Inquiry into the support available for young people who self-harm

A report by the All-Party Parliamentary Group on Suicide and Self-Harm Prevention

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All-Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. The views expressed in this report are those of the inquiry panel only, acting in a personal capacity, based on the evidence they received and heard during the inquiry.

About the inquiry

This inquiry was carried out by a panel of parliamentarians on behalf of the APPG on Suicide and Self-Harm, with support provided by Samaritans.

The panel consisted of members of the House of Commons and the House of Lords. They were:

Liz Twist MP (Labour) – Chair of the APPG on Suicide and Self-Harm Prevention and the inquiry

Jackie Doyle-Price MP (Conservative)

Jason McCartney MP (Conservative)

Bambos Charalambous MP (Labour)

Mary Glindon MP (Labour)

Baroness Tyler of Enfield (Liberal Democrat)

Baroness Finlay of Llandaff (Crossbench)

The panel would like to thank all those who submitted evidence to the inquiry. The panel would particularly like to thank those who gave oral evidence to the inquiry and who gave up their time to meet with panel members.

The panel is grateful to the mental health charity Young Minds and to Student Life, a charity led by young people which works in Kent, Sussex and Suffolk, who facilitated young people with lived

experience of self-harm giving oral evidence to the inquiry. Pseudonyms have been used for all young people who gave evidence to protect anonymity.

We would also like to thank the representatives of NHS England, Public Health England, Royal Colleges, third sector organisations, academics and others who attended a roundtable held under the Chatham House Rule in order to help us develop the terms of reference for the inquiry.

This report was drafted with help from Joe Potter, Policy Manager at Samaritans.

Terms of reference for the inquiry

This inquiry explored the experiences of young people who self-harm in accessing support services. In particular, it examined:

- Support services currently available in both clinical and the wider community settings (including schools)
- Plans for improving and expanding this support
- The changes needed to ensure that support is made more effective and widely available

It focused on the following questions:

- **Are commonly available services for young people who self-harm effective in supporting them?**
    - What needs to change to ensure these services are made more effective for this group specifically?
- **What are the main barriers faced by young people who self-harm in accessing and receiving support services?**
    - Are there specific groups of young people who face particular challenges in this regard?
    - How can these barriers be removed?
- **What impact do normalisation and stigma have on young people who self-harm getting support?**
- **What examples of effective services for young people who self-harm currently exist?**
    - What makes these services effective?
    - Are there specific examples of good practice to highlight?
- **What types of support not commonly available at present should be considered for supporting young people who self-harm?**
- **What specific policy opportunities exist for improving the support available to young people who self-harm?**

The Covid-19 pandemic arrived in the UK during the evidence collection phase of the inquiry. In response, additional questions on this topic were put to witnesses in the oral evidence sessions.

Scope of the inquiry

- This inquiry focused on the experience of young people up to the age of 25, given the high and rising rates of self-harm among this group.
- The inquiry focused on the experience of people accessing services in England, reflecting the devolved responsibility for health services in other nations.

Foreword

In recent years, we have made huge strides as a society in having more open, honest conversations around mental health. Self-harm, though, remains a taboo subject which is obscured by stigma and shame.

It is easy to understand why. The difficulty of understanding why someone may hurt themselves and fear of making things worse can stop us engaging with this difficult issue at all.

Yet that is simply not an acceptable response for parliamentarians and policymakers.

Levels of self-harm continue to rise and if a young person in England is harming themselves right now, it's more likely than not that that they'll receive absolutely no statutory support at all.

We began this inquiry because we knew this needed to change, but we did not know how.

The Government has had a number of plans in train for some time now to reduce the incidence of self-harm and increase support for those who self-harm. We found that that these plans are not moving fast enough. This means that for many, these plans aren't being translated into improved support for young people often enough, and action is still far too focused on crisis intervention alone.

The inquiry heard repeatedly of the need for early intervention and prevention, and the value of programmes which work with young people to help them to manage their emotions before they reach a crisis.

The need for such a shift towards a preventative approach to supporting young people who self-harm is at the heart of this report. Tackling issues before they escalate will help to reduce demand for expensive, specialist services which only arrive once the person is in crisis, and in so doing will help to put the NHS mental health services on a more sustainable footing.

But more important than the benefits to our health service is the simple principle: no young person should ever suffer alone, damaging their own bodies to try to find escape.

My colleagues on the APPG and I will not stop fighting until the Government implements a credible, detailed plan to make that principle a reality.

I should like to thank all those who gave evidence to the inquiry, especially the young people with experience of self-harm, and of course my fellow-panellists for their thoughtful contributions.

Liz Twist MP

Chair, APPG on Suicide and Self-Harm Prevention

Table of Contents

Executive summary

Respondents to the inquiry made clear that the single most impactful change to improve the support available to young people who self-harm would be a system shift away from the current reliance on crisis interventions towards a preventative model of support. To facilitate this long term aim, planned investment in NHS mental health support for young people should be increased and brought forward more quickly than currently planned. Investment in community-based preventative services, often delivered by the third sector, will also be key.

At the end of 2017 the Government committed to 'earlier intervention and prevention' in mental health support for young people.[1] Almost three years later, evidence received by the inquiry shows there is still much progress to be made in this regard. Young people need to receive support much sooner than at present, before their mental health needs escalate and their self-harming behaviour is more likely to become habitual.

For some young people who self-harm, specialist mental health support will be the best option from the outset. For many, though, a lower-level community-based intervention which arrives earlier and addresses the wider drivers of their self-harm would be most effective. Self-harm should be understood as the presenting behaviour for a set of underlying social or emotional problems or traumas to be addressed.

"I wouldn't have cost the NHS so much if I was helped earlier. I was in a much better place when I presented than when I was admitted." Jess

Respondents told the inquiry that the current system of support should be flipped on its head. Rather than providing specialist mental health support only once a young person reaches crisis point, the Government should focus long-term investment in early intervention provided by wider community-based services, as well as alternative third sector support specifically for self-harm. This shift must take place alongside and in addition to investment into specialist mental health support such as CAMHS and IAPT in order to reduce waiting times, lower thresholds and increase specialist knowledge and support around self-harm.

The policy background

Concerningly, rates of self-harm are increasing among every age group and across genders. This increase has been more pronounced in young people and particularly young women. As rates increase and the evidence base for the link between self-harm and suicide becomes clearer, greater prominence has been given to tackling self-harm in local and national suicide prevention plans. There have also been a number of important commitments by NHS England in recent years in terms of supporting young people who self-harm. This includes investment to increase the capacity of specialist mental health services and improving mental health crisis support as outlined in the NHS Long Term Plan.[2] Recent government investment in preventative mental health support in schools and colleges

through the introduction of Mental Health Support Teams (MHSTs) was widely welcomed by respondents to the inquiry.

This list of commitments is only a snapshot of the work already going on at a national level. It will take time to make a full assessment of whether these various plans and investments result in improved support in the long term. The inquiry found that at present, however, recent policy advancements are not consistently being translated into effective support 'on the ground'. The inquiry received evidence that many young people who self-harm still struggle to access the support they need in an acceptable timeframe. Constructive written evidence received from the Department of Health and Social Care (DHSC) acknowledged the scale of the challenge it faces in this regard.

Capacity and demand

The inquiry heard that while budgets for preventative interventions (whether through schools and colleges or wider community-based youth services) have been markedly reduced in recent years, demand for specialist NHS mental health services such as CAMHS and IAPT has increased exponentially, outstripping investment and exacerbating workforce issues. This has led to longer waiting lists, higher thresholds and, in turn, more refused referrals of young people who self-harm. The Government's target of 35% of young people who need mental health support receiving it by 2020/21 still leaves two thirds without crucial help.[3] The inquiry learnt that these problems are likely to be exacerbated by the Covid-19 pandemic, which began mid-way through the inquiry and greatly impacted the provision of mental health services, which have had to quickly adapt to provide support remotely.

Referrals of young people to NHS mental health services dropped dramatically under lockdown and, at the time of writing, are starting to increase again. The inquiry received evidence from professionals working on self-harm which expressed grave concern regarding the demand that is likely to be placed on the system post-lockdown, its ability to cope with this demand, and the impact that this will have on some of the most vulnerable young people in our society.

Barriers to support

Demand for mental health services outstripping capacity predates the Covid-19 pandemic and has led to the exclusion of young people from those services on the basis of their self-harming behaviour. The inquiry took evidence from young people who had been 'bounced' from one service to another, in crisis and struggling to get the help they needed. There are particular groups of young people, such as those from ethnic minorities, those who identify as LGBT, or are autistic, who particularly struggle to access support due to problems with service outreach and design. Much more needs to be understood about the specific interventions which work to help young people when they are self-harming, particularly for those who are most at risk and currently disproportionately struggle to access support. Evidence received by the inquiry made clear that there is a lot of promising work going on around facilitated peer support, both online and in person. More evidence is needed around how this can be undertaken most effectively and safely for a range of young people. Young

people, especially those most likely to struggle to access current services, must be involved more consistently in their design and delivery.

The inquiry heard that stigma remains a powerful and problematic force, which continues to inhibit help seeking and negatively impacts the effective design and delivery of services. To combat this, education around self-harm remains of paramount importance at all levels of society, alongside improved and expanded training for professionals who come into contact with young people who self-harm.

A shift towards prevention

The Children's Commissioner has asserted that a comprehensive system of mental health support for children and young people is ten years away[4]. Such a projection should act as a challenge to all involved in the system to realise this sooner. It should also prompt consideration of the extent to which the trajectory for statutory mental health support set out in the NHS Long Term Plan will contribute to a better, more comprehensive offer for young people who self-harm specifically. What should statutory support look like for young people who self-harm? What wider network of support should it form a part of? And, crucially, when should support arrive in the journey of a young person who is struggling?

Anyone who requires specialist mental health support should receive it when they need it. Evidence to the inquiry, however, made clear that not all young people will require such care. For some, a lower-level community-based solution arriving earlier, before needs become more severe, would be more appropriate. The current system of support has developed to compensate for years of underfunding to focus on crisis-interventions, but this can and should be changed. There is both a human and financial case for early intervention, with one study estimating the overall annual cost of general hospital management of self-harm at £162 million per year.[5]

"At a young age, you have to do something drastic to get support." Josh

Alongside investment in statutory specialist mental health services to reduce waiting times, lower thresholds, and increase capacity to deal with self-harm, local authorities need to be better supported by central government to invest more consistently in community-based self-harm prevention services. It became clear through the course of the inquiry that voluntary organisations and charities play a crucial role in providing support for young people who self-harm, filling the gaps in statutory services and also providing alternatives to them. Despite this, it was also noted in evidence that the sector's reach and responsiveness is limited by capacity issues, exacerbating regional discrepancies in care. Young people who self-harm struggle to navigate the complex patchwork of services which vary greatly in their offer and impact, entrenching a postcode lottery for support.

Evidence to the inquiry emphasised that government support for the third sector, which is facing unprecedented challenges due to the Covid-19 pandemic, must be increased so that charities and voluntary organisations not only survive the difficulties of the next eighteen months, but are better placed to offer high quality support alongside specialist NHS mental health services than before the pandemic. Local authorities must also be supported to re-

invest in wider youth services such as youth clubs and sports facilities, spending for which has been cut drastically in recent years, but which have a crucial role to play in supporting young people much earlier than at present, before mental health needs escalate.

Respondents to the inquiry welcomed the introduction of MHSTs, the Government's flagship preventative intervention initiative around tackling self-harm. However, a system shift to prevention will need to go much wider than educational settings alone, into every part of the support network. Only then will a move away from crisis support, towards a system of early intervention, be possible. This must be underpinned by an understanding of self-harm through the lens of trauma as the presenting behaviour for a set of underlying social or emotional problems to be addressed.

Summary of recommendations:

- The Government should implement a new system of early intervention to support young people who self-harm. This could be based on a network of open-access mental health services based in local communities, which provide immediate support in a non-clinical settings.

- DHSC should use the forthcoming funding settlement to increase and accelerate planned investment in existing mental health services for young people.

- DCMS, MHCLG, DHSC and NHSE should ensure that third sector and community-based organisations are able to continue helping young people who self-harm by providing a sure financial footing for the future.

- DfE should provide schools and colleges with increased mental health resource sooner to roll out Mental Health Support Teams more widely so that they are able to undertake preventative interventions around self-harm more consistently.

- DHSC, NHSE, DfE and the LGA should work together to support both Integrated Care Systems and local authorities to improve access to services. This work should particularly focus on those from at-risk and marginalised communities.

- NHSE/I, DfE, DCMS should ensure any frontline professional likely to come into contact with a young person who self-harms receives appropriate training on how best to support them.

- DHSC, NHSE and the DfE should work together to make it easier for young people to navigate the support system by providing every young person who presents to NHS services having self-harmed with the option of having a 'buddy' to help them navigate the support system and act as a caseworker.

- DHSC and NHSE/I should ensure that co-production is at the heart of design and delivery for mental health services accessed by young people who self-harm by making it a condition of funding.

- DHSC, NHSE, service providers and commissioners should work together to ensure that young people who self-harm get better support online.

- PHE, NHSE and DHSC should lead the sharing and consolidation of national real time self-harm data across clinical and community settings, supported by excellent local surveillance systems.

- DHSC and NHSE should work together to ensure that safe peer-support models are promoted.

