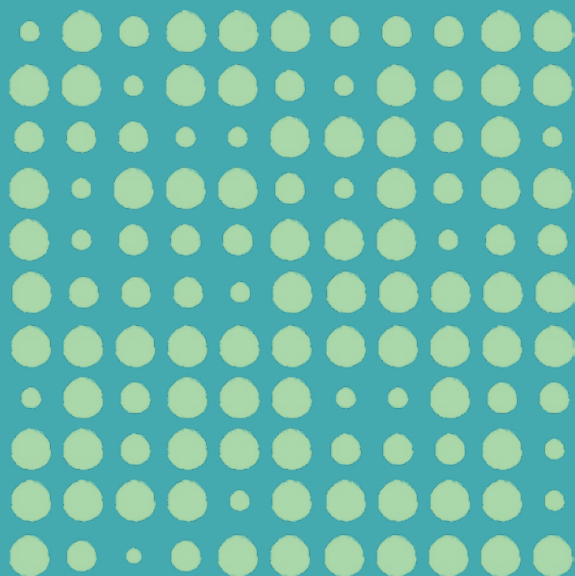# SAMARITANS
Cymru

The right support at the right time?

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

January 2021

Contents

Introduction

Last year, Samaritans provided support to someone about self-harm once every two minutes and almost 1 in 10 of the times we provided emotional support. That's a total of 272,000 conversations with people struggling across the UK and Ireland.

Self-harm is a strong risk factor for suicide.[1] Yet little is known about the quality of support available to people who have self-harmed in Wales. Self-harm is also complex, and while it is a strong risk factor for suicide, self-harm is often not suicidal[2] and this impacts on the support people need. As a result, for the purpose of this research and report, we have focused on self-harm without suicidal intent. Self-harm is a sign of serious emotional distress and it is vital that timely, effective support is available following self-harm.

Due to limited self-harm data and evidence in Wales, self-harm remains an issue that is often hidden and poorly understood. We welcome and recognise the Welsh Government's national strategy for suicide and self-harm prevention, Talk to me 2[3], yet our research demonstrates that more needs to be known about what good quality support looks like. We also need to improve our knowledge and understanding of what works in supporting particular groups and communities, including BAME communities, LGBTQ+ communities and people from socio-economically disadvantaged households in Wales.

We engaged with people with lived experience of self-harm, research experts, and those involved in the direct delivery of services in Wales. People spoke of the importance of early intervention rather than 'firefighting', the role that tackling stigma and better data could play in ensuring people who have self-harmed get better support, and the importance of compassionate responses to emotional distress and self-harming behaviours.

Through this research we aim to improve understanding of the support needs of people who have self-harmed, what may prevent this group from receiving appropriate support, and opportunities to improve the quality of support available. What has become clear from our research is that there is an urgent need to improve the availability and quality of support across the board.

The coronavirus pandemic is having an ongoing impact on the mental health and wellbeing of people across the UK and Ireland. During the months of lockdown, callers spoke about how they were feeling increasingly lonely, anxious and distressed.[4] While it is too early to know the long-term impact of the pandemic on self-harm, these insights make getting people the right support at the right time even more critical.

Methodology

Research objectives

- Understand the support needs of people have who have self-harmed
- Understand what prevents people who have self-harmed from receiving appropriate support following an episode of self-harm
- Identify opportunities to improve the quality of support available

What methods did we use?

Survey of people who have self-harmed	An online survey of 900 adults with lived experience of self-harm from across the UK and Ireland. This included 59 adults aged 16 and over in Wales. The survey was live at two time points: firstly, in September 2019 and re-opened in July 2020 to increase sample size in Wales. 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.
Samaritans service data	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.
Survey of Samaritans volunteers	251 Samaritans volunteers participated in an online survey to deepen our understanding of the needs and concerns of Samaritans callers who have self-harmed. The majority of the survey related to social and health concerns themes within the service data.
Research roundtables	In August 2020, we held a virtual self-harm roundtable which involved organisations and individuals in Wales with experience in this area, including service providers and people with lived experience of self-harm. The purpose of the roundtable was to discuss the support available to individuals with lived experience of self-harm, barriers to support and examples of good practice.
YouGov survey	An online survey of over 900 adults in Wales on perceptions and attitudes to self-harm, conducted by YouGov on behalf of Samaritans Cymru.
Literature reviews and rapid reviews	Relevant external academic research and data from the UK.

Self-Harm in Wales: setting the scene

What is self-harm?

According to the Welsh Government's suicide prevention strategy, Talk to Me 2, self-harm is usually defined as intentional self-poisoning or self-injury.[5] This covers a wide range of behaviours, including isolated and repeated events: self-cutting, poisoning, scratching, burning, banging, hitting, hair pulling and interfering with wound healing.[6]

For the purpose of this research, we focused on understanding the experiences of people who identified as having self-harmed without wanting to take their own life. Non-suicidal self-harm is defined as "any deliberate act of self-poisoning or self-injury without suicidal intent". This excludes accidents, substance misuse and eating disorders, as well as episodes of self-harm where the person was trying to take their own life.

