

SELF-HARM AND SUPPORT SEEKING

In the ROI and NI

SAMARITANS
Ireland

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This report was completed with the support of



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Executive Summary

To provide better support to people who self-harm, and to promote interventions that prevent self-harm progressing and becoming more serious, it is essential to understand who is engaging in self-harm and what works in terms of support for them after self-harming. This brief report collates data collected by Samaritans from people who have self-harmed in the Republic of Ireland (ROI) or Northern Ireland (NI), in order to better understand their help-seeking experiences. The data was collected in late 2019 and provided to research charity Quality Matters for analysis and reporting in 2020.

This report contains a detailed analysis of participants' reported experiences of non-suicidal self-harm and help-seeking behaviour after self-harming. Where possible, analysis was undertaken to identify patterns across different social groups. Considerations for future research and policy recommendations are proposed to conclude the report.

Participants

In total, 132 people in NI and the ROI took part in the survey. Participants were predominantly ethnically white (93%), female (85%) and from the ROI (83%), with a majority being under the age of 35 (67%), living in a household that made below £39,999 (€43,932) (66%) and heterosexual (58%). Demographic patterns in this cohort reflect those patterns associated with higher rates of self-harm in other research. These include being female (2,3), being LGBT+(2,3), being younger (5) and having lower income (12).

Self-Harm and Mental Health

Half of participants reported that they started to self-harm when they were under the age of 16 and half had self-harmed in the last six months.

More than half of participants reported that they had a current mental health condition, and the most common mental health conditions reported by participants were anxiety, depression and borderline personality disorder. The rates of these conditions in the cohort were significantly higher than in the general population and all of which are associated with non-suicidal self-harm. 67% of participants reported that they had a chronic physical or mental health condition.

In terms of history of suicide, 43% reported that they had made a previous attempt to take their own life.

Support Seeking after Self-Harm

Half of participants - 68 people - sought supports after their most recent self-harm. Those more likely to seek supports included those over the age of 35, heterosexual people and those with an income over £30,000 (€32,967). Half of the support-seeking participants had sought supports from GPs, doctors or medical professionals. Participants that did not seek support from a GP gave varying reasons for this: that they did not believe the self-harming was serious enough for a GP visit, were not comfortable with visiting a GP for self-harm or had a bad past experience with a GP.

The majority of participants that did visit a GP after self-harming were provided with follow-up National Health Service (NI) or Health Service Executive (ROI) support services such as talk therapies or further referrals while a small number were offered community/non-medical supports. The remaining participants who sought support, sought it from non-medical sources such as family, friends, self-help, volunteer/community groups or through online/phone support groups.

Usefulness of supports

At least half of the participants rated all seven different types of supports as not useful or only slightly useful. Online support groups, forums or advice sites, self-help (e.g. mindfulness or sport) and friends were perceived as the most useful followed by medical professionals. School, university or work supports, followed by support from family and group activities, were perceived least useful.

Considerations for Future Research

The research aligns with established literature on self-harm in terms of the profile of those more likely to engage in self-harm, the age of onset of self-harm and higher rates of mental health diagnoses and previous suicide attempts. Methodologically, for future research

the engagement of male participants must be a priority in order to develop a gendered understanding of self-harm and help seeking behaviour at a regional level. Targeted research focussing on certain socio-demographic categories, for example ethnicity, would provide a more nuanced understanding on help-seeking in minority communities. Findings suggest that those who are at increased rates of self-harm are also those who are less likely to seek support – young people, LGBT+ people and people from lower income households. The research also confirms that self-harming does not provide the relief from negative emotional states that earlier episodes may have done.

Interesting questions are raised in terms of patterns of behaviour around support seeking, specifically, low levels generally of support seeking, and supports received in the majority rated as only slightly helpful, or unhelpful. This raises questions as to the nature of the relationship between these two factors and whether improvement in quality of available supports and appropriate targeting of supports to those who may need them could increase help-seeking. The research also raises interesting questions in relation to the potential role for online supports, individual self-help programmes and the role of sports, activities and groups as supports for individuals who do self-harm.

A number of participants volunteered examples of feeling judged, feeling concerned about confidentiality and being mistreated, and such anecdotes beg further investigation into the role of professional attitudes to engagement in services and encourages readers to consider whether professionals who may encounter people who have self-harmed could play a greater role in promoting their engagement through compassionate, patient and non-judgemental approaches to their work.

Recommendations

1. STIGMA

To ensure individuals feel supported to reach out for help, the root cause(s) of stigma associated with self-harm needs to be better understood and subsequently addressed within the public and health professional settings. More needs to be done to reduce the stigmatisation so individuals who self-harm do not fear or face judgement and are more willing to seek help.

2. SERVICES

It is imperative that the variation in availability of resources, services, and general management and assessment procedures at A&Es across the country are reviewed to allow for equal and appropriate treatment to be provided regardless of where an individual who self-harms presents for help. Everyone who self-harms should be entered into a care pathway that meets their individual needs – this includes ensuring GPs, A&Es, and schools/universities all have the skills and resources to respond effectively to every person they see.

3. FUNDING

While everyone is different, some common reasons why people may self-harm are to express emotional distress or difficult feelings, or to feel more in control of their lives. COVID-19 has introduced rapid changes to supports and services. Our research has shown the pandemic and the lockdown have particularly impacted three groups at an already high risk of suicide – middle-aged men, young people, and individuals with pre-existing mental health conditions. Ensuring appropriate support is available is more important than ever and Samaritans is calling for continued financial support to ensure helplines, such as ours, are on a sustainable footing through and after the pandemic so we can continue to be there for anyone who is struggling to cope.

Republic of Ireland

The findings from this report reiterating the importance of implementing the seven strategic goals of Connecting for Life, the Republic of Ireland's National Strategy to Reduce Suicide 2015-2020 and for clear funding investments into the new Mental Health Policy, Sharing the Vision.



Northern Ireland

Similarly, allocating sufficient funding to, and implement Protect Life 2, the Northern Ireland suicide prevention strategy in full as well as a clear focus on self-harm in the new Mental Health Strategy for Northern Ireland.

4. RESEARCH

We need to better understand what individuals want and need within their care pathways with an overall recognition that individual needs may be influenced by other social and economic determinants of health. This report highlights the fact that individuals who are at increased rates of self-harm are also those who are less likely to seek support – young people, LGBTI+ people and people from lower income households. Responses also indicate that if help is sought, it may not always be fit for purpose. More should be done to understand how to further support these individuals by providing appropriate resources to gather lived-experiences to better inform the targeting and development of supports (including online and/or self-help programmes) and encourage help-seeking behaviours.

The Context for Self-Harm in Ireland

BY SAMARITANS IRELAND

In 2019, Samaritans across Great Britain and Ireland supported someone about self-harm every 2 minutes – a total of 272,000 times. Callers who discussed self-harm in 2019 were **2.5 times** more likely to express suicidal thoughts or behaviours than other callers.

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. Samaritans defines self-harm as any deliberate act of self-poisoning or self-injury carried out without suicidal intent. This definition acknowledges that people have different motivations for self-harming, and that for many, self-harm is a response to difficult circumstances or trauma, without forming part of a plan to end their lives. Although we use this definition, one of the reasons that we are so concerned about the rising rates is that people with a history of self-harm are at increased risk of suicide. Most people who self-harm will not go on to take their own life, but it is a strong risk factor for future suicide¹². 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 behaviours³⁴⁵.

Unfortunately, we also know that the great majority of people who have self-harmed never receive formal medical support. Previous research in Cork and Kerry comparing hospital presentation statistics with self-reported self-harm statistics revealed that only 5% of those who self-harm ever present at hospital for self-harm⁶. Results from the first My World Survey supported this finding that of the more than 8000 young participants, one fifth had self-harmed and they were more likely to report having problems but not seek help and were less likely to talk about their problems.⁷ Hospital presentation – indeed any help seeking – is the outcome in a minority of self-harming incidents;⁶⁷⁸ As such, this is a problem which largely stays hidden in communities.

1 Klonsky, May, and Glenn, 'The Relationship between Nonsuicidal Self-Injury and Attempted Suicide'.

2 Mars et al., 'Predictors of Future Suicide Attempt among Adolescents with Suicidal Thoughts or Non-Suicidal Self-Harm'.

3 A.L. Chapman, K.L. Gratz, and M.Z. Brown, 'Solving the Puzzle of Deliberate Self-Harm: The Experiential Avoidance Model', *Behaviour Research and Therapy* 44 (2006): 371–394.

4 E. Townsend et al., 'Uncovering Key Patterns in Self-Harm in Adolescents: Sequence Analysis Using the Card Sort Task for Self-Harm (CaTS)', *Journal of Affective Disorders* 206 (2016): 161–168.

5 L. Appleby et al., 'Suicide by Children and Young People. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).' (Manchester: University of Manchester, 2017).

6 McMahon EM, Keeley H, Cannon M, et al. The iceberg of suicide and self-harm in Irish adolescents: a population-based study. *Soc Psychiatry Psychiatr Epidemiol.* 2014;49(12):1929-1935.

