Chapter 2:
Mental Health and Wellbeing Research, Reports and Articles

This chapter will look at some of the research and reports relating to mental health and wellbeing outlining their recommendations and how support can be improved. These reports are given in the order they were published starting with the most recent.

THE PERFORMANCE OF THE NHS IN ENGLAND IN TRANSFORMING CHILDREN'S MENTAL HEALTH SERVICES. EMILY FRITH (MARCH 2017)

This report analysed data from NHS England's new Mental Health Five Year Forward View Dashboard. Published quarterly the dashboard is intended to act as a barometer to measure progress on improving children and young people's mental health across a range of indicators that reflect Government priorities identified in national policy strategies such as Future in Mind. It looked at local performance in improving child and adolescent services based on a self-assessment framework completed by CCGs and it found that 73% of local CCGs failed to meet NHS England's benchmark for improving services. The south of England performed best on service transformation based on the assessment framework with 32% of them meeting the standard. In London, the worst performing region, only 19% of CCGs met the standard.

In relation to crisis care there were serious gaps in NHS provision for children and young people in mental health crisis. Specialist mental health services do not always offer crisis support after hours. Accident and Emergency Departments often lack specialist expertise and young people can end up in police cells due to a poorly co-ordinated crisis response. In England only 31.6% of CCGs had a fully funded plan to improve crisis care. However 10.5% of CCGs had no agreed plan or funding to improve crisis care from its current level.

The quarterly report stated that 90 young people under the age of 18 were being treated on adult wards (an increase from 79 in the first quarter). In total 2,654 nights were spent by a child under 18 on an adult ward. This represented an increase of over a third in just 3 months.

MENTAL HEALTH SERVICES AND SCHOOLS LINK PILOTS: EVALUATION REPORT. LAURIE DAY, GOVERNMENT SOCIAL RESEARCH (FEBRUARY 2017)

Future in Mind (2015), a report of the Children and Young People's taskforce, outlined a number of recommendations to improve their access to mental health support. As a result of this, in Summer 2015, NHS England and DfE launched the Mental Health Services and Schools Link Pilots in 22 areas, incorporating 27 CCGs. 255 schools were funded to establish named lead contacts within Children and Young People's Mental Health Services and schools.

The pilot programme demonstrated the potential added value of providing schools and NHS CAMHS with opportunities to engage in joint planning and training activities, improving the

- Local commissioning agencies give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing.
- A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.

MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE IN GREAT BRITAIN. ONS (2004)

ONS published a report on behalf of the Department of Health and Scottish Executive into the mental health of children aged 5-16 years old, finding that 1 in 10 children and young people had a clinically diagnosed mental disorder. It found boys were more likely than girls to have a mental health disorder, and older children were more likely than younger children to have a mental disorder.

The report also looked at the characteristics of children, and found mental disorders were greater among children:

- in lone parent (16 per cent) compared with two parent families (8 per cent)
- in complex family units (e.g. families containing step-children/step-parents) (14 per cent) compared with families containing no stepchildren (9 per cent) (Figure 4.2)
- parents had no educational qualifications (17 per cent) compared with those who had a degree level qualification (4 per cent)
- in families with neither parent working (20 per cent) compared with those in which both parents worked (8 per cent)
- in families with a gross weekly household income of less than £100 (16 per cent) compared with those with an income of £600 or more (5 per cent)
- in households in which someone received disability benefit (24 per cent) compared with those that received no disability benefit (8 per cent)
- living in social or privately rented accommodation (17 per cent and 14 per cent) compared with those who owned accommodation (7 per cent)

In 2015, the Government announced a new study into the mental health of children and young people would be conducted. A National Study of Health and Wellbeing was launched in 2017 to provide survey data that would give updated estimates on mental health disorders in children and young people across England. The study incorporated standardised tools that measure psychological wellbeing and mental health, such as the Strengths and Difficulties questionnaire (SDQ) and the Development and Wellbeing Assessment (DAWBA). The results (due to be published in 2018) will inform various groups about the mental health of children and young people. This will help the Government, NHS and wider society to better understand and support those facing mental health issues.

