‘HIDDEN NUMBERS’: SELF-HARM IN CHILDREN AND YOUNG PEOPLE IN NHS GREATER GLASGOW AND CLYDE

Health Needs Assessment

NHS
Greater Glasgow and Clyde

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List of abbreviations

CAMHS	Children and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CIS	Continuous Inpatient Stay
COSLA	Convention of Scottish Local Authorities
CYP	Children and Young People
DBT	Dialectic Behavioural Therapy
ED	Emergency Department
GCC	Glasgow City Council
GGC	Greater Glasgow and Clyde
GIRFEC	Getting It Right For Every Child
GRADE	Grades of Recommendation, Assessment, Development and Evaluation
HSCP	Health and Social Care Partnership
NAC	N-acetyl cysteine
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRS	National Records of Scotland
SDQ	Strengths and Difficulties Questionnaire
SHANARRI	Safe, Healthy, Achieving Nurtured, Active, Respected, Responsible and Included
SHINE	Schools Health and Wellbeing Improvement Research Network
SITB	Self-Injurious Thoughts and Behaviours
WEMWBS	Warwick-Edinburgh Mental Well-Being Scale

Executive Summary

This work seeks to assess the needs of children and young people who self-harm in NHS Greater Glasgow and Clyde (GGC). Through a combination of information sources including surveys, service data, academic literature, interviews and focus groups of teachers and mental health workers, the report builds a picture of self-harm as a common, impactful and likely increasing issue amongst our young population.

Despite the findings laid out in this report, our understanding of population need around self-harm remains incomplete. Self-harm often remains hidden, sometimes for years, with only a minority of young people ever seeking help. Not only does it affect the person involved, it can also be highly impactful to families as well. Stigma around mental health and self-harm also remains pervasive and is likely a significant barrier to young people getting the support they need. Against this backdrop, social media will continue to remain a key challenge, requiring a nuanced approach which understands this technology to be both a help and a hindrance to good mental health.

Whilst self-harm is the focus throughout, it does not exist in isolation of other health and social issues. Addressing these may help to alleviate the underlying reasons why self-harm is being used. As such, wider systems issues which may impact on mental health including prevention, early intervention, interprofessional working, governance and strategy are also addressed.

The Scottish National Self-Harm Strategy, published in November 2023, provides key strategic context for ongoing action in NHS GGC. Throughout this report, recommendations aligning with this strategy are made based on the evidence gathered. These, along with high-level findings, are summarised in the following section.

Health Needs Assessment Recommendations

The recommendations for this report are structured in alignment with Scotland's Self-Harm Strategy and Action Plan 2023-27 ('the Strategy')[1]. Where these fall outwith the Strategy's scope, further strategic context is provided as relevant.

To take the recommendations forward, it is advised that NHS GGC creates a self-harm action plan for children and young people which aligns to the Strategy, with suitable governance structures in place for delivery and oversight.

Scottish Government Self-Harm Strategy Priority 1

'Continue to expand and deepen knowledge and embed compassionate understanding of self-harm and tackle stigma and discrimination.

Groups at higher risk of self-harm – In addition to self-harm being commoner amongst females, there are likely to be higher rates of self-harm amongst children and young people (CYP) who are lesbian, gay, bisexual, transgender and non-binary (LGBT+) and/or neurodiverse. This is largely based on academic evidence and a Scottish health needs assessment (HNA) conducted for LGBT+ adults. Less is known about the needs of these groups in younger populations and in the NHS GGC context.

- ***Recommendation 1a -*** *Further work is required to understand the support needs of at-risk groups and their families - particularly LGBT+ and neurodiverse - with evidence generated used to inform how and where interventions are delivered.*

- ***Recommendation 1b -*** *Educational and healthcare services should be supported to adopt a proactive approach to addressing self-harm risk from both prevention and early intervention perspectives for at-risk groups, informed by learning from work in recommendation 1a.*

Public misperceptions - A large public survey conducted by the Samaritans indicates that there are likely to be widespread misconceptions amongst the general public regarding reasons for self-harm, who is most affected and how to provide support.

- ***Recommendation 1c -*** *Awareness raising activities are required at local and national levels to address public health misperceptions around self-harm, with emphasis that self-harm is common, particularly amongst CYP. Public messaging should seek to explain why individuals may self-harm and outline the key steps of a compassionate response. It may be appropriate for this messaging to be tailored to groups including CYP, parents/guardians and adults. All public awareness efforts should have the core aim of seeking to address stigma and discrimination associated with both self-harm and mental health issues more broadly.*

Self-harm training for professionals - NHS GGC has developed a range of training materials and courses around self-harm for professionals involved in the care of CYP. Challenges accessing this training due to high demand have been reported as well as the need to deliver training more tailored to clinical settings.

- ***Recommendation 1d –*** *Continued widespread dissemination of self-harm training should be supported to maximise opportunities for professionals to engage, with sufficient resource*

allocated to ensure continued improvement and evaluation. Where applicable, content should be tailored to specific professional groups to increase relevance.

- ***Recommendation 1e -*** *Self-harm training activities and materials should highlight at risk groups identified in this HNA, providing the tools to proactively address self-harm risk and provide tailored support.*

Local self-harm policy documents – Though the majority of HSCPs in NHS GGC have developed self-harm guidance for professionals, feedback from different professional groups has highlighted that overall awareness of their existence may be limited.

- ***Recommendation 1f –*** *Local self-harm guidance documents should be maintained up-to-date and highly visible to frontline staff with caring responsibilities for CYP.*

Social media, self-harm and mental health – Social media is broadly perceived by professionals working with young people to have contributed to a deterioration in mental health. Research and local qualitative work suggest that while social media can offer a form of support to young people who self-harm, this support is inconsistent and that social media platforms carry unique mental health risks. This includes content that glamorises and encourages self-harm, triggering content, as well as the potential for stigmatising and negative reactions to self-harm disclosures. This serves to make social media platforms unsafe and unpredictable spaces for those who use self-harm as a coping strategy.

- ***Recommendation 1g –*** *Digital literacy development amongst young people, their families and professionals who support them should be prioritised. This is to raise awareness of the range of features and strategies available to young people and their families to ensure they have a safe and positive experience, as well as to enable professionals to have informed conversations with young people about their online habits and behaviours.*
- ***Recommendation 1h -*** *Further research is required to explore this relationship between social media and self-harm in more depth. Particular attention should be paid to how the landscape changes following the introduction of the Online Safety Bill, which requires social media platforms to take action against such harmful content being shown to users.*
- ***Recommendation 1i -*** *Further work is required to share anti-stigma messaging online in order to create safer online and offline spaces.*

Scottish Government Self-Harm Strategy Priority 2

'Continue to build person-centred support and services across Scotland to meet the needs of people affected by self-harm.'

Preventing self-harm by addressing risk-factors – The evidence base for direct interventions to prevent self-harm occurring remains limited, however this is largely due to a lack of good quality evidence. This should not detract from the beneficial effects that broader mental health improvement work may have on self-harm prevention. Work to improve mental health and address self-harm are likely to overlap by addressing risk-factors for self-harm such as those identified by Public Health Scotland in their 2023 review which include bullying, self-esteem, body-image issues, lack of parental/peer attachment, substance misuse and sleep disturbance.

- ***Recommendation 2a –*** *Awareness raising within the health improvement workforce, healthcare, education and the third sector is required to emphasise that all work which addresses self-harm risk factors may also indirectly prevent self-harm. Interventions intended to improve CYP mental health should – as a mainstreamed action – explicitly consider self-harm prevention in all phases of planning, implementation and evaluation.*

Self-harm services - There are examples of services designed to specifically address self-harm in CYP, including the NHS GGC adolescent self-harm service (no longer in operation) and the contemporary Scottish Government funded pilot service operated by the charity Penumbra. These services have sought to provide follow-up over time that both addresses the self-harm itself and its underlying causes. Evidence for their effectiveness is currently too limited to specifically recommend commissioning such a service again in NHS GGC.

- ***Recommendation 2b -*** *NHS GGC should liaise closely with Penumbra regarding its schools outreach model for CYP who self-harm which is currently in operation in Dundee. The results of evaluation of this, and any similar development, should inform development of services in NHS GGC.*

Person-centred access to support - Evidence from professional interviews, focus groups and the wider literature strongly suggests that stigma and discrimination around self-harm and mental health issues are widespread, creating barriers to accessing support. Examples were found of ways to discretely improve access - such as using QR codes to contact pastoral care teachers - which were instigated after asking young people what would work for them.

- ***Recommendation 2c –*** *Provision of mental health and self-harm supports and services should account for the widespread stigma of self-harm in their design. There should be visible opportunities for discreet access to support in a way that maximises the likelihood of ongoing engagement. Where barriers to access are identified, innovative solutions should be sought to lower these in consultation with CYP.*

Early intervention to support distressed individuals - Early interventions to support young people in distress in the form of distress brief intervention (DBI) services are being rolled out across HSCPs, with expectation that all areas will have a DBI service by early 2024. Service data indicate that distress is particularly concentrated in areas of higher deprivation. Whilst DBI services are typically for ages 16 and above, data and professional feedback have highlighted increasing distress amongst younger age groups, including primary school age. Pathways for 14-15 year olds are being trialled which have demonstrated high levels of uptake (and therefore need) in younger age groups.

- ***Recommendation 2d -*** *HSCPs should be supported to adopt DBI services and roll-out of 14-15 year-old pathways, with evaluation of implementation readily visible at NHS GGC level for shared organisational learning and improved understanding of population service need. Robust and highly visible referral routes should be in place.*

- ***Recommendation 2e -*** *It is unclear how acute distress is approached for under-14s across NHS GGC, its overlap with child protection issues and whether inequities in service provision exist in this space. Further work is required to understand these questions and establish pathways into robust and visible supports for acute distress in under-14s.*

Availability of supports for CYP and families - there is a wide variety of supports available to CYP and families for self-harm, many of which can be found online. Healthcare and Education colleagues interviewed expressed uncertainty however regarding their availability and applicability, with a desire for sources which were seen to be endorsed by the NHS.

- ***Recommendation 2f –*** *Work is required to better understand the ways in which supporting information around self-harm and mental health can best be made available so that CYP, families and professionals can easily access these when required. This may be done via existing evidence or require further engagement.*

Scottish Government Self-Harm Strategy Priority 3

'Review, improve, and share data and evidence to drive improvements in support and service responses for people who have self- harmed, or are at increased risk of doing so.'

Self-harm surveillance in the population - Understanding of the true extent and nature of self-harm in the population of young people remains limited. Self-harm is either not measured or partially measured in routinely administered local and national health surveys, hindering understanding of population mental health needs and awareness raising. Concerns regarding the harm of posing such questions require to be balanced against the harm caused by lack of understanding of population health needs, particularly given clear examples where this knowledge has led to direct local action.

- ***Recommendation 3a –*** *Surveillance of self-harm in the CYP population should be enacted to track the extent of self-harm over time and direct support to vulnerable groups, with population surveys of young people incorporating self-harm questions within mental health sections. Data gathered should incorporate protected characteristics set out in the Equality Act (2010) to enable monitoring and addressing of inequalities.*

- ***Recommendation 3b –*** *Clinical services spoken to for this HNA often reported that their recording of self-harm was of low quality or that their systems did not readily allow for such*

evaluation to take place. This again contributes to the incomplete picture of self-harm need in the population, with under-estimation likely. Services at all tiers are recommended to ensure self-harm recording is in place, including methods and demographics.

- ***Recommendation 3c –*** *The Schools Health and Wellbeing Improvement Research Network (SHINE) works with schools to undertake high quality school-level surveys which provide a rich picture of mental health and self-harm need. The survey data are not available beyond the individual school setting however and are controlled by the schools themselves. These surveys are actively used by pastoral care teachers to inform action and may also assist in better meeting CYP population mental health need. NHS GGC Children's Services Planning Partnerships should seek to establish connections with SHINE with a view to collating local SHINE survey data to inform needs assessments.*

Hospital admissions due to self-poisoning - Admissions to hospital due to self-poisoning continue to increase year-on-year amongst young people. It is unclear to what extent these are repeat admissions for a smaller group of individuals. The underlying drivers behind the observed trend are not fully understood including opportunities for prevention.

- ***Recommendation 3d -*** *Further concentrated work is required to understand the trend of increasing self-poisoning admissions and develop targeted interventions.*

Scottish Government Mental Health Strategy 2017 – 2027

Cross-disciplinary working between Education and Healthcare - Education and healthcare professionals report a widespread desire for more multi-disciplinary working and information sharing to provide mental health support, however capacity issues and staff turnover hinder this from happening consistently. There may be additional barriers including confidentiality concerns and systems issues (e.g. incompatible IT systems). Pastoral care teachers in particular report the need to provide extensive mental health support to CYP and their families in the school setting, without necessarily having a full understanding of the support that young person is receiving from clinical services. Whilst close working ties between Healthcare and Education were evident in some HSCPs, either on a relational basis or via established governance structures, this is not consistent across all of the NHS GGC catchment and likely indicates inequities in GIRFEC implementation.

- ***Recommendation 4a –*** *Governance and working structures for lower tier mental health support should enable regular interactions between healthcare and education colleagues in line with GIRFEC principles, with information-sharing agreements in place across agencies to facilitate multidisciplinary working. Whilst individual professional relationships are important, such structures should seek to avoid over-reliance on these for service continuity. Learning from areas where this has been strengthened, such as in East Renfrewshire, should be more broadly shared.*

- ***Recommendation 4b -*** *Clinical services should seek to inform the school when they are supporting a young person (with permission). Ideally, this should contain a level of detail that facilitates ongoing support in the school setting. This should also extend to emergency department attendances for mental health and self-harm. Further work is required to establish safe and acceptable mechanisms for this to take place.*

Shared organisational learning and consultation with CYP on mental health provision - Whole system consultation exercises with young people, families and professionals regarding the provision of mental health services have taken place in some HSCPs, leading to changes intended to improve service provision, coordination and ease of access. This includes the implementation of the Healthier Minds Screening Hub in East Renfrewshire and Community Wellbeing Hubs in West Dunbartonshire. Such consultation also occurs at individual service and school levels, leading to sometimes unique solutions with broader applicability. The sharing of learning, including valuable public feedback, from across and beyond NHS GGC is inconsistent which may contribute to missed opportunities for impact and inequities in service provision.

- ***Recommendation 4c*** *– NHS GGC should prioritise and facilitate sharing of learning regarding mental health and self-harm support across professional, organisational and geographical boundaries. Evidence generated for local consultation exercises should be broadly available for all HSCPs to use and extract applicable learning. Approaches to mental health provision from beyond NHS GGC, including other UK nations, should also be sought and disseminated.*

Understanding patient pathways and where demand for mental health support lies - Demand for higher tier mental health support has grown dramatically, as evidenced by increasing trends in CAMHS referrals pre-dating the pandemic. This has been accompanied by increased public and political scrutiny, awareness of waiting lists and action to reduce waiting times. Data for most tier 2 services are not collated at a health board level, creating a more fragmented landscape from which it is difficult

to gain overview. The true levels of demand for lower tier mental health services and waiting lists therefore remain unclear, though are likely to be substantial and increasing. This creates risks for achieving early intervention and has potential implications for CAMHS service planning and demand.

- ***Recommendation 4d -*** *NHS GGC should be able to readily assess demand for the mental health services it helps to provide in order to understand and identify gaps in service provision and service inequities. Where applicable, this may take the form of understanding patient pathways, waiting times for lower tier mental health services as well as overall service use.*

Introduction

Why conduct a health needs assessment on self-harm in children and young people?

Self-harm, as defined by the National Institute of Health and Care Excellence (NICE)[2], constitutes acts of 'intentional self-poisoning or injury, irrespective of the apparent purpose' (for further details on definitions, see Appendix A). It is associated with a range of subsequent adverse mental health outcomes including anxiety, depression, eating disorders and personality disorders[3–5] as well as being a significant risk factor for suicidal thoughts and behaviours[6,7]. Young people report using self-harm as a coping strategy for overwhelming emotions and a means of experiencing control[8]. Whilst it often provides a feeling of immediate emotional relief, it is also described as a form of self-punishment and can be a source of shame and guilt with associated feelings of loneliness and alienation[8]. Self-harm is also highly impactful to surrounding carers and family, who may struggle to understand and support the young person affected[9–11].

Despite its significant psychological and physical impact, the true extent of self-harm in the population remains largely unclear. The iceberg model (Figure 1) has been used to describe self-harm which is visible (i.e. presents to clinical services) versus that which is hidden[12]. Whilst visible self-harm can be measured via clinical service use, the true and likely much larger proportion of hidden self-harm is much more challenging to capture. This hinders our ability to understand the level of need in the population of children and young people (CYP) as well as the health and social care system's ability to address it.

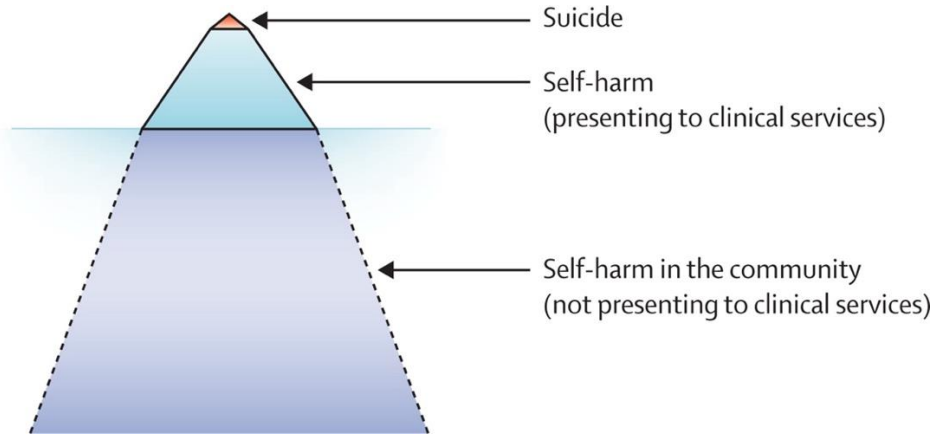

Figure 1 The iceberg model of self-harm. Image from Hawton et al. (2012)[12].

This health needs assessment (HNA) aims to better understand self-harm in young people in NHS Greater Glasgow and Clyde (GGC) and how the needs of this population and those that care for them may be better met. It is broadly split into four sections. In Section One (page 18), research and data are examined to determine what is known about the extent of self-harm in the population. Following this, Section Two (page 32) examines the evidence base around risk factors, interventions, self-harm services and the impact of social media. In Section Three (page 46), views from focus groups of pastoral care teachers and Child and Adolescent Mental Health Services (CAMHS) are explored. Finally in Section Four (page 59), demand for mental health support, different models of mental health

service delivery and self-harm resources are discussed. Further details regarding the methods employed in undertaking this HNA can be found in Appendix B.

Whilst self-harm is the focus, it does not exist in isolation of other health and social issues. Addressing these may help to alleviate the underlying reasons why self-harm is being used. As such, wider systems issues which may impact on CYP mental health including prevention, early intervention, interprofessional working, governance and strategy are also addressed where relevant. Throughout this report, recommendations aligning with Scottish Government strategy will be made based on the evidence gathered.

Impact of the COVID-19 pandemic on CYP mental health

Mental health and self-harm cannot be discussed in isolation of the profound disruption of the COVID-19 pandemic. Societal infection control measures including lockdowns were widely reported by professionals interviewed for this HNA to have been particularly harmful. In addition to the loss of social opportunities, the loss of the school as a 'safe space' was highlighted for those with challenging family circumstances.

> *'I'm just back and I've noticed a really really big difference… [the] anxieties of young people, really relying on safe spaces in the school. Throughout the school day. Very, very anxious, nervous young people.*
>
> *I think their social skills in general have been impacted by lockdown, loss of all sorts of. Clubs all closed, school closed. There was no socialising at all.'*
>
> *Pastoral care teacher, Inverclyde*

> *'…we know that COVID has had such an impact on young people and that that kind of, you know, been separated from their peers and from education … But I also wonder as well about what they were exposed to when they were at home for all that time and the impact of being around family members with significant mental health problems or self harming or an addiction, things like that… Do sort of coping mechanisms have been kind of observed and just kind of picked up a bit more than they would do if they were sort of out and about a bit more?'*
>
> *CAMHS clinical coordinator*

To assess the impact of the COVID-19 pandemic on CYP and their families, Public Health Scotland (PHS) conducted three national surveys of parents and young people in 2020 and 2021, titled 'Are the Kids Alright?'[13], with a follow-up 2023 survey ongoing at the time of writing[14]. Overall, the pandemic was reported to have had a negative effect on young people and their families, with impacts disproportionately felt by families in low-income households. In the third round of the survey, approximately 70% of parents reported that the pandemic had had a negative effect on their child's relationships with people outside the home[15].

The survey used the strengths and difficulties questionnaire (SDQ), a validated tool used for behavioural screening in CYP (see also Appendix C)[16,17]. Overall, approximately a fifth (18%) had a score of 'high concern'. There were marked differences by household income however, with 33% of CYP in the lowest category with scores of 'high concern' versus 12% in the highest income category. Multiple other inequalities were recorded between income categories including attendance at extracurricular activities, access to green space and need for financial support. Regarding financial

loss, 32% of low-income households reported a loss of income due to the pandemic in comparison with only 6% of high-income households. Unsurprisingly in this context, parental mental health was also impacted, with approximately 80% reporting that the pandemic had had a negative impact[15]. This provides important information regarding the impact of the pandemic on families. These results and stakeholder testimony suggest that, given the high levels of inequalities in deprivation present in the NHS GGC population (Appendix D), the local impact of the pandemic on CYP mental health has been both unequal and profound.

