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Deliberate self-harm (DSH) among children and adolescents: who is at risk and how is it recognised?

Key messages

- Self-harm by children and adolescents most often involves overdoses (self poisoning) and self-mutilation (e.g. cutting behaviours, burning, scalding, banging heads and other body parts against walls, hair-pulling and biting).

- Repeated self-harm is associated with risk of suicide.

- Four times as many girls as boys self-harm up to age 16, although this ratio reduces to twice as many among 18 to 19 year-olds.

- The following are the principal factors associated with increased risk of self-harm among children and adolescents: mental health or behavioural issues, such as depression, severe anxiety and impulsivity; a history of self-harm; experience of an abusive home life; poor communication with parents; living in care or secure institutions.

- Common triggers for self-harm include experience or memories of stressful life events, such as being abused, witnessing domestic violence, disruptive or abusive relationships with parents, problems with boy or girlfriends, going into care, unwanted pregnancy, or problems at home or school.

- No one factor has been shown to predict self-harm. However, a combination of external pressures from home and school life, emotions such as anger, guilt or frustration, and mental or behavioural issues such as depression, conduct disorders or impulsivity, may lead to self-harm.

- Many children and adolescents who repeatedly self-harm consider it to have a positive purpose, a way to relieve unbearable pressure or pain. Some young people view it as a suicide prevention strategy, a means of protecting themselves. It is also seen as a coping strategy over which they have control.

- Self-harm can also be a means of communicating pain and distress to others.

Introduction

This section introduces and defines the scope of the briefing and the topic.

A SCARE briefing provides up-to-date information on a particular topic. It is a concise document summarising the knowledge base in a particular area and is intended as a 'launch pad' or signpost to more in-depth investigation or enquiry. It is not a definitive statement of all evidence on a particular issue. The briefing is divided into the different types of knowledge relevant to health and social care research and practice, as defined by the Social Care Institute for Excellence (SCIE) [(1)]. It is intended to help health and social care practitioners and policy-makers in their decision-making and practice.

The topic of this briefing is deliberate self-harm (DSH) and self-injurious behaviour (SIB) among children and adolescents up to the age of 19, who live in the community. Self-harm is defined as "a non fatal act in which an individual deliberately causes self injury or ingests a substance more than the therapeutic dose" [(2)]. The National Inquiry describes self-harm as "a wide range of things that people do to themselves in a deliberate and usually hidden way, which are damaging" [(3)]. It includes overdoses (self poisoning) and self-mutilation (e.g. cutting behaviours, burning, scalding, banging heads and other body parts against walls, hair-pulling, biting, and swallowing or inserting objects) [(3-5)]. Some of these actions result in no visible harm, and others require no medical assistance. This briefing does not cover eating disorders, drug and alcohol misuse, risk taking behaviours such as unsafe sex or dangerous driving. Nor does it cover children or young people with severe intellectual or developmental disabilities.

Children and young people who self-harm often do not necessarily restrict themselves to one form of self-harm only, but may choose others when they are unable to self-harm as usual because they are being observed or monitored, or need the relief self-harm provides quickly [(5)]. Self-harm may indicate a temporary period of emotional pain or distress, or deeper mental health issues which may result in suicide. A great deal of the research and policy literature does not distinguish between self-harm with the intention of committing suicide or self-harm without that intention, sometimes called self injury or self mutilation. Although this briefing recognises that self-harm, specifically self-injury or mutilation, and attempted suicide have very different motivations, the term "self-harm" is used throughout the briefing to denote all of the behaviours described above, including attempted suicide, unless the piece of research being cited explicitly relates to a single type of self injury or mutilation alone. The focus of this briefing therefore is the act of self-harming rather than whether or not the intention was unequivocally to commit suicide.

