Teachers, parents and general practitioners may sense stigma as well as shame or blame when talking to a young person about self-injury. They may feel helpless and unsure about what to say. But poor communication only makes the problem continue.

Young people need help and support from family, friends, and their community.

Talking about the issues in a sensitive and calm way with compassion and some curiosity is often a good place to start.*

*Royal College of Psychiatrists (October 2014) Managing self-harm in young people. College Report CR192

Contents

Many of these young people are trying to gain relief from terrible feelings or to punish themselves, and discover that they can achieve some relief by hurting themselves. Around a quarter of young people will be thinking about suicide when they are carrying out the injury, but completed suicide is a very rare outcome of self-injury during adolescence.

Key Messages

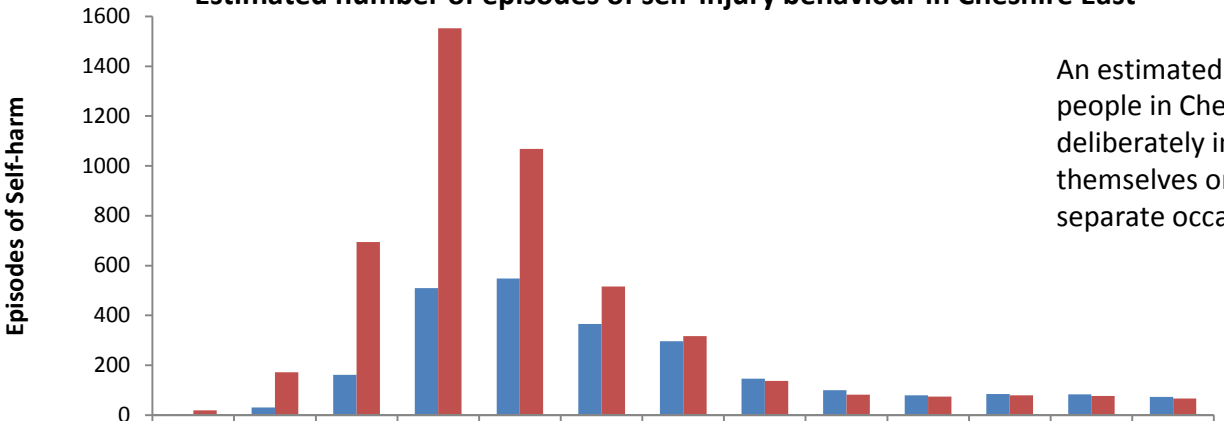
1. All schools should have counselling services that are easily and readily available to pupils
2. Intervene effectively and early during the course of a young person's self-injury journey
3. There should be provision of a rapid and supportive response throughout a time of crisis, including evening and night
4. Public health commissioners should work with head teachers to develop open access substance misuse services that are easily accessible to pupils from year 9 onwards
5. Parents should be advised to promote good sleep patterns and encourage sufficient sleep and reduce use of online games and social communication at night time
6. To reduce the likelihood of adolescent self-harmers dropping out of services, it is important to minimise barriers to accessing assessment and counselling, including speed of appointment and accessibility of the treatment setting
7. Whole school approaches to improving emotional wellbeing may improve help-seeking behaviour but there is no evidence that they reduce levels of severe suicidal thinking

Self-injury is uncommon under the age of 12. The behaviour begins around puberty and peaks around the age of 15-16 years.

Across Cheshire, in 2015 an estimated 4,350 young people under 25 deliberately injured themselves on 13,860 separate occasions. This equates to nearly 40 young people injuring themselves everyday.

52% of these are young women aged 14 to 17; a further 22% involve young men in the same age range.