What is Scotland doing to address mental health in the CYP population?

National efforts to improve CYP mental health have been ongoing since before the pandemic. Current national activity regarding CYP mental health services is directed by the Scottish Government Mental Health Strategy 2017-2027[18] which has given rise to several workstreams as summarised in Figure 2.

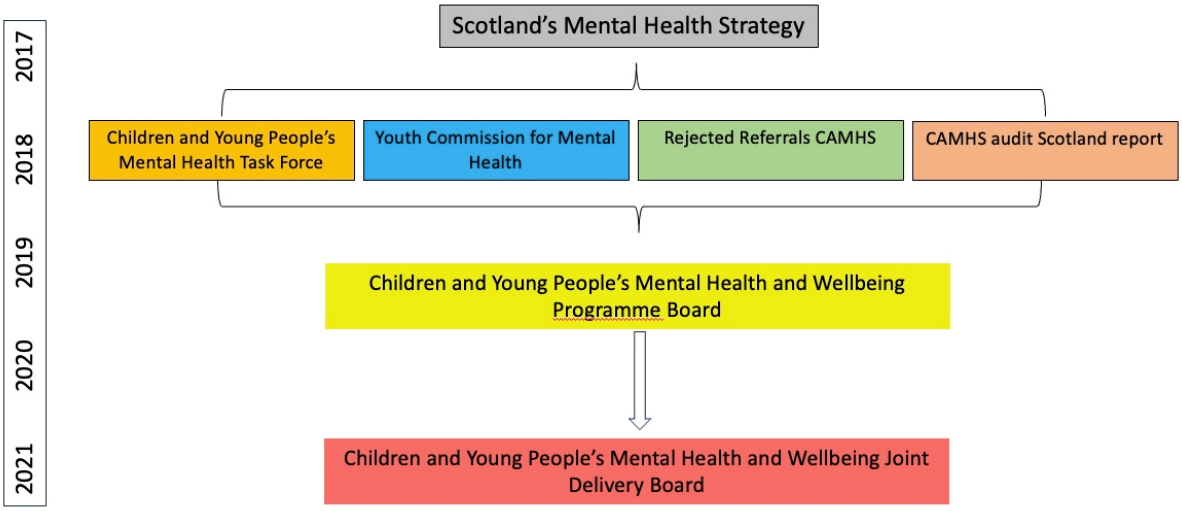

Figure 2 *Summary overview of policy and strategy work regarding children and young people's mental health at Scottish Government level. CAMHS; Children and Young People's Mental Health Services. Image adapted from publicly available Scottish Government / COSLA document[19].*

The Children and Young People's Mental Health Task Force was commissioned by Scottish Government and the Convention of Scottish Local Authorities (COSLA) in 2019 to investigate how children's mental health services and access to mental health support could be improved. The Task Force produced thirteen recommendations ranging from strategic leadership and digital systems to service co-production and the prioritisation of prevention and early intervention services. The Children and Young People's Mental Health and Wellbeing Joint Delivery Board is continuing this work, progressing eight key deliverables including crisis support, enhancement of community-based supports and development of education for staff involved in CYP mental health[19].

Following publication of the suicide prevention strategy[20] in 2022 and building on the 2020 Samaritans Hidden Too Long report[21] which investigated self-harm amongst Scottish adults, Scottish Government has produced Scotland's Self-Harm Strategy and Action Plan (2023-27) which was published in November 2023 (referred to herein as 'the Strategy'). The overall aim of the Strategy is to provide compassionate and recovery-focussed support for those who self-harm or who have contemplated it without fear of discrimination or stigma. Three key priority areas have been set out for ongoing work:

1. Expanding and deepening knowledge and understanding of self-harm whilst actively tackling stigma and discrimination.

2. Building person-centered support and services to meet the needs of those who self-harm.

3. Reviewing, improving, and sharing data and evidence to push forward improvements in service responses and supports.

Though activity to address self-harm is ongoing in many areas of NHS GGC and partner agencies, there is currently no coordinated strategic approach at a whole systems level. In this context, the priority areas set out within the Strategy form the structure for the recommendations set out in this HNA.

Getting It Right For Every Child (GIRFEC) and the tiered approach to mental health provision

An important backdrop to the above national activity is the Getting It Right for Every Child (GIRFEC) policy framework, the implementation of which is intended to provide 'children, young people and their families with the right support at the right time' in order that 'every child and young person in Scotland can reach their full potential'[22]. GIRFEC recognises that CYP wellbeing is influenced by a broad range of social and environmental factors, with use of the SHANARRI indicators (Safe, Healthy, Achieving Nurtured, Active, Respected, Responsible and Included) encouraged as part of a 'wellbeing wheel' to aid holistic assessment. A 'flexible scaffold' of support should be provided with the child or young person and family at the centre of decision-making. Core components of this support include a 'Named Person' who is the clear point of contact for advice and support as well as tiered levels of support which appropriately meet the needs of the young person according to the nature and severity of any issues which arise.

For mental health, the 4-tier model has been developed to address the requirement for different levels of support[18]. The services involved range from those which are universally available (e.g. school supports, general practice) through to highly specialised input by CAMHS, as illustrated in Figure 3.

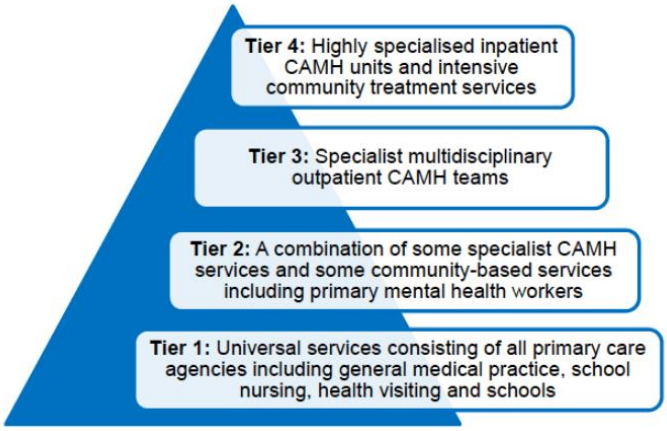

Figure 3 *The 4-tier model of mental health provision in Scotland. Image from Scottish Government[18].*

The tiered approach is a cornerstone of mental health support in Scotland and will be referred to repeatedly throughout this report.

1 What is known about self-harm in children and young people in NHS GGC?

Summary and recommendations

Self-harm surveillance in the population - Understanding of the true extent and nature of self-harm in the population of young people remains limited. Self-harm is either not measured or partially measured in routinely administered local and national health surveys, hindering understanding of population mental health needs and awareness raising. Concerns regarding the harm of posing such questions require to be balanced against the harm caused by lack of understanding of population health needs, particularly given clear examples where this knowledge has led to direct local action.

- ***Recommendation 3a –*** *Surveillance of self-harm in the population CYP should be enacted to track the extent of self-harm over time and direct support to vulnerable groups, with population surveys of young people incorporating self-harm questions within mental health sections. Data gathered should incorporate protected characteristics set out in the Equality Act (2010) to enable monitoring and addressing of inequalities.*

- ***Recommendation 3b –*** *Clinical services spoken to for this HNA often reported that their recording of self-harm was of low quality or that their systems did not readily allow for such evaluation to take place. This again contributes to the incomplete picture of self-harm need in the population, with under-estimation likely. Services at all tiers are recommended to ensure self-harm recording is in place, including methods and demographics.*

- ***Recommendation 3c –*** *The Schools Health and Wellbeing Improvement Research Network (SHINE) works with schools to undertake high quality school-level surveys which provide a rich picture of mental health and self-harm need. The survey data are not available beyond the individual school setting however and are controlled by the schools themselves. These surveys are actively used by pastoral care teachers to inform action and may also assist in better meeting CYP population mental health need. NHS GGC Children's Services Planning Partnerships should seek to establish connections with SHINE with a view to collating local SHINE survey data to inform needs assessments.*

Groups at higher risk of self-harm – In addition to self-harm being commoner amongst females, there are likely to be higher rates of self-harm amongst CYP who are lesbian, gay, bisexual, transgender and non-binary (LGBT+) and/or neurodiverse. This is largely based on academic evidence and a Scottish HNA conducted for LGBT+ adults. Less is known about the needs of these groups in younger populations and in the NHS GGC context.

- ***Recommendation 1a -*** *Further work is required to understand the support needs of at-risk groups and their families - particularly LGBT+ and neurodiverse - with evidence generated used to inform how and where interventions are delivered.*

- ***Recommendation 1b -*** *Educational and healthcare services should be supported to adopt a proactive approach to addressing self-harm risk from both prevention and early intervention perspectives for at-risk groups, informed by learning from work in recommendation 1a.*

Hospital admissions due to self-poisoning - Admissions to hospital due to self-poisoning continue to increase year-on-year amongst young people. It is unclear to what extent these are repeat admissions

for a smaller group of individuals. The underlying drivers behind the observed trend are not fully understood including opportunities for prevention.

- ***Recommendation 3d*** *- Further concentrated work is required to understand the trend of increasing self-poisoning admissions and develop targeted interventions.*

1.1 Overview

This section aims to build a picture of the extent of self-harm in the young population of NHS GGC. In line with the Iceberg Model (see Introduction), self-harm often remains hidden and is therefore challenging to fully assess[12]. Firstly, hidden self-harm will be explored using school survey data, demonstrating that self-harm is likely to be common in the GGC CYP population. Methods of self-harm and at-risk groups will then be discussed. Finally, data from hospital admissions and primary care consultations are shown to highlight rising levels of service contact for self-harm reasons.

1.2 What does the research say about the extent of self-harm amongst young people?

There is a broad range of academic research which has sought to estimate the extent of self-harm in children and young people. The UK Millennium Cohort Study (MCS) study, which has followed the lives of children born at the turn of the 21st century[23], surveyed study participants at the age of 17 regarding self-harm, attempted suicide and psychological distress[24]. Approximately a quarter of participants (24.1%) reported self-harm in the previous 12 months, with 7.4% reporting a previous suicide attempt at some point. High psychological distress was also reported by 16.1% of participants. Split by gender, 20.1% of males and 28.2% of females reported self-harm in the previous 12 months. This constituted an overall increase from age 14 (males 8.5% versus females 22.8%) which was much steeper for males. Comparing different ethnic groups, self-harm rates were highest amongst white study participants, though rates of attempted suicide were similar across ethnicities. Geographically there was reportedly little difference reported between the four UK nations, though specific national data were not presented.

Specific figures for the Scottish CYP population are less up to date. A study by O'Connor et al.[25] published in 2009 assessed extent of self-harm in S4 and S5 pupils using an anonymised survey design in Glasgow and Stirling. All 45 secondary schools in these areas were invited to participate, of which 13 (29%) accepted. In total, 2008 pupils participated. Data were collected in the years 2006 and 2007. Overall, 13.8% of the study sample reported a previous history of self-harm, of which 71% had self-harmed in the previous 12 months. Split by gender, females were approximately 3.4 times more likely to report self-harm than males, with 19.9% reporting a history of self-harm versus 6.9% in males. Similar results were found in a 2018 cross-sectional survey of 3508 Scottish young adults (18-34 years old), with 16.2% overall reporting having ever self-harmed and an approximately doubling of risk in females versus males (20.9% versus 11.6%, respectively)[26].

1.2.1 School surveys as a means of assessing 'hidden' self-harm

The Schools Health and Wellbeing Improvement Research Network (SHINE) is a research collaborative between the Universities of Glasgow and St. Andrews which, amongst other functions, delivers the application and reporting of school mental health surveys[27]. Unusually for such a survey, pupils are asked about self-harm. The following data are from a large high school in Glasgow City which

participated in the SHINE survey in 2022[28] and were kindly provided with permission for use on an anonymised basis. Participating pupils in S1-5 were asked if they had 'ever hurt themselves on purpose'. Overall, 25% answered 'yes' and 21% answered 'prefer not to say' (Figure 4).

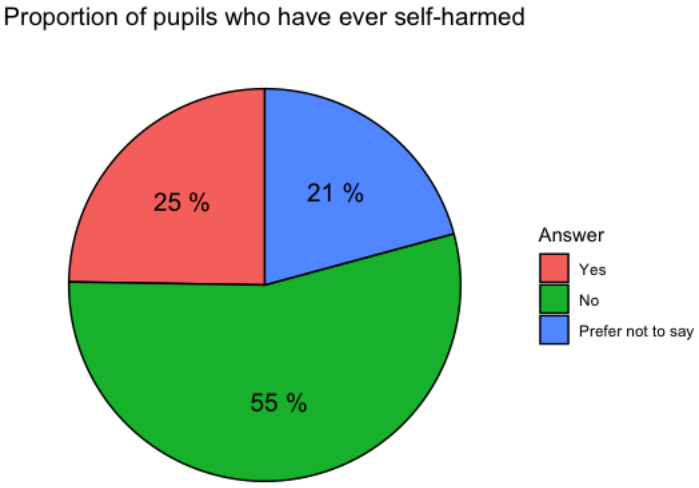

Figure 4 *Proportion of pupils at a large high school in Glasgow City who have ever self-harmed. Figure adapted from a bespoke SHINE pupil mental health survey[28] which has been re-produced here on an anonymised basis with permission.*

The self-harm question was further broken down by sex and year group (Figure 5). By sex, 18% of boys versus 29% of girls answered 'yes'. Notably, the proportion of girls answering 'prefer not to say' was approximately double that of boys (25% versus 13%, respectively). There was also a marked increase by age, with S1-3 pupils in aggregate answering 'yes' which increased to 31% in S4-5.

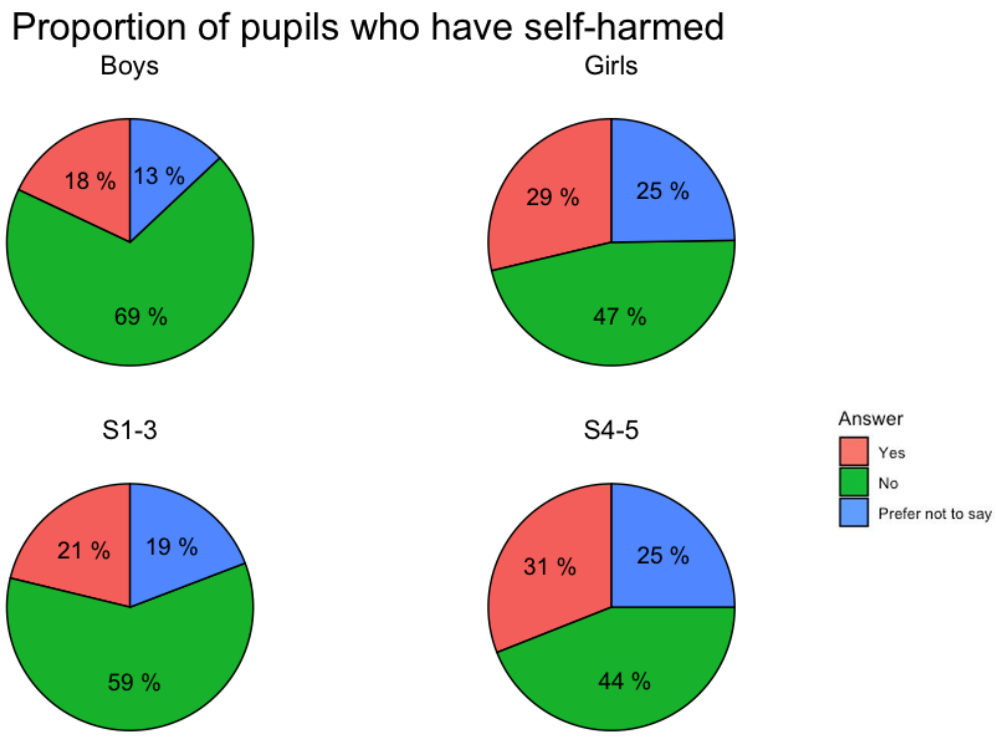

Figure 5 *Proportion of pupils at a large high school in Glasgow City who have ever self-harmed broken down by sex and school year grouping. Figure adapted from a bespoke SHINE pupil mental health survey[28] which has been re-produced here on an anonymised basis with permission of the headteacher.*

Pupils who had answered 'yes' to having ever self- harmed were then asked how often they had done so in the past year (Table 1), with 42% reporting self-harm between 1-10 times and 25% more than 10 times.

Table 1 *Frequency of self-harm in the past year as a follow-on question to pupils who have reported previous self-harm. Results are from a bespoke SHINE pupil mental health survey[28] which have been re-produced here on an anonymised basis with permission.*

Frequency of self-harm in past year	**Percentage (%)**
None	8
1-10 times	42
More than ten times	25
Don't know or prefer not to say	26

1.2.2 Planet Youth survey in a West Dunbartonshire high school

Planet Youth is a private organisation based in Iceland which was commissioned by West Dunbartonshire Health and Social Care Partnership (HSCP) to administer a survey to a local high school, with a view to implementation of the Icelandic Prevention Model to mental health[29]. The survey was administered to S3 and S4 and covered a broad range of health topics, which included self-harm.

Questions were asked regarding self-harm thoughts and whether participants had self-harmed, with examples given in the question-prompt (Figure 6). Overall, 44% reported previous thoughts of self-harm and 38% reported at least one act of self-harm, with 9% reporting self-harm 3-4 times and 10% reporting self-harm 5 times or more. The question prompt does not specify other forms of self-harm such as self-poisoning and risky behaviours and does not ask when the self-harm event(s) happened.

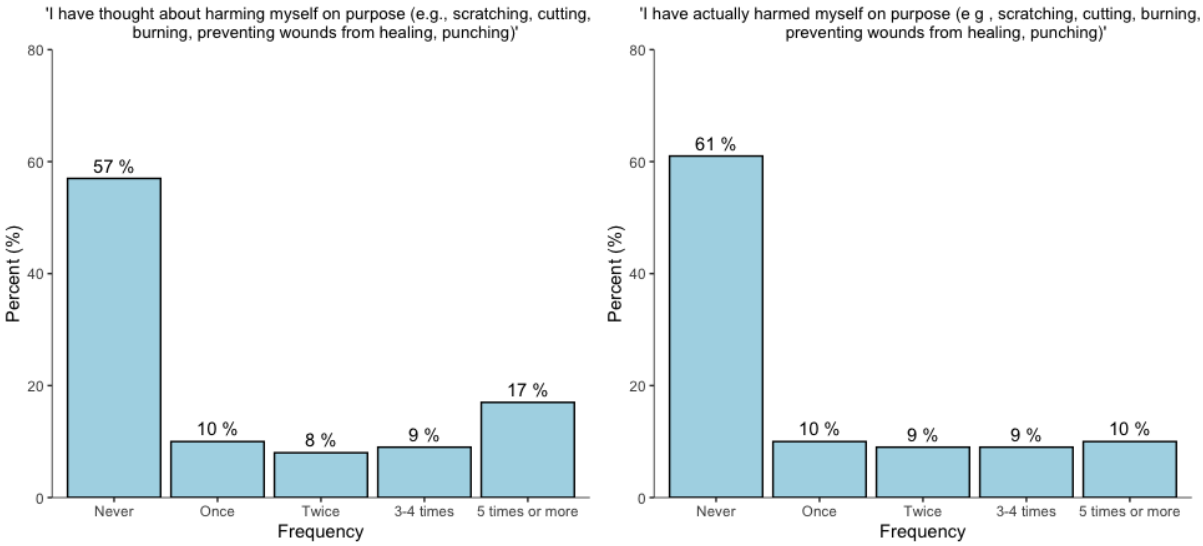

Figure 6 *Proportion of pupils who have self-harmed broken down by reported frequency. Results from Planet Youth school survey re-produced with permission.*

1.2.2.1 Suicidal thoughts and behaviours (Planet Youth)

Participants in the Planet Youth survey were also asked about suicidal thoughts and behaviours (Figure 7).

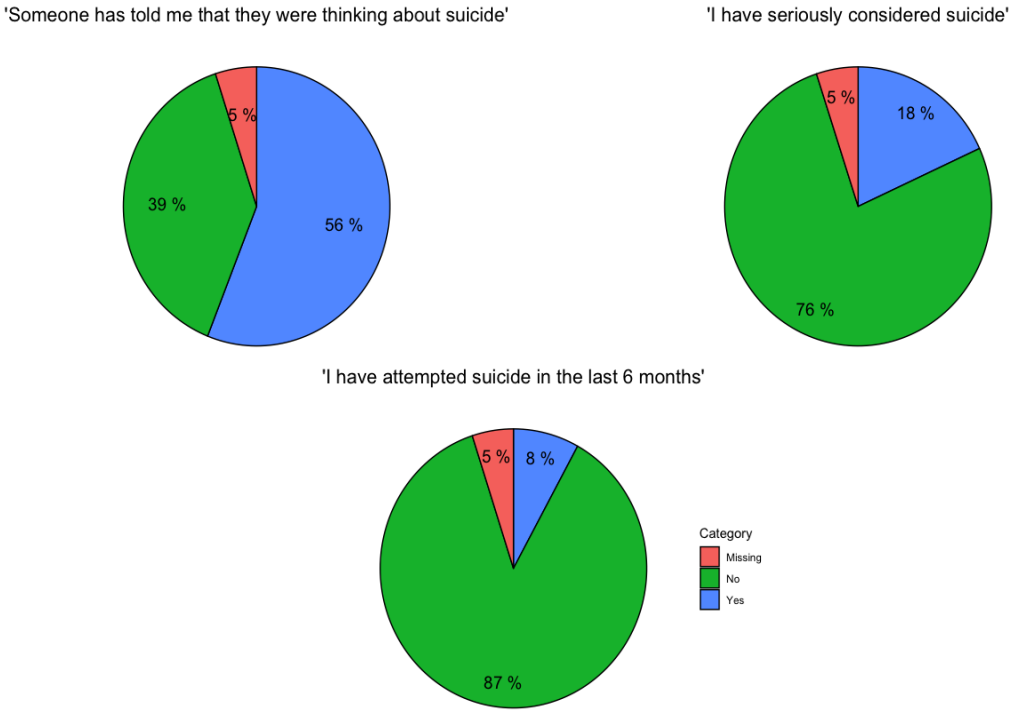

Figure 7 *Proportion of pupils who have been told by someone who was considering suicide or have considered / attempted suicide themselves. Results from Planet Youth bespoke school survey re-produced with written permission from the depute headteacher.*

56% of participants reported that someone had told them they were considering suicide, with 18% reporting having seriously considered suicide themselves and 8% reporting having made a suicide attempt in the previous six months. This provides an indication of a challenging environment in which to improve CYP mental health and wellbeing.

