

Policy Document Control Page

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Self-Harm:

Guidelines for the Assessment And Management of Self Harm

Part 1

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1. Introduction

Pennine Care NHS Foundation Trust is committed to providing the highest standard of collaborative care for Service Users and their Carers with mental health and substance misuse problems, believing safety is at the centre of good healthcare. The trust recognises the importance of clinical risk assessment for all Service Users and the effective risk management for those who may present an increased risk to themselves.

The trust is committed to support Service Users their Carers and clinical services by adopting a systematic and shared approach to risk assessment and management of Self Harm at individual practitioner, team and organisational levels. Embedding key principles and processes of generic risk assessment and management in relation to self harm and specifically the service users recovery in day to day practice, enables staff to deliver empathetic support with effective objective assessment and management of the risk of Self Harm.

2. Principles

The NICE Guidelines define broad principles that all services should meet, they include:

- People who self harm need to be treated with the same care respect and privacy as any other service user. In addition healthcare professionals should take into account the likely distress associated with self-harm to the patient and others, whether or not apparent
- Wherever possible service users who have self harmed should be offered the choice of male or female staff for both assessment and treatment
- Service users who have self-harmed should be offered full information about the treatment options by health professionals
- Self-harm is poorly understood by many National Health Service Staff. All healthcare staff who comes into contact with service users who self harm need dedicated training to better understand self ham and improve the treatment and care provided
- Providing treatment and care for service users who have self-harmed can be emotionally demanding and requires a high level of support. All staff undertaking this work should have regular clinical supervision (see Clinical Supervision Policy)

- When assessing service users who have self-harmed health care professionals should ask them to explore their feelings and understanding of their own self-harm in their own words
- When caring for service users who repeatedly self harm, healthcare professionals should be aware that triggers for self harming might be different on each occasion and therefore each episode needs to be assessed individually
- Healthcare should involve service users who self harm and where appropriate and with informed consent their carers and/or family in all discussions and decisions made about their treatment and care
- Healthcare professionals should take steps to understand how equality and diversity issues in relation to self-harm
- Healthcare staff should consider special issues for older people who have self harmed, by following the same principles as for the assessment for adults but also include a full assessment with special attention to the possible presence of depression, cognitive impairment, physical ill health, their social and home situation. All acts of self-harm in people over 65 should be taken as evidence of suicidal intent until proven otherwise
- Service users who have self-harmed should receive a comprehensive assessment of needs and risk. Referral for further assessment and/or treatment should be based upon a comprehensive assessment
- All staff that has contact in the emergency situation with service users who have self harmed should be adequately trained to assess mental capacity and to make decisions about when treatment and care can be given without consent and know how to access specialist advice about the Mental Health Act.

3. Purpose

The purpose of these guidelines is to set out a good minimum standard of clinical risk assessment and management practice of Self Harm, which should be facilitated jointly and explicitly with all service users. The framework aims to ensure service users receive equitable, quality, evidence based intervention so to reduce the risk of self-harm and reduce the number of self harm incidents. The framework and key principles will assist practitioners in all service areas working with varying client groups within Pennine Care to apply specialist evidence base to the process. It should be read in conjunction with the following Pennine Care policies:

- Care Programme Approach Policy
- Supervision Policy (clinical)
- Clinical Risk Assessment and Management Policy
- Observation Policy
- Incident reporting Policy
- Mental Capacity Act Policy
- Mental Health Act Policy
- Safeguarding Adults Policy
- Search of Patients and Property Policy

The policy also takes into consideration the requirements set out by the following publications:

- 'Best practice in managing risk' Department of Health clinical guidelines (1)
- 'Short-Term Physical and Psychosocial Management and Secondary Prevention of Self-Harm in Primary and Secondary Care' National Institute for Health and Clinical Excellence-Self-harm (2)
- Revised Guidance on Assessment following Self Harm in Adults, The Royal College of Psychiatrists (4).

The principles of good clinical risk assessment and management of self-harm described in this policy are relevant to all health and social care staff in all clinical areas working in Pennine Care and all staff should be aware of these standards of good practice. The standards of practice and training set out in this policy specifically relate to practitioners who have responsibility for assessing and managing individual service user risk of self harm e.g. Primary/Named Nurses, Care Coordinators, Key worker, Assessment Officer, Doctors, Social workers, Occupational Therapists.

4. Roles & Responsibilities

Pennine Care recognises that it cannot realistically expect or achieve risk elimination. However the Trust expects that all efforts will be made to achieve risk minimisation.

It is the responsibility of the:

Chief Executive

To ensure arrangements and resources are in place for the provision of clinical risk management processes within the Trust.

Overall management of clinical risk management will be the responsibility of the Director of Nursing and Operations including the implementation of the Trust Suicide Prevention and Self Harm Strategy, appropriate training and performance management.

Head of Patient Safety

Risk management activity within the Trust will be coordinated by the Head of Patient Safety. Incidents of self harm and suicide are reviewed at the Trusts Patient Safety Improvement Group review and lessons learnt discussed at the Suicide Prevention and Self Harm (SPSH) working group. The SPSH working group monitors the Trusts Strategy and Action Plan for reducing suicides. The Action Plan is reviewed and maintained by the SPSH representatives.

Services Managers, Ward Managers and Team Leaders

Service managers, ward managers and team leaders are responsible for the implementation of the risk management and suicide prevention strategies within their service areas.

Managers

In addition Managers are responsible for ensuring that appropriate training is made available to all professional groups, i.e. Clinical Risk Assessment Training Programme every three years. This is included in the Principles of Governance and STORM training provided by the Trust

Staff

It is the responsibility of all staff to ensure that they undertake and or contribute to formal risk assessment for service users, complete relevant documentation required within the risk assessment procedure and contribute in the formulation of a risk

management plan. Staff are responsible to attend the approved training in order to do so.

It is the responsibility of all staff in contact with Service Users to be aware of risk issues and to report these concerns on to the relevant professional or line manager for action.

Service Users and Carers also have a responsibility (to an appropriate level) in seeking help when they self-harm and using creative ways to manage their distress.

5. Self Harm

Definition

“an act with non-fatal outcome, in which an individual deliberately initiates a non habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences” (NICE Guidelines, 2004 2011).

Methods of Self-Harm

Methods of self-harm includes poisoning, asphyxiation, cutting, scratching, pinching, mutilation, burning, self striking, biting body parts, consuming non edible substances and other self inflicted injuries.

Incidence of Self-Harm

Self-harm is a very common reason for hospital presentation; the Registrar Generals figures for England and Wales for 2003 indicate 170,000 people presented to general hospitals for parasuicide. People who have self-harmed represent 4% to 5% of all A&E attendances, and self-harm is one of the top five causes of acute medical and surgical admissions in the UK, (11, 12). Although it is suggested the majority of episodes of self-harm never reach the health service (13).

Discussion

There is often controversy about the terminology used to describe an act of self-harm as defined above; disagreements generally revolve around the degree and kind of intent required. Descriptive labels found in literature include Deliberate Self Harm (DSH), Para suicide, Para suicidal behaviour, non fatal self harm, and more pejorative labels like suicide gestures and manipulative suicide attempts are present and their use has been argued to create blame and dislike toward the service user (5). For the purpose of these guidelines the term self harm will be used.

Self-harm has been the subject of extensive sociological, epidemiological, psychological, biological and clinical study, research and speculation (4). The suggested reasons why people utilise self-harm and the theories about the development of what mediates such behaviour vary. Service users can utilise self-harm as a coping strategy to deal with difficult emotions and challenging situations and has been associated with the particular groups such as adolescents, service users with enduring mental illness, personality disorder or substance misuse and the victims of abuse.

People who self harm often say that injuring themselves can make them feel better very quickly and for some people is an effective way of dealing with the pain in their lives. It is for this reason that self harm is not always a form of suicidal behaviour and can paradoxically be a way of surviving.

For all of us, if our quality of life were to fall too low in terms of basic psychosocial standards, the risk of suicide would increase. This is often clear by the fact that people often commit suicide even when they have had a good enough developmental background and are perfectly fit and well physically but have lost all current meaningful psychological and social connections.

