Care Pathway for Self-Harm **Appendix 1**

A young person has self-harmed, reported, suspected or expressed an intention to self-harm

Worker speaks to young person to assess whether emergency medical attention is required, and seek help from a first aider if necessary

Young people should not be sent to hospital Emergency Department unless this is clinically necessary

If the young person does not require first aid or other emergency medical treatment

'LOW RISK'
Young person meets criteria in Appendix 4 and consents to information sharing

Discussed within agency for information sharing with parent/carers. Individual/Family Support Plan to reduce risk. Linked to sources of support. Risk reassessed **within 10 working days**

If first aid is necessary, ensure this is administered.

If treatment at a hospital emergency department (A&E) is clinically necessary (treatment will be needed for cuts that are deep and/or bleed profusely, burns that are blistering or red, where the young person has lost consciousness or has overdosed or ingested harmful liquids) In the case of an overdose of tablets, however small and whether recent or not, advice must be obtained from a medical professional either by contacting mor supporting the young person to get a same-day appointment with their GP. If this is not possible then the young person should go to the nearest emergency department.

If a young person is expressing thoughts of suicide please stay with the young person, follow the baseline risk assessment tool, and appendix 3 & 4.
Please contact 111 or 0800 953 0285 if you need to access the Crisis Care Pathway which may provide alternative to A&E

- Clarify who in your agency is best placed to speak to the young person
- Indicate a willingness to talk to the young person about their self-harm
- Be non-judgemental and validate their feelings
- Consider contacting the parents/carers and discuss confidentiality with the young person
- Accompany young person to hospital if necessary
- Ensure all safeguarding procedures have been followed
- Consultation/advice could also be accessed through MHST (if a school and linked) or CAMHS. Note this may not be a same day response.

'Medium RISK'
Young person meets criteria in Appendix 4 Worker advises involved professionals, arranges Family Support Meeting and makes appointment to meet with young person and with parents **within 3 working days of in-depth assessment to reassess risk.**

'HIGH RISK'
Young person meets criteria in Appendix 4

Significant psychosocial problems. No clear plan to address risk.

Baseline Risk Assessment Tool

A first act of DSH is a golden opportunity for secondary prevention, that is, the prevention of subsequent self-harm or suicide. Reactions and attitudes of professionals and family can affect the potential for further self-harm. Managing our own emotions in these situations as well as providing a space for the young person to feel heard is essential. Self-harm in young people can usefully be regarded as a form of communication. This can be likened to *'a message in a bottle'*, since it is not always easy to decipher exactly what is (consciously or unconsciously) being communicated. If at least some of those messages can be *heard*, and if the content can be expressed another way, then the self-harm need not reoccur. Young people are less likely to repeat an act of self-harm if they feel understood by those around them.

Uncovering the feelings and communication behind any act of self-harm can be challenging. The young person may find self-harm difficult to talk about or find it hard to describe their feelings. The single most helpful thing a professional can do after any act of self-harm is to encourage communication between the young person in crisis and important people around them. This may include family, friends and school staff. The young person will need encouragement and support to help others understand their worries. Parents/carers and sometimes other professionals may need help to understand that blame, shame and anger or treating the episode as attention-seeking, trivial, manipulative or devious are unhelpful responses which will only increase the likelihood of further, possibly more serious self-harm.

In order of importance, the key priorities when approaching the initial assessment are:

1. The young person's **safety**
2. An **understanding** of what has caused them to have self-harmed
3. **Offering help but not forcing it on someone**

The initial baseline assessment of risk should cover the following important issues:

- Events surrounding the act of self-harm
- Degree of suicidal intent (if any) and other reasons for the act
- The young person's current problems
- Possible mental health difficulties
- Family and personal history
- Any history of mental health diagnoses or self-harm
- The nature of the young person's resources and supports
- Risk of further self-harm and / or of suicide
- Attitudes towards help and support

The degree of suicidal intent and / or depressive thoughts and feelings associated with the self-harm can be assessed with simple questionnaires (attached below) as well as via discussion.

