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NHS
North West Coast
Clinical Networks

Cheshire and Merseyside

Children and Young Persons Self-Harm Practice Guide

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Contents

Introduction

This document has been developed as a reference guide for all agencies and practitioners who meet children, young people, and their families. It is intended as a guide to supporting children/ young people who have thoughts of, are about to or have self-harmed.

Thank you to Liverpool CCG whom in conjunction with Liverpool CAMHS, Liverpool Safeguarding Children Partnership and Liverpool John Moores University created the original document which we have adapted for the Cheshire and Merseyside area.

The guidance will support practitioners to keep children safe by outlining:

What self-harm is	The triggers for self-harm	How to support young people and children who self-harm

What is Self-Harm?

NICE Clinical guidance defines self-harm as 'self-poisoning or injury, irrespective of the apparent purpose of the act'.

Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself. Self-harm describes a wide range of behaviours that someone does to themselves, usually in a deliberate and private way, and without suicidal intent, resulting in non-fatal injury. In many cases, self-harm remains a secretive behaviour that can go on for a long time without being discovered.

Many children and young people may struggle to express their feelings and will need a supportive response to assist them to explore their feelings and behaviour and the possible outcomes for them. Examples of self-harm behaviours are:

Examples of self-harm behaviour:	
Self-cutting or scratching	Punching/hitting/bruising
Burning or scalding oneself	Swallowing objects
Headbanging or hair pulling	Self-poisoning, i.e. taking an overdose or ingesting toxic substances
Over/under-medicating, e.g. misuse of insulin	

There are other behaviours that are related but which do not normally fall within the definition which include:

Self-neglect – physical and emotional	Eating distress (anorexia or bulimia)
Reckless risk-taking	Substance misuse
Staying in an abusive relationship	Risky sexual behaviour

NICE Clinical guidance1 defines self-harm as 'self-poisoning or injury, irrespective of the act's apparent purpose. However, self-harm is also commonly known as self-injurious behaviour (SIB), non-suicidal self-injury (NSSI), or deliberate self-harm.

Common characteristics of self-harm behaviours

Common characteristics of self-harm behaviour	
Compulsive, ritualistic	Sometimes, but not always, occurs with depression and anxiety
Episodic (every so often)	Serves a purpose to the child or young person
Repetitive (on a regular basis)	Serves as a way of communicating to others that something is wrong

Self-harm and suicide

Suicide is a rare event, although rates have increased in recent years.

Suicide rates among young men (aged 10-24 years) have increased significantly since 2017. However, the rate among young women in 2019 was the highest recorded since 1981.

Some people who self-harm is at high risk of suicide. However, many who do self-harm do not want to end their lives; they do it to live. It is how many people cope with emotional distress, so they don't feel the need to kill themselves.

However, there is a relationship as there is a high prevalence with suicide and self-harm. We don't always take self-harm seriously but:

50% of those who die by suicide have previously self-harmed.	Suicide is up 50-fold in 12months after going to A&E with self-harm.	1 in 50 attending A&E with self-harm have died within a year.

There are distinct differences between self-harm and suicide. The majority of those who self-harm do not have suicidal thoughts when doing so.[5]	Self-harm is the strongest clinical predictor of death by suicide, especially in those who self-harm by cutting.
Both indicate emotional distress; self-harm tends to be about coping, whereas suicide is more concerned with 'giving up'.[6]	While methods used for suicide are often different from those used for self-harm, those who repeatedly self-harm are most at risk of suicide.
Self-harm can escalate into suicidal behaviours, and intentions can change over time.	However, some young people who do not intend to kill themselves may do so because help does not arrive in time.
Almost half of the people who self-harm have reported at least one suicide attempt.[2] This is often the case when self-harm is no longer seen as an effective coping method.[7]	Others may not realise the seriousness of their behaviour and its implications, for example, other factors such as drugs or alcohol.

How many young people are affected by Self-Harm/Prevalence?

Self-harm is common, especially among younger people.

1 in 4 young women and 1 in 10 young men have self-harmed at some point in their[8] life.	Adolescents have the highest rate of self-injurious behaviours, with about 17% admitting to self-injury at least once in their life.[9]
Mental health problems may also be associated with self-harm behaviours; however, many young people will not have a diagnosed mental health condition.	Most young people reported that they started to hurt themselves around the age of 12.
A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year.	In 2017, 25.5% of 11 to 16-year old's in England who had a mental health problem said that they had self-harmed or attempted suicide at some point, compared to 3% of those without a mental health problem[10].

Studies use different definitions of self-harm and cover different age ranges. This makes it very difficult to understand how many young people are affected.

Self-harm is something that can affect anyone. It's believed that around 10% of young people self-harm, but it could be as high as 20%.

