

Self Harm and Suicide Amongst Children and Young People in Knowsley

A collaborative workforce development project in partnership with Knowsley Council and Knowsley Clinical Commissioning Group

Final Project Report

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Introduction and Background to the Project

The Knowsley Self Harm and Suicide Working Group, was formed in September 2011, in response to concerns identified in 2011 by the Knowsley Child Death Overview Panel, relating to under-18 suicide incidents and the rates of reported and un-reported self-harm for Knowsley children and young people. The group's objective was to evaluate current practice in self-harm and suicide prevention and support, with a view to making recommendations for future practice.

The local needs assessment confirmed that Knowsley has relatively low levels of reported self-harm (being 8th lowest across North West authorities for emergency admissions per 100,000 population for 2007/08 and 2009/10) and relatively low levels of suicide. Anecdotally however, practitioners across the children's workforce report high levels of identified or self-reported self-harm, and between 2008 and 2012 there have been 4 suspected child suicides and one suspected suicide for a young adult in transition.

It was apparent that there were many examples of good practice in Knowsley which could be further developed to a wider audience, for example; the Working Together reporting and analysis process for attempted suicides in young offenders, the STORM training in schools, self-harm peer group and so on.

It was also evident, however, that there was limited evidence of co-ordinated responses to young people whose self-injurious or suicidal behaviour and intentions cause concern. Partners act with very good intentions but often in isolation of each other and without access to comprehensive personal information and knowledge of other services available.

The group identified a multi-phase action plan across 5 domains:

- Evidence base
- Care Pathways
- The Voices of Children and Young People
- Multi agency responsibilities and workforce development
- Data, information and management systems

Recognising the limitations in capacity of the current workforce to successfully deliver all of the identified improvements, it was agreed that an external commission would be negotiated to deliver the required outputs through a practice-HEI partnership for the purpose of workforce and service development.

Soft market analysis identified Salford University as the preferred provider, having both the expertise and experience of children's services across mental health and safeguarding.

The commissioned workforce development project detailed within this report had clearly defined products agreed at its outset:

- A comprehensive literature review
- The production of a best practice/effective practice toolkit
- The production of an accessible guide to assessment and intervention for non specialist practitioners

- Facilitation of time limited reflective learning sets
- Facilitation of the development of a multi-agency procedure for high risk and complex cases involving self-harm or risk of suicide
- Key note address and workshop facilitation at a local conference/launch event

This project is linked to a parallel work stream by the University of Salford, undertaking qualitative research with children and their guardians regarding their experience of services to help them with issues of self harm and suicidality in the Knowsley locality (detailed in a separate research report: McAndrew et al, 2013)

The project has been funded by NHS Merseyside (on behalf of Knowsley Clinical Commissioning Group) in order to support the delivery of the Knowsley Emotional Well-being Strategy.

The Children & Young People and Public Health Commissioning Team have held the project lead and management roles within Knowsley, using a constituted steering group and practice implementation group to govern and direct as necessary. Stakeholder representation on these groups have included:

- Acute CAMHS Liaison
- Youth Offending Services
- Children's Social Care
- CAMHS Urgent Response Team
- Young Person Representation
- Schools/School Health/Colleges
- 3rd Sector representatives
- CDOP Nurse
- GP
- Walk-in-centre/Options Service
- Youth Services
- Public Health
- Social Care and Safeguarding
- Police

The University of Salford Research Governance and Ethics Committee provided scrutiny and approval of the project methods

Executive Summary

This executive summary provides an overview of the findings of the comprehensive practice-orientated literature review undertaken by the Knowsley Self Harm and Suicide Amongst Young People workforce project team at the University of Salford. The emerging themes important to the future development of practice recommendations for standards of practice across the domains of individual clinical practice, operational service delivery & service design are presented, followed by the completed project outputs that were developed from these recommendations. A summary of further actions agreed by the Knowsley locality in order to continue to process of implementation beyond the life of the project, is provided.

The full literature review, presented later in the project report is based on a review and synthesis of a comprehensive search and critical review of quantitative and qualitative research, in the field of self-harm and suicide in children and young people, with specific and related policies, clinical guidelines, expert clinical opinion and relevant organisational briefings.

