SUICIDE AND SELF-HARM IN YOUNG PEOPLE

A THEMATIC REVIEW

CHESHIRE EAST SAFEGUARDING CHILDREN BOARD

EXECUTIVE REPORT

JULY 29th 2014

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1. THE PURPOSE AND TERMS OF REFERENCE OF THE REVIEW

Following a number of completed suicides by 5 young people during 2012/2013, Cheshire East Safeguarding Children Board commissioned an independent Thematic Review to examine the cases and advise whether there were any identifiable themes, patterns or linkages between the cases. Four of the deaths were between April 2013 and November 2013. One death was in August 2012, in all making five deaths within a fifteen-month period of time.

In particular the author leading the Review was asked to:

- Examine four specific cases and make reference to other recent cases of suicide where appropriate and consider relevant factors in respect of an older care leaver who also died in the same time period
- Analyse the prevalence of completed suicides relating to young people comparing that information with national and international data.
- Determine any patterns, themes or linkages with the cases
- Examine multi-agency systems for risk assessment, monitoring and support in respect of young people’s mental health
- Consider information from other reviews
- Identify any learning for the Safeguarding Children Board and agencies in terms of working with vulnerable young people at risk of suicide or self-harm.

2. INDEPENDENCE OF THE REVIEW

The Review author is an Independent Child Protection Consultant. He is a former Assistant Director of a local authority Children’s Service and has substantial experience of chairing Local Safeguarding Children Boards. He has also led a number of Serious Case Reviews and Critical Case Reviews, including those where young people have died through suicide. The Review author is a qualified psychiatric social worker with extensive experience of work with vulnerable and at risk children and young people.
3. THE CASES - Common Themes

*Detailed information and analysis of the individual cases has been excluded from this published Executive Report in order to ensure anonymity.*

3.1 Four of the young people being reviewed were between 15 years of age and 17 years of age. One of the young people was over the age of 18 years at the time of death and therefore legally no longer a child. They were however included in the Review because of the relatively young age and also because there had been significant agency involvement with them and their family throughout their childhood. Of the five cases being considered 4 were male and one female. This mirrored national trends indicating the preponderance of males over females in completed suicides. It also mirrored national trends in that all of the young people were over the age of 15. Previous research indicated that the majority of young people who complete suicide are between 15 and 19 years of age (over 90%) making younger suicides rare.

3.2 One case was known only to universal services. In this particular case there were no suggestions of any previous concerns. The suicide seems likely to have been motivated by a perceived personal crisis that the young person was unable to resolve within their own resources. In this particular case the Young Person had withheld information from parents and peers, relating to external pressures on the young person. This highlights the vital role of protective factors such as support for young people, at times of crisis, from family and peers.

3.3 Four of the five young people selected hanging as the method of suicide. Some research (Gunnell et al 2010) suggests that significant factors influencing the decision to select hanging are the nature of the death and also accessibility. Those favouring hanging anticipated a certain, rapid and painless death with little awareness of dying. Materials for hanging were seen as being easily accessible. This perception has implications for preventative measures. It is noteworthy that at least two of the young people had
accessed “suicide sites’ on the Internet. These sites are clearly extremely unhelpful in the overall aim of safeguarding young people.

3.4 The research literature on teenage suicide also suggests a link, in some cases, between self-harm, suicide and unhappy families e.g. families where there may be, or have been, histories of difficult relationships between parental partners, which may result in domestic violence or safeguarding concerns. There was some evidence of these sorts of issues present, or previously having been present, in some of the cases reviewed in this study.

3.5 Four of the cases had been previously involved, or were currently involved, with Child and Adolescent Mental Health Services (CAMHS). There was a diversity of mental health concerns, ranging from moderate depression to ADHD to personality disorders. There is a significantly increased risk of self-harm and suicide when there are mental health problems. The majority of young people attempting suicide or self-harming do not have ongoing contact with mental health services. In the sense that four of the five young people were known to mental health services, there was identification that these were vulnerable young people with mental health problems.

3.6 There was evidence of substance misuse with three of the young people. This varied from “legal highs” to large amounts of alcohol and diverse drugs, including cocaine and ecstasy and cannabis. There is abundant research evidence of the association of alcohol/drug use and suicide attempts. Marttunen (1991), for example, reported that over 50% of adolescents who died by suicide had consumed alcohol before their death and that many were intoxicated at the time of their death. Some studies estimate that male adolescents with alcohol dependence are 15 times more likely to attempt suicide and female adolescents three times more likely (Esposito-Smythers & Spirito 2004). The increased risk of suicide or self-harm when intoxicated may be due to the associated decrease in inhibitions and resultant problems in adaptive functioning.
3.7 There was evidence of family histories of self-harming in four of the cases of the cases. A family history of self-harming is a relatively common feature in completed suicides and may have contributed to a model of behaviour when a young person is faced with adverse situations. Two of the young people had previously self-harmed, on several occasions and two others had disclosed suicidal thoughts. There is a heightened risk of completion of future suicide when there are previous suicide attempts. Overall, evidence suggests that repeat attempts at suicide should be deemed to be high-risk behaviour. There is also some evidence that, following discharge from hospital, that the first six-month to twelve month period is the highest risk for a repeated attempt. There is some tentative evidence from USA studies that repeat suicide attempts are lessened if family therapy is given as part of treatment programme following discharge from hospital.

3.8 Recent stressors are identified with several of the young people. Three of the young people were due to attend Court in the imminent future (either as defendants or to give evidence). This event appears to have been experienced by the young people as a major stress factor.

3.9 One young person was also “homeless” and this would have acted as an additional stress factor. Another young person had recently experienced the death of an influential extended family member, a particularly significant person in his life. He was also reported to be under stress because of bullying from peers.

3.10 The association between court appearances and suicide is not straightforward, although the National Strategy and Action Plan to Prevent Suicide in Scotland suggests “having a problem with the Police or a court appearance is an important factor in relation to the prevalence of suicidal thoughts” (Government of Scotland 2013).

3.11 There are some suggestions that suicidal thought takes place at an earlier age and is more common among young people than previously thought. Estimates of the prevalence rate of suicidal ideation show a wide
variation, however, there is a general consensus that suicidal thoughts are common among adolescents. The age of onset and the prevalence of suicidal ideation may have implications for the delivery of preventative programmes.

3.12 There were school-based problems in three of the cases evidenced by poor school attendance, on occasions, in two cases. In one case, there was virtually no school attendance during the young person’s secondary education years. This was largely due to the mother of the young person resisting agency interventions and also inaction by agencies.

3.13 One young person had “homeless” status. The others lived with their families. In the case of the young adult, they lived with their partner. Research evidence suggests that homeless young people are particularly vulnerable and should be viewed as a high-risk population. There seems a particularly toxic mixture of homeless status, drug/alcohol misuse and criminal behaviour that increases the vulnerability of young people.

3.14 One young person was gay. Rates of adolescent suicide attempts appear to be higher among gay, lesbian and bisexual youth than among heterosexual youth. Generally, the findings show significantly elevated rates for young people in same sex relationships, who have seriously contemplated suicide or attempted suicide. There is some evidence that these elevated rates are more likely to occur in males than females, suggesting a relationship between gender and sexual orientation with regard to suicide risk.

3.15 All of the young people, with the exception of one young person, were described as having poor impulse control with a negative self-image. There were frequent examples of sudden changes of mood, with impulsive and often high-risk behaviour. This is consistent with research findings suggesting that impulsive control disorders alongside disruptive behaviour disorders (conduct disorders), co-morbid with mood disorders, anxiety/depression or substance misuse significantly increase the risk of suicide.
3.16 In terms of criminal/anti-social behaviour, a number of the young people were both victims and perpetrators. It was particularly noteworthy that three of the young people were due to attend court in the very near future.

