

Barnet Children and Young People's Self-Harm Health Needs Assessment

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List of Abbreviations

A&E – Accident and Emergency
ADHD – Attention Deficit Hyperactivity Disorder
A-Level – Advanced Level
APC – Admitted Patient Care
ASD – Autism Spectrum Disorder
BELS – Barnet Education and Learning Service
BEST – Barnet Enhanced Support Team
BICS – Barnet Integrated Clinical Services
CAMHS – Child and Adolescent Mental Health Services
C&F – Child and Family
CBT – Cognitive Behavioural Therapy
CRS – Crisis Response Service
CSC – Children’s Social Care
CWT – Children’s Wellbeing Team
CYP – Children and Young People
CYPMH – Children and Young People’s Mental Health
DBT-A – Dialectical Behaviour Therapy for Adolescents
ECDS – Emergency Care Data Set
GCSE – General Certificate of Secondary Education
GP – General Practitioner
HES – Hospital Episode Statistics
HEYL – Healthy Early Years London
HNA – Health Needs Assessment
HSL – Healthy Schools London
HTT – Home Treatment Team
ICB – Integrated Care Board
ICD-10 – International Classification of Diseases, Tenth Revision
IDACI – Income Deprivation Affecting Children Index
IMD – Index of Multiple Deprivation
LAS – London Ambulance Service
LBB – London Borough of Barnet
LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual Plus
MASH – Multi-Agency Safeguarding Hub
MBT – Mentalisation Based Treatment
MHCYP – Mental Health of Children and Young People
MHST – Mental Health Support Teams
NCL – North Central London
NCL ICB – North Central London Integrated Care Board

NHS – National Health Service
NICE – National Institute for Health and Care Excellence
NLFT – North London Foundation Trust
NMUH – North Middlesex University Hospital
NSHN – National Self-Harm Network
OOH – Out of Hours
PINS - Partnerships for Inclusion of Neurodiversity in Schools
PMHT – Primary Mental Health Team
PSHE – Personal, Social, Health and Economic Education
QR – Quick Response
RCPsych – Royal College of Psychiatrists
RFH – Royal Free Hospital
REACH – Resilient, Engaged, Achieving Children Hub
SCAN - Service for Children and Adolescents with Neurodevelopmental Difficulties
SEN – Special Educational Needs
SEND – Special Educational Needs and Disabilities
UCLH – University College London Hospital
UK – United Kingdom
YJS – Youth Justice Service
YMHFA – Youth Mental Health First Aid
YPT – Young People Thrive

Plain Language Summary

What is this report about?

This report looks at self-harm in children and young people in Barnet, aged 0–25. It tries to understand:

- How many young people are self-harming
- Which young people are more likely to self-harm
- Why self-harm happens
- What support is available
- How to improve support

How common is self-harm in Barnet?

Self-harm has become more common among young people in Barnet in the past few years. More children and young people are going to hospitals or other services for help with self-harm than in the past. There are likely to also be young people in the community who are self-harming and not using services, which makes it hard to know exactly how many young people are affected by self-harm.

Which young people in Barnet might be more likely to self-harm?

- Girls, especially those aged 15-19
- Young people with mental health difficulties
- LGBTQIA+ young people
- Young people who are autistic or who have ADHD
- Children in care

What makes it hard for young people to get help with self-harm?

- They feel scared or ashamed to talk about self-harm
- Families don't always know where to go for help or what to say
- Schools don't always have enough staff or time to support young people with their mental health or learning needs
- Long waiting times for mental health services
- The support offered doesn't always work for the young person
- There aren't enough places to get help in the community
- Young people often have to go to Accident & Emergency (A&E) with self-harm, even when it's not the best place for them
- The mental health support available may change when young people turn 18
- Children in care don't always get the support they need
- Some adults who work with young people don't feel confident or trained enough help with self-harm

What does this report recommend?

This report gives ideas on how to better support young people with self-harm. Here are the main suggestions:

- **Work together:** Mental health services, schools, and families should work as a team
- **Better data:** Collect more information to understand who needs help
- **Start early:** Teach children about emotions and mental health from a young age
- **Support in schools:** Help schools support students with mental health needs and learning needs
- **Easier access to help:** Make it quicker and simpler to get the right mental health support
- **Help for families:** Give parents and carers advice and emotional support
- **Training and information:** Make sure adults working with young people know what to say and make sure young people and families have the information they need

This report also says **a group should be set up** to work on these suggestions. The group should involve professionals, young people and families. The group will need to decide which of these suggestions are the most important and achievable.

Executive Summary

This Health Needs Assessment (HNA) was undertaken to explore the needs of children and young people (CYP) aged 0-25 in Barnet who are self-harming or at risk of self-harm, with the aim of identifying unmet needs, barriers to services and making evidence-based recommendations to address these. The HNA uses a mixed-methods approach, combining quantitative data from providers with qualitative insights from stakeholder interviews, focus groups with CYP and school staff, and a parent-carer survey.

The HNA is grounded in the context of relevant national and local policy. The HNA also draws on guidance from the National Institute for Health and Care Excellence, the Royal College of Psychiatrists, and The Lancet to identify best practices in relation to supporting CYP who self-harm.

Local Services

Barnet's mental health and wellbeing services for CYP are structured around the Thrive framework. In the "Thriving" category, initiatives such as the Resilient Schools Programme promote mental wellbeing and resilience. "Getting Advice" includes signposting around mental health and wellbeing generally, as well as specifically in relation to self-harm, for example through Youth Mental Health First Aiders. "Getting Help" involves targeted support for self-harm through statutory and voluntary sector providers. "Getting More Help" encompasses support for those with greater needs, for example through Child and Adolescent Mental Health Services (CAMHS), including the Barnet Enhanced Support Team. Finally, "Getting Risk Support" encompasses Crisis services, the Home Treatment Team, and inpatient support.

The Epidemiology of Self-Harm in Barnet

Self-harm is a prevalent issue among CYP in Barnet. Hospital admissions as a result of self-harm peaked in 2021-22 but remain higher than London rates, particularly among females aged 15-19. There is also some evidence of rising admissions for self-harm among younger adolescents aged 10-14. This HNA also notes associations between self-harm and co-existing mental health conditions, neurodiversity and increased deprivation.

Local Needs

Qualitative findings suggest CYP use self-harm as a way to manage and express overwhelming emotions. Girls and young women, those with mental health difficulties, LGBTQIA+ CYP, neurodiverse CYP, and Looked After Children were identified as some of the groups at increased risk of self-harm in Barnet. Barriers to support include stigma, a lack of awareness of self-harm, long waiting times for mental health support, and difficulties navigating services. Unmet need included schools' capacity to support CYP with complex needs as well as a need for greater community-based support and tailored, inclusive mental health support. Effective approaches to support with self-harm included trusted adult relationships, multidisciplinary collaboration, peer support, creative therapeutic approaches, and harm minimisation strategies.

Recommendations

A summary of recommendations is provided below. A more detailed list of recommendations can be found in Section 8.

Leadership and Co-Production

- Establish a multi-agency Task & Finish group to prioritise and implement recommendations
- Integrate recommendations with other strategic work
- Promote multidisciplinary collaboration and data sharing
- Support schools to develop and implement self-harm policies
- Embed lived experience in service design and delivery

Data and insights

- Improve data collection and coding across services
- Strengthen data on links between self-harm and suicidality
- Share data to identify high-risk groups and monitor trends
- Further explore data to address limitations of this work
- Engage further with stakeholders working with CYP aged 18-25
- Consider asking about self-harm in relevant local surveys

Prevention of self-harm

- Embed evidence-based emotional literacy and resilience building in schools from primary age
- Promote open conversations and regular wellbeing check-ins in schools
- Enhance psychoeducation for the families of CYP
- Raise awareness of support for mental health, bereavement, neurodiversity and other risk factors
- Increase support at higher risk times of year
- Build stability for Looked After Children
- Raise awareness on avoiding harmful content online

Support in schools

- Support schools to meet mental health needs, special educational needs (SEN) and the needs of neurodiverse CYP
- Encourage holistic support for SEN and mental health

Mental health support

- Improve access to and navigation of mental health services
- Ensure careful use of language around self-harm
- Ensure person-centred and accessible interventions
- Deliver culturally competent, inclusive support
- Expand community-based support and diversion from A&E
- Tailor care using creative, strengths-based, and digital approaches
- Make support accessible by considering timing and setting
- Explore peer support and mentoring

- Improve transitions between children’s and adult mental health services
- Support harm minimisation where appropriate
- Review continuity of care for Looked After Children placed outside the borough

Other support services

- Provide targeted support and review transition support for Looked After Children
- Develop safe A&E diversion options with the London Ambulance Service

Support for families

- Connect families for peer support
- Provide wellbeing support for families of CYP who self-harm

Training and resources

- Provide basic training for all professionals working with CYP and advanced training for some on risk management
- Create and share written resources on self-harm for professionals
- Ensure training is accessible and supported by employers
- Offer training on supporting CYP awaiting neurodiversity assessments and LGBTQIA+ CYP
- Ensure supervision and reflective practice for staff
- Develop a centralised, accessible resource hub for families and professionals
- Ensure CYP understand support pathways and what to expect from services
- Tailor communication formats to CYP’s needs and preferences
- Train placements to support Looked After Children with mental health needs

1. Background

1.1 Introduction

This health needs assessment (HNA) sets out to understand the health needs of Children and Young People (CYP) up to, and including, the age of 25 in the London Borough of Barnet (LBB) who self-harm or are at risk of self-harm, as well as to identify unmet need and gaps in services.

1.2 Aims and objectives

1.2.1 Aims

- To understand the health needs of CYP in Barnet affected by self-harm
- To identify unmet needs and gaps in services for CYP in Barnet affected by self-harm, and make evidence-based recommendations to address these

1.2.2 Objectives

- To describe national epidemiology related to self-harm among CYP
- To describe local and national policy related to self-harm among CYP
- To describe the demographics of CYP in Barnet

- To describe the epidemiology of self-harm among CYP in Barnet, including risk factors where possible
- To describe the available services and service use for CYP affected by self-harm in Barnet
- To understand stakeholder perspectives on self-harm among CYP in Barnet, including the perspective of CYP
- To describe unmet need and barriers to services for CYP in Barnet affected by self-harm
- To develop evidence-based recommendations to address self-harm among CYP

1.3 Methodology

1.3.1 Methodology

This HNA used a mixed methods approach. A steering committee was set up to oversee this work, which first met in February 2025. The steering committee agreed the aims, objectives and scope for this HNA, as well as the approach to data collection, stakeholder interviews and focus groups. The steering committee met again in July 2025 to review a draft of the report and its recommendations, with the final document agreed via correspondence thereafter.

A narrative review of reports, research papers and guidelines was undertaken and used to describe the national epidemiology of self-harm (Section 1), the policy context (Section 2) and effective interventions for self-harm (Section 3).

Information on the demographics of CYP in Barnet (Section 4) is drawn from a range of national statistics and one local survey.

Section 5 provides an overview of services related to self-harm in Barnet. This information is based on stakeholder interviews, correspondence with professionals and online resources.

The epidemiology of self-harm in Barnet (Section 6) draws on quantitative data from a variety of sources. This includes national datasets such as the Emergency Care Dataset (ECDS) and Hospital Episode Statistics (HES). Data was also obtained from North Central London Integrated Care Board (NCL ICB) and directly from providers such as the London Ambulance Service (LAS), Barnet Integrated Clinical Services (BICS) and others.

Section 7 on local needs is based on qualitative findings from stakeholder interviews, focus groups with CYP and school staff and a parent-carer survey.

16 stakeholder interviews were conducted as part of this HNA. Some interviews were conducted in groups of two or three, with a total of 20 interviewees who took part in the stakeholder consultation process. The questions from these stakeholder interviews can be found in Appendix 2. Consent to participate in stakeholder interviews was obtained either verbally or in writing via email before the interview took place. All interviews were recorded to aid with transcription. Questions were shared with stakeholders in advance of the interview, and following completion of the interview a summary of the interview was shared with interviewees for their review and agreement.

Section 7 also draws on findings from four focus groups with CYP, three of which were conducted in secondary schools with approximately 26 participants and the other via CAMHS

with 4 participants. A further two focus groups were conducted with school staff, with a total of 5 participants. Finally, Section 7 was also informed by the results of an electronic survey shared with parents and carers in Barnet, which received 11 responses.

Section 8 (Recommendations) synthesises the findings of Sections 5, 6 and 7 into key areas of need. Recommendations are then made which are mapped against each of these areas of need.

1.3.2 Limitations

This HNA compared hospital admissions for self-harm in Barnet to neighbouring boroughs, as well as to regional and national levels, however this was not possible to do for hospital attendances. Furthermore, some admissions data is presented as rates, however much of the admissions data and attendances data is presented as percentages, meaning it can be more challenging to identify service use and associated need relative to Barnet's population.

A further limitation is that hospital admissions data is obtained from HES, which does not include all mental health specific activity, including data from mental health Trusts¹. Hence hospital admissions data presented in this HNA largely relate to admissions to acute medical Trusts. It was also not possible to obtain inpatient or outpatient mental health data on self-harm, which is a further limitation of this work.

In addition, whilst this HNA includes data on those aged 0-25, some of the services described, particularly statutory mental health services are specifically for those aged 0-17. This reflects the stakeholders that were engaged with as part of this work; for logistical reasons it was not possible to engage with all relevant stakeholders. As a result, the qualitative findings from stakeholder interviews also mainly include the perspective of mental health professionals working with those aged 0-17.

A final limitation of this work is the sample size of the qualitative engagement, particularly the sample sizes for the school staff focus group and the parent-carer survey. Some recommendations are based around the small sample of responses from the parent-carer survey.

1.4 Definitions

The steering committee selected the National Self-Harm Network's (NSHN) definition of self-harm for this work:

“Self harm can take many different forms and as an individual act is hard to define. However in general self harm (also known as self injury or self mutilation) is the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and/or self neglect.”²

The NSHN highlights that self-harm may take some of the following forms²:

- Cutting, burning, biting
- Substance abuse
- Head banging and hitting
- Taking personal risks

- Picking and scratching
- Neglecting oneself
- Pulling out hair
- Eating disorders
- Overdosing and self-poisoning

Finally, based on insights from those with lived experience, the NSHN describes a range of reasons that may be behind why a person self-harms. These can include²:

- To release tension, frustration and distress
- To feel and regain control
- To punish oneself
- To feel or to ground oneself
- To express emotion

1.5 Scope

The below table describes the scope of this HNA, as agreed with the steering committee. This scope aims to be as comprehensive as possible whilst retaining a focus on self-harm.

Where possible the HNA will look at data up to and including those aged 25, in order to capture the transition period between children’s services and adult services.

The HNA will consider the needs of CYP who are self-harming, as well as those at risk of self-harm and how self-harm can be prevented among CYP.

As noted in the above definition, self-harm can take many different forms. In addition, other mental health issues, such as eating disorders or substance misuse, can at times act as forms of self-harm, and it may be challenging to identify instances where this is the case, and where it is not. In order to comprehensively describe self-harm, the steering committee therefore chose to include associations with other mental health issues, such as eating disorders or substance misuse, that could at times act as forms of self-harm.

Self-harm can also be closely associated with a range of co-existing mental health issues, neurodivergence and suicidal ideation and attempts. Therefore, the steering committee also elected to include associations with these factors within the scope of the HNA. It is beyond the scope of the HNA to explore these factors in any greater depth.

In scope	Out of scope
<ul style="list-style-type: none"> • Self-harm, up to age 25 • Associations with mental health issues, including eating disorders and substance misuse • Associations with neurodivergence • Associations with suicidal ideation and suicide attempts 	<ul style="list-style-type: none"> • Self-harm in other age groups • Any further exploration of mental health issues, including eating disorders or substance misuse • Any further exploration of suicidal ideation and suicide attempts

Table 1. Scope

1.6 Self-harm nationally

1.6.1 The self-harm iceberg

It is widely acknowledged that our understanding of self-harm prevalence in the United Kingdom (UK) is impacted by under-reporting³. This under-reporting can be better understood through the self-harm iceberg. In this model, the very top of the iceberg represents suicide, the middle of the iceberg represents self-harm presenting to clinical services, and the bottom of the iceberg, the largest section, represents self-harm in the community, much of which is hidden⁴. Figure 1 depicts this iceberg model. One study took a retrospective approach to estimate self-harm in line with this iceberg model for CYP aged 12-17 in the UK. This found that for every young person aged 12-17 in the UK who dies by suicide, 370 present to hospital by self-harm and 3,900 report self-harm in the community⁵.

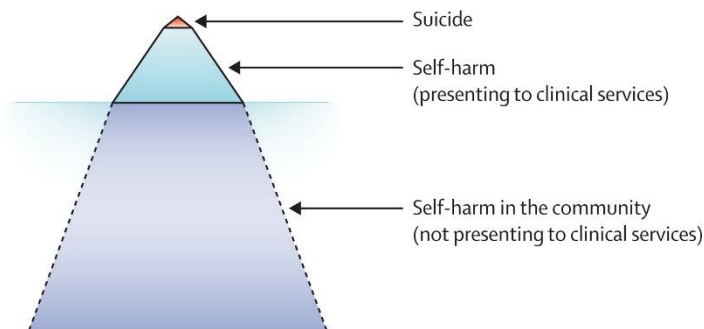


Figure 1. Iceberg model of self-harm and suicide in young people⁴

1.6.2 National prevalence of self-harm

A global systematic review and meta-analysis of studies on self-harm among CYP published between 1989 and 2018, reported an aggregate prevalence of non-suicidal self-injury, which it defined as injurious behaviour, with or without suicidal intent, which was not fatal. The authors specify that the inclusion criteria included papers where the study population included children and adolescents, however a specific age range is not provided. This work included one study from the UK. The meta-analysis identified an aggregate lifetime prevalence of non-suicidal self-injury of 22.1%, and a 12-month prevalence of 19.5%⁶. However, there is also increasing evidence that the mental health of CYP has worsened in recent years, driven most recently by factors such as the Covid-19 pandemic⁷. It is therefore important to consider that prevalence data which pre-dates the pandemic may be an underestimate.

The Mental Health of Children and Young People in England (MHCYP) 2023 survey collected data from 2,370 CYP in England⁸. Among 8-10 year olds, lifetime self-harm rates were 5.9% in 2023, whilst 2.4% had talked about self-harm in the past four weeks and 1.3% had tried to harm themselves in the past four weeks⁹. Among 11-16 year olds, lifetime self-harm rates were 11.2% in 2023, whilst 2.4% had talked about self-harm in the past four weeks and 1.7% had tried to harm themselves in the past four weeks. Among 17-24 year olds, the lifetime rate of self-harm was 36.8%, 9.1% had talked about self-harm in the past four weeks and 4.8% had tried to self-harm in this period.

For 8-10 year olds lifetime risk of self-harm was higher in boys at 7.8% as compared to 3.9% among girls. Self-harm in the last 4 weeks was also higher among boys in this age range, at 1.9%, as compared to 0.8% among girls. However, in this age group the differences between boys and girls were not statistically significant.

In older age groups higher rates of self-harm or self-harm ideation were seen among girls and young women as opposed to boys and young men. Among 11-16 year olds lifetime self-harm was 14% among girls and 8.5% among boys, however this result was not statistically significant. Similarly among 17-24 year old lifetime self-harm was 28.8% among young men but 45.7% among young women. This difference between young men and young women was statistically significant.

These questions were only asked once previously, in the 2022 iteration of the survey. Whilst there are variations in figures between 2023 and 2022, none of these variations are statistically significant⁹. This survey is one of the most up to date sources of data on self-harm among CYP nationally. However, it is limited by its small sample size.

The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24 included data on treated and untreated mental health issues in those age 16 and over¹⁰. 6.912 individuals completed phase one, a face-to-face or remote interview. A sub-sample of these (887) took part in phase two, which was a face-to-face assessment by a clinically-trained interviewer. CYP aged 16-24 were underrepresented in the survey compared to their representation in the population; it is estimated that 13% of the population were aged 16-24 in 2022, however only 4.6% of survey respondents belonged to this age group. The study found that self-harm had increased across all ages, in comparison to previous iterations of the survey. The absolute rise was highest in those age 16-24: in 2000 5.3% of this population reported self-harm without suicidal intent, compared to 21.2% in 2023/24. This result was statistically significant.

1.6.3 Risk factors

The MHCYP survey notes higher rates of self-harm rates among boys in younger age groups (aged 8-10) but higher rates of self-harm among girls and young women in older age groups⁹. Other sources also note the latter finding of self-harm being more common among girls and young women as opposed to boys and young men.

Risk factors for self-harm among CYP noted in the literature include^{4,11-14}:

Demographic factors	<ul style="list-style-type: none"> • Being female • LGBTQIA+ identity • Low socioeconomic status • Chronic illness
Educational factors	<ul style="list-style-type: none"> • Poor academic performance • Poor school attendance
Psychological factors	<ul style="list-style-type: none"> • Mental health issues • Neurodiversity • Substance misuse • Sleep disturbance • Alexithymia • Low self-esteem • Body image issues • Hopelessness

	<ul style="list-style-type: none"> • Perfectionism • Family history of mental illness
Life experiences and social factors	<ul style="list-style-type: none"> • Parental separation • Family conflict • Poor family relationships • Bereavement, including by suicide • Childhood neglect or abuse • Bullying • Poor peer relationships • Social media use

Table 2. Risk factors for self-harm among CYP

1.6.4 Protective factors

The literature also notes a range of factors that protect against self-harm. These include¹¹:

- Social support
- Good family relationships
- Good peer relationships
- Resilience
- Life satisfaction
- Good academic achievement

2. Policy context

This section describes the national and local policy context related to self-harm among CYP.

2.1 National policy

2.1.2 The 10 Year Health Plan for England

The new 10 Year Health Plan for England was published in July 2025. This puts forwards changes to the NHS through three shifts: from hospital to community; from analogue to digital; and from sickness to prevention¹⁵.

The shift from hospital to community includes the development of a Neighbourhood Health Service, allowing care to happen as locally as possible for patients; this will be facilitated by a range of measures. In relation to mental health, the government plans to develop 85 dedicated mental health emergency departments, to allow for same day emergency support in an appropriate setting. To facilitate a transition to more community-based care, there are also plans for the development of a new digital platform available to all NHS providers. This will allow information to be shared more easily, including to facilitate multidisciplinary working around mental health.

The shift from analogue to digital will include patients being able to self-refer to mental health therapies through a My Specialist tool within the NHS app¹⁵. The My Children section of the app will include advice for parents, including information on getting support if they are concerned about their child's mental health.

The shift from sickness to prevention aims to halve the gap in healthy life expectancy seen between the wealthiest and most deprived parts of the UK¹⁵. It is proposed that this will be achieved through cross-societal collaboration on a range of measures. In relation to CYP's mental health this includes expanding mental health support teams in schools as well as offering additional mental health support for CYP through Young Futures Hubs. There are also plans to reduce waiting times for mental health support for both CYP and adults, through the recruitment of 8,500 new mental health staff. The 10 Year Health Plan also specifically sets out plans to work with local authorities to support CYP with complex mental health needs who are living in residential care settings to access treatment and prevent hospital admissions.

2.1.4 Suicide Prevention Strategy for England

The Suicide Prevention Strategy for England: 2023 to 2028 has three core aims, one of which is to continue to improve support for people who self-harm. The Strategy has eight priorities and links four of these priorities with self-harm¹⁶.

The links between these four priorities and self-harm are outlined below:

- Improving data and evidence, including in relation to self-harm
- Tailoring support to priority groups; priority groups in the Strategy include both CYP and those who have self-harmed
 - This includes considering inclusion of self-harm explicitly in the school curriculum
- Addressing risk factors, including population level early intervention on risk factors for self-harm, as well as ensuring those who work in public services can identify those at risk of self-harm
- Promoting online safety, including exposure to self-harm content online and signposting and support across a range of platforms in relation to self-harm; promoting responsible media reporting on self-harm

2.1.5 Thrive framework

The Thrive framework is a needs-based conceptualisation of CYP mental health, for CYP aged 0-25, their families and professionals involved in their care. Figure 2 shows the Thrive framework, which lays out five different groups based around need¹⁷. Thrive is recommended as an approach in the NHS Long Term Plan and is being implemented nationally through the i-THRIVE programme, in which more than 75 areas in England are using the Thrive framework to achieve change in CYP mental health¹⁷.

The first group in this model is the “Thriving” group, which describes those CYP who may be experiencing normal life challenges but do not need individual support. For this group promotion of mental wellbeing and prevention of mental health issues are key, and it is also vital to consider systematic disadvantage in these promotion and prevention activities.

The second group, “Getting Advice”, describes sharing information with CYP and their families to support mental health and wellbeing. This part of the model focuses on those with “mild or temporary difficulties AND those with fluctuating or ongoing severe difficulties, who are managing their own health and not wanting goals-based specialist input”¹⁷.

“Getting Help” focuses on those requiring mental health intervention, involving a trained professional, with an agreed goal. “Getting More Help” builds on this, and is focussed on those needing more extensive support. This may include CYP with multiple needs or those whose participation in daily activities such as school or home life is being affected.

Finally, “Getting Risk Support” is focussed on those CYP who have not benefitted from or are unable to use other services, but remain at risk. Whilst risk management may be a part of other levels of the Thrive framework, this section focuses on those receiving risk support only.

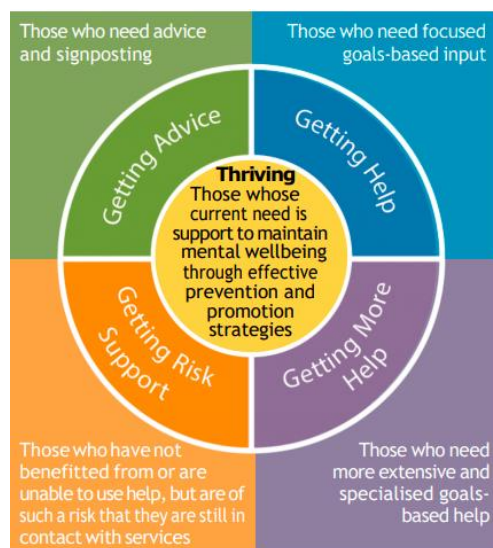


Figure 2. Thrive framework¹⁷

2.2 Local policy

2.2.1 Barnet Children and Young People’s Plan 2023-27

The Barnet Children and Young People’s Plan 2023-27 sets out how the local authority aims to improve outcomes for young people in the borough¹⁸. The plan has four key areas, one of which is Health and Wellbeing. Within the action plan for Health and Wellbeing, one of the three objectives focuses on mental health. This objective is: “To promote good mental and emotional health across all ages and different communities and work together to prevent severe mental illness, substance misuse and suicide”. Within this objective there are seven priorities¹⁸:

- Barnet Integrated Clinical Services (BICS) to provide a range of interventions to support children and young people’s mental health & wellbeing
- Ensure that a universal approach including supporting the Resilient Schools Programme, is delivered to all schools to raise awareness of mental health and reduce stigma
- Work with partners to improve access to mental health support for CYP Barnet
- Work with partners to promote parity of access to mental and physical health services for children, young people with mental illnesses or SEND
- Develop and implement a refreshed Barnet Suicide Prevention Strategy
- VCFSE to work to ensure that we continue to grow our community offer for early mental health support, (EIP) backed up with increased wellbeing activities

2.2.2 Children & Young People’s Mental Health and Wellbeing Strategy 2024-2028

The Barnet Children and Young People’s Mental Health and Wellbeing Strategy 2024-2028 sets out the borough’s priorities for CYP mental health and wellbeing. The five key priorities are¹⁹:

1. Raising awareness of services and support
2. Engaging with CYP to inform service design and delivery
3. Improving support accessibility for all CYP
4. Suicide prevention
5. Building a system that can deliver priorities and improve outcomes

Each of these priorities can be linked to self-harm. In addition, the fourth priority, on suicide prevention, specifically includes the following outcome related to self-harm:

- Access to means of suicide and self-harm are reduced for those identified as being at particularly heightened risk.

