Insights to inform a shift

From hospital to community

Young Minds, Hidden Struggles

Perceptions of self-harm from Children and Young people, Professionals and the Medway and Swale Community

August 2025

A collaborative report, together with:

healthwatch Medway

Medway Council

Medway and Swale Health and Care Partnership

MVA Supporting Communities in Kent & Medway

healthwatch Kent

Foreword

We are proud to present this report as the culmination of an important collaboration maximising the strengths of organisations from different sectors. It has embraced different ways of working with a single commitment to improving the health and wellbeing of children and young people in Medway and Swale.

This work represents a shared commitment from Healthwatch Medway, Healthwatch Kent, Medway Council's Partnership Commissioning Team, Medway Voluntary Action, and the Medway and Swale Health and Care Partnership to better understand the complex issue of self-harm among children and young people in our communities.

At its heart, this report centres the voices and experiences of young people, families, communities, and professionals. It provides an essential evidence base that helps us move beyond assumptions and towards a more informed, compassionate, and effective response to a growing public health challenge.

The findings reflect both the urgency and opportunity before us. Rates of self-harm remain worryingly high across Medway and Swale and are compounded by broader social and emotional pressures. But the report also highlights the resilience and insight of our young people, and the value of listening to them - directly and without judgment.

We are grateful to the many individuals and organisations who contributed their time, experience, and knowledge to this project. In particular, we thank the children and young people who bravely shared their perspectives; your voices are shaping the way forward.

As system leaders, we recognise that addressing self-harm requires not only better services, but also stronger communities, earlier intervention, and a more joined-up approach across health, education, social care, and the voluntary and community sectors. This report strengthens our collective ability to act, and we are committed to ensuring its findings lead to meaningful, sustained change.

Together, we reaffirm our commitment to putting children and young people at the centre of everything we do, helping them to grow up safe, well, and supported.

Dr David Whiting

Director of Public Health,
Medway Council

Dr Anjan Ghosh

Director of Public Health,
Kent County Council

Nikki Teesdale

Director of Health and Care Integration and Improvement,
NHS Kent and Medway

About us

This report is the culmination of collaborative research by a number of organisations working across Medway and Swale. Organisations included:

Healthwatch Medway and **Healthwatch Kent** are independent champions for health and social care in Kent and Medway. Our aim is to improve services by ensuring local voices are heard – we want to hear about health and social care experiences so to influence positive change for communities across the Kent and Medway area. We have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care. Healthwatch Medway and Healthwatch Kent are hosted by **EK360**.

Medway Council's Partnership Commissioning Team sits across both Medway Council and the NHS Kent and Medway Integrated Care Board (NHS K&M ICB) with a focus and commitment to commissioning and providing services, support and resources to children and young people in relation to their mental health and emotional wellbeing within Medway.

MVA Kent and Medway is an infrastructure organisation supporting Voluntary, Community, Social Enterprise & Faith (VCSEF) organisations. MVA Kent and Medway's mission is to be a catalyst for social change to support and empower communities to come together to help improve their lives and solve problems that are important within their communities. MVA Kent and Medway delivers the Involving Medway and Swale Programme on behalf of Medway and Swale Health and Care Partnership.

Medway and Swale Health and Care Partnership is made up of a wide range of stakeholders in Medway and Swale's private and public sector, including the acute hospital, community healthcare providers, the mental health trust, councils and commissioning colleagues, as well Healthwatch representatives. Medway and Swale Health and Care Partnership's vision is:

> ***To put local people at the heart of the services we design and deliver, helping local people to realise their potential; to live healthier, happier lives; and to stay well and independent in their families, homes and communities for as long as possible.***

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Summary

Introduction

This study provides insights towards the understandings and perceptions of self-harm and the factors causing children and young people between the ages of 10-24 in the Medway and Swale areas. This was conducted as a collaborative study between Healthwatch Medway, Healthwatch Kent, MVA Kent and Medway, Medway Council's Public Health Team and Medway and Swale Health and Care Partnership.

Methods

A mixture of surveys, interviews and focus groups were conducted across a total participant sample of **323** individuals. The methodological quality of this study was adjudged to hold a high risk of bias, the contributing factor being the methodological rigour used in focus groups conducted with children and young people. To avoid supplementary selection bias, this dataset has been included within the findings of the report. Findings from this dataset are clearly stated as possessing a high risk of bias.

Findings

Understanding of self-harm: "cutting yourself" was the most universally recognised form of self-harm. Some differences in perceptions across age groups and public vs professional roles were observed.

Awareness of support services: nearly half (**48%**) of the general public were unaware of any support services. Professionals showed a greater overall awareness, but **12%** still lacked awareness of support services. Children and young people most frequently identified CAMHS, Childline and Kooth.

Drivers of emotional distress: young people cited pressures with maintaining standards, social media and mental health/addiction challenges as key stressors. **57%** attempted to manage emotions independently, though a proportion (**29%**) said they felt hopeless of unsure where to turn for support.

Emerging trends: professionals reported an observed increase in cutting, eating-related self-harm and links between social media and self-harming behaviours. Neurodiverse young people were identified as particularly vulnerable.

Challenges and strengths: barriers identified include engaging with children and young people, access to services (including waiting times) and unclear referral pathways for the correct support. Empathy and active listening were highlighted as effective support strategies.

Conclusions

The landscape of self-harm is complex, shaped by personal, social and systemic factors. A multifaceted and inclusive strategy – grounded in education, early intervention, co-production and empathetic engagement – is required for creating meaningful change.

Recommendations

- Create and launch targeted awareness campaigns for professionals and communities.
- Strengthen multi-agency collaboration for self-harm prevention.
- Build learning on engagement and research methodologies within the VCSEF sector.

Introduction

This project started in June 2024 and engagement finished in February 2025. Aims of the project are to enhance system-wide understanding of self-harm and the factors driving children and young people between the ages of 10-24 to engage in such behaviours.

The project used the National Institute of Clinical Excellence (NICE) definition of 'self-harm', as ***'intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act'***.

Through collaboration between **Healthwatch Medway**, **Healthwatch Kent**, **MVA Kent and Medway**, **Medway Council's Public Health Team** and **Medway and Swale Health and Care Partnership**, the project seeks to identify contributing factors, gaps in and opportunities to improve outcomes for children and young people in Medway and Swale.

This includes:

- Gaining insights into perceptions of self-harm among children and young people, communities, and professionals.
- Exploring the underlying causes of self-harm as defined by children and young people.
- Support for children and young people, from a holistic perspective, considering broader health determinants.

There are **279,800** people living in Medway, which is about a six percent increase from 2011. Of this number, **69,800** are children and young people aged 0 to 19, up from **69,000** in 2011. Swale hosts **151,700** residents demonstrating an increase of **11.7%** between 2011-2021; 36,104 of this number are aged 0-19 years of age.

Since 2017, NHS England has conducted a series of national surveys to study the mental health of children and young people. Four follow-up surveys were conducted in 2020, 2021, 2022 and 2023. The data suggests that in Kent and Medway, **59,362** children and young people aged 5 to 17 may have a probable mental health disorder and will need to access advice, support or interventions.

The monthly average of children and young people under 18 from Medway and Swale attending A&E for self-harm at Medway Foundation Trust is higher than the national average. Specifically, the average attendance data nationally is ten CYP monthly, while at Medway Foundation Trust it was **33** from November 2022 to January 2024.

Methods

Procedure

This project was designed to leverage the strengths of various organisations to foster meaningful engagement with children and young people, communities and professionals. Each organisation implemented a different methodological approach to the collection of data, as outlined below, leading to the production of varied information and results.

Engagement with Professionals

Healthwatch Medway and **Healthwatch Kent** facilitated targeted engagement with professionals who work directly with (or interact with) children and young people as part of their roles in Medway and Swale. This involved in-person interviews and online surveys.

Engagement with General Public

Healthwatch Medway and **Healthwatch Kent** facilitated public engagement through convenience sampling by interacting with the general public in high street settings across Medway and Swale. This involved in-person surveys.

Engagement with Children and Young People

Medway Council's Public Health Team engaged with children and young people through structured focus groups and personalised one-on-one interactions, capturing understanding of the needs and concerns of children and young people.

MVA Kent and Medway engaged children and young people through its Involving Medway and Swale Programme (in collaboration with VCSEF organisations) to organise focus groups, creating dedicated spaces for children and young people to voice their insights and experiences.

Measures

Consent

All organisations engaging as part of this project took steps to ensure robust consent processes were in place and all participants were aware of the purpose for engagement, how data would be processed and used and their rights to withdraw their consent.

Risk assessment and management

Exploring the topic of self-harm requires a thoughtful and cautious approach, as it presents heightened risks for both participants and the organisational leads conducting focus groups and one-on-one discussions.

To mitigate these risks, a self-harm resource pack was developed and made available on the **Healthwatch Medway** website, with a printable leaflet also provided. This resource was shared with all engaged professionals and distributed via email to a mailing list of professionals. Additionally, a QR

code linking to the resource pack was created and handed out alongside printed leaflets during team meetings, conferences and direct engagement with members of the Medway and Swale communities, including children and young people.

A targeted communications campaign was launched during the Christmas period, encouraging professionals and communities to proactively research available mental health crisis services and their holiday opening hours. To support this initiative, a social media infographic was created, alongside a Christmas mental health leaflet detailing service availability, which was distributed to professionals and local communities.

To ensure the wellbeing of children and young people participating in this project, several additional support measures were implemented:

- Organisations engaging with children and young people offered extra support when needed.
- Follow-ups were conducted after engagement to check on their health and wellbeing and provide further assistance if necessary.
- No children or young people required immediate extra support during or after engagement.

Sampling selection

- *Children and young people*: **MVA Kent and Medway** collaborated with VCSEF organisations to connect with **100** children and young people in Medway and Swale.
- *Schools and Faith Communities*: **Medway Council's Public Health Team** facilitated engagement within schools and faith-based community groups across Medway, reaching **38** children and young people.
- *Community Engagement*: **Healthwatch Medway** and **Healthwatch Kent** carried out interactions with the general public through a convenience sampling approach on high streets, resulting in **88** community responses.
- *Professional Engagement*: **Healthwatch Medway** and **Healthwatch Kent** specifically targeted professionals who work directly with or interact with children and young people as part of their roles in Medway and Swale, with **97** responses in this cohort.

The overall sample size in this research is a total of **323** participants.

Assessment of Risk of Bias

The methodological quality of this research was evaluated using Cochrane's Risk of Bias Tool (ROBINS-E) for non-randomised studies. This tool assesses bias across several domains including: confounding variables, participant selection and missing data.

Based on the assessment, this study was judged to have a high risk of bias indicating that "the study has some important problems; characteristics of the study give rise to a high risk of bias in the result". The contributing factor to this assessment of risk of bias is the methodological rigour used in focus groups conducted with children and young people. Data collected by **MVA Kent and Medway** was assessed as demonstrating uncontrolled confounding factors, selection biases and evidence of bias through missing or incomplete data. To avoid supplementary selection bias, this dataset has been included within the findings of the report. Findings from this dataset are clearly stated as possessing a high risk of bias.

Analysis

Data analysis and report writing was undertaken by **EK360's** Social Value and Evaluation Lead to ensure independence and impartiality when analysing data from the empirical field research. Findings presented in this report were derived through both quantitative analysis and thematic analysis.

This research implemented multiple methodological approaches to the collection of data including surveys, focus groups and interviews. Findings have been derived from each distinctive methodological approach, then cross-compared to identify key topics, themes or trends that underpin across the various methodological approaches.

Findings that have been assessed to have a high risk of bias are clearly stated throughout the report and discretion is advised when interpreting this data. The authors have also taken the decision to omit drawing conclusions from this dataset.

Demographics

Healthwatch Engagement Demographics

Public participants and professionals answered several demographic questions providing context, depth and relevance to this study through insights into the characteristics of each cohort in this sample. An overview of key demographic information for each cohort is provided below:

General Public Demographics

Age: The largest response was from people aged 16-24 years (**24%**). The smallest response was from people aged 85-94 years (**1%**). The full range of ages is shown in ***Figure 1***.

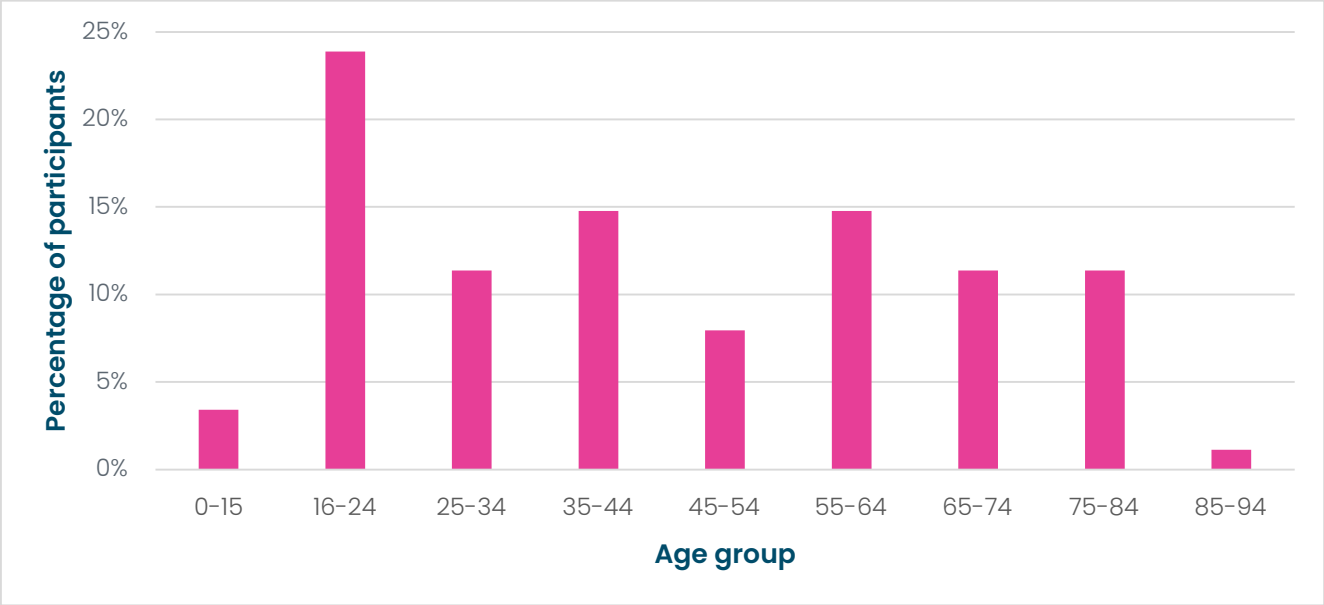

Figure 1*: the percentage of participants in the Healthwatch public sample by age group.*

Gender: **67%** of Healthwatch public participant sample were female, **31%** were male and **2%** opted to prefer not to say. Additionally, **3%** of the participant sample identified as trans.

Sexuality: **77%** were heterosexual/straight, **6%** were gay/lesbian, **3%** were bisexual and **14%** opted to prefer not to say.

Ethnicity: **91%** were English/Welsh/Scottish/Northern Irish/British, **3%** were any other White Background (**1%** Lithuanian, **1%** Latvian and **1%** Romanian), **2%** were African, **1%** were Bangladeshi, **1%** were Indian and **1%** were White & Black African.

Location: The largest response was from people living in the ME7 area (**19%**). The smallest response was from people living in the ME9 area (**1%**). The full range of locations is shown in ***Figure 2***.

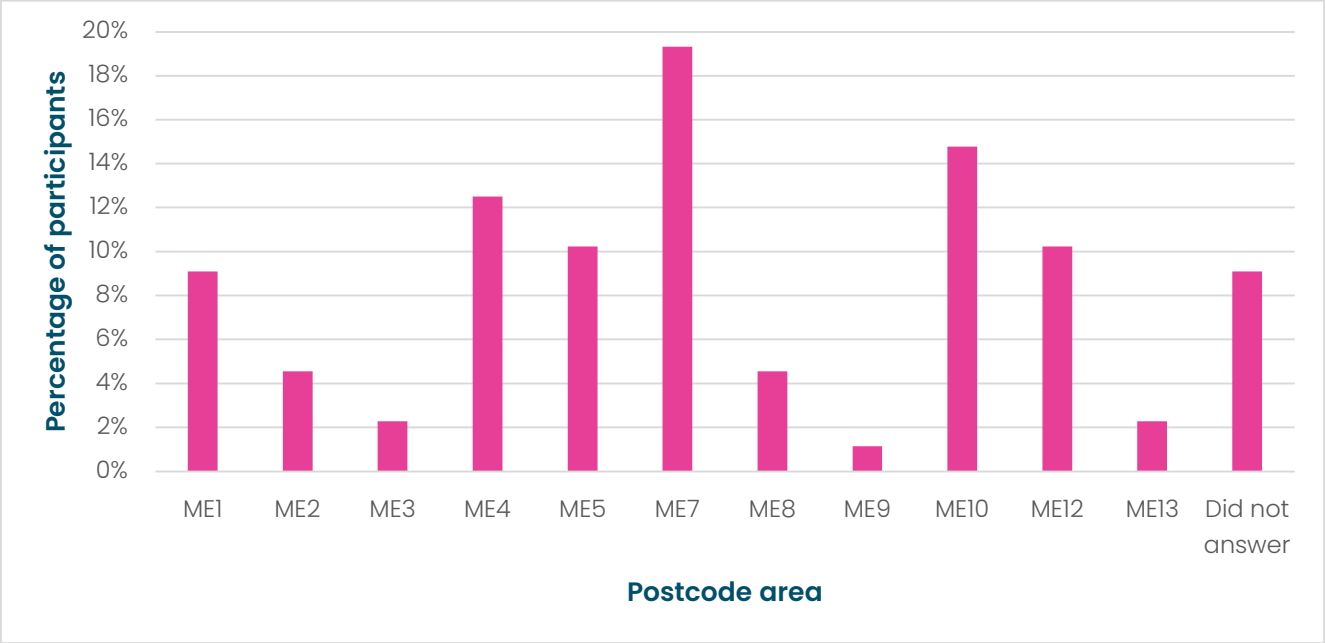

Figure 2: *the percentage of participants in the Healthwatch public sample by location.*

Carer status: **16%** were carers, **1%** were young carers, **81%** were not carers and **2%** opted to prefer not to say.

Low-income status: **31%** were from low-income households, **41%** were not from low-income households and **28%** did not answer.

Homelessness status: **5%** were homeless, **64%** were not homeless and **31%** did not answer.

Disabilities and health conditions: **34%** were disabled or had a health condition, **60%** were not disabled or had a health condition and **6%** opted to prefer not to say. The types of disabilities and health conditions reported by participants is shown in ***Figure 3***.

Neurodiversity: **22%** were neurodiverse and **78%** did not answer.

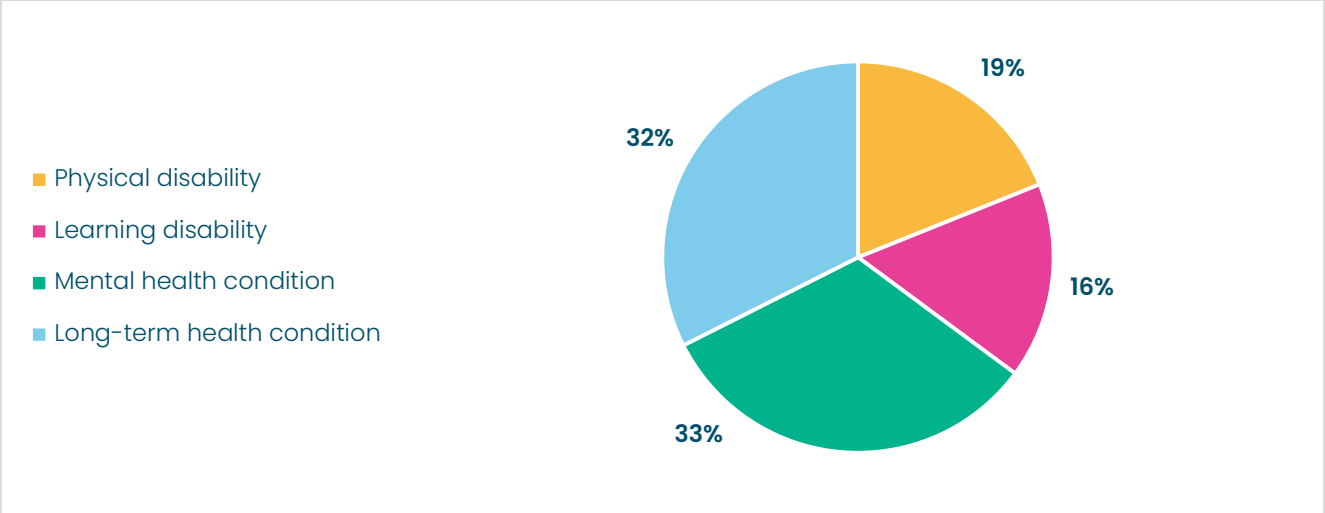

Figure 3: *the percentage of participants in the Healthwatch public sample who were disabled or had a health condition, by the type of disability or health condition.*

Professionals Demographics

Age: The largest response was from people aged 35-44 years (**30%**). The smallest response was from people aged 65-74 (**3%**). The full range of ages is shown in ***Figure 4***.