3.17 Some of these anti-social traits may have links to peer relationships. Of all of the young people, only one was described consistently as having good relationships with peers. There was some evidence of one young person being bullied as well as bullying others. Research findings have consistently demonstrated the relationship between difficulties in peer relationships (Hawton 1996, Ireland et al 1999) and suicidal ideation and suicidal attempts. There are a number of possible pathways in understanding the importance of peer relationships. Peer rejected young people experience greater levels of social isolation and low self-esteem. As an interpersonal stressor, victimisation (bullying) may be a direct precipant to suicidal behaviour. Peer rejected young people also experience difficulties forming and maintaining friendships. This is likely to lead to diminished levels of social support. Similarly young people who are rejected by peers are more likely to develop negative attributional styles, increasing the risk of depressive symptoms and in turn, decreasing problem solving capacity in relation to stressors. This seems particularly relevant to two of these cases.

3.18 One protective factor is the level of engagement and collaboration with support services. Agency information suggests that this was variable in relation to some of the young people. In one specific case there was a significant rejection by the young person of the mental health support services being offered.

4. METHODOLOGY

4.1 Information about each individual case was made available through the Child Death Overview process. This information contains brief reports from all agencies involved with the young person and their family. This information was supplemented through a series of group conversations, regarding each individual young person, between the Review author and representatives of the key agencies involved with the young person. In all there were five such
Practitioner meetings. In addition the Review author met with three groups of Practitioners in order to discuss the key themes of:

- Early prevention
- Interventions with high risk young people
- Bereavement work with relatives, friends and practitioners

There were also individual meetings held with a representatives of Public Health and also Health commissioning and safeguarding representatives in relation to CAMHS and the Learning Disabilities CAMHS Team Manager.

4.2 A matrix was developed and utilised, allowing comparative information about the young people to be analysed and common themes identified for further exploration. This matrix is excluded from this Executive Report in order to maintain confidentiality.

4.3 In addition to comparing the individual cases and their circumstances, current research literature on self-harm and suicidal behaviour in young people was examined. There were in particular three key elements that were considered:

- General community prevention strategies and school based primary prevention initiatives.
- Effective Interventions for high risk young people
- Support for bereaved families, peers and practitioners.

4.4 It was identified that there was a group of young service users who had received mental health services. They were willing to contribute to the review. Their input as a “voice” for young people was invaluable.

4.5 Additional documentation from Children’s Services was examined in relation to one specific case. This was to ensure that there was an accurate understanding of the key issues.
4.6 Parents of two of the young people indicated their wish to contribute to the Review. The major themes from this parental perspective were:

- One parent was dissatisfied with the level of inter-agency planning, and the involvement of the parent in that planning, relating to a CAMHS tier 4 in-patient facilities. The parent felt that this had worsened the situation and placed more stress on the young person.
- There was dissatisfaction with the local authority in offering an inappropriate placement several miles away from his family and peer support.
- Although the Young Person was homeless, they had not been offered accommodation within the home locality, thus limiting peer, family and work support.
- Another parent felt there had been significant problems in accessing CAMHS for both assessment and treatment.
- Both parents commented on the lack of information (including practical help) in dealing with the bereavement.

5. Suicidal and Self Harm Behaviour in Children and Young People – An Overview

5.1 Overall there were 4,215 suicides, covering all age groups, recorded in England in 2010 (aged 15 years and over). This data is based on the information provided at death registration. Most deaths are certified by a medical practitioner, however, suspected suicides must be certified after a coroner's inquest. A verdict of suicide can only be recorded when a coroner decides that there is evidence, beyond reasonable doubt that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts include cases where the evidence available is not sufficient to conclude that the death was a suicide (beyond reasonable doubt) or an accident (on the balance of probability. They include those deaths where there may be doubt about the intentions of the deceased.
5.2 Statistics on causes of death are produced by the Office for National Statistics (ONS) on an annual basis. In producing these statistics the ONS combines suicides and deaths of undetermined intent. This is based on research showing that the majority of open verdicts are “most likely suicides”. This means that the official suicide rates are measured by a definition of suicide that is wider than that used by coroners.

5.3 Over the past decade, there has been a general trend for a decrease in the overall rate of suicides. The average rate for 2008-2010 was 7.9% suicides per 100,000 population. This was 17.9% lower than in 1998-2000. There were indications of a rise in suicides in 2011.

5.4 The majority of suicides occurs in adult males. The difference in ratio between male and female suicides is around 3.1. The group with the highest suicide rate is middle-aged men in the 35-49 years age group.

5.5 Data suggests that the commonest methods of suicide for males are hanging, strangling and suffocation accounting for more than half of all male suicides. Along with drug-related poisoning these methods accounted for over a third of female suicides.

5.6 Of the total number of suicides it was estimated (2010 data) that 1078 suicides were by people in contact with mental health services in the year prior to their death. This indicates that a significant majority of those who died through suicide were not in contact with mental health services.

5.7 On a United Kingdom regional level, there were considerable variations between regions with the North East and the North West having the highest male suicide rates over the last ten years (over 15 years of age). Female suicide rates have tended to be highest in the North West and South West.

5.8 In an international context, the World Health Organisation places suicide as among the three leading causes of death among the 15 to 44 age group and the second leading cause of death in the 10-24 age group (May 2011
data). The highest rates of suicide were in South East Asia, with a particularly high rate for women aged 15-29 in South Korea. The lowest rates were in the Eastern Mediterranean region. It is of course recognised that countries use different definitions and collect data in different formulations; nonetheless the information does suggest that suicide is a global problem.

5.9 European Union data shows that the average prevalence rates in Europe are 13.9 per 100,000 population. This compares to a rate in England of around 8 per 100,000 populations. Men are almost five times more likely to commit suicide than women with particularly high rates in the Confederation of Independent States (CIS) followed by the newest European Union member states. Rates for example are particularly high in Lithuania at 30.7 per 100,000 populations.

5.10 There are significant problems in establishing accurate rates of prevalence for suicide and self-harm in the population of young people. Different definitions and differing criteria for inclusion suggest that caution should be exercised in drawing conclusions. As indicated, suicide is a major cause of death on a global dimension. Suicide rates can vary depending on regional location, gender, age, ethnic origin and definitions used in death registration practices. Prevalence rates in adolescents cross nationally are reported as being 19.8% for suicidal ideation and 3.1% for completed suicide. One study, Windfur, (2008) concluded there had been a significant decrease in adolescent deaths by suicide in the years between 1997 and 2003. Overall however, suicide rates for the general population increased in 2011 and longer-term trends in relation to child and adolescent suicide will require close monitoring.

5.11 Suicide rates in those aged 10-19 years in the United Kingdom declined by 28% in the seven-year period from 1997 to 2003. This decline appears to have continued until 2010 when there was a rise between 2010 and 2011. Despite this general decline in numbers, however, there were still 1,722 adolescent and juvenile deaths by suicide in this period. This number represented 4% of all suicides. Recent data from the Office for National
Statistics (September 2012) indicates that the majority of suicides continue to occur in adult males. The group with the highest suicide rate is now middle-aged men (35-49 years of age) at 20.8 per 100,000 populations. There continues to be significant gender differences in rates of suicide for men are approximately three times that of women. The most common methods for suicide appear to be hanging, strangling and suffocation along with drug related poisoning for women.

5.12 Overall the suicide rate in the UK is 11.6 per 100,000 populations with young males (15-24 years of age) at 13.3 per 100,000 populations. The incidence of suicide among younger adolescents, 10 years of age to 15 years of age is rare. Although the suicide rate among teenagers is below that in the general population, it is known that young people are vulnerable to suicidal feelings, the risk being greater when they have mental health problems or behavioural disorders, misuse substances, have experienced family breakdown, abuse, neglect or mental health problems or suicide in the family. The risk may also increase when young people identify with others who have taken their own life or there is sustained exposure to bullying.

5.13 There is also evidence that self-harm is common among young people, although the relationship between self-harming behaviour and completed suicide is complex. In the general population around half of people who die by suicide have a history of self-harm. One large-scale study of adolescent self-harming estimated that 16.7% of girls and 4.8% of boys, aged 14-17 years, reported an episode of self-harm (Madge et al). These percentages increased significantly to over 12% of boys and over 30% of girls when the participants reported experiencing thoughts about self-harm. Only a relatively low percentage of young people sought help following self-harm incidents or attended hospital.