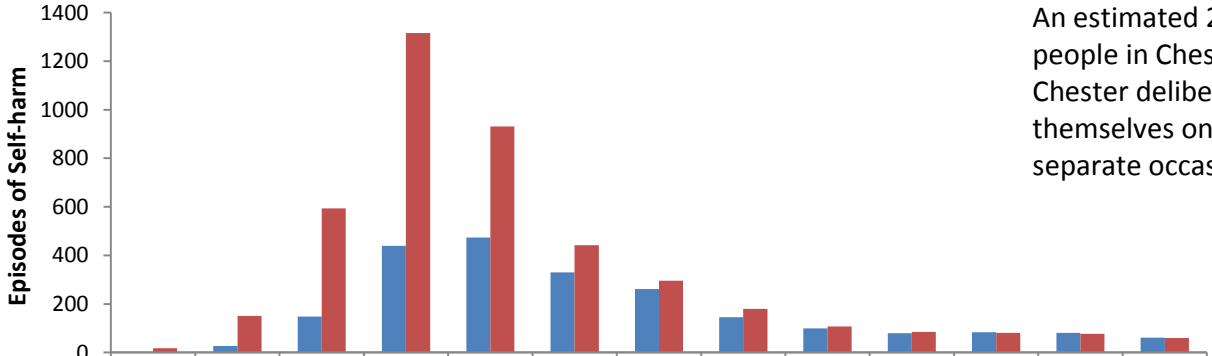
Estimated number of episodes of self-injury behaviour in Cheshire East



An estimated 2,270 young people in Cheshire East deliberately injured themselves on 7,310 separate occasions in 2015

Age	12	13	14	15	16	17	18	19	20	21	22	23	24
Male	2	30	161	510	549	365	296	145	99	79	84	83	73
Females	19	172	694	1552	1068	516	317	137	82	74	79	77	66

Estimated number of episodes of self-injury behaviour in Cheshire West and Chester



An estimated 2,080 young people in Cheshire West and Chester deliberately injured themselves on 6,550 separate occasions in 2015

Age	12	13	14	15	16	17	18	19	20	21	22	23	24
Male	2	26	148	440	474	330	262	146	99	79	83	80	61
Female	17	151	593	1316	931	442	295	180	108	85	81	77	59

Data sources: 2015 population estimates. Prevalence and incidence rate estimates for 15 and 16 year olds from studies. [1, 2] The age curve is derived from work done for Cheshire East's Annual Public Health Report, 2015. [3] The same assumptions have been used for both local authority areas.

Only 2-4% of self-injuries by young people aged 13-18 years lead to presentation to health services

Self-injurious behaviour normally involves one or more of the following acts:

- Causing an injury to the surface of one's body
- Consuming a quantity of medicine in excess of its normal dose
- Taking a recreational or illegal substance with the intention of causing physical harm
- Swallowing an object that cannot be digested

A&E attendances and inpatient admissions due to self-injury in Cheshire East by age group

Age group	Annual self-injury episodes (estimates)	Annual A&E Attendances (actuals)	Annual in-patient admissions (actuals)	Ratio of A&E attendances to self-injury episodes	Ratio of admissions to self-injury episodes
13-15 years	3118	67	78	2.1%	2.5%
16-18 years	3111	118	75	3.8%	2.4%
19-21 years	616	112	71	18.1%	11.5%
22-24 years	462	83	59	18.0%	12.8%
Total	**7307**	**380**	**283**	**5.2%**	**3.9%**

Annual attendances and admissions are based on combined data for 2012/13 to 2014/15
The number of in patient admissions was greater than the number of A&E attendances for 13-15 year olds

A&E attendances and inpatient admissions due to self-injury in Cheshire West and Chester by age group

