SAMARITANS

Pushed from pillar to post »»

Improving the availability and quality of support after self-harm in England

October 2020

Contents

Foreword

Samaritans are known for being the service that listens, without judgement, to anyone thinking about suicide.

What is less well known is that Samaritans are just as much there for those who self-harm without feeling suicidal. Never has this been more important.

For 20 years, rates of non-suicidal self-harm have increased. The rise has been across ages, but especially in the young, and it affects as many as one in eight young people. As a researcher who's been looking into rates of self-harm, I'm delighted Samaritans has written this report, shedding new light on an under-researched topic. New findings presented in this report shows that about three-quarters of those who self-harm started before age 18. It matters. Non-suicidal self-harm is an indication of distress, as well as a major risk for later suicidality, and it warrants full and specific attention in research and policy, which until now has been lacking.

Combining insight from multiple sources including surveys, in-depth interviews as well as helpline and service data, this report addresses a complex issue with clarity, putting the perspectives of people with lived experience at its heart.

No one should have to go through what this report highlights so powerfully; the experience of being knocked back and forth between services, unable to access high-quality care.

This research finds that people who have self-harmed are excluded from some types of support for being too 'high risk' while unable to access other types, due to lack of provision or not being considered 'high risk' enough.

Covid-19 has put added pressure on the nations' mental health. We know that people are struggling and many of them are facing new barriers to support. It is more important than ever that services are responsive to the needs of the most vulnerable. And people who self-harm have to be recognised as being part of this group.

This report provides new evidence of the reality of trying to find support as told to Samaritans by people who have self-harmed. It sets out a compelling case for change involving schools, universities, workplaces, primary care, mental health care, and the community and voluntary sector.

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Adult Psychiatric Morbidity
Survey analyst, NatCen

Summary

In 2019, self-harm was discussed in more than 272,000 contacts to Samaritans – that's once every two minutes and almost 1 in 10 of the times we provided emotional support.

Self-harm is complex. While it is a strong risk factor for suicide, self-harm is often not suicidal[1] and this impacts on the support people need. For this reason, in this report we focus on self-harm without suicidal intent.

As a sign of serious emotional distress, it is vital that timely, effective support is available following self-harm. In recent years tackling self-harm has been recognised by government as a policy priority for suicide prevention, yet we still know little about what good quality support looks like. With self-harm rates rising, this challenge could not be more urgent.

This report explores the experiences and needs of people in England with lived experience of self-harm and maps out how the whole spectrum of support, from self-care to healthcare, can be improved. To do this, we surveyed 565 people with lived experience of self-harm and interviewed a subset of 17 participants. We supported this with three rapid literature reviews, new analysis of the Adult Psychiatric Morbidity Survey, analysis of Samaritans service data, and a survey of Samaritans volunteers about the support needs of our callers. This has built a comprehensive picture of the needs and gaps in support for people who have self-harmed without intending to take their own life.

From speaking to people with lived experience of self-harm, we identified four key support needs for self-harm, which are essential to providing effective care:

➤ **Distraction from immediate self-harm urges.**

➤ **Emotional relief in times of stress.**

➤ **Developing alternative coping strategies.**

➤ **Addressing the underlying reasons for self-harm.**

Family and peers play a helpful role for many in providing emotional relief in times of stress. However, people we spoke to also described the risk of stigma associated with reaching out. Receiving peer support from people with similar experiences, often online, was important in helping build an understanding of triggers and coping strategies for self-harm, but such support is not without risks. **Government must use its online harms white paper process, consulting with expert third sector organisations and people with lived experience, to inform the creation of effectively moderated safe online spaces.**

Self-care plays an important role in providing both a distraction from immediate self-harm urges and the development of preventative coping strategies over the longer term. Given the impulsiveness, and often secrecy, associated with self-harm, effective self-care is vital for helping people to resist or cease the behaviour. **To better meet this need, NHS England should work with people with lived experience and the third sector to produce a self-care app for anyone who has presented to clinical services having self-harmed. This app could include therapeutic principles and exercises, distraction techniques verified by professionals and an interactive safety plan.**

Schools and universities were one of the least common types of support for self-harm and among the least useful for those we spoke to. These institutions do play a role in providing long-term therapeutic support, or linking students with local health services. However, we found that this support could be hard to navigate and wasn't always self-harm specific. The introduction of Mental Health Support Teams (MHSTs) are a welcome development and have a key role in helping to promote understanding around self-harm for students and parents and carers, in order to tackle ongoing stigma which was reported by people we spoke to. **Government needs to roll these teams out nationally and much quicker than currently planned, extending this to universities also. Full training in supporting people who self-harm is also vital.**

General practitioners have multiple roles in supporting people who self-harm: to assess their needs, as a gateway to services that address the underlying reasons for their self-harm and also to provide an accessible, ongoing source of support in times of increased stress. While 19% sought support from a GP after recent self-harm, it was striking that a third of this group were not offered any advice, follow-up support or referrals for onward care. GPs should be well placed to empower people who have self-harmed to navigate different options for care. This requires enhanced training on how to deal with self-harm in a person centred way which understands its drivers, as well as the most suitable types of care for this group.

Psychosocial assessments are key to ensuring people are offered appropriate care options and should be undertaken for everyone who self-harms and presents to a clinical setting, in line with NICE guidelines. Anyone who self-harms and receives a psychosocial assessment should be given the option of receiving a suitable community-based or NHS-provided service which is trauma-informed, in line with their level of distress and the intensity of their needs.

Voluntary and community sector support was only accessed by 12% of those we spoke to after recent self-harm, and very few participants reported having benefitted from specialist self-harm support provided by the third sector. This highlights the challenges of capacity and reach faced by community-based and volunteer-led organisations in providing alternatives to NHS mental health support for people who self-harm. National helplines were the most commonly identified support type of this kind and were considered helpful for resisting self-harm urges and emotional relief in times of stress. **Government must bolster this support and invest in voluntary and community-based organisations to create a consistent alternative to NHS support for people who self-harm.**

NHS mental health service support was sought by a quarter (25%) of people we spoke to, via a range of routes. People who self-harm face unreasonable barriers to accessing mental health services – they are caught between being deemed too high risk for primary mental health services, while not ill enough to access secondary mental health services. This exclusion, and the damaging 'ping-pong' between services that results, needs to end.

Our research also found that mental health services are rarely commissioned or designed with self-harm in mind. Instead, self-harm is often ignored or even banned by mental health services, an approach that fails to support people to stop self-harming. **It is crucial that planned investment in mental health services through the NHS Long Term Plan ensures that primary mental health support such as Improving Access to Psychological Therapies (IAPT) is available to those who self-harm and would benefit from it. Expertise and capacity must be expanded to ensure that services remove exclusion criteria based on self-harming behaviour, provide targeted support for the behaviour, and support anyone deemed likely to benefit following a psychosocial assessment.**

This report sets a challenge to all organisations providing support for people who self-harm, as well as policy makers and commissioners. The current system is simply not working for enough people consistently. Much more needs to be done to meet their distinct needs and ensure this group aren't left without support. Ultimately it is up to policy makers to resource the system of support, so that anyone who self-harms can get the support which is right for them. With self-harm rates rising, this challenge could not be more timely.
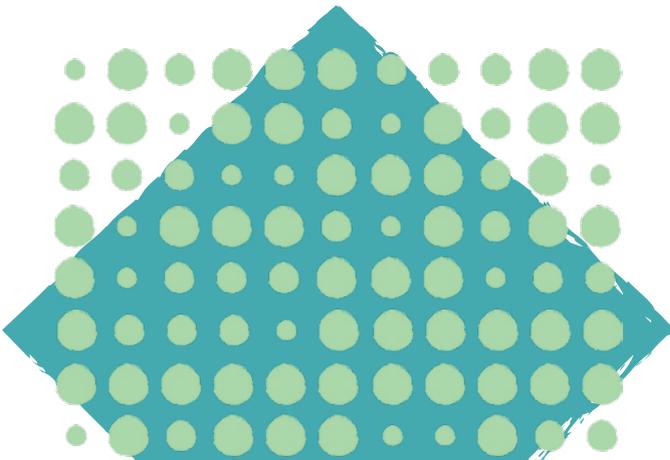
Background

In 2019, Samaritans supported someone about self-harm every 2 minutes – a total of 272,000 times. Self-harm is a strong risk factor for suicide, yet we still understand little about the quality of support available to people who have self-harmed[2,3].

What is self-harm?

For this research, we focused on understanding the experiences of people who identified as having self-harmed without wanting to take their own life. Self-harm is a complex behaviour that is not always easy to define as suicidal or not, and a person's reasons and intentions when self-harming can change over time. We actively explored this distinction during interviews, and people's reflections on the distinction can be found in the Methodological Appendix.

However, for many, non-suicidal self-harm is a way of coping with difficult or distressing feelings and circumstances[4], and this is distinct from suicide attempts[5]. Self-harm which is non-suicidal rarely reaches the attention of emergency medical teams (eg, A&E), where much of the existing evidence on effective support comes from[6]. As a result, the specific and distinct needs of people who self-harm without suicidal intent are poorly understood and too often not taken seriously. Therefore, research specifically focused on non-suicidal self-harm is essential to understand their support needs and ensure services are working effectively for them.

## What is the relationship between suicide and self-harm?

Most people who self-harm will not go on to take their own life, but it is a strong risk factor for future suicide[2,3]. Self-harm can lead to suicidal thoughts developing and, among young people, it is one of the strongest predictors of transition from suicidal thoughts to behaviours[3,7,8,9]. At Samaritans, callers who discussed self-harm in 2019 were 2.5 times more likely to express suicidal thoughts or behaviours than other callers. And new analysis of the Adult Psychiatric Morbidity Survey (APMS) shows that a third (37%) of people who self-harmed in the past year had also attempted suicide in that time.

Self-harm can also reduce a person's fear of pain or death and therefore lead to an ability to self-harm more severely over time[2,6,8,10,11]. More generally, self-harm is often a sign of complex underlying problems and serious emotional distress, yet research shows that long term self-harm does not help reduce that distress[7,8].

As shown in Figure 1, there has been a large increase in self-harm rates since 2000, particularly among young people. This is most acute in young women, whose self-harm rates nearly tripled (from 7% to 20%) from 2000 to 2014. At the same time, the suicide rate for young women has increased significantly from 2012 to 2019 to its highest level on record, with 3.1 deaths per 100,000[12,13]. Suicide is complex and is rarely caused by one thing. However, there is concern that more young people may be adopting self-harm as a way of coping with emotional distress, and this could have a long-term effect on their suicide risk.