Self-harm is a complex behaviour that is not always easy to define as suicidal or not, and a person's reasons and intentions when self-harming can change over time. Regardless of intent, self-harm is a serious public health issue and is one of the top five reasons for medical admission in the UK.[7] For many, non-suicidal self-harm is a way of coping with difficult or distressing feelings and circumstances[8], and this is distinct from suicide attempts[9].

We conducted a survey of over 900 adults in Wales to explore current understanding and perceptions of self-harm among the general public. Overall, understanding of the underlying factors that contribute to self-harm were good, with 8 in 10 (84%) of adults in Wales agreeing that people use self-harm as a way of coping when they are dealing with difficult emotions or experiences.[10] Whilst it's clear the majority of Welsh adults understand some of the causes of self-harming behaviour, a fifth of adults in Wales think that self-harm is a passing phase.[11] Women and respondents between 18-34 were less likely to agree with this statement.

Self-harm is often hidden and the specific and distinct needs of people who have self-harmed without suicidal intent are poorly understood and too often not taken seriously. Therefore, research specifically focused on non-suicidal self-harm is essential to understand their support needs and ensure services are working effectively for them.

Self-harm statistics and trends

The true scale of self-harm is estimated to be 1 in every 130 people.[12] In 2019, Samaritans supported a caller from across the UK and Ireland in connection with self-harm every two minutes – a total of 272,000 times. 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.

The most reliable data for self-harm available in Wales is derived from hospital admission data, with approximately 5,500 admissions for self-harm, regardless of suicidal intent, in Wales each year.[13] Self-harm can affect people of all ages and genders, but we know it is more common in females across all age groups.[14] Our data at Samaritans also supports this. Self-harm is discussed in twice as many calls from women than men (12% vs 6%).

For the period 2007-2016, age specific self-harm admissions regardless of suicidal intent in Wales showed the highest rate among females aged 15-19 years.[15] For males in Wales, the highest age- specific rate is in the 25-29 year age group between 2007 and 2016.[16] There has also been an increase in self-harm rates amongst those aged 10-17 in Wales.[17] There is no conclusive evidence to explain why self-harm is increasing. It could be attributed to reduced stigma and improved management of self-harm in young people, but this unlikely to explain all the increase.
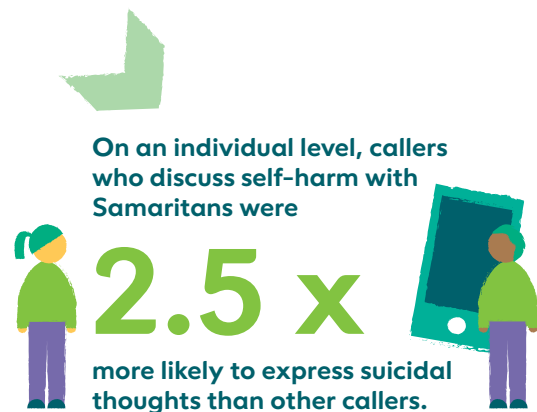
Although hospital admissions data allows us some insight into patterns of self-harm regardless of suicidal intent in Wales, it is widely acknowledged that the lack of data is a serious barrier to our knowledge and understanding of self-harm in Wales. As most people who harm themselves do not attend health services and of those that do very few will require admission, self-harm remains an issue that is often hidden and poorly understood.

What is the relationship between suicide and self-harm?

While most people who have self-harmed will not go on to take their own life, it is a strong risk factor for future suicide.[18] 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[19]. In calls to Samaritans, as expression of suicidal thoughts rises, so too does discussion of self-harm. On an individual level, callers who discuss self-harm with Samaritans were 2.5 times more likely to express suicidal thoughts 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 time.[20] More generally, self-harm is often a sign of complex underlying problems and serious emotional distress, yet research shows that long term self-harm does not help reduce that emotional distress.[21]

The Welsh Government's suicide and self-harm prevention strategy for Wales identifies people with a history of self-harm, regardless of intent, as a high-risk group for suicide.[22] The strategy highlights the need to tackle stigma, and the need to equip frontline workers with the necessary skills and knowledge to adequately support, and respond compassionately, to those who have self-harmed.[23]

On an individual level, callers who discuss self-harm with Samaritans were

2.5 x

more likely to express suicidal thoughts than other callers.

Self-harm support & help-seeking: survey findings and wider research

We welcome the steps taken by the Welsh Government to make self-harm a priority in its suicide and self-harm prevention strategy. Yet we still know little about the full range of support offered to people who have self-harmed, both in clinical and community settings, or enough about what good quality support looks like. Almost half (45%) of the adults we surveyed in Wales said they did not know where to find support or information about self-harm.[24]

We also need a better understanding of the effectiveness of more informal sources of support, away from these settings, such as support from friends and family and through self-care and online support. The effectiveness of all of these support types should be evaluated so we can offer evidenced-base support and interventions to those who have self-harmed. There also needs to be wider understanding of what works in supporting different demographic groups and communities, including BAME communities, LGBTQ+ communities and people from lower-income households in Wales.

