REPORT

Centre for
Mental Health

A space to talk

An evaluation of the WISH Centre's
services with young people who self-harm

Dr Graham Durcan & Juliet Snell

Contents

Executive summary

The WISH Centre was founded around 15 years ago to support young people who were self-harming and has developed into a community-based service to support young people on a path to recovery. Centre for Mental Health evaluated the service, analysing two years of outcome data collected by WISH, and speaking to former and current users of the WISH Centre, as well as a range of key stakeholders. This report summarises the results of our evaluation, as well as exploring how the positive features of WISH could be made available in other areas to support young people who self-harm.

The results of the evaluation demonstrate the success that has been previously demonstrated and continues in Harrow, which has been replicated in Merton. Young people (and other stakeholders) described a project that is holistic, that focuses on their strengths and in building resilience and that does so at the young person's pace. The analysis of the hard outcome data collected by WISH also demonstrates the considerable success WISH had in helping young people turn their lives around. Attendance of A&E for self-harm was markedly reduced and statistically significant positive outcomes were demonstrated for young people in both Harrow and Merton across a range of outcomes (i.e. self-harm, suicidal ideation, abuse, trauma, anxiety/stress, depression/sadness, coping mechanisms & emotional resilience).

Centre for Mental Health concludes that the approach offered by WISH is both successful and replicable.

This report therefore recommends:

1. Introducing the WISH approach to other areas

Clinical commissioning groups (CCGs) and local authorities across the country should commission services similar to WISH to address the needs of young people struggling with self-harm.

The approach offered by WISH is highly successful in bringing about improvements across a range of outcomes for young people, and part of its success is that it is attractive to young people and engages with them.

2. Increase capacity

CCGs & local authorities need to expand and develop the model used by WISH, to ensure there is enough capacity to give all young people struggling with self-harm the timely support they need. Commissioners may especially wish to focus on the role of peer support groups, which could provide the most cost-effective means of increasing capacity and which this report has found to be highly effective.

3. Developing outcome reporting and achieving more understanding of the peer support offer

Research funders should commission further studies, prospective in nature, specifically on the outcomes of young people who attend peer groups.

4. Commissioning more for young men

Commissioners should look at increasing their provision for young men struggling with self-harm, as well as young women.

This is based on the views of a range of interviewees and focus group members, who thought a broader offer was needed for young men.

5. Commissioning a specific offer for young people identifying as LGBT

Research funders should fund pilot studies to examine the benefits of LGBT-specific groups for young people struggling with self-harm.

Some people felt there should be an offer for lesbian, gay, bisexual and transgender young people, with a number suggesting that multiple groups might give young people a choice of groups to go to, including different gender mixes.

6. Better promotion

Public Health England should commission a national campaign on working with young people who self-harm, increasing awareness in young people and others of the issues, challenging the myths about self-harm and encouraging help-seeking among those who need support. This would require substantial funding, locally and nationally, both to fund the promotional activity and to build capacity in the sector to meet demand.

This is based on several group discussions in our research which centred on the promotion of WISH. Many young people said they had not recognised existing promotional material and had not known about WISH before they came. There was consensus that promotion should challenge stereotyping of young people who self-harm as being largely White British girls, and that the representation of young people should be positive and uplifting.

7. Commissioning support for parents and carers

CCGs and local authority commissioners should work with services across the country providing support similar to WISH, to explore the need for facilitated peer group offers for parents and carers, and to establish what this support might look like. Extending the support to parents and carers is likely to have benefits for young people too.

8. Support for teachers and other professionals working with young people on self-harm

Charitable funders should fund the development of a self-harm awareness training programme for teachers and professionals who work with young people.

The training offered by WISH is highly valued by delegates, but teams like WISH will always have limited capacity. A national programme to equip professionals across the sectors would improve the understanding and support given to young people struggling with self-harm, and would increase the likelihood of timely support.

Introduction

This report describes the evaluation of the WISH Centre conducted by Centre for Mental Health over the Spring and Summer of 2018. The WISH Centre supports young people who self-harm and has developed into a community-based service to support young people with a range of difficulties on a path to recovery. It is aimed at people under the age of 18 but provides an opportunity for ongoing support for those over 18 through a former service user peer support group (X XPRESS).

WISH now also has a base in south London in the borough of Merton (open for two years) and is opening a service in Camden. The purpose of this expansion has not been to grow the WISH Centre but to test the model in other settings and see if the outcomes could be replicated.

WISH provides one-to-one counselling and psychotherapy adapted to the needs of young people (Safe2Speak), delivered by qualified counsellors and psychotherapists; facilitated peer support groups (e.g. Self Harm Xpress); and outreach to young people in schools and the community. Some young people use one of these services, but others use two or more.

Prior to attending WISH, young people may well have received other forms of support, and those with ongoing needs after self-harm has been addressed may be referred to other services, but in most cases the WISH Centre is the only therapeutic support young people will receive at that time. For example, WISH will not work with cases open to local Child and Adolescent Mental Health Services (CAMHS) but will accept referrals from CAMHS and may refer on to CAMHS once the young person's self-harm has been addressed.

The WISH Centre has a range of funding sources – charitable and philanthropic grants (Children in Need and Comic Relief being significant amongst these), and some public sector grants from the local authorities and clinical commissioning groups. With recent austerity, the latter sources of funding have shrunk. Nevertheless, and despite a climate of fragile funding for charities, WISH have managed to make the case to test their model on other sites (Merton and Camden).

The WISH Centre is one of a small handful of charities to which Comic Relief have given several grants. This is unusual for Comic Relief and they are now working with WISH to look at developing sustainable funding.

The evaluation

The WISH Centre commissioned Centre for Mental Health to conduct an independent evaluation with a view to testing the model. The evaluation has spoken to young people currently using WISH and former users, as well as a range of stakeholders in Harrow and Merton. The evaluation also looked at the data that WISH collects on the backgrounds of those who use the service, and especially the outcome data collected on young service users. They use an adapted version of a validated measure, which shows whether the young people improve across a range of domains after contact with the WISH Centre.

The specific evaluation objectives were:

- Focus on the impact of the services the WISH Centre provides, and the change made to the lives of young people who self-harm.

- Consider the wider implications of delivering a community-based intervention, with a view to sharing learning and influencing the wider sector, consequently contributing to the emerging clinical evidence base as outlined in the *WISH Self Harm and Young People: Phase 1* report and findings by the Royal College of Psychiatrists (2011) and NICE (2013).

Methodology

The evaluation methods included:

- A brief and rapid review of literature and written evidence to establish what we know about best practice in addressing self-harm;

- Engagement and collaboration with current and former service users in the evaluation, to advise on questions for interview and to sense-check findings;

- Analysis of available outcome data, on both therapeutic outcomes and broader social outcomes;

- Focus groups and one-to-one interviews with:

    - Young people who currently use WISH services in Harrow and Merton

    - Former service users who are part of X XPRESS (chiefly in Harrow)

    - A broader group of stakeholders including trustees and WISH Centre staff, local commissioners, and others locally with a role in ensuring children's wellbeing (Harrow & Merton);

- Dissemination of the findings through means which empower the young people who use the WISH Centre and who have collaborated with the evaluation, and which influence local and national policy.

As the WISH Centre project with Camden has only recently launched, the evaluation has focused on Harrow and Merton. The quantitative data used in the evaluation for both sites is for a two-year period, from when Merton was established (obviously Harrow has data collected for a much longer period).

The peer support model

This section has been drawn from the qualitative findings but is presented here as it provides a good introduction to an important aspect of the WISH approach.

Across interviewees and focus group members, the peer support model was a key factor in achieving outcomes for young people, who described the model in detail. The approach had been consistent over time (in fact the model was described identically by people who had accessed groups 14 years ago and the previous week) and was delivered in the same way across areas and settings.

The key features of the model that young people and staff described were:

i. An activity where young people select good things and bad things that had happened to them recently. The focus on identifying good things was key for young people in setting a tone where positivity and recovery are central. Young people said that the bad things that were described were often used later as the basis for discussion and debate.

ii. Small group peer support without adult input. Young people were often surprised to be expected to offer support on sometimes difficult issues to their peers, but then attributed this activity to their outcome of being skilled and knowledgeable about helping both themselves and others. Before coming to the group, young people often expected that peer support would be depressing or "dark", but in fact described the time alone with peers as fun and uplifting. The overall expectation that they could and would help each other, and that they could be trusted to do this without adult supervision was returned to frequently as a turning point for them.

Young people did not say that they were negatively affected by pressure or concern about their peer support role. They knew that they should call for staff help if needed, and that they were welcome to opt out of conversation in weeks that they felt unable to contribute. This added to feelings of being in control and being skilled and confident.

iii. A planned or spontaneous large group activity. Young people said they had always chosen the activity, though staff had at times offered options. Activities were often creative or imaginative in nature – such as art projects. Young people also described activities that supported them learning relevant skills or building confidence, such as self-defence classes;

iv. Eating together;

v. A closing activity, where young people took turns to share their thoughts and expectations of the coming week.

Young people also described an "out-of-hours" peer support project – being linked together in a messaging app. The purpose of the group was to be able to share news, both positive and negative, and to ask for individual peer support by requesting a private message. As with the face-to-face peer support session, young people felt able and equipped to help each other, and knew the boundaries of the support, when to involve staff (who are in groups as moderators) and could opt out of responding to requests for support if needed.

"[Staff member] has to turn her phone off – like hours that she doesn't work, so we're here for everyone else if they need to – because we know what's going on in everyone's life, so it's easier for people to talk to"

[Young person in focus group]

The group activities were linked to a number of positive impacts by young people. They felt able to "offload" and "get things off their chest". The fact that this had happened in a safe space without judgement contributed both to a reduction in mental distress, and to the confidence to seek help and talk to friends in other places. The group also felt a responsibility to each other, and some young people commented that this had helped them to stay engaged through difficult times.