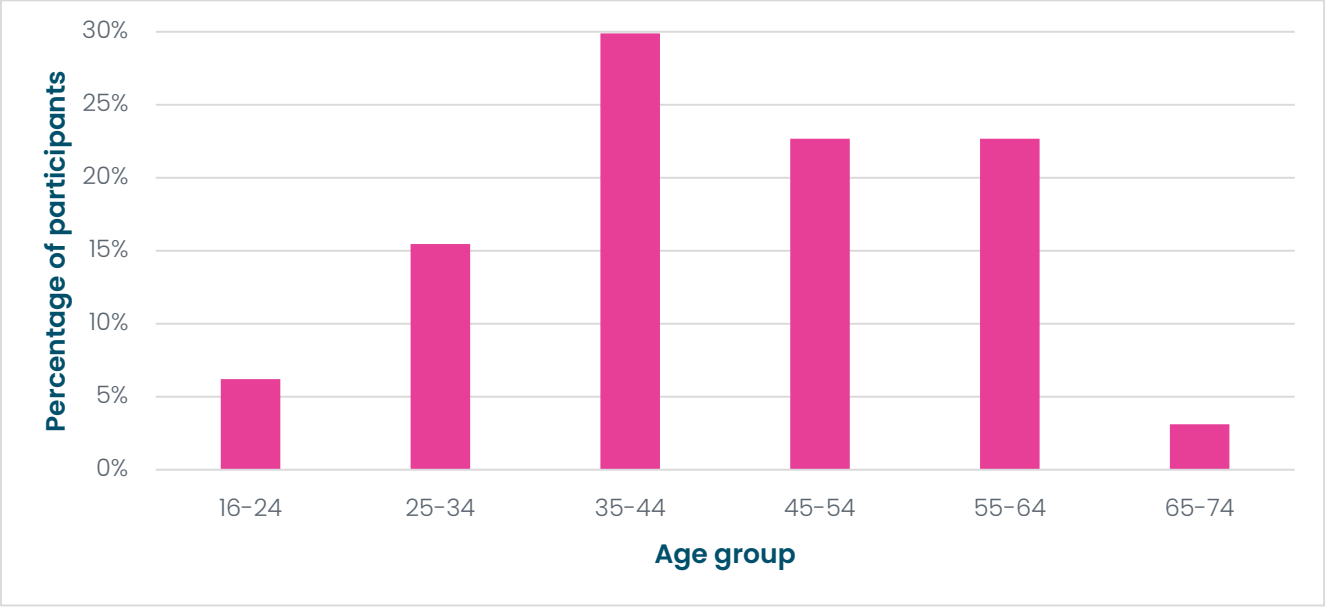

Figure 4: *the percentage of participants in the Healthwatch professional sample by age group.*

Gender: **84%** of Healthwatch professional participant sample were female, **15%** were male and **1%** opted to prefer not to say. None of the participant sample identified as trans.

Sexuality: **88%** were heterosexual/straight, **5%** were gay/lesbian, **2%** were bisexual, **3%** opted to prefer not to say and **2%** did not answer.

Ethnicity: **80%** were English/Welsh/Scottish/Northern Irish/British, **4%** were Indian, **3%** were African, **2%** were any other White Background (**1%** Polish, **1%** unspecified), **1%** were White & Asian, **1%** were White & Black African, **1%** were any other mixed/multiple ethnic background (unspecified), **1%** were any other ethnic origin (unspecified) and **6%** did not answer.

Location: The largest responses were from people in the ME4 (**8%**) and ME7 (**8%**) areas. The smallest responses were from 11 different areas: CT1, CT16, CT20, DA1, ME9, ME12, ME13, ME15, ME18, SE1 and TN1 (each at **1%**). **35%** did not answer. The full range of locations is shown in ***Figure 5***.

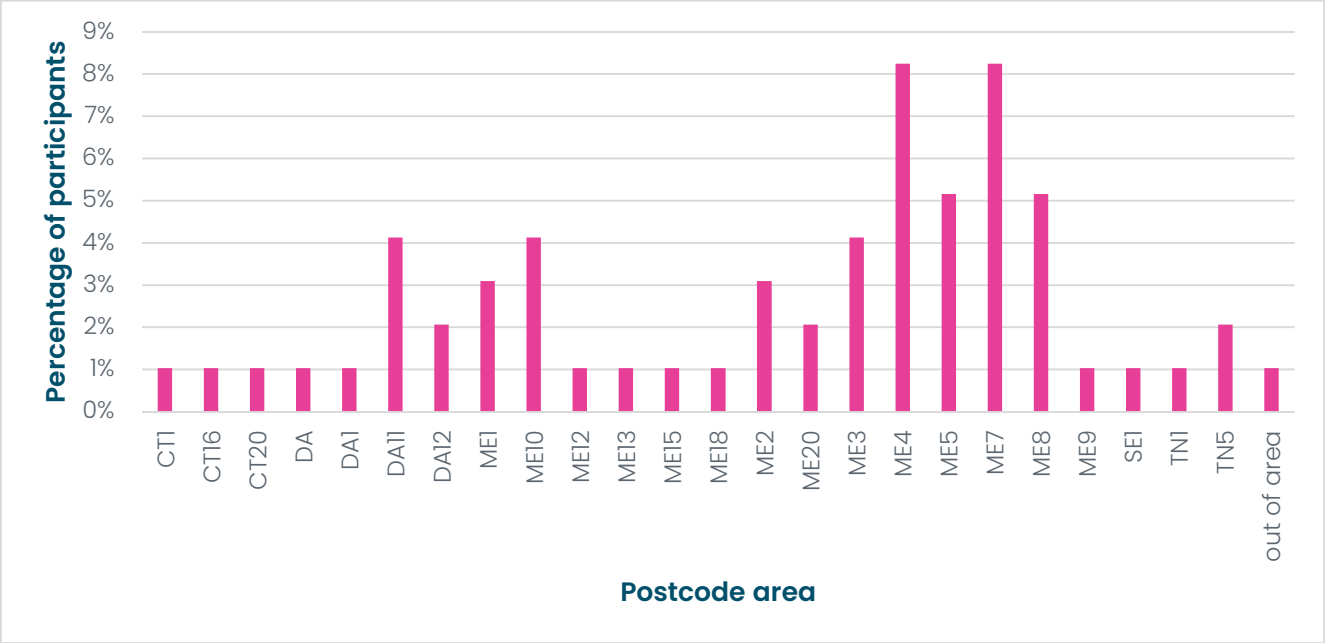

Figure 5: *the percentage of participants in the Healthwatch professional sample by location.*

Carer status: **13%** were carers, **86%** were not carers and **1%** did not answer.

Low-income status: **12%** were from low-income households, **62%** were not from low-income households and **26%** did not answer.

Homelessness status: **1%** were homeless, **72%** were not homeless and **27%** did not answer.

Disabilities and health conditions: **16%** were disabled or had a health condition, **79%** were not disabled or had a health condition, **2%** opted to prefer not to say and **2%** did not answer. The types of disabilities and health conditions reported by participants is shown in ***Figure 6***.

Neurodiversity: **14%** were neurodiverse, **20%** were neurotypical and **66%** did not answer.

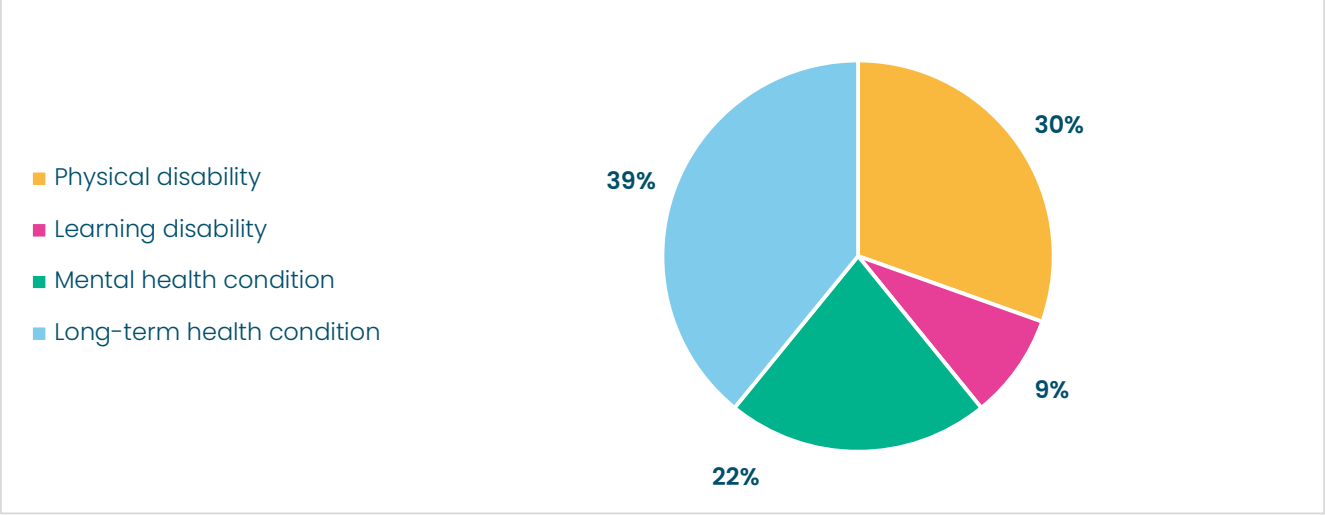

Figure 6: *the percentage of participants in the Healthwatch professional sample who were disabled or had a health condition, by the type of disability or health condition.*

Medway Council Public Health Demographics

Age: Medway Council Public Health responses were from children aged 10-13 (**55%**) and young people aged 14-24 (**45%**).

Gender: **42%** of Medway Council Public Health respondents were female, **42%** were male and **16%** did not answer.

Sexuality: **37%** of Medway Council Public Health respondents were heterosexual/straight, **3%** were gay/lesbian and **61%** did not answer.

Ethnicity: **29%** of Medway Council Public Health respondents were African, **18%** were English/Welsh/Scottish/Northern Irish/British, **13%** were any other Black/African/Caribbean background (**8%** Black British, **5%** African British), **11%** were White & Black African, **5%** were any other ethnic group (**3%** English Caribbean, **2%** English Nigerian) and **24%** opted to prefer not to say.

Location: The majority of Medway Council Public Health responses were from people who did not answer (**60%**). Of responses, most participants were from the ME5 area (**24%**). The smallest responses were from the ME7 area (**3%**). The full range of locations is shown in ***Figure 7***.

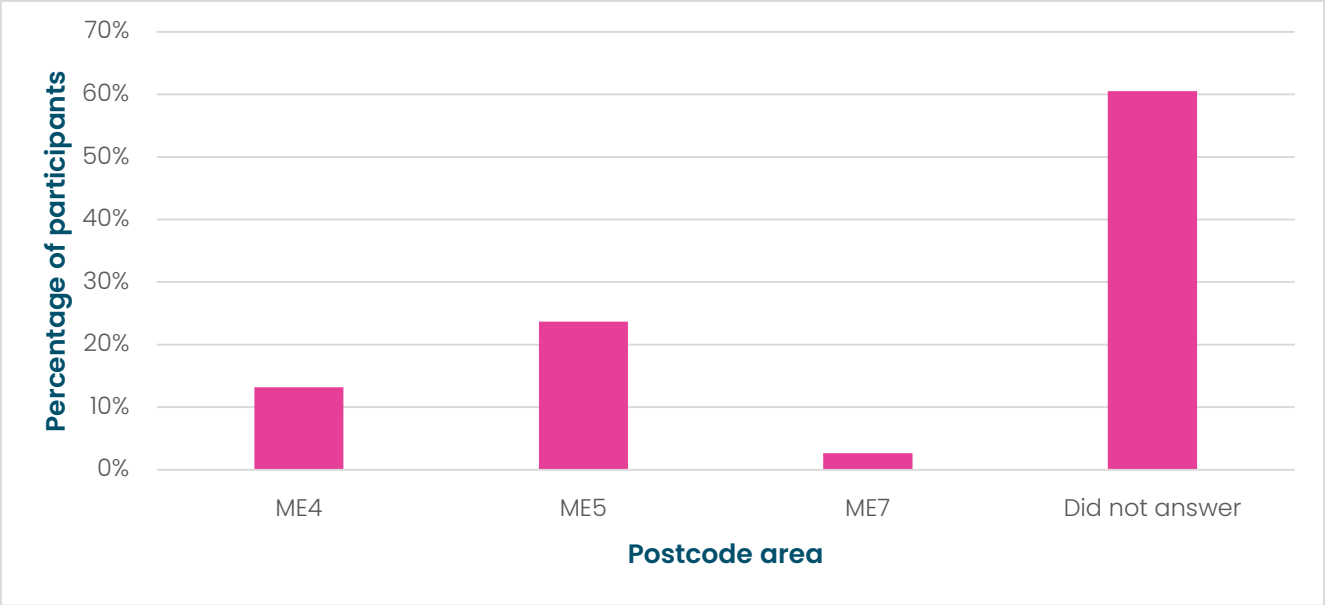

Figure 7: the percentage of participants in the Medway Council Public Health sample by location.

Carer status: **8%** of Medway Council Public Health respondents were young carers, **3%** were carers, **61%** were not carers, **3%** opted to prefer not to say and **26%** did not answer.

Disabilities and health conditions: **8%** of Medway Council Public Health respondents were disabled or had a health condition, **58%** were not disabled or had a health condition and **34%** did not answer. The types of disabilities and health conditions reported by participants is shown in ***Figure 8***.

Neurodiversity: **16%** of Medway Council Public Health respondents were neurodiverse, **61%** were neurotypical and **23%** did not answer.

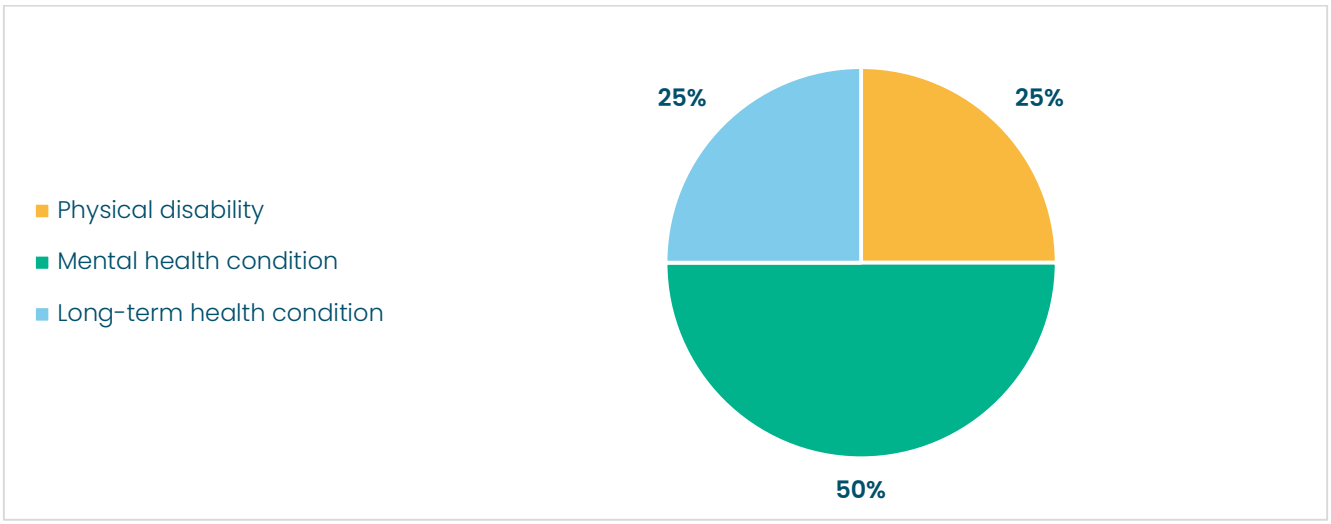

Figure 8: the percentage of participants in the Medway Council Public Health sample who were disabled or had a health condition, by the type of disability or health condition.

MVA Kent and Medway Demographics

High Risk of Bias Disclaimer:

The following demographic findings are subject to a high risk of bias due to limitations in the underlying data, methodology and contextual factors. As such, interpretation of the demographic findings should be approached with caution. The degree of uncertainty is such that conclusions drawn from these demographic findings are discretionary and should not be considered definitive or generalisable without further validation.

Age: **100%** of MVA Kent and Medway responses were from young people aged 14-24.

Gender: **46%** of participants were female, **46%** were male, **2%** were non-binary, **1%** opted to prefer not to say and **5%** did not answer.

Sexuality: **1%** of participants were heterosexual/straight. **99%** of participants did not answer.

Ethnicity: **39%** of participants were African, **37%** were English/Welsh/Scottish/Northern Irish/British, **8%** were Caribbean, **5%** were Indian, **5%** were from any other Asian background (unspecified), **2%** were from any other mixed/multiple ethnic background (unspecified), **1%** were Pakistani, **1%** were White & Black Caribbean, **1%** were Arab and **1%** were from any other Black/African/Caribbean background (unspecified).

Location: the majority of responses were from people who did not answer (**70%**). Of responses, most participants were from the ME5 area (**15%**). The smallest responses were from the ME11 area (**1%**). The full range of locations is shown in ***Figure 9***.

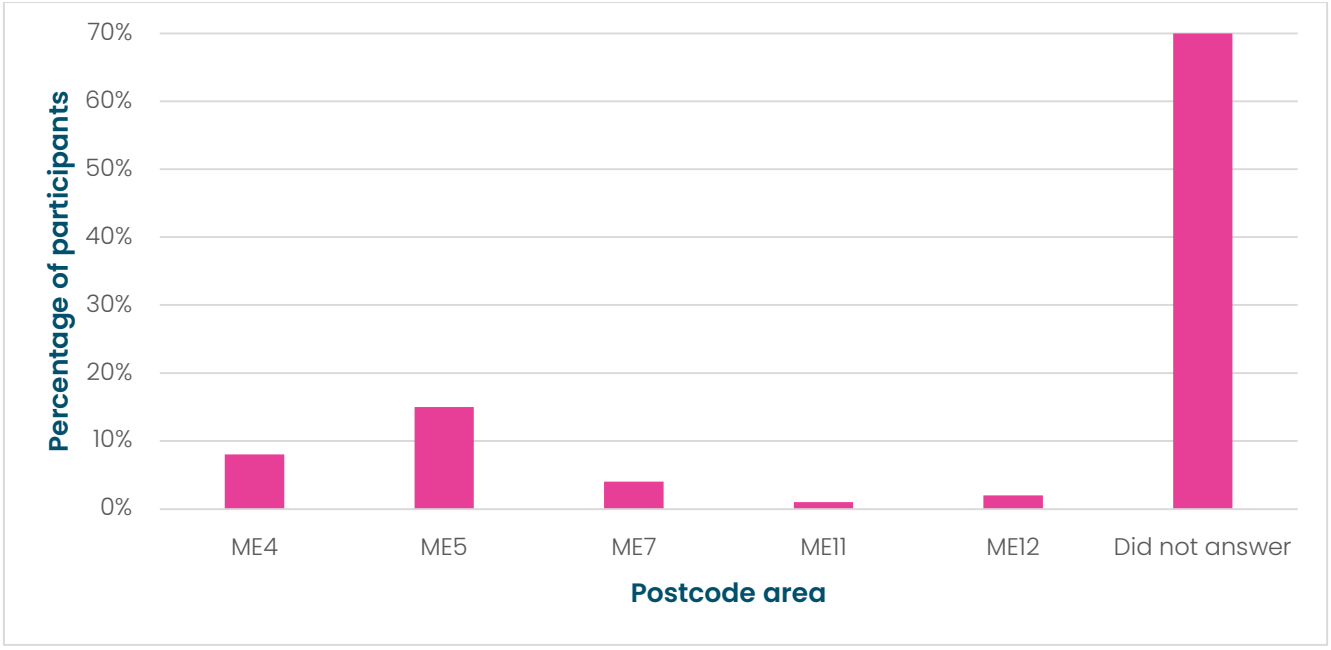

Figure 9: the percentage of participants in the MVA Kent and Medway sample by location.

Carer status: **4%** of participants were carers, **2%** were young carers, **70%** were not carers, **1%** opted to prefer not to say and **23%** did not answer.

Disabilities and health conditions: **15%** of participants were disabled or had a health condition, **53%** were not disabled or had a health condition, **12%** opted to prefer not to say and **20%** did not answer. The types of disabilities and health conditions reported by participants is shown in ***Figure 10***.

Neurodiversity: **12%** of participants were neurodiverse, **76%** were neurotypical and **12%** did not answer.

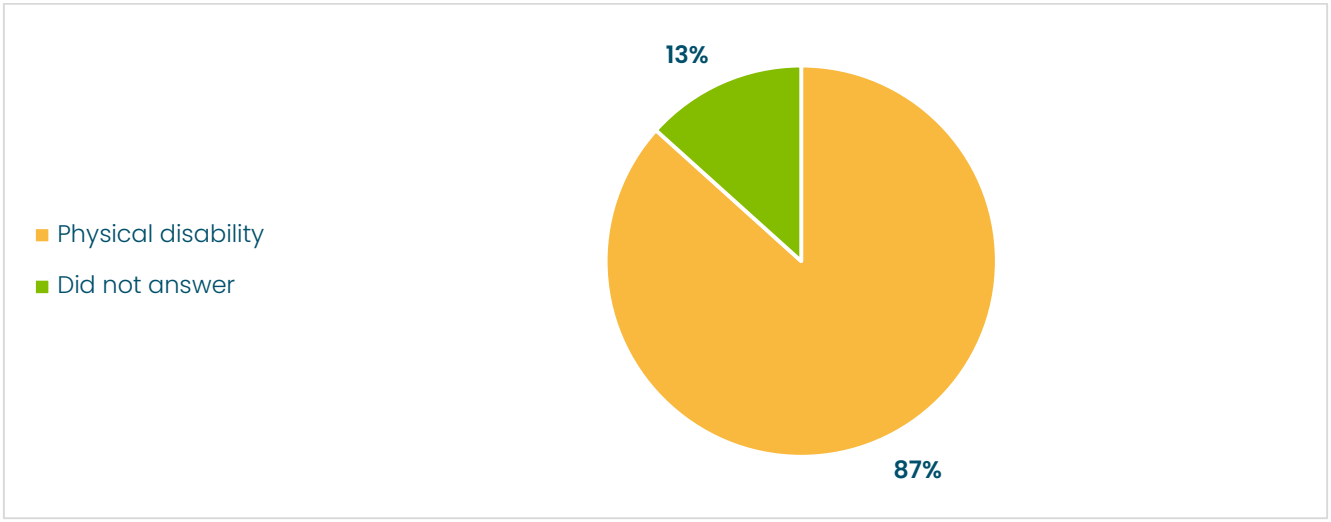

Figure 10: *the percentage of participants in the MVA Kent and Medway sample who were disabled or had a health condition, by the type of disability or health condition.*

Findings

What is considered to be self-harm?