5.14 High-risk populations of children and young people include those in custody within the Young Person’s Secure Estate and those young people who are homeless (between 2002 and 2012 six young people in custodial settings have died through suicide).
There are linkages between the status of looked after children, including care leavers, and self-harm in adulthood. This group of children is between four and five times more likely to self-harm in adulthood. They are also at a significantly increased risk of all childhood mental, emotional and behavioural problems, including conduct disorders.

5.15 One particular statistic from a study published in 2008 looking at data between 1997 and 2003 showed that rates in this period declined significantly by 35% in young males. The same study however found that only 14% of young males were in contact with mental health services in the year prior to their death (this compares to 20% of young females).

5.16 There are a number of factors associated with an increased risk of self-harm and suicide in children and young people:

- Mental health problems (including depression, hopelessness
- Family relationship problems (including parental mental health problems, substance misuse and domestic violence)
- History of suicidal or self-harming behaviour (attempted or completed) within the family or with close friends
- Isolation (social, familial or geographical), including homelessness
- Criminal behaviour, particularly youth custodial settings
- Low self image
- Experience of bullying (as victim or perpetrator)
- Stress associated with academic or work related performance
- Drug or alcohol misuse
- Bereavement
- Experience of abuse or maltreatment
- Problems associated with sexual orientation
- Perceptions of loss in close or intimate interpersonal relationships.
Protective factors appear to focus on:
- Support from family or peers
- Capacity to problem solve
- Successful integration in settings such as school or work.

6. **The Position in Cheshire East**

6.1 On a regional level male suicide rates (all ages) have tended to be highest in the North East and the North West and lowest in London and the East of England. Female suicide rates (all ages) have tended to be highest in the North West and South East and lowest in Yorkshire, the Humber and the West Midlands. There is no clear understanding of why regional rates are variable. The rate in Cheshire East for deaths by suicide of children is highly variable because of the very small numbers of children and young people who die through suicide. In 2003 and 2005, for example, there were 2 deaths through suicide in each of those years. This gave a rate of 9.61 and 9.33 per 1000,000 populations respectively. This compares to a national rate for young people in those years of 4.20 per 100,000 populations. There were several years, however, when there were no child deaths recorded in Cheshire East, because of suicide. In the three-year period 2009-2011, for example, there were no recorded deaths through suicide.

6.2 The number of deaths of young people, under the age of 19 years that occurred between August 2012 (1 death in 2012) and October 2013, (3 deaths in 2013,) is therefore much higher than expected. Overall one would expect to see 1 suicide per year on average in Cheshire East. This expected rate, of course, would need to be observed over several years to factor in the annual variations in rates.

6.3 There were two deaths in the next age group 20-24 years of age) in 2013. The relatively small numbers does mean that identifying longer-term patterns and themes is problematic. There is a possibility for example that relatively higher numbers in one particular year are a statistical anomaly.
6.4 This raises questions about the possibility of “cluster” suicides in young people. Suicide clusters are defined as an excessive number of suicides in close temporal and geographical space. There is usually an association between individuals who are socially connected through shared characteristics. It is estimated in International studies that about 2% of all suicides occur in clusters (Jones et al 2013).

6.5 The US centers for Disease Control and Prevention defines a cluster as “a group of suicides or suicide attempts or both, that occur closer together in time and space than would normally be expected in a given community”. Often the analogy of “contagious illness” is used, suggesting that there is an imitation of suicidal behaviour, often associated with media and social networks. In Bridgend, South Wales, for example there was a possible “cluster” of suicides of young people (aged 15 to 34 years) during 2007-2008. It should be emphasised that the resultant early media attention in this case tended to overstate the phenomenon and may have had a subsequent impact on the continuation of suicidal behaviour. This raises very serious questions about how the media report suicide and the influence of agencies in constraining sensationalist reporting.

6.6 When there is a tragic event such as the suicide of a young person, it is likely that this will be reported in the media. There is substantial evidence that the reporting and portrayal of suicidal behaviour by the media may have potentially negative influences and facilitate suicidal acts by others. This evidence seems to apply to newspaper and television reports of actual suicides as well as film and television portrayals of suicides (Hawton K (2002). The impact of the media on suicidal behaviour seems to be increased when the method of suicide is specified in detail or when the story is portrayed in a dramatic style. Because of this issue, any suicide prevention strategy should seek to engage the media and encourage sensitive reporting or portrayals of suicide.
6.7 There is no clear evidence of why cluster groups start, their evolution and how they spread is unclear. Some of the suggested strategies to manage potential cluster situations include:

- Avoid glorifying suicides
- Offer support to families and friends of victims
- Identify vulnerable relatives and friends and offer counseling
- Enlist the support of the media.
- Ensure that there is early action by agencies when problems start emerging.

6.8 In terms of the deaths of the five young people in Cheshire East, there were no obvious links or social connections between the young people. There was also no evidence from “suicide notes” or social networking interactions that there was any direct influence of any of the early suicides that may have lead to other suicide attempts by young people. It will be important to actively monitor this situation over the coming 2-3 years before a more clear view can be formed about whether these events are a statistical anomaly or a geographical cluster. There is, however, an issue about the management of information to the public and the preparedness of agencies to manage should these tragic individual events evolve into cluster dimensions. There was no evidence that agencies had “thought through” how they might manage a situation where there was cluster development.

7. **Self-Harm**

7.1 The relationship between self-harm and suicide is extremely complex. It is apparent from a review of the research and self-reporting from young people that in the majority of cases self-harm is not intended to kill. Most commonly self-harm was used for the relief of intensely difficult feelings and self punishment, but many young people also expressed a wish to die. There is some evidence that different forms of self-harm may indicate relatively higher risk levels. Overdoses or hanging attempts, for example, may indicate suicidal intent more than cutting incidents. The National Institute of Clinical Excellence
(NICE 2002) in a Scope Report states that those who have self-harmed are one hundred times more likely, than the general population, to die through suicide in the subsequent year. The same NICE Report also states that half the people who die by suicide each year will have self-harmed at some time in the past. The prevalence and impact on children, young people and their families or care-givers makes the issue a serious public health problem.

7.2 One large-scale study across seven European countries identified high levels of self-harm in all of the countries (Madge et al 2008). Findings from the study echoed previous themes, notably that girls were more than twice as likely to hurt themselves as boys and many young people did not seek medical or other types of professional assistance.

7.3 Self-harm is the primary reason for over 140,000 admissions to A&E departments in England and Wales every year, mostly as a result of self-poisoning. It is known that these hospital admissions are only a small proportion of the total number of people estimated to self-harm. Estimates of the prevalence of self-harm are largely based on self-reporting. The Child and Adolescent Self-Harm Study (2005) based on the responses of 30,000 15 and 16 year olds in Europe indicated an extremely high rate of 70% of respondents admitting to self-harm. Several UK and international studies confirm that self-harm in adolescence is relatively common behaviour. Prevalence rates, from the research, suggest that one in 15 young people in the UK (aged 11-25) harm themselves deliberately.

7.4 The most common methods of self-harm involve repeatedly cutting the skin, burning, scalding or scratching one’s own body, breaking bones, hair pulling and ingesting toxic substances (Mental Health Foundation 2006). Most commonly, self-harm was used by young people for the relief of intensely difficult emotional feelings. In essence, the relief of psychic conflict was aided by physical pain, although this was not always successful. Only a small proportion of young people who harm themselves will eventually complete suicide. This is consistent with findings that very few young people who think about suicide will do so. It also confirms recent findings that thinking about
suicide, (but not acting it out), is more common than many professionals have been aware of.

7.5 Although research offers a good deal of information about risks factors, there remain serious problems with identifying, in individual cases, whether a young person, who is self-harming, is likely to take their own life. Contemporary approaches advise that for young people attending A&E departments at hospitals there should be an assessment of need as well as an assessment of risks and protective factors (The Royal College of Psychiatrists 2010). The same Report comments on the often, poor quality of assessments, of people who have self-harmed, that are undertaken. The Report, in undertaking a survey of Royal College members, concluded, “fewer than 50% of respondents consider that they (or their team) had the training to undertake psychosocial assessments of risk and need with people who had harmed themselves”. The respondents also expressed dissatisfaction with the expertise of their own profession and also other staff, nurses, doctors, social workers, paediatricians, police and prison staff. These findings are particularly pertinent in the context of research information suggesting that the level of suicidal intent involved in self-harm may vary considerably for different individuals, within a short space of time (Granello 2010). This means that assessment, even good quality assessment is only valid for that given point in time.

