

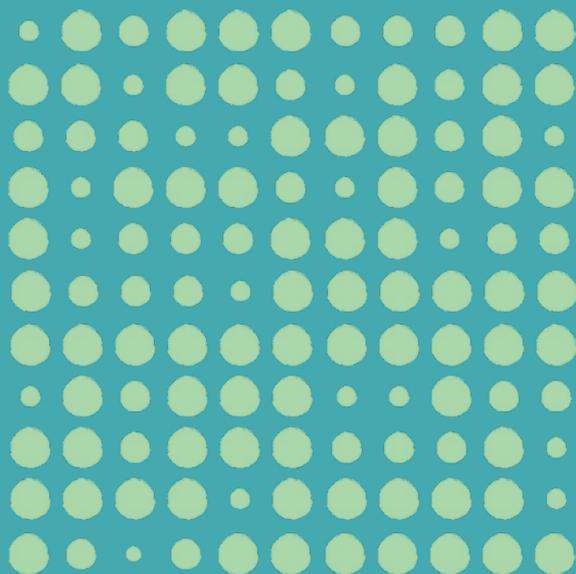
SAMARITANS
Scotland

Hidden too long:

uncovering self-harm
in Scotland

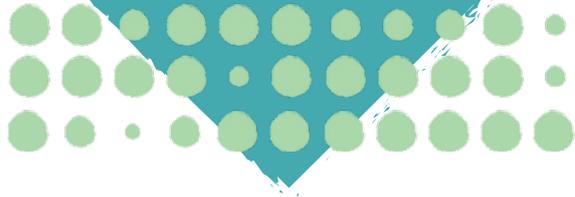


October 2020



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Foreword

Last year, Samaritans provided support to someone in connection with self-harm once every two minutes – that’s a total of 272,000 conversations with people struggling across the UK and Republic of Ireland*.

While this one figure offers some insight into the scale and impact of self-harm, our understanding of how self-harm affects individuals, families and communities in Scotland is far from complete. Although self-harm is something that touches many people – and figures suggest the number of people who self-harm is increasing – it is an issue which is often hidden and poorly understood. Deep and entrenched stigma can make seeking help particularly hard.

We have developed this report to help increase the understanding of self-harm in Scotland and build the case for improving support for people who have self-harmed, as well as their family and friends. We also want to see us all, as a country, tackle the reasons that people feel the need to self-harm at all.

In Scotland we are making great strides in our work to improve mental health and wellbeing and prevent suicide, but self-harm is not a significant feature of any current strategy. We are concerned that this has resulted in self-harm falling too far off the agenda.

Our discussions with partners across frontline services revealed a clear ambition for renewed national focus and leadership on self-harm. What we have heard from people with lived experience, as well as the general public, makes clear that urgent action is needed. The ongoing impact the coronavirus is having on our mental health and wellbeing makes this even more pressing. While it is too early to know the long-term impact of the pandemic on self-harm, we are concerned about the potential effect on already high-risk groups: young people, women, middle-age men, people with pre-existing mental health conditions and people experiencing deprivation.

There are clear challenges for us all to realise transformative change around self-harm, but we have heard a shared desire to make much needed improvements. With a particular focus in Scotland just now on encouraging people to reach out for help, we really do have a moral duty to make sure that when people take the brave step to ask, the right help is there whenever and wherever it is needed.

In publishing this report our aim is not to provide all the answers. Instead we hope to prompt a renewed national conversation about self-harm in Scotland and the role that a future strategy could play in deepening understanding, reducing stigma, improving support and tackling the issues that lead people to self-harm.

Over recent months, we have listened to the concerns and hopes of people with lived experience, service providers, policy makers, academics and the general public. This report was built on the generous sharing of experience and expertise by many, many people in Scotland. I would like to thank everyone who has taken time to inform this report. I look forward to continuing this conversation as we work towards making positive change.



Rachel.

Rachel Cackett
Executive Director,
Samaritans Scotland

* Samaritans caller data 2019



A summary of key recommendations

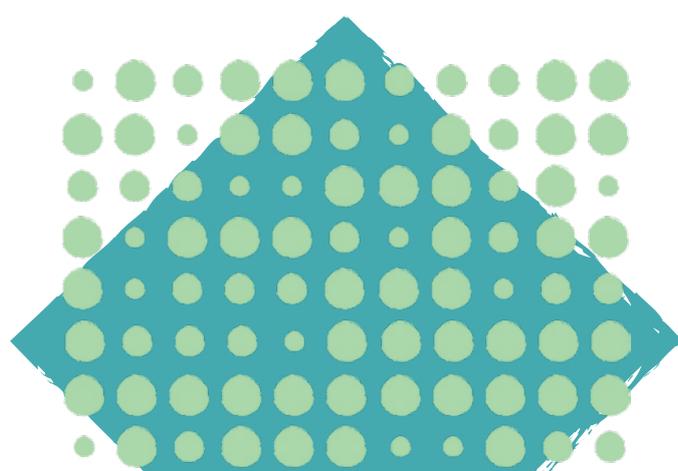
Given the lack of recent, national attention on self-harm in policy in Scotland, our recommendations are centred on the need for renewed leadership and focus through a new strategy and accompanying action plan.

Our vision for a new national self-harm strategy:

- By summer 2021 a new Scottish self-harm strategy should be developed which works in tandem with suicide prevention, mental health and public health policy
- Scotland's new self-harm strategy requires a clear definition of self-harm and clear aims
- A new self-harm strategy must be collaborative and inclusive throughout development and delivery
- A self-harm strategy should support coherent cross-sector working to address underlying causes
- There must be transparent accountability for successful delivery

Themes we believe a future strategy should explore:

- Developing data and evidence to inform policy and services
- Developing evidence-based, safe and effective self-care tools and techniques that work alongside other support sources
- Increasing public understanding and awareness to strengthen the 'hidden frontline' of informal support networks
- Realising the potential of education and youth services to support early intervention and increase mental health literacy
- Developing consistent, compassionate responses to self-harm across services and communities
- Investing in sustainable community support and third sector services so they are an integral part of the spectrum of available support





Introduction

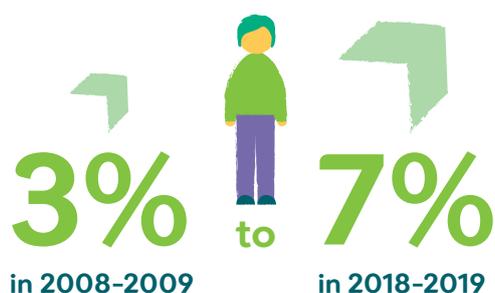
Why are we focussing on self-harm, and why now?

Self-harm is a serious public health issue that affects thousands of individuals and families across Scotland and recent data suggests self-harm rates are rising¹.

Despite this, self-harm remains an issue that is often hidden and poorly understood. While there is growing recognition among policy-makers and service providers that further action is needed to improve understanding of self-harm and strengthen support for those affected, there is currently no national self-harm strategy and self-harm is not a significant focus within existing suicide prevention, mental health or public health policy. We believe self-harm must be made a priority for policy and services and that improving understanding of, and responses to, self-harm is a vital component of strengthening mental health and wellbeing across Scotland.

Through this report we aim to generate a national conversation on self-harm in Scotland. By bringing together insights from people with lived experience of self-harm and from stakeholders working across government, health and social care, emergency services, education and the third sector we aim to increase understanding of who is affected by self-harm and explore how policy and services can strengthen support, reduce risk and address the underlying causes of self-harm.

The proportion of adults in Scotland who say they have ever self-harmed in Scotland rose from:



(Scottish Health Survey 2019)

What research and engagement have informed this report?

We carried out a programme of research and engagement to inform this report, drawing on the following sources:

- An online survey of 900 adults from across the United Kingdom (UK) and Republic of Ireland (ROI) with lived experience of self-harm, including 102 adults in Scotland. More than half of survey respondents in Scotland were under 25. Where there were fewer than 50 respondents in any question, patterns rather than specific figures are reported
- Caller data from Samaritans' 24-hour helpline and a qualitative online survey of more than 250 Samaritans volunteers from across the UK & ROI about the needs and concerns of Samaritans callers with lived experience of self-harm
- Stakeholder insights from four facilitated online cross-sector engagement sessions in Scotland on the topic of self-harm
- An online survey of over 1,000 adults in Scotland on perceptions and attitudes to self-harm, conducted by YouGov on behalf of Samaritans Scotland
- Relevant external academic research and data from Scotland and the UK

A detailed methodology can be found in the appendix.

What is self-harm?

In clinical and academic settings, particularly in the UK, self-harm is generally defined as a deliberate act of self-injury or self-poisoning² irrespective of whether someone has the intention of taking their own lives, or not.

Our focus recognises that non-suicidal self-harm differs from suicide attempts. For many, non-suicidal self-harm is a way of coping with difficult or distressing feelings and circumstances and this is distinct from people who want to take their own life.

For the purposes of this research we focussed on self-harm without suicidal intent and did not include accidents, eating disorders, and substance misuse. However, we recognise that self-harm can cover a range of behaviours and that individuals will have their own understanding of their self-harm which may not easily fit within academic or policy definitions. We will explore this theme in more detail throughout our report.

Why do people self-harm?

Self-harm is complex and the experiences and intentions behind self-harm can vary from person to person.

Research shows that many people use self-harm as a way of coping with difficult or distressing emotions or circumstances^{3,4}, something that was echoed throughout our conversations with stakeholders. In this sense, self-harm is distinct from suicide attempts⁵. A study of adolescents' subjective reasons for self-harming found that these could be grouped into four broad themes: to obtain release or relief from intense feelings, to control or cope with difficult feelings, to represent un-accepted feelings and to connect with others⁶. Research suggests there is a strong link between trauma and self-harm.⁷

Throughout our research and engagement, stakeholders emphasised the importance of understanding and addressing the underlying factors that contribute to self-harm.

While stakeholders recognised self-harm was often linked to poor mental health, they emphasised that a range of factors – both medical and non-medical – could contribute to self-harm.

Data from the Samaritans' helpline, which provides free and confidential emotional support across the UK & ROI, shows that callers who discuss self-harm are 1.6 times more likely to discuss concerns around mental health or illness, 1.5 times more likely to discuss concerns about drug and alcohol abuse and 2.1 times more likely to discuss concerns about violence and abuse, compared to callers who do not mention self-harm⁸.



