University of Sheffield

Yorkshire & Humber Self-harm Project

Barriers and facilitators to support for self-harm in the Yorkshire and the Humber region: a qualitative study

Project Report November 2022

1

Executive Summary

Self-harm is associated with a range of negative consequences. People who self-harm sometimes report poor experiences of health care and do not always seek appropriate help. In Yorkshire and Humber, there are a range of services available including voluntary sector organisations. This report describes research conducted in the region to explore the experience of accessing help for self-harm among adults in the region, with a focus on barriers and facilitators to accessing help. Our research was conducted with the involvement of a group of people with lived experience of self-harm (lay panel) who provided guidance to all aspects of the research. Semi-structured interviews were conducted with 22 people which were transcribed for further analysis. A qualitative methodology, known as thematic analysis, was applied to the interviews in order to identify important themes relevant to the research aims. Four main themes were identified. **(i) Availability of appropriate and timely support** – referred to the need for services to be tailored to meeting individual needs of people who self-harm but acknowledged that services were currently fragmented and difficult to navigate; **(ii) Fostering a sense of community** – emerged as a theme in which individuals felt more comfortable in engaging with support which gave them a sense of belonging or which had other members with similar shared experiences; **(iii) Awareness of support** – was a theme which highlighted the lack of awareness of available services both for individuals experiencing self-harm and for those delivering care. Uncertainty about the nature of support which services could offer was also described; **(iv) Employment and education** – was described as being a facilitator and barrier to accessing support. Whereas it was seen as a positive source of improving self-esteem and mental health, especially when employers were understanding, difficulties could be compounded by employers who displayed little in the way of mental health literacy. These findings were presented at a dissemination event for all those with an interest in self-harm in the region in order to understand ways in which the information could be used to improve support. Recommendations and ideas for improving regional services include: ensuring that support for those is flexible and it is clear what is involved; improving awareness through regional websites; ensuring that those who provide support are themselves supported appropriately; and ensuring that people with lived experience of self-harm are integral to services.

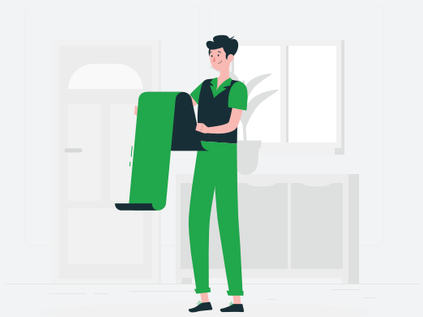
2

Research team and Acknowledgements

This research was conducted by the following individuals at the University of Sheffield - Dr Vyv Huddy, Dr Phil Oliver, Dr Joe Hulin, Dr Caroline Mitchell, Dr Jack Marshall, Dr Brigette Delaney and Dr Aarti Mohindra. We worked closely with the project lay panel - Leroy Ivanov, Ellie Wildbore and Dominic Digan and are extremely grateful for their time and input on this project.

The research was conducted in collaboration with regional public health suicide leads Laura Hodgson, Joanna Rutter and Caron Walker.

The work was funded with a grant from the Yorkshire and the Humber Mental Health & Suicide Prevention Community of Improvement (Y&H MH&SP CoI) - a network of key public health leads across Yorkshire and the Humber that deliver programmes to improve public mental health and lead on suicide and self-harm prevention activities.



3 Background

Self-harm is when someone damages or hurts themself on purpose. Examples may involve cutting, poisoning, toxic consumption of alcohol or drugs, not eating enough or not looking after themselves properly. Self-harm is a means of managing or expressing distress - it is not an illness. The distress may be triggered by negative emotions and/or experiences but these vary across people. Self-harm may be related to a having a mental-health disorder, but this is not always the case. Research has shown that people who self-harm are more likely to take their own lives than people who do not self-harm.

We know that the rates of self-harm are increasing but we also know that not every person who self-harms seek appropriate help. We need to understand better how we can support adults who self-harm in the community in the Yorkshire and the Humber Region. This is important because if we know more about how we can support those who self-harm in the community, we can put better plans in place to support these individuals, reduce the distress associated with self-harm and potentially reduce the number of people committing suicide each year.

4 Research Aims

The aim of this research was to describe the experience of adults who self-harm in order to explore what helps or hinders access to support in the Yorkshire and the Humber region. We aimed to learn from these experiences to drive sector-led improvement work and inform priorities for suicide prevention plans.

