

Child protection research briefing

Young people who self-harm: Implications for public health practitioners

March 2009

Young people who self-harm

Implications for public health practitioners

This briefing has been prepared by Angela Underdown, previously Health Awareness adviser with the NSPCC. It is intended to provide an overview of the issues relating to young people who self-harm, but is not comprehensive and does not give legal advice.

Self-harm: a national public health concern

Deliberate self-harm has emerged as a major public health issue, affecting at least one in 15 young people in the UK. It was the subject of a national inquiry carried out by the Mental Health Foundation and Camelot Foundation (MHF/CF) in 2006, which reviewed evidence from research, personal testimonies and expert opinions.¹ The NSPCC (ChildLine) was one of 350 organisations who contributed evidence of young people's views and experiences. This briefing pulls together the findings and recommendations from the national inquiry report and other research that are particularly relevant to public health professionals.

The definition of self-harm

Self-harm refers to any damaging activity that individuals deliberately inflict upon themselves, including cutting, "overdosing" (self-poisoning), hitting, burning or scalding, pulling hair, picking or scratching skin, self-asphyxiation, ingesting toxic substances and fracturing bones. Broader definitions of self-harm include drug-and alcohol misuse and eating disorders, but these fall beyond the scope of this briefing.

The prevalence of self-harm among children and young people

Prevalence figures are bound to understate the true extent of self-harming, because it is often kept secret as young people are reluctant to admit to it. In 2007/08, the NSPCC's ChildLine counselled 2,210 children and young people directly about self-harm, and another 3,883 mentioned it in the course of discussing other problems. This was however a relatively small proportion of the 175,000 young people who were counselled by ChildLine that year.

¹ *Truth Hurts*, Report of the National Inquiry into Self-harm among Young People, 2006.

Data obtained for MHF/CF national inquiry suggest that one in 15 young people in the UK (aged 11 to 25) are harming themselves deliberately. However, other studies have suggested that it may be as high as one in 10 (Hawton et al, 2003).

In 2006/07 intentional self-harm was one of the top five external causes of admissions to acute hospital services for males and females of all ages in the UK² - the majority of these cases involved self-poisoning. However, hospital admissions represent only a small proportion of those who self-harm (Green et al 2005; Hawton et al, 2002; Meltzer et al, 2001): not all injuries lead to hospitalisation and some might also be explained by other, “legitimate” activities such as sports.

The Child and Adolescent Self-harm in Europe (CASE) Study (2005),³ which was based on the responses of 30,000 15-and 16-year-olds to anonymous questionnaires, suggests an alarming rate of self-harming among young people: in the knowledge that their anonymity was protected, over 70 per cent of respondents admitted to self-harming at some stage in their lives. (Madge et al, 2008).

Higher risk and vulnerable groups

Bearing in mind that the true extent of self-harming is difficult to ascertain, some research findings give an insight into what groups may be relatively more vulnerable.

Self-harming seems to be more prevalent in older groups: a study by Meltzer et al (2001), based on parental reports, suggests that the rate among 13-to 15-year-olds is one-and-a-half times that of 11-to 12-year-olds (2.5 and 1.6 per cent, respectively). Similarly, in Hawton and Harris’ (2008) study sample of 710 under-15-year-olds who presented at a general hospital, most were aged between 12 and 14. This may of course mask the fact that some children self-harm earlier without presenting to any services.

Self-harming is more prevalent in females than in males: Fox and Hawton (2004) suggest a ratio of four to one, while Hawton and Harris’s (2008) study suggest an even higher ratio of 6.5 to one. Asian females aged between 15 and 35 are two to three times more likely to self-

² NHS Information Centre for health and social care, personal correspondence, 25 November 2008.

³ The Child and Adolescent Self-harm in Europe (CASE) study, completed in 2005, was a seven year international research project funded by the European Commission Daphne Programme and coordinated by the National Children’s Bureau.

harm than their non-Asian peers according to a study by Soni-Raleigh (1996).⁴ A complex range of family and social pressures are implicated in these higher rates of self-harm.

Young people held in custodial settings are more likely candidates. The MHF/CF inquiry (2006) found that 65 per cent of young women and 10 per cent of young men in these settings reported self-harm, and that females were also more likely to harm repetitively.