Last year, Samaritans provided support to someone in connection with self-harm once every two minutes – that's

272,000
conversations



What is the relationship between suicide and self-harm?

For many people, self-harm is distinct from suicidal thoughts and behaviour; the vast majority of people who self-harm will not go on to take their own life. However, research suggests that repeated self-harm is a strong predictor for future suicide risk⁹.

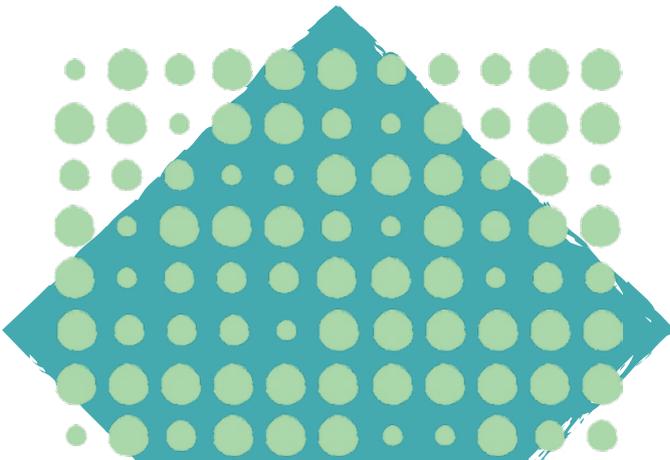
Self-harm can lead to suicidal thoughts developing and, among young people, it is one of the strongest predictors of transition from suicidal thoughts to behaviours^{10,11}. Data from the Samaritans' helpline shows callers who discussed self-harm in 2019 were 2.5 times more likely to express suicidal thoughts or behaviours than other callers.

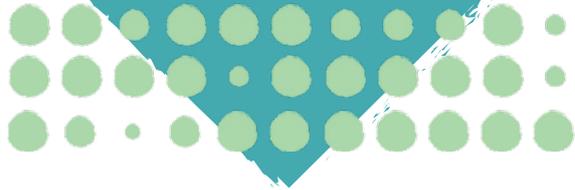
Self-harm can also reduce a person's fear of pain or death and therefore lead to an ability to self-harm more severely over time¹². More generally, self-harm is often a sign of complex underlying mental health issues and/or serious emotional distress, yet research shows that long term self-harm does not help reduce that emotional distress¹³.

Like self-harm, suicide is complex, individual and rarely the result of a single factor. It is therefore important not to over-simplify the factors that lead to suicide or view the role of self-harm in isolation from other factors.

However, in light of a recent, marked rise in suicide rates in Scotland, particularly among young people, suicide prevention policy should consider the potential for self-harm to contribute to this increase. In 2018, the overall suicide rate in Scotland increased by 14% compared to the previous year while the rate among young people under 25 reached their highest level since 2007¹⁴. While it is important to note that suicide rates can fluctuate between years and that it is too early to determine whether this increase indicates a long-term trend, the rise in rates among under 25s is a source of concern, particularly in light of the impact of coronavirus on young people, and requires further exploration to understand the factors which may contribute to this.

Our discussions with stakeholders highlighted the importance of taking a balanced approach to self-harm – recognising that while it is a risk factor for suicide, the motivations and intentions behind self-harm are often distinct from suicidal behaviour. In particular, stakeholders raised concerns that focussing primarily on self-harm as a risk factor for suicide may alienate those for whom self-harm is a way of coping, thereby creating an additional and unintended barrier to help-seeking. We will explore this theme further throughout this report.





How common is self-harm?

Self-harm is often hidden and limitations in data and evidence make it difficult to measure its true prevalence. However, existing data suggests self-harm is an issue that affects many individuals, families and communities across Scotland and that the prevalence of self-harm is increasing. Data also suggests self-harm is more common among young people, women and people living in areas of deprivation.

The Scottish Health Survey, which surveys more than 4,900 adults aged 16+ in Scotland, provides the most comprehensive picture of the prevalence of self-harm across the Scottish population.

While there is some variation between years, combined data for 2018-2019 shows that the proportion of adults in Scotland who say they have self-harmed at some point in their lives has increased significantly over the last decade – rising from 3% in 2008-2009 to 7% in 2018-2019¹⁵.

Combined data for 2018-2019 shows 5% of men aged 16+ said they had ever self-harmed, compared to just 2% in 2008-2009, while in 2018-19 9% of women said they had ever self-harmed compared to 4% in 2008-2009¹⁶. Self-harm was most prevalent among young people with 1 in 6 (16%) 16-24 year-olds saying they had self-harmed at some point in their lives; prevalence decreases steadily among older age groups¹⁷.

Prevalence of self-harm also increases with deprivation. People living in the most deprived areas were more than twice as likely as those living in the least deprived areas to say they had self-harmed at some point in their life - 13% of those living in the most deprived areas said this, compared to 6% of those living in the least deprived. This difference is more significant among men; combined data for 2018-2019 shows that men living in the most deprived areas were four times more likely to self-harm compared to those living in the least deprived (12% compared to 3%)¹⁸.

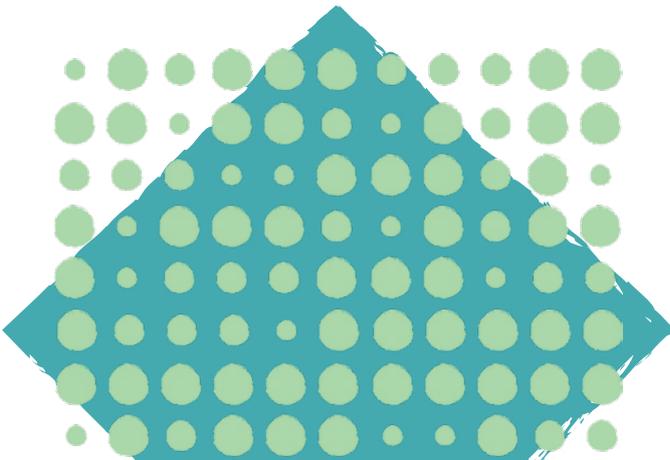
A study of prevalence among young people in Scotland found that 1 in 6 young people aged 18-34 in Scotland have self-harmed at some point in their lives. This includes 1 in 10 young men and 1 in 5 young women¹⁹.

In 2019, Samaritans supported a caller from across the UK & ROI in connection with self-harm every 2 minutes – a total of 272,000 times²⁰.

Data from Samaritans' helpline service shows that self-harm is mentioned in almost 1 in 10 contacts overall and in 1 in 4 contacts from under 18s.²¹



16-24 year-olds in Scotland say they had self-harmed at some point in their lives





Perceptions of self-harm and barriers to help-seeking

Throughout our research and engagement with stakeholders, there was a clear sense that self-harm is poorly understood and often surrounded by entrenched stigma. Stakeholders highlighted this lack of understanding both among the general public and within the context of specific sectors and services. Many stakeholders we spoke to highlighted how a lack of understanding could contribute to the stigma and make it more difficult for people to seek support.

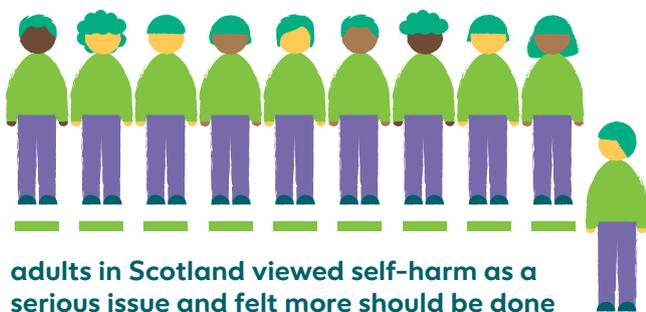
While our discussions with stakeholders highlighted that although many people – including family, friends and frontline workers – recognise self-harm as a serious issue and want to provide a compassionate and appropriate response they may lack the knowledge and confidence to do so. This can lead people to respond to self-harm in ways that may be perceived as inappropriate or insensitive, or to avoid talking about self-harm at all.

These challenges around understanding and attitudes were reflected in our public perceptions survey.

Public understanding and perceptions of self-harm

We conducted a survey of over 1,000 adults in Scotland to explore current understanding and perceptions of self-harm among the general public. This online survey was conducted by YouGov on behalf of Samaritans in September 2020.*

9 in 10 (89%)



adults in Scotland viewed self-harm as a serious issue and felt more should be done to address it.

YouGov survey (Sept 20)

* Figures from YouGov Plc. Total sample size was 1,035 adults, of which 994 were happy to answer questions on this subject. Fieldwork was undertaken between 8th-10th September 2020. The survey was carried out online. The figures have been weighted and are representative of all Scotland adults (aged 18+)

“Callers try to hide self-harm from family and friends who they feel don’t understand which leads to loneliness and isolation.”

Samaritans volunteer

Our public perceptions survey found that while almost 9 in 10 (89%) adults in Scotland agreed self-harm is a serious issue and felt more should be done to address it, 2 in 5 (40%) said they would not know how to support someone close to them if they were self-harming.

Over 4 in 5 (84%) adults viewed self-harm as a ‘coping mechanism for dealing with difficult emotions or experiences’ – though men were less likely to say this compared to women (76% compared to 91% of women). Nearly a quarter (23%) of adults in Scotland thought that self-harm was something people did to seek attention – 30% of men thought this compared to 16% of women. And 1 in 5 (20%) adults thought that self-harm is often a passing phase. Views were mixed on which groups were most affected by self-harm: a third (33%) of adults thought that mostly young people self-harmed while nearly 1 in 6 (14%) thought that mostly women self-harmed.

The findings show that while there is wide-spread recognition among the Scottish public that self-harm is a serious issue and one that requires further action, understanding of why people may harm themselves and who is affected by this is more limited. Indications of gender differences in some perceptions of self-harm may be important in shaping any future public awareness activity.

The impact of stigma

Throughout our research and engagement, stigma emerged as a recurring theme. Among stakeholders we spoke to across a range of sectors and services, there was a strong sense that self-harm, perhaps even more so than other aspects of mental health, suffered from entrenched and persistent stigma which, in turn, influences if and how individuals sought support and the way in which services respond to self-harm.

Our public perceptions survey found that 1 in 3 (31%) adults in Scotland would feel uncomfortable speaking to a partner or close family about self-harm, while 2 in 5 (39%) would not feel comfortable speaking to friends.²² One in four (24%) adults in Scotland would not feel comfortable talking to their GP or another healthcare professional about self-harm, but this was significantly higher among 18-24-year-olds, where 2 in 5 (40%) said they would not feel comfortable doing this.²³

Stakeholders across a range of sectors highlighted the need for public awareness to address stigma and increase understanding of the underlying causes that contribute to self-harm.