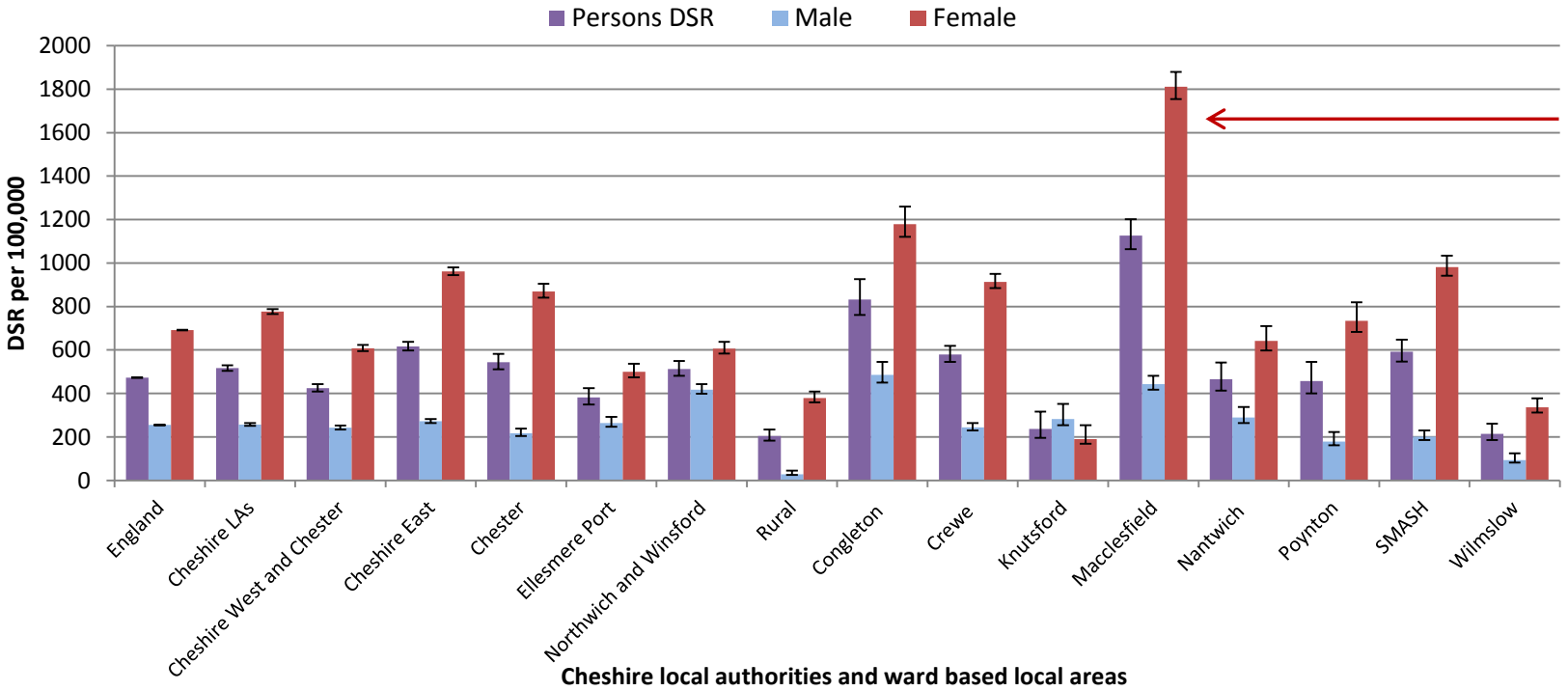
Age group	Annual self-injury episodes (estimates)	Annual A&E Attendances (actuals)	Annual in-patient admissions (actuals)	Ratio of A&E attendances to self-injury episodes	Ratio of admissions to self-injury episodes
13-15 years	2674	40	68	1.5%	2.5%
16-18 years	2735	65	43	2.4%	1.6%
19-21 years	697	88	50	12.7%	7.2%
22-24 years	441	58	31	13.1%	7.0%
Total	**6547**	**251**	**192**	**3.8%**	**2.9%**

Annual attendances and admissions are based on combined data for 2012/13 to 2014/15

Data source for A&E attendance and admission data from Hospital Episode Statistics

Emergency Hospital Admissions for Intentional Self-Harm: directly age-sex standardised rate (aged 15-24)

Source: HES 2014/15 (with 2013 ONS population estimates)



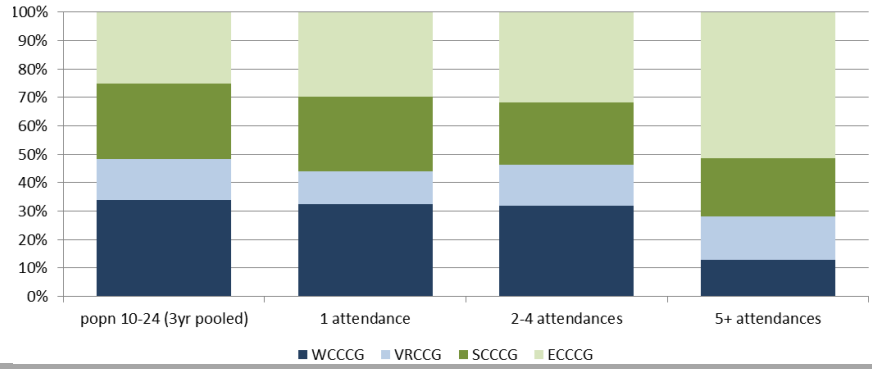
The high rates in Eastern Cheshire CCG are due to high admission rates in females aged 15-21 in Macclesfield (See Appendix for age distribution of admission rates)

The chart above shows male and female hospital admission rates for self-injury for England, both Council Areas and smaller local areas. Female and male admission rates are notably higher in Macclesfield and Congleton (both in Eastern Cheshire CCG) than the other areas. A similar pattern is seen for A&E attendance for self-injury.

