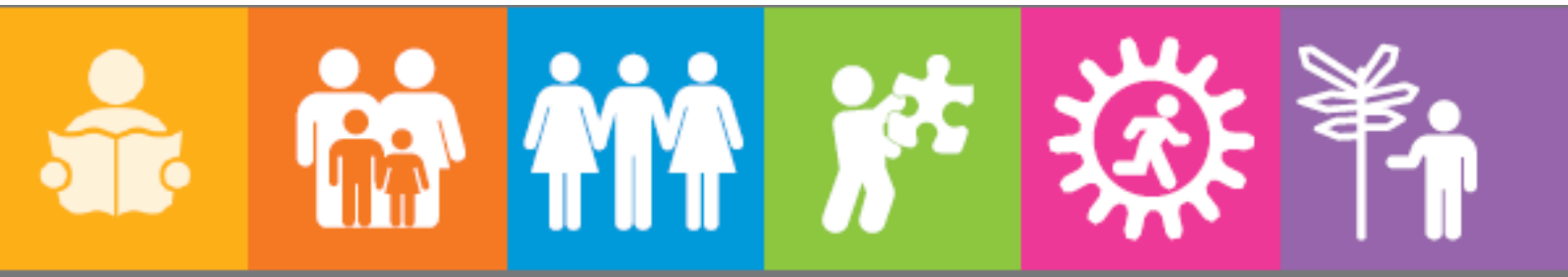
National CAMHS Support Service

National Workforce Programme

Self-harm in children and young people Handbook



Welcome to the Self-harm in children and young people Handbook

Rates of self-harm have increased in the UK over the past decade and are among the highest in Europe. Moreover rates of self-harm are much higher among groups with high levels of poverty and in adolescents and younger adults.

Self-harm results in about 150,000 attendances at accident and emergency departments each year and is one of the top five causes of acute medical admission.

All staff working with children and young people, whether in universal, targeted or specialist services, are likely to encounter children or young people who self-harm at some point in their working lives. Self-harm is distressing for all concerned and many who work in children's services feel ill equipped to deal with it.

Ignorance, fear and misunderstanding may be a reason why the National Institute for Health and Clinical Excellence (NICE, 2004) has found that staff frequently have a negative attitude towards those who carry out acts of self-harm, particularly those who harm themselves repeatedly.

This Handbook is designed to provide basic knowledge and awareness of the facts and issues behind self-harm in children and young people, with advice about ways staff in children's services can respond. It is not a definitive guide and does not replace official guidance issued by professional bodies or government policy, but provides a clear and simple starting point for easy reference.

Each section of this Handbook is accompanied by a brief summary of relevant evidence and references to source material. The full set of references is also provided at the end. It can be printed or viewed on a computer and can be navigated easily by following the links on the Contents page, or using the colour coding for each section.

All those working with children and young people need to

- understand self-harm and the underlying reasons for it
- be able to act sensitively and appropriately in supporting each child or young person to be emotionally well
- contribute to tackling the societal and professional attitudes that create stigma.

We hope this Handbook will enable you to feel confident in dealing with children and young people who self-harm.

Barry Nixon, National CAMHS Workforce

To explore issues further and/or share with colleagues, a set of online seminars accompanies this resource. Contact barry.nixon@olsenhouseschool.co.uk or yvonne.anderson@cernis.co.uk

1.1 What is self-harm?

The straightforward definition is 'Self-harm happens when someone hurts or harms themselves.'

More broadly it can also be that 'Some of us harm ourselves in less obvious - but still serious - ways. We may behave in ways that suggest we don't care whether we live or die – we may take drugs recklessly, have unsafe sex, or binge drink. Some people simply starve themselves'.[1]

Sometimes a distinction is made between self-harm and deliberate self-harm. The problem with this distinction is that we cannot know whether, for example, someone who "takes drugs recklessly" has deliberate intent to harm themselves, or whether they are less aware that self-harm is a consequence of their actions.

Since we cannot answer the question definitively of what counts as deliberate, this guidance will refer throughout to self-harm; that which can be defined as what happens when someone hurts or harms themselves. This could be by self-injury such as hair pulling, self-mutilation such as cutting and/or reckless, risk taking behaviour. When assessing self-harm it is important to consider how intentional the behaviour is, the lethality of the action and whether it is a one-off act or is something that a child or young person does frequently over a period of time.[2]

1.2 Types of self-harm

Self-harm by children and adolescents most often involves the following methods[3]:

- overdoses (self poisoning)
- self-mutilation (e.g. cutting behaviours)
- burning
- scalding
- banging heads or other body parts against walls
- hair-pulling
- biting

EVIDENCE BOX 1

In a study on self-harm conducted on 10 to 19 year-olds between 1985 and 1995, it was found that the most common method of deliberate self-harm was self-poisoning (88.7% overall). 7.5% were found to have presented with self-injury and 3.8% with both self-poisoning and self-injury. The study indicated a gender based difference in the methods of self-harm: 'self-injury was found to be more common in males than females (13.2% and 2.6% respectively). Conversely, females were more likely to have presented with self-poisoning than males (91.2% females, 82.5% males'[4]

