Suicide and self-harm: vulnerable children and young people

Children and young people are increasingly experiencing mental health problems, including self-harm and suicidal behaviour. **Maddie Burton** explores the triggers of these two conditions and explains what practice nurses can do for their patients

ABSTRACT

Children and young people's mental health continues to be a cause for concern at a time of reduced mental health service provision. Worryingly, suicide and self-harm rates continue to rise. An estimated two hundred children and young people lose their lives annually through completed suicide. Half of that number will have a previous self-harm history. Practice nurses are often favoured by young people as being less stigmatising; therefore they can potentially provide opportunities for early help through being vigilant, informed, hearing the young person's story and then knowing how to support and appropriately respond and signpost. This article explores both the differences between self-harm and suicidal behaviour, and how they are connected.

Key words | Mental health | Self-harm | Suicide | Children and young people | Safeguarding

Children and young people's mental health has continued to increase in prevalence and is a leading concern for front-line practitioners working with children and young people in all settings. A recent UK report confirmed that the number of children with a diagnosable mental health condition has risen to one in eight in 2017 (NHS Digital, 2018). All of this is taking place in a climate of reduced resources and access to specialist help from Children and Adolescent Mental Health Services (CAMHS), whose workload continues to grow as they struggle to meet demand. Therefore, access to specialist support for some children and young people is restricted.

Over 55 000 children were refused treatment in 2017 and CAMHS rejected as many as one in four referrals; many of those rejected were children and young people self-harming and/or abuse victims (British Journal of School Nursing, 2018). There was some acknowledgement of the crisis in the 2018 Budget, including a commitment to mental health support available in all A&E departments, mental health crisis teams for children and young people and a 24-hour helpline (Rosa and Smith, 2019); however, CAMHS only represent 1% of the total NHS Budget (Royal Society for the Encouragement of Arts, Manufactures and Commerce, 2018).

Suicide is the leading cause of death among 15–35-year-olds in both men and women and is a major public health concern; it occurs at a higher rate in this population than any other age group (Edwards, 2018). Suicide was recorded as the second most common cause of death among 15–29-year-olds globally in 2016 (World Health Organization (WHO), 2018). It is estimated that only one in eight children and young people attend hospital following a self-harm episode, usually from an overdose in the community (Hawton et al, 2012). An estimated two hundred children a year lose their lives through completed suicide in the UK (Papyrus, 2018). These figures are likely to be an under-estimation as coroners' verdicts can be inconclusive unless there was clear evidence of the intention to take one's life.

Suicide was a criminal act until 1961, hence the continued use of the terminology 'committed' suicide; however, the term 'completed' is more appropriate and should be promoted in healthcare settings.

Self-harm and suicide

Young people are vulnerable to suicidal feelings and self-harm is a sign of serious emotional distress (Department of Health, 2011; 2014; Royal College of Psychiatrists, 2017). The risk is greater when they have any of the factors shown in *Box 1*, which can often combine into complex experiences and events for a young person.

Often, one of the first indicators of emotional distress can be self-harm. There is can be a minimising of the significance of self-harming behaviour among professionals and others; commonly describing it as 'attention-seeking'. It must be remembered that this is a young person in psychological and emotional distress. Self-harm is often the opposite of seeking attention; the behaviours are very

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secretive and people suffering with self-harm attempt to conceal it. A more appropriate way of reframing the language of 'attention-seeking' is instead to use the terms 'attachment-seeking' or 'attachment-needing'. Many children and young people who experience negative problems during this crucial and critical period, when their brains are still forming, may have an impaired attachment quality, which then tends to be borne out in all future relationships and affects the capacity for emotional and self-regulation (Howe, 2011).

Self-harm and suicidal behaviour are emotional disorders on a similar continuum as they are both in response to stress. A young person engaging in suicidal behaviour may have a wish to die or be ambivalent about their life/future, whereas young people engaging in self-harming behaviour do not necessarily have an active wish to die (*Box 2*). Self-harm tends to be about coping, whereas suicide is more concerned with 'giving up' and to stop living (Burton et al, 2014), and as a coping mechanism, self-harm can be difficult to stop without an alternative. The differences in self-harming behaviour, as opposed to an intention to kill oneself, can be that with self-harm the young person is in touch with their body through the physical reality of pain. For them, self-harm is not a problem but instead it is seen as the solution to a problem that will not go away. Therefore, rather than solely focusing on the injuries themselves, the underlying reasons need to be explored (National Institute for Health and Care Excellence (NICE), 2004; Royal College of Psychiatrists, 2017).

Behaviours

Key considerations for health professionals when consulting or communicating with patient about self-harm and suicide are intent and motivation. For example, high intent and motivation in the case of overdosing could include collecting and hoarding several tablets over time and not telling anyone following the overdose or self-harm attempt. It is important to know what a young person thought would happen following their attempt, and the same can be true for taking a relatively low number of tablets if one thought it would have the same fatal effect. Therefore, individual assessment is highly important.