As this section will show, many people struggle to get appropriate, timely support for their self-harm.


Almost half

45%
of the adults we surveyed in Wales said they did not know where to find support or information about self-harm.[24]

What support do people seek for self-harm?

Through our survey, we asked people in Wales and across the UK and Ireland who have self-harmed whether they had sought support, specifically in order to get help with their self-harm. We also asked more generally about the support they'd received for self-harm throughout their life.

- Only a third (34%) of people in Wales sought support for their most recent self-harm, compared to over half (52%) of respondents from across the UK and Ireland.

- Help-seeking rates were broadly similar across groups, but people with a long-standing mental health condition were more likely to seek support than other groups across the UK and Ireland, driven by more frequent support from healthcare (54% vs 47%).

- People with long-lasting mental health conditions across the UK and Ireland were also more likely to access social support, defined for the purpose of this research as: support from, friends, online advice or online forums (30% compared to 25%).
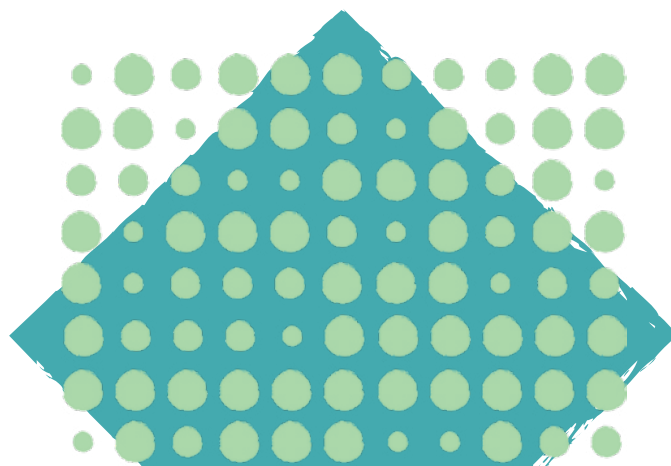
How does support for self-harm affect wellbeing?

Seeking support appeared to be associated with changes in people's mental health in the day, week and month after the self-harm. People who sought support were more likely to say their mental health worsened the day after they self-harmed, compared to those who didn't seek support (41% vs 27%), suggesting that people whose mental health deteriorates following self-harming are more likely to seek support.
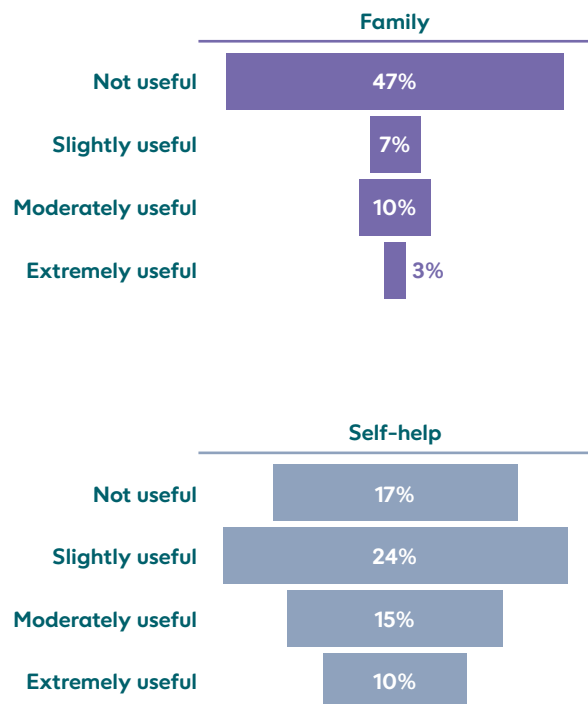
However, by a month after the self-harm, our data indicates that this changes, with people who sought support appearing to be more likely to report improved mental health, compared to those who didn't seek support (42% vs 33%). This demonstrates the value of help-seeking, and the importance of tackling stigma and increasing awareness in the community and within services to ensure more people access timely and effective support.

How useful was support for self-harm?

We also asked people about the support they'd received for self-harm throughout their life and how useful the support had been. While no specific support type is especially effective for the majority of respondents in Wales, the most positive responses were to self-help and online support, with 42% and 38% respectively finding this support at least 'moderately useful'. This contrasts with support from family and education or work, which were the least useful for our survey respondents, and were only moderately useful or better in 20% and 10% of cases respectively.

However, overall usefulness for all types of support was low. There is an urgent need to improve the quality of support across the board, as our research shows many people with lived experience of self-harm are struggling to find even moderately effective support in Wales.