1.3 What methods are young people using to self-harm?

A cross-national school survey[30] of 30,532 school pupils between ages 14-17 in European countries found that self-cutting was overall the commonest form of self-harm reported (62.6%). Those who presented to health services were likely to differ in choice of self-harming method, suicidal intent and social characteristics however, with 'lethal methods', a wish to die, self-harm in the family and alcohol/drug problems more often reported. These results echo those of similar surveys which also indicate that self-poisoning and self-burning are the next most common methods[31–33]. In four of the countries (including England), participants were more likely to have taken an overdose when presenting to hospital[30], in-keeping with hospital admissions data on page 25. Self-harm may take many forms however which are more challenging to assess including self-battery and non-recreational risk-taking[12]. Reliable data in NHS GGC regarding self-harm methods in the wider CYP population have not been identified, however referrals data from Healthier Minds in East Renfrewshire (page 63) would corroborate self-cutting as the commonest method of self-harm in the community.

1.4 Higher risk of self-harm amongst LGBT+

Young LGBT+ people are likely to be at higher risk of self-harming compared with heterosexual peers, with marked inequalities by sexuality identified in the Millennium Cohort Study[24]. Over half (55.8%) of young people identifying as LGBT+ reported having self-harmed in the previous 12 months compared with 20.5% of those identifying as heterosexual. This was also evident for attempted suicide, with 21.7% of LGBT+ participants versus 5.8% of heterosexual participants reporting a previous suicide attempt.

In Scotland, an HNA[34] commissioned for NHS GGC and NHS Lothian of LGBT+ people which surveyed 2358 people aged 16 years and above showed that while 58% disclosed self-harm overall, 83% of trans-masculine participants, 82% of non-binary participants and 70% of bisexual women reported self-harm. This was also the case for neurodiverse LGBT+ participants, with 80% of participants with attention deficit hyperactivity disorder (ADHD) or autism reporting self-harm. No age breakdown was provided in the report and so it is not possible to assess distribution of self-harm across age categories. The proportion of young people in this population who have self-harmed is nonetheless likely to be substantial.

1.5 Healthcare service use due to self-harm

Data for hospital admissions due to self-harm reasons and primary care consultations with a self-harm or suicidality clinical code are presented in the following sections. It is important to note from the outset that young people who seek clinical support for self-harm make up a small proportion of the overall population of young people who self-harm (see also page 52).

1.5.1 Acute hospital admissions

For further information on data and definitions, see Appendix B.

1.5.1.1 Self-harm admissions by geographical area

Acute admissions for self-harm (age range 0-19 years) are presented in Figure 8 for NHS GGC (dashed line) and by HSCP (solid lines).

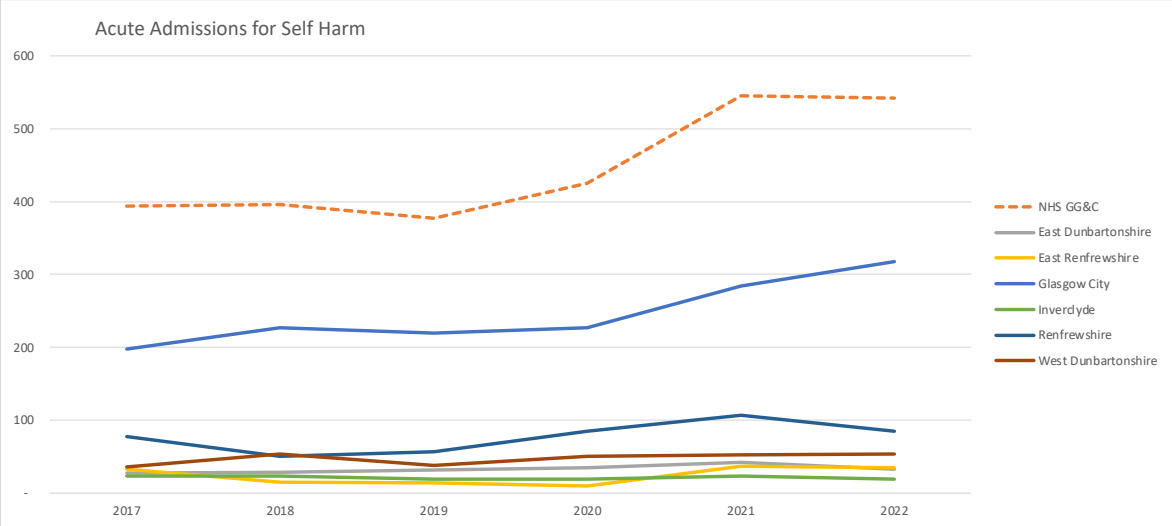

Figure 8 *Number of acute admissions for self-harm to hospitals in NHS GGC amongst 0-19 year olds stratified by HSCP area. Data are presented as crude event counts.*

The number of acute admissions for self-harm in NHS GGC rose from a low of 377 in 2019 to 545 in 2021, with a levelling off evident in 2022 (542 admissions). This rise in absolute numbers is principally driven by the continued increases seen in Glasgow City, which had 319 admissions in 2022 up from 198 in 2017. This reflects the larger population size within this area. As a proportion of its population however, West Dunbartonshire had the highest rates of self-harm of all HSCP areas with 2.80 admissions per 1000 compared with 2.22 per 1000 for NHS GGC and 2.56 per 1000 for Glasgow City.

1.5.1.2 Who is being admitted to hospital with self-harm?

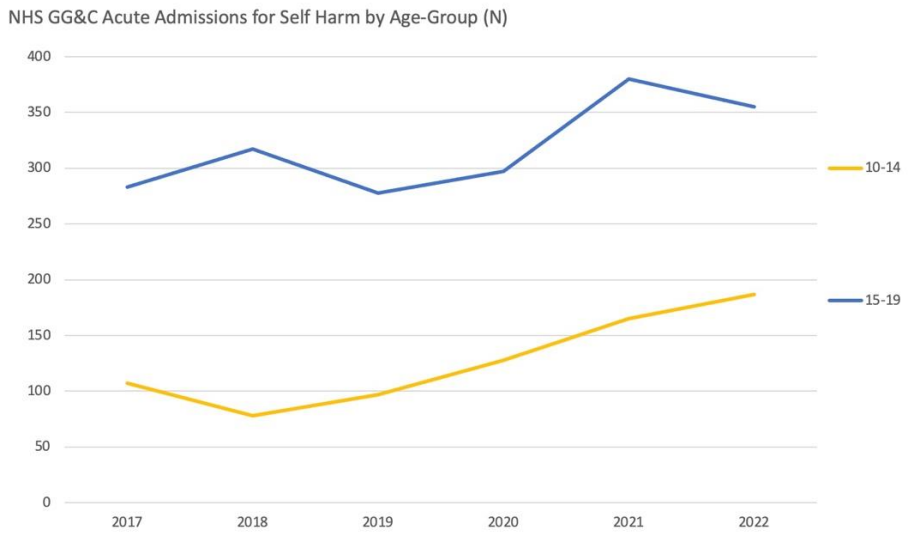

Figure 9 *Annual counts of acute admissions for self-harm to hospitals in NHS GGC amongst 0-19 year olds by age-group.*

Counts of acute admissions due to self-harm are presented by age category in Figure 9. Amongst 10-14 year olds, there has been a linear upwards trend in acute admissions for self-harm from 78 in 2018 to 187 in 2022, constituting an approximately 140% increase. Though more variable, admissions amongst 15-19 year-olds have also increased over the time period, with a rise from 278 admissions in 2019 to 355 in 2022; an increase of approximately 28%.

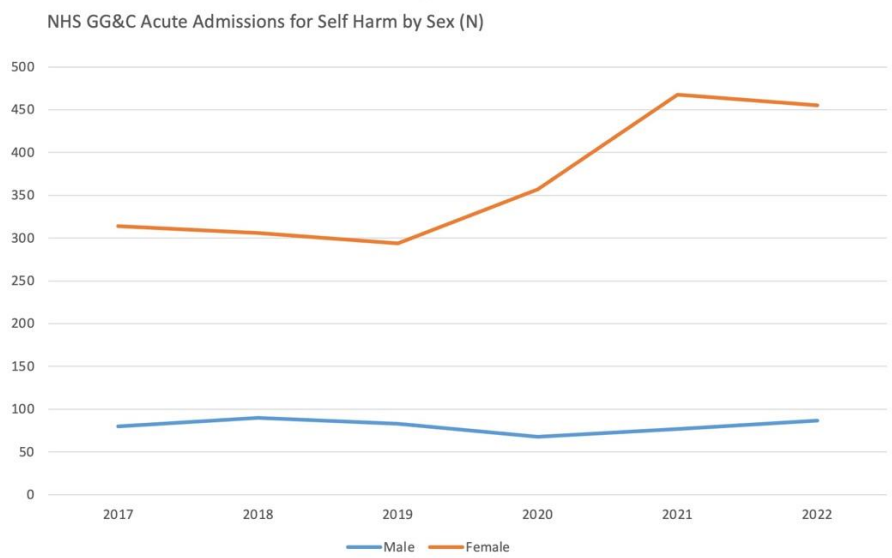

Figure 10 *Annual counts of acute admissions for self-harm to hospitals in NHS GGC amongst 0-19 year olds by sex.*

The increases in hospital admissions are largely amongst females (Figure 10), for whom a 59% increase is seen from 294 admissions in 2019 to 468 admissions in 2021. Ongoing monitoring is required to ascertain whether the plateau in 2022 (455 admissions) represents a stabilisation of this trend. Admissions amongst males have remained steady over time at much lower levels, with 87 admissions across NHS GGC in 2022.

1.5.1.3 Hospital admissions due to self-poisoning

Clinical coding of hospital admissions categorises both intentional and non-intentional self-poisoning for medication groups together. Despite this caveat, clear trends are visible for both 10-14 year olds (Figure 11) and 15-19 year olds (Figure 12) which are presented below for the whole of NHS GGC.

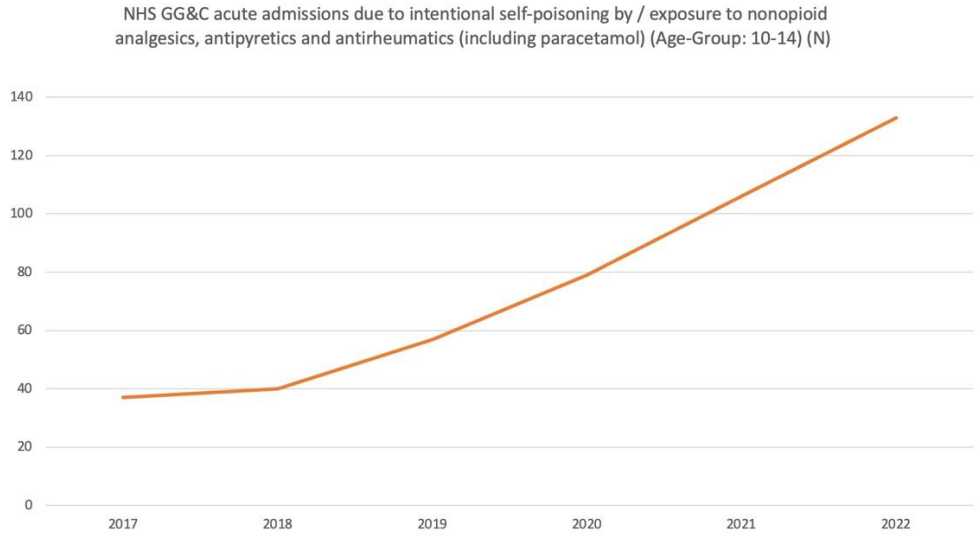

Figure 11 *Annual admissions to hospital for 10-14 year olds in NHS GGC due to intentional self-poisoning / exposure to non-opioid analgesics, antipyretics and antirheumatics (X60 clinical code). Data are presented as crude counts.*

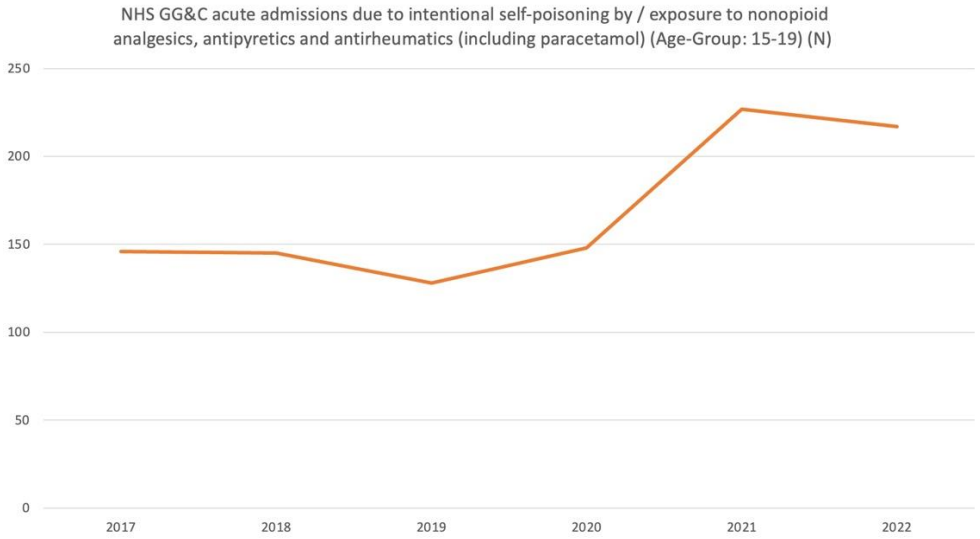

Figure 12 *Annual admissions to hospital for 15-19 year olds in NHS GGC due to intentional self-poisoning / exposure to non-opioid analgesics, antipyretics and antirheumatics (X60 clinical code). Data are presented as crude counts.*

For 10-14 year olds, a marked linear increase is evident from the 40 admissions in 2018 to 133 admissions which occurred in 2022. Admissions amongst 15-19 year olds, in addition to occurring more frequently, also increased from 128 admissions in 2019 to 227 admissions in 2021. Unlike for 10-14 year olds, there was a minor fall to 217 admissions in 2022. Ongoing monitoring is required to assess whether this represents a true change to the previous trend.

1.5.2 Primary care consultations for self-harm by sex and age

Presentations to primary care amongst 10-18 year olds for self-harm related reasons demonstrate similar patterns to hospital admissions, with an overall increase in NHS GGC between 2015 and 2022. This trend has also been driven predominantly by females from 2019 onwards (Figure 13) and is commoner amongst 16-18 year olds (Figure 14). It is unclear whether the decrease amongst males from 2019 represents a true shift in self-harm versus changes in help-seeking behaviour.

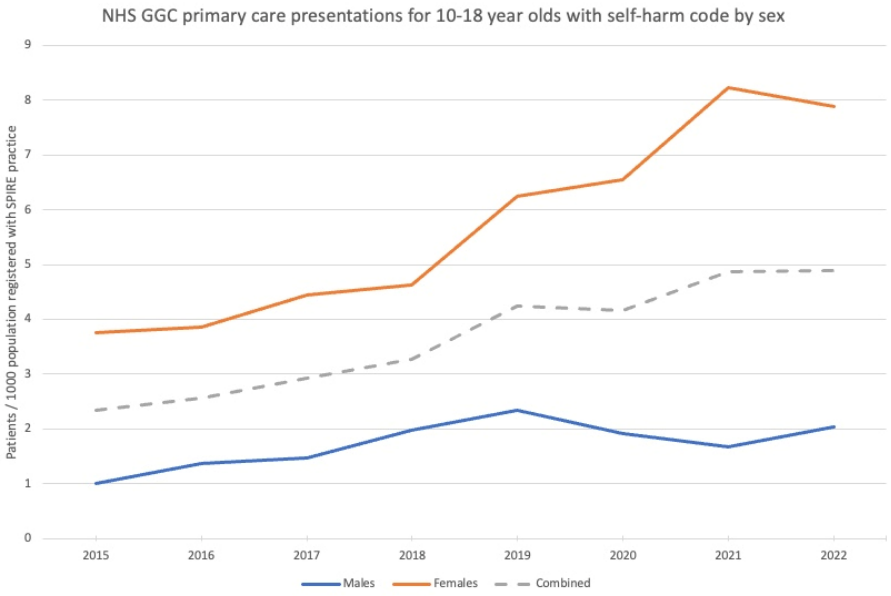

Figure 13 *Presentations to primary care with a self-harm clinical code between 2015 and 2022 amongst 10-18 year-olds in NHS GGC by sex. Data are presented as presentations per 1000 population and are applicable to the population registered with general practice surgeries which contribute data to the Public Health Scotland SPIRE system (77% of NHS GGC practices).*

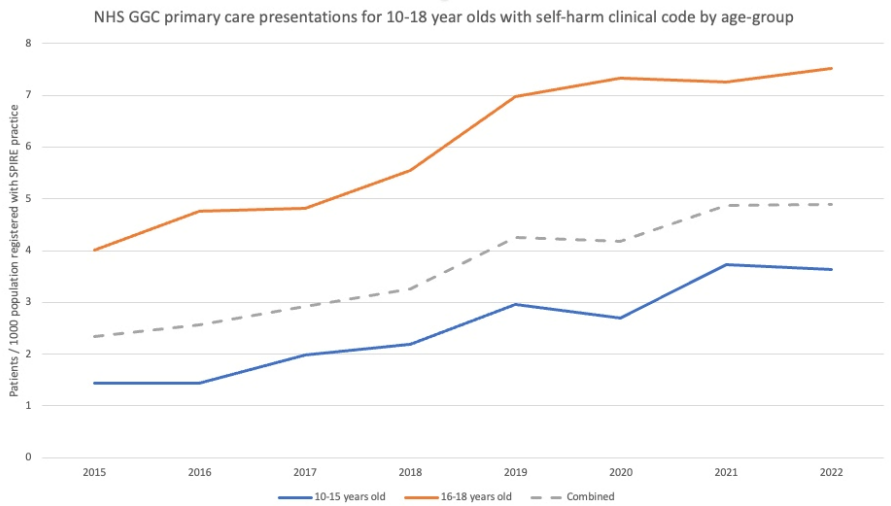

Figure 14 *Presentations to primary care with a self-harm clinical code between 2015 and 2022 amongst 10-18 year-olds in NHS GGC by age-group. Data are presented as presentations per 1000 population and are applicable to the population registered with general practice surgeries which contribute data to the Public Health Scotland SPIRE system (77% of NHS GGC practices).*

1.5.3 Primary care consultations for self-harm by HSCP area

Numbers of presentations for self-harm related reasons varied between HSCPs, with the highest rates per 1000 population evident in West Dunbartonshire compared with Glasgow City, East Dunbartonshire and NHS GGC as a whole (Figure 15). Unfortunately, it was not possible to conduct individual analyses for Inverclyde, Renfrewshire and East Renfrewshire due to limited GP practice coverage by SPIRE in these areas (see Appendix E for further details).

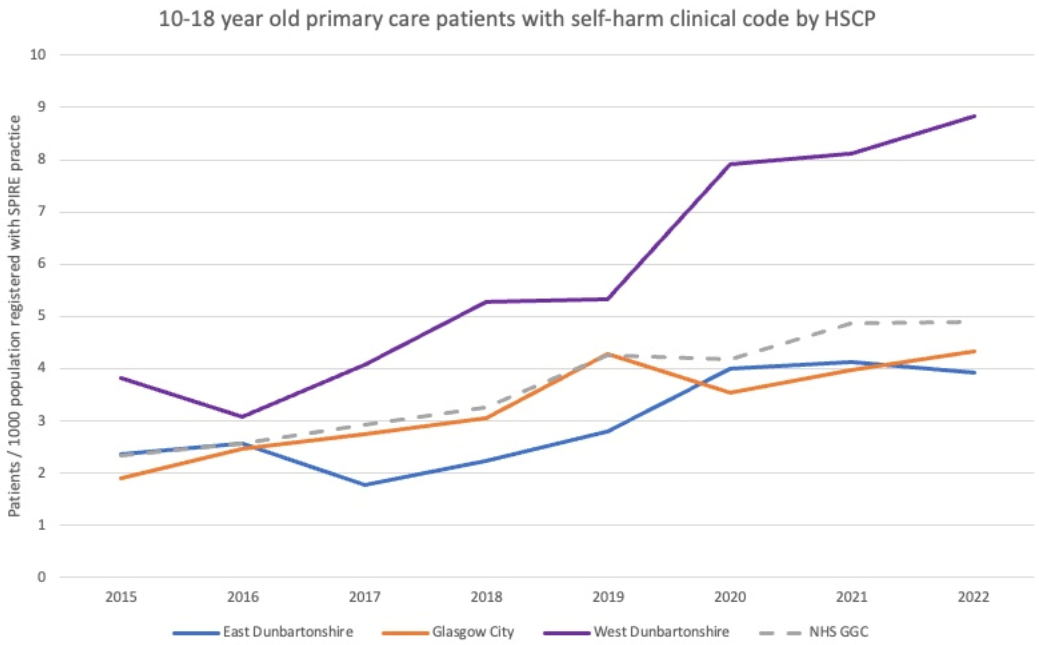

Figure 15 *Presentations to primary care with a self-harm clinical code between 2015 and 2022 amongst 10-18 year-olds in NHS GGC by HSCP area. Data are presented as presentations per 1000 population and are applicable to the population registered with general practice surgeries which contribute data to the Public Health Scotland SPIRE system (77% of NHS GGC practices).*

From 2015 – 2022, there were increases overall across the three included HSCP areas and NHS GGC as a whole. West Dunbartonshire stands out however, both for the largest increase from 2016 (3.1 per 1000) to 2022 (8.8 per 1000) and how high it sits above the average for NHS GGC (4.9 per 1000 in 2022). This is also in-keeping with admissions to hospital (page 25).