Children and young people who have spent time in local authority care are more likely to experience mental health problems (Payne et al, 2003), which results in an increased risk of self-harm. Similarly, Hurry et al (1998) found that although “looked after” children represented 1 per cent of the total child population, they accounted for 10 per cent of those who presented with self-harm to Accident and Emergency departments.

The reasons for self-harming

It is important to recognise that self-harm is not usually triggered by one isolated event but rather a set of circumstances that leave young people overwhelmed and unable to manage their feelings: it is not the core problem but a sign and symptom of underlying emotional difficulties, used as a way of coping. (MHF/CF, 2006).

The 70 per cent of respondents in the Child and Adolescent Self-harm in Europe (CASE) Study who admitted to self-harming, said that they did so to “get relief from a terrible state of mind” (Madge et al, 2008); the views and experiences of the English respondents were broadly in line with those of their European counterparts.

The MHF/CF national inquiry report (2006) points out that “people who hurt themselves often feel that the physical pain is easier to deal with than the emotional pain they are experiencing, because it is tangible.” Children and young people who self-harm may find that inflicting pain changes their mood, which can become habit-forming. Cutting, for instance, releases endogenous opioids such as endorphins, which produce a brief calming sensation, and serotonin, which lifts the mood (Smith et al, 1998).

Young people have described their self-harming as a form of relief:

⁴ Soni-Raleigh, V. (1996) Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales. *Ethnicity and Health*, 1(1), 55–63. As cited in the MHF/CF National Inquiry report (2006).

“I don’t really like school and nick off as much as I can. There’s always arguments at home so I go out and hang around with a group of lads and lasses. We all drink a bit; sometimes I cut my arm with a bit of broken glass. It feels good, but then I regret it the next day when I see the scar.”

(Dimmock, 2008:45)

“I cut myself when I’m angry, it hurts but it helps my anger.” (Dow, 2004:2).

“The thoughts are in my head every day, I can’t take it. Cutting myself is the only way I can deal with him being around.” (Dow, 2004:2).

“Cutting takes my mind off things, when I’m unhappy about myself, the way I am.” (Dow, 2004:2).

Risk factors

There are many stress factors that may trigger self-harming. The MHF/CF report lists a number of these that children and young people themselves identified:

- being bullied at school
- not getting on with parents
- stress and worry about academic performance and not getting on with examinations
- parental divorce
- bereavement
- unwanted pregnancy
- experience of abuse in earlier childhood (whether sexual, physical, neglect and/or emotional) – severe and prolonged sexual abuse is known to lead to a higher incidence of self-harm.
- difficulties associated with sexuality - lesbian, gay, bisexual and transgender young people are estimated to be two or three times more likely to self-harm than heterosexual young people, and homophobic bullying at school is implicated in higher rates of self-harm.
- problems to do with race, culture or religion
- low self-esteem
- feeling rejected.

Other studies also point to adverse family circumstances leading to a higher incidence of self-harm: dysfunctional relationships, domestic violence, poverty, parental criminality and periods spent in local authority care (Fox and Hawton 2004), or frequent punishments and family transitions, especially where step siblings are involved. (Meltzer et al, 2001).

The MHF/CF report (2006) also points out that the experience of physical and emotional changes that normally occur in adolescence can further compound stressful circumstances and lead to self-harming, noting that the most common age of onset is around 12-13 years, generally the start of puberty. Deliberate self-harm is also more likely if a family member or close friend has previously self-harmed or attempted suicide.

Mental health problems (such as anxiety, depression and feelings of hopelessness which may or may not be a result of these stress factors) are significantly associated with self-harming behaviour. The prevalence of self-harm for children experiencing specific disorders, as found by Meltzer et al (2001), is detailed in the table below:

Diagnosed condition	Percentage self-harming
Anxiety disorder	9.4%
Depression	18.8%
Conduct disorder	12.6%
Hyperkinetic disorder	8.5%

Links to suicide

In the majority of cases, self-harm appears to be a way of coping rather than an attempt at destroying life: it is usually intended to inflict harm rather than kill (MHF;CF, 2006).