PUPILS RISKING THEIR LIVES AS MENTAL HEALTH SERVICES COLLAPSE. TIMES EDUCATIONAL SUPPLEMENT (JUNE 2017)

Funding cuts to mental health services have made thresholds so high that young people are risking their lives in desperate bids to get professional help.

Increasingly stretched CAMHS has led to students putting their own lives at risk in an attempt to have their mental illnesses treated. A secondary head quoted in the article said

Chapter 3:
The Effects Of Social Media

The impact and significance of social media on children and young people should not be underestimated. The Royal Society for Public Health (Reported on Sky News on 19/05/17) warned that a particular social media platform has the most negative impact on users and puts them at risk of suffering loneliness, depression and body image anxiety. Social media is making youngsters more anxious and due to the bullying content and comments posted online is causing 'children to grow up in a culture of antagonism'.

ONS (2015) quoting the Public Health England Report (2013) says there is a negative association between screen time and mental wellbeing with 'children who spend more time watching on computers, watching television and playing video games tend to experience higher levels of emotional distress, anxiety and depression.' This was particularly the case for those who spent more than 4 hours a day doing these things. Importantly The Understanding Society Survey found that 1 in 10 girls (11%) spent more than 3 hours on social networking sites compared with just 5% of boys.

EFFECTS OF SOCIAL MEDIA

- Peer pressure from social media and cyber-bullying are making British girls feel less happy with themselves. A 2017 report from the Organisation for Economic Co-operation and Development (OECD) which surveyed 540,000 children aged 15, found that British girls were amongst the most unhappy. They came fourth on a dissatisfaction ranking amongst nations with 1 in 5 British girls saying they were unhappy with their lives.
- Internationally the UK had the highest internet usage with on average 188 minutes per weekday spent on browsing. The OECD report found that those who were online a lot had a weaker sense of belonging, felt lonely and were more likely to be bullied. Girls who are subject to a lot of pressure from social media said they were less happy with themselves. Girls in the UK are most affected with a higher percentage reporting mental health problems and being subjected to bullying or nasty rumours. The report refers to research that has shown exposure to images of overly thin girls and young women in the media and on photo-sharing media has a significant impact on girls.
- Poor body image can be associated with low self-esteem and depression particularly amongst teenage girls. The more positive a child's body image, the less depressed they were and the higher self-esteem they had.
- In relation to digital culture, social media, bullying and cyber-bullying, the Government produced a response to the House of Commons Health Select Committees inquiry into CAMHS. Recommendation 20 was that: 'In our view sufficient concern has been raised to warrant a more detailed consideration of the impact of the internet on children and young people's mental health and in particular of social media and the impact of pro-anorexia, self-harm and other inappropriate websites.'
- ONS (2015) quotes Best et al (2014) who says 'social websites are ever-present features of social life, especially for the young. While they may provide an additional

- 36% of these children got over the experience straight away or within a day, but 5% were upset for a few or many months afterwards and 4% are yet to get over the experiences.
- Although more girls have experienced something upsetting in the past year (32% compared to 24%), a higher proportion of boys than girls experienced these every day or almost every day (16% compared to 8%).
- Ghosting - being ghosted is a trend, fuelled by social media where a person is often abruptly dropped by their best friend. Often texts, e-mails are ignored and the victim is deleted from the social media account of their friend. Being ghosted undermines the victims self-confidence and the emotional effects can be devastating. It can also feel like fighting an invisible enemy - if a negative remark is made there is no way of responding. Women are the most frequent targets and their friendships can be complex and being ghosted by a close female friend creates a special class of pain. People who have been ghosted go through a grieving process of denial, anger and guilt as if they have been bereaved.

THE EFFECTS OF ADULT CONTENT ON CHILDREN

Research on the harm of pornography says that widespread exposure of minors to pornography before they would normally be sexually active may:

- Cause them distress.
- Impact on their relationships and development.
- Lead to the normalisation of the behaviours depicted in pornography.

SLEEP PATTERNS

Greater overall social media usage can be linked to poorer sleep quality and was particularly pronounced amongst night time social media users. Also for those with higher emotional investment in social media there is a correlation between social media usage and levels of depression and anxiety.