The Baseline Risk Assessment Questions outlined below provide a guide to important areas that need to be explored in all cases of actual (or suspected) DSH. The In-Depth Risk Assessment Schedule outlined in Appendix 3 should be followed in all cases of suspected 'raised' and possible 'high' risk (see Appendix 4).

The practitioner who is conducting the initial assessment should, dependent upon the young person's situation and level of ability and understanding, use their professional judgement about how to ask / phrase the question and whether each specific area needs to be covered.

Initial Questions
Area: Openers/ listening and understanding their behaviour: Q: What happened to get you to this point today? Q: What triggers those feelings? Q: What are your injuries like now? Q: How do you self-harm? Q: How do you care for your injuries?
Area: Previous thoughts of self harm Q: I'm wondering whether you have had any thoughts about hurting yourself before? Q: How long have you been feeling this way?
Area: Preventive Measures (Young Person) Q: Who else knows? Q: Perhaps we could talk a bit more about the kinds of things which could help you to keep safe? Q: what would you like to change/happen? Q: What do you want to do?
Area : Plans to Self-Harm Q: How often do you self-harm?
Area: Suicidal intent *"It's okay to talk about suicidal thoughts. Sometimes when we have thoughts of ending our lives it can be because we really want things to change rather than to die, I'm wondering what you think about that?"* Q: What are you thinking of doing that would harm you? Q: Have you been having thoughts about ending your life? Q: Have you been thinking about how you could end your life? Q: Do you need medical attention?
Area: Involvement of Others (Consider safeguarding issues) Q: Have you been thinking about harming yourself with anyone else? Q: Would you say that anyone is pressuring you to do this?
Area: Preventive Measures (Explore positive relationships, social network, family support, school, sport, music) Q: Perhaps we could talk a bit more about the kinds of things which could help you to keep safe? Q: Who do you feel safe with? Q: What will make you feel safe?
Area: What needs to happen to make the young person feel better Q: What would make you feel better? Q: How would you know when you felt better?

Responses
Urgent medical response needed call an ambulance
Tell them who you will have to share this with and when this will happen
Say when you will speak with them again
Check what they can do to ensure they keep themselves safe until they are seen again e.g. Stay with friends at break time, go to support staff.
Give reassurances i.e. It's OK to talk about self-harm and suicidal thoughts

Setting up the contract with the child or young person
Discuss confidentiality and limits
Discuss Child Protection if necessary
Discuss who knows about this and contacting parents / carers
Discuss who you will be contacting

Do’s and Don’ts

Do’s
•Make first line assessment of risk and make In-Depth assessment of risk in cases of ‘raised’ and ‘high’ risk
•Take suicide gestures / indicators seriously
•Be yourself, listen, be non-judgemental, be patient and think about what you will say
•Check associated problems such as bullying, bereavement, relationship difficulties, abuse and sexuality / gender issues.
•Check how and when parents / carers will be contacted
•Encourage social connection to friends, family and trusted adults
•Implement initial care pathway
•Implement support / behaviour contract with young person
•Make appropriate referrals
•Set up a meeting to plan the care pathway interventions based upon understanding of the risks and difficulties.
•Provide opportunities for support, strengthen existing support systems

Don’ts
•Jump to solutions too quickly
•Dismiss what the children or young people are saying
•Believe that a young person who has threatened to harm themselves in the past will not carry it out in the future
•Disempower the child or young person
•Ignore or dismiss people who self-harm
•See it or refer to it as attention seeking
•Assume it is used to manipulate the system or individuals
•Trust appearances

RECENT MOOD AND FEELINGS QUESTIONNAIRE

NAME:……………………………….DATE………..

To answer these questions, think about how you have been feeling over the past two weeks.