Healthwatch Engagement

Healthwatch Medway and Healthwatch Kent asked the general public what they considered to be self-harm, giving a range of possible options to choose from. Multiple options could be selected including the option for "*other*" categories. The most commonly accepted form of self-harm for this cohort was "*cutting yourself*" with a **100%** response. The least commonly accepted form of self-harm for this cohort was "*spending all of your time on addictive behaviours like gaming, social media or gambling*" at **66%**.

23% of participants gave further reflections on what they considered to be self-harm outside of the range of possible options provided to them. These reflections included responses such as "*jumping in and out of traffic*", "*isolating yourself*" and "*forcing yourself to sleep with people*".

The full range of responses to what the general public considers to be self-harm is presented in ***Figure 11***.

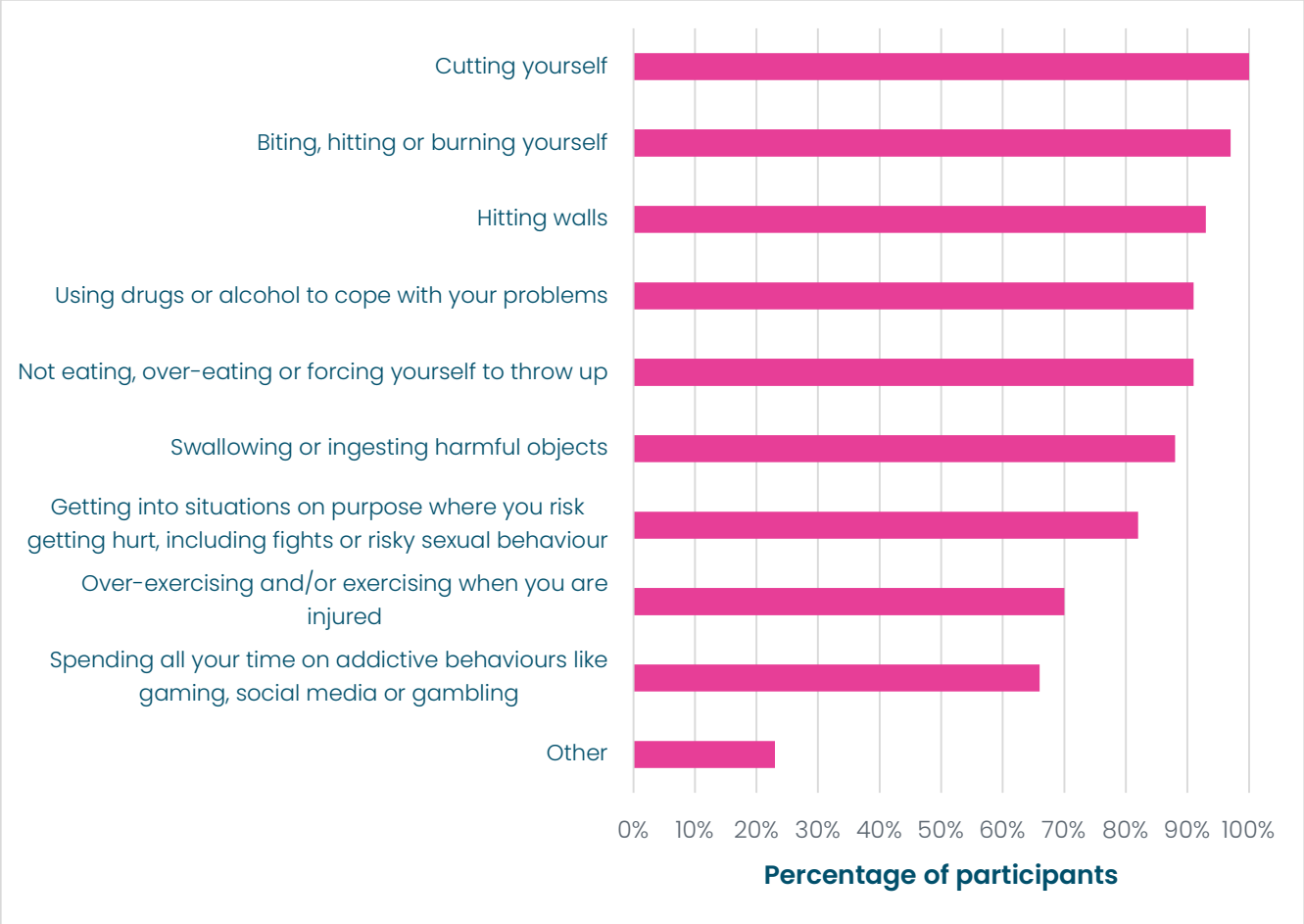

Figure 11: *the percentage of participants by responses to what is considered to be self-harm; Healthwatch general public sample.*

27% of this general public cohort were children and young people (aged 10-24). When comparing their responses with adults from this sample cohort, distinct differences emerge across

what children and young people consider to be self-harm. **100%** of children and young people in this sample consider "*not eating, over-eating or forcing yourself to throw up*" and "*biting, hitting or burning yourself*" to be self-harm. For adults in this sample, these responses are **88%** and **95%** respectively. In contrast, more adults in this sample think that "*spending all of your time on addictive behaviours like gaming, social media or gambling*" is self-harm compared to children and young people in this sample (**69%** compared to **58%**). The full range of responses by age group to what the general public considers to be self-harm is presented in ***Figure 12***.

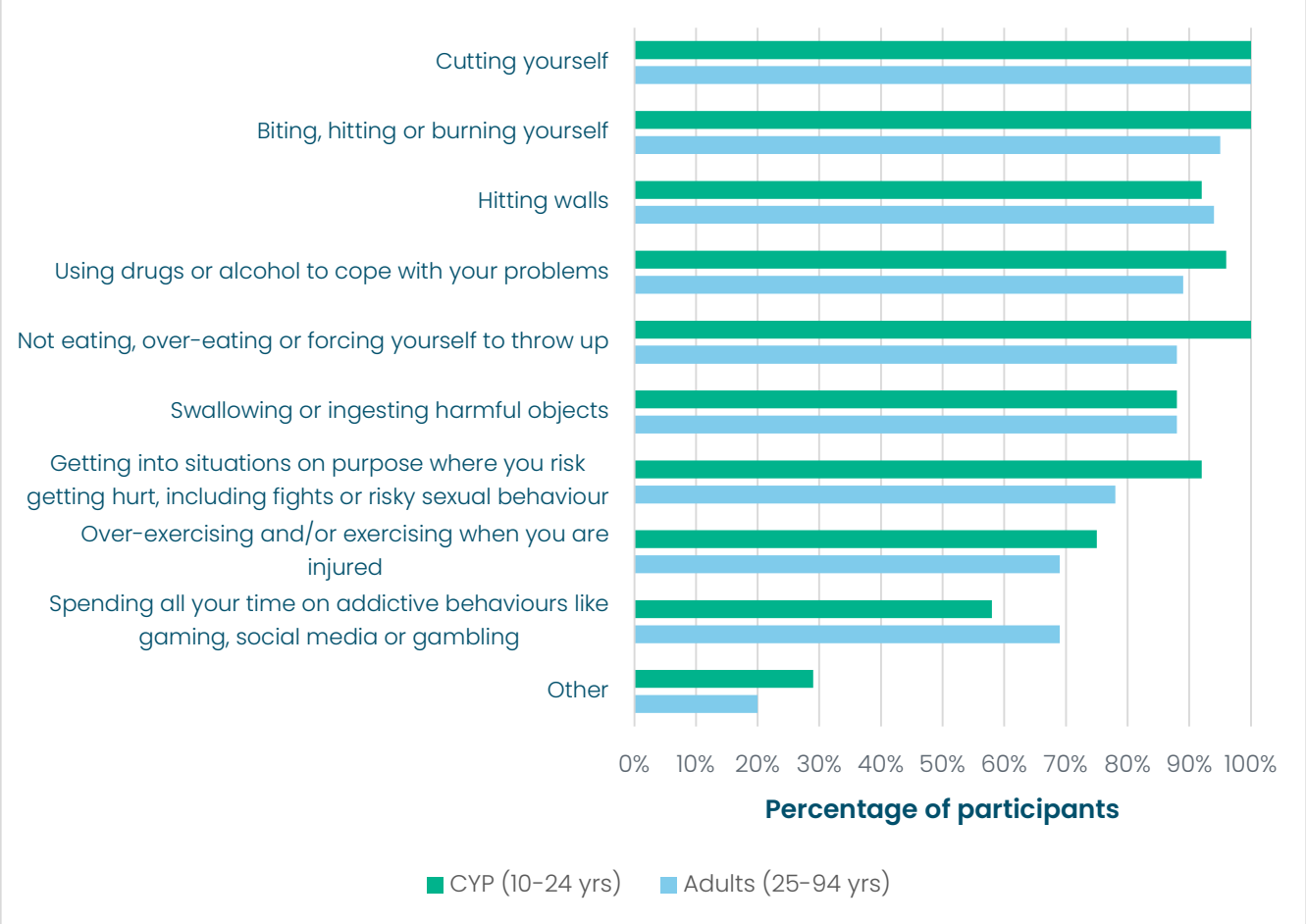

***Figure 12**: the percentage of participants by responses to what is considered to be self-harm, split by children and young people (10-24 yrs) and adults (25-94 yrs); Healthwatch general public sample.*

Healthwatch Medway and Healthwatch Kent also asked professionals working in Medway and Swale to outline what they considered to be self-harm. The same options as offered to the general public could be selected and again the option for *"other"* categories was included. **100%** of this cohort considered "*cutting yourself*", "*biting, hitting or burning yourself*" and "*swallowing or ingesting harmful objects*" to be self-harm. The least commonly accepted form of self-harm from professionals was "*spending all of your time on addictive behaviours like gaming, social media or gambling*" at **73%**.

22% of professionals gave other additional considerations to what they thought was self-harm. These included responses such as "*not taking medication*", "*pulling hair*", "*getting tattoos*" and "*excessive tanning/cosmetic procedures*".

The full range of responses to what professionals consider to be self-harm is presented in ***Figure 13***.

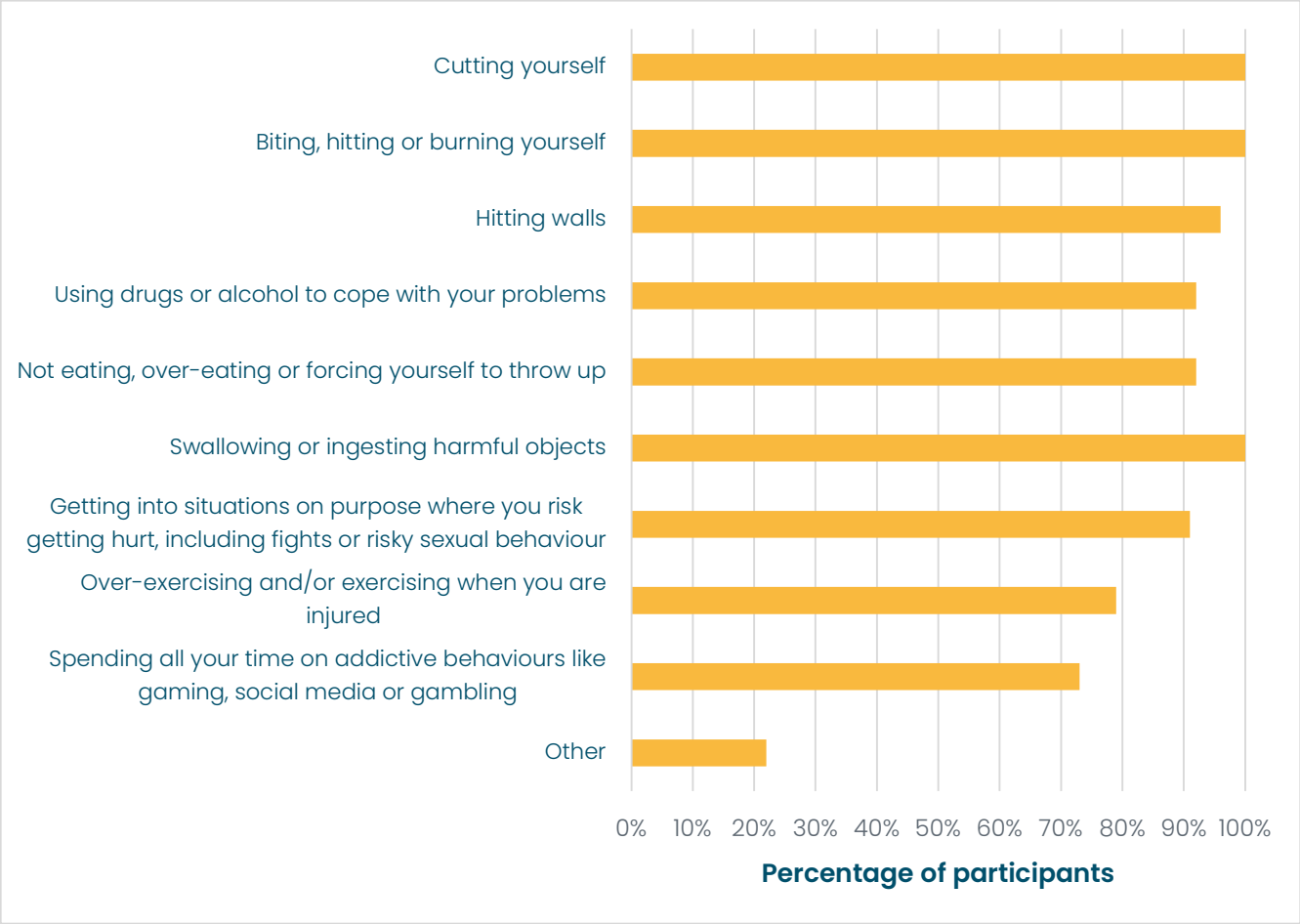

Figure 13: *the percentage of participants by responses to what is considered to be self-harm; Healthwatch professional sample.*

Professionals gave higher response rates to each of the self-harm options than the public. The biggest difference is noticed in responses to "*swallowing or ingesting harmful objects*" where **88%** of the general public considered this to be self-harm compared to **100%** of professionals. A full comparison of the responses between the general public and professional samples is presented in ***Figure 14***.

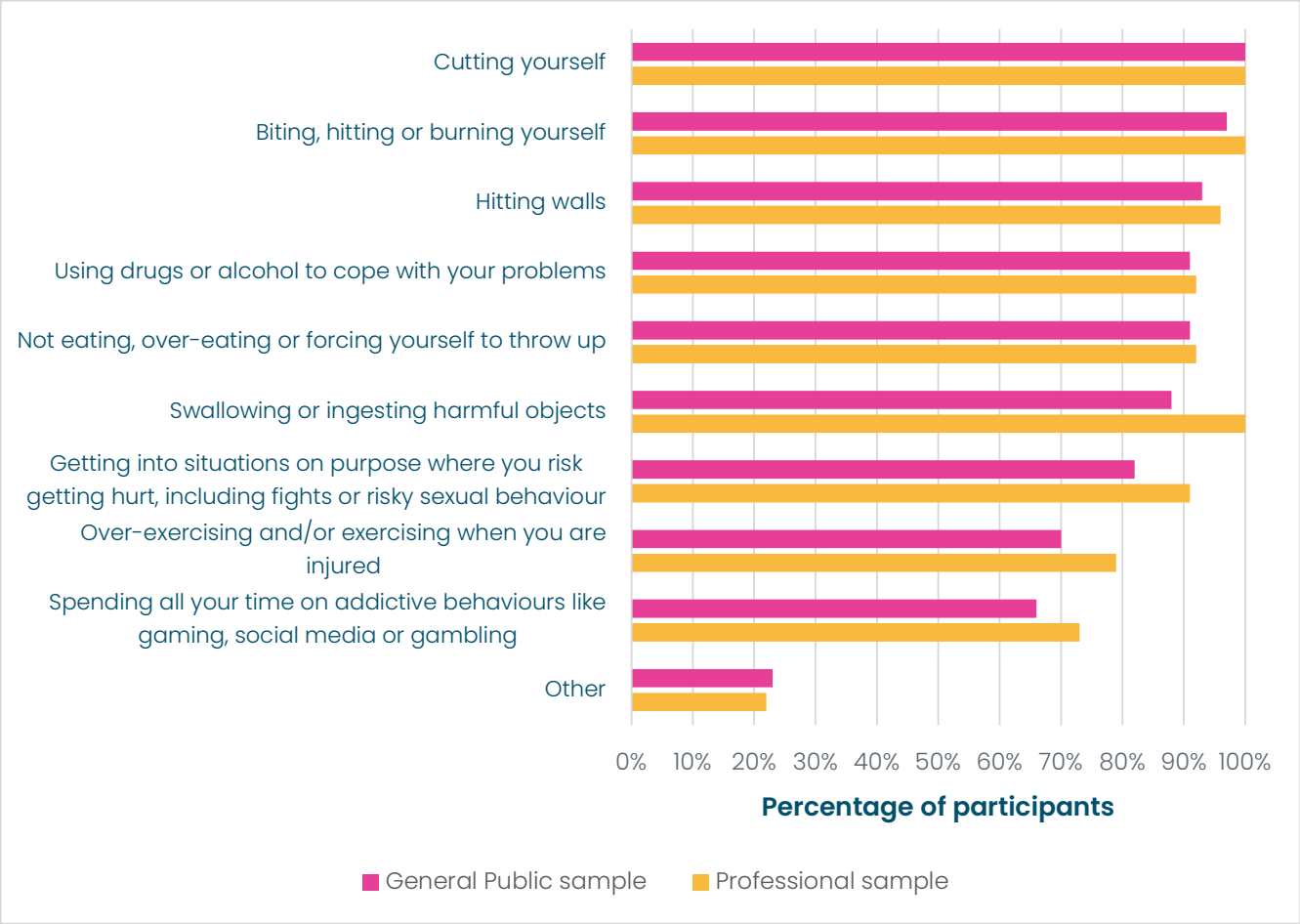

Figure 14: *the percentage of participants by responses to what is considered to be self-harm, split by General Public sample and Professional sample; Healthwatch Medway and Healthwatch Kent data.*

The general public sample and professional sample exhibit a consistent consideration to what is considered to be self-harm. Over **90%** of both cohorts considered the following actions to be self-harm:

- Cutting yourself
- Biting, hitting or burning yourself
- Hitting walls
- Using drugs or alcohol to cope with your problems
- Not eating, over-eating or forcing yourself to throw up

This indicates a generally recognised perception of these actions to be self-harm behaviours and thus to be treated as such. Of the remaining options, more professionals considered these actions to be self-harm behaviours than the general public. In particular, **100%** of professionals considered *"swallowing or ingesting harmful objects"* to be self-harm compared with **88%** of the general public. Higher rates of consideration by professionals towards these actions as self-harm behaviours than the general public could indicate that further classification of self-harm behaviours is required. However, further investigation is required to understand the rationale behind why the general public and professionals may consider certain actions to be, or not be, considered as self-harm behaviours. In addition, social and cultural factors contributing towards these considerations need to be investigated.

Medway Council Public Health Engagement

Medway Council Public Health engagement specialists spoke with 14 to 24-year-olds about what they considered to be self-harm. Multiple options could be selected, however one option that was offered in Healthwatch Medway and Healthwatch Kent's engagement with the general public and professionals was not provided (*"swallowing or ingesting harmful objects"*). The option for *"other"* categories was also not offered to this cohort.

For this cohort, the most commonly accepted form of self-harm was *"cutting yourself"* with a **94%** response. The least commonly accepted form of self-harm for this cohort was "*spending all of your time on addictive behaviours like gaming, social media or gambling*" and "*over-exercising and/or exercising when you are injured"* which both had a **29%** response. The full range of responses to what the participants in this engagement cohort consider to be self-harm is presented in ***Figure 15***.