- The royal colleges of GPs, psychiatrists and other professional bodies should work together to ensure that their members are skilled in handling issues of confidentiality so that it does not become a barrier to seeking support. DHSC's Consensus Statement should be used as a tool to guide this process.

Introduction

The policy background

National initiatives supporting young people who self-harm

i.1 In 2012 the Department of Health (DHSC)[6] published a new cross-government national suicide prevention strategy for England with the dual aims of reducing the suicide rate in the general population and providing better support for those affected by suicide. To achieve this, the strategy focused on six key areas, including 'high risk' groups, such as people with a history of self-harm. The document notes that at least half of people who take their own life have a history of self-harm.[7]

i.2 It was not until the third progress report against the strategy, published in January 2017, that self-harm was included as a distinct area for action 'given the direct link to suicide and increasing concerns about self-harm raised by professionals who work with children and young people'. [8]

i.3 Increased focus at a national policy level continued as DHSC published the first cross-government workplan to support the delivery of the National Suicide Prevention Strategy in response to a recommendation by a 2017 Health Select Committee (HSC) inquiry.[9] Two of the three overarching themes recognised in the workplan are improving data collection and self-harm, and one of the functions of the workplan is to improve accountability and transparency. This includes monitoring the delivery of key commitments, including the £25 million dedicated by NHS England (NHSE) in 2018 to be spent over the three years ending 2020/21 by Sustainability and Transformation Partnerships (STPs) in preventing suicide, with priority given to tackling self-harm. This has since been extended to £57million ending in 2023/24.[10]

i.4 The *Transforming Children and Young People's Mental Health Provision Green Paper* from 2017 made a number of important commitments relevant to young people who self-harm, with a stated ambition for 'earlier intervention and prevention', underpinned by the introduction of new Mental Health Support Teams (MHSTs). These teams will be supervised by NHS staff to act as a bridge between schools and Children and Adolescent Mental Health Services (CAMHS) - the NHS services that assess and treat young people with emotional, behavioural or mental health difficulties. MHSTs are intended to provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing.[11] These teams will be rolled out to between a one fifth and a quarter of the country by the end of 2023.[12] As this report will explore, there is a significant opportunity for schools and colleges to support young people who self-harm which is not currently being fully realised, due (at least in part) to a lack of resource.

i.5 The same green paper also committed to a trial of a four-week waiting time for access to specialist NHS children and young people's mental health services, an issue which is crucial

to young people who self-harm receiving the support they need, and which is explored in some detail later in this report.

i.6 The NHS Long Term Plan, the cornerstone of planning for the National Health Service over the next decade, makes several commitments relevant to young people who self-harm and the services they access. At a macro level, the Plan commits to funding for mental health services growing faster than the overall NHS budget, which it says will be worth £2.3bn a year by 2023/24. It also pledges that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. The document states that by 2023/24 an extra 345,000 children and young people up to 25 years old will receive mental health support every year.[13]

i.7 The third progress report of England's Suicide Prevention Strategy noted that in line with the recommendations of the Five Year Forward View for Mental Health, NHS England planned to draw on clinical research and service user expertise, including the NICE guidelines, to develop an evidence-based treatment pathway for self-harm for people of all ages in 2017/18 and 2018/19. [14] These plans have since been replaced with the development of a framework, set out in the Long Term Plan, for adult and older adult community mental health services, including for people who self-harm. For young people specifically, the Long Term Plan commits to investment to ensure that by 2023/24 all children and young people experiencing crisis will be able to access appropriate care at any time via NHS 111.[15]

i.8 In its written evidence to this inquiry, DHSC also pointed out:

' ...we are committed to ensuring that every hospital has all age Liaison Mental Health Services, to include children and young people, by 2023/24. This will mean that when a young person presents at A&E with self-harm, they will receive timelier access to appropriate mental health support.'

i.9 While national policy efforts to tackle self-harm have developed relatively recently, national guidance for clinicians has been around for longer. The National Institute for Health and Care Excellence (NICE) has produced two guidelines on the treatment of self-harm, the first published in 2004 and then updated in 2011. These guidelines set out the support that should be provided to people who self-harm, including the importance of treating them with the same care and respect as any other patient. They also include a pathway for what a person who self-harms should expect in terms of clinical treatment. NICE has produced guidance on self-harm which contains eight statements, derived from the guideline recommendations, defining what high quality care looks like.

i.10 These quality standards include an integrated and comprehensive psychosocial assessment of needs and risks of a person who has self-harmed, 3-12 sessions of a psychosocial intervention specifically structured for people who self-harm, and interventions tailored to individual needs.[16] Through the course of the inquiry, written and oral evidence demonstrated that the experiences of young people who self-harm consistently fall short of these quality standards, which are due to be updated by May 2022.

Local initiatives supporting young people who self-harm

i.11 The importance of preventing self-harm at a national policy level has been increasingly recognised over the last few years and this has been reflected in local initiatives. In its 2016 *Five Year Forward View for Mental Health,* the Independent Mental Health Taskforce recommended that every area develops a multi-agency suicide prevention plan to target high-risk locations and groups, including young people who self-harm, within their populations. This recommendation was adopted by DHSC in the 2017 update of the Suicide Prevention Strategy, which noted that 95% of areas had such plans in development at that point.[17]

i.12 These plans are the essential mechanism for co-ordinating and implementing suicide prevention at a local level and their formulation in recent years is to be welcomed in terms of supporting young people who self-harm. However, research from Samaritans and the University of Exeter in 2019 which surveyed local authorities and analysed every area's local plan, found that while 'preventing and responding to self-harm' was included in 92% of plans, actions were being delivered in only 55% of them. The report found that many of the actions were concerned with raising awareness, developing and disseminating educational resources and provision of training.[18]

Non self-harm specific community services

i.13 While national and local level policy around self-harm has been developing, wider community-based services for young people, which should play an important preventative role, have seen a severe reduction in terms of the funding they receive. Between 2010/11-2017/18, funding for local authority children and young people's services, including youth centres and preventative substance misuse programmes, fell by £3 billion. Under pressure from tightening budgets from national government, local authority spending on early intervention services for children and young people decreased by 49% (£3.7 billion to £1.9 billion). Spending on children and young people's services in the most deprived local authorities has fallen almost five times faster than the least deprived. By 2025 it is forecast that local authorities will face a £3 billion funding gap for children's services. [19] A lack of investment in community-based social interventions for young people has pushed what funding remains into crisis services. In the context of self-harm specifically, as this report will explore, this means later interventions, coming only once a person has particularly severe needs. This in turn increases demand on specialist NHS mental health services leading to increased waiting times and higher thresholds.

The overall policy picture

i.14 Preventing self-harm and supporting those who engage in the behaviour has been a growing priority for local and national suicide prevention efforts as well as wider mental health initiatives in recent years. In terms of policy the ground has been set for improvements to existing support. However, much of the evidence received by the inquiry made it clear that this is not being translated into the experiences of young people. Instead provision is patchy and in many cases statutory services fall well short of providing support within acceptable timeframes. The third sector struggles to make up this shortfall in many

areas. The situation has been exacerbated by a significant decrease in wider community-based services, which can play an important preventative role for young people who self-harm.

i.15 In its evidence to the inquiry, DHSC was clear that it is aware of the scale of the challenge it faces in this regard and is being proactive in terms of meeting that challenge. It should be noted that a number of the commitments to improving services outlined in this section, drawn primarily from the NHS Long Term Plan, are yet to be fully realised. It remains to be seen what impact these changes will have on the ability of young people who self-harm to access effective support in a suitable timeframe.

Self-harm and young people

Who is most at risk of self-harm?

i.16 According to the Adult Psychiatric Morbidity Survey (APMS), the most comprehensive data set that exists for self-harm in the community, levels of self-harm are increasing for both men and women in every age group. According to the APMS, the proportion of the population reporting having self-harmed at some point almost tripled to 6.4% between 2000 and 2014, although other surveys have found higher rates.[20] [21] It is unclear to what extent this increase can be attributed to decreasing levels of stigma around self-harm and a society-wide shift to speak more openly about mental health issues. The data is clearer in terms of the difference in prevalence between males and females. Rates of self-harm are higher among young women and girls, one in four of whom reported having self-harmed at some point – twice the rate of young men.[22]

i.17 There are specific groups who are at particularly high risk of self-harm. Stonewall highlights that LGBT young people experience very high rates, pointing to evidence indicating that 61% of gay, lesbian and bisexual young people have self-harmed at some point. This jumps to an alarming 84% of trans young people (594) who reported having deliberately harmed themselves at some point, though what constituted self-harm was not defined and therefore care must be taken not to compare rates which may include different types of behaviour.[23] Further research is needed on this issue to better understand the high prevalence of self-harm among these groups found in these studies.

i.18 There is a dearth of high quality evidence examining the experience of young people from ethnic minorities with regards to prevalence of self-harm. In terms of the general population, according to APMS data people from ethnic minorities are less likely than White people to self-harm.[24] Evidence looking at young women specifically shows that women from ethnic minorities are at heightened risk. Research from the Multi-Centre Study on Self-Harm in England found that rates of self-harm were highest among young Black women (16-34) compared to White and South Asian, but that young Black women were also less likely to receive a psychosocial assessment or re-present to A&E.[25] Another study found that South Asian women are significantly more likely to self-harm between ages 16–24 years than White women.[26] More data collection is urgently needed around ethnicity and self-

harm to get a more up to date and comprehensive picture of who is self-harming and what support they are receiving.

i.19 There is an emerging evidence base which suggests that levels of self-harm among young people with autism are very high. According to Research Autism, part of the National Autistic Society, self-harm is 'very common in people on the autism spectrum' though there is very little high-quality research evidence on the effectiveness of most interventions for people on the autistic spectrum. [27]

Why do young people self-harm?

i.20 Written evidence received by the inquiry made it clear that the reasons that young people self-harm are complex and multifaceted. There are a number of factors which can be pointed to, each affecting individuals and groups differently. While for some people it can be a one-off occurrence, for others self-harm will develop into a coping mechanism which can last a lifetime. In a minority of cases, self-harm will precede a suicide attempt or even death by suicide.[28] There is no homogenous or standard experience of self-harm, or the driving factors behind it.

i.21 Despite the fact that the majority of people who self-harm will not go on to take their lives, one of the reasons that rising rates of self-harm are of such concern is the link between self-harm and suicide. While suicide is a rare and difficult to predict event, self-harm is one of the strongest predictors of future suicide among young people.[29]

i.22 As highlighted by the Women's Mental Health Taskforce report, anxiety and depression are strongly linked with self-harming. The situation is particularly acute for young women, with over a quarter (26%) experiencing a common mental disorder such as anxiety or depression – almost three times more than young men (9.1%).[30]

i.23 Pressures centred around school, including exam stress and bullying, came through clearly as drivers for self-harm in oral evidence given to the inquiry from young people with experience of self-harm. The pressure of achieving good grades was labelled by one of the inquiry's witnesses as 'extreme'. Written evidence flagged that some high academic achievers use self-harm as a way of coping with the pressure they face at school and may struggle to admit that they need support.[31]

i.24 The role of social media in rising levels of self-harm is gaining increasing traction, especially in the light of the death by suicide of 14-year-old Molly Russell, whose father found a large amount of self-harm related material on her social media accounts following her death.[32] The evidence base is mixed as to the potential helpful or harmful role that online self-harm content plays.[33] Sally McManus, from the social research organisation NatCen and City University, pointed out that while violence and abuse among young people is increasingly carried out online, alarming and increasing rates of self-harm among young people predate social media's omnipresence in daily life.

i.25 Work by Agenda and Sally McManus recently highlighted the link between poverty and self-harm. Their report, published earlier this year, shows that poverty and austerity are key to understanding why young women self-harm. They found that young women living in the

most deprived households are five times more likely to self-harm compared to those in the least.[34] Importantly, McManus made clear in her oral evidence that while socio-economic factors have an important role to play in the prevalence of self-harm among young women, they are less likely to impact whether or not a young person receives medical support.

i.26 Individual drivers for self-harm vary from group to group and between individuals. However, a common theme across evidence received was the role of self-harm as a coping mechanism. The inquiry heard that self-harm, for many young people, is a way of staying alive and of coping with emotional trauma.

i.27 Jess told the inquiry:

'It's [self-harm] a physical display of distress. A way to show emotional pain in a physical way. They'll [health professionals] be more understanding than if you speak to them about how you feel.'

i.28 Harry explained:

'For me it was a way of coping with frustration and anger'

i.29 As a deeply personal and private issue, young people will sometimes resist engaging with services for fear of being told to stop doing the one thing they feel is helping them to manage.

i.30 Sophie told us:

"I found it easy to access services but didn't want to. It was forced on me from my parents and teachers. I didn't want the help. I didn't think there was a problem. I had the services but didn't use them correctly because I didn't think I needed them"

i.31 Sophie's experience is typical of a wider trend: the majority of young women who self-harm report do not seek help following it.[35]

i.32 A clearer yet complex picture of why young people self-harm continues to emerge over time. In order to effectively respond to increasing rates of self-harm among this group through the development and availability of support services, we need a more detailed and nuanced understanding about why young people, and especially young women, are using self-harm, and how and why this use is developing.

Recommendation: Public Health England,[36] NHS England and the Department of Health and Social Care should lead the sharing and consolidation of national real time self-harm data across clinical and community settings, supported by excellent local surveillance systems.