1.5.4 Discussion

The academic and school survey data presented above indicate self-harm to be common amongst CYP with females, LGBT+ and neurodiverse groups particularly at risk. Accurate, up-to-date and accessible local data reflecting the true extent of self-harm amongst the CYP population are however lacking. Currently, self-harm questions are not routinely posed to participants of large-scale cross-sectional surveys such as the Health and Wellbeing Census[35] or, in the case of the Scottish Health Survey[36], are only posed to those aged 16 and above. The school survey data presented in this report, whilst providing some inside into the true extent of 'hidden' self-harm, are controlled by individual schools and do not therefore contribute to publicly available population statistics. Self-harm is a sensitive topic to discuss, and concerns may be raised that asking sensitive questions may lead to individual harm. The multiple pieces of work identified for this HNA indicate that routine questions around self-harm are both possible and desirable in order to evidence need for public health action. Indeed, the UK All Party Parliamentary Group on support for self-harm conducted in 2020 identified the need for routine surveillance as a key recommendation[37].

It is notable that the extent of self-harm revealed by the school surveys is similar to that in reported in the Millennium Cohort Study. The true figures in the schools setting may in fact be higher due to a large proportion of pupils who answered 'prefer not to say'. Nonetheless, the school survey data have several limitations. Firstly, the cross-sectional design provides a 'snapshot' in time and does not give any indication about ongoing trends. Secondly, asking whether pupils have ever hurt themselves is a broad category which does not necessarily account for other less overt forms of self-harm such as risky behaviour. Thirdly, these results also do not account for the pupils who did not participate in the survey, though with a study sample constituting approximately 60% of S1-5s it can be reasonably assumed to be representative of the wider S1-5 population within this school. Finally, the availability of data for only two schools means that these results cannot be taken as representative of the broader NHS GGC CYP population. Behaviour in schools likely exhibits a 'cluster effect', whereby behaviour by individuals in a certain school is more likely to be similar to other individuals within the same setting than compared with those in another school[38]. Given the variations in deprivation across NHS GGC (Appendix D), mental health need is also likely to vary considerably across the population. These limitations further underline the necessity for surveillance and improved reporting in order to build a more reliable picture of population need for this common and impactful issue. In addition to the inclusion of self-harm questions within national population surveys, leverage of existing school-based surveys for this purpose may also be of value as they provide actionable intelligence at the individual school level (for further details on actions taken in response to school surveys see page 64).

The increasing hospital admissions and primary care presentations for self-harm related reasons are a cause for concern, with increasing trends underway in the years prior to the COVID-19 pandemic. Geographically, the highest numbers are seen within Glasgow City due to its larger population, though the highest rates per 1000 population for both admissions and primary care presentations were seen in West Dunbartonshire. As may be expected, admissions and primary care presentations are more common amongst females and older teens. Nonetheless, the decreasing rates of primary care presentations amongst males in contrast with the steep increase for females is notable, particularly given that these changes coincide with the COVID-19 pandemic. It is not necessarily the case however that this represents a true decrease in male self-harm or mental health issues more generally, as

differing impacts of lockdown between sexes on help-seeking behaviours may also play a role. Though direct pandemic effects cannot be robustly inferred from these data alone, the impacts of the pandemic on CYP mental health have been profound, complex and enduring (see Introduction).

The rapidly increasing rate of self-poisoning amongst 10-14 year olds is striking. Whilst these data likely include repeat admissions for some individuals, they would nonetheless appear to corroborate broader stakeholder views that self-harm is increasingly occurring amongst younger age-groups. These data also reflect CAMHS reports of increases in self-poisoning and appear to coincide with 'Tik-Tok challenges' which encourage self-harm and hospital admission as was reported by CAMHS colleagues.

> *"I think for me the biggest thing that I'm noticing is the fact that the age of these young people self-harming and seems to be going getting lower and lower. I think that's a bit more concerning and suppose from our perspective, teenagers have always had that component, but now we're getting primary school folk coming through, which is quite concerning."*
>
> CAMHS coordinator

The results presented here cannot be used to provide a general estimate of self-harm in the population given that the proportion of young people who seek help with primary care and/or are admitted to hospital is likely to be low (page 52). The increase in self-poisoning is also unlikely to indicate broader changes in methods of self-harm, with research (page 23) and tier 2 service data (page 63) indicating that self-cutting remains commonest overall.

Hospital admissions for self-harm related reasons are resource intensive and require input not only from the admitting team but also further mental health service support both acutely and possibly the longer term. Admission for self-poisoning due to paracetamol overdose may require administration of N-acetyl cysteine (NAC), an intravenous medication which protects is intended to prevent paracetamol-mediated liver damage[39]. Up-to-date costs for NAC in the public domain could not be identified, however previous work in 2014 by Bateman et al.[40] indicated a typical admission for NAC to be £768. This does not account for the costs of psychiatric evaluation or prolonged stay. A 2017 analysis of admissions to the John Radcliffe hospital in Oxford, UK, yielded similar estimates[41]. Extrapolating to the whole of England, self-harm admissions were estimated to cost £162 million. It should be noted that these papers also included the adult population and Scottish estimates were not identified. Based on the admissions data alone, it would not be appropriate to attempt a cost estimate at a local level. Nonetheless, rising hospital admissions constitute an avoidable yet increasing use of healthcare resource.

2 What factors contribute to risk of self-harm and how can it be addressed?

Summary and recommendations

Preventing self-harm by addressing risk-factors – The evidence base for direct interventions to prevent self-harm occurring remains limited, however this is largely due to a lack of good quality evidence. This should not detract from the beneficial effects that broader mental health improvement work may have on self-harm prevention. Work to improve mental health and address self-harm are likely to overlap by addressing risk-factors for self-harm such as those identified by PHS in their 2023 review which include bullying, self-esteem, body-image issues, lack of parental/peer attachment, substance misuse and sleep disturbance.

- ***Recommendation 2a –*** *Awareness raising within the health improvement workforce, healthcare, education and the third sector is required to emphasise that all work which addresses self-harm risk factors may also indirectly prevent self-harm. Interventions intended to improve CYP mental health should – as a mainstreamed action – explicitly consider self-harm prevention in all phases of planning, implementation and evaluation.*

Early intervention to support distressed individuals - Early interventions to support young people in distress in the form of distress brief intervention (DBI) services are being rolled out across HSCPs, with expectation that all areas will have a DBI service by early 2024. Service data indicate that distress is particularly concentrated in areas of higher deprivation. Whilst DBI services are typically for ages 16 and above, data and professional feedback have highlighted increasing distress amongst younger age groups, including primary school age. Pathways for 14-15 year olds are being trialled which have demonstrated high levels of uptake (and therefore need) in younger age groups.

- ***Recommendation 2d -*** *HSCPs should be supported to adopt DBI services and roll-out of 14-15 year-old pathways, with evaluation of implementation readily visible at NHS GGC level for shared organisational learning and improved understanding of population service need. Robust and highly visible referral routes should be in place.*

- ***Recommendation 2e -*** *It is unclear how acute distress is approached for under-14s across NHS GGC, its overlap with child protection issues and whether inequities in service provision exist in this space. Further work is required to understand these questions and establish pathways into robust and visible supports for acute distress in under-14s.*

Self-harm services - There are examples of services designed to specifically address self-harm in CYP, including the NHS GGC adolescent self-harm service (no longer in operation) and the contemporary Scottish Government funded pilot service operated by the charity Penumbra. These services have sought to provide follow-up over time that both addresses the self-harm itself and its underlying causes. Evidence for their effectiveness is currently too limited to specifically recommend commissioning such a service again in NHS GGC.

- ***Recommendation 2b -*** *NHS GGC should liaise closely with Penumbra regarding its schools outreach model for CYP who self-harm which is currently in operation in Dundee. The results of evaluation of this, and any similar development, should inform development of services in NHS GGC.*

Social media, self-harm and mental health – Social media is broadly perceived by professionals working with young people to have contributed to a deterioration in mental health. Research and local qualitative work suggest that while social media can offer a form of support to young people who self-harm, this support is inconsistent and that social media platforms carry unique mental health risks. This includes content that glamorises and encourages self-harm, triggering content, as well as the potential for stigmatising and negative reactions to self-harm disclosures. This serves to make social media platforms unsafe and unpredictable spaces for those who use self-harm as a coping strategy.

- ***Recommendation 1g –*** *Digital literacy development amongst young people, their families and professionals who support them should be prioritised. This is to raise awareness of the range of features and strategies available to young people and their families to ensure they have a safe and positive experience, as well as to enable professionals to have informed conversations with young people about their online habits and behaviours.*
- ***Recommendation 1h -*** *Further research is required to explore this relationship between social media and self-harm in more depth. Particular attention should be paid to how the landscape changes following the introduction of the Online Safety Bill, which requires social media platforms to take action against such harmful content being shown to users.*
- ***Recommendation 1i -*** *Further work is required to share anti-stigma messaging online in order to create safer online and offline spaces.*

2.1 Risk factors and self-harm prevention

A 2023 PHS rapid review[42] of literature reviews sought to determine what is known about risk and protective factors associated with CYP self-harm, along with evidence of effective interventions to help prevent this behaviour from occurring. This review is an important piece of work intended to inform ongoing policy, service and resource development at a national level.

Areas examined included the effects of socioeconomic status, discrimination, bullying and body image. The following paragraphs provide a summary of this work, along with any new evidence that has subsequently been published. Where possible, the work has been contextualised with data relevant to NHS GGC. Results have been reported in line with PHS mental health indicators[43], further details of which can be found in Appendix F. Social media was not assessed within this work however use and access to social media is likely a significant driver of self-harm behaviour; this is discussed further on pages 40 and 41.

2.1.1 Socioeconomic status

No association was identified between socioeconomic status and self-harm. The studies included covered distinct populations including perinatal mothers[44], Hong Kong students[45], Australian school students[46] and an English cohort study[47]. Though not included in this review, social patterning of self-harming behaviour was also not observed in the Millennium Cohort Study[24] (page 19) with broadly similar levels across all quintiles of family income.

2.1.2 Discrimination due to sexual orientation

Discrimination due to sexual orientation was identified as an important risk factor in one review by Batejan et al[48]. As discussed on page 24, evidence from the Millennium Cohort Study[49] and a recent HNA[34] indicate that self-harm amongst LGBT+ young people is likely to be common.

2.1.3 Social factors

In the social context, those at most risk of self-harm included those either experiencing bullying, perpetrating bullying or those who had a lack of parental or peer attachment. The evidence around the role of family structure, peer popularity and cyber-bullying perpetration was inconclusive.

2.1.4 Individual factors

At the individual level, there was an increased risk of self-harm for those suffering body-image issues, low self-esteem, alexithymia (inability to describe or recognise one's emotions), dissociation (disruption of normal integration of consciousness), substance misuse and sleep disturbance.

2.1.5 Qualitative evidence

This umbrella review also considered qualitative evidence which highlighted self-harm as a coping strategy to deal with unbearable emotions, gain control, obtain immediate relief and reduce emotional suffering. A rapid review of qualitative literature with regards to help-seeking and supporting families of young people who self-harm is presented on page 52.

2.1.6 Can self-harm be prevented?

The 2023 PHS review[42] discussed above did not find any review-level evidence regarding interventions or policies for the primary prevention of self-harm. As the authors noted, it is challenging to demonstrate effectiveness for an intervention if the event of interest never occurs. This is further compounded by the difficulties of measuring self-harm. Nonetheless, prevention is a key priority, given emerging evidence that earlier onset of self-harm increases the risk of a more severe trajectory in terms of further self-harm, suicidal behaviours and other adverse mental health outcomes[50,51].

A systematic review[52] has however since been published which has highlighted an evidence base of limited and low quality. The review assessed the evidence regarding direct interventions to reduce self-harm and improve other mental health outcomes including emotional regulation, psychological distress, problem solving and coping skills in educational settings. Only six studies were found met the inclusion criteria[53–58]. These took place either in secondary school[53,56–58] or university settings[54,55]. The schools-based studies focussed on in-classroom self-harm education[57,58], classroom-adapted cognitive behavioural therapy (CBT)[53] and targeted group sessions[56] of which three studies modified existing interventions[53,57,58] and one study utilised a newly created programme[56]. Unfortunately, the quality of most of the studies was assessed to be weak, with issues including small study samples and lack of comparison groups limiting confidence in the results. Furthermore, all included studies utilised different outcome measures for self-harm which hinders direct comparison. In this context, the evidence base is currently insufficient to support a directed self-harm primary prevention strategy. Further research is required to address this evidence gap.

2.1.7 Preventing self-harm repetition

In contrast to the evidence for primary prevention, the evidence-base for prevention of self-harm repetition does provide more direction. A 2021 Cochrane review[59] examined trials for self-harm interventions in CYP who had self-harmed within the previous six months. The trials included in this review assessed a range of interventions including cognitive behavioural therapy (CBT)-based psychotherapy, dialectic-based therapy for adolescents (DBT-A), mentalisation-based therapy and family therapy. No effects on repetition of self-harm were found for individual CBT-based psychotherapy, mentalisation based therapy and family therapy. As the authors noted, the quality of the evidence for these interventions is low overall, and further work is required particularly for CBT-based psychotherapy using adequately powered randomised controlled trials.

For DBT-A however, an approximately 54% decrease in self-harm was observed in combined analysis of four randomised controlled trials [60–63] which was judged to be a 'high confidence' result using a validated scoring tool. Individually, the included trials made comparisons of DBT-A against 'treatment as usual'[60–62] and individual/group supportive therapy[63]. DBT focuses on providing skills to develop acceptance and awareness of emotions and thoughts, including distressing experiences, without attempts to suppress, avoid or alter these experiences[64]. The primary goals of DBT are to reduce self-harm, the behaviours that may hinder treatment success (e.g. non-adherence) and address any other factors which may impact that person's quality of life[59]. A further 2021 systematic review[65] found similar effects and it was noted that longer duration of DBT-A appeared to confer greater benefit. No studies were found which combined both DBT-A with pharmacological treatment.

2.1.8 Current UK guidelines on self-harm – NICE 2022

Based on the above results, the National Institute for Health and Care Excellence (NICE) 2022 guidelines 'Self-harm: assessment, management and preventing recurrence' has also recommended DBT-A in cases in which there is 'significant emotional dysregulation difficulties' and frequent self-harm[2]. Though the included evidence did not extend to participants under 12 years of age, the guideline committee felt that there was sufficient evidence to recommend DBT-A also for children. DBT-A is costly however, and NICE economic analysis found it to be cost-effective only for this high-risk sub-group of young people who self-harm. For those who do not fall into this category, there are currently no specific recommended psychological or pharmacological interventions for prevention of self-harm repetition.

The NICE guidance also provides recommendations which are applicable more broadly to young people who self-harm[2]. A psychosocial assessment should be carried out 'at the earliest opportunity after an episode of self-harm' by a mental health professional, accounting for confidentiality and child-protection concerns relevant to the young person's age and circumstances. When assessing risk, the use of specific tools and scales is not recommended. Information and support should be provided to the young person and their families regarding the nature of self-harm, self-care, safety plans, stigma, care plans and availability of local services (including peer support). This should also extend specifically to parents and carers regarding the psychological impact of the young person's self-harm on them and other family members.

Educational settings are recommended to have policies and procedures in place to support students who self-harm which should include identification of self-harm behaviours, assessment of student needs, what to do when self-harm is suspected and how to support the student's friends and peer group. A designated lead within the school should take responsibility for implementation of these policies, maintaining them under review, raising awareness and supporting staff where required. For students who have self-harmed, this designated lead is recommended to seek advice from mental health services to develop a support plan involving the student and their family members / carers whilst in the educational setting.

Harm minimisation is an approach which accepts the person's ongoing urge to self-harm while attempting to limit the frequency of injury and long-term damage. Strategies which take a harm minimisation approach can include suggestions to delay, reduce or avoid self-harm. The NICE guidance does not make specific recommendations regarding harm minimisation strategies, instead stating that these should only be considered 'in the spirit of hope and optimism' having been discussed collaboratively with the person and - as appropriate - their family / carers. Potential approaches include distraction techniques, self-care, wound-hygiene, provision of education regarding self-harm complications and the role of alcohol and drugs.

2.2 Early intervention for self-harm

In addition to prevention, early intervention is a key tenet of mental health provision to prevent escalation and worsening outcomes[66]. No specific evidence was identified which specifically assessed early versus delayed intervention for self-harm in young people. Given that self-harm is a significant risk factor for subsequent suicide however[6,7], an early intervention approach to self-harm

management is nonetheless warranted and is a theme of the 2022 Scottish Government Suicide Prevention Strategy[20].

Distress brief interventions (DBI) are a relatively novel means of providing time-limited mental health support where acute and short-term input is needed[67]. DBI is non-clinical and consists of two parts. In Level 1, trained frontline staff (e.g. Health, Police) provide an initial compassionate response to ease a person's distress and, where appropriate, can refer onto a Level 2 DBI service. Level 2 DBI is provided by trained third sector staff to provide time-limited problem-solving support, distress management, wellness planning and signposting[67]. DBI was originally developed by the Scottish Government following consultation with service-users, service providers and literature review which identified the need for improved services for people in distress[68]. Though initially for 18 years old and over, this has been extended down to 16 years and over[67] and is currently being piloted for 14 years upwards. Since the initial evaluation of the DBI-pilot recommended broader roll-out[69], there has been continued expansion of DBI provision throughout Scotland[67].

The Compassionate Distress Response Service (CDRS) - run by the Glasgow Association for Mental Health (GAMH) - is a third sector service active since 2021 which provides DBI in Glasgow City. There are multiple referral routes in from emergency services. Referrals out of hours receive a response within one hour, and referrals from GPs receive a response in-hours within 24 hours. Staff report that many of their calls are for young people with suicidal ideation and self-harm. Sessions are provided by trained responders who do not have a clinical background, lasting one hour and provided once a week for four weeks. Coping strategies are provided and there is consideration of where the person should go next for ongoing support. For young people (16-25 years old), this can take the form of the Young Adult Wellbeing Service.

An evaluation of CDRS conducted in 2022 gathered views of 70 stakeholders including referrers and clients[70]. CDRS was perceived to be much needed and was seen to provide 'an excellent level of care', with all stakeholders expressing a wish to see it continue as an embedded service. A recurring theme from referrers was having a safe and dependable referral route for ongoing immediate support for people in crisis. Clients reported both the positive short-term impact of receiving immediate support and longer-term impact the coping strategies provided have had. The report did not differentiate between younger and older service users however. At a national level, ScotCen are conducting the DBI Impact Evaluation on Suicide and Self-harm (DIMES) project to evaluate DBI services across Scotland[71]. This evaluation was not published in time for inclusion here.

2.3 Self-harm services – delivery models and evidence base

Whilst the majority of mental health services will address harm as part of a programme of work with a young person in the context of their broader mental health needs, there are very few examples of services specifically commissioned to address self-harm. Only two were identified in the literature; the Adolescent Self Harm Service (ASH) in NHS GGC (no longer in operation) and Brief Interventions in Repeat Self-Harm (BIRSH) in Oxford. These are discussed below along with more recent developments regarding a self-harm service currently being piloted by the mental health charity Penumbra in Dundee.

2.3.1 NHS GGC Adolescent Self-Harm Service (ASH)

The ASH service ran within NHS GGC for over a decade having been commissioned in 2002. ASH was nurse-led and principally covered Glasgow City (and variably other local authority areas) which assessed any young person 12-17 years old presenting to an NHS GGC hospital with self-harm of any form, with automatic referral mechanisms in place. Referrals tended to occur mostly for those admitted to hospital. If the young person was not yet open to CAMHS, a period of work was undertaken to address both the self-harm and the underlying factors driving the self-harm behaviours. The nursing team linked with schools and provided support to young people in non-clinical settings such as appointments in cafes. The service ran Monday - Sunday from 9am to 5pm, with young people presenting to hospital overnight assessed the next day. Clinical progress was measured using a self-esteem tool which was applied at baseline, 3 months, 6 months and at one year. Wider support to families was also provided and the team would also provide training to professionals working with young people.

A 2004 article reported a retrospective notes audit of ASH[72]. Unfortunately, the authors only reported patient characteristics and did not assess outcomes. In line with contemporary admissions data (page 25), patients were predominantly female and the commonest method was self-poisoning. A more recent service evaluation was not identified, though CAMHS workers who previously worked in ASH were interviewed as part of focus groups for this HNA (page 48).