Wales data

Family

Not useful	47%
Slightly useful	7%
Moderately useful	10%
Extremely useful	3%

Self-help

Not useful	17%
Slightly useful	24%
Moderately useful	15%
Extremely useful	10%

Family and peers

Opening up to friends and family

Research shows that positive social support is key to resisting self-harm in the moment and ceasing self-harm longer term.[25] We also know that meaningful social support is more common among people who have stopped self-harming compared to those who continue to self-harm.[26] However, over a third (31%) of adults in Wales told us that they would not feel comfortable talking to a partner or close family about self-harm.[27] Likewise, almost 2 in 5 (39%) of the adults we surveyed in Wales said they wouldn't feel comfortable talking to a friend about self-harm.[28] People aged 18-24 are more likely to feel comfortable talking to friends about self-harm than older age groups.[29]

Survey respondents with lived experience of self-harm, as well as Samaritans volunteers we surveyed, indicated that self-harm can have a specific stigma attached to it. Concerns about this meant that some people didn't feel able to tell loved ones about their self-harm:

> ❝ I've never told anyone about my self-harm. Family and friends sometimes found out by accident. They were mainly angry or concerned and I found it very embarrassing. ❞

UK & Ireland survey

> ❝ I've tried talking to [my] partner. He sticks his head in the sand. ❞

UK & Ireland survey

Over a third

31%

of adults in Wales told us that they would not feel comfortable talking to a partner or close family about self-harm.[27]

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

- Family concerns
- Loneliness or isolation
- Relationship problems

Volunteers said that worries and difficulties in relationships with partners, family, friends, and feelings of loneliness and isolation could be a factor that contributes to a caller self-harming. Volunteers also said 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.

Volunteers told us:

> ❝ Callers try to hide it from family and friends who they feel don't understand, which leads to loneliness and isolation. ❞
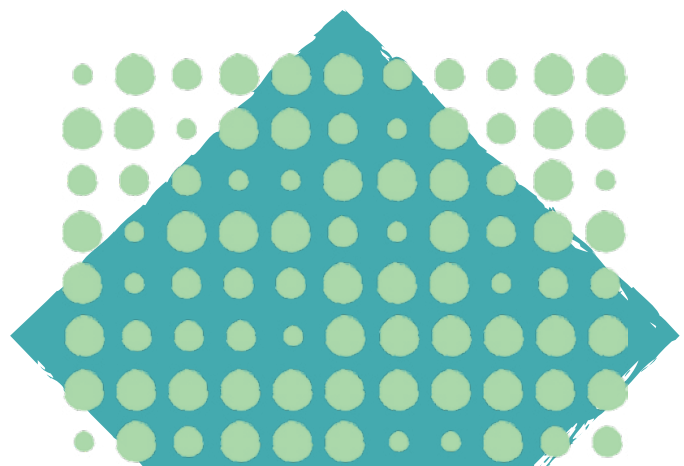
9 in 10

adults in Wales agreed that self-harm is a serious issue and more should be done about it, less than half (47%) of respondents said they would know how to support someone close to them if they were self-harming.[30]

66 Callers often want to keep the fact that they have self-harmed away from their friends and family. 99

Less than a quarter (24%) of survey respondents in Wales found support from friends useful. Of our UK and Ireland respondents, those out of work were less likely to say that their friends were a useful source of support for self-harm. Just over a third (36%) of people not in work said support from friends was at least moderately useful, compared to almost half (48%) of employed people. This might be because people who are not in employment lack the regular support network that a work environment can provide. Reducing stigma around self-harm and increasing guidance to supporters of people who have self-harmed is essential to encouraging more people to open up, and to receive support that would help them.

While 9 in 10 adults in Wales agreed that self-harm is a serious issue and more should be done about it, less than half (47%) of respondents said they would know how to support someone close to them if they were self-harming.[30] We must ensure information about how to support and respond to people who have self-harmed is disseminated widely amongst the general public so they can offer meaningful and appropriate support to those close to them.

Peer and online support

Many survey respondents sought understanding and support online. One respondent in Wales said that using online forums makes them feel less 'abnormal' while another respondent said advice forums 'make me feel less alone'.

Another respondent from Wales described how the use of online forums helped them understand how their anxiety was linked to their autism, which helped them want to develop better coping strategies:

66 I've recently accepted that I have historically self-harmed when I'm hugely anxious and triggered. This isn't the sort of info you'd find from your average day-to-day conversation, I got this from an online forum and the realisation alone was enough to make me want to change my coping strategies. 99

However, we know that in some cases peer-to-peer discussion can normalise or glamourise self-harm as a way to cope with emotional distress. Research also shows that young people who repeat self-harm/attempt suicide are more likely to have a family member or close friend who has done the same, and there are concerns that peer-to-peer discussion could amplify this social influence.[31]

Mental health services

Self-harm can be linked to mental health conditions such as depression, anxiety, borderline personality disorder and post-traumatic stress disorder.[32] Mental health services provided by the NHS in Wales have the potential to support people who have self-harmed both to address the underlying causes of self-harm and to understand the triggers of the behaviour. However, our discussions with people with lived experience of self-harm and research experts highlighted that there are many barriers to people accessing support through mental health services, including support being guarded by high thresholds. They told us that as their needs are seen as less serious, people who have self-harmed without wanting to take their own life are being excluded from this support.

In a survey of Samaritans volunteers, over a third (32%) said callers who are concerned about their mental health most frequently talk about NHS mental health treatment not being effective.

Volunteers spoke of a number of barriers to help-seeking faced by callers, including long waiting lists and a lack of appropriate services, as well as concerns around the attitude/judgement of frontline workers.

