and support to their families and friends. We fully endorse the recommendations.

Appendix 1:
glossary, references & further reading

Glossary

A & E	Accident and Emergency
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CFACS	Child Family & Adolescent Consultation Service
CNWL	Central North West London NHS Foundation Trust
DoH	Department of Health
DV	Domestic Violence
EPS	Educational Psychology Service
GP	General Practitioner
HASH	Hillingdon Association of Secondary Headteachers
HCH	Hillingdon Community Health
HDAS	Hillingdon Drug and Alcohol Service
NEET	Not in Education, Employment or Training
PCT	Primary Care Trust
POC	Policy Overview Committee
UASC	Unaccompanied Asylum Seeking Children
UHS	Uxbridge High School
WBP	Well-Being Project

Further reading

- Draft Suicide Prevention Action Plan; **Suicide Prevention Group**; December 2010
- Working Towards a Better Understanding of Self-Harm; **Dr Stephen Gregson**; British Journal of School Nursing, December 2010/January 2011, Vol 5 No 10, Pages 428-429
- Calls to ChildLine about depression and mental health; **ChildLine Casenotes**; 2007
- Children talking to ChildLine about suicide; **ChildLine Casenotes**; March 2009
- Suicide in London 2005-2007: An update; **Geoff Mole and Allan Baker**; London Health Observatory; May 2009
- National Suicide Prevention Strategy for England; **Department of Health**; September 2002
- Young people who self-harm: Implications for public health practitioners; Child protection research briefing; **NSPCC**; March 2009
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- **Suicide Prevention Group** meeting notes; 16 November 2010
- Welsh youth consultation on suicide and help seeking behaviours; **Mind Crmyu Positive Choices Project**; 2010
- Choose Life; **A national strategy and action plan to prevent suicide in Scotland**
- Talk to Me; **The national action plan to reduce suicide and self harm in Wales**
- Self-Harm: Recovery, Advice and Support; Exploratory and evaluative research; **YouthNet, 42nd Street, Depaul UK,** June 2009
- Promoting the emotional wellbeing and mental health of unaccompanied young people seeking asylum in the UK; **Thomas Caram Summary Research Unit**

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http://www.merton.gov.uk/community/safeguardingchildren/lscbprofessionals/lscbtraining/matp-specialist_courses/matp-c7.htm

http://www.sutton.gov.uk/index.aspx?articleid=3217&contactid=4119

http://www.smhft.nhs.uk/services/for-children-and-young-people/39-deliberate-self-harm-service

http://www.devon.gov.uk/index/childrenfamilies/fostering/foster_carer-2/fostering-trainingprogramme/fostrain09-selfharm.htm

http://www.gloucestershire.gov.uk/cypp

http://www.sheffield.gov.uk/your-city-council/council-meetings/scrutiny/archive/education-/agenda-17-november-2004/report-missing-children

http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/self-harminyoungpeople.aspx

Appendix 2:
National Self Harm Network Response

Please find below the written submission from NSHN, Dr. Stephen Gregson
NSHN Chair, to the London Borough of Hillingdon's Scrutiny Review of Children's Self Harm:

1. What are the levels of children's self-harm across the country/London? How is self-harm currently measured and reported?

NSHN is a peer support organisation for those who self harm and those family, friends and professionals involved in their care. We do not, nor are we in a position to, keep statistical information about levels of self harm at a regional/national level.

That said, nationally available data shows that two thirds of those who self harm are under 35, which compares with an NSHN internal membership audit (2007) showing that:
• 9.5% were under 16
• 50% were 17-25
• Just over 20% were 26-34

A NSHN membership poll conducted in 2009 found that:
• 19% started to self harm between 11-15
• 13% started when they were younger than 10

2. What procedures are currently in place within your organisation to identify those children/young people who are at risk of self harming?

The NSHN website carries information on the support services and online resources the charity offers not only to those who self-harm, but also to family, friends and professionals involved in their care. The charity also offers an online forum, which currently has around 3 500 members offering peer to peer support. Fully checked, trained and experienced administrators and moderators ensure that the forum is a safe and secure place in which to be supported, signposted and/or distracted from impulses to self-harm.