7 Dooley, B., O'Connor, C., Fitzgerald, A., & O'Reilly, A. My World Survey 1: The National Study Youth Mental Health in Ireland. Jigsaw and UCD School of Psychology. (2012)

8 Sullivan, C., Arensman, E., Keeley, S. H., Corcoran, P., & Perry, I. J. (2004). The National Suicide Research Foundation. Young people's mental health: A report of the findings from the lifestyle and coping survey

Limited data exists specifically on rates of non-suicidal self-harm in Northern Ireland and the Republic of Ireland. However, rates of self-harm and/or suicide attempts have been increasing in the ROI since 2016 and in the first six months of 2019, the National Self-Harm Registry Ireland (NSHRI) reported there were 6252 presentations to hospital as a result of self-harm and/or suicide attempts which is 2% higher than for the same period in 2018. More than half of these presentations were by females and approximately half were by persons under the age of 30.⁹

There are also geographic disparities in self-harm and/or suicide attempts with South East Community Health (South Tipperary, Carlow/Kilkenny, Waterford, and Wexford) having a rate of self-harm and/or suicide attempts 24% (male) and 22% (female) higher than the respective national average. In 2018 the NSHRI reported a variation in availability of resources, services, and general management and assessment procedures across the country for individuals who have self-harmed and/or attempted suicide.¹⁰

The NI Registry of Self-Harm has been in operation across all five Health and Social Care Trusts since April 2012 as part of the Protect Life Strategy Action Plan. The WHO highlighted the Registry as a model of best practice in its 2014 publication 'Preventing Suicide – A Global Imperative'.

From 1 April 2012 to 31 March 2015, the Registry recorded 25,620 self-harm and/or suicide attempt presentations to emergency departments in NI, involving 16,301 individuals. In a different category, referred to as 'ideation' presentations, i.e. those who presented to emergency departments with thoughts of suicide who had not taken any action, 10,563 presentations were made by 6,909 individuals. Over half of these (53%) involved alcohol.¹¹

The WHO highlighted the NI Registry as a model of best practice in its 2014 publication 'Preventing Suicide – A Global Imperative'.

Between the years 2012/13 to 2014/15 the rates of self-harm and/or suicide attempt presentations to emergency departments increased by 30% for 15 to 19-year olds. The rates are higher in deprived urban areas, particularly for males. In contrast to other regions the male rate of self-harm and/or suicide attempt is higher than the female rate in NI, and this seems to be a result of the high male rate in Belfast.¹¹

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 emotional distress¹². This survey was conducted prior to the pandemic – we know COVID-19 has introduced rapid changes to supports and services. Samaritans volunteers have told us that callers are generally more distressed than before the pandemic, meaning ensuring appropriate support is available for individuals who might be struggling to cope is more important than ever.

⁹ National Self-Harm Registry Ireland Interim Report Jan-Jun 2019

¹⁰ National Self-Harm Registry Ireland Annual Report 2018

¹¹ HSC Public Health Agency. Northern Ireland Registry of Self-harm. Three year report. 2012/13 to 2014/15.

¹² A.L. Chapman, K.L. Gratz, and M.Z. Brown, 'Solving the Puzzle of Deliberate Self-Harm: The Experiential Avoidance Model', Behaviour Research and Therapy 44 (2006): 371–394; Townsend et al., 'Uncovering Key Patterns in Self-Harm in Adolescents: Sequence Analysis Using the Card Sort Task for Self-Harm (CaTS)'

01

About this Report

CONTEXT

To provide better support to people who self-harm and to support a reduction in self-harm progressing and becoming more serious, it is essential to understand what works in terms of support for people who have self-harmed. This brief report collates data collected by Samaritans from people who have self-harmed in the Republic of Ireland (ROI) or Northern Ireland (NI), in order to better understand their help-seeking experiences.

Research, through an online survey, was undertaken by the Samaritans UK Head office in Winter 2019, with an aim to understand help-seeking among people who had self-harmed without intention to take their lives. The responses from people in ROI and NI were anonymised and provided to Samaritans Ireland in order for them to create a report that would support a better understanding of these issues at a regional level. Samaritans Ireland commissioned independent research charity Quality Matters to analyse the data and create this report.

GUIDE TO THE REPORT

This report is presented in three sections, preceded by a brief methodology:

- **Demographic Profile** includes information on the gender, age, ethnicity, sexuality and income brackets of the people who took part in the survey and provides a comparative analysis to available data on the general population
- **Self-Harm and Mental Health Profile** includes information on the history of self-harm and mental health diagnoses of those who participated and provides a comparative analysis to international research on patterns of self-harming behaviour
- **Help-Seeking** details participants histories of help-seeking after self-harming

02

Methodology

Methodology of the Overall Great Britain, Northern Ireland, and Republic of Ireland Survey

The survey was conducted in line with [Samaritans' Research Ethics Policy](#) and all data is stored in accordance with the policy and kept strictly confidential to the research team. The survey with people who have self-harmed, was submitted to and approved by the Samaritans Research Ethics Board.

Throughout the research, Samaritans defined 'self-harm' as: "any deliberate act of self-poisoning or self-injury without suicidal intent. This does not include accidents, substance misuse and eating disorders."

Research objectives

OBJECTIVE 1: Understand what prevents people who have self-harmed from receiving appropriate support following an episode of self-harm

- Do people approach support services, including clinical services (GP, MH liaison etc), for support after a self-harm incident?
- What are the barriers people face when trying to access support?

OBJECTIVE 2: Understand whether the support available helps people stop self-harm and reduce their emotional distress

- Are people offered self-harm specific treatment?
- To what extent are people referred by their GP to other services (community and clinical) or offered follow-up support after a self-harm presentation to GPs?
- Where do people who self-harmed feel the gaps in support are?

Survey of people who have self-harmed

An online survey was carried out among 132 adults aged 16 and over in the Republic of Ireland and Northern Ireland between September and December 2019. This was part of a wider survey of people with lived experience across the UK and Republic of Ireland, but only the ROI and NI results are included in this report.

Dissemination and sampling

The survey sample was self-selecting and promoted across Twitter, Facebook, Instagram, Samaritans website, email mailings and sector newsletters. All wording used for dissemination was approved by the Samaritans Research Ethics Board. The survey sample was self-selecting and, to ensure it reached a wide range of people, organisations and academic working on mental health, self-harm or related topics were contacted and asked to support the dissemination of the survey.

To meet ethical requirements, the following groups were screened out:

- Under 16s
- Living outside UK or ROI
- Attempted suicide in the past 6 months
- Stating 'prefer not to say' for any of the above options

In addition, people who had never self-harmed without wanting to take their own life were screened out. 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 respondents could adequately recall the experience.

Due to the sensitive nature of the survey, all questions not necessary for screening purposes could be skipped. This means that not all questions were answered by everyone. In addition, sources of support (such as Samaritans and Mind) were included at the start and end of the survey, and Research Team contact details were provided, in case of any distress caused by the survey questions.

Methodology for Development of the Republic of Ireland and Northern Ireland Report

An anonymised database of survey responses, including information from 132 participants in total, was provided to the research team for analysis. Included in the database were responses from 22 people in NI and 106¹³ in the ROI. Patterns of self-harm and help-seeking were explored by cross-tabulating certain demographic information such as age, gender and location against experiences of self-harm and experiences of help-seeking.

Quantitative analysis was undertaken using Microsoft Excel and Tableau, and qualitative analysis was undertaken using excel. Analysis was undertaken by a research team, with data analysis and interpretation being undertaken by a data analyst and independently reviewed by a senior researcher before presentation to Samaritans for final review.

13 Four participants did not provide their location

Limitations of the Survey

There are three central limitations to the survey resulting from this approach:

- Firstly, as the survey was self-selecting, this may have introduced bias. For instance, those with particularly positive or negative experiences of self-harm support may be more likely to participate than others.
- Secondly, while efforts were made to disseminate the survey far and wide, its primary dissemination route was via Samaritans social media. In addition, the survey used Samaritans branding and was associated with Samaritans and, as a result, we expect the survey will overestimate the percentage of people using helplines for support after self-harm and be skewed towards participants with a history of suicidal thoughts/attempts.
- Thirdly, the ethical exclusion of people who have attempted suicide in the past 6 months means we were not able to explore the important needs of this group.

Limitations of Analysis and Reporting

- Low response rate in certain categories: In many cases, the numbers of people in certain categories are very low so the findings must be treated with caution- it should not be presumed that inferences can be made about the wider population of people with lived experience of self-harm.
- Reporting on low response rates: Where there were fewer than 50 respondents in any question, patterns rather than specific figures were reported on.

03

Demographic Profile of Participants

Overview

This section contains a brief profile of the 132 participants included in this research including their place of residence, gender (male/female and trans/cisgender), age range, sexuality, ethnicity, relationship status, household income and employment status.

Place of Residence: Republic of Ireland or Northern Ireland

One hundred and six (83%) participants lived in the ROI while 22 (17%) lived in NI.

Gender

The majority of participants, 85%, were female (n=83), with 12% male (n=12) and a minority, 3%, were non-binary (n=3). Participants were also asked if they were transgender; 4% (n=4) were transgender while 96% were not (e.g. were cisgender).