1.3 How common is self-harm?

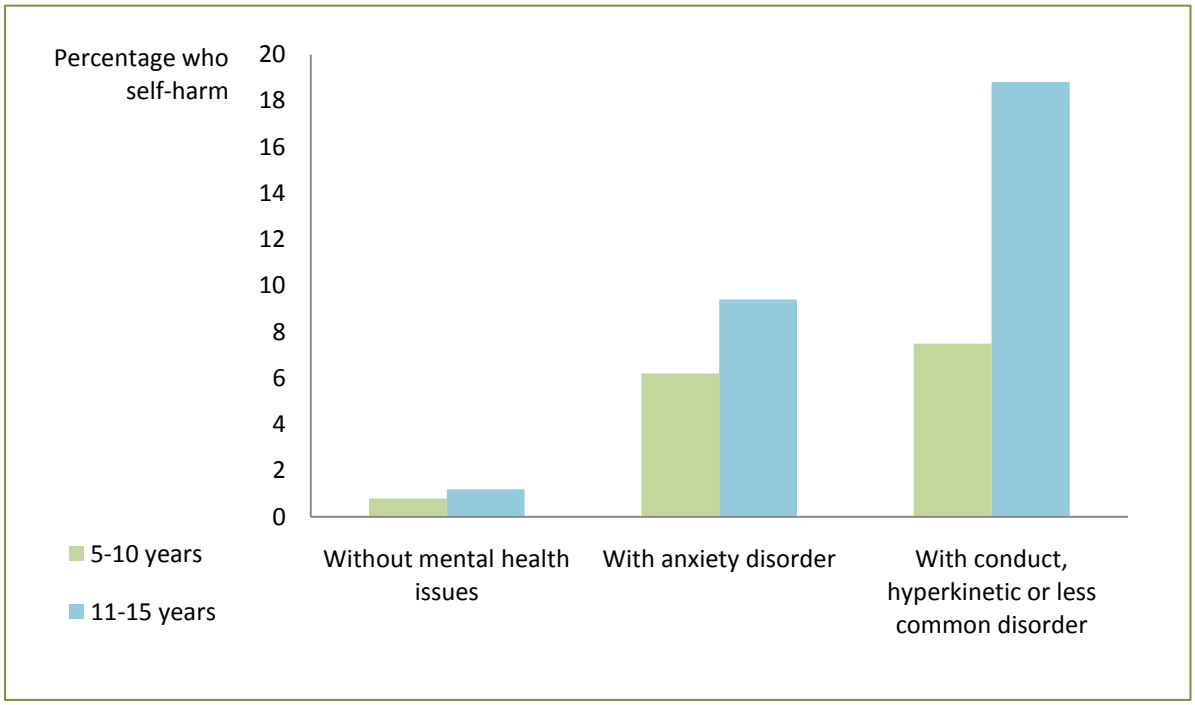
It is difficult to provide accurate numbers on how widespread self-harm is among children and young people. This is because definitions of self-harm vary, so cases may be reported differently, but also because many cases of self-harm probably go unreported. Despite these issues, estimates are available for the prevalence of self-harm. Self-harm becomes more common after the age of 16, but is still prevalent among younger children and teenagers.

EVIDENCE BOX 2

A national survey of more than 10,000 children found that the prevalence of self-harm among 5-10 year-olds was 0.8% among children without any mental health issues, but 6.2% among those diagnosed with an anxiety disorder and 7.5% if the child had a conduct, hyperkinetic or less common mental disorder. The figures increase dramatically for 11-15 year-olds, with the prevalence of self-harm at 1.2% among children without any mental health issues, but 9.4% among those diagnosed with an anxiety disorder, and 18.8% if the diagnosis is depression[5].

More information from the evidence is shown in the chart below.

Chart 1. Percentage of self-harm by age and disorder



Are there variations by ethnicity?

The prevalence of self-harm is disproportionately high among young Asian women, but this applies specifically to adult women, defined as aged 15-35 years. Otherwise, there is no reported difference in prevalence between young people from different ethnic backgrounds. But the way in which mental health is understood and experienced differs between cultural groups, therefore reporting rates are probably varied.

Is self-harm becoming more prevalent?

ChildLine reports that the number of children disclosing self-harm has risen steadily since the mid-1990s, with a 65% increase between 2002 and 2004. Other organisations, such as Samaritans and Mental Health Foundation report similar increases, although heightened awareness of the issue by both young people and professionals may be responsible for some of the increase.

[1] Royal College of Psychiatrists accessed November 2010 http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/self-harm.aspx

[2] McDougall, T, Armstrong, M and Trainor, G (2010)*Helping Children and Young People Who Self-harm. An introduction to self-harming and suicidal behaviours for health professionals.* Routledge

[3] Social Care Institute for Excellence (2005) *Briefing 16* http://www.scie.org.uk/publications/briefings/briefing16/index.asp#research

[4] Fox, C., & Hawton, K., (2004) *Deliberate Self-harm in Adolescence.* London: Jessica Kingsley Publishers

[5] Social Care Institute for Excellence (2005) *Briefing 16* http://www.scie.org.uk/publications/briefings/briefing16/index.asp#research

2.1 Reasons why young people self-harm

Young people often cannot explain why they self-harm, especially when the self-harm itself is a means of communicating what cannot easily be put into words or even into thoughts (it has been described as an inner scream). Self-harm is a way of expressing very deep distress. Afterwards, people feel better able to cope with life again, for a while.