In the words of young people:

“People often link self-harm to suicide but for me it was something very different; it was my alternative to suicide; my way of coping even though sometimes I would wish my world would end.” (MHF;CF, 2006: 28).

“The only time I overdose is when I want to die. The cutting up’s not about wanting to die whereas the overdoses were because I wanted to die.” (ibid: 2).

Bywaters et al (2005) confirm that overdoses are more likely to reflect suicidal intent than cutting, which tends to be a survival response to distress and depression. However, overdose survivors sometimes claim that they never wished to kill themselves, and some suicides may in fact be the result of accidental overdoses.

Fox and Hawton (2004) estimate that between 40 to 100 times as many young people have engaged in self-harm than actually ended their own lives: i.e. for every one young person who has committed suicide, there are between 40 and 100 who have self-harmed. Although this supports the view that self-harm in most cases does not lead to suicide, the National Institute for Clinical Excellence Self-Harm Scope report (2002) indicates that those who have self-harmed are 100 times more likely than the general population to die by suicide in the subsequent year. It also states that half of the 4,000 people who die by suicide each year will have self-harmed at some time in the past (NICE 2002). – The same figure is reported in an earlier study by the Samaritans (2001). The risk increases for those who self-harm repeatedly, as evidenced by a study of Zahl and Hawton (2004).

While some would argue that that self-harm is in fact the opposite of suicide, i.e. a way of coping with life rather than giving up on it, there is an equally compelling argument that they are part of the same continuum, both being a response to distress. There is sufficient evidence to suggest that skilled support at the time of the first episode of self-harming offers an opportunity to prevent further self-harming and, potentially, a suicide attempt.

Service response

Myths and misconceptions

The MHF/CF inquiry confirmed that self-harm is frequently misunderstood and stigmatised, and consequently remains hidden. Young people often feel guilty and ashamed and these feelings may be compounded by the reaction they receive when disclosing. This is a critical determinant of whether they choose to access services. (MHF;CF, 2006).

There are numerous negative stereotypes and myths that act as barriers to accessing appropriate care, such as the suggestion that children and young people self-harm to

manipulate people or situations; to draw attention to themselves; because they are mentally ill; or because it is part of the “Goth” sub-culture. As one young person effectively summarised:

“Some young people do it for attention, like I did when I first started. That doesn’t mean they should be ignored. There are plenty of ways to go and get attention, why cause yourself pain? And if someone cries for help, bloody well give them it, don’t just stand there and judge the way in which they’re asking for it.” (MHF;CF, 2006:27).

Children and young people gave the MHF/CF national inquiry a number of reasons why it was difficult to ask for help, saying that they:

- thought it would be a ‘once only’ event that they could manage
- wanted to put it to the back of their minds
- felt that they had no one to share their feelings with
- had no idea how to access services
- were concerned that their coping strategy would be taken away from them by being prevented from self-harming
- were worried that they would be judged as “attention seeking” or “stupid”
- felt that their physical injuries were not serious enough to need help
- were anxious that disclosure of self-harm would limit their future career opportunities
- were concerned that they would lose control over their situation if their behaviour became public knowledge.

As a consequence, they often felt that they were facing extremely stressful situations on their own:

“As someone who had self-harmed I found it hard to accept that I wasn’t alone as I’d never heard of it - I wanted someone else to clarify what I did, show that they understood and be willing to listen and not judge.” (MHF;CF, 2006:6).

Confidentiality issues

Children and young people may be reluctant to disclose their self-harming because they are fearful that their disclosure will not be treated confidentially and that their parents and their GP will be informed. According to the MHF/CF report, “those young people who spoke directly to an adult said that once they had done this, all decision-making and control were

taken from them. They were not being consulted about the services that might be contacted, or about the exact sort of help and information that would support and help them deal with their self-harm. Many were unsure - and felt unable to ask about - who else would be told or involved after they had disclosed private and sensitive information.” (MHF;CF, 2006: 53).

One study by Best (2005) looked at school policies and found that in many cases parents were routinely contacted with the urgent recommendation to contact their GP, though another school, which catered predominantly for pupils from a minority ethnic group, avoided informing parents in some cases as they believed the response could be harmful or even abusive:

“Where ongoing or previous abuse by parents lies at the heart of the self-harming behaviour, informing the parents might not be in the best interests of the child at all, let alone the automatic first step.” (Best 2005:7).