2.2.3 Barnet Suicide Prevention Strategy 2021-2025

The Barnet Suicide Prevention Strategy 2021-2025 is an all-age Strategy, developed by the multi-agency Barnet Suicide Prevention Partnership²⁰. The framework for this Strategy includes three key themes, one of which is: Prevention of suicide and self-harm. The Action Plan for this Strategy was refreshed for 2023-2025²¹. The refreshed action plan involved multiple actions around self-harm, some of which were specific to CYP. These included using and sharing data to understand risk and protective factors, the development of a self-harm prevention toolkit for schools, which is currently underway, and provision of supervision to Safeguarding leads in schools who may be the first port of call for CYP experiencing self-harm or suicidal ideation. Key successes from this Strategy impacting CYP include the delivery of Youth Mental Health First Aid Training to multi-agency practitioners across Barnet, as well as the development of the Peer Champion Scheme, both of which are discussed further in Section 5.

A new Barnet Suicide Prevention Strategy 2026-2030 and an associated Action Plan is currently under development. This will include targeted support for those presenting with self-harm as well as universal actions such as the provision of training to frontline professionals.

3. Evidence-based approaches

This section outlines guideline recommendations around self-harm, drawing on a number of resources. This includes the National Institute for Health and Care Excellence (NICE) guideline on self-harm, which incorporates the assessment and management of self-harm as well as prevention of recurrence²². Recommendations within this guideline were synthesised through reviews of evidence. The Royal College of Psychiatrists (RCPsych) has also produced a report on managing self-harm in young people; this was published in 2014 and draws on evidence and opinion²³. Finally, this section also draws on the Lancet’s 2012 publication on self-harm and suicide in adolescents⁴ as well as their 2024 series outlining a public health approach to suicide prevention²⁴.

3.1 Prevention

In 2024, the Lancet published its model on the public health approach to suicide prevention²⁴. Whilst the model is centred on suicide prevention, the authors also make reference to prevention of self-harm within the series, given the links between self-harm and suicide. Key to the public health approach proposed in this model, is that prevention needs to be population-wide, given the complex drivers of suicide and self-harm. The model proposes therefore that some interventions should take a universal approach, targeting the whole population. Such interventions may include resilience building in schools and media campaigns. The model also suggests that those who have risk factors that place them at increased risk of self-harm or suicide in the future, should receive targeted intervention. This could include ensuring access to mental health treatment and support. The authors argue that these preventative interventions are essential, and should sit alongside clinical support for those in crisis.

This builds on the Lancet's 2012 work on self-harm and suicide in adolescents, where they outlined interventions aimed at the whole population, including⁴:

- Public awareness campaigns
- School-based psychological wellbeing programmes
- Encouraging help-seeking
- Reducing stigma associated with mental health and help-seeking
- Training peers and adults to recognise signs of self-harm

They also proposed targeted interventions for higher risk groups, including⁴:

- Timely access to psychosocial support for risk groups, including those with mental health issues or trauma

The subsequent sections outline guidelines for supporting those who have self-harmed.

3.2 Information and support

Information and support should be provided to those who have self-harmed, as well as their family members or carers, as appropriate. This can include providing information to the individual and their family members or carers on support, self-care, safety planning, seeking support for injuries and crisis support²². It is important that this advice is tailored to individual needs, including aspects of the individual's identity, their history of self-harm and their health, neurodevelopmental conditions or learning disability.

3.3 Consent and confidentiality

NICE highlight that those who work with people who self-harm should have access to specialist support around capacity and consent. They should also be aware of the benefits of sharing information with families and carers, and seek consent to do this²². RCPsych also emphasise that frontline professionals should avoid promising young people that they will keep disclosures of self-harm a secret from others²³.

3.4 Safeguarding

Those who work with people who self-harm should understand safeguarding principles and procedures and if safeguarding referrals are made, a multi-agency approach should be taken by those working in health or social care. This should involve working with the education sector and potentially also those in the third sector, in order to understand how best to support the individual, taking into account different aspects of their life²².

3.5 Involving family members and carers

Professionals should support individuals who self-harm and their families in helping the individual to express their needs, including non-verbal communication²².

3.6 Psychosocial assessment and care

Psychosocial assessments should take place early, and occur in collaboration with the person who is self-harming to understand the individual's circumstances, including why self-harm occurs, to ensure the person receive the required care²².

3.7 Risk assessment

RCPsych emphasise that those in frontline roles should be able to carry out basic mental health risk assessments, including discussing the role of self-harm as a coping strategy for that young person and any experiences of suicidal ideation²³.

NICE guidelines also advise that professionals should undertake a risk formulation as part of every psychosocial assessment²². The guideline advises against the use of risk assessment tools or global risk stratifications into low, medium and high risk to predict repetition of self-harm or risk of suicide, or to make treatment or discharge decisions. This is because such tools cannot accurately predict risk and so their use could lead to repeated self-harm or distress for individuals.

NHS England's guidance on staying safe from suicide reiterates the importance of not using risk stratification tools and builds on this further, recommending instead a nuanced approach to assessing risk, recognising that risk is variable, and that self-harm is a significant risk factor for suicide²⁵. This guidance also highlights that the intention to self-harm can arise suddenly, meaning that it is important for risk assessments to consider risk factors and protective factors for future self-harm²⁵.

3.8 Assessment and care

This section outlines recommendations for assessment and care in different settings. RCPsych highlight the importance of collaborative working between acute hospitals, mental health services and the local authority²³.

They also emphasise that all front-line professionals have a role to play in asking about self-harm when speaking to young people who may be struggling in a range of ways. When discussing self-harm with young people, professionals should avoid reacting with strong emotions and avoid too much focus on the self-harm itself²³.

3.8.1 Primary care

Assessment and care in primary care should include consideration of referral to mental health or social care services for further assessment²². NICE recommend that if support and care is being provided in a primary care setting, this should include regular appointments, medication review, advice on non-NHS support services, as well as care for mental health conditions²². Similarly RCPsych highlight that a clear follow up plan is important, including weekly or fortnightly follow up appointments²³.

3.8.2 Ambulance staff and paramedics

If urgent physical care is not required, ambulance staff and paramedics should follow the young person's care plan or safety plan where these are available, discuss with the individual how best ambulance services can help them, get advice from mental health professional where appropriate and consider alternate sources of support such as mental health services or their General Practitioner (GP)²². When making these considerations, ambulance staff should consider safety concerns as well as accessibility and availability of alternative services.

3.8.3 Non-mental health emergency department professionals

Assessment in the emergency department following self-harm should consider the severity of the physical injury, the person's emotional state, safeguarding and safety concerns, willingness to accept treatment, the appropriate nursing observation level and whether the person has a care plan²².

Children and young people should be referred, as soon as possible after arrival, to a crisis response service²².

3.8.4 General hospital settings

Following a hospital admission for self-harm, referral to liaison psychiatry should be made as soon as possible. An age-appropriate liaison psychiatry professional should see any individual admitted after an episode of self-harm²².

For CYP specifically, NICE guidelines note that for those admitted to a paediatric ward following self-harm there should be²²:

- Access to child and adolescent mental health services (CAMHS) or age-appropriate liaison psychiatry available 24 hours per day, 7 days per week
- Joint daily paediatric and CAMHS review
- Daily access to family or carers
- Regular multidisciplinary meetings between general paediatric and mental health services

3.8.5 Schools and education settings

RCPsych recommend that schools need to support self-harm training among their staff, so that they are well-equipped to support young people²³. NICE recommend that educational settings should be able to establish the severity of injuries, determine how urgently medical treatment is required and also determine whether a referral is required to mental health services²².

Education settings should have policies and procedures to support staff and students around self-harm²². All staff should be aware of the policies and procedures and know how to implement them. There should be a designated lead who is responsible for making sure policies are implemented and other staff are aware of these. Where self-harm occurs, the designated lead should seek support from mental health professionals to develop a support plan for the young person.

RCPsych also emphasise the importance of statutory services, voluntary services and education settings working together effectively to support CYP, including to maintain access to services²³.

3.9 Admission to and discharge from hospital

Where 16- or 17-year-olds are admitted to hospital following self-harm, this should be to a ward that can meet the needs of young people. Before discharge following self-harm, the following should take place²²:

- A psychosocial assessment
- A plan for further management involving appropriate agencies
- A discharge planning meeting involving appropriate agencies
- Arrangements for aftercare, including written communication to the primary care team

3.10 Aftercare

The approach to aftercare following an episode of self-harm should be discussed with the individual and their family or carers, and recorded in a care plan. If there are ongoing safety concerns after an episode of self-harm, aftercare should occur within 48 hours of the initial psychosocial assessment. This is because self-harm is most likely to be repeated within 2-3 days of a previous episode²².

3.11 Interventions

NICE advises the following regarding interventions for self-harm²²:

- To consider coexisting conditions
- To offer person-centred cognitive behavioural therapy (CBT)
- For children and young people, to consider dialectical behaviour therapy adapted for adolescents (DBT-A)
- To consider developing a safety plan, that is held by the individual and shared with family and professionals of their choosing
- To consider harm minimisation strategies including coping strategies and distraction techniques, self-care and aftercare

RCPsych mention that support for self-harm could include Tier 3 services such as CAMHS, or Tier 2 services such as a primary mental health service. They emphasise that a collaborative approach should be taken to interventions. They highlight that evidence-based interventions may include²³:

- CBT

- Problem-solving therapy
- Psychodynamic psychotherapy
- Family therapy
- Dialectical behavioural therapy

They also note the role of medication in treating co-existing health issues²³.

3.12 Safer prescribing and dispensing

When prescribing for an individual who has self-harmed in the past, professionals should consider toxicity in overdose, recreational drug, access to prescribed medication and effective communication with other prescribers²². Prescribers should work with the individual to limit supply of medications, for example, through weekly prescriptions. Community pharmacy staff should also be aware of warning signs related to self-harm, such as purchasing large quantities of over-the-counter medications.

3.13 Training and supervision

Training for all staff who work with people who self-harm should be regular, ongoing and available in a range of formats. Staff who work with those who self-harm should have training that allows them to carry out the recommendations made in the NICE guideline on self-harm, including but not limited to managing self-harm, assessing self-harm, making appropriate referrals and involving those who self-harm in their care²².

Those who work with people who self-harm should have access to regular, high-quality supervision²². This should include support for the staff member around how working with those who self-harm impacts them, as well as around delivery of compassionate care, development of skills, building competence and confidence and to provide an opportunity for reflections. Those who work with people who self-harm should also be able to readily access support from a senior colleague.

RCPsych also recommend that young people who self-harm should be involved in the planning and delivering of training²³.

3.14 Service design

RCPsych recommend that healthcare providers should agree a joint protocol for the management of self-harm across organisations, and that the service should be led jointly by CAMHS and a consultant paediatrician²³.

4. Demographics of CYP in Barnet

This section details the demographics of Barnet, and where possible provides a specific focus on CYP. According to the 2021 Census there are 119,027 CYP aged 0-24 living in Barnet, which represents a rise of 4.1% as compared to 2011²⁶.

4.1 Age

Barnet has a younger population as compared to London and England. Figure 3 shows CYP as a percentage of the total population in Barnet, compared to London and England, based on the

2021 Census²⁷. Barnet has a higher proportion of CYP aged 4 and under, 5-9 and 10-15. However, it has a lower proportion of CYP aged 16-19 and 20-24 compared to London and England. Within Barnet, Golders Green has a particularly young population, 28.9% of its residents are aged under 15; the lowest proportion of those under 15 was in Woodhouse (18.1%)²⁸.

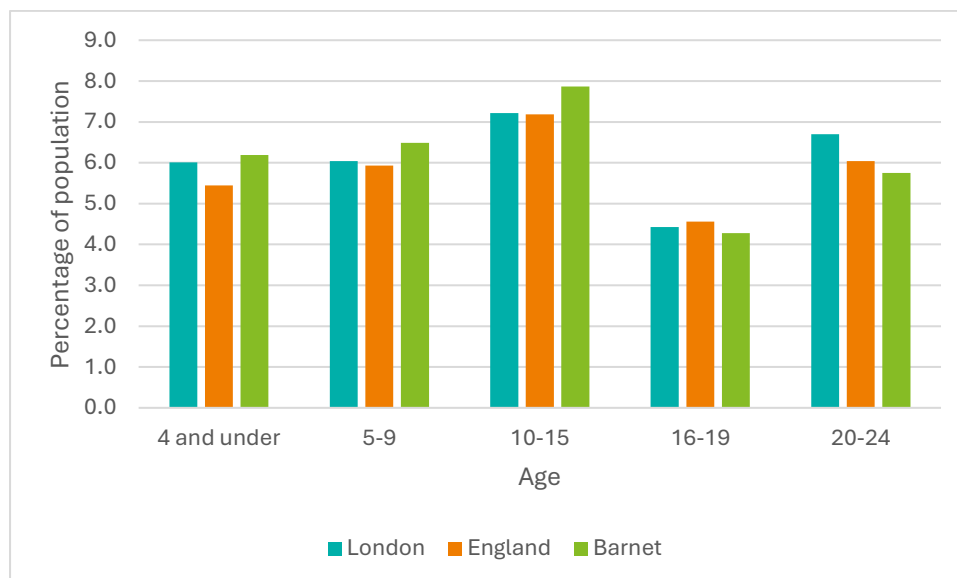


Figure 3. The population of Barnet, London and England aged 0-24 as per the 2021 Census

4.2 Deprivation

Based on the 2019 Income Deprivation Affecting Children Index (IDACI) 12.2% of 0-15-year-olds in Barnet live in income deprived families²⁶. In 2022/23 9.0% of children in Barnet were in absolute low-income families, as compared to 12.3% in London and 15.6% in England. 20.8% of CYP in Barnet are eligible for free school meals, as compared to 26.6% regionally and 24.6% nationally²⁶.

4.3 Ethnicity and language

The 2021 Census shows that 57.27% of Barnet residents aged 0-24 identify as White; 17.15% of those living in Barnet identify as Asian, 10.71% as Other ethnicity, 9.69% as Black and 10.18% as Mixed²⁹.

The most commonly spoken languages after English are Romanian (3.0%), Persian/Farsi (2.3%), Polish (1.5%), Gujrati (1.4%) and Portuguese (1.0%)³⁰. Language data pertains to the whole population, not specifically CYP.

4.4 Sexual orientation and gender identity

The 2021 Census only asked about sexual orientation and gender identity in those aged 16 and over. For those aged 16-24, 82.91% of those in Barnet identified as straight or heterosexual²⁹. 5.28% of Barnet residents aged 16-24 identified as lesbian, gay, bisexual or other. 11.81% did not respond this question. 0.48% of residents identified with a gender different to their sex registered at birth; 9.01% of residents did not answer this question²⁹.

4.5 Education

83,439 children and students in Barnet are in full-time education; this equates to 23% of Barnet residents²⁷. This figure includes adults in full-time education.

For 2023/24 71.4% of children in Barnet were noted as achieving a good level of development by the end of Reception²⁶. This is higher than the London figure of 70.1% and the England figure of 67.8%. In the same year only 0.9% of 16-17 year olds in Barnet were not in education, employment or training, as opposed to 3.4% regionally and 5.4% nationally²⁶. In 2023-24 8,131 pupils (11.5%) in Barnet received SEN support. This figure was 12.7% for London and 13.6% for England. 3,420 pupils (4.9%) in Barnet have an Education, Health and Care plan. This figure is the same for London and 4.8% for England²⁶.

In Barnet, 71% of children met the expected standards in reading, writing and maths by the end of Key Stage 2 in 2023/24²⁶. This is higher than London (69%) and England (61%). In Barnet 66.6% of children met expected attainment in maths and English for Key Stage 4 in 2023-24; this was 55.1% for London and 46.2% for England.

4.6 Social care

The rate of children in need aged under 18 in Barnet in 2023 was 213.9 per 100,000. This is significantly lower than regionally (369.8) and nationally (342.7)²⁶. Rates of children subject to child protection plans were also lower in Barnet (32 per 10,000) as compared to London (40 per 10,000) and England (43 per 10,000)²⁶. In 2024, the rate of Looked After Children in Barnet was 36 per 10,000, as compared to 51 per 10,000 in London and 70 per 10,000 in England²⁶. In Barnet in 2024 96% of care leavers were in suitable accommodation, as compared to 88% regionally and 89% nationally²⁶. The percentage of care leavers in education, employment or training in Barnet in 2024 was 69% in Barnet, 58% in London and 54% in England²⁶.

4.7 Life satisfaction

Figure 4 shows the percentage of young people in Barnet who report being satisfied with their lives, as identified in the Barnet Young Person Perception Survey³¹. Those reporting 'high' satisfaction has fallen between 2021/22 and 2023/24, whilst 'low', 'medium' and 'very high' satisfaction rose in the same period.

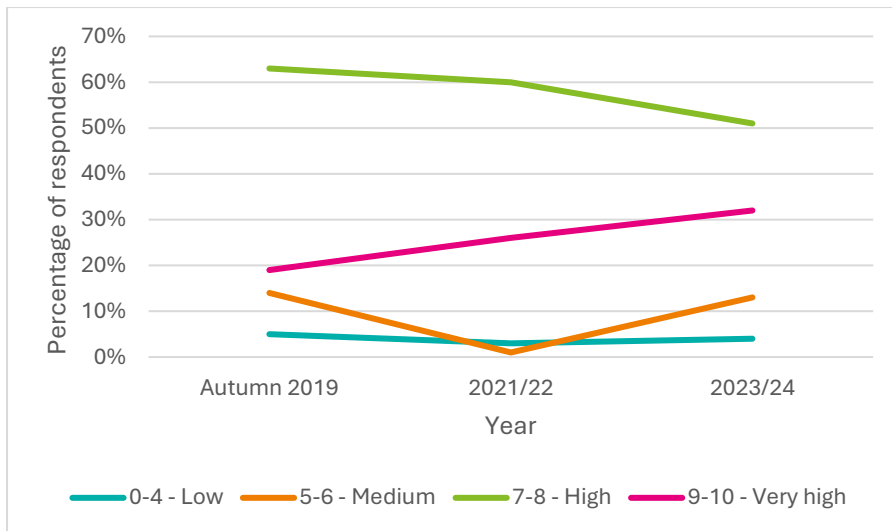


Figure 4. Barnet Young Person Perception Survey results for “Overall, how satisfied are you with your life nowadays?”³¹

4.8 Perceptions on help-seeking

Figure 5 shows young people in Barnet’s perceptions on whether they would talk to someone if they were feeling anxious or depressed. These data are also from the Barnet Young Person Perception Survey.³² The percentage of those who would not talk to someone has fallen, whilst the percentage of those who would talk to someone, or who would want to talk to someone but would not know whom to talk to, have both risen.

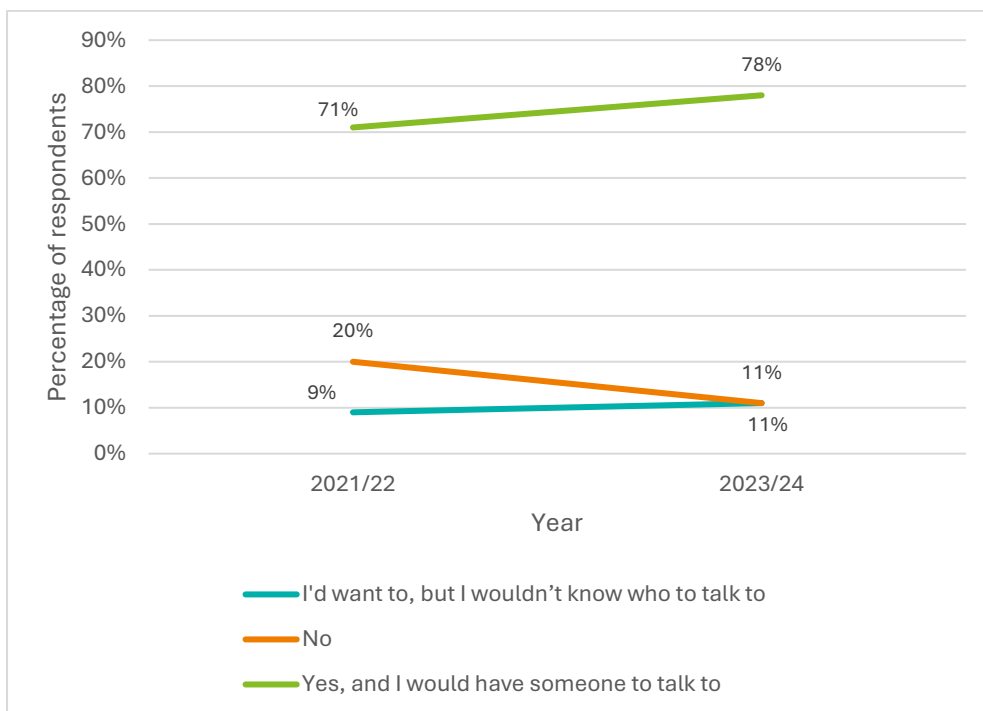


Figure 5. Barnet Young Person Perception Survey results for “If you were feeling depressed or anxious, would you talk to anyone about it?”³²

4.9 Mental health

2.8% of primary school children in Barnet have social, emotional and mental health needs. This figure is 2.4% regionally and 2.8% nationally³³. For secondary school children this figure is 3.0% in Barnet, compared to 3.2% regionally and 3.5% nationally³⁴. It is important to note that this measure has a very specific definition; it describes the number of school pupils with SEN, where the primary need is a social, emotional and mental health need³³. It therefore will not capture CYP with SEN, who have social, emotional and mental health needs, but where this is not the primary need. It also will not capture any CYP with mental health needs, who do not have SEN.

Hospital admissions for mental health in those under 18 were 81 per 100,000 for Barnet in 2023/24. This figure was 63 per 100,000 for London and 80 per 100,000 for England²⁶. However, the differences between Barnet and both London and England are not statistically significant. These figures are also not reflective of all mental health admissions, as this data is derived from HES, which largely does not capture admissions to mental health units¹.

5. Local services

Barnet's approach to CYP mental health and wellbeing is underpinned by the Thrive framework, and Figure 6 shows the mental health offer for CYP in Barnet; further information on the Thriving domain can be found below and in the Barnet Children & Young People's Mental Health & Wellbeing Strategy 2024-2028¹⁹.

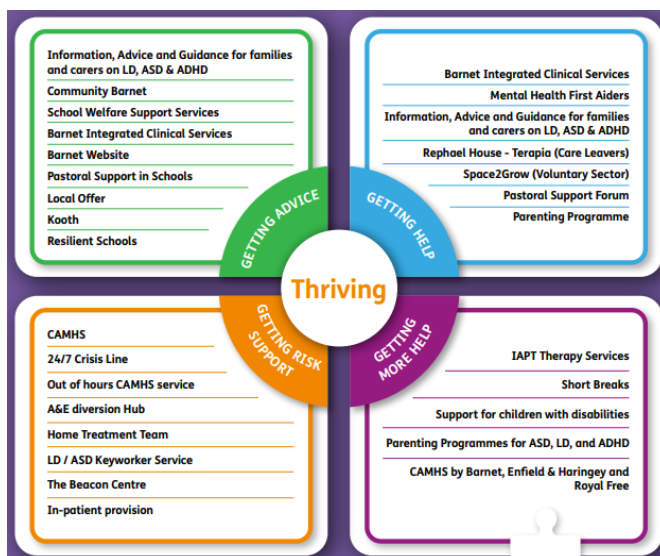


Figure 6. Thrive framework showing mental health offer for CYP in Barnet¹⁹

This section outlines support related to self-harm that is available in Barnet. It includes information on both statutory services and some voluntary sector provisions. Some services and organisations described in this section provide interventions and treatment related to self-harm and mental health issues, whilst others will signpost and refer to other organisations. This information has been compiled from stakeholder interviews, correspondence with professionals and online resources.

This section is organised by the Thrive framework, however it is important to note that some services will work with CYP with varying levels of need and so may work across multiple areas of Thrive.

5.1 Thriving

There are many services and interventions that support young people within the Thriving domain in Barnet. Some are outlined below, but this is by no means an exhaustive list.

5.1.1 Resilient Schools

Barnet's Resilient Schools programme takes a whole-school approach to supporting mental wellbeing, with the aims of raising awareness and destigmatising mental health issues, helping school communities to recognise mental health need and seek support, as well as prevention of the escalation of mental health difficulties³⁵. These activities link to the Thriving and Getting Advice sections of the Thrive framework and can contribute to the prevention of mental health issues, which can be associated with self-harm.

A self-harm pathway for schools is also currently being developed by Barnet Public Health and BELS; this pathway will aim to better equip schools to support CYP who are self-harming.

5.1.2 Peer Champion Scheme

The Peer Champion Scheme, commissioned through the Resilient Schools Programme, is available to all secondary schools in the borough, and focuses on promoting mental wellbeing and reducing stigma³⁶. CYP who act as peer champions receive mental health awareness training and take part in a co-production workshop, to develop how they will approach promoting mental wellbeing within their school community. CYP may choose to deliver assemblies, or to develop resources that promote mental wellbeing and resilience across the school community.

5.1.3 Barnet Wellbeing Service

The Barnet Wellbeing Service is a partnership between mental health services, Barnet Council and voluntary and community sector organisations³⁷. One of the key components of their work is Barnet Young People Thrive (YPT), which provides wellbeing services to CYP aged 18-25³⁷. Barnet YPT delivers wellbeing webinars and community engagement to increase mental health awareness and reduce stigma through outreach work³⁸. YPT's work also expands into the Getting Help domain of Thrive, through the provision of psychoeducation, group sessions and individual CBT³⁸.

5.1.4 Healthy Schools London (HSL) and Healthy Early Years London (HEYL)

HSL and HEYL are awards programmes, sponsored by the Mayor of London, that recognise work that schools³⁹ and Early Years settings such as nurseries and children's centres⁴⁰ do to support the health and wellbeing of CYP. HSL and HEYL support settings to take further steps to promote health and wellbeing³⁹ and reduce inequalities⁴⁰, with different levels of award to recognise the work settings do.

5.1.5 The Healthy Child Programme 0-19 services

The 0-19 Healthy Child Programme in Barnet includes both the Health Visiting and School Nursing Service, for CYP and their families⁴¹.

Health visitors are nurses who provide health promotion advice to families and monitor the physical and emotional health of CYP aged 0-5 through health reviews⁴¹. They also provide advice and support to parents and carers around their own emotional health and wellbeing⁴¹.

Details on the role of school nurses can be found in Section 5.2.5.

5.2 Getting Advice

5.2.1 Youth Mental Health First Aid (YMHFA)

Through the Resilient Schools Programme, 409 frontline staff across education, Family Services and the voluntary sector have undertaken YMHFA training, which covers how to identify CYP experiencing poor mental health as well as developing the skills and confidence to provide initial advice, so that CYP can receive early support⁴².

5.2.2 Schools Community of Practice

The Schools Community of Practice is a meeting of education staff and other services, that aims to work together with schools to raise the profile of support services⁴³. These meetings can include an opportunity to discuss specific cases schools need support with, as well as sharing best practice and developing networking opportunities between schools⁴³.