SEXTING

There is a growing concern that sexting, sexual bullying and assaults are now commonplace in schools. A large number of children are accessing porn via their phones and tablets. This distorts their views on relationships. Children's charities have warned that many young girls are now being subjected to sexual harassment on a daily basis and are pressurised into taking part in activities for which they are not ready. This exposure has a significant negative impact on children's mental health and wellbeing.

The UK Council for Child Internet Safety (UKCCIS) reports that a 2016 NSPCC/ Office of the Children's Commissioner England study found that:

- 13% of boys and girls had taken topless pictures of themselves (1 in 4 of these were girls) and 3% had taken fully naked pictures.
- Of those who had taken sexual images 55% had shared them with others – 31% of this group had also shared the image with someone they did not know.

be made to see whether existing procedures are fit for purpose and that schools are able to show that they record and track levels of incidents.

KEY POINTS

- OECD Report found UK had highest internet usage with15 year olds spending on average 188 minutes per day browsing.
- OECD found those who were online a lot had a weaker sense of belonging, felt lonely and were more likely to be bullied.
- Social media websites are an ever present feature of social life but can be a source of social comparison, cyber-bullying and isolation which can have an effect on mental health.
- The speed of social media and technological advances makes it difficult for parents and teachers to keep up to date and to be aware of interventions to make.
- 28%f 11-16 year olds are upset by incidents on social networking sites according to an NSPCC study.
- Trolling, being excluded from a social group or friendship, aggressive comments and pressure to look a particular way are upsetting experiences.
- Widespread exposure to adult content causes distress in children and young people and can lead to normalisation of behaviours depicted.
- Greater social media usage can be linked to poorer sleep quality.
- Because higher emotional investment is involved in social media usage there is a correlation between it's usage and levels of depression and anxiety.
- Sexting can distort views on relationships.
- NSPCC/OCCE study found 13% of boys and girls had taken topless pictures of themselves and 3% had taken fully naked pictures. 55% of those who had taken sexual images had shared them.
- Sexting should be referenced in all relevant school policies.
- A clear statement needs to be made in school policies that incidents of sexting will not be tolerated and if it occurs clear procedures will be followed and sanctions applied.
- Awareness in relation to sexting needs to be raised amongst staff, pupils and parents. The topic should be part of the curriculum. Appropriate training should be given to staff.

Cyberbullying

> 'Any behaviour performed through electronic or digital media by individuals or groups that repeatedly communicates hostile or aggressive messages intended to inflict harm or discomfort on others.'

Tokunaga (2010)

In Chapter 3 the effect of Social Media on the mental health of children and young people was discussed. Social Media sites can have a real impact on vulnerable teenagers. Some sites allow anonymous comments to be made on individuals which can have a devastating effect and can be a form of extreme bullying. These are often a platform for unrestricted cyberbullying. These sites can expose children to a deep psychological horror.

New communications technology and the internet give students many ways to socialise, communicate and connect with others. The technology and applications are rapidly changing and so it is extremely difficult to ensure we are keeping up to date with some of the negative things that can occur through its use. Cyberbullying is a real concern and its' impact is more devastating due to its' 24/7 nature. It can make students feel helpless, sad, frustrated and socially anxious. It is more of a problem with British children with many reporting aggressive and unpleasant behaviour online.

<u>What is Cyberbullying?</u>

Cyberbullying is a method of bullying that is concerned with the use of ICT to upset, threaten or humiliate someone. Cyberbullying takes place online, on social networking websites or through mobile phones. The technology has provided a medium for 'virtual' bullying and signs of it are not always obvious and can happen at all times of the day.

Cyberbullying includes:

- Sending threatening or disturbing text messages.
- Homophobia, racism or sexism.
- Making silent, hoax or abusive calls.
- Creating and sharing embarrassing images or videos.
- Sending explicit messages, also known as 'sexting'.
- 'Trolling', the sending of menacing or upsetting messages on social networks, chat rooms or online games to intimidate, usually under a pseudonym.
- Excluding children from online games, activities or friendship groups.
- Setting up hate sites or groups about a particular child.
- Encouraging young children to self-harm.
- Voting for someone in an abusive poll.
- Creating fake accounts. Hijacking or stealing online identities to embarrass a young person or cause trouble using their name.
- Pressurising children into sending sexual images or engaging in sexual conversation.