Many stakeholders emphasised the role of self-harm as a way of coping and raised concerns that an approach to self-harm which focusses solely on prevention may compound stigma and alienate people who would otherwise seek support. Stakeholders highlighted the need to strike a balance between reducing the stigma of self-harm by recognising its role as a way of coping with difficult emotions or experiences while still being aware of the risks associated with self-harm.

Some stakeholders we spoke to emphasised the value of a harm reduction approach which recognises that people may continue to use self-harm as a way of coping even after seeking help, emphasising safety while encouraging people to identify tools and techniques to support them through difficult emotions and experiences.



adults in Scotland would not feel comfortable speaking to a partner or close family about self-harm

YouGov survey (Sept 20)



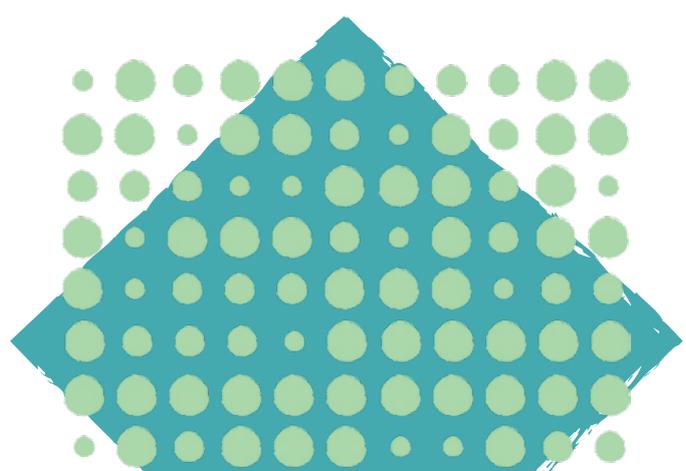
adults in Scotland would not feel comfortable talking to their GP or another healthcare professional about self-harm

YouGov survey (Sept 20)



adults in Scotland would not feel comfortable speaking to friends about self-harm

YouGov survey (Sept 20)



The full spectrum of support

Our research and engagement identified a wide spectrum of sources of support which people may turn to – both in connection with their own self-harm or if they are worried about a loved one.

This spectrum encompasses varying degrees of formality. More informal sources of support include seeking support via self-help tools and techniques, online advice or forums, from family or friends, and from community groups or clubs. More formal sources include seeking support via external settings including school, university, the workplace or healthcare. People may seek support from multiple sources in connection with self-harm and different types of support can work in tandem with each other. It is therefore helpful to view these sources as overlapping and interacting.

Existing data on support-seeking in Scotland is limited. Even in formal settings self-harm data is either not recorded at all, or not routinely published. And more informal sources of support – such as seeking support from friends, family or through self-care – are even less visible to policy makers, making them more difficult to quantify or evaluate. There is a clear need to widen and deepen the evidence base around self-harm and help-seeking, and informal sources of support should not be over-looked due to a lack of visibility.

Throughout our research and engagement, informal sources emerged as an integral element of support systems and stakeholders across all sectors highlighted the crucial role these sources can and do play, working alongside more formal sources such as health, social care and other public services.

Different sources of support appear to be more popular with different demographics. Our public perceptions survey asked people in Scotland where they would seek support in connection with self-harm for themselves or a loved one, if they wanted to. Younger people were less likely to say they would seek support and advice from a GP or other healthcare professional. Less than half

(48%) of 18-24-year-olds said this compared to 64% of adults overall²⁴. It also showed that over half of people in Scotland (52%) said they would seek advice online while almost 1 in 3 (31%) said they would seek support from family and 1 in 4 (25%) said they would seek support from friends. Among 18-24-year-olds, almost 2 in 5 (39%) said they would seek support from friends.²⁵

In some cases, people with lived experience of self-harm viewed informal sources of support – like support from friends, online support and self-help techniques – as more useful than support from formal sources such as healthcare services.

Within Scotland, and across the UK & ROI, our survey of people with lived experience of self-harm found that people were as likely, or more likely, to seek support from a number of informal sources (including friends, online forums and information, and self-help techniques), as they were to seek support from formal sources like healthcare. In some cases, they viewed these informal sources as being more useful.

Stakeholders working across health, social care, education, adult and youth services recognised the importance of social support – through friends, family and other trusted relationships – and the importance of engaging with wider support networks, including community and third sector organisations. Many stakeholders highlighted this as an area for potential development and improvement.

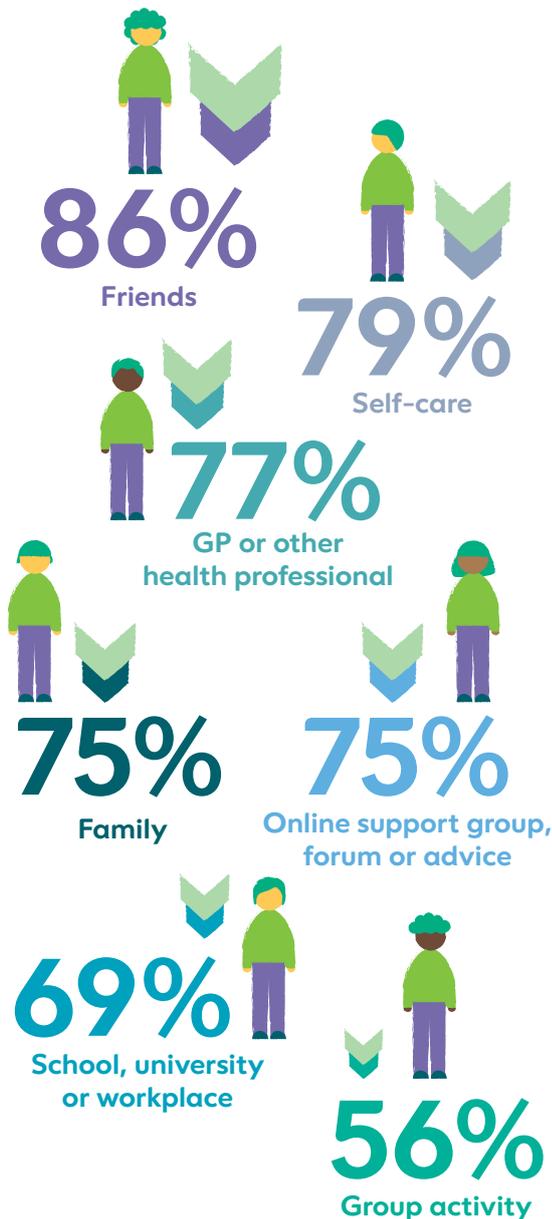


Lifetime use of support sources

Our survey of people with lived experience of self-harm explored their experiences of seeking support. We found that the vast majority of people – both in Scotland and across the UK & ROI – had sought support in connection with self-harm at some point over their lifetime.

Figure 1: Percentage of people who sought support from the following sources over the course of lifetime (Scotland data).

People may access multiple sources of support over their lifetime.



We also asked people about how useful they had found the various sources of support they had tried throughout their lifetime. Experiences were mixed and no single source appeared especially useful for the majority of people in Scotland. However online support emerged as the most useful source with 45% of respondents describing this as 'at least moderately useful'. Similarly, 43% of people described seeking support from friends as at least moderately useful, while 39% said this about self-help techniques. People who responded to our lived experience survey in Scotland were slightly more likely to describe online support and support from friends as useful and slightly less likely to describe support from GP or other healthcare professional as useful, compared to people from across the UK & ROI²⁶. However, these differences may be due to the fact that our sample in Scotland is skewed towards a young demographic; 57% of respondents in Scotland were aged between 16 and 25.

Support after most recent experience of self-harm

Only half of respondents to our lived experience survey sought support following their most recent experience of self-harm.

While the vast majority of people – both in Scotland and across the UK & ROI – had sought support in connection with self-harm at some point in their lives, only half did so following their most recent experience of self-harm.

Again, our survey found that people sought support from a spectrum of informal and formal sources following their most recent experience of self-harm. To illustrate this, we grouped the sources of support that people across the UK & ROI accessed following their most recent experience of self-harm into themes. Please note that people may have accessed multiple sources of support at once, so the figures will not add up to 100 percent.