Why this issue is important

Paracetamol overdose and cutting are the two most common forms of self-harm reported for children and young people [4,6-10]. Self-harm becomes more common after the age of 16, but is still prevalent among younger children and adolescents. Although it is generally difficult to provide accurate prevalence figures for self-harm, partly because of the various possible definitions of this concept, as described above, but also because it may not be reported, some numbers can still be given. It is estimated that about 19,000 adolescents under 16 years of age are admitted to emergency hospital care each year in England and Wales after attempting suicide [11]. A national survey of more than 10,000 children found that the prevalence of self-harm among 5-10 year-olds was 0.8% among children without any mental health issues, but was 6.2% among those diagnosed with an anxiety disorder and 7.5% if the child had a conduct, hyperkinetic or less common mental disorder [12]. These figures increase dramatically for the 11-15 year-old age group, with the prevalence of self-harm being 1.2% among children without any mental health issues, but 9.4% among those diagnosed with an anxiety disorder, and 18.8% if the diagnosis is depression. The prevalence was between 8 and 13% for children with conduct, hyperkinetic or less common mental disorders [12].

A survey found that more than 60,000 young people aged 12-24 presented to A&E departments with recognised self-harm in 1996-1997, half of whom were admitted as in-patients [13]. The number of children disclosing self-harm to ChildLine counsellors has risen steadily since the mid-1990s, with a 65% increase between 2002 and 2004, although increased awareness of the issue by both children and counsellors may be responsible for some of the increase [4]. However, self-harming is usually a private act, and many people who self-harm, including children and young people, may not seek medical assistance or approach health services. For example, in a self-report survey of adolescents, less than 13% of reported episodes of self-harm had resulted in presentation to hospital [14]. This may be because cutting usually does not require medical assistance [14]. The numbers may therefore be much higher [5,15]. The prevalence of self-harm is disproportionately high among young Asian women, but this applies specifically to adult women, aged 15-35 years [16,17]. Otherwise, there is no difference in prevalence between adolescents from the white or black or ethnic minority communities, although some of the factors involved may be different [18]. For example, one small study found that adolescents from South Asian families were more likely to have problems at school, experience culture and intergenerational conflict at home, and report greater feelings of isolation, than their white counterparts. They were less likely to feel depressed, however [9].

Research has also shown that self-harm is often not a singular occurrence, but is commonly repeated and can go on for many years [4,5,7,19]. A self report survey of more than six thousand pupils aged 15-16 found that almost 400 (6.9%) had self-harmed in the previous year [14]. According to a survey of self-harming among participants of NCH projects, 27% of those who reported self-harming did so at least once a week, and 41% at least once a month [5]. Self-harming is therefore often performed regularly and persistently. Children and adolescents under 16 years of age account for about 5% of all self-harm episodes presenting to hospital, and 10-15% of these cases are repeaters with a history of self-harm [20]. It has been found that rates of repeated self-harm are increasing, rates of first-episode of self-harm have not reduced, and that the resulting pressure on services is affecting the response to the assessment and treatment of self-harm episodes [8]. It has also been found that children and young people who repeatedly self-harm have a greater number and range of the type of problems discussed in this briefing than young people who are "first-time" self-harmers [10].

There is also the issue of the lack of appropriate assessment of cases which present to emergency care in hospital. Less than a quarter of hospitals have been found to have a specialist psychosocial assessment team [13]. The absence of specialist assessment means at risk people are less likely to be assessed properly, admitted if necessary, and receive the appropriate treatment [6,13,21,22]. It is estimated that only 54% of 12-15 year-olds, and 40% of 16-24 year-olds are examined by specialists in psychosocial assessment when they present to A&E departments [23]. Specialist psychosocial assessment usually results in admission to in-patient care for children and young people presenting with self-harm, but the presence or absence of guidelines has been found to make no difference to the number of young people being assessed in A&E departments [13,23,24]. Children and young people are also less likely to have an assessment if there is no record of previous self-harm in their medical records [6,13,23], but because they can be confused, emotional and unwilling to talk about what has happened to them when they appear in hospital, a full medical history may not be taken [25]. Therefore, a referral to specialist support is not guaranteed by presenting to hospital with self-harm, even if it requires medical assistance.

Children and young people who live in residential care or secure institutions are more likely to self-harm than those who do not live in these circumstances [26,27]. One survey found that 10% of those presenting to A&E departments with self-harm were in care, even though only 1% of children are in care nationally [13]. In other studies, between one and two thirds of the young people interviewed who self-harmed were or had been in care [5,28].