2.3.2 Brief Interventions in Repeat Self-Harm

The Brief Interventions in Repeat Self-Harm service, operating from the John Radcliffe Hospital in Oxford, ran a similar model for patients presenting to the emergency department (ED) with self-harm who were identified as being at risk of self-harm repetition. The service was developed in response to high levels of self-harm seen at the ED. Based on the 2017 evaluation[73], service development did not appear to draw on an evidence-base beyond the use of quality improvement methodology. It is also unclear what was the target population as patient demographics and referral criteria were not provided, though it is likely to have included adults. Similar to ASH, this was a nurse-led service which provided outpatient follow-up. Patients were offered a maximum of six sessions. During the 12-month trial implementation period, 38 patients were offered the intervention of which 26 (68%) attended at least one session. Uptake beyond this was low however, with only 14 (37%) attending two or more sessions. Overall, repeated ED presentation with self-harm decreased from a mean of 3.5 presentations per patient in the 6 months prior to the intervention to 0.75 presentations in the 6 months following. Statistical tests were not conducted and this calculation only included 23 (61%) of the original 38 patients, with 15 excluded due to being psychiatric inpatients or in prison. Changes in mental health using this service were measured using various validated tools, with some benefit evident. Again, the numbers of patients for which these were reported was small.

2.3.3 Penumbra self-harm service

Penumbra is a Scottish mental health charity which provides services to 23 Integrated Joint Boards and HSCPs across a range of services[74]. A recent development has been the commissioning of a pilot self-harm service and online supports funded by the Scottish Government in response to a perceived need from the charity that specific self-harm services were required. There are two pilot services for

people aged 16 and above in Glasgow and Highlands & Islands as well as a service in Dundee for 12-18 year olds. Penumbra also run an online portal where self-harm resources can be accessed for both clients and for people supporting others who self-harm.

The different locations have different referral partners and clients are also able to self-refer. In Glasgow, CDRS (page 36) can directly refer. The youth service running in Dundee has partnered with schools and had at the time of interview (Spring 2023) held three drop-in sessions in different Dundee high schools. Penumbra reports that these sessions were well attended by pupils mostly in S2-4 and have resulted in 10 referrals to the self-harm service for formal one-to-one support.

Given the recent commissioning of the service, evaluation remains ongoing. Early qualitative feedback shared by Penumbra from teachers and pupils participating in the Dundee project was positive. It was highlighted by pupils that having staff with lived experience of self-harm was of key importance, and that service-users felt less expectations and pressure compared with standard medical models of care. Penumbra also report that their work has invoked conversations around mental health and self-harm amongst school staff and parents and has allowed them to explore further information and resources for themselves through the team and the online portal. Early feedback from the Dundee practitioners indicates that the young people they have been working with one-on-one have reduced their frequency of self-harm and have been utilising the alternative coping mechanisms provided.

Data shared by Penumbra for the last quarter of the financial year 2022/23 indicate that most service use is amongst younger people, with 46% under age 16 and 20% 16-25 years old. Whilst this likely reflects higher demand amongst younger people in line with national trends[36], differences in referral patterns and outreach activities between Dundee versus Glasgow and Highlands may also play a role. Service-use numbers also remain small overall. Outcome data were provided in the form of before/after distress scores, though analysis was not possible due to statistical considerations which would have required access to the raw data. Further evaluation over a longer time-period is warranted to assess demand as well as outcomes.

2.4 What is the role of social media in self-harm?

There is growing recognition of the role social media can play in CYP mental health. Amongst stakeholders and focus groups there was widespread consensus that social media has played a critical role in both self-harm and a broader observed deterioration in CYP mental health. Of concern also at a local level are reports of social media self-harm challenges.

> *"A perfect example is that wee girl [redacted], and it was a form of self-harm as she was wanting to numb her feelings… but she saw that on TikTok… there's a lot out there… as [the] internet becomes more visual, you see it on Instagram, obviously all the posts, Instagram's all about pictures, so you've got all the self-harming things like that, all the visual stuff which wasn't around previously"*
>
> *Intensive CAMHS*

Concern is also increasing internationally regarding online harms, with the 2023 UNESCO Global Education Monitoring Report[75] finding that approximately a quarter of countries globally have enacted laws which ban smartphone use in schools. At a local level, controlling smartphone use in the school setting has not been without controversy, with focus groups of pastoral care teachers reporting difficulty in implementing controls with complaints from both pupils and parents. Extensive attempts at education regarding online safety were also reported as part of routine curricula, though it was perceived to have little effect in altering young people's online behaviour.

Though no ban on school smartphone use exists in the UK, the Online Safety Bill[76] has been drafted by the UK Government to compel social media platforms to remove illegal content, enforce age limits, prevent access to age-inappropriate content, ensure risks on social media platforms are made more transparent and provide parents and children with clear pathways to report issues online. Explicit reference is made to self-harm content in the UK Government website overview[76].

A literature review regarding the effects of social media on CYP mental health (including self-harm) is, at the time of writing, being undertaken in NHS GGC. Pending this work, a brief discussion of selected recent review-level literature is provided below. This is followed by a summary of focus-group work undertaken by the NHS GGC mental health improvement team to assess the social-media self-harm relationship further.

2.4.1 What does the research say about social media and self-harm?

The relationship between social media use and self-harm is complex. Negative effects such as viewing self-harm related content, cyberbullying and social exclusion may exacerbate mental health issues, whilst positive effects including immediate social support and strengthening existing social ties may promote mental health[77,78].

A 2021 systematic review[78] examined the role of social media use on self-injurious thoughts and behaviours (SITB) amongst adolescents and young adults. Several concepts were examined including cybervictimisation, cyberbullying perpetration, SITB-related social media use, frequency of social media use and sexting. Victims of cyber-bullying had an approximately four-fold increased risk of self-harm, though no association was found for those perpetrating cyber-bulling. Both consumption of

SITB-related content and sexting was also associated with an approximately three-fold increased odds of self-harming. No relationship was found for frequency of social-media use, suggesting content and online behaviour are of greater importance than simply amount of time spent online. None of the included studies were in UK populations, with the majority in the USA or Canada, meaning direct application to the NHS GGC population should be undertaken with caution as social/cultural factors in these countries may also influence results. Furthermore, where no associations were found, this may reflect small study sizes rather than a true lack of effect.

A further systematic review[77] sought to specifically assess the impact of viewing self-harm images online. All fifteen studies identified harmful effects of viewing self-harm including escalation of self-harm, encouragement of social comparison (comparing self-harm with others), development of a self-harm identity and reinforcement of 'engagement behaviours' (e.g. sharing images, posting comments). In line with the complex nature of social media use however, nine of the studies also found protective effects which included reduction of self-harm, encouragement of social connection and providing help. Further research is needed to investigate the complex mechanisms uncovered.

2.5 Social media and self-harm – focus groups of young people in NHS GGC

"It's not safe and consistent": **An exploration of social media and self-harm among young people**

This section has been developed and authored by Laura Hills, Health Improvement Senior (Digital – Mental Health NHS GGC) on behalf of the Social Media and Self-Harm Working Group.

Background

Youth Interventions were funded to undertake an exploratory project with a group of young people to hear their views on social media's relationship to self-harm and mental health and wellbeing. The findings from this exploratory project are to be used to provide recommendations for clinical service improvements, including supporting professionals to engage with young people who self-harm around their online habits and experiences.

Methodology

Four focus groups were run by Youth Interventions February - March of 2023. 18 young people aged 16-23 living in the Renfrewshire area were recruited to take part. The young people were those who had previously engaged with Youth Interventions and were recruited directly through the organisation.

The social media platforms most used by focus group participants included Instagram (16), Facebook (15), TikTok (13), Twitter (9), and Snapchat (9).

Key themes

1. **Social media as an unsafe space**

Participants felt that social media is not always a safe space for people who use self-harm as a coping strategy. Instead, they can encounter a range of harmful content and behaviour that negatively impacts on their mental health and wellbeing. This includes self-harm content that is glamorised

through the use of filters or quotes, making it look *"trendy and aesthetic".* There was a concern among participants that this style of self-harm content in particular appeals to more vulnerable or younger individuals and could increase their risk.

Participants also voiced concerns that social media spaces are not always safe for people to share their experiences of self-harm. those who share their experience of self-harm can be subject to negative responses. This in turn creates barriers to help-seeking, as people are afraid to speak out about their own experiences or seek online support:

> *"Sometimes when others show their self-harm on social media it gets a really negative reaction. People calling them attention seeking and telling them to cut deeper if they mean it. That makes me feel like I need to be careful who I talk to about it."*

2. An inconsistent source of support

Despite concerns around social media not always being a safe space, a theme that emerged during discussions is that of the support that it can also provide. This support, however, is not seen as consistent, leading participants to describe social media and self-harm as having *"a complicated relationship".* At times, participants find social media a place where they can learn coping strategies from others and hear stories of recovery, including from influencers. Others, however, shared how they have not ever come across anything helpful on social media.

Participants also had mixed feelings about the extent to which social media helps to normalise self-harm. For some, they felt people sharing their experiences can help others to feel more understood. Other participants, however, felt that it can in fact normalise it in a harmful way by encouraging people to *"think it was okay and an easy way to deal with things".* Some participants also reported feeling that people sharing their experience online can in fact create more stigma around it due to the likelihood of receiving a negative response or abuse.

Peer support that is experienced on social media was also described as unpredictable. At times, responses to someone sharing their experiences could be positive, while at other times, it could be negative and harmful. This led participants to describe the support received online as *"not safe and consistent":*

> *"You could be on one side of TikTok one day and it's full of the most supportive lovely people and you could speak about self-harm and get what you need from there. Then the next day you could go on the opposite side and you could get absolutely slaughtered for something you're trying to share or if you're nice to someone else who is struggling, next thing you are being trolled. Like sometimes it's supportive and sometimes it's not, but when it's not, it's really not."*

3. A triggering and unpredictable algorithm

The influence of the algorithm on participant's experience of social media was another key theme that arose during the focus groups. Participants described social media platform algorithms recommending self-harm related content that was triggering for them when they were not actively looking for it, such as when they were online looking for entertainment. A particular area of concern was the algorithm's inability to predict their current mood, instead sharing self-harm related content based on their past behaviour and previous engagements with that type of content. Regardless of their current state of

mental health and wellbeing, participants described how seeing this content could be triggering and cause their mental health to deteriorate.

Participants also felt that recommendation algorithms are often unable to differentiate between positively intended content, such as content focused on recovery, and content that is more negative. This meant that if young people were actively searching for help and support, often they instead were recommended content of a more negative and harmful nature:

> *"You can be searching looking for helpful stuff and next thing there's stuff related to but in a different more negative context, showing on your social media." "It's almost like they are trying to make it worse."*

4. Helpful responses

Discussions were also focused around what approaches or responses could support young people around social media and how it relates to their self-harm. In general, participants called for greater awareness and understanding of self-harm, both online and offline. Educating other young people in schools and getting influencers to play a more *"positive and pro-active role"* in talking about self-harm were welcomed.

Participants also shared helpful responses that professionals could adopt when engaging with young people around social media and self-harm, including:

- Being knowledgeable about social media platforms themselves, and strategies young people can adopt online to keep themselves safe, as well as providing them with factual information.
- Creating a non-judgemental space, where professionals adopt a harm minimisation approach, rather than telling young people to not self-harm or to stop using social media.
- Being curious about young people's experiences of being online and asking them genuine and informed questions about how they spend their time on the internet and on social media.
- Being relatable by sharing personal experience of using social media or of self-harm.
- Presenting a balanced view of social media, while also highlighting the specific risks that people can face online.

Conclusion

This exploratory project has highlighted some key themes that surround social media's complicated relationship to self-harm. It suggests that while social media can offer a form of support to young people who self-harm, that this support is inconsistent and that these platforms carry unique mental health risks. This includes content that glamorises and encourages self-harm, triggering content, as well as the potential for stigmatising and negative reactions to self-harm disclosures. This serves to make social media platforms unsafe and unpredictable spaces for those who use self-harm as a coping strategy.

At present, social media platforms have also not been designed in a way that ensures the safety of their users. Instead, the recommendation algorithm emerged in this project as an area of particular

concern. It creates a personalised and endless 'For You' feed, where users can be shown unwanted and unexpected self-harm related content. This puts vulnerable users at risk and can cause a decline in mental health and wellbeing.

The recommendations from this work have been incorporated within the overall HNA recommendations, specifically 1g, 1h and 1i (see page 32).

This report has been based on field work and initial processing that was conducted by Youth Interventions, the commissioned partner for this project. Original commissioning specifications available on request.

2.6 Discussion

There has been an increase in national activity around self-harm in the last three years with the self-harm strategy, PHS evidence review and Penumbra self-harm services all shedding further light on this highly prevalent issue. As the PHS review highlighted, though risk factors for self-harm are well-characterised, there remains little good quality evidence regarding best-practice for primary prevention[42]. It is also challenging to ascertain when mental health interventions for another purpose (e.g. anxiety management) have an indirect effect on self-harm when self-harm is not directly measured as part of research study design. The evidence for secondary prevention of self-harm repetition is also constrained, with DBT-A remaining the only intervention with clear effect based on well-designed clinical studies. As discussed however, this is only cost-effective for a narrow and high-risk group of young people and would not be recommended for broader deployment amongst CYP who self-harm. Research and local work seeking to evaluate mental health interventions in school and other settings should additionally consider measuring impact on self-harm behaviours.

Similarly for early intervention, little evidence was found specific to self-harm. Nonetheless, early intervention is widely seen as beneficial in addressing underlying mental health issues[66,79], which may also reduce risk of self-harm. DBI represents a novel means of offering rapid early mental health support. The pilot expansion of the age cut-off to 14 years and over is a positive development, with initial service data from West Dunbartonshire indicating highest demand in the youngest age-groups. Ongoing work is required to evaluate these developments and assess subsequent mental health outcomes and self-harm (including, where relevant, its repetition). HSCPs should be supported to develop and evaluate these services in line with national work-plans, with a view to ensuring equity of access across NHS GGC.

The evidence-base for specific self-harm services is also limited, with the only apparent services targeted to young people internationally having been in NHS GGC and now in Dundee. The current healthcare fiscal environment is challenging, with growing demand for increasingly scarce resource. The previous ASH model was resource intensive and would unlikely be equipped to handle contemporary levels of need. Whilst holistic and readily accessible services for young people who self-harm and their families is important, there is currently insufficient evidence available to make recommendations regarding the commissioning of a specific self-harm service. Ongoing evaluation of Penumbra's self-harm service may in due course address this evidence gap and it is recommended that NHS GGC remains cognisant of this, given the levels of need around self-harm demonstrated in

this report. Notably, focus groups of CAMHS workers have suggested a need for such a service again. This is discussed further on page 51.

Social media will continue to remain a help and hindrance to mental wellbeing and self-harm specifically. Rapid developments in technology will likely continue to outpace healthcare systems' ability to understand and develop appropriate supports. Nonetheless, the system must try to keep up. Further work in this area around digital literacy and online safety, as highlighted in the recommendations for this section, will be required with ongoing efforts to ensure that any supports and tools developed remain up to date.

3 What are the views of those who support young people with mental health and self-harm?

Summary and recommendations

Cross-disciplinary working between Education and Healthcare - Education and healthcare professionals report a widespread desire for more multi-disciplinary working and information sharing to provide mental health support, however capacity issues and staff turnover hinder this from happening consistently. There may be additional barriers including confidentiality concerns and systems issues (e.g. incompatible IT systems). Pastoral care teachers in particular report the need to provide extensive mental health support to CYP and their families in the school setting, without necessarily having a full understanding of the support that young person is receiving from clinical services. Whilst close working ties between Healthcare and Education were evident in some HSCPs, either on a relational basis or via established governance structures, this is not consistent across all of the NHS GGC catchment and likely indicates inequities in GIRFEC implementation.

- ***Recommendation 4a –*** *Governance and working structures for lower tier mental health support should enable regular interactions between healthcare and education colleagues in line with GIRFEC principles, with information-sharing agreements in place across agencies to facilitate multidisciplinary working. Whilst individual professional relationships are important, such structures should seek to avoid over-reliance on these for service continuity. Learning from areas where this has been strengthened, such as in East Renfrewshire, should be more broadly shared.*

- ***Recommendation 4b -*** *Clinical services should seek to inform the school when they are supporting a young person (with permission). Ideally, this should contain a level of detail that facilitates ongoing support in the school setting. This should also extend to emergency department attendances for mental health and self-harm. Further work is required to establish safe and acceptable mechanisms for this to take place..*

Availability of supports for CYP and families - there is a wide variety of supports available to CYP and families for self-harm, many of which can be found online. Healthcare and Education colleagues interviewed expressed uncertainty however regarding their availability and applicability, with a desire for sources which were seen to be endorsed by the NHS.

- ***Recommendation 2f –*** *Work is required to better understand the ways in which supporting information around self-harm and mental health can best be made available so that CYP, families and professionals can easily access these when required. This may be done via existing evidence or require further engagement.*

Public misperceptions - A large public survey conducted by the Samaritans indicates that there are likely to be widespread misconceptions amongst the public regarding reasons for self-harm, who is most affected and how to provide support.

- ***Recommendation 1c -*** *Awareness raising activities are required at local and national levels to address public health misperceptions around self-harm, with emphasis that self-harm is common, particularly amongst CYP. Public messaging should seek to explain why individuals may self-harm and outline the key steps of a compassionate response. It may be appropriate*

for this messaging to be tailored to groups including CYP, parents/guardians and adults. All public awareness efforts should have the core aim of seeking to address stigma and discrimination associated with both self-harm and mental health issues more broadly.

Person-centred access to support - Evidence from professional interviews, focus groups and the wider literature strongly suggests that stigma and discrimination around self-harm and mental health issues are widespread, creating barriers to accessing support. Examples were found of ways to discretely improve access - such as using QR codes to contact pastoral care teachers - which were instigated after asking young people what would work for them.

- ***Recommendation 2c –*** *Provision of mental health and self-harm supports and services should account for the widespread stigma of self-harm in their design. There should be visible opportunities for discreet access to support in a way that maximises the likelihood of ongoing engagement. Where barriers to access are identified, innovative solutions should be sought to lower these in consultation with CYP.*

3.1 Views from different ends of the spectrum of mental health support – focus groups with teachers and CAMHS

In the following section, analysis of cross-cutting themes arising from focus groups of pastoral care teachers and workers from the community and intensive CAMHS teams is presented. For further detail regarding methodology and ethics considerations, see Appendix B.

3.1.1 Self-harm in the school setting

All groups of teachers engaged for this HNA acknowledged that self-harm was common in the school setting, with one teacher estimating that '60% of my disclosures for self-harm'. The approach to self-harm varied between schools, with some (but not all) viewing self-harm as a child-protection issue. Similarly, disclosure to parents was also not universal. A person-centred approach was often cited, with discussions around what supports the young person felt they wanted or needed.

Cases of self-harm would often not exist in isolation. Social contagion, a well-documented phenomenon by which self-harm behaviours spread through social groups[80], was reported to occur across schools:

> *'… there's quite a powerful personality who actively self-harms, and I would say that at the start of the year there wasn't self-harm issues for that group, there now is for a considerable number of them.'*
>
> *Pastoral care teacher, Glasgow*

Often, self-harm was reported to stay within tier 2 services and did not constitute an automatic referral to CAMHS. In situations where lower tier mental health support had been instituted successfully and the situation had improved, CAMHS support was sometimes felt no longer to be required.

> *'I would say if it's not a child at crisis point, like they're not at that "I've got a plan" "I want to end", then usually the interventions that we're doing at school level, you're then phoning CAMHS and saying "actually take them of the waiting list". Like the child's in a much better place, the child feels a lot more able to deal with different situations now and the child feels themselves that they don't need CAMHS.'*
>
> *Pastoral care teacher, Inverclyde*

It should be noted that it was not possible to quantify how often this happens; this evidence therefore remains anecdotal.

3.1.2 Increasing complexity

In addition to the increased volume of demand for mental health support services, both school nursing and CAMHS workers have noticed an increase in the complexity of the mental health issues and self-harm they are seeing clinically.

'Then I also think mental health difficulties are no longer straight forward either, they're always co-morbid and there always seems to be extra things coming into it. Em, you know you've got lots of things in the mix, so I think they're becoming much more complex, then I think that's making the self-harm more complex as well too…'

Intensive CAMHS

School nurses reported that this increasing complexity has required additional time to be spent supporting individual cases, which in turn affects their working capacity.

3.1.3 Challenges gaining early access to mental health support

Participating pastoral care teachers appeared to have a broad understanding of the supports locally available at a Tiers 1 & 2 level. Concern was expressed however about delays in getting access to these, with different methods being employed to shorten the time a young person had to wait to gain access to support. In Inverclyde, teachers reported having to check with different services to assess which had the shortest waiting list in order to better target their referral:

''…so we'll have a chat and say 'oh how quickly do you think you'll have availability for… Oh right okay, you're going to be that long, right okay, well it's okay, we'll go that sector'...

…You're not putting one referral to four different agencies for it but you're trying to find the quickest route."

Pastoral care teacher, Inverclyde.

In Glasgow, teachers reported sending out multiple referrals:

'…so it's trying to get a service that will come in quickly, and I think what we all tend to do is a scattergun approach, just refer everywhere with the hope that something will come up. We can refer to the school counsellor, we can refer to Youth Health [Service], we could refer to CAMHS, we can get these other agencies involved. But what basically happens is that we often end up doing check-ins with them on a regular basis'

Pastoral care teacher, Glasgow.

Several teachers spoken to in focus groups and at a teaching event mentioned that their schools had commissioned additional support in-house using money available via the Pupil Equity Fund, money broadly intended to target learners impacted by poverty in the domains of literacy, numeracy and health and wellbeing[81]. Teachers at these schools highlighted the future stability of the funding for these services as a key concern. CAMHS community coordinators also expressed concern regarding variation in provision of Tiers 1 & 2 services across NHS GGC, referring to a 'postcode lottery':

'But there are no Tier 2 services in [redacted]. So they're all coming in to us. So the waiting lists are huge. So in terms of signposting them elsewhere, there's not a lot that you can you can direct them to because they don't have access to Glasgow services.'