Links to good supervision, management and space for reflection are essential organisational sources to support clinical staff.

With direct clinical care the accessibility and quality covering partner relationships, work related relationships, family attachments, friends and social and professional attachments including the assessing service are important factors that without will influence internal resilience or mental health. In the same way without some degree of internal resilience no amount of externally available care and support can really make an impact. Even a good psychotherapy relationship however skilled and compassionate may not always be enough.

One of the key elements in the assessment and management of risk is the development of a trusting relationship and knowledge of the individual. It is clearly evident that encouraging individuals to talk about their experience is an essential component of therapy and the receptivity of staff to recognise the despair, distress of service users without invalidating the service users experience is paramount.

6. Risk Assessment of Self-Harm

The Comprehensive Risk Assessment Self Harm

All Service users who present with threat of or incidents of Self Harm should receive a full risk and psychosocial assessment; the findings of risk assessment of self-harm should be documented.

Risk assessment is integral to deciding on the most appropriate level of risk management and intervention with a service user, whereby the assessor aims to

make every effort to achieve harm minimization. Best practice of risk assessment is a decision based on the knowledge of research evidence, knowledge of the individual Service User and their social context, the Service users own experience and clinical judgement.

Assessment of Self Harm should be conducted in conjunction with the risk domains of violence/risk to self and others, serious self neglect, vulnerability and exploitation and substance misuse in line with the Trusts approved risk assessment tool and training guidance.

When assessing the risk of self harm particular consideration should be given to the risk assessment of suicide and the evidence that previous and present acts of self harm increase the risk of suicide, assessors should established whether the intent of self harm was to cope or carry out suicide (see table of risk factors which research consistently indicates a high risk for suicide in Pennine Care Clinical Risk Assessment and Management Policy page 14).

Some Salient factors to assess about the intent of self-harm would be ambivalence toward dying, hopelessness, relationship problems, debt, physical health and chronic pain, anniversaries, significant events and mental state in conjunction with the following factors being evident: These would be relevant across all age groups

Potential lethal method – attempted hanging

- Attempted to conceal – discovered
- Denying or trivialising serious attempt
- Procuring the means – purchased rope
- Detailed plan / tested out
- Recently made a will
- Written suicide note
- Sold or given away possessions
- Risk assessment should form the following process:
 - Assessment
 - Establish Risk Level
 - Develop Formulation

- Risk Management Planning
- Communication of plans to all relevant agencies or parties
- Implementation of plans
- Evaluation and review of plans and planned reassessment .

Establishing the level of self-harm risk would involve covering the following aspects of risk with the service user to help estimate each of these aspects (1):

- How likely it is that the event will occur
- How soon it is expected to occur
- How severe the outcome will be if it does occur.

Risk factors should be considered during the assessment process. A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. Risk factors have been categorised in a number of ways (1):

- **Static factors** are unchangeable e.g. history of child abuse or suicide attempts
- **Dynamic factors** change over time e.g. alcohol misuse or attitudes to carers, these can be aspects of the service user or their environment; these factors are more amenable to change
- **Dynamic factors** that are stable and change slowly are called **Stable** or **Chronic** risk factors
- **Acute factors** or **Triggers** change rapidly
- **Change of protective factors (change in personal circumstances e.g. Loss of friend, relative, children).**

When assessing the risk of self-harm the following areas need to be examined in detail:

- Risk factors
- History
- Ideation/Mental State (hopelessness & ambivalence toward harming self or suicide)
- Intent
- Planning

- Preparation.

The assessor should attempt to obtain information from a variety of sources such as the Service User, GP/medical practitioners, family/carer, referrer, friends, care coordinator, medical reports/notes, MDT notes/reports, NCRS (computer records), consideration should be given to any previous names that may have been used or aliases. It is recognised that for service users not previously known to the service, information may be limited; however it is the responsibility of the assessor to make every effort to gain as much information as possible to aid effective risk assessment and management so to identify the support required.

Staff will need to ask questions concerning those that are within the service users home environment, especially children and others they may be providing care to. Consideration should be given to the service users self harming behaviour and the effects this may have on others and the support that may be required to those that may be vulnerable within the home environment.

All risk & psychosocial assessments should be conducted jointly with the service user in a transparent manner, measurements, outcomes and formulations should be explicitly shared with the service user, carer/family (with consent). Service users opinions about the validity of assessments and formulation should be explored jointly so to inform care planning and further risk management.

Established risk levels can vary from low to high. E.g. **Low** may include having attempted or threatened self harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment, the service user is likely to cooperate well and contribute helpfully to risk management planning and they may respond to treatment; there's a sufficient number of protective factors (e.g. trusting relationship with staff, good response to treatment, supportive carer). To support ongoing desistance from self harm.

High risk or the risk of committing an act either planned or spontaneous which is very likely to cause serious harm, with few or no protective factors to mitigate or reduce that risk and requires long term risk management, including planned supervision and close monitoring or organised treatment.

All assessment, formulation and care planning decisions should be discussed in a multi disciplinary team when available (MDT), operating an open, democratic and transparent culture that embraces reflective practice, notes are to be recorded, and care planning is agreed jointly with the service user and their carers.

However if due to operational reasons or the time of assessment is out of hours and an MDT is unavailable, following a full risk and psychosocial assessment the outcome and proposed care planning decisions for an inpatient who has self harmed or voiced ideas to do so should be discussed jointly with the individual service area

on call clinical manager or identified deputy medical personnel who can facilitate advice from the on call Psychiatrist if required.

In each case of non admitted previously known or unknown Service User presenting who has self harmed or voice ideas to self harm and following assessment by a medical practitioners (e.g. in A&E) practitioners should conduct a joint full risk and psychosocial assessment. Both should have received relevant training in risk assessment. It is recognised that not all Service Users who self harm require hospital admission, at the point consideration should be given as whether any of the following interventions are required:

- Access and Crisis /Home Based Treatment Team referral
- Community Mental Health Team referral
- Primary Mental Health Care Team referral
- Signposting to voluntary organisation e.g. MIND, Samaritans contact details given
- Hospital Admission
- General Practitioner referral
- Care Coordinator referral
- Carer or Family support (with consent).

Treatment options could include personal problem solving techniques, coping strategy enhancement, crisis prevention planning and distraction techniques. These techniques may be given by services including inpatients, crisis resolution home treatment teams, psychological therapy and community mental health teams.

Joint Partnership work Samaritans

From December 2014 the Trust has arranged with Samaritans that people who have been assessed by our services in A&E, or as part of a crisis response, if following that assessment no further contact is planned by mental health services they will be contacted by the Samaritans within 48 hours. The service user can opt out of receiving the call from the Samaritans.

The purpose of the contact will be to offer service users support and a listening ear. Only the service user's first name, telephone number, and preferred time of contact will be given to the Samaritans. No diagnosis or details of assessment or treatment will be given.

The Samaritans will not leave a message if the call is not answered or answered by someone else and the details will remain confidential to them. This means Samaritans will not contact mental health services or discuss the call. However the Samaritans will offer assistance or advise the service user where appropriate

NICE guidelines require that a health care professional conducts and records a comprehensive assessment of psychosocial needs for every service user who self

harms and presents to a health service. The need assessment would normally include information upon the service users:

- Current problems
- Social situation (living arrangements, work, social isolation)
- Financial problems (debt)
- Family network
- Diversity (age, race, faith, gender, disability, sexual orientation)
- Physical ill health
- Personal relationships
- Recent life events, current difficulties or triggers that preceded self harm
- Psychiatric history (diagnosis, previous treatments)
- Past history of self harming behaviour (trends, patterns, relapse signature)
- Current Self harming behaviour and its implications to self or others
- Current Alcohol & substance misuse
- Coping resources and available support (protective factors what might help to reduce risk)
- Concern expressed by others
- Current mental state examination (psychiatric disorder, mood, psychosis, hopelessness, ambivalence about risk to self from self harm-possible suicide)
- Enduring psychological characteristics associated with self harm
- Function of behaviour
- Detailed account of the circumstances and motivation for the act
- Most appropriate aftercare
- Service users willingness and engagement with assessment & treatment
- Service user receiving abuse or the victimisation of others.