Although some young people want help to find alternative means of coping with emotional pain and distress, and use self-harm as a means of communicating the severity of their anguish, trauma and pain to others, many children and adolescents who self-harm may not see their actions as a problem. This is in part because their actions are non-fatal and are perceived to affect no-one but

themselves [5]. However, it is also principally because self-harm provides an effective, controllable relief from distress or pain, which they see is not manageable in any other way [4,5,29,30]. Some young people view self-harm as something "positive", an effective coping strategy [4,5]. These children and adolescents may therefore rarely present to A&E departments or seek help themselves.

Finally, a history of self-harm is a significant risk factor for suicide [8,31-33], with repeated episodes of self-harm relatively more likely to result in suicide than single episodes [33,34]. It is therefore important to be able to recognise self-harm among children and adolescents and the risk factors associated with these actions. Social care, health and education professionals may all be involved in identifying and managing self-harm among children and adolescents.

What do the different sources of knowledge show?

Organisational Knowledge

This section lists and briefly summarises documents that describe the standards that govern the conduct of statutory services, organisations and individuals in relation to the parents of disabled or chronically ill children.

Department of Health (2005). National Suicide Prevention Strategy for England: Annual report on progress
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/DHAnnualReportsArticle/fs/en?CONTENT_ID=4101668&chk=ZALnoC
This document provides information about how the national suicide prevention strategy is to be implemented by Development Centres in each region of the England, including some specific plans for adolescents and looked after children. Self-harm is explicitly included in the strategy because it is a risk factor significantly associated with suicide.

Department of Health (2004). National Service Framework for Children, Young People and Maternity Services: The mental health and psychological wellbeing of children and young people
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4089114&chk=CKZObO
This best practice guidance defines the standards on child and adolescent mental health which form part of the National Service Framework for Children, Young People and Maternity Services. It addresses the responsibilities of CAMHS and other services, and the provision of appropriate support or help for children with mental health needs. Although self-harm is not covered specifically,

there is a clear association between self-harm and the presence of mental health issues [12,35-37].

Policy Community Knowledge

This section summarises documents describing proposed structural models and guidance for the delivery of policy and improved practice. These documents are published by public policy research bodies, lobby groups, think tanks and related organisations.

Dow P. (2004). "I feel like I'm invisible". Children talking to ChildLine about self-harm. ChildLine.
http://www.childline.org.uk/pdfs/selfharm.pdf
This document reports the findings of an 18-month inquiry conducted by the Mental Health Foundation and Camelot Foundation. It aims to connect research and practice, raise awareness and make policy recommendations. This document states that practitioners need to know why children self-harm and what the triggers are (eg. bullying), and there needs to be better training and sources of advice for professionals, including teachers.

Richardson G., Patrridge I. (2003). Child and Adolescent Mental Health Services: An Operational Handbook. London, Gaskell.
http://www.rcpsych.ac.uk/publications/gaskell/96_X.htm
This book describes “in operational terms” how Child and Adolescent Mental Health Services (CAMHS) should be developed and delivered in line with the National Service Framework (NSF) for Children, Young People and Maternity Services. Specific examples are given for each of the four tiers of service provision. Click here for a review (http://pb.rcpsych.org/cgi/reprint/29/4/158-a)

Bywaters P., Rolfe A. (2002). Look Beyond the Scars. Understanding and responding to injury and self-harm
http://www.nch.org.uk/uploads/documents/selfharm.pdf
This reports the findings from interviews with a group of people who self-harm or who have self-harmed in the past, and some of their partners. It was commissioned by the NCH. The report concludes by making extensive recommendations to policy makers, commissioners, service providers, and staff in social care, health and education. The recommendations include the establishment of a national network of locally based services for young people who self-harm, improved training of professionals and efforts to raise awareness of self-harm among practitioners and people generally.

Practitioner Knowledge

This section describes studies carried out by health and social care practitioners, documents relating their experiences regarding the topic, and resources produced by local practitioner bodies to support their work.

Young People and Self-harm, National Children's Bureau. Self-harm projects database
http://www.selfharm.org.uk/index.php?section=projects&projectid=6&backletter=C
This is a database of self-harm projects, including those with protocols, in the UK.

The Basement Project
http://freespace.virgin.net/basement.project/default.htm
This is a local Welsh project which provides support groups for those who have been abused as children and people who self-harm.