This should bring together all clinical and community data sources on self-harm to provide the most comprehensive picture possible regarding the real time prevalence and trends of self-harm across different settings.

What services are available for young people who self-harm?

i.33 There is a complex patchwork of services available to young people who self-harm, varying depending on local context. These inconsistencies may go some way to explaining why, despite increasing rates of self-harm and new policy initiatives to improve support, contact with services among young people remains low.[37]

NHS provided services

i.34 Mental health services provided by the NHS are the most uniformly available across England, but, as acknowledged by DHSC in its evidence to this inquiry, most young people who self-harm do not present to 'mainstream services' and instead are more likely to look to community-based solutions, if they seek help at all.

i.35 For many young people, the first step in seeking clinical support following self-harm will be their GP. From there, many are likely to be referred into CAMHS which provides multidisciplinary mental health support for children and young people. Those over the age of 16 (or in some areas 18) are most likely to be referred to the Improving Access to Psychological Therapies (IAPT) programme, the flagship NHS initiative for providing psychological therapies to adults with common mental health disorders such as depression and anxiety.

i.36 For those over the age of 18 who are based in the community, whose needs are more acute than IAPT can address, Community Mental Health Teams may provide more intensive support. For others who have complex mental health needs, support for people who self-harm may come as part of a package of inpatient care. DHSC, alongside NHSE, is working to ensure that young people who turn up to A&E having self-harmed will have access to all-age Liaison Mental Health Services to ensure quicker access to mental health support. While this is welcome, it will not be fully available until 2023/24.

i.37 As this report will explore in detail, this seemingly comprehensive provision of NHS support is in fact fraught with issues of accessibility and suitability for young people who self-harm. The third annual progress report of the National Suicide Prevention Strategy, published in 2017, noted that there was 'a lack of high-quality self-harm services across the country'. [38] Based on evidence received by the inquiry, this picture does not seem to have consistently improved in the intervening years.

Third sector services

i.38 It is apparent from evidence submitted to the inquiry that the third sector, including charities and community-based organisations, plays a central role in plugging gaps and offering alternatives to the provision of NHS services supporting young people who self-harm. These third sector services range in the nature and intensity of support they offer – from lower level preventative support based on group activities and peer support models, through to intensive psychosocial support for those who have fallen between the cracks of primary and secondary NHS mental health services. Local and national helplines for people

struggling with self-harm and suicidality such as Samaritans provide an essential service for helping people to cope day-to-day. The role that the third sector should play in the overall system of support will be explored in more detail later in this report.

Educational settings

i.39 For other young people, educational settings will be the first place that the need for support is recognised, acknowledged and acted upon. Many schools offer mental health support services through counsellors, school nurses or MHSTs. However, this is not consistent: according to a study by Place2Be and NAHT, 66% of schools offered school-based support for student's emotional and mental wellbeing in 2019, a welcome rise from 36% in 2016. [39] However, this still leaves around a third of schools who are currently not offering on-site mental health support. As will be explored, schools, colleges and universities have a crucial role in identifying and supporting young people who self-harm on a preventative basis.

Private care

i.40 For people with the means to do so, private care is one way to circumvent issues of waiting times, high thresholds and services which exclude or simply aren't designed to support people who self-harm. This often takes the form of counselling or psychotherapy. For many individuals and families however, this is simply not a plausible option due to financial restrictions.

Section 1: What challenges do young people face in accessing services?

1.1 Through the course of our inquiry, it became clear that young people face myriad challenges in accessing effective services to help with their self-harming behaviour. Some of these challenges are well established: particularly around service waiting times, high thresholds and the prevalence of stigma. [40] The Covid-19 pandemic, which reached the UK during the course of this inquiry, has in some cases further complicated and entrenched these challenges.

Covid-19 and self-harm services

1.2 It is too early to make a definitive judgement about how the pandemic will impact rates of self-harm in England. While most of the evidence we received expressed concern that the pandemic and lockdown would exacerbate existing vulnerabilities and risks among young people struggling with poor mental health, some pointed to the potential of protective factors emerging for some young people who self-harm.

1.3 At the time of writing, a large-scale study looking at the social impact of Covid-19 estimated that the percentage of people having thoughts of self-harm had remained relatively stable throughout lockdown. Rates were higher among young people, those with a lower household income and those with a diagnosed mental health condition. [41] However, there were a number of 'red flags' raised through the course of the inquiry, in terms of how access and quality of support for young people who self-harm has been and will continue to be affected.

1.4 Dr Cecil Kullu, Consultant Psychiatrist at MerseyCare NHS Foundation Trust, explained that his colleagues had seen a drop in the number of people attending A&E having self-harmed since the onset of the pandemic. There is concern that a decline in help-seeking from statutory services does not correlate to a decline in rates of self-harm, which poses the question of how young people are coping in the absence of such help.

1.5 This decline in help-seeking can likely be attributed to people who self-harm not wanting to overburden already stretched services. Evidently this phenomenon is not restricted to self-harm; there are concerns about people deferring presentation at hospital for a range of issues. [42] But the persistent stigma surrounding young people who self-harm adds a layer of complexity in terms of whether or not to present. The inquiry heard how health professionals often dismiss young people who self-harm as being 'time wasters' or 'attention seekers'. On top of the issue of stigma, a number of respondents raised concerns that an understandable focus on reacting to the pandemic had resulted in reduced capacity and added stress among health professionals, thereby leading to more young people who self-harm being dismissed.

1.6 At the time of writing, self-harm support services across the country have stepped up where they can to meet demand during the pandemic. Caroline Harroe, the CEO of Harmless, a specialist community-based self-harm support organisation based in the East Midlands, has reported a 200% increase in demand for the service. Kooth, an online mental health service for children and young people which is commissioned in over 85% of NHS CCG areas in England, has reported a 38% rise in demand for its services as traditional means of support are unavailable to many. Concerningly, Kooth also report a 45% increase in children and young people presenting with self-harm issues. [43] A lot of support for self-harm is adapting by moving to online – through webchat, self-help and email. There is a mixed picture emerging about the propensity of young people who self-harm to make use of this support. It is unclear how those who choose not to take up remote services are coping, and what this will mean for demand of in-person services as lockdown continues to ease. However, it is clear that that how and where young people present for support is changing, and services must be ready to adapt to reflect this change.

Capacity and demand

1.7 Young people were faced with a complex set of challenges to get the support they need in the pre-Covid-19 world. Many of these challenges have their roots in the capacity of, and demand for, common mental health services such as CAMHS and IAPT.

CAMHS capacity

1.8 DHSC, in its evidence to the inquiry, acknowledged that a lack of capacity within CAMHS presents 'a significant barrier for many young people receiving support', including those who self-harm. As a result of this lack of capacity, waiting times are continually increasing - the most frequent problem raised by respondents in evidence to the inquiry.

1.9 According to NHS Digital data on CAMHS waiting times for 2018-19, only around a quarter of NHS mental health referrals for under-18s in England resulted in treatment within 12 weeks. Eight per cent of young people waited over 12 weeks after being referred before starting treatment; 34% of referrals were still awaiting assessment or treatment at the end of the year; and a further 35% of referrals were closed before treatment with no indication of whether they were triaged to other services or left with no support. [44] The inquiry heard many times how waiting lists and delays in getting support lead to an escalation of self-harming behaviour.

1.10 Multiple submissions of evidence to the inquiry pointed out that anyone not actively and imminently suicidal would be placed on a waiting list for CAMHS. Barnardo's evidence to the inquiry quoted one of its practitioners:

'Access to CAMHS has become almost impossible, unless a child is in crisis. Even young people who have made suicide attempts… are seen in hospital and then discharged with no further follow up.'

1.11 Delays in getting support can be extremely detrimental to young people who self-harm whose mental health and self-harming behaviour often deteriorate while they wait. A

YoungMinds survey of more than 2,000 parents and carers of children looking for mental health support found that 76% said that their children's mental health had deteriorated while waiting for support.[45]

1.12 Capacity and demand issues for specialist mental health services raise important questions about the nature of support for self-harm and how it is delivered. Too often, available services relevant to this group only have capacity to step in once a person has reached crisis and by this time specialist mental health services are likely to be required. While specialist support may have been the only option for some young people, for others who have reached crisis, community-based preventative support may have helped them if it had been available before their needs escalated.

1.13 The problem of delays may be improved with pledged increased funding for CAMHS services.[46] However, as the Education Policy Institute (EPI) has noted, an extra £1.4 billion of spending announced in 2015 for CAMHS had not altered the proportion of rejected referrals in the four years up to 2019 which also saw significant increase in demand.[47]

1.14 Questions remain about the suitability of an approach to dealing with self-harm which relies so heavily on crisis interventions. As this report will argue, the Government should move towards a preventative model for dealing with self-harm which integrates social interventions based in the community alongside NHS mental health services.

1.15 Harmless told us that the sooner a young person receives help having started self-harming, the quicker their recovery. Despite this, Jess, a young person who gave evidence to our inquiry, explained that she was referred to CAMHS 16 times while self-harming before getting support:

"I wouldn't have cost the NHS so much if I was helped earlier. I was in a much better place when I presented than when I was admitted... At last I got referred to tier 2 CAMHS. But then I was moved to tier 3. I was too ill by that time though; I couldn't do therapy."

Meeting current demand

1.16 In the short term, to meet the existing need for mental health support among young people who self-harm, planned increased resource to expand the capacity of specialist NHS mental health services needs to be expedited and made more ambitious. More frontline staff are needed to address workforce issues, ensure that thresholds for support are lowered, waiting lists are shortened and capacity and expertise around dealing with self-harm are increased.

1.17 In the short term, many more young people need to be receiving specialist mental health care than at present. This support must arrive much sooner after developing problems, before young people reach crisis point and their needs become acute. In the context of an anticipated backlog of referrals owing to the Covid-19 lockdown, the need for such resource is particularly urgent.

Navigating the support system

A postcode lottery for support

1.18 Evidence received by the inquiry points to great variation in the type of support a young person who self-harms can expect and how quickly they can expect to receive it, depending on where they live. YoungMinds, a prominent organisation working on young people's mental health, pointed to a patchwork of existing services, often unable to reach young people who need them most.

1.19 The most up-to-date figures for waiting times for CAMHS illustrate a concerning variation in average delays across the country. For the period April 2018 - March 2019, the gap between referral and second contact was 11 days longer (62 days) in the South West compared to the North (51 days). [48] Concerningly, Dr Paul Chrisp, Director of the Centre for Guidelines for NICE, explained to the inquiry that the implementation of his organisation's standards of clinical care a person should expect having self-harmed also varies by region.

1.20 There is wide variation in spending by local areas on 'low level' mental health services. A report by the Children's Commissioner for 2019 explained that local authorities in the highest spending 25% laid out almost £1.1million or more for such services, with the bottom 25% spending £177,000 or less for the financial year 2018/19. [49] Considering what is increasingly understood about the association between self-harm and disadvantage, such a discrepancy has problematic implications for the support available to those young people who need it most.

An opaque system

1.21 Where support for self-harm does exist, the inquiry heard that young people are often unaware of where it can be accessed. Others lack the confidence that services will know how to help them.

1.22 James, one of the young people who provided powerful oral evidence to the inquiry, explained that accessing support services is 'riddled with puzzles' which he felt unable to navigate when he was struggling. The inquiry heard that services are often developed to meet specific needs based on age or gender, excluding those who don't fit their criteria, which can be a confusing and alienating experience for young people trying to get help.

1.23 Most concerningly of all, the inquiry heard that common mental health services often exclude young people on the basis of their ongoing self-harm. This may be a particular problem in IAPT services for older young people.

1.24 The evidence received by the inquiry around the role of parents and carers in ensuring that young people get the care they need was mixed. For some young people, parents and carers can be effective advocates who help them navigate an often frustrating set of services and systems. For others, dynamics within the home can be a primary driver for self-harm and seeking support is a process which must be done alone due to concerns around

stigmatising views. There is of course a large overlapping grey area between these two groups.

1.25 In cases where parental or carer involvement is deemed to be helpful by independent professionals, there should be more information, outreach and guidance to parents and carers on how they can support young people not only to navigate services but to cope with their feelings and challenges when they are not engaged with services. For this to be successful, parents and carers are also going to need to be more consistently educated around what self-harm is, why it happens and how they can best offer support in a non-judgemental way.

Recommendation: The Department for Health and Social Care, NHS England and the Department for Education should work together to make it easier for young people to navigate the support system.

This should be achieved by:

- Providing every young person who presents to NHS services having self-harmed with the option of having a 'buddy' to help them navigate the support system and act as a caseworker. This could be a health professional provided through mental health liaison teams.
- Running campaigns in educational settings to increase literacy and understanding among young people about self-harm and where they can go to seek support when they are struggling.
- Creating and maintaining verified support resources for young people who self-harm, including how to develop new coping mechanisms, which are curated and located in one easy to access online space.
- Encouraging the sharing of information between different agencies as young people move between services, in line with data sharing and privacy laws, to avoid young people having to repeat their story.
- Providing more support for families, carers and guardians of young people who self-harm in the form of educational materials and self-help tools. Where appropriate, more family-based interventions and outreach should be offered in order to guide their support of young people in the home environment.

Stigma and normalisation

1.26 One of the most significant barriers to young people receiving support for self-harm is stigma. The continued impact of stigma on inhibiting help seeking and on the quality of care that young people can expect to receive from professionals, was a striking, if not totally unsurprising, theme of the inquiry.