According to the NSPCC:

- 38% of young people have been affected by cyberbullying.
- 26% have received abusive e-mails.
- 24% have received abusive text messages.

Key points about cyberbullying:

- Cyberbullying can occur on a vast and rapid scale.
- Electronic content is very hard to control once it has been posted and can never be guaranteed to be removed totally from circulation.

Supporting the Victim /Target

- Reassure them that they have done the right thing by telling someone.
- Use existing pastoral systems to support the pupil and inform parents etc.
- Encourage them:
  - Not retaliate or reply.
  - Consider any information they have posted online.
  - To keep information/evidence for investigations e.g. by not deleting messages, taking screenshots etc.
  - To block contacts, to report problems, in order to prevent a reoccurrence.

What can schools do?

Cyberbullying and e-safety should be dealt with as a whole school approach. Schools should have a co-ordinated response to cyberbullying and e-safety:

- Ensure the school includes cyberbullying in the behaviour/bullying policies. Have clear statements relating to cyberbullying and how it will be dealt with by the school: this should be linked to an anti-bullying policy.
- Ensure the school has an e-Safety Policy in place and a designated e-Safety officer.
- Have Acceptable Use Policies (AUPs) that clearly state the rules pupils must follow when using ICT – ensure they are signed and read by staff, students and parents.
- Review and update policies on a regular basis.
- Ensure staff understand what e-Safety and cyberbullying means and the different methods in which it can take place. Encourage all staff to be vigilant for signs of cyberbullying.
- Encourage young people to be aware of their responsibilities in their use of ICT.
- Have clear sanctions in place for pupils/staff who misuse ICT.
- Ensure pupils, staff and parents are aware that cyberbullying is taken seriously and have strategies in place that enable them to report incidents.
- Have a clear procedure for staff to follow should they receive a disclosure or witness cyberbullying. Have clear systems for recording any incidents and actions.
- Educate pupils how to keep themselves safe online and how to use new technologies responsibly.
- Educate pupils to understand the impact and effect cyberbullying can have. Educate pupils via induction programmes about the potential risks and what they should do if any problems arise: they must always promote 'netiquette' and e-Safety.
- Ensure pupils are aware how to report problems both in and out of school.
- Log and keep records of any cyberbullying incidents. (Important if the police need to be involved.) Keep messages, texts/photos/videos/emails. Save Instant Messenger conversations, take Screen prints (N.B. Not of illegal images).

Key Advice to Pupils

- Always respect others – think about what you say online and what images you send/post
- Remember that anything you publish online can be made public very quickly and you will never be sure who may have seen it. Once something is posted you lose control.
- Treat your password like a toothbrush – never share it with anyone and only give your personal information like mobile phone number or e-mail address to trusted friends.
- Learn how to block or report online bullies or anyone behaving badly.
- Don't retaliate or reply.
- Save the evidence – text messages, online conversations, pictures etc.
- Always make sure you tell:
  - An adult you trust.

Chapter 5:
Mental Health Conditions

In this chapter a number of mental health conditions will be discussed giving a definition, likely causes, symptoms and characteristics together with support strategies to use in the classroom, treatments and useful references and websites. A list of the 16 syndromes and conditions plus the page number where they are located are given below:

AGORAPHOBIA

WHAT IS AGORAPHOBIA?

Agoraphobia is an anxiety disorder. The person with it will have an intense fear of being in public or open spaces and will become panicky in locations where they feel their escape route might be difficult. People with agoraphobia can be seriously disabled by their condition.

CAUSES

- It often develops as a complication of a panic disorder.
- It can be inherited from a parent's genes and if a parent suffers from an anxiety disorder the child is more likely to have agoraphobia.
- Events in child's life can lead to panic attacks and agoraphobia e.g. friendship issues, problems at school, worry associated with parents divorcing or from abuse.

- Develop distraction/diversionary activities.
- Re-assure them that they still have two parents who will care for them and love them.
- Both parents should ensure they are able to spend time with their child and ensure that arrangements to have access are clear and parents are reliable to meet these arrangements.
- Parents should avoid asking the child to take sides or use child as a weapon to get back at their ex-partner.