7. Risk Management of Self Harm

Accident and Emergency Staff contact

NICE guidelines (1) recommend all people who have self-harmed should be offered a preliminary psychosocial assessment at triage or the initial assessment in primary or community settings. The standard for a psychosocial assessment should be completed within four hours of referral and that Psychiatric assessment when required to commence within four hours.

Comprehensive Risk Management of Self-Harm

Multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice should develop risk management plans.

Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user

requires a consistent and individualised approach. With this in mind it is worth recognising that transition points defined within the Care Programme Approach Policy where service users are transferred to different care coordinators, teams and services may increase the risk of self harm especially if the service user views the change as negatively or even rejection. Equally non acceptance and waiting times following referrals to services can have an impact.

Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

Knowledge and understanding of mental health legislation is an important component of risk management. The assessment of capacity can become an important issue if the service user who refuses medical treatment for the physical sequelae of the self-harm. All registered Doctors should be able to assess capacity; in cases of self-harm this can be difficult as capacity may be temporarily impaired by the service users' mental state.

Learning from trust investigations has highlighted recommendations that decision-making following a full risk and psychosocial assessment should not be made unilaterally.

Following a full risk and psychosocial assessment the Trust risk formulation and management plan should be completed or updated identifying situations in which identified risks may occur, and the actions to be taken by practitioners and the service user in response to negative change, reassessment should be planned. This information should be communicated with all professionals involved and where consent is obtained to carers or family in the process of ongoing care or as a discharge.

Sharing Decision making with Service Users and Carers

Each stage along the process of developing a risk management plan should be based on discussions with the service user and those involved in their care, the service user should be given the opportunity to have a lead role in identifying risk from their own perspective and when it comes to devising plans to deal with difficult situations indicating the service users preference of the type of support.

Staff will need to discuss the options of support available with the service users and carer/relative to determine the management plan. The Trust has developed leaflets that give information that includes advice and support to the service user and their relatives following an incident of self harm. The details of these are included in appendix 1 and 2

Positive Risk Management

Positive risk management incorporates the service users' quality of life and plans for recovery, whilst remaining aware of the safety needs of the service user, their carer and the public (1). Concepts of positive risk management include:

- Working with the service user to identify what is likely to work
- Ensuring that the service user carer and others who might be affected are fully informed of the decision, rationale for it and associated plans
- Weighing up the potential benefits and harm of choosing one action over another
- Paying attention to the views of carers and others the service user when deciding on a plan
- Being willing to take a decision that involves an element of risk due to the potential positive benefits outweigh the risk
- Being clear to all involved about the potential benefits and the potential risks.
- Giving advice on behaviours to reduce the risk in self harming
- Clear self harm approach that includes risk assessment, crisis management, problem solving and self help skills.

For individuals who use self harming as a way of a coping mechanism it should be recognised that this is only a temporary and surface strategy and it can in the longer term increase as what begins as a means of staying in control becomes out of control itself.

The person should not be forced into unrealistic bargains and it is often difficult for someone who is self harming to stop immediately and can potentially put them at greater risk. Discussions regarding the methods used, the risks associated with the self harming behaviour and whether the risks can be mitigated if the client can not stop immediately should be documented within the risk assessment and care plan

Positive risk taking could involve making a decision not to admit someone to an inpatient ward because the risk of them being on the ward outweighed the risks posed if they are treated in the community. In these circumstances effective management of the short term risks could lead to longer term gains for the service user. However due to the potential risks of such an approach any decision to proceed must be based on the service user having the capacity to engage in the agreed plan of care, and a detailed knowledge of the service users past history, their current self harming and the service users' ability to develop alternative coping mechanisms.

In such cases the multidisciplinary team, service user and their carers (subject to consent) should be involved in the decision and in agreement with the plan of care. All discussions must be documented and detailed in the clinical notes, risk assessment and a detailed care plan agreed.

Consent

Staff often face difficult decisions about whether they should intervene to provide treatment and care to a person who has self harmed and then refuses help. Not only are these decisions difficult they can provoke disagreements between staff.

The concept of mental capacity is central to determining whether treatment and care can be given to a person who refuses it. The Mental Capacity Act (2005) gives clear definition of capacity and best interests how to measure and record decisions which staff should refer to

A person may lack capacity to make the decision in question because of either long term mental disability or because of temporary factors such as unconsciousness, confusion or effects of fatigue, shock, pain, anxiety, anger alcohol or drugs. If a person has capacity to make the decision then this decision must be respected even if a refusal may risk permanent injury or death to that person.

Compulsory treatment can include medical and surgical treatment for the physical consequences of self poisoning or self injury if the self poisoning or self injury can be categorised as either the consequence of or a symptom of a patients mental disorder, providing it can be shown and recorded that the person lacks capacity and the treatment satisfies the conditions best interests as defined by the Mental Capacity Act (2005)

8. Diversity & Risk Assessment & Management of Self Harm

All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

Treatment for the physical consequences of self-harm

NICE guidelines for self-harm state healthcare staff should offer treatment for the physical consequences of self-harm, regardless of the Service Users willingness to accept psychosocial assessment or psychiatric treatment.

Appropriate medical personnel should be alerted or accessed to provide medical assessment and treatment as deemed necessary, whether this is facilitated by the Accident & Emergency service, the local or on call medical practitioner.

Learning Disabilities

The prevalence of self-injury in people with Learning Disabilities has ranged from 1.7% - 24%, but in institutional studies rates of up to 41% have been reported

(Cooper et al., 2008). Across all ages, Cooper calculated the overall rate of self-injury as being 3% of over 2000 people with Learning Disabilities in the population. Overall, 24% were considered to self-injure, the majority of whom (67%) were female.

The reasons that a person engages in self-injurious behavior can be wide and varied and will often involve a complex interaction between multiple factors. On one hand, it might be a means of communicating needs, wants or feelings especially if the person is non-verbal. Some self-injurious behavior may indicate underlying mental health issues such as depression and anxiety, especially in people with Mild or Moderate Learning Disabilities. The self-injurious behavior may reflect a coping mechanism to deal with stress similar to the non LD population, but with a lower threshold.

Influencing factors

- Genetically-determined syndromes: Self-injury has been regarded as a core feature of Cridu Chat syndrome (Collins and Cornish, 2002); to have a higher prevalence in people with Cornelia de Lange syndrome than other people with severe learning disabilities generally (Hyman et al., (2002); and to be associated with Lesch-Nyhan Syndrome, Rett Syndrome, Smith-Magenis Syndrome and others (Oliver and Petty, 2002; Mikhail and King, 2001; Deb,1998). It is possible that self-injury is not syndrome-specific but related to underlying brain abnormality or damage (Deb, 1998).
 - Severity of learning disability: an association between self-injury and increasing severity of learning disability has been reported (Cooper et al., 2008; McClintock et al., 2003; Deb et al.,2001; Emerson et al., 1997).
 - Developmental delay: it has been suggested that stereotyped behaviour, potentially a precursor of self-injury (Richman, 2008), may appear later in developmentally delayed children. This would allow the behaviours to be perpetuated and social reinforcement to take place (Symons et al., 2005).
 - Autism: the degree of autism is a risk marker for self-injury – those with more severe autism and associated difficulties were more likely to show more self-injury. The pattern of higher risk included lower age and higher daily living skills delay (Baghdadli et al., 2003; McClintock et al., 2003). This was not found to be the case by Cooper et al., 2008.
 - No speech: the occurrence of self-injury was highest in people with no speech (Baghdadli et al., 2008; McClintock et al., 2003; Deb et al., 2001). This was not found to be the case by Cooper et al., 2008.
 - Pain: congenital insensitivity to pain (Zafeiriou et al., 2004) or the presence of physical pain (Moss et al., (2005). Breau et al., (2003) suggest that children with chronic pain may exhibit self-injury differently from children without pain.
 - Environmental setting: some forms of self-injury were associated with environmental events in individuals with Cornelia de Lange syndrome, but the characteristics of the settings are variable across individuals (Moss et al., 2005).
- Impoverished environments that lack stimulation and where there are poor relationships are also considered to be associated with self-injury (Emerson and Bromley, 1995).