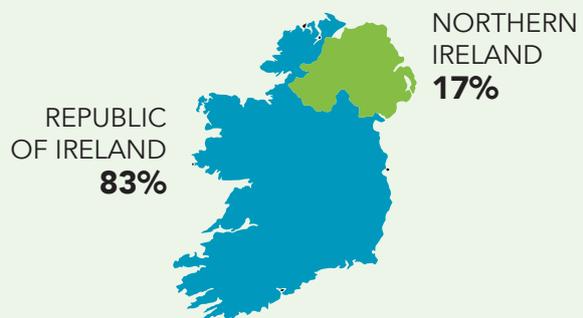


FIGURE 1
GENDER OF PARTICIPANTS (N=97)

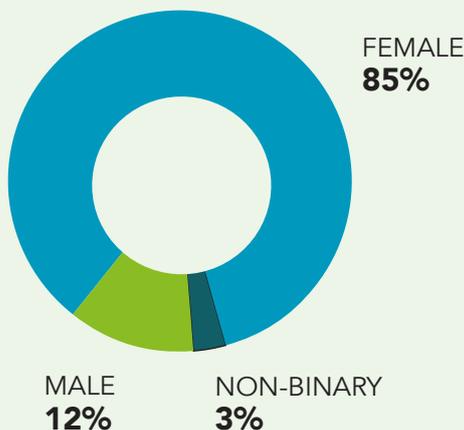
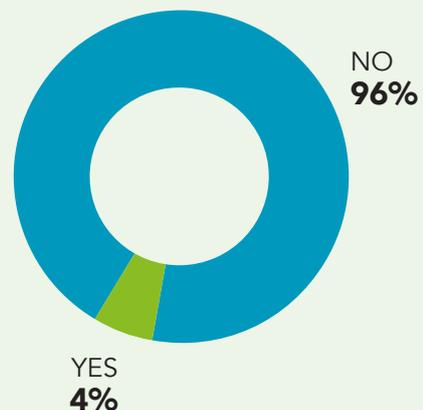


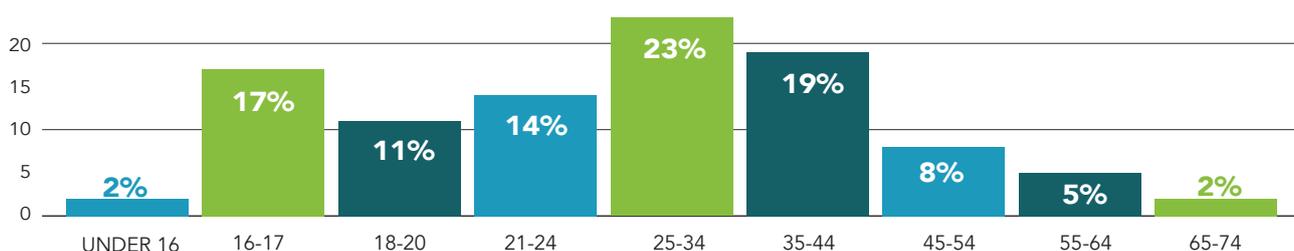
FIGURE 2
ARE PARTICIPANTS TRANSGENDER (N=94)



Age Range

Two thirds of participants were under the age of 35 (67%, n=87), with one in five participants being under the age of 18 (19%, n=24) and a quarter between 18 and 24 years (25%, n=33) and between 25 to 34 years (23%, n=30). One in five reported being aged between 35 to 44 years (19%, n=25) and 15% (n=19) of participants were aged 45 or older. To meet ethical requirements, the twenty-four participants who were under 18 were directed out of the survey once identified as the research examined the experiences in relation to non-suicidal self-harm.

FIGURE 3: AGE RANGE OF PARTICIPANTS (N =131)



Sexuality

Almost six in ten participants in the survey described themselves as heterosexual (58%, n=54). More than a quarter identified as bisexual (27%, n=25) with 9% (n=8) stating they were gay and 6% (n=6) as other¹⁴.

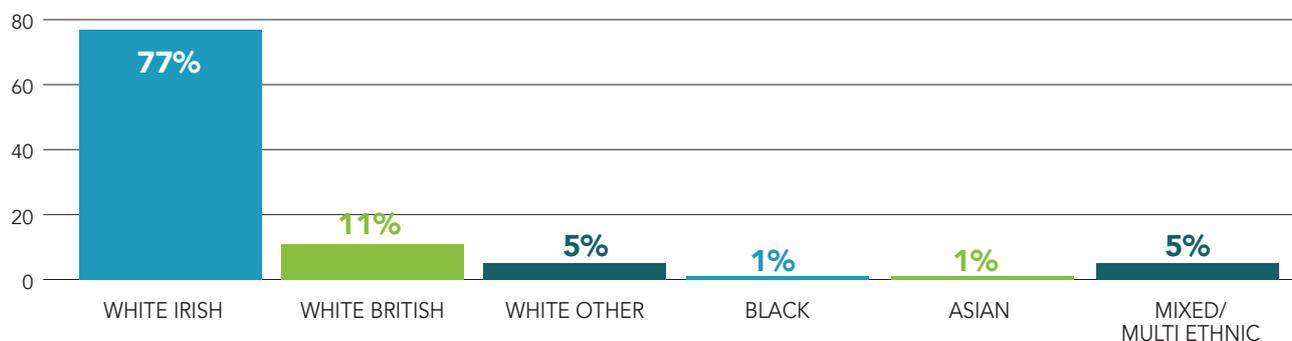
FIGURE 4: SEXUALITY OF PARTICIPANTS (N=93)



Ethnicity

The vast majority of participants who identified their ethnicity – 93% (n=87) - identified as white, with (77%, n=72) being White Irish, one in ten White British (11%, n=10) and 5% (n=5) as other white.

FIGURE 5: ETHNICITY OF PARTICIPANTS (N=94)

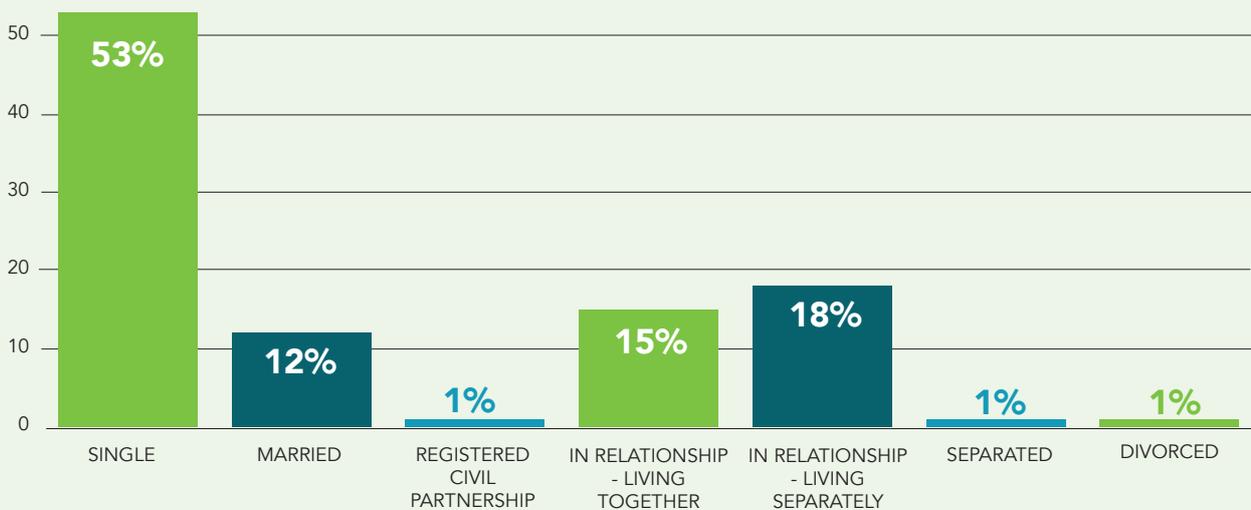


¹⁴ Other: includes asexual, pansexual, demi-/homo-sexual and romantic

Relationship Status

More than half of participants reported that they were single (53%, n=50). Thirteen percent reported that they were either married (n=11) or in a civil partnership (n=1). A third reported that they were in a relationship, either living together (n=14), or living separately (n=17) and 1% respectively reported that they were separated (n=1) or divorced (n=1).

FIGURE 6: RELATIONSHIP STATUS OF PARTICIPANTS (N=95)



Household Income

Household income was weighted towards the lower end of the spectrum amongst survey respondents with two thirds falling below £39,999 (€43,932¹⁵). A third of participants reported that they lived in a household where the income was less than £17,500 (€19,221) (33%, n=22). Marginally less than a third of participants reported that their household income was between £17,500 and £39,999 (€19,231 - €43,955) (32%, n=21) and marginally more than a third reported household income in excess of £40,000 (€43,956) (34%, n=22).