7.6 There is some supporting evidence confirming this lack of expertise. Analysis of Serious Case Reviews, for example has consistently found that overall assessments are of poor quality and have a tendency to be static, failing to appreciate the dynamic nature of behaviour and environmental factors (Brandon et al 2012).

7.7 There are also some indications from research (Palmer et al 2009) that people attending A&E departments because of self-harm, in a significant minority of cases, were blamed for wasting time as staff felt that the problems were self inflicted.
7.8 In undertaking this Thematic Review, it was apparent in discussions with a number of practitioners, from different disciplines, that there were anxieties about being able to identify those young people who were self harming who may go on to complete suicide (high risk cases).

7.9 The Mental Health Foundation sets out some of the key stressors that may trigger self-harming. These are largely factors identified by young people:

- Being bullied at school
- Not getting on with parents
- Worry about academic performance
- Parental divorce
- Bereavement
- Unwanted pregnancy
- Experience of abuse in early childhood
- Difficulties associated with sexuality
- Problems related to race, culture or religion
- Low self-esteem
- Feeling rejected

7.10 All of the information available on deliberate self-harm suggests that such behaviour should be taken seriously. Young people who are engaged in self-harming are often, severely distressed, have significant emotional problems and have experienced severe trauma. Childhood abuse, loss and rejection with their families are relatively common, as is exposure to suicidal behaviour, or self-harm within families, are all factors that increase the risk of self-harming and suicidal behaviour. Current stressors such as bullying, social isolation and homelessness add to the level of risk. There are additional internal factors such as poor problem solving skills and high levels of impulsivity and aggression that further elevate risks.
7.11 Self-harm is not in itself a mental disorder and is in all probability an adaptive response to severe distress, however the level of diagnosable mental health problems in young people is significantly higher among self-harmers than the general population.

The Situation in East Cheshire

7.12 Statistical Information on self-harm in young people in Cheshire East and the North West region is collated and analysed by the North West Public Health Observatory. This information is made available in the form of a Briefing Report. In collecting this information, there is an acknowledgement that “it is difficult to quantify the proportion of children who are affected by self-harm. Published prevalence figures are likely to underestimate the true degree of self-harm among children and young people because it is often a hidden and secretive behaviour and young people are reluctant to admit to or talk about it” (North West ChiMatters July 2011).

7.13 This Briefing Report, from the North West Public Health Observatory, looked at data on attendances at accident and emergency departments by children and young people aged 0-18 years as a result of self-harm between January 2007 and December 2009. It was not possible to include information from Cheshire as data was only available from two Cheshire hospitals. Similarly, some information from Greater Manchester was excluded because the data was incomplete. The available data did show that the emergency hospital admissions of North West resident children for self-harm, equated to an emergency hospital admission rate of 179.9 per 100,000 populations. This is the second highest regional rate in England and is significantly above the England average of 137.8 per 100,000 populations.

7.14 Within the North West region, the rate of child emergency hospital admissions for self-harm varies from 119.9 per 100,000 population to 373.7 per 100,000 population. The following table sets out the rates for individual authorities.
Sourced from NWPHO Hospital Episode Statistics and Office for National Statistics (June 2011)

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<th>LOCAL AUTHORITY</th>
<th>RATE OF ADMISSIONS</th>
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<td>Blackburn with Darwen</td>
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<td>Blackpool</td>
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<td>Trafford</td>
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<td>Warrington</td>
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<td>Wirral</td>
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<td><strong>North West</strong></td>
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<td><strong>England</strong></td>
<td><strong>137.8</strong></td>
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7.15 As indicated Cheshire East is ranked at number 12 out of 23 local authorities. It is significantly higher than the England rate, but average for the North West rate. As emphasised earlier, these rates are only of hospital
admissions and figures for deliberate self-harm, in various forms, where there is no hospital admission, will be much higher than these figures.

7.16 It was not possible to extract, from the recorded data, the type of self-harm or the proportion of young people who were referred on to specialist services. Discussions with practitioners indicated that there was a protocol in place whereby young people who are admitted from A&E because of deliberate self-harm, are seen by a CAMHS Mental health practitioner the following day at Hospital A, and within two working days at Hospital B. They would normally be admitted to a Children's ward overnight. Information, by letter, is sent by A&E to the GP and school nurse, informing them of the attendance. Children's Social Care would also be informed, through the Trust Safeguarding Unit, if there appeared to be any child safeguarding concerns. It was unclear from discussions with practitioners whether teaching staff were informed by school nurses about the self-harm attendance at A&E. Generally teaching representatives did not think that they were made aware of many incidents of self-harm where there had been attendance at A&E departments.

There were also some concerns expressed by GP representatives about CAMHS services available for the 16-19 age group. The view was expressed that because of capacity issues, the 16-19 age group were not receiving an adequate service. Some young people in this age group referred by their GP’s to CAMHS, for example, had not been seen by CAMHS because of these capacity problems. It is understood that this is an issue that has been acknowledged within the CAMHS Service and that there are current discussions taking place to resolve the problem. This is addressed as a recommendation.

8. National Initiatives

8.1 The key strategic central government guidance is the National Suicide Prevention Strategy, a cross-Government strategy to save lives. The first Suicide Prevention Strategy was published in 2002 and was revised and updated in 2012. This section summarises that main findings and key issues contained in the Suicide Prevention Strategy and Preventing Suicide in
England One year On. This section indicates what needs to be in place in order to deliver a suicide prevention plan.

- In January 2014 the Department of Health published Preventing Suicide in England One Year On. This was the first annual report on the cross Government strategy.
- Preventing Suicide in England One Year On outlines the latest trends in suicides in England. It summarises the findings of recent research into suicide prevention and suggests measures that local areas can take to prevent suicides and support those affected.
- It identifies particular groups at high risk of suicide; middle aged men, those affected by the economic crisis and people in contact with the Criminal Justice System and children and young people, and sets out what needs to be done to meet their needs.
- Preventing Suicide in England supports No Health Without Mental Health, the cross-Government strategy dealing with all aspects of mental health published in 2011.
- The Department of Health published setting out Government priorities for improving mental health in the next two to three years. This briefing draws on this document where appropriate.

Preventing Suicide in England is a ten-year strategy published in September 2012. It drew on the rich experience gained from the first suicide prevention strategy of a decade earlier. The strategy aims to reduce the suicide rate in England and better support those bereaved or affected. It identified six key areas for action:

1. Reduce the risk of suicide in key high-risk groups, such as young and middle aged men, people who receive mental health services, those with a history of self-harm, people in contact with the criminal justice system and those in specific occupational groups such as doctors; nurses; veterinary; and agricultural workers.
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

*Preventing Suicide in England One Year On* outlines the findings of recent research on suicide:

- *The effects of unemployment on suicide rates:* Recent studies reveal areas of England with high unemployment tend to have increased suicide rates. This is also borne out in international studies. Those in employment have also been affected by poor health as a result of the recession.

- *What works in suicide prevention:* One study found the implementation of 24 hour crisis care, improved support for those with dual diagnosis and multi agency reviews after suicides brought about the largest falls in suicide rates between 1997 and 2006. Another found that improved discharge planning for mental health inpatients including follow-up with seven days led to a drop in repeat self-harm.

- Another found that rates of repeat self-harm reduced if a patient received a psychosocial assessment – only half of patients receive such assessments at present. A further study suggests treatments like Cognitive and Dialectical Behavioural therapies help prevent repeat self-harm. The Government plans to increase the number of people who access psychological therapies from 600,000 to 900,000 a year.

- People with physical conditions were found to be at higher risk of clinical depression, leading to higher suicide risk among this group.