Self-harm becomes more common after the age of 16 but is still prevalent among teenagers and younger children from the age of eight.	Rates amongst young Asian women can be even higher, but other than this, there is no reported difference in prevalence between young people from different ethnic backgrounds.
A quarter of young men aged 16-24 have used self-harm as a way of coping.	Lesbian, gay, bisexual and transgender (LGBT) young people are more likely to self-harm.
Young women are up to three times more likely to self-harm than young men.	

Why do young people Self-Harm?

Causes

There is no one specific cause of self-harm. It is not a clinical condition but a response by a young person to stress. It may be in relation to repeated or long-standing stress, such as that arising from abuse or domestic violence, or a reaction to a single event such as bereavement. It may be the only way a young person has learned to cope with powerful emotions, or it might be the method of choice – the one that works best for them.

Some reasons young people give for self-harming include:

Using it as a way to feel **more in control** when they are feeling desperate about a problem and don't know where to turn to for help.	For those who feel 'numb' from previous trauma, such as Adverse Childhood Experiences detached from the world, may use self-harm as a way to **feel more connected and alive.**
It is a way to **relieve tension** that has been building up.	Using it as a way to **communicate their emotional pain** and **seek care from others or from themselves.**
They have feelings of guilt/shame or have low self-esteem, and self-harm is a way of **punishing themselves.**	Self-harming may express a powerful sense of despair that needs to be taken seriously. **Such behaviours should not be dismissed as "attention-seeking".**

Self-harm is primarily a coping mechanism, a means of releasing tension and managing strong feelings. Marginalised young people, for example, those in custody, LGBTQ+, victims of abuse, or those affected by sexual exploitation, are at greater risk. This is partly because they are more at risk of depression and anxiety and are less likely to have role models demonstrating effective, alternative coping strategies. They may also be more likely to know others who use self-harm themselves or who have attempt suicide. These factors have been identified as risk factors in several studies. See section 4 for more details.

Prevention

It can be difficult to identify young people at risk of self-harm even though they may seek help before they self-harm. This is partly due to the secrecy and shame that tends to surround self-harm or impulsiveness that precipitates an act of self-harm, but also because there are no unique individual or behavioural characteristics to look out for.

Nevertheless, **schools are** well placed to take action to address some of the issues known to be associated with self-harm such as bullying/cyber-bullying, child sexual exploitation, peer pressures and exam pressures. This can be achieved in the following ways:

By being aware of students who display the risk factors associated with self-harm (see page 11).	Observing behaviour change – some may become withdrawn and isolated, others may become disruptive or more animated.
By being alert to any specific incident that might trigger an act of self-harm.	Building resilience in children and young people.
By being alert to changes in demeanor and behaviour that suggest anxiety or low mood.	Observing expressions of hopelessness or suicidal feelings.
Breaking the cycle of ACEs.	

Remember that young people seek out a trusted adult they are comfortable with, not just teachers or pastoral care staff.

Be pro-active – show concern and ask if there is a problem, and take seriously any expression of emotional distress.	Be aware of strategies that offer alternatives to self-harm (Section 4 Toolkit).
Record and take action upon any incident of self-harm within the school or affecting a student.	Have a referral pathway that all school staff are aware of (see self-harm process flowchart).
Have good links with key services such as CAMHS partners, School Health and Early Help Services.	Attend awareness sessions for schools and other organisations.
Have policies and procedures that support these actions (See Section 2 and Section 9 of the Toolkit).	

Similar approaches can be taken by other services who work with young people who are known to have additional vulnerabilities such as:

- Out of school services/Pupil Referral Units and Support Centres
- Targeted services for young people
- Children's and foster homes

- Aftercare services
- Youth Offending Services
- Barnardo's Action with Young Carers
- Services for those who run away and those who are at risk of child sexual exploitation
- CAMHS partners

Becoming Self-Harm Aware

Vulnerability and Risk Factors

There can be many factors within a young person, their immediate and wider social networks and their environment which might predispose him/her to a wide range of vulnerabilities and not just self-harm. Protective factors mitigate those vulnerabilities.

Young people in closed settings, e.g. armed forces, prison, sheltered housing, boarding schools.	Children in Local Authority Care.
Custody.	YP with learning disabilities.
Black and minority ethnic young people.	Refugee and asylum-seeking children.
Lesbian, Gay, Bisexual and Transgender (LGBT).	Children with HIV/AIDS.

Characteristics of young people who self-harm

Common characteristics of adolescents who self-harm is like the characteristics of those who died by suicide. Physical, psychological, emotional, or sexual abuse may also be a factor. Recently there has been increasing recognition of the importance of depression in non-fatal as well as fatal self-harm in young people. Substance misuse is also common, although the degree of risk of self-harm in young people attributable to alcohol or drug misuse is unclear. Knowing others who self-harm an important factor may be.

As many as 30% of young people who self-harm report previous episodes, many of which have not come to the attention of professionals. At least 10% repeat self-harm during the following year.