66 Many people want to find support, but are prevented by long waiting lists and exclusionary criteria, or find it difficult to get the support which is right for them. 99

Samaritans volunteer

GP services

A quarter (24%) of the general public in Wales said they would not feel comfortable talking to a GP or another healthcare professional about self-harm. Women were less likely than men to feel comfortable (67% vs 56%).

Less than a quarter (23%) of survey respondents with lived experience of self-harm in Wales found support from a GP, doctor or medical professional at least moderately useful after self-harming. Over half (53%) of respondents in Wales who didn't seek support from a GP after recent self-harm thought their GP wouldn't or couldn't help.[33] This compares to less than a quarter (22)% of respondents across the UK and Ireland. Similarly, almost half (47%) of respondents in Wales didn't think their self-harm was serious enough to seek support from a GP, compared to just over a quarter (26%) of respondents from across the UK and Ireland.[34]

66 I didn't think about going to the GP and didn't think it was serious enough to get any help. 99

Wales, survey

Others felt they had exhausted the options available via their GP and that referrals from GPs did not result in further support being offered:

66 I've never really considered going to my GP after self-harming. My general experience of GPs is that most aren't really sure what to do with me with regards to my mental health...If I went to my GP, they would refer me on, and then that referral would be refused, so I'd see the GP again and then the referral would be refused again... it's a very tiring dance for everyone and it often all feels a bit hopeless - so why even bother? 99

Wales, survey

The importance of trauma informed support services

People who have experienced trauma are at increased risk of self-harm.[35] Trauma which is enduring or cumulative is most strongly linked to self-harm, as are certain traumatic life events such as; running away from home, being expelled from school, sexual abuse, homelessness, serious assault and having spent time in prison.[36] This is supported by our call data which shows a strong link between self-harm and violence/abuse. Callers who discuss self-harm are twice as likely to have concerns about violence/abuse

Trauma can decrease a person's tolerance for stress and mean that they are more likely to adopt unhelpful coping strategies, such as self-harm. Support services need to be trauma-informed so they can provide alternative coping strategies which acknowledge and address the impact of trauma. Services also need to be flexible so they can offer strategies and methods of accessing services that meet the complexity of an individual's need.

School and university

Self-harm often emerges during adolescence.[37] Over two-thirds (70%) of survey respondents in Wales had self-harmed for the first time aged 17 or under and 44% were between the ages of 11-15. Schools and universities, and in particular secondary schools, have a key role to play in providing early, preventative support to people who have self-harmed before their needs escalate. However, people across the UK and Ireland were less likely to seek support from schools, university or work, compared to some other sources, both over their lifetime and following their most recent experience of self-harm.

Self-harm is complex, and there are many factors particularly affecting young people that are associated with an increased risk of self-harm; such as academic stress[38], worry about sexual orientation[39], or history of sexual abuse.[40] 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.

Offering children and young people the right support and equipping them with the skills to cope with distress, can act as a preventative measure and can help break cycles of self-harming behaviour. It can also help children and young people develop alternative ways of coping.
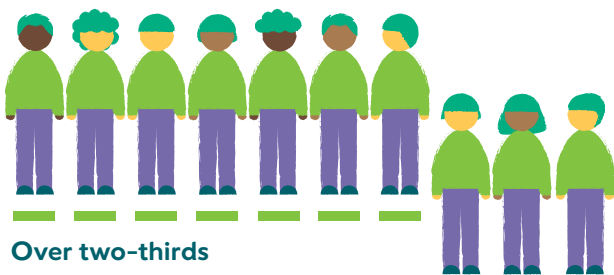
Over two-thirds

70%

of survey respondents in Wales had self-harmed for the first time aged 17 or under

Wales self-harm roundtable: August 2020

We held a roundtable discussion with a range of individuals with expertise on self-harm. They included research experts, policy makers, people with lived experience of self-harm and those involved in the direct delivery of services.

We heard about how support could be framed more effectively and about a number of support needs that need to be addressed, along with the key principles needed to underpin the nature of this support.

There was significant consensus on the main themes which need to be addressed and on the actions which need to be taken at a number of levels.

The main themes to emerge were:

The definition of self-harm

There was a challenge to the existing definition of self-harm. A number of participants felt that the current definition was too narrow and that it should include any behaviour which harms the self, for example, alcohol abuse and under eating.

Stigma

Stigma is considered a major barrier to people who have self-harmed receiving timely and effective support. Terms like 'attention seeking' and 'manipulative' are still being used by professionals. This may not be said directly to the patient, but it was felt to come through in the way patients are treated and spoken to.

Stigma and uncertainty over the response was said to result in people who are self-harming feeling unable to speak to friends and family, and feeling that they are not receiving the right care when having contact with health services.

66 A lot of the young people are already in touch with services, but are not getting what they want from them. What they need is compassion, kindness, being present. 99

The response by agencies and services to self-harm

Roundtable participants told us that a number of barriers exist which make ensuring a good standard of support across services challenging. Training and awareness were identified as a clear need across healthcare services to ensure frontline professionals have the knowledge and confidence to respond to self-harm safely and appropriately.