5 How the research was conducted

This qualitative study interviewed people with lived experience of self-harm to gather detailed first-hand accounts of people's experiences of seeking help. Recruitment was primarily through third sector organisations in the Yorkshire and the Humber region. Seventy-two organisations throughout the Yorkshire and the Humber region were contacted. Participants were included in the study if they were aged 18 years or older, self-identified as having lived experience of self-harm and resided in the Yorkshire and the Humber region. Interviews began in October 2021 and were completed in April 2022.

Interviews were carried out in a semi-structured manner – where only part of the questions are planned beforehand – and followed a topic guide. The topics were taken from academic literature, policy documents, input from the lay panel (see box A) and key stakeholders. The interviews were recorded and later transcribed by a professional service. The interviews were analysed using thematic analysis – this is a qualitative method used to identify, analyse, and report themes in a data set. It is well suited to describing experiences that are relevant to policy development in healthcare.

We worked closely with the lay panel on a implementing a distress protocol to support participants with any adverse effects of taking part in the study. Participants reported feeling well supported and many described feeling that their involvement had been both positive and an opportunity to share experiences.

Box A: Lay panel (Patient and Public Involvement group)

People with lived experience of self-harm supported the study throughout. They have roles in third sector organisations or statutory organisations support people who self-harm.

The panel advised on the study information sheet, the conduct of interviews, recruitment, how to best make sense of findings and dissemination.A

Three members of the panel contributed to dissemination event where they reflected on the study findings, advised on service implications and contributed to the discussion.

6 Findings

Twenty-three people were interviewed, with an age range from 18 to 66 years. 74% of the group were female; 17% were of non-white British ethnicity; 52% lived in areas within the 5th or higher IMD decile and 65 % had been in higher education.

Four key themes were identified from the data relating to: the availability of support, the benefits of perceiving a sense of community, the importance of becoming aware of support and the role of employment and education. These are described further in Table 1 and the text below.

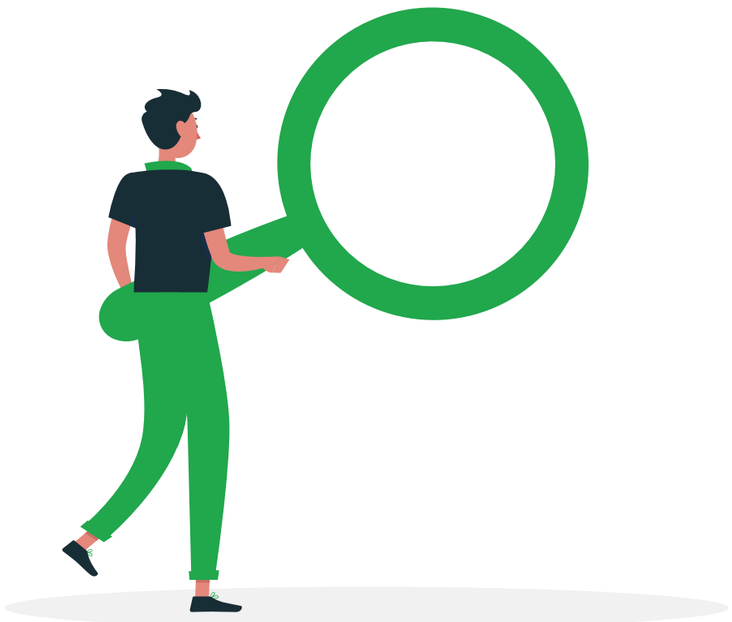


Table 1: Summary of themes and sub-themes

Key themes	Sub-themes	Example quotes
Availability of appropriate and timely support	Tailored services	"I was still self-harming so like at the beginning of the session she'd be like "So how was your week?" and I would be like tell her how many times I'd self-harmed and it was just felt really tailored to exactly what I needed at that time." White British female, aged 18-25
	Navigating complex systems	"And if your mental health problems are complex or long term it's basically "Well we don't deal with that" so you're left floating in this world" White British female, aged 56-65.
Fostering a sense of community	Shared experiences	"So you go to the meetings, as many as you can, and you sit and listen and you identify with people and you look for similarities, not for differences." White British female, aged 56-65.
	Online communities	"Since I've had this computer I've not self harmed because I've had people to talk to and people just to hear me" White and Black Caribbean male, aged 46-55.A
Awareness of support	Knowledge of services	"I think services being well advertised would have made a big difference because I really honestly didn't know about any services apart from just going to the GP." White British female, aged 26-35.
	Lack of clarity	"You're kind of worried then waiting for what you're getting, you don't know what it is, so you don't know what to expect, like, I quite like knowing what I'm doing and what I'm expected to do and things." White British female, aged 26-35.
Employment and educa-tion	Creating supportive environments	"...it's my secret, I can hide that from you, I can mask, let youA know that everything's OK and keep on doing my job, butA behind it you don't know what's there, but had you asked theA question I might have told you" White British Male, aged 56-65A
	Empowerment and self esteem	"I do quite a lot of art that I put on my Etsy shop in my spare time as well but it's been quite nice getting my work because of my mental health" White British female, aged 18-25.