"There was a time I was forcing myself to come. [I kept coming because...] You just feel obligated – you know when you have grown an attachment to someone. Out of respect for other people"

[Young person in focus group]

"We have a lot of stuff to offload. So, like, if we've had a bad week we vent, but if we've had a good week we just go on and on about the thing that happened. I think it quickly turns into just conversations"

[Young person in focus group]

"Once we did a thing about inspirational cards – so we wrote something on a card for yourself – and they sent it to us at a random time, so we can have that piece of inspiration"

[Young person in focus group]

"When there were some older [young people] they were more willing to share things, and you could ask them for advice"

[Young person in focus group]

"You're talking to someone you know is either in it or was in it in the last few years and they kind of understand you – and you know that they're going to talk as well, and you're going to listen to them – so you have that empowerment – like you can be useful to someone else and I can help someone else"

[Young person in focus group]

Literature review: self-harm and young people

The most recent literature review for the WISH Centre was published in 2014 (WISH, 2014) and this provided a good summary of what was known about prevalence, the reasons for self-harm in young people, the evidence on what works, and the recommended guidelines from the evidence for working with young people who self-harm (primarily taken from NICE guidelines, e.g. NICE, 2013). The purpose of our brief and rapid review of the literature was to update what has been learned since that review was published in 2014.

Prevalence of self-harm in young people

Most of the new evidence on self-harm in young people since WISH's last literature review has been on the understanding of prevalence. However, despite calls from both NICE (2013) and the Royal College of Psychiatrists (2011), as reported in the previous review, for a detailed mapping of the incidence of self-harm by localities (local authorities and clinical commissioning group areas), prevalence is still not well understood. A recent large-scale cohort study published by Morgan and colleagues (2017) has sought to address this. As Morgan *et al.* states, much of the current understanding around the incidence of self-harm comes from hospital admissions (e.g. see figures 1 and 2 overleaf). They note:
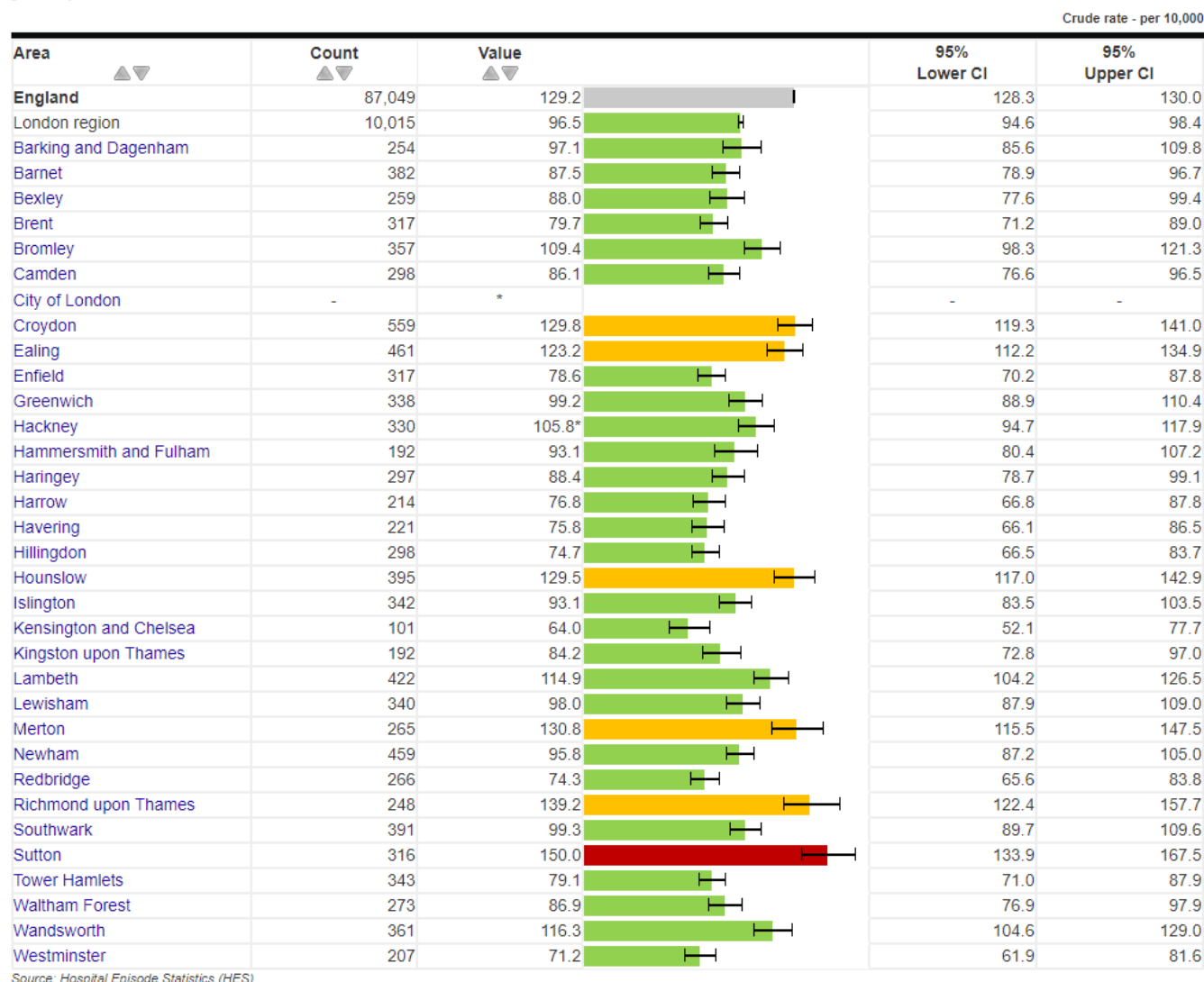
"The elusive nature of self-harm represents a major obstacle. Less than a quarter of children and adolescents who self-harm are believed to present to healthcare service" (page 2, Morgan *et al.*, 2017).

Hospital admission data presents only the 'tip of the iceberg'. Morgan and colleagues reviewed general practitioner records from 674 GP practices in the UK (via UK Clinical Practice Research Datalink), and studied the records of 16,912 young people between the ages of 10-19 who had self-harmed between 2001 and 2014. In the event 8,638 were able to be included in the study and these were each matched with up to 20 children and adolescents who had not self-harmed. The sample size for this latter group was 170,274. Bearing in mind the quote from Morgan and colleagues above, there may well be three times or more children who self-harmed but did not present to any services.

What Morgan and colleagues found was that the annual incidence of self-harm in children aged 10-19 years was 37.4 per 10,000 girls compared with 12.3 per 10,000 boys. But they also found there was a marked increase in self-harm in girls aged 13-16 between 2011 and 2014, rising from 45.9 per 10,000 to 77.0 per 10,000.

Figure 1: Admission to hospital for undeliberate and deliberate self-harm in London by Borough (15-24 years old)

2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years) 2016/17

Crude rate - per 10,000

Area	Count	Value		95% Lower CI	95% Upper CI
England	87,049	129.2		128.3	130.0
London region	10,015	96.5		94.6	98.4
Barking and Dagenham	254	97.1		85.6	109.8
Barnet	382	87.5		78.9	96.7
Bexley	259	88.0		77.6	99.4
Brent	317	79.7		71.2	89.0
Bromley	357	109.4		98.3	121.3
Camden	298	86.1		76.6	96.5
City of London	-	*		-	-
Croydon	559	129.8		119.3	141.0
Ealing	461	123.2		112.2	134.9
Enfield	317	78.6		70.2	87.8
Greenwich	338	99.2		88.9	110.4
Hackney	330	105.8*		94.7	117.9
Hammersmith and Fulham	192	93.1		80.4	107.2
Haringey	297	88.4		78.7	99.1
Harrow	214	76.8		66.8	87.8
Havering	221	75.8		66.1	86.5
Hillingdon	298	74.7		66.5	83.7
Hounslow	395	129.5		117.0	142.9
Islington	342	93.1		83.5	103.5
Kensington and Chelsea	101	64.0		52.1	77.7
Kingston upon Thames	192	84.2		72.8	97.0
Lambeth	422	114.9		104.2	126.5
Lewisham	340	98.0		87.9	109.0
Merton	265	130.8		115.5	147.5
Newham	459	95.8		87.2	105.0
Redbridge	266	74.3		65.6	83.8
Richmond upon Thames	248	139.2		122.4	157.7
Southwark	391	99.3		89.7	109.6
Sutton	316	150.0		133.9	167.5
Tower Hamlets	343	79.1		71.0	87.9
Waltham Forest	273	86.9		76.9	97.9
Wandsworth	361	116.3		104.6	129.0
Westminster	207	71.2		61.9	81.6

Source: Hospital Episode Statistics (HES)

(Source for figures 1 and 2: Public Health England - https://fingertips.phe.org.uk)

Figure 2: Admission to hospital for undeliberate and deliberate self-harm in London by Borough (0-14 years old)

2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2016/17

Crude rate - per 10,000

Area	Count	Value		95% Lower CI	95% Upper CI
England	100,728	101.5		100.8	102.1
London region	13,307	78.1		76.8	79.5
Barking and Dagenham	377	70.0		63.1	77.5
Barnet	477	61.7		56.3	67.5
Bexley	351	74.1		66.5	82.2
Brent	410	62.7		56.7	69.0
Bromley	405	65.2		59.0	71.9
Camden	234	57.4		50.3	65.2
City of London	-	*		-	-
Croydon	825	102.9		96.0	110.2
Ealing	546	77.8		71.4	84.6
Enfield	635	89.1		82.3	96.3
Greenwich	434	74.4		67.6	81.7
Hackney	429	77.9*		70.7	85.7
Hammersmith and Fulham	239	78.5		68.8	89.1
Haringey	445	85.1		77.4	93.4
Harrow	343	70.9		63.6	78.8
Havering	332	71.0		63.6	79.1
Hillingdon	519	84.3		77.2	91.9
Hounslow	465	84.4		76.9	92.4
Islington	241	68.8		60.4	78.0
Kensington and Chelsea	169	68.6		58.6	79.7
Kingston upon Thames	352	107.4		96.5	119.2
Lambeth	512	93.9		85.9	102.4
Lewisham	567	96.0		88.3	104.2
Merton	434	107.0		97.2	117.6
Newham	479	65.4		59.7	71.5
Redbridge	379	58.9		53.1	65.2
Richmond upon Thames	403	103.8		93.9	114.5
Southwark	488	87.9		80.3	96.1
Sutton	422	106.0		96.2	116.6
Tower Hamlets	352	60.3		54.2	67.0
Waltham Forest	286	49.9		44.3	56.0
Wandsworth	593	108.4		99.8	117.5
Westminster	164	43.3		37.0	50.5

Source: Hospital Episode Statistics (HES)

Risk

Figures 1 and 2 reveal that a total of 700 young people in Merton and 557 in Harrow have had a serious enough injury to warrant admission to hospital due to unintentional and deliberate self-harm. The data doesn't reveal the proportion of those with deliberately caused injury, and one might expect a greater proportion of unintentional self-harm in the very young age groups covered in figure 2. It should be noted that whilst Harrow falls below the national average for England, in both cases Merton is above the national average. Whilst we cannot know the number of children who self-harm in Harrow and Merton, we can estimate that it will be several hundred in each borough.