42nd Street
http://www.nshn.co.uk/resources.html
42nd Street is a Manchester-based mental health service for young people aged 15 to 25 who face a broad range of issues, including self-harm and suicide. They offer a variety of individual and group-based support.

Teachernet. Self-harming pupils. Department for Education and Skills
http://www.teachernet.gov.uk/teachingandlearning/library/self-harm/
This resource defines and explains self-harm, and identifies at risk groups among children.

Research Knowledge

This section summarises the best available research literature. The focus is on studies undertaken in the United Kingdom, so that the findings are as relevant as possible to the intended audience of the briefing.

The limitations of the research
The research covers several different definitions of self-harm, from self injury or mutilation with no intention to commit suicide [4,5] to definitions based on the actions alone, regardless of the specific intention, which often cannot be ascertained accurately [14]. The research also either focuses on a particular form of self-harm, such as overdose or self poisoning, or considers all forms of self-harm together. The result is that it is difficult to establish whether there are any significant differences between the different types of self-harm. The summary below is therefore not always comparing like with like in terms of the research,

but the findings do tend to be very consistent in terms of risk factors for self-harm, regardless of the nature of the intentions behind the actions. Also, qualitative studies principally only gain the views of young people willing to discuss their self-harm, usually repeat self-harmers [5]. The literature therefore may be missing groups that are "hard to reach", such as boys, or children or young people who self-harm irregularly, only by certain methods, or who are unwilling to disclose their self-harming. Finally, girls are much more likely to self-harm than boys. The high prevalence of self-harm among girls may also mean that the research is identifying factors principally associated with self-harm by girls [35]. Factors more significant for boys may therefore potentially be being missed. There has also been no research on how the interaction of individual and environmental factors contributes to self-harm among this age group [38].

How can self-harm be recognised?

Parents can often be unaware that their children are self-harming [12]. It can also be difficult to recognise self-harm if the young person does not seek help or present at A&E departments with clear indications. However, one study of attempted suicide cases among 15-year olds found that they were twice as likely to go to their local doctor than 15-year olds who did not attempt suicide (four times per year compared to twice per year, on average) [39]. They were also much more likely to present to their GP with mental health concerns or upper respiratory tract infection, for which there were no physical symptoms [39]. The high use of primary care resources by people who self-harm has been found by another study also [7].

A systematic review of the psychological and psychosocial factors associated with self-harm concluded that no one factor predicted self-harm [35]. Young people may resort to self-harm when personal pressures and emotional distress are combined, especially if they have conduct or behavioural issues. The following personal, emotional and behavioural factors have been shown to be associated with increased risk of self-harm among children and adolescents. Health and social care professionals who work with children and adolescents therefore need to be aware of the factors that are associated with self-harm in order to gauge whether a young person is at risk of self-harming. Their risk of doing so may be increased if they fulfil certain characteristics or demonstrate certain emotions or behaviours:

- History of self-harm
- Mental health and behaviour
- "Life" events
- Domestic environment
- Relationships
- Gender (adolescent girls are much more likely than boys to self-harm)

History of self-harm

A history of self-harm has been found to be strongly associated with on-going self-harm [4,5,7,40]. A survey of children and young people up to 19 years of age presenting to A&E departments with self-harm found that about one fifth had deliberately self-harmed on at least one previous occasion [13]. Higher numbers have been found by other studies [25]. The older the child or young person, the more likely they are to self-harm and to disclose it [4]. It has been found that children and adolescents who repeatedly self-harm are significantly more likely to have higher levels of depression, despair, anger and lower self esteem than those who self-harm only once [36].

Mental health and behaviour

Instances of self-harm are frequently associated with feelings or symptoms of depression, including clinical depression, as well as personality disturbance or disorder [5,19,22,36,37,40-43]. An analysis of calls received by ChildLine found that 15% of callers who were self-harming also said they had depression or other mental health problems [4]. A national survey of more than 10,000 children found that the prevalence of self-harm among 5-15 year-olds was between six and seventeen times higher among children with depression, anxiety or conduct disorders than among children with no such mental health issues [12]. Feelings of anxiety, despair or hopelessness are also commonly associated with self-harm [35,37]. The prevalence of self-harm among children and adolescents with mental health issues was about 1% [12]. Children and adolescents prone to impulsiveness are also more likely to self-harm than those who do not share this behavioural characteristic, especially if the self-harm involves overdosing [9,35,44]. The taking of drugs or alcohol has been found to accompany many cases of self-harm [4,6,13,25].