5.2.3 Barnet Education and Learning Service (BELS)

BELS works with schools to better support CYP affected by self-harm in a range of ways. Barnet's Virtual School supports education for Looked After Children and those with a social worker. Where the Virtual School has concerns about self-harm, they can then engage with schools and other agencies to ensure support for the young person.

If self-harm is contributing to absences or school avoidance, the Education Welfare Team can support schools and families around attendance.

If self-harm is being driven by circumstances in a particular school, the Admissions Team can support with moving schools.

Finally, the School Improvement Team works with schools to ensure their educational provision is as strong as possible, and each school has an allocated Learning Network Inspector. Where schools highlight an issue with mental health or self-harm, the Learning Network Inspector can help direct schools to appropriate services such as BICS.

5.2.4 The Local Offer

The Local Offer in Barnet is a resource that helps the families of CYP with Special Education Needs and/or Disabilities identify support that is available across the Barnet area⁴⁴.

5.2.5 Partnerships for Inclusion of Neurodiversity in Schools (PINS)

The Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme is a national initiative that started in 2024 led by the Department of Health and Social Care, the Department

for Education, and NHS England. The aim is to strengthen the capacity of mainstream primary schools to support neurodiverse children by deploying health and education specialists to upskill staff and embed inclusive practices⁴⁵. The programme promotes collaboration between integrated care boards (ICBs), local authorities, schools, and parent-carers, drawing on the successful Autism in Schools model. It focuses on early intervention and inclusive support to reduce the need for more intensive services and will inform future national policy through evaluation and learning.

In 2024-25 seven primary schools in Barnet were involved in the PINS pilot. In 2025-26, Barnet is participating in the second year of the PINS programme with a further seven primary schools involved. The borough has been allocated funding to support local delivery, including coordination, embedding learning in the seven PINS schools who participated in 2024-25, and enhancing parent-carer engagement. This funding also covers the development of resources such as parent-carer booklets. The PINS programme spans multiple Thrive domains.

5.2.6 Barnet Mencap

Barnet Mencap's Children's Services support the parents and carers of CYP aged 0-18 with learning disabilities, Attention Deficit Hyperactivity Disorder (ADHD) or who are autistic⁴⁶. This support includes helping to access disability benefits such as Disability Living Allowance and Personal Independence Payments, applying for other disability services such as the Blue Badge and Short Breaks and help with making charity applications. They also offer Parenting Courses and advice. For families with children aged five and under they offer activities and coffee mornings. Barnet Mencap also have a range of services to support adults, and would seek to identify the best team to respond to any family who contacted them regarding a young person aged 18-25.

5.2.7 School nursing service

School nursing services provide early intervention support for the physical health and emotional wellbeing of all children in schools. This includes reviewing CYP who have Child Protection Plans. The team are piloting a drop-in service for CYP at ten secondary schools; CYP can drop-in or they may be referred by their school. Where school nurses identify self-harm, the young person may already be in contact with mental health services. However, where this is not the case, self-harm can be highlighted through a referral to the Multi-Agency Safeguarding Hub (MASH), with subsequent referrals to BICS or other services.

5.2.8 Looked After Children's Nursing Service

The Looked After Children's Nursing Service is a statutory service, which oversees the healthcare of children in care. The service offers health assessments twice a year for under 5s and annually for over 5s; this can include use of screening tools for mental health issues, as part of a wider health assessment. Staff in the Looked After Children's Service frequently encounter self-harm. The service will liaise with social workers to identify existing mental health support, and where CYP have not already been referred to mental health services, referrals can be made to BICS or CAMHS.

5.2.9 Pastoral Support in schools

While a safeguarding team is standard practice in mainstream education, pastoral care varies based on the needs of the school. The core offering typically includes learning mentors, counsellors, and form tutors who also have pastoral care responsibilities as part of their roles.

5.2.10 The Pavilion Whetstone, The Pavilion Meadway and Northgate School

This section highlights support for self-harm across three specialist educational settings.

The Pavilion Whetstone is a school which works with CYP with behavioural issues; these may co-exist with mental health issues and self-harm.

The Pavilion Meadway provides interim intervention for CYP whose health needs, including mental health challenges, prevent them from attending mainstream school.

Both the Pavilion Meadway and Whetstone sites have Mental Health First Aiders, an onsite counsellor, and access to CAMHS practitioners who support CYP who may be struggling with self-harming behaviours. While both settings can support lower-tier mental health needs, higher-risk cases are referred to specialist services.

The Northgate School, based at the Edgware Community Hospital (and linked to the Beacon Centre which is discussed further below) works with CYP requiring more intensive support. This may include those referred from other schools, from the Pavillion, or CYP admitted to the inpatient unit at the Beacon Centre.

5.2.11 Student support at Middlesex University

Middlesex University provides a wide range of support to students, including a dedicated team of mental health and wellbeing advisors, alongside a range of other support interventions⁴⁷.

5.2.12 Barnet Parent-Carer Forum

The Barnet Parent-Carer Forum offers signposting to the parents and carers of CYP experiencing mental health issues. This may include support on finding out whether a referral has been accepted as well as where CYP are on waiting lists. The Parent-Carer Forum may also signpost to online resources, services with self-referral pathways such as BICS and to non-statutory mental health services.

5.3 Getting Help

5.3.1 Barnet Kooth & Qwell

Barnet Kooth offer support within the Getting Advice and Getting Help sections of the Thrive model. Kooth provide digital, anonymous online advice and support around mental health⁴³, including for self-harm. CYP aged 10-25 can self-refer to Kooth, where they can access a live text chat, messaging with trained counsellors and emotional wellbeing practitioners and continue with weekly goal focused therapy if needed. Kooth also offers online forums with other CYP as well as access to activities, resources and articles to support with managing mental wellbeing.

Qwell are commissioned to provide equivalent support for all school staff and BELS staff in Barnet.

5.3.2 Barnet Educational Psychology Team

The Barnet Educational Psychology Team support CYP in educational settings with learning, relationship, behaviour and communication difficulties⁴⁸. This may be through training for staff or through development of the school's SEN or behaviour policies.

Self-harm may be one of several needs of CYP seen by Educational Psychology Teams. Typically CYP will be referred to Educational Psychology Teams for support with other needs such as ADHD, autism or learning needs, with self-harm identified later on.

Where Educational Psychology teams identify self-harm, they may offer training for education settings and parents and carers to develop their knowledge and skills around self-harm, in line with the Getting Advice section of Thrive. They may also work individually with CYP to consider alternative coping strategies, as per the Getting Help element of Thrive.

Educational Psychology Teams also work closely with BICS, and may refer onto BICS or CAMHS where required.

5.3.3 Terapia

Terapia is an organisation that offers training, Child and Adolescent counselling and psychotherapy⁴⁹. In Barnet Terapia work in schools and with other organisations to support CYP. Terapia also offer one-to-one support for CYP, and occasionally for parents and carers at a subsidised cost at their site in Finchley. CYP receiving support through counselling and psychotherapy from Terapia may have past or current self-harm.

5.3.4 Rephael House

Rephael House is a charity that offers counselling services to CYP⁵⁰. They offer two counselling services in Barnet, both of which may be accessed by CYP who are self-harming. Referrals can be via CAMHS, GP practices, schools, social workers or through self-referrals. Rephael House offer a 12 week service commissioned by CAMHS; this service is for those with lower levels of need and may include support for self-harm. They also offer a paid service which includes a year of counselling for those aged under 18, or two years for those over 18. This service is for those with more complex needs and in the context of self-harm may be more suitable for those with longstanding self-harm or those who are experiencing suicidal intent alongside self-harm, as this service allows for long-term support. Both services offered by Rephael House are outlined here in order to give a comprehensive overview of the services they provide. However, other private services are generally not discussed within this HNA.

5.3.5 Barnet Integrated Clinical Services (BICS)

BICS is a clinical service, supporting children and young people's mental health and emotional wellbeing. They are embedded into Family Services within the London Borough of Barnet and work across Early Help and Children's Social Care settings, both within schools, the community and virtually. BICS supports CYP and their families who either live in the borough or attend a Barnet school, offering a range of group, individual and family evidence-based interventions, alongside workshops, staff training, consultations, online resources, and

signposting. BICS can link in with other services in Barnet's or a family's network, including stepping up to CAMHS if more appropriate. BICS also run a support line to facilitate discussion around appropriateness of potential referrals or other queries and signposting. They are, however, not an emergency service.

BICS is split into five teams. The Early Years Parenting Hub for families with children aged 0-5 is a specialist service offering multi-family interventions, including group and individual Mentalisation Based Treatment (MBT), video feedback and guidance, and parent-child attachment-based work. BICS Children Social Care team have Clinical Practitioners embedded throughout Barnet's Social Work teams. BICS also have three multidisciplinary Early Help teams including Wellbeing Practitioners in the community and in schools, alongside a variety of Clinical Practitioners with varied therapeutic training backgrounds. There are additional clinical staff who BICS support within the Resilient, Engaged, Achieving Children Hub (REACH) Programme, the Youth Justice Service (YJS) and Residential Homes, however they are fully embedded, and line managed within their respective teams.

In term of self-harm, BICS have delivered parent and carer workshops on supporting a young person with low mood which includes talking about self-harm. They have also delivered workshops to young people in schools, joined their Early Help colleagues to deliver sessions as part of groups to parents and CYP, and delivered training to wider Family Services colleagues and multiagency professionals. Clinicians can also support individuals when the presentation fits within the Getting Advice and Getting Help domains of Thrive, and will step up to CAMHS where more appropriate.

5.4 Getting More Help

5.4.1 Barnet CAMHS

North London Foundation Trust (NLFT) provides CAMHS services in Barnet. Referrals are through the single point of access for CYP in Barnet, Enfield and Haringey⁵¹.

5.4.2 The Barnet CAMHS Generic Team

The Barnet CAMHS Generic Team offer assessment, treatment and specialist intervention for CYP up to the age of 18⁵² in line with the Getting Help or Getting More Help domains of Thrive. The Generic Team is a multidisciplinary team comprised of psychiatry, clinical and counselling psychology, family therapy, nursing, child and adolescent psychotherapy, arts therapies and allied health professionals.

CYP who present with complex moderate to severe mental health and emotional difficulties are offered evidence-based interventions in the form of individual therapy, psychoeducation workshops, group work and family therapy interventions. The range of emotional difficulties supported by CAMHS may include depression, anxiety, conduct disorder, trauma, suicidal behaviours and self-harming behaviours. Neurodiversity may be present alongside these difficulties.

5.4.3 Barnet Enhanced Support Team (BEST)

BEST is a multidisciplinary service in Barnet for CYP aged 13-18 with complex mental health needs and serious mental health issues⁵³. This service includes psychiatrists, psychotherapists, psychologists, family therapists and social workers. Within the context of self-harm, BEST will support those with higher risk self-harm behaviours.

5.4.3 Barnet Service for Children and Adolescents with Neurodevelopmental Difficulties (SCAN)

Barnet SCAN are a multidisciplinary team who offer a full CAMHS provision to children and adolescents aged 0-17 with a diagnosis of moderate to severe Learning Disability and co-existing mental health problems. The young person also has to be registered with a Barnet GP and attend a specialist school provision.

The team offers positive behaviour support, family therapy and psychiatry interventions. They also carry out assessments for autism and ADHD for those aged 7 and above. Autism and ADHD assessments for younger children are carried out by paediatric teams. Referrals to the team are through the CAMHS single point of access.

5.4.4 Barnet Neurodevelopmental team

The neurodevelopmental team are comprised of nurses, psychologists, psychiatrists, assistant psychologists and clerical administrators and work with CYP aged 0-17. The team offer neurodevelopmental assessments for ADHD and ASD for those aged 7 and above and post-diagnosis offer psychoeducation on ADHD as well as prescribing of medication used in the treatment of ADHD. Referrals to the team are through the CAMHS single point of access.

5.4.5 Barnet 18-25 Transition Pathway

The 18-25 Transitions Pathway Team work with CYP who are residents in Barnet to ensure that every young person already under CAMHS is identified within 6 months of their 18th birthday and assessed for further support. They can also work with individuals who are over 18 and have a history in CAMHS, and consider cases for those aged 18-25 where they would benefit from the specialist skills of the team. The team do not hold cases in their own right and therefore will only work with CYP who are open to another team, where there is a destination team into which they can support transition. The team offers a range of support around transition. This includes liaising between mental health services, supporting education and job applications, providing mental health support such as interventions for anxiety and sleep, and helping CYP to engage with their local communities.

5.5 Getting Risk Support

5.5.1 NLFT 24/7 Crisis Line

A 24/7 Crisis Line is in operation across NLFT, which CYP and their families can contact for Crisis support. The Crisis line may direct CYP to A&E if medical intervention is required, or to the Barnet, Enfield and Haringey Crisis Response service, discussed below.

5.5.2 Barnet, Enfield and Haringey Children and Young People's Mental Health (CYPMH) 24/7 Crisis Response Service

In April 2025, a CYPMH 24/7 Crisis Response Service (CRS) was established across Barnet, Enfield and Haringey for CYP aged 0-17. This service includes a 24/7 telephone number which professionals, including schools, can use to contact the CRS team directly if they are concerned about a young person. A clinician from the CRS will then triage the referral. If medical intervention is required, CYP will be directed to A&E at Barnet Hospital or North Middlesex University Hospital (NMUH). These CYP will be seen in A&E departments by the CRS team, within one hour of referral. The CRS at Barnet Hospital and NMUH is a 24/7 service.

However, where possible the CRS aims to divert away from A&E. Therefore, where medical intervention is not required, the CRS will review CYP in Barnet, Enfield and Haringey at their nearest CAMHS base, in as little as one hour, depending on risk. This diversion service currently operates 9am-5pm Monday-Friday, however there are plans to offer this as a 24/7 provision.

Where CYP are not known to CAMHS they will be followed up by CRS within 7 days depending on risk. Where CYP are already known to CAMHS, they will be followed up by their CAMHS team after assessment by the CRS. This offer is designed to ensure continuity of care. It is important to note that the CRS sits alongside the Crisis Line described in Section 5.5.1, and does not replace this.

CYP over the age of 18 presenting to Barnet Hospital or NMUH will be seen by adult psychiatry liaison services; this service is also a 24/7 provision.

5.5.3 Liaison teams and Crisis Hub

A CAMHS liaison service for those aged 0-17 previously operated between 9am-5pm Monday-Friday at Barnet Hospital and NMUH, however this has now been replaced by the CRS outlined above. A CAMHS liaison service still operates at three other acute medical hospitals in North Central London (NCL), which may be accessed by CYP living in Barnet. These are at the Royal Free Hospital (RFH), Whittington Hospital and University College London Hospital (UCLH). Part of the role of these liaison teams is to undertake assessments of CYP in crisis.

In addition to this, a Crisis Hub also operates in Islington, commissioned by Whittington Health. A Crisis Hub previously also operated in Barnet, however this has also been replaced by the 24/7 CRS outlined above. The Crisis Hub allows those CYP aged 0-17 who have been seen by a GP and who do not require medical intervention, to be diverted away from A&E if they are in crisis, and to be seen at the Crisis Hub instead.

The hospital-based liaison teams will receive referrals from the A&E and from hospital wards, whilst the Crisis Hub will receive referrals from General Practitioners (GPs) and community-based mental health teams.

5.5.4 Out of Hours (OOH) Crisis Service

The OOH Crisis Service operates across NCL, based out of the RFH for CYP age 0-17. This service operates at the five hospital sites discussed above, as well as a Crisis Hub in Islington. This service operates 7 days per week for 12 hours per day between midday and midnight. A CAMHS Consultant psychiatrist also provides out of hours support for Barnet Hospital and NMUH. For the other three hospitals, out of hours support is available from both a CAMHS Consultant psychiatrist and psychiatry registrar. The OOH Crisis team do not respond to Section

136 referrals, so responsibility for this sits with the Consultant and registrar. Alongside this, support is also provided by a senior clinician 7 days per week from different teams within NCL.

As noted above, a 24/7 CRS is now in place at Barnet and NMUH. However, at present the OOH service also continues to operate at these sites, and can support the CRS between midday and midnight when required. CYP from Barnet seen by the OOH Crisis Service at any site in NCL, will subsequently receive follow up from CRS.

5.5.5 Home Treatment Team (HTT) & Beacon Centre

The HTT work with high risk CYP aged 12-17 to support them in the community, with the goal of preventing admissions.

The Beacon Centre, based on the Edgware Community Hospital site, includes a 15-person inpatient unit and a 5-person day unit. The Beacon Centre provides crisis support to CYP aged 13-17.

The Beacon Centre have recently undertaken quality improvement work around self-harm. In recent months self-harm on the unit has been low due to a range of measures including staff training, senior presence on the floor, consistency with ward debriefs and safety huddles and robust reviews of paperwork at admission to ensure it is appropriate for the young person to be admitted to the ward. The Beacon Centre plans to sustain this work through ensuring staff training needs are regularly reviewed, provision of further training for staff including input from the CAMHS co-production team, greater embedding of debriefs and safety huddles and the creation of a flowchart to facilitate ongoing robust reviews of paperwork at admission.

5.5.6 London Ambulance Service (LAS)

When receiving callouts for self-harm, LAS will perform an initial assessment and then convey CYP to an appropriate setting for further care. Most often LAS in Barnet will convey CYP who have self-harmed to a hospital, typically Barnet Hospital. At times LAS may try to access alternative care pathways for CYP who have self-harmed, such as via their GP or via mental health services, however it can be challenging to find alternatives to A&E for CYP who have self-harmed.

6. The epidemiology of self-harm in Barnet

This section outlines the available data on self-harm among CYP in Barnet. This includes hospital attendances, hospital admissions, LAS data, data from NHS crisis services and data from some other mental health service providers. It has not been possible to obtain inpatient data for mental health units or outpatient data for CAMHS services. For some providers, exact numbers of CYP known to services and experiencing self-harm was not possible to obtain, as this data would only be available in case notes. In such cases, data from the service was either not presented, or where available, surrogate measures such as the number of referrals for self-harm were used instead.

6.1 Language note

Much of the data available for this HNA is aggregated by sex, specifically the categories of male and female. As this is the language used in the data, it is also the language used when the data

is reported in the HNA. However, it is important to note that this data therefore may not necessarily capture the gender identity of CYP who are self-harming. This is particularly important as it is recognised that transgender and gender diverse individuals have an increased risk of self-harm⁵⁴.

6.2 Hospital attendances for self-harm

This section presents A&E, Urgent Care Centre and Walk-In Centre attendances for self-harm among Barnet residents. The total number of attendances has decreased slightly each year from 2022/23 onwards. Female patients make up a majority of attendances. This data is derived from the Emergency Care Data Set (ECDS)⁵⁵ and as per National Health Service (NHS) data rules, values between one and seven are not reported and all remaining figures are rounded to the nearest five. Where percentages are reported, these have been calculated from rounded figures, which may cause some slight inaccuracies in percentage data. Data prior to 2021/22 is not presented due to poor coding completion.

6.2.1 Total attendances

Figure 7 shows the total number of attendances for CYP living in Barnet. Attendances have declined slightly since 2022/23. The lower total in 2021/22 may be due to poor data collection in this financial year, as opposed to a true lower number of attendances.

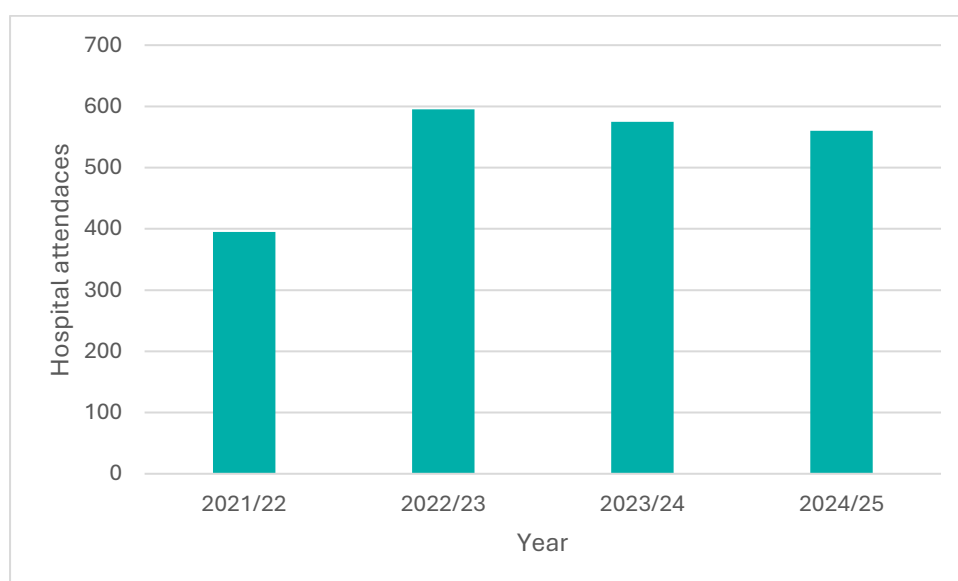


Figure 7. Self-Harm A&E, Urgent Care Centre and Walk-in Centre attendances for Barnet residents aged 0-25

6.2.2 Attendances by sex

Figure 8 shows the percentage of hospital attendances by sex from 2021/22 to 2024/25. In this period there were a total of 1335 attendances among females, compared to 790 attendances among males.

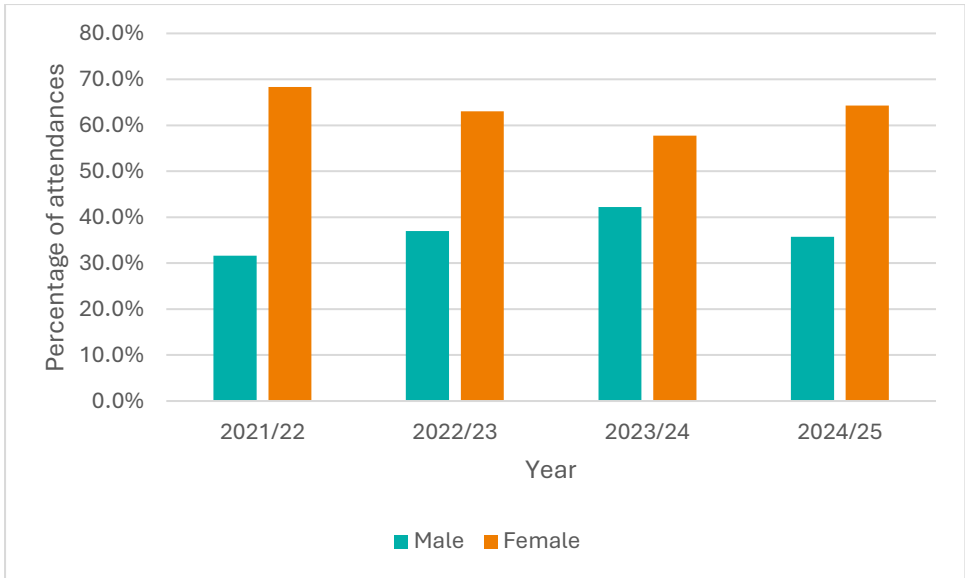


Figure 8. Self-Harm A&E, Urgent Care Centre and Walk-in Centre attendances for Barnet residents aged 0-25 by sex

6.2.3 Attendances by age

Figure 9 shows hospital attendances for self-harm broken down by age. Over the four financial years for which data is presented, attendances were highest for those aged 16-20 (26.8% of all attendances). This was followed by those aged 11-15 (24.7%). All attendances for patients aged 0-5, and many attendances for patients aged 6-10, are coded as self-inflicted injury, but not as self-harm, which may suggest these attendances were related to accidental self-injury rather than self-harm specifically.

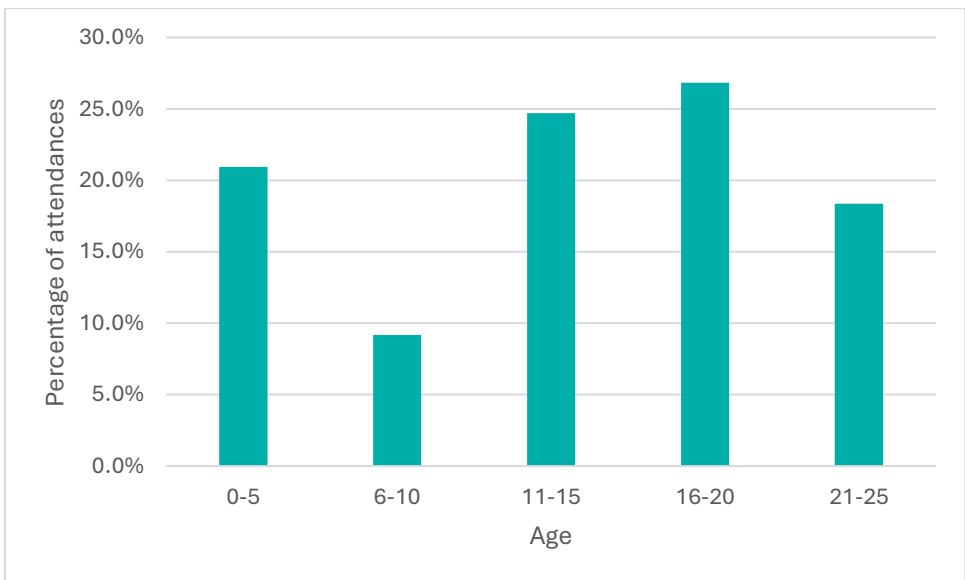


Figure 9. Self-Harm A&E, Urgent Care Centre and Walk-in Centre attendances for Barnet residents aged 0-25 by age band

6.2.4 Attendances by ethnicity

Figure 10 shows attendances for self-harm by ethnicity as compared to the 2021 Census. Those from a White background have a similar representation in both self-harm attendances and in

the Census. Those in an Other ethnic group appear to be overrepresented in terms of attendances, whilst those from Asian, Black and Mixed backgrounds are underrepresented. Of note, ECDS data includes 'Unknown' as a category, whilst the 2021 Census did not have this category, which limits this comparison. It is also important to note that self-harm attendance data is for those aged 0-25, whilst the Census data is for those aged 0-24.

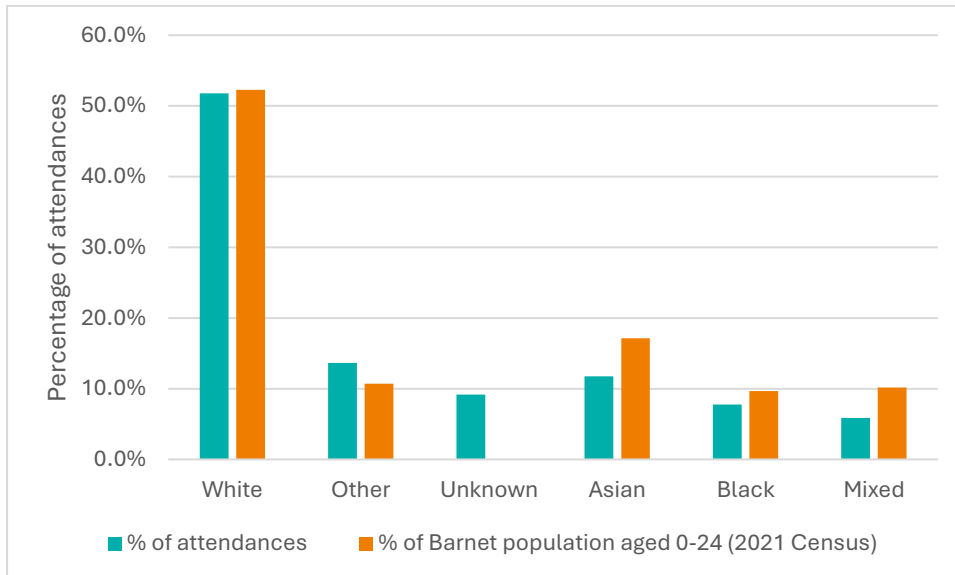


Figure 10. Self-Harm A&E, Urgent Care Centre and Walk-in Centre attendances for Barnet residents aged 0-25 by ethnicity, as compared to the 2021 Census

6.2.5 Attendance by socioeconomic status

Figure 11 shows self-harm attendances by Index of Multiple Deprivation (IMD) quintile, where 1 is the most deprived quintile and 5 is the least deprived, as compared to the 2021 Census. The three most deprived quintiles are slightly overrepresented in terms of attendances, whilst the two least deprived quintiles are slightly underrepresented. This analysis excludes 10 individuals for whom the deprivation quintile could not be derived. As with the data on ethnicity, self-harm attendance data is for those aged 0-25, whilst Census data is for those aged 0-24.