FIGURE 7: HOUSEHOLD INCOME OF PARTICIPANTS (N=65)¹⁶



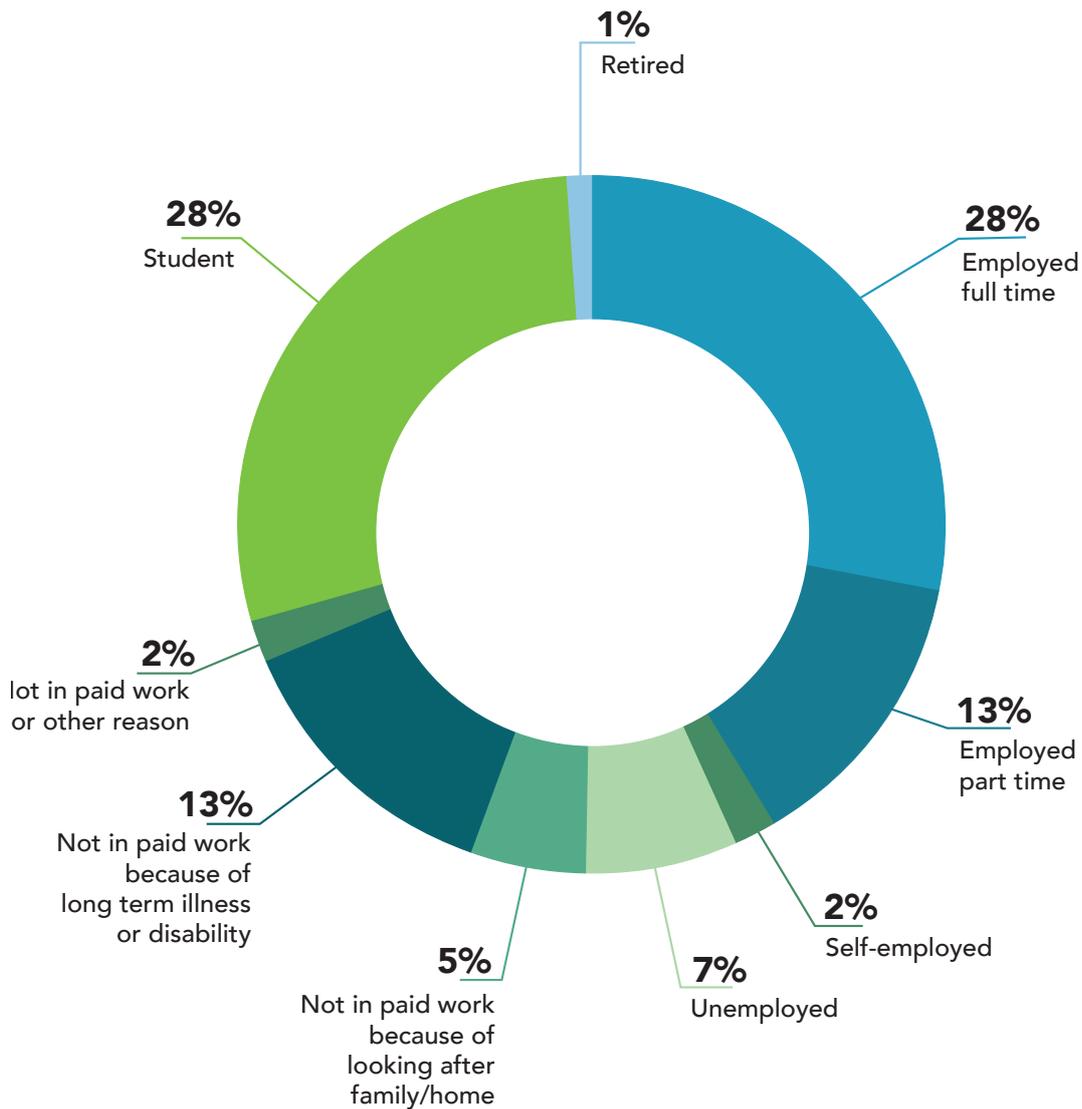
¹⁵ *exchange rate €1 = £0.91 22/07/2020

¹⁶ Up to £9,499 (€10,439) / £9,500 (€10,440) - £17,499 (€19,230) / £17,500 (€19,231) - £29,999 (€32,966) / £30,000 (€32,967) - £39,999 (€43,955) / £40,000 (€43,956) - £49,999 (€54,944) / £50,000 (€54,944) or more

Employment Status

Less than half of participants (43%, n=41) reported that they were in full-time, part-time or self-employment. Seven percent (n=7) were unemployed, 20% (n=19) were not in paid employment because they were looking after their family, had an illness or disability or other reason. More than a quarter (28%, n=27) were students and 1% (n=1) were retired.

FIGURE 8: EMPLOYMENT STATUS OF PARTICIPANTS (N=95)



Socio-Demographic Patterns of Self-Harm: A Comparison to Literature

This section compares the profile of the survey participants with the profile of the general public to establish if there are any particular cohorts more or less represented, and to identify if the profile reflects patterns of self-harm from other research.

GENDER AND AGE

Although numbers are too low in this survey to infer anything about the wider population, the higher representation of female (85% compared to 51% in the general population) and trans participants (4% compared to 1-2% in the general population) is in-line with evidence of higher levels of mental health difficulties and self-harm among trans people(2,3) and higher levels of self-harm among women(4). Likewise, the age profile in this research reflects patterns in self-harm prevalence data in the ROI where peak rates for female self-harming was 15-19 years old and 20–24 years for males at a national level. Self-harm gradually decreased with increasing age in men, this is also the case to a lesser extent in women (5). The relationship status of participants in the population is not aligned with national figures, but does align with the age range represented in this survey – higher numbers of younger people means that the representation of married people in the survey (12%) is much lower than the rate in census statistics (37%)¹⁷.

SEXUALITY

In terms of sexuality and representation, 42% of people in this survey identified as a sexuality other than heterosexual, and 58% identified as heterosexual. The My World Survey of young people in the ROI (4) found that 76% of the young adult sample identified as heterosexual. Other estimates tend to have an even higher number of people identifying as heterosexual, for example Irish Times IPSOS MORI Family Values Poll in 2015 only 4% of people identified as LGBT¹⁸. The higher rate of people participating in this survey who identify as other than heterosexual, again with the caveat that the numbers of people participating in this survey are small, is nonetheless in line with evidence from national and international research that people who are LGBT+ are more likely to engage in self harm (2).

ETHNICITY

The ethnic profile of participants compares almost exactly with census figures on ethnicity in the ROI which puts white people at approximately 93%, and NI at 98%. Five percent (n=5) reported they were from a mixed or multi ethnic background compared with 2% in the ROI and <1% in NI, while 1% reported they were either Black (n=1) or Asian (n=1) respectively, while citizens reporting as Black and Asian in the ROI census figures were 1% and 2% respectively and <1% and 1% NI. Research on prevalence of self-harm behaviour in ethnic minorities is scarce, which indicates it is an area that needs further exploration. Figures of self-harm from the National Suicide Research Foundation in the ROI and the National Office for Statistics in the UK do not report data by ethnicity or nationality in their record of self-harm cases. However, there have been a few studies in Europe reporting higher rates of self-harm cases, suicide attempts and suicidal ideation in migrants of first and second generation when compared to non-migrants (6),(7),(8),(9),(10).

Furthermore, problems with culture, religion and ethnicity has been considered a trigger factor for self-harm and/or suicide attempts in young people (11). Higher prevalence of self-harm and/or suicide attempts in ethnic minorities has also been reported but findings are mixed (8). A study conducted in the UK looking at self-harm rates in black and ethnic minorities in three cities found that black young women had the highest rates of self-harm and/or suicide attempts and that in general black and ethnic minorities were “less likely to receive psychiatric assessment and to re-present with self-harm” (8).

An important consideration in relation to ethnicity is the established association between economic deprivation and self-harm. First generation and second generation migrants are more likely to report economic difficulties than non-migrants (18.6% of first-generation migrants,

¹⁷ CSO Census 2016: Profile 4 – Households and Families

¹⁸ <https://mpactglobal.org/how-many-people-in-ireland-are-gay/>

16.4% of second-generation migrants compared 6.8% of non-migrants) (7), which is important, considering the impact of deprivation on rates of self-harm detailed further in the report.

EMPLOYMENT STATUS^{19,20}

In terms of employment status of participants, there was relative parity to national figures in the ROI and NI – levels of employment (full time, part time or self) were slightly lower in this cohort than in national figures (43% compared to 53% in the ROI and 54% in NI), unemployment levels in the cohort (7%) were slightly lower than the ROI (8%) and marginally higher than NI (5%). There were higher levels of people out of work due to disability or illness in this research (13%) compared to ROI (4%) and NI (7%) - this is unsurprising given that almost 32% of respondents to the survey reported that they are 'limited a lot' on a day-to-day basis by a mental health condition. Given the younger age profile of participants in this survey it is also unsurprising that there is a higher representation of people in full-time education in this research (28%) compared to national figures in the ROI (11%) and NI (9%).

HOUSEHOLD INCOME

Household income was weighted towards the lower end:

- less than £17,500 (€19,221²¹) (33%, n=22)
- between £17,500 and £39,999 (€19,221 to € 43,932) (32%, n=21)
- more than £40,000 (€43,933) (34%, n=22)

The median gross income per household in the ROI in 2016 was £41,204 (€45,256) and £27,434²² (€30,143) in NI in 2019²³. The majority of participants lived in households with income below the ROI median household income²⁴.

Research from NI(12) highlights the association between deprivation, including household income, and rates of self-harm, where rates of self-harm can be two to four times higher in neighbourhoods with highest levels of deprivation. In research on ethnicity and self-harm in Sweden, socio-economic disadvantage was found to be more of a determining factor when examining variations in self-harm between ethnic groups (13). Socioeconomic deprivation, social fragmentation and population density have been found to have a significant association with increased rates of self-harm and/or suicide attempts (14).

Demographic Profile Summary

This research involved 132 people who have previously self-harmed in NI and the ROI, who volunteered to take part in an anonymous survey on their experiences. Where the numbers facilitated an analysis, it was found that demographic patterns in this cohort reflect those patterns of characteristics associated with higher rates of self-harm in other research. These include being female, being LGBT+, being younger and having lower income.

It was found that demographic patterns in this cohort reflect those patterns of characteristics associated with higher rates of self-harm in other research.