Issues of language, definition and the sensitive application of these have been identified as important precursors to effective organisational strategies for addressing the issue of self-harm and suicide (R. Coll. Psych., 2010; Allen 2007). For the purpose of this report the definition adopted in the NICE clinical guidelines for the management of self-harm (2011; 2004) will be utilised:

“An expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion and should not be presumed to be the same.” (p. 8)

2. Context of the Issue

Issues of prevalence and epidemiology in relation to self-harm and suicide in children and young people are complex. While there have been many studies published over the last twenty years seeking to establish accurate rates of occurrence, problems with differing definitions, criteria for inclusion, recruitment process and ways in which sample groups are selected, make aggregating data, difficult. This means that statistical estimates of prevalence rates should be held lightly. In addition, persistent pursuit of definitive rates of occurrence are likely to be unrealistic, offer only limited new insights and potentially deflect from the more important task of understanding the individual experience of those who self harm in order to respond in a way that is respectful and helpful.

The report into the National Inquiry into Self-harm in Children and Young People (MHF:CF, 2006) concluded that an estimated prevalence rate of between 1 in 12 and 1 in 15 young people could be assumed. The most recent assumptions made by the research team at the Oxford Centre for Suicide Research are that prevalence across the full age range of children and adolescents, both male and female, can be estimated at 10% (Hawton, Saunders and O’Connor, 2012).

Madge et al., (2008) undertook a seven country pan-European collaborative investigation of self-harm in young people (The CASE study). It is the largest systematic research study of this kind to

date. The study found that in the UK, an estimated 16.7% of girls and 4.8% of boys reported an episode of self-harm across their lifetime. This compares to prevalence in the total pan-European sample of 13.5% of girls and 4.3% of boys. When participants were asked about experiencing thoughts of self-harm as opposed to episodes in which they had acted on their thoughts, the rate in the total sample group rose to 12.5% of boys and 30.4% of girls.

Just over half of the participants reported more than one episode of self-harm across their lifetime. Only 12.4% of young people reported seeking help or presenting at hospital for treatment following their self-harm.

The CASE study adopts a definition of self-harm that does not distinguish between episodes of a suicidal nature and those without associated intention to die, so it is not possible to extrapolate from the reported episodes, the number of suicide attempts. However, the participants were asked to identify the reason for their self-harm and 59% identified 'I wanted to die' as a reason (although not necessarily exclusively). Of these, overdose/self-poisoning was the method of self-harm most commonly reported by participants (Madge et al, 2008).

Age

The commissioners of this report specifically asked that the issue of age and the phenomena of self-harm and suicide in younger children were reviewed.

Average age of onset of self-harm and suicidality is 12 years old and rates of self-harm across the life course peak in adolescence (Moran et. Al. 2012; MFH, 2006). Self-harm and particularly suicide in younger children is a tragic but relatively speaking rare event, making design of studies from which generalisations can be drawn highly problematic. All studies found in this review that did relate to younger children focused exclusively on quantitative data and prevalence rates. This adds further support to Knowsley M.B.C.'s decision to ask that the qualitative research component of the commissioned project include interviews with children younger than 12.

A number of research studies indicate that the onset of self-harm is associated with the onset of puberty, both its physical and psychological characteristics (Nock, 2010; Patton, 2007). This finding may offer a theoretical explanation for the anecdotal report of increases in episodes of self-harm in younger children, in that the average age of onset of puberty has been shown to be decreasing over time (Pierce & Hardy, 2012).

Moran et. al.'s (2012) study shows the peak rate of self-harm to be in the latter phase of pubertal development in late adolescence, which is then followed by a tapering off of self-harm rates in early adulthood. This is in contrast to figures for completed suicide which peak in early adulthood (25-34 years) and again in later life (Hawton and Harriss, 2008; NICE 2004, 2011).

Evidence presented by young people to the National Inquiry into self-harm, identified the earliest age of onset as 5 years old. However, service user evidence submitted to another qualitative research study reported the earliest age of onset as 3 years old (Warm et al, 2002). Onset as young as this is likely to be uncommon as highlighted by a national survey of more than 10,000 children which calculated the prevalence of self-harm among 5-10 year-olds as 0.8% among children without

any mental health issues. The rate for children who were diagnosed with an anxiety disorder was 6.2% and 7.5% if the child had a diagnosis of conduct, hyperkinetic or other less common mental disorder (Meltzer et. Al., 2001).