Girls are more than twice as likely to self-harm as boys according to The Children's Society (2018), based on interviews with 65,000 children. They also found that 46% of children attracted to people of the same sex had self-harmed.

Self-harm occurs in children from all communities and socio-economic groups, but there is an observed link to social deprivation (see Brooks *et al.*, 2017 & Children's Society, 2018) and in the Morgan *et al.* study there was a higher rate of incidence at GP surgeries with greater social deprivation. Children from these practices were significantly less likely to be referred to mental health services. This is a real concern given that suicide in young people is

the second highest cause of death (Patton *et al.*, 2009) and that the previous incidence of self-harm is the most significant risk factor for suicide (Hawton & Harris, 2007). The incidence of suicide in young people (particularly 15 to 19 year olds) is reported to have increased in recent years (between 2010 and 2015) (Office of National Statistics, 2016).

Why do young people self-harm?

The knowledge around this has not moved on significantly since the last review. However, the role of cyberbullying is more prominent in the recent literature, which may at least be a partial reason for increases in self-harm amongst young people in recent times, given the growth in access to social media platforms.

Brooks and colleagues found that 49% of young people who reported self-harm had been bullied (physically and emotionally in person) and 32% had been cyberbullied. In each case this was over a 2-month period (Brooks *et al.*, 2017).

The Children's Society found self-harm to be associated with children and young people having low life satisfaction, high depressive symptoms and high emotional and behavioural difficulties (2018).

Social isolation has long been known to play a role in self-harm, and Brooks and colleagues have recently reported that young people who got on with their neighbours, were happy with where they lived and had good places to go/ facilities were less likely to have self-harmed (Brooks *et al.*, 2017).

Adverse incidents earlier in childhood are also strongly correlated with self-harm and the evidence for this is summarised by Lewis and colleagues (2017).

What works for young people who self-harm?

Once again there have been no dramatic changes in the knowledge about what works. NICE revisited its 2013 guidelines (NICE, 2013) but did not find enough evidence for changing any of the guidelines. It is still recommended

that interventions can include cognitive behavioural, psychodynamic or problem-solving approaches, all of which form the approaches used by psychotherapists and counselling staff at WISH.

NICE also recommends that young people collaborate in their risk management plans, and we found evidence of this at WISH, too.

Saunders and Smith (2016) conducted an evidence review of what works in self-harm and included the evidence for children and young people. They summarised a recent Cochrane review (published in 2015) and unsurprisingly found that there was little evidence. Interventions in schools had not been included, there were no pharmacological studies and there were very few high-quality studies of psychological evidence. Saunders and Smith comment that the reliance on data from randomised control trials, "while methodologically robust, leads to a limited summary of the available evidence and overlooks a number of important interventions for the reduction of self-harm" (page 3).

A recent study reviewed evidence on the perspectives of both young people who self-harm and parents of children who self-harm on what helps. Curtis and colleagues (2018) conducted a review of the literature and found fourteen papers that reported on the perspectives of either young people or parents. Four of the papers reported on what young people thought and ten reported on parents' perspectives, the impact of self-harm on them, and their views.

The views of young people found by Curtis and colleagues can be summarised as:

- Young people want to talk and be listened to by their parents, and though less commonly reported, also by professionals who could help them.

- Crucially the 'talking and listening' must be non-judgemental.

- Parents should make school staff and other family members aware of the problems they are facing and help find ways to resolve these problems.

Stigma and the fear of a negative response are a barrier to a young person seeking help, and reassurance of a non-judgemental response is critical (see also Lewis *et al.*, 2018 for a recent review and summary of barriers).

• Understandably, young people are sensitive to dynamics in the home and these impact on the incidence of self-harm in young people's view.

Parents report that they lack information and often require support to help them help their child. Offering a non-judgemental response is understandably a huge challenge for any parent. Parents thought they would benefit from professional help but also by having strong and supportive social networks.

The research evidence for group support (i.e. peer support groups) is limited. Most of the evidential reviews have focused on formal and manualised group therapy, which is not the same thing. The findings of Curtis and colleagues can be considered to advocate for young people having opportunities to talk with parents and professionals (therapy) in a non-judgemental way. Another means of realising this and addressing the social isolation, and particularly in providing a sympathetic and non-judgemental context, is support from peer support networks and groups. One could also make a similar case, based on Curtis and colleagues' findings, for establishing similar support for parents.

The next part of this report looks at the 'hard' data that WISH collects (e.g. background data and outcome data) and provides an analysis of this.

Quantitative findings

Who uses WISH?
Socio-demographics, referrals source and service use

Background data was received on a total of 310 cases or episodes of care. There was a total of 301 individuals in this dataset, but 9 individuals had more than one episode of care. The young people in this dataset were evenly spread between Harrow (154 people) and Merton (156 people). The average age across both sites was 15.7 years (15.8 years in Harrow and 15.5 years in Merton). The ages ranged from a small group of service users aged 11 or under to a group in their 20s. The latter group consisted of ex-service users. When all those aged 19 years and over are excluded, the overall average age was 15.3 years (15.2 years in Harrow and 15.4 years in Merton).

Table 1: Male and female service users

	Male	%	Female	%
Harrow	27	17.6%	126	82.4%
Merton	40	25.6%	116	74.4%
Overall	67	21.7%	242	78.3%

In both sites females formed the majority of young people using the service, with a higher proportion of males using WISH in Merton than in Harrow (just over 25% compared to under 20%).

The proportion of overall cases from Black and minority ethnic communities was 43.9% (136); 50.6% (78) in Harrow and 37.2% (58) in Merton. Table 2 gives a more detailed background:

Table 2: Ethnicity [1]

	All White		Black		Asian		Mixed		Other	
Harrow	69	44.8%	20	13.0%	39	25.3%	12	7.8%	7	4.5%
Merton	90	57.7%	25	16.0%	9	5.8%	20	12.8%	4	2.6%
Overall	159	51.3%	45	14.5%	48	30.8%	32	10%	11	3.5%

The vast majority of the young people who used WISH services lived at home with a parent(s):

- Whole sample living with parents = 82.5% (256)
- Harrow = 77.9%
- Merton = 87.2%

A total of five young people were in care.

[1] There was no ethnicity recorded for approximately 5% of young people using this service at both Merton and Harrow.

Table 3: Referral source [2]

	Harrow	Merton	Overall
Social care	45 (29.2%)	30 (19.2%)	75 (24.2%)
School	60 (39.0%)	79 (50.6%)	139 (44.8%)
Parent/self	31 (20.1%)	15 (9.6%)	46 (14.8%)
Health services	11 (7.1%)	31 (19.9%)	42 (13.5%)
Other statutory services	12 (7.8%)	6 (3.8%)	18 (5.8%)

Schools were the most significant source of referrals on both sites, and represented over 50% in Merton. Parental referral or self-referral in Harrow was just over double the rate of these referral types in Merton. This might be expected given that the Harrow service is well into its second decade of operation, whereas WISH in Merton has existed for just over two years.

Table 4: Multiple vs single service use [3]

	Multiple service		Single service	
Harrow	44	(28.6%)	110	(71.4%)
Merton	48	(30.8%)	107	(68.6%)
Overall	92	(29.7%)	217	(70.0%)

Over two thirds of the 310 cases in this dataset, and on each site, were for young people using just one WISH Centre service. This was primarily Safe2Speak, the one-to-one counselling/ psychotherapy service (around 55% of Harrow cases and 59% of Merton cases). The different types of single-service users are listed in the table below.

Table 5: Multiple vs single service use

	Harrow	Merton[4]
Safe2Speak	84	92
Self Harm Xpress	11	4
Outreach[5]	7	8

Outcomes

A & E Attendance

Data was supplied on 84 young people who had attended A&E due to self-harm over a 12-month period (with the number of attendances for each) prior to attending WISH (period 1). The data also provides the number of attendances at A&E for the same young people during their time with WISH (typically 6 months to 12 months – period 2). The results were that 84 young people had a total of 138 attendances before coming to WISH. However, only three young people attended A&E (one had been three times and two had each been twice, equalling seven attendances) whilst attending WISH. So, whilst in some cases the data from period 2 may have been collected over a shorter period than period 1, this still indicates that the young people's time at WISH is associated with a significant reduction in attendance of A&E for self-harm.

WISH collects two other forms of data that can capture the outcome(s) of their intervention(s) with a young person. These are:

• The End of Therapy form;
• The Young Person's Core.

The former is designed as a single rating which the therapist/WISH worker completes with the young person at the end of an episode of care i.e. when therapy is finished, (although some young people may return to WISH for further help).

The End of Therapy form has nine items:
1. Anxiety/stress
2. Depression/sadness
3. Emotional resilience
4. Coping mechanisms
5. Trauma
6. Abuse
7. Self-harm
8. Suicide ideation
9. Sexual exploitation

The therapist and young person decide, for each of the domains, from the following:

• The issue has significantly increased;

• The issue has moderately increased;

• There has been no change;

• The issue has reduced moderately;

• The issue has reduced significantly;

• The issue is no longer a problem.

There may have been no problem in some domains in the first place, so 'not an issue' could also be stated in such cases.