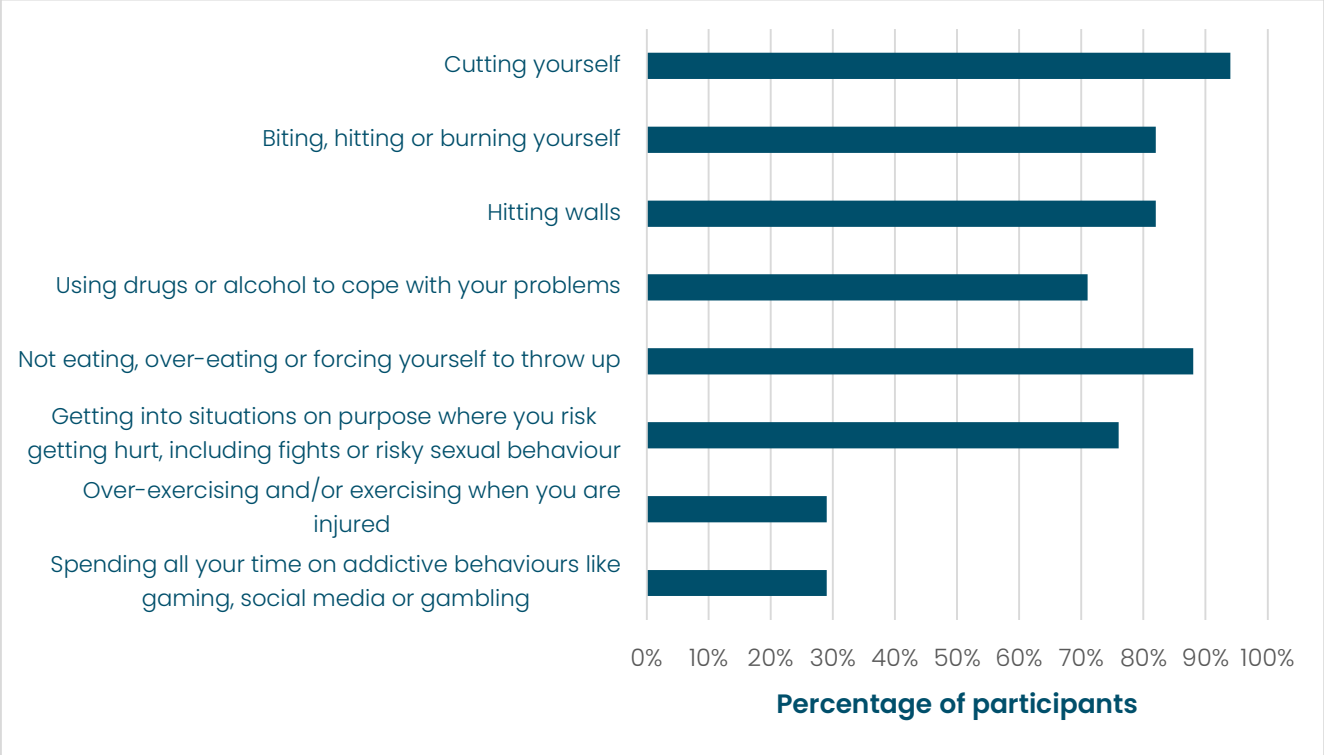

Figure 15: *the percentage of participants by responses to what is considered to be self-harm; Medway Council Public Health sample.*

When comparing responses by this cohort to the responses from 10 to 24-year-olds in the Healthwatch general public cohort, there is a significant statistical difference in responses to:

- Using drugs or alcohol to cope with your problems
- Over-exercising and/or exercising when you are injured
- Spending all your time on addictive behaviours like gaming, social media or gambling.

More participants in the Healthwatch general public cohort considered these actions to be self-harm behaviours than participants in the Medway Council Public Health cohort. This large statistical difference in responses could indicate towards self-harm behaviours being subjective practices for children and young people as opposed to objective actions that can be outright considered to be self-harm. However, further investigation is required to understand the rationale

behind why children and young people may consider actions to be, or not be, considered as self-harm behaviours. A full comparison of the responses between the Medway Council Public Health cohort and the Healthwatch general public cohort (children and young people, 10 to 24-years-old) is presented in ***Figure 16***.

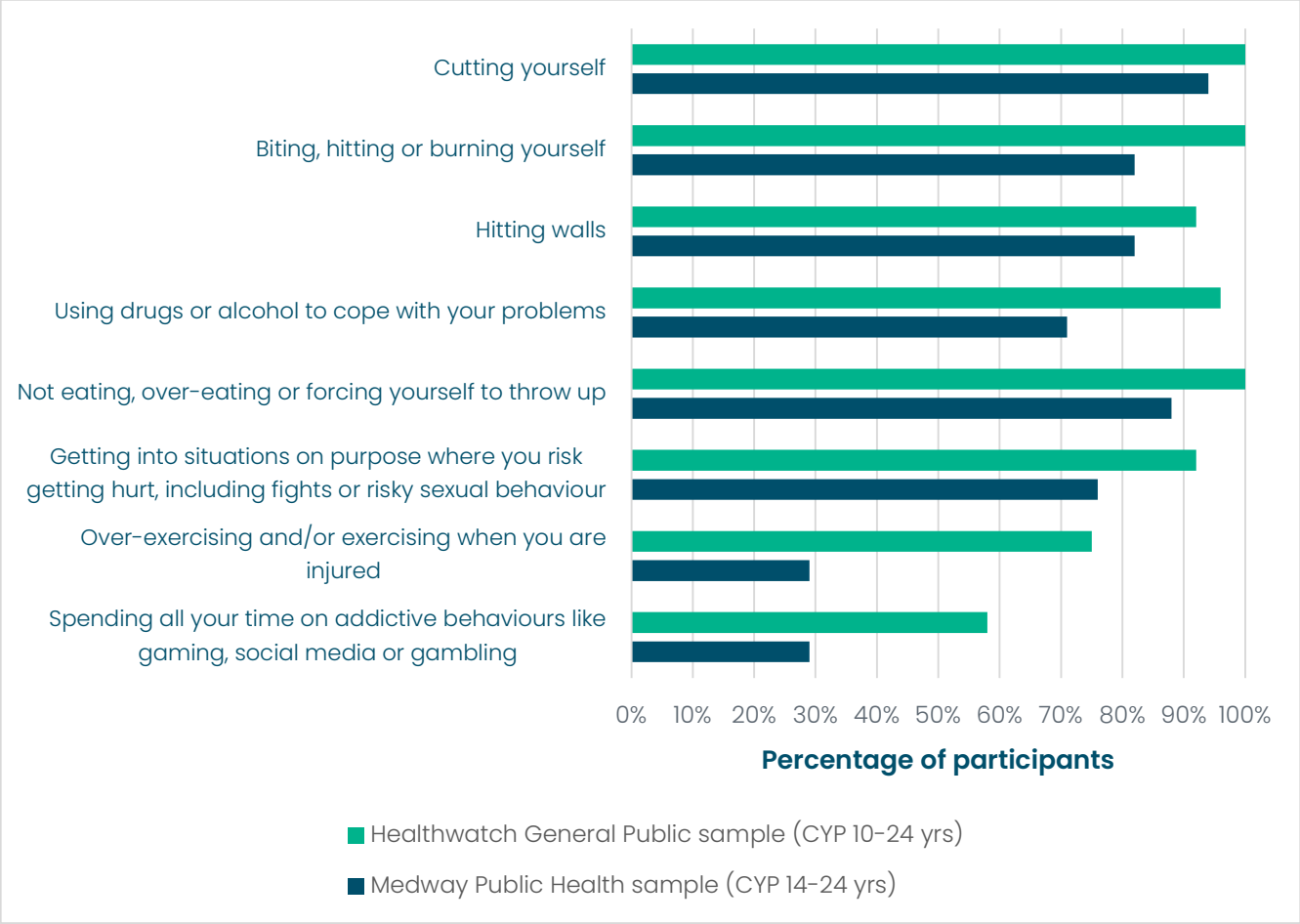

Figure 16: *the percentage of participants by responses to what is considered to be self-harm, split by Medway Council Public Health sample and Healthwatch General Public sample (children and young people, 10-24-years-old); Medway Council Public Health data, Healthwatch Medway and Healthwatch Kent data.*

MVA Kent and Medway Engagement

High Risk of Bias Disclaimer:

The following finding is subject to a high risk of bias due to limitations in the underlying data, methodology and contextual factors. As such, interpretation of the finding should be approached with caution. The degree of uncertainty is such that conclusions drawn from this finding are discretionary and should not be considered definitive or generalisable without further validation.

MVA Kent and Medway engagement specialists spoke with 14 to 24-year-olds about what they considered to be self-harm. Multiple options could be selected, however one option that was offered to the general public cohort and the professional cohort was not provided (*"swallowing or ingesting harmful objects"*). The option for *"other"* categories was also not offered to this cohort.

For this cohort, the most commonly accepted form of self-harm was *"cutting yourself"* with a **74%** response. The least commonly accepted form of self-harm was *"getting into situations on purpose where you risk getting hurt, including fights or risky sexual behaviour"* with a **3%** response. The full range of responses to what the participants in this engagement cohort consider to be self-harm is presented in ***Figure 17***.

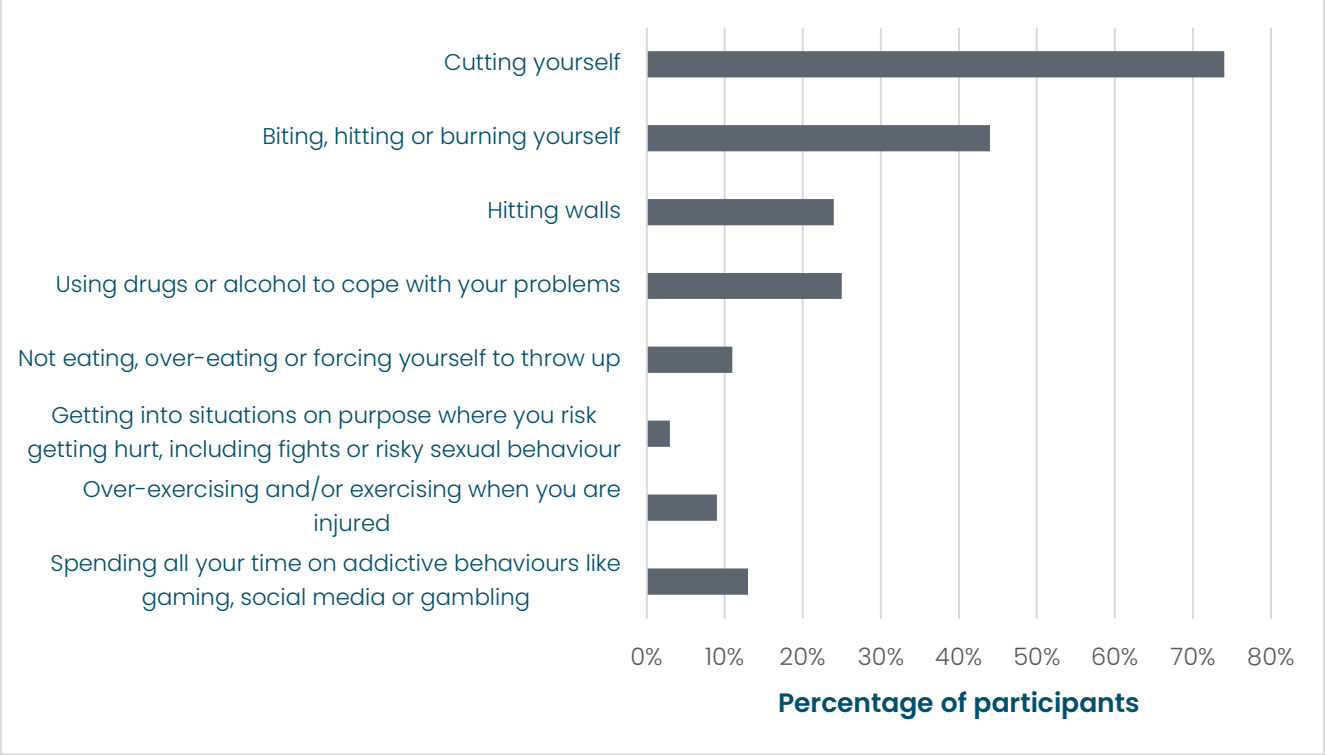

Figure 17: *the percentage of participants by responses to what is considered to be self-harm; MVA Kent and Medway sample.*

Which support services for children and young people are well known?

Healthwatch General Public Engagement

Healthwatch Medway and Healthwatch Kent asked the general public what support services for children and young people they knew about. **52%** of participants in this cohort knew of one or more services, whereas **48%** of participants did not know of any services. **2%** of participants knew of seven different services, the highest number of individual services by all participants. The most commonly known service amongst participants was CAMHS (**35%**). The full range of responses to the number of services known by participants is presented in ***Figure 18*** and the top four most commonly known services amongst participants is presented in ***Figure 19***.

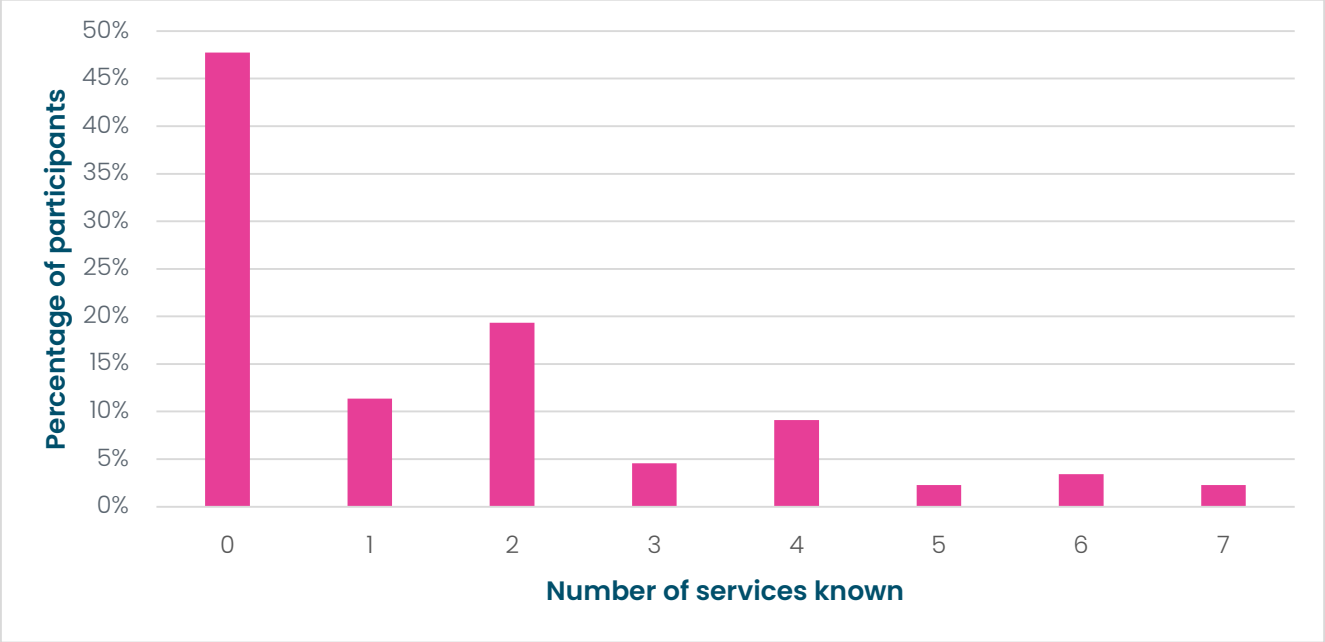

Figure 18: *the percentage of participants by responses to the number of services known; Healthwatch general public sample.*

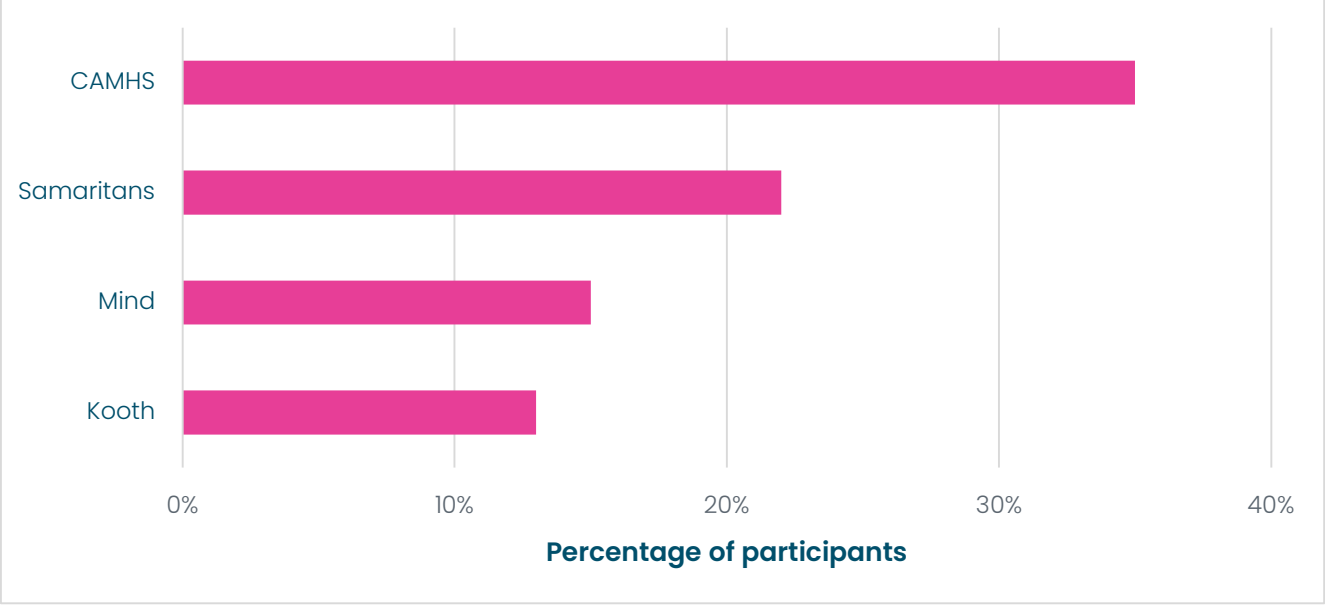

Figure 19: *the percentage of participants by responses to the most commonly known services; Healthwatch general public sample.*

27% of this general public cohort were children and young people (aged 10-24). When comparing their responses with adults from this sample cohort, children and young people presented consistency in their knowledge of support services with the knowledge exhibited by adults. **50%** of children and young people did not know of any services (compared to **47%** of adults) and **38%** knew of two or more services (compared to **42%** of adults). When it came to which services children and young people knew of, a higher percentage were aware of CAMHS (**50%**) compared to adults (**29%**). In contrast, **0%** of children and young people were aware of Samaritans whereas **29%** of adults knew of Samaritans. The full range of responses by age group to the number of services known is presented in ***Figure 20*** and the top four most commonly known services by age group is presented in ***Figure 21***.

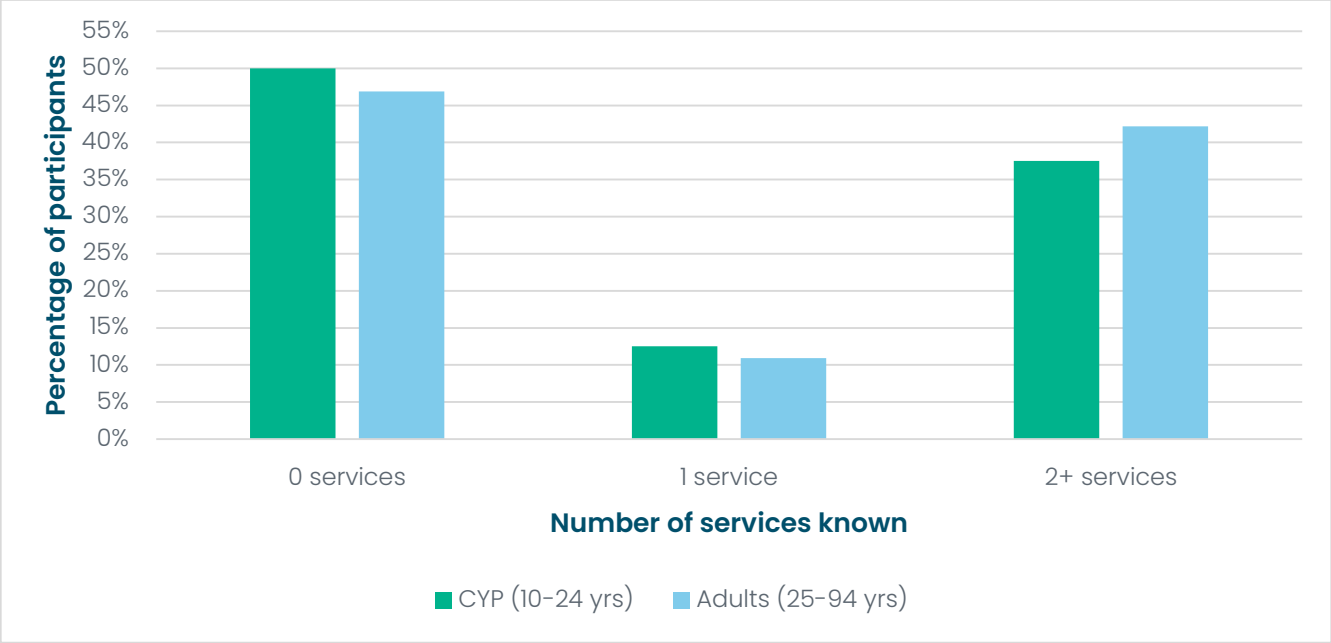

Figure 20: *the percentage of participants by responses to the number of services known, split by children and young people (10-24 yrs) and adults (25-94 yrs); Healthwatch general public sample.*

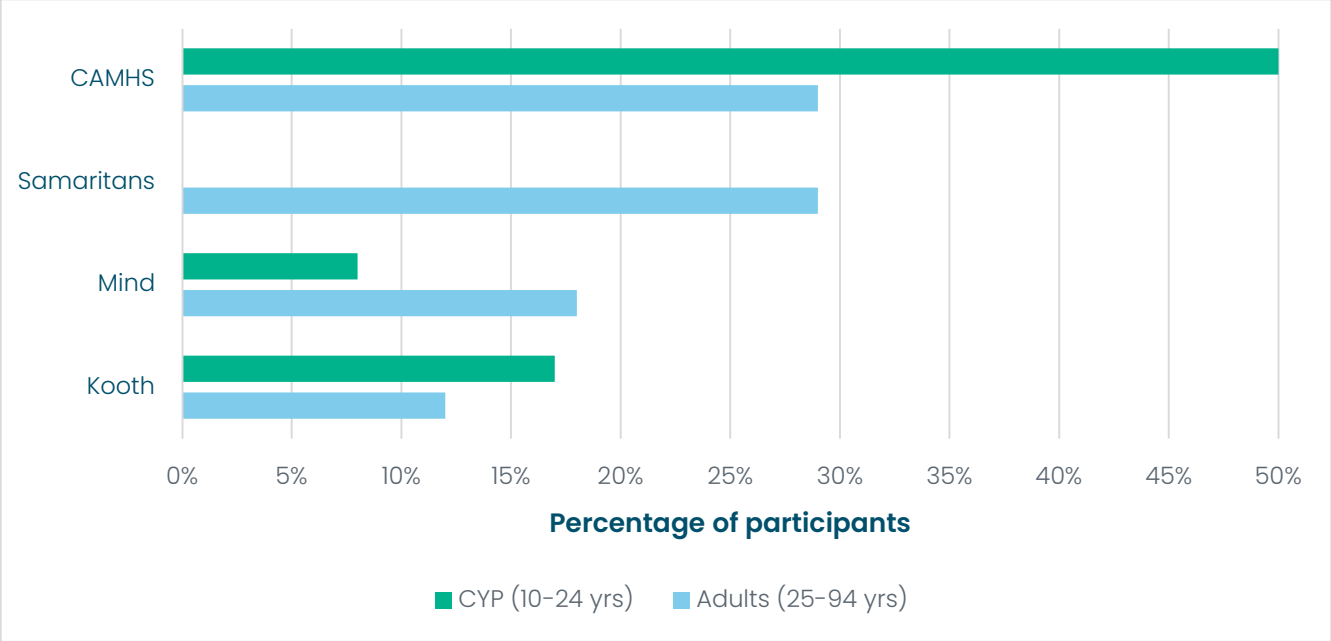

Figure 21: *the percentage of participants by responses to the most commonly known services, split by children and young people (10-24 yrs) and adults (25-94 yrs); Healthwatch general public sample.*

25% of participants in the general public cohort reported accessing (or knowing someone that has accessed) one or more of the services they had mentioned. These participants reported 34 total experiences with services. The types of experiences had with these services were themed by sentiment into positive experience, mixed experience and negative experience. **47%** of experiences were positive, **18%** were mixed and **35%** were negative. Examples of each sentiment are presented in ***Figure 22***.