Gender

Headlines from statistical evidence indicate that the prevalence of self harm is much higher (up to four times) in girls than in boys (Hawton, Saunders et al, 2012; Madge et. Al, 2008).

However, detailed analysis of the data available indicates a much more complex picture than this, which needs to be held in mind when considering service design to meet the needs of the local population:

Methods of recording and coding incidents may lead to exclusion of more diverse forms of self harm that are more frequently used by young men. Research participant recruitment strategies may be more likely to recruit young women and the differences in how young men and women seek help may also skew our information about the gender profile of those who self harm or who experience suicidal or self harm thoughts. A number of studies have showed no gender differences in those who attended hospital following an episode of self harm (Marchetto, 2006; Sansone et al, 2010).

In addition the rates of reported self harm between young men and young women actually inverse as adolescence progresses, with young men having the highest recorded rates in late adolescence and early adulthood.

BME

Rates of self-harm have been shown to be disproportionately high among young Asian women aged 15-35 years, in comparison to general population prevalence figures (Bhardwaj, 2001). This is a difficult statistic to make use of in child and adolescent mental health services, as the sub population identified encompasses both adolescents and adults. Other than this, there is no difference in prevalence between adolescents from white, black or ethnic minority communities in data published at the current time.

Areas for future work/ horizon scanning for the Knowsley locality, in relation to understanding the context:

- Emerging evidence of possible differences in trends between rural and urban areas (lower overall incidence in rural areas, but higher levels of suicidal intent expressed by individual within the rural population, Harriss & Hawton, 2011)
- Developing a better understanding of the experience of Younger (under 12yrs) Children
- Developing a better qualitative experience of boys and young men who self harm

Statistically Associated Risk Factors

The evidence for the bio-psychosocial factors and characteristics that are statistically associated with an increased risk of self-harm and future suicide in children and young people has been summarised in Box 1.

Box 1. Factors statistically associated with increased risk or self harm and suicide in children and young people.

- Experience of abuse or maltreatment (sexual, physical, emotional, and/or neglect)
- Adverse family circumstances (e.g. parental mental health difficulty, criminality, domestic violence and/or family poverty);
- Mental health problems (hopelessness and depression, anxiety, impulsivity, inc. ADHD)
- Disrupted upbringing (periods of local authority care, parental marital problems such as separation or divorce);
- Family relationship problems.
- Close friend or family member attempting suicide or harming themselves
- Low self-image or self esteem
- Isolation (social, family and or rural)
- Drug use and or alcohol use
- Experience of bullying (victim or perpetrator)
- Stress and worry around academic performance, education or occupation
- Bereavement
- Unwanted pregnancy
- Problems associated with sexuality
- Problems to do with race, culture or religion
- Perceived loss, rejection or separation in interpersonal relationships

Usually complex range of experiences, not one event or factor (risk is not directly associated with number of factors present)**Summarised From: Hawton, Saunders & O'Connor, 2012; Underwood, 2009; Madge et al, 2008; MHF:CF, 2006; Skegg, 2005; Hawton & James, 2005; Fox & Hawton, 2004;**

It can be seen from the list provided that the risk factors associated with self-harm are almost the same as the factors associated with an increased risk of developing most mental health problems common to children and adolescents. There is consensus within clinical guidelines and systematic reviews of clinical evidence that due to low specificity and predictive value, knowledge of these risk factors does not serve to sensitively distinguish children at high risk of self-harm or predict future acts of self-harm or suicide and should not be used to try and do so. (Appleby et. al., 2012, 2006, 2001; NICE, 2011; R. Coll. Psych., 2010; MHF:CF, 2006).

Suicide and self-harm are multi-determined acts in which a complex range of experiences come together in a way that is unique for the individual and the particular occasion (RCPsych., 2010; Underwood, 2009; Hawton & James, 2005). This means they have limited use in informing care pathways or individual care plans, which require establishing a therapeutic rapport with a young person in order to understand and respond to their particular unique combination of factors and subjective experience.