Appropriate and timely support

Tailored services

Participants told us services need to be tailored to meet individual needs. For example, one person told us that one-to-one support was essential to them:

"I said I'll think about it, on the phone but when I thought about it I knew deep down I really wanted one to one. It kind of upset me a bit. I'm not sure why, maybe because I thought they were just going to get rid of me or something, I don't know, but yeah that kind of threw me off. If I'd have wanted group therapy, I would have said it at the beginning."
White British female, aged 46-55.

The perception that needs and preferences of those seeking support were not being heard by those providing care, was an issue frequently discussed by participants:

'I think I'd want them to, like, listen to me a bit more, because, I mean, you know, they're the expert in medicine or whatever, but I'm the expert in myself, like, the patient is the one who is the expert in living their life in their body and their mind and knowing what's actually going on.'
White British female, aged 18-25.

"He didn't react, he didn't say anything; he just suggested antidepressants and a sick note you know, and I were like "Cheers, great. This is one of the biggest things I've ever done, one of the scariest things I've ever done" and he didn't react at all"
White Greek female, aged 46-55

Navigating complex pathways

The complexity of care pathways limited access to help. One individual described how:

"you've got to be the right sort of mad at the right time" [to be able to receive appropriate support].
White British female, aged 56-65.

Services were found to be fragmented with, at times, little support in helping navigate these care systems:

"So then I was a little bit sort of taken aback then, it's like 'well where do you want to go from here' and I'm like 'well I don't really know, I was hoping you'd kind of help me', but then, no, so then I was just kind of on my own again." White British female, aged 26-35.

Fostering a sense of community

Individuals were more likely to engage with support in settings which fostered a sense of community or belonging. Some individuals highlighted that being valued aided their recovery:

"People don't recover in our institutions, they recover in community. Once you've been accepted within a community and welcomed within a community and seen a value asset within a community and that you've got a purpose of you've got something to give"
White and Black Caribbean male, aged 46-55.

Shared experiences

The sense of community was often from seeking support from those with shared experiences:

"Group X, which is a peer support group which really helps me and it allows me to talk about my experiences without being ashamed of it, because there's other people with similar experiences. So being part of Group X makes me feel as though I belong somewhere."
White and Black Caribbean male, aged 46-55.

One individual also discussed how being able to support others was also viewed as having a positive impact on their own wellbeing and mental health:

"I find it quite helpful because it's like I try to be the person that I needed when I was younger, that person who is safe to talk to who will fight for the underdog"
White British female, aged 26-35.

Online communities

Participants also highlighted how a sense of community or belonging could often be created through engagement with others online:

"It's like an online Big White Wall so with like post-it notes and different little forums where people can talk about stuff. And the main message is like "You're not alone" which is a really important thing with self-harm; you do feel like "Oh my God, what's going on with me? I've never experienced this before".
White British female, aged 18-25.

Awareness of support

Knowledge of services

Some individuals felt that access to support was hindered by a lack of awareness of available services for self-harm, with services not clearly communicating the support available:

"I think had I known where to go sooner and had it been talked about more, I might have stopped self-harming sooner or sought out services sooner."
White British female, aged 18-25.

One individual also described how they had a perception that self-harm would not be addressed in primary care:

"...it feels like too small of an issue to go to a GP with, because I feel like depression is a big enough issue, any other mental illness is a big enough issue, but self-harm is like this tiny little subcategory where it's like, you know, yeah, so I think I was like oh I'll manage it"
Indian female aged 18-25.

This lack of awareness was also reported to be mirrored by those involved in delivering support:

"...in the conversation with the receptionist I just said mental health and then she started panicking being 'oh we're not equipped to deal with this, we can't...', like, I kept it very, very general and then she was like 'we're not equipped to deal with this, you couldn't be calling us, you should be calling someone else, blah blah blah"
White British female, aged 18-25.