Figure 1: percentage that have self-harmed at some point in their lives, APMS 2000, 2007 and 2014

Year 2000 ● 2007 ● 2014 ●
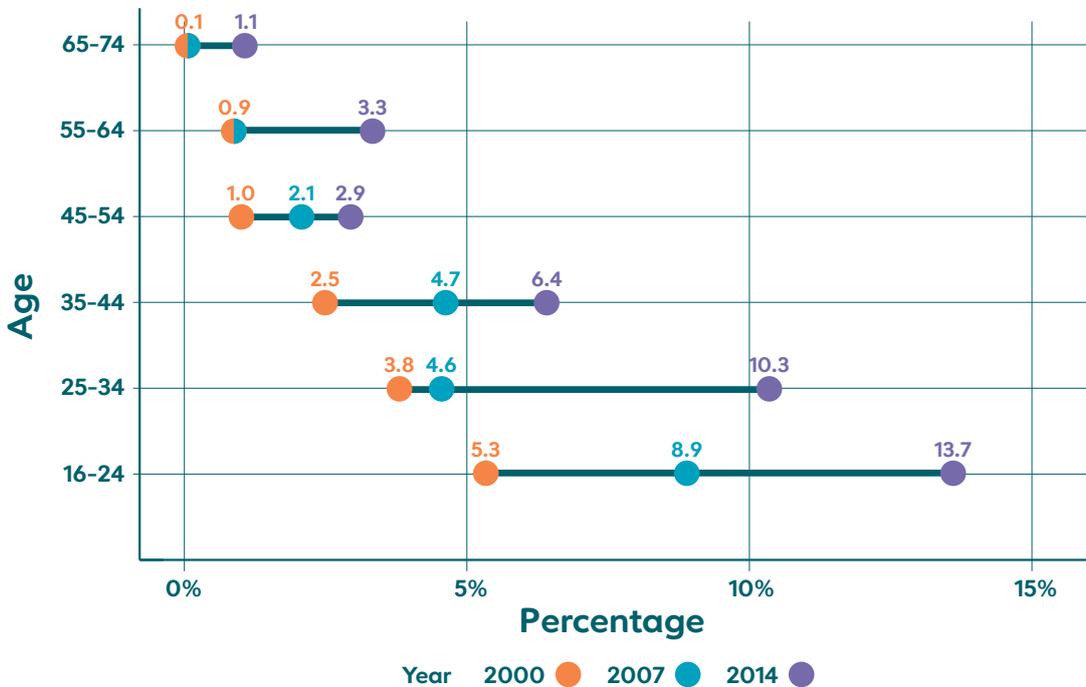
What support is available to people who have self-harmed?

It is vital that policymakers ensure early and adequate support is available to people who have self-harmed, before self-harm becomes an embedded coping mechanism. A number of welcome steps have been taken at a national and local level to improve government-funded support for self-harm (see policy appendix), including making self-harm a key priority within government's suicide prevention strategy, citing the "direct link to suicide"[14]. Yet we still know little about the full range of support offered to people who have self-harmed or what good quality support looks like. Only a minority (38%) of people who have self-harmed have received medical or psychological help[6] and evidence suggests support is even more patchy for people who self-harm in the community (who don't have contact with mental health services). The effectiveness of the available support at reducing self-harm is also poorly understood, especially in community settings, because most clinical studies recruit participants via emergency departments,

mental health services or GP settings[15,16]. As this report will show, people struggle to get appropriate, timely support for self-harm.

With self-harm rates more than doubling since 2000, the challenge to improve support for self-harm could not be more urgent[6]. This research provides the first full picture of the support accessed by people with lived experience of self-harm and their experiences of doing so. It focuses on earlier intervention including non-hospital care, community spaces and social support, recognising the importance of these support types and the lack of research exploring them. Through this research we aim to improve understanding of the support needs of people who have self-harmed, what may prevent this group from receiving appropriate support and opportunities to improve the quality of support available.

Figure 1 data source: McManus et al., 'Prevalence of Non-Suicidal Self-Harm and Service Contact in England, 2000–14'.

Methodology

This research adopted a range of different methods and analysis of both primary and secondary data relating to self-harm and people's experiences. Here we provide an overview of our research objectives and research methods used to achieve them. For full details, see our full Methodological Appendix.

Research objectives

- Understand what prevents people with lived experience of self-harm from receiving appropriate support following self-harm.

- Understand whether the support available helps people to stop self-harming and reduce their emotional distress, and how the support could be improved.

What methods did we use?

Survey of people who have self-harmed
An online survey was carried out among 585 adults aged 16 and over in England between September and December 2019. The survey sample was self-selecting and promoted through Samaritans' website and social media channels and a wide range of organisations working on related topics. 50% of participants were aged between 25 and 44 years, and 84% of the sample were female. All data reported is significant to p = <0.05 unless otherwise stated.

Interviews with people who have self-harmed
17 in-depth interviews were carried out in February and March 2020 with a sub-sample of survey participants who had self-harmed in the last two years. We spoke to people from across England and a mix of ages, to ensure we heard a range of views and experiences. Most interviews were carried out face to face in a Samaritans branch, four were conducted over the phone. The interviews used a set of cards as memory prompts for participants, which were adapted from the Card Sort Task for Self-harm (CaTS).

Samaritans service data
The themes, or 'concerns', raised in emotional support contacts to Samaritans in 2019 were explored by demographic group, and compared to contacts where self-harm was not raised. As a confidential service, we record some non-identifiable information, such as gender and distress level, but we do not report on specific people[a].

Survey of Samaritans volunteers
251 Samaritans volunteers participated in an online survey in August and September 2019 to deepen our understanding of the needs and concerns of Samaritans callers who self-harm. The majority of the survey related to social and health concerns within the service data.

Adult Psychiatric Morbidity Survey analysis
The APMS is a nationally representative survey commissioned by NHSD exploring mental illness in England that has been conducted every seven years since 1993. It is the most robust data source available on people who have self-harmed without wanting to take their own life. For the purposes of this research, Sally McManus at NatCen conducted new analysis of the 2014 APMS dataset to explore the link between self-harm and three topics: suicidal behaviours, mental health problems and loneliness.

Literature review
To inform this research, three rapid reviews were conducted:

- Self-harm rates and the effectiveness of support for self-harm: conducted by the Suicidal Behaviour Research Lab at the University of Glasgow in March 2019

- Relationship between traumatic life events and self-harm: conducted by Dr Marc Bush at Human Experience in March 2020

- Further exploration of the effectiveness of support for people who self-harm: conducted by Dr Vladimir Kolodin and Samaritans researchers in April 2020

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a More information about how we collect our data can be found in the Methodological Appendix.
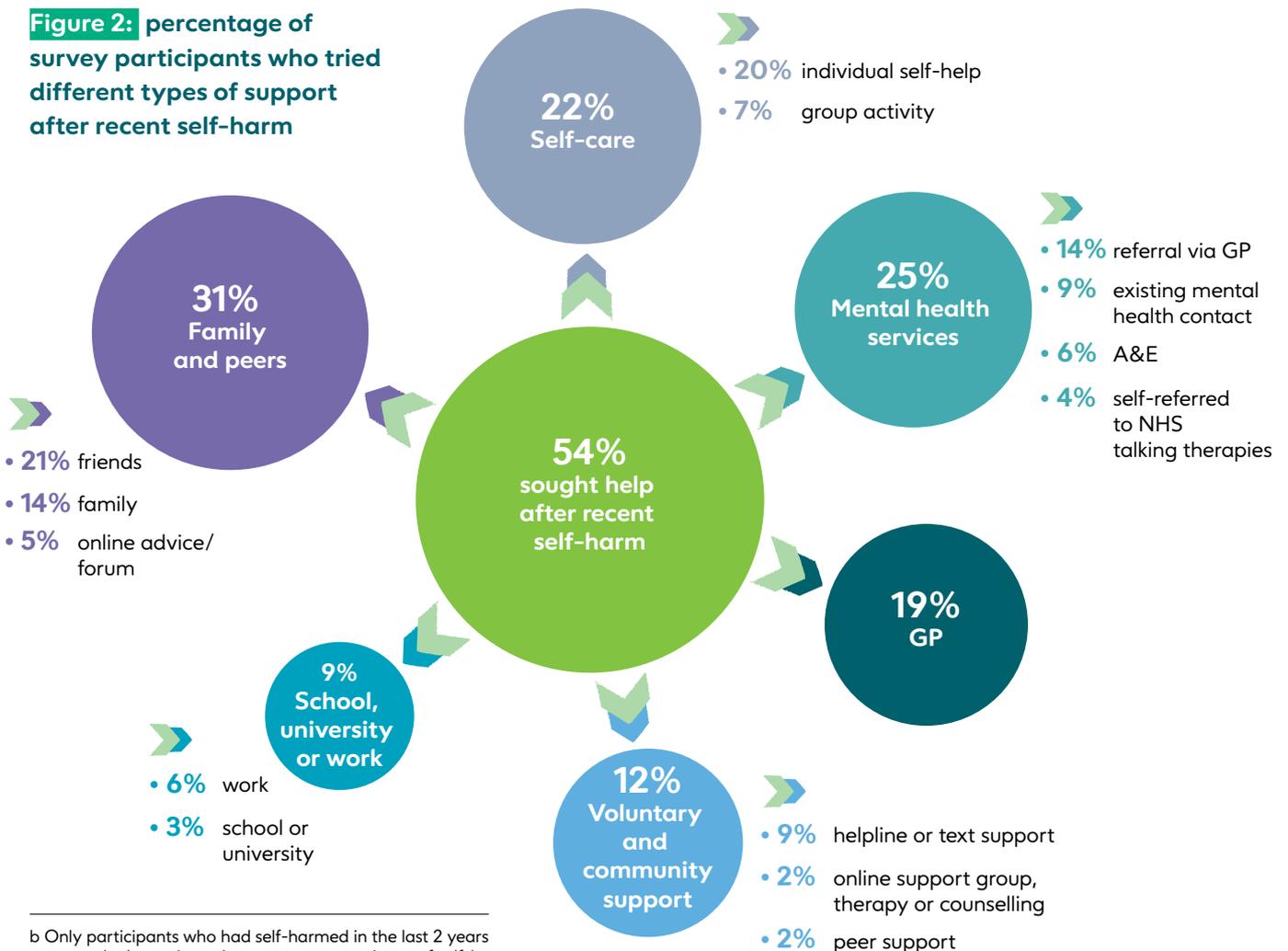
What support do people seek for self-harm?

In our survey, we asked people about the most recent time they had self-harmed (referred to as recent self-harm) and the support they sought afterwards[b]. We also asked more generally about the support they'd received for self-harm throughout their life. 'Support' was defined in the broadest sense, including a wide range of formal and informal support types, as shown in Figure 2.

- Nearly 9 in 10 (87%) participants had sought help for self-harm at some point in their life, and more than half (54%) had done so after their most recent self-harm.

- Levels of help-seeking were broadly similar across groups, though variation in the type of support sought is explored later in the report. People with a long-standing mental health condition were more likely to seek support than other groups, driven by more frequent support from healthcare (37% vs 20%).