- Oppression: the higher incidence of the use of self-injury by people with learning disabilities is thought to be reflective of the severity and nature of oppression they experience (Jones et al., 2004; Northway, 1998)
- Coping with a difficult set of life circumstances: self-injury could be regarded as a rational response to difficult, sometimes impossible, circumstances (Lovell, 2007) or abusive, neglecting or traumatic environments or events (Halliday and Mackrell, 1998). Self-injury was also regarded as a coping strategy in a study of women with learning disabilities in a secure unit (James and Warner, 2005).

Interventions include The first consideration when thinking about self-injurious behavior is to rule out possible medical or dental problems such as illness, pain, seizure activity or general loss of well-being due to constipation, skin conditions, digestion problems etc.

Positive behavioural support, communication assessments, and interventions, Pharmacological interventions and Psychological Therapies.

The above examples of treatment interventions must be provided in the context of a person centred approach which includes a thorough understanding of the person historical and current experiences, cognition and emotions.

<http://www.selfinjurysupport.org.uk/hidden-pain-self-injury-and-people-learning-disabilities>

9. Incident Reporting

Incidents of self harm are often described by the service user as a way of coping /surviving and there is no intent to end life. For some people it is an effective way of dealing with emotional distress. It is for this reason that self harm is not always a form of suicidal behaviour. For patients managed in community and where this is recognised, as part of the service users coping behaviour, there would not be a requirement to complete an incident form following each episode of self harm behaviour. However for inpatients and in cases where service users have been either referred and received into services and their actions of self harm have been perceived to have been with the intent to end their life, or required medical intervention, the incident must be reported as an incident on the Trust Electronic Incident reporting system.

All incidents of suspected suicide where the service user has been in receipt of services within the last twelve months of the incident must be reported as a grade 5. Please see grading matrix within Incident Investigation and Management Policy.

10. Training

The importance of providing a formal system of Clinical Risk Assessment Training is highlighted in several key documents:

Safety First (2001)

“All staff in contact with patients at risk of suicide should receive training in the recognition, assessment and management of risk, of self harm, suicide and violence, at intervals of no more than three years”.

National Service Framework for Mental Health- standard on suicide prevention

“Training for staff in specialist mental health services and risk assessment management is a priority, and (should be) updated at least every three years.”

The Pennine Care Training Strategy identifies Clinical Risk Assessment Training as mandatory for all services where qualified staff has responsibility to undertake clinical risk assessment and management of clinical risk.

A programme of Clinical Risk Assessment training and STORM training which is specific to self harm is coordinated by the Trust Learning and Development Department. Training dates and booking arrangements are circulated to all senior managers for dissemination to staff teams. It is the responsibility of line managers to ensure that staff has received appropriate risk assessment training and updates. This will be monitored through annual appraisals and development of personal development plans.

11. Supervision

Staff working with people who self-harm will require opportunity to reflect on performance, develop needs, and obtain support. In accordance with Pennine Cares Clinical Supervision and Management Supervision Policies all staff should be in receipt of clinical and managerial supervision.

12. Monitoring

The provision of Clinical Risk Assessment Training is under continuous Review to ensure that the content of training is up to date, and effectiveness is evaluated and improved. The Pennine Care Suicide Prevention & Self Harm working group will oversee this evaluation process and recommend future strategic development of Risk Assessment training within the Trust through the Core and Essential Skills working Group.

The Learning and Development Department will produce a monthly report to Service Line Managers identifying staff members who have completed required training. In addition the Learning and Development Department will produce a 6 monthly report identifying numbers of staff who have been in receipt of Clinical Risk Assessment Training and STORM training. This report will be reviewed by Education Learning and Development Group (EGG) who will be responsible for the development of any action plans required regarding training.

The Divisional Integrated Governance Groups will be responsible for implementation and monthly monitoring of the actions required. In addition the Learning and

Development Department will notify by email the authorising manager of any staff member who does not attend pre booked training for future dates to be arranged.

Service Managers conduct an ongoing audit of individual care plans to include a review of completed risk assessments and risk management plans. In addition, supervision at a clinical level will include monitoring of risk assessments and risk management plans.

Serious Untoward Incident Review meetings are conducted weekly which will monitor and scrutinise risk assessments and risk management plans included in the Team Investigation Report documentation submitted.

The Report will be signed by the Team Leader/ service manager who will be responsible for the development of local action plans and monitoring their completion. However any additional themes emerging from the scrutiny by the PSIG will be sent to the Divisional Governance Groups and Suicide Prevention Group.

Links to Useful Resources

World Health Organization
<http://www.who.int/mentalhealth/en/>

NICE
<http://www.nice.org.uk>

Links to Support organizations

Life Signs
<http://www.selfharm.org>

Samaritans
<http://www.samaritans.org>

Pieta
<http://www.pieta.ie>

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Self Harm:

Guidelines for the Assessment and Management of Self –Harm in Inpatient CAMHS Services (Hope and Horizon) within Pennine Care NHS Foundation Trust

Part 2

1. Introduction and scope of guideline

1.2 Child and Adolescent mental health Services (CAMHS)

Services across the CAMHS Directorate aim to provide high quality emotional well-being and mental health services in a safe effective, equitable and timely manner to children, young people and their families/carer's in a range of community, outpatient and inpatient settings. A multi-disciplinary approach to care has been adopted which focuses on the needs of individual children, young people and their families/carer's and aims to promote the five outcomes of Every Child Matters (**Every Child Matters: Change for Children 2004**)

These are:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being.

For the purpose of this document the term CAMHS will be used to refer to those multidisciplinary services that have a particular role and specialist expertise relating to child and adolescent mental health. Incorporated into this are the five Borough based Outpatient services, affiliated Community teams and the two inpatient units the Hope Unit and The Horizon Unit and Trafford CAMHS.

1.3 CAMHS In-patient services

The Hope Unit and the Horizon Unit are specialist inpatient services for young people presenting with mental health disorders between the ages of 13 up to 18 years. The Hope Unit is an acute short stay unit providing assessment and treatment for young people for up to six weeks. The Horizon Unit provides a longer term treatment/ rehabilitation service for young people with complex needs.

The Tier 4 services accept referrals of young people presenting with acute mental health disorder where risk to self and others cannot be managed in the community or where community treatment has been ineffective. The Services work in partnership with district services towards discharge as soon as possible. Both services accept young people with a range of mental health disorders. A high proportion of young people being treated within the services have a history of self harming behaviour.

Risk to self is a key factor leading up to admission to an in-patient adolescent unit. Self harming behaviour can be very challenging to manage in any institutional

setting and can actually increase in frequency and severity following admission. It is good practice to conduct assessments of young people prior to admission during which a formulation of their difficulties and a set of clear goals for the admission can be identified. This will guide the tasks of assessment and treatment over the course of the in-patient episode.

1.4 Scope of this Guideline

This guideline refers to young people aged up to 18 years of age who self harm and are referred to CAMHS.

The guideline refers to in-patient management primarily. The principles apply to out-patient services

1.5 Self harm in young people: definitions and clinical background Definition of Self harm

“an act with non-fatal outcome, in which an individual deliberately initiates a non habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences” (NICE Guidelines, 2004, 2011).

Rates of self harming in young people

The rate of self harm is low in early childhood but increases rapidly with the onset of adolescence (Hawton et al 2003). Hawton and colleagues (2002) conducted a questionnaire survey of 6,020 Year 11 pupils in the Oxford area. They reported that 13.2% of young people responding had self-harmed at some point in their lives, 6.9% in the previous year. Only 12.6% of those who had harmed themselves had presented to hospital, the vast majority of acts of self-harm being ‘invisible’ to professionals and parents are often unaware of the problem (Meltzer et al 2002) Although a manifestation of distress, self harm in young people is often a “marker” for the presence of child physical and sexual abuse, substance misuse, poor school attendance, low academic achievement, unprotected sexual intercourse, bullying, domestic violence, victimisation (King et al 2001). Self harm is therefore a symptom of many child and adolescent mental health disorders.