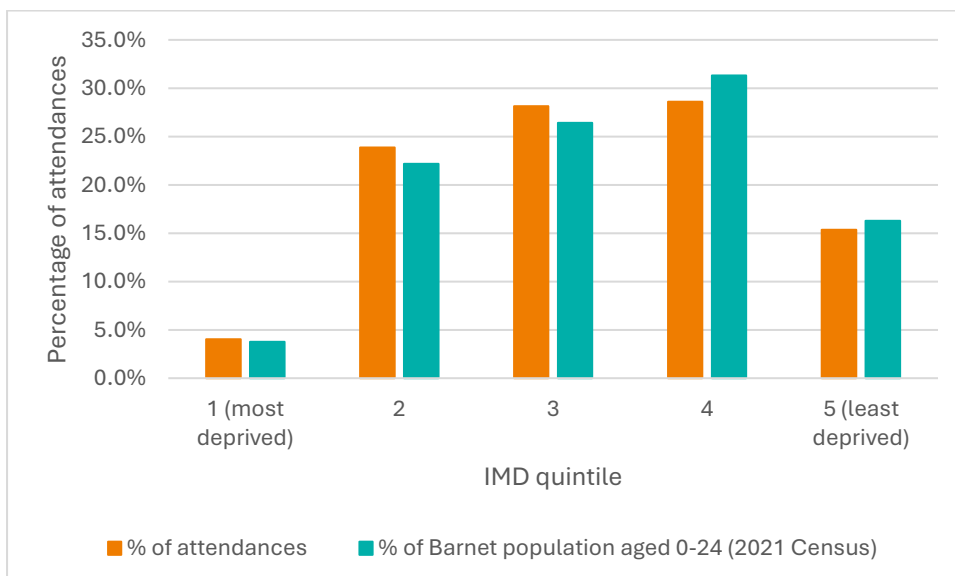


Figure 11. Self-Harm A&E, Urgent Care Centre and Walk-in Centre attendances for Barnet residents aged 0-25 by IMD quintile, compared to IMD quintiles for Barnet residents aged 0-24 in the 2021 Census

6.3 Hospital admissions for self-harm

This section outlines data on hospital admissions for self-harm for CYP living in Barnet aged 0-25 (or in some cases 10-24), derived from Admitted Patient Care (APC) data within Hospital Episode Statistics (HES)⁵⁶. In some cases, data originating from the APC dataset has been taken from the Office for Health Improvement and Disparities' Fingertips data⁵⁷. This section includes data on Barnet residents admitted to sites in Barnet as well as instances where Barnet residents were admitted outside of the borough. Comparison is also provided to the other NCL boroughs, and to London and England. It is important to note that due to the nature of the HES dataset the admissions for Barnet residents were largely to acute medical Trusts, and so represent admissions to medical wards, rather than admissions to mental health units.

As with the previous section on hospital attendances, figures between one and seven are not reported and other counts are rounded to the nearest five. Where percentages are reported, these have been calculated from rounded figures.

6.3.1 Total admissions

Figure 12 shows the overall numbers of admissions for self-harm among Barnet residents for ten financial years, from 2014/15 to 2023/24. The number of admissions peaked in 2021/22 at 205, with a reduction to 145 seen in both 2022/23 and 2023/24.

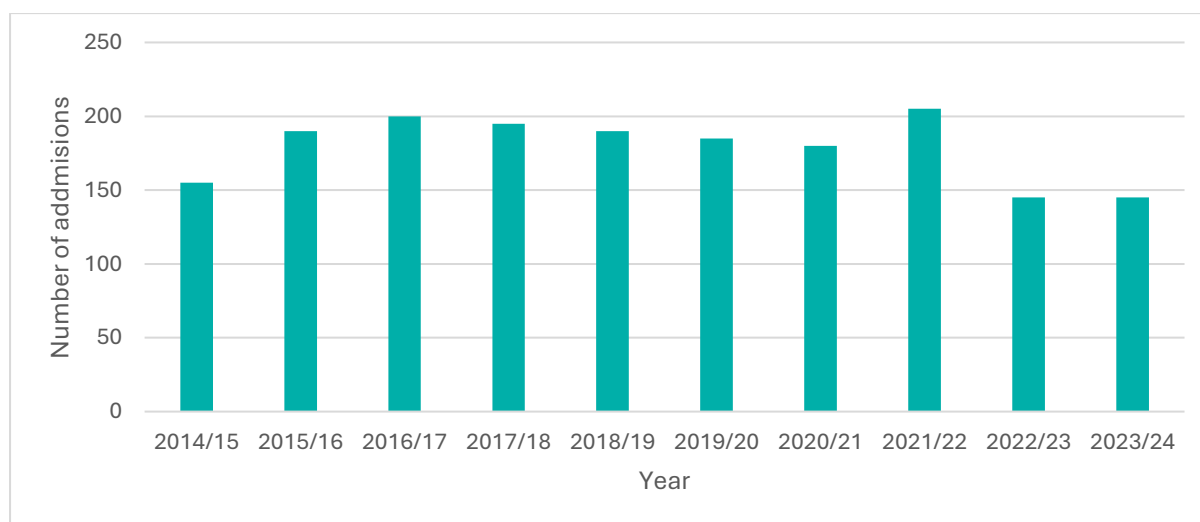


Figure 12. Hospital admissions as a result of self-harm for Barnet residents aged 0-25

Figure 13 shows self-harm admissions across London in this same time period. This data similarly demonstrates a peak of admissions in 2021-22, with a decline in this figure in more recent years.

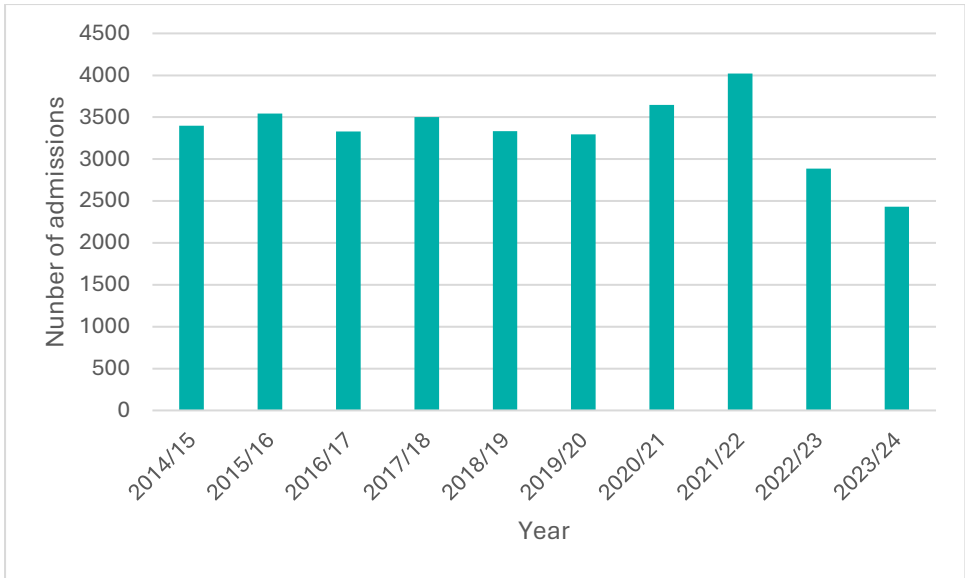


Figure 13. Hospital admissions as a result of self-harm for London residents aged 0-25

Figure 14 shows rates of hospital admissions as a result of self-harm for CYP age 10-24 in Barnet, with regional and national comparisons⁵⁸. Rates of admissions have fallen locally, regionally and nationally since 2021/22. Rates of hospital admissions for self-harm in Barnet are significantly lower than those for England. However, rates of admissions in Barnet are higher than regional levels, with this difference being statistically significant in 2023/24⁵⁸.

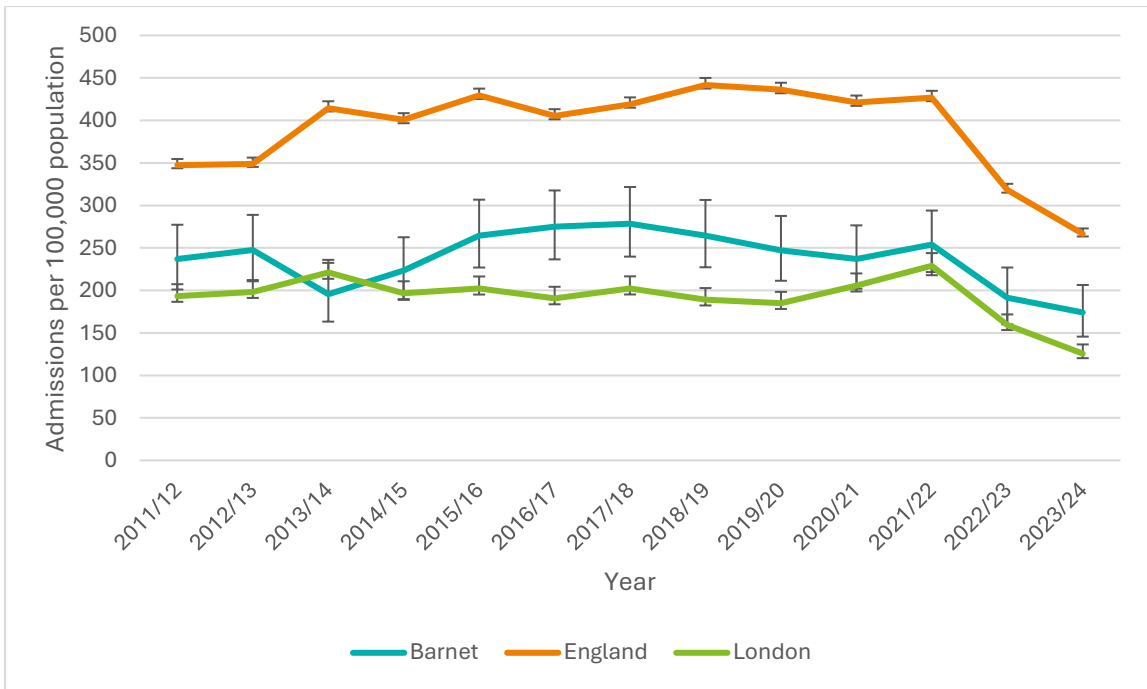


Figure 14. Rates of hospital admissions as a result of self-harm for Barnet, London and England residents aged 10-24, per 100,000 population⁵⁸

Figure 15 shows hospital admissions as a result of self-harm for CYP aged 10-24 living in Barnet, as compared to the other NCL boroughs⁵⁸. Since 2021/22 rates of admissions in Barnet have generally been higher than in some neighbouring NCL boroughs. In 2023/24 Barnet had the

second highest rates of admissions within NCL, with the highest rates seen in Islington. However only rates in Enfield were significantly lower than those seen in Barnet⁵⁸.

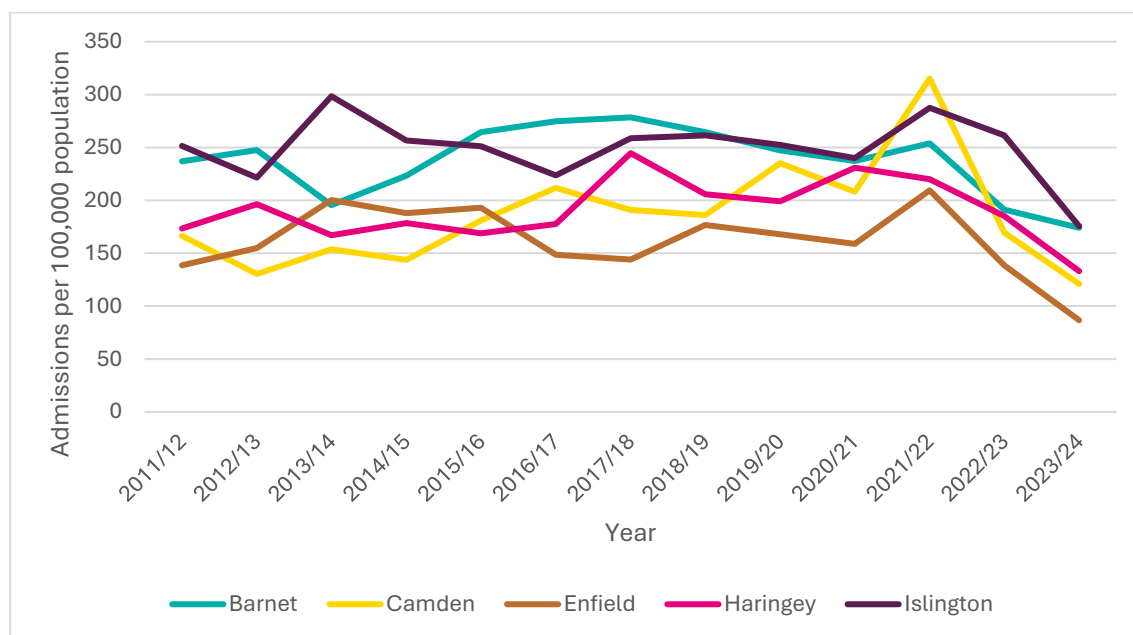


Figure 15. Rates of hospital admissions as a result of self-harm for NCL residents aged 10-24, per 100,000 population

6.3.2 Admissions by sex

Figure 16 shows hospital admissions by sex between 2014 and 2024. Over 70% of admissions have consistently been among females, and most recently in 2023/24 82.8% of CYP admitted to hospital as a result of self-harm were female.

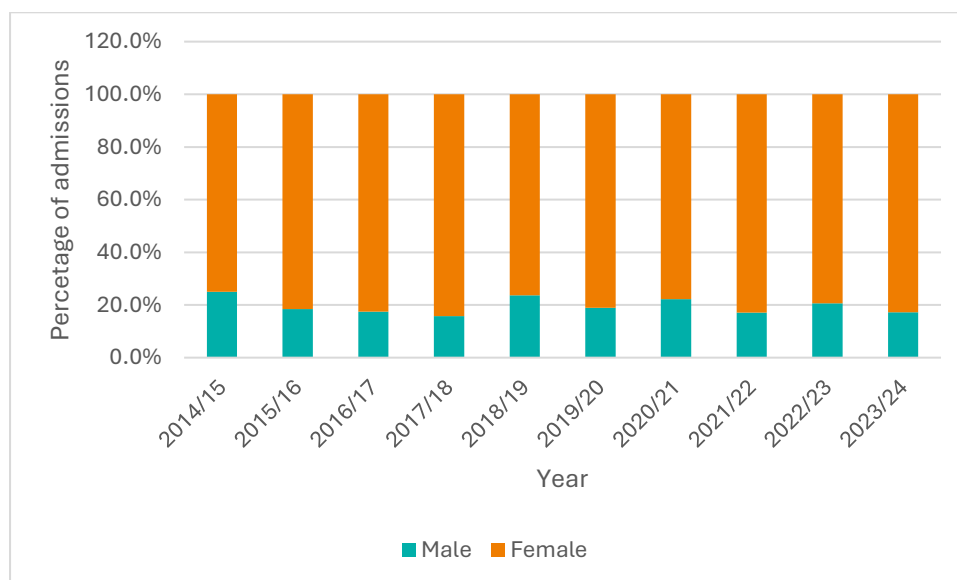


Figure 16. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by sex

Rates of hospital admissions as a result of self-harm among females in Barnet, are shown in Figure 17, as compared to rates in London and in England⁵⁸. Rates in Barnet are significantly lower than in England, but as seen for overall admissions Barnet admissions were significantly higher than London in 2023/24.

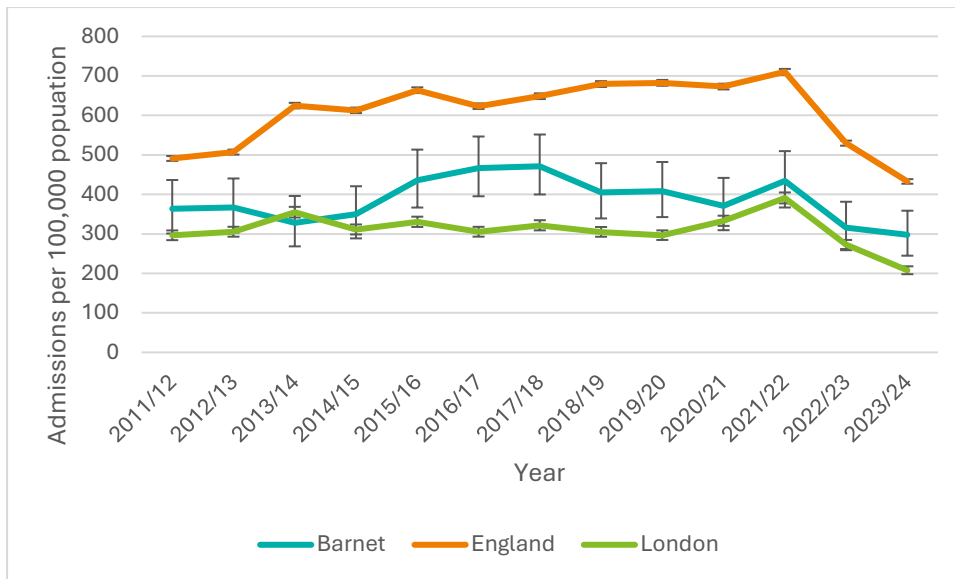


Figure 17. Rates of hospital admissions as a result of self-harm for females in Barnet, London and England aged 10-24, per 100,000 population

Figure 18 compares self-harm admissions for males in Barnet to London and England⁵⁸. Rates in Barnet are higher than for London, however the overall number of male CYP presenting with self-harm in Barnet is small. The confidence intervals are therefore wider for these data points and the differences between Barnet and London are not statistically significant. This could suggest that the higher rates of admissions in Barnet compared to London are predominantly due to higher rates of female admissions.

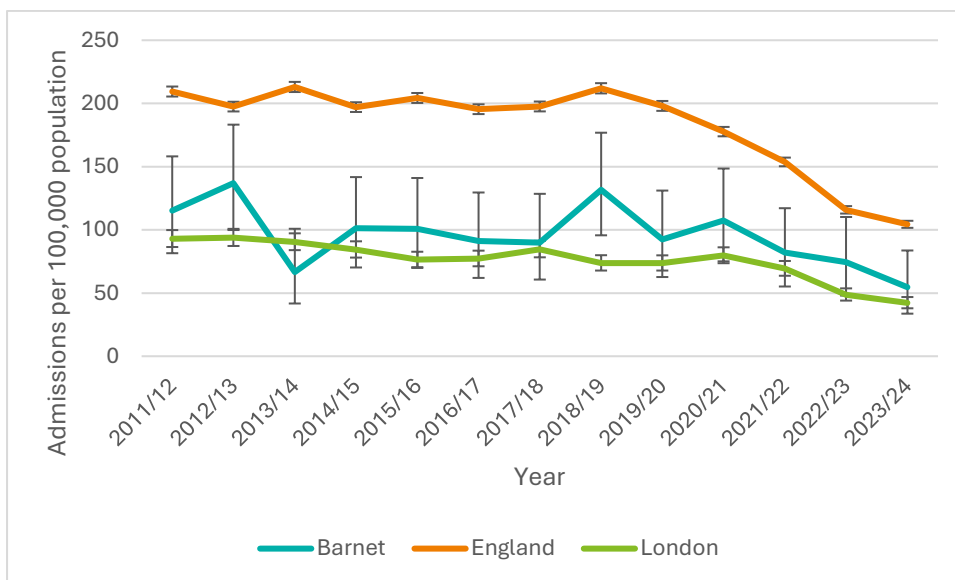


Figure 18. Rates of hospital admissions as a result of self-harm for males in Barnet, London and England aged 10-24, per 100,000 population.

Comparisons between Barnet and NCL boroughs for male and female CYP admitted due to self-harm are shown in Figures 19 and 20⁵⁸. For females, rates in Barnet in 2023/24 were higher than other NCL boroughs (297.8 per 100,000 population), however only rates in Enfield were significantly lower than in Barnet. Based on the data available, rates of admissions for Barnet

are also higher in males than in other NCL boroughs. However, rates of male admissions for some boroughs could not be calculated as the number of cases was too small.

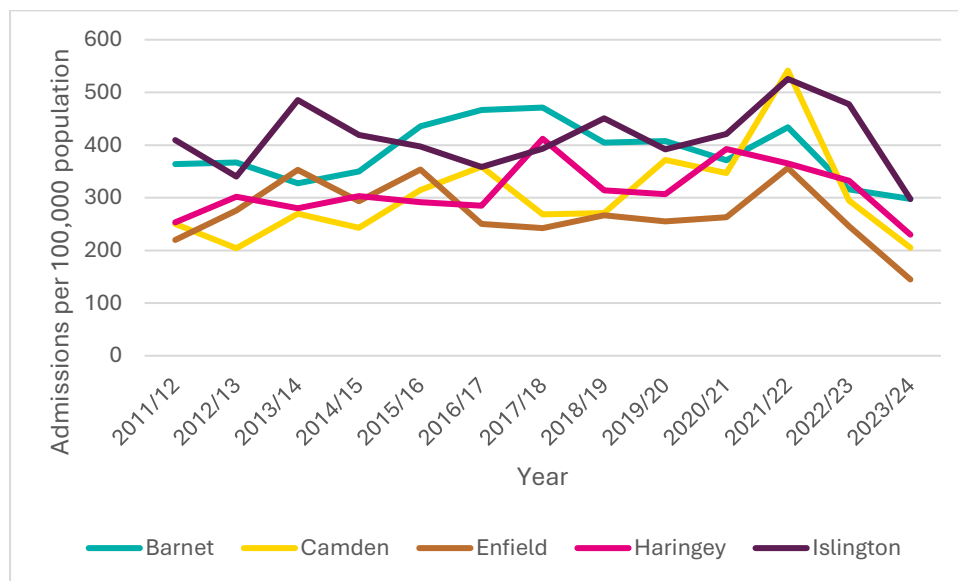


Figure 19. Rates of hospital admissions as a result of self-harm for females in NCL boroughs aged 10-24, per 100,000 population

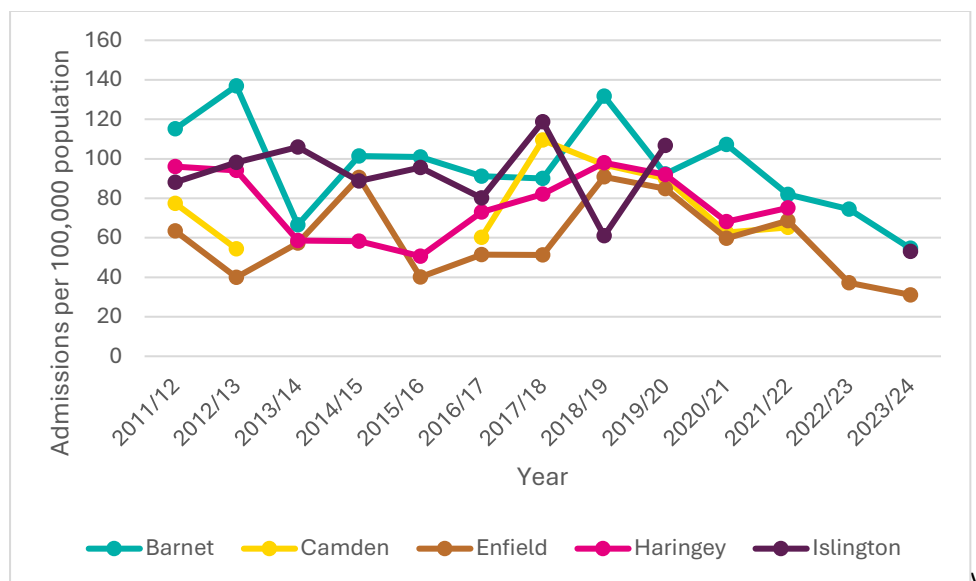


Figure 20. Rates of hospital admissions as a result of self-harm for males in NCL boroughs aged 10-24, per 100,000 population

6.3.3 Admissions by age

Figure 21 shows self-harm admissions in Barnet by age between 2014 and 2024. The highest proportion of admissions was in those aged 15 (16.0%), this was followed by those aged 17 (14.8%) and then those aged 14 (12.6%).

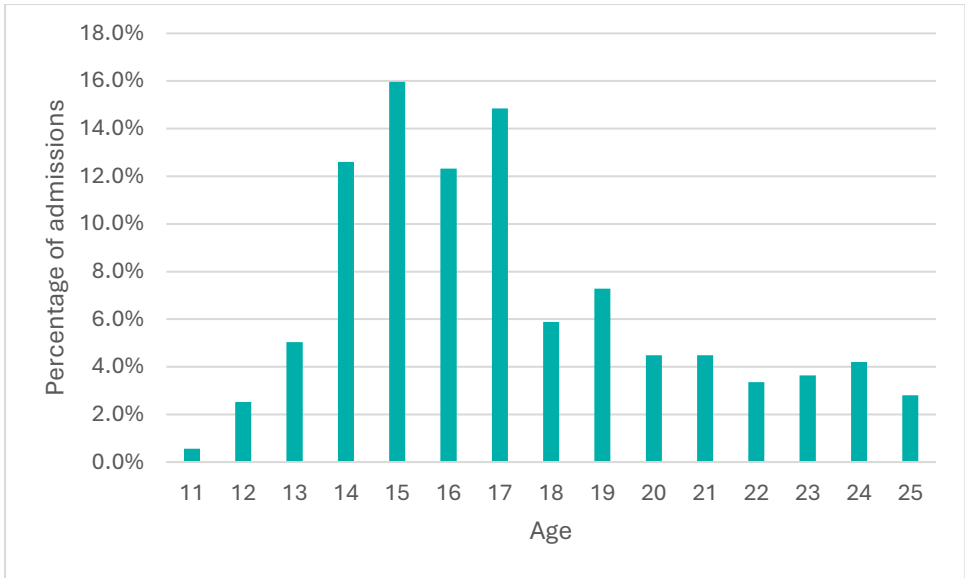


Figure 21. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 for 2014/15 to 2023/24, by age

Figure 22 shows changes over time in the age profile of those admitted as a result of self-harm. Historically admissions have been highest in those aged 15-19, followed by those aged 20-25 and lowest among CYP aged 10-14. However, in recent years there appears to be a rise in admissions among 10-14 year olds. In 2023/24, 10-14 year olds accounted for 41.4% of admissions, 15-19 year olds for 51.7% of admissions and 20-25 year olds made up 6.9% of admissions, suggesting a potential rising area of need in the population aged 10-14. As this change was seen for the first time in 2023/24, it will be important to monitor data to ascertain if this change persists.