19 Central Statistics Office, Statbank, Census 2016, Profile 11 - Employment Occupations and Industry,

20 NISRA Census 2011: Labour Market, Economic Activity by Age by Sex, Table CT0092NI

21 Exchange rate €1 = £0.91 22/07/2020

22 NISRA, NI Department for the Economy, 2019 NI Annual Survey of Hours and Earning Statistics. Report

23 NI Statistics and Research Agency

24 CSO Census 2016, PUBLICATIONS / GEOGRAPHICAL PROFILES OF INCOME IN IRELAND 2016

04

Self-Harm & Mental Health Profile

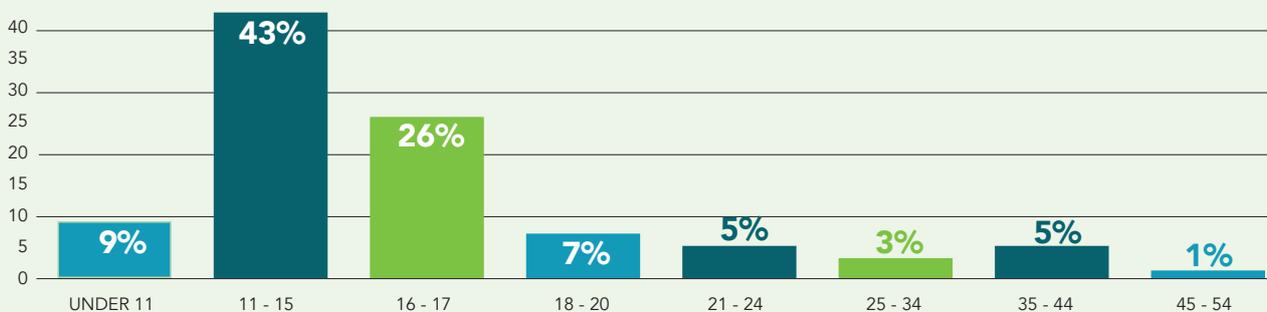
Overview

This section includes information on participants' self-harm and mental health conditions. Participants reported on the age of self-harm onset, their most recent self-harm, how their most recent self-harm affected their mental health, whether they had ever attempted to take their own lives and whether or not they had a physical or mental health condition. The findings are contextualised in international literature to compare patterns in this cohort to others.

Initiation of Self-harm

Participants were asked at what age they started to self-harm without wanting to take their own life (e.g. non-suicidal self-harm). More than half of participants started to self-harm when they were under the age of 16 (52%, n=50), a third of participants started to self-harm between the age of 16 and 20 (33%, n=32), the remaining 14% (n=14) started to self-harm between the ages of 21 and 54.

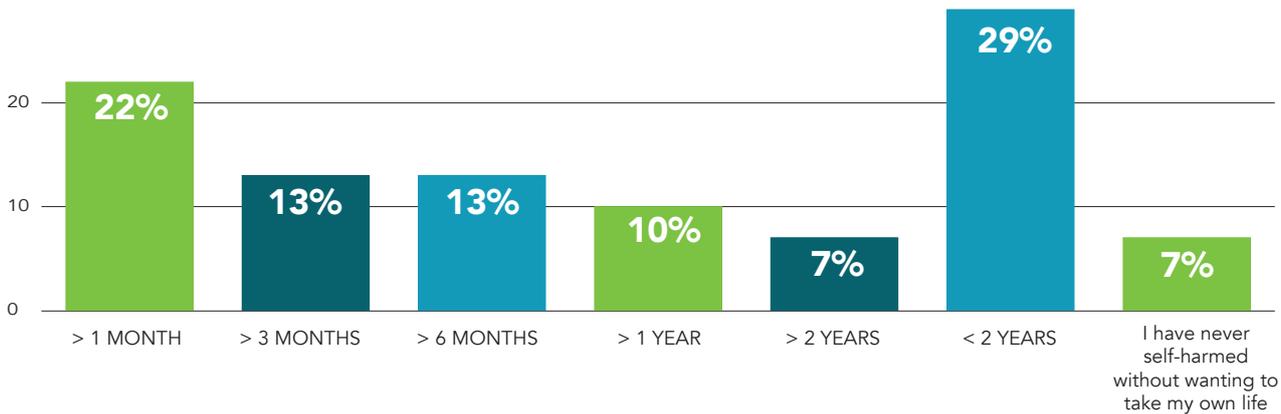
FIGURE 9: AGE AT WHICH PARTICIPANTS BEGAN TO SELF-HARM (N=96)



Most Recent Incident of Self-harm

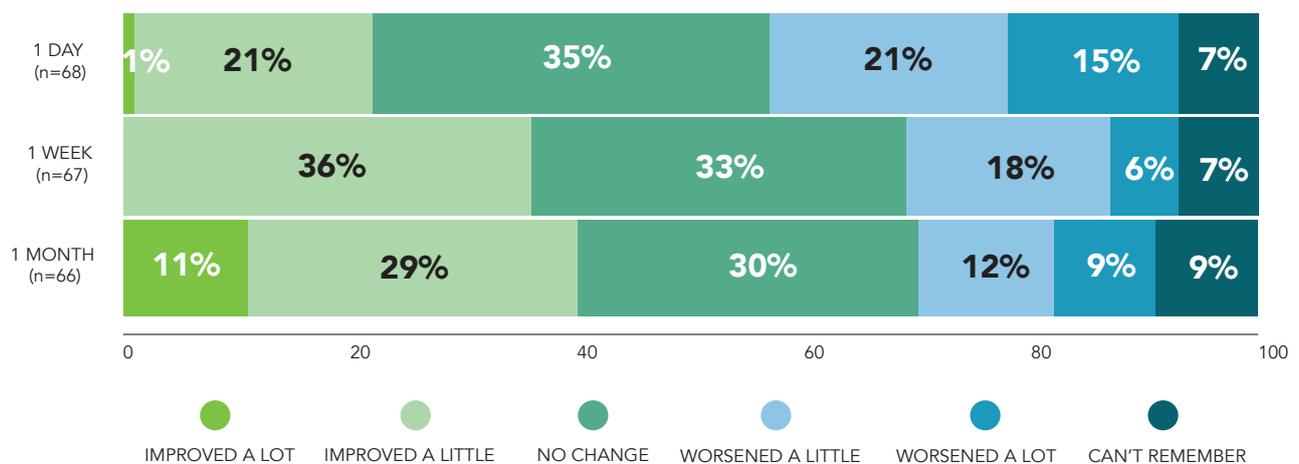
Participants were asked when was the last time they self-harmed without wanting to take their own life. More than a third of participants had self-harmed without wanting to take their own life less than three months ago (35%, n=44). Almost half of the participants had done so within the past six months (48%, n=60). Seven percent (n=9) of participants have never self-harmed without wanting to take their own life²⁵.

FIGURE 10: WHEN WAS THE LAST TIME YOU SELF-HARMED WITHOUT WANTING TO TAKE YOUR OWN LIFE (N=128)



Participants were further asked, thinking about their most recent experience of non-suicidal self-harm, how their mental health changed one day, one week and one month after the self-harming. For most participants, there was no change or their mental health had gotten worse since they last engaged in self-harm – 71% after one day and 51% after one month- however, the more time that passed, the more likely participants were to report an improvement in their mental health. Twenty-two percent (n=15) reported that their mental health had improved a little or a lot one day after the self-harming compared with 36% (n=24) after a week and 40% (n=26) after a month. Conversely, the proportion of participants reporting that their mental health had worsened decreased slightly the more time that passed since the self-harming. Thirty-six percent (n=24) reported that their mental health had worsened by a little or a lot after one day after the self-harming compared to 24% (n=16) after a week and 21% (n=14) after a month.

FIGURE 11: AFTER YOUR MOST RECENT OF NON-SUICIDAL SELF-HARM, HOW DID YOUR MENTAL HEALTH CHANGE²⁶



²⁵ The nine participants who had not engaged in non-suicidal self-harm were directed out of the survey once identified as the research examined the experiences in relation to non-suicidal self-harm

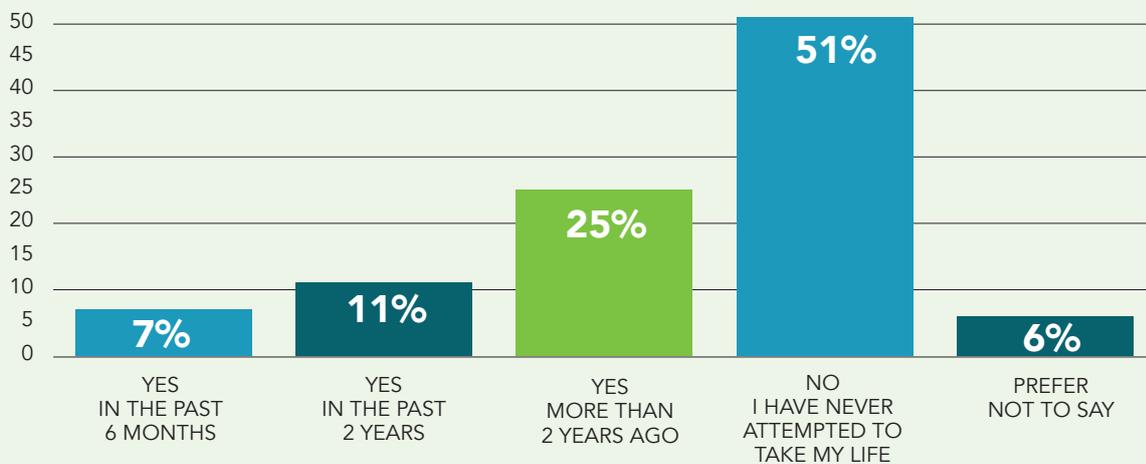
²⁶ N = varies by item, illustrated in the graph

History of Ever Attempting Suicide

Participants were asked had they ever attempted to take their own life. In total, 43% (n=56) of those who responded said that they had made an attempt to take their own life, half of the participants had never made an attempt (51%, n=67), a quarter had done so more than two years ago (25%, n=33) and 18% (n=23) had attempted to take their life in the past two years.