The National Inquiry produced a separate briefing to outline the legal perspective on children and young people’s consent to treatment without the need for parental involvement. It pointed out the relevance of assessing “Gillick competence” and the provisions of the 1989 Children Act in this context: “overall these provisions will mean that most older children and young people will be able to give informed consent and can expect confidentiality in their dealings with services and staff. The Mental Health Act 1983 is also relevant as will be the Mental Capacity Act 2005.”⁵ (MHF;CF 2006:51).

“Gillick competence” is assessed to decide whether a child under 16 is able to consent to his or her own medical treatment without parental permission or knowledge: a child should fully understand the medical treatment that is proposed.

School nurses should be trained to assess Gillick competence, and adhere to a strict code of confidentiality. Their assessments should be underpinned by the National Institute of Clinical Excellence Guidelines (NICE) and the Common Assessment Framework (CAF). However, the lack of school nurses means that they are not easily accessible to every child and young person. Moreover, in some areas they are more likely than in others to have received training about self-harm and how to conduct risk and resilience assessments to inform decisions about whether to refer a child. (CPHVA⁶, 2008: personal communication).

⁵ This came into force in 2007.

⁶ Community Practitioners and Health Visitors Association.

The Royal College of Nurses told the MHF/CF national inquiry that schools may be reluctant to acknowledge that self-harm is happening. There is also evidence that many teachers are in fact ill-prepared to manage such emotionally distressing situations, expressing feelings of “sorrow, alarm, panic, anxiety, and shock, and of being scared, distressed, upset, taken aback, fazed, freaked out, repulsed, bewildered, frustrated and mystified.” (Best 2005: 7).

Experiences of Accident and Emergency services

It is clear that treating the physical injuries caused by self-harm in a sensitive and non-judgemental manner is an important first step in encouraging children and young people to engage with support services. National Institute of Clinical Excellence Guidelines (NICE) are available for health staff in England and Wales, and particularly focus on care in A and E departments, ensuring that physical, psychological and social assessment are carried out in the first 48 hours after presentation at hospital. (MHF/CF, 2006).

The attitude of A and E staff is the most important factor that influences later coping. The Royal College of Psychiatrists, who surveyed 509 people of all ages attending A and E for treatment following self-harm, found that a significant minority of patients had been blamed for wasting time, as staff felt their problems were self-inflicted (Palmer et al, 2007). But as one patient pointed out:

“I have not self-harmed in order to annoy staff, but rather because something is very, very wrong inside” (Palmer et al 2007: 5).

The MHF/CF inquiry reported a similar finding among young people, and noted that many did not find that attending accident and emergency departments helped with their wider problems:

“When I go to A and E I just want appropriate medical care. Sometimes I want to see the duty psychiatrist but this shouldn’t be inflicted on me (as it often has been). I feel hospital staff are just covering their backs rather than actually being concerned about me when they make a referral straight away.” (ibid: 50).

According to Fortune et al (2005) the majority of adolescents believe that they can cope on their own and choose not to engage with services, which probably also indicates a lack of belief in their efficacy.

Who do they turn to: sources of support for children and young people

Given their reluctance to confide in adults, children and young people who self-harm are three times more likely to turn to a friend than a professional: approximately half of the young people who responded via the inquiry's consultation sites had confided in friends who had then, in turn, disclosed to teachers (MHF;CF, 2006).

Telephone helplines were another common source of help mentioned to the National Inquiry (MHF;CF 2006) by children and young people, undoubtedly because they felt that consistent, non-judgemental advice could be accessed and some control could be maintained.

ChildLine

ChildLine is the NSPCC's free, confidential 24-hour helpline for children who are in distress or danger and need to talk to someone who is impartial. Trained volunteer counsellors comfort, advise and protect young callers, but remain non-judgemental and leave them to feel safe and in control.