The percentage of attenders that are from Eastern Cheshire CCG also increases as the frequency of attendance increases with over 50% of people attending 5 or more times, coming from this CCG (see the chart to the right).

People attending A&E for deliberate self-harm aged 10-24 by regularity

3 yr pooled 2012/13 to 2014/15, CCGs from ward



These factors include:

- self-injury in others, especially friends and family
- loss or impending loss (e.g. relationship, home, bereavement, or self-esteem)
- acute intoxication
- access to the means of self-injury (e.g. sharp objects and medicines)
- exposure to accounts of self-injury or suicide in the media (contagious influence)

Initiatives to reduce self-injury should focus on responding to school bullying, physical abuse, sexual orientation and interpersonal problems as well as the management of anxiety

Factors independently associated with an increased risk of deliberate self-injury

	England, Hawton[1]		Scotland, O'Connor[4]	
	Females	Males	Females	Males
Being bullied in school			3.09	2.18
Physical abuse			2.15	
Self-harm by friends	3.13	4.88	2.89	
Self-harm in family	2.86	3.26	2.19	8.85
Being drunk 10+ times (in past year)	4.73	3.01	3.45	5.33
Any drug use (in past year)	2.57	2.72	1.95	
Smoking (6+ cigarettes/week)			2.06	7.74
Worries about sexual orientation			2.57	3.82
Serious boy/girlfriend problems			2.30	
The figures indicate the level of extra risk compared to pupils without the factor				

Based on the above figures, females are around 4 times more likely to self-injure and males are between 3 and 5 times more likely to self-injure if they have been drunk 10 or more times in the past year. Where figures are not included in the table above, the study did not find an association between the factor and self-injury. For example, in the Scotland study, drug taking was associated with self-injury in girls only.

Anyone who comes into contact with young people in any setting should have a basic understanding of self-injury.

This includes parents, friends, teachers, youth workers, school nurses, general practitioners and counsellors.

They should be advised that when a young person discloses self-injury, it is important to ask them about whether there has been any self-poisoning and whether any suicidal thoughts are still present, and arrange for them to go for emergency care if either factor is present.