There is some “weak evidence” for increased risk of self-harm among young people aged under 18 who are taking selective serotonin reuptake inhibitors (SSRIs) for depression compared to those taking tricyclic antidepressants, although this slight difference has not been found for other age groups [45]. Children with severe intellectual or developmental disabilities may also be prone to self-harm [46-48]. Children under 10 years of age who have autism or a similar intellectual disability may be more likely to engage in self injurious behaviour if they had lower developmental ages compared to other such children, and more limited mobility [47,48].

“Life” events

Self-harm episodes can be triggered by either specific events or more general feelings of distress. Children aged 5-10 were between 3 and 15 times more likely to self-harm if they had experienced either 3 or more, or 5 or more stressful life events. These include witnessing domestic violence, having a family break-up, being placed in care, unwanted pregnancy or bereavement [5,12,35,37,38,41,44,49,50]. Childhood abuse, both physical and sexual, has been found by several studies to be an important factor in the self-harming of some young people [4,5,7,27,37,38,51].

One fifth of the callers to ChildLine said abuse was a major factor in their self-harming [4]. Issues concerning sexual orientation can also be a source of distress, and is another factor associated with self-harm, especially for young men [35].

Domestic environment

Children and young people who live in residential care or secure institutions are more likely to self-harm than those who do not live in these circumstances [26-28,51]. One survey found that 10% of those presenting to A&E departments with self-harm were in care, even though only 1% of children are in care nationally [13]. In one NCH study, two thirds of the adults interviewed described self-harming when they were children and had been in care [5]. Looked after children are also more likely to experience mental health problems than children who are not in care [52], and mental health issues are another risk factor associated with self-harm. Young men aged 15-21 years old who are resident in Young Offender Institutions are three times more likely than the general population to have mental health problems, a factor associated with self-harm among young people [53]. There is also a clear association has been found between the frequency of self-harm and the amount of time served: the longer the duration of a sentence, and more likely an adolescent male is to self-harm, and to do so regularly [54]. Children and adolescents are also much more likely to engage in self-harming behaviours if they are around other people who self-harm [26]. For example, young men aged 15-21 years who are resident in Young Offender Institutions are more likely to be exposed to self-harm and attempted suicide than those not living in such circumstances, and therefore are more likely to self-harm themselves [26]. Self-harm by friends or family has also been found to trigger self-harm among adolescents living in the community [14]. Some young people have reported that “carer stress” from looking after a parent contributed to their self-harm [7].

Among 5-15 year olds, self-harm has been found to be approximately twice as prevalent among children from the lowest socio-economic income group and those living in rented compared to private accommodation, and 5-10 year-olds living in terrace houses compared to detached or semi-detached houses [12]. Socio-economic adversity or deprivation has also been found to be a significant independent factor associated with self-harm among adolescents and young people [37,55]. The factors associated with self-harm can also change over time. There is a strong relationship between self-harm and domestic or family problems in early adolescence, but self-harm becomes more associated with problematic relationships with partners as a child gets older [10].

Relationships with family, friends and peers

A national survey found that, among 5-15 year olds, self-harm was approximately twice as prevalent among children from single-parent compared to two-parent families, and when the child is an only child compared to being in a family of three or more children [12]. This has also been found by other studies [6]. Children

aged 5-15 who were punished frequently at home were about twice as likely to self-harm as children who were seldom or occasionally [12]. This has been found by other studies also [37]. Parental mental health issues have also been shown by UK and Danish studies to be associated with self-harm by children and adolescents, although the nature of this relationship is unclear [27,40]. Poor communication between parents and children is also associated with self-harm by children and young people, that is, if the child and parent do not feel able to speak freely, do not feel understood, or are unsatisfied by their exchanges [35,37,38,56,57]. Forty percent of callers to ChildLine who were self-harming referred to problems at home, such as family tensions or conflict, as a major reason for their self-harming [4]. Self-harm behaviour can also have a group dynamic. Young people may get into self-harming groups at school, college or elsewhere [5] and it may also form part of "rituals of initiation" [58]. Studies report that many children and young people who self-harm are also experiencing problems at school, such as work or exam pressures, but bullying is the most common issue [4,6,35,49,50]. One UK survey of the incidence of self-harm found that rates dropped during school holidays, reinforcing the link between self-harm and school-related stress [10]. This suggests that more support should be provided by schools for children who self-harm.