In 2007/08 ChildLine counselled more than 175,000 children and young people: almost 500 every day – around 500,000 calls were actually received, which indicates that the demand for the service is still much higher than can presently be met. In total, 6,093 children and young people talked about self-harm (almost double the number in 2002/03): for 2,210 it was the main reason for making the call, but another 3,883 disclosed in the process of talking about other problems. Even though these children had often already spoken to someone prior to contacting ChildLine (many young people who phone in will already be in touch with other help agencies), their needs had clearly not been met, which highlights the benefits of a 24-hour, direct access service.

When self-harm is disclosed to a ChildLine counsellor, it is considered to be a child protection issue and a supervisor will be involved throughout the process. The counsellor will explore how and when the caller self-harms and help them to reflect on how they feel before, during, and after. This process often aids children and young people to identify the reasons for self-harm. Acceptable alternatives to self-harm are explored with the caller and the counsellor will suggest that the next time the young person feels the urge to self-harm, they should ring ChildLine first.

As self-harm is considered a child protection issue, an individual risk assessment is carried out by ChildLine workers to decide whether confidentiality needs to be broken. Only when this need has been identified, usually because there is an immediate danger, the emergency agencies are contacted (Dow, 2004).

There4me

There4me is the NSPCC's online help service, aimed at 12-to16-year-olds. The site offers message boards, access to an "agony aunt", and an opportunity to talk to an adviser in confidence.

The There4me approach to dealing with self-harm, as submitted to the MHF/CF national inquiry, can be summarised as follows:

"We recognise the importance of talking to young people who self-harm in a non-judgemental way. We take the approach that there is a reason for their self-harming and we explore why they might need to do this as a coping mechanism. We are never critical, we listen and try to find different ways to cope or deal with the issue that might be causing the self-harming behaviour. We do not approach self-harmers as attention seekers or in any other negative/judgemental way." (MHF;CF, 2006)

There4me also reported to the inquiry that young people enter the site to talk about many issues, and confirmed that self-harm is often a symptom of other concerns, such as being sexually, physically or emotionally abused, being bullied (by the peer group and/or family) parental rejection, domestic violence, poor family relationships, exam pressures etc.

Within the constraints of an online service, There4me advisers continually assess risks posed to young people by themselves and others, explore the issues sensitively, and suggest support.

Therapeutic interventions

The MHF/CF national inquiry cites examples of effective therapeutic practice, though availability of such services generally appears to be "patchy". One of these is the "Adolescent deliberate self-harm service", delivered by a nursing team in Glasgow, which focuses on rapid intervention and regular review. Intervention is home-based, uses cognitive behaviour techniques and also offers sessions to parents. After treatment, patients are

monitored and reviewed regularly, and they can continue to access the service in times of crisis (MHF;CF, 2006).

Types of therapeutic interventions mentioned in the MHF/CF report (2006) include:

- counselling that concentrates not on the injuries but the underlying problems that have triggered the self-harm
- family therapy
- in-patient treatment e.g. in a specialist unit
- brief psychological therapy (problem-solving therapy)
- crisis cards (showing the card assures the holder of quick access to mental health workers and admission to hospital in a crisis)
- behaviour therapy involving individual therapy.

Professional practice implications

Dismantling the misconceptions

Children and young people identified the need to de-stigmatise self-harm and to ensure that informed professionals are available to listen empathetically and constructively to the difficulties many face:

“However self-harm is tackled within schools or anywhere else, if they didn’t make it such a dirty subject people would come forward a lot more quickly to get help”

“What they fail to consider is that maybe a young person simply needs someone to talk to, not specifically about self-harm, but about the problems and issues they are facing in their daily lives which makes them turn to self-harm as a way of simply surviving.” (MHF;CF, 2006: 43).

Respect confidentiality and young people’s wishes

The Child and Adolescent Self-harm in Europe (CASE) Study (2005), mentioned earlier, showed that a significantly higher proportion of young people admitted to self-harming (70 per cent) than other studies have suggested. The young respondents clearly felt safe in the knowledge that their answers would remain anonymous. It is probably fair to say that this demonstrates the importance of confidentiality to young people, and their wish to control their

own situation. Ultimately, this means that strict reporting requirements have to be balanced out against young people's wishes and their wellbeing, which produces challenging moral, ethical and legal issues that will need to be fully debated. In any case, if a young person is prepared to disclose, their courage to do so needs to be acknowledged and their views on the pace of events, and on how things should be handled, should be respected.