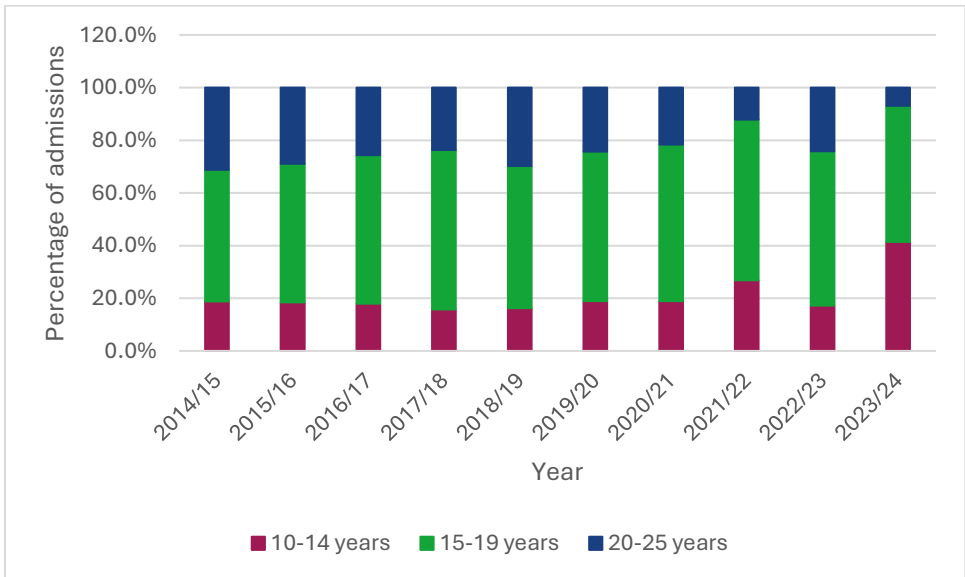


Figure 22. Hospital admissions as a result of self-harm for Barnet residents aged 0-25, by age

Given the high proportion of admissions among 15-19 year olds, Figure 23 shows a comparison of admissions in this age group alongside admission rates for Barnet and England⁵⁹. Notably in this age group, admissions in Barnet are significantly higher than London levels, representing a

key area of additional need. In contrast to this, admissions for 10-14 year olds⁶⁰ and 20-24 year olds⁶¹ in Barnet are not significantly higher than London averages.

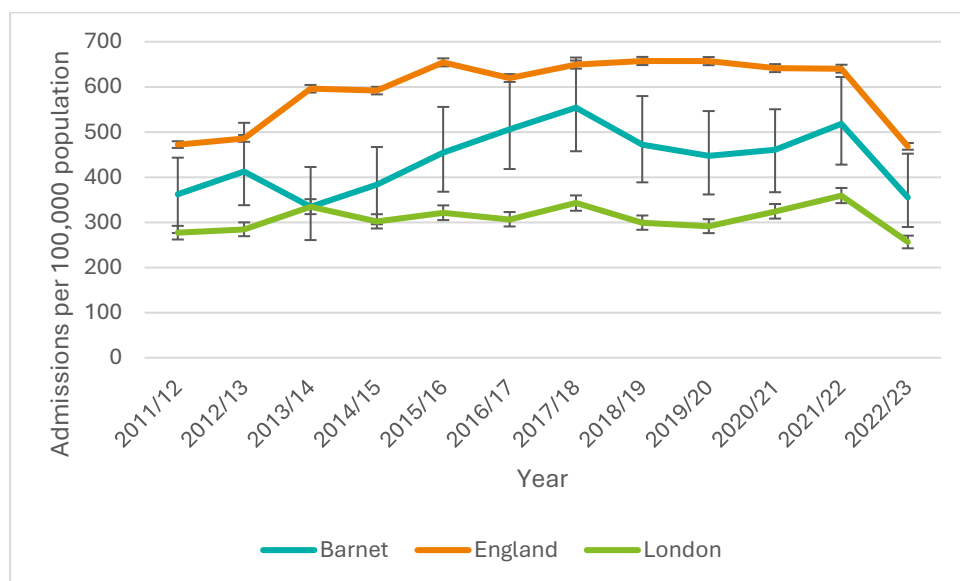


Figure 23. Rates of hospital admissions as a result of self-harm for Barnet, London and England residents aged 15-19, per 100,000 population

To explore this difference further, Figure 24 presents a comparison to London and England for female patients only. When considering female patients aged 15-19, self-harm admissions in Barnet remain significantly higher than for London⁵⁹. This statistically significant difference was not seen in 2023/24 for among female CYP aged 10-14⁶⁰ or 20-24⁶¹, nor is it seen in the age breakdowns for male CYP⁵⁹⁻⁶¹.

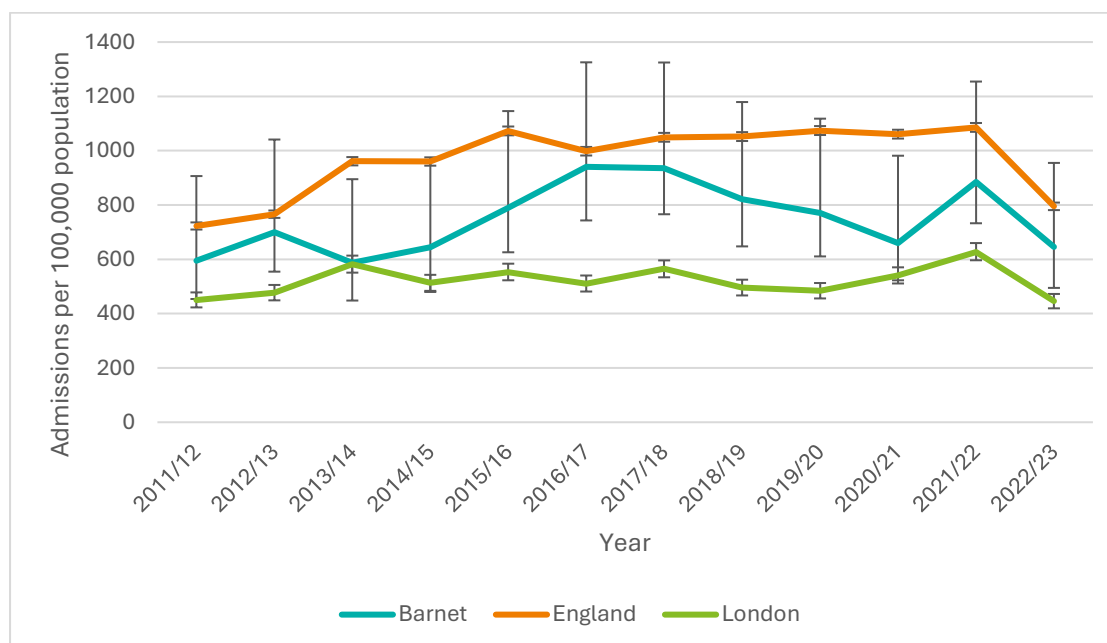


Figure 24. Rates of hospital admissions as a result of self-harm for females in Barnet, London and England aged 15-19, per 100,000 population

6.3.4 Admissions by ethnicity

Figure 25 shows hospital admissions for self-harm by ethnicity, as compared to data for Barnet residents in the 2021 Census. Those from a White background and Other ethnic background are overrepresented in admissions as compared to the Census. Those from Asian, Black and Mixed backgrounds are underrepresented, similarly to the data for hospital attendances. Of note, APC data includes ‘Not known’ as a category, whilst the 2021 Census did not have this category, which limits this comparison. In addition, self-harm attendance data is for those aged 0-25, whilst the Census data is for those aged 0-24.

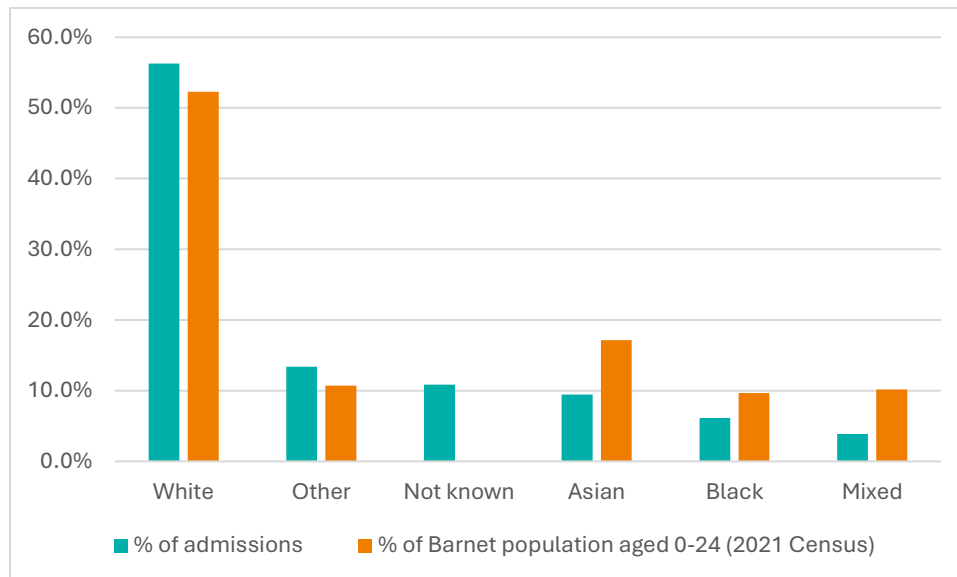


Figure 25. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by ethnicity, as compared to the 2021 Census

6.3.5 Admissions by socioeconomic status

Figure 26 makes a comparison between the percentage of admissions as a result of self-harm for each IMD quintile, and the percentage of the population belonging to each IMD quintile in Barnet as per the 2021 Census. Importantly, those belonging to the most deprived quintile are overrepresented in terms of admissions as a result of self-harm, whereas those in the least deprived quintile are underrepresented. This is in line with other sources that report an association between increased deprivation and increased rates of self-harm⁴. However, this trend is not seen clearly throughout the data; those in the third quintile for example are overrepresented in admissions whilst the second quintile is underrepresented. This suggests that associations with deprivation in Barnet may not fully follow trends seen elsewhere.

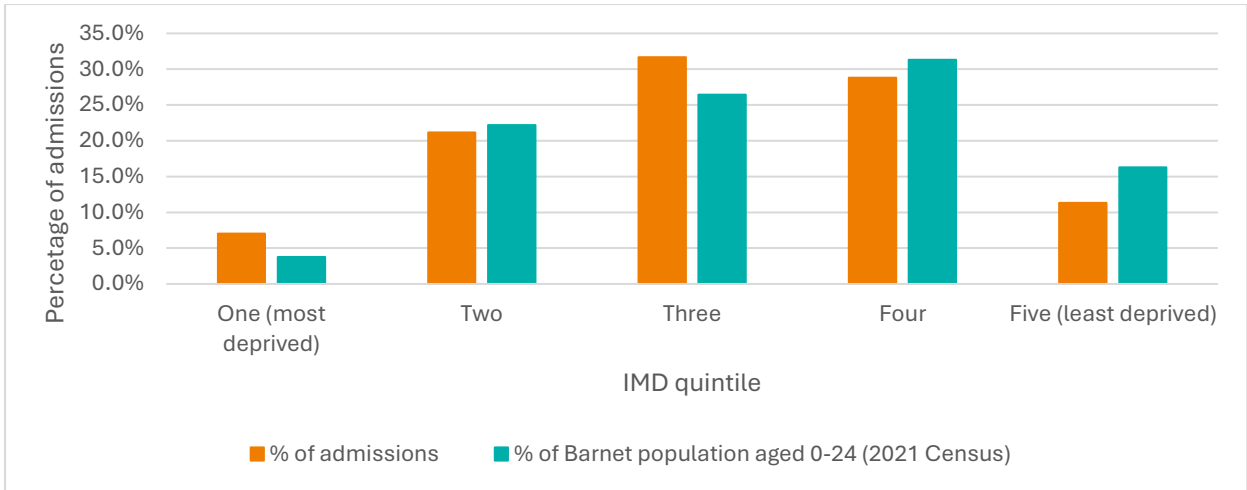


Figure 26. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by socioeconomic status, as compared to the 2021 Census

6.3.6 Monthly and weekly variations in admissions

Figure 27 shows hospital admissions for self-harm between 2014 and 2024 by month. Notably, there is a slight rise in admissions in the March-May period, in line with the lead up to school and university examinations. There is also a peak in attendances in November, potentially correlated with the start of winter.

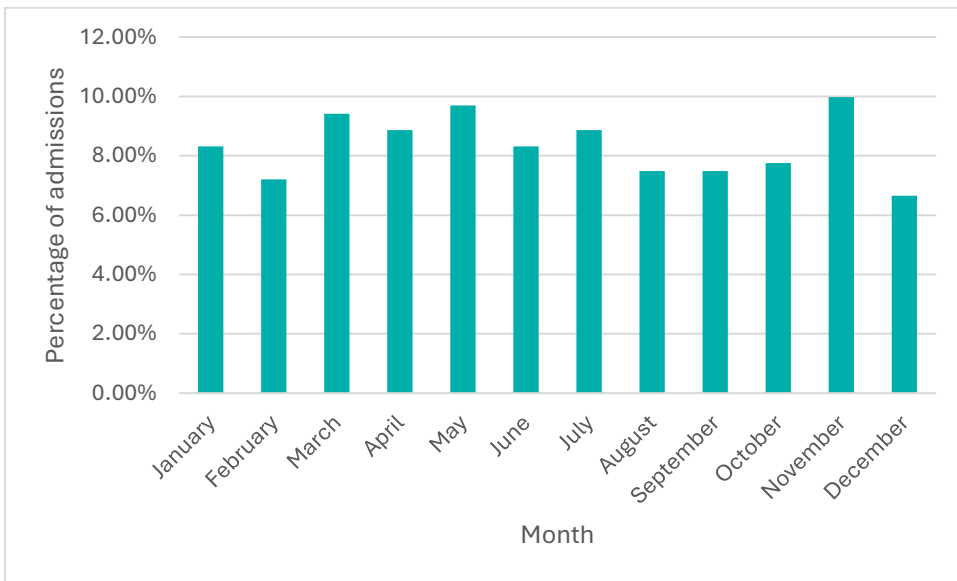


Figure 27. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by month

Figure 28 shows the monthly variations in admissions for specific age groups of CYP. For those aged 15-16 there is a peak in admissions in April. This may be correlated with the lead up to General Certificate of Secondary Education (GCSE) examinations, which this age group undertake. For those aged 17-18, there is a peak in admissions in May, potentially reflective of the Advanced Level (A-Level) examination period which commences slightly later. Finally for those aged 19-20 there are peaks in March and August. The March dates may correlate with the lead up to university deadlines and examinations whereas the peak in August may correlate

with the lead up to the start of a new academic year. It is not possible to present data on those who would be transitioning from primary to secondary education, due to small counts.

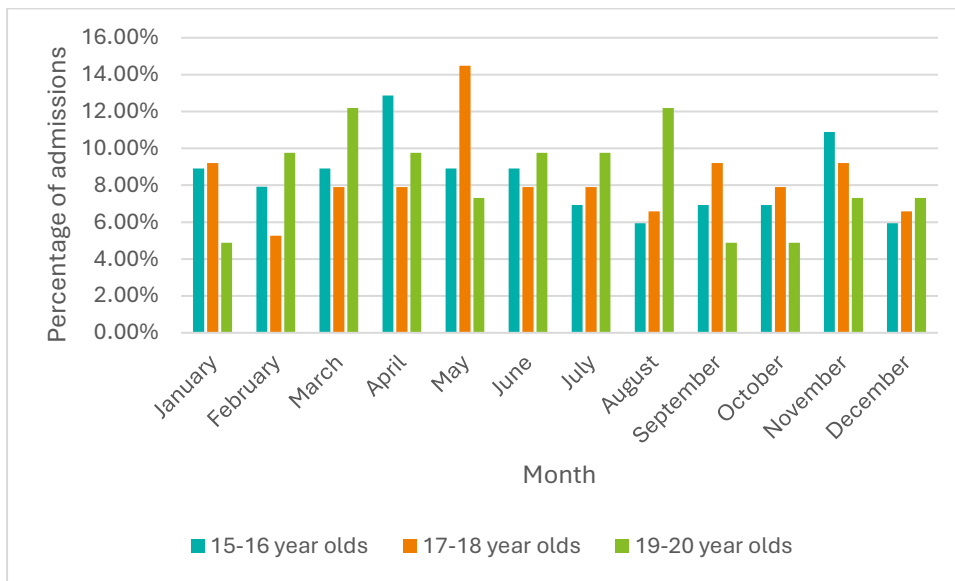


Figure 28. Hospital admissions as a result of self-harm for Barnet residents aged 15-16, 17-18 and 19-20 by month

The percentage of admissions by day of the week is shown in Figure 29. Notably, there is a peak in admissions on Mondays, coinciding with the start of the school and working week, with the lowest numbers of admissions seen on Friday and over the weekend.

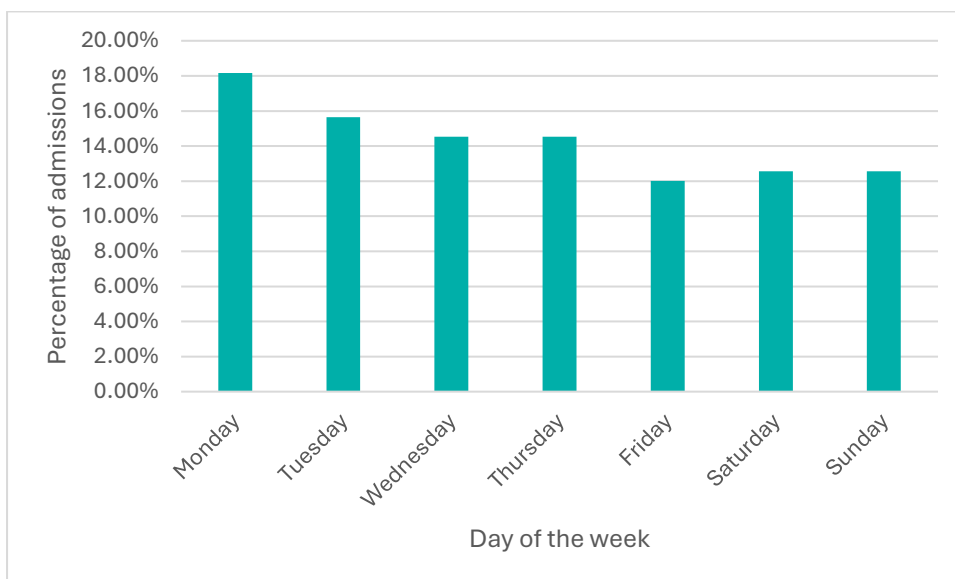


Figure 29. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by day of the week

6.3.7 Repeat admissions

In Barnet, approximately three quarters of those admitted for self-harm between 2014-2024 were only admitted on a single occasion (Figure 30). However approximately a quarter of presentations were by those with multiple admissions, suggesting that there is unmet need around prevention of re-presentation and readmission.

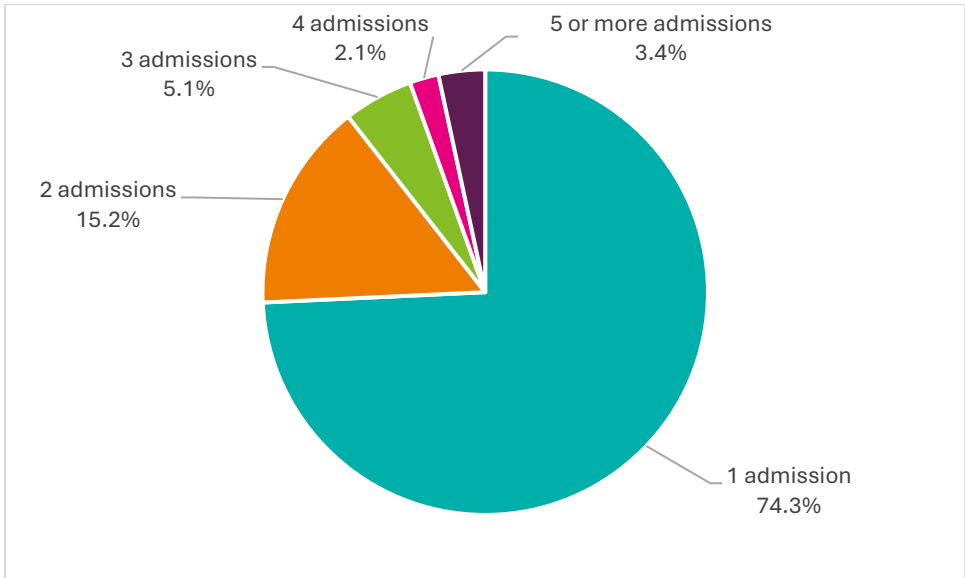


Figure 30. Single and multiple admissions as a result of self-harm for Barnet residents aged 0-25

6.3.8 Admissions by area of residence

Figure 31 shows the percentage of admissions for self-harm by ward for the period 2014-2022. The highest admissions were from those residing in Edgware (7.7%) and Burnt Oak (7.0%). These ward boundaries were revised in 2023, therefore data beyond 2022 is not shown here.

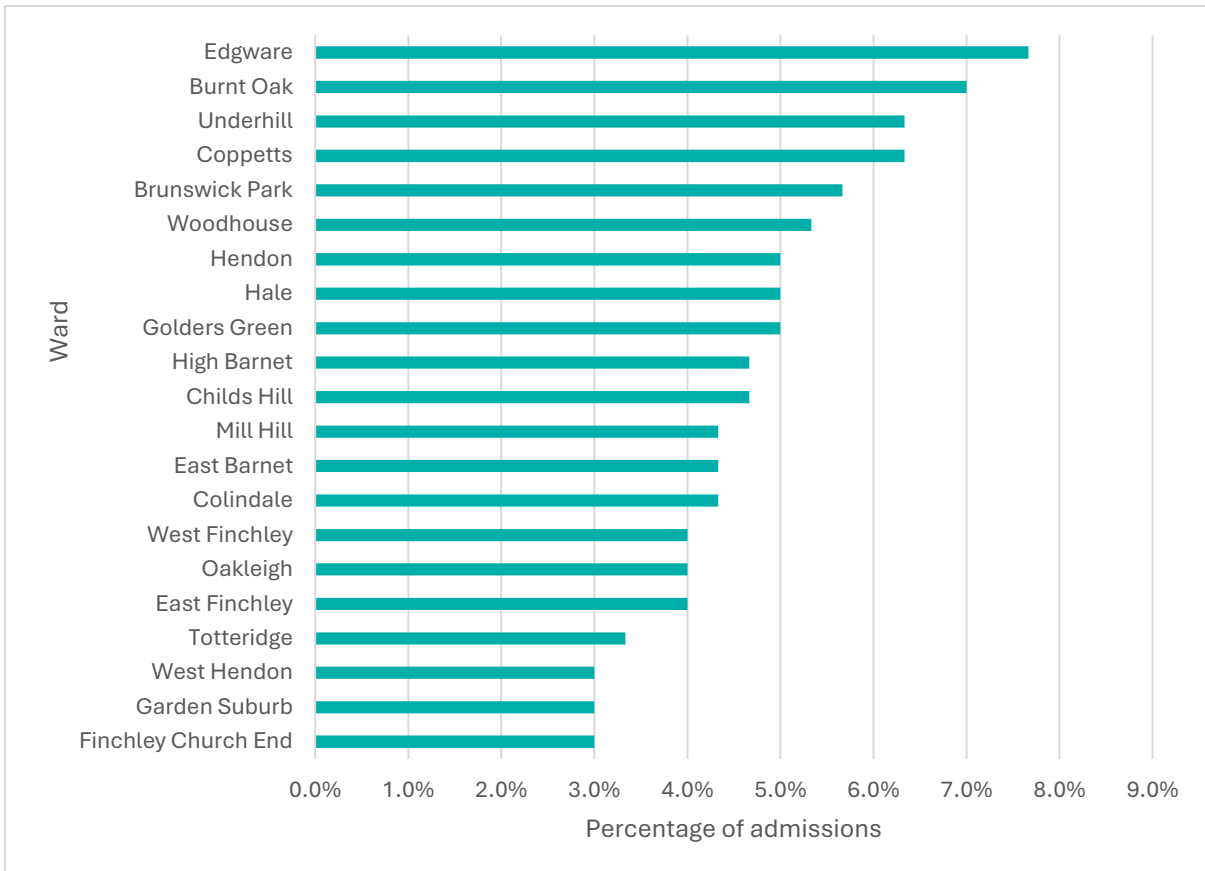


Figure 31. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by pre-2023 wards

Figure 32 shows the percentage of admissions by current ward boundaries. As these ward boundaries are newer, counts for several wards are suppressed due to low values, and therefore appear as zero in Figure 31. The highest admissions were seen in Burnt Oak (12.5%) and West Hendon (10.4%). Percentages are calculated from suppressed data and so may be subject to slight inaccuracies.

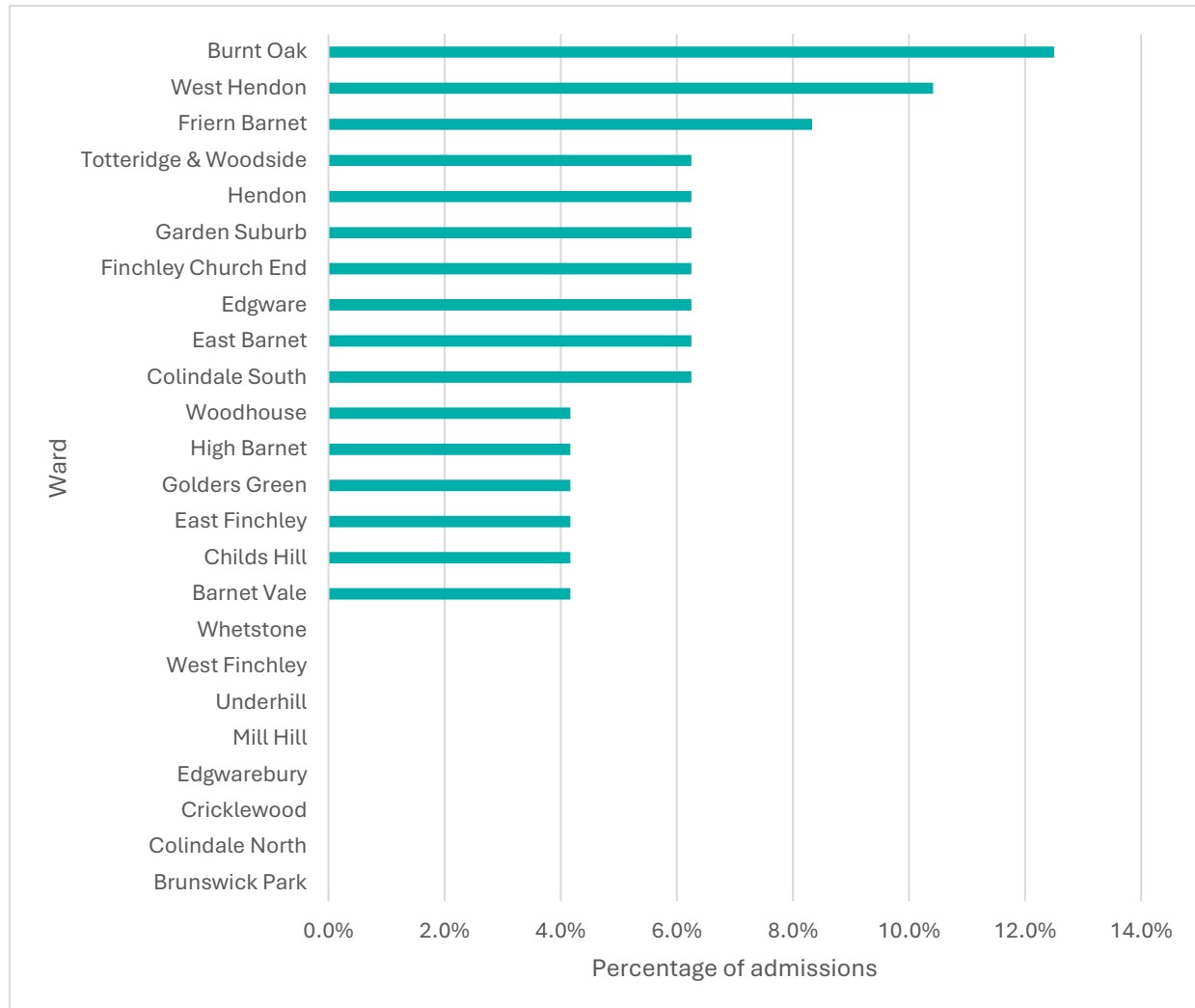


Figure 32. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by post-2023 wards

6.3.9 Admissions by diagnostic code

Figure 33 shows admissions by International Classification of Diseases, Tenth Revision (ICD-10) diagnostic code. Per year, approximately half of self-harm admissions were due to overdoses of common medications such as analgesics. Other common diagnostic codes included overdose of psychotropic medications, and self-harm using a sharp object.