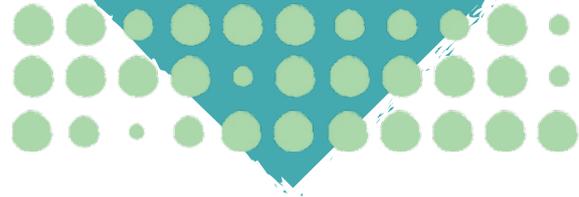
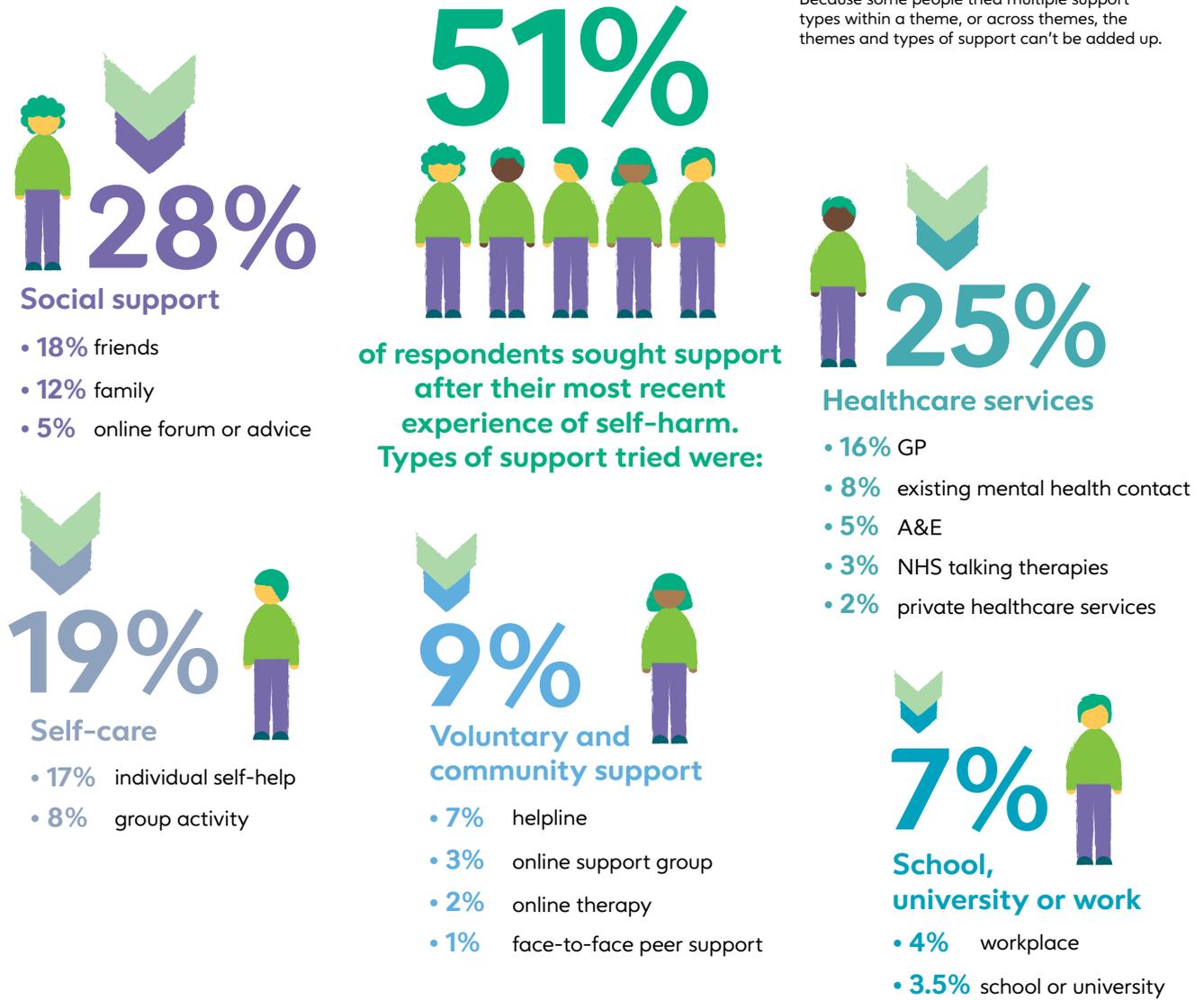


Figure 2: Percentage of people who tried different types of support after most recent self-harm (UK & ROI data)



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.

While separate analysis was not conducted on the data from Scotland due to the small sample size, it appears that the sources of support people sought following their most recent experience of self-harm were broadly consistent with UK & ROI data. However, our lived experience survey did find that people in Scotland were slightly more likely to seek support from friends and community services and slightly less likely to seek support from healthcare services, compared to respondents overall²⁷. These differences may reflect that survey respondents in Scotland tended to be younger compared to respondents from across the UK & ROI.

People across the UK & ROI who sought support following their most recent experience of self-harm were more likely to experience a worsening in their mental health the day after they self-harmed compared to people who did not seek support. However, a month on from their most recent experience of self-harm, our data indicates that this changes, as 42% of people who sought support reported an improvement in their mental health compared to 33% of those who did not.²⁸

Self-care

Experiences of self-care

Self-care emerged as a common source of support among people and could take a variety of forms including distraction techniques, physical exercise or seeking advice and support online.

Self-care is a broad term that can encompass a range of individual or group activities including using mindfulness techniques or self-help apps, individual or group exercise or sport, creative activities or other hobbies.

As people experiencing self-harm may feel uncomfortable seeking external support, self-care can play an important role in supporting people to reduce self-harming behaviour and to identify alternative ways of coping.

Our lived experience survey found that 4 in 5 (79%) people in Scotland said they had used some form of self-care in connection with self-harm at some point over their lifetime. And nearly 1 in 5 (19%) of respondents across the UK & ROI said they had sought support through self-care following their most recent experience of self-harm. Among those who sought support through self-care, 17% sought some form of individual self-help while 8% sought some form of group activity. It appears a similar proportion of people in Scotland sought support from self-care following their most recent experience of self-harm.²⁹

Challenges and opportunities associated with self-care

Given that many people self-harm as a way of coping with difficult emotions and experience, it is important that self-care techniques and tools are sensitive, and responsive, to both to the immediate urge to self-harm and to the underlying emotions and circumstances that contribute to self-harm. Discussions with stakeholders highlighted the importance of recognising and maintaining the agency of the person self-harming and seeking to minimise harm.

Self-care can help to maintain a sense of agency and support people to find alternative ways of coping.



Scottish respondents to our lived experience survey said they had used some form of self-care in connection with self-harm at some point

However, there are a number of challenges around self-care, including a lack of evidence around the effectiveness of some commonly promoted techniques. There is limited empirical evidence that techniques which aim to replace the self-harming behaviour – such as pressing an ice cube against the skin, drawing red marker pen on arms or snapping an elastic band against the wrist³⁰ are useful. There is even a suggestion that in replicating, rather than overcoming³¹ the need for the behaviour, these techniques may actually help to maintain it.³² Similarly, there is limited evidence for online and mobile apps' effectiveness in reducing self-harm and/or suicide attempts and the available evidence is limited.³³ There is a clear need for further research to understand and evaluate effective self-care techniques in relation to self-harm.

Discussions with stakeholders highlighted the importance of mental health literacy in supporting people to understand their emotions and the triggers which can lead to self-harm, and to identify alternative coping mechanisms and sources of support.

Self-care relies on a high degree of mental health literacy on the part of the individual to access credible and safe information and to identify and maintain habits and techniques without additional support.

It is notable that our public perceptions survey found that two in five (42%) adults in Scotland said they do not know where to find support and information about self-harm³⁴. This suggests that current support and information may be hard to navigate and that some people may struggle to find credible and effective resources on their own.

In particular, online information and forums emerged through our engagement as an important form of self-care. However, there is evidence that some types of online content and activity relating to self-harm and/or suicide can increase risk of self-harm, suicidal thoughts and plans among some people³⁵. Further research is needed to understand both the potential benefits and risks surrounding online content and internet use and how we can create safe online spaces³⁶. Samaritans has recently embarked on a [wider programme of work](#) to understand the potential risks relating to online activity and content, as well as opportunities for internet use to support help-seeking and harm reduction – this includes further research and the development of industry and user guidance.

Efforts to increase mental health literacy should consider the positive role internet-use and online content can play in help-seeking, while recognising the risks, and consider how policy and services can support the creation of safe online spaces where people can share their experiences and seek support.



Social support

Experiences of social support

Throughout our research and engagement, both people with lived experience and stakeholders emphasised the important role of social connection and support, with family, friends and peers. While social support emerged as one of the most common sources of support, experiences of seeking support from family, friends and peers were mixed.

Our lived experience survey found that nearly 9 in 10 (86%) of people in Scotland had sought support in connection with self-harm from their friends over their lifetime, while 3 in 4 (75%) had sought support from family. Experiences of seeking support from friends and family were mixed. While 2 in 5 (43%) people in Scotland said that they had found support from friends to be at least moderately useful, just 1 in 4 (24%) said the same about support from family.

Our lived experience survey also asked people about their experiences of seeking social support online via forums. Three in four (75%) of people in Scotland had sought support from an online group, forum or advice site at some point over their lifetime and more than 2 in 5 (45%) said they found this at least moderately useful.

Following their most recent experience of self-harm, more than 1 in 4 (28%) of people across the UK & ROI sought social support including 1 in 5 (18%) who sought support from friends, 1 in 10 (12%) who sought support from family and 1 in 20 (5%) who sought support from online forums.

Nearly

9 in 10 (86%)



The role of loneliness, isolation and stigma

Our discussions with stakeholders highlighted how feelings of loneliness, isolation and challenges in relationships with partners, family members and friends, are factors that may contribute to, or trigger, self-harm.

Stakeholders from across a range of sectors and services highlighted the ways in which stigma surrounding self-harm could compound loneliness and isolation, where people feel their self-harm is something that they must conceal from social support networks, creating additional barriers to help-seeking.

Data from Samaritans' helpline in 2019 shows that many callers who mentioned self-harm also frequently spoke about concerns relating to social support: nearly 2 in 5 (37%) had concerns about family, 1 in 4 (25%) had concerns about loneliness and isolation and 1 in 5 (22%) had concerns about relationship problems, while more than 1 in 4 (26%) mentioned concerns about violence and abuse. Callers who mentioned self-harm were slightly more likely to talk about worries in connection with family, and loneliness and isolation compared to callers who did not and twice as likely to mention concerns about violence and abuse.

A survey of Samaritans' helpline volunteers in the UK & ROI explored the connection between self-harm and concerns about social support in more detail. Volunteers shared how some callers felt their self-harm was something to be ashamed of or something that their partner, family, friends would not understand. Fear of their self-harm being discovered or being judged by others could increase callers' sense of loneliness and isolation.



“Many callers are reluctant to socialise if they self-harm because they may have to explain the injuries they inflict on themselves. Self-harm has an effect on how they dress, who they socialise with and how often.”

Samaritans volunteer

Challenges and opportunities for social support

Throughout our research and engagement social support emerged as a hidden frontline. While the scope and effectiveness of informal sources of support, such as friends and family, are difficult to measure, our survey found that many people turn to these sources either instead of, or in conjunction with, seeking support from formal services such as healthcare. Further research could help us to better understand the role these social networks play in individuals’ overall experiences of help-seeking and how they can work alongside formal sources of support.

Stakeholders spoke positively about the role family, friends and peers could play in reducing isolation and providing emotional support. In particular, peer-to-peer support was identified as a positive model for reducing stigma, sharing real experiences and encouraging help-seeking.

However, stakeholders also highlighted a number of challenges around social support. Generally, stakeholders felt that public awareness and understanding of self-harm was limited which could in turn reinforce misconceptions and stigma. Our public perceptions survey showed that while the vast majority of adults (84%) in Scotland recognised that self-harm “is a way of coping that people may turn to in response to difficult emotions or experiences”, deeper understanding of who self-harms and why, was more limited.

Stakeholders also recognised that the self-harm of a child, partner, family member or friend could be a source of significant distress and anxiety and that people may be unsure of how to respond to or support a loved one. These factors could contribute to negative experiences of social support, deepening the sense that self-harm is something to be hidden and discouraging someone from reaching out in future. Our public perceptions survey found that two in five (40%) adults in Scotland also said they would not know how to support someone close to them who was self-harming, while over half (53%) of 18-24 year-olds said this.³⁷



adults in Scotland said they would not know how to support someone close to them who was self-harming

YouGov survey (Sept 20)

Stakeholders from the youth and education sectors also highlighted concerns around the potential for social contagion where self-harm may become normalised or glamourised within a peer group both in person and online. While stakeholders from youth and education sectors were broadly positive about the role that social media and online forums could play in encouraging young people to seek support through channels which may feel more anonymous and accessible, they also highlighted risks associated with online spaces where self-harm may be encouraged and where moderation is limited.