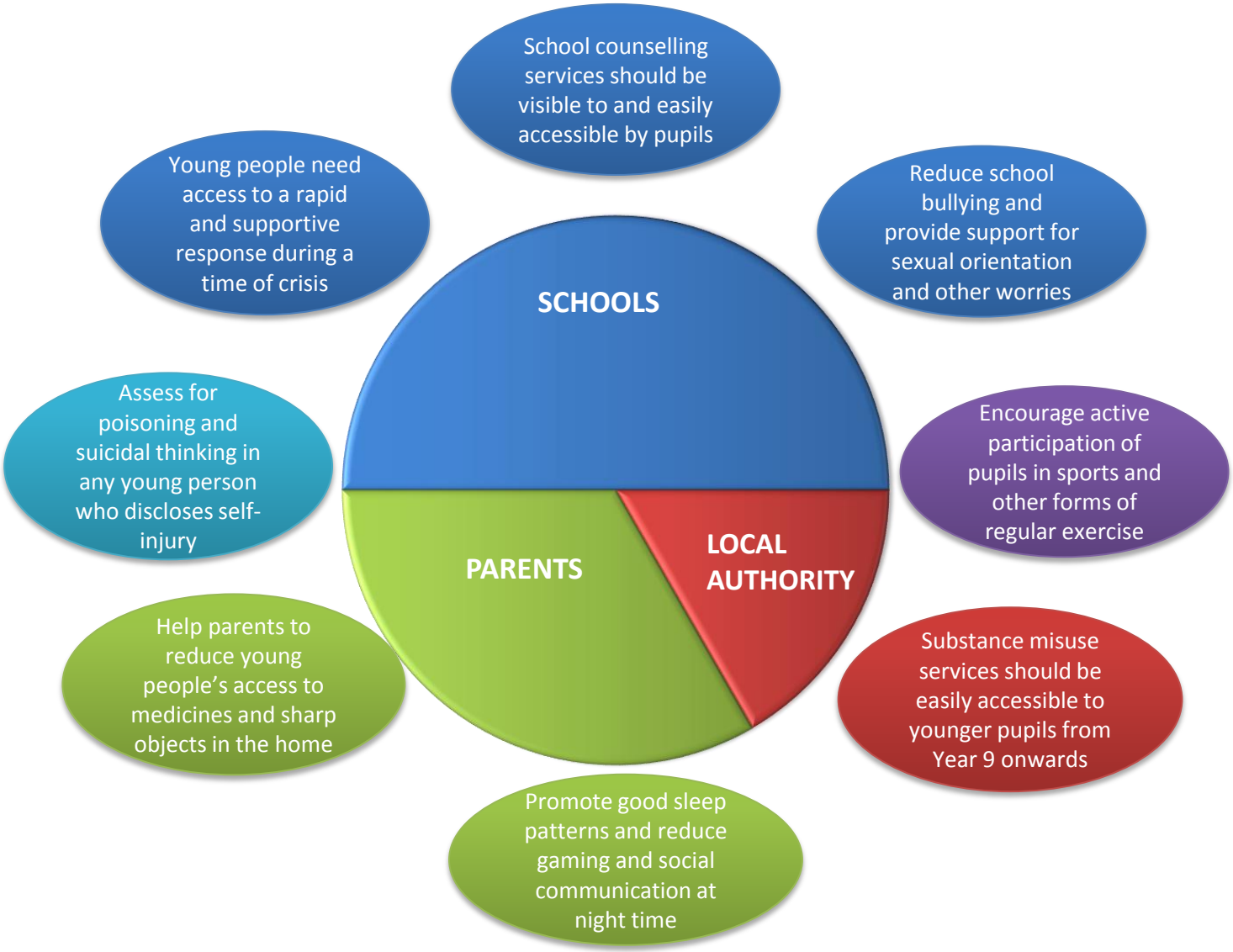
Opportunities for improvement

1. Head Teachers should make counselling services available to their pupils, and set up school-based counselling services where these do not currently exist
2. It is particularly important to intervene effectively and early in the course of a young person's self-injury journey to prevent repetitive behaviour from becoming established. Head Teachers should ensure that counselling and other support services are visible to and easily accessible by pupils
3. Provide rapid and supportive response throughout a time of crisis, including evening and night. This should be widely advertised among young people, and act as continuations of day time care plans rather than ad-hoc support, in order to facilitate a feeling of continuity of care for young people who are in crisis
4. Smoking and alcohol are both independent risk factors for self-injury. Public Health commissioners should work with Head Teachers to develop open access substance misuse service provision in schools, and ensure that these services are easily accessible to younger pupils from Year 9 onwards
5. Head Teachers should promote awareness among parents about the three "invisible risk" behaviours of high levels of media use, sedentary behaviour and reduced sleep. Parents should be advised how to promote good sleep patterns and encourage sufficient sleep, and how to reduce use of online games and social communication at night time
6. Adolescent self-harmers are more likely to drop out of treatment than other outpatients and this is associated with an increased risk of repeat self-injury. It is therefore important to minimise barriers to accessing assessment and counselling, including speed of appointment and the accessibility of the setting in which the young person is seen
7. Unfortunately, there is no evidence that whole-school approaches to improving emotional wellbeing are effective in reducing suicide attempts, although they may improve help-seeking behaviour. Single suicide prevention training lessons (such as the PSHE lesson on self-harm) are very unlikely to reduce levels of severe suicidal thinking and suicide attempts

Diagram shows interventions to tackle factors associated with self injurious behaviour based on expert groups' recommendations. Each colour represents the key parties to lead on interventions:

- Blue – schools
- Purple– joint effort schools and local authorities
- Red – local authority
- Green –parents
- Turquoise – parents and schools

There are limited evidence-based interventions that are effective in preventing new cases of suicide attempts. One intervention proven to be highly effective is the Youth Aware of Mental Health, which consist of two one-hour interactive lectures about mental health at the beginning and end of a 4-week period, interspersed with three hours of role play sessions in a school setting[5]