CAMHS clinical coordinator

Where Tier 2 resources have been more widely developed however, there was concern from CAMHS focus group participants that access was hampered by rising demand. Waiting times for MH services are further discussed on page 60.

3.1.4 When should self-harm go to CAMHS?

CAMHS referral criteria do not include self-harm in itself as a reason to refer to CAMHS. Instead, there must be a suspicion of a mental disorder resulting in 'persistent symptoms of psychological distress' along with an 'associated risk that the child/young person may cause serious harm to themselves'[82]. CAMHS staff were clear that an associated mental disorder was key to merit their input.

> *'It's a moderate-severe mental health difficulty.*
>
> *If it's self-harm and em, as a way to…cope with school stress… I wouldn't envisage CAMHS being the… best place environment to see them. You've got a long wait and actually, for something school-related, your teachers are in a much better position to look at those stresses and manage some of those, do a bit of problem solving, you know, put things in place, or get the counsellor to do this.'*
>
> *Intensive CAMHS*

3.1.5 Bridging the gap between Health and Education: Multidisciplinary working, clinical communications and the role of school nursing

Focus groups with teachers highlighted the value that a clinical perspective brings to their ability to support the mental health of young people in their care and a desire for more multi-disciplinary working.

> *'What I've noticed is, trying to get agencies round the table, and I appreciate the challenge of trying to get CAMHS professionals or other professionals round the table, but the value of that, if we're truly talking about getting it right for that child, that multi-agency approach, mental health professionals round the table with us educators is crucial. I appreciate that even if it's using technology, over Teams... that could be very valuable.'*
>
> *Pastoral care teacher, Glasgow.*

Teachers also expressed a desire for more information about the mental health support their young people are receiving in order to better align their own efforts. One teacher in Glasgow said that they often feel that they are operating 'in the dark' as they must rely on what the young person and their families tell them, which may not always be reliable.

> *'I think there is also a lack of joined up working, if we have the young person at school, and they are being supported by Youth Health or CAMHS, we don't get any information, understandably, but even if we could find out what grounding techniques they're using, we could then mirror it in school.'*
>
> *Pastoral care teacher, Glasgow.*

Engagement with teachers and school nurses indicated that the school nurse service can help to bridge this gap between 'Health' and 'Education' by providing clinical context and supporting teachers to provide better mental health support.

'…we also used to have a nurse, and we're looking for a joined up solution… but that is for us really a missing link…but sometimes it's a Health barrier and we are relying on information from the parent or carer…and Health used to break down those barriers... I think there's some pilots of school nurses sitting on it…and that is so beneficial…sometimes you just get stuck.'

Pastoral care teacher, Glasgow

Teachers in Inverclyde were positive about the proactive support they receive from the school nursing team, while in East Renfrewshire the school nurse was able to provide relevant clinical information that informed the decision of the multidisciplinary team within the Healthier Minds Screening Hub (page 63). School nursing teams engaged for this HNA confirmed that a large proportion of their current workload is around mental health, with regular dealings with self-harm. Demand is high for school nursing input, with concern that rising demand is hampering the service's ability to provide effective early intervention.

'So I just feel we're missing a trick…by the time that we get to the children and young people, they're four months down the line now and you kind of feel like you're [sticking a] sticky plaster on it. And that defeats the whole purpose of public health work, doesn't it?'

School nurse, NHS GGC

Workload remains a key challenge to consistent partnership working across the system however.

' Everybody is so busy and got so little time throughout the whole of the system that we're all basically stuck in the same in the loop basically. And no matter what we're trying at the moment, that loop just seems to go round and round…'

CAMHS clinical coordinator

3.1.6 A 'lost population'

CAMHS staff who previously were employed in the Adolescent Self-Harm Service (ASH; page 38) highlighted concern that young people who previously would have been seen by ASH are being 'missed' if presenting to ED with relatively 'superficial' self-harm not deemed to require formal CAMHS assessment. Examples were cited of cases seen in CAMHS who could have been picked up at presentation to ED and provided with earlier support. Focus groups with the intensive CAMHS service and community CAMHS teams also independently brought up the need for further support for young people not meeting criteria for tiers 3 and 4 mental health services but who nonetheless require support with self-harm and their mental health. It was suggested that earlier support, in the form that ASH took, may help to reduce CAMHS waiting lists in this regard and provide better support to families.

'It would be good to have a sort of standalone self-harm service as there was when [name redacted] was talking about in the past. Where there could be some work with the young people, but also with parents, for a bit of education.

I think quite often we also see a lack of parents being able to contain situations, and if that's what's being modelled to young people then they struggle. And there's much a case of here's what happened and straight away it goes to self-harm, there's no in-between. Em, there's very little other coping strategies, it seems to be the first line for young people now…'

Intensive CAMHS

One interviewee raised concerns over a 'lost population' of young people who are no longer eligible to receive the help that ASH would have provided. There was broad consensus from CAMHS focus groups that ASH provided a valuable and needed service. Ultimately, ASH was incorporated into intensive CAMHS as part of NHS GGC-wide service re-design.

> *"…it kind of continued and it amalgamated into intensive CAMHS… So I would initially still pick up young people who would self-harm and come to hospital and we would still do a piece of work with them and try and prevent that referral onto locality teams. That stopped in 2017, 2018 and that was due to resources. We were getting too busy with other intensive stuff from tier 3, we weren't then able to pick up from hospitals and do that piece of work.*
>
> *So we didn't have enough staff, so that definitely disbanded and stopped at that point, but there was a bit of a, part of a continuation when it was first made into the intensive CAMHS teams in 2012."*
>
> *Intensive CAMHS*

Further discussion of the ASH service and other self-harm services can be found on page 37.

3.2 Engagement with young people and families: Review of the evidence

This HNA has not directly engaged CYP or their families regarding self-harm. Nonetheless, there is a wealth of qualitative research in the literature which helps to paint a picture of young people's and families' experiences. Many of the experiences described in these studies resonate with views from focus groups and interviews conducted locally, with clear need to ensure support for the families of young people who self-harm.

3.2.1 Seeking support for self-harm – review of the evidence

Seeking support for self-harm is likely to be a major step in a young person's life, with long delays between initial self-harming behaviour and help-seeking. A cross-sectional survey[83] of 672 German adolescents between 11 and 19 years old participating in the AtR!Sk cohort study[84] found a mean delay in seeking help of 1.98 years after first thoughts of self-harm and 1.65 years after first episode of self-injury. No significant differences were detected between males and females. As alluded to previously (page 25), young people who self-harm are unlikely to seek medical attention in a hospital setting, with national and international surveys indicating approximately only 12% do so[30,32].

A 2014 systematic review[85] sought to assess the sources of support adolescents who self-harm access and the barriers and facilitators to seeking help. Between a third and a half of those self-harming did not seek help at all. When seeking support, the majority turned to friends and family rather than medical services. The internet was highlighted as a potentially common means of disclosing self-harm rather than for seeking help. Barriers identified to seeking help included stigma, fear of a breach of confidentiality and fear of being seen as attention-seeking. A 2008 school-based survey[86] included in this review of 5293 UK 15-16 year-olds found that 47% would turn to a friend and 23% to family whereas only 8% would turn to a doctor and 5% to a teacher.

Stigma around mental health issues generally was also highlighted within the school setting by pastoral care teachers:

> *'…we've done a survey as well to ask them about, you know, do you feel you could talk to your peers about any issues you're having and like 80% came back and said no.*
>
> *They're like "no I wouldn't tell my friends". And I was really shocked at that and they were like "yeah, no I wouldn't tell because they'll tell this and they'll twist it", and even their relationship with their peer group is completely fractured.'*
>
> *Pastoral care teacher, Inverclyde*

Despite the apparent stigma around mental health issues, teachers also point to a 'normalisation' of talking about self-harm in the school setting:

> *'You have these kind of issues where it's openly discussed amongst the groups, I've had young people come to me and say "well it's not that bad", so there's almost like a degree of "well how bad can you self-harm"?'*
>
> *Pastoral care teacher, Glasgow*

Clinically too, workers in the intensive and community CAMHS teams have noted a change in the way some young people talk about self-harm which they attributed to social media.

> *'…kids would maybe conceal it more, whereas recently I've seen it they're more willing to have it on show and they want their wounds to be seen, and it's not like a secretive thing that they're keeping to themselves, and again I think that coincides with social media and it's almost like becoming a bit of a trend in a way for some kids, it's not all kids but some kids. It's like they need to be shown their self-harm whereas others would have been quite secretive about it.'*
>
> *Intensive CAMHS*
>
> *'…normalisation. That's it. You know that, like young people talking about it as if it's the most normal thing. And that often is what happens when we have them in the room … you can see that and they've normalised it, we're not normalising it but they are and that is a worry you know for young people who are hearing and seeing chats and different things that they're they're having access to.'*
>
> *Community CAMHS*

3.2.2 Supporting families of young people who self-harm

Multiple studies indicate that the impact of self-harming on surrounding family can be profound. Parents are often 'bewildered' by self-harm and go through a difficult period of sense-making to understand and come to terms with it[10].

> *"…at first, when you see these marks on your child's beautiful skin, you're just filled with every emotion that you can possibly think of—fear, anxiety, disbelief, anger and just not knowing what to do."*
>
> *Quote from Ferrey et al (2016)[9].*

A series of twelve interviews undertaken with parents of young people receiving treatment for SH in CAMHS in Croydon[87] sought to explore parental experiences of their child's self-harm. Parents may struggle to accept and make sense of the situation, not knowing how to respond. This can result in altered parenting, a deterioration of family communication and increased parental burden. Strong emotional reactions were also described, the most prominent of which being a persistent sense of loss and sadness. Many parents took 'wait and see' approach, with some likely aware long before the disclosure of self-harm having accepted implausible explanations from their child. The study also highlighted that formal confirmation that the child is self-harming can often be mediated externally, for example by the school. The timing between first disclosure and referral to support was influenced by the willingness of schools and general practitioners to discuss with self-harm parents.

A qualitative study of 37 parents of young people aged under 25 years old[11] found that parents often had an initial feeling of 'walking on eggshells', though were later able to take more control. Parents were also worried that they were less able to give attention to the siblings of young people who were self-harming. Specific coping strategies were developed by some in order to avoid blaming themselves or their children. Encouragingly, parents were generally eager to pass on knowledge to those in similar situation, suggesting a role for peer support groups.

A separate analysis of the same study sample[9] pointed to significant strain on relationships between family members, with parents feeling a sense of isolation and desire to keep child's problems private. Some parents interviewed had stopped socialising to avoid answering questions about their child. Impacts on finances and work to support the child were also reported, with a particular impact noted on self-employed parents.

Regarding what support parents of young people who self-harm require, a 2021 systematic review[88] identified several specific themes including how to talk about self-harm and more information to help with offering appropriate support, the parents' own understanding of self-harm and informing decision-making.

Teachers in focus groups also highlighted the challenges around supporting families:

> *'…communicating with parents and sometimes supporting the parent is actually more difficult than supporting the child.'*
>
> *Pastoral care teacher, Inverclyde*

They also report that families may use schools as the first point of contact for support rather than contacting medical services:

> *'…parents tend to panic, there needs to be a support in place for parents in terms of…a) managing their expectations of what help and support is out there, b) helping them to help the young person because we only have them when they're at school, so much of what's happening…I mean they wait two weeks after the Easter Holidays to tell you "I've discovered they're self-harming", they haven't thought to go to the doctor, and when they go to the doctor, well often we're being told, they're saying to go to the school and go and get a counsellor.'*
>
> *Pastoral care teacher, Glasgow*

Where family workers were available, these were reported to be of value to support teachers' efforts. A desire was expressed both in focus groups and stakeholder interviews for a centralised set of resources from the NHS which could be used to support families of those with young people who self-harm. Further discussion of locally available self-harm resources can be found on page 66.

3.3 What does the Scottish public think about self-harm?

Samaritans' Hidden Too Long report[21] conducted a survey of 1000 Scottish adults to assess public perception of self-harm. Whilst 89% felt SH was serious issue and more needs done to address it, 40% said they wouldn't know how to support someone. There was a high level of understanding about reasons for self-harm, with 84% viewing it as a coping mechanism for life stressors. Approximately a fifth (23%) also thought it was to seek attention, and 20% thought it was a passing phase. Interestingly, there was a common misconception regarding who was self-harming, with only 33% of respondents answering that it was mostly young people. Extensive stakeholder engagement by Samaritans also raised stigma as a key theme with recommendations for increased public awareness and engagement.

3.4 How has the mental healthcare system engaged with children and young people?

Engagement and co-production with young people was highlighted as a key component of service design by the CYP mental health task force (for policy and strategic context see also page 16)[89]. National work undertaken by the Youth Health Commission[90] which engaged extensively with young people identified several recommendations for improvements in mental health provision including broader availability of crisis support out of hours, standardisation of services (irrespective of geography) and reduction of waiting times for CAMHS. At a UK level, the 2020 All Party Parliamentary Group 'Inquiry into the support available for young people who self-harm'[37] identified a 'systems shift' to prevention and early intervention as the key most impactful change to improve support to young people who self-harm. This inquiry consulted extensively with young people and professional stakeholder groups.

Within NHS GGC, work has taken place to differing degrees between local authority areas to explore the views of young people regarding mental health services. At a whole-systems level, West Dunbartonshire and East Renfrewshire have conducted large-scale consultation exercises which have led to alterations in coordination and provision of support. East Dunbartonshire has also recently undertaken an HNA with a view to development of a youth health service, though actions from this are at an earlier stage.

3.4.1 West Dunbartonshire

A 2022 mixed-methods needs assessment undertaken by the University of Glasgow was commissioned by West Dunbartonshire to assess how best to implement a whole-systems approach to CYP mental health provision, with engagement of professional stakeholders, parents and young people themselves. For young people, school was described as the place where they would be most likely to get information about mental health, though they also highlighted the stress and pressures associated with academic expectations. Mental health stigma was also clearly apparent, with young males in particularly describing gender norms around mental health which may also lead to them seeking help online rather than in-person.

Respondent 1: 'Men just get told to like man up, like…'

Respondent 5: 'Suck it up.'

Respondent 1: 'Yeah stuff like man up and all that like 'you shouldn't be feeling that stuff. Only girls should cry, then obviously like women face issues as well but I feel like with the mental health is quite hidden. Not hidden, but like men get told to hide their emotions.'

Focus group participants from West Dunbartonshire HNA[91]*.*

Information supporting mental health which is available online was highlighted as potentially less effective as it may not reach the intended audience. Instead, a more diverse range of information sources were suggested which also included schools and social media.

'If you're putting stuff online, it's the luck of the draw if people find it or not. You can put it out there but whether or not young people find it. We can post it on the council website all you want but realistically how many young people are looking at the council website?'

Focus group participant from West Dunbartonshire HNA[91]*.*

A physical roadmap of mental health resources and services available within schools was suggested to ensure improved accessibility and visibility. The trustworthiness of sources was mentioned by most participants, with official and 'well known' sources of importance to finding reliable information online. Concerns were also raised about transitions between educational settings (e.g. secondary school to university) and between child and adult mental health services.

For parents, a need for knowledge sharing regarding general mental health management as well as tailored support for those whose child has a specific diagnosis was highlighted. Workshops similar to baby classes were also suggested for different ages and stages of development to keep informed and connect with other parents at similar stages. Transitions were also a concern for parents, particularly for neurodiverse children transitioning from primary to secondary school. Overall, there was frustration about a lack of visibility and communication of the supportive systems available within West Dunbartonshire.

3.4.2 East Renfrewshire

In response to distribution of Scottish Government money to support recommendations made by the CYP Mental Health Taskforce (see also page 16) and a specific increase in funding for school counselling services, East Renfrewshire HSCP undertook a co-production event in November 2019 which included professional partners as well as CYP and families to determine how best to target the investment[89,92]. Two key actions arising were the further development of school counselling provision to include upper Primary school and holiday periods and the commissioning of a new model of individual and family support which would work between home and school. Further funding has led to the development of the Healthier Minds Service Hub as well as a set of resources to upskill school staff and the wider workforce to react to escalating distress. The Healthier Minds Service Hub and its model for coordinated lower tier mental health support is discussed further on page 63.

3.4.3 East Dunbartonshire

East Dunbartonshire HSCP Public Health Improvement Team have recently undertaken a Youth HNA in conjunction with NHS GGC Public Health. Young people were directly engaged in this process through a series of focus groups and an online survey to understand young people's needs, existing supports and preferred options for a youth health service. A key theme which arose was the desire for better access to mental health services, particularly Tier 1 services. The HNA is still in consultation with stakeholders and is not at the time of writing publicly available. Next steps include findings being presented to the East Dunbartonshire Delivering for Children & Young People Partnership (DCYPP) and holding discussions with key partners on how to take forward the recommendations, ensuring that young people are involved in any future service development. Findings will also be provided to the groups of young people who took part in the HNA.

3.4.4 Engagement within schools

The schools engaged for this HNA showed responsiveness to the needs of pupils, with some implementing novel strategies based on their own consultation work. One such example was the use of QR codes in an Inverclyde high school to seek pastoral care support. The intention was to improve uptake by creating a discrete but highly visible way to seek help, in the hope of circumventing some of the stigma the teachers knew to exist. Data regarding evaluation are not available, however a similar approach has been taken in the USA with a large increase in requests for support[93]. This highlights the importance of ongoing dialogue to generate new ideas and intelligently design supportive systems which decrease barriers to access.

3.5 Discussion

Though self-harm was the focus of this HNA, the systems issues highlighted by teachers, CAMHS workers and school nurses are broader than this single issue. Struggles to meet demand for mental health support are evident across the system. Increased multi-disciplinary working is clearly desired, though day-to-day workload challenges hinder this from happening consistently. This was also captured by West Dunbartonshire's HNA (Page 55), where professionals involved in the care of young people citing lack of resources (63.6%), lack of time (57.6%) and lack of opportunity (45.5%) as common barriers to collaborative workiing[91]. Having structures in place to facilitate joint working on a regular basis, such as occurs in East Renfrewshire's Healthier Minds Screening Hub (Page 63) may go some way to address this. East Renfrewshire is a small HSCP area however with a relatively affluent population. Direct application to a much larger and/or more deprived populations would need careful planning and consideration.

Stigma is a common theme as highlighted by teachers and young people. It is also by no means a new problem. NHS GGC has undertaken work over the past decade to tackle mental health stigma, however it remains a deeply ingrained societal issue. Indeed, the effects of mental health stigma on young people can be profound and wide-ranging. A study[94] involving in-depth interviews of 22 young people with depressive symptoms found that stigma could be both public (initiated by others) and internalised (self-imposed) with consequences including increased social isolation, reduced self-esteem and a degradation of relationships. Stigma was also likely to foster secrecy instead of disclosure of mental health issues. Unfortunately, the evidence regarding stigma-reduction is limited,

with tested interventions found to have only small effects and for short timescales, the majority of which were education-based such as seminars and interactive discussions[95]. No specific research regarding interventions to tackle self-harm stigma was identified. Nonetheless, provision of service and supports should account for stigma when considering how young people disclose issues and seek help. Examples such as the use of QR codes in an Inverclyde high school are important, though further work would be required to evaluate uptake. Further discussion of actions taken following consultations in East Renfrewshire and West Dunbartonshire can be found on page **Error! Bookmark not defined.**.

4 Mental health provision and self-harm support for children and young people in NHS GGC

Summary and recommendations

Understanding patient pathways and where demand for mental health support lies - Demand for higher tier mental health support has grown dramatically, as evidenced by increasing trends in CAMHS referrals pre-dating the pandemic. This has been accompanied by increased public and political scrutiny, awareness of waiting lists and action to reduce waiting times. Data for most tier 2 services are not collated at a health board level, creating a more fragmented landscape from which it is difficult to gain overview. The true levels of demand for lower tier mental health services and waiting lists therefore remain unclear, though are likely to be substantial and increasing. This creates risks for achieving early intervention and has potential implications for CAMHS service planning and demand.

- ***Recommendation 4d -*** *NHS GGC should be able to readily assess demand for the mental health services it helps to provide in order to understand and identify gaps in service provision and service inequities. Where applicable, this may take the form of understanding patient pathways, waiting times for lower tier mental health services as well as overall service use.*

Shared organisational learning and consultation with CYP on mental health provision - Whole system consultation exercises with young people, families and professionals regarding the provision of mental health services have taken place in some HSCPs, leading to changes intended to improve service provision, coordination and ease of access. This includes the implementation of the Healthier Minds Screening Hub in East Renfrewshire and Community Wellbeing Hubs in West Dunbartonshire. Such consultation also occurs at individual service and school levels, leading to sometimes unique solutions with broader applicability. The sharing of learning, including valuable public feedback, from across and beyond NHS GGC is inconsistent which may contribute to missed opportunities for impact and inequities in service provision.

- ***Recommendation 4c*** *– NHS GGC should prioritise and facilitate sharing of learning regarding mental health and self-harm support across professional, organisational and geographical boundaries. Evidence generated for local consultation exercises should be broadly available for all HSCPs to use and extract applicable learning. Approaches to mental health provision from beyond NHS GGC, including other UK nations, should also be sought and disseminated.*

Self-harm training for professionals - NHS GGC has developed a range of training materials and courses around self-harm for professionals involved in the care of CYP. Challenges accessing this training due to high demand have been reported as well as the need to deliver training more tailored to clinical settings.