Rates of psychiatric disorder in young people

Psychiatric disorders are common and present in about 10% of children and young people in the general population (Melzer et al 2000). “The most comprehensive statistical survey of the prevalence of mental disorders in and life challenges, and their learning.” **(Children and Young People in Mind:** Great Britain identified these children/young people as having a “clinically diagnosable mental disorder that is

associated with considerable distress and substantial interference with personal functions such as family and social relationships, their capacity to cope with day-to-day stresses **the final report of the National CAMHS Review – 2010)**

Working with young people who self harm

There has been controversy about the terminology used to describe acts of self harm. For the purposes of this document the term “self harm” will be used. It is recognised that self harm may be a coping strategy for young people to manage overwhelming emotion; it may also be a manifestation of suicidal thoughts and urges. It is helpful to recognise a continuum of motivation with suicidal intent on one end and preservation of life on the other. Often motivation varies within the same individual and not caring about the outcome may reflect profound hopelessness and perceived lack of control.

Each act of self harm needs to be assessed in context. Self harming behaviour can evoke strong responses in staff and the behaviours are often seen as communications with carer’s. Staff support and supervision is crucial to collaborative working with young people and their families. Self harming behaviour usually reflects unmet needs. Young people have mental health, social and family and educational needs. CAMHS multi-disciplinary teams need to link with multi agency partners of care in the community. It is always preferable to manage young people as out-patients; however admission in crisis can be helpful and should enable assessment and long term care planning.

NICE (2004) identified a number of special issues for children and young people. Initial recommendations refer to the assessment and treatment in A&E and the need to admit all young people for assessment to paediatric wards for a full assessment following incidents of self harm. With respect to the assessment and further management of risk NICE made the following recommendations:

- In the assessment and treatment of self harm in children and young people, special attention should be paid to the issues of confidentiality, the young person’s consent, parental consent, safeguarding and the use of the Mental Health Act
- All young people who have self harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm. The 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 and safeguarding issues
- Child and adolescent mental health practitioners involved in the assessment of children and adolescents who self-harm should:
 - Be trained specifically to work with children and young people and their

- families
 - Be skilled in the assessment of risk
 - Have regular supervision
 - Have access to consultation with senior colleagues.
- Initial management should advise of the need to remove all medication or other means of self harm available to the child or young person who has self-harmed
- For young people who have self harmed several times, consideration may be given to offering developmental group psychotherapy for 6 sessions.

NICE guidance for the Longer term Management of self harm compliment the earlier NICE guideline on short term management and have recently been published. (November 2011) Recommendations cover the age span 8 to 65 years and include:

- General principles of care: compassionate, non judgemental approach, trusting, collaborative relationships, reduction of stigma, fostering autonomy where possible and maintaining continuity of therapeutic relationships
- Psychosocial assessments aim to offer integrated assessment with on-going therapeutic relationships, including building on skills, strengths and protective factors. It is recommended that professionals complete a comprehensive assessment of psychosocial functioning.

When assessing risk of repetition of self harm, identify and agree with the young person the specific risks for them taking into account:

- Methods and frequency of current and past self harm
 - Psychiatric illness and its treatment
 - Current and past suicidal intent
 - Personal and social context and any other factors preceding self harm such as affective states, changes in relationships
 - Coping strategies that the young person has used in the past
 - Important relationships that may either be supportive or represent a threat and lead to changes in risk
 - Immediate and longer term risks.
- Do not use risk assessment tools and scales to predict future suicide or repetition of self harm because the modest predictive value of those currently available makes them of limited usefulness in clinical practice
- Discuss, agree and document the aims of longer term treatment in the care plan with young people. Aims may be to reduce harm arising from self harm, reduce and stop other risk taking behaviours, improve social and

occupational functioning, quality of life and treat underlying mental health disorders.

- Care plans should be multi-disciplinary and developed collaboratively with young people. Identify short, medium and longer term goals and identify roles and responsibilities of team members involved
- A risk management plan should be a clearly identifiable part of the care plan. This should outline how to deal with risks and associated factors and should include a crisis plan
- Inform the young person of the limits of confidentiality and that information in the plan may be shared with other professionals
- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self harm with the aim of reducing self harm. The intervention should be tailored to the individual need and could include Cognitive behavioural, psychodynamic or problem solving elements. The therapists should be trained and supervised in the therapy they are offering and be able to work collaboratively with the person to identify the problems causing distress or leading to self harm
- Associated mental health problems should be treated with psychological, pharmacological and psychosocial interventions. Conditions associated with self harm include depression, schizophrenia, Borderline personality disorder, Drug and alcohol misuse, bipolar disorder. These are covered by NICE guidance.

2. Consent/ Capacity and Confidentiality

The ongoing management of self-harm can be complex and the issues that arise when individuals refuse the treatment that healthcare professionals feel they need are especially difficult. These issues are discussed in ***Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*** (NCCMH, 2004) and are re-visited by the NICE guideline on the management of self harm: longer term issues (NCCMH 2012) Another important principle of care is confidentiality. There is a need to balance the protection of sensitive data with the appropriate sharing of information in order to ensure optimal care.

Mental capacity refers to the ability of an individual to make a decision (or take a particular course of action) at a time when it is needed (HMSO, 2007b). Capacity can change over time, for example if an individual's level of consciousness changes or they are under the influence of alcohol or drugs. It is also important to note that capacity may vary according to the decision that needs to be made. An individual

may have capacity to make simple everyday decisions but may lack capacity to make more complex decisions about treatment. Assessment of capacity should therefore be made on a case by case basis.

2.1 The Mental Capacity Act

The Mental Capacity Act 2005 (HMSO, 2005) provides a legal basis to enable decisions to be made on behalf of those who lack the mental capacity to make decisions for themselves. The Act is based on principles previously established by individual legal cases (that is, 'common law'). All people aged 16 years and over are presumed to have capacity. Any decision made on behalf of someone who lacks capacity must be made in their best interests. The Act aims to balance an individual's right to make decisions for themselves with their right to be protected from harm.

The Mental Capacity Act establishes five principles

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing capacity

All young people who are admitted to in-patients services or where this is being considered require an assessment of capacity. To enable a person to make a decision about receiving medical treatment, that person must receive sufficient information about the specific treatment that is being offered and in a form that can be understood by him/her. Information must be provided about the seriousness and the nature of problems that are associated with the condition under question, the objectives of the treatment, the consequences of being treated, and the consequences of not being treated. Throughout treatment attempts must be made to provide information when necessary and to obtain the person's consent.

Any individual assessing capacity should do so as part of a two stage process (HMSO, 2007b).

Two stages for assessing capacity from Mental Capacity Act Code of Practice

Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

Stage 1 requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act.

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.

Assessing ability to make informed decisions

A person is unable to make a decision if they cannot

1. Understand information about the decision to be made (the Act calls this 'relevant information')
2. Retain that information in their mind
3. Use or weigh that information as part of the decision-making process, or
4. Communicate their decision (by talking, using sign language or any other means).

Assessments of capacity are conducted by the professional providing care for the individual at the time the decision needs to be made. Multidisciplinary teams may be involved in the process but the final decision must be made by the person proposing the treatment. The assessment of capacity at admission is conducted by the admitting doctor and nurse. It is essential for young people under 16 that their parents/ are involved.

Factors that can impair capacity include long-term mental illness or disability, or more temporary factors such as impairment due to medication, drugs, alcohol, acute illness, or emotional distress.

However there should be no delay in the physical treatment for overdoses or other forms of self harm due to uncertainties regarding whether or not a young person has capacity. If there is a delay in administering any appropriate treatment on the ward then ward staff should ensure a young person is accompanied to accident and emergency for further assessment and treatment. If a young person is refusing

treatment, advice should be sought following escalation to the ward manager/service manager or on call deputy and the Consultant on Call.

In the event of the young person being at high risk of physical harm if treatment is refused or delayed, an early decision must be made by the senior clinical team regarding the young person's capacity and treatment administered under the principles of Common Law. Ultimately the best interest of the young person should be the driving factor in the decision making process.