Positive sentiment (47%)

"I am currently with North Kent Mind and attend a [group] every [week]. I have had a really positive experience, and it is nice to have someone to talk to."

Mixed sentiment (18%)

"I have had friends use CAMHS and had mixed responses – some excellent, some average and some mind-blowingly bad."

Negative sentiment (35%)

"I have reached out to Social Services. I've been told my situation is "not severe enough" and that I'm "too low in the pecking order we won't look at your case". I wasn't given any other support, and I didn't reach out again."

Figure 22: *examples of sentiment of experience with services; Healthwatch general public sample.*

Children and young people tended to have had or know of more negative experiences (**56%**) with services than positive experiences (**33%**) compared to adults who tended to have had or know of more positive experiences (**52%**) with services than negative experiences (**28%**). This is presented in ***Figure 23***.

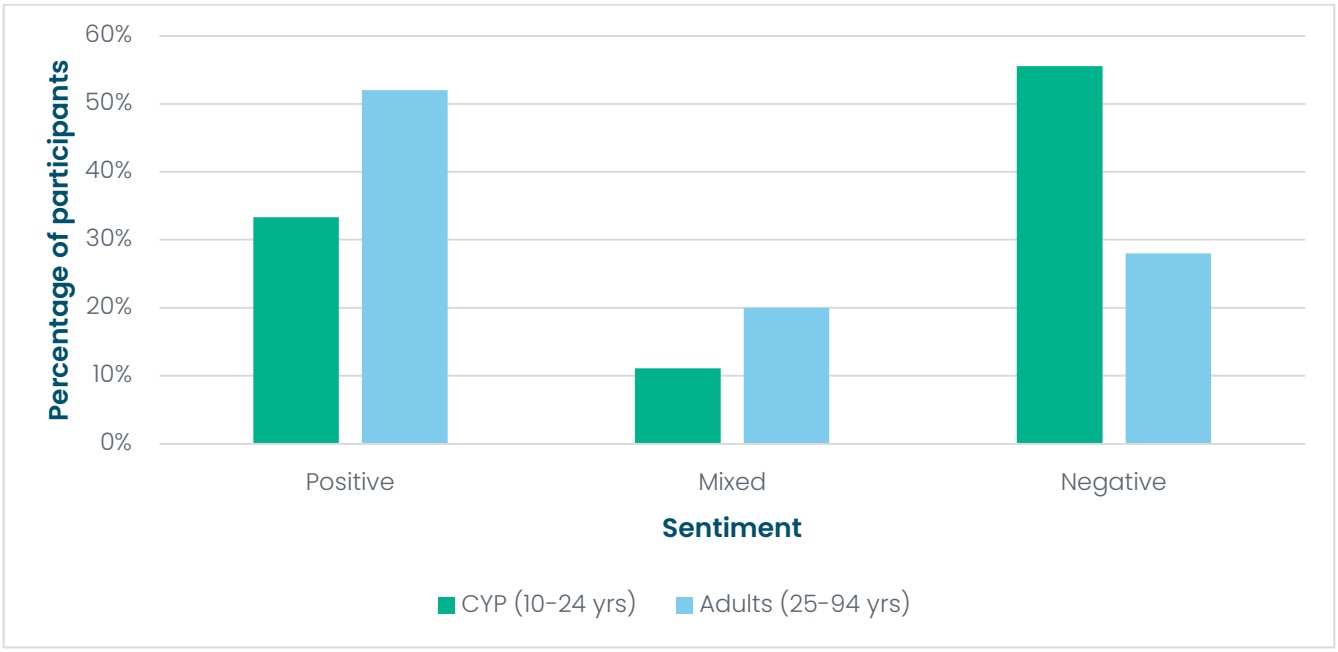

Figure 23: *the percentage of participants by sentiment of experience with services, split by children and young people (10-24 yrs) and adults (25-94 yrs); Healthwatch general public sample.*

Healthwatch Professionals Engagement

Healthwatch Medway and Healthwatch Kent also asked professionals working in Medway and Swale what support services for children and young people they knew about. **88%** of participants in this cohort knew of one or more services, whereas **12%** of participants did not know of any services. **12%** of participants knew of eight or more different services, including one participant who knew of 15 different services (the highest number of individual services by all participants). The most commonly known service amongst participants was CAMHS (**44%**). The full range of responses to the number of services known by participants is presented in ***Figure 24*** and the top four most commonly known services amongst participants is presented in ***Figure 25***.

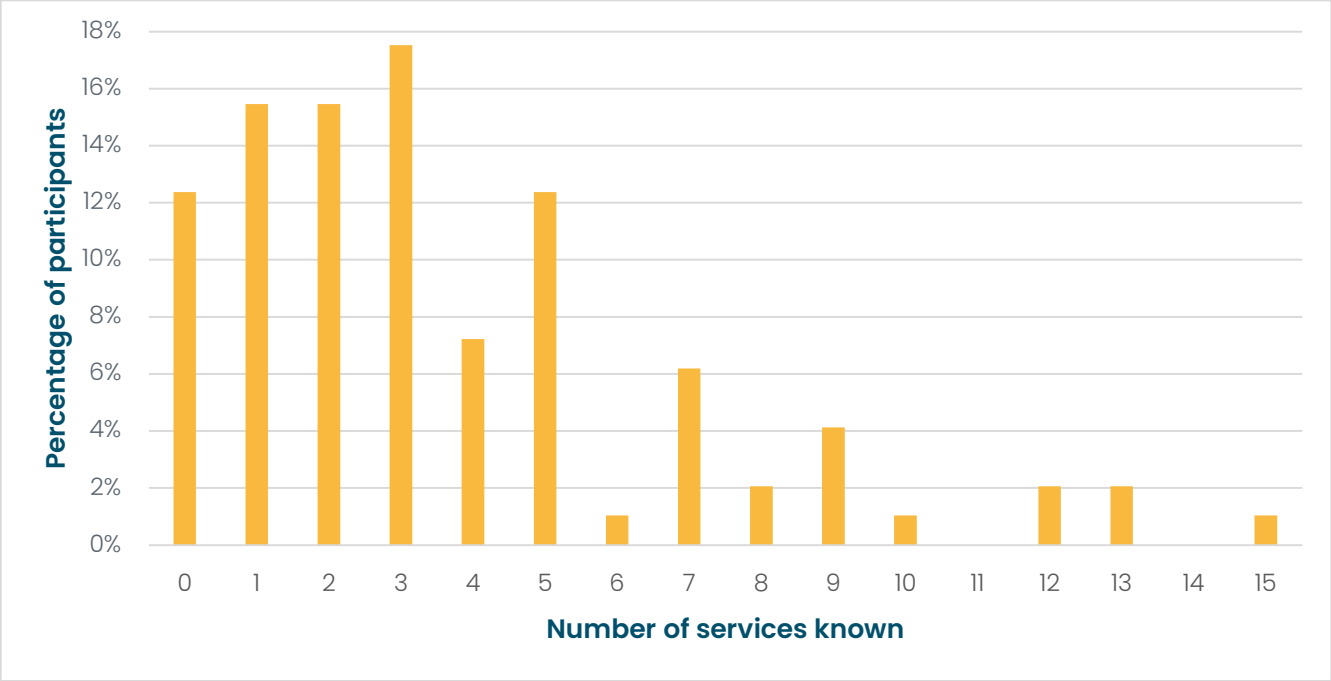

Figure 24: *the percentage of participants by responses to the number of services known; Healthwatch professional sample.*

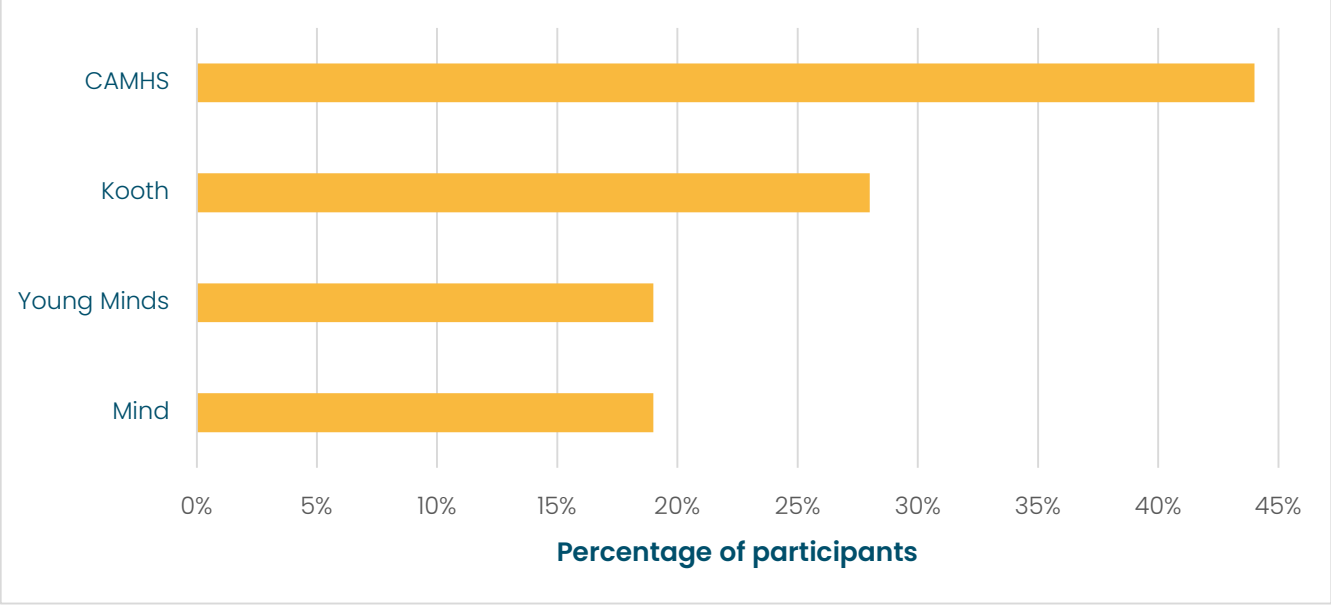

Figure 25: *the percentage of participants by responses to the most commonly known services; Healthwatch professional sample.*

90% of the participants in this cohort were working to support children and young people through direct support services (**47%**), signposting (**42%**) and safeguarding (**16%**). The remaining **10%** of participants either did not work to support children and young people, or were unsure whether their work included children and young people.

Professionals were more aware of support services than the general public, with **88%** of professionals knowing of one or more services compared to **52%** of the general public. CAMHS was the most commonly known service by both the general public and professionals. However, none of the **52%** of the general public who knew of one or more services mentioned Young Minds, a service that **19%** of professionals were aware of. Additionally, double the proportion of the general public were aware of Samaritans compared to professionals (**22%** of the general public compared with **11%** of professionals). A full comparison of responses to the number of services known between the general public and professional samples is presented in ***Figure 26*** and the most commonly known services between the general public and professional samples is presented in ***Figure 27***.

Figure 26: *the percentage of participants by responses to the number of services known, split by General Public sample and Professional sample; Healthwatch Medway and Healthwatch Kent data.*

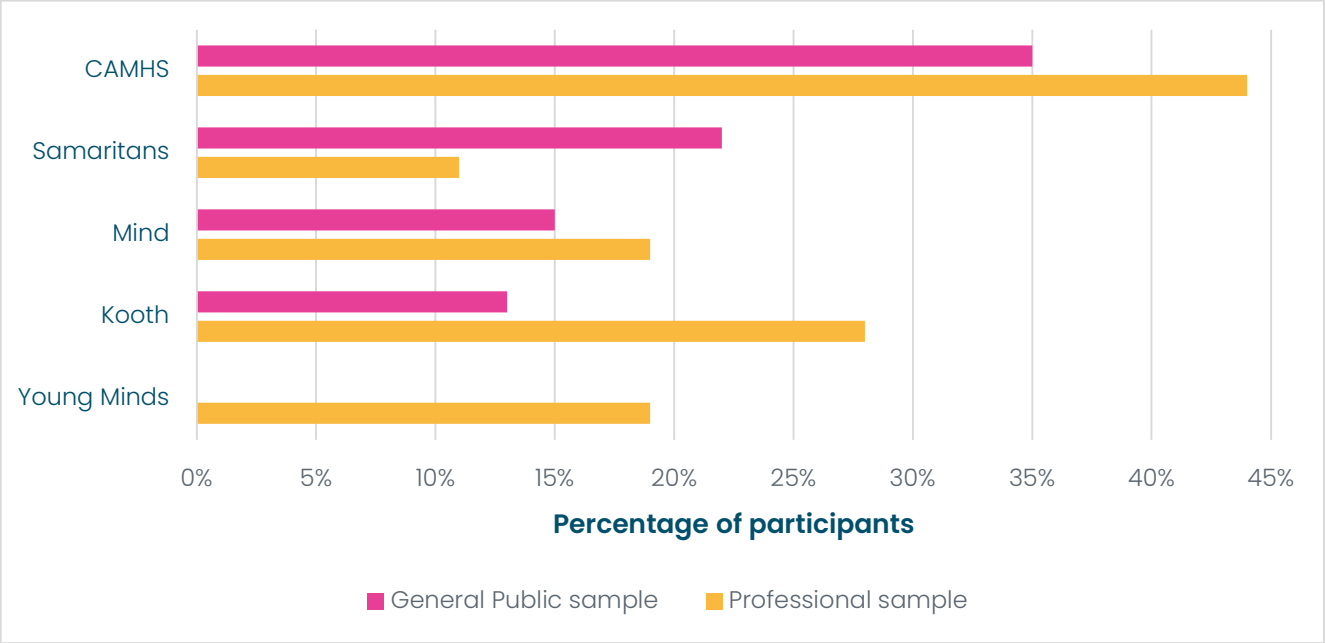

Figure 27: *the percentage of participants by responses to the most commonly known services, split by General Public sample and Professional sample; Healthwatch Medway and Healthwatch Kent data.*

The general public sample and professional sample exhibit a distinct difference in the knowledge of support services available for children and young people, with professionals having a far greater breadth of knowledge compared to the general public. The large number of general public cohort responses stating no known services (**48%**) indicates that increasing the awareness of available support services could better aid the general public in addressing and/or accessing support for the issues of self-harm in children and young people. In addition, the **12%** of professionals unaware of any services highlights the potential for issues in safeguarding and signposting children and young people for suitable support for their mental health and addressing self-harming behaviours.

For the general public and professionals, CAMHS, Mind and Kooth were amongst the most commonly mentioned services, indicating these could be the most signposted to and accessed by children and young people. However, further investigation is required to understand the rationale behind why these services are most commonly known. Additionally, further investigation is required to identify whether there is a substantial link between how well known a support service for children and young people is, and how utilised it is.

Medway Council Public Health Engagement

Medway Council Public Health engagement specialists spoke with 14–24-year-olds about which services they are aware of that support with mental health or self-harm. The most commonly known service in this cohort was Childline (**40%**). The least commonly known services in this cohort were NELFT, Medway Talking Therapies and church/faith groups (each at **7%**). The full range of responses to the most commonly known services amongst participants is presented in ***Figure 28***.

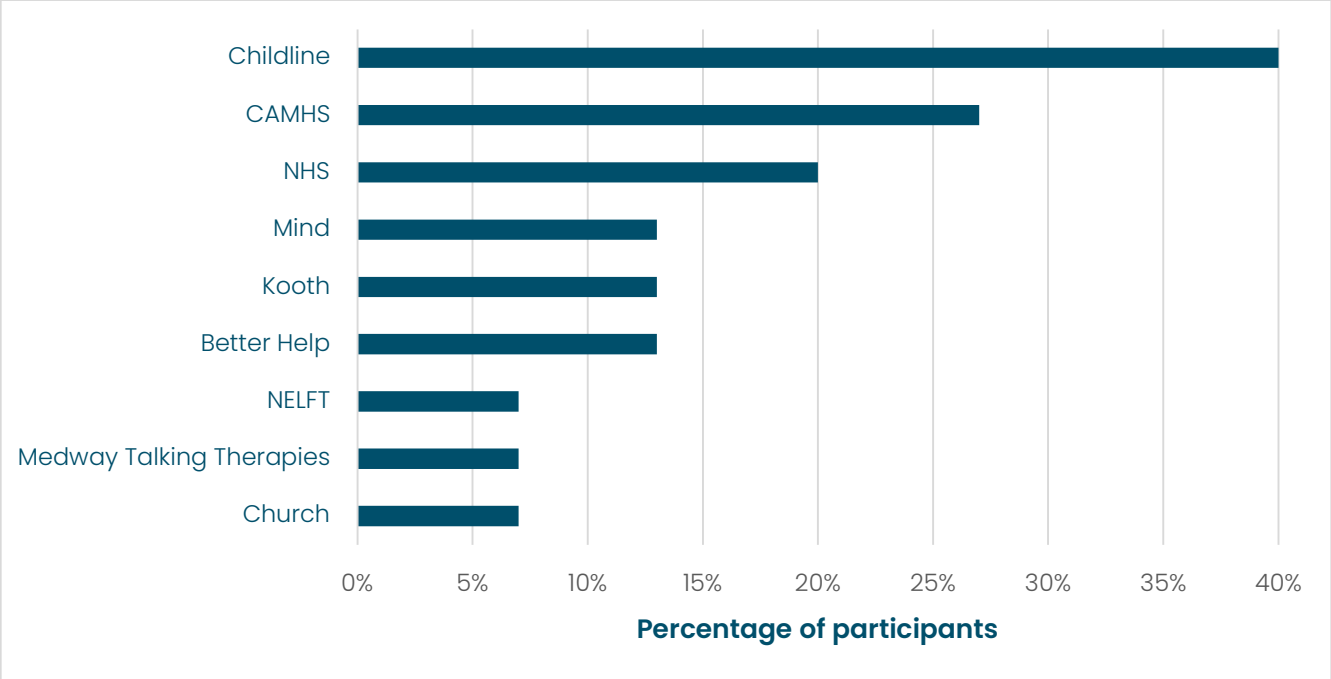

Figure 28: *the percentage of participants by responses to the most commonly known services; Medway Council Public Health sample.*

When comparing responses by this cohort to the responses from 10-24-year-olds in the Healthwatch general public cohort, significant statistical differences are present in the percentage of participants that know of the following services:

- Childline (**40%** of Medway Council Public Health sample compared with **13%** of Healthwatch general public sample).
- CAMHS (**27%** of Medway Council Public Health sample compared with **50%** of Healthwatch general public sample).
- NHS (**20%** of Medway Council Public Health sample compared with **4%** of Healthwatch general public sample).
- Better Help (**13%** of Medway Council Public Health sample compared with **0%** of Healthwatch general public sample).

These statistical differences in responses require further investigation that considers wider contextual explanations as to why certain services may be more (or less) commonly known amongst different cohorts of children and young people. A full comparison of the responses between the Medway Council Public Health cohort and the Healthwatch general public cohort (children and young people, 10-24-years-old) is presented in ***Figure 29***.