Disclosing self-harm to parents needs to take into account individual circumstances and appreciate that parents may be shocked and confused. The National Inquiry produced further information to help parents to better understand the issues (MHF;CF, 2006c).

Setting the right priorities

A "harm minimisation" approach, which prioritises "least harm" rather than focusing on stopping it altogether, may be appropriate when it is likely that immediate referral or information sharing will compound difficulties and not be in the best interests of the child or young person. Merely stopping the behaviour, without offering support in tackling the underlying difficulties, can actually increase distress and lead to alternative forms of self-harm.

In essence practice must be defensible within the context of the current relevant legislation and codes of practice:

"Practice must be demonstrably defensible in the context of the current law, codes of practice etc: for example, a robust risk assessment which is sound in its own right and which properly takes account of other professional assessments and judgements might reasonably conclude that tolerating or accepting a degree of self-harm whilst tackling the underlying causes of that self-harm is preferable to pursuing complete cessation where that is likely to result in more serious self-harm and associated injury or damage (i.e. the 'harm minimisation' approach)." (MHF;CF, 2006b:21).

As self-harm is a coping mechanism, inadequate or inappropriate responses can leave the child in greater jeopardy, so treating children and young people with respect and understanding is crucial.

Training and supervision of professionals

Changes in professional attitudes can and should be achieved by offering training that explains the reasons for self-harm and provides suggestions on how to respond (Palmer et al 2007). Young people's views and experiences should be an essential element of planning and implementing effective training. Supportive supervision for staff is equally important. (Best 2005).

The UK Department of Health report *You're welcome* (DH, 2005) recommends that all staff receive interdisciplinary child protection training in conjunction with the Local Safeguarding Children Boards, and that this should include training about the moral, legal and ethical issues around self-harm.

Early prevention

A public health approach should aim to promote emotional well-being, security and resilience from an early age, so that children do not resort to self-harm to cope with their problems. Recent research (Fonagy et al 2004; Gunnar et al 2002) underpins the importance of the early environment for brain development, for building resilience and for dealing with stress in later life, proving that early identification of distress and accessible, informed support are crucial in preventing the escalation of difficulties.

Other research also underlines that the best prevention for self-harm is having accessible people at home or school who can listen to difficulties and anxieties (Fortune et al 2005). Peers should not be placed in a position where they receive confidences about self-harm without effective support frameworks being in place. Adults who work with children need to be well-informed and clear about their responsibilities.

Promoting mental health in schools

Initiatives that aim to promote mental health in schools can contribute to raising awareness and prevention of self-harm. The UK Department for Children, Schools and Families (DCSF) has invested £60 million in the "Social and Emotional Aspects of Learning" (SEAL) programme, which will be used to promote mental health in all primary schools and half of secondary schools by 2012. The Healthy Schools Standard will include 75 per cent of schools by 2009 and the new anti-bullying guidance, *Safe to Learn*, includes new strategies on combating homophobic and cyber-bullying.

The Welsh Department for Children, Education, Lifelong Learning and Skills published a strategy in April 2008 to ensure high quality, accessible counselling in every school. The aim is to make professional counselling services available in every school so that pupils are confident that their needs will be heard and addressed. This is in addition to other mental health promotion within schools.

Conclusion

Children and young people may resort to self-harming as a way of coping with serious distress. However, much of this is hidden and will remain so until young people feel assured that their disclosure will be treated in strictest confidence, and that any action taken will be with their consent and at their pace. Currently, they do not feel that service providers fully understand their problems, or are able to meet their needs. They fear that once they tell someone, they will be misjudged and lose control of what happens next. Initial responses by professionals to self-harm disclosure are crucial in engaging young people in further counselling or other treatment.

Service providers and individual practitioners need to become more accessible. They also need to be skilled in assessing the priorities when dealing with individual cases of self-harm: there can be no generalised approach. This has implications for professional training in that, while best practice within moral, ethical and legal frameworks must be ensured, promoting the young person's recovery and wellbeing remains the overriding objective.

Young people also need to be equipped with the skills to be aware of their own mental health, and to tackle self-harm as early as possible. School-based primary prevention has a big part to play in this.