- ***Recommendation 1d –*** *Continued widespread dissemination of self-harm training should be supported to maximise opportunities for professionals to engage, with sufficient resource allocated to ensure continued improvement and evaluation. Where applicable, content should be tailored to specific professional groups to increase relevance.*

- ***Recommendation 1e -*** *Self-harm training activities and materials should highlight at risk groups identified in this HNA and provide the tools to proactively address self-harm risk and provide tailored support.*

Local self-harm policy documents – Though the majority of HSCPs in NHS GGC have developed self-harm guidance for professionals, feedback from different professional groups has highlighted that overall awareness of their existence may be limited.

- ***Recommendation 1f –*** *Local self-harm guidance documents should be maintained up-to-date and highly visible to frontline staff with caring responsibilities for CYP.*

4.1 Overview

In this section, the challenges in assessing demand for lower tier mental health services are examined. Following this, local responses to consultations exercises regarding mental health provision are discussed, along with consideration of the English model of lower tier schools-based supports. Finally, local self-harm resources and developments are explored.

4.2 Mental health service demand – CAMHS and school nursing

The landscape of tiers 1 & 2 services across NHS GGC is complex, with different provisions and arrangements between HSCP areas. In addition to pan-GGC services (e.g. CAMHS, school nursing), each HSCP area administers service provision differently. For example, counselling is commissioned to a variety of providers and certain areas have unique services, such as the Youth Health Service in Glasgow City. Educational Psychology also provides input at a schools level both to individual pupils and for service coordination.

Demand for higher tier mental health support has grown dramatically over recent years, as evidenced by increasing trends in CAMHS referrals pre-dating the pandemic. Evidencing this for tiers 1 & 2 services is challenging however. Unlike CAMHS, for which there is publicly available centrally collected data on waiting times (see below), data for most tier 2 services are not coherently collated at a health board level, creating a more fragmented landscape from which it is difficult to gain overview. A pluralistic range of data systems and direct reporting to Scottish Government further hinder understanding of population need.

4.2.1 CAMHS

CAMHS waiting times and referrals rates are collated nationally by PHS and are publicly available, with a dashboard active since June 2022[96]. Waiting times are broken down by health board and these can be compared nationally. Regarding treatment starting within 18 weeks, at 84.9% NHS GGC remains above the national average of 74.2% by quarter one of 2023. Though below the Scottish Government target of 90%, this nonetheless constitutes a clear increase from 62.9% in quarter one of 2022 (Figure 16).

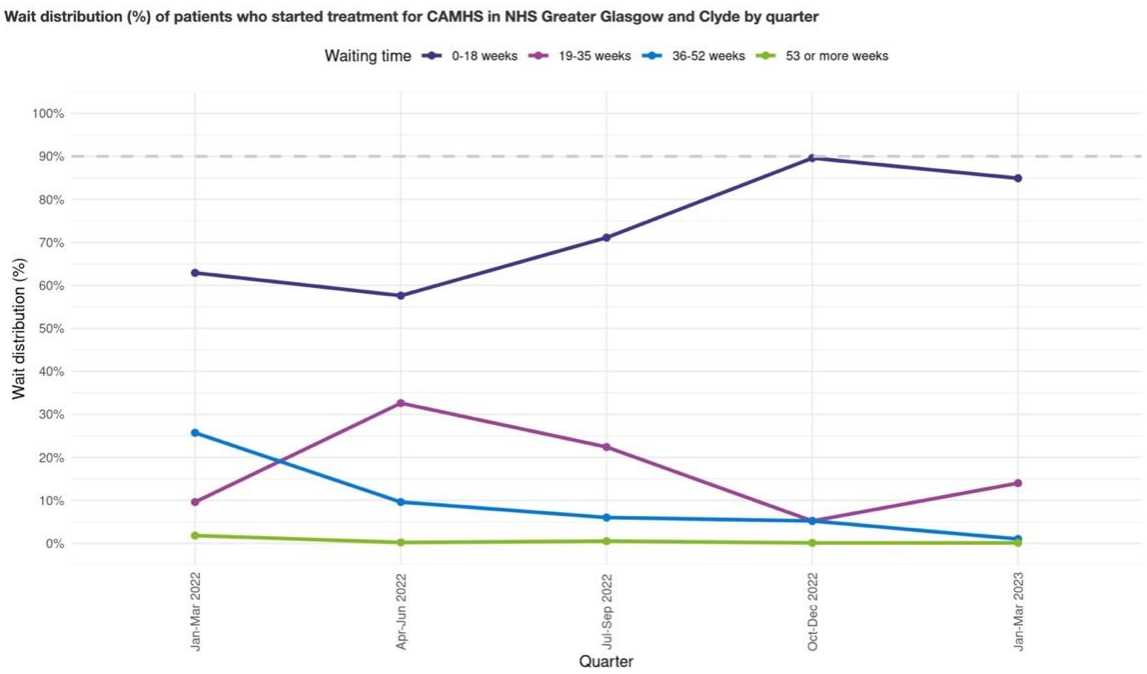

Figure 16 *Waiting times for CAMHS appointments for NHS GGC in 2022-23. Graph from PHS CAMHS waiting times dashboard[96] (screenshot).*

4.2.2 School nursing and mental health support

School nursing has undergone significant transformation in recent years with a large workforce expansion funded by Scottish Government. Full details are of this expansion are beyond the scope of this report but can be found in the Glasgow City 2023 IJB report[97]. Of the eleven priority areas and pathways originally developed by Scottish Government for school nurses to focus on, NHS GGC school nursing has prioritised and developed three; Emotional / Mental Health & Wellbeing, Child Protection and Vulnerability & Transitions[97].

School nurses spoken to for this HNA confirm that a significant proportion of their workload revolves around mental health support and that they regularly deal with self-harm. Demand was reported to be high, though this varied across HSCPs. Waiting times are not yet centrally collated by the service, however the 2023 Glasgow City IJB reported a 'a current waiting list of 1000 young people awaiting assessment'[97]. Interviews with Glasgow City school nurses indicated that this constituted an approximately 9-10 month wait. East Dunbartonshire and Inverclyde also reported a wait for intervention of several months, though the first assessment appointment in Inverclyde was reportedly prioritised to minimise the initial wait to be seen. In contrast, the East Renfrewshire team reported no current waiting list at all for their service. Several factors may play into this including higher need, differing referral pathways and differing awareness of the school nursing service.

Scottish Government were approached regarding waiting times for school nursing services and have confirmed that this information is not being collected. It was confirmed that they are aware of issues around longer waits in NHS GGC, though had no plans to gather further data at the time of writing.

4.3 Early intervention for mental health – stages of DBI rollout in NHS GGC

The roll-out of DBI services is at varying stages between HSCP areas at the time of writing (for further background on DBI see page 36). As of November 2023, Glasgow City, Inverclyde, East Dunbartonshire and West Dunbartonshire had a DBI service for 16 years and above. Though East Renfrewshire and Renfrewshire did not currently have DBI (as of December 2023), it was anticipated that this would go out to tender soon.

In addition to the 16+ services, CDRS in Glasgow City and the Scottish Association for Mental Health (SAMH) in West Dunbartonshire are trialling a service for 14-15 year olds with (initially) more limited referral pathways. In West Dunbartonshire, 42% of male referrals and 44% of female referrals to the service as a whole were for the 14-15 year old pathway, with the majority of referrals (67%) coming from education. This is likely indicative of the high levels of need in West Dunbartonshire also evidenced by admissions and primary care data in this report (pages 25 and 29). It is expected by Scottish Government that all HSCP areas will have a DBI service by March 2024.

A bespoke data report related to self-harm was provided by GAMH for the purposes of this HNA. Between June 2020 and March 2023, 70 referrals were made to GAMH where the person was between 16 and 18 and a risk of self-harm was identified, representing 23% of referrals of people in this age-group. In line with all other trends presented in this report, the majority of referrals (69%) were for females. Most people (81%) reported that they were not currently accessing mental health services. For referrals where socioeconomic status could be assessed, most were in either Scottish Index of Multiple Deprivation (SIMD) quintiles 1 (46%) or 2 (23%). CDRS report that they have made links with Penumbra's self-harm service (page 38) and have begun making onward referrals to them. At the time of engagement with CDRS, this was a new development and so numbers of referrals were still reportedly small.

CDRS staff have highlighted that they receive relatively few referrals from education services (approximately 6% of referrals to Young People pathway between April and December 2022), despite this being an agreed referral pathway. When this was raised at a focus group of pastoral teachers in Glasgow, few were aware that they had the option to refer on to CDRS. Whilst this is a small sample of teachers, this may reflect low awareness amongst teachers of the CDRS service more broadly.

4.4 Acting on feedback: System responses to the views of young people and families

As discussed on page 55, whole system consultation exercises for mental health provision have been conducted by West Dunbartonshire, East Renfrewshire and – more recently – East Dunbartonshire. Based on this feedback, systems have been re-structured in West Dunbartonshire and East Renfrewshire with the broad aims of simplifying access to mental health supports and facilitating cross-disciplinary working. As mentioned, the HNA in East Dunbartonshire has only recently been completed.

4.4.1 West Dunbartonshire

Many of the actions taken from the research have sought to improve cross-system working, with the opening of multidisciplinary community wellbeing hubs implemented at the end of June 2023. These hubs are intended to provide community support for families. In addition, a website ('West

Dunbartonshire Wellbeing')[98] was developed as part of a multi-agency project to address the research findings that visibility of services in the local area was low, with new services in particular finding it difficult to form relationships and connections across the system. The website also aims to provide CYP and their families as well as those who work with young people with the knowledge of local supports and services to help support mental health and emotional wellbeing. This website was launched in July 2023 and monitoring of uptake is ongoing.

A more integrated approach to some of the services that currently operate has also been taken, with access to school counselling services currently being negotiated. This is intended to open pathways for young people via education and primary care. A new triage post is being explored that will sit within primary care but will work across the system to help CYP navigate the system and services to ensure they are getting the right help at the right time. This post is still in the development phase.

Changes have also been made at a strategic level, with the establishment of the working group of strategic decision makers and the leadership provided by the Head of Children's Health, Care and Justice. This has reportedly facilitated and strengthened the establishment of cross system relationships. The whole system approach development sessions that were delivered when the work started also supported these changes.

4.4.2 East Renfrewshire – Healthier Minds

Healthier Minds is a tier 2 service run by East Renfrewshire HSCP which coordinates mental health support referrals via weekly multi-agency meetings. A range of partners are involved (Figure 17) which allows identification of the most appropriate support for each referral based on individual need. Healthier Minds was originally developed in November 2020 as part of COVID-19 recovery work in response to the consultation exercise discussed on page 56. The principal route of referral is from education, however any young person aged 10-18 years old can self-refer.

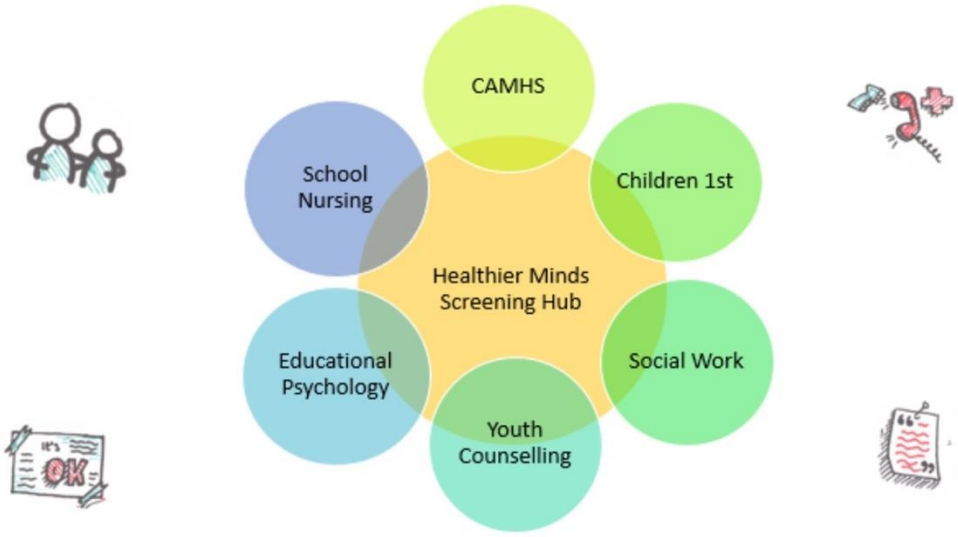

Figure 17 *Overview of services involved in the Healthier Minds Screening Hub operated by East Renfrewshire Health and Social Care Partnership (HSCP). Image adapted from East Renfrewshire HSCP 2021 Integration Joint Board Report (publicly available)[92].*

Around 1000 CYP were referred to the service over approximately 2.5 years (from initiation until April 2023). In around 15% self-harm was noted at the time of referral. Regarding methods, approximately 60% of self-harm was cutting. The average age of referrals was age 14. Approximately 15% of the 1000 total referrals were for self-harm, with around 60% of these for cutting and the large majority being for females. Mean age was however similar, with 14.1 years for females and 14.6 years for males. It is noted by staff that this is likely an underestimate, as self-harm disclosures will often come as part of the therapeutic process which were not recorded in the original referral data. All referrals were reviewed by the team as part of weekly meetings. Around half of the self-harm referrals were referred on for counselling, with those remaining having a range of other outcomes including the Healthier Minds Team, school nursing, CAMHS, Children 1st service and social work (numbers individually too small to disclose).

4.4.3 Actions arising from school surveys

The SHINE and Planet Youth school surveys referred to on page 19 have led to valuable intelligence and direct action. As a result of the Planet Youth survey, a multi-disciplinary team meeting was called to address clear and urgent mental health needs in the school population. Specific actions undertaken included a 'mental health day', wider communication with parents and improved mental health supports within the school. Pastoral care teachers at the Glasgow City high school also found the intelligence gained from the SHINE survey to be valuable in directing their efforts to meet mental health needs of their pupils. As previously stated, results of these surveys are not in the public domain and are not visible to healthcare services for planning purposes.

4.5 Mental Health Support Teams: The English model of tier 2 provision

The Children and Young People's Mental Health Trailblazer Programme is an ongoing programme jointly led by the Department of Health and Social Care, Department for Education and NHS England to trial an alternative model of lower tier mental health provision[99]. The programme was set up to take forward proposals set out in the Transforming Children and Young People's Mental Health Provision Green Paper in 2017[100]. The broad aims were to offer early intervention, reduce waiting times and improve access to services via direct outreach to schools from newly created Mental Health Support Teams (MHST). The MHSTs work was intended to have three core functions:

- Provision of direct support to CYP with mild to moderate mental health problems in the educational setting
- Support educational institutions with the introduction or development of whole institution approaches to mental health and wellbeing
- Direct provision of advice to staff and liaison with external specialist services

MHST provision has continued to expand from the original 58 'Trailblazer Teams', with 287 teams in operation across 4700 schools as of Spring 2022 and a further 100 commissioned for 2023. Approximately 500 are expected to be active by 2024. Each MHST is expected to have capacity to deliver services to approximately 7000-8000 pupils, or between 10 and 20 educational settings[101].

A National Institute for Health Research interim evaluation[99] for the 2020-2022 time-period found challenges posed by the pandemic, as well as relationship-building with education colleagues and staff retention. School staff reported feeling more confident regarding mental health issues and valuing having faster access to advice, though concerns were raised about pupils with mental health problems more serious than 'mild-to-moderate' but not serious enough for CAMHS.

4.6 Local self-harm resources

In this final section, local supports produced by NHS GGC specific to self-harm are explored.

4.6.1 Supports for young people and families

Ongoing work is being undertaken to develop supports and sessions for families via the NHS GGC Self-Harm Forum. A one hour introductory session from the What's the Harm training (see also staff training and support services below) has also been adapted for parents and caregivers which is deliverable by any What's the Harm trainer. The mental health charity Penumbra have developed an extensive suite of self-harm resources both for people affected and those around them[102,103]. This is currently the resource recommended by the NHS GGC mental health improvement team.

4.6.2 Teaching materials for young people

NHS GGC has developed On Edge, a set of lesson plans and materials for teachers and other professionals working with young people[104]. The lessons cover topics including understanding self-harm, dealing with difficult feelings, exploring stereotypes and getting help. There was broad awareness amongst teachers interviewed for this HNA regarding On Edge. Though all schools received a copy during roll-out of the resource, it is not known what the current uptake of On Edge is in NHS GGC.

4.6.3 Staff training and support services

What's the Harm Awareness and Skills Training is a full-day training programme developed in-house by the NHS GGC Mental Health Improvement Group. Participants come from a broad range of professional backgrounds including both healthcare and education. Core content seeks to educate participants regarding the reasons for self-harm, address commonly held misconceptions and provide strategies to support people who self-harm. A key component of this an understanding of self-harm as a maladaptive coping strategy and response to distress, along with steps that can be taken to support the person who is self-harming whilst employing a harm-minimisation approach.

Due to the limited resource within the Health Improvement team to deliver What's the Harm directly, a capacity building approach using a 'train the trainers' model (T4T) has been employed, with T4T delivered to Educational Psychology across all six Education Directorates within GGC. Further examples of capacity building can be found in Glasgow City, where Educational Psychology are seeking to embed a trainer within each Learning Community (a combined unit of nurseries, primary schools and a secondary school which feed into each other as children progress through their education careers). Though progress was hampered by the COVID-19 pandemic, work is still underway to continue this process.

To support the delivery of training for professionals working with young people, a Whole School Approach to Self-Harm framework has been developed which specifies three levels of knowledge and skills; 'Informed', 'Skilled' and 'Advanced' (Figure 18).

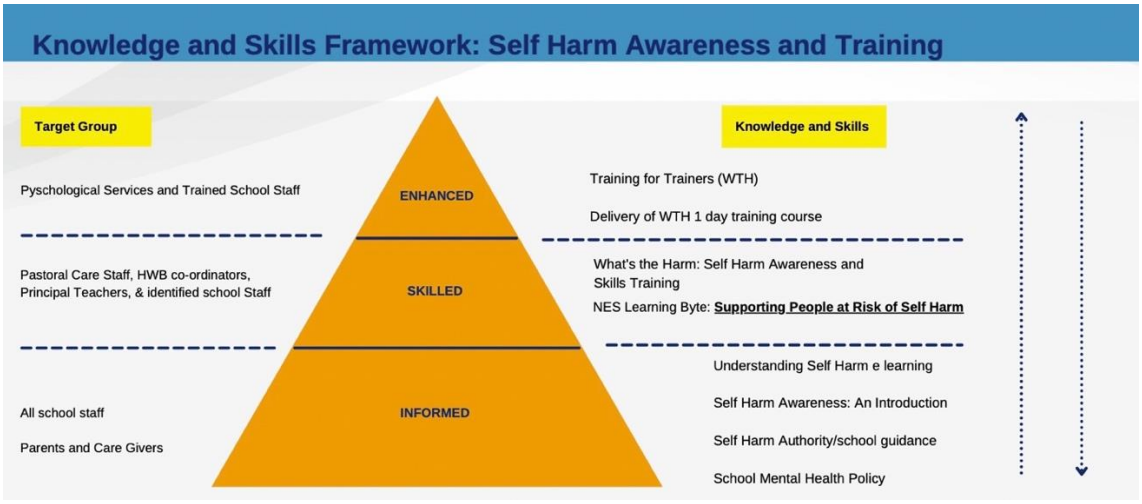

Figure 18 *Summary image of the NHS GGC Whole School Approach to Self-Harm Awareness and Training: A knowledge and Skills Framework* [105].

Awareness regarding What's the Harm was mixed within focus groups of teachers, though difficulty accessing training places due to demand was also reported. There was consensus that such training would be important, however challenges were cited regarding work capacity and difficulty identifying suitable time to take a day away from school.

Building on What's the Harm, East Renfrewshire Educational Psychology have developed training for self-harm to suit local requirements (Figure 19). The East Renfrewshire Self-Harm framework[106] specifies four incremental levels of training which runs for all staff (level 1) through to staff who have completed specific self-harm training and are likely to be working with young people who have self-harmed or are likely to self-harm (level 4).

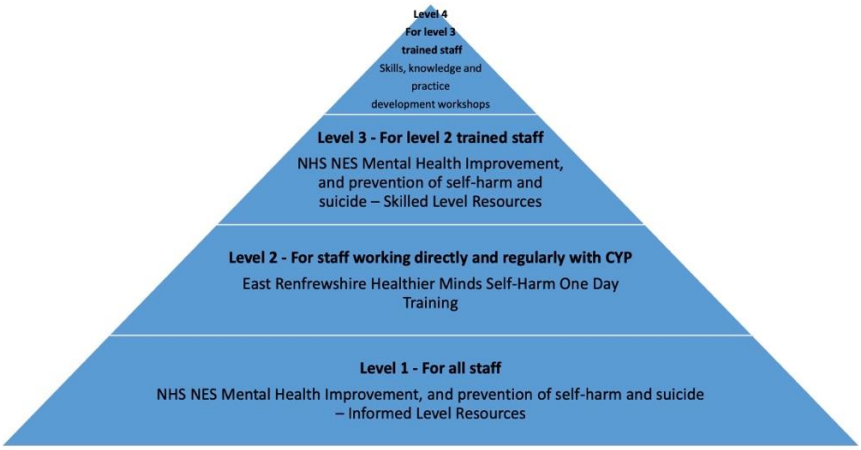

Figure 19 *Image summarising the East Renfrewshire Self-Harm framework*[106] *specifying the levels of knowledge and skills required for staff dealing with children and young people.*

Guidance documents have also been developed at an HSCP level. Of the six NHS GGC HSCP areas, five (West Dunbartonshire[107], Inverclyde[108], East Dunbartonshire[109], Glasgow City[110] and Renfrewshire[111]) have a self-harm guideline with East Renfrewshire's reportedly still in development. Broadly, all cover

reasons for self-harm, warning signs, escalation pathways, communication techniques and risk assessment, with links to local supports. There is a large degree of overlap between these documents. It is unclear how visible these guidelines are to frontline staff overall, with some stakeholders interviewed being unaware of their existence.