- Lithium was found to be an effective treatment for people with mood disorders.

- There has been an increase in the number of suicides recorded as accidental deaths or death by misadventure, especially where the death involved poisoning.
Suicide Prevention in England One Year On highlights a range of practical measures that local areas can take to address the main causes of suicide.

8.2 Self harm
Half of those who commit suicide have a history of self-harm, so effective health promotion in the community and timely intervention at Accident and Emergency Departments are seen as key to suicide prevention. Local areas are encouraged to follow a new quality standard for the care and support to people who self harm published by the National Institute for Clinical Excellence (NICE). In its Spending Review the Government committed to ensuring mental health professionals are available in Emergency Departments at all times. The Care Quality Commission is carrying out a review of emergency mental healthcare including after self harm. The new Public Health outcomes Framework includes an indicator on self-harm which will help track the number of self-harm incidents at Accident and Emergency departments and the proportion receiving a psychosocial assessment. Local areas are encouraged to use this data to inform commissioning and service provision.

An example of good practice in relation to work with children and young people is given in the Report.

In Derby a Community Mental Health Liaison service, based at the Royal Derby Hospital, provides rapid support and discharge planning to all children who present with self-harm, suicide or acute mental health concerns. The service works closely with a Safeguarding Nurse to ensure effective joint working between acute, community and safeguarding services.

8.3 Mental health in a financial crisis
The report comments that although the economy is now growing, people facing unemployment, debt or homelessness may still be at risk of suicide. The report stresses the need to build strong, inclusive communities which are supportive to people who are unemployed or facing debt.
The Department for Work and Pensions provides guidance for staff working with vulnerable clients. It is also working with the Department of Health to see how mental health and employment support service can be better co-ordinated. A number of street triage services have been established to enable police and front line mental health workers to intervene more rapidly. The police, NHS Confederation, Home Office and others are developing a Crisis Mental Healthcare Concordat to ensure that offenders with mental health problems receive effective treatment and early intervention. The Government is also considering piloting Health and Criminal Justice Liaison and Diversion Services in 20 areas, to ensure that vulnerable offenders are placed appropriately and receive the right support.

8.4 Helping those affected or bereaved
The report stresses that friends and relatives are often the first to spot that something is wrong. They may be reluctant to approach professionals for fear of damaging their relationship or making things worse. Professionals are sometimes confused about what information they can share with relatives for fear of breaching confidentiality rules. The Department of Health has agreed a consensus statement with royal colleges to improve information sharing. Families who lose a relative to suicide often find it hard to access the support they need. The report urges local areas circulate Help is at Hand, a resource for those bereaved by traumatic and sudden death, to relatives. New resources will be available in 2014-15.

1. As an example of good practice, Leeds Bereavement forum has produced a booklet outlining national and local sources of help.
2. Outlook South West runs a service to support those bereaved through suicide.

8.5 Children and young people
The report emphasises how schools and colleges have a key role to play in mental health promotion. A consortium of voluntary organisations is piloting new ways of providing mental health services in schools. Mental health will form part of the new Special Educational Needs Code of Practice to be
published in September 2014. This should enable children to access support more quickly. The report outlines how the internet can present risks to young people who are vulnerable. All internet providers are providing free, easy to use filters.

As an example of good practice, *Resilience and Results* is a guide to help schools support children and young people’s mental health.

### 8.6 What local areas can consider

The report concludes that now Clinical Commissioning Groups, Public Health Teams, Health and Wellbeing Boards and the National Public Health Outcomes Framework are in place there is an expectation that much of the planning and work on suicide prevention will take place at local level. A report by the All Party Group on Suicide and Self-Harm Prevention in 2013 found that over a quarter of authorities had no suicide prevention plan in place.

**Recommendations**

*Preventing Suicide in England One Year On* recommends local areas:

- develop local suicide prevention strategies – if not in place
- track and monitor suicide trends
- engage with local media regarding suicide reporting
- work with partners like transport to identify suicide hotspots
- work to improve mental health generally.

### 8.7 As an example of good practice

Bolton’s Suicide Prevention Partnership is in its sixth year. It has a Suicide Prevention Strategic Framework with measures to lower suicide risk in the general population and high-risk groups. The suicide rate in Bolton fell from 12.9 in 2008-10 to 12.0 in 2009-11.
Comment
The Government wants the *Preventing Suicide in England* strategy to be a dynamic document, responding to new innovations in research and service provision. *Preventing Suicide in England: One Year On*, the first annual report on the delivery of the strategy, provides a relatively concise summary of current research and good practice in suicide prevention. The research findings will be of particular interest to non-clinical professionals who may not have ready access to medical journals.

8.8 As an estimated one in four people in the UK can expect to face some form of mental health difficulties sometime in their lives, suicide prevention is one part of a very large and complex continuum of mental health treatment and prevention activity. The mechanisms in place to support improved mental health in England reflect this, with the national mental health strategy *No Health Without Mental Health* and its implementation frameworks, the *Public Health Outcomes Framework* and a planned *Five Year Plan to Reduce Avoidable Deaths in Mental Health*. Some local areas may feel that incorporating suicide prevention in wider mental health, public health and community planning processes might be a better way to ensure people most at risk get the services they need and that everyone acts to prevent suicides.

9. The Position in Cheshire East - Discussion
9.1 This section considers developments in suicide prevention in Cheshire East in the context of Government initiatives and guidance on suicide prevention. It also draws on information from practitioner groups during the course of the Thematic Review and also case material from the five cases of suicide examined as part of this Review. Using a systems approach, the case material is used as a “window“ on wider systems to help identify weaknesses and strengths in working with self-harm and suicide prevention. The section has, for convenience, been divided into three sub sections:

- Prevention,
- Interventions with identified young people at risk
Supporting Families, Peers and Practitioners in the aftermath of Suicide.

**Prevention**

The Government guidance *Preventing suicide in England* (2012) called for the establishment of Local Suicide Prevention Plans. Whilst not a mandatory requirement, the development of such plans was seen as a key mechanism for delivering Suicide Prevention Strategies at a local level. The Cross Government Report published in January 2014 *Preventing suicide in England: One year on*, commented that one of the actions local areas could consider over the coming year would be “developing, If already not in place, a local suicide prevention action plan as part of local health and wellbeing work with clinical commissioning groups and other partners”.

A parallel Government All Party Parliamentary Group on Suicide and Self-harm Prevention (January 2013) strongly advocated the development of local suicide prevention groups in order to steer local implementation of preventative actions. This Parliamentary Group commented that there were local strategic plans in 75% of authorities with some additional authorities stating that they intended to implement local suicide prevention plans.

9.2 Some authorities have developed regional or sub-regional suicide reduction networks that offer advantages in sharing data and having a consistent approach across the region, with common priorities. This is the position in Cheshire East, where there is not, at present, a local suicide prevention strategy. Cheshire East is, however, a member of a sub-regional group across Cheshire and Merseyside, consisting of nine local authorities with a collaborative approach to suicide prevention.

9.3 There is a strong focus from Public Health in Cheshire East on a reduction of substance misuse among young people. This is particularly relevant to alcohol, drugs. There are also links made to smoking in the knowledge that young people under 15 years of age are potentially at greater risk of becoming dependent on drugs or alcohol. There is an association between alcohol/drug use and self-harm/suicide in young people and by addressing
alcohol and drug use; there should hopefully be an improvement in the overall health of young people in the area.

9.4 These measures, however, could be significantly improved by all agencies, including Public Health, collaborating in the development and production of an annual plan for suicide and self-harm prevention in Cheshire East.

9.5 One of the historical constraints to this collaboration is that a Public Health representative has not been active member of the Local Safeguarding Children Board. It would not be helpful to explore the historical reasons for this; however, there are now very clear indications that there will be, in future an active contribution from Public Health to Cheshire East Safeguarding Children Board.