Self-harm can be a way to help someone to cope with painful emotions that threaten to overwhelm them such as:

- rage
- sadness
- emptiness
- grief
- self-hatred
- fear
- loneliness
- guilt

The statements below are from young people [1]

TESTIMONY

"Self-harm used to be a way to get rid of the feelings inside of me. To get out all the hurt, anger and pain that I was feeling."

"My emotions can vary rapidly and be very intense. If in an emotionally charged situation, I will either during or shortly after harm myself. I'm not good at dealing with emotions or communicating mine to others.

A number of purposes may be served by self-harm: it may be a way of getting the pain out, of being distracted from it, of communicating feelings to somebody else and of finding comfort. It can also be a means of self-punishment or an attempt to gain some control over life.

2.2 Multiple causes

It is rarely one single event or experience that causes a young person to self-harm, but a multi-faceted combination.

Research has shown that the experiences most closely linked to self-harm in young people are:

- mental health problems (including hopelessness and depression)
- family issues (such as parental criminality and/or family poverty)
- disrupted upbringing (being in local authority care, parental marital problems, separation or divorce)
- being abused
- continuing family relationship problems.[2]

The evidence box provides more detail

EVIDENCE BOX 3

The Child and Adolescent Self-harm in Europe (CASE) Study has gathered self-reported information from a total of 30,437 young people from seven countries and illuminates many of the factors associated with self-harm among young people.

The work of CASE involves a group of international experts in designing, planning and implementing a European multi-centre study to provide robust information on the scale and characteristics of the problem. [3,]

Other research on adults has indicated a clear link between self-harm and sexual abuse in childhood[4]

2.3 Myths

Even among health care professionals there can be myths and negative attitudes surrounding self-harm and assumptions may be made about why a young person is self-harming and therefore how to treat them.

Some young people have reported experiences of an unsympathetic attitude from staff when they have presented with injuries.

The National Institute for Health and Clinical Excellence (NICE) has produced guidelines on the treatment of self-harm, explaining the need to explore the underlying reasons someone may be self-harming, rather than focusing on the injuries themselves (*see section 8*).

The statements below are from young people [5]

TESTIMONY

"The last time I had a blood transfusion the doctor said I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked if I was proud of what I had done."

"My doctor looked at me differently once I told her why I was there. It was as if I were being annoying and wasting her time."

Self-harm may be believed to be:

- manipulative - **Myth**
- attention seeking - **Myth**
- for pleasure - **Myth**
- a group activity - **Myth**
- only carried out by those who are interested in 'Goth' sub-culture - **Myth**
- a failed suicide attempt - **Myth**
- evidence of borderline personality disorder – **Myth**

[1] Mental Health Foundation (2006) *Truth Hurts Report The final report of the National Inquiry into self-harm among young people.* http://www.mentalhealth.org.uk/publications/?entryid5=38712&q=684278%c2%actruth+hurts%c2%ac
[2] Mental Health Foundation (2006) *Truth Hurts Report The final report of the National Inquiry into self-harm among young people.*
[3] Fox, C. & Hawton, K. (2004). Deliberate Self-harm in Adolescence. London: Jessica Kingsley Publishers.
[4] Romans, S.E., Martin, J.L., Anderson, J.C., Herbison, G.P. & Mullen, P.E. (995). Sexual abuse in childhood and deliberate self-harm. American Journal of Psychiatry, 152, 336-342.
[5] Mental Health Foundation (2006) *Truth Hurts Report The final report of the National Inquiry into self-harm among young people.*

3.1 Who reports self-harm

A study conducted by The Child and Adolescent Self-harm in Europe (CASE) in 2005 (based on a sample size of 30,000 15 and 16 year-olds) suggests 'an alarming rate of self-harming among young people: in the knowledge that their anonymity was protected, over 70 per cent of respondents admitted to self-harming at some stage in their lives'.[1]

Self-harm is more common among some groups than others. This knowledge is based on large samples and population studies, so it does not help us to assess the vulnerability of any individual, but creates a context for understanding risk factors. Many of the figures are likely to be under-estimates.

3.2 Age, gender, ethnicity

- About 1 in 10 young people will self-harm at some point, but it can occur at any age.
- It is more common in young women than young men.
- It is important to note that males may engage in different forms of self-harm that could be easier to conceal, potentially accounting for the degree of apparent difference between genders.

The evidence box provides more detail

EVIDENCE BOX 4

Self-harming seems to be more prevalent in older groups: a 2001 study based on parental reports, suggests that the rate among 13-15 year-olds is one and a half times that of 11-12 year-olds.[2] Similarly, in a later study sample of 710 under 15 year olds seen at a general hospital, most were aged between 12 and 14[3] However it is possible that some younger children self-harm without presenting to any services.

The greater prevalence of self-harm among females was demonstrated in a study conducted on 10-19 year-olds over a period of 10 years, in which the majority of cases (73.1%) were women.[4] This is echoed in national figures which show that 6.5% of girls and 5.0% of boys reported that they had tried to harm themselves.[5]

- Studies of self-harm in Black and minority ethnic (BME) groups have been restricted to single geographical areas, with few studies of Black people.
- Despite the increased risk of self-harm in young Black females fewer receive psychiatric care.
- It is likely that some BME groups under-report self-harm.

The evidence box provides more detail

EVIDENCE BOX 5

A study of three cities in England (Manchester, Derby, Oxford) found that of a total of 20 574 individuals (16–64 years) presenting with self-harm; ethnicity data were available for 75%. Rates of self-harm were highest in young Black females (16–34 years) in all three cities. Risk of self-harm in young South Asian people varied between cities.