Number of young people who are thought to be self-injuring themselves

Cheshire East Schools	Estimated numbers of young people affected			Estimated number of self-injuries		
	12-16 years	17-18 years	**12-18 years**	12-16 years	17-18 years	**12-18 years**
All Hallows Catholic College	55	11	**66**	200	36	**236**
Alsager School	59	11	**70**	216	37	**252**
Brine Leas School	59	14	**73**	215	46	**261**
Congleton High School	47	12	**59**	170	39	**209**
Eaton Bank Academy	36	7	**43**	134	23	**156**
Holmes Chapel Comprehensive School	57	11	**68**	199	36	**234**
King's Grove School	33	0	**33**	112	0	**112**
Knutsford Academy and The Studio	52	15	**67**	183	47	**231**
Malbank School and Sixth Form College	48	9	**57**	167	28	**195**
Middlewich High School	38	0	**38**	135	0	**135**
Poynton High School and Performing Arts College	68	19	**87**	231	62	**293**
Ruskin Sports College - A Community High School	27	0	**27**	97	0	**97**
Sandbach High School and Sixth Form College	57	15	**72**	195	48	**243**
Sandbach School	56	14	**70**	193	44	**237**
Shavington High School	30	0	**30**	105	0	**105**
Sir William Stanier Community School	48	0	**48**	166	0	**166**
St Thomas More Catholic High School,	36	0	**36**	123	0	**123**
The Fallibroome Academy	65	20	**85**	220	64	**284**
The Macclesfield Academy	21	0	**21**	70	0	**70**
Tytherington High School	49	11	**60**	173	36	**210**
Wilmslow High School	83	27	**110**	280	88	**368**
Total	1024	196	**1220**	3584	634	**4218**
Young people in other settings*	95	301	**396**	1172	860	**2032**
Total	1119	497	**1616**	4756	1494	**6250**

Cheshire West and Chester Schools	Estimated numbers of young people affected			Estimated number of self- injuries		
	12-16 years	17-18 years	**12-18 years**	12-16 years	17-18 years	**12-18 years**
Bishop Heber High School	56	14	**70**	201	44	**245**
Blacon High School Specialist Sports College	21	0	**21**	81	0	**81**
Ellesmere Port Catholic High School	38	8	**46**	140	26	**166**
Hartford Church of England High School	45	0	**45**	165	0	**165**
Helsby High School	59	15	**74**	210	50	**260**
Queen's Park High School	24	7	**30**	89	21	**110**
St Nicholas Catholic High School	56	11	**67**	186	36	**222**
The Whitby High School	71	11	**82**	237	36	**273**
Upton-by-Chester High School	66	15	**81**	228	49	**277**
Weaverham High School	55	0	**55**	191	0	**191**
University of Chester Academy Northwich	21	0	**21**	77	0	**77**
Christleton High School	56	17	**73**	190	54	**244**
The County High School, Leftwich	52	0	**52**	175	0	**175**
The Catholic High School, Chester	38	13	**51**	131	41	**172**
Neston High School	72	17	**89**	239	56	**295**
Tarporley High School and 6th Form College	48	11	**59**	162	37	**199**
The Bishops' Blue Coat Church of England	48	9	**57**	163	30	**193**
University of Chester CE Academy	35	9	**44**	117	29	**146**
Winsford E-ACT Academy	47	2	**49**	159	6	**165**
Total	908	159	**1067**	3141	515	**3656**
Young people in other settings*	129	284	**413**	958	814	**1772**
Total	1037	443	**1480**	4099	1329	**5428**

Data source: Estimates applied to pupil numbers from 2015 School census

*Refers to pupils in independent schools , colleges, apprenticeships or not in education or training

Further information:

Studies that have asked young people about how they injure themselves have found that self-cutting or other forms of skin damage (self-scratching, carving, biting, or preventing wounds from healing) occurs in around two thirds of self-injury involving teenagers aged 15 to 17. Other forms of injury include self-hitting (such as pulling hair and head-butting walls), overdosing, and (less commonly) burning. Girls are more likely to carry out self-cutting while boys have higher rates of self-burning and self-hitting. Around twenty percent of young people will use more than one method of self-injury at once.