We asked survey participants to identify all the types of support they had reached out to after recent self-harm and grouped these into themes. Because some people tried multiple support types within a theme, or across themes, the themes and types of support can't be added up.

Figure 2: percentage of survey participants who tried different types of support after recent self-harm

22%
Self-care
- **20%** individual self-help
- **7%** group activity

31%
Family and peers
- **21%** friends
- **14%** family
- **5%** online advice/forum

25%
Mental health services
- **14%** referral via GP
- **9%** existing mental health contact
- **6%** A&E
- **4%** self-referred to NHS talking therapies

54%
sought help after recent self-harm

19%
GP

9%
School, university or work
- **6%** work
- **3%** school or university

12%
Voluntary and community support
- **9%** helpline or text support
- **2%** online support group, therapy or counselling
- **2%** peer support

b Only participants who had self-harmed in the last 2 years were asked questions about a recent experience of self-harm, in order to ensure relevance for the current policy environment and that participants could adequately recall the experience.
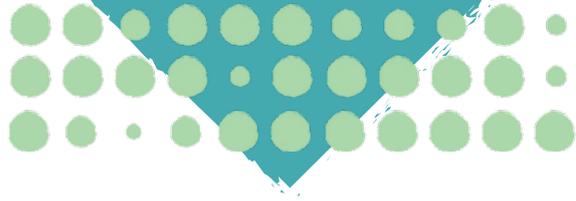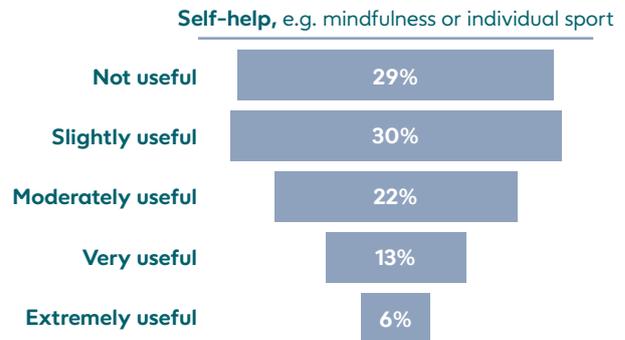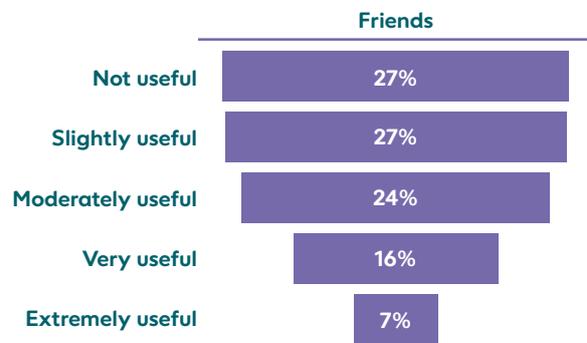
How does support affect wellbeing?

Seeking support appeared to be associated with changes in people's mental health in the day, week and month after self-harm. People who sought support were more likely to say their mental health worsened the day after they self-harmed, compared to those who didn't seek support (58% vs 40%), suggesting that people whose mental health deteriorates following self-harming are more likely to seek support. However, by a month after the self-harm, our data indicates that this changes, with people who sought support appearing to be more likely to report improved mental health, compared to those who didn't seek support (58% vs 48%[c]).

How useful is support?

We also asked people about the support they'd received for self-harm throughout their life and how useful the support had been, in general. Most survey participants had tried a wide range of support at some point and said that overall usefulness for all types of support was low. There is an urgent need to improve the quality of support across the board, as these findings show many people with lived experience of self-harm are struggling to find even moderately effective support.

While no one support type is effective for the majority, there were differences between support types.

The most positive responses were to self-help and support from friends, and these were also the most common support types that people had used (84% and 86% respectively). Just under half said these types of support were moderately useful or higher. Comparatively few said these were not useful forms of support (less than 3 in 10).

Friends

Not useful	27%
Slightly useful	27%
Moderately useful	24%
Very useful	16%
Extremely useful	7%

Self-help, e.g. mindfulness or individual sport

|	
Not useful	29%
Slightly useful	30%
Moderately useful	22%
Very useful	13%
Extremely useful	6%

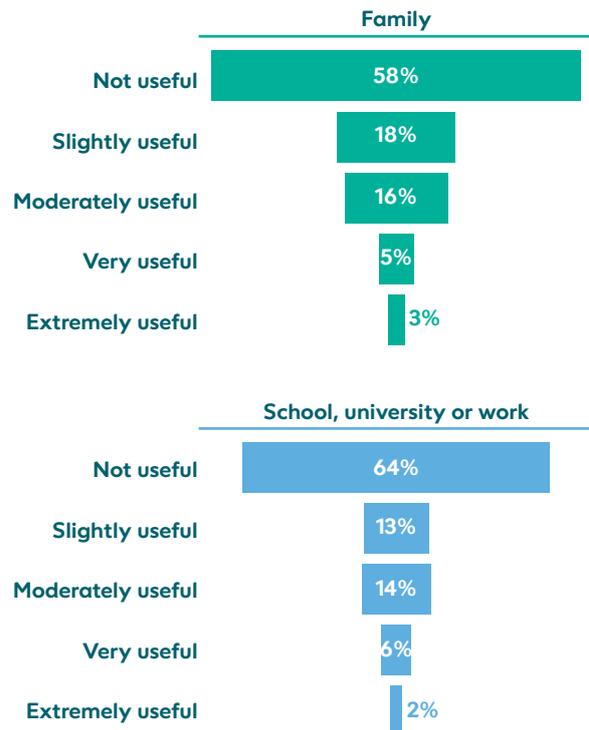c Difference not statistically significant; p=0.172

What support do people seek for self-harm?
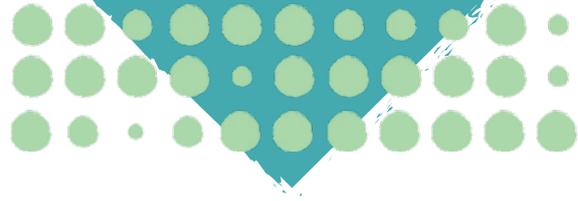
Next was healthcare, online help and group activities. Group activity had been tried by less than half of participants (47%), far lower than all other types of support. Healthcare was one of the most frequently tried types of support, with 4 in 5 having tried it for self-harm, while two-thirds (68%) said they had used online sources for self-harm support. Around a third of people said these types of support were moderately useful or higher. While relatively few people said that online help was not useful (30%), similar to friends and self-help, fewer people had highly positive experiences of online help.
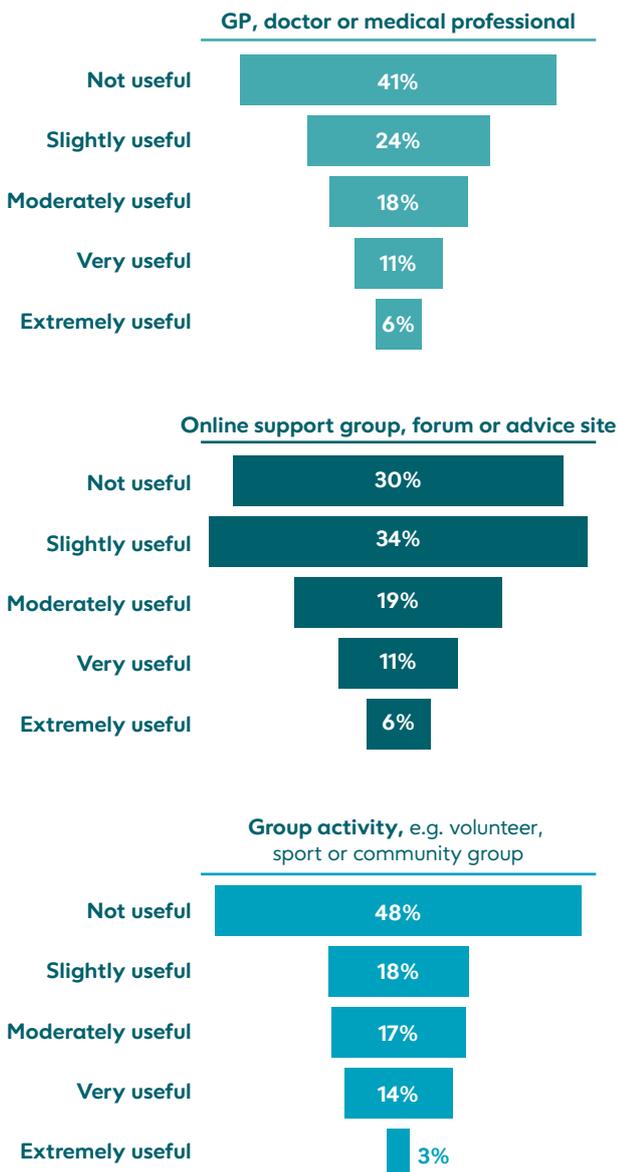
The least useful support was reported from family, and education or work. Over three-quarters (78%) had gone to their family for support at some point, while two-thirds (67%) had sought support from education or work. Only around 1 in 4 people found these types of support moderately useful or higher, with around 3 in 5 not finding the support useful.

Family

Not useful	58%
Slightly useful	18%
Moderately useful	16%
Very useful	5%
Extremely useful	3%

School, university or work

Not useful	64%
Slightly useful	13%
Moderately useful	14%
Very useful	6%
Extremely useful	2%

GP, doctor or medical professional

Not useful	41%
Slightly useful	24%
Moderately useful	18%
Very useful	11%
Extremely useful	6%

Online support group, forum or advice site

Not useful	30%
Slightly useful	34%
Moderately useful	19%
Very useful	11%
Extremely useful	6%

Group activity, e.g. volunteer, sport or community group

Not useful	48%
Slightly useful	18%
Moderately useful	17%
Very useful	14%
Extremely useful	3%

Through our interviews, people with lived experience of self-harm told us about the unique nature of their support needs and how support could be more useful for them. We found there are four key support needs which must be addressed:

- Distraction from immediate self-harm urges
- Emotional support in times of stress
- Developing alternative coping strategies
- Addressing the underlying reasons for self-harm

To meet each of these needs, a holistic approach to care is required – no one support type can effectively address each of these four components. In the following sections, we explore the roles each type of support plays for people with lived experience of self-harm and how the availability and effectiveness of support could be improved.

Family and peers

In our research, people with lived experience of self-harm were most likely to seek support from family and peers. They spoke of the helpful role of family and peers in providing emotional relief in times of stress, but they also spoke of the stigma associated with doing so. Because of this, peer support from people with similar experiences, often online, was important; particularly in building understanding of triggers and coping strategies for self-harm. In total, 31% of survey participants sought support from family or peers after recent self-harm.