Stakeholders highlighted the need for increased public awareness and support for people supporting others with self-harm to facilitate and strengthen safe and compassionate responses to self-harm among family, friends and peers.



Community support

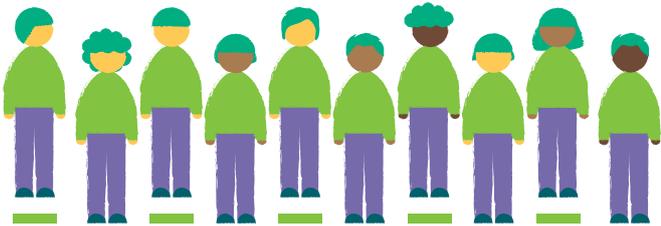
Experiences of community support

Community support emerged throughout our research and engagement as an underutilised source of support – one which has the potential to work in tandem with other sources of support like education and healthcare services.

Through our survey of people with lived experience we explored a range of different types of community support; including peer support, helplines, online support groups and online therapy as well as participation in group activities like community groups, youth clubs, sports clubs or volunteering. There are areas of overlap between community support, social support and self-care.

Our lived experience survey found the most commonly accessed source of community support following people’s most recent experience of self-harm was a helpline or text service such as Samaritans. Data from our helpline shows that around 1 in 10 contacts to Samaritans mentions self-harm, and that in 1 in 7 of these calls the person contacted Samaritans as a means of resisting or avoiding self-harm.

5 in 10



people in Scotland had sought some form of community support in connection with self-harm at some point

Our lived experience survey found that over half (56%) of people in Scotland had sought some form of community support in connection with self-harm at some point, with 27% describing it as ‘at least moderately useful’.

Among respondents in the UK & ROI, 8% sought support from some type of group activity following their most recent experience of self-harm, while nearly 1 in 10 (9%) sought community support in the form of peer support, a helpline or text support, online support groups and online therapy.

In a survey of Samaritans volunteers, many spoke positively of the role talking could play in reducing the urge to self-harm and providing a source of support until the urge to self-harm or emotional distress had subsided, though volunteers also recognised the relief may be temporary.

For example, one Samaritans volunteer told us – “Often callers need to talk as an alternative to cutting. They need support until the feeling passes.”

1 in 10



contacts to Samaritans mentions self-harm. In 1 in 7 of these calls the person contacted Samaritans as a means of resisting or avoiding self-harm



Challenges and opportunities for community support

Stakeholders emphasised the potential for third sector, voluntary and community organisations and services to provide an important source of support in their own right and to work in conjunction with a range of other sectors and services. In the context of our discussions with stakeholders, community support was understood to encompass a range of services and activities – including face to face support, helpline, text and online support, group activities and youth work. This encompassed both community initiatives focussed on self-harm specifically, as well as those aimed at improving health and wellbeing more broadly.

Stakeholders emphasised the potential for community services to foster safe spaces and trusted relationships which could in turn encourage open discussions and help-seeking.

Within the youth sector, stakeholders highlighted the importance of 'opt-in' services where young people actively chose to engage, as spaces where they may be more comfortable to talk about self-harm or other difficulties, compared to statutory services, where young people may feel they have less agency and choice.

Similarly, discussions with stakeholders working with at-risk adult groups highlighted the positive role of community services, particularly those involving peer support. Engagement with stakeholders highlighted the importance of ensuring community support met the needs and experiences of different demographic groups – men, women, young people, LGBTQI communities, BAME communities –

recognising where tailored approaches may be beneficial in addressing specific challenges and barriers faced by those groups.

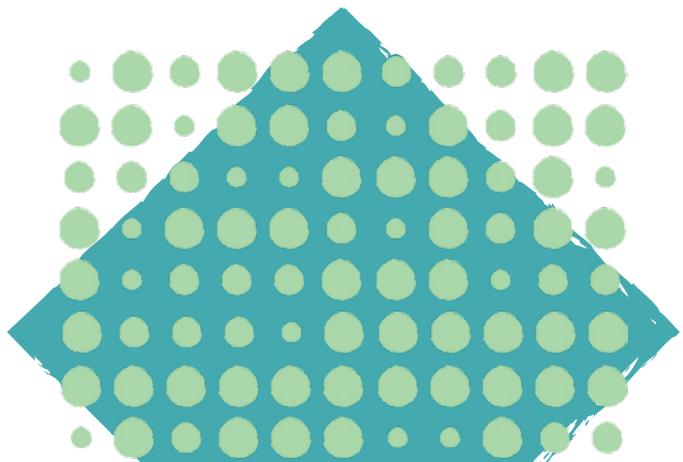
Across all sectors, there was a strong sense that community services like peer support groups, helplines, and third sector initiatives play an important role in supporting people in connection with self-harm specifically or by addressing the underlying causes of emotional distress. Stakeholders highlighted the role national and local policy could play in elevating and investing in community services to ensure that they are sustainable, and supporting community services to work in conjunction with other sources of support.

Stakeholders advocated for community services to be viewed as an integral source of support and for national and local policy to value and strengthen this role.

In particular, stakeholders from across health and social care, third sector and community settings all highlighted the potential for policy to strengthen the links between community and healthcare services through improved knowledge sharing and referral processes.

"I regularly go to a sports club... they accept me and don't turn me away."

Lived experience survey participant in Scotland





School, university and work

Experiences of seeking support from school, university and work

Throughout our research and engagement, education – encompassing school, college and university – emerged as another important source of support as well as an opportunity for early intervention and prevention. And for adults, workplace and employer support services were also highlighted as a potential source of support. However, overall these supports seem to be underutilised and were not always seen as useful.

Our survey of public perceptions of self-harm in Scotland found that 14% of 18-24 year-olds said that they would seek support from their school, college or university if they wanted to seek support for self-harm, for either themselves, or a loved one. While 4% of all adults would seek support from their workplace, rising to 10% among 35-44 year-olds³⁸.

People were less likely to seek support from schools, university or work, compared to other sources, both over their lifetime and following their most recent experience of self-harm.

Our lived experience survey found that over two thirds (69%) of people in Scotland said they had sought support from school, university or work over the course of their lifetime; however, only 18% said they had found this source of support to be at least moderately useful – ranking the lowest of all support sources we asked about. This is broadly consistent with survey findings from across the UK & ROI where support from school, university and work also ranked the lowest of all support sources³⁹. However, it is worth noting that as the sample in Scotland is skewed to under-25s this may over-represent experiences of seeking support in education settings and under-represent experiences of seeking support in work settings.

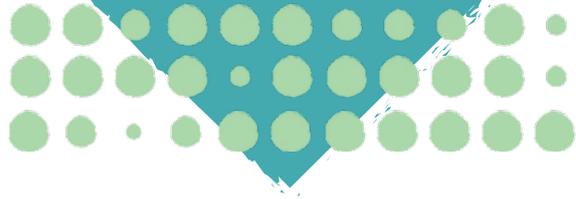
Following their most recent experience of self-harm only 7% of respondents across the UK & ROI sought support from school, university and work. Among younger respondents age 16-24, 8% sought support from school or university including speaking to a teacher, counsellor, nurse, lecturer or a mental health first aider at their university or college. While separate analysis was not conducted on the data from Scotland due to the small sample size, it appears people in Scotland were slightly more likely to seek support from school compared to those across the UK & ROI; this is most likely due to the younger profile of our sample.

Only 4% of respondents from across the UK & ROI sought support from work including a mental health first aider, line manager or workplace counselling service following their most recent experience of self-harm.



18-24 year olds in Scotland said that they would seek support from their school, college or university in connection with self-harm while only 4% of all adults would seek support from their workplace

YouGov survey (Sept 20)



Challenges and opportunities around school, university and work

Both our survey and discussions with stakeholders highlighted the potential for educational settings to play a crucial role in supporting young people by recognising self-harm early on. They also highlighted the potential for education settings to work in tandem with wider youth sector services to promote mental health literacy and provide support, recognising that some young people may feel more comfortable engaging and seeking support from non-statutory settings.

Self-harm, with and without suicidal intent, often emerges during adolescence⁴⁰. Eight in ten people in our lived experience survey in Scotland were aged 17 or under when they self-harmed for the first time, while 47% were between 11-15. This is broadly consistent across with survey findings from across the UK & ROI. 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. Some stakeholders from the youth and education sectors highlighted increased risk for young people around transition periods such as moving up to secondary or leaving home after school.

Although self-harm often emerges during school years, respondents across the UK & ROI were less likely to seek support from school or university following their most recent experience of self-harm compared to other sources, suggesting education may be an underutilised source of support. Further exploration is needed to understand the barriers to help-seeking in education settings.

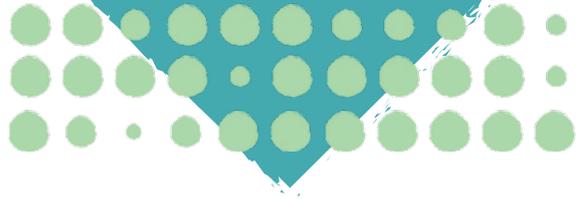
Education and youth settings can support early prevention and intervention by recognising when young people may be at risk of starting to self-harm and through promoting mental health literacy.

Stakeholders working across a range of sectors highlighted the important role of education in supporting early prevention and intervention, by recognising and intervening at the onset of self-harm or where young people may be at risk of starting to self-harm. Stakeholders also highlighted the importance of mental health literacy and the role education can play in supporting young people to understand emotions and the triggers which can lead to self-harm and to identify alternative ways of coping and sources of support.

For adults, workplaces were highlighted as another space that could be further developed through strengthening workplace support programmes and mental health first aid training.

Across all settings, stakeholders emphasised the need for increased training that specifically addresses self-harm and is tailored to the role and remit of professionals working in different settings. In education and youth settings, stakeholders highlighted how a lack of knowledge and confidence in talking to young people about self-harm could prevent workers from recognising and responding to self-harm or lead to inappropriate responses.