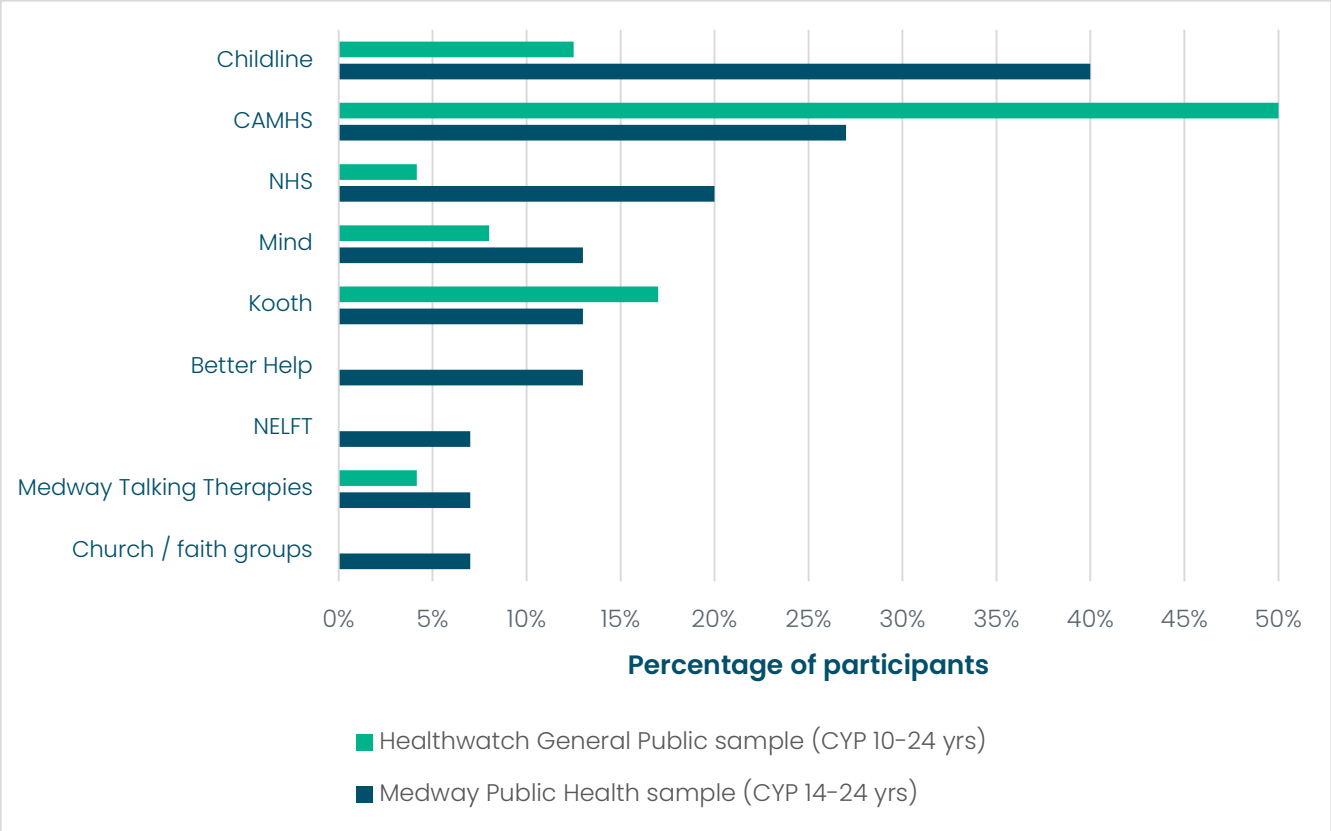

Figure 29: *the percentage of participants by responses to the most commonly known services, split by Medway Council Public Health sample and Healthwatch General Public sample (children and young people, 10-24-years-old); Medway Council Public Health data, Healthwatch Medway and Healthwatch Kent data.*

MVA Kent and Medway Engagement

High Risk of Bias Disclaimer:

The following finding is subject to a high risk of bias due to limitations in the underlying data, methodology and contextual factors. As such, interpretation of the finding should be approached with caution. The degree of uncertainty is such that conclusions drawn from this finding are discretionary and should not be considered definitive or generalisable without further validation.

MVA Kent and Medway engagement specialists spoke with 14–24-year-olds about which services they are aware of that support with mental health or self-harm. The most commonly known service in this cohort was CAMHS (**67%**). The least commonly known services in this cohort were Childline and church/faith groups (each at **17%**). The full range of responses to the most commonly known services amongst participants is presented in ***Figure 30***.

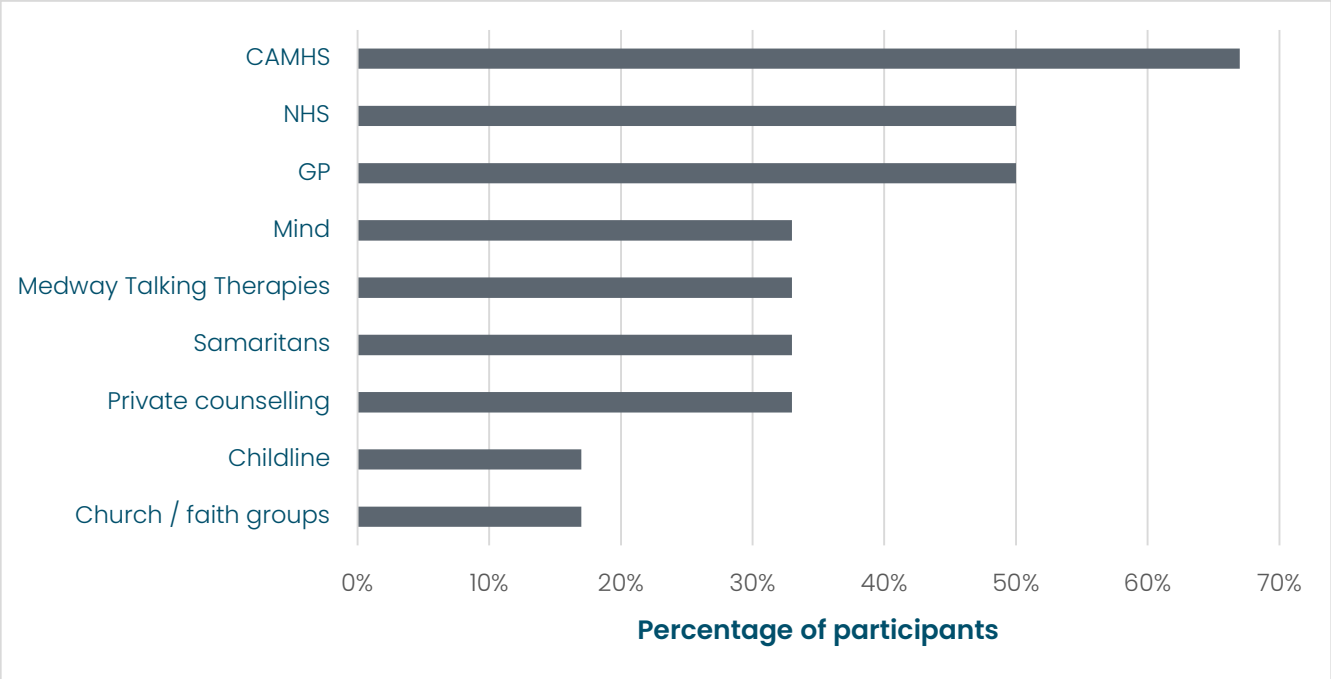

Figure 30: *the percentage of participants by responses to the most commonly known services; MVA Kent and Medway sample.*

What makes children feel overwhelmed/anxious/worried/frustrated?

Medway Council Public Health Engagement

Medway Council Public Health engagement specialists spoke with participants aged 10-13 years about what makes them feel overwhelmed, anxious, worried and/or frustrated. Responses were segmented into three categories during analysis of findings: "*something that someone else does*", "*something that I do*" and "*nothing/no answer*". Examples of each category are presented in ***Figure 31***.

Something that someone else does	Something that I do
"When people wind me up, I get frustrated"	*"If I am behind on something"*
"When I see banter and teasing and people that are down"	*"When things do not go my way"*
"When I am timed or time limited to do something"	*"Anxious when I do something wrong and someone asks if I have done it"*
"Rude and manipulating people"	*"When I am unable to do something right the first three times"*

***Figure 31**: examples of responses that form each category for what makes children feel overwhelmed/anxious/ worried/frustrated in the Medway Council Public Health sample.*

Participants were then asked what they do when they feel overwhelmed, anxious, worried and/or frustrated. Responses were again segmented into three categories during the analysis of findings: "*sort it on own*", "*do nothing/feel hopeless*" and "*seek out support*". The number of responses to each segmented category are presented in ***Figure 32*** and examples of each category are presented in ***Figure 33***.

	Sort it on own	Do nothing/feel hopeless	Seek out support	TOTAL
Something that someone else does	**28%**	**10%**	**10%**	**48%**
Something that I do	**19%**	**19%**	**5%**	**43%**
Nothing/no answer	**10%**	**0%**	**0%**	**10%**
TOTAL	**57%**	**29%**	**15%**	**~100%**

***Figure 32**: the percentage of responses by category to what makes children feel overwhelmed/anxious/ worried/frustrated and what children do when they feel this way in the Medway Council Public Health sample.*

Sort it on own	Seek out support	Do nothing/feel hopeless
"Go sit in a calm place"	*"Talk to my friend"*	*"I don't really do anything. I kind of just sit there and wait"*
"Go and read; I love reading"	*"Usually, I talk to my parents and some of my friends about it, but it takes time for me to confess my feelings"*	*"Cry sometimes but I try to keep it down"*
"Play with a toy or something"	*"I talk to my friends"*	*"I would just say the wrong thing"*

***Figure 33**: examples of responses that form each category for what children do when they feel overwhelmed/ anxious/worried/frustrated in the Medway Council Public Health sample.*

The most common response was that participants feel overwhelmed, anxious, worried and/or frustrated from something that someone else does and attempt to sort those feelings on their own (**29%**). School exams, homework and marks/grades were all commonly mentioned as causing these feelings and the majority of respondents who cited these would look to sort it on their own.

What activities do children do to make themselves feel better, and where/who would they go to ask for help?

Medway Council Public Health Engagement

Medway Council Public Health engagement specialists also spoke with participants aged 10-13 years about what activities they do to make themselves feel better when they are feeling overwhelmed, anxious, worried and/or frustrated. Responses were segmented into the following categories during the analysis of findings: "leisure activities", "exercise/sport activities", "social activities", "faith-based activities", "school activities" and "nothing". The full range of responses is shown in ***Figure 34*** and examples of each category are presented in ***Figure 35***.

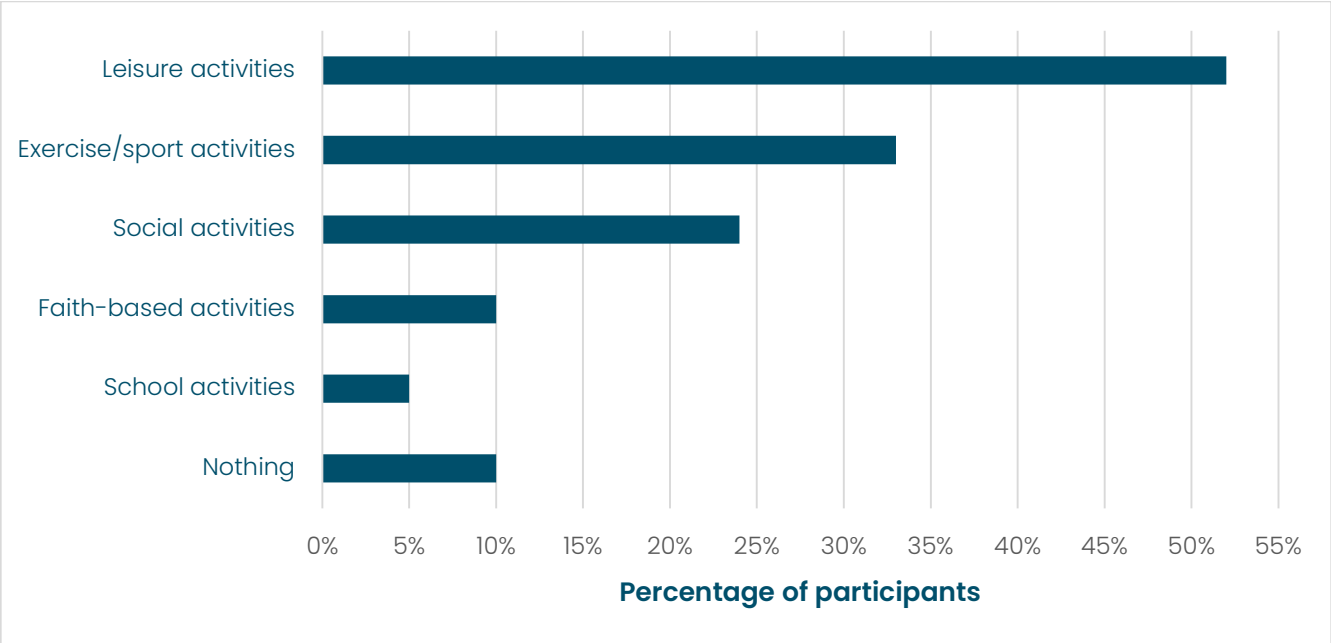

***Figure 34**: the percentage of responses by category to what activities children do to make themselves feel better in the Medway Council Public Health sample.*

Leisure activities	*"Usually, I would draw some clothes or designs in my notebook"*	*"I watch TV, and I eat food"*	*"I draw, read, play piano"*
Exercise/sport activities	*"Play football or basketball"*	*"Go on a walk"*	*"Play ping pong"*
Social activities	*"Talk to my friends"*	*"Go play with my friends"*	*"Talk with my best friend"*
Faith-based activities	*"Read my bible"*	*"I just pray"*	
School activities	*"Do homework"*		
Nothing	*"Wait for it to go away"*	*"Wait until it gets better"*	

***Figure 35**: examples of responses that form each category for what activities children do to make themselves feel better in the Medway Council Public Health sample.*

Participants were then asked where or who they would go to ask for help. Responses were segmented into the following categories during the analysis of findings: "*parent/guardian*", "*friend*", "*teacher/tutor*", "*trusted person*", "*sibling*", "*God*", "*pet*" and "*no one*". The full range of responses is shown in ***Figure 36*** and examples of each category are presented in ***Figure 37***.

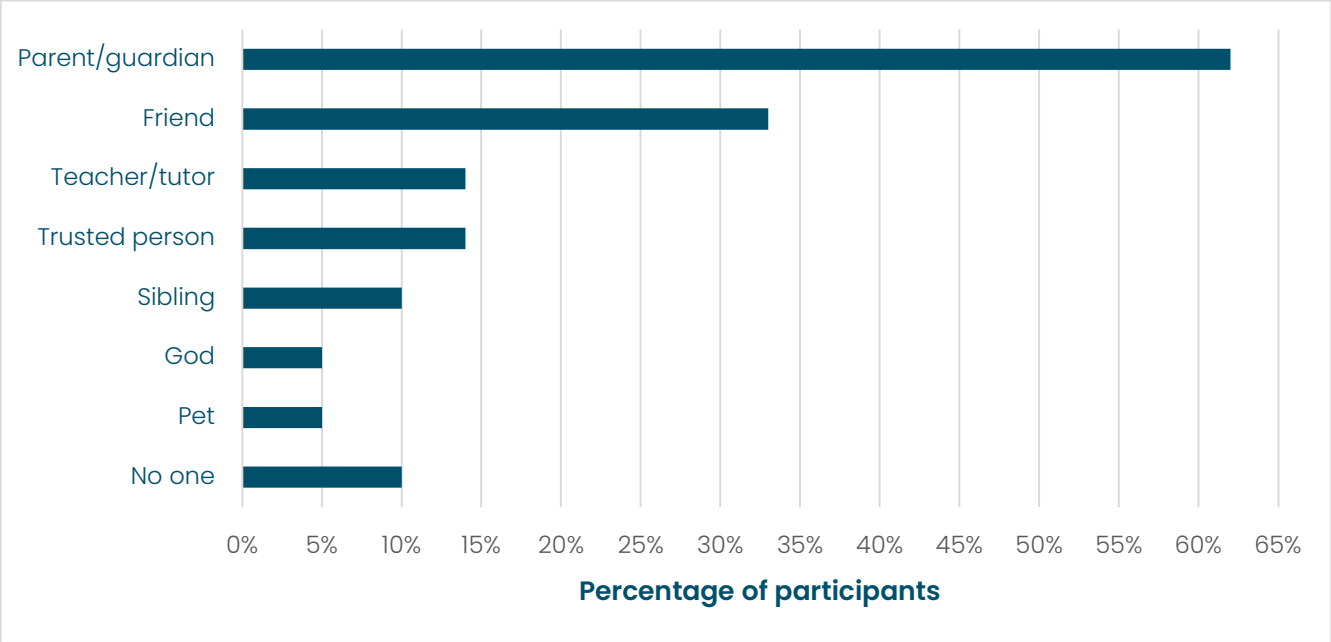

***Figure 36**: the percentage of responses by category to where or who children would go to ask for help in the Medway Council Public Health sample.*

"I would usually go to my parents or my brother. I go to my brother because he's the person in my life who has experienced most of the things I have and the things I will experience"	*"I don't like to talk to people. I don't like people worrying about me"*
"My mum because she is the only person I trust"	*"God or [my] parents or form tutor"*
"In school, teachers, but outside of school, teachers and friends"	*"People who I trust"*

***Figure 37**: examples of responses that formed each category to where or who children would go to ask for help in the Medway Council Public Health sample.*

Leisure activities and speaking with a parent/guardian were the most popular responses amongst participants. Those whose responses were categorised as "*nothing*" all identified a "*parent/guardian*" as who they would go to ask for help, indicating that although they did not necessarily know what to do to help them to feel better, they did know someone they could turn to.

Finally, participants were asked if there was anything that they didn't have right now that could make them feel better when they were feeling down, upset or angry. Responses were segmented into the following categories during the analysis of findings: "*nothing*", "*a commodity/item*" and "*a life change*". The full range of responses is shown in ***Figure 38*** and examples of each category are presented in ***Figure 39***.

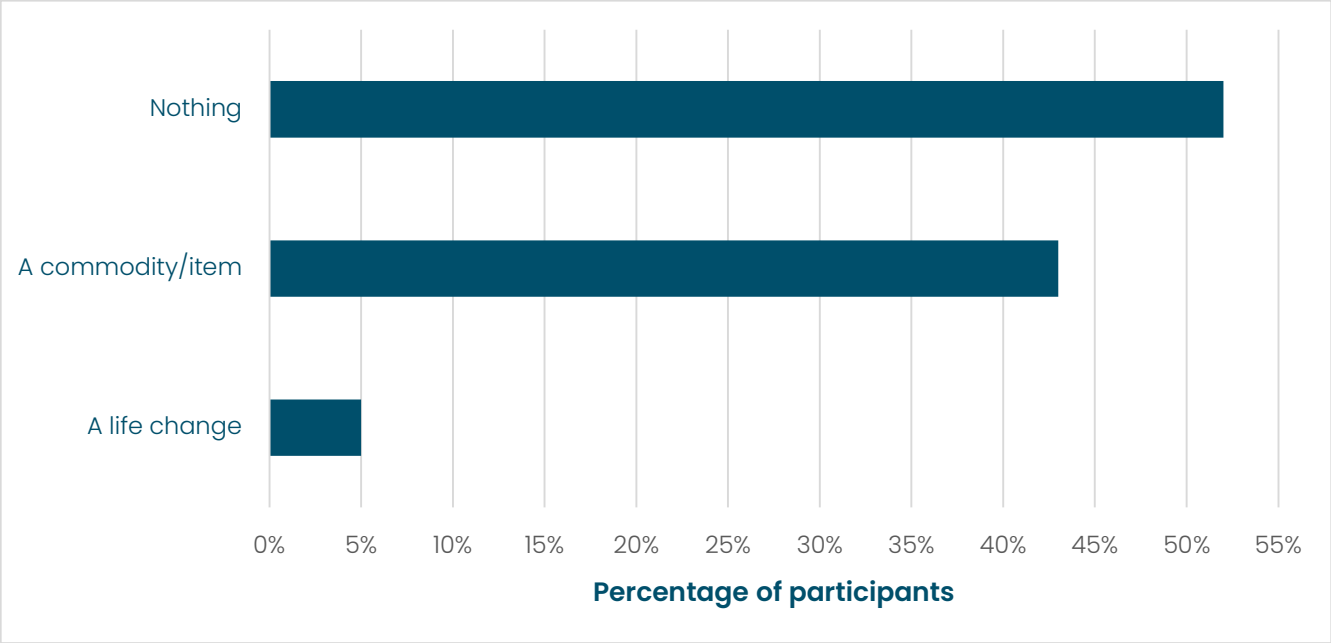

***Figure 38**: the percentage of responses by category to if there was anything children didn't have right now that could make them feel better when they are feeling down, upset or angry in the Medway Council Public Health sample.*

Nothing	*"I have everything I need"*	*"Not really, I can't think of anything"*
A commodity/item	*"An iPad"*	*"Porsche, Lamborghini, handshake from Elon Musk"*
A life change	*"To not be the middle child"*	

***Figure 39**: examples of responses that formed each category to if there was anything children didn't have right now that could make them feel better when they are feeling down, upset or angry in the Medway Council Public Health sample.*

What are the biggest issues that children and young people are currently facing?

Medway Council Public Health Engagement

Medway Council Public Health engagement specialists spoke with participants aged 14-24 years about what they think the biggest issues are that children and young people are currently facing. Responses were segmented into categories during the analysis of findings: "*pressures & standards/expectations*", "*social media*", "*addiction & mental health*" and "*bullying & violence*". The most commonly reported issue was pressures & standards/expectations with a **59%** response. The least commonly reported issue was bullying & violence with an **18%** response. The full range of responses from Medway Council Public Health engagement participants is presented in ***Figure 40*** and examples of each category are presented in ***Figure 41***.