Note: The NSPCC has published "Procedures and core standards" relating to self-harm, used in its work with children, young people and their families:

www.nspcc.org.uk/Inform/resourcesforprofessionals/PSPs/PCS10DealingWithSelfHarm_wdf53336.pdf

Bibliography

- Best, R. (2005) Self-harm: A Challenge for Pastoral Care. *Pastoral Care in Education*, 23, (3) 3-11.
- Bywaters, P. and Rolfe, A. (2005) *Look beyond the scars. Understanding and responding to injury and self-harm*. NCH.
- Department for Children, Education Lifelong Learning and Skills (2008) *School-based counselling services in Wales: A National Strategy*. Information Document 060/2008.
- Department of Health (2005) *You're welcome*. London: The Stationary Office.
- Dimmock, M. and Grieves, S. and Place, M. (2008) Young people who cut themselves – a growing challenge for educational settings. *British Journal of Special Education* 35 (1) 42-48.
- Dow (2004) ChildLine Evidence 'I feel like I'm invisible. Children talking to ChildLine about self-harm. Submission to the National Inquiry into Self-harm among young people. London: NSPCC.
- Fonagy, P. Gergely G. Jurist, E. and Target, M. (2004) *Affect Regulation, Mentalization and the Development of the Self*. London: Karnac.
- Fortune, S. Sinclair, J. and Hawton, K. (2005) *Adolescent Views on Prevention of Self-harm, Barriers to Help-Seeking for Self-harm and How Quality of Life Might be Improved. A Qualitative and Quantitative Study*. Oxford: Centre for Suicide Research, University of Oxford.
- Fox, C. and Hawton, K. (2004) *Deliberate Self-harm in Adolescence*. London: Jessica Kingsley.
- Green, H.McGinnity, A. Meltzer, H. Ford, T. and Goodman, R. (2005) *Mental Health of Children and young People in Great Britain 2004*. London:ONS.
- Gunnar, M. and Donzella, B. (2002) Social Regulation of the cortisol levels in early human development. *Psychoneuroendocrinology* 27, 199-220.
- Hawton K., Fagg J., Bale E., Bond A. (2000). Deliberate self-harm in adolescents in Oxford, 1985-1995. *Journal of Adolescence*, 23 (1), 47-55.
- Hawton, K. Fagg, J. Platt, S. Hawkins, M. (1993) Factors associated with suicide after parasuicide in young people. *British Medical Journal* 306, 1641-1644.
- Hawton, K. and Harris, L. (2008) Deliberate self-harm by under 15-year-olds: characteristics, trends and outcomes. *Journal of Child Psychology and Psychiatry* 49: (4) 441-448.
- Hawton, Keith, and Rodham, Karen, and Evans, Emma, Samaritans; University of Oxford. Centre for Suicide Research (2003) *Youth and self harm: perspectives. A report*. Oxford, Samaritans.
- Hawton, K. Rodham, K. Evans, E. and Weatherall, R. (2002) Deliberate self-harm in adolescents: Self report survey in schools in England. *British Medical Journal*, 325, 1207-1211.
- Heeringen, van, K., Hawton, K. and Williams, J. (2000) Pathways to suicide: An integrative approach. In: K, Hawton and K. Van Heeringen (Eds) *The International Handbook of Suicide and Attempted Suicide*. 223-234 Chichester: John Wiley.