Implications for prevention strategies

However, these risk factors do highlight that self-harm and suicidality in children and young people is often/mostly a psychosocial issue, often requiring a non-psychiatric, pragmatic resolution of the precipitants and triggers, e.g. the experience of bullying, discrimination or maltreatment or social adversity (Webb, 2002, Crowley et. Al 2003).

Two of these factors are particularly important in relation to informing strategies for prevention. There is a clear and direct relationship established between self-harm and suicide in children and young people with:

- childhood abuse
- bullying (MHF: CF, 2006)

Worldwide, childhood abuse (particularly sexual and physical abuse) is consistently the strongest predictive risk factor for future suicide (Bruffaerts et. Al., 2010). This has serious implications for local health and social care authorities looking to implement strategies to reduce incidents of self-harm and suicide in the longer term. Suggesting that strengthening the reach, resource and efficacy of safeguarding and child protection procedures to reduce the level of exposure of children to maltreatment, combined with collaborative work between mental health and social care departments, may have the most significant impact.

In relation to bullying, it is important to note that both victims and perpetrators of bullying are at a significantly increased risk of suicide. Whole school/system strategies for tackling bullying have been identified in a number of policy and guideline documents as an important strategy for reducing suicide and self harm in young people (MHF:CF, 2006; DH/DfES, 2004).

3. Understanding the Issue: Function & Meaning of Self Harm and its Relationship with Suicide

Establishing a shared understanding of the function and meaning of self-harm with a young person at each particular time constitutes the foundation of all assessment, response and intervention recommendations (NICE, 2011, 2004; Nock, 2010; Skegg, 2005). This needs to be embedded in to all local policy initiatives and priorities and into the philosophy of care within the local workforce. Very detailed discussion of the many functions and meanings that self harm can serve is contained within the full report and will be central to the development of the next steps of the project: the resource to support primary care practitioners with first responses and decision making and the reflective learning sets.

A very brief summary of the issues are described here. The function and meaning of self harm can be broadly split into intrapersonal (within the self) and interpersonal (between self and other).

Intrapersonal Functions

Functional understandings of self-injury embrace the idea that it helps the person cope with negative life events. The most commonly reported experiences are surviving childhood sexual abuse, loss and coping with depression.

Severe trauma in childhood can disrupt development of the body systems involved in the regulation of stress. Self harm has also been conceptualised as a method of communicating or symbolizing earlier traumas that cannot be spoken about. (Van der Kolk et al, 1996; Van der Kolk et al, 1989).

Childhood experiences of loss and deprivation can leave individuals with a profound internal emptiness and self injury can be conceptualised as an attempt to live with an inside that feels deadened and empty (expressed as self injuring to conjure up feelings of being 'real or alive')

Depression or depressed states of mind are highly correlated with self harm in adolescents (Moran, 2012; Prymachuck & Trainor, 2010). Self harm can give short term relief from the feelings of helplessness and hopelessness associated with depression.

As self-harm is such a multi-factorial issue, experiences of depression, childhood sexual abuse or loss are rarely the only reason that a person will injure themselves. However, the despair associated with these events may be the key to understanding self-injury. The feelings of helplessness, hopelessness and feeling trapped that underpin these experiences also exist in all of the difficult life experiences linked to self-injury. They can also help us understand why rates of self harm increase in boys and girls in restricted or controlled environments such as prison.

In addition to these prior life events the following intrapersonal functions have been documented:

Preventing suicide: ensuring survival

The use of self-harm as an alternative to suicide or for the preservation of life has begun to emerge strongly with the small body of literature examining young people's own understanding of their actions (NSPCC, 2009; MHF:CF, 2006; Yip, 2005; SCARE, 2005; Spandler, 1996). The corollary to this is agreeing that self-injury at the level of a lived experience, is not consciously destructive, but is a survival mechanism to deal with overwhelming problems.

In relation to adolescence, this is a developmental stage in which the use of the body to solve psychological conflict tends to predominate (Briggs, 2002). This is due to the whole developmental focus of this stage being on psychophysical integration, prompted by the onset of puberty. In cases where young people find themselves in a situation where they feel they have no other way of coping, here self-injury can be understood in terms of sacrificing a part of their body in order to enable both their body and mind to survive. This may include the body, or parts of the body, becoming unconsciously and concretely identified with hated or disturbing aspects of the self, significant others and relationships, or lost objects (Lemma, 2009; Polmear 2004, Bell, 2000).