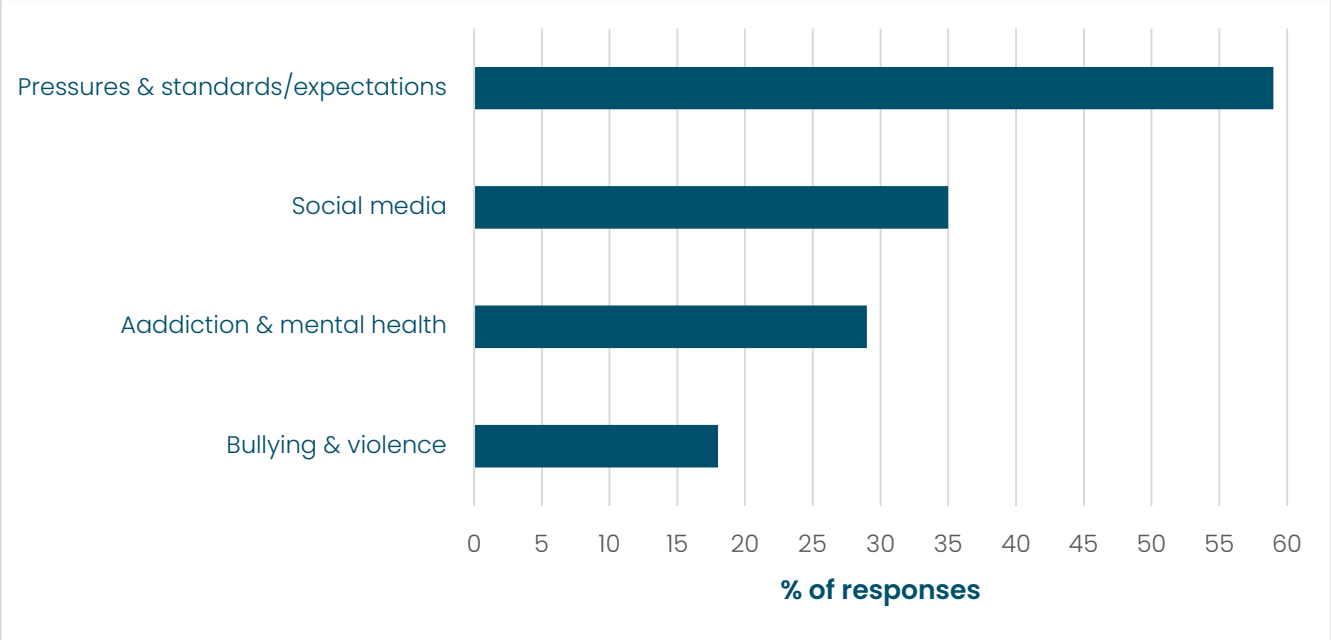

***Figure 40**: the percentage of responses by category to what children and young people think are the biggest issues currently being faced in the Medway Council Public Health sample.*

Pressures & standards/ expectations	*"Coping with today's problems and expectations…just the sheer pressure of wanting to be a better person"*	*"Pressure to succeed in life and make money"*
Social media	*"I think social media and the way that it has control over lives has become a massive issue for young people"*	*"One thing I think young people are faced with is social media"*
Addiction & mental health	*"Being subjected to addictive behaviour as [young people] are impressionable and easily influenced"*	*"Bad mental health, body image problems"*
Bullying & violence	*"Knife violence"*	*"Bullying…being overwhelmed with various factors"*

***Figure 41**: examples of responses that formed each category to what children and young people think are the biggest issues currently being faced in the Medway Council Public Health sample.*

Participants were then asked by Medway Council Public Health engagement specialists to identify some of the ways they deal with difficult emotions or ways that might be useful for someone who self-harms. Responses were segmented into categories during the analysis of findings: "*coping mechanisms*", "*talking through problems*", "*self-help techniques*" and "*therapy/mental health resources*". The most commonly reported way for dealing with difficult emotions was coping mechanisms with a **53%** response. The least commonly reported way for dealing with difficult emotions was therapy/mental health resources with a **12%** response. The full range of responses is presented in ***Figure 42*** and examples of each category are presented in ***Figure 43***.

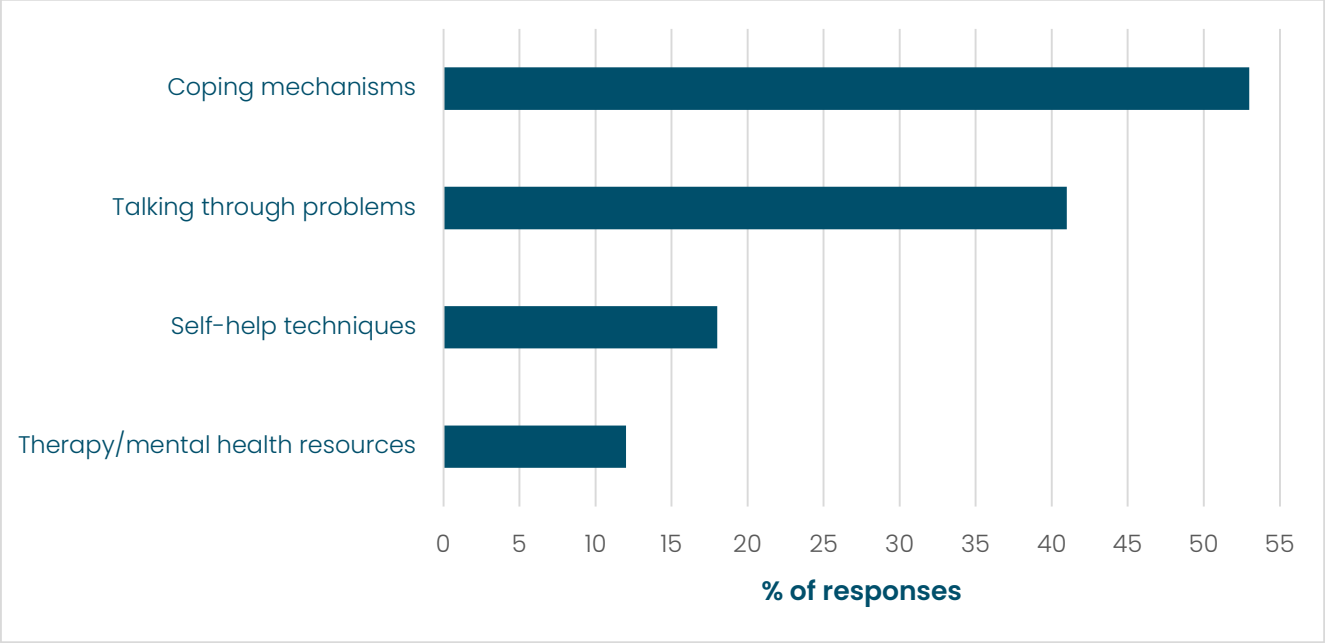

***Figure 42**: the percentage of responses by category to what ways children and young people deal with difficult emotions in the Medway Council Public Health sample.*

Coping mechanisms	*"I listen to music in order to deal with difficult emotions"*	*"Writing down issues in a journal"*
Talking through problems	*"Talking to someone you trust"*	*"I speak about my issues with people who don't know me so their opinion can't affect me"*
Self-help techniques	*"I used to use [a] hairband…and ping it on my wrist. The vibration on my arm felt better than hurting myself"*	*"I take a break from everything"*
Therapy/mental health resources	*"I've been in therapy and whilst I've never really found the content of the therapy very beneficial there are a few skills that I've taken away"*	*"Maybe resources online"*

***Figure 43**: examples of responses that formed each category to what ways children and young people deal with difficult emotions in the Medway Council Public Health sample.*

MVA Kent and Medway Engagement

High Risk of Bias Disclaimer:

The following findings are subject to a high risk of bias due to limitations in the underlying data, methodology and contextual factors. As such, interpretation of the findings should be approached with caution. The degree of uncertainty is such that conclusions drawn from these findings are discretionary and should not be considered definitive or generalisable without further validation.

MVA Kent and Medway engagement specialists spoke with participants aged 14-24 years about what they think the biggest issues are that children and young people are currently facing. Responses were segmented into categories during the analysis of findings: "*pressures & standards/expectations*", "*social media*", "*addiction & mental health*" and "*bullying & violence*". The most commonly reported issue was pressures & standards/expectations with a **100%** response. The least commonly reported issue was addiction & mental health with an **71%** response. The full range of responses from MVA Kent and Medway engagement participants is presented in ***Figure 44***.

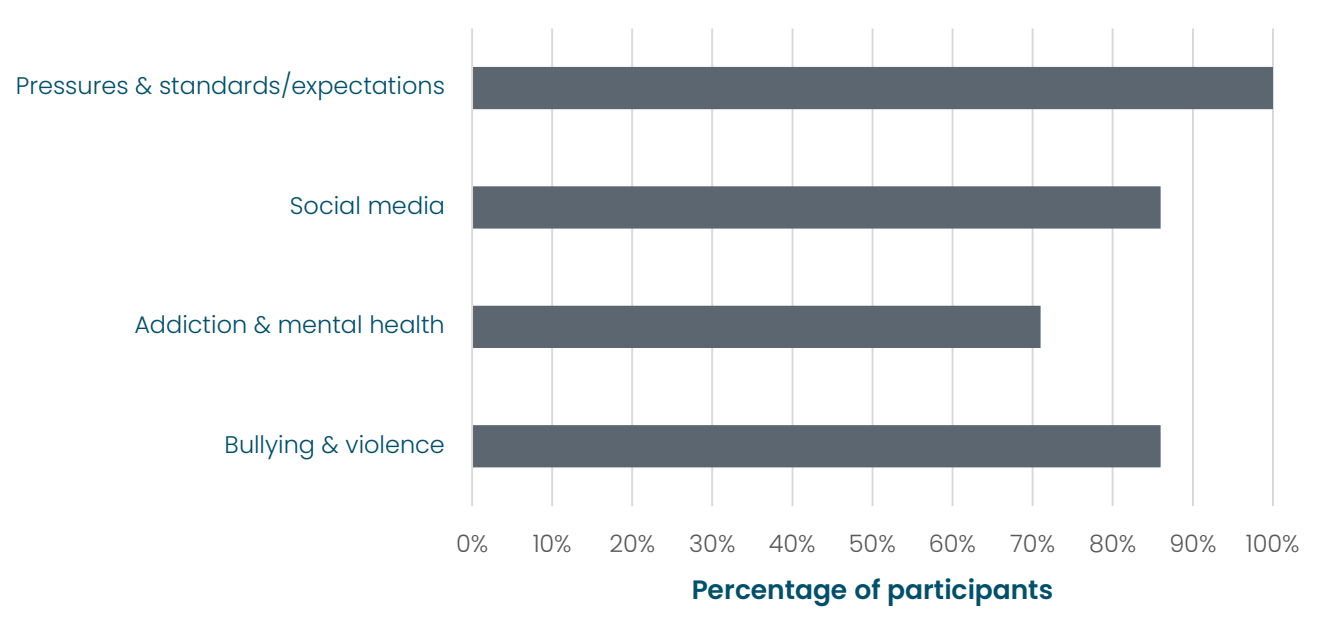

***Figure 44**: the percentage of responses by category to what children and young people think are the biggest issues currently being faced in the MVA Kent and Medway sample.*

Participants were then asked by MVA Kent and Medway engagement specialists to identify some of the ways they deal with difficult emotions or ways that might be useful for someone who self-harms. Responses were segmented into categories during the analysis of findings: "*coping mechanisms*", "*talking through problems*", "*self-help techniques*" and "*therapy/mental health resources*". The most commonly reported way for dealing with difficult emotions was talking through problems with an **86%** response. The least commonly reported way for dealing with difficult emotions was self-help techniques with a **14%** response. The full range of responses is presented in ***Figure 45***.

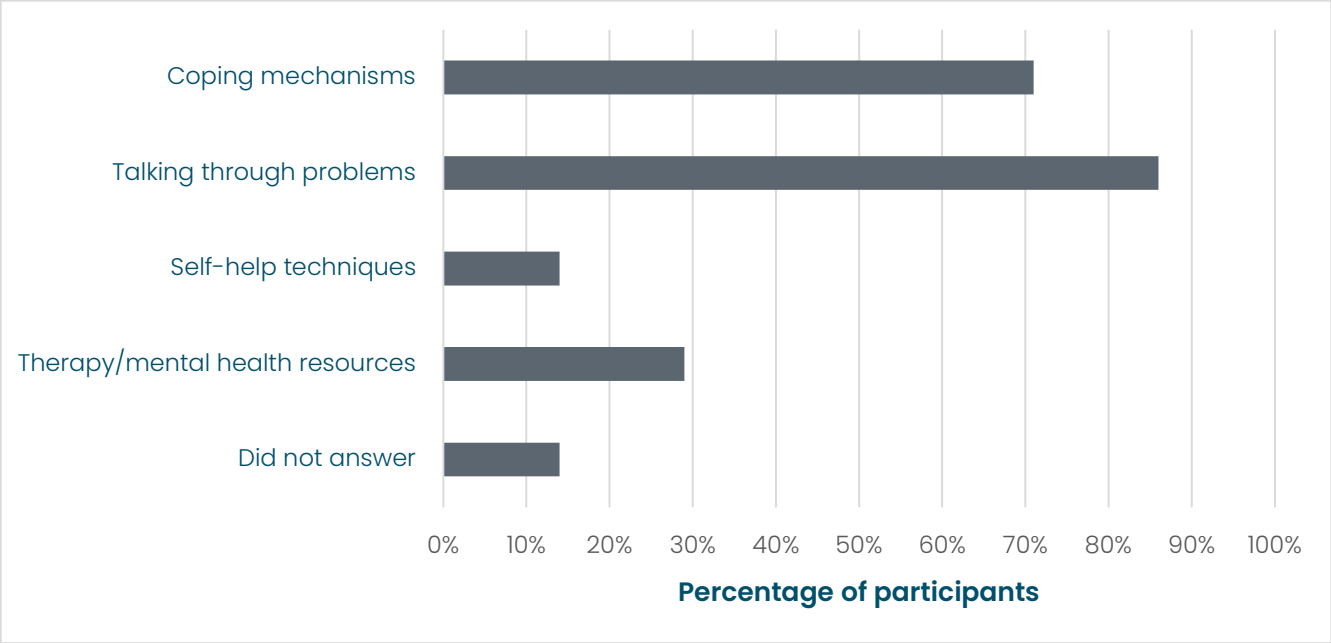

Figure 45: *the percentage of responses by category to what ways children and young people deal with difficult emotions in the MVA Kent and Medway sample.*

Are there any emerging trends or habits?

Healthwatch Engagement

Healthwatch Medway and Healthwatch Kent asked professionals to identify any emerging trends or habits that they have noticed in the last 12 months from people with regards to self-harm. Responses were then categorised into thematic groups during evaluation.

16% of participants did not identify any emerging trends or habits. Of the trends and habits identified, the most emergent was an **increase in self-harm through cutting** (**19%**). Other notable occurrences were an **increased association between social media and self-harm** (**7%**), a **rise in eating disorders and eating-related self-harm** (**6%**) and an **increased association between neurodiversity and self-harm** (**5%**).

41% of professionals recognised that there was an overall increase in self-harm in children and young people, but did not give specific examples of trends or habits. ***Figure 46*** presents the top four trends and habits identified by professionals and examples of each category are presented in ***Figure 47***.

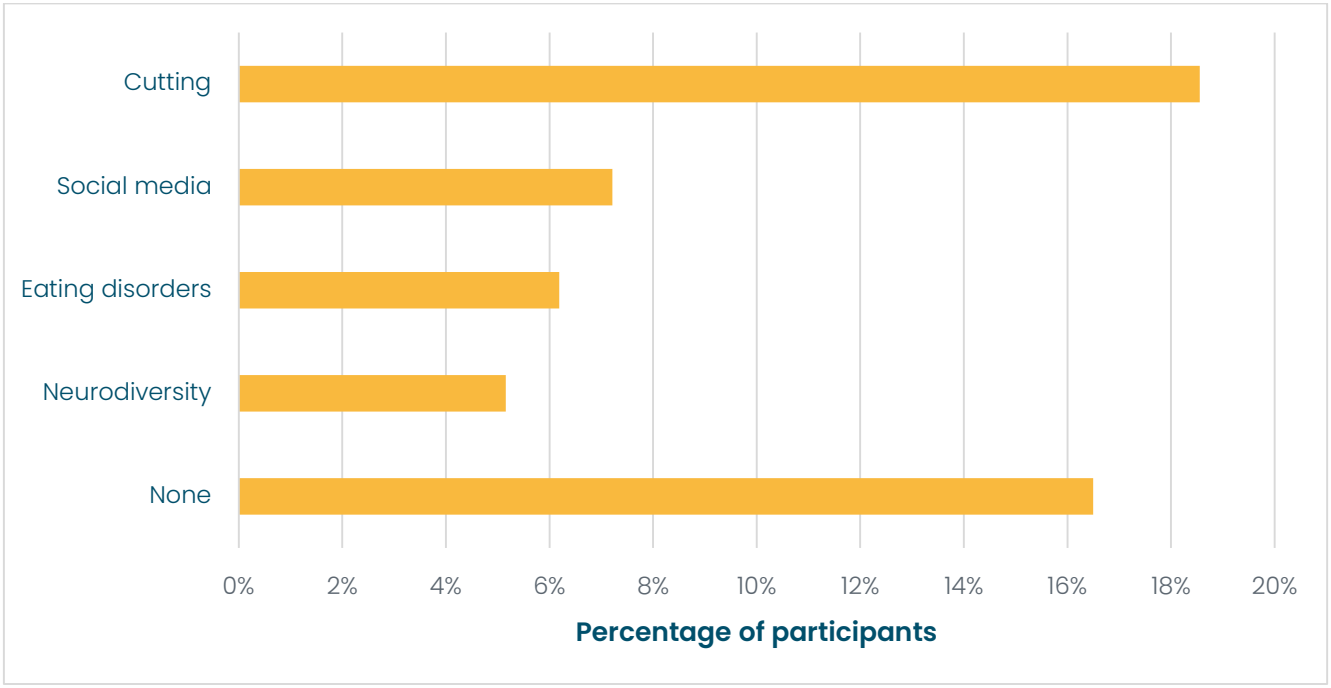

Figure 46: the percentage of responses by category to emerging trends or habits in self-harm in the Healthwatch professional sample.

Increase in self-harm through cutting	*"We have noticed a lot more cutting"*	*"There has been an increase in young people cutting themselves or inserting sharp objects under the skin"*
Increased association between social media and self-harm	*"Influence of social media and social contagion within schools"*	*"TikTok trends"*
Rise in eating disorders and eating-related self-harm	*"A lot more eating disorders"*	*"The swallowing of objects such as batteries, cutlery, sharp objects"*
Increased association between neurodiversity and self-harm	*"Self-care is deteriorating amongst neurodiverse young people, as is risky behaviour. Self-harm and suicidal ideation are increasing in this group"*	*"Young people who have underdiagnosed ASC or ADHD (overall neurodiverse) who suffer from significant problems"*
None	*"I haven't noticed an increase"*	*"No trends but just an increase in self-harm"*

***Figure 47**: examples of responses that formed each category to emerging trend or habits in self-harm in the Healthwatch professional sample.*

88% of Mental Health Voice feedback highlighted **issues of service eligibility** (entry requirements being a barrier to begin receiving treatment and support) for children and young people. This cohort had experienced negative interactions with children and young people's mental health services (CYPMHS), mental health crisis services and specialist mental health services. All of this feedback presented children and young people struggling with self-harm as being left stranded by services without effective signposting.

What are the challenges and what is working well?

Healthwatch Engagement

Healthwatch Medway and Healthwatch Kent asked professionals to identify the challenges they have faced when supporting children and young people who self-harm or are at risk of self-harm. Responses were then categorised into thematic groups during evaluation.

86% of professionals identified challenges, **9%** chose not to answer the question and **5%** did not recognise any challenges. Of the **86%** of professionals that did identify challenges, the most common were challenges in engaging with children and young people (**23%**) and issues with access to services (**23%**). The full range of most common responses is presented in ***Figure 48*** and examples of each category are presented in ***Figure 49***.