For children and young people with Learning disabilities who are non-verbal or minimally verbal. This can take the form of hitting or biting themselves, hitting their head against hard surfaces, scratching themselves, putting their finger in their bottoms or genital areas, and eating items which are not food (Pica) This could be anything in their environment e.g. twigs, stones, leaves, discarded sweets, batteries, nails, paper, dishwasher tablets etc.

Common problems preceding self-harm

Being bullied or hate crime.	Pressure at school.	Low self-esteem.
Health problems, illness.	Sexuality.	Gender identity.
Breakdown in relationships.	Bereavement.	Alcohol or drug misuse.
Anger, shame.	Family conflict.	Perfectionism.
Sexual, physical, emotional abuse.	To make thoughts, feelings visible.	Speech and language impairment.
Express suicidal thoughts/ feelings without taking your own life.	Difficult feelings such as anxiety, depression or other mental health disorders.	Incident of homophobia or bi-phobia, or trans-phobia (including internalised).
Being in care.	Racism.	A sense of being in control.
Exclusion or social isolation.	Parental criminality.	Poverty.

Warning signs to look out for

There may be a change in the behaviour of the young person that is associated with self-harm or other serious emotional difficulties:

Changes in eating/sleeping habits.	Talking about self-harming or suicide/suicidal ideation.	Becoming socially withdrawn.
Increased isolation from friends/family.	Cuts, scratches or burns that may not be accidental.	Suicide or self-harm history in the family.
Changes in activity and mood, e.g. more aggressive/ withdrawn than usual.	Risk-taking behaviour (substance misuse, unprotected sexual acts, driving dangerously).	Reluctance to take part in activities where a change of clothes is required.
Changes in appearance, sudden /drastic weight loss/gain.	Expressing feelings of failure, uselessness or loss of hope.	Wearing long sleeves, tights/legging's, trousers even in hot weather.
Lowering of academic grades.	Giving away possessions.	Abusing drugs or alcohol.

What to do if a young person discloses that they have, or intend to, self-harm, express suicidal thoughts or you have concerns and need to approach them

Protective and supportive action the general approach to be taken

What matters for many young people is having someone to talk to, a trusted adult, who will take them seriously. Previous studies have found that most people want to be able to talk about self-harm and help young people but do not have the language/vocabulary to communicate effectively.

Try to find out about not only the risks and vulnerabilities but also about any strengths and protective factors (see Appendix 3).

A supportive response demonstrates respect and understanding together with a non-judgmental stance, focusing on the person, not what they have said or done.

Remember, most young people who self-harm:

- Do not have mental health problems – they are feeling overwhelmed and have no other means of managing their emotions.
- Feel shame and stigma – it may not be easy for them to talk about it.

Do	Don't
Listen and care. This is the most important thing you can do. It might not seem much, but showing that you want to know and understand can make a lot of difference. They may find it more helpful if you focus on their feelings, and this shows that you understand that, at that time, self-harm works for them when nothing else can.	Tell them off (e.g. this behaviour is wrong') or punish them in some way. This can make the person feel even worse, so it could lead to more self-injury.
Accept mixed feelings. They might hate their self-harm, even though they might need it. It helps if you accept all of these changing and conflicting feelings.	Jump in with assumptions about why they are self-harming. Different people have different reasons, and it's best to let them tell you why they do it.
Help them find further support. They may need help in addition to what you can give - you can support and encourage them in finding this.	Blame them for your shock and/or upset. You have a right to feel these things, but it will not help if you make them feel guilty about it.
Show concern for their injuries. If the person shows you a fresh injury, offer the appropriate help in the same way as if it was an accident. Don't overreact just because it is self-inflicted.	Treat them as mad or incapable. This takes away their self-respect and ignores their capabilities and strengths.
Help them find alternatives to self-harm (there are lots of distracting techniques in section 4 in the Toolkit)	Avoid talking about self-harm. It won't make it go away but will leave them feeling very alone
	Ask them to promise not to self-harm. This will not work but is likely to put a lot of emotional pressure and can set them up to feel guilty.
Voice any concerns you have. Make sure you also listen to their feelings about what they want to happen. Work out together a way of taking care of their health and safety.	Try to force them to stop self-harming. Doing things like hiding razor blades or constantly watching them doesn't work and is likely to lead to harming in secret, which can be moredangerous.
Recognise how hard it may be for them to talk to you. It may take a lot of courage for them to discuss their self-harm and feelings, and it may be difficult for them to put things into words. Gentle, patient encouragement can help.	Panic and overreact. This can be very frightening for the person. It is better to try and stay calm and take time to discuss with them what they would like you to do for them or the next steps they'd like to take.

Simple things you can say:

‘I’ve noticed that you seem bothered/worried/preoccupied/ troubled. What has happened?’

‘I’ve noticed that you have been hurting yourself. What has happened to you?’