Black and minority ethnic groups were less likely to receive a psychiatric assessment and to re-present with self-harm.[6]

3.3 Psychological/mental health and family

- Self-harm is more common amongst those suffering from mental health disorders.
- People who self-harm are more likely to have experienced physical, emotional or sexual abuse during childhood

The evidence box provides more detail

EVIDENCE BOX 6

A national survey found the prevalence of self-harm was higher among children who had a mental disorder compared to other 11-15 year-olds without a mental illness. In particular, a high prevalence of self-harm was found among children suffering from depression, conduct disorder and anxiety disorder. [7]

3.4 Sexuality and social context

- Gay and bisexual people seem to be more likely than their heterosexual peers to self-harm.
- Sometimes groups of young people self-harm together - having a friend who self-harms may increase your chances of doing it as well.
- Self-harm is more common in some youth sub-cultures.

The evidence box provides more detail

EVIDENCE BOX 7

Research in 2005 reported that 25% of men had a risk of self-harm that was attributable to same-sex attraction. Another study, lasting more than 7 years, found that adolescents who identified themselves as gay, lesbian or bisexual reported increased rates of self-harm compared with heterosexual adolescents[8].

It is held that self-harm is more common in some youth sub-cultures This could be explained by young people emulating cultural icons or peers who self-harm. Alternatively, it could be explained by selection, in which young people with a particular propensity to self-harm are attracted to the sub-culture. [9]

3.5 Multiple stress factors

A national inquiry report states that "people who hurt themselves often feel that the physical pain is easier to deal with than the emotional pain they are experiencing, because it is tangible."

The experience of physical and emotional changes that occur normally in adolescence can exacerbate stressful circumstances, which may lead to self-harming. (The most common age of onset is around the start of puberty.)

Self-harm is more likely if a family member or close friend has previously self-harmed or attempted suicide.

Other stress factors include adverse family circumstances, dysfunctional relationships, domestic violence, poverty, parental criminality and being looked after by the local authority.

Children and young people who self-harm may discover that inflicting pain changes their mood, which then may become habit-forming. Cutting, for example, releases endorphins, which produce brief feelings of calm, and serotonin, which is mood-lifting.

[1] The Child and Adolescent Self-harm in Europe (CASE) study, completed in 2005, was a seven year international research project funded by the European Commission Daphne Programme and coordinated by the National Children's Bureau.
[2] Fox, C., & Hawton, K., (2004) *Deliberate Self-harm in Adolescence.* London: Jessica Kingsley Publishers
[3] Meltzer, H. Harrington, R. Goodman, R. and Jenkins, R. (2001) *Children and adolescents who try to harm, hurt or kill themselves.* London: Office for National Statistics.
[4] NSPCC, (2009) *Young people who self-harm: Implications for public health practitioners*. http://www.nspcc.org.uk/Inform/research/briefings/youngpeoplewhoselfharmpdf_wdf63294.pdf
[5] Meltzer, H. Harrington, R. Goodman, R. and Jenkins, R. (2001) *Children and adolescents who try to harm, hurt or kill themselves.* London: Office for National Statistics.
[6] Cooper, J., Murphy, E., & Webb, R., (2010) Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study. *The British Journal of Psychiatry* (2010) 197: 212-218.
[7] Meltzer, H. Harrington, R. Goodman, R. and Jenkins, R. (2001) *Children and adolescents who try to harm, hurt or kill themselves.* London: Office for National Statistics.
[8] Skegg, K. (2005). Self-harm. LANCET, 366, 1471-1483.
[9] Grant, J., E., & Potenza, M., N., (2007) *Textbook of Men's Mental Health* American Psychiatric Pub, p372.

4.1 Build resilience

The environments in which children and young people thrive and are emotionally well are supportive, nurturing, affirmative, safe and have clear boundaries.

While professionals cannot change the home and family circumstances of children, it is possible to provide health, education, social and youth services in environments that promote emotional well being and strengthen resilience.

Creating an environment that will strengthen young people's resilience means showing concern for their psychological well being through:

- Leadership
- Policy
- Example set by adults
- Respect shown between adults as well as between adults and young people

4.2 Be aware

Within a safe, nurturing, open organisation children and young people may feel more able to share feelings, but those who self-harm often find it difficult to ask for help, because they:

- think it will be a one-off event that they can manage
- want to put it to the back of their minds
- feel they have nobody with whom one to share their feelings
- have no idea how to access services
- are concerned that their coping strategy will be taken away from them if they are prevented from self-harming
- feel worried they will be judged as attention seeking or stupid
- believe their physical injuries are not serious enough to need help anxiety that disclosure of self-harm will limit their future career opportunities
- are concerned they will lose control over the situation if their behaviour becomes public knowledge.

The evidence box gives more detail

EVIDENCE BOX 8

Children and young people may be reluctant to disclose their self-harming because they do not believe it will be treated in confidence.

The national inquiry *Truth Hurts* found that children and young people who self-harm are three times more likely to turn to a friend than a professional. The report states

"those young people who spoke directly to an adult said that once they had done this, all decision-making and control were taken from them. They were not being consulted about the services that might be contacted, or about the exact sort of help and information that would support and help them deal with their self-harm. Many were unsure - and felt unable to ask about - who else would be told or involved after they had disclosed private and sensitive information."[1]

Be aware that children and young people who are self-harming will find it difficult to ask for help.