4.7 Discussion

A coherent overview of tier 2 mental health provision supply and demand is notably absent at NHS GGC level, hindering understanding of CYP population mental health need. It is clear that CYP mental health has deteriorated over the previous decade, a trend which has been catalysed by the societal restrictions enacted during the COVID-19 pandemic (page 15). What is less clear however is where the burden of demand for mental health support sits overall. Currently, tier 2 services operate within a pluralistic set of data systems. Reporting from these systems is often direct to Scottish Government, bypassing the healthcare system. Furthermore, the information that is reported does not include waiting times; a key measure of demand and capacity within the system to meet population need. It would be challenging to make a comprehensive and evidence-based case for additional resource and funding from a whole system level in such a fragmented data landscape. Visibility across the different systems is also poor, with awareness of developments in adjacent HSCP areas highly variable.

Each HSCP area administers mental health provision differently, both in terms of the types of services (e.g. Youth Health Service being unique to Glasgow City) and their overall coordination. The Healthier Minds Service Hub is the only example in NHS GGC where the system is designed to formally coordinate referrals to lower tier mental health supports at a whole systems level. Teachers in other areas of NHS GGC report difficulty in timely access to these supports for their pupils. The 'scattergun' approach to referrals used by some (page 49) may be leading to inefficiencies in the system, with young people waiting simultaneously (and perhaps unnecessarily) on more than one waiting list. Corroborating this, school nurses report having little visibility over who is waiting for what. Quantifying this is challenging and is further compounded by the lack of overview of lower tier mental health service demand (page 60). A more detailed and up-to-date understanding of the pressures faced by lower tier services may help address these issues. Notably, the single point of access model provided by Healthier Minds also allows for comprehensive data collection including providing a richer and more detailed picture of self-harm in the community. Consideration of a similar approach in other HSCP areas may be of benefit.

A large amount of work has gone into producing resources to assist professionals in supporting self-harm. Access and capacity to attend training remains a challenge, though efforts are ongoing to address this with the capacity building train the trainer model. The majority of HSCPs have produced local self-harm guidance, though it is unclear how broad the awareness is of their existence amongst education and healthcare professionals. As previously mentioned, teachers have expressed desire for authoritative resources and guidance (page 53) to support families around self-harm. This is under development, however it would seem that visibility of the resources at the front line rather than availability may be more of an issue. Engagement with education professionals may be required to assess how best to provide information so that it is readily accessible at the time it is required.

5 Conclusion

This work has sought to assess the needs of children and young people who self-harm in NHS Greater Glasgow and Clyde (GGC). Through a combination of information sources including surveys, service data, academic literature, interviews and focus groups of teachers and mental health workers, the report has built a picture of self-harm as a common, impactful and likely increasing issue amongst our young population.

Despite the findings laid out in this report, our understanding of population need around self-harm remains incomplete. Self-harm often remains hidden, sometimes for years, with only a minority of young people ever seeking help. Not only does it affect the person involved, it can also be highly impactful to families as well. Stigma around mental health and self-harm also remains pervasive and is likely a significant barrier to young people getting the support they need. Against this backdrop, social media will continue to remain a key challenge, requiring a nuanced approach which understands this technology to be both a help and a hindrance to good mental health.

Whilst self-harm is the focus throughout, it does not exist in isolation of other health and social issues. Addressing these may help to alleviate the underlying reasons why self-harm is being used. Wider systems issues including lack of joined up working and difficulties accessing timely support have been highlighted by professionals across the system. There are no straightforward solutions to address these. The landscape is complex, variable and is under considerable strain due to increasing demand and fiscal pressure.

We hope that the recommendations – structured to align with the Self-Harm Strategy – will inform future work and improvements across Healthcare, Education and beyond. Much remains to be done.

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7 Appendix A - Self-harm definitions

Self-injurious behaviours encompass a range of actions and thoughts involving deliberate, non-fatal self-directed self-harm[11]. More than 33 terms have been used in the literature to describe self-harm (SH), including self-injury (SI), deliberate self-harm (DSH), self-mutilation, self-inflicted violence, self-injurious behaviours and non-suicidal self-injury (NSSI), of which SH, DSH and NSSI are most often used[12].

Self-harm is often dichotomised as to whether there was suicidal intent, with NSSI frequently used to describe self-harm without suicidal intent[13]. NSSI has become increasingly used in North America and has been formally recognised in the Diagnostic and Statistical Manual of Diseases (DSM-V)[14]. Whilst this may improve standardisation of research and improve prevalence estimates[14], this is not without controversy given the well-established association of self-harm with subsequent suicide[15] and the difficulty ascribing intent (both by the individual self-harming and medical professionals)[13].

Taking a broader approach, the NICE define self-harm as 'intentional self-poisoning or injury, irrespective of the apparent purpose'[16]. Given the issues described above, this HNA does not formally distinguish between non-suicidal and suicidal self-injury and will instead adopt the NICE definition as quoted.

8 Appendix B - Methods

This HNA was conducted between January and July 2023 and can be broadly split into three sections; self-harm data, stakeholder engagement and literature review.

8.1 Ethical approval

Ethical approval was not sought due to the service-improvement nature of this project. Young people were not directly engaged for the main aspect of this HNA, with the exception of a standalone qualitative component undertaken by NHS GGC mental health improvement group (page 41).

8.2 Self-harm data

8.2.1 Population and service data

Analysis of routine data from primary and secondary care was analysed. Further data from surveys were kindly provided and were of benefit given the lack of larger survey data. It was not possible to analyse CAMHS data specific to self-harm. Given the lack of routine data available, estimates from academic data were been used.

8.2.2 SHINE survey (page 19)

SHINE currently encompasses 617 schools across 32 Scottish local authority areas. Reports are produced at the school level which provide intelligence on the state of mental wellbeing amongst pupils. Schools have individual control over the results of their survey and are encouraged by SHINE to share findings widely with pupils, families and staff[28]. Answers to questions about self-harm which are provided in school-level mental health survey reports are not in the public domain. Permission

has been granted by the school in question to present the data on an anonymised basis; technical details including sample-size and school SIMD characteristics have therefore been omitted to preserve school anonymity.

8.2.3 Acute hospital admissions (page 25)

Data are presented for acute admissions due to self-harm for patients aged 0-19 years in calendar years 2017 – 2022. A single admission is termed a continuous inpatient stay (CIS) and includes any transfers between departments or hospitals until the time of discharge. These data do not exclude readmissions for the same patients with more than one CIS and do not reflect length of stay or treatment given. Population denominators were derived using National Records of Scotland (NRS) mid-year population estimates for 2021[112].

8.2.4 Primary care presentations for self-harm and suicidality (page 28)

The Scottish Primary Care Information Resource (SPIRE) is a secure platform administered by Public Health Scotland which allows extraction of primary care data at practice, cluster, locality and national levels[113]. It is used for a range of functions including quality improvement, service planning and public health intelligence gathering.

A bespoke data request was submitted to SPIRE for self-harm presentations to primary care in NHS GGC for 10-18 year-olds from 2015 – 2022. Primary care data rely on the clinical coding of events and diagnoses using Read terms[114] which cover a multitude of self-harm situations. Based on a previous data request held by the SPIRE team, Read terms were grouped according to 'self-harm risk', 'event of suicidal attempt / self-harm' and 'self-harm assessment'.

Data were extracted by the SPIRE team at aggregate (practice) level to circumvent additional ethical considerations warranted with individual-level data given the timeframe of this HNA. It is not however possible with aggregate data to investigate outcomes including onwards referral. Denominators were derived from estimated annual coverage by SPIRE of the local target population. Analyses were conducted using RStudio version 1.4.1717. Analyses of Inverclyde, Renfrewshire and East Renfrewshire were not possible due to limited coverage of GP practices by the SPIRE system, with smaller numbers in these areas increasing the risk of individual patient identification.

8.3 Stakeholder engagement

One-to-one interviews were conducted with stakeholders with representation from CAMHS, educational psychology, Health Improvement (Public Health, HSCP), Penumbra, CDRS, teachers, school nursing, Scottish Government, academia, PHS and the Youth Health Service. These interviews were not formally transcribed, though served to inform much of the conduct and content of this report. All HSCP areas have been represented in this process.

Four focus groups were held between March and May 2023. Two were with pastoral care teachers from Inverclyde and Glasgow City. Two focus groups were held with the intensive CAMHS team and the community CAMHS clinical coordinators. These sessions were recorded and transcribed for which verbal consent was obtained from all participants. Recordings and transcriptions are kept on NHS computer systems. Analysis was conducted thematically.

8.4 Safety consideration and ethics for focus groups of young people (page 41)

Due regard was paid to the safety of all participants and an ethical framework was developed prior to the focus groups being held. All participants were provided with an information sheet and completed a consent form prior to participating. They also completed a CORE-10 form before attending the focus groups to ensure that no one in distress participated. During the sessions, two trained psychotherapists were in attendance – one delivered the session, while the other offered a safe space for de-escalation if someone was triggered and needed to step away from the group. Following the focus groups, all participants were provided with a verbal debrief, a range of signposting information, and completed an additional CORE-10 form to ensure that the focus groups had not caused distress. While a situation did not arise where someone was seen to have been in greater distress following participating in the group, processes were in place to refer them on to further support should it have been required.

8.5 Literature review

A formal systematic review was not carried out for this HNA given the 2023 review of reviews by Buckton et al.[42] (Public Health Scotland) on risk factors for CYP self-harm and the recently published systematic reviews on primary and secondary prevention of self-harm[52,59]. A narrative review approach was therefore adopted for discussion of the evidence was required.

9 Appendix C – Strengths and difficulties questionnaire

The SDQ is a 25-item questionnaire grouped thematically by emotional problems, conduct, hyperactivity, peer-problems and social pro-social behaviour. Items are scored as 'Not true', 'Somewhat true' and 'Certainly true'. Scores for each category are summed and categorised as 'normal', 'borderline' and 'abnormal'[17,115]. For the WEMWBS, pupils were asked how often they had thoughts and feelings relating to 14 positively worded statements regarding their mental wellbeing. Each statement is scored on a five-point scale ranging from '1-None of the time' to '5-All of the time'. Scores can range from 14 to a maximum of 70[115,116].

10 Appendix D - Population profile

10.1 Epidemiological profile of the 10-18 year old population in NHS GGC

An epidemiological profile by age, sex and deprivation for the population of 10-18 year-olds in NHS GGC is provided below. Mid-year population estimates for 2021 from NRS[24] broken down by age, deprivation and local authority area were used. Deprivation is defined using the Scottish Index of Multiple Deprivation (SIMD), an area-based composite score encompassing income, employment, education, health, access to services, crime and housing[25]. Analyses were conducted using RStudio version 1.4.1717.

10.2 Population demographics

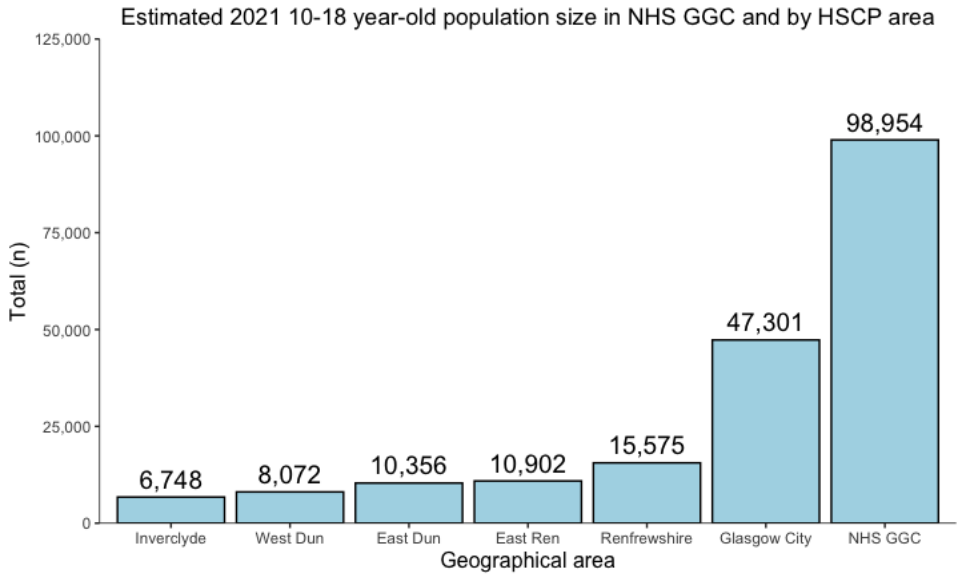

Figure 20 *Number of 10-18 year olds in NHS GGC and by HSCP area. Derived from NRS 2021 mid-year population estimates.*

In total, there were an estimated 98,954 10-18 year-olds in NHS GGC in 2021 (Figure 20), with Inverclyde estimated to have the fewest (n=6748) and Glasgow City the most (n=47,301). For NHS GGC as a whole, the estimated distribution by year of age was broadly similar, with an overall downward trend from 10 years old (n=13,553) to 18 years old (n = 11,794). Stratified by sex, there were similar estimated numbers of females (n=48,138) and males (n=50,816) in 2021.

10.3 Deprivation

The distribution of deprivation varies markedly when broken down by local authority area (Figure 21), with Glasgow City having the highest proportion of young people in SIMD 1 (50.2%), followed by Inverclyde (44.2%) and West Dunbartonshire (43.6%). Renfrewshire had a relatively flat distribution, with 23% in SIMD 1 and 23% in SIMD 5. In contrast, more than half of young people in East Dunbartonshire and East Renfrewshire were in SIMD 5 (52.8% and 56.1%, respectively) with comparatively low proportions of young people in SIMD 1 (4.5% and 5.3%, respectively).

Figure 21 *Deprivation scores for 10-18 year olds in NHS GGC broken down by local authority area. Derived from NRS 2021 mid-year population estimates[112].*

11 Appendix E - SPIRE population coverage and clinical codes

11.1 Population coverage by SPIRE system

Health Board	*Total Practices*	*Practices included in Spire extract*	*Completeness (% practices)*	*Completeness (% population)*
NHS Greater Glasgow and Clyde	231	177	77%	71%
Health & Social Care Partnership	Total Practices	Practices included in Spire extract	Completeness (% practices)	Completeness (% population)
East Dunbartonshire	15	14	93%	93%
East Renfrewshire	15	3	20%	14%
Glasgow City	144	131	91%	84%
Inverclyde	13	3	23%	35%
Renfrewshire	28	11	39%	35%
West Dunbartonshire	16	15	94%	97%

Note: completeness as % of the population is based on all ages.

11.2 Clinical codes used for query of SPIRE system

Group	Read code	Description
Self Harm risk	1BD1.	Suicidal ideation
	1BD2.	Morbid thoughts
	1BD3.	Suicidal plans
	1BD4.	Suicide risk
	1BD5.	High suicide risk
	1BD6.	Moderate suicide risk
	1BD8.	At risk: deliberate self harm
	1BDA.	Thoughts of deliberate self harm
	1BDB.	Plans for deliberate self harm without intent
	1BDC.	Intent of deliberate self harm with detailed plans
	1BDD.	Unknown risk of deliberate self harm
	1BDE.	Suicide risk increased from previous level
	1BDF.	Suicide risk unchanged from previous level
	1B19.	Suicidal
	9j2..	Initiation of suicide risk management document

Summary

1BD..% Harmful thoughts (except 1BD7. and 1BD9.)

1B19. Suicidal

9j2.. Initiation of suicide risk management document

Event of suicidal attempt / self harm	TK0..	Suicide and selfinflicted poisoning by solid and liquid substances
	TK1..	Suicide + selfinflicted poisoning by gases in domestic use
	TK2..	Suicide and selfinflicted poisoning by other gases and vapours
	TK3..	Suicide and selfinflicted injury by hanging, strangulation and suffocation
	TK4..	Suicide and selfinflicted injury by drowning
	TK5..	Suicide and selfinflicted injury by firearms and explosives
	TK6..	Suicide and selfinflicted injury by cutting and stabbing instruments
	TK7..	Suicide and selfinflicted injury by jumping from high place
	TKx..	Suicide and selfinflicted injury by other means
	TKz..	Suicide and selfinflicted injury not otherwise specified
	TKy..	Late effects of selfinflicted injury
	U20..	Intentional self poisoning by and exposure to noxious substances
	U21..	Intentional self harm by hanging, strangulation and suffocation
	U22..	Intentional self harm by drowning and submersion
	U23..	Intentional self harm by handgun discharge
	U24..	Intentional self harm by rifle, shotgun and larger firearm discharge
	U25..	Intentional self harm by other and unspecified firearm discharge
	U26..	Intentional self harm by explosive material
	U27..	Intentional self harm by smoke, fire and flames
	U28..	Intentional self harm by steam, hot vapours and hot objects
	U29..	Intentional self harm by sharp object
	U2A..	Intentional self harm by blunt object
	U2B..	Intentional self harm by jumping from a high place
	U2C..	Intentional self harm by jumping or lying before moving object
	U2D..	Intentional self harm by crashing of motor vehicle
	U2E..	Self mutilation
	U2y..	Intentional self harm by other specified means
	U2z..	Intentional self harm by unspecified means

	U720.	Sequelae of intentional self-harm
	14K1.	Intentional overdose of prescription only medication
	1JP..	Suspected drug overdose

Summary

TK..% Suicide and self inflicted injury

U2..% Intentional self-harm

U720. Sequelae of intentional self-harm

14K1. Intentional overdose of prescription only medication

1JP.. Suspected drug overdose

Self Harm assessment	388s.	Pierce suicide intent scale score
	38B0.	Suicide risk assessment
	38B9.	Assessment of risk for self harm

12 Appendix F - Public Health Scotland mental health indicator set

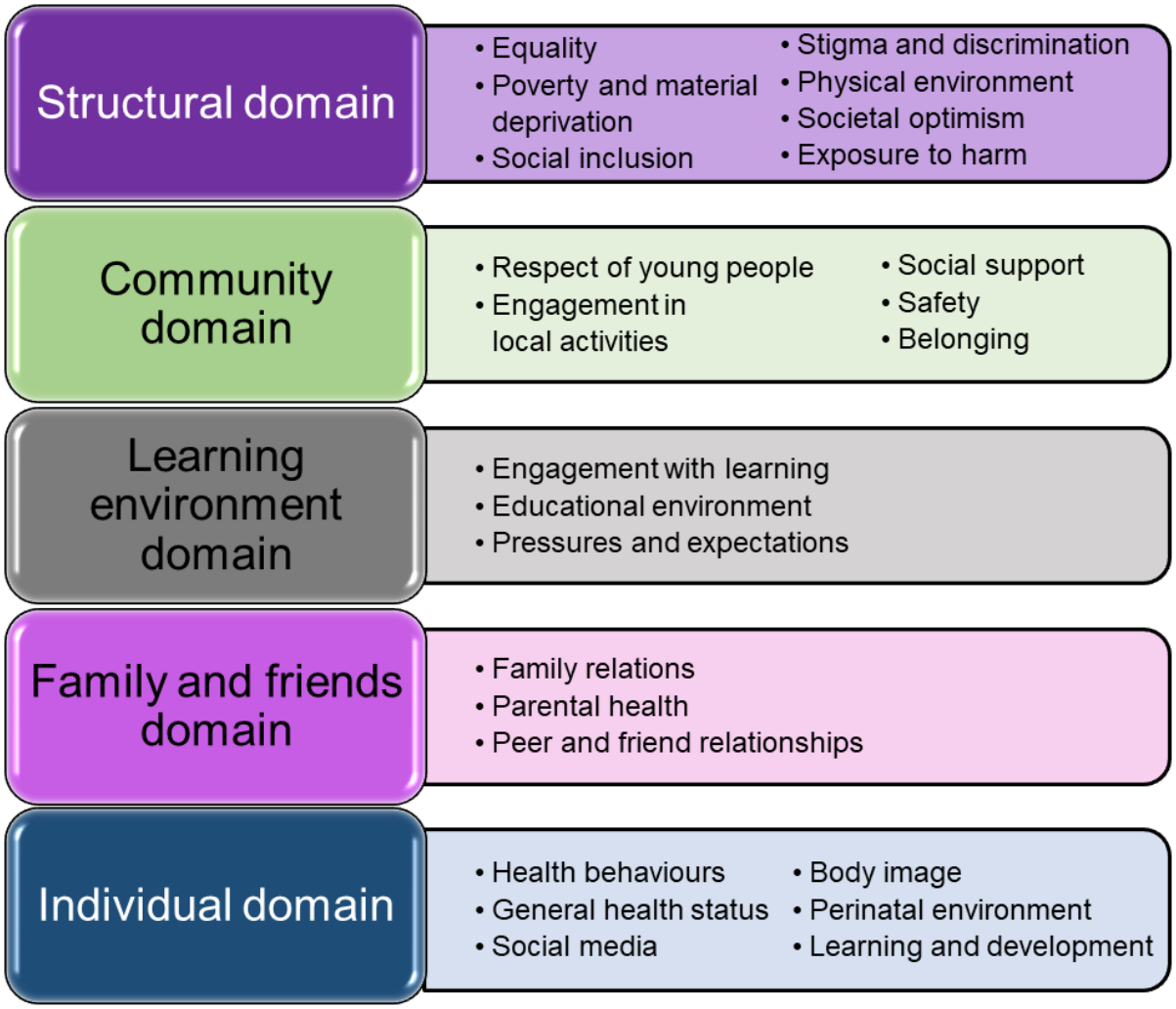

Figure 22 *Public Health Scotland mental health indicator set[43]. Image adapted from Buckton et al[42].*