Figure 33. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by ICD-10 diagnostic code

There are some differences in ICD-10 codes for self-harm between male and female CYP. Females are more likely to self-harm through overdoses of over-the-counter medications, such as analgesics, whilst males are more likely to self-harm via overdoses of psychotropic medications, which would typically be prescribed.

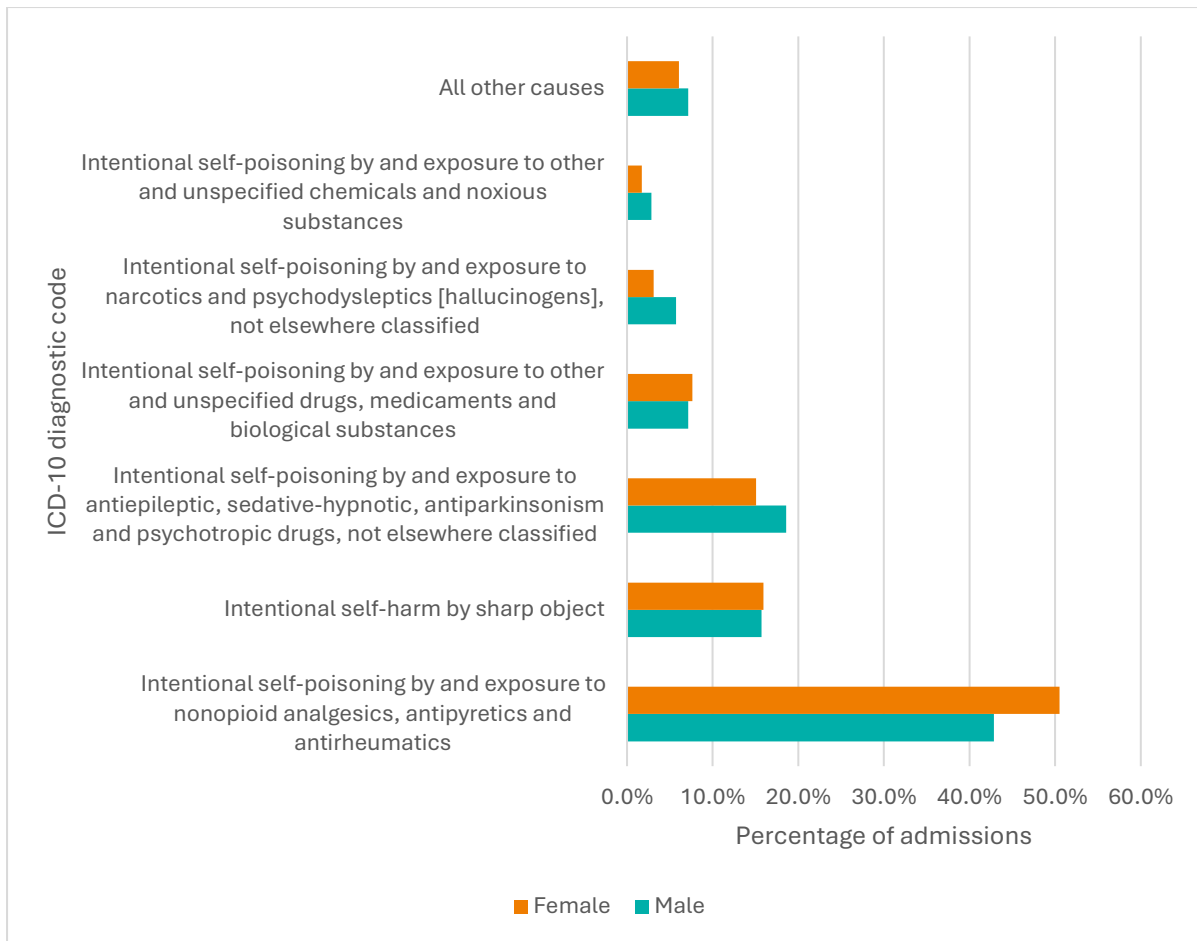


Figure 34. Hospital admissions as a result of self-harm for Barnet residents aged 0-25 by ICD-10 diagnostic code and sex

6.3.10 Admissions by associated mental health conditions

It is noted that those with mental health issues⁴ or those who are neurodiverse^{4,62} are at greater risk of self-harm. Analysis was therefore performed on this dataset to identify associations with mental health conditions and neurodiversity. Each year, a majority of those admitted as a result of self-harm had an associated ICD-10 code related to mental health within their clinical record. Most recently in 2023/24, 65.5% of CYP admitted for self-harm had a co-existing mental health diagnosis within their clinical record.

In Barnet, CYP admitted for self-harm were most likely to have a co-existing code of ‘depressive episode’ (Figure 35). Other co-existing mental health issues included ‘other anxiety disorders’, which includes panic disorder and generalised anxiety disorder, as well as personality disorders and eating disorders. There were also associations between self-harm and tobacco use. CYP may have more than one of the associated mental health codes shown in Figure 35.

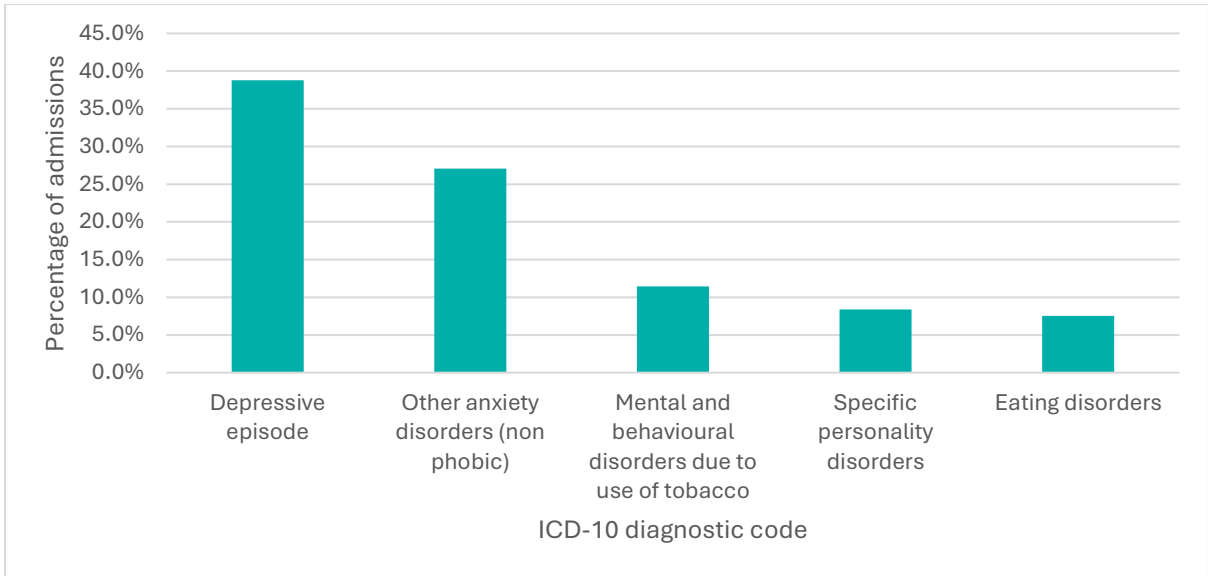


Figure 35. The five most common ICD-10 mental health diagnostic codes associated with hospital admissions as a result of self-harm for Barnet residents aged 0-25

We also explored associations between self-harm admissions and ICD-10 codes related to neurodiversity. The term ‘pervasive developmental disorders’, used in ICD-10 is broadly similar to autism spectrum disorder (ASD)⁶³. As shown in Figure 36 there has been a rise in the presence of this diagnostic code among those admitted with self-harm in recent years. The ICD-10 diagnostic code ‘hyperkinetic disorders’ encompasses ADHD, and Figure 35 also shows an increase in the presence of this diagnostic code. These trends may reflect an increasing need for support for neurodiverse CYP in relation to self-harm, and may also reflect increased rates of diagnosis for neurodiversity.

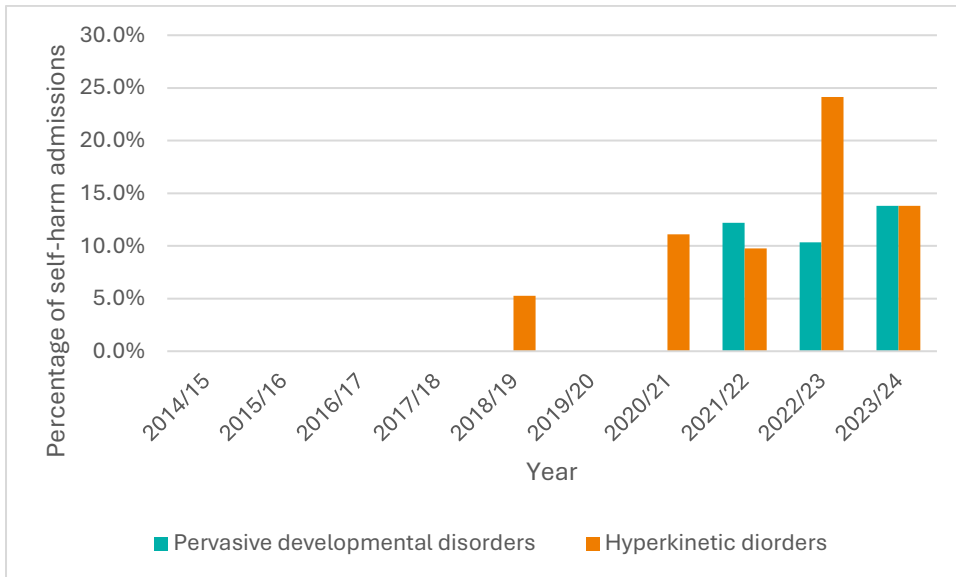


Figure 36. Association of ICD-10 diagnostic codes for pervasive developmental disorders and hyperkinetic disorders with hospital admissions as a result of self-harm for Barnet residents aged 0-25

6.3.11 Admissions by site and discharge destination

Admissions as a result of self-harm among Barnet residents were mainly to the two hospitals located within the London Borough of Barnet: Barnet Hospital (57.5% of self-harm admissions), followed by the Royal Free Hospital (17.3% of self-harm admissions). When exploring discharge location following admissions for self-harm, the majority (78.6%) of individuals were discharged to their usual residence. Small proportions of CYP were admitted to a mental health unit (3.1%), to an alternate general ward (1.7%) and to a secure psychiatric hospital (1.4%). 1.7% were discharged to a temporary residence.

6.4 Self-harm seen Barnet Integrated Clinical Services (BICS)

Between April 2024 and March 2025, of 1719 referrals made to BICS, 89 (5.2%) had self-harm listed as the main concern by the referrer. However, CYP may also be referred to BICS with a different primary reason for referral, but with concurrent self-harm reported.

In May 2025 BICS asked staff from across their teams to review their current caseloads to identify CYP reporting either current or historic self-harm. Of the 319 cases within the current caseload, 11.3% of CYP reported current self-harm and a further 10.0% reported historic self-harm. This data is based on four of the five BICS teams: the Primary Mental Health Team (PMHT), Mental Health Support Teams (MHST) the CWT (Children's Wellbeing Team) and the Children's Social Care (CSC) team.

This includes practitioners working across Children's Social Care and Child and Family Early Help settings, but does not include the Early Years Parenting Hub or clinical staff embedded within the REACH Programme, the YJS or Residential Homes. It was not practically possible for BICS to gather caseload data from all clinical staff. This analysis also did not include new staff members who joined the team shortly before this data collection exercise.

6.5 Self-harm seen by NHS crisis services

This section outlines some of the data related to NHS crisis services utilised by Barnet residents. It is important to note that the quality of this data is variable and not all data fields are completed for all patients. Some fields in this dataset are also manually entered by clinicians. Where there is free text coding of presenting issues in the below dataset, presentations of self-harm have been identified by selecting those entries which specifically included the term 'self-harm'. Crucially, this will not capture presentations described in other ways, which may have included self-harm. This section may benefit from being read alongside Section 5.5, which provides an overview of Crisis services.

6.5.1 Crisis line service

The Crisis line is now provided by NLFT but was formerly provided by Barnet, Enfield and Haringey Mental Health Trust in partnership with Camden & Islington Foundation Trust. In 2023/24 289 CYP aged 0-17 in Barnet accessed support through this Crisis line. This figure was 595 in 2022/23, 364 in 2021/22 and 233 in 2020/21. For 2021/2022 and 2022/23 the dataset does not include referral reasons for some CYP. In 2023/24 referral reasons were available for all but one individual accessing Crisis line services. Of those for whom a referral reason is listed, in 2023/24 11% of referrals were in relation to self-harm.

For this dataset, reasons for accessing Crisis line services are manually inputted by clinicians. This analysis may therefore be an underrepresentation of those accessing the Crisis line for support related to self-harm, as only cases where the phrase ‘self-harm’ was specifically used have been included. This analysis therefore may not capture entries by clinicians where a behaviour has been noted by the clinician that could be in keeping with self-harm, but the phrase ‘self-harm’ was not specifically used.

6.5.2 CAMHS liaison teams and Crisis Hubs

In 2023/24 127 CYP from Barnet presented to CAMHS liaison teams across NCL and to the Crisis Hub at Edgware Community Hospital with self-harm. This figure was 109 for 2022/23, 58 for 2021/22 and 26 for 2021/21.

Across these four financial years, for those patients presenting with self-harm for whom gender was recorded, 80.7% are described as female and 15.5% as male. The remainder are described as female (trans) or male (trans); specific breakdowns for these CYP are not provided in this document due to small counts. It is important to note that data on gender is not available for 87 CYP over the four years.

As noted in Section 5.5, at Barnet Hospital and NMUH, the paediatric liaison teams have been replaced with a 24/7 CRS. Paediatric liaison teams continue to operate at the other acute hospital sites.

Figure 37 shows presentations to CAMHS liaison teams with self-harm between 2020 and 2024 by age, with a rise in presentations in early teenage years, a peak in those age 15 and a subsequent decline in older teenagers. Due to small counts, those aged under 11 have been excluded from the analysis. Age data is not available for some CYP within this dataset, hence these CYP are also excluded from this analysis.

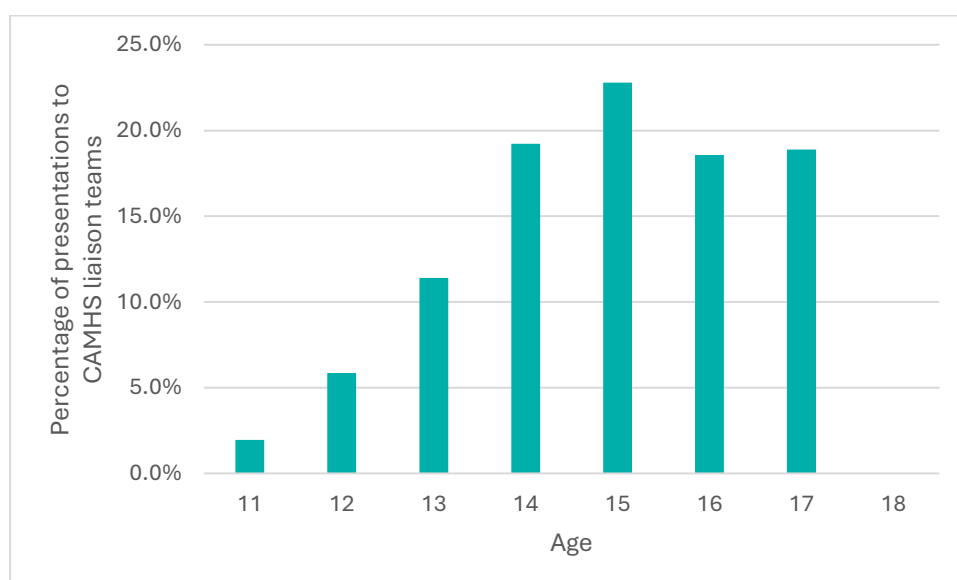


Figure 37. Percentage of presentations to CAMHS liaison teams with self-harm 2020-2024, by age

Figure 38 shows the percentage of presentations to CAMHS liaison teams with self-harm for 2020-2024 by month. Presentations are markedly high in March (17.5% of all presentations), which corresponds to the build up to the school and university examination period. There is a

notable drop over the examination period itself and the summer holidays. Other peaks are seen in the autumn and winter months, particularly January and October.

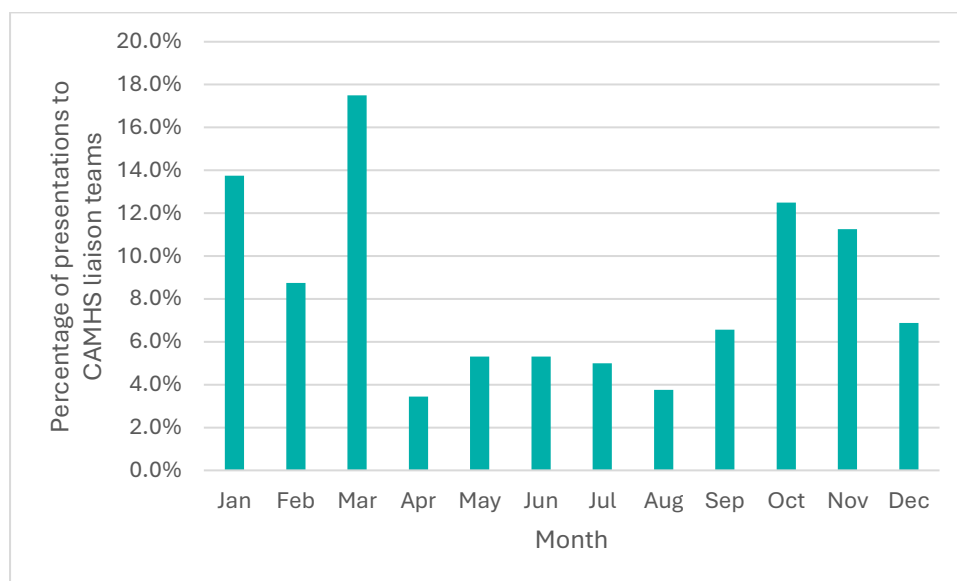


Figure 38. Percentage of presentations to CAMHS liaison teams with self-harm 2020-2024, by month

6.5.3 Out of Hours (OOH) Crisis service

In 2023/24 121 CYP from Barnet with a primary referral reason of self-harm were seen by the OOH Crisis service across the five NCL hospitals. This figure was 111 for 2022/23, 127 for 2021/22, 77 for 2020/21 and 36 for 2019/20. This data does not capture those CYP seen by the OOH team at Crisis Hubs in NCL. Of those seen in this five year period, 29.6% were admitted to hospital, whilst 69.9% were discharged to the community.

As noted in Section 5.5, as of this year a 24/7 CRS is in place at Barnet Hospital and NMUH, however the OOH Crisis Service also continues to operate at these sites at present.

6.6 Self-harm seen by the London Ambulance Service (LAS)

This section presents LAS data for ambulance callouts originating in Barnet related to self-harm between 2018 and 2024. This data is for all cases with an incident code of self-harm, which is the coding selected by the first LAS unit on the scene of the callout. Callouts are for locations within Barnet, and so not all callouts will necessarily pertain to CYP who live in Barnet.

6.6.1 Overall callouts

Figure 39 shows the total number of callouts for self-harm per financial year between 2018 and 2024⁶⁴. Callouts peaked in 2020/21 and have reduced in subsequent years.

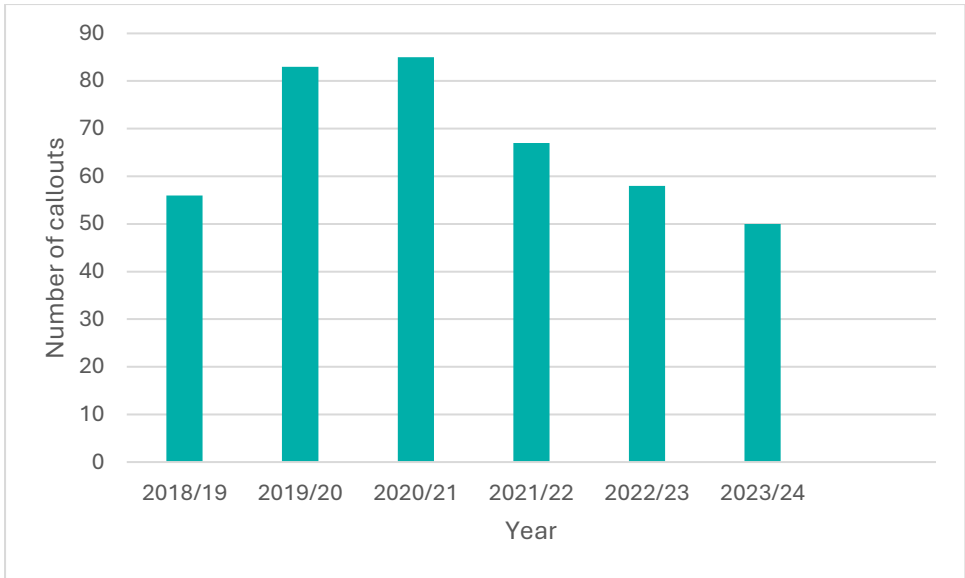


Figure 39. London Ambulance service callouts to Barnet for self-harm for those aged 0-25

6.6.2 Callouts by sex

Figure 40 shows LAS callouts in Barnet for self-harm by sex. The majority of callouts are for female patients; in 2023/24 84% of callouts were for females as opposed to 16% for male patients. This mirrors the overrepresentation of female patients also seen in hospital admissions.

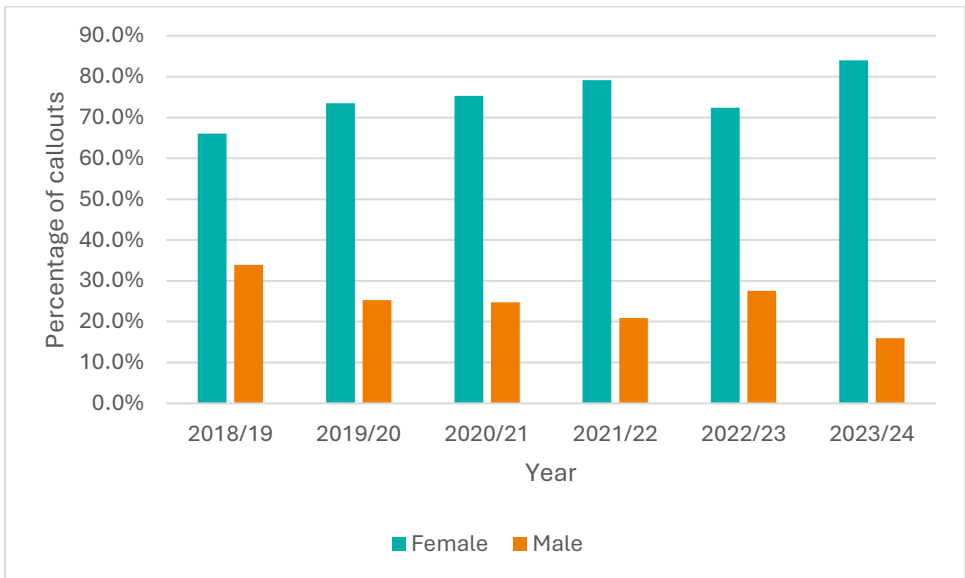


Figure 40. London Ambulance service callouts to Barnet for self-harm for those aged 0-25 by sex

6.6.3 Callouts by age

Figure 41 shows LAS callouts for self-harm in Barnet by age. Callout numbers are lower for young teenagers with an increase in later teenage years. The highest proportion of callouts (12.8%) was for those aged 20, with a decrease seen in CYP aged over 20. CYP below the age of 13 have been excluded from this analysis due to small counts.

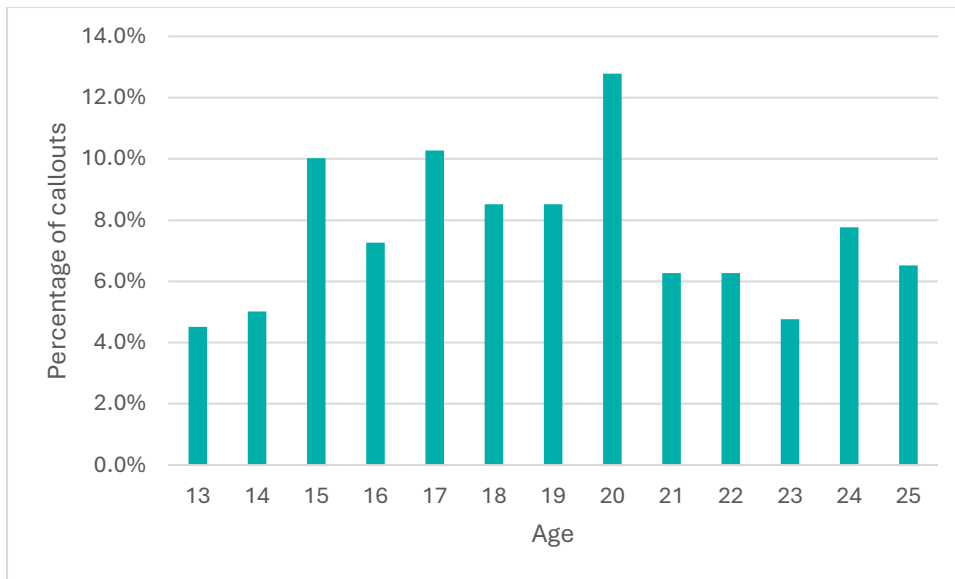


Figure 41. London Ambulance service callouts to Barnet for self-harm for those aged 0-25 by age

6.6.4 Callouts by destination

A majority of those seen by LAS in Barnet in relation to self-harm between 2018 and 2024 were conveyed to Barnet Hospital (56.1%). 17.0% were conveyed to the Royal Free Hospital, 8.8% to the Whittington Hospital and 5.5% to Northwick Park Hospital. 9.3% of CYP seen in Barnet by LAS in relation to self-harm were not conveyed, and so may have received care or support in the community instead.

6.7 Self-harm seen by other providers

6.7.1 Suicidal ideation and self-harm data collection exercise

Between May to July 2024 the Barnet Council Public Health Team undertook a data collection exercise to assess the prevalence of people presenting with suicidal thoughts and self-harm to partner organisations within the Barnet Suicide Prevention Partnership. This data was collected for all ages, but data is presented below specifically on those aged 0-25 who reported self-harm. Data is included from two providers (Barnet Kooth and Middlesex University) whose records allowed for collection of data on both suicidal ideation and self-harm.