The Mental Capacity Act does not in general apply to children under 16, whose care and treatment will be determined by common law principles. Most provisions of the Mental Capacity Act apply to young people aged 16-17, with the exception of making advance treatment decisions (individuals need to be 18 years old and over to make advance decisions). If a young person aged 16-17years has capacity and refuses treatment there may be difficulties if those with parental responsibility wish to consent on their behalf. The Family Division of the High Court can rule on such cases (HMSO, 2007b).

For those aged 16-17 who lack capacity, parents can consent on their behalf. However, it should be noted that healthcare professionals are able to provide treatment regardless of whether parental consent has been given as long as the principles of the Act are followed and the course of action is judged to be in the young person's best interests.

Young people referred for admission to the Hope or Horizon services may consent to admission and be able to work collaboratively with staff throughout. If they are suffering from a mental disorder and the risks to themselves and/or others are high, use of the Mental Health Act 2007 must be considered. Mental disorders where self harm and suicidal behaviours are common include depression, post traumatic stress disorder, eating disorders, schizophrenia.

Self harming behaviour is a component of borderline and other personality disorders where the mental health act may be invoked if hospital admission/treatment is seen to be preventing further deterioration and reducing risk. Young people over 16 years of age can not be managed with the consent of their parents. They may only be admitted to the in-patient services if they consent or if they are detainable under the mental health act.

2.2 Confidentiality

Protecting the personal information of service users is a key principle in the provision of health services. Healthcare professionals have a legal and professional obligation to protect confidentiality, but there are circumstances in which personal information can be disclosed (General Medical Council, 2009) as outlined below.

- If it is required by law (for example, by regulatory bodies, judges)
- If the patient consents implicitly for the sake of their own care (for example, disclosure to other members of the care team, or for local clinical audit) or if the patient consents specifically for other purposes (for example, disclosure, to employers, insurers, or benefit agencies)
- If it is justified in the public interest (for example to protect society or individuals from harm or to enable medical research or other uses of data that will benefit society over time).

Issues of confidentiality are particularly challenging with children and young people who self-harm who have capacity yet refuse the involvement of their parents or in their treatment or refuse consent to disclose issues relating to their safety to their parents or carer's. In these circumstances healthcare professionals need to weigh carefully the rights of the young person to confidentiality and the risk to the therapeutic relationship of a breach of confidentiality whilst providing the family and with sufficient information to enable them to appropriately protect and care for their young person.

The younger the service user and the more risky or severe the self-harm the less justifiable a decision to maintain confidentiality may be considered to be. Healthcare professionals making these judgments are encouraged to discuss with a senior colleague and / or consult with the Named Doctor / Named Nurse for Safeguarding. If the healthcare professional decides on balance that a breach of confidentiality is warranted, involving the young person as much as possible in how and when this is done can mitigate some of the damage to the therapeutic relationship.

3. Safeguarding

Pennine Care NHS Foundation Trust as with all other NHS bodies has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people in its care. Agencies need to work together to promote children's welfare and prevent them from suffering harm. Pennine Care NHS Foundation Trust has comprehensive single and multi-disciplinary policies and procedures in place to safeguard and promote the welfare of children and to protect them from abuse or the risk of abuse. Please refer to child Safeguarding Policy CL10.

Self harm may be a symptom or marker of abuse. All staff working with young people who self harm must be aware that there may be safeguarding issues and in assessing risk be mindful of the "bigger picture". Risk assessment will carefully establish the presence of safeguarding concerns. Young people may make disclosures of abuse during their treatment. These disclosures may be made to the least experienced members of the multi-disciplinary team. Members of staff must be supported in managing these incidents sensitively and swiftly to ensure that wellbeing of young people are promoted and safety of all young people is

established. Close liaison will take place with Trust safeguarding personnel to ensure best practice.

Awareness of safeguarding procedures and the issues related to practice underpin all of the work of staff on the inpatient unit and their interactions with young people. From admission through to the point of discharge and transition from the ward a chronology is kept of any safeguarding concerns, protection issues, disclosures, referrals to social care/safeguarding teams or serious untoward incidents on the ward. This chronology details actions that arise from such instances and logs communications with all other professionals. This is shared with community teams at the point of discharge and is located on the young persons lilac file.

There are factors associated with self harm that the staff team will need to manage to ensure a young person is kept safe and cared for in a way that maintains their dignity and safeguards against any form of abuse. Examples of this are where restraint of young person occurs to prevent significant risk of self harm. Any young person for whom there is a potential likelihood of physical interventions being required will have a detailed individual Management of Violence and Aggression care plan (MVA). This will identify the level of hold that an individual young person may require and the reasons for this. If any higher level holds are required or if a young person ever suffers injuries as a consequence of physical restraint then a safeguarding review is held with members of the senior team that will include a Trust Named Doctor to ensure the practice of staff is safe and appropriate and that the young person's needs were attended to.

Ward staff also aim to involve the young person in a post incident review following any restraint procedure so as they are able to voice any concern and explanations of the incident and the rationale for staffs actions are offered. Details from these reviews are documented in the nursing notes.

The searching of a young person also needs to be carried out with the safeguarding needs of the young person paramount through staff's actions. These search procedures are described in section 6.2 however staff will always act in a manner to preserve the young person's dignity and safety and will never complete these procedures without the authorisation of a senior nurse and ensure that there are at least two gender specific staff in attendance at all times.

4. Risk Assessment of Self Harm

On admission a young person must be provided with a comprehensive risk assessment, carried out by the inpatient Multidisciplinary Team (MDT). Each risk assessment is documented in clinical notes and the Trust Approved Risk Assessment (TARA) is completed on admission. Previous risk assessments and information are obtained and forms part of the initial assessment process with regard to risk. The risk is continuously discussed and evaluated on a weekly basis, or more frequently as required.

A comprehensive assessment and formulation of risk is integral to the management and intervention plan of each young person on the ward as well as the observational level required.

The key areas of enquiry are as follows:

- Nature of previous self harming
 - Number of previous incidents and severity
 - Whether severity/ potential lethality of previous attempts have increased with time
 - Whether the young person thought that the self harm attempt would kill them even if the professional opinion was that the method of self harm or suicide attempt was not likely to cause significant harm.
 - Whether they wished to die
 - Degree of pre-meditation/ impulsivity
 - Factors which may have contributed/ triggered the attempt
 - Precautions that the young person took to avoid discovery
 - Relationship of alcohol, substance/ medication misuse
 - Whether the young person left a suicide note, made efforts to give away belongings and possessions or placed any expressions of potential risk on social media sites
 - Whether the young person acted to get help during/ after the attempt
 - Young person's current reaction to the attempt
 - Current thoughts of suicide
 - Current expressed plans for the future
 - Current expressed plans for future attempts
 - Current attitude towards dying/ living
 - Known triggers that may increase the risks of future self harm
 - Hopelessness
 - Depression
 - Young person's and carer's knowledge of self harm and how to manage future incidents
 - Care team and young person and carer's crisis plan
 - It is critical for professionals to include an assessment of the Young person's online life as part of clinical assessments, especially where there are concerns about self-harm
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- The level of risk and the associated observational levels are defined by the likelihood, imminence and severity of any further self-harm. The level of risk is categorised as low, medium or high risk. A multi-disciplinary assessment is conducted in order to identify the intentions, function and motives of the self-harm and drives the psychological treatment of the young person's self-harm and their wider psychological and emotional difficulties. Procedures are in place in order to

communicate the level of risk and the intervention plans both within the multidisciplinary team, the family and to community teams as appropriate. The risk level is continuously monitored and evaluated with specific timescales for reassessment.

Risk assessments must involve young people and their families when community and home leave is planned. Periods of leave are care planned and are highly structured. Parents and are integral to this process.

5. Risk Management

Following a comprehensive risk assessment and formulation, a risk management plan is agreed with each young person. Care plans are developed to inform staff and engage the young person in their personal management plan. Risk management involves the provision of strategies and techniques in order to support the young person to identify their distress and to implement alternative coping strategies to manage distress i.e. distraction, use of elastic bands, ice cubes etc. Information is documented as to the triggers, early warning signs and coping strategies for each young person on the ward in order to work preventatively.