No.	Read each statement carefully and tick the box on the right, which you agree with most	True	Sometimes true	Not true	Clinical use only
1	I felt miserable or unhappy				
2	I didn't enjoy anything at all				
3	I was less hungry than usual				
4	I ate more than usual				
5	I felt so tired I just sat around and did nothing				
6	I was moving and walking more slowly than usual				
7	I was very restless				
8	I felt I was no good anymore				
9	I sometimes blame myself for things that are not my fault				
10	It was hard for me to make up my mind				
11	I felt grumpy and cranky at my parents				
12	I felt like talking less than usual				
13	I was talking more slowly than usual				
14	I cried a lot				
15	I thought there was nothing good for me in the future				
16	I thought life was not worth living				
17	I thought about death or dying				
18	I thought my family would be better off without me				
19	I thought about killing myself				
20	I didn't want to see my friends				
21	I found it hard to think properly or concentrate				
22	I thought that bad things would happen to me				
23	I hated myself				
24	I was a bad person				
25	I thought I looked ugly				
26	I worried about aches and pains				
27	I felt lonely				
28	I thought nobody really loved me				
29	I didn't have any fun at school/work				
30	I thought I could never be as good as other kids				
31	I did everything wrong				
32	I didn't sleep as well as I usually sleep				
33	I slept a lot more than usual				
34	I was not as happy as usual even when praised or rewarded				

Any other comments you would like to make about how you are feeling, or what you are worried about?

The questionnaire should be scored and the findings interpreted using the guidance in order to determine the level of depression.

Scoring

True = 2 Sometimes True = 1 Not True = 0

A score of over 27 indicates a ‘depressed mood’ and needs further questioning. It does **not** mean that the young person is depressed, for example s/he could be feeling low after having just broken up with their boy/girlfriend. Through completing the questionnaire and the initial questioning process the practitioner/professional should be able to determine whether a more in-depth assessment is required.

In-depth Assessment of Risk

SECOND LEVEL QUESTIONING

Please remember that risk factors are **not**, nor can they ever be, tools for prediction.

Also, any risk assessment can only be valid for the moment at which it is carried out and so may need to be repeated at suitable intervals according to professional judgement or advice.

Risk of self-harm is **not** the same as risk of mental illness, and one does not need to be mentally ill to self-harm, although there may be links (see below).

Bear in mind that some information can be obtained from the young person, but not all, which may need to come from other sources, such as parents / carers, peers or other professionals.

The order of the factors in the list is not necessarily significant, as they are all worthy of consideration.

RISK FACTORS:

- **Previous deliberate self-harm or suicide attempt**

- **Lethal Intent** – does the young person wish to die? What do they understand by death? Do they think that what they have done, or are planning to do, will kill them? N.B. it is the young person's perception of or belief in potential lethality that is important here, **not** what a professional thinks.

- **Evidence of mental illness**, especially depression, psychosis or an eating disorder.

- **Poor problem-solving skills** – are problems seen as overwhelming? Does the young person see themselves as capable of solving, or coping with, problems? Have they been able to solve problems in the past? May be linked to poor communication skills.

- **Impulsivity/planning** - Were steps taken to avoid discovery? Were any preparations for death made? A tendency to impulsive behaviour may increase risk of repetition and thus the likelihood of significant harm, but evidence of planning may indicate higher levels of seriousness for any given attempt. But remember that an impulsive act can be just as damaging as a planned one.

- **Substance use** (especially important in impulsive males).

- **Hopelessness** – is there a future, or any reason to continue living? What plans for the future does the young person have? This has been described as "the missing link" between depression and suicide. It can be especially significant if there has been previous deliberate self-harm or attempts at suicide.

- **Anger/hostility/anti-social behaviour** – some research suggests conduct disorder may be a higher risk factor than depression. This may be difficult to assess, as information will be needed from sources other than the young person.

- **Family factors** – instability (this can mean more than divorce or separation and can include repeated house moves). History of suicide or mental illness, especially in first-degree relatives. History of substance use. Arguments or disputes can be important.

- **History of abuse**, whether physical, emotional or sexual, but especially the latter.

- **Loss or bereavement** – this may include such things as loss of status as well as deaths. Anniversaries of losses can be significant.

- **Bullying or other victimisation**, such as experiencing racial or sexual discrimination, and including homophobic bullying (see below).

- **Issues of gender or sexual orientation** – a very high proportion of young people who either are homosexual, or think they might be, self-harm or attempt suicide.

- **Current stressors or life events**.