Gender

Girls have been found to be much more likely to self-harm than boys. ChildLine has reported counselling ten times as many girls as boys about self-harm, and 93% of calls about self-harm by others (friends or family) are made by girls [4]. An audit of children and adolescents under 16 presenting to A&E with self-harm found that four times as many girls as boys were self-harming [20]. Even taking into account that girls are much more likely to phone for help than boys, the difference in rates of self-harm between girls and boys is still very great. In one self-report survey of 6,020 children aged 15-16 years, four times as many girls as boys said they self-harmed [4,10,13,14,49]. This disparity is also reflected elsewhere in the research [5,50]. However, it has also been found that this difference reduces after age 16 with girls of 18 or 19 years of age only twice as likely as boys to self-harm [50]. Factors significantly associated with self-harm among girls were self-harm by friends and family, problems with relationships, drug misuse, depression, anxiety, and low self esteem [10,14]. Some of these factors affect boys, especially drug and alcohol misuse and family problems, although issues with school, studying, money and housing have also been found to affect boys more than girls [10,14].

User & Carer Knowledge

This section summarises the issues raised by young people who self-harm, both as described by the literature and as defined through local consultation.

Why do children and young people "harm" themselves?

Young people say they self-harm partly because of issues with self-esteem, and because they can feel frustrated and angry [59]. In one UK study a boy said that he first cut himself after a row with his parents because "they made me feel little, useless and depressed" [4]. Many young people say that they cut or burn themselves, or perform other forms of self-harm, because it is a form of escapism, a release or relief from the pressure of mental, emotional or personal problems [4,5,7]. Self-harm provides a physical release from unbearable emotional or mental pressures. One girl said that, "Cutting myself is the only way to forget" [4], another that it "felt really good, especially when I cut myself, because too me, it felt as if all the badness . . . that I had inside was all coming out, and it was releasing it all" [5]. Some have therefore said that they often do not see self-harm as something negative, but rather as a strategy to protect themselves, an effective means of coping. It makes the unmanageable manageable. Some young people say that it is also something over which they feel they have control, a coping strategy which they can exercise when necessary [4,5,29,30,44,60]. Some therefore describe it as a suicide prevention strategy because it provides sufficient temporary relief from a range of pressures for which suicide may be thought to be the only release [5,29]. Young people can therefore see a very real difference between self-harm which involves self–injury or mutilation, and self-harm which may encompass attempted suicide [5]. However, some adolescent and young people also say that self injury can be performed as a punishment, something that is "deserved", either for something that has happened in the past or something that is happening in the present [5,44].

Young people have also said that self-harming can "feel good" [4]. Consequently, some have said that they do not feel they should stop, as the action performs an important and worthwhile function for them, and does not harm anyone else [5]. This is why some young people have also said that they think it is impossible for people without personal experience of self-harm to understand what self-harm means for them, that it can be viewed as something "good" [5]. Because of the "positive" associations of self-harm, some young people do not wish to stop, and may even find themselves addicted to self-harm [5]. However, others have said that they do not want to continue with self-harm as a means of release, coping or control [5]. Professionals may therefore face a difficult challenge with young people who self-harm because they may feel a responsibility to protect children from harming themselves, but their intervention may be neither wanted nor reduce the amount of self-injurious behaviour. For example, children in one study reported that being monitored, or having their means of self-harming taken away from them, did not prevent them from self-harming. Instead, they simply found alternative means of self-harming, such as not eating, and felt more distressed because they felt they had lost a means of control and had had responsibility for their own actions taken away from them [5].