Conversation prompts	
Topic	Possible prompt questions
Confidentiality	“I appreciate that you may tell me this in confidence, but it’s important that I let you know that your safety will always be more important than confidentiality. If I am sufficiently worried that you may be feeling unsafe or at risk of hurting yourself, part of my job is to let other people who can help you know what’s going on, but I will always have that discussion with you before and let you know what the options are so that we can make these decisions together.”
Starting the conversation/ establishing rapport	“Let’s see how we can work this out together. I may not have the skills to give you the help you need, but we can find that help for you together if you would like.” Use active listening - for example: “Can I just check with you that I have understood that correctly?”
The nature of the self-harm	“Where on your body do you usually self-harm?” “What are you using to self-harm?” “Have you ever hurt yourself more than you meant to?” “What do you do to care for the wounds?” “Have your wounds ever become infected?” “Have you ever seen a doctor because you were worried about a wound?”

Reasons for self-harm	"I wonder if anything specific has happened to make you feel like this or whether there are several things that are going on at the moment? Can you tell me a little more?" For example, peer relationships, bullying, exam pressure, difficulties at home, relationship break-up or substance misuse or abuse.
Coping strategies and support	"Is there anything that you find helpful to distract you when you are feeling like self-harming? Perhaps listening to music, playing on your phone, texting a friend, spending time with your family, reading or going for a walk?" "I can see that things feel very difficult for you at the moment, and I'm glad that you have felt able to talk to me. Is there anyone else that you have found helpful to talk to before, or is there anyone you think may be good to talk to? How would you feel about letting them know what's going on for you at the moment?" "How could we make things easier for you at school?" "What feels like it is causing you the most stress at the moment?" "What do you think would be most helpful?"

Speaking to parents (where appropriate)	"I understand that it feels really hard to think about telling your parents, but I am concerned about your safety, and this is important. Would it help if we did this together? Do you have any thoughts about what could make it easier to talk to your parents?"
Ongoing support	"Why don't we write down a plan that we have agreed together? Then you will always have a copy that you can look at if you need to remind yourself about anything. Sometimes when you are feeling low or want to self-harm, it is difficult to remember the things you have put in place - this can help remind you".

When hospital care is needed

When a young person requires hospital treatment in relation to physical self-harm, clinical practice should comply with NICE guidance.

- Triage, assessment and treatment for under 16's should take place in a separate area of the Emergency Department.
- All children and young people should normally be admitted into a paediatric ward under the overall care of a paediatrician and assessed fully the following day with input from the Child and Adolescent Mental Health Service (CAMHS).
- Assessment should be undertaken by healthcare practitioners experienced in this field.
- Assessment should follow the same principles as for adults who self-harm but should also include a full assessment of the family, their social situation, family history and safeguarding issues.

Any child or young person who refuses admission should be reviewed by a senior Paediatrician in the Emergency Department and, if necessary, their management discussed with the on-call Child and Adolescent Psychiatrist.

Follow Up

Having dealt with any immediate medical problem, make sure there is proper follow-up and provide a report using your agency's incident form.

- Seek advice and support for yourself from your line manager, safeguarding lead, CAMHS or other source.
- Contact the young person's parents/carers, unless it places the young person at further risk.
- Provide advice and written information on the nature of help, helplines and other sources of advice and support.

Consider the need for:

- Early Help Assessment – consider if / what support is needed for the wider family.
- referral to CAMHS.
- referral to children's Social Care where there are serious or complex needs or child protection concerns.
- Ensure information is shared appropriately.
- Ensure that there is a plan to provide help and support and that the young person understands it.
- Follow your agency's own local policies safeguarding children procedures regarding confidentiality, recording, identification of needs and decision-making, including determining whether an early help assessment or referral to children's Social Care is needed.
- Record what has happened and what needs to happen next, following your own agency's procedures.

Confidentiality and Information Sharing

Young people will be concerned that they do not lose control of the issues they have disclosed. They will be concerned that sensitive and personal information is not shared without their agreement. Where it is shared, with or without their agreement, they will be concerned that it is properly safeguarded and not misused. This is often expressed as a request for confidentiality.

At the earliest, suitable time, there needs to be a discussion with the young person about who needs to know what and why. It needs to be explained in terms of:

- seeking help from relevant agencies and professionals.
- ensuring those who need to know (such as teachers/pastoral care, GP's) can be understanding and supportive.
- parental expectations that information they need to have is not withheld from them – except where there are concerns about parenting, outcomes for young people are invariably better with parental engagement.

Where a young person is withholding their consent, professional judgment must be exercised to determine whether a child or young person in a situation is competent to consent, or to 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 young person, especially if they are distressed and anxious, may not appreciate the seriousness of the risks they are taking and the harm that might occur and not be judged competent to make decisions at that point about who needs to be told what.

The Fraser guidelines Gillick Competency Fraser Guidelines should be used to determine whether information should be shared without agreement in circumstances where:

The situation is urgent, and there is no time to seek consent.	There is a pressing need to share the information.
Seeking consent is likely to cause serious harm to someone or prejudice the prevention or detection of serious crime.	Sharing information with parents would prevent the young person from engaging with services.
The risk is sufficiently great to outweigh the harm or the prejudice to anyone which may be caused by the sharing.	

