



**Assessing the Impact of harm-ed’s 2014/2015 training courses**

**for members of the Children, Young People and Families’ Workforce**

**entitled *“Children and Young People who Self-Harm”***

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1 **Introduction**

1.1 Background

Commission for self-harm training courses

1.1.1 Harm-ed Limited is a specialist, user-led, self-harm training and consultancy organisation established in 2007. It is a Lancashire based not-for-profit organisation which delivers training on both a local and a national level for partners including social services, schools, colleges, mental health services, young people’s centres, residential children’s homes, homeless organisations for young people and young people’s addiction services.

1.1.2 In January 2014, Lancashire County Council (LCC) commissioned harm-ed to design, deliver and evaluate a minimum of 10 full day training courses on the subject of children and young people who self-harm to members of the Children, Young People and Families' Workforce (CYPWF) across Lancashire. Members of the CYPWF include the voluntary sector and cover eight different sectors, namely early years; education; health; social, family and community support; sports and culture; youth; justice and crime prevention and the managers and leaders of children's and wider public services.

1.1.3 One of the core objectives of the service was to deliver the training “across Lancashire ensuring equity of access and an even representation of the workforce” and one of the key outcomes was to ensure that participants were made aware of services which could be accessed locally throughout Lancashire in order to provide effective support to children and young people who self-harm. This therefore required a county-wide approach to the delivery of self-harm training.

1.1.4 The service was designed so as to contribute to the priorities identified in Lancashire's Children & Young People Plan and the emerging priorities of the Lancashire Emotional Health and Wellbeing Commissioning strategy. A comprehensive list of expected outcomes was stated in the Service Specification, and the overall outcome was for members of the CYPWF to be equipped with the knowledge, skills and confidence they need to support young people who self-harm.

Meeting demand for training places

1.1.5 In total, 820 requests for training places were made, 117 of which were identified as ineligible - mainly by reason of location, or being adult service providers. As demand for places significantly exceeded the number of training places available, harmed and LCC agreed strict guidelines for the allocation of training places, with priority being given to organisations which worked with CYP who were self-harming. As a general rule, it was decided that only one place per course per service could be offered, but greater leniency was extended to services which were regarded as `county-wide’.

1.1.6 It soon became clear to LCC that additional courses to the 10 planned would need to be arranged and therefore, in addition to two extra courses that harm-ed organised within the contract price, LCC commissioned three further training dates from harm-ed. The final of these training courses was delivered on 10 July 2014.

1.1.7 In total, 265 partners attended one of the 15 available training dates. Care was taken to ensure that each training course represented the diversity of the services supporting CYP and care was also taken to provide a mix of boroughs to facilitate the sharing of good practice/networking; this also complied with LCC’s requirement for whole system relationships to be promoted throughout the service.

Involvement of training partners in course content

1.1.8 Those allocated places on one of the self-harm training courses were regarded by harm-ed and LCC as training partners. As such, harm-ed sought to fully engage them and involve them in shaping course content in order that the training specifically met their needs and expectations.

1.1.9 Prior to attending the training, each partner was asked to complete a pre-course questionnaire in which they were asked to describe any specific issues or areas of concern they had regarding self-harm that they would like to be addressed during the training. They were also asked to state anything else they hoped to gain from the training course. Some examples of their responses are given in paragraph 3.26 of the Evaluation Report.

1.1.10 Before leaving the training course, partners were asked whether they felt that the course had met the needs and personal learning outcomes they expressed in their pre-course questionnaires. All but 2 of the 265 (99.2%) partners responded affirmatively.

Key outcomes delivered

1.1.11 The 15 courses were delivered in four main venues to ensure geographical representation:

* Burnley 4 training courses 72 partners trained
* Preston 4 training courses 70 partners trained
* Chorley 5 training courses 90 partners trained
* Lancaster 2 training courses 33 partners trained

1.1.12 The chart below shows the breakdown of sectors within the CYPWF which received self-harm training.

1.1.13 The chart below shows the total number of partners trained per borough.

1.1.14 The chart below illustrates harm-ed’s performance against targeted outcomes:

1.1.15 In relation to schools attending the training, 100% reported having increased knowledge of self-harm; increased confidence in the subject area; and increased confidence in being able to support young people who self-harm.

1.2 Follow-up Impact Assessment

1.2.1 In January 2015, LCC commissioned harm-ed to consult all partners who attended the above April to July 2014 training to find out whether, and if so how, the knowledge and insight gained by partners translated into a change in working practice.

1.2.2 Consultation will be by way of an online Impact Assessment Survey, and partners will be invited to participate by way of a telephone interview also.

1.2.3 Care will be taken to ensure that responses are representative of partners both in terms of geographical area and sector, and any sectors/areas under-represented will be specifically targeted for feedback.

1.2.4 The draft report will be produced for a meeting between LCC’s lead commissioner and harm-ed on Tuesday, 24 March 2015, and the final version of the report will be completed by the end of March 2015.

1.2.5 A copy of the survey questions is attached at Appendix I.

2 **Planning and Methodology**

2.1 Since survey response rates are notoriously low, guidance was taken from the University of Nottingham’s Survey Unit[[1]](#footnote-1) as to the best ways of achieving a favourable response rate. It was also anticipated that the positive evaluations of the training might lead to higher levels of participation.

Survey Format

2.2 According to Solomon, 2001, `several studies have found Internet surveys have significantly lower response rates than comparable mailed surveys.’[[2]](#footnote-2) However, since all partners had submitted email addresses, it was decided that an online survey would offer the best format to ensure accessibility and convenience.

2.3 The only compulsory field for completion was `organisation’.

2.4 To take account of time constraints, the survey was designed so that partners could complete as much or as little as they wished to, or felt relevant to their service. It was felt that this would improve participation and lead to partners contributing feedback relevant to their service and sector.

Target Population and Method of Distribution

2.5 The nature of this study was such that the views of as many partners as possible were sought. As such, all partners attending this training were included in the study.

2.6 As the survey was appropriate to all partners, a positive impact on response rates was anticipated.

2.7 According to Solomon, 2001, `personalized email cover letters, … [and] pre-notification of the intent to survey’[[3]](#footnote-3) are factors which have been found to increase response rates.

2.8 Care was taken to identify with individual partners by personalising email messages to all non-LCC partners; since the training and impact assessment survey were both commissioned by LCC, higher response rates were anticipated from LCC staff.

2.9 A momentum-building strategy was also adopted by emailing advance notification of the survey a week before sending training partners the link to the online survey.

2.10 Training partners were offered the opportunity for a telephone interview as an alternative means of participating in the study. It was envisaged that richer evidence may be obtained this way as it would allow the interviewer to delve deeper into information provided and the impact of the self-harm training.

Incentive to participate

2.11 The advance notification letter advised training partners that the impact assessment study provided a good opportunity for training partners to share good practice, including changes in working practice and strategies for supporting children and young people who self-harm.

2.12 Harm-ed offered an additional incentive for training partners by inviting them to take part in a free prize draw, where the prize-winner could win £50 worth of free self-harm training publications.

Return of the Survey

2.13 The covering letter for the survey contained a link to direct training partners to the survey.

Time Limits

2.14 Training partners were given a deadline of 23 February 2015 to submit their completed survey forms online. It was hoped that by sending out advance notification about the survey at the end of January, the 14-19 days allowed for completing the survey would be sufficient, particularly taking into account the fact that the half-term week fell in the week before the deadline.

2.15 Advance testing of the survey, including test submissions, was carried out before making it `live’.

Reminders

2.16 Reminders were only used with those training participants who had advised harm-ed following the advance notification email that they would be happy to participate in the study.

The Questions

2.17 To give training partners the opportunity to provide comprehensive and meaningful feedback, the survey questions were formulated with reference to LCC’s Service Specification, course learning outcomes, pre-course evaluation responses and qualitative data contained in the post-course evaluation feedback.

2.18 Care was taken to group relevant questions in a meaningful structure.

2.19 In all, there were 17 questions to the survey, but several had more than one part to the question in order to collate both quantitative and qualitative data.

2.20 Through test submissions, it was estimated that the survey would take 15-20 minutes to complete. Obviously this would depend on how much feedback training partners wished to provide. Training partners were notified in advance of how much time the survey would take to complete in full, and were advised that they were under no obligation to complete the entire survey. Instead, they were asked to spend as much or as little time as they could spare and to focus their feedback on those questions which provided the best opportunity for them to describe the impact of the training on their organisation/service. This was possible because `name of organisation’ was the only compulsory field to be completed before the survey could be submitted online.

Survey Timeline

2.21 End of January Sent out advance notification of survey via email and cover letter

attachment (Appendix II)

5-10 February Sent out email with covering letter containing link to survey.

Deadline set for 23 February (Appendix III)

25 February Email explaining response update considerably lower than expected

and extending deadline to 2 March (Appendix IV)

2 March Survey deadline

3 **Findings**

Response Rates

3.1 Despite implementing many of the suggestions from the University of Nottingham’s Survey Unit, the initial response rate was only 11%. Harm-ed did not feel that this would lead to sufficiently representative findings, and therefore wrote to those partners who had not participated explaining these concerns and extending the deadline for submission by one further week. The low initial response rates indicate that the positive evaluations did not provide any initial advantage, although the peak in response rates following the email sent on 25 February 2015, together with the comprehensive nature of the feedback provided on the survey responses, suggests that partners were very keen to ensure the success of this impact assessment study.

3.2 The final response rate was 29.1%, representing 77 responses from the 265 partners trained. As a total of 12 emails did not reach the training partners, the total percentage of returns was 30.4%. When training partners were absent for the period of the survey, alternative contacts were sought to complete the survey.

3.3 It was found that the response rate for non-LCC partners was significantly higher than that for LCC staff. This would indicate that the personalised approach to targeting partners was one of the factors which influenced non-LCC partners’ decisions to participate in the study. 23 out of a possible 103 LCC training partners took part in the study (22.3%); this compares to 55 out of a possible 162 non-LCC training partners taking part in the study (34%).

3.4 In total, 5 training partners elected to participate by way of telephone interview and these lasted between 30-50 minutes.

3.5 Although the free prize-draw incentive to participate was well-received by training partners, in that 85.9% participated in the prize-draw, the initial response rate of just 11% indicates that this incentive had little bearing on the decision of training partners to participate in the study.

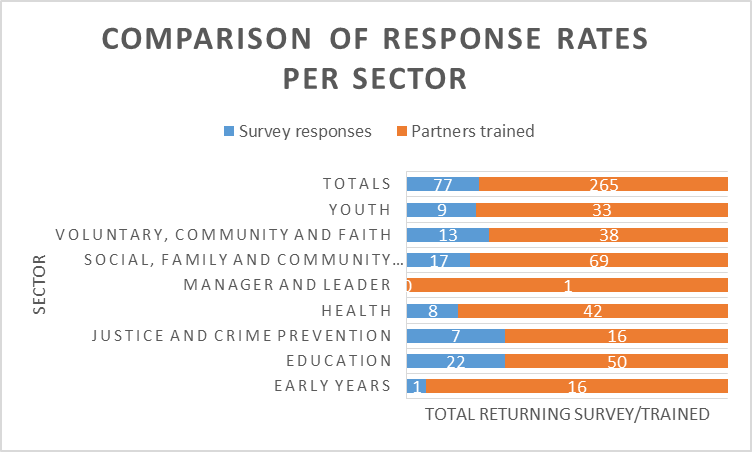
3.6 The low initial response rates could also be indicative of the fact that many training partners were taking leave the week before the deadline of 23 February 2015. It was for this reason that the deadline was extended by a further week, to 2 March 2015.

3.7 Although training partners were given the opportunity to submit only part of the survey due to time constraints, in fact all 77 participating in the study completed the full survey, albeit in varying depths.

3.8 Response rates from schools may have been impacted due to the fact that several schools reported having access problems due to Firewalls in operation within their establishments. This resulted in 4 of the 5 telephone interviews mentioned in 4.4 being conducted with schools. One head teacher was able to get around this problem by accessing the survey from home.

3.9 The Education sector accounted for 22 (28.2%) of total response rates. Given the above accessibility problems, it is likely that the proportionate response rate for this sector may have been even greater.

3.10 A breakdown of responses per sector is given in the graph below. For each sector, this is compared against the number of partners trained per sector.



3.11 From the above, it can be seen that the sectors trained are not evenly represented in the survey results. This outcome is beyond the control of this study. Furthermore, the Sports and Culture sector is not represented in this study due to the fact that there was no uptake on the offer of self-harm training from within this sector.

3.12 The chart below shows the proportionate representation in the study per sector. The figures represent the percentage of training partners who took part in the study per sector. For example, from the chart above, it can be seen that 13 out of a possible 38 training partners from the Voluntary, Community and Faith Services (VCFS) sector completed an impact assessment survey. This represents the 34% shown below.

3.13 From the chart at 3.12, it is reasonable to assume that the study results will be most representative of the Education, and Justice and Crime Prevention sectors.

Recording, Analysing and Interpreting of Data

3.14 In some cases, the responses provided did not seem to correlate to the question asked. Where it was seen that the responses in fact matched later questions better, then this feedback was analysed in relation to those questions, with care taken not to double-count such feedback.

3.15 When the telephone interviews were being conducted, it became clear that participants had additional things to say on some questions where no space was provided. This would have benefited from a telephone interview forming part of the trial run.

3.16 There may have been some ambiguity in the interpretation of the scale 0-5 in Question 12 where participants are asked to grade how successful they feel their engagement with and support of carers has been. For instance, it has been interpreted in this study that, because participants were told to take 0 to mean `not at all successful’ and 5 to mean `extremely successful’, that a mark of 1 means `not very successful’; 2 means `quite successful’; 3 means `successful’; and 4 means `very successful but still room for improvement’. Because this more detailed explanation was not provided to participants for fear of alienating them due to the length and apparent complexity of the preamble to this Question, it is not clear whether participants will have interpreted the categories in the same way. See 4.126.

4 **Survey Results**

Q1: Do you consider that you have developed a better understanding of the social, environmental and psychological factors which might help explain a CYP’s (child or young person’s} self-harm?