In the time period when this data collection exercise took place, a total of 26 CYP who reported self-harm were seen by these two organisations. 88.5% of those seen were female. 61.5% of those reporting self-harm also reported suicidal ideation, and 15.4% reported a history of a previous suicide attempt. 11.5% of those seen with self-harm required crisis intervention or referral to emergency services; all individuals who required crisis support were also experiencing suicidal ideation. Whilst the data reported here looks at a small number of CYP across two services, this does provide valuable insights into the correlations between self-harm and suicidal ideation as well as referrals for crisis and emergency support made by providers in Barnet.

6.7.2 Self-harm seen by Barnet Kooth

Barnet Kooth is a digital counselling service that supports CYP aged 11-25. In 2022/23 self-harm or ideation of self-harm was a presenting issue for 25.6% of CYP accessing Barnet Kooth services; this figure was 21.7% for 2023/24. Self-harming behaviours (excluding thoughts of self-harm) were the seventh most common presenting issue in 2023/24 (13.7% users). It is important to note that those presenting to Barnet Kooth can have multiple presenting issues.

The proportion of service users presenting to Barnet Kooth with suicidal thoughts in 2022/23 was 27.3%, as compared to 27.7% in 2023/24.

In 2022/23 68.3% of CYP presenting to Barnet Kooth with self-harm or thoughts of self-harm identified as female; this figure was 77.6% in 2023/24. The remaining CYP who accessed Barnet Kooth services for self-harm identified as male, non-binary or other. Specific breakdowns for these groups are not provided due to small counts. CYP who access Kooth services can also opt out of detailing their gender identity.

6.7.3 Self-harm seen by the Looked After Children's Nursing Service

The Looked After Children's Nursing Service performed a random dip sample of records within their current caseload to explore the prevalence of self-harm among CYP aged 10-17. They reviewed records of 25 CYP and found that 32% reported self-harm. 64% had a history of mental health issues, including anxiety and depression. 20% of these CYP were unaccompanied asylum-seeking children; no self-harm was reported by this group of CYP although there was a history of other mental health issues such as post-traumatic stress disorder.

6.7.4 Self-harm seen by Children's Social Care

All CYP who have a referral accepted to Children's Social Care in Barnet will have a Single Assessment, known as the Child and Family Assessment (C&F Assessment). This assessment includes noting the presence of certain risks such as self-harm. Of note, this data will not include all those referred to services such as Early Help or the MASH with self-harm, as these CYP will not necessarily undergo a C&F assessment.

Figure 42 shows C&F assessments for CYP aged 0-17 that noted self-harm, as a percentage of all C&F assessments performed per year for Barnet, in comparison to the same figure for London. The proportion of assessments identifying self-harm in Barnet has been consistently higher than London; in 2024 6.1% of assessments in Barnet noted self-harm, in comparison to 4.2% in London. This may reflect higher rates of self-harm in Barnet among CYP referred to Children's Social Care as compared to London.

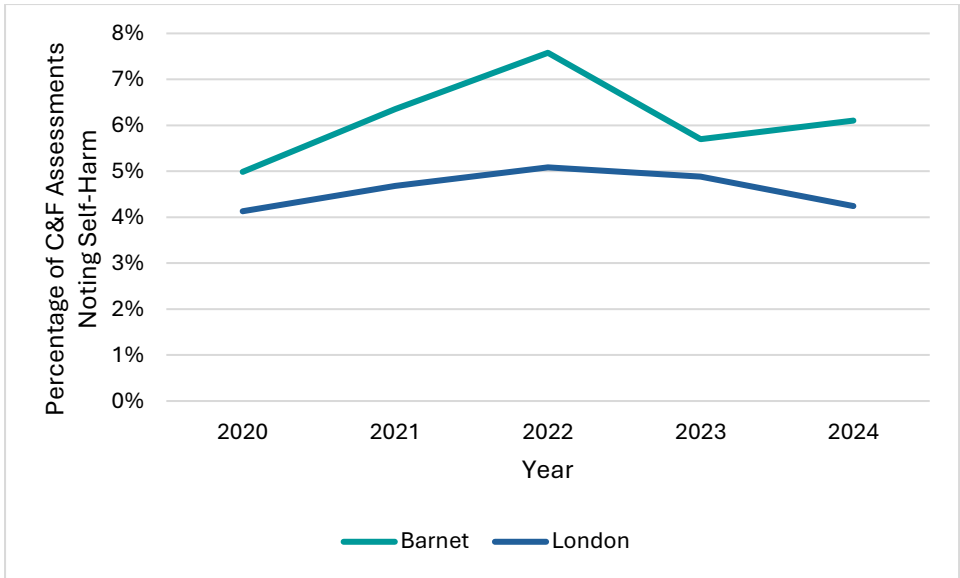


Figure 42. Percentage of all C&F assessments for Barnet that noted self-harm per year, as compared to the London average

Figure 43 shows the percentage of C&F assessments in 2024 that noted self-harm in Barnet, as compared to other London boroughs. Barnet and Islington have a higher percentage of assessments noting self-harm as compared to other NCL boroughs; these are also the two NCL boroughs with the highest rate of hospital admissions as a result of self-harm, as noted in Section 6.3.

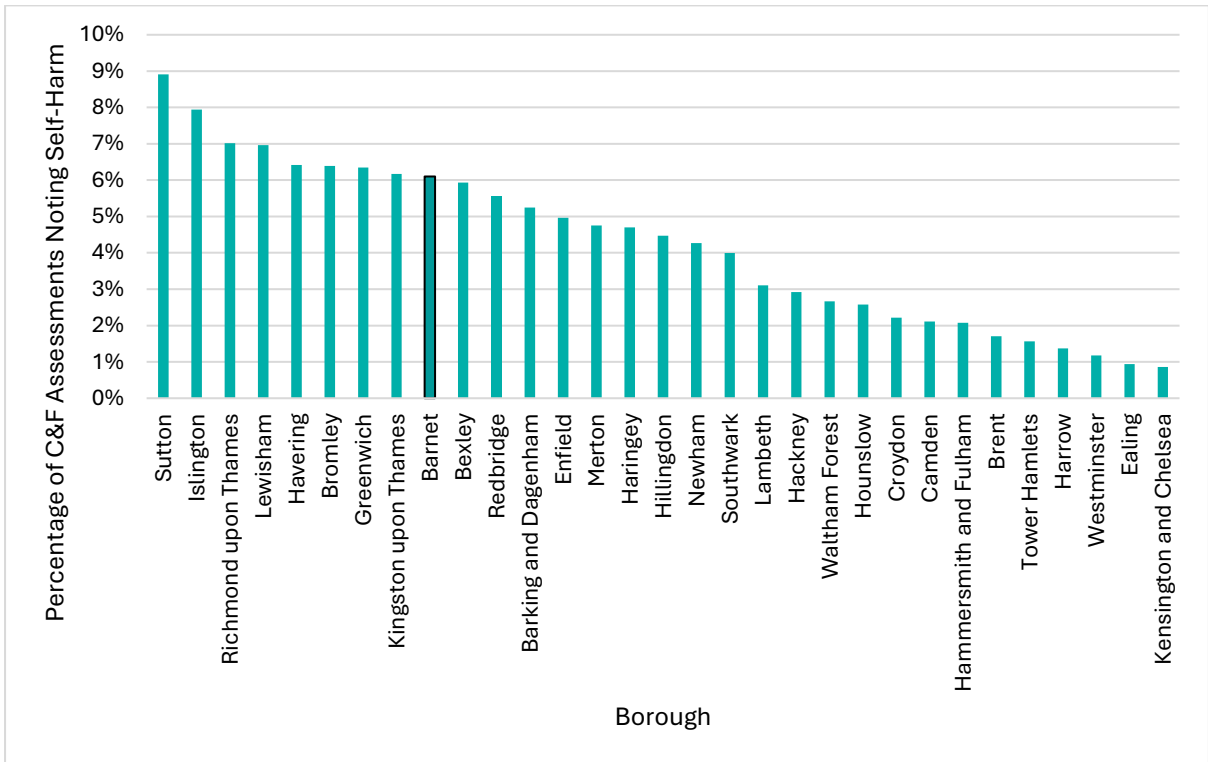


Figure 43. Percentage of all C&F assessments for London boroughs that noted self-harm in 2024

6.8 Estimated prevalence of self-harm in Barnet

The other data presented in this HNA on self-harm among CYP relate to those CYP whose self-harm is known to services. The Mental Health of Children and Young People (MHCYP) in England 2023 survey asked 17-24 year olds about their history of self-harm, and asked the same to parents of 8-16 year olds about their child. Using the survey results⁹ and 2023 mid-year population estimates for Barnet we calculated estimates for rates of self-harm in Barnet based on age and gender. Using this approach, there are an estimated 526-1,326 8-10 year olds in Barnet who have attempted self-harm at some point in their life; this estimate is 2,896-4,277 for 11-16 year olds and 11,280-14,190 for 17-24 year olds. The full list of estimates is available in Appendix 2.

It is important to note that these calculations have significant limitations. The original MHCYP survey had a sample size of 2,370, which is not particularly large. In addition, many factors including the demographics of CYP in Barnet and local services can impact self-harm at the local level, causing prevalence to differ from national data collected in the MHCYP survey. These data are therefore only estimates, and subject to inaccuracies.

7. Local needs

This section outlines local need in relation to self-harm based on the findings of stakeholder interviews, focus groups and a survey.

16 stakeholder interviews were conducted as part of this HNA. Some interviews were conducted in groups of two or three, with a total of 20 interviewees who took part in the stakeholder consultation process. The questions from these stakeholder interviews can be found in Appendix 2.

This section also draws on findings from four focus groups with CYP, two with school staff and an electronic survey shared with parents and carers in Barnet.

Quotations from professionals and young people who participated in interviews and focus groups, respectively, have been included in this section. The potential use of quotations in the final document was explained in advance to participants. As parents and carers were engaged with via a survey, quotations have not been included, as it was felt that the written format of the survey did not allow for sufficient explanation and discussion of how quotations would be used.

7.1 The extent and drivers of self-harm

7.1.1 The scale of the issue

Professionals who participated in stakeholder interviews broadly reported that self-harm had risen in recent years, with increased self-harm seen in educational settings and increased presentations to mental health services and emergency services. Historically, within CAMHS, all cases of self-harm may have been seen by services such as BEST, which support CYP with greater mental health needs. However self-harm will also now be supported by BICS and generic CAMHS teams, reflecting the scale of the issue. One stakeholder noted that CYP are now also more likely to highlight self-harm as a presenting issue and clinicians are now more likely to enquire about self-harm.

Some stakeholders working in both healthcare and education settings also reported increasing self-harm in younger age groups, particularly those in later primary or early secondary education, which is mirrored by findings in the data (Section 6.3.3).

Despite this, one stakeholder highlighted that self-harm is not particularly well understood:

“Self-harm is a hidden harm that we don’t have as much data on or as [much] knowledge about as we should do” Professional

This reflects observations in the literature that self-harm is not well understood and that much self-harm in the community remains hidden^{4,5}.

7.1.2 Forms of self-harm

Stakeholders and CYP in focus groups highlighted that self-harm can take on a range of forms. Methods of self-harm such as cutting and burning are more widely recognised. However,

interviewees emphasised that other behaviours, some of which may be more normalised, can also constitute self-harm.

“People don’t realise that self-harm can also be picking your skin, ripping your hair a bit, picking out your eyelashes [or] eyebrows, going out to have a smoke” Young person

Stakeholders and young people also noted that behaviours such as disordered eating, substance misuse and sexual activity at a young age can all be forms of self-harm for some CYP.

Expanding this understanding of what can constitute self-harm is important, as it allows the scale of the problem to be better understood. It can also help to prevent some forms of self-harm from being normalised and ensure they are met with appropriate concern.

7.1.3 Unmet need

Stakeholders highlighted that a key driver of the scale of self-harm is unmet need, wherein CYP are unable to access timely support for mental health issues, leading to self-harm as coping mechanism. This unmet need is not limited to mental health services, but also for example in the capacity of schools to support CYP who are neurodivergent or who have mental health needs. Unmet need is discussed in greater detail in Section 7.6.

7.1.4 Online environments

Both CYP and stakeholders highlighted the impact of online materials and environments on CYP’s mental health. This includes content specifically about self-harm, some of which may be beneficial and may provide CYP with support; however online materials and social media groups can also be extremely detrimental and some may promote self-harm.

As well as content related to self-harm, CYP may encounter graphic materials or news of global events online, all of which can lead to distress and anxiety. CYP reported that graphic content can sometimes be tagged inappropriately on social media, in order to facilitate a wider reach, meaning CYP encounter this unexpectedly.

7.1.5 Peer relationships

Some stakeholders reported that self-harm can be associated with peer relationships. Those with peers online or in-person who self-harm may be more likely themselves to self-harm. Some stakeholders described how self-harm can provide a sense of belonging through connecting with others online or in-person, with similar experiences, who are also self-harming. One stakeholder noted that CYP with peers who self-harm may also be more likely to partake in self-harm in an experimental manner.

7.1.6 Loneliness and social isolation

Some stakeholders noted that loneliness and isolation are key drivers of self-harm, despite the interconnectedness fostered through modern technologies:

“[Self-harm] is an issue because of the deteriorating nature of children and young people’s mental health...young people tell us about that kind of crisis in their mental health driven by anxiety, isolation. A lot of young people live quite lonely, isolated lives despite...the thought that they’re more connected than ever.” Professional

Stakeholders noted that the isolation brought on by the Covid-19 pandemic was a key driver of this loneliness, but that the post-pandemic return to relative normalcy also brought with it adjustments for CYP and associated challenges.

7.1.7 The role of academic pressure

Some stakeholders noted the role of rising academic pressures as a driver of self-harm among CYP, given the societal value placed on academic success and the resulting pressure to perform well in examinations and to compete for entry into prestigious schools.

More than one stakeholder noted the pressure of the transition from primary to secondary education and the significant changes in environment between the two settings. This includes a lack of primary attachment figures in secondary schools as compared to primary school; a move towards adult led interactions; different social norms; increased independence; physically larger school environments; academic pressures; increased focus on appearance and behaviour and the challenges of peer relationships. In relation to this transition to secondary school, one stakeholder commented:

“Children and young people hav[e] said to me over the years, they’re up ‘til midnight trying to keep up with that intense work and keep at the top of their class and...working solidly [at] weekends with little downtime” Professional

7.2 CYP at risk of self-harm

In addition to the above factors contributing to the extent of self-harm in Barnet, stakeholders were asked about risk factors for self-harm among CYP in Barnet. These risk factors are outlined in Table 3 and in many cases match the risk factors outlined in the literature, presented in Section 1.

7.2.1 Age

Many stakeholders noted that older teenagers were at increased risk of self-harm. Those aged 15-16, undertaking examinations, were highlighted by some stakeholders as a specific risk group. Some stakeholders also reported risk associated with the transition from primary to secondary school. This is broadly reflected in the data, where hospital attendances are highest in those aged 16-20, closely followed by those aged 11-15 (Figure 9, Section 6.2.3). Similarly, hospital admissions for self-harm are highest in those age 17 between 2014 and 2024 (Figure 21, Section 6.3.3), but trends over time show a rise in admissions in the 10-14 age groups, particularly in the year 2023/24 (Figure 22, Section 6.3.3).

7.2.2 Deprivation

There was disagreement between stakeholders on the associations between deprivation and self-harm in Barnet. Some felt increased self-harm was associated with increased deprivation, as noted in the literature⁴. However, more than one stakeholder noted that in their experience CYP in Barnet from more affluent backgrounds, were more likely to present with self-harm. This may reflect the demographics of Barnet overall, which has an overall more affluent population⁶⁵. The data presented in Section 6 did suggest some associations between self-harm and increased deprivation. In terms of hospital attendances for self-harm, the three most deprived IMD quintiles were overrepresented (Figure 11, Section 6.2.5), however for hospital admissions, the first and third quintiles were overrepresented, whilst the others were underrepresented (Figure 25, Section 6.3.5).

7.2.3 Ethnicity

There was also some disagreement from stakeholders on the relationship between ethnicity and self-harm among CYP in Barnet. One stakeholder reported seeing higher rates of self-harm among CYP from White backgrounds. This is similar to the findings of Adult Psychiatric Morbidity Survey which noted that self-harm was more commonly reported in White and Mixed populations, however this analysis was across all ages¹⁰.

Other stakeholders highlighted that ethnically minoritised groups can be at greater risk of self-harm, as a result of experiences of racism and discrimination. Local data discussed in Section 6 was somewhat inconclusive on the association between ethnicity and self-harm. When looking at hospital attendances, only Other ethnic groups were overrepresented in self-harm admissions (Figure 10, Section 6.2.4), however for hospital admissions those from White and Other backgrounds were overrepresented (Figure 25, Section 6.3.4). Those from Black and Asian backgrounds were however underrepresented in both attendances and admissions.

7.2.4 LGBTQIA+ identities

CYP who are LGBTQIA+ are highlighted as being at greater risk of self-harm in the literature⁵⁴. Stakeholders also emphasised that transgender CYP and those questioning their gender identity were at particular risk. In addition, those from communities and backgrounds where their identity is not accepted were also noted by one stakeholder as being at greater risk of self-harm.

7.2.5 Other local risk factors

Locally, academic pressure was highlighted frequently by stakeholders. This is in contrast to the literature where educational difficulties such as poor performance and attendance are noted as risk factors^{4,12} but in keeping with the association between perfectionism and self-harm⁴. One systematic review noted a relationship between academic pressure and mental health difficulties, however no studies were identified specifically exploring the association between academic pressure and self-harm, suggesting a paucity of published data in this area⁶⁶. However the paper did identify one study reporting reduced self-harm during periods of school closure; similar findings were noted in Barnet, where hospital admissions were lower over the summer months and in December (Figure 27, Section 6.3.6) as well as at weekend (Figure 29, Section 6.3.6).

Multiple stakeholders locally also specifically noted that CYP with mental health needs, Looked After Children and neurodiverse CYP were at a particular risk of self-harm. Parents and carers also described how neurodiverse CYP are particularly at risk of self-harm where their needs are not being met or understood in schools, or where they are in an inappropriate school environment to meet their needs.

Finally, it was noted that belonging to a friendship group where others are self-harming can mean CYP are at increased risk of self-harm.

Demographic factors	<ul style="list-style-type: none"> • Being female • Secondary school age • Low socioeconomic status; contrastingly, high socioeconomic status • Those from White backgrounds; contrastingly, those from ethnically minoritised backgrounds • LGBTQIA+ identity
Educational factors	<ul style="list-style-type: none"> • Academic pressure
Psychological factors	<ul style="list-style-type: none"> • Mental health issues, including eating disorders • Neurodiversity • Loneliness and isolation • Body dysmorphia • Family history of mental illness • Low self-esteem
Life experiences and social factors	<ul style="list-style-type: none"> • Adverse childhood experiences • Trauma • Looked After Children • Asylum seekers and refugees • Physical and sexual abuse • Poor family relationships • Parental separation • Caring responsibilities • Friendship groups where others are self-harming • Viewing of self-harm promoting materials

Table 3. Locally identified risk factors for self-harm

7.3 Reasons for self-harm

This section outlines the reasons for self-harm as described by CYP and professional stakeholders. Section 7.1 and 7.2 have already outlined drivers and risk factors for self-harm. This section instead seeks to describe the function of self-harm behaviours from the point of view of CYP and the professionals who work with them.

7.3.1 Managing and expressing emotions

Both CYP in focus groups and stakeholders frequently mentioned that self-harm can serve as a way for CYP to manage overwhelming emotions, where self-harm can provide a feeling of

release from these emotions. Managing emotions is also noted by the National Self-Harm Network as a reason for self-harm².

Stakeholders described how this is particularly the case for CYP who do not have an opportunity to express their emotions in other ways, due to feeling that their experiences will not be heard or understood by others or because they do not have access to a trusted person with whom they can discuss these feelings. In addition, some CYP may find it more challenging to express their emotions; this can be more common among neurodiverse CYP. Finally, some CYP may not have the means to process their experiences such that they can then communicate emotions resulting from these experiences. In all of these cases self-harm can therefore serve as a way for CYP to communicate distress and other emotions to those around them.

Several stakeholders also noted that self-harm serves as a coping strategy to manage difficult emotions, for CYP who do not have access to other coping strategies. CYP in one focus group made similar comments, highlighting that self-harm can serve as a way of managing emotions, such that they do not escalate to suicidal thoughts or behaviours.

7.3.2 Regaining control

CYP and professionals also described how self-harm can serve as a way of regaining control for CYP who feel they have little control over their lives. This can be the case for CYP with unstable home environments and for Looked After Children who may experience several changes in placements and changes in schools.

7.4 Prevention of self-harm

7.4.1 Psychoeducation, emotional literacy and resilience building

Many stakeholders highlighted the importance of psychoeducation and emotional literacy in the prevention of self-harm. It was widely felt that emotional literacy should be addressed in schools, beginning in primary school and remaining embedded throughout primary and secondary education. The approach to emotional literacy should include encouraging CYP to express their emotions as well as being taught about healthy methods of managing these emotions. For older CYP, encouraging open conversations about difficulties they may be having such as stress, exam pressure and family relationships, was deemed to be important. This is supported by evidence from stakeholders and CYP, that self-harm can be driven by challenges in expressing and managing emotions.

One stakeholder also suggested that as well as education for CYP, psychoeducation for school staff and families is also important, so that they feel able to co-regulate CYP and to help CYP to build good communication in their home environments and at school.

There was also strong support for the importance of embedding open conversations about mental wellbeing into everyday life, in homes and schools. CYP highlighted that whilst assemblies, workshops and Personal, Social and Health Education (PSHE) lessons may all have value, what would be particularly valuable is having an openness about mental wellbeing embedded across school life and in the curriculum, to encourage its normalisation and to reduce stigma around self-harm and mental health more broadly. This approach is in keeping

with the principles of the Resilient Schools Programme in Barnet³⁵.

Two focus groups of CYP also mentioned that anonymous boxes in classrooms could be valuable, where students could share questions and concerns, to then be addressed in form time. CYP also queried whether PSHE lessons could be made more interactive and engaging. Stakeholders noted that PSHE is not always prioritised in schools given the other pressures of the curriculum, and may also not always be taken seriously by CYP.

CYP across more than one focus group were supportive of the idea of regular one-to-one check-ins for all students in schools, for a few minutes once a month, which could provide an opportunity to highlight any needs or difficulties early on.

Finally, one stakeholder also noted the importance of the insights of those with lived experience of self-harm in shaping prevention efforts, in order to understand the views of these CYP on what support would have been helpful for them.

7.4.2 Early identification of and intervention for risk groups

It was widely acknowledged by interviewees that identification of those at increased risk of self-harm, and intervention to support these CYP before self-harm develops, is vital. This is in keeping with the Lancet model of suicide prevention, which emphasises the importance of targeted support for risk groups to prevent self-harm²⁴.

“Have...people trained in schools to...pick up vulnerable students and...have those conversations before you get to the level where they’ve actually started to self-harm”

Professional

This includes support for CYP with a range of risk factors for self-harm, for example ensuring CYP with mental health difficulties have swift access to clinical support and that neurodiverse CYP have access to assessments and adjustments where this is required. Parents and carers also highlighted that timely access to bereavement support for CYP following the death of a loved one was key, as this can be a risk factor for self-harm. Those who work with Looked After Children noted how important it is to create permanency and stability for these CYP, who may often experience changes in placements and changes in the schools they attend. It may also be beneficial to offer increased support at specific times of year, such as exam periods, when CYP generally may be at greater risk of self-harm.

Stakeholders also noted exposure to online materials as a key risk factor; some believed banning of smartphones could help to address this, whilst others felt this was only addressing a small element of the underlying issue of online harms. Some stakeholders noted that responsibility to better regulate online materials lay with national government and with corporations, and was challenging to improve at a local level. CYP themselves noted that filtering social media content to remove exposure to distressing materials, as well as restricting

one's social media feed to only include content from accounts CYP follow, could reduce exposure to harmful online content.

As outlined in Section 7.2, stakeholders also noted a range of other demographic, educational, psychological and social risk factors for self-harm, including but not limited to sexuality, gender identity, deprivation and migration status; providing support in relation to these risk factors is also important in preventing self-harm.

7.5 Unmet need and barriers to support

This section outlines the unmet need and barriers to support experienced by CYP who are self-harming and those around them such as parents, carers and school communities.

7.5.1 Stigma

CYP, parents and carers, school staff and stakeholders all highlighted that stigma continues to be a barrier to accessing support for self-harm. CYP may be hesitant to access support due to fear of worrying their families as well as fear of being judged, ridiculed or dismissed. Some CYP in focus groups noted that sadly in school communities some CYP may trivialise self-harm, which can perpetuate stigma, thus reinforcing the importance of psychoeducation and emotional literacy, as noted in the previous section.

7.5.2 Awareness of support and willingness to seek support

Whilst awareness of self-harm has grown, CYP, parents and carers and professionals all mentioned that CYP and their families can struggle knowing where to access support. CYP may also not realise they require support or may not be able to express their need for support. Parents and carers meanwhile reported not knowing how best to offer support to CYP, how to communicate around self-harm, what actions to take and where to go for additional support.

In addition to this, CYP, their families and stakeholders also noted that CYP's willingness to seek support can also be a barrier. The first stage of this barrier is CYP recognising that self-harm is a harmful way of managing their emotions and realising they require support. However, those CYP who recognise they need support may also be reluctant to seek this out. Many CYP are aware of the pressures on mental health services, and so may be hesitant to seek support because they expect to experience lengthy waiting times. CYP in focus groups noted that fear that professionals will insist they stop self-harming completely can be a barrier, rather than focussing on the factors that are causing CYP to self-harm. Professional stakeholders also noted that rhetoric around statutory mental health services can at times be quite negative, particularly online, thus negatively shaping some CYP's perceptions of services and their willingness to engage with these services.

Finally, it was also noted that additional pressures in life can be a barrier to willingness to engage with support; for example Looked After Children experience many challenges, including navigating relationships with families and the need to arrange accommodation when they turn 18, all of which may be perceived by these CYP as priorities in comparison to support for self-harm and other mental health issues.

7.5.3 Barriers and unmet need in schools

Qualitative insights highlighted a range of barriers and unmet need experienced by CYP in schools in relation to self-harm, underpinned in many cases by resourcing and the demands placed on schools.

Firstly, there is unmet need around schools' capacity to focus on young people's wellbeing, given the focus on areas such as examination results, attendance, behaviour and Ofsted inspections. One stakeholder noted:

"In practice [a relational approach] is not always there because there are expectations in terms of...grades and behaviour policies etcetera and so the focus becomes more on that and not so much on the wellbeing of the young person or...building their emotional resilience or emotional literacy" Professional

Related to this, there is also unmet need around schools' ability to support those with additional needs, such as SEN and neurodiversity. Parents and carers report that SEN departments in schools can be overstretched and so the provision of support to CYP and families can be impacted. Mainstream schools are also not an appropriate educational setting of all CYP, and so may struggle to support those CYP who are awaiting assessments and moves to alternate settings. Finally, parents and carers did also note that some families may feel dismissed by schools when highlighting additional needs.

Similarly, school can often be a first point of contact for families who learn that CYP are self-harming. Some parents and carers described how schools may not have the resources or capacity to often support to families, and will instead signpost to other services. It was also highlighted that a lack of communication or effective working between schools and families can be a barrier to CYP getting the support they require.