The second outcome gauging method used by WISH is the WISH Psychosocial Assessment Tool (WPAT), which is adapted from the Young Person's Core, which is a validated tool. This is designed to be repeated, testing before intervention has taken place and then later after the intervention has started, and at least at the end of the intervention. It should be noted that as an adaptation of a validated tool it may not have the same psychometric properties and we need to be cautious in validating the results.

The tool has nine domains, identical to the End of Therapy Form. The form used to collect the WPAT has an additional question at the end on A&E attendance. The domains are:
• Anxiety/stress
• Abuse
• Depression/sadness
• Self-harm
• Emotional resilience
• Suicidal ideation
• Coping mechanisms
• Sexual exploitation
• Trauma

The rating is done in much the same way as the previous outcome measure, with the young person being asked to complete it, or being supported to complete it by the therapist/WISH worker.

End of Therapy Rating

Data on 'End of Therapy' outcomes was provided in 123 cases; 35 young people did not have an End of Therapy rating but did have another recorded outcome. In 25 of these cases this was because either:

- The young person did not want to continue therapy;
- The young person had a crisis;
- There was a loss of contact with the young person;
- There was another unplanned ending of therapy.

For the purposes of analysis, each of the domains were allotted a score. Positive outcomes were given a lower score (0-2) and more negative outcomes were given a higher score (3-5).

The proportion of positive scorers versus negative scorers as a percentage by domain is given in table 6.

Table 6: End of Therapy – Improvements in wellbeing versus no change or further decline in wellbeing

Domain	N =	Improved	No change/worse
Abuse	50	76.0%	24.0%
Anxiety/stress	90	70.0%	30.0%
Coping mechanisms	91	69.1%	30.8%
Depression/sadness	89	65.2%	34.8%
Emotional resilience	90	71.1%	28.9%
Self-harm	75	81.3%	18.7%
Sexual exploitation	31	64.5%	35.5%
Suicidal ideation	55	69.1%	30.9%
Trauma	64	64.1%	35.9%

Most young people who use WISH and have an End of Therapy rating show an improvement. The proportion of those cases that rated an improvement ranged from 64.1% to 81.3%. The average overall positive change (across all items) was 70%. Notably, the most marked positive change was for 'self-harm', with 81.3% of young people who had been actively self-harming at the outset having reduced self-harming behaviour by the end of therapy. Of these, over 90% had either reduced self-harming significantly or stopped all together.

What this outcome measure does not show is the degree of change made, be it positive or negative, as there is no baseline rating with which to compare. The next section addresses this with an analysis of the ratings of the WPAT.

Outcome score – WISH Psychosocial Assessment Tool (WPAT)

Basic descriptive data

These are some basic descriptive statistics on the sample that completed outcome measures (WPAT – regarding at least two ratings, i.e. a pre-intervention rating and the last post-intervention rating).

The WPAT outcome dataset had 179 young people, but only 115 of these had at least two ratings (so 64 people had a single rating before receiving intervention, but no further rating). There may be a variety of reasons why young people did not have a second rating, which include that they stopped attending therapy, or continued with therapy but did not want a further rating to be made.

Where there is only one rating it is not possible to measure potential improvements and so only cases where there are at least two ratings are included in the analysis.

Of the 115 individuals who had both pre- and post-intervention ratings, eight had collectively 19 episodes of care (ranging between two and four episodes of care), and so there were 126 cases or episodes of care in total. It is the results for these episodes of care that are analysed in the next section.

Sites

Harrow

59 cases (46.8%[6])

The services used by cases from Harrow were Safe2Speak (41) and Self Harm Xpress (18).

Merton

67 cases (53.2%)

The services used by cases from Merton were Safe2Speak (50), Outreach (10) and Self Harm Xpress (7).

Change in young people as measured by the WPAT

Statistical testing of the differences before and after intervention were performed on the following:

1. The total WPAT score for the whole sample (all episodes of care across both sites);

2. The total WPAT score for all episodes of care in Harrow;

3. The total WPAT score for all episodes of care in Merton;

4. The total WPAT score for all episodes of care for the Safe2Speak Programme (90 episodes of care);

5. The total WPAT score for all episodes of care for the Self Harm Xpress Programme (25 episodes of care);

6. The total WPAT score for all episodes of care for the Outreach Programme (10 episodes of care[7]);

7. The total WPAT score for those using more than one WISH programme;

8. The total WPAT score for those using a single WISH programme;

9. The WPAT scores for each of the nine WPAT domains tested, i.e:

Anxiety/stress	Self-harm
Depression/ sadness	Suicidal ideation
Emotional resilience	Sexual exploitation
Coping mechanisms	Trauma
Abuse	

All but one of the 17 areas above tested showed a statistically significant improvement in the young people. The one area that did not show a statistically significant improvement in the pre- and post-testing was for young people using more than one WISH programme (See '7' above) and this was for 18 episodes of care, a relatively small group of young people.

Several limitations to these findings should be noted. There were no 'controls' with which to compare the outcomes of the young people using the WISH Centre, and the data was collected by WISH practitioners (in conjunction with young people), rather than prospectively and independently. One must therefore be cautious in attributing causation. An additional note of caution is that the bulk of outcome data concerns those who use one-to-one therapy.

Nevertheless, the results reinforce those of the previous outcome data and provide a strong indicator of the efficacy of the WISH model. Young people using WISH do not usually attend other therapeutic services, and the attendance at WISH would reasonably be assumed to be a significant event in their lives. It is therefore not unreasonable to suggest the statistically significant and positive changes across virtually all those areas tested could be attributed to the WISH one-to-one programme.

---

[6] Proportion of all those across both sites with x 2 WPAT measures.

[7] This is a small sample and caution should be taken when interpreting the statistic, i.e. one would not be confident to generalise from the result, but it may be indicative.

Qualitative analysis

Young people helped design the methodology for collecting interview and focus group data, and helped in deciding the questions both young people and other stakeholders were to be asked.

Three focus groups took place involving a total of 20 young people (five in Harrow, eight in Merton and seven young people attended a group for former service users). Another six young people had a one-to-one interview. A total of 14 other stakeholders were interviewed and these included:

- Staff at WISH;

- Trustees;

- Referrers to WISH;

- Local health and local authority commissioners;

- Funders.

The results of all three exercises (focus groups with young people, interviews with young people and wider stakeholder interviews) are combined in this section.

Outcomes for young people

Young people and stakeholders were all asked what they felt had changed for young people as a result of WISH services. Themes from all interview transcripts were analysed.

Young people are better at coping with mental distress

This outcome was identified by young people who had accessed all WISH services or combinations of WISH services, and by staff and external stakeholders. This was the most commonly mentioned outcome.

Young people said that while they still had periods of feeling distressing symptoms such as anxiety, depression or urges to self-harm, they felt that they could cope with these better. They recognised that this period of feeling unwell would pass and had identified strategies to cope with the feelings. Workers said that young people had learned alternative coping strategies and techniques. The coping strategies themselves were a mix of self-help, and accessing help from others, most commonly friends.

"...early intervention, to prevent longer more severe mental health issues occurring"

[School staff]

"...but you learn how to deal with situations. And how not to care as much about what people think – being more resilient"

[Young person in focus group]

"I still have the negative experiences and thoughts but, like, I am able to deal with them much better than I did before"

[Young person in interview]

"More positive. Even when I feel a little bit down or go back to a depressive state, it is easier to get out of because I have the tools and knowledge, the things WISH is giving to me to better myself"

[Young person in interview]

"An awful lot of this is about young people working with young people, sharing their learning"

[Wider stakeholder]

"It doesn't look as bleak as it used to, a change in mood - and through coming here I have learned not to let a set-back keep me down"

[Young person in focus group]

"They are much better at managing their emotions"

[External stakeholder]

Young people have made good friendships

This was exclusively identified by young people, and more often by those accessing the group, though those accessing one-to-one support did identify a change to their friendships and peer relationships. It was striking that friendships made in groups were generally identified

as being permanent or "for life", and this permanence was evidenced by the older group, some of whom had left WISH over a decade ago, and were still in close friendships with other ex-group members. Young people said these friendships had reduced or reversed a previous sense of isolation and loneliness.

"You know you're going to be able to take care of yourself, and you know you've got friends for life"

[Young person in focus group]

"I get messages at 3 in the morning from [friend from group] because she's got some big news. It's that kind of bond you have here"

[Young person in focus group]

"'Cause a lot of people don't have friends – like for me the people I had in school, they weren't really supportive"

[Young person in interview]

"I had friends! Up till then I never had friends, and then suddenly I had friends in school. Towards the end I knew everyone in my year"

[Young person in focus group]

Young people are better at social situations or feel better in large groups

This outcome was identified only by young people. In this case, it was more often mentioned by young people in one-to-one interviews. These interviews included several young people who had only accessed one-to-one support at WISH, and it may be that they were young people who had previously found social or group settings challenging. Young people said they felt better when meeting new people, being in group settings such as in groups of friends, or in social settings such as classrooms or busy places of work.

"Talking to people – anyone… going out in public, there has been a difference. I used to never leave my bedroom but now I can go out in public. [It was because] I didn't want to do it. I wasn't willing to try, I wasn't willing to do it"

[Young person in interview]

"I don't like speaking to people a lot of the time. Just random people. I don't like being in crowded places. I still don't – but I've learned more about how to just be in myself… in a room"

[Young person in interview]

"I was so shy when I was 13. I was the shyest person. I didn't talk to anyone, I was really quiet. A lot has changed. I thought everyone hated me – and then I was like, 'Oh wait, no'"

[Young person in focus group]

"Before I would just avoid talking to new people. I would just stand there, head down, say nothing. Now it's easier to socialise and to be myself – now I am less worried about people's judgement of me"

[Young person in focus group]

Young people are more able to talk about their issues

This was brought up by young people in both group and one-to-one settings. In discussion, young people often described having felt silenced about mental distress and self-harm by stigma and prejudice. After accessing WISH most said they had a different view of people with mental ill health or who self-harm, and they felt less concerned about what other people, especially peers, would think of them, and so felt more confident to disclose their experiences.