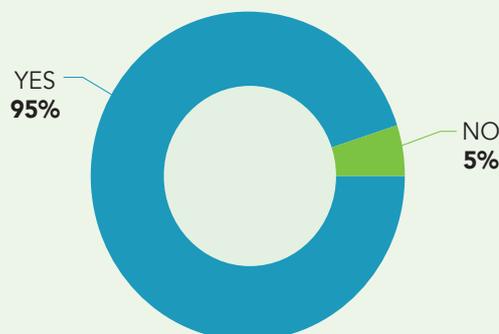
To meet ethical requirements, the nine participants who attempted to take their own life within the past six months were directed out of the survey once identified.

FIGURE 12: HAVE YOU EVER MADE AN ATTEMPT TO TAKE YOUR LIFE? (N=131)



Participants were further asked had they ever thought about taking their life but at the time knew that they would not do it. The overwhelming majority of participants responded that they had (95%, n=90).

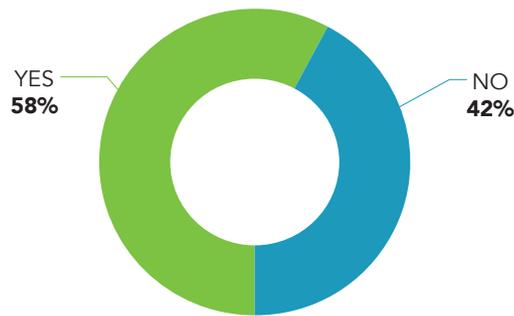
FIGURE 13: HAVE YOU EVER THOUGHT ABOUT TAKING YOUR OWN LIFE BUT KNOWN AT THE TIME YOU WOULDN'T DO IT (N=95)



Mental Health Status

Participants were asked if they a current diagnosis for any mental health conditions or illnesses. Fifty-eight percent (n=56) of participants responded that they had a current mental health condition while 42% (n=40) did not.

FIGURE 14: DO YOU HAVE A MENTAL HEALTH CONDITION (N=96)



Participants who had a current mental health condition were asked further to state their diagnosis. Fifty-one of the 56 participants that reported having a mental health condition gave information on their diagnosis. There were 97 separate diagnoses, meaning that participants often had more than one diagnosis.

Anxiety (63%) and depression (61%) were the most common diagnoses, followed by 22% of participants who had a diagnosis of borderline personality disorder. Almost half of all participants (47%, n=24) reported that they had both anxiety and depression. The table below compares rates of diagnosis in this cohort compared to those reported in general population research. Following the table, a list of conditions reported by five or fewer people is also included.

FIGURE 15: DIAGNOSIS OF MENTAL HEALTH CONDITION

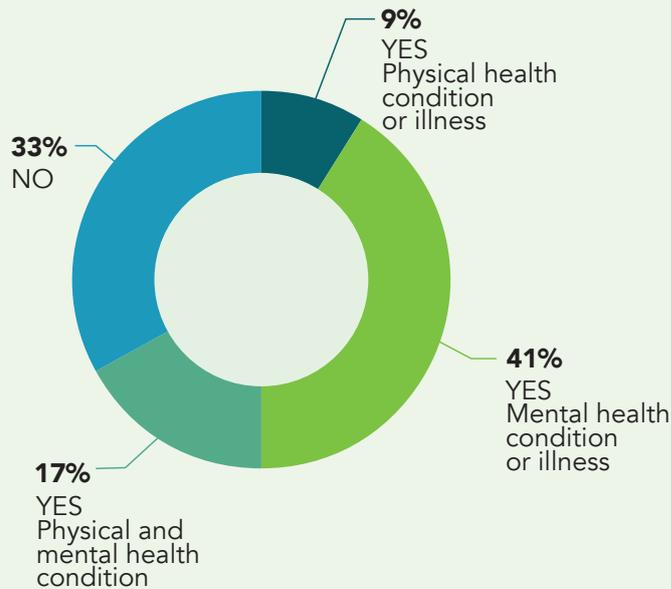
DIAGNOSIS	# participants with diagnosis	% of those who had a mental health condition	% of all participants	% of general population (15,16)
Anxiety	32	63%	24%	3.6%
Depression	31	61%	23%	4.4%
Borderline personality disorder	11	22%	8%	1-2%

Diagnoses reported by 5 or fewer people:

- ADHD
- Bipolar disorder
- Panic Disorder
- Agoraphobia
- PTSD
- Eating disorder
- Autism Spectrum
- OCD
- Trichotillomania
- Cyclothymia
- Insomnia

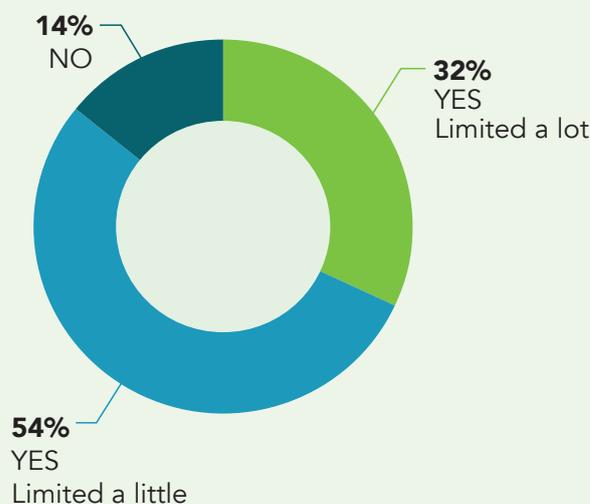
Participants were asked if they had a physical or mental health condition that they expect to last for the next 12 months. Four in ten reported having a mental health condition only (41%, n=39), one in ten reported having a physical health condition only (9%, n=9), 17% (n=16) reported having both mental and physical health conditions. A third of participants had no such condition (33%, n=31).

FIGURE 16: DO YOU HAVE A PHYSICAL OR MENTAL HEALTH CONDITION THAT YOU EXPECT TO LAST FOR THE NEXT 12 MONTHS (N=95)



Finally, participants who had a mental health condition or illness (n=56) were asked whether their day-to-day activities were limited because of their mental health condition or illness. A third of those participants who had a mental health condition or illness (32%, n=18) reported that their day-to-day activities were limited a lot, more than half (54%, n=30) reported they were limited a little and 14% (n=8) reported that they were not limited by their mental health condition.

FIGURE 17: DOES YOUR MENTAL HEALTH CONDITION LIMIT YOUR DAY-TO-DAY ACTIVITIES (N=56)



Non-Suicidal Self-Harm and Mental Health: Comparison to Evidence in Literature

The most common age of onset of non-suicidal self-harm in this cohort was under 16. This is in line with international research of the average age of onset being 15-16 years of age (17,18). 43% of participants had ever attempted to complete suicide, and almost all participants had thought about taking their own life but knew they would not do it. Literature on non-suicidal self-injury (NSSI) and suicide attempts illustrates a complex relationship, noting importantly that NSSI is a predictor of suicidal ideation or suicide in some cohorts, but not so in others (19). While most people who self-harm will not go on to take their own life, it is a strong risk factor for future suicide and self-harm amongst young people, is one of the strongest predictors of transition from suicidal thoughts to behaviours (20),(25),(26),(27),(28).

Other risk factors that influence the relationship between these experiences are major depressive episodes, post-traumatic stress, the type of method of self-harm, and the frequency of self-harm (19). This research also inquired as to the change in perceptions of well-being after the most recent suicide attempt, with most people noting that they felt the same or worse after

the self-harming (although positive feelings generally increased the more time passed). Evidence in literature highlights that although relief from negative emotions is associated with early self-harming and/or suicide attempt, this functionality disappears over time (20).

In terms of the prevalence of mental health conditions, 58% of the cohort in this study had a diagnosed mental health condition. Unsurprisingly, this is a higher rate of prevalence of mental health conditions than in the general population where prevalence of any mental health condition vary and include estimates such as 18% in the adult US population (21) to 31- 35% among an international cohort of college students (22). The data in this survey indicates that rates of anxiety, borderline personality disorder and depression are four to six times higher than those rates estimated for the general population (15,16). The higher rate of experience of mental health conditions among self-harm survey respondents is unsurprising. Non-suicidal self-harm is associated with a broad range of mental health difficulties including depression, anxiety and borderline personality disorder (23).

Summary: Experiences of Mental Health Issues and Self-Harm

Survey participants shared their experiences of self-harm in relation to initial onset, recent episodes, impact on mental health, ever attempting suicide, and mental health diagnoses and impact of this on day to day life. The experiences that participants reported were aligned with data from established research. Among this cohort, there were significantly higher rates of diagnosed mental health conditions including depression, anxiety and borderline personality disorder, than estimates in the general population, all of which

are associated with non-suicidal self-harm. The age of onset among this cohort - under 16 - is in line with international research and the complex relationship between non-suicidal self-harm and suicide/suicidal ideation is evident, with a significant minority of participants ever having attempted suicide. Again, mapping evidence in research, self-harm episodes were not shown to alleviate or provide relief from mental distress in the aftermath of the self-harming, as may have been the case in the initial onset episodes.

05

Support Seeking after Self-Harm

Overview

This section details participants' support seeking behaviour after their most recent self-harm. This includes where they sought support - from family, friends, activity groups, online supports, supports from schools/universities/work, self-help supports and supports from GPs or medical professionals- as well as their rating of how useful this support was. Where there was enough information to do so, data was cross-tabulated to see if there were differences in support seeking based on socio-demographic characteristics. A comparison to evidence on support seeking behaviour concludes the section.