1.27 Recent mental health campaigns have helped to reduce stigma, and there is a growing awareness of the behaviour, according to evidence we received from groups working with young people. There have been a number of high-profile government-backed mental health campaigns in recent years, including 'Time to Change' and 'Every Mind Matters'. [50] [51] Despite this, it is obvious from the evidence received, including from young people themselves, that stigma around self-harm remains prevalent.

1.28 The inquiry heard many times that stigma inhibits talking and help-seeking. According to DHSC, between a third and one half of adolescents who self-harm do not seek help. Josh told us that he felt unable to seek any form of support for six months due to crippling stigma. Shame, a by-product of stigma, was a term which came up multiple times in evidence as preventing young people from help seeking.

1.29 Many young people fear a negative reaction, provoking anger, upset or even an unwelcome mental health diagnosis from the people they might disclose to, including friends and family. Harry, a young person who gave evidence to the inquiry told us:

'I would do anything I could to hide it. I convinced my parents I was very clumsy. All I could think in my head is that what I'm doing is very, very wrong. They'll [my parents] blame me, have a negative opinion...stigma played a massive part in holding back my recovery'

1.30 The inquiry heard that for other young people, fears lie in being dismissed as an 'attention seeker' or not being taken seriously enough.

1.31 No young person should have to carry such an intense burden alone. It is fair to assume that the longer a person goes without support for self-harm, the slower their recovery will be and the more potential for damage, both physical and mental. Stigma doesn't only lead to alienating and upsetting individual interactions, but also inhibits help seeking and results in self-censoring, which in turn leads to less support and worse outcomes for young people who self-harm, even before the limitation of available support is factored in.

1.32 Stigma also negatively impacts the quality of support young people receive. The first NICE quality statement covering people who self-harm is that 'People who have self-harmed are cared for with compassion and the same respect and dignity as any service user'. [52] Unfortunately, the inquiry heard evidence from NICE which suggests that this standard is not being met often enough by clinical services. This is consistent with evidence from other respondents, who relayed accounts of being labelled by health professionals as 'time wasters' or, often, 'attention seekers'.

1.33 A strong theme through the inquiry was that young people often don't believe that professionals, whether working in healthcare settings, schools or the third sector, understand what they are going through.

1.34 The inquiry heard that approaches and interactions which focus on self-harming behaviour, rather than underlying distress or trauma, can make young people feel they are only being listened to when they are self-harming, or self-harming severely enough to warrant attention. Cuts being referred to as 'superficial' can be an alienating experience which encourages a mode of thinking that suggests that the level and importance of distress being experienced can be measured by the severity of the self-harm. Self-Injury Support, a national self-harm-specific service, told the inquiry that their model focuses on asking 'what is going on for you?' rather than a sole focus on stopping a young person from self-harming. They report that, using this model, 70% of people who use their service stop self-harming.

1.35 The inquiry received written and oral evidence recounting distressing cases where medical professionals had reportedly withheld anaesthetic while attending to wounds caused by self-harm[53]. YoungMinds said that these disturbing examples were reflective of the experience of their activists and Caroline Harroe, CEO of Harmless, echoed this.

1.36 Dismissive language and humiliating practice are problematic as standalone events, but the inquiry also heard of the knock-on effect of stigma as young people are put off from accessing support in the future due to previous bad experiences when dealing with health professionals.

1.37 In its call for evidence, the inquiry included a question about the term 'normalisation', to describe the concept of self-harm becoming seen as a regular or unremarkable reaction to distress. It should be noted that some respondents, including some of the young people the inquiry heard oral evidence from, found this term unhelpful.

1.38 It should be noted that normalisation received much less attention than stigma in evidence received, and that there were divergent views as to its impact. Some respondents offered that normalisation of self-harm was necessary in order for more young people to feel able to seek help, while others felt it could be a barrier to support as young people view self-harm as a totally normal coping mechanism which in turn leads to more young people trying it. Caroline Harroe, CEO of Harmless, warned that services are seeing so many young women self-harming at the moment that there is a danger of apathy among professionals.

1.39 In between stigma-based dismissal and normalisation-based apathy sits a mid-point for how services can approach the support they provide. In its evidence to the inquiry, Self-Injury Support noted that it is important for a young person's experience of self-harm to be validated without ever viewing the behaviour as inevitable. As will be explored later in the report, a trauma-focused approach (as opposed to an approach focused on behaviour) is key to balancing the divide between stigma and normalisation. Young people should always be dealt with compassionately and with an understanding of the nuanced role that self-harm plays for many young people dealing with trauma.

1.40 Alongside this, training for all professionals coming into contact with young people who self-harm is crucial. It is key that the roll out of MHSTs is accompanied by training in self-harm for those teams, to ensure they understand the specific challenges faced by this group.

1.41 The need for training, however, goes beyond mental health support teams. Professionals across education settings, health and social care and youth services must all be better informed about spotting signs of self-harm, knowing how to support young people, and where to signpost them. Training must ensure that educational settings have the skills and confidence to keep young people who are self-harming in school or college or enable them to return to school safely after absence.

1.42 Society is undergoing historic changes in the way it understands, talks about and deals with mental illness, yet this progress is patchy and inconsistent. Acceptance of certain mental health issues among specific groups will move more quickly than others and unfortunately, there remain taboos, misunderstanding and shame around self-harm.

1.43 In order to empower young people to make choices around the care they receive for self-harm, stigma must be tackled – through awareness campaigns and education in schools and wider society. Talking about self-harm in a safe way should be 'normalised' at all levels of society without ever being seen as an inevitable or encouraged reaction to difficult feelings.

Recommendation: NHS England/Improvement, the Department for Education and the Department for Digital, Culture, Media and Sport should ensure any frontline professional likely to come into contact with a young person who self-harms receives appropriate training on how best to support them.

This should include training for social workers, teachers, youth workers, and health professionals on:

- The different behaviours which can constitute self-harm.
- The difference between self-harm and suicide and implications for support.
- How to speak about self-harm in a trauma-informed way.
- How to meet the needs of marginalised young people who self-harm or are at risk of self-harm.
- How to support and keep a young person who is self-harming safe in school.
- Undertaking holistic psychosocial assessments in line with NICE guidelines for GPs specifically.

Groups who particularly struggle to access services

1.44 It is important to note that the challenges outlined in this chapter are not experienced equally by all young people.[54] There are a number of groups identified in evidence to the inquiry who, for a range of reasons, face particular barriers in getting the help they need.

1.45 As has been evidenced, while rates of self-harm are rising among all groups, young women are disproportionately impacted. While a focus on this group in terms of services is therefore understandable, it has also created challenges for young men who self-harm to get support.

1.46 This focus on young women influences how self-harm as a behaviour is categorised: the inquiry heard how the behaviour often undertaken by young men – such as hitting walls or excessive alcohol consumption – is not often understood as self-harm and therefore may be dismissed or misunderstood. We know that proportionately young women access services much more than young men.[55] The reasons for this are varied, but evidence received by the inquiry suggests a focus on young women influences how services are developed, advertised and accessed in a way which makes young men less likely to access them.

1.47 Stonewall set out significant detail in its evidence on the specific barriers in accessing services faced by the young LGBT community for whom rates of self-harm are particularly high. These barriers include discrimination on the basis of their sexuality resulting in unequal treatment as well as a lack of understanding of their specific needs. One in five LGBT people who accessed mental health services in the past year reported a negative experience.[56] This may also include a disproportionate focus on someone's sexuality as opposed to the issues they are facing.

1.48 Stonewall quote Imogen, from 2018 research:

'I was told my health conditions and issues were all caused by the fact I'm bi, even though I'm monogamously married and have dealt with the symptoms since I was 11.' [57]

1.49 At the time of writing, the Black Lives Matter movement has recently highlighted the racial inequalities that pervade all levels of UK society. These structural issues influence the design and accessibility of health services, and contribute to why young people from ethnic minorities, especially young men, struggle to access them. We know that White people are more likely to access support compared to other groups and that people from ethnic minorities face specific problems in accessing mental health services, in some cases due to a lack of cultural sensitivity.[58] The Centre for Mental Health found that a lack of culturally appropriate mental health services was a barrier to young black men in particular accessing support, despite men from African Caribbean communities having far higher levels of diagnosed severe mental illness than other communities.[59]

1.50 There is an emerging picture which suggests that self-harm is highly prevalent in young people with autism spectrum disorders, particularly those with a higher severity of autism,

but that they also face additional barriers to accessing support.[60] [61] Evidence received by the inquiry noted that young autistic people have specific needs in terms of how services are delivered which are not currently being met despite the high prevalence of self-harm among this group noted earlier in the report.

1.51 In their report *Neglected Minds,* Barnardo's highlighted a range of barriers to young care leavers receiving mental health support, including the inflexibility of services and their refusal to support young people with substance misuse issues which can disproportionately impact this group.[62]

1.52 This list is not exhaustive. Some young people will fall into more than one of these groups and therefore face multiple barriers to accessing services as well as multiple risk factors for self-harm. In its evidence to the inquiry, DHSC acknowledged 'there may be other characteristics which increase an individual's vulnerability for self-harm or likelihood of receiving treatment'. In response, MHSTs are required to set out how they plan to support more vulnerable groups such as LGBT young people, young people from ethnic minority backgrounds and those who have experienced trauma and/or disadvantage.

1.53 Issues of accessibility span the whole system of support rather than one entry point. Services must be co-designed with young people from at-risk and marginalised backgrounds who currently struggle to access services in a way that actively combats and eliminates these disparities as much as possible.

Recommendation: The Department of Health and Social Care, NHS England, the Department for Education and the Local Government Association should work together to support both Integrated Care Systems and local authorities to improve access to services.

They should:

- Invest in research to inform service design in how best to reach and support marginalised and minority ethnic groups who self-harm.
- Ensure that commitments in the NHS Long Term Plan to increase provision of crisis services result in support for local authorities and services to undertake outreach and culturally appropriate provision.
- Enable ICSs to make services more welcoming, accessible and able to meet the needs of a diverse range of young people who self-harm by engaging young people at all stages of service development. Appropriate messaging should be used to attract young people who usually struggle to access services including young men, LGBT and ethnic minority communities as well as those with a range of neurodivergent needs.
- Ensure all centrally allocated funding for mental health has specifically taken the needs of marginalised groups such as LGBT and minority ethnic populations into account.

Section 2: How suitable are available services?

2.1 Various barriers faced by young people who self-harm in accessing support have been outlined above. But how adequate are services if young people manage to receive help? Unfortunately, evidence gathered through the inquiry suggests a mixed picture at best. While respondents probably represent some selection bias, the theme of young people who self-harm being failed by support systems was common despite the best intentions of many hard-working staff.

2.2 It became clear through the course of the inquiry that there is no 'one size fits all' in terms of effective support offers to young people who are self-harming. The needs and experiences of this group are diverse and often complex. Rather than any one approach, the inquiry heard that it is about the 'right intervention at the right time' and consistent support from a trusted adult or peer which takes account of underlying distress and trauma rather than concentrating on the presenting behaviour.

2.3 The Children's Commissioner's report into the state of children's mental health services from earlier this year described 'a chasm between what children need and what is being provided.' In her foreword, the Children's Commissioner estimates that 'we are at least a decade away from a comprehensive mental health service for children'. [63] It is important to note that this estimation does not take into account the distinct and specific challenges faced by young people who self-harm.

Funding constraints lessen the impact of mental health services

2.4 The introduction to this report set out commitments in the NHS Long Term Plan to increase spending on mental health services for children and young people. While the impact of promised investment through the Long Term Plan is yet to be realised, this is to be welcomed.

2.5 The aforementioned report from the Children's Commissioner makes it clear that progress is being made in terms of NHS services expanding, despite the fact that children make up 20% of the population but account for just 10% of current mental health spending.[64]

2.6 It is obvious that more resource for specialist mental health services such as CAMHS and IAPT is needed and is needed quickly. Many respondents felt that plans within the NHS Long Term Plan should be expedited and made more ambitious if they are to improve services to an acceptable level for young people who self-harm. The inquiry heard a number of times about the shortage of mental health professionals.

2.7 Dr Jonathan Leach, Joint Honorary Secretary of the Royal College of GPs (RCGP) told the inquiry that there is a 'real shortage' of mental health professionals which makes GP referrals to services difficult, to the extent that he is often surprised when he receives a

positive response from CAMHS. Jess, a young person who gave evidence to the inquiry, explained that she only ever came across locums rather than established members of staff, in the two and a half years she spent in Child and Adolescent Mental Health Services.

2.8 Cuts to budgets in recent years have resulted in case overloads for NHS mental health staff which in turn has reduced the amount of contact that young people get with professionals as well as the consistency of relationships. One respondent to the inquiry, the parent of a young person who has self-harmed, described the contact time with staff through CAMHS as 'minimal'. This inevitably increases demand on third sector and community-based organisations who attempt to pick up the shortfall in provision with limited resources.

2.9 NHS provided mental health support is strictly time limited in most cases. The inquiry received a mixed picture from expert organisations as to the effectiveness of short-term support as provided through CAMHS and third sector organisations. However, a number of individual respondents explained that the support they received, whether through NHS or charities, was for too short a time period. They needed longer term support but help ended as soon as they were deemed to no longer present an immediate risk to themselves, whether or not their issues had fully been addressed.