Best practice would always be to share and include parents in interventions, whenever this is possible and in the best interests of the children and young people. However, if a competent child wants to limit the information given to their 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.

Next Steps

Consider convening a meeting to consider the need for an early help assessment at a mutually convenient time and place within the school environment or other setting where the young person feels comfortable. Invite representation from the relevant services. Be clear about information sharing.

Help the young person to:

Express their needs and what would be helpful.	Build up resilience and/or self-esteem.
Identify his or her own support network, e.g. using protective behaviours.	Find a safer way of managing the problem, e.g. talking, writing, drawing or using safer alternatives.
If the person dislikes him or herself, begin working on what he or she does like. If life at home is impossible, begin working on how to talk to parents/carers.	Provide information about advice on support agencies, including websites and advice on which are safe and recommended.
Stay safe and reduce the risk of self-harm e.g. • washing implements used to cut • avoiding alcohol/other substances if it's likely to lead to self-injury • taking better care of injuries (the school nurse may be helpful here)	In line with your agency's procedures, ensure full recording of all meeting, contacts with the young person, concerns and actions taken in response. Ensure meetings are recorded, agreed actions circulated, and review dates adhered to.

Working with friends and peers

These can often be the first to recognise the signs and symptoms of self-harm amongst their group.

- It is important to encourage young people to let you know if one of their group is in trouble, upset or shows signs of harming.
- Friends can worry about betraying confidences, so they need to know that self-harm can be dangerous to life and that by seeking help and advice for a friend they are taking a responsible action.
- They also need to know that they can seek advice without disclosing the identity of the young person in question – should a serious risk requiring such a disclosure arise, it can be addressed as necessary
- Peers can play an important part in protecting a young person from harm

Occasionally concerns may arise in relation to self-harming behaviours occurring within a group context.

Self-harm and group contexts

Settings which work with young people in groups, especially schools, need to be alert to the possibility that peers/close contacts of a young person who is self-harming may also behave in a similar way. Occasionally, schools discover that several students in the same peer group are harming themselves. **Some young people, for example, get caught up in mild repetitive self-harm, such as scratching, which is often done in a peer group. In this case, it may be helpful to take a low-key approach, avoiding escalation, although at the same time being vigilant for signs of more serious self-harm.**

Self-harm can become an acceptable way of dealing with stress within a peer group and may increase peer identity. This can cause considerable anxiety both in staff and in other young people. Pro-active steps such as using PHSE in schools to engage young people in dialogue about the stresses and pressures that some young

people seek to manage through self-harm is an effective way of encouraging young people (and their peers) to seek early help and of building resilience.

- Each young person will have individual reasons for self-harming which should be assessed individually leading to an individual action plan - professionals must not assume that all the young people involved have the same needs and respond in the same way.
- There may be evidence that group dynamics/pressures are an additional factor in determining/ maintaining the behaviours - social media and electronic communications will need to be considered as part of overall picture including young people accessing websites supporting self-harm but may also be used as a positive influence.
- Where there is any evidence suggesting that the self-harm is wholly or in part "group behaviour", the advice of both safeguarding and CAMHS needs to inform an action plan.
- It may be helpful to convene a meeting to discuss the matter openly within the group of young people involved. In general, however, it is not advisable to offer regular group support for young people who self-harm.

Working with young people who Self Harm – Understanding what maintains Self Harm behaviours

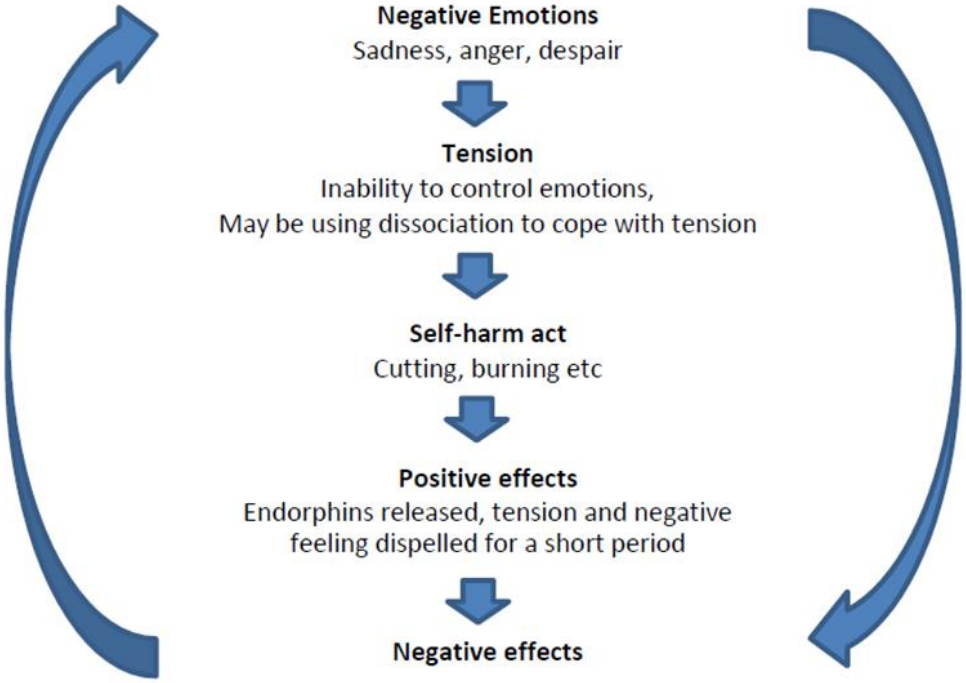
Self-harm behaviour in young people can be transient and triggered by stresses that are resolved quickly. Others, however, develop a longer-term pattern of behaviour that is associated with more serious emotional/mental health difficulties.