Across school, university and work settings, stakeholders highlighted the importance of addressing stigma by talking openly about self-harm. In school settings, stakeholders highlighted the importance of talking about self-harm in the wider context of mental health and wellbeing and ensuring the topic is covered in a safe and age-appropriate way.



Health, social care and emergency services

Experiences of seeking support from health, social care and emergency services

Healthcare services were a popular source of support among people who had self-harmed. Our lived experience survey found that 77% of people in Scotland had sought support from healthcare services in connection with self-harm over their lifetime – this was broadly consistent with respondents across the UK & ROI. However, only a third people found this support at least moderately useful.

Our public perceptions survey found that 64% of adults across Scotland said they would seek support for self-harm from a GP or another healthcare professional, making it the most popular source of support overall, though this drops to 48% among 18-24 year-olds⁴¹.

Our lived experience survey found that among people in Scotland who had sought support from healthcare services at some point in their lives, only 33% respondents described this support as being at least moderately useful. This is broadly consistent with respondents across the UK & ROI. Younger people (aged 16-24) across the UK & ROI were slightly less likely to describe healthcare services as being at least moderately useful compared to older age groups (32% compared to 39%)⁴².

While the vast majority of survey respondents across the UK & ROI had sought support from healthcare services in connection with self-harm at some point, only 1 in 4 sought healthcare support following their most recent experience of self-harm. This was largely consistent with respondents in Scotland, however separate analysis was not conducted on the data from Scotland due to the small sample size.

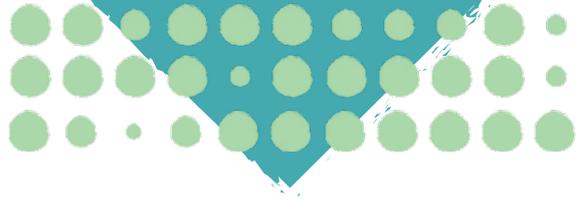
Among lived experience survey participants across the UK & ROI who sought support from healthcare services, 16% made an appointment with their GP surgery, 8% spoke to their existing NHS (HSE in the Republic of Ireland) mental health contact, 5% went to an hospital accident and emergency department, and 3% self-referred to NHS or HSE-provided talking

therapies. Only 2% sought support from private healthcare providers. Data from Scotland shows that a similar proportion of people made an appointment with their GP, while respondents appear to be slightly more likely to seek support from A&E⁴³. However, the sample is too small to draw robust conclusions about these differences.

Of those who attended a GP appointment in connection with self-harm, nearly 7 in 10 (69%) of survey respondents across the UK & ROI were offered some type of support service including a referral to other healthcare services, a referral to community or third sector support or a follow-up appointment with their GP. A similar proportion of respondents in Scotland were offered follow-up support.⁴⁴ Six in ten (62%) respondents across the UK & ROI were offered further healthcare services, including a prescription for medication, a referral talking to therapies or a referral for further assessment with mental health services.



people in Scotland had sought from healthcare services in connection with self-harm over their lifetime but only 1 in 3 (33%) of these people said that they found this support at least moderately useful.



Across the UK & ROI, a helpline was the most common source of community support for GPs to signpost to; nearly half of people (48%) from our lived experience survey were signposted in this way. Other follow-up community support sources offered included online support sites, a peer support groups or support from volunteering or community groups.

Of those who were offered any type of follow-up support across the UK & ROI, 2 in 5 (43%) attended the support services offered, while 1 in 10 (12%) attended some of them and 1 in 5 (22%) didn't attend any of the follow-up services offered. Across the UK & ROI, people gave a range of reasons for not using the follow-up support services offered at their GP appointment. These included practical and logistical barriers such as waiting lists, difficulty accessing services during their opening hours or in travelling to services, and difficulty in maintaining contact with the service. Other reasons included feeling that the type of follow-up offered was not appropriate to their needs or concerns and anxieties about accessing the support.

"I was given a place on a group for young people with severe anxiety but I didn't attend because I didn't feel comfortable talking in front of others. My problems were more serious than just anxiety as I was self-harming at the time but no one knew."

Lived experience survey participant in Scotland

Barriers to seeking support from healthcare services

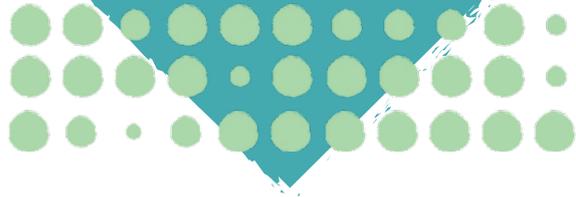
Our research and engagement also explored the reasons why people didn't seek support from healthcare following their most recent experience of self-harm, focussing on GP services.

Our lived experience survey found that some of the most common reasons people in Scotland gave for not seeking support from their GP surgery were:

- They didn't think it was serious enough to require support from a GP (63%)
- They didn't think their GP could or would help (37%)
- They didn't feel comfortable going to their GP about self-harm (36%)
- They didn't consider going to their GP (34%)
- They thought their GP would be judgemental (20%)
- They couldn't an appointment quick enough (15%)
- They had a previous negative experience seeking support from their GP (14%)
- They were concerned about confidentiality (14%)
- They had heard about negative experiences of seeking help from a GP (6%)

One in three (31%) said they didn't seek support from their GP because they were already in contact with mental health services, while 6% said they were already getting the support they required elsewhere.

The most common reasons for not seeking support from a GP were broadly consistent between people in Scotland and respondents across the UK & ROI.



Additional detail from participants in our Lived Experience Survey reveal a range of experiences which led them not to seek support from their GP. Here's what some participants in Scotland told us:

"Although my GPs have been nice I have had previous bad experiences with NHS mental health services, which did me more harm than good, so from now on I prefer to avoid the NHS for mental health problems if I possibly can."

"I was hitting myself in frustration of myself. I was suffering from low self-esteem so I would bang my head off walls, slap my own face etc. I didn't think that was serious enough to see a doctor about."

"I was scared about what would happen if I spoke to them about it."

Our research with Samaritans volunteers highlighted a number of barriers to help-seeking including long waiting lists and a lack of appropriate services, as well as concerns around the attitude/judgement of frontline workers.

One volunteer said: "Callers tend to express negative experiences of stigma (from family, friends, employers, colleagues, health professionals), which seems to be at the root of many issues in accessing support. Many people want to find support, but are prevented by long waiting lists and exclusionary criteria, or find it difficult to get the kind of support which is right for them. Some forms of support assume what people will be looking for, or aren't aware of the ways in which some activities or formats can re-traumatise people."

"There is help for dealing with flesh wounds, but little help for the emotional issues behind the self-harming. Even then, [people] are sometimes made to feel like they are wasting hospital time."

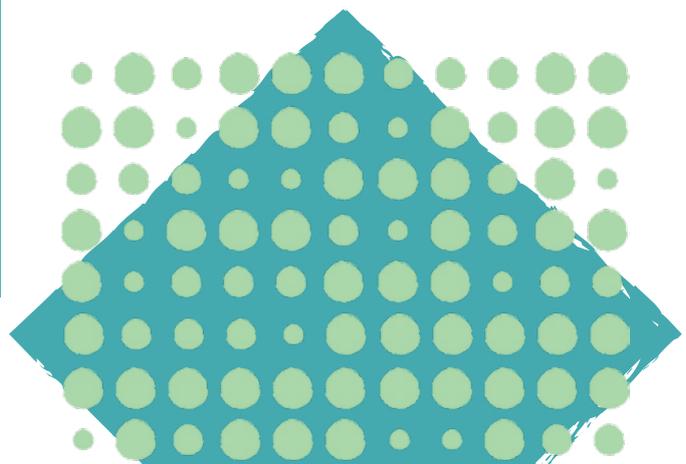
Samaritans volunteer

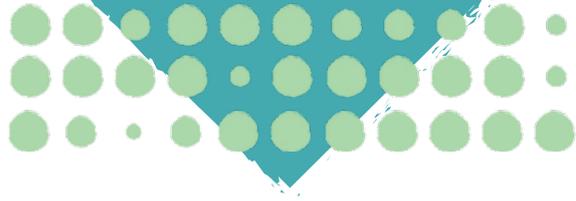
Discussions with stakeholders working across sectors highlighted a number of barriers to seeking support from health and social care services. Some stakeholders highlighted that people want support but fear a loss of agency and control and may have concerns around the consequences of disclosing self-harm. This could include concerns that health and social care professionals will seek to stop them from self-harming completely, when individuals may still view self-harm as a way of coping with difficult emotions and experiences. Other consequences could include concerns about confidentiality or the possibility of mandatory treatment.

Challenges and opportunities for healthcare, social care and emergency services

Throughout our engagement, stakeholders working across health and social care services expressed a clear ambition to provide a compassionate response to self-harm and a high level of person-centred care.

Among these stakeholders, self-harm was widely understood to be a response to emotional distress and for many people it serves as a way of coping, though our research suggests self-harm offers only temporary relief and does not address the underlying causes of distress. Stakeholders also recognised that self-harm was not necessarily linked to a particular diagnosis, though mental illness was often viewed as a significant factor that contributed to self-harm, alongside non-health related factors.





Stakeholders working in health, social care and the emergency services highlighted a number of principles that characterised a compassionate and effective response to self-harm including addressing the immediate, physical harm as well as the underlying distress and challenges which led to the person self-harming. They also highlighted the importance of a non-judgemental approach that focussed on an individual's specific experience, circumstances and needs. There was broad recognition that addressing the underlying factors which led to self-harm would generally require some form of follow-up support, though this would not necessarily be clinical in nature and stakeholders spoke positively of the role of community and third sector services and of engaging with wider support networks which surrounded the individual.

While there was a clear ambition to provide consistent, compassionate and person-centred care for everyone who sought support for self-harm, stakeholders also highlighted a number of barriers which made realising this standard across services challenging.

Training and awareness was identified as a clear need across services to ensure frontline professionals had the knowledge and confidence to respond to self-harm safely and appropriately. Some stakeholders also highlighted that existing examples of good practice often relied on committed and informed individuals acting as advocates within the context of their particular service, but there are obvious challenges in how this good practice can be replicated and standardised.

Stakeholders emphasised the importance of tailoring support to individual needs and circumstances, particularly as the underlying factors and intentions behind self-harm could vary from person to person. However, they felt realising this ambition requires flexibility and trust so that frontline workers felt empowered to take a person-centred approach and a range of options for follow-up support.