Emotional relief in times of stress: opening up to family and friends

People with lived experience of self-harm spoke of a complex relationship between social support and self-harm. Positive social support helped them reduce or stop self-harming, while stigma associated with self-harm led some to secrecy and further isolation from potential support networks. In our interviews, many spoke of valuable support from others who had also self-harmed in the past or who were open about their own experiences of emotional distress. This was described by one participant as relationships where no topic was "off-limits" – where opening up was normal:

> ❝ [My friend is] someone who at least is familiar with my mental health issues and he has his own challenges... it's easier, isn't it, to have a conversation where they already know that's part of the landscape. If I talk to someone who I only see at football, or with the kids... they're not really prepared to receive that kind of information, whereas my other friend, it's a lesser leap, I guess. ❞

Jeffrey[d], 45-54

However, many of those we interviewed, as well as Samaritans volunteers we surveyed, spoke of a specific stigma relating to self-harm, which ran deeper than stigma about mental health in general. Concerns about this meant some people we spoke to didn't feel able to tell loved ones about their self-harm:
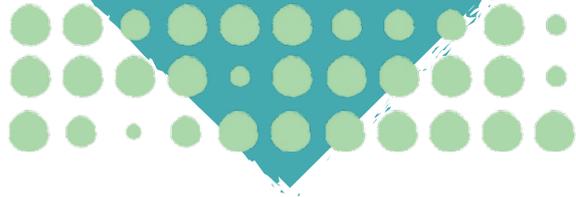
> ❝ Because self-harm is quite taboo it's quite hard to talk about, and I was worried about how people would react. ❞

Debbie, 21-24

> ❝ Many try to hide it from family and friends who they feel don't understand, which leads to loneliness and isolation. ❞

Samaritans volunteer

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d All names have been changed throughout this report.

This left some without the support they needed, particularly during difficult times in their life. Some linked this to an increase or return of their self-harm, which reflects data from the latest Adult Psychiatric Morbidity Survey (APMS).

New analysis of the APMS shows that 3 in 10 people (31%) who self-harmed in the past year said they felt lonely and isolated "very much"[e]. This is more than 10 times higher than those who hadn't self-harmed in the past year (2.4%).

Half (50%) of people who had self-harmed in the past year reported "some" or "severe" difficulties in getting and keeping close relationships. This is more than 4 times higher than those who hadn't self-harmed in the past year (12%).

We see this link at Samaritans. In 2019, some of the most common concerns among people who discussed self-harm were:

37% **Family concerns**

25% **Loneliness or isolation**

22% **Relationship problems**

Research shows that positive social support is key to resisting self-harm in the moment and ceasing self-harm longer term[17,18,19,20]. We also know that meaningful social support is more common among people who have stopped self-harming compared to those who continue to self-harm[17].

In our survey, people who were currently in employment were almost twice as likely to have sought support from their friends following recent self-harm than people who were not employed (23% vs 14%). Those out of work were also more likely to say that their friends were not a useful source of support for self-harm in general: more than a third (34%) of people not in work said this, compared to only one in four (25%) employed people. This might be because people who are not in employment lack the regular support network that a work environment can provide. Reducing stigma around self-harm and increasing guidance to supporters of people who self-harm is essential to encouraging more people to open up, and to receive support that would help them.

Developing alternative coping strategies: peer support

When speaking to people with lived experience of self-harm, a need to feel 'understood' came through strongly. Some of those we interviewed found that, when they did open up to friends or family, a lack of understanding and knowledge about self-harm meant they didn't get the support they needed. This often led to an increased sense of isolation:

66 I don't talk to anyone about it, my partner finds it disturbing but basically ignores it. **99**

Ben, 25–34

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e The APMS defines self-harm as 'Non-Suicidal Self-Injury' and uses the following survey question: "Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?"

When people lacked open, supportive friendships/relationships, many had sought understanding and support online. For instance, one survey participant described using online forums because

❝ I want to be understood and I want people who've been through similar experiences to give me coping advice. ❞
Felicity, 25–34

However, research shows that young people who repeatedly self-harm/attempt suicide are more likely to have a family member or close friend who has done the same, and there are concerns that peer-to-peer discussion could amplify this social influence[21].

Recommendations

(i) Government should use its ongoing online harms white paper process[22], in consultation with expert third sector organisations, to inform the creation of safe online spaces that are effectively moderated to improve the availability and quality of online support by trusted organisations.

Given the value of peer support for those we interviewed, it is vital that safe spaces for discussing self-harm are created. Policy makers need to give consideration to the relationship between self-harm, isolation, and community and peer support.

Mental health services

Self-harm is linked to mental health conditions such as depression, anxiety, borderline personality disorder and post-traumatic stress disorder[23]. Mental health services provided by the NHS have the potential to support people who self-harm both to address the underlying causes of self-harm and to understand the triggers of the behaviour. However, our research finds that such services are not commissioned or designed with self-harm in mind.

This impacts on people who self-harm in two ways:

- **Exclusion from psychological therapies offered in primary care and secondary mental health services.**
- **Ineffective provision that often ignores or excludes self-harm and fails to recognise the link between trauma and self-harm.**

In total, 25% of survey participants sought support from mental health services after recent self-harm.

What prevents people accessing this support?

The National Institute for Health and Care Excellence's (NICE) guidelines recommend that anyone who self-harms should receive mental health treatment. In 2019, 3 in 4 people who contacted Samaritans to discuss self-harm were concerned about their mental health, far higher than callers who don't mention self-harm. However, our research found that many who have self-harmed could not access support. In our interviews, people described being considered "too high risk" from primary mental health, while not ill enough for secondary mental health services.

Too 'high risk' for psychological therapies

Improving Access to Psychosocial Therapies (IAPT) is the flagship NHS programme for treating common mental health disorders and aims to reach over a million people every year[24]. While national guidance does not suggest excluding people who self-harm[25], in practice the local

Trusts delivering IAPT often reject people who self-harm (normally not differentiating between those who have attempted suicide and those who haven't) based on a blanket perception of suicide risk[26]. Many services feel they lack the expertise to support a person who self-harms and lack the capacity to manage the perceived risk. For example, one Foundation Trust states on its website that "in line with national IAPT standards" their service does not work with "people who present with active risk of significant self-harm or suicide", while another Trust advises clinicians against referring anyone at "significant risk of self-harm"[27] to IAPT. In our interviews, we heard how this exclusion plays out in practice.

> 66 [A mental health nurse] said she would refer me to therapy, like CBT, again… She said, 'I don't think they'll accept you because your risk level is too high with your self-harm'. 99
>
> **Jane, 21-24**

> 66 GPs… will just refer you on to other services which do not deal with people who are actively self-harming or at risk of suicide. 99
>
> **Kadir, 21-24**

Waiting lists and struggles to access mental health services are a well-documented problem in England[28]. However, this research points to additional, unique challenges faced by people who self-harm in accessing IAPT, a service presented by the Government as 'the most ambitious programme of talking therapies in the world'[29].

Not meeting the threshold for secondary care

Community Mental Health Teams, a central part of secondary mental health provision, are designed to support people who self-harm. However, access to these teams is guarded by high thresholds. To be eligible, as well as being at significant risk of persistent self-harm, a person must have a severe, complex or enduring, mental health disorder[30]. As such, many who self-harm, in particular those who self-harm without wanting to take their own life, will be excluded from this support too. As their needs are seen as less serious, people who have self-harmed without wanting to take their own life are slipping through the cracks in support.

❝ Generally, my self-harm has not been regarded as serious as I have carried on working and functioning, so my mental health is not considered as being bad enough for NHS help. ❞

Amelia, 35–44

❝ I have already undergone CBT (cognitive behavioral therapy) and feel I have gained as much as I can from it. Ideally, I need DBT (dialectical behavior therapy), but my case isn't serious enough for me to get DBT under the NHS. ❞
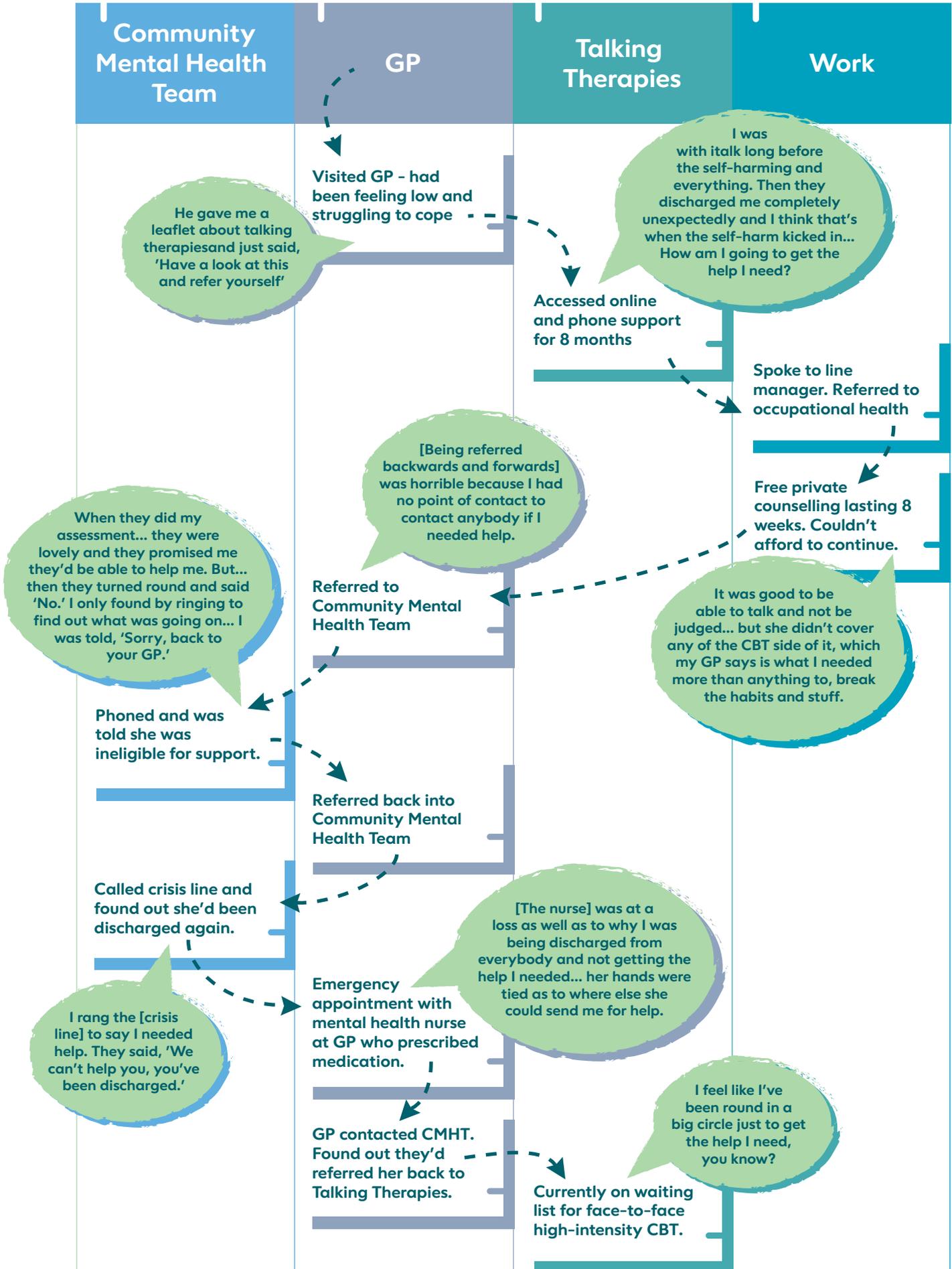
Jo, 25–34

Having taken the daunting first step of seeking help, people with experience of self-harm are too often told that their needs do not fit with the available provision. Our survey supports this, finding that people without a long-standing mental health condition (60% of participants) were less likely to seek support from health services than those with a long-term condition (20% vs 37%), and were more likely to say healthcare had not been useful for their self-harm (55% vs 35%).