9.6 It is understandable that some local areas may feel that incorporating suicide prevention in wider mental health, public health and community planning processes might be a better way to ensure people most at risk access the services they need and that everyone acts to prevent suicides. There does seem to be a growing acceptance however, that in order to steer successful suicide and self-harm prevention interventions, for children and young people, there needs to be local plan, in addition to any wider regional or sub-regional strategic plans. The report from the Royal College of Psychiatrists sums up this point succinctly, echoing the Government position. “Suicide prevention should remain a priority of public health policy in all countries in the UK. There should be structures at national, regional and local level and mechanisms to ensure effective implementation. A partnership approach should be adopted wherever possible” (See recommendation 1).

9.7 It is probable that any local suicide and self-harm prevention plan for young people would need to dovetail with any similar initiatives in relation to adults, if nothing else because of the transition from childhood to adulthood. The Health and Wellbeing Board may wish to consider these wider issues.
9.8 Prevention, in the widest sense is dependent on the general population having enough information to recognise and identify problems and take appropriate action to help address the problem. There are some particular areas of activity that may have a significant impact on self-harm in the community:

- Reducing the stigma of mental health problems in young people.
- Helping the general public, including young people, to be more aware of sources for help for young people such as Young Minds, Samaritans and Papryus.
- Refining educational programmes for young people to ensure a consistent approach to suicide and self-harm prevention.

9.9 There were indications of some very good work being undertaken in CAMHS in Cheshire East to use the views of young people who had experienced mental health problems. These young people consistently spoke of the need to address the stigma felt by those young people with mental health problems. CAMHS had also been in discussion with two schools in Cheshire East about the possibility of a worker, focusing on prevention, being funded by the schools and located within the school setting. This is very creative, innovative thinking and the parties concerned should be praised for their problem solving approach. The one reservation is that it may be a possibility that those schools that have direct experience of serious self-harm or suicide are more likely to follow these creative pathways. This could potentially create significant gaps in expertise between schools in different localities.

Prevention and Practitioner Awareness

9.10 One of the consistent issues that has arisen during this Thematic Review has been with regard to the general awareness and level of understanding, held by practitioners about self-harm and suicidal behaviour. In particular, there was a degree of understandable anxiety expressed by a number of practitioners, across disciplines, about whether there were clear indicators of
the likelihood of serious self-harm and/or suicide, in young people who were presenting with relatively minor, deliberate self-harm. There was also some uncertainty about which groups of vulnerable children and young people were most at risk and how that level of risk could be assessed.

These concerns raised by practitioners during the Thematic Review were consistent with numerous studies suggesting many practitioners, primarily because of their lack of understanding of self-harm, are unsure about how to manage these situations. Practitioner responses can range from anxiety and alarm in some staff (teaching staff – Best 2005) to being blamed for wasting time with self-inflicted injuries (A&E staff – Palmer 2007). There is a general sense that practitioner attitudes and capacity to manage situations non-judgmentally and sensitively improve with training about the reasons why people self-harm.

The issue of staff training and awareness, across the different disciplines, should be a key component of any local suicide and self-harm prevention strategy. It would be advisable to consult with key organisations in the voluntary sector that have experience and expertise in delivering training and staff awareness programmes. (See recommendation 2).

9.11 Secondary Prevention – Working with risk
As previously indicated the majority of young people who self-harm or make suicide attempts will do so without coming to the attention of any agency. Even with this limitation, however, a number of young people present at A&E departments every year because of deliberate self-harm or a suicide attempt. (Two of the cases had repeat attendances at hospital A&E departments). This presents as a unique opportunity to engage with vulnerable young people and assess both risk and need. Data from Cheshire East A&E departments, for 2013, shows 79 females and 31 males attending A&E (hospital A) and 45 males and females (hospital B). These were cases where the primary presentation at A&E was of self-harm. It is probable that there were additional cases where self-harm was a secondary presentation.
9.12 It was not possible, with these cases, to extract information about the type of self-harm or if the young people were referred to specialist mental health services as a result. This would be useful information within the context of developing a strategy for suicide and self-harm prevention. It is equally important that all agencies are confident that the systems in A&E for assessing risk and need in young people who self-harm are of a good standard (Recommendation 3).

The standardised process is that when a young person attends A&E because of self-harm, children under the age of sixteen are admitted direct to a pediatric ward. If admitted overnight (on a Children’s Ward), they are seen by practitioners from CAMHS the following day at Hospital A, and within two working days at Hospital B. It is normal practice for two CAMHS practitioners to see the young person together at Hospital B, and one practitioner at Hospital A. This is sensible practice.

A letter is sent from A&E to the designated school nurse and also to the GP informing them of the attendance and detailing any actions. There is a “special register” maintained on the A&E database to “flag up” when an individual has had three or more attendances, alerting attending hospital staff to repeat attendances. The Safeguarding Unit within the hospital are also advised of any attendances and will contact relevant agencies such as the Police and Children’s Social Care should there be any indication of safeguarding concerns.

9.13 In theory the processes and mechanisms for sharing information about individual self-harm episodes are sound. Discussions with practitioners, however, raised concerns about what happened to the information when it reached the school nurse. Representatives from schools described ad hoc systems of finding out when a pupil had attended A&E because of self-harm. There did not appear to be a systematic process whereby schools were given information about self-harm incidents. This raises wider issues about information sharing and confidentiality.
The Department of Health produced a Consensus Statement on *Information sharing and suicide prevention* in January 2014. Although the statement is intended to focus on adults, it does reiterate the position with children and young people in relation to confidentiality when there are concerns about self-harm.

The Consensus Statement says, as follows:

“*The situation for children and young people under the age of 18 differs, although the same duties of confidentiality apply when using, sharing or disclosing information about children and young people as about adults. Information can be shared about a child or young person where it is in the public interest to do so. In practice, this means that practitioners should disclose information to an appropriate person or authority if this is necessary to protect the child or young person from the risk of death or serious harm. A decision can be made to share such information with family or friends, and normally would be*” (Dept of Health – January 2014)

9.14 The overall impression gained from this Thematic Review is that whilst the sharing and use of information within the hospital A&E setting is clear, once that information leaves the hospital setting, there is a lack of clarity about which agencies have access to that information. In particular information shared with schools seemed to be inconsistently managed. There is an urgent need for all agencies to ensure that there are jointly understood, owned and shared protocols in place for the sharing of information in cases where self-harm has led to attendance at hospital A&E departments.

9.15 *Multi-Agency work*

There were clearly extremely complex issues in several of the cases, where a whole range of different services were involved. The majority of these cases had for example some mental health input at various levels. There was Children’s Social Care involvement on an intensive level with two of the young people. There was also involvement with Youth Offending Services, Housing agencies, the Police, GP’s, Hospital A&E Departments and various school based issues.
Of the five cases, two were probably high-risk (although problems in accurate prediction have been acknowledged earlier in this Report). The repeat nature of previous self-harm in these cases, alongside numerous other indicators suggested that continuation of self-harm and suicide attempts were probable. Given this high risk situation there should have been an expectation of careful joint planning and information sharing between agencies.

9.16 One case has been the subject of a Cheshire East Safeguarding Children Board Learning Review. Health services are undertaking a Clinical Review in relation to the involvement of health related agencies for the cases involving young people under the age of 18 years. It is important that the findings from the Clinical Review are shared in order to maximise learning opportunities. The Learning Review findings have previously been shared within the LSCB. It would not be appropriate to duplicate the findings from these two reviews in this Thematic Review. Some features however relating to one case are highlighted because they emphasise the necessity of well thought out, multi-agency planning, in high-risk cases. There was a known, high level of risk with this case, however, there were a number of incidents and events that suggest weaknesses in joint planning processes that are alluded to earlier in this Report. Some of these are highlighted to demonstrate the complexity of joint planning:

- The placement away from the geographical area was not based on good evidence (loss of peers as a protective factor) and may have led to increased risk.
- There seemed to be no joint planning about decisions to discharge from Tier 4 provision and no joint assessment of risk and need based on updated information about his personal circumstances.
- There was no available accommodation in the geographical area that he was familiar with, where he held down a job and where his peer support was. Offers to relocate him several miles away were unrealistic and were likely to place further stress on the young person.
The overall impression of multi-agency work with this young person was of a lack of coordination and joint planning in both the assessment and ongoing work. This tendency for agencies to work in “silos” has been commented on by a number of researchers (Brandon et al 2012) and it is apparent, from a systems approach perspective that a deficit in joint working may be a risk factor in itself.