The process of intervention to address an act of self-harm is documented in each young person's care plan. This process and approach is determined by the assessment and formulation of the function of the self-harm act and from an immediate assessment of the risk level on discovering a patient who is self-harming. During an act of self-harm, the staff team initially adopts the strategies of verbal de-escalation, medication if appropriate and assist the young person to utilise alternative coping strategies in order to attempt to reduce the immediate level of risk. Physical restraint is used as a last resort unless the initial assessment indicates an immediate threat to the patient's life and the patient is unresponsive or unable to maintain an airway in the event of a ligature.

Each young person has an individualised treatment plan, based on a formulation that has been developed as a result of the comprehensive assessment which is designed to treat underlying causes of self harming/ to reduce risk and to promote recovery. Treatment plans include the provision of psychological interventions such as Cognitive Behaviour Therapy and Dialectical Behaviour Therapy for young people. In inpatient settings, it is often unrealistic that the cessation of self-harm can be achieved during admission. However inpatient intervention strives to encourage and support young people to engage in a therapeutic process where they can explore the function of their self-harm, gain a greater understanding of the triggers and maintaining factors and begin to learn alternative strategies and skills to manage their extreme emotions and distress. The aim is to reduce the level of risk by addressing the young person's accompanying psychosocial issues. There are additional interventions to help educate the young people about the risks of cutting and to encourage personal responsibility and appropriate self-care following self-

injury i.e. washing and dressing wounds with support to prevent the risk of secondary problems such as infection.

When incidents of self harm occur, the patient should be checked for injuries and assessed by the medical team if indicated. If they have taken tablets they must be assessed by the medical team and referred to A & E. Young people should be engaged in a post incident review when they are medically fit. Immediately following the incident a risk assessment should take place to determine the need for observations. A more detailed analysis of the incident can be undertaken with a member of their care team. These may take place with their therapist and forms part of therapeutic work.

As highlighted above, inpatient settings have a high rate of self-harm and acts of self-harm can often increase in frequency and severity following admission. There is often a risk of young people harming themselves in the presence of other patients and sharing implements. In order to manage the risk of young people witnessing other's acts of self-harm, the team responds by providing the individual who is self-harming with support as well as ensuring that other young people are moved away from the situation into other areas of the ward. Each young person is provided with one to one support to talk through what they may have seen and the impact that this may potentially have had upon them. With regard to sharing implements, the ward encourages an open environment where young people are supported to disclose and hand in dangerous items. This is always encouraged prior to any decisions to carry out any personal searches or searches of patient rooms and the ward.

After any incident where young people are suspected to have shared implements the patients are medically examined and consultation with infection control occurs. Incident forms are completed and the observational levels and risk assessments are reviewed. Where there may be incidents of young people causing injury to each other these must always be dealt with as a safeguarding issue as well as being reported to the police as a possible act of assault. Staff who attend to young people following their self harm must always establish, by asking the young person, that they themselves were responsible for the injury, especially if they do not have a previous history of self harming behaviour.

Throughout in-patient stays, CPA reviews take place every 4 to 6 weeks. These meetings involve the young person's full care team so that risk management strategies can be shared and as young people commence leave, appropriate monitoring can be put into place leading up towards discharge. A comprehensive plan is provided upon discharge to support a young person within the community.

6. Reporting Incidents

Incidents involving a young person who self harms must be reported via the Trust electronic safeguarding system. Staff need to be mindful of ensuring incident reporting is completed in a way that describes the incident and is factual without using emotive language and details the actions and management of the young persons risk and ongoing care. Young people may present in such a way as they

have a series of self harming incidents within a specific time frame and it is acceptable that providing these incidents are of the same grade and nature that these can be reported using one incident log covering that time period. However this needs to be underpinned by the staff team using a consistent approach and ensuring that any incidents that fall outside of the young persons usual pattern of self harming behaviour within a twenty four hour period is always reported separately. This will allow staff to detect any increase in risks a young person may be presenting. If this approach to recording a series of incidents within a specific time frame is to be taken this must be agreed with the Consultant Psychiatrists and documented in the young persons care plan.

The named nurse will take responsibility to ensure this is communicated via the care plan at each handover so that all members of the team, including temporary staff adopt a consistent approach.

7. Environmental and Personal Searching

A young person and their belongs should only be searched if it is necessary for their safety and protection and/or others, therefore;

- to prevent injury/harm to the patient
- to prevent injury/harm to others
- to maintain security and safety.

Searching should be used when clinically necessary and where alternative interventions have failed or were inappropriate at the time.

Risk assessment and clinical risk management are important tools in providing clinical reasons why a search may be required i.e. the person may be concealing something harmful and they have a propensity to use the concealed item against themselves or others.

Although it resides in the domain of clinical risk assessment, searching young people who are at risk of concealing items for the purpose of attempted self harm and suicide is an important part of both national and Pennine Care NHS FT Trust Suicide Prevention strategy.

Additionally reasons to implement a search maybe indicated for detained persons on admission, return from leave or return from a period of being absent without leave.

7.1 Types of search

Staff should refer to the Trust policy: **Search of Patients: Persons and Property** (Version 2). However there are ordinarily three levels of searching that can be permitted by ward staff within the CAMHS inpatient service that should reflect the level of risk posed by individuals or a group of young people;

1) Search of the wards communal areas:

This **does not** include a young person's belongings or personal space. A young person's consent is not required for this search, but where appropriate it is good practice to inform the young people that a search is about to take place. This should be done in a community meeting where all young people are given the opportunity to assist staff in handing over any contraband items staff feels may be present on the ward and to work with staff. Agreement to conduct a ward search should be agreed with the ward manager or their deputy in their absence, and should be recorded on a Trust incident form.

2) **Search of a young person's property and personal space:**

The need for consent is required for the search of a young person's property including their bedroom, however if the person is detained under the Mental Health Act their consent is not required but it should be considered good practice to inform the person the search is going to take place. The Mental Health Act Code of Practice (Chapter 25) makes it clear that the power of search extends to a patient's belongings and not just their person. This search includes bedroom furniture, cases, bags, bed space area, stored clothing and personal items. A young person's parents or carers may need to be consulted to advise them of the planned search or to seek parental consent if the young person is unable or unwilling to consent. The Trust policy details these consent issues in detail and staff should read this policy in conjunction with the Trust policy. Appendix 1 of the Search of Patients Policy should be completed in all instances of a young person's property and personal space being searched and this record should be held within the young person's nursing records.

The decision to carry out a search must be made by the person in charge of the ward or department who will coordinate the consent process. Any search of a young person must be agreed by the Ward Manager, Service Manager or CAMHS On call Manager out of hours.

3) **Search of a Young Person**

The need for consent or lawful authority is required for the search of a young person. A personal search may be conducted on three levels:

Personal: Supervised Where possible asking the young person to assist the procedure e.g. running their fingers through their own hair or turning out their own pockets before staff begin a tactile search. The use of the Hand Held Metal Detector may also be considered where appropriate and staff need to refer to the separate protocol for use.

Personal: Observational (Looking for objects concealed in the mouth, hair, ears or in the clothing)

Personal: Tactile (Touching the patient to search for objects). Outer clothing to be searched and the person, permitted to one layer of clothing.

This search procedure should not be exercised merely on a suspicion that the person is in possession of an article, implement or substance that may pose a risk. The member of staff must have reasonable grounds, based on contemporaneous intelligence, evidence, direct observation or reliable report, to implement a search procedure. If a young person is subject to a personal search the Service Manager or the CAMHS on call manager must always be consulted along with the young persons Consultant Psychiatrist. Appendix 1 of the Search of Patients policy must always be completed and filed in the nursing records. Consideration should always be given to discussing the search prior to completing it with the young person's parents/ carer's. If this is not felt appropriate reasons for this must be documented in the young person's notes.

Enhanced Personal Search

Only in **exceptional** circumstances, for example where it is known a young person has brought implements back to the ward with them to use to self harm or share with other young people could a further enhanced search be undertaken. Again the member of staff must have reasonable grounds to implement this search procedure. A senior manager and the young persons Consultant Psychiatrist (or deputy) must always be consulted prior to the search being completed and where appropriate the young person's parents/ consulted. A young person should be kept under supervision and if necessary nursed in isolation until such consents are obtained. In these exceptional circumstances a young person may be required to change their clothes to allow staff to conduct a fuller search of their personal items.