People who have self-harmed but do not have an enduring mental health condition are either too high risk for one service, or not ill enough for another. Services must do much more to provide support after a person makes the first difficult step to get better.

New analysis of the APMS suggests that 48% of people who self-harmed in the past year did not have severe levels of anxiety/depression when interviewed, which means they may have been unlikely to meet the threshold for secondary mental health care.[f] This highlights the importance of providing accessible support in other settings.

f This was measured using the revised Clinical Interview Schedule (CIS-R), a standardised measure of common mental disorders such as anxiety or depression. A score of 18 or more is considered severe and requiring intervention.

Figure 3: Freya's experience of accessing NHS care for self-harm

Community Mental Health Team	GP	Talking Therapies	Work

Visited GP - had been feeling low and struggling to cope

He gave me a leaflet about talking therapiesand just said, 'Have a look at this and refer yourself'

Accessed online and phone support for 8 months

I was with italk long before the self-harming and everything. Then they discharged me completely unexpectedly and I think that's when the self-harm kicked in... How am I going to get the help I need?

Spoke to line manager. Referred to occupational health

Free private counselling lasting 8 weeks. Couldn't afford to continue.

[Being referred backwards and forwards] was horrible because I had no point of contact to contact anybody if I needed help.

Referred to Community Mental Health Team

When they did my assessment... they were lovely and they promised me they'd be able to help me. But... then they turned round and said 'No.' I only found by ringing to find out what was going on... I was told, 'Sorry, back to your GP.'

It was good to be able to talk and not be judged... but she didn't cover any of the CBT side of it, which my GP says is what I needed more than anything to, break the habits and stuff.

Phoned and was told she was ineligible for support.

Referred back into Community Mental Health Team

Called crisis line and found out she'd been discharged again.

[The nurse] was at a loss as well as to why I was being discharged from everybody and not getting the help I needed... her hands were tied as to where else she could send me for help.

Emergency appointment with mental health nurse at GP who prescribed medication.

I rang the [crisis line] to say I needed help. They said, 'We can't help you, you've been discharged.'

I feel like I've been round in a big circle just to get the help I need, you know?

GP contacted CMHT. Found out they'd referred her back to Talking Therapies.

Currently on waiting list for face-to-face high-intensity CBT.

NHS England plans to address the problem of medical 'ping-pong' in part through the expansion of Community Mental Health Teams[31]. However, this will not help the large group of people who do not meet the threshold for secondary mental health care.

Of those who did access healthcare, few found it useful for self-harm. Only a third (35%) of survey participants said support from their GP, doctor or medical professional was moderately useful or better. And in a survey of Samaritans volunteers, a third (32%) said callers who are concerned about their mental health most frequently talk about NHS mental health treatment not being effective.

Our research shows this is because mental health services often ignore or exclude self-harm, and fail to recognise the link between trauma and self-harm. As a result, people who have self-harmed are not supported either to understand the triggers, patterns and coping mechanisms for their self-harm, or to adequately address the underlying reasons for their self-harm.

Recommendation

(ii) NHS England and DHSC must use planned investment in specialist mental health services to expand capacity and expertise to support people who self-harm. This should enable these services to remove exclusion criteria and to provide targeted support to people who self-harm. This should be available to anyone deemed likely to benefit following a psychosocial assessment.

Developing alternative coping strategies: acknowledging self-harm within mental health services

NICE guidelines state that someone who has presented to NHS services following self-harm should be offered between 3 and 12 sessions of a psychological intervention specifically structured for people who self-harm, with the aim of reducing the behaviour[33].

In spite of this guidance, mental health services are rarely commissioned to deal with self-harm directly. This means that some of the most common psychological interventions fail to recognise the specific needs of this group or to address self-harm as part of their treatment:

66 [The self-harm] was pretty much ignored. It was kind of, like, have you done it? No, yes, next thing... [the therapist] never asked me a direct question about it. I've sometimes told her something related to it or when I've done it or something, but she's never asked me. 99

Tabby, 18–20

Among those we interviewed, some were given access to mental health support on the condition that they did not mention self-harm during treatment, usually in group therapy settings. This meant some people opted out of the support, while others didn't find it beneficial.

❝ Actually the mental health people have tried to get me to do a type of therapy... and they tell you that you mustn't self-harm while you're doing it. I'm like, 'Okay, well, how are you going to support me then, because it's my coping mechanism.' ❞

Marie, 35–44

❝ [In group therapy] you're not allowed to say the words self-harm, and you're not allowed to talk about any situations, like, you can't use examples, using self-harm. So, it's another way of, stigmatising it... It's not helpful... And then I'm left with no one to speak to about self-harm, suicide, everything else that goes on in my life. ❞

Tabby, 18–20

Even where the treatment experience was otherwise positive, this left people less able to cope with the self-harm, particularly in the short and medium term.

❝ I can't complain that the long-term game was wrong, it's just that, at the time, you maybe could do with a little bit more directed support about trying to handle the urges. ❞

Gordon, 45–54

In positive experiences, people were supported to develop alternative coping techniques to address self-harm behaviour, alongside treatment of underlying mental health conditions, but this was rare in the NHS:

❝ I'm a voice hearer, so we talked about using the techniques around voice hearing, more to help with the self-harm as well because the voices were telling me to self-harm. ❞

Lisbeth, 45–54

New analysis of APMS shows that almost 1 in 5 people (18%) receiving mental health treatment had self-harmed in the past year.

Given how frequently this occurs, it's vital that mental health services are equipped to deliver effective support for self-harm.
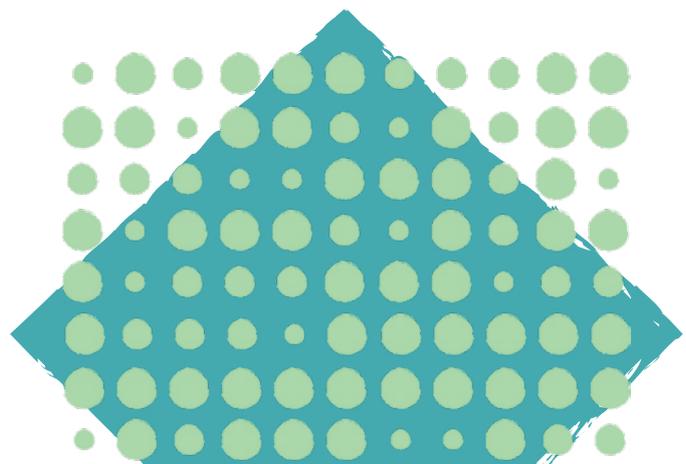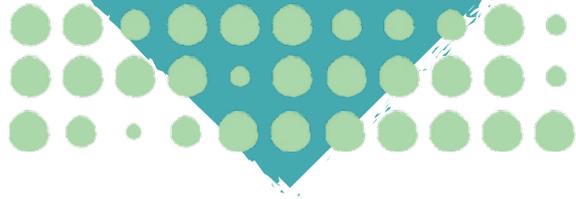
The benefits of self-harm specific support – an example of support provided by a local self-harm charity

Jenny, a woman in her early 20s, had started to self-harm aged 15 and accessed psychological therapies through her GP, privately and through college over the course of three years. During this time, Jenny's self-harm became progressively more severe and escalated to the point that she attended A&E, aged 18. At this point she was given the details of a local self-harm charity.

Of the range of support she had received, Jenny found the support from the local self-harm charity the most beneficial. It addressed her self-harm directly, helping her understand the underlying causes of her self-harm and supporting her to learn techniques to manage urges to hurt herself in the long term.

❝ It focussed solely on the self-harm. Obviously, I had underlying issues which needed to be dealt with, but it was finally someone that was actually looking at the self-harm as a separate thing that needed a different approach... I feel like it had been brushed off beforehand, she gave me distraction techniques and different ideas of support. She talked about urge levels and how you've got to split it into different types of how intense they are and how different urges can have different things that you do, because it's quite complex. Sometimes I'll self-harm because I don't feel anything, sometimes I'll self-harm because I feel too much, and actually she made me realise that, yes, there are different types of self-harm, and you might exhibit them at different times, and you need to have different techniques for each type. It's not like a one size fits all approach. ❞

It is vital that people who have self-harmed are offered support to address the behaviour directly, alongside support for the underlying reasons for self-harm, early enough to prevent their self-harm worsening and reaching crisis point.

This will require a thriving third sector, which is supported with funding from central and local government to step up and provide alternative support, often earlier than NHS-provided services can respond.

People with lived experience of self-harm told us how, at present, they are often not allowed to mention the behaviour when accessing services and can be banned from self-harming when receiving help. To fully support people who self-harm, techniques to manage the behaviour and understand triggers need to form part of NHS mental health support. This means allowing self-harm to be discussed in a safe way in group and individual settings and not excluding people who self-harm on the basis of continued self-harming.

Recommendations

(iii) More research should be undertaken as a priority into the benefits and risks of group therapy within clinical settings for self-harm.

(iv) Planned investment in mental health services outlined in the NHS Long Term Plan[32] should focus on increasing the capacity and expertise of services so that, where possible, safe group spaces are created to support people who self-harm.

Addressing the underlying reasons for self-harm: trauma-informed services

There is a strong link between trauma and self-harm[23]. In particular, enduring or cumulative trauma is linked to self-harm, as are certain traumatic life events[35,36]. This is backed up by Samaritans' service data which shows that callers who discuss self-harm are more than twice as likely to have concerns about violence/abuse than those who don't talk about self-harm (26% vs 12%). Many people that we interviewed had experienced traumatic life events or childhood trauma and spoke of how they contributed to their self-harm:

66 Each big cycle [of self-harm] has been triggered by a trauma and because of the traumas I will have days where... my stress tolerance is maybe a little bit lower now. 99

Monica, 25–34

Trauma can decrease a person's stress tolerance and mean that they are more likely to adopt unhelpful coping strategies, such as self-harm. It can also mean their support needs are more unique.