USEFUL REFERENCES

Refer to the Bereavement references.

OBSESSIVE COMPULSIVE DISORDER (OCD)

WHAT IS OBSESSIVE COMPULSIVE DISORDER (OCD)?

Obsessive-Compulsive Disorder (OCD) is an anxiety-related disorder in which children are distressed by or limited in everyday functioning by obsessions and compulsions. They have no control over certain thoughts, ideas or urges. These can often be frightening or distressing or seem so unacceptable that the sufferer cannot share them with other people.

It is perfectly normal to have worries (e.g. fires or parents dying). Normal worrying helps children to learn how to be safe and careful. However, OCD is much more than that. Worries associated with OCD are so intense that the brain plays it over and over again and the feelings become obsessions. Sufferers will perform various actions that they think will make the worry go away or stop the bad things happening. These actions are called compulsions and people can spend many hours a day doing them.

According to the World Health Organisation, OCD is listed as one of the top 10 most debilitating illnesses. It strikes men and women in equal numbers and affects 1-2% of the population. This means that at least 130,000 children and young people have it.

If unchecked these problems can lead to a very difficult family and work environment. People with this condition often try to hide their problems from family and co-workers.

CAUSES

- Chemical Imbalance - OCD may be caused due to an imbalance in the brain of a chemical called serotonin. Insufficient levels of serotonin causes communication problems with the brain structure.
- Hereditary - Childhood onset of OCD is normally inherited. Genes do play a part in this disorder.
- Learned Behaviour - OCD can also be a learned behaviour – one or both parents may have had a similar anxiety and shown similar behaviour.
- Trauma and Stress - It can be linked to trauma such as abuse/bereavement.
- May also be triggered after a difficult time in a young person's life e.g. after having an accident or by particular memories or experiences.

- Illness - It may start after an illness e.g. after a severe throat infection. Columbia University found that 10% of throat infection antibodies that attack bacteria can also affect an area of the brain which can lead to OCD onset.
- Life Changes.

CHARACTERISTICS/SYMPTOMS

The American Psychiatric Association in DSM-4 (1994), states that for someone to be diagnosed with OCD, they will need to meet the following criteria:

- Have either an obsession or compulsion (or both).
- Realise these obsessions/compulsions are unreasonable/excessive.
- The activities must be time-consuming (taking up more than one hour per day).
- Activities must cause either distress or anxiety.

The latest version of DSM-5 (2014) stated that the bulk of criteria for OCD remain the same. Based on the criteria set out by the American Psychiatric Association (1994:422-423), this section will now define Obsessions and Compulsions, and highlight the key associated activities with each.

Obsessions (Intrusive thoughts)

These are unwanted, recurrent and persistent intrusive thoughts, ideas or pictures that keep coming into your mind. They are often inappropriate, difficult to get rid of and can feel unpleasant causing marked anxiety or distress. They are more than excessive worries about real-life problems. A person with OCD will attempt to ignore or suppress such thoughts, or will neutralize them with some other thought or action (compulsion). The person will recognise the obsessional thoughts are not based in reality, however will be unable to control these irrational obsessions.

Some key characteristics/types of obsessions include:

- Fear of contamination – feeling the need to protect people close to you and themselves from poisons, chemicals, germs and dirt.
- Fear of aggressive urges.
- Fear of wishing harm upon someone close to them or imagining doing harm.
- Feelings of excessive doubt and caution - fear of having harmed someone but not being aware of it.
- 'Forbidden' thoughts - Having inappropriate thoughts of a sexual or religious nature.
- Needing to confess something.
- Fear of illness or injury (to themselves or to someone close).
- Pre-occupation with detail – rules, lists, order, schedule.
- Fear of making mistakes or getting something wrong.
- Rigidity and stubbornness.
- Unable to discard no longer needed possessions.
- A desire for order e.g. always keeping possessions in a particular order.

Compulsions (Repeated Behaviours)

These are repetitive behaviours or mental thoughts that are time consuming in response to an obsession, aimed at reducing doubt or preventing harm. There is no realistic connection between performing these acts and preventing the hypothesised situation. A person with

OCD doesn't want to perform these rituals, but it is the only way to stop these bad feelings. This causes marked distress and has a significant impairment in daily functions.