Self-harm behaviours include poisoning, cutting, excessive alcohol, illegal drugs, hitting or burning oneself (Royal College of Psychiatrists, 2017). Other signs of self-harm include unexplained injuries, covering up the body (perhaps inappropriately for the season), and an unwillingness to participate in sports where less clothing is required. All these activities have the potential to proceed from self-harm to suicidal behaviour or ideation, depending on the individual and, for example, when cutting or excessive alcohol use become significantly escalated with enough lethality to be classed as a suicide attempt.

Having a self-harm history can predispose a young person to eventual suicide completion (Hawton et al, 2011). More than half of people completing suicide had a self-harm history (NHS, 2018). Some children and young people may have both physical illness and mental health problems combined. For example, a young person with diabetes may place themselves at risk through non-compliance with treatment and be at risk of serious complications.

Box 1. Factors affecting self-harm and suicide

- Behavioural disorders
- Substance misuse
- Family breakdown
- Rejection
- Mental health problems
- Suicide in the family or a friend
- Academic pressures
- Bullying
- Bereavement
- Substance misuse
- Childhood abuse
- Sexual abuse

Links with the developmental process

Suicide and suicidal ideation are often linked to relationships, which is a challenge to explore and understand and there are always emotional and psychological components. Studies of suicidal behaviour in young people confirm that relationship difficulties predominate (Hawton et al, 2012). Exceptions include those responding to delusions or hallucinations linked to drug misuse or psychosis.

Other self-injurious behaviours in younger children, such as head banging or rocking, could also be considered on a spectrum of self-harm. While there could be other reasons for these actions, head banging and rocking behaviours can also be coping mechanisms for when the individual is feeling overwhelmed by external stressors. This is especially so with younger children who have more limited communication.

High numbers of suicide attempts during the adolescent period has been linked to the developmental process. Adolescence is a turbulent period with considerable challenges in biological, psychological and social change; risk-taking activity is also part of normal adolescent pathology. This can lead to vulnerability to developing psychosocial disorders, which peak during

Box 2. Definition of suicide

- The consideration of or desire to end one's life
- Ranges from passively wanting to die to active ideation
- Suicidal thoughts may occur as frequently as once per week
- Suicide attempt differs from ideation with an attempt there is an action intended to end one's life
- Suicide death defined as a fatal action to deliberately end one's life

Cha et al, 2018

Box 3. Trigger factors for self-harm

Individual triggers:

- Bullying
- Difficulties with parental and peer relationships
- Bereavement
- Earlier abusive experiences
- Difficulties with sexuality
- Problems with ethnicity, culture, religion
- Low self-esteem
- Feeling rejected

Contextual triggers:

- Adverse family circumstances
- Dysfunctional relationships and domestic violence
- Poverty
- Parental criminality
- Time in local authority care
- Frequent punishments
- Family transitions
- Compounded by physical/emotional changes of adolescence

adolescence, such as suicide, self-harm, substance misuse, offending behaviour, depression and eating disorders (Anderson, 2008).

Physical pain: a medium of communication

During human development, infantile experiences are internalised and attachment patterns are laid down, affecting later relationships, and events that trigger self-harming behaviour are rooted in these old patterns (Gardner, 2001). Although experiences are not necessarily traumatic (not all who self-harm have been victims of abuse or trauma in childhood), the skin becomes a medium for communication (Gardner, 2001).

Often the shocking nature of self-harm communicates the rawness of the emotions and impulses in the individual (Turp, 2001). Physical pain is often easier to manage than emotional pain, and when inflicted, it can change the individual's mood and consequently habits are formed. Cutting releases endorphins, providing a brief calming effect, and when combined with serotonin, a mood enhancer, the experience is one of temporary relief (Howard et al, 2017).

It is important to recognise first aid, 'patching up' and 'repairing' either by the individual or helpers, and these repairing acts can be experienced as therapeutic.

Triggers for self-harm and suicide

There are several risk factors that predispose a young person to self-harm and suicidal behaviour (*Box 1*), yet many individuals will tick several of those boxes. What is important to understand is that triggers are often what precipitate, and are the reason behind, an act of self-harm. These include both individual and context-specific aspects and can be seen in *Box 3*.

For example, bullying and the role of social media are being more frequently cited as a reason. The death of Molly Russell, aged 14, is an example of social media being identified as a cause (BBC News, 2019).

Looked after children and young people

Children who have been looked after (children who have been, or are, in care) are over-represented in young people who self-harm. The number of children in care is increasing each year and with 75 420 in England in 2018, together with increasing levels of neglect and abuse, the numbers of children struggling to manage their distress is on the rise (Rosa, 2019).