66 I've been through the [healthcare] system. I know that I need EMDR [Eye Movement Desensitisation and Reprocessing therapy for treatment of trauma and PTSD] because it worked last time. I saw the psychotherapist... they insisted that I had to go to a group meeting. There's no flexibility in any shape or form, they create this pathway that is one size fits all that's incomprehensible. 99

Jack, 55–64

Recommendation

(v) All support services for people who self-harm, whether NHS provided or community-based, should provide trauma-informed support, which acknowledges and supports with underlying issues driving self-harm.

Services also need to be flexible so they can offer strategies and methods of accessing services that meet the complexity of an individual's need.

Self-care

People with lived experience of self-harm told us about the important role of self-care in providing both a distraction from immediate self-harm urges and developing preventative coping strategies over the longer term. Given the impulsiveness, and often secrecy, associated with self-harm, effective self-care is vital for helping people to both resist and stop self-harm. In total, 22% of our survey participants used self-care techniques after recent self-harm:

▶▶ Distraction from immediate self-harm urges: online lists and apps

Among those we interviewed, self-care techniques were the most common way to distract from self-harm urges, reflecting the immediacy of these urges. Most knew a range of self-care distraction techniques, some of which were effective as a short-term strategy to resist harming themselves in the moment. Other support options, like going to the doctor, weren't immediately available and were therefore unlikely to help in these circumstances. Many organisations supporting people who self-harm publish lists of distraction tips and techniques. Views of these were generally positive, with a number revisiting and revising content online:

❝ I always go on the website Mind, the Samaritans website, NHS, other little websites. They tell me things I already know... but yes, I do use websites for tips and stuff. ❞

Aarav, 18–20

Apps that provided distraction methods had mixed reviews. Accessible support on a phone appealed and had been tried by many of those we interviewed, but apps often required more decision-making and concentration than reading an online list – for instance to remember a password or choose an activity. This wasn't always possible when experiencing urges to self-harm:

❝ They're trying to distract you and keep your brain occupied... [but] I found that really overwhelming. Too much to process, and it was too much to ask of me... when you've got compulsion. ❞

Lee, 45–54

Recommendations

(vi) App, website and service developers should not attempt to mimic self-harm behaviours when providing distraction techniques. Instead they should involve clinicians, third-sector experts and people with lived experience throughout the development lifecycle to ensure what is being produced will be effective and usable in the intended context.

There's a lack of high-quality evidence on effective distraction techniques. Some commonly promoted techniques to resist self-harm, such as flicking an elastic band or rubbing an ice cube, attempt to replace self-harm behaviours. Research has found limited evidence that these techniques work and they may even have the effect of further embedding self-harm as a habit[37,38].

There are opportunities to develop standards and guidelines for organisations aiming to provide distraction techniques for people who self-harm based on established user needs and good practice, and for NHS England app and web content to be developed in line with these standards and guidelines.

▶ Developing alternative coping strategies: assisted self-care

Many people with lived experience of self-harm said that understanding patterns, triggers or underlying causes associated with their self-harm was the turning point in developing effective long-term coping strategies:

> 66 I now know what my triggers are… I know the places that stress me out and I've developed fairly robust mechanisms. 99
> **Michael, 55-64**

Others recognised the importance of this step to reducing their self-harm:

> 66 It does feel if I understood why I [self-harm], that would be a massive shift, and I might not want to do it anymore… because if you know why you can make changes. 99
> **Jen, 35-44**

There were as many approaches to longer term coping strategies as there were participants. While no single approach works for everyone, or even the majority, there were two common routes to building an understanding of triggers, patterns and therefore coping strategies:

Trial and error: a number of people described finding coping strategies through trial and error or re-visiting hobbies they had enjoyed in the past. For most, this was a lengthy and challenging process, based on online ideas or exercises in self-help books:

> 66 I find it really hard to motivate myself for self-help. So I'll read the books, and I'm fine with that and I'll know all the tips and tricks, but actually implementing them, I feel like I needed someone to be there to actually support me. 99
> **Iesha, 21-24**

Guided: others spoke of how assistance from someone else, often involving face-to-face therapy or counselling, but sometimes helplines or friends, had helped them to recognise their patterns and triggers. This helped them enact effective self-care in a way they didn't feel able to without support.

Our survey found that people with long-standing mental health conditions were less likely to find self-help useful than other participants (moderately useful or better: 35% vs 44%). It may be particularly hard for people with long-standing conditions to engage with or get the benefit of self-help without additional guidance.

Recommendation

(vii) NHS England should work with third sector experts, such as Samaritans (who have developed a self-care app[9]) and people with lived experience, to develop an app for anyone who has presented to clinical services having self-harmed. This could build on therapeutic principles and exercises[16], such as elements of CBT, DBT and mentalization therapies or adaptations of treatments such as habit reversal therapy. It should also contain personalised support features, which could include verified distraction techniques based on the person's existing interests and interactive safety plans.

There is an opportunity to develop more interactive and assisted forms of self-care, via apps and online guides, to support people who are struggling to access relevant therapy or that standalone self-help is ineffective for.

g You can find out more about the app here: https://selfhelp.samaritans.org/

Group activity – a missed opportunity to build meaningful connections?

Less than half (47%) of people in our survey had ever tried group activities, such as volunteering and team sports, for support following self-harm. And less than 1 in 10 (7%) had sought this support from after the most recent time they self-harmed. This is much lower than most other support types. While, as described in this section, our research shows that effective coping strategies are highly individual, this appears to be a missed opportunity for social contact and to build caring connections over time.

❝ I also received a lot of support from my vicar who helped me to stay busy at church – she gave me lots of little jobs to do which made me feel useful and wanted. **❞**

Dee, 25–34

❝ Sport helps to reconnect with my body in a positive way and lifts my mood. **❞**

Jameela, 21–24

Local authorities are well placed to support and develop services based on group activity and fostering positive social connection. As recommended in the NHS England Five Year Forward View for Mental Health, every local area should have a multi-agency suicide prevention plan[39]. However, a 2019 study found that while 92% of these include plans to support people who self-harm/attempt suicide, only 55% of areas were putting their plans into action[40]. These actions include training in healthcare settings, reducing stigma and negative attitudes, and auditing current clinical practice to assess compliance with NICE guidelines.

Recommendation

(viii) Within the confines of shrinking budgets, and with support from central government, local areas should diversify the support offered to people who self-harm, to more consistently include group activities which foster connection.

This report has shown how important peer support and social connections can be to people with lived experience of self-harm. With more consideration of how group activities that foster connection could support this group, such activities could provide an alternative to more clinical interventions, reaching more people who have self-harmed without wanting to take their own life, and providing an option for support through social prescribing.

Engagement with people with lived experience to develop these activities is vital to ensure their effectiveness – our research found, at the moment, group activities have only been moderately useful or better for a third (34%) of people who tried it to help with their self-harm.

GP care

In our research, people with lived experience of self-harm said GPs had two key roles in providing support:

- **Assessing needs and providing a gateway to services that can address the underlying reasons for the self-harm.**
- **Providing an accessible, ongoing source of support in times of stress.**

The people we spoke to had mixed experiences of the quality of support they had received from GPs. For GPs to effectively support people who have self-harmed, personalised needs assessments and more consistent referrals into services are required. However, we found that a third (31%) of people who saw their GP after recent self-harm were not offered any advice or follow-up support. As the most common form of healthcare support sought by people in our survey, high-quality and supportive GP care is vital. In total, 19% sought support from a GP after recent self-harm.

Addressing the underlying reasons for self-harm: assessments and advice

GPs can provide valuable support to address the underlying reasons for a person's self-harm by assessing a person's needs and being an ongoing source of advice.

Psychosocial assessments are a key tool to understand the underlying reasons for a person's self-harm. NICE guidelines state that whenever someone who self-harms comes into contact with the NHS in any clinical setting, a comprehensive psychosocial assessment should be carried out. These assessments aim to go beyond health needs and explore the underlying personal factors driving self-harm[41]. GPs are well-placed, in some respects, to undertake these assessments due to the ongoing relationship they can build with the person. However, carrying out a meaningful psychosocial assessment takes time and GPs are restricted by the length of appointments. Research in hospital settings shows that a psychosocial assessment alone can reduce the likelihood the person will present to hospital settings again, following self-harm or attempt suicide, but the impact on repeat self-harm in the community is unknown[42]. Despite this, very few of those we interviewed said their GP asked about the issues which might be driving their self-harm as part of a psychosocial

assessment. One person we interviewed described the positive effect of their GP taking previous life events into account when assessing her needs:

> 66 [My GP says] there's more to me than a person who self-harms. Let's get to know the person behind the self-harm so we can support you. So, it's knowing your history, knowing what you've been through. And not judging you for some events that in your life that you've gone through. 99
>
> **Mia, 45-54**

The frequency of psychosocial assessments in GP settings is unknown, but even within A&E departments, where there has been a greater focus on ensuring they are carried out consistently, assessments are variable, taking place in anywhere from 22-88% of self-harm/suicide attempt cases[43]. The NHS Long Term Plan commits to having a mental health liaison service in A&E departments and inpatient wards by 2020/21[32], which will help to ensure assessments are carried out more consistently. But this will not help most of the people we spoke to, as very few of them attended A&E. As with many recent commitments to improve support for people who self-harm/attempt suicide, the focus is on those who have presented to clinical services, rather than those in the community.
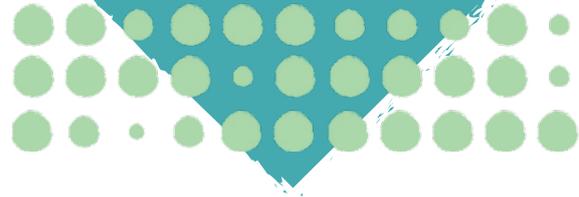
While conversations assessing the person's needs were extremely rare, 27% of survey participants were offered in-appointment advice by their GP. In our interviews, some people spoke of how their GP helped them understand the care options available to them, advising and empowering them to make decisions about their care, and providing a stable source of support throughout their treatment and recovery period.

66 I think the trouble is that you can get overwhelmed by so much information, and lots of things to try and consider... the GP, someone who's got much more experience can help whittle down that decision-making tree, to make it a lot clearer. 99

Samuel, 45-54

Recommendations

(ix) Psychosocial assessments must be undertaken for everyone who discloses self-harm in a clinical setting, including to their GP.

(x) Anyone who self-harms and receives a psychosocial assessment should have the option of receiving a suitable community-based or NHS-provided service in line with their level of distress and the intensity of their needs.