66 There is too little training. We need people to be better educated. 99

An example given of good practice was nurses who have had some training in Dialectical Behaviour Therapy (DBT). Even if this did not involve doing the full course, it was said to help patients considerably. Also raised was the new NHS Cardiff and Vale Health Board Recovery and Wellbeing College.

DBT was raised by many participants as having a positive role to play.

It was felt that disseminating guidance for non-mental health specialists who have contact with people who have self-harmed was needed. Information should be easily accessible, for example a central repository with multiple checkpoints should be available online. There should be no 'wrong door'.

It was also felt to be important to manage the expectations of those who have self-harmed, their families and professionals. It is important to recognise that there is a journey to recovery rather than a quick fix.

66 Key are authentic relationships and agility 99

It was also pointed out that services often lack time and resource and staff are 'burnt out' and under great pressure.

66 We are piling on the stress and pressure to an already overstretched workforce. 99

This impacts on staff ability to provide compassionate care. It was felt that staff need more support with managing stress and burnout, and with understanding how these things can impact on their ability to provide compassionate care. Managers for example need to encourage staff to take annual leave and need to ensure that all staff receive the right training.

It was noted that a number of schools are undertaking self-harm training and staff are taking a more proactive approach to mental health policies. It was also noted that there has been a noticeable improvement in the emergency response since there have been specialist mental health workers in police stations.

However, participants spoke about how the need to improve support across the board is crucial, with emerging evidence around coronavirus showing that the mental health and wellbeing of young people has been hugely impacted. There were reports from participants that it seems that more young people are feeling more desperate.

It was agreed that there is a need to take self-harm seriously every time it presents. One step which would help is for there to be strong follow up of people once they have been discharged from A&E as this is not currently the case.

Lack of understanding and knowledge about sources of help and support

It was clear from our roundtable discussions that many third sector and community-based organisations, as well as statutory services are providing consistent, high quality, compassionate and person-centred care for people who have self-harmed. A number of examples of good practice were identified by participants, including support offered face to face, through helplines, text and online support, group activities and work with young people. Organisations and services provided people who have self-harmed with a safe space, where individuals could form trusted relationships and have agency over the treatment and support they received.

However, such examples of good practice and support are not necessarily widely known about, available or understood. Such examples of good practice should be made widely available across frontline services and projects. They should also be used to inform future service-development and policies relating to self-harm.

Prevention and early intervention

Access to timely interventions from appropriate services was felt often to be difficult to secure. Such intervention is however very important. A major theme here was that thresholds for secondary care are high which has the consequence of people not being offered help at an early stage, which in turn leads to them experiencing more serious levels of distress and self-harming behaviours.

❝ I have an ongoing struggle with self-harm. However, I'm not eligible for treatment because I don't meet the criteria. They shouldn't be pushing people to meet that level of ill-health before they get help – this is a firefighting approach. ❞

Participants also felt that a person who has self-harmed isn't always taken seriously if they have a long history of self-harm, and it can often be considered 'a habit' rather than a sign of 'serious intent'. Likewise, participants spoke of the fact that distress isn't taken seriously unless there is evidence of self-harm, which many believe is linked to the prioritisation of physical health. It was widely felt that all signs of emotional or physical distress must be taken seriously by everyone who comes into contact with people who have self-harmed:

❝ We must move away from the idea that the severity of the physical injury caused by self-harm is in direct correlation to the severity of the mental distress. ❞

Low threshold, universal services were felt to have an important role to play.

There was discussion about young people learning strategies to cope with challenges in their lives, to prevent future self-harming behaviour as a way of coping with distress and trauma. The whole school approach to mental health and emotional wellbeing currently being developed by the Welsh Government was raised as a positive thing. However, there were concerns about the availability of the knowledge and understanding to teach emotional literacy in schools. It was felt to be of great importance that the approach is supported by access to resources and skills to make it a reality.

Understanding of diversity

Engagement with stakeholders highlighted the importance of ensuring community support met the needs and experiences of different demographic groups including LGBTQ+ communities and minority and ethnic communities.

Participants said that there is a need to take better account of the specific experiences and needs of different communities and individuals. For example, the issues affecting the mental health of people from BAME communities were raised. These included increased abuse and hate crime. There are also issues specific to refugees and asylum seekers.

Trauma

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

Participants agreed that it is important to realise that self-harm may be arising from trauma, including abuse, and that self-harm is often 'a symptom of deeper issues'. It can be a way of coping with that, and that simply stopping it may be stopping a needed coping mechanism. Helping someone to address the underlying issues to find other ways through is key.

It is evident that many people who have self-harmed are not supported either to understand the triggers, patterns and coping mechanisms for their self-harm, or to adequately address the underlying reasons for their self-harm. It was felt that there is not a common understanding among services about what a trauma informed response should be. Examples were given of work with young people which is effective and available to those who do not meet the CAMHS (Child and Adolescent Mental Health Services) threshold. This support is one to one in nature and is led by the young person. It not however as widely available as it should be.