Stakeholders shared that a general lack of appropriate services or long waiting lists, rigid criteria for certain types of support or geographical variation in the types of support available locally, could all create challenges in responding to individual needs and circumstances. Some stakeholders felt existing systems were not well equipped to deal with the complex factors that contributed to self-harm, which often encompassed a mixture of health and non-health challenges. And some spoke of personal frustration and sadness when an individual had taken what is often a difficult step of seeking help, but where frontline workers are unable to refer them to appropriate support, either because the support doesn't exist locally, or because there are barriers to access such as waiting lists or rigid eligibility criteria.

While stakeholders working in the health, social care and emergency services generally felt that community and third sector services could play an integral role in expanding the range of support available they also highlighted challenges around the awareness and sustainability of these services. There was a sense that referrals to these services often relied on the local knowledge of the frontline worker. Community databases and link-workers were identified as resources which could improve awareness of and referrals to non-clinical support services.



Conclusions and recommendations

Our research and engagement has helped us to develop a more detailed picture of self-harm in Scotland. We know that data suggests self-harm is becoming more common in Scotland, particularly among young people. We know self-harm continues to be stigmatised and poorly understood and that this can deepen isolation and discourage help-seeking. And we know that people's experiences of seeking support in connection with self-harm are varied and that frontline workers, friends and family may feel unsure of how to respond.

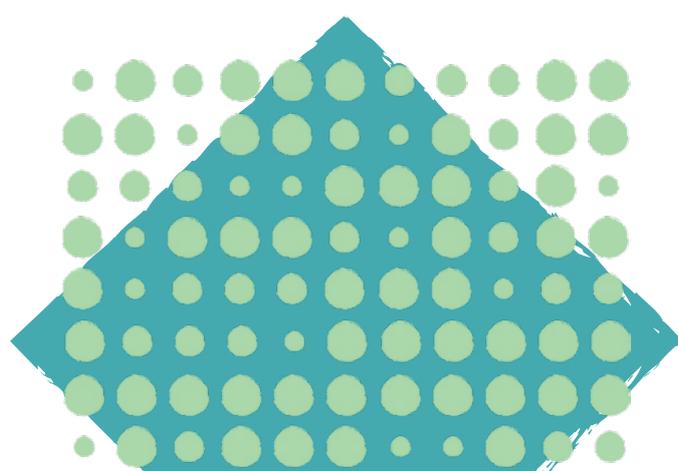
The process of developing this report also identified a number of opportunities to deliver a step-change in our understanding of, and response to, self-harm. Our research with people who have lived experience of self-harm found that most people do seek support at some point over their lifetime from a broad range of sources. And where people do seek support, they were more likely to report an improvement in their mental health over the medium to long term.

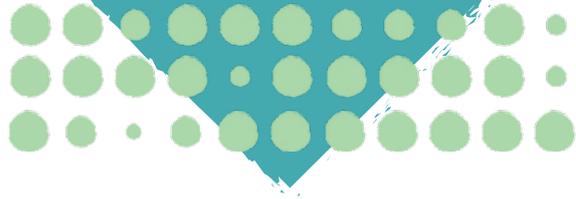
Contributors to our report recognised people may seek support for self-harm from a wide spectrum of sources including formal and informal sources which can overlap and interact. In particular, our research with people with lived experience highlighted the role of social support from family, friends and peers, who may act as a 'hidden frontline'.

Our discussions with stakeholders revealed a strong, cross-sector ambition to reduce stigma, strengthen support and address the underlying causes of emotional distress that can lead to self-harm. Among frontline services there was a clear desire to respond with compassion and provide the right support at the right time.

A national strategy on self-harm would provide renewed focus and leadership, harnessing this ambition to strengthen support, reduce risk and address the underlying causes of self-harm. Developing this strategy requires an ongoing conversation, one that is further shaped by the voices of people who have lived experience of self-harm, as well as with families and communities, and with stakeholders working across services and sectors.

Our intention through these recommendations is to highlight the principles, challenges and opportunities that emerged throughout our research and engagement, which we believe a future strategy should address.





Key principles for a new self-harm strategy for Scotland

Development and delivery of a future self-harm strategy should be informed by the following key principles which emerged over the course of our research and engagement.

➤ By summer 2021 a new Scottish self-harm strategy should be developed which works in tandem with suicide prevention, mental health and public health policy.

Scotland has a particular opportunity in 2021 to take forward a new approach to self-harm. The Scottish Government and CoSLA have already accepted that a new, long-term suicide strategy should be developed next year, building on the foundations of the current Suicide Prevention Action Plan. Given the lack of focus on strategic self-harm policy in Scotland in recent years, there is the chance to re-invigorate focus through a bespoke self-harm strategy which works in tandem with this development, and which also links to wider ongoing work, such as the Transition and Recovery Plan for Mental Health and the Children and Young People's Mental Health and Wellbeing Programme Board.

We would note that discussions with stakeholders emphasised that while there are clear areas of overlap between self-harm, suicide prevention and wider mental health policy, self-harm requires a distinct approach. Stakeholders expressed concerns that positioning self-harm within suicide prevention alone may overlook the distinct intentions and experiences of people with lived experience of self-harm, leading to policy and service approaches that don't fully address their needs and concerns.

➤ Scotland's new self-harm strategy requires a clear definition of self-harm and clear aims

Stakeholders highlighted a range of behaviour which could be considered self-harm and emphasised that understandings and experiences of self-harm may vary among different demographic groups. There was a strong feeling that self-harm policy should take an inclusive approach and that the definition of self-harm it adopts should be informed by people who have lived experience.

Stakeholders also highlighted the need to consider the objectives of a self-harm strategy. Views were mixed on the degree to which a future strategy should focus on harm prevention versus harm reduction. Some stakeholders warned that focussing solely on prevention could alienate those who use self-harm as a way of coping, and that policy and services should focus in the first instance on minimising harm for individuals who have self-harmed while supporting them to address the underlying causes of distress. Others emphasised a more preventative approach focussed on reducing population-wide risk factors for self-harm and addressing the connection between self-harm and suicide explicitly.

Through engaged development, Scotland's future self-harm strategy should seek consensus on the aims of the strategy in relation to self-harm prevention and harm reduction.

A new self-harm strategy must be collaborative and inclusive throughout development and delivery

Many of the stakeholders we spoke to highlighted the importance of an inclusive and collaborative approach that recognises how demographic and cultural differences affect understandings and experiences of self-harm. A future self-harm strategy must be informed by a broad range of perspectives and shaped by people with lived experience. In particular, a future strategy should consider how policy and services can mitigate barriers to support arising from inequality and ensure that support is relevant and appropriate to the needs of different demographic groups.

Given the importance of coherent leadership in a new strategy we would urge cross-party support for such a strategy.

A self-harm strategy should support coherent cross-sector working to address underlying causes

Self-harm is complex and individual experiences will vary. Self-harm should not be viewed in isolation; there is a range of factors which may co-exist with or contribute to self-harm including experiences of mental illness, bullying and abuse, drug and alcohol issues, and trauma. A future strategy should support cross-sector working to address the underlying causes of self-harm; it must not only address the expressions of distress.

There is already a plethora of government groups, collaboratives and programmes underway which touch on areas of self-harm and underlying causes. For example, the aspirations of the Children and Young People's Mental Health and Wellbeing Programme Board – which include those on reducing CAMHS waiting times and

improving community support – must be realised as a matter of urgency for any new approach to self-harm to have impact. Similarly, existing commitments on link workers in General Practice could play an important role in delivering a new approach. A new Scottish strategy and action plan must focus on shaping a coherent response which complements, enhances or challenges existing work, where appropriate.

There must be transparent accountability for successful delivery

Across our discussions with stakeholders there was a sense that the lack of national strategy and leadership had led to a lack of accountability around self-harm. There was a strong sense that any future policy must include clear actions, measures and timeframes if it is to lead to meaningful change. In 2011 the Scottish Government published a report mapping out actions to improve responses to and support for self-harm in Scotland⁴⁵. It is not clear to what extent recommendations from this report were implemented, but we note that this report was not mentioned once in any of our engagement with stakeholders.

Any new strategy must be accompanied by a detailed implementation plan and full evaluation framework to support improvement and ensure well-targeted investment and focus.



Key themes for a new strategy

Our research and engagement suggests a future self-harm strategy should explore the following key themes. We do not expect this list to be exhaustive, but we intend it to prompt a further civic discussion on the practical deliverables any new strategy should focus on.

Developing data and evidence to inform policy and services

Existing data and evidence around self-harm offers an incomplete picture of experiences of self-harm in Scotland. A future strategy should consider ways to develop and deepen our evidence base to inform policy and services. This should include robust research and evaluation to understand the types of interventions and support that are most effective for people who self-harm and develop best practice.

Discussions with stakeholders highlighted a number of areas where further insight could help to inform services and policies, including how self-harm is experienced by different demographic groups, the underlying causes and motivations behind self-harm and the types of intervention and support that are most effective for people who self-harm. Stakeholders raised concerns that an incomplete understanding of self-harm could lead to policies and services that fail to recognise or meet the experiences of certain groups or lead to ineffective or inappropriate interventions.

Developing evidence-based, safe and effective self-care tools and techniques that work alongside other support sources

Self-care emerged as a one of the most common types of support people sought out in connection with self-harm. However, because self-care is often private and personal, we have limited evidence on what types of self-care people use in connection with self-harm and how effective these tools and techniques are. Identifying and evaluating effective self-care techniques and tools should be a focus of further research.

Through our lived experience survey and engagement with stakeholders, self-care and, in particular, the role of digital support tools like forums and apps were highlighted as an area for development and improvement. External support services such as healthcare should consider their role in supporting people to identify and maintain safe and effective alternative coping mechanisms. Public awareness campaigns and education should consider how to foster mental health literacy to support people to navigate self-care information and techniques and identify safe and effective support mechanisms that meet their needs. This is particularly important in the context of online spaces, where research shows internet-use can provide a valuable source of information and support but where there are clear risks relating to online content which may glamourise or encourage self-harm and/or suicidal behaviour.



Increasing public understanding and awareness to strengthen the 'hidden frontline' of informal support networks

Among stakeholders there was a sense that limited public understanding and awareness around self-harm impaired the ability of informal support networks – like family and friends – to respond to self-harm. This is reflected in our public perceptions survey which found that two in five (40%) adults in Scotland would not know how to support someone close to them who was self-harming⁴⁶.