Children with OCD find it hard to concentrate on anything else and it can take the fun out of everything.

Some key characteristics / types of compulsions include:

- Seeking reassurance.
- Checking (e.g. repeatedly checking if the door is locked or checking if the gas or electricity is off).
- Switching light on and off a certain number of times until it feels right.
- Handwashing/showering.
- Praying.
- Symmetry/ordering/arranging things in a particular way (e.g. things must be straight, even).
- Rigid routines.
- Repeating words, phrases or actions a number of times, counting or repeating words in your head.
- Repeating phrases until they sound right.
- Not stepping on cracks on paving stones.
- Tying and retying shoelaces.
- Hoarding and saving.

Over time, compulsions become less effective e.g. checking if a door is locked once is replaced with checking more and more times. Getting reassurance results in feeling more unsure and trying to analyse or make sense of the intrusive thoughts makes them more real.

OCD ranges in severity from causing distress and negatively impacting on everyday routine to being totally debilitating, where you are unable to function normally.

SUPPORT STRATEGIES/TREATMENTS

Without treatment, OCD is usually a lifelong illness with periodic worsening and improvement of symptoms. Some ways we can help to reduce the Obsessions/Compulsions associated with OCD include:

- Therapy
    - Cognitive Behaviour Therapy (CBT) – Children are helped to face the very situation they fear without resorting to their rituals. This has to be done gradually. Coping thoughts and strategies may be introduced. Logging incidents for their frequency and duration and listing associated compulsions may be recommended. Response prevention may involve partial prevention of rituals e.g. reducing washing hands from 10 times to 5 times. Many obsessions and compulsions can be reduced to a point where they no longer interfere with functioning or are eliminated altogether.
    - Exposure and Response Prevention (ERP). The therapist helps the child to face the things that they fear and have been avoiding.
    - Counselling.
    - Self Help Groups – some find it useful to share experiences and methods of coping with others.

    - Parental involvement – because of their close proximity to OCD families may become involved in the rituals. Therapist can help parents to find ways of helping the child to resist the rituals.
- Empathy
    - Positive non-critical comments.
    - Show patience, kindness, be sympathetic.
    - Do not tell them to stop performing the ritual. However, at same time do not actively support the behaviour.
- Medication
    - Medication often is only used when accompanied by other strategies. Its use can provide an almost instant relief to people suffering from OCD. However people who improve on medication can become unwell again when medication is stopped.
    - Anti-depressants.
    - Serotonin re-uptake inhibitor medications can be used. These can help people with OCD gain control over their obsessions/compulsions.
- Other Strategies
    - Neurosurgery – can be given when other treatments have been unsuccessful.
    - Relaxation techniques.

Mary Atkinson and Garry Hornby (2002) also suggest the following strategies can be used with students with OCD:

- Provide parents/carers and children with information about OCD.
- Reduce anxiety-provoking situations (e.g. avoiding the playground).
- Create a positive classroom environment.
- Address learning needs.
- Be aware of signs of relapse.
- Set reasonable limits for behaviour.
- Foster friendships with peers.

In school we need to ensure:

- We liaise with parents and health care professionals.
- We follow guidelines for support given by health care professionals.
- We provide learning environments which are safe and secure.
- There is an adult available to support child at any time.
- Colleagues are aware of characteristics of OCD.

USEFUL REFERENCES

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders (4th Edition) Washington: American Psychiatric Association.

Atkinson, M. & Hornby, G. (2002) Mental Health Handbook For Schools. London: RoutledgeFalmer.

D'Ath, K. & Willson, R. (2016) Managing OCD with CBT for Dummies. Chichester: John Wiley & Sons Ltd.

De Silva, P. & Rachman, S. (1992) Obessive-Compulsive Disorder: The Facts. Oxford: Open University Press.

- It is important to be aware that children with Selective Mutism may be exposed to risk if they are ill or injured. An adult or classmate with whom the child is willing to communicate should be identified and used in such circumstances.