OTHER CONSIDERATIONS:

- **Function of deliberate self-harm** (other than a clear suicide attempt) – what did the young person hope the act would achieve: a sense of relief or release; punishment; purification; a desire to feel physical rather than emotional pain; a form of communication of distress or other significant matter; something else?

- **Method of self-harm** – be aware of unintended consequences, such as liver damage from Paracetamol overdoses and risk of infection through cutting with dirty instruments.

- **Time of year** may be significant, especially when school-related factors are involved, such as bullying or exams. Hence the start of terms or exam periods may see an increase in self-harming behaviour.

Appendix 4

LEVELS OF RISK AND CARE PLANNING GUIDANCE:

Low risk:

- Suicidal thoughts are fleeting and soon dismissed
- Few or no signs of depression
- Any mood changes are transient
- Superficial cutting
- No other self-harming behaviour
- Sensible attitude to experimentation with drugs and alcohol
- Nothing to indicate past or present abuse
- Current problem / situation felt to be painful but bearable.

Possible Intervention:

- Ease distress as far as possible. Consider what may be done to resolve difficulties
- Link to other sources of support
- Convene Family Support Meeting to draw up single agency plan of support
- Review and reassess at agreed intervals.

Raised risk:

- Suicidal thoughts are frequent but still fleeting
- No specific plan or immediate lethal intent
- Indications of current mental health disorder, especially depression, anxiety and eating disorder
- Deep scarring or cutting
- Previous history of overdose or other self-harm
- Significant or potentially dangerous drug or alcohol use
- Indications of possible abuse or significant traumatic experience
- Problem situation felt to be painful, but no immediate crisis.

Possible Intervention:

- Ease distress as far as possible. Consider what may be done to resolve difficulties
- Consider safety of young person, including possible discussion with parents/carers or other significant figures
- Convene Family Support Meeting to draw up either single agency or multi-agency Family Support Plan
- Possible mental health assessment – discussion with, for example CAMHS or G.P
- Referral to MARAT, Children’s Social Care
- Consider consent issues for the above
- Consider increasing levels of support/professional input
- Review and reassess at agreed intervals – higher frequency than for low risk.

High risk:

- Frequent suicidal thoughts, which are not easily dismissed
- Specific plans with access to potentially lethal means
- Evidence of current mental illness
- Significant drug or alcohol use
- Situation felt to be causing unbearable pain or distress
- Increasing self-harm, either frequency, potential lethality or both.

Possible Intervention:

- Ease distress as far as possible. Consider what may be done to resolve difficulties

- Safety – discussion with parents/carers or other significant figures more likely
- Urgent CAMHS referral and/or referral to Children's Social Care (MARAT)
- Consider consent issues
- Consider increasing levels of support/professional input in the mean time
- Monitor in light of level of CAMHS involvement.

N.B. at any time during assessment and review emergency medical treatment may be found to be necessary or child protection concerns may need to be acted upon.

Key Contacts in Trafford

Below is a list of advisors who can be contacted by anyone working with young people in Trafford who have a query or concern about self-harm. Some are able to offer advice on specific specialist areas, others will be able to respond or to signpost key services where appropriate.

Trafford CAMHS duty workers	0161 549 6456
Trafford First Response- Children's Social Care	0161 912 5125
GM Mental Health Helpline	0800 953 0285

Please note that these contacts are for advice and discussion, usually by telephone. If an urgent referral is required then this should be direct to FRT or CAMHS.

In the case of self-inflicted injuries needing urgent treatment or when substances or tablets have been ingested then an emergency referral to A&E would be required, via a 999 call for an ambulance if necessary.

Useful National Organisations/Contacts

Childline 0800 1111 www.childline.org.uk

British Association for Counselling and Psychotherapy (BACP)
BACP House, 35–37 Albert Street, Rugby CV21 2SG
tel. 0870 443 5252, minicom: 0870 443 5162
email: bacp@bacp.co.uk web: www.bacp.co.uk

Mindinfoline
tel. 0845 766 0163
Mind is the leading mental health organisation in England and Wales, providing a unique range of services. MindinfoLine is Mind's helpline and information service.