"…like stigma maybe from our own communities – that was one of the major things for me – stigma within my culture"

[Young person in focus group]

"When I first told people I self-harm I had a really bad reaction to it, like a backlash – and I think that affected me for a long time, so I didn't want to talk about it at all"

[Young person in focus group]

"I'm pretty open about stuff to other people. I used to not talk about what happened to me – someone asks me, I just tell them. I'm not embarrassed or ashamed anymore. WISH has taught me it doesn't matter if you do or you don't [self-harm] – you just accept"

[Young person in interview]

"My experience is that you have to go at the young person's pace…and that can vary a lot… but if you are patient it's rare that you don't get to the point that they feel they can share"

[WISH staff]

"[making a film about self-harm] helped me as a person – to talk about the past is difficult for everyone, but to tell the whole world – like it shows that you are a stronger person than you was – it's definitely therapeutic I would say"

[Young person in focus group]

"Acceptance – it's made me accept that I can talk about self-harming – this group has shown me it's OK to self-harm and it's not something you have to hide from other people. I get that sometimes people don't want to tell people because they are nasty and mean, but for me I've learned that some people who haven't been through it will never understand it. I've come to terms that people don't understand it, but it doesn't mean that I'm wrong"

[Young person in focus group]

"'Cos I'm used to talking to [staff member] it has made me more accustomed to talking about what has happened in the week"

[Young person in interview]

"… because I know that the things I talk about matter and they are worth listening to – things I have been able to put into words [once] I can put into words again [somewhere else]"

[Young person in interview]

Young people are more able to seek help

This was identified by young people who had accessed all kinds of services, by staff and by external stakeholders. Young people were more able to recognise that their mental health was deteriorating, to have an understanding that it would help them if they accessed support, to know where to go, and to do so.

"Even if I have a bad couple of days, I'll message [group member] and say, 'I feel really shit' and they'll say, 'OK what happened? And tell me something good' – and I'll say '…and that happened and that made me happy'."

[Young person in interview]

"Like I know that if I do need to talk about that with the teacher then – because I was in that environment in the first place I kind of find it easier then to talk about with other people…"

[Young person in interview]

Young people are achieving better at school, college and work

While this was raised by young people from all kinds of service use, it was also mentioned by staff, trustees and external stakeholders. It was clear that people thought that both attainment and attendance had improved. Young people said this was due to them being enabled to participate and to believe in their academic abilities. The ability to manage in group environments also played a part, as young people found it easier to stay consistently in lessons.

"I would be in the sick room all day in year 8, trying to go home. My grades were all U's. In year 10, I was growing up – and I just flipped it – came back with results"

[Young person in interview]

"So I feel like in the lessons the teachers who have done that [made adjustments for young person's needs], I feel more comfortable with and I can actually get involved in the lessons"

[Young person in interview]

"I think when they are in a place [where] they feel negative about themselves and everything about them, school is seen as a negative place. However, when the support is there they realise school is actually a place where you come, and you learn. So I think their perception of school changes. As their perception of how they interact with their school and their peer group changes, they want to come to school more because they don't have that negativity around all those different things."

[External stakeholder]

"Secondary school I definitely didn't like, but I think that's because of everything that was going on. But after WISH I realise[d] that I kind of enjoy school and that's why I decided to go to the sixth form"

[Young person in interview]

Young people are more confident

This outcome was identified by all groups of interviewees. Confidence was often mentioned in relation to another outcome, such as confidence in groups, confidence in school, or confidence to challenge stigma.

"Last year I was a mess – I'm more confident now, I can express myself"

[Young person in interview]

"A booster – like it's boosted me, my confidence"

[Young person in focus group]

"I think I'm more confident, especially with expressing my own opinions…"

[Young person in interview]

Young people are safer from suicide risk

Young people more often talked about this in group settings, in particular amongst the older young people who were reflecting back on their experience of WISH. They suggested that without the support they may have taken their own lives. Several young people talked about a history of suicide attempts prior to coming to WISH. None of the young people in one-to-one situations talked about this outcome. But some wider stakeholders also talked about what they saw as the "preventative" nature of WISH. Staff and trustees were also aware of suicide prevention as an outcome.

"When it comes to mental health it's actually just surviving, getting through the day – that's resilience"

[Young person in focus group]

"I was just depressed, I wanted to kill myself a lot, I was doing some dodgy stuff – like overdosing. But now: I feel better. Not amazing. Just better. It takes some time to recover from mental health."

[Young person in focus group]

"I just think it saved my life. I hope it continues so it saves other people's lives."

[Young person in focus group]

"There is no question about it…you just have to sit down and talk to the young people…there is no question….it saves lives"

[Wider stakeholder]

"If it wasn't for WISH I wouldn't be here"

[Young person in focus group]

"In my view it's really trying to prevent suicide as much as possible – getting through traumas and struggles"

[WISH staff member]

"we have supported it for just that reason [prevents self-harm and suicide] – it really makes a difference"

[Wider stakeholder]

"it's essentially to save lives – that is what it does"

[WISH Trustee]

Young people are more able to accept difficult situations

In particular, older young people talked of having reached an accommodation with having periods or symptoms of mental ill health. They were able to understand that symptoms could be managed or would pass. Staff members also talked about this outcome.

"I became a lot more accepting of myself. I stopped feeling I had to please everyone around me. I realised I have acceptance now. Before I used to panic. I used to worry. I used to get myself worked up to the point I was sick. Acceptance of anything in my life. I used to just worry about everything."

[Former service user]

Young people have improved self-esteem

This outcome was more often mentioned by stakeholders than young people, though it was raised both individually and in focus groups by young people. Self-esteem was often attached to body confidence, or the feeling of being "okay as you are".

"Confidence about my scars – before I used to hide it and stuff. But now, I really don't care – if someone's looking at me I just look back at them"

[Young person in focus group]

"We make each other feel good"

> [Young person in focus group]

"[other group members] build up your trust – like by asking how you are on a random day, or little things we say, and that makes you feel important"

> [Young person in focus group]

"Self-care is given back to them – they say 'I love myself more'..."

> [WISH staff member]

Young people are happier

This outcome was very simply stated by young people as being able to enjoy life, have fun and be happy. Staff also identified this outcome. And a positive difference being noticed by others was also a significant marker of change for some young people.

"My parents noticed I was happier"

> [Young person in interview]

"I have a lot more upbeat moments and cheerful moments"

> [Young person in interview]

"I'm a little bit more perked up. Although I have my moments just like anyone else. I have my down days, but I more look forward to things"

> [Young person in interview]

"People just generally think I'm a happier person"

> [Young person in focus group]

Young people stop self-harming, or self-harm less

Reduction of self-harming was often not the first outcome to be identified by young people, and not identified at all by many interviewees and focus group members. Stopping self-harm was not a major focus for external stakeholders or staff either, though trustees did identify this both as an aim and an outcome. When young people talked about their reduction or stopping of self-harm, it was often a gradual transition that they had been quite unaware of. Several stated that they had "noticed" that they had stopped after a long period of not harming, or when asked about self-harm. This lack of focus on self-harm as an indicator of wellbeing was something young people recognised as a strength of the WISH approach.

"I haven't self-harmed now since March"

> [Young person in focus group]

"I don't self-harm any more, which is a big thing for me. That went on for a while, and it's why I came to WISH in the first place. It has taken me right up to this year. I've been 'clean' this year, but before then that wasn't the case"

> [Young person in focus group]

"Reducing or stopping self-harm – if not completely stopping..."

> [WISH staff member]

"When a young person is in remission, and there is no longer self-harm – and that form of control is gone, and they feel that they can now control themselves. In regard to feelings and emotions they have adapted and learned, and 'now I don't need to self-harm, maybe I can go and do something else'. It might be there in their heads, but they don't do it anymore"

> [WISH staff member]

Young people can see a future

Often related to discussions about suicidal feelings for young people at the group was the sense that there was a vision of the future for them that they had not been able to envisage before they accessed help. This was less about ambition or aspiration, and more about being able to imagine existing or continuing to grow up. Quite simply, young people would say that they had not imagined that they would exist as adults. A focus on positivity, skills and fun were described as factors, as was a perception that they had made long term friendships at the group. Another notable theme was the fact that young people in peer support groups were very aware of their own development and "growing up" as a group. The presence of young people in the group at different stages of development (both of life course and of recovery) acted as a trigger for reflection about their futures and pasts.

"WISH was the only time that I thought I could have a future without self-harm – like I realised I could take back"

[Young person in focus group]

"It opened so many doors – it changed everything."

[Young person in focus group]

"We're growing up together, and we are changing together"

[Young person in focus group]

"I think the fact that so many people [former service users] get involved with us after they leave...to give something back... is a testament to the change made in so many...though it can be sad, sometimes it's a really positive sign when a young person is so busy and occupied in their life that they have less time to 'put back' in here"

[WISH staff member]

Young people have skills to help others

Young people attached this outcome very much to the experience of peer support, and of having gained skills in helping others. They said that this had come from the learning they had gained from the staff (such as ideas for managing distress), and the fact that they had been trusted and in fact expected to support each other.

Many had taken this skill set to volunteering and work experience, often at WISH. Some of the older group had progressed to careers in caring professions.

"So subconsciously it helps – but you don't actually learn here about what to do – you come and pick up things without your knowledge. It's like the environment you're in – and you keep taking from that environment. And then when you go into other environments you feed your new environment with that energy and help other people"

[Young person in focus group]

"You're not just a victim anymore, you're helping someone"

[Young person in focus group]

"I feel like it's given us the confidence where we can go out and help other people: yes it helped me, and now I can help someone else"

[Young person in focus group]

"One of my friends – she's always struggled with mental health but she's terrified to get help. But I can sit with her on the phone... just to make sure she is alright. Because I know what it's like, and I know she needs that help. It makes me feel better to know I can help her"

[Young person in focus group]

Other outcomes

Some less commonly mentioned outcomes for young people were:

- Body confidence – including confidence about weight and about scars from self-harming;

- Ability to do more and develop skills for adult life;

- Ability to form healthier relationships;

- A reduction in risk-taking behaviour;

- More self-awareness;

- A better understanding of how stereotypes including gender stereotypes affect mental wellbeing.