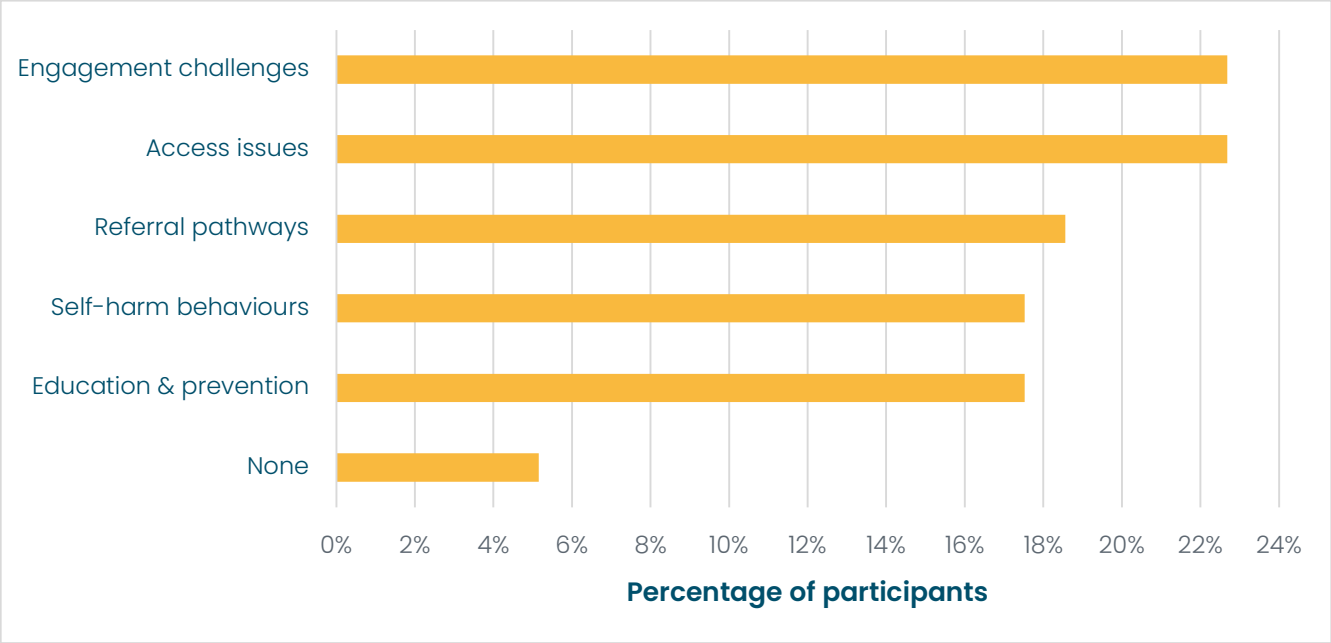

***Figure 48**: the percentage of responses by category to the challenges being faced in the Healthwatch professional sample.*

Engagement challenges	*"Lack of engagement, relying on self-referrals, long waiting lists which leads to people losing faith in the service"*	*"Finding the children hard to reach"*
Access issues	*"There are appalling and damaging delays to accessing CAMHS and Social Services"*	*"Waiting times on other services, [children and young people] need immediate support when self-harming"*
Referral pathway	*"Knowing where to refer/signpost clients"*	*"Not knowing where we can signpost them to and when we do the waiting lists for help is too long"*
Self-harm behaviours	*"Making sure their room is cleared of anything that they could harm themselves with"*	*"CYP who choose not to disclose risk and therefore safety plans may be missed"*
Education & prevention	*"Lack of understand about self-harm"*	*"What advice to give, where to refer and managing expectations"*

***Figure 49**: examples of responses that formed each category to the challenges being faced in the Healthwatch professional sample.*

Healthwatch Medway and Healthwatch Kent also asked professionals to identify what works well with regards to support services for children and young people who self-harm or are at risk of self-harm. Responses were then categorised into thematic groups during evaluation.

83% of professionals identified examples of what works well, **12%** chose not to answer the question and **5%** were unsure of what was working well. Of the **83%** of professional that did identify examples, the most common was listening with empathy to children and young people (**15%**). The full range of most common responses is presented in ***Figure 50***.

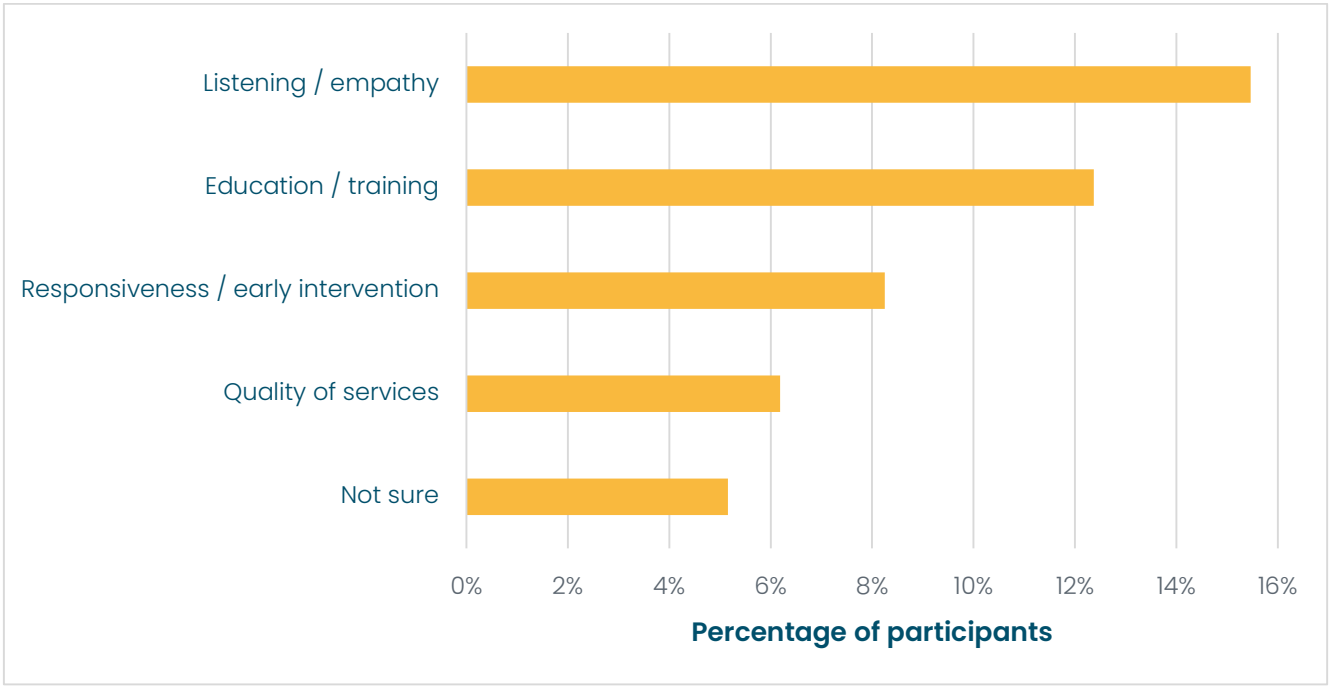

***Figure 50**: the percentage of responses by category to what works well with regards to support services for self-harm in the Healthwatch professional sample.*

The insight offered by professionals into what the challenges are and what is working well emphasises the importance of engaging with children and young people in a compassionate and understanding manner. The breadth of responses to challenges and what is working well suggests that a singular approach to making improvements will not address the extent of issues currently facing children and young people with regards to self-harm. Building the skills and techniques for engaging with empathy and compassion could bring an improvement to the support offered for children and young people.

What will support children and young people to stop self-harming?

Healthwatch Engagement

Healthwatch Medway and Healthwatch Kent asked the general public and professionals what they thought would support children and young people to stop self-harming. To the general public, we phrased this as *"what do you think could or should be put in place for children and young people in Medway and Swale?"* and to professionals, we phrased this as *"if you were in charge of planning support services for children and young people, what would you implement to prevent children and young people self-harming and to support their health and wellbeing?"*. Responses were analysed into thematic categories during evaluation.

43% of the general public felt that **improvements made to services' accessibility, availability and effectiveness** were critical for children and young people. **5%** of the general public commented that **preventative mental health services needed increased prioritising**. The full range of responses is presented in ***Figure 51***.

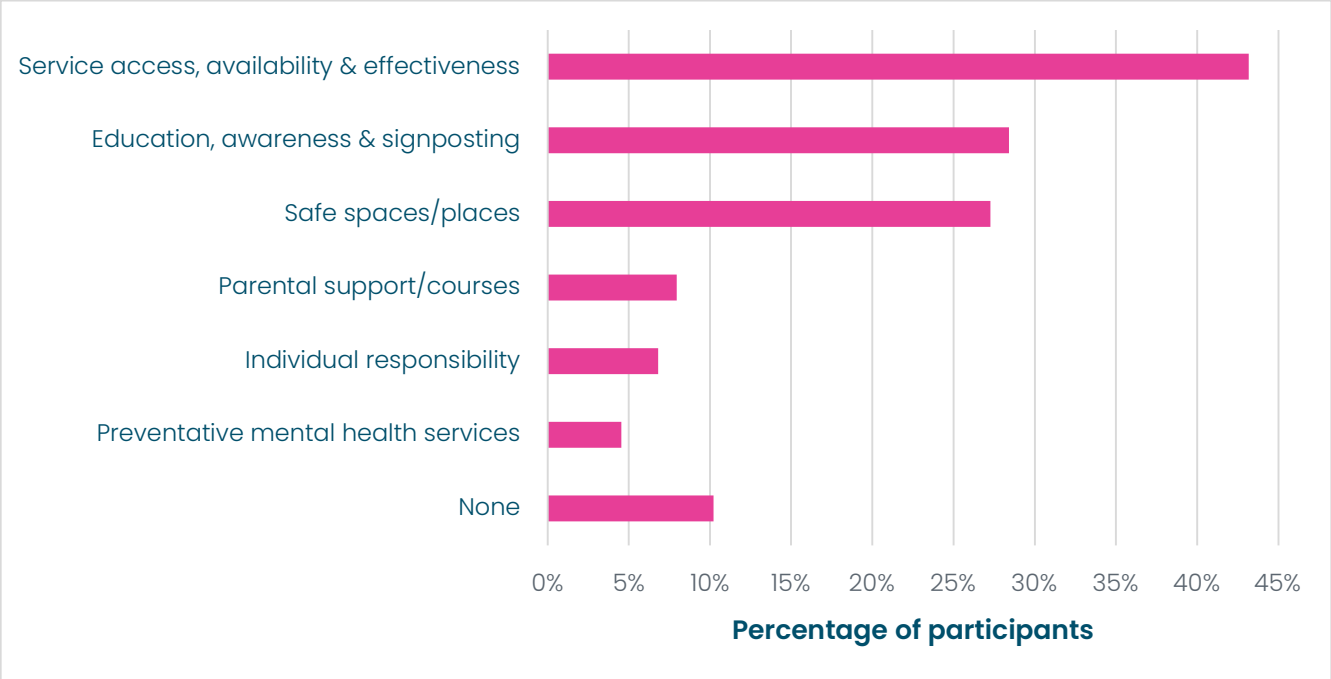

***Figure 51**: the percentage of responses by category to what would support children and young people to stop self-harming in the Healthwatch public sample.*

Children and young people **identified improvements to education, awareness and signposting** and **leaving people to take individual responsibility** at a higher rate than adults (a difference of **6%** and **8%** respectively). Conversely, adults identified **improvements made to services' accessibility, availability and effectiveness** and **more safe spaces and/or places** at a higher rate than children and young people (a difference of **14%** and **9%** respectively). Additionally, **11%** of adults identified **additional parental support and/or courses** compared to **0%** of children and young people. The full range of responses split by each cohort is presented in ***Figure 52***.

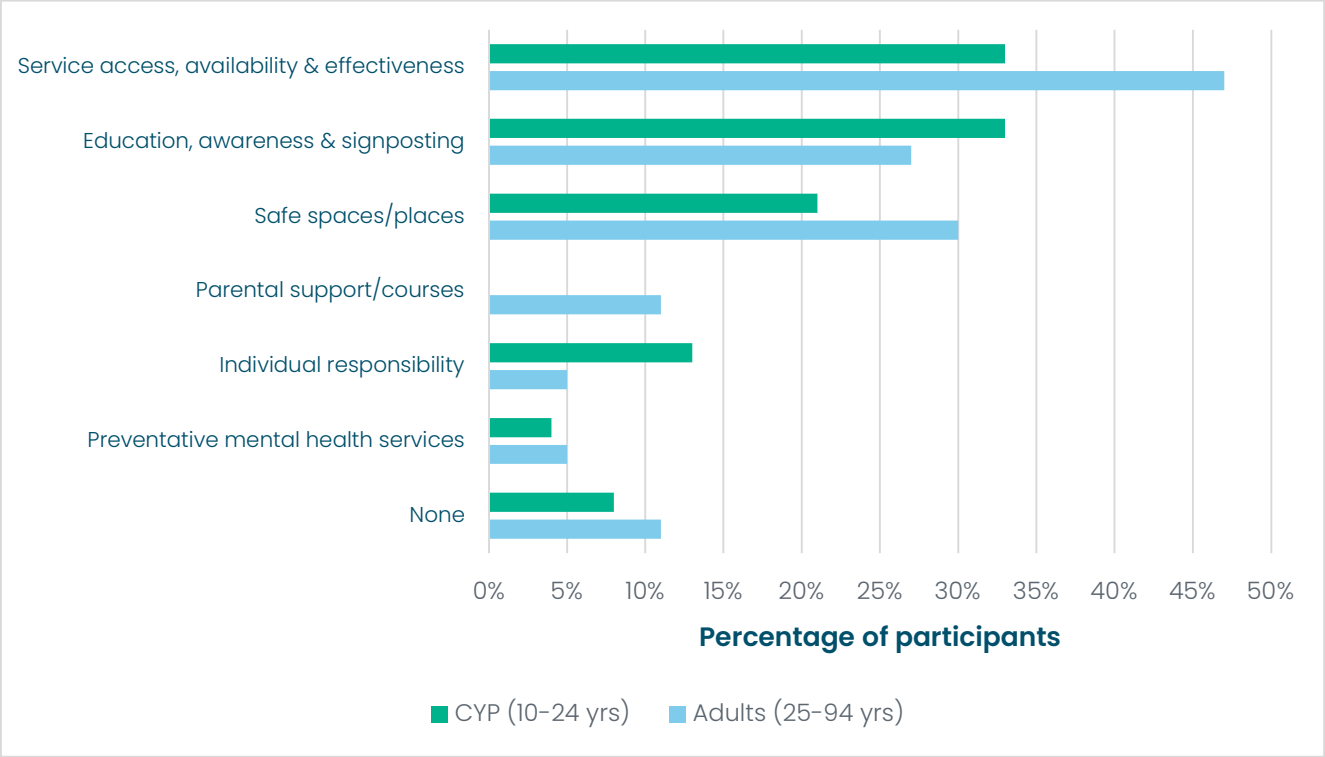

***Figure 52**: the percentage of responses by category to what would support children and young people to stop self-harming, split by children and young people (10-24 years) and adults (25-94 years) in the Healthwatch public sample.*

42% of professionals identified **improvements to multi-agency support** as the most common response. The least common response identified was **improvements to early intervention** at **11%**. In addition, **8%** of professionals chose not to provide an answer to this question. The full range of responses from professionals is presented in ***Figure 53***.

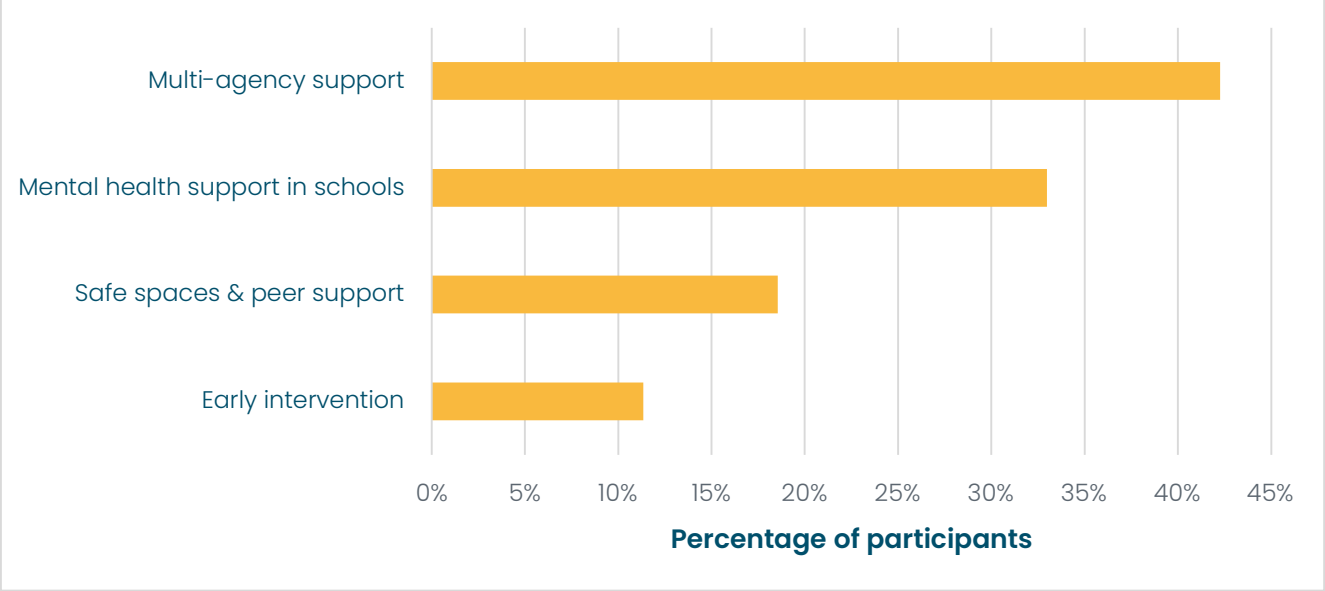

***Figure 53**: the percentage of responses by category to what would support children and young people to stop self-harming in the Healthwatch professional sample.*

Both the general public and professional cohorts highlighted improvements to various aspects of services as the key to supporting children and young people to stop self-harming. These responses highlighted the division in what both the general public and professionals feel is most pressing for

supporting children and young people to stop self-harming. The breadth of responses across both cohorts suggests that a singular approach to making improvements will not address the extent of issues currently facing children and young people with regards to self-harm.

Conclusions

This report has brought together the voices of children and young people, professionals working with children and young people, and the wider general public to deepen the insight into how self-harm is identified and understood in Medway and Swale. The findings reveal the complexity and multifaceted nature of how self-harm is shaped by a range of personal, social and systemic factors.

Whilst "cutting yourself" was identified as the most universally recognised form of self-harm across varying participant cohorts, findings in this research reveal there are wider variations in how different demographics – particularly professionals, adults and young people – recognise, understand and categorise self-harm behaviours.

Awareness of available support services also varies across participant cohorts. Nearly half of the general public respondents were unaware of any services for children and young people. And while professionals demonstrated a higher overall awareness, a notable portion (**12%**) lacked knowledge of any relevant services. Children and young people most frequently identified CAMHS, Childline and the NHS, while adults and professionals most frequently identified a much broader range of services. Crucially, direct experiences with services varied significantly, with children and young people reporting more negative encounters than adults.

Children and young people identified pressures and standards related to school performance, social media and mental health as key drivers of distress. While **57%** of children reported attempts to manage their emotions independently, **29%** reported feeling hopeless or unsure where to turn. Leisure activities and trusted adults (especially parents/guardians) play an important role in helping children to cope. However, gaps remain in consistent support and early intervention. Professionals identified several emerging trends, including increasing instances of cutting, increasing links between social media and self-harm and a rise in eating-related self-harming behaviours (including disordered eating and intentional ingestion of dangerous substances).

Professionals highlighted systematic barriers, such as service inaccessibility, referral challenges and limited mental health education/prevention initiatives. Despite these barriers, empathy and active listening were identified as key strengths in successful support approaches.

Finally, both public and professional respondents agreed that improvements in service accessibility, awareness and multi-agency collaboration are essential to supporting children and young people to stop self-harming. However, responses also demonstrated that no single solution would address the wide range of issues and challenges presented. A multifaceted and inclusive strategy – grounded in education, early intervention, co-production and empathetic engagement – is required for creating meaningful change.

Recommendations and/or next steps

Create and launch targeted awareness campaigns for professionals and communities

Resources developed and disseminated as part of the self-harm campaign, targeting the public, young people and professionals, were well received during the engagement project. Data from October 2024 to March 2025 show a downward trend in A&E attendances at Medway Hospital.

Actions: In 2025/2026 financial year.

- Co-design self-harm awareness campaign resources with young people and young adults.
- Co-design self-harm awareness campaign resources for professionals, education partners and communities promoting relevant mental health services in statutory, private and VCSEF sectors.
- Design and coordination of awareness campaigns across social media and printed materials, overseen by the Medway and Swale Health and Care Partnership Communications Group.
- Utilise data to draw on self-harm emergency attendance trends to time awareness campaigns, supporting early intervention before expected increases in demand.

By Whom: Medway and Swale Health and Care Partnership Board.

Intended Outcomes: Evident changes in referral trends, with increased emphasis on preventive, community-based self-harm interventions and a corresponding decline in A&E presentations.

Strengthen multi-agency collaboration for self-harm prevention

By bringing together multiple agencies, the self-harm working group enabled richer knowledge sharing and joint idea generation, improving the quality and reach of interventions.

Actions: In 2025/2026 financial year.

- Set up a joint working group across sectors to track self-harm data and referrals, helping make services easier to access and improving collaboration between agencies.
- Encourage early intervention, education, and empathetic engagement through partnerships with healthcare providers and schools for promotion.
- Develop and implement joint initiatives with education, community and healthcare partners that focus on early intervention, awareness raising and empathetic communication strategies.

By Whom: Medway and Swale Health and Care Partnership Board.

Intended Outcome: Demonstrable system changes in patterns of self-harm referrals, data capture and reporting.

Build learning on engagement and research methodologies within the VCSEF sector

By working collaboratively with the VCSEF sector, areas where research improvements could be made were identified especially concerning mitigating risk of bias.

Actions: In 2025/2026 financial year.

- Develop and deliver practicalities of engagement training with particular emphasis towards methodological techniques.
- Develop and deliver risk of bias in research training with particular emphasis towards confounding, participant sampling, missing data and mitigation.
- Work with the VCSEF sector to identify gaps in knowledge, skills and capacity where further learning and development can take place.

By Whom: Medway and Swale Health and Care Partnership Board.

Intended Outcome: Improved knowledge, skills and capacity within the VCSEF sector for engagement and research methodologies and mitigation of risk of bias.

Acknowledgments

Healthwatch Medway and Healthwatch Kent would like to acknowledge and thank all those who took the time to participate in interviews and focus groups, and to share their experiences for this research. Their contributions are both warmly received and greatly appreciated.

Healthwatch Medway and Healthwatch Kent would also like to acknowledge and thank **Medway Council**, **NHS Kent and Medway Integrated Care Board**, **Medway Council's Public Health Team**, **MVA Kent and Medway** and **Medway & Swale Health and Care Partnership** for their collaboration, support and assistance in making this research possible.

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