CYP noted that schools' approaches to offering support for self-harm through a specified individual such as a pastoral lead or counsellor, can serve as a barrier. The presence of a known contact for support means that when CYP access support, their peers will be aware that they are requiring this support. This can be a stigmatising experience for CYP.

"I really didn't go to the school counsellor at all during school because one, I knew that once I went to her office everybody would notice that I was obviously struggling, and two, going to a teacher felt much more calm, much more person-to-person, rather than 'how do you feel on a scale of 1 to 10?'... it felt more... humanising" Young person

7.5.4 Barriers and unmet need in mental health services

CYP also experience barriers and unmet need in relation to mental health services.

The first barrier experienced by CYP is in relation to gaining access to the right mental health service to meet their level of need. In the parent and carer survey, respondents described being turned away from multiple services, or services signposting to each other as the right setting to

meet the young person’s level of need. This difficulty in getting access to the right mental health service ultimately reflects the current demand on mental health services, that also means waiting times can be lengthy for support, in addition to families reporting some referrals can end up lost or delayed. As a result, CYP’s mental health may deteriorate in this period whilst they are waiting to be seen. Some families may consider accessing support through non-statutory services, with some subsidised or low-cost support available, however non-statutory services can also have significant financial barriers.

“One big barrier is just the level of need...with the amount of kids that are self-harming it can be hard to provide a really early intervention” Professional

A second barrier when accessing mental health support reported by CYP was experiences of feeling dismissed because their self-harm was deemed “mild” or “superficial”. CYP noted that these experiences can have lasting impacts on their willingness to engage with services.

A further area of unmet need when accessing support includes the type of support available. Multiple stakeholders highlighted the importance of services and interventions being tailored to meet the needs of CYP. For example, one stakeholder noted that Barnet has a diverse community, including those from a range of religious backgrounds, meaning that culturally sensitive and tailored interventions may be important in supporting some CYP from these backgrounds. It is also important to recognise that CYP who are autistic or who have other communication needs may find it challenging to utilise a talking therapy, one of the recommended interventions for self-harm²².

“Young people that have social communication needs or have a diagnosis of autism [may not] ...have the means to be able to communicate effectively how they’re...feeling, and so engaging in... a talking therapy...that isn’t adapted to meet their needs can be quite difficult for them” Professional

Parents, carers and stakeholders also highlighted unmet need around community-based support for self-harm. Parents and carers described experiences of GPs and schools advising families to attend A&E for self-harm, when specific medical intervention may not be required. One stakeholder noted the importance of diversions from A&E, to a setting where CYP can be seen by trained staff, well-equipped to support with self-harm.

A further area of unmet need is around the transition period between children’s and adult mental health services. Stakeholder highlighted the importance of starting this transition early, in order to make it more seamless.

“That cliff edge of service provision when they turn 18 is still too prevalent” Professional

This transition was noted as particularly important among Looked After Children, who will no longer receive other support after they turn 18, such as support from the Looked After Children’s Nursing Service.

Similarly, Looked After Children under 18 may be moved into or out of Barnet. Services in different areas may not be adequately connected, leading to a loss of referrals. CYP may also experience differences in the services available in different areas, leading to a lack of continuity in the care they receive.

7.5.5 Barriers and unmet need in other settings

One stakeholder also highlighted unmet need in relation to mental health support for Looked After Children in their placements. These CYP can have significant mental health needs, which staff in their placements are not trained to support with. This can lead to repeat presentations to A&E, or even lengthy inpatient mental health admissions.

7.5.6 Support for families

Parents and carers highlighted that self-harm can have a significant emotional impact on parents, carers and the wider family. CYP self-harming is often distressing for parents and carers, and caring for these CYP becomes a priority, but can be at the expense of parents and carers' own self-care and can also lead to other siblings feeling ignored. Supporting CYP who are self-harming can also impact on parents and carers' work, and for some may even lead to needing to leave a job, with a resulting financial impact on the family. There is therefore an unmet need currently around support for the families of CYP who are self-harming, particularly around their wellbeing.

7.6 Effective approaches to address self-harm

This section outlines stakeholder, CYP, parent, carer and school staff perspectives on what works well to address self-harm. Some of these approaches may already be in place in certain settings, whilst others were proposed as effective approaches that could be implemented more widely.

7.6.1 Trusted adults

There was broad support among CYP and stakeholders for the importance of trusted adults in allowing CYP to disclose self-harm and access support for this. CYP in particular felt that the professionals who work with them should all have some basic training in mental health and how to navigate conversations around mental health and self-harm.

However, CYP also emphasised that extensive training on mental health was not essential in effectively navigating a conversation around self-harm; instead it was the young person's ability to choose who they approached, as well as the adult demonstrating empathy, a non-judgemental approach and a willingness to listen, that were crucial. Parents and carers also noted that staying calm when CYP disclosed self-harm, being present and offering support were all important in helping to address self-harm.

One stakeholder also noted the importance of a team of adults around a young person, so that CYP do not become heavily reliant on a single individual. Another stakeholder noted that time and resources are an important factor in ensuring that school staff have the opportunity to understand and listen to their pupils' needs.

7.6.2 Collaborative working

There was broad consensus among stakeholders that holistic, multidisciplinary collaborative working was highly beneficial in supporting CYP experiencing self-harm.

“When you’ve got multiagency practitioners who are working closely together, communicating, sharing information or working with the best interests of the child at heart...working in a well-supported and resourced system...that’s when you can help young people address their self-harm” Professional

Stakeholders also highlighted the importance of having a safety plan in place for young people who are self-harming, and ensuring this was communicated to CYP and everyone involved in supporting them. One stakeholder also noted that any professional working with CYP, regardless of professional background, should be trained to be able to compile a safety plan.

One stakeholder similarly noted the importance of there being support or emotional regulation plans in place for CYP, and making sure this is communicated to the young person and everyone involved in supporting them.

Some stakeholders also noted that information sharing was an important part of effective collaborative working. This may include sharing the necessary information on specific CYP to best support them, but could also include sharing of data and insights between organisations, to support professionals with identifying those most at risk of self-harm.

Finally, some professional stakeholders also noted that collaborative working is important in supporting young people in relation to underlying triggers for self-harm. For example, this may include working with schools if self-harm is related to academic pressures, or working effectively with families if self-harm is related to difficulties within the family.

7.6.3 Peer support

Many of those who took part in interviews or participated in focus groups highlighted the importance of peer support and peer relationships for those who self-harm. This is important firstly, as social isolation and loneliness can be a risk factor for self-harm¹².

“Those who self-harm are usually quite isolated...it’s important for that child to be amongst their peers to be...encouraged to become part of a social circle” Professional

Secondly, peer support can also be helpful in CYP being supported by those with similar experiences. Stakeholders particularly highlighted the importance of services and organisations working with those with lived experience of self-harm, so that CYP currently struggling with self-harm could hear from those with similar experiences to them. School staff also mentioned the importance of mentors from similar backgrounds to CYP, who could act as a point of guidance and support.

Some parents and carers also highlighted that they had benefitted from support from other parents in relation to self-harm. In particular, families found it useful to speak to parents and

carers whose children had specific needs and experiences similar to theirs, for example speaking to families who also had an autistic child.

7.6.4 Interventions for self-harm

Some stakeholders suggested that community-based support could be an effective intervention in allowing CYP to access support whilst on waiting lists for services, and also prevent unnecessary referrals to A&E. This could include providing schools and GPs with the skills and training to assess risk among CYP who are self-harming and for early interventions to be provided in the community. Similarly, it was also highlighted that providing ambulance services with a referral pathways and access to community-based support could also be beneficial in providing alternatives to conveying CYP to A&E.

Many stakeholders described how support for self-harm needed to include explorations of the underlying causes of self-harm and taking steps to address this. This could include mental health treatment for those with mental health needs, assessments and adjustments for those who are neurodiverse and understanding and addressing academic or social factors such as exam stress or bullying that may be contributing to self-harm.

It was broadly agreed that interventions for self-harm needed to be tailored to meet the needs of CYP. Effective interventions could include talking therapies, medication or both, but these needed to be person-centred.

Some stakeholders also noted that the accessibility of interventions is important. As already noted, this includes considering how talking therapy may not be accessible for all CYP. However, as stakeholders noted it also involves ensuring the interventions are accessible in terms of setting and timing. One stakeholder suggested that mental health services needed to consider offering support outside of school hours. Another stakeholder noted that the setting of support needs to be considered, as mental health service settings can feel very medicalised, and as a result can be uncomfortable to attend for some CYP.

Stakeholders, parents and carers also noted the importance of interventions being tailored to certain groups. For example, for CYP with SEN, parents and carers felt it important to recognise that SEN are not separate to mental health needs, and support should be offered to address the two in conjunction. Similarly, one stakeholder also noted the importance of targeted support for Looked After Children, who may have complex mental health needs and trauma, and the need for their placements to be adequately trained to support with these needs. Stakeholders also noted the importance of personalised support for LGBTQIA+ CYP, recognising the increased risk of self-harm in this group. Other points included interventions exploring CYP's specific triggers for self-harm, in order to better support CYP to manage self-harm.

7.6.5 Creative and strengths-based approaches

Stakeholders highlighted that it is important for our approaches to supporting CYP with self-harm to be more creative. Talking therapies may be suitable for some but will not meet the needs of all. Alternative approaches could include art therapy, drama therapy, movement therapy and equine therapy. Equine therapy was noted by one stakeholder as an effective approach for CYP with high-risk recurrent self-harm.

Some also highlighted that digital support can be valuable, including live therapy or mood tracking through mobile applications. School staff also described finding the Stay Alive app useful in supporting some CYP and that some students have found the Calm Harm app effective.

It was also noted that approaches that draw on CYP's strengths and interests could be beneficial. These could include sporting activities, or physical places for CYP to socialise.

“Sometimes it’s about... building joy ...and building some sort of hope and something for them to look forward to” Professional

7.6.6 Coping strategies

Stakeholders highlighted that it was important to pair longer-term interventions to address self-harm, which short-term coping strategies that CYP can use to manage feelings of distress in the short-term. It was also felt that non-mental health professionals working with CYP, such as school staff and social workers, would benefit from having greater skills and confidence around emotional regulation and coping strategies.

7.6.7 Harm minimisation

Both CYP and professionals made reference to the role of harm minimisation in managing self-harm. It was felt that families and some professionals could benefit from an increased understanding of how self-harm can for some CYP, be a way of managing difficult emotions and perhaps prevent the development of suicidal thoughts or behaviours. In the short-term therefore, mandating that CYP stop self-harming completely, may pose risks to some CYP. In addition to this, CYP in one focus group also noted that where self-harm serves as a way of regaining control, being forced to stop can result in a further loss of control.

“If you take away all the control then...they’ll feel powerless, and they’ll feel more compelled to [self-harm]” Young person

Harm minimisation, which can include coping strategies, wound hygiene and aftercare can therefore be important for some CYP. However as per guidelines this should be for those CYP who are not yet in a position to stop self-harming, should be with the goal of reducing the severity or recurrence of self-harm, should be discussed collaboratively with CYP and their families, and be part of a wider array of support that is being offered²². One stakeholder noted that this requires a specialist CYPMH team to assess the self-harm and formulate a plan to support the risk identified.

CYP also noted that completely removing the access to means for self-harm can drive CYP to seek out other ways to self-harm. In contrast, feeling trusted by parents and carers can encourage CYP to feel that they have a choice about whether they self-harm and may encourage them to choose not to do so.

7.7 Training and resources

7.7.1 Training for professionals

Training for professionals was felt to be key by stakeholders and by CYP in improving support for self-harm. It was felt that those working in frontline roles, including clinical settings such as A&E, may benefit from training on why self-harm occurs, in order to reduce stigma and ensure empathy towards CYP presenting to services with self-harm.

Training was also felt to be important in ensuring that professionals respond in the right way to what can be very difficult conversations.

“How to listen to someone and understand them without trying to talk them out of the mental anguish or pain they are feeling and actually being prepared to work with someone through quite difficult, challenging conversations to help them to find an alternative” Professional

One stakeholder also emphasised the importance of recruiting the right staff into frontline roles.

“We need to get better at recruiting the appropriate staff, staff that care, staff that are passionate about making change and holding hope” Professional

One stakeholder noted that provision of training alone is not sufficient; instead, training needs to be delivered in way that is accessible in terms of timings, and staff need to have the support of their organisations to attend training.

Some stakeholders felt that increasing the number of staff able to have an initial conversation around self-harm, through training such as Youth Mental Health First Aid⁴², was important. It was also suggested that a widely shared factsheet or resource with key information on self-harm, including practical suggestions for supporting CYP, could be helpful for non-mental health professionals working with CYP. Stakeholders also queried whether the self-harm pathway, currently being developed as a resource for schools, could be shared more widely, such as with social workers.

A few stakeholders felt they would benefit from training that goes further than having an initial conversation around self-harm. These stakeholders thought that increased training on assessing risk and strategies to manage self-harm, could help to avoid CYP unnecessarily being signposted to A&E, even when urgent medical care is not needed.

“Maybe...training hasn’t gone...far enough in terms of...the school feeling equipped to be able to teach that young person alternatives” Professional

There were also suggestions on broader training needs for professionals, such as how schools can support those CYP waiting for assessments in relation to neurodiversity. Stakeholders also felt there were training needs around supporting LGBTQIA+ CYP, with one stakeholder

highlighting that some professionals do not feel confident in navigating conversations with CYP who are transgender, non-binary or questioning their gender identity.

Finally, one stakeholder also noted that they are currently exploring training for schools that will support with developing a school policy on self-harm, taking a whole school approach, with practical guidance for schools on what steps to take and how to communicate with CYP and their families.

7.7.2 Supervision and reflective practice

As noted in NICE guidelines, multiple stakeholders highlighted how supporting CYP with self-harm can be distressing for professionals, and that appropriate supervision needs to be offered to these professionals²². This can be the case for settings such as schools, where supervision may not have historically been utilised.

“Some of things that they are experiencing or witnessing can feel quite difficult and distressing and there isn’t then that support for those staff” Professional

Whilst supervision is more ingrained in mental health services, the impact of working with CYP with self-harm can nonetheless impact staff significantly, underlining the importance of supporting staff to engage in reflective practice.

7.7.3 Resources for and awareness among parents and carers

Alongside professionals being able to recognise self-harm, it is also important for parents and carers to have access to resources that support this. This could include for example ensuring schools have capacity to run regular sessions for parents, so that this awareness is continually developed and refreshed.

“More education around self-harming... for not just the children and young people but for families [and] parents to... be aware that it’s happening and the signs to look out for in their child so they can support their child” Professional

Parents and carers who responded to the survey emphasised how important it is that parents have access to a centralised resource of information on self-harm. This includes statutory and voluntary sector services that can support with self-harm. The Waiting Room website can serve this type of purpose but may not contain all the relevant services and information.

One stakeholder also discussed how these resources should be made as accessible as possible:

Parents are...integral in this as well...ensuring that parents...know where to find what available support [there] is and how they access that and also recognising that Barnet is very multicultural [and] multilingual” Professional

7.7.4 Resources for and awareness among CYP

Awareness of self-harm and relevant resources among CYP is also key. This can provide an opportunity for CYP to access personal support, should they not feel able to disclose self-harm to schools, families or other professionals. Awareness among CYP can also help to facilitate CYP to recognise signs of self-harm among their peers and signpost them to support.

Ensuring that CYP have knowledge of the pathways of support for self-harm and what kind of support may be offered, can also help CYP to feel more able to disclose self-harm, as it can reduce apprehension about what the next steps will be.

The format in which information is provided for CYP is also important. Information should be available in digestible format. Easy access to digital resources such as through Quick Response (QR) codes on posters can be helpful, but if using these in schools, it is important to consider whether the school permits smartphone access.

8. Recommendations

This section takes the findings from Sections 5, 6 and 7 and summarises these into areas of need. The areas of need identified are: leadership and co-production; data and insights; prevention; support in schools; mental health support; support from other services; and finally, training and resources. Recommendations have been mapped against each of these areas of need.

Leadership and co-production	
Areas of need	Recommendations
<ul style="list-style-type: none"> • Greater multi-disciplinary collaboration, including sharing of safety plans and support plans • School staff requiring guidance on how to best support CYP and their families • Increased work with CYP with lived experience, to shape prevention and interventions, and to provide CYP with access to those with similar experiences 	<ul style="list-style-type: none"> • Establish a Task & Finish Group to take forward and prioritise the findings and recommendations of this HNA, ensuring co-production with multi-agency partners involved in the HNA and other relevant partners, as well as CYP and their families • Consider integrating recommendations into other strategic work in Barnet • Promote multi-disciplinary collaboration and data sharing to support CYP who are self-harming, for example through all professionals encouraging CYP and their families to share safety plans and support plans with relevant parties • Build on existing work to further support schools to develop and implement clear policies and procedures around self-harm, ensuring all staff are trained and confident in applying these

	<ul style="list-style-type: none"> Encourage organisations working with CYP who self-harm to actively integrate lived experience into service design, delivery, and evaluation
Data and insights	
Areas of need	Recommendations
<ul style="list-style-type: none"> There are variations between services in the quality of data captured on CYP presenting with self-harm, including some services recording self-harm only within case notes There is limited data on the links between self-harm and suicidality locally Lack of information sharing around risk groups Limited data on the sexuality and gender identity of CYP affected by self-harm locally Monitoring of trends such as the possible rise in attendances in those aged 10-14, as well as associations with ethnicity and deprivation Limitations to this HNA, including lack of access to inpatient and outpatient mental health data, only some figures being presented as rates and limited service use data for those aged 18-25 Limited qualitative engagement with stakeholders who work with those aged 18-25 Limited understanding of the scale of self-harm not presenting to clinical services in Barnet 	<ul style="list-style-type: none"> Improve data collection (including for demographic factors) and coding across services to better capture self-harm presentations and trends Explore strengthening data collection on the links between self-harm and suicidality, including working with providers on how this data could practically be captured Share data to identity groups in Barnet at higher risk of self-harm Monitor trends in self-harm by demographic factors such as age, gender identity, sexuality, ethnicity, and deprivation Explore data further where possible to address limitations of this work, including access to inpatient and outpatient mental health data, looking in greater detail at rates of admissions and attendances as well as looking at service use data for those aged 18-25 Explore opportunities for qualitative engagement with stakeholders working with those aged 18-25 such as the Barnet 18-25 Transition Pathway Team and Middlesex University Consider if a question on self-harm could be incorporated into existing relevant local surveys, to capture self-harm not presenting to clinical services
Prevention of self-harm	
Areas of need	Recommendations
<ul style="list-style-type: none"> Increased psychoeducation and emotional literacy from primary school age, in schools Open conversations around mental wellbeing in schools, to encourage normalisation and reduce stigma 	<ul style="list-style-type: none"> Further promote evidence-based and age-appropriate psychoeducation and emotional literacy for CYP in schools, beginning at primary school age Further embed resilience building in school life, including raising

<ul style="list-style-type: none"> • Increased psychoeducation for school staff and families • Identification of risk groups and early intervention to prevent self-harm • Increased support at high-risk times of year • A lack of stability in placements for Looked After Children that can impact on wellbeing • Exposure to harmful online materials 	<p>awareness around mental wellbeing via the Resilient Schools Programme and MHSTs</p> <ul style="list-style-type: none"> • Promote open conversations about mental wellbeing in schools, potentially through regular one-to-one wellbeing check ins, anonymous feedback tools and evidence-based engaging PHSE lessons • Enhance psychoeducation for school staff and families to support emotional literacy in CYP • Increase awareness among CYP, families and schools of available support for mental health issues, neurodiversity, bereavement and other risk factors • Increase support at higher risk times of year such as examination periods • Build permanency and stability for Looked After Children • Raise awareness among CYP and their families on how to avoid harmful online content, including strategies such as filtering social media
<p>Support in schools</p>	
<p>Areas of need</p>	<p>Recommendations</p>
<ul style="list-style-type: none"> • Schools' resources and capacity to support with mental wellbeing, SEN and neurodiversity as well as self-harm • SEN being conceived as separate to mental health need 	<ul style="list-style-type: none"> • Support schools to better meet the needs of CYP with mental health difficulties, SEN and neurodiversity, as well as self-harm, including considering possible links to the PINS programme where the programme's capacity allows • Support practitioners to provide holistic support for SEN and mental health needs
<p>Mental health support</p>	
<p>Areas of need</p>	<p>Recommendations</p>
<ul style="list-style-type: none"> • Lack of timely access to mental health support services, difficulty identifying the right mental health service and challenges with being redirected between different services • CYP feeling dismissed through language used by professionals 	<ul style="list-style-type: none"> • Continue work to improve access to appropriate mental health services, reducing delays, improving support for families whilst they wait and reducing service navigation issues • Ensure careful use of language around self-harm

<ul style="list-style-type: none"> • Support not being accessible for all CYP or tailored to their needs • A lack of community-based support and alternative support to A&E • Greater access to peer support, including from those with past experience of self-harm • Loss of support when transitioning from children's to adult services • Greater access to harm minimisation where appropriate, including coping strategies • Lack of continuity of care in mental health support for Looked After Children placed outside Barnet 	<ul style="list-style-type: none"> • Ensure interventions are person-centred, accessible, and adapted for communication needs, including the needs of those who are neurodiverse • Deliver culturally competent, inclusive support, including for LGBTQIA+ and ethnically minoritised CYP • Collaborate with MHSTs and primary care providers to expand community-based self-harm support, especially for those on waiting lists • Continue work to strengthen diversion pathways from A&E to reduce unnecessary hospital visits for self-harm • Tailor mental health interventions to CYP's needs, including creative therapeutic support, strengths-based approaches and digital tools • Ensure mental health support is accessible by considering timing and setting • Explore peer support and mentoring opportunities, including lived experience involvement • Further strengthen transition planning between children's and adult mental health services • Support harm minimisation strategies where appropriate, including coping strategies, as part of a broader care plan • Review continuity of care in mental health support for Looked After Children placed outside Barnet
<p>Support from other services</p>	
<p>Areas of need</p>	<p>Recommendations</p>
<ul style="list-style-type: none"> • Placements not being equipped to support Looked After Children in relation to mental health needs and self-harm, which may contribute to mental health admissions • Looked After Children experiencing a range of challenges and pressures 	<ul style="list-style-type: none"> • Provide targeted support for Looked After Children including adequate training for placements (see Training and resources for additional Recommendations)

<p>that impact engagement with support for self-harm, including support ending at age 18</p> <ul style="list-style-type: none"> • Lack of alternative locations to A&E where London Ambulance Service can convey CYP who have self-harmed 	<ul style="list-style-type: none"> • Review transition support for Looked After Children turning 18, with mental health issues or self-harm • Work with the London Ambulance Service to develop safe diversion options from A&E for CYP who self-harm
<p>Support for families</p>	
<p>Areas of need</p>	<p>Recommendations</p>
<ul style="list-style-type: none"> • Access to peer support networks for parents and carers • Impact on the families of CYP who are self-harming, including wellbeing and financial impacts 	<ul style="list-style-type: none"> • Facilitate peer support by connecting families with shared experience • Provide wellbeing support for the families of CYP who are self-harming
<p>Training and resources</p>	
<p>Areas of need</p>	<p>Recommendations</p>
<ul style="list-style-type: none"> • CYP can find it stigmatising to access support in schools, where there is a designated contact for mental health support or self-harm • Any adult working with CYP, including frontline A&E staff, being able to navigate a conversation around self-harm sensitively • Those working with CYP having the skills to compile a safety plan • Accessibility and timing of training for professionals • Lack of knowledge among professionals on supporting CYP who are awaiting assessments for neurodiversity and around working with LGBTQIA+ CYP • A lack of supervision or reflective practice, especially for non-mental health professionals • Families not knowing where to access support • Families not knowing how to communicate with CYP around self-harm, and CYP's fears around how their families will react to disclosures • CYP's willingness to access support 	<ul style="list-style-type: none"> • Provide basic training in mental health and self-harm for all professionals working with CYP, including school staff • Train non-mental health professionals, including A&E staff, to respond non-judgementally • Create and share a written resource for those working with CYP, on key information about self-harm and how to support CYP • Offer advanced training for some non-mental health professionals e.g. education staff and social workers on risk assessment, safety planning, and coping strategies • Ensure that training for professionals is accessible, with support from employers to attend training • Provide training for professionals on supporting CYP awaiting assessments for neurodiversity, and LGBTQIA+ CYP • Ensure supervision and reflective practice are available to staff supporting CYP who self-harm • Develop a centralised, accessible resource hub for parents and carers,

<ul style="list-style-type: none"> • Placements not being equipped to support Looked After Children in relation to mental health needs and self-harm 	<p>schools and other professionals working with CYP on self-harm support, and how to navigate conversations with CYP, considering the role of the Waiting Room as a source of information</p> <ul style="list-style-type: none"> • Ensure CYP are aware of support pathways and what to expect from services • Tailor communication formats to CYP’s needs and preferences • Ensure adequate training for placements to support Looked After Children with mental health needs and self-harm
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Appendices

Appendix 1: Stakeholder interview questions

Stakeholder interview questions

1. What services does your organisation offer that are relevant to children and young people (CYP) who self-harm?
2. In your experience, to what extent is self-harm an issue among CYP in Barnet and why?
3. Which groups of children and young people are particularly at risk of self-harm in Barnet?
4. In your experience, what are the reasons why CYP self-harm?
5. What actions or support for CYP who self-harm have you seen work well that should continue?
6. What is the unmet need and what are the barriers to services for CYP who self-harm?
7. What new actions or support should be introduced for CYP who self-harm?
8. What could be done to prevent CYP from starting to self-harm?
9. Do you think that you and others receive sufficient training to support CYP affected by self-harm and what additional training might be helpful?

Appendix 2: Estimated prevalence of self-harm in Barnet

		8 to 10 year olds		11 to 16 year olds		17 to 24 year olds	
		National data (%)	Barnet estimates	National data (%)	Barnet estimates	National data (%)	Barnet estimates
All							
In the last 4 weeks, talked about harming themselves	Yes	2.4	372	2.4	761	9.1	3139
	No	97.6	15275	97.6	31242	90.9	31443
In the last 4 weeks, tried to harm themselves	Yes	1.3	211	1.7	558	4.8	1654
	No	98.7	15436	98.3	31445	95.2	32928
Over the whole of their lifetime, tried to harm themselves	Yes	5.9	926	11.2	3586	36.8	12735
	No	94.1	14721	88.8	28417	63.2	21847
Boys							
In the last 4 weeks, talked about harming themselves	Yes	2.2	180	1.9	310	5.6	978
	No	97.8	7986	98.1	16144	94.4	16522
In the last 4 weeks, tried to harm themselves	Yes	1.9	152	1.5	252	1.3	234
	No	98.1	8014	98.5	16202	98.7	17266
Over the whole of their lifetime, tried to harm themselves	Yes	7.8	641	8.5	1407	28.8	5032
	No	92.2	7525	91.5	15047	71.2	12468
Girls							
In the last 4 weeks, talked about harming themselves	Yes	2.6	192	2.9	451	12.9	2200
	No	97.4	7289	97.1	15098	87.1	14882
In the last 4 weeks, tried to harm themselves	Yes	0.8	60	2.0	306	8.5	1458
	No	99.2	7421	98.0	15243	91.5	15624
Over the whole of their lifetime, tried to harm themselves	Yes	3.9	291	14.0	2176	45.7	7799
	No	96.1	7190	86.0	13373	54.3	9283

Table 4. Barnet estimates for self-harm rates, based on the Mental Health of Children and Young People Survey 2023^a and 2023 Mid-Year Population Estimates for Barnet