USEFUL REFERENCES

Johnson. M and Wintergens, The Selective Mutism Resource Manual. Speechmark Publishing.

www.nhs.uk - NHS website contains a useful section on Selective Mutism

www.smira.org.uk – Selective Mutism Information and Research Association [SMIRA]

www.talk4meaning.co.uk/selective-mutism/ - Supporting children's language, communication and meaning

www.afasic.org.uk AFASIC (Association for all Speech Impaired Children)

www.selectivemutismfoundation.org Selective Mutism Foundation (USA)

SELF-HARM

WHAT IS SELF-HARM?

Self-harm is when someone intentionally injures or harms themselves. Self-harm can take the form of cutting, deliberately hitting, bruising or burning oneself, overdosing and self-strangulation. It is usually a way of dealing with difficult feelings, overwhelming emotional distress, painful memories and experiences that are out of control. Around 10% of young people self-harm at some point with girls 3 to 4 times more likely to self-harm than boys.

CAUSES

Most people have overwhelming emotional issues caused by:

- Feeling desperate about a problem and not knowing where to go for help. They feel helpless and trapped. By self-harming they feel more in control.
- The need to deal with difficult feelings inside them (e.g. anger and tension). Self-harm can relieve those feelings.
- Social problems such as bullying, other problems at school including fear of exams.
- Social isolation and despair.
- Having relationship difficulties and young people coming to terms with their sexuality.
- Parental separation.
- Trauma such as physical or sexual abuse. In particular childhood sexual, emotional or physical abuse where feelings of guilt or shame can develop that become unbearable. Self-harm is a way of managing these traumatic feelings by converting them to physical pain and helps them to avoid the pain of the memory by developing physical pain.
- Loss of close friend or family member.
- Psychological causes which can mean they have repeated thoughts and are being directed to self-harm – Also linked to BPD.
- Anxiety, depression and Post Traumatic Stress Disorder.
- Drugs and alcohol misuse.
- Confinement or restriction (e.g. rural isolation or custodial setting).

- Illness/health problems.
- Deliberately starving themselves or binge eating.
- Low self-esteem.

CHARACTERISTICS/SYMPTOMS

If you think a friend or relative is self-harming look out for the following signs:

- Unexplained cuts, bruises, cigarette burns, scratches, bite marks usually on their wrists, arms, thighs and chest.
- Punching themselves.
- Keeping themselves fully covered at all times even in hot weather.
- Inserting sharp objects under their skin.
- Signs of depression, such as low mood, tearfulness or lack of motivation or interest in anything.
- Self-loathing and expressing a wish to punish themselves.
- Banging their heads or throwing their body against something hard.
- Not wanting to go on and wishing to end it all.
- Becoming very withdrawn and not speaking to others.
- Changes in eating habits or being secretive about eating, and any unusual weight loss or weight gain.
- Signs of low self-esteem, such as blaming themselves for any problems or thinking they're not good enough for something.
- Signs they have been pulling out their hair.
- Drinking poisoned fluids e.g. bleach.
- Signs of alcohol or drugs misuse.
- Swallowing objects including glass or sharp objects.
- Overdosing on prescription medicines or taking too many tablets.

SUPPORT STRATEGIES/TREATMENTS

- View all incidents of self-harm seriously and attempt to limit access to materials/methods involved in self-harm.
- Early intervention, identification and referral is essential.
- Ensure staff are fully aware of how significant a problem self-harm is and the essential interventions that are necessary.
- If there is ever a suspicion that a pupil is self-harming it is essential to report the suspicion immediately to a line manager with any evidence to support your suspicion. Sometimes medical attention will be the first priority, especially in extreme cases of self-harm. It is essential that the person gains support and help. Parents will need to be informed and often a referral needs to be made to the GP by the appropriate person.
- Involve Child and Mental Health services if appropriate.
- Develop support mechanisms that allow them to talk to someone about their feelings:
    - School Counsellor.
    - Circle of friends/circle time.
    - Peer support – buddies.
    - School medical staff – school nurse.
- Get parents involved and provide help, support and training for parents.
- Encourage family therapy which could look to reduce conflict and stress which will lead to a more stable environment and will help the child to cope.
- Have information on helplines readily available.
- Strategies to help children cope with stress should be given.
- Development of distraction techniques:

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American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Health (4th Edition) Washington: American Psychiatric Association.

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