4.3 Knowledge and/or removal of the means of self-harm

In environments in which children and young people are not supervised all medicines and potentially harmful substances should be locked away.

Knives, razors and other potential cutting instruments should be removed.

4.4 Skilled helping

Skilled helping creates a sense of involvement or a caring presence when working with another person. The main techniques of skilled helping can be learned by anyone and are remembered by the acronym **SOLER.**[2]

- The first condition of skilled helping is to accept that the emphasis is on the young person's agenda, not yours.
- The second condition is that the core principles of genuineness, respect, and empathy are upheld.
- The third condition is that the skilled helper practises active listening throughout.

Sit squarely

Open posture

Lean forward when necessary

Eye contact

Relaxed body language

4.5 Confidentiality

The best prevention for self-harm in young people is to have people they can talk to, who will listen and take them seriously.

Unless a child or young person's self-harming poses a safeguarding issue, you must obtain their consent to share information about them, establishing that they have a reasonable understanding of:

- What information might be shared
- The main reason/s for sharing the information
- The implications of sharing or not sharing that information

Consult a senior colleague and use your organisation's policies and procedures on confidentiality and consent, information-sharing and safeguarding to guide you (see Section 9).

EVIDENCE BOX 9

Young people responding anonymously reported a much higher rate of self-harm than was previously believed. From this we can infer the importance of confidentiality to young people and their wish to control their own situation. The NSPCC states:

"Ultimately, this means that strict reporting requirements have to be balanced out against young people's wishes and their wellbeing, which produces challenging moral, ethical and legal issues that will need to be fully debated. In any case, if a young person is prepared to disclose, their courage to do so needs to be acknowledged and their views on the pace of events, and on how things should be handled, should be respected."[3]

Children and young people need to know they can trust the adults around them to keep confidentiality.

[1] Mental Health Foundation (2006) *Truth Hurts Report The final report of the National Inquiry into self-harm among young people.* http://www.mentalhealth.org.uk/publications/?entryid5=38712&q=684278%c2%actruth+hurts%c2%ac

[2] Egan, G., (1965) *The Skilled Helper : A Systematic Approach to Effective Helping.* 1st edition. (now in 9th edition)

[3] NSPCC (2009) *Young people who self-harm: Implications for public health practitioners. Child protection research briefing* http://www.nspcc.org.uk/Inform/research/briefings/youngpeoplewhoselfharmpdf_wdf63294.pdf

5.1 Shame, covering up, hiding

After self-harming a child or young person may feel shame and embarrassment at their actions and may hide scars, wounds, bruises or cuts. Some feel ashamed at the feelings which made them want to self-harm.

Many young people recognise that their self-harming will be viewed negatively by others, so they become secretive in order not to be exposed to criticism and prejudice. They are aware of the stigma associated with self-harm.

A fear of the unknown can perpetuate prejudice.

EVIDENCE BOX 10

It is often easier to see mental health problems as belonging to others (i.e. the *them-and-us* concept) as this allows individuals not to have to consider the vulnerability we all have to experiencing mental health problems. [1]

The term *stigma* has been described as the negative effects of a label placed on any group.[2]

5.2 Societal (and professional) responses

Young people report prejudice from all sections of society, including among some of the professionals to whom they turn for help. Some of the common prejudices are given below, with young people's responses to them[3].

All people who self-harm are suicidal	**NO. Only a very small number, for most it is a release from emotional pain.**
Self-harm is attention seeking	**NO. Many young people go to great lengths to hide their self-harm.**
The more serious the injury, the more serious the problem	**NO. The nature and severity of the self-harm does not reflect the nature or severity of the problem.**
They must like the pain	**NO. It is not about pain, it is about coping.**
Self-harm is a young person's issue	**NO. People of all ages self-harm.**
People who self-harm can stop easily if they want to	**NO. It is a way of coping and is very difficult to stop unless a better way of coping can be adopted.**
Self-harm is the problem, if we stop this then the person will be fine	**NO. Self-harm is not really the problem and may be seen as a solution to problems that will not go away.**

5.3 Ways to counter prejudice/remove stigma

Ignorance and fear of the unknown are the underlying factors in prejudice and stigma.

The more people talk about "taboo" subjects, the less alien and frightening those subjects will be.

Share the information and resources in this guide with as many colleagues as you can.

Start the conversation in your organisation – initially just between colleagues, but working towards involving children and young people in dialogue.

THE CONVERSATION

What do we know about emotional well being?

How well do we understand self-harm?

What can we do to tackle stigma?

How can we involve young people more in our organisation?

Involve young people in a campaign to tackle stigma.

Or

Support young people to run their own campaign.

There are many resources available to help you.

TACKLING STIGMA RESOURCES

www.chimat.org.uk/tacklingstigma

www.time-to-change.org.uk

www.shift.org.uk

www.changingminds.co.uk

Image reproduced from Tackling Stigma Toolkit (see above)

[1] National CAMHS Support Service (2010) *Tackling Stigma Toolkit* http://www.chimat.org.uk/tacklingstigma/about

[2] Hinshaw S (2005) The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, 46 (7), 714-734.