National Self-harm Network (NSHN)
PO Box 7264, Nottingham NG1 6WJ
Web: www.nshn.co.uk
Survivor led organisation supporting those who self harm

Samaritans www.samaritans.org.uk
Phone: 08457 909090
Befriending service for anyone going through a personal crisis who is at risk of suicide.

NICE Guidelines (Self harm: Short term treatment and management)
Web: www.nice.org.uk

YoungMinds
102–108 Clerkenwell Road, London EC1M 5SA
parents information service: 0800 018 2138
web: www.youngminds.org.uk

For anyone concerned about a child's mental health

Websites for help, information and self help literature
www.selfharm.org.uk
www.rcpsych.ac.uk
Self-harm: assessment, management and preventing recurrence (nice.org.uk)

Personal Information Consent Form

We may want to share information about you with other people or agencies if we think sharing with them will help you.

You don't have to give permission, but if you don't you may not get all the help you need.

Consent

Do you give us permission to share information about you with other people and agencies who can help you?	Yes/No
Is there any specific information you do not want us to share?	Yes/No
Are there any people or agencies you do not want us to share with?	Yes/No

Please give details of any information you do not want us to share and/or any people or agencies you do not want us to share with.

Signed by ………………………
(if appropriate) on behalf of ………………………

Printed name ………………………
(if appropriate) printed name of the child ………………………

Date ………………………

SELF-HARM: Concise Guidance on Sharing Information

1. This is concise guidance for sharing recorded information about children who harm themselves or are perceived to be at risk of self-harm including suicide.

2. **Purpose of Sharing Information**
The purpose of sharing information is to ensure children in need and in particular children who harm themselves or are perceived to be at risk of self harm including suicide are given the help and support to which they are entitled.

3. **What will be shared?**
Information shared will be no more than is necessary. All information will be handled with respect and care. Unrecorded information/ observations, which may be significant, will be freely shared within statutory agencies and between partners in the interests of meeting the statutory functions of the partners**. Information should be recorded if it is significant.**

4. **Consent**
Professionals will use the Consent Form to record the competent child's consent to share recorded information. Fresh consent should be sought if the existing consent does not cover the proposed sharing or there has been a break in involvement. The child should be told what information may be shared and why it would be shared and the consequences of sharing.

5. **Sharing without Consent**
Informed consent should be sought from the competent child to share recorded information unless;
   - The situation is urgent and there is not time to seek consent, or
   - Seeking consent is likely to cause serious harm to someone or prejudice the prevention, detection of serious crime.

   If consent to sharing recorded information is refused by the competent child, or can/should not be sought from the child, information should still be shared in the following circumstances;
   - There is reason to believe that not sharing is likely to result in serious harm to the child or someone else or is likely to prejudice the prevention or detection of serious crime, and
   - The risk is sufficiently great to outweigh the harm or prejudice to anyone that may be caused by the sharing, and
   - There is a pressing need to share the information.

6. **When is a child "competent" to give consent?**
Anyone under the age of 18 is a child. A judgement must be made as to whether a particular child in a particular situation is competent to consent or refuse consent to sharing information. Consideration should include the child's chronological age, mental and emotional maturity, intelligence, vulnerability and comprehension of the issues. A child at serious risk of self-harm may lack emotional understanding and comprehension.

7. **Sharing Information**
Professionals who request or refer information should state;
   - What the information is and why it should be shared
   - Whether there is informed consent and any limits to it
   - If there is no consent, why they believe the information should be shared without consent
   - The proposed method of sharing and storage of the information,
   - The period of time for responding to the request or referral.

Professionals who refuse or cannot comply with a request or referral should say why and what could be done to secure their agreement to share information. Local authorities, education authorities and health authorities/trusts must comply with requests for information from Social workers carrying out an s47 inquiry unless it would be unreasonable to do so.

8. **Families**

Professionals should keep parents informed and involve them in the information sharing decision even if a child is competent or over 16. However, if a competent child wants to limit the information given to his parents or does not want them to know it at all, the child's wishes should be respected, unless the conditions for sharing without consent apply. Where a child is not competent, a parent with parental responsibility should give consent unless the circumstances for sharing without consent apply.