The more underlying risk factors that are present, the greater the risk of further self-harm. Once self-harm, particularly cutting behaviours, are established, it may be difficult to stop. Self-harm can have several purposes for young people, and it becomes a way of coping, for example:

- by reducing in tension (safety valve)
- a distraction from problems
- a form of escape
- outlet for anger and rage
- opportunity to 'feel real'
- way of punishing self
- way of taking control
- to not feel numb
- to relieve emotional pain through physical pain
- care-eliciting behaviour
- means of getting identity with a peer group
- non-verbal communication (e.g. of abusive situation)
- suicidal act
- shame and guilt over self-harm act

The cycle of self-harming/cutting

When a person inflicts pain upon him- or herself, the body responds by producing endorphins, (which are like the drugs opium and heroin) a natural pain-reliever that gives temporary relief or a feeling of peace. These chemicals are released when a person feels in danger, experiences fear and particularly when the body is injured in any way. They produce insensitivity to pain that will help the individual survive when having to deal with danger. The addictive nature of this feeling can make the stopping of self-harm difficult. Young people who self-harm still feel pain, but some say the physical pain is easier to stand than the emotional/mental pain that led to the self-harm initially.



Coping Strategies

Replacing the cutting or other self-harm with safer activities (Distraction Strategies) can be a positive way of coping with the tension. What works depends on the reasons behind the self-harm. Activities that involve the emotions intensively can be helpful. Successful distraction techniques include:

- Using a creative outlet e.g. writing poetry & songs, drawing, collage, or artwork and talking about feelings.
- Using stress-management techniques, such as relaxation.
- Having a bath.
- Reading a book.

- Looking after an animal.
- Writing a diary or journal.
- Writing negative feelings on a piece of paper and then ripping it up.
- Talking to a friend (not necessarily about self-harm).
- Going online and looking at self-help websites or ringing a helpline.
- Using a red water-soluble felt tip pen to mark instead of cut; *(the butterfly project)*
- Scribbling on a large piece of paper with a red crayon or pen.
- Hitting a punch bag to vent anger and frustration.
- Rubbing ice instead of cutting.
- Putting elastic bands on wrists and flicking them instead of cutting.
- Getting out of the house and going to a public place, e.g. a cinema.
- Going into a field and screaming.
- Physical exercise or going for a walk/run.
- Listening to loud music.
- Making lots of noise, either with a musical instrument or just banging on pots and pans.

For some young people, self-harm expresses the strong desire to escape from a conflict of unhappiness. In the longer term, the young person may need to develop ways of understanding and dealing with the underlying emotions and beliefs. Regular counselling/therapy may be helpful. Family support is likely to be an important part of this. It may also help if the young person joins a group activity such as a youth club, a keep-fit class or a school-based club that will provide opportunities for the person to develop friendships and feel better about him or herself. Learning problem solving and stress- management techniques, ways to keep safe and how to relax may also be useful. Increasing coping strategies and developing social skills will also assist.

These strategies should always be used alongside addressing the underlying reasons for the behaviour.

CAMHS and Clinical interventions

It is now evident that adolescent self-harm is an important indicator of future mental health status in young adulthood. Adolescents who report self-harming behaviour (regardless of whether they report suicidal intent) should be carefully followed-up to assess their need for support and treatment. Interventions should not only focus on reducing self-harm, but should also treat the anxiety, depression and substance use problems that may accompany self-harming behaviour.

All young people who have self-harmed in a potentially serious way should be assessed in hospital by a CAMHS specialist. This is necessary for the management of medical issues and to ensure young people receive a thorough psycho-social assessment.

A small number of young people will be at high risk of developing a serious and persistent pattern of repeat/high risk self-harm behaviours which may be linked to co-morbid mental health conditions. These are a priority group within specialist CAMHS services. The evidence base on interventions for self-harm is not very conclusive, but it seems likely that interventions based on a problem-solving approach such as Cognitive Behavioural Therapy or Dialectic Behaviour Therapy (DBT) or which teach new methods of coping and that offer brief but swift response to crisis, will prove helpful. It is also suggested that using several different interventions tailored to meet the individual young person's needs as part of an ongoing care plan may provide a good response.