[3] National Self-Harm Network http://www.nshn.co.uk/misconceptions.html

6.1 Signs to look for

Not knowing how to broach the subject is often what prevents concerned individuals from probing. Yet concern for their well-being is often what young people who self-harm need most.

What to look out for:

- Unexplained burns, cuts, scars, or other clusters of similar markings on the skin can be signs of self-injurious behaviour.
- Arms, hands and forearms opposite the dominant hand are common areas for injury. (However, evidence of self-injurious acts can and do appear on any body part.)

Other signs include:

- Inappropriate dress for the season (consistently wearing long sleeves or trousers in summer)
- Constant use of wrist bands or other coverings
- Unwillingness to participate in events or activities that require less clothing (such as swimming or other sports)
- Frequently wearing bandages
- Unusual or inexplicable paraphernalia (e.g. razor blades or other implements, inappropriate medication)
- Heightened signs of depression or anxiety.

If you suspect a young person has self-harmed it is important that your approach is non-threatening and emotionally neutral.

However, expect to receive evasive responses.

When asked, young people who self-harm may offer stories which seem implausible or which only partially explain physical indicators.

"Can't remember"

"Fell off my bike"

"Me and my friend were mucking about"

"I was playing with our cat"

"What are you on about?"

6.2 Caution

A child or young person displaying any of the signs listed above, whom you suspect is self-harming, may be at risk of harm or being harmed by others. Injuries may have been inflicted by others.

Safeguarding concerns should be paramount – always seek advice from a senior colleague.

6.3 Your reactions

You may experience a number of unfamiliar reactions if you discover a young person has been self-harming, especially if you find them in the act of self-harming, or with fresh wounds.
Research in education settings found that adults responded in a number of ways to young people's self-harm, as quoted in the box.

sorrow, alarm, panic, anxiety, shock, *being:*
scared, distressed, upset, taken aback, fazed, freaked out, repulsed, bewildered, frustrated, mystified[1]

Own your feelings, but try not to let them make you powerless to act.

6.4 What to do[2]

DO	*DON'T*
Inform yourself as much as you can about self-harm. Read this document and look up some of the original research listed in the references. Then share with colleagues. The more you understand the better the outcomes for you and the young people.	*Think the problem does not exist or will go away, you will be wrong. If you work with children and young people, at some point one of them will self-harm.*
Make it your business to inform colleagues. The more people know about self-harm, the less stigmatising it will be. You also need the support of your organisation as you cannot act in isolation.	*Keep the information in this document to yourself. Everyone who works with children and young people should have an understanding of mental health and emotional well being and be aware of the effects of stigma.*
Try to be a good listener by allowing the young person to speak without interruption or judgement. If a young person feels able to open up to you it could be a great breakthrough, so tread carefully.	*Make assumptions, they are unlikely to be correct and you will risk alienating the young person altogether.*
Look after yourself – it is hard to support someone if you are feeling overwhelmed or out of your depth. Make sure you also have a source of support for yourself.	*Feel that you have to be able to cope. It is fine to be honest about your own fears, but make sure you have other people or organisations to help you.*
Set boundaries around what you can offer and be clear with yourself and your organisation about what you cannot offer and which other individuals or organisations can be used for help.	*Try to work alone. The burden will be too great on you and will not be helpful to the young person. You do not need to breach confidentiality, just be sensible about what you can and cannot do.*

DO what you can to encourage the young person to seek professional help such as counselling.

6.5 If First Aid is needed

You must not attempt to give first aid unless you have been trained and kept up to date, so first get help.

You should be fully knowledgeable about the first aid procedures in your organisation and you will have a named first aider.

Why not take this opportunity to find out about first aid training for yourself.

If you are not a trained first aider the best "first aid" you can provide is a calm, empathic presence, being non-judgemental and supportive, encouraging the young person to talk and trying to establish some facts so you can help the first aider and/or other services when they arrive.

[1] Best, R. (2005) Self-harm: A Challenge for Pastoral Care. *Pastoral Care in Education*, 23, (3) 3-11.
[2] The Site http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm/supportingsomeonewhoselfharms

7.1 Good reasons for early intervention

Young people self-harm as a way of coping with emotional pain. Early intervention can tackle the cause of the emotional pain, or offer alternative ways of coping.

Some young people want to stop self-harming, but they may need help and encouragement.

Early intervention can prevent escalation.

It is the beginning of the recovery process.

7.2 Wanting to stop self-harming

Young people often reach the point at which they want to stop self-harming.

The reasons given are that they:

- begin to see that they are "growing out" of it – it begins to feel like an immature way to deal with life problems
- start to find other, more positive, ways of coping and want to improve their overall mental health
- want to take care of their physical health
- feel the shame, embarrassment or secrecy becomes too overwhelming and uncomfortable
- need to escape pressure and reactions from others
- dislike the physical scars it leaves behind
- recognise the pain it causes to their friends and families
- realise it is no longer working or helping them to cope.

7.3 What works

The reaction a young person receives when they first disclose self-harm can potentially have a profound influence on whether they go on to seek help from support services.

Dealing with a young person's disclosure does not require any specials skills or extra training. You need to use your core skills and be aware of your own feelings in aiming to treat the young person with respect, unconditional regard and warmth.

One necessary skill is the ability to signpost to services that provide what the young person wants.