9.17 CAMHS in Cheshire East in the national context
A starting point in considering CAMHS in Cheshire East is to look at what is defined as an acceptable child and adolescent mental health service. The Annual Report of the Chief Medical Officer (2012) addresses this issue in some depth. The overall view was that “an adequate service must be able to offer comprehensive assessment by clinicians who are skilled in engaging children and young people and who have a good understanding of how mental health problems manifest at different developmental stages and ages” The report goes on to specifically mention “interventions for suicidality and self-harm” as being one of the most common child and adolescent mental health problems.

9.18 The report of the Chief Medical Officer of Health raised serious concerns about both the extent to which children and adolescents are affected by mental health problems and also with gaining access to appropriate treatment. As a result of these expressed concerns, the Parliamentary Health Committee made the decision to undertake an inquiry into children’s and adolescent mental health and CAMHS. The terms of reference for the inquiry are to consider:

- The current state of CAMHS, including service provision across all four tiers, access and availability: funding and commissioning: and quality
- Trends in children’s and adolescent mental health, including the impact of bullying and of digital culture
- Data and information on children’s and adolescent mental health and CAMHS
• Preventative action and public mental health including multiagency working
• Concerns relating to specific areas of CAMHS provision, including perinatal and infant mental health: urgent and out-of-hours care: the use of S136 detention for under 18’s: suicide prevention strategies: and the transition to adult mental health services.

The Inquiry is currently at the stage of hearing evidence. It will be vital that key findings from this enquiry are embedded in any local CAMHS developments.

9.19 There is also the very recent publication of a highly critical report from the Centre for Social Justice (2014) suggesting that both child protection and CAMHS services are failing to offer an acceptable level of service. There has also been a recent Serious Case Review in the North West region of a suicide by a young person where CAMHS services have been judged as inadequate (Cumbria LSCB 2014). Among the findings from that serious case review were:

• There was a lack of understanding among professionals about high risk indicators in young people
• There were unacceptable delays in the young person being seen by Child and Adolescent Mental Health Services
• Agencies continued to refer cases to CAMHS even though there was a general awareness that the service was not “fit for purpose”. In a sense there was collective professional denial.

There are echoes of these findings in the present situation in Cheshire East. There are for example very serious issues about the capacity of the 16-19 service.

The waiting list time period of up to 4 months following referral and Initial assessment for other non-urgent cases, (outside the 16-19 service), also feels
excessively high and relies a lot on a parent or professional notifying CAMHS if there is a significant change in the young person's mood or behaviour that may indicate an earlier appointment is required.

9.20 Within the national context, there were a number of issues raised in conversations with practitioners. Overall there was an appreciation that CAMHS were able to offer a very specialist and highly skilled service to young people with mental health problems. This was evidenced by the present consideration of two schools to funding a prevention worker (tier 2 CAMHS). CAMHS expressed a wish to extend this service to other schools if funding could be secured. There were also some progressive and innovative steps seen in the training of Young Advisors and the consultation with young service users being integrated in service delivery.

9.21 There were, however, some concerns expressed. In particular the capacity of the 16-19 Service, was viewed as worrying, some referring agencies being informed that the subject of the referral could not be seen at present because of capacity issues. Although this did not seem to apply to crisis/emergency situations, it is extremely worrying, if confirmed, that vulnerable young people in this age range, are not able to access mental health services.

9.22 There were some concerns expressed, which may in part be cultural, about difficulties in accessing CAMHS and the isolation of the service. Overall, there seemed a lack of clarity held by some agencies about what CAMHS did, what its core tasks were, and perceived difficulties in partnership working. All agencies (including CAMHS) wanted an active role for CAMHS in the management of self-harm and suicide behaviour.

9.23 There are very clearly some capacity issues in relation to CAMHS that need to be addressed. In the context of the ongoing Inquiry by the Chief Medical Officer, referred to earlier, these capacity problems are not unexpected. It is important, however, given these constraints, that there is a very clear understanding and agreement, at senior managerial level, across
all agencies, about the level and type of activity that CAMHS is able to undertake. It is equally important that, on a practical level, referring agencies are kept appraised of any significant changes in service capacity. (Recommendation 4).

9.24 Bereavement Services
It should be the aim of any suicide prevention strategy to provide better information and support for those bereaved or affected by suicide. Apart from the simple wish to offer a humane response at a time of great sadness and loss, there are some serious potential impact issues, including:

- Family members and friends bereaved by a suicide are at increased risk of mental health problems and there is an increased risk of suicide for those family members and friends
- Suicide can have a profound impact on communities. The impact can seriously affect neighbours, school friends, and professionals whose work brings them into contact with suicide- this can include health professionals, teachers and other practitioners.
- There may be an increased risk of cluster suicides in a community, particularly among young people. The risk may increase depending on the community and media response to the suicide.

9.25 Overall there was some impressive, calm and dignified work in Cheshire East in relation to the suicides that occurred. This was particularly apparent in school settings. There were a number of reasons for this. Building on the experience of two suicides, in the same locality, some years earlier, when the tragic event had not been managed well, there was established a Critical Incident Team to support schools in managing the aftermath of the suicide. This team led by an Educational Psychologist, with Early Years, Home Education and Youth Support input comes together, when there is a critical incident, to support the school (both staff and pupils). The Critical Incident Team adopt a “light touch”, which might include offering a group session for staff or pupils. Any student who appears to need additional specialist support
would be immediately referred to the School Psychological Service. This approach is sound. There is some evidence that bereavement counseling is helpful for those actively seeking such support (Modaid et al - 2008). It should not however be seen as a prescriptive response in all cases.

9.26 The previous suicides (in 2007) had led to attempts by a commissioned agency to offer intensive counseling to students at the school concerned, reports suggesting that this had escalated the emotional climate within the school and been found to be intrusive by pupils. Cheshire East is to be complimented in learning from this event and using the Critical Incident Team in a positive manner.

9.27 There were also key teaching staff within the schools concerned who maintained an extremely professional, calm but caring approach that undoubtedly helped students express their grief. There was a calm acknowledgement of the loss with students aware that there was space and time to talk about their feelings if they wished. Contact with parents of the deceased young people was maintained and this was an important statement to parents and family members about the shared sense of loss in the school community.

9.28 In one school there was also input from CAMHS that served as a reassurance and support for staff. The early and speedy involvement of CAMHS was extremely valuable in this scenario.

9.29 Planning and information sharing processes also seem reasonably tight when there is a suicide. There is a Rapid Response Meeting, within 3-5 days of the suicide, with all of the key agencies involved. Inter professional meetings focus on the family, siblings, peers and the community. It was unclear, if specific information resources were routinely given to family members. The NHS resource Help is at Hand: a resource for people bereaved by suicide and other sudden, traumatic death (Howton et al -1997). It is also particularly helpful for use by practitioners.
9.30 As indicated there are some very positive messages about agency responses in these difficult circumstances. When the young people had left school, this was not always the case. The mother of one young person who had left school, for example, described how, in the aftermath of the suicide, there had only been one contact from Social Services and no contact from CAMHS. She described being given a list of counseling services by the GP receptionist and had attended one general (not specifically for bereavement) counseling session but found it too general to be helpful. In another case, where the young person had left school, there was early and appropriate support through CAMHS for a vulnerable sibling but no indication that the parents had been given guidance about ongoing counseling or supplied with practical information that would help them cope with their loss.

9.31 One of the primary aims of a suicide prevention strategy is to offer appropriate support to families, friends, peers and the community. It is important that there is a needs led, systematic planning process with a diversity of resources. These resources should include information to signpost and facilitate appropriate specialist counseling as well as practical information to help those grieving to manage what will be for them a unique and tragic situation. An important step in developing support services for families/friends lies with statutory agencies consulting with the voluntary sector.