4.1 100% of all participants (77) considered that they had developed a better understanding following the training of the social, environmental and psychological factors which might help explain a CYP’s self-harm.

4.2 When asked whether this increased understanding helped explain **why certain groups** have higher rates of self-harm, 81.3% (61) confirmed that it did.

4.3 When asked to expand on their affirmative answer to whether their increased understanding helped explain why certain groups have higher rates of self-harm, in the main the comments made related more to the ways in which the training had helped them to understand about why CYP generally self-harm, rather than specifically why *certain groups* of CYP self-harm. This may be because participants had not identified any trends relating to specific groups of CYP. The main categories of responses are given in bold below.

4.4 **Groups of CYP prone to self-harm**: 18% (11) of participants shared their increased understanding of why certain groups self-harm. 63.6% (7) of responses under this head came from schools, who found that self-harm was prevalent amongst the following groups: boys (this view was shared by Barnardos); Asian females aged 15 and over; groups who face higher levels of adversity including looked-after children and those who are lesbian, gay, bisexual or transgender (LGBT); teenagers, particular Years 9-11 due to GCSE pressures, self-image and insecurities about future aspirations. Another example was given of young people who are subject to trauma who may use self-harm as a way of coping: `It is something they can keep control of’.

4.5 **What makes CYP self-harm:** 37.7% (23) put forward their understanding of what makes CYP self-harm. For example, `as a method for expressing other concerns’; `self-harm can be a coping mechanism when control is lost in other areas, e.g., helps them cope with emotions’; `if a child or young person has experienced an abusive situation they may want to gain control of their body through self-harm’; `it may be a way to help them transfer their inner pain outside’; `people who self-harm often have an extremely negative image of themselves, have very low self-esteem and believe they are “worthless” because of experiences they have been through’; `people … self-harm to release that build-up of pressure/anxiety’; `emotionally vulnerable children find it difficult to express their feelings’; `I have used this along with safety planning in my interventions with young people and found it to work very well’; `self-harm not being the issue but the issue that causes it to happen’; `it seems to be those who are lacking power and control in their lives. It is a way for them to take this back’; `desperate response to distress’.

4.6 One health professional described how this increased understanding enables them `to be more empathic and therefore support the development of positive and therapeutic relationships’ with CYP who self-harm.

4.7 One participant stated that self-harm itself can be seen as a medical diagnosis in some cases.

4.8 7 participants specifically emphasised that self-harm amongst CYP was not a form of attention-seeking, and 2 of these participants confirmed that the training had altered any such misconceptions they previously had, particularly when the self-harm took the form of superficial cuts: `It’s not for attention but genuine self-help’; `It doesn’t matter how deep or shallow scratches are; don’t see it as seeking attention – it’s because they need help’; `If there’s a mark, there’s a problem’; `It is an illness which needs dealing with sensitively like any other illness’; `Think more carefully without judging.’

4.9 The term ‘attention-seeking’ is discussed during the training in respect of the negative responses that can result from using this term, i.e., the usual response is ‘it’s just attention-seeking so ignore it’. Participants are instead encouraged to acknowledge that a CYP may indeed be trying to seek some care and attention through their self-harm and they should not be judged negatively for this.

4.10 **Self-harm triggers:** 29.5% (18) expanded by demonstrating their awareness of the self-harm triggers for CYP. Most stated that CYP may be experiencing difficult social circumstances, and lack sufficient support networks. One participant explained that `Young people who, through no fault of their own, may find themselves in circumstances that are so challenging and beyond their control, that self-harming can provide temporary distractive relief’. The importance of understanding the impact of their background on them was also emphasised. Examples of triggers included abuse, neglect, bullying, family issues, sexual identity issues, socio-economic issues, significant life events, appearance and lack of confidence. Many participants described how CYP may encounter increased stress and anxiety due to pressure from parents, education (particularly around exam times), media, culture and peer pressure/social groups.

4.11 **Other responses**: Five participants described how the trainers’ own personal experiences of self-harm had been fundamental in helping to improve their understanding of the social, environmental and psychological factors causing CYP to self-harm. Four participants described how the training had been invaluable in helping them to perform their roles better, and a further 2 stated that they had not realised how much they didn’t know about self-harm before attending the course.

Q2: Do you feel better able to identify the signs that may indicate that a CYP is self-harming or at risk of self-harming?

4.12 90.9% (70) of all participants reported feeling better able to identify the signs that may indicate a CYP is self-harming or at risk of self-harming.

4.13 7.8% (6) were unsure whether or not they were better able to identify the signs of self-harm. Of these, 50% (3) giving this response were schools.

4.14 Two participants who responded `Don’t know’, and the 1 participant who answered `No’, did not take advantage of the opportunity provided to expand on their response. However, of those who did, they explained: `I would know how to identify a CYP who is experiencing mental distress rather than specifically self-harm’; `Even though the training was really good, students today seem to be more alert as to how to be able to hide it without drawing attention to themselves … I am now more aware and more alert at looking for things however’; and `… the least likely students are presenting out of the blue’; `I think I was aware anyway.’

4.15 Most of those who answered affirmatively gave examples of the signs that they might look out for to indicate a CYP may be self-harming or at risk of self-harming; these included behavioural factors which might indicate self-harm and specific forms that self-harm might take. Three participants, including two from the Health sector, placed some reliance on research findings and the CYP’s `biopsychosocial’ background as a risk factor to indicate self-harm or the risk of self-harm. One participant indicated that they would look at the triggers more than the responses in order to identify CYP who might be self-harming or at risk of self-harming.

4.16 The most frequently occurring signs indicating self-harm or the risk of self-harm in CYP were those cited by participants working in the Education sector (though it must be noted that some of these responses were not confined to training partners from this sector). These included CYP covering their arms and legs; missing school; avoidance of certain lessons such as physical education and swimming; disengagement, e.g., with usual friendship/activity groups; increasingly becoming disengaged, withdrawn, spending time alone; attending clubs to avoid lunch; and lowering academic achievement.

4.17 Other indicators of self-harm cited included more subtle changes in behaviour; nervous behaviour such as picking lips; over/under confidence; signs of depression; lack of motivation; unusual weight loss/gain; poor self-image; wearing weather-inappropriate clothing; low self-esteem; other responses to stress such as anger, volatility, secrecy, and mood swings.

4.18 Those participants who put forward examples of behaviour which they regarded as indicative of self-harm or the risk of self-harm included; cutting[[4]](#footnote-4); burning; head-butting; eating control; pinching, bruising/marks especially on wrists; substance abuse; and risk-taking.

4.19 Some other respondents found more subtle indicators of self-harm. For example, one participant from the Youth sector found that the words the young person used and the experiences they describe can alert them to the risk of self-harm and one participant from the Justice and Crime Prevention sector stated `I have recognised it through some recent inputs/work with youngsters through probing questions and signs that I would probably not have seen before.’ One participant from the Health sector acknowledged that the ability now to recognise the subtle signs have helped him a lot: `Things are not always cut and dry.’

4.20 One participant from the Youth sector made reference to having benefited from the multi-agency nature of the training partners at their course: `The group discussions around the signs we had all picked up were very useful. I was aware of certain signs but other members of the group were aware of different signals. Information sharing with the group was good as we were from different agencies and remits.’

Q3: Has your increased awareness of the reasons why a CYP might not want to disclose or access support for their self-harm resulted in your being able to implement strategies to help break down these ‘barriers’

4.21 84.2% (64) of the 76 participants responding to this question, said that their increased awareness of the reasons why a CYP might not want to disclose or access support for their self-harm has resulted in them being able to implement strategies to help break down these `barriers’.

4.22 7.9% (6) participants said that they had not implemented strategies to break down barriers preventing CYP from disclosing their self-harm or accessing support. The same number of participants responded that they didn’t know whether any such strategies had been introduced within their service/organisation.

4.23 One participant from the Education sector included a comment for this question in her feedback for question 4. With her improved understanding of why some CYP might choose not to disclose or access support for their self-harm, she now adopts an open approach with the CYP rather than trying to `brush it under the carpet’. By broaching their self-harm with them in an environment of trust and understanding, this now enables her to help the CYP ensure that, if they cannot stop self-harming, then they do it more safely, e.g., clean blades, elastic band, red pen.

Q4: What strategies/change in working practice, if any, has your team/service developed to reduce the risk of self-harm in CYP?

4.24 81.8% (61) of the 77 responded to this question.

4.25 In order to facilitate the sharing of good practice, responses have been analysed and reported per sector.

4.26 **Education sector:** 27.8% (17) of responses were from the Education sector who cited the following strategies/changes in working practice following the training to reduce the risk of self-harm in CYP: `school nurse drop-in every week; individual mentoring sessions weekly; 2 school counsellors; other trained staff on hand full time’; pastoral staff to support students who self-harm on a day-to-day basis; cascading training down (including to mentors); involving more colleagues in handling issues of self-harm so that they are building their own confidence where once they used to panic; awareness raising through targeted assemblies; effective referrals for support from other agencies; ensure CYP know where they can go to talk in a safe space without being judged for their method of coping; working in partnership with school nurse who will be delivering group work sessions; proactively identifying pupils at risk; encouraging teaching assistants to talk to CYP who self-harm or are at risk of self-harming; getting senior management on board to find best ways of helping to reduce self-harm and support CYP who self-harm; providing CYP who self-harm with someone they can talk to without feeling judged and ensuring that, if the CYP is going to self-harm, they will do so safely by providing `clean blades, elastic band, red pen’.

4.27 One pastoral member of staff in a primary school described how the training had enabled her `to develop a positive relationship with children so they come along and chat to her’. She struggles to identify those who don’t disclose/come for support and so informs other school staff about the things to look for and seeks to develop their awareness about the children’s emotional needs and behaviour. `Also since the training I have identified a lot of children that do self-harm compared to secondary school where there would be more self-harm. Even children as young as 4 show signs of self-harm, e.g., scratching, banging heads, so the pastoral support team has grown and strengthened. `Empathy has come through information and development. It needs to be considered all of the time’ in the support of CYP who self-harm.

4.28 Several schools emphasised the importance of now adopting early intervention strategies, with one school coupling these with giving students who self-harm `a 4-week block of help and support with follow-ups during the year’. Another school described how they have adopted an holistic approach by changing their `pastoral/safeguarding structure in order to secure a consistent approach to working with pupils who may self-harm’; updating information relating to self-harm for all staff and increasing the hours of their school counsellor.

4.29 One school described how they seek early involvement of agencies when there is any risk of self-harm, together with involvement of school nurse and counsellor for additional support - `We have a self-esteem group work in-house as well as being delivered by other agencies such as Safelink’. They also described how `We have changed our Pastoral/Safeguarding structure to secure a consistent approach to working with pupils who may self-harm. We have provided updated information for all staff. We have increased the hours of our school counsellor.

4.30 Another school spoke about placing reliance on information via a carer, parent or friend `gossiping’, and working closely with ELCAS[[5]](#footnote-5) in Burnley and CAMHS[[6]](#footnote-6) in Rochdale.

4.31 In relation to supporting families, one participant said that they give any CYP who self-harm a copy of a free MIND booklet[[7]](#footnote-7) relating to strategies to support families and CYP; `Don’t just say they can’t do it, as they will do it all the more. Try and get them into positive ways of thinking. If they are doing it, make sure they keep wounds clean’; when finding out about a CYP who self-harms, invite their family to come into school or talk on phone – talk with CYP there so they hear. Emphasise to parents that they must not shout at the CYP about their self-harm as it is an illness. Try and work through it together. Give parents booklet from MIND and tell them about harm-ed website. Tell them to seek support of their GP if they are concerned. This school used to be able to refer parents to the Butterfly and Phoenix projects, but these are not taking on new referrals now since their funding ceased from the end of March 2015. These projects also came in to talk to CYP individually and were widely used in the school to great success. The school (from Lancaster and Morecambe) is concerned that there are no alternative referral services in their area. They said they could possibly go through the early intervention panel to see if they have any suitable services, but otherwise would welcome hearing about any other similar services to the Butterfly and Phoenix projects. They did mention they could use the CAMHS service for really serious cases but described how over-stretched CAMHS is and how they have an 8-month waiting list.

4.32 **Social, Family and Community Support** **sector:** 21.3% (13) of responses came from participants from within the SFCS sector. Many training partners under this sector were employed by Lancashire County Council, under its Children and Young People Directorate, and respondents to this question included the following services: Safeguarding, Family Group Conference; Residential Care Homes; Fostering; Children’s Social Care; and the Post-Adoption Team.

4.33 Participants from the Young People’s Service are grouped under the Youth sector at 4.49 below.

4.34 Participants stated how, since the training, they had now asked management to encourage more staff to attend this training so the value is felt across the whole service. One participant described how her service would signpost the CYP/family to early intervention services, and would access a person in a school that the child could relate to for emotional support. She would also support parents and foster carers in supporting the CYP who is self-harming.

4.35 One Residential Care Home emphasised the importance of educating not only those CYP who self-harm, but also those who look after or care for them. To them, the increased incidence of self-harm in CYP suggested an inadequacy in their emotional wellbeing, therefore emphasising the importance of improving listening, communicating and nurturing skills. Another Residential Care Home described their work in using robust risk assessments, SCAYT+[[8]](#footnote-8) involvement, one-to-one key working, and referrals to counselling. Another described how her service had now introduced a form for young people to complete so that they can describe how they feel before, during and after self-harming; the form also asks what the service can do to help prevent them from self-harming, or what is the best way for the young person of the service responding to their self-harm. This form of questioning is also practised by Preston City Social Services.

4.36 The Safeguarding Inspection and Audit team described how, `through more robust audit processes, we are able to read a case file and identify possible indicators, raise this with social workers and facilitate support for the young person.’

4.37 A member of Lancashire County Council’s Family Group Conference team described how she had, following the training, changed the way she works with young people who self-harm. She went on to say that she no longer feels afraid to acknowledge and ask about signs that a young person is self-harming, and to explore their emotional difficulties with them.