Additional information about self-injuring and its characteristics in young people can be found in the Cheshire East Annual Public Health Report for 2015 found here - http://www.cheshireeast.gov.uk/council_and_democracy/your_council/health_and_wellbeing_board/health_and_wellbeing_board.aspx

References

[1] Hawton, K. et al. (November 2002) Deliberate self harm in adolescents: self report survey in schools in England. BMJ VOLUME 325, 23
[2] Kidger, J. et al. (2012) Adolescent self-harm and suicidal thoughts in the ALSPAC cohort: a self-report survey in England. BMC Psychiatry, 12:69
[3] Cheshire East Annual Public Health Report (2015)
[4] O'Connor, R. et al. (2009) Self-harm, in adolescents: self-report survey in schools in Scotland. BJ Psych. 194, 68-72. doi: 10.1192/bjp.bp.107.047704
[5] Wasserman, D. et al. (2015) School based suicide prevention programmes: the SEYLE cluster-randomised, control trial. Lancet 385, No 997 1489-1491

What we don't know but would like to know…

- The frequency of the different risk factors (see page 5) in different schools and colleges
- Current structure, content and capacity of school based counselling services in each secondary school (and college)
- Views of young people about how to make support easily and quickly available to those in acute need of help
- Proportion of young people requesting emotional health support in secondary school year groups

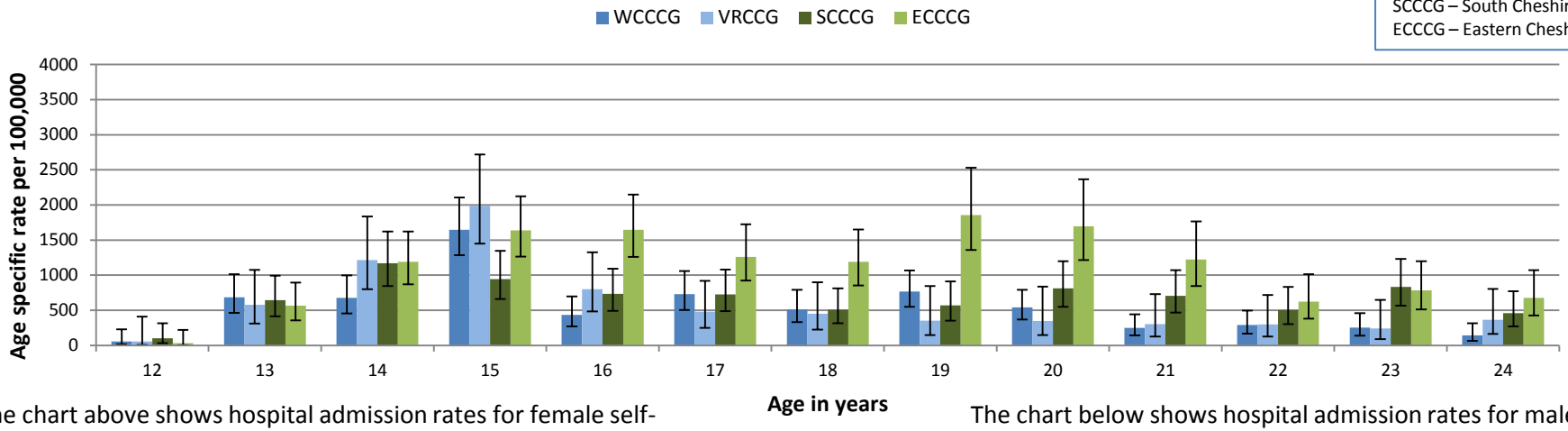
Version control

Publication date	Changes made	Sign-off
May 2016	New JSNA section created	Guy Hayhurst and Helen Bromley (Public Health)

JSNA section contributors: Jean Bennie, Jill Oakley, Rory Strand and Anna Whitehead (Public Health)

WCCCG – West Cheshire CCG
VRCCG – Vale Royal CCG
SCCCG – South Cheshire CCG
ECCCG – Eastern Cheshire CCG

Inpatient admissions for self harm: females 3 year pooled (actuals) 2012/13 - 2014/15



The chart above shows hospital admission rates for female self-injury in the 4 Clinical Commissioning Group (CCG) areas by individual year of age. There is a steep rise in early adolescence to a peak at age 15, before rates fall from age 16 onwards in all areas except Eastern Cheshire CCG

The chart below shows hospital admission rates for male self-injury in the 4 CCG areas by individual year of age. Admission rates rise to a peak at age 15 and then remain stable up to age 18. They increase again from age 19 to 24.

Inpatient admissions for self harm: males 3 year pooled (actual) 2012/13 - 2014/15