- The problem-solving approach can also be extended to involve the whole family.
- Pharmacological interventions for this age group are generally discouraged.
- Ensuring young people know where to go for quick access to help if they require support or are hurt is very important.
- A crisis intervention model is often most appropriate. Compliance, however, can be a problem because the self-harm may have a positive effect by providing temporary relief from a difficult situation. Also, take-up of treatments depends largely on parental background and attitudes.
- Group work can also help some young people.
- Adolescents who report self-harming behaviour (regardless of whether they report suicidal intent) should be carefully followed-up to assess their need for support and treatment. Interventions should not only focus on reducing self-harm, but should also treat the anxiety, depression and substance use problems that may accompany self-harming behaviour.

Support for practitioners

The needs of practitioners

Practitioners may also experience a range of feelings in response to self-harm in a young person, such as anger, sadness, shock, disbelief, guilt, helplessness, disgust, and rejection. It is important for all work colleagues to have an opportunity to share the impact that self- harm has on them personally and receive help and support. Colleagues need to be open to the possibility that having to deal with self-harm in a young person for whom they have a duty of care may require a member of staff to confront issues within their own lives, past or present, or that relate to someone close to them.

- **It is important that any plan to address a young person's self-harm needs is clear about the expectations of individual staff/practitioners – failing to set limits on the roles of individuals can leave them feeling too responsible for too long.**

- Staff in some settings such as children's homes will have more intensive and enduring responsibilities and may need additional training and access to consultation to support them in their role.

The responsibility of managers and supervisors

Managers/supervisors are responsible for creating a workplace environment where these sensitive issues such as self-harm can be discussed within an atmosphere of openness, mutual trust/respect and reciprocal support and sensitivity. They are also responsible for facilitating access to training on self-harm and encouraging take up. In house training – for example INSET days in schools – provide an excellent vehicle for training the network of staff who need to work together and CAMHS and other services will always aim to respond positively to any such request. An important aspect of prevention of self-harm is having a supportive environment in the school / organization that is focused on building self-esteem and encouraging healthy peer relationships.

Other related issues that can form part of a wider programme will include, anti-bullying, internet safety, child sexual exploitation and substance misuse. Those who have the care of young people on a day or full-time basis have additional responsibilities to build resilience:

- in the young people themselves so they can cope with the ups and downs that they will have to cope with
- in the staff who are the adult's young people are most likely to turn to for help, so they are better equipped to respond positively
- in the agency/organisation through policies and procedures that promote safe and effective practices.
- they also need to be alert to the possibility of self-harm – a young person may conceal injuries such as cuts or present for first aid because they cannot verbalise their need for help.

Appendix

Appendix 1 – NICE Self-Harm Guidance

Self-harm in over 8s: long-term management - https://www.nice.org.uk/guidance/cg133

Self-harm in over 8s: short-term management and prevention of recurrence - https://www.nice.org.uk/guidance/cg16

Self-harm Quality standard - https://www.nice.org.uk/guidance/qs34

Appendix 2 – My Safety Net

There are different categories or types of people in our lives. Try to identify some people in each of the groups below that you would feel most comfortable talking to:

- family and close friends
- friends and people, you see every day
- help lines and professional people you could go to for help.

Also, write into the space below the safety net, the things that you can do yourself to cope with difficult feelings and keep yourself safe. Things I can do myself to cope with difficult feelings:

The following link provides some useful distraction techniques that can help: http://www.nshn.co.uk/downloads/Distractions.pdf

Appendix 3 - A child's legal rights Gillick competency and Fraser guidelines

Taken from NSPCC website: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines

When we are trying to decide whether a child is mature enough to make decisions, people often talk about whether a child is 'Gillick competent 'or whether they meet the 'Fraser guidelines.

The Gillick competency and Fraser guidelines help us all to balance children's rights and wishes with our responsibility to keep children safe from harm.

What do 'Gillick competency 'and 'Fraser guidelines 'refer to?

Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. In 1982 Mrs Victoria Gillick took her local health authority (West Norfolk and Wisbech Area Health Authority) and the Department of Health and Social Security to court to stop doctors from giving contraceptive advice or treatment to under 16-year-olds without parental consent. The case went to the High Court in 1984 where Mr Justice Woolf dismissed Mrs Gillick's claims. The Court of Appeal reversed this decision, but in 1985 it went to the House of Lords and the Law Lords (Lord Scarman, Lord Fraser and Lord Bridge) ruled in favour of the original judgement delivered by Mr Justice Woolf:"...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent." (Gillick v West Norfolk, 1984).

How are the Fraser Guidelines applied?

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Lord Fraser stated that a doctor could proceed to give advice and treatment: "provided he is satisfied in the following criteria:

1. that the girl (although under the age of 16 years of age) will understand his advice.
2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice.