Coping with Emotions, coping with thinking and not thinking

'Relief from a terrible state of mind' was the most commonly cited reason by young people participating in the CASE study (Madge et al, 2008).

Feelings of shame guilt, blame and anger have been particularly emphasised as negative affectual states that can lead to self harm as a means of trying to cope with being overwhelmed (Milligan and Andrews, 2005; McAllister 2003; Pembroke, 1994; Babiker and Arnold, 1997).

Shame has also been associated with range of other mental health difficulties common in young people (eating disorders, post traumatic stress, depression and borderline personality disorder).

Understanding the role of shame in the dynamics of self-harm is particularly important given the strong evidence given by young people to the national inquiry into self-harm, that adult responses to disclosures of self-harm could often compound feelings of shame (MHF:CF, 2006). Rissanen et al (2009) also found that experience of shame and guilt actively inhibits children and young people from seeking help for their self-harm and associated problems. Issues of shame and guilt may also go some way to making sense of the potency of the experience of bullying or of being bullied, as a risk factor for self-harm and suicide in children.

Self-injury can be used as a method of helping the person avoid emotions and thoughts. This may be achieved by dissociation or a diversion of focus (Babiker and Arnold, 1997; Wright et al, 2005).

Self harm has been described a means of regulating emotions (Klonsky, 2007) or of creating emotion. For example, painful stimulation has been demonstrated to result in increased release of endorphins (Farber, 2000).

Self Punishment

Self-punishment was the second most cited reason for self-harm by young people taking part in the CASE study (over 30,000 respondents to an anonymised self-report questionnaire). In addition it was highly correlated with repeated use of self-harm and self-cutting in particular (Madge et. Al, 2008). Expressions of “I don’t deserve any better”, “I need to be punished” and guilt and responsibility in terms such as “I’m to blame” have been highlighted as common when people self-injure. (Collins, 1996)

Externalisation

Self-injury can externalise the internal emotions and thoughts onto the body, or onto other people or objects. Babiker and Arnold (1997) have reported the idea that people can understand physical pain more than emotional pain.

Object relations analysts regard the self-injury as a method of eliminating the bad object/self that has polluted the body (Nathan, 2004), sometimes expressed through the need to get the “bad, evil blood” out of their system. This has been reported specifically in the few studies in which young people are invited to explore the meaning of their self-harm (Smith, 2002).

Communicating to the self

This may be a communication to the self or to other people. McAlister (2003) refers to self-injury as a symbolic method of crying. As with crying, the person may not have the words to describe why they cut, but just know that it helps.

Interpersonal functions

Communication with others

Self-injury has also been described as a vehicle for the expression of feelings, including rage, frustration, guilt and shame (Connors, 1996). Work with adolescent girls with a trauma history, identified that cutting themselves elicited a response from others, when others do not listen to their speaking voices. In this research it was also apparent that if the young people were not responded to helpfully, cutting developed into a repeated means of regulating emotions, in the absence of helpful others (Machoian, 2001)

Maintaining interpersonal boundaries & seeking interpersonal influence

Self-injury can be used as a response when the person is feeling rejected, but it can also be used to encourage people to reject them to prevent a close relationship occurring and further rejection (Farber, 2000). It may be used as a retaliative behaviour, in order to get someone in trouble or to express frustration, anger and helplessness (Madge et al, 2008). Here, self-harm is conceptualised as a method of acting out intra-personal difficulties due to past experiences of rejection. Whilst this is one of the most commonly held assumptions by professionals/adults working with young people, it should be noted that in the literature pertaining to self-reported reasons by young people, this function is one of the least commonly cited reasons, alongside seeking attention. It is also more likely to be associated with one off episodes of self-harm in young people (Madge et al, 2008).

Problem Solving

There is much in child and adolescent literature regarding the relationship between problem solving and self-harm (Hawton et. Al, 2012; Prymachuk & Trainor, 2010; Speckens & Hawton, 2005). This is concerned with the potential impairments in problem solving ability or differences in problem solving styles (Evans et al, 2005) and problem solving training as a helpful intervention.