On the whole people who self-harm reject the "attention seeking" label because this trivialises and misunderstands the triggers and reasons behind self-harm

[5,59]. However, some young people do admit that they self-harm in order to have their pain acknowledged: it is a means of "communicating" to others how much distress or hurt they are feeling, and can be a sign that they want and need help [5,59]. Some adolescents who have self-poisoned said their life had improved after the overdose, partly because this led to recognition of their pain [22]. According to young people, triggers for self-harm can include problems with family or friends, depression, anxiety, painful thoughts about past events, such as abuse or bereavement, or current issues such as bullying [4,5,59]. Another major trigger can be the young person's environment, such as being in residential children's homes or psychiatric units [5]. The many functions of self-harm have been found by many studies [38].

Finally, the divergent attitudes of young people to self-harm, especially the view that self-harm can be seen as something which is helpful and not needing of any intervention, raises legal and ethical issues for professionals. However, there is currently no research on this issue.

Useful Links

This section lists sources of information relevant to professionals who work within this field, and may also be of value to service users.

ABC of Adolescence. Suicide and Deliberate Self Harm in Young People
http://bmj.bmjjournals.com/cgi/content/full/330/7496/891
This is the tenth in a series of twelve brief overviews published by the British Medical Journal of findings on adolescence health and well-being. It is written by Keith Hawton and Anthony James.

British Psychological Society
http://www.bps.org.uk/home-page.cfm
This organisation makes available a number of documents relating to DSH.

ChildLine
http://www.childline.org.uk/
ChildLine is the free 24-hour confidential helpline for children and young people in the UK. Children and young people can call this helpline about any problem, at any time.

Mental Health Foundation
http://www.mentalhealth.org.uk/
This web site provides access to information about mental illness, including a fact sheet on self-harm
http://www.mentalhealth.org.uk/html/content/selfharm.cfm

Mind
http://www.mind.org.uk/
Mind is a charity which that promotes and protects good mental health for all, and treats people with experience of mental distress fairly, positively, and with respect. The organisation also provides a leaflet aimed at people who self-harm and who can help
http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+self-harm.htm?wbc_purpose=Basic&WBCMODE=PresentationUnpublished

NCH
http://www.nch.org.uk/
The NCH is a charity which provides services to support some of the UK's most vulnerable and excluded children and young people. The web site provides a list of FAQs on self-harm by children and young people
http://www.nch.org.uk/information/index.php?i=136

National electronic Library on Mental Health
http://www.nelmh.org/home_suicide.asp?c=14
This national specialist library provides information on self-harm and suicide.

National Self-harm Network
http://www.nshn.co.uk/
This national charity aims to provide support to people that self-harm and the people affected by self-harm, including family and professionals.

Samaritans
http://www.samaritans.org/
The Samaritans provides a confidential help service for people who want to discuss issues or problems in their lives.

Trust for the Study of Adolescence
http://www.tsa.uk.com/
This organisation offers training and related resources for professionals working with young people who self-harm.

Young Minds
http://www.youngminds.org.uk/
This is the principal online information resource designed for young people who are experiencing personal or emotional problems. It has a section specifically on self-harm among young offenders
http://www.youngminds.org.uk/youngoffenders/2002_03_7/dsh.php

Young People and Self-harm
http://www.selfharm.org.uk/
This is the principal web resource for children and young people who self-harm. It is maintained by the National Children's Bureau (NCB).

Young People and Self-harm: a National Inquiry
http://www.selfharmuk.org/
This website provides access to the findings and documents of three national inquiries into self-harm among young people.

Related SCARE briefings

Therapies and approaches for helping children and adolescents who deliberately self-harm (DSH)
http://www.scie.org.uk/publications/briefings/briefing17/index.asp

ADHD: Background, assessment and diagnosis
http://www.scie.org.uk/publications/briefings/briefing07/index.asp

ADHD: How it is treated
http://www.scie.org.uk/publications/briefings/briefing08/index.asp

The Health and Well-being of Young Carers
http://www.scie.org.uk/publications/briefings/briefing11/index.asp

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This document analyses and defines the different types of knowledge and information which may inform social care research and practice.

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This book covers a range of issues relating to deliberate self-harm

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This body examines research on self harm, develops guidelines and makes policy recommendations.

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