2.10 Josh told the inquiry that he resorted to an attempt on his life to get the help he was looking for. He told the inquiry:

'At a young age, you have to do something drastic to get support.'

Having to depend on private care

2.11 For those who can afford it, private care offers a way to circumvent a public mental health system constrained by a lack of funding. Evidently, for many people private care is simply unaffordable. For others, it is a real struggle. Two of the young people who gave oral evidence to the inquiry had used private therapy due to challenges in accessing support through the NHS.

2.12 Josh told the inquiry:

'For me it was either suicide or private counselling... I had private therapy. I'm from a working class family and it's very expensive and difficult to keep money coming from somewhere to fund it.'

2.13 Private mental health care, however, is not a panacea and varies in effectiveness. Supporting young people who self-harm is a specialist area and written evidence received by the inquiry suggested that many mental health professionals working privately lack the necessary skill set or experience to really help.

Recommendation: The Department of Health and Social Care should use the forthcoming funding settlement to increase and accelerate planned investment in existing mental health services for young people.

This should:

- Triple the Government's current stretch target of 35% of children and young people who need mental health services receiving them so that 100% receive them by 2025.

- Expand CAMHS capacity, address workforce issues, shorten waiting lists and lower thresholds for support to meet existing demand specifically for self-harm.

- Support specialist mental health services such as CAMHS and IAPT to improve training and safeguarding practices in order to ensure that young people who self-harm are not excluded from support on the basis of their behaviour.

- Use commitments in the NHS Long Term Plan to expand community multi-disciplinary teams to ensure that mental health services for young people are fully integrated into primary health care.

- Strengthen the existing evidence base to inform future commissioning with research into:

    - Which interventions work best for individual groups when self-harming, including how cognitive-behavioural psychotherapy and dialectical behavioural therapy interventions can best be used to support different groups.
    - The prevalence of self-harm among young people from different ethnicities and the support they receive.
    - How mainstream NHS mental health services for young people can be digitally enhanced, taking into account international examples of good practice.

- Ensure the continued re-commissioning of the Adult Psychiatric Morbidity Survey (APMS), a population-wide survey including data around the prevalence of self-harm in the community.

NHS Mental health services and self-harm

Services are not set up to deal with self-harm

2.14 The inquiry heard how mental health services which deal with a wide range of issues, such as CAMHS and IAPT are not equipped to support people who self-harm. Publicly available access criteria, however, seem to suggest that CAMHS services are more prepared to support young people who self-harm than IAPT. The website of one NHS Foundation Trust explains that 'in line with national IAPT standards', its service will not work with 'people who present with active risk of significant self-harm'.[65]

2.15 DHSC points to the fact that it is increasing investment in CAMHS capacity to ensure young people get the mental health support they need. However, the extent to which this will increase support for people who self-harm specifically is unclear. At present, in many cases, presentation of self-harming behaviour does not act as a trigger for NHS support and often is a basis for denial of care. Research from the EPI lists self-harm as one of the key reasons that a quarter of CAMHS referrals are rejected.[66]

2.16 While the impact of increased CAMHS funding remains to be seen, at the time of the inquiry it was clear that there exists a real issue with CAMHS not providing services to deal with self-harm specifically.

2.17 An individual responding to the inquiry in a personal capacity wrote:

'Self-harm is not a prerequisite for accessing a service, nor seen as a valid measure of distress that drives service provision. Much support in the third sector manages what should be a primary care responsibility but there is no primary care provision within the NHS.'

2.18 A practising GP in Birmingham explained that the local CAMHS service does not offer self-harm specific support services. This is concerning given that Birmingham is one of England's largest population centres.

2.19 A lack of training for mental health professionals around self-harm came up a number of times in the evidence. Many young people will present to A&E following an episode of self-harm where they should, as per NICE guidelines, receive a psychosocial assessment in order to better understand their underlying distress and build a picture of what is going on for them.[67] However the most recent evidence available from the Multi-Centre Study of Self-harm, funded by DHSC, showed that a psychosocial assessment was only carried out in 53% of cases where a young person presented at A&E for an injury of self-harm.[68] As previously noted, the NHS Long Term Plan commits to introducing all-age mental health liaison in A&E departments and inpatient wards in all hospitals by 2021.

A lack of self-harm specific services to fill gaps in statutory support

2.20 Unfortunately, a lack of alternatives to CAMHS compounds the issue of young people who self-harm struggling for support. Youthscape, which provides an online programme run by trained counsellors for young people who self-harm, told the inquiry that in their

experience there is a 'dearth' of alternatives available to young people who have mustered the courage to seek help but do not meet CAMHS thresholds.

2.21 As the EPI notes, alternative mental health support services for those unable to access CAMHS have been decommissioned in many areas over the past eight years.[69] This speaks to a theme throughout this report: of a system currently based on mental health interventions which arrive only once a young person reaches crisis. This report will argue that there must be a shift towards a system of community-based interventions which arrive much earlier.

Being bounced between services

2.22 A distressing result of long waiting times, increasing thresholds and a lack of self-harm specific services is that young people are passed or 'bounced' between services. The inquiry heard how schools will often automatically refer a young person who is self-harming into CAMHS as they feel unable to hold the risk presented by the behaviour. Often, young people do not meet the threshold for CAMHS support and so their referral is bounced back to the school. The to-ing and fro-ing between different sources of support can be very distressing for the young person involved.

2.23 Harmless, in oral evidence to the inquiry, explained how despite receiving no statutory funding for their self-harm service, they welcome young people who have fallen through the gaps of NHS primary and secondary mental health services. Often the young person's needs are deemed too severe for primary mental health services due to their self-harming behaviour, but not acute enough to warrant secondary mental health support. Dr Jonathan Leach contrasted the clear pathway available to a young person presenting with physical symptoms such as chest pain and shortness of breath with the opaque system which someone must navigate having self-harmed.

2.24 A particularly fraught transition is between children and adult mental health services. The inquiry heard accounts of young people falling outside of CAMHS eligibility on the basis of being too old while at the same time being too young for IAPT and therefore stuck in limbo. Respondents also highlighted that for those who successfully make the transition, valuable relationships built in mental health services for young people are lost in the move to adult services.

2.25 DHSC, through the Long Term Plan, has committed to extending mental health models 'to create a comprehensive offer for 0-25 year olds' by 2028 in order to ensure that there is no 'cliff edge' for support and improve transitions. Dr Jonathan Leach of RCGP explained to the inquiry that while this is to be welcomed, it does not address the imbalance in terms of the effectiveness of children and adult services for self-harm.

How helpful are GPs in supporting young people who self-harm?

2.26 GPs represent an essential part of a system of support for young people who self-harm which is primarily geared towards crisis intervention. Despite this, the inquiry received a mixed picture in terms of their impact. For young people who are self-harming, their local

GP will often be the first medical professional they disclose the behaviour to. The inquiry heard that this is often because their families have become involved, rather than how comfortable the young person feels disclosing to a GP.

2.27 Unfortunately, despite being part of the curriculum for general practitioners, the ability of GPs to assist a young person in this situation is often limited by a lack of specialist knowledge of the issue or the support available for referral. A Young Minds report from 2018 found that 29% of young people had trouble accessing support from their GP for mental health issues. [70] Evidence from the University of Birmingham explained that young people who self-harm lack confidence in their GP being able to support them.

2.28 Josh, a young person who gave oral evidence to the inquiry, explained:

"My GP didn't know how to approach it [self-harming behaviour]. He didn't have much training. I felt I had to educate him, which was kind of sad. I'm not a GP, it should be the other way around"

2.29 The RCGP, in its oral evidence to the inquiry, acknowledged that there are known barriers to young people accessing GP support which they are working hard to overcome by focusing on issues such as confidentiality, a person-centred approach and treating young people as individuals. There are, however, well documented issues of capacity and workload for GPs, who are under considerable pressure. [71]

2.30 A striking feature of the oral evidence received from Dr Jonathan Leach, representing RCGP, was that GPs are 'terrified of getting it wrong' in terms of supporting young people who self-harm. It became clear that GPs lack a framework or pathway of care when dealing with self-harm, particularly for young people.

2.31 Dr Leach told the inquiry that the ability of a GP to 'absorb risk' represented by a young person self-harming is much reduced compared to an adult. As a result, there is a propensity among GPs to refer young people who are self-harming automatically onto health professionals within CAMHS or IAPT who have more experience dealing with these issues. The problem, as has been set out in this report, is that the capacity of those services is severely diminished, leaving GPs with few options of where to turn next. Despite this, GPs represent an important first step to young people receiving support.

The role of the third sector

2.32 In order to shift towards prevention, away from crisis interventions and long waiting lists for support, significant investment from central government for community-based support services, delivered by the third sector, will be key.

2.33 As has already been noted, Samaritans and University of Exeter research from 2019 found that while supporting people who self-harm was included in 9 out of 10 local authority suicide prevention plans, only just over half were actually delivering actions. Most of these centred on awareness raising, educational resources and training. [72] The inquiry also heard about the patchwork of services available to young people who self-harm with regional inconsistencies; levels and consistency of care are variable depending on where a

young person lives. Having a thriving third sector, dedicated to supporting young people who self-harm and based in the communities where they live, will be key to improving the support that local areas can provide.

2.34 While anecdotal evidence at the time of writing suggests that CAMHS referrals reduced dramatically under lockdown in response to the Covid-19 pandemic, the community-based charity Harmless reported a 200% increase in demand for its services[73]. More alternatives to NHS provided mental health services, such as CAMHS and IAPT, are needed.

2.35 While NICE provides the closest thing that exists to a care pathway for young people who self-harm, in reality this is not translated into the experience of young people who self-harm, whose care varies greatly.[74] Where local pathways do exist, however informally, there should be more collaboration between NHS and the third sector in order to provide preventative care earlier.

2.36 Even before the Covid-19 pandemic hit, the inquiry received evidence suggesting that the demand for the community-based services which do exist was extremely high. As demand for mental health continues to rise following lockdown, community-based third sector services must be supported to respond alongside CAMHS and IAPT, to plug the gaps in provision but also provide an earlier, more agile and responsive offer which arrives before issues escalate. [75]

2.37 Increased capacity in the third sector would also help GPs to deal with young people who self-harm. In oral evidence to the inquiry, Dr Jonathan Leach expressed frustration regarding the lack of referral options and alternative pathways available to GPs when supporting young people who self-harm. While many young people who turn up at GP surgeries having self-harmed will require specialist mental health support, for others a lower-level, community-based intervention may be more appropriate. GPs must be supported in seeking out alternative care pathways for those who present to them.

2.38 The NHS Long Term Plan commits to over 1,000 trained social prescribing link workers being in place by the end of 2020/21. The plan is for this figure to rise again by 2023/24, so that over 900,000 people can be referred to social prescribing schemes.[76] For this scheme to properly benefit young people who self-harm, there must be more community-based third sector options available for referral. At present, due to the patchwork of services available, the social prescribing link worker roll out risks further highlighting the regional disparities in terms of support available.

Recommendation: The Department for Digital, Culture, Media and Sport, the Ministry of Housing, Communities & Local Government and The Department for Health and Social Care should ensure that third sector and community-based organisations are able to continue helping young people who self-harm by providing a sure financial footing for the future.

Ministry of Housing, Communities and Local Government and Department for Digital, Culture, Media and Sport should ensure that:

- Local authorities are supported to fund community-based non-clinical services and pathways specifically for self-harm prevention to support young people who self-harm before they reach crisis point.

Department for Health and Social Care should ensure that:

- Its funding for voluntary organisations includes provision for those who self-harm.

NHS England should ensure that:

- Integrated Care Systems work closely with the third sector to ensure that community-based support services are integrated into care plans and that these services are funded and utilised so that young people who self-harm are supported earlier.

The role of schools

2.39 The inquiry repeatedly heard about the important role that schools have to play in supporting young people who self-harm, particularly in terms of early intervention, before their mental health needs begin to escalate. Both RCGP and the National Suicide Prevention Alliance (NSPA) explained that existing trust and support networks in schools stand them in good stead to consistently engage young people earlier.

2.40 Preventative action by schools, before a young person reaches crisis, will be a crucial part of moving towards an early intervention model which could lessen the burden on specialist mental health services provided by the NHS.

2.41 This role was also acknowledged by DHSC in its evidence, which identified schools and colleges as being in a unique position to reduce mental health problems as part of an integrated approach. The roll-out of counselling support in schools through MHSTs, which was welcomed as a positive intervention by a number of respondents, is reflective of this. Over the next five years the NHS will fund new MHSTs working in schools and colleges, which will be rolled out to between one-fifth and a quarter of the country by the end of 2023. However, many areas of the country will still not be covered by school support at the end of 2023. [77] Respondents told the inquiry that they wanted this roll out to happen sooner and more widely.

2.42 As well as supporting young people who have self-harmed, schools were identified through the course of the inquiry as having the potential to play a key role in promoting understanding of self-harm and in tackling stigma.

2.43 If schools are going to play an increased role in identifying and supporting young people who self-harm, they need more resource and capacity. The inquiry heard that presently, the support provided in schools is patchy and inconsistent. Dr Jonathan Leach explained that in his experience the link between school nurses and GPs was much weaker than it had been previously.