"Confidence about my scars – before I used to hide it and stuff"

[Young person in focus group]

"Not following the line of drugs, alcohol, attempted suicides"

[WISH Trustee]

How WISH Works

All interviewees were asked to describe the way that WISH works in their own words and experience, and to comment on what aspects of the services were achieving the outcomes they had identified.

Young people have control of their support

This was by far the most prominent feature of the WISH model for all interviewees. External

stakeholders tended to describe this as a "young person-led" approach, while young people went further and described themselves as having a high level of control over their experience. The notable exception of this control was in their referral to WISH, which was often managed and enabled by someone else, such as a parent or social worker. Young people acknowledged that they generally would not have come to WISH without this external pressure.

Once they had come to WISH, though, young people said they were handed a lot of control. The ways that this was done included having control over speaking or not speaking, over deciding the agenda of conversations, deciding their goals, and control over their own information. Often young people made a direct comparison to other services where they had felt controlled and manipulated. Focus groups in particular discussed that in other services an adult would set the agenda of the conversation and activity, and bring the conversation to issues that the adult had an interest in (commonly risk and self-harm).

Young people linked this feeling of control to the outcomes of confidence, social skills and communication.

"[CAMHS] kind of get the answer out of you that they want. They ask you biased questions. They are not open questions. They want the answer that they want"

[Young person in focus group]

"[CAMHS are] like 'Why are you here?' – like I don't think anyone here [at WISH] has ever asked me that question – I have never been asked. Whereas at CAMHS it's like: 'Why are you here?' 'What brings you here today?' 'Why do you think you are here?'"

[Young person in focus group]

"Our offer here is open-ended therapy, until the issues are resolved or resolved enough; we often move quite slowly if that's what the young person wants…CAMHS just don't have time and have to get straight to the point…the trouble is that won't work with a lot of young people"

[WISH staff member]

"There was never pressure to talk – some groups I just sat here and cried – and I never talked – and there was no pressure of 'just because you are sad you have to share'"

[Young person in focus group]

"they know they can control the sessions"

[WISH staff member]

"The girls get a lot of say in the things that they do. What activities they do, what happens in the sessions…"

[WISH Trustee]

"having a peer-led or peer support led model"

[External stakeholder]

"My understanding of it is of going at the children's pace and talking about what they want to talk about; unfortunately statutory social work is driven by an investigatory approach and understanding harm and risk, whereas the WISH is able to offer a very different style of service which is at the pace of young people, which is a better approach – children feel heard and they don't feel pressured, and they don't mirror the response of someone who is controlling and oppressive"

[External stakeholder]

Young people have a choice about how they leave WISH, and are enabled to stay connected

A number of young people commented that the good outcomes of their contact with WISH had taken some time to come about. When accessing shorter term support in other organisations, they felt that they were being pressured to reach outcomes within a specific timeframe, and in some cases, they would lie about an improvement in their mental health in order to meet these expectations.

"Took a while!"

[Young people in focus group]

"It got to a point where you lie about it – so, 'this happened – did you self-harm?' and you would just say 'no'"

[Young person in focus group]

All groups of interviewees said WISH has a long-term model, with young people having complete or partial control over when they left. All interviewees and focus groups viewed this as a positive feature. There was, for most, an understanding that staying connected long term was an option, with the exception of male interviewees, who saw their contact as time-limited. Amongst older interviewees and focus group members, there was a strong perception that the support of WISH was indefinite and that "no one ever leaves". This perception was perhaps strengthened by the fact that they themselves had remained engaged. Some young people said that leaving the support of the staff had been difficult and that they were sometimes concerned that they were dependent on it.

"Towards the end I became a little reliant on them in a sense. I talked that through with [the staff member] and tried to elaborate on that – so I wouldn't be completely reliant on them. I didn't have it for very long – so I wasn't 100% sure I could stop and still feel fine."

[Young person in interview]

Some stakeholders recognised the challenge of offering long-term/open-ended support, and the primary concern was offering a timely response for new referrals, including a therapeutic offer.

A small number of one-to-one interviewees had permanently left WISH services, and while they did describe this as being imposed by external factors (such as a staff member leaving), they described having reached a point in their support where they felt they needed the service less.

For those who had left a WISH service of their own choice but remained connected to the organisation, the process was described as finding that the service seemed less and less relevant to their lives, and that other things, such as college or work, made demands on their time. The majority had joined the older peer support group and were using that group to different degrees. Many had individual friendships with older WISH service users and were accessing these friendships for support.

Several interviewees and focus group members had an awareness that the "door was open" and that they could come back, and they found this flexible ending very supportive. The sense that WISH was there as a safety net, and that there would be easy and swift support on request appeared to encourage young people to manage without WISH support after leaving. Several young people made a contrast to other services such as Child and Adolescent Mental Health Services (CAMHS) with distinct "open" or "discharged" statuses and felt that, if anything, this revolving door encouraged re-referral.

"And there was no rush – there was no 6 weeks or 8 weeks, it was like 'take as long as you need'. So you were never thinking, 'it's going to end, what am I going to do?'"

[Young person in interview]

"When you leave WISH you're not really leaving. You know you can still contact [the staff]"

[Young person in interview]

"It will get to the point where we talk so much outside of group anyway – almost like we've created a group outside group"

[Young person in focus group]

"Even if you think like you've left, the door is still open. And there isn't a "discharge" like you've been fixed and you can go"

[Young person in focus group]

"I was going to college... so I knew it was coming. But they always made me feel so comfortable about leaving. They said there is always a place for me if I need it. And the good thing about the older girl's group is it seems very flexible – you book a date. I haven't attended any so far since I've been busy"

[Young person in interview]

"The good thing about WISH is that we have all [the] time; I don't need to rush the process of therapy and I do really do go with them. In most situations I will be a lot more gentle and use creative stuff until they are ready to talk in front of me – we need to go with their process otherwise there's a huge resistance straight away and you can see it quite quickly"

[WISH staff member]

WISH has positive relationships with other agencies

Good interface with other agencies was more commonly mentioned in stakeholder interviews. The relationship with CAMHS in Merton is understandably less established than that of Harrow, and is still developing. Overall good relationships, and especially in Harrow, were felt to be the norm. The most prominent factor was good information sharing, mentioned equally by WISH staff and by external stakeholders. Often the WISH staff member was representing or advocating for the views of the young person. External stakeholders also valued co-working arrangements, in particular in schools and in the outreach project. The only recognition of this by young people came when WISH had supported them to negotiate a better understanding of their needs within school, and so had improved their ability to engage with learning.

Commissioners were aware that WISH was holding young people who were on waiting lists for other services, who had been discharged from other services, or who were not reaching statutory service thresholds. This role was valued, though a risk was identified that statutory service workers would step away from their risk-holding responsibilities once a referral to WISH was made.

"Often I am working closely with safeguarding officers in schools"

[WISH staff member]

"Maybe with social workers or social care teams, I might get more information from them and might go to meetings with the young person. It's tricky so I will try to stay disconnected at groups so that it's clear I am there for the young person"

[WISH staff member]

"Also to signpost for other services that the young people may require"

[External stakeholder]

"We have been here [Harrow] quite a long time now, we are part of the architecture in a sense"

[WISH staff member]

"Sometimes a young person can be open to a Child Protection or Child in Need plan – so I would be the person who goes to sit on the board for that young person"

[WISH staff member]

"Sometimes acting as a go-between between the young person and the school to negotiate a package"

[WISH staff member]

"The mum has a bit of an ambivalent relationship with children's services and the police, which impacted on her letting us know [what was happening with the child] but [WISH staff] helped with the meeting – and also gave advice to Mum"

[External stakeholder]

WISH campaigns for better awareness and services

While this theme was prominent, there was a significant group of people who were unaware of WISH as a campaigning organisation. These were generally younger interviewees and focus group members who had not been involved in media campaigns which took place a few years ago.

Strategic level stakeholders felt that WISH had an important role to educate others about the issues of self-harm and Child Sexual Exploitation by training or by co-working. Young people had often been affected by stigma about self-harm amongst peers and professionals and were keen for WISH to challenge damaging perceptions. Trustees and young people felt that secondary mental health services should do better, and that WISH had a role as a critical friend to commissioners and providers.

Young people identified activities related to campaigns and awareness raising as having had an impact on their awareness and eloquence on issues such as gender bias, body image, eating and weight, bullying, and mental health stigma. One group drew attention to the wide range of discussion and debate that there was in groups. Older focus group members were able to talk about their ability to challenge bias and stigma in the workplace or in their adult relationships.

Some external stakeholders expressed concern about the capacity to deliver promotion and awareness (of self-harm, how to help and the support available), but also awareness of WISH, and that this often fell on the shoulders of the WISH Chief Executive.

"We should be a critical friend to statutory services – to influence service design. E.G. suicide prevention bodies, health service working groups"

[WISH Trustee]

"Raising awareness of the issues. We have been politically active over the years. Young people may not realise this – that they are feeding in to informing people"

[WISH Trustee]

"It would be great to get some people in from the corporate world perhaps…to put some time and investment into something this good and to help push the message"

[Wider stakeholder]

The young people have a sense of belonging and WISH has a "family feel"

Peer support groups encouraged a sense of belonging, as did the fact that the model of support was both flexible and long term. Young people valued being introduced to people who had similar experiences to theirs. For some, especially if they spent time in families, communities or schools where self-harm or mental ill health was stigmatised, it was a revelation to find that their experiences were not unusual.

Young people described their relationship with WISH as "us" rather than "them". This was not the case for those young people who had accessed only one-to-one support, who had a relationship with a single worker and were often unaware of the broader offer of services. Young men did not describe this sense of belonging.

Young women, and trans or non-binary young people who had been identified as girls at birth tended to refer to WISH as a family, and to each other as sisters. The space was seen as an alternative and safe "home" for some.

A particular feature of the sense of belonging and family was the mixed ages in the groups. All groups described this as positive. For younger people and new arrivals in the group, it was helpful to see older young people who had been through similar experiences and challenges and who had recovered. Young people particularly attached this to the outcomes of coming to accept themselves and their issues and being able to imagine a future.