- Hurry J., Storey P. (1998). *Deliberate Self Harm among Young People*. Institute of Education. <http://www.ioe.ac.uk/tcru/pub-ib-7.htm> (Accessed January 2009).
- Kerkhof, J. (2000) Attempted suicide: patterns and trends. 49-64: In: (K. Hawton and K. van Heerington (Eds) *The International Handbook of Suicide and Attempted Suicide*. Chichester: John Wiley.
- Madge, N. Hewitt, A. Hawton, K. de Wilde, E. Corcoran, P. Fekete, S. van Heeringen, K. De Leo, D. and Ystgaard, M. (2008) Deliberate self-harm within an international community sample of young people: comparative findings from the Child and Adolescent Self-harm in Europe (CASE) Study. *Journal of Child Psychology and Psychiatry* 49 (6) 667-677.
- Meltzer, H. Harrington, R. Goodman, R. and Jenkins, R. (2001) *Children and adolescents who try to harm, hurt or kill themselves*. London: Office for National Statistics.
- Mental Health Foundation (1999) *Bright Futures*. Mental Health Foundation.
- Mental Health Foundation; Camelot Foundation (2006) *Truth hurts: report of the national inquiry into self-harm among young people*. Mental Health Foundation.
- Mental Health Foundation; Camelot Foundation (2006b) *Young People and Self-Harm: A Legal Perspective*. Mental Health Foundation.
- Mental Health Foundation; Camelot Foundation (2006c) *Help for Families*. Mental Health Foundation.
- Milnes, D. Owens, D. and Blenkiron, P. (2002) Problems reported by self-harm patients: perception, hopelessness and suicidal intent. *Journal of Psychosomatic Research*, 53, 819-822.
- NHS Centre for Reviews and Dissemination (1998) *Deliberate self-harm*. University of York.
- National Institute for Clinical Excellence (2002). *Scope*. London: NICE. <http://www.nice.org.uk/nicemedia/pdf/Self-HarmScopeFinalV3140502.pdf> (accessed January 2008)
- National Institute for Clinical Excellence (2004). *Self-Harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. London: NICE.
- O'Carroll, P. Mercy, J. Steward, J. (1988) CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters. *Morbidity and Mortality Weekly Report* 37 (S-6) 1-12.
- ONS (2003) Death rates from suicide by gender and age 1971-1998. London: ONS.
- Palmer, L. Blackwell, H. and Strevens, P. (2007) *Service users experiences of emergency services following self-harm: A National Survey of 509 patients*. College Centre for Quality Improvement/Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/docs/National%20SU%20Survey%20Final%20LOCKED%202.doc> (accessed January 2009).
- Payne H., Butler I. (2003). *Promoting the mental health of children in need*. Research in Practice. <http://www.rip.org.uk/publications/documents/QPB/brief9.pdf> (Accessed January 2009).
- Romans, S. Martin, J. Anderson, J. Herbison, G. and Mullen, P. (1995) Sexual abuse in childhood and deliberate self-harm. *American Journal of Psychiatry*, 152, 1336-1342.

Samaritans (2001) *Key Facts: Young People and Suicide*. Ewell: The Samaritans.

SCIE (Social Care Institute for Excellence) research briefing 16 (2005): *Deliberate self-harm (DSH) among children and adolescents: who is at risk and how is it recognised?* <http://www.scie.org.uk/publications/briefings/briefing16/index.asp> (accessed January 2009)

Smith, G. Cox, D. and Saradjian, J. (1998) *Women and self-harm*. London: Women's Press.

Turrell, S. and Armsworth, M. (2000) Differentiating incest survivors who self mutilate. *Child Abuse and Neglect*, 24 (2) 237-249.

Wilson, P. Furnivall, J. Barbour, R. Connelly, G. Bryce, G. Phin, L. and Stallard, A (2007) The work of health visitors and school nurses with children with psychological and behaviour problems. *Journal of Advanced Nursing* 61 (4) 445-455.

Winchel, R. and Stanley, M. (1991). Self-injurious behavior: A review of the biology and behavior of self-mutilation. *American Journal of Psychiatry*, 148, 306–317

Zahl, D. and Hawton, K. (2004) Repetition of deliberate self-harm and subsequent suicide risk: long term follow-up study of 11,583 patients. *British Journal of Psychiatry* 185 70-75.

Weston House
42 Curtain Road
London EC2A 3NH
Tel: 020 7825 2500
www.nspcc.org.uk/inform

The National Society for the Prevention of Cruelty to Children (NSPCC) has a vision – a society where all children are loved, valued and able to fulfil their potential.

Our mission is to end cruelty to children.

The NSPCC is the UK's leading charity specialising in child protection and the prevention of cruelty to children. For over 100 years it has been protecting children from cruelty and is the only children's charity with statutory powers, enabling it to act to safeguard children at risk.

© NSPCC 2009

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted by any means, electronic, mechanical, photocopying or otherwise without the prior written permission of the copyright holder.

First published 2009 by the NSPCC.

Registered charity numbers 216401 and SC037717