There is a need to find alternative means of coping

Self-harm is often viewed as a type of self-preservation but it can be dangerous for the person self-harming if the methods used to cope with mental anguish become more extreme. Participants discussed self-harm as a means of expressing distress and the importance of helping people who have self-harmed to find alternative means of coping with these emotions.

66 *What matters is being authentic, honest, real: understanding that this is a coping mechanism and that there are other coping mechanisms which serve the same purpose.* 99

Alternative methods of self-expression need to be supported. Suggestions included talking and making art or music.

Data and recording

There was agreement that we need better data on self-harm in Wales. There are dashboards in England looking at population level self-harming. We need better all Wales data to be available.

It was said that lack of relevant data makes it harder to achieve funding in this area.

A specific issue raised was that in A&E injuries resulting from self-harming may not be recorded as such but as lacerations or minor injuries. This makes it difficult to get a picture of the situation at a local and national level.

The importance of a person-centred approach and compassionate responses to distress

66 *People do not necessarily want a lab coat, they want compassion.* 99

Previous Samaritans Cymru research has emphasised the importance of compassionate responses to distress. Compassion and empathy can save lives. During the roundtable discussions, participants spoke about the importance of a non-judgemental approach that focuses on an individual's specific experience, circumstances and needs. Kindness, respect and authenticity were seen as key, even where the responder did not have expert knowledge.

66 *We need to have conversations in a compassionate way, without it being a tick box exercise.* 99

It was emphasised that *"you don't have to be an expert; it's about showing compassion, kindness and really listening."*

Roundtable participants spoke of the importance of treating people 'as individuals' as there 'is no one size fits all solution' to preventing self-harm and supporting people experiencing distress. One participant emphasised that *"it is so simple. We need a basic human dignified response."*

Many roundtable participants suggested that delivering person-centred care was key to ensuring individuals were well cared for: *"The best forms of support are not a one size fits all. It is impossible to pin down a universal safety plan – we need a multi-faceted approach."*

Others supported this view and emphasised that individuals with lived experience of self-harm must be central to shaping service design.
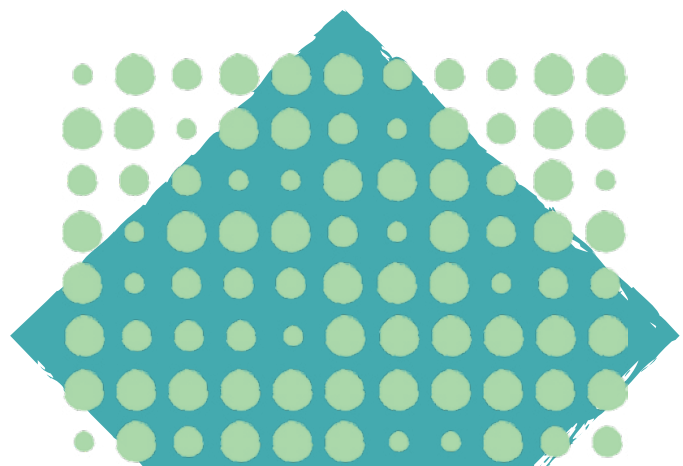
Conclusions

Our research in Wales has highlighted that people who have self-harmed without wanting to take their own life face unique barriers to accessing effective support. Mental health support is often guarded by high thresholds and people can find themselves excluded from services. The consequence is that people are not being offered help at an early stage, which in turn leads to them experiencing more serious levels of distress and self-harming behaviours. This has been described by stakeholders and people with lived experience of self-harm in Wales as a 'firefighting' rather than a preventative approach.

It is also evident from our research that the lack of accessible and transparent self-harm data in Wales is a significant impediment to our knowledge and understanding of what works in supporting this group. It also means that self-harm without suicidal intent often remains hidden within Welsh communities. As well as better data, we need a better understanding of the effectiveness of informal sources of support, such as support from friends, family and online forums. There also needs to be wider understanding of what works in supporting different demographic groups and communities, including BAME communities, LGBTQ+ communities and people from socio-economically disadvantaged households in Wales.

Our roundtable discussions revealed that in order to ensure better and more timely support for those who have self-harmed, we must reduce stigma and address the underlying causes of emotional distress that can lead to self-harm. We must also respond compassionately across all services and sectors to ensure people receive the care that's right for them. Crucially, thresholds for therapies and other sources of help for people need to be set at a level which means they are available as an early intervention.

After hearing directly from people with lived experience of self-harm and our volunteers, and through engagement with research experts and those involved in the direct delivery of services in Wales, it's clear that many people struggle to get appropriate, timely support for their self-harm. This indicates an urgent need to improve the availability and quality of support across the board.

Through our research, we have aimed to improve understanding of the support needs of people who have self-harmed and to assess whether their needs are being met. We also aimed to identify opportunities to improve the quality of the support available. Our report is a contribution to this much needed debate, and we hope it will stimulate further thinking, understanding and action.

Recommendations

1. Thresholds for therapies and other sources of help for people need to be set at a level which means they are available as an early intervention, rather than depending on the level of self-harm itself.