4.38 The Fostering Service described how they encourage carers to be more open-minded about self-harm, give advice on the best approach to take when advising a child who feels the need to self-harm. They also encourage carers to approach the service for further advice and support. One foster carer responding described how the training had caused him to become more aware of his looked-after CYPs’ behaviour and possible pre-cursors to self-harm. A member of the Recruitment and Assessment Team which trains and approves foster carers and adopters described how she will use the insight into CYP who self-harm `when undertaking viability visits and delivering pre-approval training to applicants in preparation for the different needs CYP may present once in placement on approval’.

4.39 **Voluntary, Community and Faith Services sector:** 14.7% (9) of responses came from participants representing the VCFS sector. Inter alia, this sector included training partners from Barnardos, and a diverse range of other community services.

4.40 The five participants from Barnardos who responded to this question on strategies and changes in working practice to reduce self-harm provided the following feedback. One participant described how Barnardos focusses its service on supporting CYP who self-harm by promoting their emotional resilience. This focus on a CYP’s emotional wellbeing appear to be a common cross-sectorial focus in this study. One support worker explained that she is now making more referrals to Barnardos’ Emotional Health and Wellbeing Service if the risk of self-harm is more than she feels able to deal with.

4.41 When giving harm minimisation advice, one Barnardos support worker described how she now offers alternative suggestions to self-harm as a result of the training. In line with the comments in 4.38 above, this support worker is no longer putting on action plans that the CYP will self-harm less because she now understands that this merely adds to the CYP’s shame and guilt if they fail. Another Barnardos support worker described how she has tried to control her reaction when a CYP tells her they are self-harming; one young person whom she was supporting advised her that this response made them more likely to open up than if someone acts shocked or disapproving.

4.42 Barnardos’ Edge of Care service has also been increasing its resources to help offer appropriate support and advice to families who have experience of self-harm.

4.43 Responses from other community services stated that their increased understanding of self-harm allowed them to offer better advice to young people who self-harm or who are at risk of self-harming; they better understood when and where to make referrals on to; better referrals resulting from increased knowledge of relevant support groups; keeping channels of communication open and encouraging CYP to talk to people they can relate to; giving CYP access to self-help phone numbers and helpline information; and one counselling and advice service described how they had established `policies/procedures that need to be adhered to in the risk of `harm’ reporting system after process of counselling with person’.

4.44 **Health sector:** 13.1% (8) of responses came from participants from within the Health Sector. Several participants described how they try to ensure that the CYP they see who have self-harmed are supported by CAMHS, including using a CAMHS Link Nurse on the ward; provide `individual psychological work or group work with a DBT basis’[[9]](#footnote-9); and provide harm-minimisation advice.

4.45 Lancashire Care NHS Foundation Trust’s Criminal Liaison Team described how they were now using specific assessment tools for young people rather than the generic adult tools that were previously used. This is because they regard young people as `individuals in their own right and not as young/mini adults’.

4.46 Blackpool Teaching Hospitals described how they seek to ensure quicker access to support services for CYP who self-harm. They also encourage CYP to return to their service regarding the same issue if the CYP does not feel they are being adequately supported elsewhere. They encourage visits to the school nurse who has the opportunity to see the CYP more frequently. For those CYP who do not wish to be referred, they discuss with them ways of improving their self-esteem, for example by helping them find ways of improving difficult relationships or finding a hobby, etc.

4.47 University Hospitals of Morecambe Bay NHS Foundation Trust described how they are taking the lead in developing a suicide and self-harm pathway for CYP in their region where they will work closely with other agencies to develop strategies for supporting CYP who self-harm. The lead on this pathway, which has still to be ratified, praised the interactive nature of the training from trainers with personal experience of self-harm and described how the training helped him in his role as he now appreciates that self-harm is a complex condition.

4.48 **Justice and Crime Prevention sector:** 4.9% (3) of responses came from participants from within the Justice and Crime Prevention sector. Two participants mentioned the cascading of information to colleagues following the training.

4.49 One strategy put forward by the Police Early Action Team was `earlier referral to PAEH[[10]](#footnote-10) panels for emotional health support for the CYP which I may not have considered before attending the course’.

4.50 One participant from Cumbria and Lancashire Community Rehabilitation Company explained how, as a result of the training, they have shifted their focus from solely trying to prevent self-harm and more on trying to understand *why* a young person may self-harm: `for the young person that is their way of coping so, without it, what is in place’.

4.51 **Youth sector:** 9.8% (6) of responses came from participants from the Youth sector. These were all representing the Young People’s Service (YPS).

4.52 One participant described how their improved understanding of the signs to watch for meant that they now asked open-ended questions when talking to a young person they suspect may be self-harming in order to give the young person an opportunity to open up to them. Another participant described how they place greater emphasis on identifying young people who are vulnerable to mental health difficulties in order that they can be offered suitable support as early as possible. Another member of the YPS stated that the training had made her realise that she can’t change the young person’s self-harm overnight or even at all: `Talking is good and trying to safeguard the young person is important.’

4.53 One participant from Lancashire County Council’s Targeted Youth Support Alternative Education Service described her service as `an early intervention support service – we promote positive activities as a way of increasing emotional well-being and self-esteem. Our way of working is “person centred” where we aim to put the young person first and build a relationship on trust. It is because of this that we are able to build positive relationships with the young people we work with’. This focus on developing emotional wellbeing was touched on by another participant who stated that his service works on building the self-esteem of both males and females.

4.54 **Early Years sector:** 1.6% (1) of responses came from within the Early Years sector. This participant described how they have made all the members of their team aware of the early signs of self-harm and how to make referrals to the service’s own counsellor.

Q5: Please describe any other strategies, procedures, or change in working practice that have been developed following your attendance at the self-harm training (please include any that are in the process of being developed also).

4.55 When asked to describe any other strategies, procedures or change in working practice (existing or pending), 51.9% (40) participants responded. Of these 40 responses, 14 (35%) were from the SFCS sector; 10 (25%) were from the Education sector; 6 each (15%) from the health and VCFS sectors; 3 (7.5%) from the Youth sector; and 1 (2.5%) from the Justice and Crime Prevention sector. Responses are broken down per sector, in chronological order according to the number of participants within each sector. Note, however, that where feedback is merely a restatement of participants’ comments for Question 4, this will not be included. This is the same with those respondents who responded `as above’, indicating that their answer for Question 5 has already been given under Question 4.

4.56 **Social, Family and Community Services sector:** Participants’ responses included harm minimisation advice and safety planning; explaining the risks of self-harm to the CYP and using examples of other CYP who have self-harmed in order to take the focus away from them; taking care to show a shared understanding of why CYP feel the need to self-harm; signposting CYP/family to early intervention services such as SCAYT+[[11]](#footnote-11) or ELCAS, and finding a balance between this and the CYP’s feelings of having no control; monitoring patterns/timings of self-harm and trying to identify whether it is copycat behaviour; professionals are better able to control their reactions which allows them to distinguish those who self-harm as a copying strategy from those who have deep-rooted reasons for self-harming; and understanding that trying to remove coping strategies can lead to an escalation in self-harm.

4.57 The Fostering Service stated `We are looking to discuss self-harm further at our foster carer support groups to increase knowledge over the whole service rather than just carers working with CYP who are self-harming’.

4.58 **Education sector:** Participants’ responses included strategies to support the cause not the action; explaining to parents and carers reasons for self-harm and that it is no one’s fault; developed a self-harm policy and how have a team to support students; starting group work with school nurse; and developing a leaflet for pupils about self-harm strategies in conjunction with the school nurse’s effective referral mechanism to CAMHS.

4.59 One school described how they have established a better procedure for communicating with parents, making recommendations regarding when medical help is needed, offering advice on how to initially deal with the shock of discovering their child is self-harming, making referrals to the school nurse, and follow-up calls to the CYP’s home thereafter. Throughout all this, the child will be encouraged to discuss any issues with allocated staff in the school.

4.60 One school described the pastoral team’s use of forms for teachers or teaching assistants to complete about any causes for concern which then goes to designated senior staff who discuss the best course of action for the CYP who is self-harming. The Pastoral Manager then speaks to the parent with the child’s consent, and the child can choose to be present or otherwise.

4.61 One school is exploring the possibility of inviting speakers to talk to children at assemblies about self-harm and its effects on friends and family as a PSHE topic (healthy living). This same school has noticed that there are about 10 prolific `self-harmers’, mostly boys, in Year 10 and therefore a system has been developed where, if they go to the toilets for longer than a certain time, a member of the pastoral team will check on them to ensure there are `no red mist moments’.

4.62 One school felt that, by keeping self-harm as low key as possible, they will be better able to find out who are genuine self-harmers and who is `jumping on the bandwagon’.

4.63 **Voluntary, Community and Faith Services sector:** Participants’ responses included the development of a new self-harm policy and including self-harm as part of induction training; including brief information about self-harm on volunteer training courses; use of Rainbow journals; better liaison with schools to establish wound management procedures, and working more closely with parents.

4.64 Barnardos reported having shared the list of local services they received from harm-ed with their team and `encouraging team members to complete the training as it was so valuable to our service and dealing with self-harm.’

4.65 **Health sector:** Participants’ responses included having introduced a `study day within the trust attended by social care, CAMHS, paediatricians, public health to increase awareness’; having put care plans in place for self-harming patients; and providing self-harm training for all staff.

4.66 A participant working within Lancashire Care Foundation Trust reported that its service is changing as from 1st April 2015 from an adult service to an all-age service and therefore they will have to develop strategies for CYP from 10 years upwards as opposed to aged 16 and over.

4.67 **Youth sector:** one young people’s service explained how their greater understanding of self-harm and the differences with suicide and reasons for CYP self-harming enables them to provide better support and service delivery to young people at risk.

4.68 **Justice and Crime Prevention sector:** The probation service described how they have shared course information to support others in offering a better quality service.

Q6: Do you feel that your increased awareness and understanding around self-harm has resulted in ‘conflict’ with work colleagues re approach/attitudes to self-harm?

4.69 Only 15.6% (12) of participants felt that their increased awareness and understanding around self-harm had resulted in `conflict’ with work colleagues re approach/attitudes to self-harm. 75.3% (58) reported no such `conflict’ was evident, and 9.1% (6) were unsure.

4.70 During a number of telephone interviews conducted, this was a question that did give rise to some uncertainty. From further discussions, it appeared that some participants who were going to respond `no’ to this question, had in fact noticed that there was a difference in approach and attitude amongst other staff. However, it appeared that the word `conflict’ was problematic for them since it seemed to suggest more than the participants would wish to convey. It is therefore suggested that a differently worded question may have generated a different result since at least two of those participants who were originally going to answer `no’ in fact answered `yes’ once they were satisfied that their answer conveyed a less resistant approach/attitude by work colleagues. Interestingly, 4 of those 12 participants who reported `conflict’ with work colleagues relating to differing approaches/attitudes to self-harm took part in telephone interviews; this could be interpreted to support the above aforementioned point surrounding the use of the word `conflict’.

4.71 Those answering Question 6 in the affirmative were asked to explain the nature of any such `conflict’. The main problems identified were colleagues’ lack of awareness and understanding of self-harm, and the tendency to view self-harm as a form of attention-seeking. This latter view was more evident in the Education sector, and in fact one participant from the VCFS sector described how any conflict which arose was with parents and other professionals. They cited one example where `One girl was stopped from going on a school trip because of self-harm and insurances however this added to her feeling of letting people down and she self-harmed again.’

4.72 Most examples of `conflict’ were cited by participants in the Education sector. They included statements that some staff would rather `ship the students out for fear of anything more serious happening. Rather than managing self-harm they are preferring to move it onto somewhere else. … Some take it too far (999) – not many’; `It’s NOT necessarily conflict – more due to lack of knowledge and understanding as well as not traditionally coming under their remit. Some teachers have limited understanding of children’s emotional and well-being needs due to their pressures about retention, attainment and education’; `Teachers tend to be more impatient’; `Many think self-harm doesn’t happen in primary schools and others think it is outside their realm as teachers’; `Colleagues are very happy for trained, experienced staff to deal with this, rather than every member of staff dealing with CYP. They generally prefer to refer to an allocated member of staff who has the knowledge, up to date information, sound knowledge of procedures and confidence to deal with self-harm’; `Some heated moments with teachers who see them as trying to get out of class where pastoral care team have had to insist on being able to deal with a CYP who is self-harming.’

4.73 Participants from the SFCS sector commented on a tendency to have conflict in dealing with incidents based on `old theories versus new theories in ways of minimising risk. Examples being “let’s get rid of all the glass and sharps within the building to stop them cutting” vs “If they want to cut, they will find a way and this may lead to using smashed plates or mugs or something else which may lead to more serious wounds. We cannot eradicate or police everything which can be used. We need to speak to the young people and ask them why and when they feel like they need or want to cut and ask if they want support when this happens and what would that support be if it could be given.’ Another participant described how `Some have felt that self-harm is always incredibly dangerous and needs to be addressed and stopped immediately, without understanding why it may be happening.’

4.74 One participant from the VCFS sector described how `Some of my colleagues think that I am encouraging self-harm by offering care and compassion to the young person – they have the view that the colder you are then the less likely the young person is to do it again.’

4.75 Participants from the Health sector noted there can be a `lack of understanding with some staff regarding self-harm and how best to deal with it in an inpatient setting’; and `some colleagues have an outdated view on mental health and they see it as a CAMHS case whereas it is everyone’s problem. Medics could do better but need training to do so.’

Q7: Do you feel more confident now in being able to broach the issue of self-harm with a CYP you suspect is self-harming?

4.76 97.4% (75) of the 77 participants responding felt more confident now in being able to broach the issue of self-harm with a CYP they suspect is self-harming. Only 2.6% (2) of participants were unsure whether they felt more confident in this regard; both of these were from the SFCS sector.

Q8: In what ways, if any, do you consider yourself/your service better able to offer a helpful response to a CYP who self-harms?

4.77 87% (68) of participants gave examples of the ways in which they felt better able to offer a helpful response to a CYP who self-harms.