Ensuring that psychosocial assessments are undertaking could be the responsibility of liaison mental health teams in clinical settings outside of A&E departments, which this report recommends should be created. These teams, with a distinct focus on mental health would have the expertise and time to undertake such assessments and also advise on next steps for support.

Addressing the underlying reasons for self-harm: referrals to longer-term support

GPs can also refer people to relevant support services, within or outside of the NHS. In the majority of cases in our survey, GPs suggested one or more forms of support, but a third (31%) of patients were not offered further support:

Percentage offered different support options by GPs following recent self-harm

54% **Follow up GP appointment**

37% **NHS services**

27% **In-appointment advice**

11% **Voluntary and community services**

A third (32%) of those who didn't seek support from their GP after recent self-harm thought their GP wouldn't or couldn't help. People on low incomes were more likely to think this than those on middle/high incomes (44% vs 27%). This was the case even though people on low incomes appeared to be less likely to report getting the support they needed elsewhere (5% vs 11%[h]). This belief was often linked to unhelpful past experiences or unsupportive reactions from GPs.

h Difference not statistically significant; p =.084

Others felt they had exhausted the options available via their GP or that the options a GP could offer weren't effective:

> GPs are very limited in what assistance they can give. Signposted to talking therapies which I've already accessed several times. Or offered medication which I've also tried several different forms of over the years.
>
> **Louise, 25-34**

This is supported by previous research which has highlighted the lack of self-harm support services in primary care for GPs to refer people to[43]. In some cases, this led to persistent re-referrals:

> [What my GP] keeps doing is keep re-referring me back, hoping that eventually they get the right help, you know.
>
> **Christie, 45-54**

As well as referring to NHS services, GPs have a role in referring people to voluntary and community support services. This is known as 'social prescribing'. However, our research finds that people are currently three times more likely to be offered NHS treatment (37%) than voluntary and community support (11%).

To rebalance this, and to help increase the percentage of people offered support by their GP, social prescribing will be important. In October 2019 the Government announced a new National Academy of Social Prescribing, to standardise the quality and range of social prescribing available[44]. The Government aims to refer 900,000 people into social prescribing schemes by 2023/24[32]. To ensure this is as impactful as possible, investment in social prescribing link workers must also be matched by increased funding from central government for the voluntary and community-based organisations that will deliver the support, and who face unprecedented challenges due to the Covid-19 pandemic[45].

Recommendations

(xi) GPs should be supported through training in dealing with people who have self-harmed in a person centred and trauma-informed way which better understands self-harm and its drivers than at present.

It's vital that GPs recognise the importance of supporting people who self-harm and are aware of the full range of support options available. Too many people we spoke to either had stigmatising interactions with their GP, which inhibited help-seeking, or conversations which did not lead to support.

(xii) Central government should provide voluntary and community-based organisations with funding so they can provide a more consistent alternative to NHS support for people who self-harm.

The level of funding must account for the anticipated increased demand for services created by the continued link worker roll out and allow third sector services to expand their offer and reach. Without such investment, the roll out of social prescribing link workers risks lacking impact for people who self-harm.

As well as ensuring that social prescribing is consistently available and offered across the country, referrals for voluntary and community support needs to be appropriate to people's needs. These needs will be diverse and often complex so, for social prescribing to be effective, a wide range of voluntary sector options are needed. Among our survey participants, some who were offered community support didn't take it up because it didn't feel suitable for them:

❝ [I was referred to] a walking group – having chronic pain issues and severe anxiety and PTSD, meeting strangers and walking in unfamiliar places is not appropriate. ❞

Hayley, 35-44

The aims of social prescribing can only be achieved through thriving community-based organisations.

Emotional relief in times of stress: accessible, ongoing support

Just over half (54%) of survey participants who went to their GP after recent self-harm were offered a follow-up appointment. The precise nature of this follow-up support is unclear, but our research suggests that GPs could provide an accessible, ongoing source of support to help people manage their self-harm in times of heightened stress. Some of those we interviewed had benefitted from this type of support, but usually it came from an existing mental health contact or close friends or family:

❝ [When I was struggling, my mental health contact] just reminded me to go for a swim. He was like, go and see your family, eat better, you know, stop eating junk food and what have you. So, it was very much outlining what has worked for me in the past and just telling me to do it, basically. Which was quite good. ❞

Klara, 25-34

Not everyone will have these support options and for those who don't, a GP is well-placed to provide this. This approach relies on a strong, ongoing relationship between GP and patient, and does not appear to be commonplace at the moment.

As the most accessible part of the health system, GPs could play a much more significant role in supporting people during times of increased emotional stress. During these times, when many described a 'build up' in urges to self-harm, something as seemingly simple as being reminded of coping mechanisms that have helped previously can help diffuse the stress. Adaptations of safety plans, created in collaboration with GPs, could also be used during emotionally intense times.
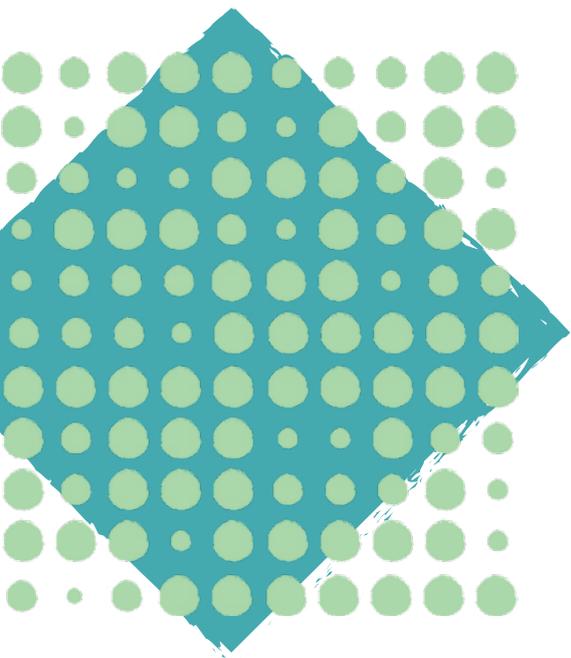
What prevents people accessing this support?

Of our survey participants who didn't go to their GP after recent self-harm, 53% had never been to a GP for support with self-harm. We heard many reasons people hadn't sought support from their GP after they had self-harmed, but two common themes emerged:

1) Perceived seriousness or stigma of self-harm

Of those who didn't seek support from their GP after recent self-harm, half (50%) said it was because they didn't think the self-harm was serious or important enough. This was often linked to feeling that the physical injury didn't require medical attention.

> 66 I didn't need to [see a GP], it healed on its own. 99

Karolina, 25–34

Others said that their self-harm occurred either too regularly, or not regularly enough to seek support from a GP.

> 66 It happens too regularly, and I didn't feel it was bad enough to need treatment. 99

Prasheena, 25–34

> 66 I always felt my self-harm wasn't important... it was not regular. 99

Charlie, 25–34

In addition, a third (34%) of survey participants said they weren't comfortable going to their GP about self-harm. Qualitative data from our survey and interviews indicate that this may be a particular issue for men. Shame around self-harm was directly linked to expectations of masculinity by some, reflecting what we know from past research on Men and Suicide.

> 66 It's all part of being a man and the stigma surrounding men and therefore feeling that you have to keep things bottled up so that people can't see any signs of weakness. 99

Jack, 35–44

As self-harm is a strong risk factor for future suicide, it's vital that stigma and shame surrounding self-harm is reduced, to encourage help-seeking before self-harm becomes a long-term coping mechanism.

2) Prior negative experiences of GP support

As mentioned above, the lack of referral options available for people who have self-harmed is a significant barrier to people attending their GP after self-harm. A third (32%) of our survey participants said they didn't think the GP could or would help them, so improving the availability and quality of referral options could help encourage people to attend their GP after self-harm.

But a positive interaction within the GP appointment is also vital. One in five survey participants (20%) were put off seeking support because of previous bad experiences with their GP, and a further one in five survey respondents (19%) said they did not go because they thought a GP would be judgmental. In our interviews, people mentioned unhelpful or unsupportive reactions to their self-harm: experiences included GPs not taking their self-harm seriously, not feeling listened to, or experiencing a lack of compassion, empathy and understanding of their self-harm. Studies of GPs have suggested that they lack confidence and feel unprepared when communicating with people who have self-harmed or attempted suicide[43]. GPs also reported a lack of consultation time as a barrier.

Voluntary and community support

This section explores wellbeing initiatives outside of the health service. We found voluntary and community support served two main roles in supporting people with lived experience of self-harm: distraction to resist self-harm urges and emotional relief in times of stress. In total, 12% of survey participants sought support from voluntary and community support after recent self-harm.

There are a number of local organisations around the country providing specialist self-harm support, such as those run by Harmless[i] and We Are With You[j]. Across both the interviews and survey, these types of organisations came up infrequently, which likely reflects the fragmented and under-funded nature of voluntary sector-led self-harm support. These services, including online support groups and face-to-face peer support services (each used by 2% of those we surveyed), are a potential alternative to NHS provided services, and one case study of the benefits of these types of services can be found in the 'Mental health services' section. More commonly reported was help received from national helplines, outlined below.

Distraction from immediate self-harm urges: helplines

Self-harm is often impulsive[8,46], and previous research has highlighted that coping strategies, such as talking to someone supportive and non-judgmental can be helpful in resisting self-harm in the moment[17]. In our interviews some people spoke of the role that telephone helplines had played in calming them when experiencing intense distress or providing distraction from urges to self-harm. This is also supported by Samaritans call data, which shows that one in seven people who discuss self-harm have contacted us to resist self-harming.

66 They [Childline] just calmed me down because when I called them I was stressing out and talking really fast. They just calmed me down and chatted to me... I am just not really looking for advice, I am just looking for a general conversation to distract me, maybe, and calm me down. 99

Aarav, 18-20

66 I was broken so I actually rang Samaritans and it was nice just to be able to talk... and to be listened to. They're really helpful... And probably stopped me at that point from self-harming. 99

Simone, 25-34

Emotional relief in times of stress: helplines or text support

For some, helpline or text support was important during a build-up of intense stress, described for instance as feelings of a "pressure cooker" or a need for "head venting". In these instances, sharing thoughts anonymously helped to release the emotional pressure.

66 I emailed Samaritans. More just because I wanted to express how I was feeling rather than looking for advice. I needed to 'vent' so to speak... I describe it as a pressure cooker in my head... bashing away at a keyboard and then clicking send is my way of getting it out of my head and just pushing it to one side. I'm never really looking for a reply as such, I'm just looking to get rid of my thoughts, almost. 99

Emily, 25-34

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i Website can be found here: http://www.harmless.org.uk/

j Formerly *Addaction*, website can be found here: https://www.wearewithyou.org.uk/

School and university

Our research found that schools and universities play a role in addressing the underlying causes of self-harm and linking students with local health services. However, we found that this support could be hard to navigate and wasn't always self-harm specific. Physical and mental health aftercare for self-harm were also an important part of supporting students. In total, 9% of our survey respondents sought support from school, university or work after recent self-harm.