Where this may be necessary staff must ensure a young person has given their consent to this process. In the absence of consent the young person's age will be taken into account. If they are under 16 then parents/ can be consulted and parental consent gained. For those young people over the age of 16 and/or where parents also refuse to give consent consideration should be given to an assessment as to whether the young person needs to remain in hospital. A period of home leave or discharge from hospital may need to be considered in collaboration with the young person, their family and the clinical team. Where this is not clinically appropriate consideration may need to be given to use of the Mental Health Act. Where staff has significant concerns for a young person's welfare or that of their peers in relation to concealing contraband items on their person the young person must remain on constant observations, at arms length, with their hands visible at all times until such time as a search can be completed. Staff should consider the need to nurse a young person in the extra care areas during this time whilst implementing the Nursing in Isolation Policy.

In relation to this enhanced type of search staff must adhere to the following guidance:

- Complete appendix 1 of the search policy prior to completing the search, following agreement with a Service Manager and Consultant or their deputies
- Have a full set of the young persons clothing available, that has already been

- searched, ready for the young person to change into
- Ensure the young person is given sufficient privacy away from other peers i.e. use their own en-suite bathroom so their dignity maintained at all times
 - Have gender specific staff only in the room when the search is completed. A minimum of two staff should be present
 - Keep a discrete observation of the young person with the bathroom door slightly ajar
 - Ask the young person to pass out one item of clothing at a time which they can then be exchanged with an item of clothing that staff pass back into them.

On completion of a search the Trust electronic incident form must be completed along with Appendix 2 of the Trust Search Policy. Staff should detail the outcome of the search and consider if contraband is found whether this requires reporting to the police. The ward Consultant should be consulted regarding this before the police are contacted about individual young people.

8. Care Planning

Each young person has a named nurse. Care plans are agreed with young people and aim to engage young people in identifying and managing urges to self harm. Young people are supported in communicating risk to staff and are involved in decisions regarding the need for nursing observations, removal of high risk items, personal and room searches. Young people who utilise self harm as a coping strategy find the prevention of their self harm very difficult. They may be suffering from trauma related symptoms and can present with very high levels of distress and agitation which can be difficult to de-escalate. Care plans utilising a step-wise approach to de-escalation and identifying triggers early are important. Using this approach, the use of medication can be reduced and young people can be engaged in collaborative work with staff. Care plans can link periods of time when young people have managed to avoid self harm with commencing and increasing leave and achieving identified goals.

9. Inpatient Milieu

Both the Hope and Horizons in-patient services provide dedicated in-patient therapeutic environments for adolescents. The Hope unit is focused on assessment and short stay and the Horizon provides intensive treatment programmes for young people extending up to 12 months. The culture of the Services is non-judgmental, young person centred and collaborative. It is accepted that self harm is a method of coping with overwhelming emotion. Self harm is not considered healthy or acceptable in the longer term and is not permitted within the services. Young people are taught alternative methods/ strategies for managing difficulties. The in-patient milieu aims to increase self confidence, increase independence and self reliance and to promote autonomy and reflection. The following are ingredients of the milieu:

- **Community meetings:** Whilst in-patients, young people are encouraged to participate in community living where they are able. Meetings are held weekly and more often to address issues such as bullying, self harming, safety and interpersonal issues.
- **Individual therapy:** each young person will have individual sessions where their self harming and risk can be addressed therapeutically.
- **Key nurse sessions:** Each young person will meet with their key nurse to review care plans and engage in supportive work. This is an opportunity to review risk management.
- **Family involvement:** Whilst young people are in-patients professionals work in partnership with parents and carers. Regular meetings are useful to plan leave and focus on education and sharing progress with families. Family members of young people who self harm often react very strongly to this behaviour and providing psycho education and a forum for discussing self harm can be very beneficial. Young people over the age of 16 may not initially consent to their parents/ carers involvement. In these circumstances we would wish to work with the young people to help them to understand that in order to live in their families they need to be able to share information and work collaboratively with them to some degree.
- **Therapeutic programme of activities;** each young person has escorted leave to engage in community activities as part of a structured timetable. As young people achieve greater confidence and independence they can have unescorted periods of community leave. All leave is risk assessed as described and care planned
- **Education:** There is a formal education programme which is provided within the ward environments. Each young person has an individualised education plan. Individual and group sessions are combined to meet educational needs. Self harm and its management would be addressed within this setting
- **Liaison with professionals:** Some young people are looked after by social services and are discharged to placements. Throughout in-patient stays we liaise closely with young people's care teams to enable them to be discharged from hospital safely as soon as they are ready.
- **Safeguarding:** Many young people presenting with self harming behaviours have histories of abuse and neglect. The staff team work closely with community social services teams to address any safeguarding issues.

Joint partnership work with Papyrus.

The Trust is currently developing joint work with Papyrus.

This will include:-

- Raising staff awareness of Papyrus and the work they do with young people and suicide prevention
- Increase availability of information for service users and their carers re Papyrus especially with regards to their helpline
- Development of community project work with the involvement of service users

- Consideration to additional training for staff regarding self-harm and suicide prevention.

10. Discharge Planning

The Hope unit accepts emergency admissions for periods of assessment and initial stabilisation. All young in-patients must have a care co-ordinator. If this is not in place at admission, urgent referrals are made to the appropriate community team.

A common reason for referral is suicidal behaviour. Initial assessment may determine unmet social care needs. A formulation of mental health need may propose discharge to community provision. For some young people the in-patient environment is perceived as nurturing and self harming behaviour may become a means of eliciting care. Self harm may increase within the in-patient environment and there is a risk of contagion. The multi-disciplinary team may make a decision that the young person's longer term needs will be best met by discharged to community care/ treatment. Within the CPA process joined up decisions need to be reached with community teams and the young people and their parents/ carer's involved in this process. Planned step-down in care is important with periods of leave gradually extended to support transition. Young people and their carer's may be very sensitive to loss and abandonment and precipitate discharge likely to activate these dynamics resulting in further crises. Careful liaison with A&E teams and crisis teams to agree crisis plans are essential to avoid multiple re-admissions. Every act of self harm needs to be assessed and may be different in risk and required response. The crisis plan must outline plans for risk assessment following self harming. Excellent communication between professionals is essential to managing on-going risk.

Following admission to the Hope unit if self harming increases in frequency, severity and risk and the young person is not able to take responsibility for their safety, transfer to the Horizon service may be considered. A Mental Health Act assessment will usually be required as staff intervention to promote safety may be required. The Horizon team will commence in-depth assessment of mental, physical and social needs and begin therapeutic work. Discharge planning takes place within the wider care team and will involve a phased step-down in care. Periods of leave with crisis plans in place will be utilised.

11. Training and Supervision

See page 18 and 19.

The CAMHS Inpatient Service offers regular in house training and weekly supervision to the multidisciplinary team as well as an opportunity for debriefing meetings following any serious untoward incident.

Resources for young people

There is an extensive array of websites and other sources of information regarding self-harm and its management on the internet. Much of the information is informative, professionally written and treatment oriented. Examples include the following (see Appendix for publication details and links):

- information leaflets on the Royal College of Psychiatrists' website
- information from NICE, NHS Choices, well known and regarded organisations such as MIND, Papyrus or Childline (which offers advice and a freephone helpline).
- The Site seems to be recovery oriented, with suggestions for support and information from professionals.

Other sites have greater input from young people themselves, for example:

- Selfharm.co.uk is a moderated site where young people can post video footage or stories about their life and self-harm; the overall aim is to support others in helping recovery
- self-injury.net includes a discussion forum, but the context is US based and may not accurately reflect evidence-based treatments 24 CR192 and approaches in the UK; also, descriptions of what happens during emergency department attendance are not particularly encouraging.

Online counselling and phone support such as that offered by the Samaritans is increasingly common. It is really important for parents and professionals to be clear about safety mechanisms employed in these services, particularly if a young person makes risk statements that require an urgent response. This may be out of the control of parents and professionals, but it is an important area of discussion when considering safety plans.

12. References

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