The evidence box shows what young people prefer

EVIDENCE BOX 11

Support preferred by young people[1]	%
Individual support/counselling	85.2
Group support/drop-in	71.1
Self-help group (facilitated)	60.6
Creative Initiatives	59.9
Multimedia/internet access	57
Information point	50.7
Outreach team	45.1
Family support	37.3
Self-help (no facilitator)	20.4

7.4 Distraction and self-help

Self-harm can become a preferred way of coping, which then makes it difficult for the young person to believe that anything else will help. But other ways of coping can be encouraged and have been found to be effective.

The National Self Harm network lists over 100 distracting activities that have been found to help young peoples who want to stop self-harming. [2]

The box lists types of distraction with examples.

DISPLACEMENT	Snap an elastic band on your wrist
REINFORCING	Think about not wanting scars
PHYSICAL	Go to the gym
CREATIVE	Write poetry
COMFORTING	Cuddle a soft toy/pillow
CONSTRUCTIVE	Write a to do list
FUN	Go to a movie

7.5 Relationship between self-harm and suicide

Although it is argued that that self-harm is the opposite of suicide, that is, a way of coping with life rather than giving up on it, there is an equally valid argument that they are both linked in being a response to distress. The NSPCC finds sufficient evidence to suggest that skilled support at the time of the first episode of self-harm provides an opportunity to prevent further self-harming and, potentially, a suicide attempt.[3]

EVIDENCE BOX 12

It is estimated that for every one young person who has committed suicide, there are between 40 and 100 who have self-harmed.[4] This supports the view that self-harm in most cases does not lead to suicide, but the National Institute for Clinical Excellence (NICE) indicates that those who have self-harmed are 100 times more likely than the general population to die by suicide in the following year.[5] This supports earlier work by the Samaritans (2001). The risk increases for those who self-harm repeatedly.[6]

If you see or suspect a young person self-harming, you need to act.
Early intervention can help the young person cope differently with their distress.
It may prevent escalation.
It could prevent a future suicide.

[1] Mental Health Foundation (2006) *Truth Hurts Report The final report of the National Inquiry into self-harm among young people.* http://www.mentalhealth.org.uk/publications/?entryid5=38712&q=684278%c2%actruth+hurts%c2%ac
[2] National Self Harm Network (2007) *Distractions that can help* http://www.nshn.co.uk/downloads/Distractions.pdf
[3] NSPCC (2009) *Young people who self-harm: Implications for public health practitioners*. Child protection research briefing
[4] Fox, C. and Hawton, K. (2004) Deliberate Self-harm in Adolescence. London: Jessica Kingsley.
[5] National Institute for Clinical Excellence (2004) *Self-harm The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16* http://www.nice.org.uk/nicemedia/live/10946/29422/29422.pdf
[6] Hawton, Keith, and Rodham, Karen, and Evans, Emma, Samaritans; University of Oxford. Centre for Suicide Research (2003) Youth and self harm: perspectives. A report. Oxford, Samaritans.

8.1 Emergencies

If a wound is bleeding profusely or if you suspect the young person has swallowed any form of toxic substance, including overdosing on medication and/or alcohol, you must get the young person to A&E straight away.

The most helpful actions you can take are:

- **Recognise** a potential emergency and contact emergency services on 999 immediately.
- **Assist** the emergency services by giving clear directions about the location of the young person, their name, your name and your relationship to the young person.
- **Reassure** the young person and gently but persistently ask neutral questions to establish what has happened.
- **Accompany** the young person to the A&E department and wait with them until other arrangements are made.
- **Convey** to A&E staff all the facts you have gathered.
- **Remain** until you are sure the young person is happy for you to leave and is receiving appropriate treatment.

8.2 Urgent medical treatment

If a young person has a wound that is anything beyond purely superficial, they will need medical treatment. In this case you need to get the young person safely to primary care, whether a GP Clinic, Walk-in Centre, or Minor Injuries Unit.

If in doubt, contact emergency services on 999.

8.3 Acting on Concerns

In all circumstances in which a young person has self-harmed and has recent wounds or other potential injuries, use the **ABCDE** checklist below to help you be aware and, if possible, record all the important aspects of the situation.[1]

A	B	C	D	E
Appearance and atmosphere: what you see first – everything, including physical problems.	**Behaviour:** what the individual in distress is doing, and if this is in keeping with the situation.	**Communication:** how the individual in distress is communicating, what they say and how they say it.	**Danger:** whether the individual in distress is in danger and whether their actions put other people in danger.	**Environment:** where they are situated, and whether anyone else is there who will either exacerbate the situation or offer support.

8.4 What should happen next

How people who have self-harmed are treated by emergency and primary care services is set out in guidance from the National Institute of Clinical Excellence (NICE, 2004). You can use the following brief summary of the NICE Guideline as a checklist to ensure a young person you have accompanied is receiving appropriate care.[2]

Respect, understanding and choice

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training

- Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Activated charcoal

- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

Triage

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.
- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.
- If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

Assessment of needs

- All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of risk

- All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Psychological, psychosocial and pharmacological interventions

- Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

8.5 Other agencies

In all aspects of children and young people's mental health and emotional well being it is generally more effective and helpful for professionals and agencies to work together, provided the young person and their parents or carers if appropriate, agree.