Older group members said that contact with younger group members helped them to reflect on the distance travelled and how much they had grown and recovered. They had a sense of achievement in being able to support younger group members, and they attached this to outcomes of improved confidence and skill.

Food was a common theme for group members. While many young people described having previously had some concerns or issues with food or eating with others, the shared eating experience was a part of feeling connected, and for some had the added benefit of overcoming a concern about eating in public.

"I always felt like WISH was mine – and counselling and other therapy were things that I had to – were done to you"

[Young person in interview]

"You can feel like you can come here and like all of you have been through similar things, and so you can relate and you don't even have to talk about it. We all understand – we're all here for similar reasons"

[Young person in focus group]

"Seeing other people visually – you can see when they say they are suicidal or something like that, depressed, you can see yourself that, 'You will get past that. You are at my stage where I was years ago, and I can see that you will come through that'"

[Young person in focus group]

"I feel like here you grow together. You don't really get a sense of other girls being horrible to you. We are all like family"

[Young person in focus group]

"I didn't feel like an outsider. I felt included. From the second I came – well maybe there were about 5 minutes when I felt awkward – and then I hear everyone talking and I thought okay, I like these people, it was like a little family. It's always been like that to the point that I have people say aunty, sister, mummy. I feel included"

[Young person in focus group]

"Like the counsellors [in other services] I had when I was young, I don't even remember their faces, whereas [staff member] here – if something happens in my life, I want to tell her"

[Young person in focus group]

"We offer formal therapy, but I think the young person is still very much in control and in a sense crafts their own 'cure' – we just facilitate it, but I do think that gives them a sense of ownership and belonging"

[WISH staff member]

"I used to be anxious eating around people, but here I would just eat. I don't know why, I would just eat. Without a care in the world"

[Young person in interview]

"... there is so much love and respect between the girls that they just are not judgemental"

[WISH Trustee]

The focus is on fun and positivity, not self-harm

Three themes are grouped here. Firstly, the fact that WISH staff and group activities do not focus on self-harm. Young people said that in contrast to their expectations, the discussion and agenda was not related to self-harm or to traumatic experiences. This was universally described as a good thing. Young people were fearful of being "made to" talk about difficult things – and said this was the feature of almost all other services they had experienced. At WISH they felt able to open up about their symptoms or difficult experiences if they wanted to, but it was not the focus of the discussion, and this helped the young people to focus elsewhere on the issues underpinning their self-harm, or on their resources and strengths.

Secondly, there was a real focus on fun. Young people, both in groups and in one-to-one, said they found the support enjoyable. In groups young people said there was chatting, music and laughter. Young people went on occasional trips or did things that made them happy. Having fun in a safe environment was attached to outcomes of improved mood and reduced distress.

And thirdly, young people said that both group and one-to-one support focused on the positive. Staff and peers tended to challenge any "victim mentality". For example, there was a focus on education and learning, and an expectation that young people could and would succeed. Again, this was in contrast to other settings, where young people felt that the adult world had "given up" on their education and ability to succeed as adults.

"I was nervous – I didn't really want to talk about myself – I thought it was going to be a case of, 'tell everyone exactly why you started self-harming'"

[Young person in focus group]

"The main thing I remember is how chilled and relaxed group is – like we have a laugh – it's not just all centred around depressing stuff"

[Young person in focus group]

"Even at Christmas – bowling, things like that"

[Young person in interview]

"I thought it was going to be like a bunch of sad girls, and all of them would have mascara running down their faces and everyone will be really drab"

[Young person in focus group]

"I remember realising that I didn't have to feel guilty when I self-harmed any more. Because although you never had to say at group if you self-harmed at all, but if I said at group that I had been feeling really bad and I had to – then it was never that guilt of, 'well I've let everyone down'. It almost wasn't spoken about"

[Young person in focus group]

"We talk about religion, politics. Everyone puts their opinion in – and there's no judgement.

Because we are family, we can debate, and it doesn't get heated. That helps practice for other places"

[Young person in focus group]

Staff have skills in engaging young people

While most interviewees drew attention to the approachability of the staff, this was a particular feature for young people, who often saw the staff as a key strength of the organisation. The word "relatable" was often used, and the idea that staff were somehow different to those in other agencies. Most commonly mentioned were warmth, care, youth and ability to empathise. Some young people said that the staff had had similar experiences to them and that this was important.

The staff modelled and maintained a lack of judgement and this set the tone. In one-to-one support young people described having the relief of sharing difficult issues with someone who did not react or judge. Young people in groups said that they could share issues with each other, especially in peer support, trusting that they would be accepted.

"More caring than staff in other places – younger, easier to talk to. She's just really nice. She doesn't judge and she relates to you, she's been through what you've been through – she grew up in this part of London."

[Young person in focus group]

"They listen and respond to what you have just said – it's not like pre-planned questions. You say what you need to say – and then they try and figure it out"

[Young person in interview]

"The engagement work – a lot of them can't really engage with professionals. A lot of them have real anger. Behind anger is pain and sadness"

[WISH staff member]

"I wasn't even up for admitting I had a problem. But then I thought…. 'they're really nice' – and then I started coming"

[Young person in focus group]

"I didn't want it to be tense to go and to not know what to talk about and, like, how to open up. It was really easy just to talk to them."

[Young person in interview]

The environment is calm and relaxing

The physical space was important to young people. In focus groups and interviews they spoke about the sofa-style furniture, bright colours, creative or interesting objects, music and low lighting. Given that most had approached their first group with nervousness or even fear, this welcoming space went a long way to make most of them feel immediately at ease.

However, young people who were seen in school also described the same calm and relaxing atmosphere, suggesting that the staff are able to create this same feeling in more formal environments.

"I think it contributes to the casual atmosphere. Like you're just chilling with mates – sat on the floor. Munching on some chocolate chatting"

[Young person in focus group]

"Sensory things are very important – like things to fiddle with, the light in the corner – it makes it soft"

[Young person in interview]

"I liked the fact that it was a really calming, relaxing atmosphere and I think that's what I had been really worried about"

[Young person in interview]

The staff have specialist knowledge

This feature of the WISH model was identified more by external stakeholders. Commissioners in particular valued the level of expertise in the staff team about CSE, causes of self-harm, online exploitation and contextual safeguarding. External stakeholders included in this skill set an ability to understand and engage with young people with whom their own teams were not progressing, and they valued the opportunity to co-work.

School development and training was well received and described as being in high demand.

Particularly in one-to-one support, young people recognised that staff had specialist knowledge that offered them specific ideas and techniques for their needs. Staff recognised their role in providing psychoeducation and provided specific resources or tools to young people.

In one-to-one support specifically, young people felt that their preconceptions and patterns of thinking or behaving might be challenged by staff, and the fact that the staff did this from a position of knowledge and empathy was connected to an improvement in ability to cope.

In interviews staff said that a key part of their success was the investment WISH made in their clinical practice – through maintaining small caseloads and offering good levels of clinical governance.

"[It's] been really helpful in terms of developing social workers' knowledge, understanding and practice around online grooming, and what young people have access to, and might be getting up to online. [Staff have] helped with strategy meetings, given advice. [Staff] have been helpful in talking through some CSE risk assessments we've done for [a young person]"

[External stakeholder]

"In terms of delivery, of course, we could deliver [training] ourselves. We have our own workers but the knowledge they have in WISH, the time it takes for us to train someone up, it doesn't make any sense for us. Because they are an organisation with very strong links with the school, people and families and the understanding, then it makes better value for money because we are saving on those training staff. Because they do training up in schools, safeguarding, they are very well regarded, and it requires much less from the council"

[External stakeholder]

"Dealing with emotions... psychoeducation about what's going on with their body but then also trying to find out what do they enjoy: writing, drawing, dancing, singing; just trying to

find out their interests and using that as self-expression rather than going to self-harm"

[WISH staff member]

"I tried all of the things – like she bought me a book, and it really related. She gave me breathing exercises which I would use"

[Young person in interview]

"Also, I feel able to look after myself at WISH. I have a maximum size caseload and I don't go over that"

[WISH staff member]

"I have weekly external supervision. That's on a Friday and that helps"

[WISH staff member]

"One young person I am thinking about who is particularly complex – and difficult for professionals to understand what is happening there. What other professionals have really struggled with – including a really excellent child-focused social worker – [WISH] has been able to quite quickly build trust with this child and her mother, which we have really not managed in eight months of the case"

[External stakeholder]

WISH offers a range of support in a flexible way

Young people were accessing varying combinations of support, and amongst the older young people there had been a number of routes through the project. Young people and staff saw young people's needs as shifting over time, and the ability to react to these changes was a key factor in achieving outcomes. Young people often described other services as linear – with an expectation that you would access help, resolve an issue and move away from the service. Young people described moving in and out of group and one-to-one support at different times.

"It was really useful for some of the stuff that I didn't want to say in front of people – not that it was the people, just that I was like "I don't know if I want to say that in front of everyone!""

[Young person in focus group]

Staff and external stakeholders said that the referral had often not fully captured or understood the needs of the young person, and the ability to work with a young person over time to test approaches was seen as crucial to success.

Amongst young people who accessed one-to-one support, the flexibility in terms of convenient days and times to access the help was seen as a strength.

"I do the one-on-one sessions, I didn't end up doing the group. I was allowed to choose in a sense, I did try and get into the group and then I didn't get in for whatever reason. At first I was only given the option to do the one-on-one."

[Young person]

"Outreach is selected for any referrals where it's felt more appropriate than counselling. Also, they may access outreach for 6 sessions before later accessing Safe2Speak"

[WISH staff member]

Some young people had experienced unplanned changes to their support due to a loss of funding, and had found this difficult.

"If funding is going to stop, be aware of that, before the person has to open up and tell them their business. If it stops all of a sudden..."

[Young person in focus group]

WISH and working with parents?

WISH are focused on young people but do offer advice to parents and carers, and work with them as part of the team around the family.

"Because you don't only see the young person, you might be seeing their parents as well, as much as it's confidential. You tend to find there are not a lot of places where parents can access support to help them understand their young person's situation and get some help."