Adverse childhood experiences are associated with an increased risk of suicide (Department of Health, 2011; Cleare et al, 2018). Looked after children as compared to the general population have an increased risk of self-harming behaviour and mental health problems; care-leavers are between four and five times more likely to self-harm in adulthood (National Audit Office, 2015). They are also at a five-fold increased risk of all childhood mental, emotional and behavioural problems, and 6–7 times more likely to have conduct disorders (Department of Health, 2013). There have been relatively few studies on looked after children and self-harming behaviours. Studies that have been undertaken have shown that they are a high-risk group with high self-harm rates (Wadman et al, 2017). It must be remembered these are children likely to exhibit attachment-seeking behaviours due to poor and adverse early experiences. Studies from Sweden and North America concluded that children in and from care should be considered a high-risk group for suicide attempts and completed suicides, the risk being two–four times higher than the general population (Wadman et al, 2017).

Cultural concerns

Mental health can be understood differently and varies between cultures; few studies have been undertaken with a focus on children and young people's mental health and ethnicity. A recommendation in the Chief Medical Officer's report refers to ethnic minorities, as this is a poorly researched area (Department of Health and Social Care, 2013). Globally, suicide and self-harm is the second most common cause of death after road traffic accidents, and the most common cause of death in women aged 15–19 (Hawton et al, 2012). There are variations across the globe but findings from community-based studies show that around 10% of adolescents report having self-harmed, of whom some will report an extent of suicidal intent underpinning their self-harm (Hawton et al, 2012).

The role of practice nurses

Those often in the best position to recognise that a child or young person is experiencing mental health difficulties include the family members, friends, peers, or the individual themselves may refer. Workers and professionals in healthcare services including practice nurses, health visitors, school nurses, GPs, teachers, youth workers, and social workers are also on the front-line of contact. These practitioners have a key role but are often left managing young people waiting for referral to specialist interventions (White, 2018). Schools and teachers have been reported to take children to A&E when they cannot access timely CAMHS support (British Journal of Nursing, 2018).

Practice nurses are in a unique position with their communication skills and have the opportunity to observe any behaviour which may give cause for concern. Practice nurses may observe physical signs, such as scarring, cuts, bruises or burns, but also changes in behaviour. This can be challenging to interpret when working with adolescents, given adolescent pathology includes risk-taking as part of the developmental process. However, it is important to respond to any intuitive feelings that arise during contact with a young person who could be self-harming.

Treatment pathways

Many young people never have access to specialist services or attend A&E, and subsequently they may be first noticed in primary care (known as Tier 1 settings) by practice nurses. The CAMHS tiered service, Tiers 1–4, was set up following a Health Advisory Service report (Department of Health, 1995). Tier 1 includes all services in contact with children and young people, up to Tier 4, inpatient CAMHS (Department of Health, 1995). It is important, where possible, to seek advice and supervision from CAMHS professionals. Very often, CAMHS clinicians will work jointly with other professionals such as practice nurses, school nurses and counsellors.

Practice nurses can make referrals to Tier 2 and 3 CAMHS. They may continue to have ongoing contact with the young person given the increased waiting times for specialist CAMHS. An important additional principle is that of containment and holding by the professional, no matter which model of intervention is adopted. Containment and reciprocity are valuable principles for infants, children and young people, not only for parents but also professionals. These principles also form part of the parenting programme 'The Solihull Approach' (Douglas and Ginty, 2001). Containment is the process where a health professional helps the patient process intense emotions, and the reciprocity element involves the professional being attuned the patient's feelings communicating their understanding back to them.

Practice nurses and school nurses are often favoured by young people and consultations can be experienced as less stigmatising than seeing a counsellor. A practice nurse will need to refer to CAMHS Tier 2 and 3 services; however, it must be acknowledged that with the raising of CAMHS thresholds for children and young people who self-harm and variations across the country in service provision (Weale, 2019), patients are waiting much longer to be seen and, in some cases, referrals are not being accepted. This places a huge strain on those left in a holding capacity.

The requirement for supervision has never been more important, especially if this is the focus of a health professional's experience. An accurate assessment and understanding of the young person's mental health is critical in order to manage and treat patients (Bell, 2000).

Without a thorough psychosocial assessment, a conclusion cannot be drawn on what the intended outcome may have been. NICE (2004) guidelines recommend that specialist assessment by a CAMHS clinician should take place within 48 hours of admission to hospital. The clinician would then decide about discharge both in conjunction with the young person and their family. However, a study has found that as many as 43% of young people attending hospital are not receiving a psychosocial assessment. This is certainly an area for attention as studies with adults have demonstrated that those who do receive a thorough psychosocial assessment were associated with a 40% lower risk of repetition (Kapur et al, 2013).