NSHN also offers a confidential, freephone helpline for individuals who self-harm (including those under 16 years of age) and family, family and professionals involved in their care. All those working on the helpline are required to undergo a training programme and supervised at all times by an experienced supervisor. The helpline also operates a child protection policy if a call is taken from a child indicating their life is in danger from another; a copy is available on request.

All those working directly on any of the charity's services—including Board members—have been checked with the Criminal Records Bureau.

3. What support and guidance does your service currently provide to those children/young people who self harm?

As 2.

4. How do you work with other organisations to provide a more joined up approach to helping children that self-harm?

NSHN has, in the past, offered awareness training for organisations working with vulnerable children. However, the charity is entirely volunteer run (except for one part time helpline supervisor) and does not receive any funding to deliver awareness training to meet demand. Awareness training has now been suspended until a time when there are adequate resources available for this purpose.

5. What support and guidance does your service currently provide to parents/carers of those children/young people that self harm?

As 2.

6. Do these measures adequately address children's needs in a timely, effective and cost efficient way?

Advice and support are delivered via online or telephone interventions. There have been occasions when parents have requested in person support for their children. However we do not have the resources or range of expertise to provide such a service. In line with data protection we do not keep records that allow us to follow through on the impact of our services upon those who contact us for advice and support.

7. What additional measures could be put in place to help these children/young people and their parents/carers?

While NSHN would hope to offer a complete range of services – including face to face – what we currently offer is at the peak of our capability.

8. What external training of staff or awareness activities, if any, has your organisation undertaken with regard to children who self harm?

NSHN is currently unable to fund external training for volunteers that is specific to children who self harm, as opposed to the general population. However, the paid helpline supervisor has the autonomy to arrange her own training in this field, within budgetary limits, with a view to disseminating new information to volunteers. Board members are also encouraged to focus on a specific area of awareness raising, which may involve children who self harm.

9. Do you know of any cross-borough initiatives that are in place regarding self harm?

Not applicable.

Appendix 3:
Hillingdon's draft suicide prevention action plan

Background and context: The average regional suicide rate is going down. Hillingdon's rate is fairly static, but lower than in the neighbouring boroughs of Hounslow and Ealing. High risk groups include those with a history of depression or self-harm, substance misusers, homeless individuals and those suffering a sudden economic change. Following a multi-agency meeting in November 2010, it was agreed to draft and populate an action plan setting out a borough-wide response to suicide prevention, which would combine some whole population initiatives with targeted interventions.

1. Universal interventions:

NOS.	OBJECTIVES	KEY ACTIONS	START DATE	END DATE	LEADS
1	Enable universal services, including GPs, hospital staff and schools, to identify and refer individuals at risk.	• Develop a third party referral system with GP practices in the borough, including training if necessary. • Train schools staff to increase their awareness and capacity to identify and respond to risks. • Ensure that all schools have up-to-date bullying policies. • Train hospital staff to improve their management of risks and enable them to make appropriate referrals. • Circulate leaflets on mental health first aid and brief partner agencies on how to identify clients potentially at risk. • Promote emotional wellbeing via mental health events in the spring and			GP contracting team, Primary Care Advisers, GPs, PBC, Samaritans, Hillingdon Hospital staff, CNWL

NOS.	OBJECTIVES	KEY ACTIONS	START DATE	END DATE	LEADS
		autumn of 2011.			
2	Raise public awareness through the borough's stations and transport hubs.	• Undertake training for British Transport Police and relevant Transport For London staff to raise awareness of suicide prevention issues and increase their capacity to manage risks. • Display posters, leaflets and the Samaritans helpline number at stations in the borough.			Samaritans, British Transport Police, Transport for London
3	Plan interventions in response to the ongoing changes in economic circumstances	• Train debt counsellers, Job Centre staff, benefits advisers, Human Resources and Occupational Therapy staff. • Display leaflets, posters and helpline numbers in Citizens' Advice Bureau offices and via local voluntary and community organsiations.			