Self harm in children and young people may be best conceptualised as an active attempt to find a solution to a problem when help is not available, or other solutions have failed, rather than a help seeking action or 'cry for help' (Souter & Kraemer, 2004)

It is important to hold in mind the pragmatic value of self-harm as a problem solving strategy for children and young people: young people have less well developed coping skills and far more limited access to other more adult-accepted strategies for coping with emotional and social difficulties (e.g. alcohol and drugs). Whereas, self-harm is readily available to young people and can be undertaken quickly, quietly and in almost any setting (Nock, 2010). Using the framework for understanding, children with cognitive difficulties or additional learning needs may require additional support in this domain (Bridges et al, 2012)

Being Different

Some professionals focus on theories to understand the differences that are thought to exist in people who self-injure (Speckens & Hawton, 2005; Evans et al, 2000). These theories need to be held lightly and with a critical eye as they can appear to help the professionals by creating a split between staff and client and locate the problem in the client (Procter, 2004).

One of the professional theories of why people self-harm is because they are more impulsive than other people. A recent study into the factors that contribute to some young people acting on thoughts of self-harm rather than just thinking about it, has concluded that children who act on their thoughts are likely to be more impulsive and concurrently experience more life stressors than those who do not act (O'Connor et al., 2012). However, it is not possible to distinguish the level of individual contribution that impulsivity and the experience of life stressors make. Two assumptions are made here that people are either impulsive or not impulsive and that acting on thoughts of self-harm is more serious or important than having thoughts of self-harm. In reality people can be impulsive at times and not impulsive at other times according to context. For children and adolescents, levels of impulsivity are tethered to developmental stage and exacerbated by the experience of stress.

There is evidence to suggest that children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) are at an overall increased risk of acting on thoughts of self-harm and of experiencing suicidal thoughts and impulses (Manor et al, 2010; James et al, 2004). Some estimations are that up to 18% of children with a diagnosis of ADHD have self-harmed (Green et al, 2005). However this increased risk has also been attributed to the secondary effect that symptoms of ADHD can have on the severity of depressive illnesses and conduct problems, rather than primarily as a result of the hyperkinetic symptoms themselves (Hawton et al, 2012).

In relation to the literature concerning Borderline Personality Disorder (BPD), a diagnosis commonly given to people who repeatedly self-harm, a number of authors have reported on a range of specific neurophysiological dysfunctions in the brain. These affect memory, regulation of emotional experience and expression. These neurological hallmarks have been associated with the experience of severe or prolonged relational trauma (Mearns et al, 1999; Bunner, 1995; Schore, 1994). This has been a commonly reported issue not only in BPD, but also with people who self-injure. This theory has been supported by Van der Kolk et al (1993) who found this to be an effect of psychological trauma in children and adults. Thus, people who self-harm may experience overwhelming emotions that they cannot cope with, or verbalise, due to these differences in the physiology of the brain. They may then need to self-harm in order to cope with these emotions.

Self-injury has many intrapersonal and interpersonal functions and meanings. These are also varied within the context of each individual episode of self-injury. Due to the multi-factorial nature of self-injury there are often many functions occurring at the same time for each episode (Rayner et al, 2005) and may be complementary or competing at the same time. The functions described here can be a useful method to assist in the understanding of why people self-harm particularly for practitioners working with children and young people who may not always be able to easily articulate the meaning of their experiences without support.

Link or otherwise with self-harm and suicide

In line with emerging consensus within studies that seek to understand service user views, self-harm and suicide are understood and named as primarily different but conceptually linked phenomena, with self-harm predominantly concerned with survival and coping, rather than death (MHF;CF, 2006; Yip, 2005; SCIE, 2005; Spandler, 1996; Solomon and Farrand, 1996).

There is a well publicised link between self harm and an increased risk of suicide later in life (NICE, 2011). Estimations are that 2% of those who self harm will die by suicide after 1 year, increasing to 5 % after 9 years (Owens, 2002), making self harm the best available predictor of suicide (Hawton et al 2004).