4.78 Many of the examples cited have already been mentioned under feedback for Questions 4 and 5 above. In brief, these include: `Staff are much more confident in their ability to help and know that sometimes just listening is enough - doesn't always meant that a referral is necessary’; more effective signposting to help and advice; improved confidence in discussing self-harm with CYP and their families without fear of having a negative impact; greater awareness of harm minimisation and local support services; `We prefer to deal with the issues ourselves and refer to in-house counselling and/or with CYP permissions support parents/carers. If we refer to CAMHS services, a 6+ month wait if far too long and may result in issues escalating’; focus on causes not on securing immediate cessation of self-harm; improved understanding of self-harm as a coping mechanism; `Ideas to defer the physical harm, better idea how services might work together and possibly where to refer to’; `I've found people are more open and honest if they feel listened to and not told what they should and shouldn't do’; improved confidence discussing self-harm with CYP; able to offer a more proactive approach; `I am much less judgemental about the action which assists therapeutic relationships’; recognising that self-harm is a CYP safeguarding issue and, if not dealt with properly, it can `open a huge can of worms’. This training should be compulsory for all members of the pastoral team as well as heads of year; providing a needs-led service to CYP; improved communication skills when dealing with CYP who self-harm; importance of treating CYP with respect, genuine empathy and non-judgmental listening; put together up–to-date resource list to provide resources to support CYP who self-harm; disseminated understanding of causes and triggers which helps in support of pupils who self-harm; better understanding of *when* referrals are needed and *to whom*; no longer a taboo subject; using useful resources from the training; `use positive body language and allow patients to express feelings and feel confident in my responses’; better able to advise foster carers on how to minimise risks for CYP, along with signposting to other resources; `by being a better contact/safe person for the child, ensuring the child feels able to approach me when they are upset or have anything bothering them; more awareness of the psychological state of young people and respecting their choices; recognising the possibility that self-harm can result from an abusive environment; experienced staff who are trained and adopt a prompt and structured procedure; being prepared and able to cope, and always having first-aid materials ready; understanding their need for coping strategies but helping them to remain safe; the training has given me `the fundamental starting blocks to develop and adapt my practice in a way which is more focused on the child or young person’s needs’.

4.79 One participant from the health sector stated, `Become less focused on the negative and maladaptive behaviours and focus more on positive strategies, collaborative and therapeutic relationships, positive risk-taking. Also for all parties to have realistic expectations with regards to self-harming behaviours and a greater understanding that until the individual adopts more adaptive behaviours, the individual’s engagement in self-harming behaviours is likely to continue and in fact may increase. The short-term goal for the individual is to feel able to disclose any incidents of self-harming behaviours to health professionals without feeling negatively judged and hopefully for self-harming behaviours to reduce in severity and frequency.’ Another participant from this sector said, `I think a young person expects me to tell them to stop, whereas I will discuss the risks and ask them about what their goals are. Do they want to stop, how they want to stop, and keep the work client-focused.’

4.80 One participant from the SFCS sector stated, `I now understand the “bespoke” nature of self-harm and that each person does it in different ways and for different reasons. A good practitioner makes the effort to understand the reasons and ask questions to support and to listen. By caring and nurturing, hoping to develop a sense of self-worth and identity and eventually a rationale to find other coping strategies or to minimise the need and severity of the self-harm for the young person. This however will usually be a long process and a supportive approach.’ Another participant from this sector said, `Through trust, show you care, show you are upset, share own experiences, reinforce their positivity, raise self-esteem.’

4.81 Several participants commented on the value of having the course delivered by trainers who had personal experience of self-harm. One participant from the SFCS sector said, `This course was really good and very informative, particularly hearing from people who have experience of self-harming. I have heard from colleagues that this has had a positive impact for many front line workers who support CYP across the whole continuum of need.’

Q9: Do you feel that the outcome for the CYP who self-harm within your service has improved because of your increased knowledge?

4.82 53.2% (41) of all participants felt that their increased knowledge had led to a better outcome for CYP within their service/organisation. 39% (30) were unsure, and 7.8% (6) did not believe it had.

4.83 Those who answered this question affirmatively were asked to expand on their response. One major outcome cited was the shift from seeing self-harm as a form of attention-seeking and challenging their own and colleagues’ prejudices and stereotypical ways of thinking. Several participants gave examples of specific positive outcomes including one case where a young person had been prevented from self-harming further through openness and trust.

4.84 In the Education sector, one school described how `peers have referred friends who self-harm for help and support and they feel more able to do this as I have attended the course and am able to help them’. Another school described how `One parent was particularly struggling with their child. They could not understand the reasons as their child was bright, sporty and popular. When put to them as a coping strategy as in some people have a drink others take a bath they slowly started to change their view. It took a lot of intervention.’ A further school described how they are getting CYP to try other coping strategies such as red pens, elastic bands, writing rude words and shredding: `Find out what works. If all fails, make a referral to the next level of specialist help. If the CYP will not engage with specialists, I explain to their families that they are not ready to take the next step but encourage them to keep a close eye on the CYP and if their self-harm deteriorates to get medical help through the GP or A&E. Those are the most worrying cases for me. Some self-harmers get wobbly at the idea of half-term – they miss the support and nurturing. We’ve got a good rapport with local PCSOs[[12]](#footnote-12) so ask them to check on them.’ Further examples of positive outcome in this sector were, `I know of at least one CYP who is now managing difficult emotional triggers without resorting to self-harm’; and `We discuss with the CYP how we will proceed and help them take control of the situation and access help. We also support parents and link better with medical professionals’; `having been on the training and then supporting a Year 6 child through self-harm has enabled him to be able to verbalise some of his feelings rather than keeping them inwards and knowing it’s OK to do that. That has helped him.’ This particular participant had good links with the boy’s senior school and has been able to ensure continuity of care and support for him there: `He’s doing really well and has come back to see me. The most important thing for him was to know that he wasn’t being judged and that what he was doing was OK and that people didn’t think any less of him. He appreciated that we cared.’ The same participant cited another example of a young person who, before the training, used to pull her hair out: `She’s now at college and has done fantastically’. One participant described how a 6-year old pupil was regularly picking at scabs and making them bleed. The school supported her by chatting to her one-to-one and caring for her wound. She opened up about her feelings and now very rarely self-harms.

4.85 One participant from the VCFS sector explained, `I am working with a 16 year old at the moment and she self-harmed every day. I have worked with her for nearly a year now and her self-harm has reduced. She uses some other distraction techniques that I advised her on due to the training I received and these work for her. They do not work every day for her and some days are worse for her than others, but she knows if she cuts too deep she can come to me and I will help her clean her wound and dress it properly.’ Barnardos also confirmed that the outcomes indicate that their approach has impacted on CYP in a positive way. One participant from a residential service described how a young person who was known to self-harm came to live in his care home. `She has since had many occurrences of cutting, attempts to take her own life and set fires. Over the 6 months she has been resident, the incidents have almost reduced to zero. This has been largely, I believe, due to a more stable environment and nurturing adults around her without judgmental attitudes.’

4.86 Other responses included: CYP are better supported now following the training. This and their improved access to specialist support is leading to good results; being able to talk about it without fear of being judged has had a positive impact `and in each case there has been a reduction in self-harm’; `Some you win, some you lose. The ones that win are because the kids know they aren’t going to be told off for it’; ability to explain to parents and carers from the self-harmer’s perspective; `One of our young people has told me that the need to self-harm is less now that she knows someone is there for her.’

4.87 Some participants described how outcomes were improved as a result of the improved knowledge, understanding and attitudes of those supporting CYP who self-harm and their families.

4.88 One participant from the health sector described how they support unconditional positive regard, empathy and trusting therapeutic relationships to support CYP who self-harm to consider and experiment with other more adaptive coping strategies as alternatives to self-harming behaviours. Another participant from this sector explained how funding issues meant that CAMHS are coming in at weekends and out-of-hours which has helped.

Q10: Since attending your training, have you had to deal with any occurrences of self-harm in children and young people?

4.89 70.1% (54) of all participants confirmed that they had dealt with occurrences of self-harm in CYP since attending the training; 29.9% (23) reported not having done so.

4.90 When asked approximately how many different self-harming CYP they had dealt with, most participants stated 1 to 3 cases.

4.91 However, higher levels were recorded in the Education and Health sectors. In the Education sector, higher levels included: `several’; `10-15’; `20-25’; `10’; `10-20’;`5-7’; `8’; `currently dealing with 9 cases’. Each of these responses came from secondary education establishments. This seems to relate to some of the causes/triggers for self-harm put forward in 4.4 to 4.9 above. However, some participants made it clear that there were high levels of self-harm within primary education establishments also. The school which recorded 20-25 cases since the training explained that since training, they have `new kids coming in as it’s a high school. We inherit some from their previous schools though they don’t forewarn us. Parents often don’t want it disclosing as they want a fresh start (clearly not understanding the issue).’ This raises the question whether information-sharing protocols could be improved between feeder schools and secondary education establishments.

4.92 Participants working within the Youth sector, specifically the Young People’s Service, have also dealt with higher levels of self-harm. One participant had dealt with 6 different cases of self-harm in CYP, and another participant who works in a secure mental health unit reported that many of the young people he works with have used self-harming behaviour.

4.93 Higher levels of self-harm in CYP are also evident in the Health sector where responses included: `We deal with CYP self-harming on a weekly basis mainly paracetamol overdoses’; `Lots – more than 10’; and `3-4 patients admitted to the children’s ward per week with self-harming’.

4.94 In the VCFS sector, one participant from Barnardos stated that almost all of her cases involve an element of self-harm; and Safenet reported that they had dealt with 10 cases in CYP from as young as 4 years.

What type of support were you able to offer?

4.95 Of the 54 participants who described the type of support they had offered since the training, 100% (54) of participants had offered care and compassion to CYP who self-harm; 98.1% (53) had provided information re alternatives to self-harm; and 94.4% (51) had provided wound care/first aid, and referrals.

4.96 From responses scrutinised elsewhere in the report, it is clear that some participants do not have direct contact with CYP who self-harm but with others who care for them. It was also clear that one or two had not had to deal with any incidents of CYP self-harming since the training.

4.97 19.5% (15) of respondents also provided `other’ forms of support in addition to those listed in 4.92. Examples of `other’ support given included: anger management; self-care and boosting self-esteem; target-setting; time out and opportunity to talk to trained nurse in school; weekly drop-ins with school nurse; purchase of Rainbow journals[[13]](#footnote-13); succinct list of relevant helplines; issuing small cards with PAPYRUS[[14]](#footnote-14) numbers on for CYP who self-harm and their families; supporting colleagues to deal with CYP who self-harm; offer of counselling services; utilising principles of Solution-Focused Therapy[[15]](#footnote-15); flexible availability to meet needs of CYP; offering other forms of support when not available; explaining reasons for low mood and devising activities to improve mood; and peer group work.

4.98 During the training, the Rainbow Journal was highlighted to training partners as a really useful resource.

Have any of these CYP gone on to self-harm again?

4.99 Of the 56 participants responding to this question, 60.7% (34) confirmed that CYP they were supporting had gone on to self-harm again. 33.9% (19) were unaware of whether CYP they were supporting had gone on to self-harm again. Only 3.9% (3) of participants were able to report that the CYP they were supporting had not gone on to self-harm again.

Did you feel that there were any barriers to the support your service could offer?

4.100 Of the 57 participants responding to this question, 45.6% (26) felt that there were barriers to the support their service could offer CYP. 43.9% (25) felt there were no barriers; and 10.5% (6) were unsure.

4.101 Those participants who had answered this question in the affirmative were asked what barriers interfered with the support their service could offer. Responses given included: too few team members had attended the training and therefore there was no joined-up approach to support between workers; `When working with a YP who self-harms we are encouraged to get a referral to CAMHS’; `on the referral side it was the request for a CAF[[16]](#footnote-16) to be submitted to the commissioned service to access the support’; difficulties accessing/receiving support and guidance from CAMHS; referrals from CAMHS not always accepted if CYP don’t meet their criteria; referrals to counselling services have been either slow or haphazard in the past; parents’/carers’ attitudes to self-harm; abusive parent causing the self-harm is a barrier to the effectiveness of the support you can give; `poor level of services to refer onto - large waiting lists for mental health service input’[[17]](#footnote-17); closing down of services without alternative provision (raised by both Youth sector and Education sector); poor handling of support by staff who lack understanding of self-harm issues; restrictions arising within faith school; CYP who don’t want help; teacher focus around academic achievement and attendance; not qualified to give mental health support; processes and legal frameworks; busy children’s wards not conducive to provision of support; when parents want to tackle problem when they are in fact part of the cause; accessibility of support services for CYP who self-harm; insufficient direct contact time; timescales for referrals generally; nationally, more needs to be done around emotional and behavioural problems; and reliant on carers to work from same perspective as social worker.

Did you feel as though the support the CYP received was appropriate to their perceived need/risk?

4.102 Of the 54 participants responding to this question, 74.1% (40) felt the support CYP received was appropriate to their perceived need/risk. 22.2% (12) were unsure, and only 3.7% (2) of participants did not feel that the support meet the perceived need/risk.

What went well?

4.103 When asked what went well with the support offered to CYP, 41 participants responded. Responses included: listening; reference to harm-ed’s list of local services; improved approach to communicating with CYP who self-harm led to greater trust and openness (mentioned by several participants); improved relationships with CYP; being able to offer appropriate support and information to parents and carers; helping CYP change to less harmful alternatives; Barnardos emotional health and wellbeing counselling service (according to one school); `Being able to offer emotional support, practical advice, reassurance and being confident that support was appropriate’ (per Barnardos Edge of Care Service); use of distractors, eg, elastic bands (according to two schools); `the evident reduction in incidents and frequency of self-harm; when CYP open up and accept support and wound care; alternatives to self-harm leaflet; no blame culture; CYP-centred approach; tailoring support to need; gaining parental recognition; CYP returning to service for ongoing support; `There is greater understanding and empathy from health professionals who care for individuals who self-harm and this supports the development of therapeutic and collaborative nurse-patient relationships. It also allows both health professionals and patients to understand that engagement in self-harming behaviours is not related to failure for either party but part of a longer journey towards recovery’; `the external support we were able to put in place’; having clear procedures and nominated staff to support them; `my increased confidence in how I deal with the situation’; new agency/service leading to reduced response times; being able to refer CYP for the right kind of support once they opened up about sexual assault.

What could have gone better?