(Recommendation 5)

10. The Views of Young People

10.1 An important element in conducting this Thematic Review is the views of Young People. CAMHS helpfully facilitated a focus group of young people who had experienced mental health problems. The following key messages were offered.

What would young people find useful in terms of prevention?
“Young people often feel what they are feeling is not taken seriously and not enough support is given”
“Greater support prior to crisis is needed ….. if during a crisis out of hours it was possible to gain access to a mental health professional trained in dealing with suicidal behaviour”

“Somewhere young people can meet with other young people who have mental health difficulties like the group CAMHS ran last summer. This was when I was at my worst point and it really took my mind off things”

"Information in schools on where this support is but also mental health education e.g. in PHSE as standard"

**What information is out there e.g. is there information at school, would it be helpful if there was information available in schools?**

“It would be more helpful if there was information at school because at my school there isn’t any at all”

It would be good if more information about mental health was integrated into the curriculum, this would help with stigma as well"

Definitely information and education in school, there isn’t anything and if you are struggling you wouldn’t know who to go to”

**How could professionals improve on their skills when talking to and exploring with some young people about “feeling sad”?**

“Teachers need to know how to spot warning signs and understand the different ways young people might express themselves. We are not always being naughty or disruptive”

“Whenever an adult talks to me about feeling sad, they talk to me in a childish way, like they don’t think I will understand words that they are using, some professionals need to talk to young people more maturely”
“treat them as equals, they are just people too. Everyone has been young sometime, don't be patronizing. They are not necessarily having mood swings, their emotions are just as real as yours”

How would young people want to help their friends who are feeling sad or suicidal?
“I found that in my experience most of the time I didn’t know what to do – all I could do was show them that I was there for them as much as possible”

“Positive posters and messages to help with the mental health stigma”

“More work like our group has done, visiting high schools highlighting mental health issues and stigma”

What support would be helpful for young people who have friends or peers who have died as a result?
I have never experienced this but I think having a place for the person who has lost someone close to them where they can just let all the anger and emotions out"

Support in schools, somewhere to talk and share our memories”

10.2 The feedback from young people echoes many of the comments expressed in the Mental Health Foundation publication *Truth Hurts* (2006). It also offers an insight into the information and service approaches that young people, who are at risk of self-harm or suicide, find helpful. It is clear that the views of young service users can make an important contribution towards the development and implementation of a local strategy for the prevention of suicide and self-harm (Recommendation 6).
10.3 The Young Minds charity response to the consultation on the Suicide Prevention Strategy for England made the following key points:

- There are significant links between young people who commit suicide who are involved with the criminal justice system (this is consistent with the Cheshire East scenario)
- Parental mental health is a key factor in the development of mental health problems in their children
- The importance of children and young people being involved in the planning and delivery of mental health services
- The importance of schools having access to information about how to deal with suicides
- Information about mental health and emotional wellbeing should be easily accessible to young people and the stigma of mental health needs to be addressed
- The suicide prevention strategy needs to sit alongside the mental health strategy – more data needs to be routinely collected on the prevalence of mental health problems in children and young people
- All staff working with children and young people should receive training in mental health and child development – this would include suicide prevention training

11. Summary

11.1 At a superficial level, suicide in young people can be viewed as a tragic but relatively rare event. The prevalence of suicide in the UK among young people in comparison with other European and International countries is also relatively low. The headline rate of suicide, however, masks extremely serious public health concerns. Possibly the closest analogy lies with rates of child deaths in the UK because of maltreatment. The rates overall are low but behind the absolute death rates lies a picture of many surviving children whose lives have been seriously damaged, (and in many continue to be damaged), through ongoing abuse and neglect. Similarly the comparison could be extended to domestic violence where numbers of deaths are
thankfully relatively low but it is also known that there are very high numbers of people who have had their lives substantially and negatively impacted upon by domestic violence. In considering suicide in young people it is necessary to look beyond the base rate figure of deaths by suicide and also consider self-harm as a continuum of behaviour that is widespread, and is frequently a manifestation of severe distress in young people.

This Thematic Review argues strongly that it is not realistic to attempt to properly address the issue of suicide and self-harm in young people without a local strategic approach involving all agencies. This strategic approach is consistent with Government guidance on suicide prevention as seen in Preventing Suicide in England where local services are urged to consider “developing, if not already in place, a local suicide prevention action plan as part of local health and wellbeing work with clinical commissioning groups and other partners”.

11.2 A number of recommendations are set out in this Thematic Review. The first recommendation covers the need to establish a strategic framework for suicide prevention. Ideally the framework should encompass both young people and adults. There are clearly some transitions issues, as evidenced by one of the young people, who after a series of self-harm episodes in her childhood eventually took her own life in early adulthood.

11.3 Recommendation 2 addresses the need for all staff to be aware of indicators and signs of self-harm and possible suicidal behaviour. It was striking throughout this review to note the very high levels of anxiety and uncertainty amongst practitioners who were dealing with very challenging behaviours.

11.4 Recommendation 3 addresses the need to develop much better outcome data about young people who present at A&E hospital departments because of a self-harm incident. The existing data does not offer adequate information about outcomes and ongoing referrals of these cases.
11.5 The fourth recommendation echoes national concerns about capacity issues with Child and Adolescent Mental Health Services. Particular concerns were expressed during the course of this Thematic Review about shortfalls in the 16 to 19 year olds service.

11.6 Recommendation 5 addresses the need to ensure there are support systems in place, including counseling, for families, friends, peers and the local community when bereavement through suicide occurs. As well as offering much needed compassionate help appropriate support can reduce the possibility of additional suicide attempts locally.

11.7 The final recommendation is based on the views of young people. Their contribution to this Thematic Review is extremely valued and it is hoped that they will continue to have a significant involvement with any local initiatives to prevent suicide and self-harm in young people.

11.8 Overall there some heartening examples of good practice. The calm, dignified and sensitive approach taken by school staff, when faced with the aftermath of the death of students, should be recognised. Similarly the early intervention of local authority Crisis Response team has helped to manage potentially very difficult situations.

11.9 There remain however many challenges. The nature of ad hoc developments and responses has meant that there is a lack of consistency of approach across all agencies. There is also a high level of anxiety felt by practitioners in working with young people who are self-harming. Training of practitioners across all agencies working with young people is key to increasing understanding and confidence of staff.

11.10 There is also a lack of consistency about supporting people experiencing bereavement. A specific recommendation is made about the development of bereavement services in partnership with the voluntary sector.
Overall the significance and impact of self-harm and suicide has not been adequately understood or addressed in Cheshire East (or in many other localities nationally). This Thematic review offers the opportunity to take a new and more creative approach to a serious public health issue.

12. Recommendations

1. A suicide and self-harm prevention group should be established to lead the implementation and ongoing monitoring of a Suicide and Self-Harm Prevention Plan. The Plan should be based on current Government guidance.

2. As part of the suicide prevention strategy, a training programme covering indicators and management of suicidal behaviour and self-harm, should be introduced across all staff groups.

3. A&E hospital services, should review their existing arrangements for assessment of risk and need of young people who self-harm. This review should include the processes for information sharing and the type of information collected. The LSCB may wish to consider if these issues also apply to Walk in Centres and Minor Injury Units.

4. There should be a review of CAMHS services in Cheshire East, focusing in particular on the level of provision for the age group 16 to 19 years. The review should also include ease of access to the service for all age groups, particularly in relation to waiting times for initial assessment and subsequent treatment. The review should also consider the effectiveness of joint working arrangements with other agencies.

5. Discussions should take place between the LSCB and the voluntary sector (specialist suicide prevention organizations) with the aim of delivering a coherent service for those experiencing bereavement because of suicide.
6. Future planning on suicide prevention and self-harm should ensure that the views of young people are embedded into the planning processes.
RESEARCH SOURCES


Cumbria Safeguarding Children Board (2014 Serious Case Review Publication.


Eastman Adele (2014) Enough is Enough: A report on child protection and mental health services for children and young people Centre for Policy and Social Justice


Hawton K et al *Evaluation of Help is at Hand: a resource for people bereaved by suicide and other sudden, traumatic death.* University of Oxford Centre for Suicide Research