However, these statistics are largely derived from adult studies (particularly in relation to adult men), they do not provide a 'good' predictive ability (Appleton et al, 2012) and equally highlight that the vast majority of people who harm themselves will not go on to die by suicide. In addition, it is a relative minority of children and young people who harm themselves are likely to repeat this action (NICE 2011).

That is not to say that identifying those who are suicidal and responding to reduce the likelihood of enactment is not an important task, but it needs to be understood as no more important than responding helpfully to those whose self harm is not based upon an intention to die.

Key to this task is equipping practitioners to feel confident to ask directly about intentions to die, and other functions of a young person's self harm, in the knowledge that asking such questions does not increase the young person's risk of suicide in any way (Nock, 2010).

The link between self-harm and suicide in young people can be thought of as a dynamic continuum along which young people continuously move up and down. The kinds of emotional experiences and phenomena that may move a young person towards the intention to die include:

Social isolation, feelings of shame and guilt, perceived hopelessness, a reduction in choice and control and the loss of structures that give personal meaning to life (MHF:CF, 2006; Skegg, 2005; Souter & Kraemer, 2004; Bell, 2000).

Conversely Carer support, combined with peer acceptance and integration, have been identified as some of the most significant preventative factors for suicide (Groholt, 2000)

4. Responding Therapeutically from a Position of Understanding

Clinical guidelines for the management of self-harm (NICE 2011, 2004) stress the underpinning principles of respect, dignity and choice and the pivotal nature of trusting and empathic relationships.

The management of self-harm may or may not involve its prevention (Hume and Platt, 2007). The National Inquiry into Self-harm amongst Young People recommends that the starting point of all intervention is to understand that self-harm is not an illness and to identify underlying issues. The inquiry found direct evidence that if the focus of care is on self-harm, rather than underlying causes it can leave young people with no choice but to self-harm again (MHF: CF, 2006). Truth Hurts (MHF:CF, 2006) emphasises in its recommendations that the most effective strategies for helping young people who self-harm are founded upon the core values of all health and social care and helping professions and therefore are within all professionals ability to provide. As such, strategies deemed to be helpful are in many cases, neither complex nor financially prohibitive.

Listening, in and of itself, has been identified within the literature as a mechanism for both prevention and therapeutic intervention for children and young people (Lindgren et al, 2011; Rissanen et al, 2009; MHF:CF, 2006; Fortune 2005; Machoian, 2001). Helpful listening is defined as coming from adults who make themselves accessible, within a wider context/environment that is felt to be caring, and who are interested in listening to all kinds of issues about young people's daily lives, worries and pressures not just self-harm.

For some helpers the principles outlined below will be all that is required.

Recommendations & Principles for working with people who self harm

- Reconceptualization of self harm
 - Use of non pejorative or objectifying language that distinguishes between self harm and suicide; understanding of its worth in relation to survival, coping and communication functions
- Validation and acceptance
- Looking beneath the physical self harm to what is being communicated
- Helping the person to become more compassionate towards themselves
- Helping the person reflect on thoughts and feelings (mentalization)
- Supporting development of problem solving strategies
- Recognizing and mitigating the impact of helper responses
 - Understanding that Young people who repeatedly self harm are at particular risk from negative helping responses compounding their difficulties (Rayner et. Al, 2005; RCPsych, 2010)
- Sensitive management of issues relating to consent, confidentiality and safeguarding
- Implementing recommendations from people who self harm (see section 5.1.8)

5. Recommendations for Assessment, Decision Making and Risk Management

NICE (2011, 2004) clinical guidelines give clear evidence based standards for assessment, treatment and risk management of young people in contact with secondary services. Section 2 and 3 of the full report provides a summary of clinical guidelines and research findings for primary care staff regarding how to talk to young people about their self harm. These include some recommendations that may be counterintuitive and contrary to organisational custom and practice. Implementation requires a whole system understanding of these issues and a support and informed management framework for front line staff (Box 2)

Box 2.

Assessing/ finding out about self harm should use a narrative approach to focus on gathering an integrated knowledge of needs and risks for purpose of understanding and engaging the individual. The focus should be on person centred care and establishing a trusting therapeutic relationship (Nice, 2011; 2004; Royal Coll Psych., 2010; Skegg, 2005).