4.104 When asked what could have gone better with the support offered to CYP, 22 participants responded. Their responses included: if staff had flagged up suspicions earlier and refrained from using inappropriate language, e.g., `Promise not to do that again’; staff attitudes; referrals could have been picked up quicker; support and visits from CAMHS with their specialist knowledge; services need to adopt a more unified approach as they very rarely talk together; often the roots of the problems are not addressed at all; need continued funding for local charitable organisations; more `next steps’ support needed for CYP; need more knowledge on managing emotions; more direct contact within school from outside agencies; `parental responsibility’; need clearer advice for parents and carers on how to deal with self-harm; `Information about the future impact and how to offer this sensitively’; staff supporting CYP need to be reliable otherwise it causes unnecessary stress for the CYP; and multi-agency support.

4.105 One participant from Barnardos stated, `we have struggled to identify support in the Barnoldswick/Earby area’.

4.106 One participant from the health sector stated, `NHS Trust deal with acute issues. Having better pathway where SC taking care of their social care needs, and them helping in local community. Co-ordinated multi-agency approach needed otherwise people get missed.’ Another participant said, `There is a greater number of patients who are admitted to the ward with diagnosed personality disorders and who engage in self-harming behaviours. When there are significant numbers of patients with these difficulties it can be challenging for both patient and staff. Greater support and supervision needs to be available for staff but often the lack or limited resources compromise the degree of support available’.

4.107 One participant from the Education sector recommended that teachers ought to receive the same self-harm training as the Pastoral team (and Safeguarding training) to ensure a consistent approach to dealing with CYP who self-harm; there is a tendency for teachers not to read handouts which are produced by the Pastoral team.

Do you feel there are any gaps in the multi-agency provision of support for CYP who self-harm?

4.108 When asked whether they felt there were any gaps in the multi-agency provision of support, 64 participants responded. Of these, 60.9% (39) felt there were gaps in multi-agency provision of support; 9.4% (6) of participants felt there were no gaps; and 29.7% (19) of participants were unsure.

4.109 Those participants who responded affirmatively were asked to state what gaps they had found. The responses given by the **Education sector** included: access to referral agencies takes too long; holistic, cross-agency approach needed with greater communication; as incidence of self-harm increases amongst teenagers, there needs to be a wider range of agencies available to offer support to the CYP, family and teachers to secure a positive outcome long-term; more contact time needed; at times, it is not taken as seriously as it should be; CAMHS are so stretched by budgetary constraints that they cannot intervene as often as they would like; ELCAS intervention; closure of Butterfly and Phoenix projects without replacing them with alternative services. Other schools stated, `Referrals can be slow and in one instance I am aware of a CYP being discharged when the evidence that self-harming was still taking place was evident’; `Services are not quick enough to deal with issues that are raised in the first instance and so this can escalate and cause greater problems for children. There are some agencies who reject inquiries or referrals and the reason is never clear. The CYP suffers as a result because advocates of the CYP are trying in vain and may give up on the process’; and `When a case is serious, particularly gender related, it is difficult to know who to refer the CYP to, to get more immediate help. Not all LGBT support is appropriate for very young students e.g. 12 year olds.’

4.110 Participants from the **SFCS sector** responded as follows: `Multi agency understanding and recognition of indicators and trigger factors needs to be more consistent’; problems with CAMHS who refuse to take referrals either because the say there are no mental health problems or because 16+ CYP are in limbo until they reach 18 as they do not qualify as children or as adults by CAMHS (several commented on difficulties accessing CAMHS/delays/ discussions around mental health vs environmental aspect of self-harming); lack of information-sharing; needing others to have more widespread knowledge and understanding of self-harm to ensure consistency and joined-up approach; some agencies too quick to call home before negotiating next steps with CYP – breaks down trust and confidence with CYP; agencies looking too narrowly at `what is their responsibility’ and seeing self-harm as a mental health issue and therefore needing referral to a mental health practitioner.

4.111 Participants from the **Health sector** responded as follows: insufficient community CAMHS support and poor resources for inpatient provision; feedback from young people is that they have not been happy with support they have received from CAMHS so they do not show up for appointments and instead return to the hospital for further support; the problem is the acceptance criteria for other services; need to understand social issues and more co-ordination and pulling together; and no specific service for CYP in crisis. One further participant stated `Working on an acute admission mental health ward, the focus is generally on facilitating short admissions during the patient’s acute phase of illness. The provision of a more diverse multi-disciplinary team such as psychologists, occupational therapists, activity nurses, etc. would help to support the provision of an increased therapeutic milieu on the wards and also provide a more holistic approach to support the patient in their journey of recovery’.

4.112 Participants from the VCFS sector responded as follows: Many agencies are still very uncomfortable talking to CYP about self-harm, and have no understanding of things such as distraction techniques and safer ways to self-harm; specialist advice and counselling services needed; and some schools will not offer any help re wound management. Several participants from Barnardos raised a number of issues. One participant had found access to other services to be a problem: `It is very hard to get ELCAS to take on or keep cases. They are often left with us to continue the work when it is obvious that the service user needed some more focused sessions or support around depression.’ Another participant described difficulties with lack of communication once referrals are made – having to chase up with the agency to check they had received the referral and not knowing whether the CYP has been seen or what support they were given. One final comment was that there should be more intensive support provided to the CYP over a longer period of time.

4.113 Participants from the **Justice and Crime Prevention sector** responded as follows: there are large numbers of young offenders who self-harm who do not have support in place; excessive delays before CYP can access support due to long waiting lists; and `children’s mental health service don’t leave their office despite every other agency doing so. Why!? They are the ones who could solve a large number of social disorders, and mental health issues if they went out into the community.’

4.114 Participants from the **Youth sector** commented that it is unclear as to the remaining support organisations in the area; and there is insufficient capacity at CAMHS or for counselling should the CYP wish to access this.

4.115 The participant from the **Early Years sector** echoed some views already expressed – that the lack of knowledge of other agencies leads to the CYP losing confidence in their support; and a feeling that many think `it’s not our job’.

Q11: Please describe a time that you have been able to offer support to CYP who self-harm

4.116 A total of 39 participants described a time they had offered support to a CYP who self-harmed, and a further 2 participants who responded `ongoing’ to this question. Responses have been recorded per sector below in order that any patterns in types of self-harming, triggers, or detection, can be ascertained from the descriptions given.

4.117 There were 13 responses from the **Education sector.** Examples of support offered to CYP who self-harm include:

* `A student - 15 years is under the Tavistock Centre in Leeds for transgender counselling. She becomes very stressed in between her 2 monthly appointments and wants to harm. She gets even more depressed if she cuts. By coming and talking it does help. She has supportive family but in school it is difficult because peers do not know. Talking/listening does help her and can talk her down from cutting.’
* `Finger scratching to a boy whose parents were arguing and seeking a divorce. We gave alternative strategies of ice administration or fingers being crossed. We spoke to parents over the trigger and the cause. Also on coping strategies.’
* `Prior to training a young girl would pull her hair when she felt upset, I provided her with an elastic band as an alternative and also allowed her to speak me as she needed.’
* Provision of weekly counselling sessions and talking through some strategies with staff involved with a particular child.
* `Due to my previous support and reputation for dealing with this type of issue, CYP come to me or bring their friends to see me for advice. Many CYP just come and talk to me about a variety of issues but often admit that they are self-harming.’
* `Young lady, mum was very apprehensive and blaming (due to another student in school). More underlying issues for child (split between parents). Got Barnardos who give emotional health and wellbeing counselling - nothing for several months thank goodness'.
* `Young lady has had a lot of MH issues and self-harm linked. She came from another school and when NO said to her she would strut off in tears and then would have found anything at all to self-harm. Would come and present with cut arms. Stopped that. Cleaned her up and talked and no more reports of self-harm.’
* `When one CYP looked stressed, I have been open and asked if they have self-harmed and they have shown me her harm and I have treated it.’

4.118 There were 8 responses from the **SFCS sector**. Examples of support offered to CYP who self-harm include:

* `In my personal life I know a girl who began self-harming after her brother was killed. I helped her with strategies like the elastic band on her wrist, ice cubes etc., and now she uses these techniques instead of cutting.’
* `Emotional support giving the young person someone to talk to about how difficult things are at home / school and helping the young person to focus on positives about themselves as they felt nothing was going right and felt very low.’
* `A young person who self-harms had cut her arms. I gave the young person some first aid equipment to clean the cuts, and offered them time to talk. The young person thanked me for understanding and not 'stressing' at them.’
* `Due to the enhanced understanding and "actual understanding that she was going to self-harm because she needed to at the time" we stocked up our first aid kits with equipment which could be used to help nurture the cutting wounds after the fact rather than a vain attempt to hide everything that could be used to cut. This had an effect of bringing the self-harm into the open and provided us an opportunity to develop open discussion and present a nurturing environment. This subsequently and undoubtedly along with several other factors has massively reduced the frequency and severity of the self-harming.’
* `Worked with a young girl of 13 years old who was depressed and self-harming: Poor family environment, lack of family support networks, financial issues. ASD assessment being completed by CAMHS. Sexual identity concerns. Inappropriate sexualised comments when at hospital. Internet Safety. Bullying. Young Carer. Poor school attendance and attainment. Impact of behaviours upon the younger children. Paternal family rejection and father that passed away through suicide. Child wanted to be accommodated and did not want to return home - risk of family breakdown. Appropriate support and advice offered. Assessment formed part of multiagency working.’
* ` During a section 47 enquiry following a child who self-harmed.’

4.119 There were 8 responses from the **VCFS sector**. Examples of support offered to CYP who self-harm include:

* `I have offered advice to a young person and parent following a report that the young person had self-harmed. This was by way of providing written information, practical advice on being safe/keeping wounds clean, and emotional support to young person.’
* `A prolific self-harmer as a result of child abuse - for the first time she felt someone listened to her and understood. We worked on strategies to help her stop self-harming, including joining a music group. We purchased her a Rainbow journal and also gave her helpline numbers for when we weren't there. Her parents would not engage with any info sessions, etc. At the end of support, she had not self-harmed for 3 weeks, the first time she had ever managed as long.’
* `During a 1:1 with a young person who disclosed they self-harmed, I gave reassurance and advised them how to be safe and we discussed what support they could access online.’
* `There was a young person who was self-harming at home but was not at school. When I first began working with her I was told a lot by parents about how she was doing it because mum had a new boyfriend and she was jealous. I spent time with the young person. Although we broached on the subject of how I focussed on work around feelings and within a couple of sessions I was able to pinpoint that the self-harm was because she was being told things by the new boyfriend that scared her. Through having an agency involved and a referral to social care due to potential grooming the boyfriend left the home and the self-harm stopped.’
* `One of my service users disclosed that she was self-harming. She didn't like the word self-harm so said she was scratching herself. She went to the GP with her mum and was referred to ELCAS. However due to the distance she had to travel this was not an option and ELCAS closed her case due to non-engagement. I worked with the young carer on keeping wounds clean, offering care and compassion and alternative methods, however it was felt that she needed more support than LYC[[18]](#footnote-18) service could provide. We looked at her attending counselling and she attended one session but again struggled with accessing the support. The family have now been referred to social care due to other issues in the family home and the self-harm will be supported by social care now.’
* `I had a young person who I noticed cuts on her arm - because of my increased confidence, I felt able to broach the issue with her and she ended up admitting that she had been self-harming for a while.’
* `I am working with a 16 year old at the moment and she self-harmed every day. I have worked with her for nearly a year now and her self-harm has reduced. She uses some other distraction techniques I advised her on due to the training I received and these work for her. They do not work every day for her and some days are worse for her than others but she knows if she cuts too deep she can come to me and I will help her clean her wound and dress it appropriately. I have also implemented some of the distraction techniques before a young person has turned to self-harm and these are reducing chances of self-harm with the young people I work with. "

4.120 There were 4 responses from the **Youth sector**. Examples of support offered to CYP who self-harm include:

* `I have had a few young people come to speak to me at our drop-in sessions over the past few years. I have offered a sympathetic non-judgemental ear, encouragement to share with parents/GP (if the young person feels they are able to do so) and a referral to a counselling service.’
* `We had to discuss one young woman and one young man's self-harm who we were taking away on residential to ensure they could participate in activities safely and understood the boundaries and expectations of themselves and others when in our care.’

4.121 There were 4 responses from the **Health sector**. Examples of support offered to CYP who self-harm include:

* `A young girl who I have cared for, for about 4 years, regarding mainly her contraception. She has been in a controlling relationship for those 4 years and this has impacted greatly on her self-esteem and then led to her self-harming. She has attended my clinic many times and has been referred to both CAMHS and the Butterfly project for self-harm on separate occasions and both were relatively unsuccessful. I have spent a lot of valuable time with this client discussing friendships in school, relationship with mum, dad and boyfriend and discussing ways in which to improve her circumstance. One of the problems was that her mum allowed her from the age of 14 to stay over at the boyfriend’s house from a Thursday night to Monday morning each week, then she would be in school with him having no time for herself. She is now in college which seems to be improving the situation and she has made many new friends. Her self-harm seems to have ceased at the moment but she knows she can contact me or visit me in clinic if she needs support.’
* There are 4-5 on the ward and at least 3 self-harm. I get their history and because of the winter pressure fund have been able to fund CAMHS to assess them. This has been invaluable.

4.122 There were 3 responses from the **Justice and Crime Prevention sector**. These included:

* `I previously worked in supportive housing and have experienced self-harming by females (cutting) on a number of occasions, I feel that, at the time, I lacked some understanding of why people self-harmed. However, I feel that due to highlighted incidents and more awareness, there is a more open approach from services and other around CYP who self-harm.’
* `I visited a home regarding an argument between a mother and son. Whilst I was there I noticed marks and spoke with the YP in private and they admitted to self-harming. I gave details of who to contact, a website and got them to agree to approach their GP for referral to children mental health services.’

Q12: To what extent do you feel that you have been able to successfully engage with and support carers of CYP who self-harm?

4.123 When how successfully they had been able to engage with and support carers of CYP who self-harm, participants were asked to select a number between 0 and 5. 0 denotes `not at all successful’ and 5 denotes `extremely successful’. There were 60 responses to this question.