Lack of clarity

The lack of information on what services entailed also had a significant impact on engagement with support. One individual described how they did not know what to expect from services and this made them more reluctant to access care:

"...a bit more clarity would be good, because I got told I was going to this core psychology and that I had this meeting, but I didn't know what it was, how long it were going to be for, who it was with and it ended up being with a psychologist rather than a...like a counsellor or summat, I didn't know whether it was going to be a weekly counselling thing or what or whether I'd meet her once and then I'd have to wait for something else..."
White British female, aged 25-36.

Education & employment

Creating supportive environments

Employment settings were highlighted as key sources of support for individuals, with a lack of mental health literacy among employees and available resources noted as a particular barrier to accessing support:

"...my direct manager isn't the most understanding person of mental health...she's not able to recognise signs, symptoms of like people who are in crisis or whatever, you know, but her manager is a little bit more, so I've gone and spoken to her about stuff, and yeah so she recommended that I go to see the OTs and I've tried contacting them but they've never come back to me... even when you ask for that help they're not always there."
White British female, aged 25-36.

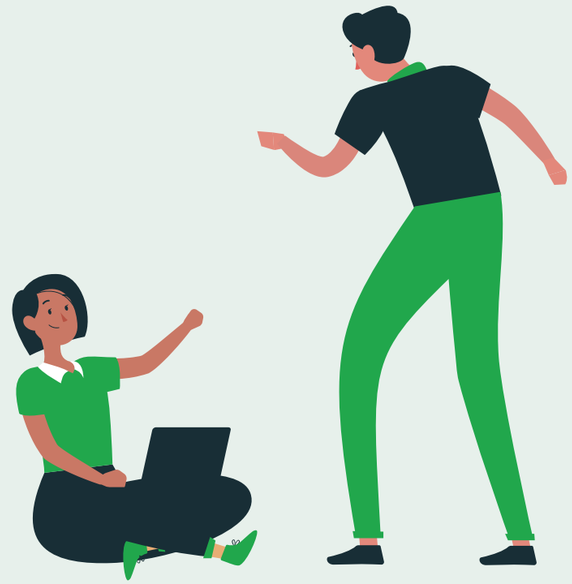
Support in education settings was also seen as crucial for some individuals, especially when students felt academic pressure was having a negative impact on their mental health:

"my tutor was brilliant as well and they were just really helpful because they didn't – they let me have like extensions, they didn't put pressure on me in terms of my work and things, they were just brilliant, can't say a bad word about uni really."
White British female, aged 25-36.

Empowerment and self-esteem

It was also noted how employment and volunteering opportunities could play a role in improving individuals mental health and wellbeing and reducing experience of self-harm:

"I'd been doing volunteering all along but then when I started to get into paid work, that was really massive for me in terms of like self-esteem, self-worth, like structure, routine, all of that kind of thing".
White British female, aged 36-45.



7 Stakeholder Feedback

A dissemination event was held in July 22 at which the main study findings were presented. This was attended by over 70 delegates including mental health practitioners, public health staff, academics, and voluntary sector staff. Members of the lay panel talked about their experience of being involved in the research and their perspective on the findings. A recording of the event can be found by clicking on the link below:

Download RecordingA

The event was illustrated by a visual scribe from LokiCoki Design & Illustration.

During this event, delegates were asked a series of questions to help us better understand the implications of our results for services and to inform our recommendations. These included:

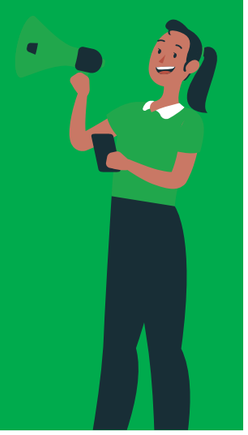
1. Is there anything surprising that you did not expect to see in the findings?A
2. What interventions do we need to focus on locally, considering the themes raised.
3. Which of these practical solutions will be most feasible to implement?
4. What key actions do we need to include in our local Suicide Prevention Plans to address the gaps or barriers in relation to self-harm?
5. Reflecting on the research findings, where do you feel that you are making progress locally?
6. What are the challenges in your local area in implementing interventions to address some of the issues raised this morning?