2.44 A study from earlier this year indicated that while support for students' emotional and mental wellbeing is increasing, a third of schools still offer no such school-based support. [78] A number of the young people who gave oral evidence to the inquiry explained that getting mental health support through school was fraught with difficulty. Written evidence from Self-Injury Support noted that lots of counselling services had been stripped out of schools, with the responsibility passed onto teachers.

2.45 A YoungMinds survey of more than 3,000 secondary teachers found that 84% reported having taught a child in the previous year whom they believed was self-harming, while 77% of teachers felt they had not had sufficient training in young people's mental health, and only around one-third felt confident in knowing how to support young people with mental health issues or how and when to make a referral to CAMHS. [79] The inquiry heard how this has led to increased referrals, and in turn rejections, to CAMHS, as schools feel unable to bear the risk of a young person self-harming, whether or not they meet the increasingly high thresholds for NHS mental health support.

2.46 A lack of capacity in schools means that the gulf in provision between what education settings can offer compared to NHS mental health services can be huge, further emphasising the necessity and timeliness of the introduction of MHSTs. The roll-out of these teams must be expedited, made more comprehensive across the country and they must be trained in self-harm and suicide prevention specifically.

Recommendation: The Department for Education should provide schools and colleges with increased mental health resource sooner so that they are able to undertake preventative interventions around self-harm more consistently.

This should ensure:

- Mental Health Support Teams are rolled out more quickly to ensure that every school and college in the country has access to them as soon as possible.
- Every Mental Health Support Team is trained in understanding issues of self-harm and suicide as central elements of policy and practice.
- Schools and colleges are supported to adopt a 'whole school/college' preventative approach to supporting students who self-harm.

- Self-harm awareness and education is integrated into core elements of the curriculum.
- Approved guidance around dealing with self-harm is distributed to every teacher in the country.

Section 3: What elements contribute to an effective service?

3.1 As well as better understanding the challenges that young people face in accessing services, alongside the effectiveness of those services, this inquiry also sought to understand what good work is already going on to support young people who self-harm.

3.2 As has already been outlined, the needs of this group are various and will differ from person to person. Some broad themes did, however, come through in evidence and are explored below.

Involving young people in service design and delivery

3.3 In order to move towards a preventative, early intervention model of care for young people, system change will be crucial. However, a focus on the needs and views of young people must not be lost. Young people should be empowered with options in the care they are offered and how they access it.

3.4 As has been pointed out, there is no 'one-size-fits-all' when it comes to the needs of young people who self-harm and yet all too often pathways are funnelled towards CAMHS and IAPT for want of alternatives. Dr Jonathan Leach of RCGP told the inquiry that it is crucial to involve the young person in finding the correct intervention for them. The young people who gave evidence were clear in what they needed from services and eloquent as to how their experiences fell short.

3.5 Some of the changes required to services are very practical: for example, interventions providing more than one access point would be particularly beneficial for many autistic young people who may find phone calls challenging.

3.6 Other changes are more systemic. The report has outlined how certain young people, such as those from ethnic minorities or care leavers, particularly struggle to access support. Services, in consultation with marginalised groups, need to get better at reaching vulnerable young people who currently struggle to get help and stay engaged. This might include expansion of referral routes or ensuring that the service offer is culturally relevant and sensitive to the needs of a wider set of demographics than at present.

3.7 A number of respondents outlined the importance of having young people themselves at the heart of service design. The user involvement element of the soon to be updated NICE guidelines for working with children and young people who self-harm was welcomed and should help in ensuring that it is young people with lived experience who are driving forward the care that they receive.

3.8 Harmless was identified by others as effectively involving young people in service design to provide a flexible and highly effective model in terms of reducing severity and frequency of self-harm.

3.9 Written evidence received by the inquiry noted that young people are continually questioning accepted ways of working and using technology in new and interesting ways. As such, services which are disconnected from their experience in terms of service design face the prospect of falling behind quickly and struggling to effectively engage young people.

Recommendation: The Department of Health and Social Care and NHS England/Improvement should ensure that co-production is at the heart of design and delivery for mental health services accessed by young people who self-harm by making it a condition of funding.

This should:

- Ensure young people are engaged at all stages of service development, both in NHS mental health services and community-based services, from design to delivery to strategic decision making.
- Prioritise the voices of young people from marginalised groups including LGBT, ethnic minority groups and those with autism in this co-production process to improve accessibility of services.

Person centred support

3.10 'Person centred' is not always an easy term to define and is one that is used in different settings as a catch-all term for different practices. In the context of the evidence received, person centred meant starting with the needs of young people, asking what matters to them and then providing services accordingly. Such practice was consistently identified as being important but rare.

3.11 James explained to the inquiry how at a young age he felt that the sole focus of services was to get him back to school, where he was struggling badly, rather than supporting him with the range of issues which lead to his self-harm. As a result, it was many years before he received support:

'Rather than trying to fix the problem, they were trying to get me into school. I was anxious about going into school, but they wanted to fine my mum [for non-attendance]. That creates more of a burden. I believed I was a burden on society... It was all about getting back into school.' James

3.12 Self-harm is a deeply personal behaviour with individual drivers which require individual responses. For some young people self-harm will be a one-off event, while for others it is a long-term coping mechanism. Self-Injury Support outlined to the inquiry that empowering young people to set the agenda for what they want to talk about is important.

3.13 While for some people self-harm is a topic they will inevitably want to discuss, for others the context surrounding that behaviour is just as, if not more, important. Dr Paul Chrisp from NICE told the inquiry that in their experience, people were sometimes fitted into a guideline, or a set structure of support, rather than receiving care that is based on their individual needs. Others outlined how a focus on a young person stopping self-harm, as opposed to an exploration of the context for that behaviour, was in the long run counterproductive.

Peer support

3.14 Another way young people can be empowered is helping each other through safely facilitated peer support. Confiding in another person with similar experiences is one way to tackle the issue of stigma and to help young people discover alternative coping mechanisms.

3.15 The inquiry received strong and differing opinions on the role that peer support should play in supporting young people who self-harm. Some respondents felt that peer support should definitely be more common. It should be backed up by professional supervision and moderation which does not stifle helpful conversation as part of a system of group working which helps to reduce stigma and shame.

3.16 For others, peer support offered the chance to improve their mental health using social (as opposed to clinical) interventions such as team sports. Peer support was identified as the fastest way to encourage young people to broach difficult conversations and encourage young people to open up. In their evidence YoungMinds reported that young people had identified peer support as being helpful on the basis that it is less prescriptive than other types of intervention and allows for empathetic conversations between people who understand each other's points of view. Research by Lavin and Winter seems to back this up, noting that young people are often resistant to external support.[80]

3.17 The advantages of peer support, especially involving people with similar experiences, are intuitive given the deeply private nature of the behaviour and the strong inhibitive effect that stigma has on help-seeking through other routes. It should be noted, though, that without proper structure and supervision, its impact can be limited or even harmful. Research by YoungMinds, The Mix and Self-Harm UK found that although 75% of young people know someone who self-harms or who has self-harmed, only 9% felt "very confident" about knowing what action to take if someone opened up to them.[81]

3.18 A number of models which are currently working well were flagged to the inquiry, but more evidence is needed about how peer support can be used most effectively and safely both online and in person.

Recommendation: The Department of Health and Social Care and NHS England should work together to ensure that safe peer-support models are promoted.

They should do this by:

- Commissioning research, as a priority, to understand how group models of peer support can be used safely and effectively both online and in person.
- Encouraging the commissioning of online and face-to-face peer support services, taking into account the evidence base, on what works best and how this can be done safely. These services should be co-developed and evaluated by young people with experience of self-harm.

Online support and utilising technology

3.19 The inquiry began before the Covid-19 pandemic took hold of daily life and forced mental health services around the country to adapt the way their offer is delivered. The way services have adapted, and to what effect, has been varied across the country but a move towards remote, and often online support, has been widespread. At the time of writing there does not exist reliable data on how successful this transition has been, and more research is needed into which digital interventions work best to support young people who self-harm.

3.20 KOOTH, an online counselling and emotional well-being platform for children and young people, has evidenced an exponential increase in demand for its service during lockdown.[82] KOOTH is accessible through mobile, tablet and desktop and is free at the point of use in those areas where Integrated Care Systems (ICSs) have commissioned it.

3.21 While it will not be right for everyone, it seems inevitable that online support will continue to play a more important role in supporting young people who self-harm as society continues to move out of lockdown and into recovery.

3.22 Much of the evidence received by the inquiry, predating the pandemic, pointed to online support as an important aspect of useful services. A Youth Action Group connected to Birmingham University identified the need for digital enhancement of traditional NHS mental health services to support their needs in a way which better suited them than face-to-face services.

3.23 Youthscape run online support groups for young people who self-harm which they described as ‘inundated despite next to no advertising’. An online model is seen as crucial as it allows the organisation to sidestep the often debilitating aspect of face-to-face interactions. Feedback for their service as a place where young people are able to share

thoughts and feelings without having to show their face is highlighted as a key reason for their popularity.

3.24 The use of social media by young people who self-harm is a complicated picture. As acknowledged by DHSC in written evidence, young people are more likely to disclose their use of self-harm through social media than to a healthcare professional. This largely unsupervised peer support presents opportunities and challenges which the Government is currently grappling with through its online harms white paper process. The helpfulness of social media for support is particularly complex due to the often blurred lines between supportive and harmful content or forums.

3.25 Research from Birmingham University, in press at the time of writing, suggests that peer support is a central aspect to online conversations of self-harm and has been described as 'lifesaving' by social media users. Young people often turn to social media for support in the early stages of self-harm, while they are waiting for formal support in order to be listened to without judgement and to have painful and stigmatised experiences validated.

3.26 As pointed out in Birmingham University's written evidence, online interactions also provide an opportunity for offline peer-to-peer interventions if done safely and in a way that reflects some of the important attributes of online support.[83] The formal evidence base around how best to facilitate online and offline peer support groups is currently underdeveloped and more must be understood about how such groups can be used most safely and effectively.

Recommendation: The Department of Health and Social Care, NHS England, service providers and commissioners should work together to ensure that young people who self-harm get better support online.

They should do this by:

- Developing and evaluating digital online interventions for both young people and parents to ensure their efficacy.
- Capitalising on digital technology, including social media, to facilitate engagement, assessment and management of self-harm among young people, as well as learn from, and harness existing models of peer support online.

Responsive, long term and consistent support

3.27 The inquiry heard that rather than a specific type of intervention, the support of a trusted, consistent figure who the young person feels understands what they are going through is most important. Whether the person who delivers the support is a professional or peer, and whether the support comes online or in person, is for many young people of secondary importance.

3.28 For a young person who may be struggling with a range of underlying issues, the stability of consistent support is key. The reverse of this can be very damaging in terms of accessing and staying engaged with services. The experience of having to re-tell your story to different health professionals again and again was reported as being very difficult and even a barrier to reengaging with a service.

Confidentiality

3.29 For such a private act, which is often surrounded by so much stigma, confidentiality is understandably important. The inquiry heard that young people are often terrified of seeking help for fear of their parents being notified of their self-harming behaviour, which in turn inhibits help seeking. Dr Jonathan Leach stressed the importance of GPs dealing with confidentiality in a way which does not alienate young people, while acknowledging that it cannot be absolute and that the safety of young people must be a priority.

3.30 Medical professionals must consider 'Gillick' competency if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge. For GPs this is a complex judgement call which bears heavily on their capacity to shoulder the risk involved. As this report has already explored, GPs are often extremely worried about this risk and 'getting it wrong.' The involvement of young people in decision making and obtaining consent, alongside parents and other trusted adults is key. DHSC's Consensus Statement can be instructive in guiding this process.[84]

3.31 The inquiry received evidence asserting that the issue of consent should be approached with more nuance than it is currently afforded. Conversations with families, which don't jeopardise confidentiality, should form part of risk assessments. While families and carers should also be supported by medical professionals to understand more about self-harm and how best they can support loved ones. DHSC's Consensus Statement is a useful tool to guide this process.

3.32 Understanding self-harm as a possible precursor to suicide has been an important development in ensuring that the behaviour is taken more seriously and is less likely to be dismissed as a fad or attention seeking (though as evidenced through this report, there is still much progress to be made in this regard). This could also, however, go part of the way to explaining why young people are bounced between services which feel unable to bear the perceived risk that a young person who self-harms represents to themselves.

3.33 With overstretched services and overworked professionals throughout the formal system of support for self-harm, it is perhaps understandable that services often find it

difficult to accept the risk posed, despite the fact that the majority of young people who self-harm will not go on to take their own lives.[85] Reorienting our approach to dealing with this group in a person centred way, moving from a focus on behaviour towards the underlying context, health professionals may be able to more consistently assess risk and the need for confidentiality.

3.34 Alongside this, services need to be more consistently clear about their confidentiality agreements and what they can and cannot promise young people in terms of disclosure and be more skilled at talking to young people about this. This will be of paramount importance in terms of building trust and empowering young people to seek help.

Recommendation: The royal colleges of GPs, psychiatrists and other professional bodies should work together to ensure that their members are skilled in handling issues of confidentiality so that it does not become a barrier to seeking support.

This should:

- Take into account the Department of Health and Social Care's Consensus Statement
- Involve family, carers and other trusted individuals in risk assessments
- Ensure that families, carers and others understand more about self-harm, so they are best positioned to provide support

Section 4, Conclusion: What needs to change to ensure young people who self-harm are better supported?