4.124 46.7% (28) of participants responding felt their work with carers had been very successful. Four participants, 3 of whom were in the VCFS sector and one of whom was in the Education sector awarded the top mark of 5 for this question. Three of these participants were from the VCFS sector, and 1 from the Education sector. 24 participants had awarded a mark of 4 for this question classified by sector as follows: SFCS (7); Education (5); Health (4); Justice and Crime Prevention (3); VCFS (3); and Youth (2).

4.125 40% (24) of participants responding felt their work with carers had been `successful’, awarding a mark of 3 against this question. Eight of these 24 participants were in the Education sector; 4 in the SFCS sector; 3 each in the VCFS, Health, and Youth sectors; 2 in the Justice and Crime Prevention sector, and 1 in the Early Years sector.

4.126 5% (3) of participants responding felt their work with carers had been `quite successful’, awarding a mark of 2 against this question. Note, however, that some participants may have intended this mark to indicate that success levels were below average. See 3.16 above.

4.127 8.3% (5) of participants felt their work with carers had `not been very successful’, awarding a mark of 1. Two of these participants were from the Education sector, and 1 each was from the SFCS, VCFS and Health sectors. There were no participants responding to this Question who felt that their work with carers had been `not at all successful’.

What improvements, if any, can your organisation make in relation to supporting parents/carers?

4.128 26 participants responded to this question.

4.129 38.5% (10) of participants from the **Education sector** responded to this question. The school which felt they had not been at all successful in engaging with and supporting carers of CYP who self-harm suggested that more should be done to raise staff awareness about self-harm. Other Education sector responses to this question included: `I have discussed with our DSL setting up an information page for parents and contact number for further advice from trained staff in school’; communicate with parents and carers in the same way as the school does about promoting emotional wellbeing and self-esteem; more agency support needed; developing strategies to help parents and carers to support the CYP’s emotional wellbeing; referrals to agencies other than just CAMHS or GPs, preferably a support group specifically for self-harm; need to build connections with parents; encourage parents not to brush it under the carpet; need to be able to support those that worry about self-harm.

4.130 26.9% (7) of participants from the **SFCS sector** responded as follows: signposting to specialist services where relevant; more training to keep knowledge and understanding of carers relevant and up-to-date; giving parents safety advice and strategies to support the CYP, but that will require support staff to be given further and more specific training around this; helping parents recognise the signs and support the CYP; and continue to offer staff the access to relevant training. One further participant stated, `Helping them to understand their need to protect their children from harm is not the same as this particular issue, as this is about control for the young person. Helping with coping strategies is the best way to maintain communication and open and honest relationships so parents can monitor what their children are doing and are able to understand why.’

4.131 19.2% (5) participants from the **VCFS sector** responded as follows: `I would like our service to run a support group for parents/carers of CYP who self-harm’; training for parents; helping parents overcome their fears of self-harm; continue to offer staff the opportunity to access relevant training; and `I find that the carers want immediate fixes and see the self-harm as the issue rather than what is underneath it. This causes a barrier when parents aren’t prepared to accept that there is more than just attention issues.’

4.132 7.7% (2) participants from the **Justice and Crime Prevention sector** gave the following responses: `further awareness, more engaging programmes of intervention; faster access to support’; and `more understanding of why young people self-harm to a wider audience’.

4.133 One participant (3.8%) from the **Youth sector** advised educating parents and advocating on behalf of the CYP.

4.134 The participant from the **Early Years sector** (3.8%) saw continuing to offer staff the opportunity to access relevant training as the way forward to improving support for parents and carers.

Q13: Did you cascade the training down to anyone else in your team/service?

4.135 Of the 71 participants who responded to this question, 67.6% (48) confirmed that they had cascaded the training to other members of their team/service. Of these, 15 were from the Education sector; 12 were from the SFCS sector; 6 were from the VCFS sector; 5 from the Health sector; 4 were from the Youth sector; 5 were from the Justice and Crime Prevention sector; and 1 was from the Early Years sector.

4.136 32.4% (23) of participants responded that they had not cascaded the training to other members of their team/service. Of these, 6 were from the SFCS sector; 4 each from the Education and Youth sectors; 3 from the Health sector; and 2 each from the VCFS and the Justice and Crime Prevention sectors.

If you answered "Yes", how did you disseminate this information and to how many?

4.137 The table below breaks down the ways in which different sectors have disseminated information from the training. Most participants did not state how many people received this information, but the numbers supplied by those who did are recorded on the table.

|  |  |  |
| --- | --- | --- |
| **Sector** | **How was information disseminated?** | **To how many?** |
| Education | Team meetings for admin/pastoral staff; given information to head of year and safeguarding officer; emailed team members the packs and went through with them; head teachers cascaded to staff; forwarding on resource pack; establishing self-harm procedures with all staff; | 40 |
| SFCS | Team meetings and wider; encouraging staff to attend training; through positive practice and role modelling (residential care); through supervision meetings and development days; Fostering team discussed in team meeting and shared with all carers; peer supervision sessions; | 34 |
| Health | Emailed handout to staff; discussed with carers at Children’s Homes and with colleagues in Sexual Health; Clinical supervision - individual and group; Student mentorship; Role modelling; providing access to information and resources; |  |
| VCFS | Barnardos: Team meetings, emailed list of services across whole of Lancashire; placed training notes in file of resources; encouraged others to attend; informally relaying information in conversations;  Other voluntary organisations: as part of volunteer training; team meetings; one-hour presentation to team members | 25  Across  Lancs  18 |
| Youth | Gave colleagues copies of information; emailed support service list to wider team and line manager; team meetings; individual staff discussions; encouraged others to attend training as personal experience of trainers cannot be replicated | 33 |
| Justice and Crime Prevention | Team meetings; general conversations around the workplace; team training; | 4 |
| Early Years | Shared with line manager, and at Outreach Worker meeting, plus individual discussions. | 9 |

Q14: Do you feel their level of knowledge and confidence is satisfactory or do you feel they would benefit from attending self-harm training?

4.137 Of the 63 participants responding to this question, 54% (34) felt that their colleagues would benefit from attending self-harm training; and 46% (29) participants felt that their colleagues’ level of knowledge and confidence was satisfactory.

4.138 Those 34 participants who felt that their colleagues would benefit from self-harm training represented the following sectors:

|  |  |
| --- | --- |
| **Sector** | **Number of participant suggesting further need for training** |
| SFCS | 10 |
| Health | 8 |
| Education | 6 |
| VCFS | 4 |
| Youth | 4 |
| Justice and Crime Prevention | 2 |

Q15: Are you more confident in your ability to support CYP who self-harm within your service without the need for referral?

4.139 Of the 73 participants who responded to this question, 60.3% (44) reported that they felt more confident in their ability to support a CYP who self-harms without having to make a referral. 15.1% (11) reported that they were not more confident in their ability to support a CYP without the need for a referral, and 24.6% (18) were unsure about whether they felt sufficiently confident to support a CYP without the need to make a referral.

4.140 Of those 11 participants who responded `no’ to this Question, 4 represented the SFCS sector, 3 the Education sector, 3 the Health sector and 1 the Justice and Crime Prevention sector.

4.141 One participant from the Health sector said that a multi-disciplinary approach was needed. One other participant added that it would depend on the severity of the harm.

Q16: Have you used any of the local services from the directory that was circulated?

4.142 Of the 72 participants who responded to this question, 22.2% (16) of participants have used local services from the directory that harm-ed circulated at the end of the training; 66.6% (48) of participants have not used any of the local services in the directory; and 11.1% (8) of participants were unsure whether anyone within their organisation/service may have used any local services listed in the directory.

If you have answered ʺYesʺ, please state which ones?

4.143 Respondents listed the following local services that they had used from the directory: Barnardos’ Emotional Health and Wellbeing Open Door Counselling; Jigsaw; YPS; ELCAS; CANW[[19]](#footnote-19) for further emotional support (2); Butterfly project (7); Phoenix project (3); CAMHS (2); Twinkle House; Young Addiction; Kids in the Middle; Big White Wall; ACE; A&E; GP; based on location, it is easier to access Manchester services; give out names and addresses to pupils.

4.144 The 7 participants referring to the Butterfly project were from a range of different sectors.

Have you had any problems accessing these services?

4.145 48 participants responded to this question. Of these, 56.3% (27) participants said they had not had problems accessing the above services; 25% (12) participants were unsure; and 18.7% (9) participants reported having had problems accessing services.

4.146 Of these 6 who stated they had had problems, the services they listed were: ELCAS (2); Butterfly project (3); Phoenix project (2); Jigsaw; Barnardo’s Emotional Health and Wellbeing Open Door Counselling; CAMHS; ACE; CANW. In the preceding question, one participant had grouped Butterfly and Phoenix projects together, and one participant had grouped ACE, CANW, Butterfly and Phoenix together. From this, it is therefore difficult to determine with accuracy which services these participants had problems accessing. However, from the information provided in 4.147, it becomes clearer that the issues were to do with the Butterfly project.

If you have answered ʺYesʺ, please state which service and describe the problem

4.147 The answers to this question have been attributed to the relevant service:

* Barnardo’s Emotional Health and Wellbeing - `we feel that the first session was really good however due to transport this wasn't available’.
* Jigsaw – long waiting list.
* ELCAS - problems meeting criteria; waiting time; `I struggle with ELCAS’
* Butterfly/Phoenix – waiting list 3 months.
* Butterfly - `it took a long time to get an allocated Butterfly worker to deal with the referral’; `There is a temporary halt on referrals to Butterfly Project due to high numbers accessing the service.’; `Butterfly Project - problem was self-harm!’
* CANW - `don't work with young people who are Tier 4, i.e. the young person referred had a Social Worker so they could not support him’.
* `There is a temporary halt on referrals to Butterfly Project due to high numbers accessing the service’.
* `A lot of the services are not available in our area (St Annes) or have very long waiting lists.’

Please state any other local services you have used that we can add to the directory

4.148 11 participants responded to this question. Their suggestions included:

* Safelink - offer 6-week group work session specifically for boys or girls.
* Winston's Wish for bereavement.
* HYPE in Rochdale.
* Encompass.
* SCAYT+.
* Barnardos.
* `Pam McInnes, Client Services Co-ordinator at CancerCare, has asked me to share some information about the additional services they now offer: (a) Counselling support for young people who are suffering as a result of a bereavement (it does not have to be due to Cancer) or a life limiting condition of a family member/close friend). (b) They can only work with young people at Tier 3 or below, i.e. not Tier 4 young people who are working with CAMHS or Adult Mental Health Services. (c) Additional support for families (parental guidance support and one-to-one sessions with children) who are suffering as a result of a bereavement through accidental death (also includes suicide, drug overdose, and murder). For further information please contact Pam McInnes or Tracey Smith at CancerCare: Mon & Tues 09:00-17:00; Wed & Thurs 09:00-16:00; Fri 09:00-15:00. Slynedales, Lancaster (01524 381820).’
* Dr Pravin Sreedharan, a Paediatric Doctor from University Hospital of Morecambe Bay confirmed that he will be in a position to identify further local services once the Suicide and Self-Harm Pathway is finished.

4.149 Many participants were concerned over the fact that the Butterfly and Phoenix projects were closing due to funding cuts.

Q17: Is there any further support you need from within your organisation relating to CYP who self-harm?

4.150 In all, 69 participants responded to this Question. Of these, 33.3% (23) of participants said they did need further support from their organisation relating to CYP who self-harm; 50.1% (35) participants said they did not need any further support from within their organisation, and 15.9% (11) participants said they were unsure.

4.151 Of those who said they needed further support, the responses are sorted under each sector.

4.152 **Voluntary sector** responses included: `training for supervisors to support staff through internal supervision’.

4.153 **Youth sector** responses included: `always good to have refresher courses. May be good for colleagues to refresh understanding’; `Refresher briefings’.

4.154 **SFCS sector** responses included: Children’s Social Care suggested that all knowledge is good and if a trainer could attend a full team brief. `That would be great’; `For managers to attend the training so that they have a greater understanding of the emotional impact working with YP who self-harm has’; ` I found the training to be one of the most useful training days I have been on, workers coming to the teams monthly team meetings to discuss the topic and provide the services that are available within Preston would be highly beneficial’; `SCAYT+ have provided additional understanding and supported the current views and opinions which were discussed on the training’; `More support for workers and for families that are dealing with self-harm. More intervention and awareness in education’; `how to do impact assessment on CYP who self-harm’; `If we had a severe self-harmer then support with the emotional impact could be beneficial. At present we don't have any self-harmer where this support would be needed but may be useful in the future as our young people are ever changing’.

4.155 **Education sector** responses included: ` follow-on course would be good’; `Strategies for children and parents. Dealing with the emotional impact and role of safeguarding within school. The fear of a child going too far’; `Seeing the young people not just as academic robots but as whole persons’; `sometimes a debrief would help, i.e. people to confirm you're doing well. That kind of support is sometimes lacking’; `How to correctly record and monitor SH issues, personal support’; `everybody needs to take more seriously so need to incorporate into INSET training and make people more aware of incidence of self-harm. They are kept confidential but other teachers need to be more aware. Don't dismiss concerns and moan about retention figures. Some self-harmers leave without permission and get into trouble but won't explain. Some don't leave school but go and cry and hurt selves to go to pastoral support’; `Further courses for other members of staff;’ `A session with all staff would be supportive - key points as a reminder.’

4.156 **Health sector** responses included: ` "Increased clinical and group supervision. Access to training and protected time to enhance knowledge and learning’; ‘Further training aimed particularly for School Nurses’; `Dealing with CYP who self-harm on an acute inpatient ward’; `Need help with emotional support’; `ongoing training updates’.

4.157 **Justice and Crime Prevention sector** responses included: `CAMHS services’.

4.158 **VCFS sector** responses included: `I struggle to switch off so if I know that someone is self-harming I will check my phone when I am not working so that I don't leave them alone. I don't think the rest of the team have this issue though.’

5 **Conclusion**

5.1 The purpose of this Impact Assessment Study was to determine whether, and if so how, the knowledge and insight gained by partners translated into a change in training partners’ working practices.

5.2 A total of 77 (29.1%) partners participated in the study either by way of completing the online survey or speaking to harm-ed via a semi-structured telephone interview shaped predominantly around the survey questions.