Increasing vigilance

There are common misunderstandings about self-harm, often leading to poor responses (Mental Health Foundation, 2006). Health professionals need to be vigilant in recognising signs and responding appropriately.

It is worth noting that adolescents who self-harm carry a 100 times greater risk than that of the general population of completing suicide in the subsequent year. Half of all those individuals who complete suicide will have previously engaged in self-harming behaviour, and a quarter will have done so in the year before suicide completion (Department

Box 4. Additional resources

- National Suicide Prevention Strategy for England: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
- Five Year Forward View for Mental Health: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
- MindEd: https://www.minded.org.uk/Catalogue/Index?HierarchyId=0_36571_36842_38444_38446&programmeId=36571
- The National Society for the Prevention of Cruelty to Children: https://www.nspcc.org.uk/preventingabuse/keeping-children-safe/self-harm/
- Papyrus UK: https://papyrus-uk.org/wpcontent/uploads/2018/10/400734-Schools-guide-PAPYRUS.pdf
- Royal College of Nursing: https://www.rcn.org.uk/professional-development/publications/pub-003311
- Young Minds: https://youngminds.org.uk/
- The Association for Child and Adolescent Mental Health: https://www.acamh.org/
- The Association for Infant Mental Health: https://aimh.org.uk/

KEY POINTS

- Self-harming behaviour is often negatively referred to as 'attention-seeking'; however, self-harm is indicative of emotional distress and should be termed as 'attachment-seeking' or 'attachment-needing'
- Self-harm and suicide always have a relationship component
- Reframing of language from 'committed suicide' to 'completed suicide' is important as it is no longer a criminal offence
- Looked after children and young people have an increased risk of self-harm and suicide and are therefore highly vulnerable
- Risk factors predispose a young person to self-harm and suicidal behaviour; triggers precipitate an act of self-harm or suicidal behaviour
- Increased mental health service thresholds and waiting times mean practitioners can be left in a holding capacity
- Access and good relationships with local mental health service provision and to individual supervision is essential

of Health, 2014a; NICE, 2014). The task is one of knowing how best to respond and support young people who are engaging in self-harming behaviours.

Government commitments

England has a national suicide prevention strategy and although suicide rates are comparatively low for people under 25, for 15–19-year-olds there had been an increase in the 3 years before the publication of a suicide prevention report (Department of Health and Social Care, 2017).

There are several commitments to reduce the national suicide rate by 10% by 2020/21, including an emphasis on the key role of schools and colleges through personal, social, health and economic (PSHE) education and age-appropriate lesson plans on mental health. The Government has also set out a commitment to children and young people's mental health in their Green Paper (Department for Health and Social Care and Department of Education, 2017; 2018).

The Green Paper endorsed school approaches in terms of preventative strategies (Colebrook, 2018). It cited a survey that found that 7% of children aged 5–16 had self-harmed, and this rose to 28% for those living with an emotional disorder (Green et al, 2004). References were made to a recent study that reported that self-harm rates may have risen by as much as 68% in girls aged 13–16 since 2011 (Morgan et al, 2017).

The Children's Society (2018) estimated that 109 000 children aged 14 may have self-harmed across the UK in 2015: 76 000 girls and 33 000 boys. NHS data showed the number of admissions to hospital of girls aged 18 and under for self-harm had almost doubled in two decades, from 7327 in 1997 to 13 463 in 2017 (The Children's Society, 2018).

Conclusion

Key concerns cited by workers and practitioners by Foster et al (2015) not specifically trained in CAMHS included:

- A lack of understanding
- Feeling their skills were not transferable
- Engaging with young people around the issue of self-harm may make things worse.

However, practice nurses are in a unique position on the front line of primary care and have well-developed communication and empathy skills. Stewart (2018) identified three themes as important:

- Attitudes towards the young person
- Practical aspects of help
- A need for parents to be involved.

Attitudes towards the young person need to be validating, helpful, caring and non-judgemental and relationship building is important. This was also identified by young people in the *Truth Hurts* (Mental Health Foundation, 2006: 69) report:

> *'Long term relationships with workers rather than offers of time limited work provide continuity and the chance to build rapport. I want workers to be more concerned about me, genuinely, than only to be thinking about risks.'*

Peplau (1952) defined nursing as an interpersonal process, and that the two interacting components of health are physiological demands and interpersonal conditions. She identified that the foundation of the therapeutic process is the corrective interpersonal experience, and that closeness in the therapeutic relationship builds trust, empathy, self-esteem and healthy behaviour which she described as 'psychological mothering'. Despite this statement being nearly 70 years old it remains ever timely, resonant and applicable for healthcare today. **PN**

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CPD reflective practice

- Why is it important to be aware of the differences and connections between self-harm and suicidal behaviour?
- How important is it to understand the young person's context and to hear their story?
- What is the importance of vigilance and a therapeutic approach when concerned about a young person who may be self-harming?

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