Recommendation: The Government should fund and implement a new system of early intervention, involving departments including the Department of Health and Social Care, the Department for Education, Ministry of Housing Communities and Local Government and the Department for Digital, Culture, Media and Sport, to support young people who self-harm.

The National Suicide Prevention Strategy Delivery Group could be the coordinating body to ensure delivery.

This should:

- Encourage the creation of a network of open-access mental health services based in local communities which provide immediate support in a non-clinical setting, alongside advice on employment and education.
- Run parallel to increased and expedited investment in statutory CAMHS and IAPT services based on commitments in the NHS Long Term Plan.
- Be based on a whole system (as opposed to clinical) approach, underpinned with investment in wider community-based services for young people, which is trauma informed and understands self-harm as a reaction to emotional distress.
- Involve commissioners and public health teams to fund preventative services based on social interventions which reach young people much earlier, before their needs escalate and they reach crisis. Ensuring CCGs and Local Authorities regularly publish data on their spending on Tier 1 and Tier 2 CAMHS (i.e. for prevention and early intervention) would support this.

A shift towards early intervention

4.1 The inquiry found that the single most important potential change to the system of support offered to young people who self-harm would be earlier intervention. While immediate government investment in the current system is necessary to improve support for young people who self-harm, a more fundamental and holistic system shift towards prevention and away from crisis intervention is required.

4.2 A government green paper in December 2017 committed to 'earlier intervention and prevention' in mental health support for young people.[86] There is much work to do in that regard almost three years later. Young people still need much faster interventions before their mental health needs escalate and the possibility of self-harming behaviour becoming habitual is increased.

4.3 The Long Term Plan, with reference to early intervention for mental health, points to the roll-out of mental health teams in schools and colleges.[87] This development was widely welcomed by respondents to the inquiry, many of whom called for the scheme to be implemented more comprehensively, sooner than currently planned. Though schools are an unarguably important domain for prevention, a system of early intervention must go further than education settings.

4.4 It is crucial that anyone who needs specialist mental health support should be able to get it in a timely fashion. However many young people, given the opportunity for earlier intervention from community-based support, may never need to access CAMHS or IAPT.

4.5 The system, in effect, needs to be flipped on its head so that young people are supported long before ever reaching crisis. Young people facing adversity need to be identified and supported earlier by those working in health, social care and education to build their emotional resilience. This will require a shift in focus and funding to support those professionals. Reaching young people much earlier, before they reach crisis and self-harm becomes a central part of their ability to cope, is crucial to effectively preventing self-harm.

Investing in prevention

4.6 In order to facilitate a longer term move towards a preventative system of early intervention, government investment to reverse years of underfunding in wider community-based services will be key.

4.7 To shift away from the current model of crisis intervention, local authorities must be supported by central government to consistently invest in a broad range of services for young people to support them much earlier, before problems escalate, based on an understanding of self-harm as the presenting behaviour for a wider set of underlying, often social or emotional, issues that a young person might face.

4.8 Investment in youth clubs and groups, as well as sports facilities, will be key. Youth services can create positive environments which enhance belonging and connectedness. They help young people to develop a wider network of support, increase positive relationships with trusted adults or peers and make the disclosure of self-harm behaviours more likely.

4.9 There will also need to be investment in community-based services specifically created for tackling self-harm delivered by the third sector so they can innovate, more effectively plug gaps in provision and also offer community-based alternatives to statutory support.

4.10 All of this must run concurrently with investment in common mental health services for young people to increase capacity and expertise to deal with self-harm, reduce waiting times, lower thresholds and end the practice of exclusion based on self-harming behaviour.

4.11 There is a clear financial, as well as human, motivation to make this change. Research has shown that the overall mean hospital cost per episode of self-harm is £809, which results in roughly £162m per year spent on hospital management of self-harm[88]. Apart from the clear human motivation for a shift towards community-based prevention, as our health systems continue to recover from responding to Covid-19, any financial savings which can be made to health budgets should be explored.

A focus on trauma

4.12 Integral to a shift towards prevention will be interventions and approaches that concentrate on dealing with underlying trauma and issues faced by a young person, rather than focusing solely on the presenting self-harming behaviour. Self-harm should be understood as a coping mechanism employed by young people to manage emotions related to trauma or other difficulties. It should be viewed a symptom and signal of distress which often has its root in a range of social issues rather than as an end in itself to be dealt with.

4.13 By focusing on the underlying issues which young people are facing, rather than the physical manifestation of their distress, and what does or does not constitute self-harm, preventative help can come earlier when problems first emerge.

4.14 Young people must be treated as individuals, with the full range of challenges they face, rather than narrowly in terms of their medical needs or presenting behaviour. A number of respondents advocated for a trauma-informed model of care, taking into account adverse childhood experiences or 'ACEs', and citing the strong association between traumatic stress exposure and self-harm and suicidality.[89]

Full list of recommendations

Recommendation:

The Government should fund and implement a new system of early intervention, involving departments including the Department of Health and Social Care, the Department for Education, Ministry of Housing Communities and Local Government, and the Department for Digital, Culture, Media and Sport, to support young people who self-harm.

The National Suicide Prevention Strategy Delivery Group could be the coordinating body to ensure delivery.

This should:

- Encourage the creation of a network of open-access mental health services based in local communities which provide immediate support in a non-clinical setting, alongside advice on employment and education.

- Run parallel to increased and expedited investment in statutory CAMHS and IAPT services based on commitments in the NHS Long Term Plan.

- Be based on a whole system (as opposed to clinical) approach, underpinned with investment in wider community-based services for young people, which is trauma informed and understands self-harm as a reaction to emotional distress.

- Involve commissioners and public health teams to fund preventative services based on social interventions which reach young people much earlier, before their needs escalate and they reach crisis. Ensuring CCGs and Local Authorities regularly publish data on their spending on Tier 1 and Tier 2 CAMHS (i.e. for prevention and early intervention) would support this.

Recommendation:

The Department of Health and Social Care should use the forthcoming funding settlement to increase and accelerate planned investment in existing mental health services for young people.

This should:

  - Triple the Government's current stretch target of 35% of children and young people who need mental health services receiving them so that 100% receive them by 2025.

  - Expand CAMHS capacity, address workforce issues, shorten waiting lists and lower thresholds for support to meet existing demand specifically for self-harm.

- Support specialist mental health services such as CAMHS and IAPT to improve training and safeguarding practices in order to ensure that young people who self-harm are not excluded from support on the basis of their behaviour.

- Use commitments in the NHS Long Term Plan to expand community multi-disciplinary teams to ensure that mental health services for young people are fully integrated into primary health care.

- Strengthen the existing evidence base to inform future commissioning with research into:

    - Which interventions work best for individual groups when self-harming, including how cognitive-behavioural psychotherapy and dialectical behavioural therapy interventions can best be used to support different groups.
    - The prevalence of self-harm among young people from different ethnicities and the support they receive.
    - How mainstream NHS mental health services for young people can be digitally enhanced, taking into account international examples of good practice.

- Ensure the continued re-commissioning of the Adult Psychiatric Morbidity Survey (APMS), a population-wide survey including data around the prevalence of self-harm in the community.

Recommendation:

The Department for Digital, Culture, Media and Sport, the Ministry of Housing, Communities & Local Government, the Department of Health and Social Care should ensure that third sector and community-based organisations are able to continue helping young people who self-harm by providing a sure financial footing for the future.

Ministry of Housing, Communities and Local Government and Department for Digital, Culture, Media and Sport should ensure that:

- Local authorities are supported to fund community-based non-clinical services and pathways specifically for self-harm prevention to support young people who self-harm before they reach crisis point.

Department for Health and Social Care should ensure that:

- Its funding for voluntary organisations includes provision for those who self-harm.

NHS England should ensure that:

- Integrated Care Systems work closely with the third sector to ensure that community-based support services are integrated into care plans and that these services are funded and utilised so that young people who self-harm are supported earlier.

Recommendation:

The Department for Education should provide schools and colleges with increased mental health resource sooner so that they are able to undertake preventative interventions around self-harm more consistently.

This should ensure:

- Mental Health Support Teams are rolled out more quickly to ensure that every school and college in the country has access to them as soon as possible.
- Every Mental Health Support Team is trained in understanding issues of self-harm and suicide as central elements of policy and practice.
- Schools and colleges are supported to adopt a 'whole school/college' preventative approach to supporting students who self-harm
- Self-harm awareness and education is integrated into core elements of the curriculum.
- Approved guidance around dealing with self-harm is distributed to every teacher in the country.

Recommendation:

The Department of Health and Social Care, NHS England, the Department for Education and the Local Government Association should work together to support both Integrated Care Systems and local authorities to improve access to services.

They should:

- Invest in research to inform service design in how best to reach and support marginalised and minority ethnic groups who self-harm.

- Ensure that commitments in the NHS Long Term Plan to increase provision of crisis services result in support for local authorities and services to undertake outreach and culturally appropriate provision.

- Enable ICSs to make services more welcoming, accessible and able to meet the needs of a diverse range of young people who self-harm by engaging young people at all stages of service development. Appropriate messaging should be used to attract young people who usually struggle to access services including young men, LGBT and ethnic minority communities as well as those with a range of neurodivergent needs.

- Ensure all centrally allocated funding for mental health has specifically taken the needs of marginalised groups such as LGBT and minority ethnic populations into account.

Recommendation:

The Department for Health and Social Care, NHS England and the Department for Education should work together to make it easier for young people to navigate the support system.

This should be achieved by:

- Providing every young person who presents to NHS services having self-harmed with the option of having a 'buddy' to help them navigate the support system and act as a caseworker. This could be a health professional provided through mental health liaison teams.

- Running campaigns in educational settings to increase literacy and understanding among young people about self-harm and where they can go to seek support when they are struggling.

- Creating and maintaining verified support resources for young people who self-harm, including how to develop new coping mechanisms, which are curated and located in one easy to access online space.

- Encouraging the sharing of information between different agencies as young people move between services, in line with data sharing and privacy laws, to avoid young people having to repeat their story.

- Providing more support for families, carers and guardians of young people who self-harm in the form of educational materials and self-help tools. Where appropriate, more family-based interventions and outreach should be offered, in order to guide their support of young people in the home environment.

Recommendation:

The Department of Health and Social Care, NHS England, service providers and commissioners should work together to ensure that young people who self-harm get better support online.

They should do this by:

- Developing and evaluating digital online interventions for both young people and parents to ensure their efficacy.
- Capitalising on digital technology, including social media, to facilitate engagement, assessment and management of self-harm among young people, as well as learn from, and harness existing models of peer support online.

Recommendation:

NHS England/Improvement, the Department for Education, and the Department for Digital, Culture, Media and Sport should ensure any frontline professional likely to come into contact with a young person who self-harms receives appropriate training on how best to support them.

This should include training for social workers, teachers, youth workers, and health professionals on:

- The different behaviours which can constitute self-harm.
- The difference between self-harm and suicide and implications for support.
- How to speak about self-harm in a trauma-informed way.
- How to meet the needs of marginalised young people who self-harm or are at risk of self-harm.
- How to support and keep a young person who is self-harming safe in school.
- Undertaking holistic psychosocial assessments in line with NICE guidelines for GPs specifically.

Recommendation:

The Department of Health and Social Care and NHS England/Improvement should ensure that co-production is at the heart of design and delivery for mental health services accessed by young people who self-harm by making it a condition of funding.

This should:

- Ensure young people are engaged at all stages of service development, both in NHS mental health services and community-based services, from design to delivery to strategic decision making.

- Prioritise the voices of young people from marginalised groups including LGBT people, ethnic minority groups and those with autism in this co-production process to improve accessibility of services.

Recommendation:

Public Health England[90], NHS England and the Department of Health and Social Care should lead the sharing and consolidation of national real time self-harm data across clinical and community settings, supported by excellent local surveillance systems.

This should bring together all clinical and community data sources on self-harm to provide the most comprehensive picture possible regarding the real time prevalence and trends of self-harm across different settings.

Recommendation:

The Department of Health and Social Care and NHS England should work together to ensure that safe peer-support models are promoted.

They should do this by:

- Commissioning research, as a priority, to understand how group models of peer support can be used safely and effectively both online and in person.

- Encouraging the commissioning of online and face-to-face peer support services, taking into account the evidence base on what works best and how this can be done safely. These services should be co-developed and evaluated with young people with experience of self-harm.

Recommendation:

Recommendation: The royal colleges of GPs, psychiatrists and other professional bodies should work together to ensure that their members are skilled in handling issues of confidentiality so that it does not become a barrier to seeking support.