5.3 Response rates from non-LCC partners was significantly higher than for LCC staff, primarily due it is felt to the personalised approach taken in approaching these training partners.

5.4 It was very pleasing to note that, despite being given the option of focusing only on questions that were relevant to their organisation, all participants completed the full survey and it is suggested that many may recognise the value of being able to share good practice on a per sector basis.

5.5 Despite many schools having reported access problems due to school security settings, the Education sector accounted for 28.2% of total response rates and therefore, without these access issues it is anticipated that this proportionate response rate would have been higher.

5.6 Arguably the most representative data has been gathered from the Education sector where 44% of the 50 training partners participated in the Impact Assessment Study. A similar proportion from the Justice and Crime Prevention sector participated, although total numbers of training partners from within this sector were relatively low.

5.7 One of the recurring comments throughout this study, expressed by most sectors, was the fact that the trainers’ own personal experiences of self-harm had a very positive impact in helping training partners to contextualise about self-harm, and this in turn opened their minds to the causes and triggers that cause CYP to self-harm, and the different support strategies available. Several participants also remarked on the benefits of the multi-agency information-sharing nature of the training courses.

5.8 100% of participants reported having developed a better understanding following the training of the social, environmental and psychological factors which might help explain a CYP’s self-harm. 81.6% of these confirmed that this increased understanding helped to explain why certain groups have higher rates of self-harm, although participants were not able to clearly identify in 4.3 any trends in self-harm relating to specific groups. In 4.4, however, several schools noted that there were relatively higher incidents of self-harm amongst Year 9-11 students and it was suggested that this was due to GCSE pressures, and insecurities about future aspirations and self-image. One participant from the education sector and one from the VCFS sector identified boys as showing a greater tendency towards self-harm than girls.

5.9 The main reasons stated for why CYP might self-harm were given as a coping mechanism for those CYP who feel they lack power and control in their lives, or who are unable to cope with their emotions. This recognition of the causes of self-harm in CYP has clearly helped training partners to understand that the main focus of their support should be aimed at promoting the emotional wellbeing and resilience of CYP; helping to alleviate any negative pressures on them, and helping them to find alternative coping strategies and adequate support networks, rather than to stop the self-harm itself. This is why participants placed greater importance on being able to communicate effectively and empathise with CYP, and exploring their problems so that they can help set up the support needed to address these problems.

5.10 90.9% of all participants reported feeling better able to identify the signs that may indicate a CYP is self-harming or at risk of self-harming. This is despite the fact that many acknowledged that young people are becoming more adept at disguising the fact that they self-harm, including cutting themselves on parts of their bodies that are not easily discovered, such as their ankles or stomachs. Participants generally felt that CYP who self-harm display sometimes subtle changes in their behaviour including disengagement, mood swings, low self-esteem, signs of depression, wearing of weather-inappropriate clothing. There was a general consensus, particularly within the education sector, that self-harm should not be dismissed on the basis that it is merely attention-seeking.

5.11 97.4% of participants felt more confident in being able to broach the issue of self-harm with a CYP they suspect is self-harming, and great emphasis was placed by participants on the importance of effective and non-judgmental communication skills, and the use of in-house support in helping the CYP explore the causes of their self-harm rather than securing the immediate cessation of self-harm.

5.12 60.3% of participants reported feeling more confident that they could adequately support a CYP who self-harms without having to make a referral.

5.13 84.2% of participants described how their increased awareness of the reasons why CYP choose not to disclose about their self-harm or access support had resulted in them being better able to implement strategies to break down such barriers. Self-harm was identified as a safeguarding issue which, if not dealt with properly and collaboratively at an early stage, could escalate hugely. Most participants responded that they now promoted a more calm, open and non-judgemental approach to initiating communication with CYP. By creating a more supportive environment based on trust and understanding in which CYP can discuss their self-harm, participants have found that CYP are more willing to open up to them about their private feelings and concerns. This then allows participants to provide the most appropriate support based on the individual needs of the CYP, and make suitable and timely referrals to other support services. One participant gave an example where a young person had compared their approach favourably against that of another of their support workers who acted shocked on discovery of their self-harm and made them promise not to do it again – something that merely adds to the CYP’s shame and guilt if they fail to stop self-harming.

5.14 In terms of strategies and changes in working practice that had been developed following the training, most participants wrote of having adopted strategies highlighted through the training, including care and compassion, information about alternatives to self-harm, wound management, and referrals. Outside of these strategies, one of the most frequently cited examples of strategies developed was to cascade the training down to their colleagues or line management (67.6% of participants had done so, mostly through team meetings). Others included providing dedicated staff in schools that teaching staff can refer CYP to or report concerns to; monitoring patterns/timings of self-harm; harm-minimisation advice; helping CYP to understand the risks of self-harm; target-setting; anger-management; use of solution-focused therapy; peer support work; and developing positive ongoing relationships with CYP so that they can access support informally. Several schools noted that holiday periods cause increased anxiety in CYP who self-harm as they feel cut off from the very people who have become so effective at meeting their support needs. One school reported having developed close links with PCSOs who can help to monitor and support the CYP during the holiday periods. One residential care home had introduced a form for young people to complete in which they are able to express how they feel before, during and after self-harming; what the service can do to help them to prevent from self-harming; and what their preferred response is by the service to their self-harm.

5.15 In the education sector, staff talked of self-harm occurring in children as young as 4 years old, and the importance of early intervention strategies and continuity of support as students make the transition from primary education to secondary education. Support staff described the problems of those well-meaning parents who preferred not to set up the necessary support structures, preferring instead to give their child an opportunity to make a fresh start. Much work has been done in many schools to, with the consent and involvement of the self-harming CYP, help parents and carers to better understand the complex nature of self-harm and the best ways of supporting the CYP at home. Several participants, including some schools, described how they provided access for CYP to their own in-house counsellor. Within the Health sector, care plans are being used for self-harming patients, and a multi-agency suicide and self-harm pathway for CYP is being developed to develop support strategies for CYP who self-harm.

5.16 Relatively few participants identified any `conflict’ with work colleagues’ approaches and attitudes towards self-harm. Further exploration of this question with some of the telephone interviewees suggested that this may have been more to do with the negative choice of word `conflict’ rather than a lack of differentiation between attitudes and approaches of staff who performed different roles within the service or who had not had the information from the training course cascaded down to them. It is felt that a differently worded question may have therefore generated a different response amongst some participants. The main reasons given for any `conflict’ arose due to colleagues’ lack of awareness and understanding of self-harm, and the tendency to view self-harm predominantly as a form of attention-seeking. Whilst the training identified that, in some cases, there may be an element of attention-seeking, the key message was that empathy and support for the CYP was the appropriate response in each case. Within the Education sector, there was some suggestion that `conflict’ arose due to the pressure that teachers were under to focus on attendance and achievement levels, and the occasional over-reaction of teachers to self-harm by bypassing the pastoral support team and instead calling emergency services in, or failing to recognise self-harm as anything other than attention-seeking behaviour. Instances were cited within both the Education and the Health sectors of teachers and medics failing to see self-harm support as part of their role, and therefore, as more than one participant suggested, self-harm training would be of benefit to heads of year and managers of medical teams. Within the VCFS sector, `conflict’ arose when colleagues saw adoption of an impatient and cold approach towards self-harming young people as an effective form of `aversion therapy’.

5.17 When asked whether they considered that their work colleagues would benefit from attending self-harm training, 54% reported that they would benefit (a breakdown per sector is given at 4.138 above).

5.18 53.2% of participants felt that the outcome for CYP who self-harm within their service had improved as a result of their increased knowledge. This was mainly attributed to the willingness of CYP to open up without fear of being judged negatively. Within the Education sector, pastoral teams spoke of how CYP now recognise their service as one which offers CYP who self-harm effective support, and described their successes of working with families by helping them to understand more about the complex nature of self-harm. They also talked of successes in helping CYP to manage difficult emotional triggers without resorting to self-harm, and keeping the offer of continuity of support in place to enable self-harming CYP to access support as and when they need it. The high level of participants who were unsure whether outcomes for self-harming CYP had improved may indicate that some participants were unclear about what outcomes were being measured. For instance, evidence gathered in the report suggests that high levels of participants felt better able to broach the issue of self-harm with CYP and offer appropriate and effective support, which in itself is a positive outcome. However, 60.7% reported that CYP they were supporting had gone on to self-harm again and therefore may have regarded this as a failure or a negative outcome. This therefore suggests that, despite demonstrating a good awareness for the fact that the focus should be on addressing the cause rather than the action of self-harm, many participants have struggled to translate this positive work when it comes to measuring positive outcomes resulting from the support they give to CYP.

5.19 The higher incidences of self-harm in CYP appear, from the evidence, to occur in the Education sector. In particular, secondary schools had the highest levels of self-harm cited, which appears to relate to some of the causes/triggers for self-harm put forward in 4.4 to 4.9 above. It should be noted, however, that many of these cases involved CYP who had started self-harming in primary schools.

5.20 The main barriers to the support participants were able to offer were cited as budgetary constraints; a lack of joined-up approach to support between workers due to the fact that insufficient staff had attended the training; difficulties accessing support and guidance from CAMHS and other services such as the Butterfly project; time delays accessing counselling support and other referrals; failure of parents and carers to recognise the causes of self-harm; closure of support services; CYP who do not wish to receive support; teacher focus around academic achievement and attendance; parents who want to tackle the problem when they are in fact part of the cause; and the need for carers to work from the same perspective as social workers.

5.21 Not surprisingly, when asked what had gone well with the support CYP received, most participants cited their improved approach and support to CYP who self-harm and their families following the training. The ability to focus on the CYP’s specific needs as an individual was also cited, as was the ability to understand that engagement in self-harming behaviours is not related to failure but is more seen as part of a longer journey towards recovery. 74.1% of participants felt that the support the CYP received was appropriate to their perceived need/risk.

5.22 When asked what could have gone better with the support offered to CYP, participants felt that non-trained staff could have flagged up their suspicions earlier and used the same consistent non-judgmental and trusted approach that trained staff used. Participants also felt that support from outside services such as CAMHS should have been provided earlier and a more joined-up approach to ensure continuity of care between different services. In the Education sector, it was recommended that teachers should undergo the same training as pastoral staff.

5.23 60.9% of participants felt that there were gaps in multi-agency provision of support. Many of these gaps in relation to referral waiting lists and eligibility criteria have been mentioned already. The Education sector recommended that, as the incidence of self-harm increases amongst teenagers, there needs to be a wider range of agencies available to offer support to the CYP, family and teachers; and the SFCS sector expressed concern over the fact that there was a gap in support services available for young people aged 16+ as they were regarded by CAMHS as too old to be regarded as children and yet too young to be able to access adult services. The problem of information-sharing between different agencies was also identified as a problem, and in particular there was a distinct lack of communication from the referral services back to the referring service. The Health sector described how CYP themselves had sometimes felt disillusioned with the support they received from CAMHS which led to them missing future appointments and instead returning to hospitals for further support. Health professionals also felt that the provision of a more diverse multi-disciplinary team would help provide a more holistic support approach for CYP who self-harm. 5.24 The VCFS sector reported that many agencies are still uncomfortable talking to CYP about self-harm and are unable to provide the support needed, and many outside support services who specialise in certain types of mental health problems fail to provide the support needed for the cause because of the fact that the CYP self-hams. The Justice and Crime Prevention sector expressed concern for the fact that there are large numbers of self-harming young offenders who do not have support in place; and there is a reluctance in children’s mental health services to venture out into the community to provide the support needed. The Early Years sector felt that the lack of other agencies’ knowledge of self-harm leads to CYP losing confidence in their support.

5.25 In relation to the support that participants had been able to offer to parents and carers, 86.7% felt that this aspect of their work had been either successful or very successful. When asked what improvements could be made to their support for parents and carers, one school suggested setting up an information page for parents relating to self-harm in CYP and providing the contact numbers for trained staff within the school; and several sectors suggested developing strategies to help parents and carers in supporting the emotional wellbeing of CYP. The VCFS sector suggested setting up support groups and training for parents/carers of CYP who self-harm.

5.26 Most participants were familiar with local support services following harm-ed’s distribution of the local support service directory, although only 22.2% had actually used any of the local services from the directory. However, problems with making effective referrals were hindered due to excessive waiting lists and strict eligibility criteria, for example of CAMHS, ELCAS, Butterfly project, ACE, CANW and Jigsaw. Referrals were further hindered by the impact of public service austerity measures resulting in funding cuts to support services such as the Butterfly and Phoenix projects which, despite having been widely used by schools in particular, are closing down. Furthermore, certain areas such as Barnoldswick and Earby have little by way of support services.

5.27 A number of other local support services that had been accessed by participants were given at 4.148 and these will be added to harm-ed’s local services directory and distributed to participants.

5.28 From the above, it is very evident that the self-harm training delivered by harm-ed has had a very positive impact on training partners, and on the quality and suitability of support provided by training partners. Not only are training partners more skilled at identifying signs that indicate a CYP is either self-harming or at risk of self-harming as a result of the training, but they are more confident in being able to broach the subject with a CYP they suspect is self-harming. They were also able to demonstrate their understanding of the importance to enter into a meaningful, open and non-judgmental dialogue with a CYP and focus the support on addressing the causes rather than the effects of their self-harm. In this way, they are able to work towards improving the CYP’s emotional wellbeing and help the CYP explore different coping strategies and lead to better outcomes for CYP who self-harm. The work that has been done since the training to support parents and carers of CYP who self-harm has also been successful.

5.29 Although rates of self-harm within CYP remain high, there is clear evidence within this study to show that huge progress has been made by training partners in helping to reduce both the frequency and severity of self-harm in CYP as a result of the training.