Child and adolescent mental health services (CAMHS)

CAMHS practitioners have specialist knowledge and skill in all aspects of mental health and emotional wellbeing and are accustomed to working with children and young people who self-harm.
You can request advice and consultation from CAMHS and will find they will observe stringent boundaries of confidentiality, within their codes of clinical practice. This will still enable you to share information appropriately which is in the interests of the child or young person.
You may also discuss with a child/young person and their parents or carers if appropriate, whether a referral to CAMHS would help. Referral to some CAMHS is open, so you may be able to do it on behalf of the child/young person or they may be able to self-refer. Sometimes referral has to be from designated people or agencies, such as educational psychologist, education welfare officer, or GP.

Voluntary organisations

Some young people do not wish to attend CAMHS and may express a preference for more informal supports. Many areas have youth organisations offering drop-in support services including counselling. Your local authority will probably have a directory of voluntary organisations, which may be on the website, or the young person you are working with might know of them.

Online help

There are many organisations offering online support to young people in stressful situations. Some are specifically aimed at supporting young people who self-harm, others help with general mental health difficulties and a number offer support in areas that may be underlying issues for a young person who is self-harming. The list on the next page is not exhaustive and you will wish to add to it with your own knowledge and include local organisations too.

8.6 List of online help

National Self Harm Network (NSHN)	Aims to support, empower and educate those who self-harm, their families and those who support them.	http://www.nshn.co.uk/index.html
The Site	Young person's guide to the real world, including mental health and self-harm, among many other topics.	http://www.thesite.org/
Samaritans	Provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide.	http://www.samaritans.org/
MIND	Aims to help people take control of their mental health, by providing information and advice, and campaigning to promote and protect good mental health for everyone. More suitable for older young people.	http://www.mind.org.uk/
YoungMinds	The only national charity dedicated to promoting the mental health and emotional wellbeing of children and young people.	http://www.youngminds.org.uk/
Directgov – public services all in one place	Has information on young people and: Domestic violence http://www.direct.gov.uk/en/YoungPeople/CrimeAndJustice/TypesOfCrime/DG_10027680 Health and relationships http://www.direct.gov.uk/en/YoungPeople/HealthAndRelationships/index.htm Disability http://www.direct.gov.uk/en/YoungPeople/Youngdisabledpeople/index.htm Crime and justice http://www.direct.gov.uk/en/YoungPeople/CrimeAndJustice/index.htm	http://www.direct.gov.uk/en/index.htm
Consortium of LGBT networks	The directory allows you to search and list all the organisations that are members of the Consortium of Lesbian, Gay, Bisexual and Transgendered Voluntary and Community Organisations.	http://www.lgbtconsortium.org.uk/directory

[1] Hewson, L., (2010) *Getting it Right Responding to acute mental health needs of young people for first contact staff* Training materials
Available from: amanda.hodgson@yhip.org.uk

[2] National Institute for Clinical Excellence (2004) *Self-harm The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16*
http://www.nice.org.uk/nicemedia/live/10946/29422/29422.pdf

9.1 What safeguarding means

Safeguarding and promoting the welfare of children is defined in government guidance as:

The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully (*Working Together to safeguard children*).[1]

9.2 Where there may be safeguarding concerns

Working Together to safeguard children identifies a number of reasons why children and young people may self-harm, all of which indicate safeguarding concerns:

EVIDENCE BOX 13 (from Working Together)

Forced marriage (p.198)
Sexual abuse (p.260)
Being bullied (p.305)
Witnessing domestic violence (p.310)

If any of the underlying causes for self-harm shown in Evidence Box 13 are suspected they need highly specialised help. You responsibility is to share your concerns immediately with a professional who is named as the safeguarding or child protection lead for your organisation or to contact a senior children's social worker.

In addition, a child or young person's self-harming may in itself be cause for concern in that they are at risk of significant harm. All organisations that work with children and young people share a commitment to safeguard and promote their welfare; additionally many organisations have specific roles and responsibilities in safeguarding, which are underpinned by a statutory duty or duties. These duties are clearly described in *Working Together to safeguard children.* If in doubt about your own role, consult *Working Together* as well as your own organisation's policies on safeguarding and/or child protection.

9.3 What to do

You should discuss concerns about a child's safety and welfare with, and seek advice from, colleagues, managers, a designated or named professional, or other agencies but:

- never delay emergency action to protect a child from harm
- always record in writing concerns about a child's welfare, including whether or not further action is taken
- always record in writing discussions about a child's welfare in the child's file
- at the close of a discussion, always reach a clear and explicit recorded agreement about who will be taking what action or that no further action will be taken.

[1] Department for Children, Schools and Families (2010) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*
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http://www.mentalhealth.org.uk/publications/?entryid5=38712&q=684278%c2%actruth+hurts%c2%ac

National CAMHS Support Service (2010) *Tackling Stigma Toolkit*
http://www.chimat.org.uk/tacklingstigma/about

National Institute for Health and Clinical Excellence (2004) *Self-harm The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16*
http://www.nice.org.uk/nicemedia/live/10946/29422/29422.pdf

National Self-Harm Network
http://www.nshn.co.uk/misconceptions.html

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http://www.nspcc.org.uk/Inform/research/briefings/youngpeoplewhoselfharmpdf_wdf63294.pdf

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http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/self-harm.aspx

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Social Care Institute for Excellence (2005) *Briefing 16*
http://www.scie.org.uk/publications/briefings/briefing16/index.asp#research

The Site http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm/supportingsomeonewhoselfharms

National CAMHS Support Service

National Workforce Programme

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