[WISH staff member]

"Parents can see change in that the young person is accessing support – and then they might see a change. Modelling might be happening – young person practices a respectful relationship with me – I expect

respect from them and I will respect them. They then learn that for another relationship. If you can do that with me, then that can happen with Mum. Though I don't go into the home or work with parents. But we do have impact with parents"

[WISH staff member]

"Also helping parents to understand self-harm and there isn't a one-stop fix – learning to understand the self-harm."

[WISH staff member]

Cost Benefits

Stakeholders were asked to comment in interviews about their perception of whether WISH services were cost effective, and why. This was a difficult question for many to respond to without context or data to hand.

The overarching response was that WISH services were cost effective for two main reasons:

1. They are relatively low cost. Group activities in particular are seen as inexpensive, but the organisation as a whole was seen as being good at controlling costs.

2. There are cost savings to statutory services. These were described as being to:

   - **Health services:** by reducing GP appointments, A&E attendances, medication and paramedic call-outs;

   - **Local authority services:** keeping young people closed to social services or reducing social services referrals;

   - **School budgets:** reducing demand for in-school support in particular pastoral support and learning support.

"We try and save money in every which way we can"

[WISH Trustee]

"Students working with WISH – we find that actually once they finish with WISH we would downgrade the support... So in terms of cost-effectiveness, I would say it is cost effective. And as a school, we do value their support greatly"

[External Stakeholder]

"It does prevention work – otherwise could be on a waiting list somewhere else. Referrers often don't know what to do – like if someone does not reach the threshold for CAMHS. That has an effect on the referrers and on the young people; WISH has a holding role there"

[External stakeholder]

"It saves the council, the borough, the CCG, hospital"

[WISH Trustee]

"Data tells me that people have less suicidal thoughts, don't present to A&E"

[WISH Trustee]

"they don't have to be open to a statutory service and they get their needs met through the community"

[External Stakeholder]

"They are great at picking up cases which otherwise might be open on a child in need plan – sometimes child protection, but we might be treading water and not actually having any impact or outcomes. They're able to quickly make a difference to children and their families in a way that we don't"

[External stakeholder]

Discussion

Both the evidence from the two types of outcome measure that WISH collects, and the interviews and focus groups with young people and wider stakeholders, lend strong support for the model and approach that the WISH Centre offers. WISH makes a significant and positive difference to most of the children and young people that it supports.

The view of WISH and its stakeholders has been, for years, that its approach was effective with the young people it worked with in Harrow. And from 2014 onwards, it has been making the case for implementing pilots in other areas to test if the approach and its impact can be replicated elsewhere. The project in Camden has been launched very recently, but the service in Merton is now well established. This evaluation has found that the WISH Centre is as successful in Merton as it is and has been in Harrow.

The qualitative evidence lends strong support for the peer support group work provided by WISH. This is critical as this is a relatively low-cost intervention and reasonably easy to replicate. There is also support for this from the analysis of outcome data: the difference in pre- and post-intervention measures for those in the Self Harm Xpress group showed a statistically significant improvement. However, data was only available on a smaller group of 25 young people who attended groups. Measuring outcomes by completing tools such as the WISH Psychosocial Assessment Tool (WPAT) can sometimes 'jar' with the therapeutic session it often follows. Therapists have reported some young people don't wish to complete the measures, and also that its introduction can be "inappropriate" on occasions, particularly following highly emotionally charged conversations in a therapy session. This might also be true of trying to measure outcomes after a group. We believe the peer group support is a powerful tool, but we also believe it warrants further study in its own right.

A real challenge for WISH is meeting the demand. At the time of writing this report, WISH has two psychotherapists/counsellors and has waiting lists on both sites. The WISH approach is to offer counselling for as long as the young person requires (subject to age criteria) and this 'time-unlimited' offer means that both therapists have full caseloads and may not be able to take on new young people for weeks and sometimes months. Of course, WISH can utilise other offers during any wait for therapy, such as peer groups and outreach. But the risks associated with young people self-harming beg for a more rapid response. This requires further resourcing, which is a huge challenge for any charity in the current climate. Researching the benefits of the other offers WISH makes in more detail is also critical, and as previously stated the peer group offer may be able to support a larger group of young people or be an important adjunct to one-to-one counselling. But it is important to establish who it can help, and to understand more robustly the impact it can have. Choice is also important in helping young people find "their own cure", and some young people may struggle with group settings and would prefer to have one-to-one conversations.

The young people that WISH supports live in their local communities; most attend school and live with their families. There is growing evidence that both parents/guardians and school staff want, need, and can benefit from support. WISH has offered training in schools and this has been welcomed and valued. There is a strong argument for providing information and support to parents, and evidence that this might also reduce self-harm. This is not necessarily a service that WISH need to provide. Commissioners should explore the possibility of commissioning an offer for parents. One possibility alluded to in the literature review is a support group, perhaps a facilitated peer group equivalent for parents.

Young people who self-harm are at greater risk of prolonged poor mental health and, most importantly, are significantly more likely to have tragically short lives due to self-inflicted causes (suicide, but also through misuse of drugs and alcohol). CAMHS have a function to play, but thresholds of entry and volumes of need suggest there is a huge gap. In Harrow and Merton, the WISH Centre is attempting to meet that gap: it is able to do so in a way which overcomes some of the barriers that prevent young people from seeking help, and it has a significant positive impact on the young people it is able to work with.

Centre for Mental Health conclude that the approach offered by WISH is both successful and replicable.

Recommendations

1. Introducing the WISH approach to other areas

Clinical commissioning groups (CCGs) and local authorities across the country should commission services similar to WISH to address the needs of young people struggling with self-harm.

The approach offered by WISH is highly successful in bringing about improvements across a range of outcomes for young people, and part of its success is that it is attractive to young people and engages with them.

2. Increase capacity

CCGs & local authorities need to expand and develop the model used by WISH, to ensure there is enough capacity to give all young people struggling with self-harm the timely support they need. Commissioners may especially wish to focus on the role of Peer Support groups, which could provide the most cost-effective means of increasing capacity and which this report has found to be highly effective.

3. Developing outcome reporting and achieving more understanding of the peer support offer

Research funders should commission further studies, prospective in nature, specifically on the outcomes of young people who attend peer groups.

4. Commissioning more for young men

Commissioners should look at increasing their provision for young men struggling with self-harm, as well as young women.

This is based on the views of a range of interviewees and focus group members, who thought a broader offer was needed for young men.

5. Commissioning a specific offer for young people identifying as LGBT

Research funders should fund pilot studies to examine the benefits of LGBT-specific groups for young people struggling with self-harm.

Some people felt there should be an offer for lesbian, gay, bisexual and transgender young people, with a number suggesting that multiple groups might give young people a choice of groups to go to, including different gender mixes.

6. Better promotion

Public Health England should commission a national campaign on working with young people who self-harm, increasing awareness in young people and others of the issues, challenging the myths about self-harm and encouraging help-seeking among those who need support. This would require substantial funding, locally and nationally, both to fund the promotional activity and to build capacity in the sector to meet demand.

This is based on several group discussions in our research which centred on the promotion of WISH. Many young people said they had not recognised existing promotional material and had not known about WISH before they came. There was consensus that promotion should challenge stereotyping of young people who self-harm as being largely White British girls, and that the representation of young people should be positive and uplifting.

7. Commissioning support for parents and carers

CCGs and local authority commissioners should work with services across the country providing support similar to WISH, to explore the need for facilitated peer group offers for parents and carers, and to establish what this support might look like. Extending the support to parents and carers is likely to have benefits for young people too.

8. Support for teachers and other professionals working with young people on self-harm

Charitable funders should fund the development of a self-harm awareness training programme for teachers and professionals who work with young people.

The training offered by WISH is highly valued by delegates, but teams like WISH will always have limited capacity. A national programme to equip professionals across the sectors would improve the understanding and support given to young people struggling with self-harm, and would increase the likelihood of timely support.

Centre for Mental Health   REPORT   A space to talk

References

Brooks, F., Chester, K., Klemera, E. and Magnusso, J. (2017) *Intentional self-harm in adolescence: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England, 2014.* London: Public Health England.

Children's Society (2018) *The Good Childhood Report 2018* [Online] Available from: www.childrenssociety.org.uk
/good-childhood-report [Accessed 23 October 2018]

Curtis, S., Thorn, P., McRoberts, A., Hetrick, S., Rice, S. and Robinson, J. (2018) Caring for Young People Who Self-Harm: A Review of Perspectives from Families and Young People. *International Journal of Environmental Health and Research.* 15: 90

Hawton, K., Hariss, L. (2007) Deliberate self-harm in young people: characteristics and subsequent mortality in a 20-year cohort of patients presenting to hospital. *Journal of Clinical Psychiatry* 68:1574-83.

Lewis, C., Ubido, J. & Timpson, H. (2017) *Case for Change: Self-harm in Children and Young People.* Liverpool: Liverpool John Moores University.

Morgan, C., Webb, R., Carr, M., Kontopantelis, E., Green, J., Chew-Graham, C., Kapur, N. and Ashcroft, D. (2017) Incidence, clinical management, and mortality risk following self-harm among children and adolescents: cohort study in primary care. *British Medical Journal* 2017; 359:j4351

NICE (2013) *Self-harm Quality standard qs34* [Online] Available from: www.nice.org.uk/ guidance/qs34 [Accessed 23 October 2018]

Office of National Statistics (2016) *Statistical bulletin: Suicides in the UK: 2015 registrations.* London: ONS.

Patton, G., Coffey, C., Sawyer, S. *et al.* (2009) Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet* 374:881-92.

WISH (2014) *Self-Harm and Young People: Phase 1 Report: evidencing the need and demand for a pilot programme to replicate and test The WISH Centre Model of self-harm support services for young people.* London: The WISH Centre.

A space to talk

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here:
www.centreformentalhealth.org.uk

REPORT

Centre for
Mental Health

A space to talk

An evaluation of the WISH Centre's services with young people who self-harm

Dr Graham Durcan & Juliet Snell

Centre for
Mental Health