Unsurprisingly, young people (16-25) were more likely to seek support from school or university than older ages (9% vs <1%). Of those who had ever sought support from school, university or work, less than a quarter (23%) of our survey participants reported that it had been moderately useful or better, making it the worst performing type of support. While this was higher for young people, with 3 in 10 (30%) say it was moderately useful or better, this is still clearly far from good enough.

Why is support from schools and university so important?

Self-harm often emerges during adolescence[47]. Three quarters (75%) of survey respondents had self-harmed for the first time aged 17 or under, half (53%) were between the ages of 11-15. Schools and universities, and in particular secondary schools, have a key role to play in providing early, preventative support to people who have self-harmed before their needs escalate.

Self-harm is complex, and there are many factors particularly affecting young people that are associated with an increased risk of self-harm; such as academic stress[48], worry about sexual orientation[49], or history of sexual abuse[50]. Adolescence can also be a time of major change. Many people move away from home to live at university or start work and this can cause a gap in support, for example registering with a new GP, reduced contact with family or changing friendship groups. This transition can be hard and for one person we interviewed the freedom of being away from home contributed to an increase in their self-harm.

66 I found the freedom was, kind of, too big an issue to contend with. Like, being able to do what I wanted when I wanted was too much of a temptation [to self-harm]. 99

Samantha, 21-24

Addressing the underlying reasons for self-harm

Because all our interview participants were aged 18+, our interviews focused on the quality of university support. Some participants highlighted that support from university counsellors helped them work through the underlying causes of their self-harm, but it was less effective at helping them understand the triggers and patterns associated with the self-harm.

66 [The self-harm] had been left for so long, that it was really hard to get out of it. So, even though it was quite nice visiting [the university counsellor] every week and just talking about my issues, I didn't feel like I was getting better in the sense of my self-harm. I still had the urges. I still was finding it really difficult to control them. 99

Tasmin, 21-24

Concerns about the suicide risk of students who self-harm can also lead to them being bounced between university and NHS support. Specific mental health contacts or linked practitioners can help students to navigate mental health services and get the support they need.

66 The thing was, when I first went, they would say, you need to contact the NHS, and the NHS would say seek support from the university, so I bounced around between the two. Then, the last person I saw was called a 'link practitioner', so she worked within the NHS and at the uni, and she seemed more willing to tackle things rather than just passing it on to somebody else. 99

Tasmin, 21–24

After-care

Alongside specialist mental health support, some people with lived experience of self-harm had received support from other staff members in their schools or universities. This included first aid and emotional support from welfare officers, teachers and security teams.

66 [The university security team] were there 24/7, and they were all first-aid trained, so, sometimes, if I wasn't sure about whether I needed to go to A&E or didn't want to go to A&E, they would help with the physical aspect. I definitely felt like they understood and got it, and they spent a lot of time with me, and I felt like they did care. 99

Frankie, 21–24

Recommendation

(xiii) The nationwide roll out of Mental Health Support Teams (MHSTs)[32,51] should happen sooner than currently planned and should be extended to university settings too. These teams should play a key role in helping to promote understanding around self-harm for students and parents and carers.

MHSTs will be rolled out to between one fifth and a quarter of the country by the end of 2023, and nationwide roll out by within the next decade.

The experience of those we interviewed shows the importance of support which is self-harm specific, dealing with the behaviour directly, as well as underlying issues. Department for Education must ensure that these teams have an adequate understanding of self-harm and its treatment. As well as among MSHTs, this training needs to be made available to all staff in educational settings, regardless of their role.

Conclusions

Through talking directly to people with lived experience of self-harm and our volunteers who support this group every day, it is clear that the needs of people who have self-harmed are not being met. The whole spectrum of support, from self-care to healthcare, urgently needs improvement to ensure the availability and suitability of help for everyone who needs it.

As our research in England has shown, people who have self-harmed without wanting to take their own life face unique barriers to accessing effective support. They can find themselves excluded from services or without the vital support to help them resist and stop self-harm.

Rates of self-harm are rising, a fact that should be of concern to the whole of society. In recognition of this, and the well documented link between self-harm and suicide, the Government and NHS services are attempting to tackle this worrying trend through ringfenced funding, suicide prevention strategies and increased mental health provision. However, as this report makes clear, such efforts are starting at a deficit, and there is much to do to better reach and effectively support people who have self-harmed.

The vast majority of people we spoke to for this research (87%) had sought help for self-harm at some point in their life. But only half (54%) had done so after their most recent self-harm, and only a quarter (25%) sought support from mental health services. It is obvious from the testimonies we received that negative experiences of support plays a role in inhibiting help-seeking. No support type is consistently providing effective care following self-harm and unless this situation improves soon, there is a risk that levels of help seeking will be inhibited for years to come.

People with lived experience of self-harm told us about the unique nature of their support needs. We found there are four key aspects of care which must be addressed to effectively support people manage and stop self-harming:

- Distraction from immediate self-harm urges
- Emotional support in times of stress
- Developing alternative coping strategies
- Addressing the underlying reasons for self-harm

These aspects will be more or less relevant to different people, depending on their reasons for self-harm and the risks and protective factors in their lives at the time. To meet each of these unique needs, a holistic approach to care is required – no one support type can effectively address each of these four support needs.

Recommendations

(i) Government should use its ongoing online harms white paper process, in consultation with expert third sector organisations, to inform the creation of safe online spaces that are effectively moderated to improve the availability and quality of online support by trusted organisations.

Given the value of peer support for those we interviewed, it is vital that safe spaces for discussing self-harm are created. Policy makers need to give consideration to the relationship between self-harm, isolation, and community and peer support.

(ii) DHSC and NHS England should ensure that planned investment in mental health support through the Long Term Plan results in specialist mental health services such as IAPT being supported with additional resource to increase expertise and capacity to support people who self-harm. This should enable these services to:

- remove exclusion criteria based on self-harming behaviour

- support people specifically with their self-harming behaviour and allow self-harm to be discussed in a safe and supportive way

- provide support to anyone deemed likely to benefit following a psychosocial assessment.

(iii) NHS England and DHSC should commission research as a priority into the benefits and risks of group therapy within clinical settings for self-harm.

(iv) Planned investment in mental health services outlined in the NHS Long Term Plan should focus on increasing the capacity and expertise of services so that, where possible, safe group spaces are created to support people who self-harm.

(v) All support services for people who self-harm, whether NHS provided or community-based, should provide trauma-informed support, which acknowledges and supports with underlying issues driving self-harm.

(vi) App, website and service developers should not attempt to mimic self-harm behaviours when providing distraction techniques. Instead they should involve clinicians, third-sector experts and people with lived experience throughout the development lifecycle to ensure what is being produced will be effective and usable in the intended context.

(vii) NHS England should work with third sector experts, such as Samaritans, and people with lived experience to develop a free self-care app for anyone who has presented to clinical services having self-harmed.

The app should include:

- Interactive and assisted ideas for self-care, to develop alternative coping strategies. These could potentially be based on therapeutic principles and exercises, such as elements of CBT, DBT and mentalization therapies.

- A centralised, easy to access list of professionally verified distraction techniques based on the person's existing interests.

- An interactive safety plan template which can be used during emotionally intense points.

- A self-harm tracker to help the person better understand their behaviour and coping techniques which work for them.

(viii) Local authorities should diversify the support offered to people who self-harm, to more consistently include group activities which foster connection. Local Authorities should engage people with lived experience in the development of these activities to ensure their effectiveness.

(ix) NHS England and DHSC should work together to ensure that Psychosocial assessments are undertaken for everyone who discloses self-harm in a clinical setting, including to their GP. Liaison mental health teams should be created in clinical settings outside of A&E departments, and these teams should undertake these assessments.

(x) Anyone who self-harms and receives a psychosocial assessment should have the option of receiving a suitable community-based or NHS-provided service in line with their level of distress and the intensity of their needs.

(xi) GPs should be given more training in line with Health Education England and the National Collaborating Centre for Mental Health suicide prevention frameworks.

This should support GPs to:

- Deal with people who have self-harmed in a person centred and trauma-informed way which better understands self-harm and its drivers.

- Be better informed about the types of care, both clinical and non-clinical, that can be effective in supporting people with lived experience of self-harm.

(xii) DHSC and DCMS should provide voluntary and community-based organisations with funding, to account for continued link worker roll out and allow for expansion, so they can provide a more consistent alternative to NHS support for people who self-harm.

(xiii) DfE should ensure that the mental health support team model, currently being rolled out in schools and colleges, is brought to all schools and colleges sooner and extended to universities. These teams should play a key role in helping to promote understanding around self-harm for students and parents and carers and be trained specifically in supporting young people who self-harm. This training should be made available to all staff in educational settings, regardless of their role.

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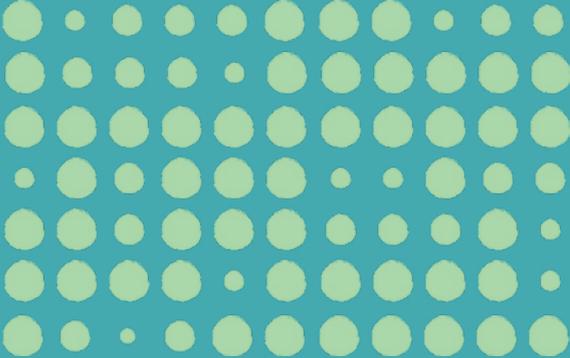- Dr Becky Mars
- Keith Waters

This research was undertaken in line with Samaritans Research Ethics Policy.

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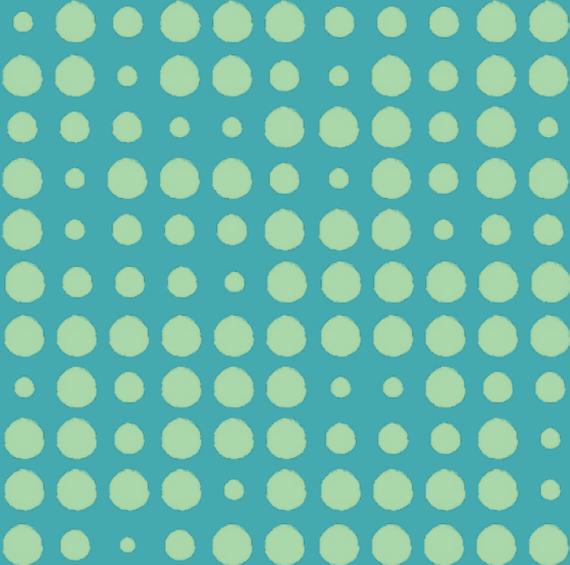
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