Our research and engagement found that these informal networks often act as a 'hidden frontline' and may be the first source people turn to in connection with self-harm but experiences of seeking support from family and friends were mixed. Family and friends may feel unsure of how to respond to self-harm and provide support. Stakeholders also highlighted that supporting someone with self-harm could be difficult and distressing, and emphasised the need to support partners, parents, and families in addition to the person who is self-harming.

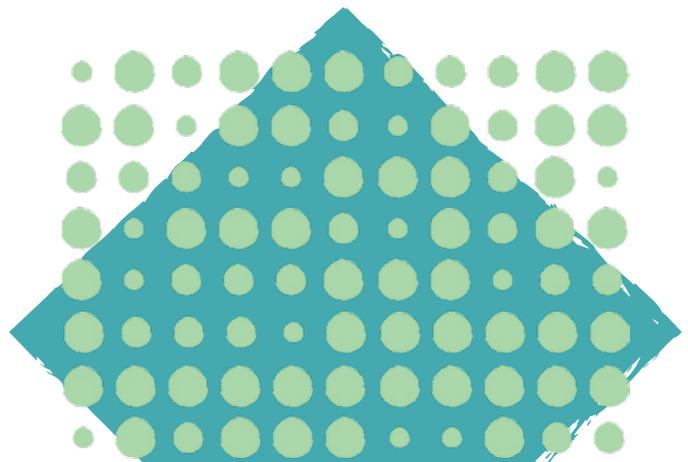
A future strategy should recognise the vital role that this hidden frontline of support from family and friends plays, and explore how this role can be strengthened by increasing understanding of self-harm and supporting partners, parents, families and friends to respond with compassion, while still looking after their own needs.

Realising the potential of education and youth services to support early intervention and increase mental health literacy

Self-harm often emerges in adolescence and throughout our research and engagement, education and wider youth services were highlighted as an important and potentially under-utilised source of support.

Stakeholders highlighted the potential role for these services in supporting early intervention, by recognising and responding to signs of emerging self-harm. Our discussions with stakeholders also highlighted the potential role education and wider youth services could play in developing mental health literacy, equipping young people to understand the emotions and the triggers which can lead to self-harm and to identify alternative coping mechanisms and sources of support. However, there was a strong sense that further training, tailored to education and youth settings, was vital to ensure professionals had the knowledge and confidence to discuss and respond to self-harm in ways that were safe, age-appropriate and non-judgmental.

A future strategy should recognise the crucial role education and wider youth services can play in early intervention and mental health literacy, and how this role can be strengthened through sector-specific training.





Developing consistent, compassionate responses to self-harm across services and communities

Our research and engagement found that support did not always meet the needs of people who self-harmed and that frontline services were not always able to offer the compassionate, person-centred approach they aspired to.

Stakeholders from health and social care services, and from wider sectors, highlighted the need for further training to ensure frontline workers across all settings understand the underlying causes and factors that contribute to self-harm, have the knowledge and confidence to respond to self-harm and an understanding of wider support available including community and third sector services.

A future strategy should explore the principles of a compassionate response to self-harm and best practice within different sectors and services to inform a consistent standard of support across services and geographies.

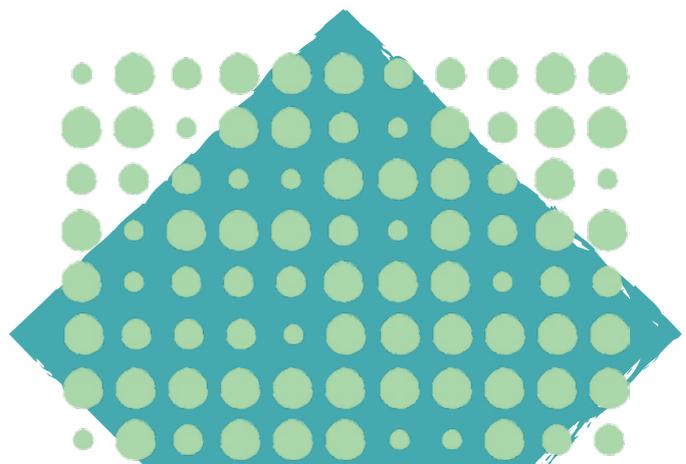
Investing in sustainable community support and third sector services so they are an integral part of the spectrum of available support

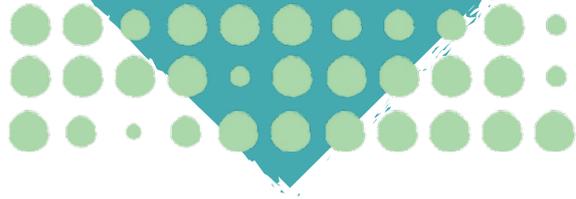
Among the stakeholders we spoke to, there was a strong sense across sectors that third sector services and communities already play a crucial role in supporting people who self-harm and in helping to address the underlying causes of emotional distress. Stakeholders also highlighted the potential of community support to provide the types of safe spaces and trusted relationships that encourage help-seeking and reduce stigma.

Many stakeholders felt this role could be strengthened through sustainable investment, training and improved systems to support signposting and referrals to and from more formal services like healthcare.

Next steps

In publishing this report our aim is not to provide all the answers. Instead we hope to prompt a renewed national conversation about self-harm in Scotland and the role that a future strategy could play in deepening understanding, reducing stigma, improving support and tackling the issues that lead people to self-harm. We look forward to continuing and widening engagement as we all work towards positive change in Scotland.





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The conclusions and recommendations made in this report are those of Samaritans alone and do not necessarily reflect the views of any organisation or individual listed.

Organisations who spoke with us included:

- Breathing Space
- Community Pharmacy Scotland
- Emily Test
- Families Outside
- Glasgow City Health and Social Care Partnership
- Inverclyde Health and Social Care Partnership
- Mental Health Foundation
- Mental Welfare Commission
- National Rural Mental Health Forum
- National Suicide Prevention Leadership Group - Academic Advisory Group
- National Union of Students Scotland
- NHS Greater Glasgow and Clyde Mental Health Improvement Team
- Penumbra
- Place2Be Scotland
- Police Scotland
- Public Health Scotland
- Queens Nursing Institute Scotland
- Royal College of Psychiatrists
- Samaritans Scotland volunteers and board members

- Scottish Association for Mental Health
- Scottish Mental Health Nursing Forum
- Scottish Prison Service
- The Junction
- Vox Scotland
- West Dunbartonshire Health and Social Care Partnership

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Project team

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The project team at Samaritans Scotland were:

- Mairi Gordon (report author)
- Rachel Cackett
- David Yule

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



Appendix: Methodology

This programme of 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.

Research objectives

- Understand what prevents people 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.
- Understand perceptions of self-harm among key stakeholder groups and their views of how policy and services can improve support and reduce self-harm.
- Understand public perceptions and understanding of self-harm

What methods did we use?

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| <p>Survey of people who have self-harmed (Lived experience survey)</p> | <p>An online survey was carried out among 900 participants across UK & ROI adults aged 16 and over including 102 in Scotland between September and December 2019. The survey sample was self-selecting and promoted through multiple channels including Samaritans’ website and social media channels and a wide range of organisations working on related topics. General descriptive analysis and sub-group analysis for key demographic groups. Anyone who had attempted suicide within the 6 months prior to completing the survey were excluded, in line with Samaritans research ethics policy.</p> <p>36% of participants across the UK & ROI were aged 16-25, 44% were aged between 25 and 44. 83% of the UK & ROI sample were female.</p> <p>In Scotland our data skewed towards younger age groups - this is likely due to the channels used to promote the survey. 57% of participants in Scotland were aged between 16-25, while 29% were aged between 25 and 44. 85% of participants in Scotland were female.</p> <p>Not all respondents answered all survey questions. Where our sample of Scotland was below 50 respondents we have supplemented with data from the UK & ROI sample. We have stated which sample we are using throughout this report.</p> <p>All data reported is significant to $p = <0.05$ unless otherwise stated.</p> |
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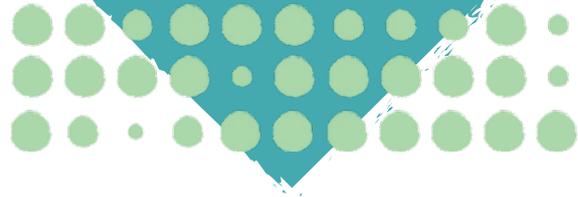


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| <p>Stakeholder engagement</p> | <p>We held four facilitated engagement sessions with more than 45 stakeholders working in Scotland across a range of sectors and services including health, social care, emergency services, education, youth work, third sector, research and government. These sessions explored stakeholders' perceptions of self-harm and its impact on the individuals and communities they support, as well as their views on how policy and services could strengthen support and reduce self-harm. These sessions were held under the Chatham House rule to allow stakeholders to speak freely. A list of some of the organisations we engaged with over the course of this work can be found in the acknowledgements.</p> |
| <p>Samaritans service data</p> | <p>In 2019, Samaritans gave emotional support 272,100 times to people who discussed self-harm, across a range of contact methods. The themes, or 'concerns', raised in these contacts were explored by demographic group, and compared to contacts where self-harm was not raised. As a confidential service, we record some statistical information on each contact but never collect or record personal data.</p> |
| <p>Survey of Samaritans volunteers</p> | <p>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 with lived experience of self-harm. The majority of the survey related to social and health concerns themes within the service data.</p> |
| <p>Literature review</p> | <p>To inform this research, three rapid reviews were conducted:</p> <ul style="list-style-type: none"> ● 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 (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 |
| <p>Public perceptions survey</p> | <p>This research was conducted by YouGov during September 2020 among a sample of 1,035 adults in Scotland, of which 994 were happy to answer questions on this subject. The survey was carried out online. The figures have been weighted and are representative of all Scotland adults (aged 18+).</p> |

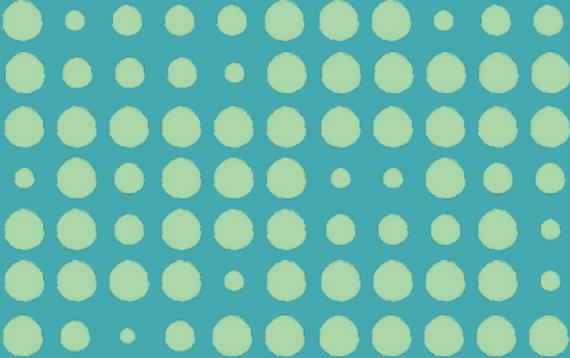


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