5.30 There are certain barriers which interfere with the support that training partners are trying to offer CYP who self-harm, and strategies they are trying to implement to further reduce the incidence and severity of self-harm in CYP. These include the lack of joined-up working between agencies which prevents the continuity of care and support that training partners are keen to promote in the interests of securing the emotional well-being of CYP who self-harm. There have also been difficulties in accessing outside support services such as CAMHS, ELCAS, and others; this is due to long waiting lists for referrals, during which period the CYP’s self-harm may escalate if they are not accessing the right kind of specialist support. There are also reported cases of lack of communication from referral agencies which again interferes with the continuity of care and cohesive approach to support that is needed; and some referrals are rejected due to ineligibility in meeting the criteria. For example, there is a gap in the referral routes for CYP aged 16+ as they are not regarded as children or as adults by services such as CAMHS and therefore there is a real need for adequate mental health support services for self-harming CYP aged 16 and 17. There are distinct differences within certain organisations in the way in which CYP who self-harm are treated, with those who have not attended the self-harm training failing to recognise that safeguarding the interests of CYP who self-harm is everyone’s responsibility and not just the responsibility of dedicated officers within the organisation. This can lead to `conflict’ arising due to cases of self-harm being regarded as purely attention-seeking and a resultant failure in self-harming CYP being able to access the right kind of support. This highlights the need for a wider number of front-line staff to attend self-harm training to ensure that any interventions are co-ordinated, prompt and effective.

5.31 Although training partners report feeling more confident in the support they can offer to CYP who self-harm and are more aware of the underlying issues that CYP need support with, there are limitations in terms of what training partners can do to help prevent or minimise the onset of these underlying issues. This highlights the need for timely multi-agency involvement and early intervention services. These services can play a pivotal role in supporting CYP who are struggling to cope before they resort to using self-harm as a way of coping.

5.32 The continued cuts to public spending and the consequent budgetary cuts that support services have had to sustain has resulted in the closure of certain support services. This means that cross-sectorial information-sharing is needed to further develop the directory of local services. However, it is hoped that an improved multi-agency approach to self-harm strategies, and joined-up approach within services will enable the good work that has started since the training to be strengthened, thus reducing the need for referrals to be made to external agencies for any cases other than those which are either severe or require specialist mental health support.

**APPENDIX I**





2 February 2015

**Impact Assessment Survey**

LCC and harm-ed are interested to learn about the impact on your service/organisation of the CYP self-harm training you attended. Your responses will be treated in confidence and your service/organisation will not be identified unless it is in relation to sharing any good practice developed since your training. If you do NOT wish your service/organisation to be identified in the limited circumstance of sharing good practice, please tick this box.

**Please tell us who you are:**

Name:

Organisation:

Email/telephone:

Please tick box if you wish to be entered into our prize draw for £50 worth of self-harm resources? 

**Please submit your completed survey by Monday, 23 February 2015. Thank you.**

**Please complete as much or as little of this survey as you feel able. Thank you.**

1. Do you consider that you have developed a better understanding of the social, environmental and psychological factors which might help explain a CYP’s (child or young person’s} self-harm?

Yes 

No 

Don’t know 

If you responded “Yes”, does this increased understanding help explain why certain groups have higher rates of self-harm.

Yes 

No 

Don’t know 

If so, how? ………………………………………………………………………………………………………………………………………………………………..

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1. Do you feel better able to identify the signs that may indicate that a CYP is self-harming or at risk of self-harming?

Yes 

No 

Don’t know 

Please expand: ………………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………

1. Has your increased awareness of the reasons why a CYP might not want to disclose or access support for their self-harm resulted in your being able to implement strategies to help break down these ‘barriers’

Yes 

No 

Don’t know 

1. What strategies/change in working practice, if any, has your team/service developed to reduce the risk of self-harm in CYP? These strategies may be aimed at reducing the risk involved in self-harm (harm-minimisation advice) and/or may be early intervention strategies aimed at promoting emotional resilience.

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1. Please describe any other strategies, procedures, or change in working practice that have been developed following your attendance at the self-harm training (please include any that are in the process of being developed also).

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……………………………………………………………………………………………………………………………………………………………………………………

1. Do you feel that your increased awareness and understanding around self-harm has resulted in ‘conflict’ with work colleagues re approach/attitudes to self-harm?

Yes 

No 

Don’t know 

If so, please provide further details? …………………………………………………………………………………………………………………………

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1. Do you feel more confident now in being able to broach the issue of self-harm with a CYP you suspect is self-harming?

Yes 

No 

Don’t know 

1. In what ways, if any, do you consider yourself/your service better able to offer a helpful response to a CYP who self-harms?

……………………………………………………………………………………………………………………………………………………………………………………

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1. Do you feel that the outcome for the CYP who self-harm within your service has improved because of your increased knowledge?

Yes 

No 

Don’t know 

If you answered “Yes”, please elaborate: ……………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………………………………….

1. Since attending your training, have you had to deal with any occurrences of self-harm in children and young people?

Yes 

No 

Don’t know 

If so, approximately how many different self-harming CYP have you dealt with? ……………………………………………………..

What type of support were you able to offer? (tick all that apply)

Information re alternatives to self-harm 

Referrals 

Offering wound care/first aid advice 

Offering care and compassion 

Other  Please state: …………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………..

Have any of these CYP gone on to self-harm again?

Yes 

No 

Don’t know 

Did you feel that there were any barriers to the support your service could offer?

Yes 

No 

Don’t know 

If so, what were they? ………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………………………………..

Did you feel as though the support the CYP received was appropriate to their perceived need/risk?

Yes 

No 

Don’t know 

What went well? ………………………………………………………………………………………………………………………………………………………

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What could have gone better? .………………………………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………………………………………………………………

Do you feel there are any gaps in the multi-agency provision of support for CYP who self-harm?

Yes 

No 

Don’t know 

If so, what are they? ………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………………………………..

1. Please describe a time that you have been able to offer support to CYP who self-harm? ………………………………………….

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1. To what extent do you feel that you have been able to successfully engage with and support carers of CYP who self-harm? Please select a score between 0 (not at all successful) to 5 (extremely successful)

0 1 2 3 4 5

What improvements, if any, can your organisation make in relation to supporting parents/carers? …………………………

…………………………………………………………………………………………………………………………………………………………………………………..

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1. Did you cascade the training down to anyone else in your team/service?

Yes 

No 

If so, how did you disseminate this information and to how many? …………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………….

………………………………………………………………………………………………………………………………………………………………………………….

1. Do you feel their level of knowledge and confidence is satisfactory or do you feel they would benefit from attending self-harm training?

Satisfactory  Further training needed 

Is there any further training that would assist you/your service? If so, please state: ……………………………………………….

………………………………………………………………………………………………………………………………………………………………………………….

1. Are you more confident in your ability to support CYP who self-harm within your service without the need for referral?

Yes 

No 

Don’t know 

1. Have you used any of the local services from the directory that was circulated?

Yes 

No 

Don’t know 

If so, which ones? ………………………………………………………………………………………………………………………………………………………

Have you had any problems accessing these services?

Yes 

No 

Don’t know 

If so, please state the service and describe the problem ……………………………………………………………………………………………..

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Please state any other local services you have used that we can add to the directory? …………………………………………….

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…………………………………………………………………………………………………………………………………………………………………………………….

1. Is there any further support **you** need from within your organisation relating to CYP who self-harm?

Yes 

No 

If so, please state what support: ………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………………………………..

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**That concludes the Self-Harm Impact Assessment Survey**

**Please remember to tick the box if you wish to be entered into the prize draw,**

**and be sure to include your contact details**

**Once again, thank you for your valuable time**

**SUBMIT**

**APPENDIX II**





22 January 2015

Dear Delegate

**Impact Assessment following 2014 Self-Harm Training**

We had the pleasure of welcoming you onto one of the free full-day training courses we ran between April and July 2014 for Lancashire County Council’s Children and Young People’s Integrated Health Team on **“Children and Young People who Self-Harm”.**

You may recall that at the end of your training course you were asked to complete an end-of-course evaluation questionnaire; your responses were analysed and reported back to LCC to demonstrate that we had achieved the targeted outcomes set by them.

LCC have now commissioned harm-ed to undertake some follow-up consultation in order to identify the impact this training has had on you, your organisation and the service it provides to children and young people who self-harm.

The purpose of my email is to advise you that we will be sending you a short survey later this month in order to collate this feedback from you. We are also hoping to speak directly with those of you who would be willing to expand upon any feedback you provide during a telephone interview with me. We would be extremely grateful if you will participate in this survey and, as a self-harm training provider, we will also be very interested to learn from your feedback.

We will be asking for your survey responses by mid-February. If you are unlikely to be around when we are sending this survey out, and would prefer me to call you instead, please email me at [julia@harm-ed.co.uk](mailto:julia@harm-ed.co.uk) with a telephone number I can reach you on.

Kind regards.

Julia Jennings



**Appendix III**





5 February 2015

**Impact Assessment following 2014 Self-Harm Training**

Further to my letter dated 22 January, please find below the link to the **survey** we have prepared for Lancashire County Council following the training we delivered on **“Children and Young People who Self-Harm”.** The purpose of this survey is to identify the impact this training has had on you, your organisation and the service it provides to children and young people who self-harm.

Your feedback will be analysed and presented within an Impact Assessment report which has been commissioned by LCC, and which may be circulated to interested parties/services. We’d like your feedback to be full and frank and therefore want to assure you that every care will be taken to protect your own and your service’s/organisation’s specific identity in our report. However, we hope to be able to credit your service/organisation with any examples of good practice that you have developed since the training; in these limited circumstances only, we will assume that you are happy for your service/ organisation to be identified unless you indicate otherwise at the end of the survey.

As mentioned previously, I’m hoping to speak directly with those of you who would be willing to expand upon any feedback you provide during a telephone interview with me; thank you to those of you who have already forwarded me your contact details. If anyone feels the need to elaborate on or clarify any specific points, then a telephone conversation can be arranged. Please click on the following link to access the Survey: <http://goo.gl/forms/KCzpDjOApv>

As a big thank you for your time in completing this survey, harm-ed Limited is offering £50 of externally-produced self-harm resources. The prize draw will be made at the end of February 2015 and the winner will be notified in March 2015, when they will be given the opportunity to make a selection from a list of relevant publications from the following sites: http://www.harmless. org.uk/store/ and <http://www.selfinjurysupport.org.uk/publications-about-self-injury>.

Thank you in anticipation of your completing the survey. Please submit your feedback by **Monday, 23 February 2015 at the latest.**

Kind regards.

Julia Jennings



**APPENDIX IV**

Hi

You were contacted by us a couple of weeks ago with a request for you to participate in the above survey, commissioned by LCC. As the deadline of 23rd Feb has now passed, we were hoping to be in a position to collate the feedback; however, the response uptake has been considerably lower than expected which is why we are contacting you again.

The purpose of the survey was to enable us to gather a sufficiently broad picture of the impact our training has had on the services/organisations who accessed the training and we are concerned as to how accurately we will be able to demonstrate this based on the low level (11%) of responses received to date. We were also hoping that this survey might provide a valuable opportunity for examples of good practice to be highlighted and shared.

In view of the fact that half-term week may have interfered with response rates, Lancashire County Council have agreed that we may extend the survey deadline by a further week. The new deadline for survey responses is Monday, 2 March 2015.

We would be most grateful for any time you can spare to help us gather the feedback needed for our impact assessment. Although the whole survey will take about 15-20 minutes to complete, it is possible to submit your response without completing the whole survey and therefore you can focus your responses only on those questions which you feel would provide the richest feedback for our study. So if you feel you can spare 5 minutes, then please check out our survey by clicking on the following link: <http://goo.gl/forms/KCzpDjOApv>. If you have any problems using this link, please copy and paste it into the address bar at the top left side of your web browser page.

And don't forget we're offering £50 of free self-harm publications to the winner of the prize draw we're running for those responding to our survey! I'm happy to call anyone who would prefer to discuss the impact of the self-harm training over the phone – just let me have your landline number and a note of the best day/time to reach you.

Many thanks.

Julia

1. <http://www.nottingham.ac.uk/survey-unit/surveyFAQs.htm>. [↑](#footnote-ref-1)
2. <http://cogprints.ecs.soton.ac.uk/archive/00002357/>. [↑](#footnote-ref-2)
3. At ref 1 above. [↑](#footnote-ref-3)
4. One school described how one pupil was cutting on their ankles in order to avoid detection [↑](#footnote-ref-4)
5. East Lancashire Child and Adolescent Services [↑](#footnote-ref-5)
6. Child and Adolescent Mental Health Services [↑](#footnote-ref-6)
7. Available at <http://shop.mind.org.uk/shop/printed_information_booklets> [↑](#footnote-ref-7)
8. SCAYT+ is an integral part of the Comprehensive Child and Adolescent Mental Health Service in Lancashire. [↑](#footnote-ref-8)
9. DBT is Dialectical Behaviour Therapy, a specific type of cognitive behavioural therapy. [↑](#footnote-ref-9)
10. The `Prevent and Early Help’ (PAEH) service used to be known as the Early Support team. It is a multi-agency service which provides integrated support to children, young people and their families. The key objective of the service is to offer practical advice, support and direct case work to prevent issues escalating and requiring statutory intervention. If families are found to be struggling, then referrals can be made to the PAEH panel. Further information of Lancashire’s PAEH service is available at <http://www.lancashirechildrenstrust.org.uk/resources/?siteid=6274&pageid=44603> [↑](#footnote-ref-10)
11. Supporting Carers and Children and Young People Looked after Together [↑](#footnote-ref-11)
12. Police Community Support Officers [↑](#footnote-ref-12)
13. The Rainbow Journal is a book (free to under 18s) aimed at helping young people move from self-harm to self-care. It has blank pages for writing about feelings and for drawing. It includes artwork, quotes and poems by young people who self-injure. <http://www.selfinjurysupport.org.uk/self-injury-self-help-ideas> [↑](#footnote-ref-13)
14. PAPYRUS is the national UK charity dedicated to the prevention of young suicide [↑](#footnote-ref-14)
15. A goal-oriented approach to problem-solving. [↑](#footnote-ref-15)
16. <http://panlancashirescb.proceduresonline.com/pdfs/con_need_thresh_guid.pdf> [↑](#footnote-ref-16)
17. This was a concern for many participants who needed to make referrals to, for example, CAMHS. [↑](#footnote-ref-17)
18. Lancashire Young Carers. [↑](#footnote-ref-18)
19. Child Action Northwest [↑](#footnote-ref-19)