This should:

- Take into account the Department of Health and Social Care's Consensus Statement
- Involve family, carers and other trusted individuals in risk assessments
- Ensure that families, carers and others understand more about self-harm, so they are best positioned to provide support

References

[1] Department of Health, Department for Education, *Transforming children's and Young People's Mental Health Provision: a Green Paper*, (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
[2] NHS England, *The NHS Long Term Plan*, (2019), available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[3] NHS England, Implementing the Five Year Forward View for Mental Health, (2016), available here: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
[4] The Children's Commissioner, *The state of children's mental health services*, (2020), available here: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/01/cco-the-state-of-childrens-mental-health-services.pdf
[5] Tsiachristas et al, *General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis* (2017), available here: https://www.thelancet.com/action/showPdf?pii=S2215-0366%2817%2930367-X
[6] The Department of Health changed its name to the Department of Health and Social Care in 2018 and will be referred to by the acronym 'DHSC' throughout the report
[7] Department of Health, *Preventing suicide in England, A cross-government outcomes strategy to save lives*, (2012), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[8] Department of Health, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives,* (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf
[9] House of Commons Health Committee, *Suicide Prevention: sixth report of session 2016/17*, (2017), available here: https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/1087.pdf
[10] NHS England, *NHS Mental Health Implementation Plan 2019/20 – 2023/24*, (2019), available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf
[11] Department of Health, Department for Education, *Transforming children's and Young People's Mental Health Provision: a Green Paper*, (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
[12] NHS England, *The NHS Long Term Plan*, (2019), available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[13] Ibid
[14] Department of Health, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives,* (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf
[15] Department of Health and Social Care answer to written parliamentary question (73045), (24.07.20), available here: https://questions-statements.parliament.uk/written-questions/detail/2020-07-13/73045
[16] National Institute for Health and Care Excellence, *Quality Standard 34: Self-harm*, (2013), available here: https://www.nice.org.uk/guidance/qs34
[17] Department of Health, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives,* (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

[18] Samaritans and University of Exeter, *Local Suicide Prevention Planning in England*, (2019), available here: https://media.samaritans.org/documents/Local_suicide_prevention_planning_in_England_full_report.pdf
[19] Various organisations, *Children and young people's services: Funding and spending 2010/11 – 2017/18*, available here: https://www.childrenssociety.org.uk/sites/default/files/childrens-services-funding-csfa-briefing_final.pdf
[20] NHS Digital, *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, (2016), available here: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf
[21] Self-Harm UK, The Mix, Young Minds, *New survey shows more than a third of young people have self-harmed*, (2018) available here: https://youngminds.org.uk/about-us/media-centre/press-releases/new-survey-shows-more-than-a-third-of-young-people-have-self-harmed/
[22] NHS Digital, *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey*, (2014), P295, available here: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf
[23] Stonewall, *The school report: the experiences of lesbian, gay bi and trans young people in Britain's schools in 2017*, (2017), available here: https://www.stonewall.org.uk/system/files/the_school_report_2017.pdf
[24] GOV.UK, Self Harm and suicidal thoughts and attempts, (2019), (drawn from Adult Psychiatric Morbidity Survey (2014), available here: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-reporting-suicidal-thoughts-attempts-and-self-harm/latest#by-ethnicity
[25] Cooper et al, *Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study, (2010), available here:* https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/ethnic-differences-in-selfharm-rates-characteristics-and-service-provision-threecity-cohort-study/CDBA53F0AC230909E892C263781A0A51
[26] Husain et al., *Self-harm in British South Asian Women: Psychosocial Correlates and Strategies for Prevention*, (2006), available here: https://www.researchgate.net/publication/7065982_Self-harm_in_British_South_Asian_Women_Psychosocial_Correlates_and_Strategies_for_Prevention
[27] Research Autism, *Self Injurious Behaviour and Autism*, (2017) available here: http://www.researchautism.net/issues/11/self-injurious-behaviour-and-autism/currentresearch
[28] Mars et al. *Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population based birth cohort study*, (2019), available here: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30030-6/fulltext
[29] Ibid.
[30] The Women's Mental Health Taskforce, *Final Report*, (2018), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf
[31] The link between school pressure and self-harm has been explored within the wider evidence base. For more information see here: https://neu.org.uk/press-releases/pressures-school-making-pupils-suicidal-neu-survey
[32] BBC News, Molly Russell: *Instagram extends self-harm ban to drawings*, (2019) available here: https://www.bbc.co.uk/news/technology-50129402
33 Unpublished rapid review of evidence provided by Samaritans and last accessed 29.07.2020
[34] Agenda, Often overlooked: young women, poverty and self-harm, 2020, available here: https://weareagenda.org/wp-content/uploads/2017/03/Often-Overlooked-Young-women-poverty-and-self-harm-2.pdf
[35] NHS Digital, *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, (2016), available here: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf
[36] Public Health England or the body/bodies which come to replace it
[37] McManus et al., Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population, (2019), available here: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30188-9/fulltext
[38] Department of Health, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives,* (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

[39] Place2Be, *Significant rise in number of school-based counsellors*, (2020), available here: https://www.place2be.org.uk/about-us/news-and-blogs/2020/february/significant-rise-in-number-of-school-based-counsellors/
[40] BBC News, *Child mental health: Camhs 'not fit for purpose'*, (2018), available here: https://www.bbc.co.uk/news/health-45607313
[41] Facourt et al., *Covid-19 Social Study: Results Release 12*, (last accessed 12.06.2020), available here: https://b6bdcb03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_ba131d192faa4d249cde0914be4189dd.pdf
[42] NHS England, *NHS warning to seek help for cancer symptoms, as half of public report concerns with getting checked,* (2020), available here: https://www.england.nhs.uk/2020/04/nhs-warning-seek-help-cancer-symptoms/
[43] Kooth, Data release July 06 2020, *Week 16: How Covid-19 is Affecting The Mental Health of Children and Young People* (CYP), (2020), available here: https://xenzone.com/wp-content/uploads/2020/07/Week16CYPv2.pdf
[44] NHS Digital, *Waiting times for children and young people's mental health services, 2018 – 2019 additional statistics,* (2019), available here: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/waiting-times-for-children-and-young-peoples-mental-health-services-2018---2019-additional-statistics
[45] Young Minds, *A new era for young people's mental health*, (2018), available here: https://youngminds.org.uk/media/2620/a-new-era-for-young-peoples-mental-health.pdf
[46] NHS England, *The NHS Long Term Plan*, (2019), available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[47] Education Policy Institute, *Access to child and adolescent mental health services in 2019*, (2020), available here: https://epi.org.uk/wp-content/uploads/2020/01/Access-to-CAMHS-in-2019_EPI.pdf
[48] NHS Digital, *Waiting times for children and young people's mental health services, 2018 – 2019 additional statistics,* (2019), available here: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/waiting-times-for-children-and-young-peoples-mental-health-services-2018---2019-additional-statistics
[49] The Children's Commissioner, *Early access to mental health support*, (2019), available here: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/04/Early-access-to-mental-health-support-April-2019.pdf
[50] You can find the Time to Change campaign website here: https://www.time-to-change.org.uk/
[51] You can find the Every Mind Matters campaign website here: https://www.nhs.uk/oneyou/every-mind-matters/
[52] National Institute for Health and Care Excellence, *Quality Standard 34, Quality Statement 1: Compassion, respect and dignity*, (2013), available here: https://www.nice.org.uk/guidance/qs34/chapter/Quality-statement-1-Compassion-respect-and-dignity
[53] Nonpublished evidence provided to this inquiry from a Wellcome Trust-funded study of self-harm content on social media led by Dr Anna Lavis at the University of Birmingham
[54] Asarnow and Mehlum, *Practitioner Review: Treatment for suicide and self-harming adolescents - advances in suicide prevention,* (2019), available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/jcpp.13130
[55] NHS Digital, *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, (2016), available here: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf

[56] Government Equalities Office, *National LGBT Survey Research Report*, (2018), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf
[57] Stonewall, *LGBT in Britain: Health Report,* (2018), available here: https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf
[58] Race Equality Foundation, *The importance of promoting mental health in children and young people from black and minority ethnic communities*, (2014), available here: http://raceequalityfoundation.org.uk/wp-content/uploads/2018/02/Health-Briefing-332.pdf

[59] Centre for Mental Health, *Against the odds: Evaluation of the Mind Birmingham Up My Street programme*, (2017), https://www.centreformentalhealth.org.uk/sites/default/files/2018-10/Against%20the%20odds%20-%20Up%20My%20Street%20evaluation.pdf
[60] Rattaz et al., *Symptom severity as a risk factor for self-injurious behaviours in adolescents with autism spectrum 2015..Journal of Intellectual Disability Research*, (2015), available here: https://www.researchgate.net/publication/270967030_Symptom_severity_as_a_risk_factor_for_self-injurious_behaviours_in_adolescents_with_autism_spectrum_disorders_Risk_factors_for_SIB_in_adolescents_with_ASD
[61] Crane et al., *'Something needs to change': Mental health experiences of young autistic adults in England,* (2018), available here: https://journals.sagepub.com/doi/10.1177/1362361318757048
[62] Barnardo's, *Neglected Minds: A report on mental health support for young people leaving care*, (2017), available here: https://www.barnardos.org.uk/sites/default/files/uploads/neglected-minds.pdf
[63] The Children's Commissioner, *The state of children's mental health services*, (2020), available here: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/01/cco-the-state-of-childrens-mental-health-services.pdf
[64] Ibid
[65] Examples of publicly available exclusion criteria include Cambridgeshire and Peterborough NHS Foundation Trust, available here: https://www.cpft.nhs.uk/services/pws/psychological-wellbeing-service.htm and Ealing IAPT service, available here: https://ealingiapt.nhs.uk/how-to-get-help/iapt-services-west-london-nhs-trust-referral-criteria/
[66] Education Policy Institute, *Access to child and adolescent mental health services in 2019*, (2020), available here: https://epi.org.uk/wp-content/uploads/2020/01/Access-to-CAMHS-in-2019_EPI.pdf
[67] National Institute for Health and Care Excellence, *Quality Standard 34, Quality Statement 3: Comprehensive psychosocial assessments*, (2013), available here: https://www.nice.org.uk/guidance/qs34/chapter/Quality-statement-3-Comprehensive-psychosocial-assessments
[68] The Multicentre Study of Self-harm in England, *Overview of trends of self-harm, 2000-2012*, available here: http://cebmh.warne.ox.ac.uk/csr/mcm/MCM%202000-12_SITE%20summary.pdf
[69] Education Policy Institute, *Access to child and adolescent mental health services in 2019*, (2020), available here: https://epi.org.uk/wp-content/uploads/2020/01/Access-to-CAMHS-in-2019_EPI.pdf
[70] Young Minds, *#Fighting for report*, (2018), available here:https://youngminds.org.uk/media/2258/youngminds-fightingfor-report.pdf
[71] General Medical Council, *The state of medical education and practice in the UK: the workforce report*, (2019), available here: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2019
[72] Samaritans and University of Exeter, *Local Suicide Prevention Planning in England*, (2019), available here: https://media.samaritans.org/documents/Local_suicide_prevention_planning_in_England_full_report.pdf
[73] Health Service Journal, *Major drop-off in referrals to children's mental health services*, (2020), available here: https://www.hsj.co.uk/coronavirus/major-drop-off-in-referrals-to-childrens-mental-health-services/7027373.article
[74] National Institute for Health and Care Excellence, *Self-harm overview interactive flowchart*, (last accessed 14.09.2020), available here: https://pathways.nice.org.uk/pathways/self-harm#path=view%3A/pathways/self-harm/self-harm-overview.xml&content=view-index
[75] Evening Standard, *Doctors warn of 'rising tide' in demand for serious mental health services as lockdown eases*, (August 2020), available here: https://www.standard.co.uk/news/health/doctors-nhs-mental-health-severe-coronavirus-a4523076.html
[76] NHS England, *The NHS Long Term Plan*, (2019), available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[77] The Children's Commissioner, *Early access to mental health support*, (2019), available here: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/04/Early-access-to-mental-health-support-April-2019.pdf
[78] Place2Be, NAHT, *Huge rise in number of school-based counsellors over past three years, (2020),* available here: https://www.place2be.org.uk/media/rnuf5drw/place2be-and-naht-research-results.pdf

[79] Young Minds, *Teachers need more support to tackle self-harm*, (2019) available here: https://youngminds.org.uk/about-us/media-centre/press-releases/teachers-need-more-support-to-tackle-self-harm/
[80] Findings featured in article in The Conversation, *Self-harm and social media: a knee-jerk ban on content could actually harm young people, (2019),* available here: https://theconversation.com/self-harm-and-social-media-a-knee-jerk-ban-on-content-could-actually-harm-young-people-111381
[81] Self-Harm UK, The Mix, Young Minds, *New survey shows more than a third of young people have self-harmed*, (2018), available here: https://youngminds.org.uk/about-us/media-centre/press-releases/new-survey-shows-more-than-a-third-of-young-people-have-self-harmed/
[82] Kooth, *Data release July 06 2020, Week 16: How Covid-19 is Affecting The Mental Health of Children and Young People* (CYP), (2020), available here: https://xenzone.com/wp-content/uploads/2020/07/Week16CYPv2.pdf
[83] From written evidence provided by Birmingham University, Lavis and Winter in press (2020)
[84] Department of Health, *Information sharing and suicide prevention consensus statement*, (2014), available here: https://www.nspa.org.uk/wp-content/uploads/2018/05/Consensus_statement_on_information_sharing.pdf
[85] E. Klonsky et al., *The Relationship between Nonsuicidal Self-Injury and Attempted Suicide: Converging Evidence from Four Samples*, (2013), available here: https://doi.org/10.1037/a0030278
[86] Department of Health, Department for Education, *Transforming children's and Young People's Mental Health Provision: a Green Paper*, (2017), available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
[87] NHS England, *The NHS Long Term Plan*, (2019), available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[89] Asarnow and Mehlum, *Practitioner Review: Treatment for suicide and self-harming adolescents - advances in suicide prevention,* (2019), available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/jcpp.13130
[90] Public Health England or the body/bodies which come to replace it