"Making it everybody's responsibility to have conversations which hopefully will normalise it over time"

The findings from the study appeared to reinforce perceptions about the known difficulties with services. Ideas to improve interventions included trauma-informed approaches, better access for those in crisis and providing people with a range of options for interventions. The importance of having someone to talk to with lived experience was mentioned frequently, including in prison settings. Ensuring that clear information on self-harm within internet search results was also suggested along with having information available in pharmacies to share. Further research to better understand and support those self-harm in prison was mentioned by several attendees.

It was felt that training was an area that may be feasible to implement, and that providing harm minimisation advice was also important for those who didn't wish to engage with services. Engaging disparate groups within the community to raise awareness could also lead to a wider 'snowball' effect.

"Self-harm is often viewed as a young-peoples issue and adults sometimes get forgotten"



For suicide actions plans, attendees commented that better partnership working was needed. The importance of support for family and friends of people affected by suicide was highlighted. Having specific support for those from BAME communities and efforts to engage people with limited English language was also highlighted.

Attendees at the meeting commented that progress had been made in a number of areas including training, the development of a non-clinical self-harm unit and raising awareness both in primary care and more generally. Support for schools and colleges and men's mental health was also mentioned as areas in which progress was being made. Despite this, it was acknowledged that support for adults still had some way to go, thresholds to access services were a barrier and that community peer support groups themselves also need support.

A number of challenges to implementing interventions were mentioned including limited resources, workforce issues, funding and capacity leading to long waiting times for statutory services. Whilst local services for children were praised, we were remined that self-harm affects all ages. Pathways were considered sometimes unclear and complex. Echoing our research findings, there was a comment that support services viewed self-harm as too high risk and so people were left in the middle.

8 Recommendations

The following recommendations were produced by bringing together the findings from the study, feedback from our lay panel, the dissemination event and stakeholder input.

1. **Flexibility** – support for those who self-harm appears to work best when it is tailored to the individual, both in terms of the timing of support and availability of types of interventions offered. Commissioners of services need to ensure flexibility is built into service design and local partnerships need to review interventions across the pathway, ensuring different types of interventions are available, including community-based projects, as well as treatment and crisis interventions. Consideration should be given to offer both virtual and face to face services.

2. **Clarity** – people who self-harm should be given clear information about what to expect from the services that they are being recommended or referred to. Commissioners and providers of services that support people who self-harm should provide literature to explain the offer, type of intervention and frequency.

3. **Awareness** – Some individuals felt that access to support was hindered by a lack of awareness of available services for self-harm. It is recommended that webpages with details of various services that support people who self-harm are created on a regional or sub-regional footprint. Details of services aimed at particular groups should be considered.

4. **Experts by experience** - should be integral to all services for people who self-harm and this should be clearly specified in all contracts for commissioned interventions. Employment and volunteering opportunities play a key role in reducing experience of self-harm and there is a need for more opportunities, with access to appropriate supervision.

5. **Supporting the supporters** – staff who work within voluntary and community services should be offered supervision, support and training with a focus on ensuring that their own mental health is protected. Advice and guidance of securing ongoing funding would be helpful to reduce uncertainty and promote continuity.

6. **Creating supportive environments** – Employment and education settings were highlighted as key sources of support for individuals. Training programmes and resources for these settings need to be developed, to increase mental health literacy amongst managers and educational leaders.

7. **Training and Education** - training for the wider workforce was identified as an area requiring further development and it is recommended that local and regional programmes are established. This should also include harm minimisation approaches.

8. **Interventions across the life course** – local and regional approaches should consider interventions across the life course. There needs to be an increased focus on preventative measures and early intervention in childhood, whilst also considering the needs of adults and older adults.

9. **Pathways into services** - should be clear so that people are not left between services. Local partnerships need to review interventions across the pathway, ensuring interventions focus on prevention, early intervention, treatment and crisis interventions. Gaps needs to be identified and the range of different interventions need to be well publicised to both the public and professionals.

10. **Crisis services** - As self-harm is correlated with periods of distress and mental health difficulties, commissioners should work to improve access and ongoing support for those in crisis.

11. **Strategic approaches** – work across the self-harm pathway needs to be reflected in local and regional mental health and suicide prevention strategies and plans. Priorities and actions need to be informed by evidence and lived experience and consideration needs to be given around how success will be measured and how interventions will be evaluated.

12. **Further research** - is needed to:
    - better understand and support those who self-harm in prison
    - find out more about the needs of volunteers providing support to those to self-harm, many of which also have their own experiences of this and for whom the burden of care may be distressing.

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