Support Seeking after Last Self-Harming by Age, Sexuality, and Income²⁷

Participants were asked if whether, after last self-harming, they looked for support. Approximately half of participants sought support (51%, n=35) and half did not (49%, n=33).

FIGURE 18: PARTICIPANTS WHO SOUGHT SUPPORTS AFTER LAST SELF-HARMING (N=68)



- **Age:** participants that were aged 35 and over were more likely to seek support than participants under the age of 18
- **Sexuality:** Heterosexual participants were more likely to seek support after last self-harming compared to members of the LGBT+ community
- **Income:** participants that came from a household with an income above £30,000 (£32,967) were more likely to seek help than participants that came from a household with income below £30,000

²⁷ Due to low response rate of males a comparison by gender was not possible. Specific figures are not included due to lower numbers of respondents.

Sources of Support: Non-Medical²⁸

- **Supports from family/friends and Self-help:** A small number of participants said that they sought help from family, friends or through self-help. Participants were more likely to seek support from friends compared to self-help and family.
- **Supports from group activity and online/phone supports:** A small number of participants said that they sought help from group activity, e.g. volunteer, sport, or community groups or through online or phone-based support groups, forums, or advice sites. Examples of such supports mentioned included education programmes, a helpline, text support service or online support group/counselling, exercise/physical activity groups or activities, creative activities and volunteering with local community groups.

Participants provided information of their experience of the services, detailed here:

FIGURE 19: PARTICIPANT FEEDBACK ON ACTIVITY GROUPS AND ONLINE SUPPORTS

Support Sought	Participant Response to Support
Therapy	<i>"It's therapy!! it didn't really help that much though"</i>
Online advice or forum	<i>"It gave me an outlet to talk about what was going on and helped rationalise it all"</i>
Pieta House	<i>"I got therapy at Pieta House"</i>
A helpline or text support service	<i>"I used Samaritans e-mail. Was nice to tell someone and not feel judged. Also, easier to send a message instead of face to face".</i>
Watched YouTube psychology therapy videos	<i>"I researched self-harm, read NHS website and other forums where individuals spoke about their self-harm. It helped to hear other people's experiences and thinking around self-harm. It helped me understand why I might be thinking of suicide but instead, self-harming. Understanding the 'logic' behind it helped me feel better in control of the self-harming and I didn't need to do as much damage"</i>
Exercise/physical activity	<i>"Boxing helped with my anger"</i>
Education or learning programmes	<i>"I learned distraction techniques mostly".</i>

- **Supports in School/University/Work:**
A minority of participants reported that they sought supports from school, university or work. A participant that spoke to a university nurse described the experience as 'not good.'
A second participant that spoke to a university counsellor stated that:

“ The university counsellor was very good, and I didn't have to wait long but I heard other people had a really long wait. **”**
PARTICIPANT

²⁸ Specific figures are not included due to lower numbers of respondents, instead, patterns from the data are provided with the caveat that numbers are low and not guaranteed to be representative of a wider population

Sources of Support: Medical (GPs, Doctors or other Medical Professionals)

General

Participants were asked if they had ever been to their GP about non-suicidal self-harm. Approximately half of participants had never been to their GP regarding self-harm while the other half had either gone within the past two years or longer than two years ago²⁹. Half of participants who had sought help after their last self-harming had done so from a GP or other medical professional.

Most participants who sought help from a medical professional either made an appointment at their own GP surgery or spoke to their existing NHS (or HSE) liaison, nurse etc. A minority of participants self-referred to NHS (or HSE) talking therapies, such as counselling or cognitive behavioural therapy, spoke to a psychiatrist, went to a hospital A&E department or used private healthcare services.

Why participants did not seek GP/ Doctor support:

The most common reasons given for not visiting a GP after self-harming were:

- not thinking that it was serious enough to warrant a visit
- not comfortable going to a GP surgery about self-harm
- not thinking a GP would or could help them
- having a bad past experience with a GP
- already being in contact with mental health services

A smaller number of participants also reported that they thought the GP would be judgemental, that they never considered going to a GP, that they were concerned about confidentiality, that they were getting the supports they needed elsewhere, that they couldn't get an appointment quickly enough or that they had heard about bad experiences with a GP from others. Some of the concerns of participants are illustrated in these quotes:

“It didn't seem like something you could go to a doctor about - also doctors tend to be slightly cold because of how matter of fact they are and I didn't want to be told what I did was wrong or feel judged.”

PARTICIPANT

“They cannot help. They just refer you to A&E.”

PARTICIPANT

Follow-up support offered by GP

Was support offered: Participants were asked at the GP appointment, were they offered any follow-up support services? This includes: - referral to other NHS or HSE services, such as talking therapies- referral to support organisations in their local area, such as a charity or council service, or a follow-up appointment with their GP. Approximately two thirds of participants were offered supports and a third that were not.

Types of support offered: A small number of participants³⁰ that were offered NHS or HSE services were asked to identify which services they were offered. Half of participants were referred for further assessment with healthcare professional at a community mental health service. Other participants were referred to community services and talking therapy. A small number of participants reported that they were offered community/non-health support services as a follow up at their GP appointment.

Other follow-up supports: A small number of participants³¹ received other forms of support at their GP visit, these included, the anxiety medication Fluoxetine, general advice or a follow up appointment at a GPs surgery.

29 Specific figures are not included due to lower numbers of respondents.

30 Specific figures are not included due to lower numbers of respondents.

31 Specific figures are not included due to lower numbers of respondents.

Attendance at Follow-Up Services

Of those who reported they were offered support services at their GP appointment, approximately two thirds of participants attended all or some of the services offered. The other third did not attend the follow-up service offered³².

Participants that did not attend the support services that were offered to them were asked to provide reasons as to why they did not avail of the services. These quotes illustrate two participants' experiences of waiting lists and insensitive treatment:

“ I am put on waiting lists for services ... I ended up going to private therapy to help my problems though it's hard to afford so I don't go as frequently as I should. ”
PARTICIPANT

“ They were insensitive and talked down to me despite the fact that I was having a panic attack and they didn't help me, so I didn't go back. ”
PARTICIPANT

Summary: Support Seeking Experiences

More than half of participants sought supports after last self-harming, with the most common source of support being a GP or medical professional. A small number of participants sought supports from either family, friends, self-help (e.g. mindfulness or individual sport), from school/university or work, from group activities or online/phone supports. Where participants did not seek supports from a GP or medical professional, the most commonly cited reasons were that they did not think the self-harm was serious enough to do so, they were not comfortable going to a GP about self-harming or they did not think that a GP would or could help. Most participants who saw a GP were offered follow up supports either in the health service or elsewhere. Participants over the age of 35, heterosexual people and households with an income of over £30,000 (€32,967) were more likely to seek supports than participants under the age of 35, members of the LGBT community and households with an income of under £30,000 (€32,967).

³² Specific figures are not included due to lower numbers of respondents.

06

Perceived Usefulness of Supports after Self-Harm

Overview

This section details participants' perception of the usefulness of supports that they sought after a self-harming incident. Participants were asked, thinking generally about times when they had self-harmed without wanting to take their own life, how useful were the supports that they availed of. Supports evaluated by the participants included: family, friends, self-help materials, group activities, online supports, GPs and medical professionals and schools/universities/work.

General

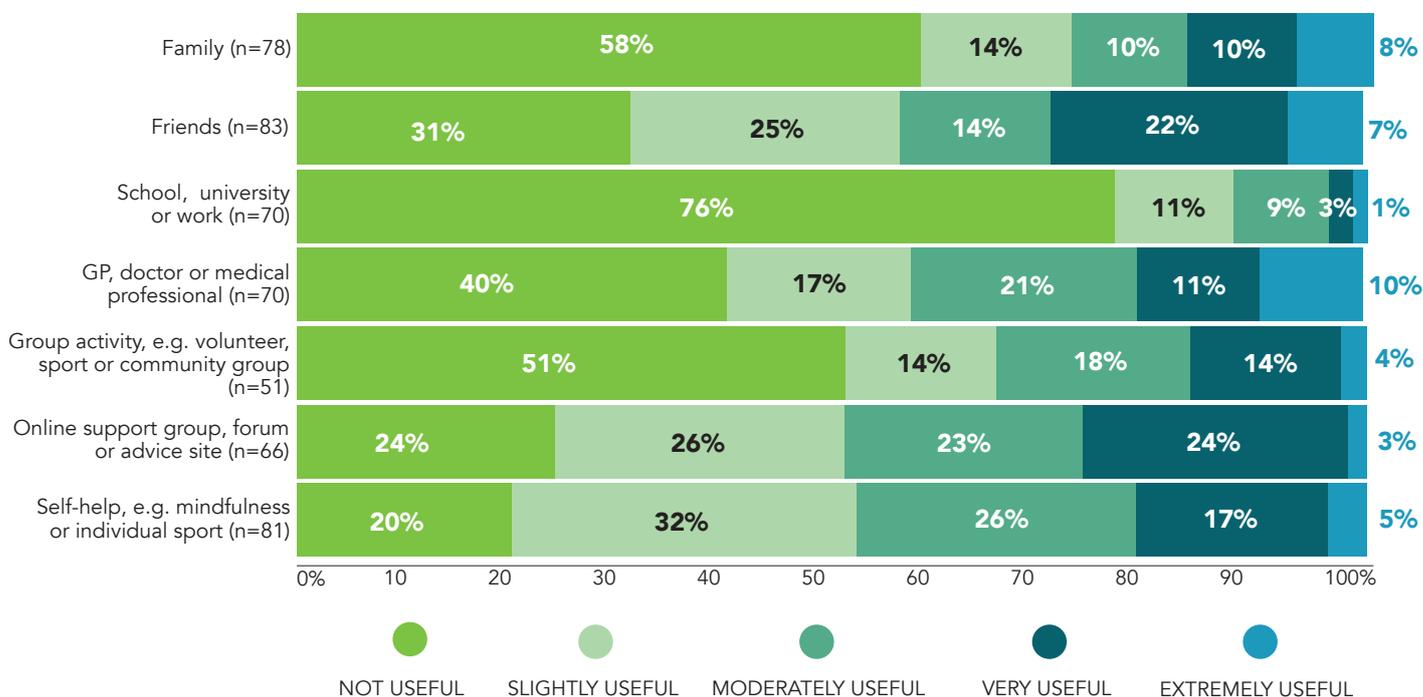
All seven support types were rated by at least half of participants as not useful or only slightly useful³³. In terms of what proportion of people rated each support as moderately, very or extremely useful:

- Online support groups, forums or advice sites (50%, n=33),
- Self-help - mindfulness or sport (48%, n=39)
- Friends (43%, n=36)
- Medical professionals: (42%, n=34)
- Family (28%, n=36)
- Group activities (18%, n=14)
- School, university or work (13%, n=10)

Further analysis on what supports are perceived to be 'very' or 'extremely' useful illustrates that no support type was rated as 'very' or 'extremely' useful by 30% of people, with only friends, GPs, online support groups or self-help being ranked this way by 20-30% of people.

³³ A potential limitation in relation to this section: it is unclear if participants rated supports as 'not useful' if they had not used them after self-harming (e.g. ticked 'not useful' because they had not used them and therefore they were not useful). The wording of the question, although it indicated that they should complete in relation to their last incident, was not emphatic that they should only complete if they tried to avail of this specific type of support. While a number of people did tick 'non applicable' it is possible that some people who did not use support types, rated them as not useful, and findings should be considered in this light.

FIGURE 21: HOW USEFUL WERE THE FOLLOWING SUPPORTS



Usefulness of Support Type: Socio Demographic Patterns

Perceived usefulness of supports was analysed by demographic categories in order to understand for which groups different support types were perceived to be more useful.

More than 50 people responded about usefulness of each type of support, which means that analysis can be undertaken on all categories, however where the numbers were particularly low in any response category for any socio demographic group (fewer than 5), analysis on patterns is not provided.

Wherever possible, categories were grouped together (e.g. age ranges and income) to facilitate the provision of analysis. This ultimately resulted in data only facilitating analysis on three categories – whether participants were LGBT+ or not, or whether participant’s income level was above or below 30k and in some instances it was possible to analyse based on age range.

Due to low numbers of men and people of ethnicities other than white it was not possible to any support type by the categories of gender or ethnicity.

Given the low number of participants in this research caution must be exercised in making inferences from these findings – at such low numbers a difference in responses between one or two individuals can make a significant percentage difference and easily skew the data.

Family (n=78)

Overall, family was not generally perceived to be a very useful source of support, with 72% (n=56) of people rating it as not useful or only slightly useful. Participants from the LGBT community were slightly more likely to report that family supports were very useful / extremely useful than heterosexual participants³⁴.

³⁴ Specific figures are not included due to lower numbers of respondents.

Friends³⁵ (n=83)

A small majority of people ranked friends as not useful or only slightly useful, while 43% (n=36) ranked friends as moderately to extremely useful. Participants aged under 18 were more likely to report that support of friends were very useful or extremely useful compared to those aged 18 – 34 and those aged over 35. Participants from the LGBT community were more likely to report that support of friends were very useful or extremely useful than heterosexual participants and households with income below £30,000 (€32,967) were more likely to report positively on this than households with an income above £30,000 (€32,967).

School, University or Work (n=70)

A significant majority of respondents, 87% (n=60), rated school/university or work as not useful. The spread of responses across socio-demographic sub-categories meant that additional analysis is not provided.

GP, Doctor or Medical Professional (n=70)

A small majority of participants rated medical professional support as not useful, while 42% (n=34) rated it as useful. The spread of responses across socio-demographic sub-categories meant that additional analysis is not provided.

Online Support Group, Forum or Advice Site (n=66)

This type of support was one of the higher rated supports in terms of usefulness, with 50% (n=33) of participants rating the category as useful. Participants from households with income above £30,000 (€32,967) and participants from the LGBT community were more likely to report that online support groups, forums or advice sites were very useful or extremely useful than households with an income below £30,000 or heterosexual participants.

Self-help, e.g. Mindfulness or Individual Sport (n=81)

Just under half of respondents (48%, n=39) rated this type of support as useful. Heterosexual participants were more likely to report that self-help supports were very useful or extremely useful than participants from the LGBT+ community. Participants from households with income above £30,000 (€32,967) reported similar levels with households with an income below £30,000 (€32,967).

Summary

Online support groups or advice forums, self-help (e.g. mindfulness or individual sport) and friends were perceived to be the most useful supports. Conversely, supports in school/university/work, family and group activities e.g. volunteering, sport or community groups were perceived to be less useful. Due to limited participation of people from certain demographic categories in the research, analysis could only be undertaken on broad based categories such as LGBT or heterosexual, household income bracket above or below 30k. The analyses by demographic characteristic should be considered with caution as even small percentage changes can create an illusion of difference or parity that may not be reflected in other research, for example, similar numbers of LGBT+ people reported that family was useful as heterosexual people, while research would indicate that LGBT+ people generally will experience greater levels of disconnection from their family (24) which can be a contributing factor to poorer health outcomes.

³⁵ Specific figures are not included due to lower numbers of respondents.

07

Conclusion and Considerations

FOR FURTHER RESEARCH

This research aligns with established literature on self-harm in terms of the profile of those more likely to engage in self-harm, the age of onset of self-harm and higher rates of mental health diagnoses and previous suicide attempts. Methodologically, for future research the engagement of male participants must be a priority in order to develop a gendered understanding of self-harm and help seeking behaviour. Targeted research focussing on certain socio-demographic categories, for example ethnicity, would provide a more nuanced understanding on help-seeking in minority communities.

Findings suggest that those who are at increased rates of self-harm are also those who are less likely to seek support – young people, LGBT+ people and people from lower income households. The research also confirms that self-harming does not provide the relief from negative emotional states that earlier episodes may have done.

Interesting questions are raised in terms of patterns of behaviour around support seeking, specifically, low levels generally of support seeking, and supports received in the majority rated as only slightly helpful, or unhelpful. This raises questions as to the nature of the relationship between these two factors and whether improvement in quality of available supports and appropriate targeting of supports to those who may need them could increase help-seeking. The research also raises interesting questions in relation to the potential role for online supports, individual self-help programmes and the role of sports, activities and groups as supports for individuals who do self-harm.

A number of participants volunteered examples of feeling judged, feeling concerned about confidentiality and being mistreated, and such anecdotes beg further investigation into the role of professional attitudes to engagement in services and encourages readers to consider whether professionals who may encounter people who have self-harmed could play a greater role in promoting their engagement through compassionate, patient and non-judgemental approaches to their work.

08

Recommendations

1 STIGMA

To ensure individuals feel supported to reach out for help, the root cause(s) of stigma associated with self-harm needs to be better understood and subsequently addressed within the public and health professional settings. More needs to be done to reduce the stigmatisation so individuals who self-harm do not fear or face judgement and are more willing to seek help.

2 SERVICES

It is imperative that the variation in availability of resources, services, and general management and assessment procedures at A&Es across the country are reviewed to allow for equal and appropriate treatment to be provided regardless of where an individual who self-harms presents for help.

Everyone who self-harms should be entered into a care pathway that meets their individual needs - this includes ensuring GPs, A&Es, and schools/universities all have the skills and resources to respond effectively to every person they see.

3 FUNDING

While everyone is different, some common reasons why people may self-harm are to express emotional distress or difficult feelings, or to feel more in control of their lives. COVID-19 has introduced rapid changes to supports and services. Our research has shown the pandemic and the lockdown have particularly impacted three groups at an already high risk of suicide – middle-aged men, young people, and individuals with pre-existing mental health conditions. Ensuring appropriate support is available is more important than ever and Samaritans is calling for continued financial support to ensure helplines, such as ours, are on a sustainable footing through and after the pandemic so we can continue to be there for anyone who is struggling to cope.

REPUBLIC OF IRELAND

The findings from this report reiterating the importance of implementing the seven strategic goals of Connecting for Life, the Republic of Ireland's National Strategy to Reduce Suicide 2015-2020 and for clear funding investments into the new Mental Health Policy, Sharing the Vision.



NORTHERN IRELAND

Similarly, allocating sufficient funding to, and implement Protect Life 2, the Northern Ireland suicide prevention strategy in full as well as a clear focus on self-harm in the new Mental Health Strategy for Northern Ireland.

4 RESEARCH

We need to better understand what individuals want and need within their care pathways with an overall recognition that individual needs may be influenced by other social and economic determinants of health. This report highlights the fact that individuals who are at increased rates of self-harm are also those who are less likely to seek support – young people, LGBTI+ people and people from lower income households. Responses also indicate that if help is sought, it may not always be fit for purpose. More should be done to understand how to further support these individuals by providing appropriate resources to gather lived-experiences to better inform the targeting and development of supports (including online and/or self-help programmes) and encourage help-seeking behaviours.

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