2. Targeted interventions for high risk groups:

NOS.	KEY ACTION	ACTIVITIES FOR KEY ACTION	START DATE	END DATE	RESPONSIBLE PERSON
1	Profile the suicides in the borough over the last ten years in order to identify high risk indicators, trends, and cohorts to be targeted.	• Produce a summary of identified needs and the supporting evidence that can directly inform the strategies, workplans, policies and practices of			Public Health and PCT Information Team

NOS.	KEY ACTION	ACTIVITIES FOR KEY ACTION	START DATE	END DATE	RESPONSIBLE PERSON
		local partner agencies. • Develop recommendations in response to any gaps and trends identified, highlighting areas for improvement.			
2	Undertake joint planning, information-sharing and joint working with partner agencies.	• Develop an information-sharing protocol between mental health and housing services enabling the sharing of information about high risk clients and, where appropriate, joint care-planning. • Where appropriate, support and train schools using the Samaritans DEAL package. • Train A&E staff to raise awareness of risky behaviour and self-harm as indicators of risk. • Develop protocols with local hotels, particularly around Heathrow Airport. • Share learning points and findings of sudden untoward incidents in the borough and agree multi-agency responses. •			Hillingdon Housing Services, Mental Health Services, schools, Samaritans, Hillingdon Hospital, CNWL, bereavement services, Safer Hillingdon Partnership, Community Safety team
3	Specify interventions with known high risk cohorts, including young men, older people, substance misusers and mental health service users.	• Use social networking sites and work via local schools, colleges and universities to promote key preventative messages to young people.			Public Health, Children and Families Services, Brunel University, Uxbridge College

Appendix 4:
Children's Self Harm Statistics

Statistics provided by Hillingdon A & E Year 2010/11

Count of Category		FYear	FQuarter				
		2010/2011				**2010/2011 Total**	**Grand Total**
Category	Status	Q1	Q2	Q3	Q4		
AlcoholIntoxication	Admitted	5	16	7	3	**31**	**31**
	NonAdmitted	20	19	22	0	**61**	**61**
AlcoholIntoxication Total		25	35	29	3	**92**	**92**
Assault	Admitted	0	0	0	0	**0**	**0**
	NonAdmitted	3	1	2	0	**6**	**6**
Assault Total		3	1	2	0	**6**	**6**
MentalHealth	Admitted	7	13	7	0	**27**	**27**
	NonAdmitted	6	11	7	3	**27**	**27**
MentalHealth Total		13	24	14	3	**54**	**54**
Overdose	Admitted	17	20	10	0	**47**	**47**
	NonAdmitted	25	20	32	2	**79**	**79**
Overdose Total		42	40	42	2	**126**	**126**
SelfHarm	Admitted	7	5	2	0	**14**	**14**
	NonAdmitted	2	2	2	0	**6**	**6**
SelfHarm Total		9	7	4	0	**20**	**20**
SexualAbuse	Admitted	0	0	0	0	**0**	**0**
	NonAdmitted	0	1	0	0	**1**	**1**
SexualAbuse Total		0	1	0	0	**1**	**1**
SubstanceMisuse	Admitted	0	1	3	0	**4**	**4**
	NonAdmitted	2	1	2	0	**5**	**5**
SubstanceMisuse Total		2	2	5	0	**9**	**9**
Grand Total		**94**	**110**	**96**	**8**	**308**	**308**

(ASS,65.1,65.2,65.3,65.4) Assault
(AEAE,AEAI,AEAP,AEAW) AlcoholIntoxication
(PSAGT,PSBP,PSCON,PSDEP,PSMAN,PSOMHP,PSPD,PSSCH,PSSI) MentalHealth
(AESH,AESHB,AESHC) SelfHarm
(MDSA) SexualAbuse
(SUDI,SUDR) SubstanceMisuse
(AEODA,AEODI) Overdose

Appendix 5:
Children's Self Harm Statistics

STATISTICS PROVIDED FEBRUARY 2011
UXBRIDGE HIGH SCHOOL - ACADEMIC YEAR 2010/11

Cutting	Banging	Anorexia	Swallowing	Poisoning	Sexual	Suicidal
						Y7 M
				Y7 M		
Y9 F						
						Y9 F
Y9 F						
						Y9 F
					Y9 F	
					Y9 F	
	Y9 M					
Y10 M						
Y10 F						
		Y10 M				
						Y10 F
Y10 F						
			Y10 F			
			Y10 F	Y10 F		
						Y12 M
		Y13 M				
Y11 F						
			Y11 F	Y11 F		

KEY
Y7 = 11-12 years old
Y9 = 13-14 years old
Y10 = 14-15 years old
Y11 = 15-16 years old
Y12 = 16-17 years old
Y13 = 17-18 years old
F = Female
M = Male