3. that she is very likely to continue having sexual intercourse with or without contraceptive treatment.
4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer.
5. that her best interests require him to give her contraceptive advice, treatment or both without the parental consent." (Gillick v West Norfolk, 1985).

How is Gillick competency assessed?

Lord Scarman's comments in his judgement of the Gillick case in the House of Lords (Gillick v West Norfolk, 1985)are often referred to as the test of "Gillick competency":"...it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. "He also commented more generally on parents' versus children's rights: "parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

What are the implications for child protection?

Professionals working with children need to consider how to balance children's rights and wishes with their responsibility to keep children safe from harm. Underage sexual activity should always be a possible indicator of child sexual exploitation. Sexual activity with a child under 13 is a criminal offence and should always result in a child protection referral.

Appendix 4 - Self harm or Self-Injury in CYP with Learning disabilities

Children and young people with learning disabilities can also show the range of self-harming behaviour s of "typical "children and young people "and the usual risk factors should be assessed

However for children and young people with Learning disabilities who are non-verbal or minimally verbal, this can take the form of hitting or biting themselves, hitting their head against hard surfaces, poking their eyes, scratching themselves, putting their finger in their bottoms or genital areas, This can result in significant tissue damage and injury. Also eating items which are not food (Pica). This could be anything in their environment e.g. twigs, stones, leaves, discarded sweets, batteries, nails, paper, dishwasher tablets etc , This represents a significant risk and families should be advised to have high level of supervision and remove access to high risk items.

In addition, self-injury or self-harm can occur in response to a physical health problem when the child or young person is in pain. it is recommended that an appointment is arranged with their GP or paediatrician.

it is recommended that a referral is made to the local CYPMH service who specialise in the mental health problems of children and young people with Learning disabilities.

For additional resource: https://cerebra.org.uk/download/self-injurious-behaviour-in-children-with-intellectual-disability-2/

Appendix 5 - National advice and helplines

Beat – Beating Eating Disorders Helpline 0345 3641414	Beat provides helplines, online support and a network of UK-wide self-help groups to help adults and young people affected by eating disorders, difficulties with food, weight or their shape. www.b-eat.co.uk Youthline 0345 634 7650 (Mon to Fri 4.30pm to 8.30pm and Sat 1pm - 4.30pm)
Childline Freephone 0800 1111	The UK's free NSPCC 24hrs helpline, online chat and message boards for children and young people under 18. www.childline.org.uk
Children's Legal Centre (CORAM) Child Law Advice Service 0300 3305485	A charity that promotes children's rights and gives legal information, advice and representation to children and young people www.childrenslegalcentre.com
FamilyLives Helpline service 0808 800 2222	Provides information, guidance, advice and support in all aspects of family life, including bullying. www.familylives.org.uk
Talk to FRANK Helpline 0300 123 66 00 (24 hours)	Friendly confidential drug advice. www.talktofrank.com
Get Connected Freephone 0808 808 4994	Free, confidential telephone helpline service for young people, who need help but don't know where to turn www.getconnected.org.uk
Harmless	Support providing a range of services about self-harm including support, information, training and consultancy to people who self-harm www.harmless.org.uk/
Hearing Voices Network 0114 271 8210	Information and support for people who hear voices, see visions or have other unusual perceptions www.hearing-voices.org
Karma Nirvana Helpline 0800 5999247	Supporting victims of honor crimes and forced marriages www.karmanirvana.org.uk
LifeSIGNS	Self-injury guidance and Network Support www.lifesigns.org.uk
MIND MIND Infoline 0300 123 3393	Advice, information and support for anyone experiencing a mental health problem www.mind.org.uk
National Self-Harm Network	On-line support forum for people who self-harm, provides free information pack to service users www.nshn.co.uk
NSPCC professional's helpline 0808 800 5000	Information, advice and support services about preventing child abuse. www.nspcc.org.uk
PAPYRUS Prevention of Young Suicide HOPEline UK 0800 068 41 41	Provides a range of services including information, advice and support to help reduce young suicide www.hopelineuk.org.uk
RU-OK	Helping young people helping themselves - coping with common, and sometimes serious problems, as well as using your strengths www.ruok.org.uk
Samaritans Free helpline 116 123	Confidential emotional support for anybody in crisis. Samaritans volunteers listen in confidence to anyone in any type of emotional distress, without judging or telling people what to do www.samaritans.org.uk
The Butterfly Project	An anonymously run blog supporting young people with coping techniques which include drawing butterflies around cut marks. www.butterfly-project.tumblr.com
The Site	An online 24/7 guide to life for 16 to 25 year-olds. It provides non-judgmental support and information on everything from sex and exam stress to debt and drugs. Online advice, forums apps and tools www.thesite.org
Young Minds Parent helpline 0808 8025544	Range of information, advice, support services for young people, parents and professionals to improve the emotional well-being and mental health of children and young people. For young people http://www.youngminds.org.uk/for_children_young_people