Thresholds for help are widely experienced and understood to be too high. People need to be able to access therapies such as DBT early on and not have to wait until their self-harming becomes serious enough to meet current thresholds. This alone would make a significant difference.

2. There needs to be wider recognition of the importance of a compassionate response to self-harm.

Underpinning all our discussions and recommendations was the need to adopt a compassionate approach to those who have self-harmed. Responding with compassion to someone experiencing distress can help ensure better outcomes and future help-seeking.

3. There needs to be proactive follow up of people who have been discharged from A&E following self-harm.

People presenting at A&E with self-harm represents opportunity for positive intervention. There is currently insufficient systematic follow up of individuals after discharge.

4. We need to establish a known, central repository for information and good practice on self-harm, bringing together the many examples of effective projects and good practice which exist.

We must recognise and build on this and recognise the role the third sector in providing effective support which engages the individual in finding their own way forward.

It was evident during our roundtable sessions that many community-based and third sector organisations play a crucial role in supporting people who have self-harmed in Wales by delivering person-centred care. As a result, we identified many examples of good practice during our roundtable discussions. Such examples of good practice should be made widely available across frontline services and projects. They should also be used to inform future service-development and policies relating to self-harm.

5. The Welsh Government should work with third sector experts and people with lived experience of self-harm to develop self-care tools and techniques.

There is a need to develop evidence-based, safe and effective self-care tools and techniques that work alongside other support sources. These tools and techniques must help people who self-harm to develop alternative methods of coping. They must be made widely available and healthcare professionals must have a good understanding of these so they can signpost appropriately.

The Welsh Government should also work with third sector experts and people with lived experience of self-harm to develop a free evidenced-based self-care app for anyone who has presented to clinical services having self-harmed.

The app should include:

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

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

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

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

6. The Welsh Government should properly support and resource the whole school approach to mental health and emotional wellbeing so that young people have access to the learning they need to understand emotional wellbeing.

Schools need to have the tools available to teach emotional literacy and embed this in the culture of the school. Students should know where and when to turn for help. Teachers should also receive training to ensure they have the knowledge and confidence to discuss and respond to self-harm in ways that are safe, compassionate and non-judgmental.

The suicide and self-harm guidance which supports teachers and professionals who regularly come into contact with young people, should be disseminated to all schools in Wales. This guidance focuses on early intervention and the safe management of self-harm and suicidal thoughts when they arise. This is an accessible source to the principles of best practice and signposts to other sources of support and advice.

7. We need to tackle stigma and promote a wide understanding of self-harm.

We need to promote a better understanding of the root causes of self-harming behaviours, alternative coping mechanisms, and effective support for self-harm among professionals through training. We must also increase this awareness in the general public.

8. Support services need to be trauma informed.

All support services for people who self-harm, whether NHS provided or community based, should provide trauma-informed support, which acknowledges and supports the underlying issues driving self-harm. Simply stopping self-harming behaviour may be stopping a needed coping mechanism. Helping someone to address the underlying issues to find other ways through is key.

9. GPs are a key point of contact for people who self-harm and should be supported through more training, so they are properly equipped to:

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

- Be better informed about the types of care, both clinical and non-clinical, that can be effective in supporting people with lived experience of self-harm so that they can make the most appropriate referral to further support.

- Spot the warning signs of distress to they can help prevent people from reaching crisis point.

10. The Welsh Government should ensure that self-harm is given equal weight in local and regional self-harm and suicide prevention forums.

We recognise and welcome the Welsh Government's suicide and self-harm strategy for Wales. However, we must ensure that local and regional forums give equal attention to self-harm and the ways in which agencies can collaborate to prevent and support people with self-harm.

11. There must be investment in evidenced-based interventions to develop appropriate support for people who self-harm from different communities.

The Welsh Government and NHS Wales should engage with people with lived experience to further develop their approach to self-harm. There needs to be wider understanding of what works in supporting different demographic groups and communities, including BAME communities, LGBTQ+ communities and people from socio-economically disadvantaged households in Wales. We must hear from people with lived experience of self-harm from these groups and carry out 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.

12. The Welsh Government must improve data collection practices and present population level self-harm data in an accessible and transparent way.

This would enable government departments, local authorities and third sector organisations to evaluate the impact/success of different services/interventions and would lead to evidence-based interventions. It would also make it easier to achieve funding in this area.

Acknowledgements

Our thanks to all participants involved with our roundtable discussion and engagement on this subject. This report is based on these discussions; however, the recommendations are from Samaritans Cymru.

- ProMo Cymru
- Professor Ann John
- NHS Wales Health Collaborative
- Welsh Ambulance Service NHS Trust
- Mental Health Foundation
- ACE Support HUB
- Church Army
- Charlie Waller Memorial Trust
- Time to Change Wales
- South Wales Police
- Betsi Cadwaladr University Local Health Board - Child & Adolescent Health
- Diverse Cymru
- Denbighshire County Council
- Platfform
- Wrexham County Borough Council
- Children's Hospital for Wales
- Heads Above the Waves

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