DONTS:

- Do not use risk assessment tools and scales to structure the assessment process or predict future suicide or repetition of self-harm (NICE, 2011; RCollPsych, 2010; Appleton et al 2010)
- Do not use method of self harm as an indicator of intent, risk or severity of difficulties – it is not a reliable measure (Wolpert et al 2006)
- Do not use level of premeditation/planning as a measure of seriousness of intent. Research indicates that over half of children who self harm decide to do so less than 1 hour before the event, regardless of their level of intent to die (Madge, 2008)
- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged
- Do not use rates of repetition as a means of evaluating outcomes or changes in presenting risk

Do's

- Place an equal importance on the treatment of young people who self harm without any underlying suicidal intent or mental disorder as those with (Appleton et al 2010; MHF:CF, 2006)
- Be clear with the individual about the limits of confidentiality and issues of information sharing before you start (NICE 2011)
- Ask directly and openly about self harm, thoughts of wanting to die and suicidal behaviour – research shows this **does not** increase risk of a child enacting self harm or suicidal behaviour. It provides relief and modelling that difficult issues can be talked about (Nock 2010; Souter & Kraemer 2004)
- Encourage young people to explain their feelings and understanding of their own self-harm in their own words, actively listening and validating their experiences (NICE 2004; Machoian, 2001).
- Ask children you come across who are anxious or experiencing low mood, about thoughts or episodes of self harm or suicide (Hill, Castellanos et. Al. 2011).
- Communicate to young people their strength and courage for disclosing and proceed at a pace led by them (MHF:CF, 2006)
- Avoid adult-orientated appraisals of severity or impact of perceived losses that children report (e.g. relationship break ups) – establish their view of it (Souter & Kraemer, 2004)

6. Recommendations from Evidence Base for Provision of Psychological Interventions

Systematic evaluation of psychological interventions is complex. To date rigorous controlled studies designed to evaluate clinical effectiveness of particular treatments have not yielded any definitive or generalisable results due to a number of limitations. (Fonagy et al, 2002; Webb, 2002; Burns, Dudley, Hazell & Patton, 2005; Wolpert, Fuggle et al, 2006; Hawton et al, 2009). Treatments that have shown to reduce rates of self harm have not been effective in providing relief from underlying distress and vice versa (SCARE, 2005b)

From a pragmatic service design perspective, the central issue is that if self-harm is understood as a coping response rather than an illness, secondary to a diverse range of other issues and difficulties, it should be anticipated that there will not be a single advised treatment for all. In addition, evidence across the life course highlights the quality of the relationship with the helper as the most pivotal contributor to outcome (Skegg, 2005). A range of approaches and interventions need to be available to meet the needs of a heterogeneous population (Hulme & Platt, 2007).

Based on this the Royal College of Psychiatry recommendation is that Commissioners need to ensure that a range of evidence based psychological therapies are available based on the therapies that have shown effectiveness for some, rather than all people (Royal Coll. Psych., 2010).

Problem solving training

This is direct, easy to understand, can be used in a range of settings, can be delivered by non specialist practitioners, has a low risk/contra indication profile, is inexpensive in relation to workforce training and can be extended to family work.

Problem solving interventions, have been shown to improve adolescent feelings of depression and suicidality, improve maternal attitudes towards treatment and be useful to individuals who repeatedly self harm (Hawton, 2012; Prymjachuk & Trainor, 2010; Wolpert, Fuggle et al, 2006; McAuliffe et al, 2006; Skegg, 2005; Townsend, 2001).

As such, a recommendation of this report is that dissemination of problem solving training/interventions within the universal workforce who commonly come into to contact with young people who self harm should be considered.

Interventions for young people requiring secondary or specialist CAMHS care

The portfolio if interventions available should ideally include:

- Brief family Interventions with a focus on problem solving
- Dialectical Behaviour Therapy
- Developmental Group Psychotherapy
- Psycho education on harm minimisation techniques and wound management
- Evidence based treatments for underlying mental health disorders commonly associated with self harm (depression, anxiety and trauma):
 - Cognitive Behavioural Therapy
 - Interpersonal therapy
 - Brief psychodynamic therapy (DIT)

7. Good practice standards & recommendations for service delivery and design

Prevention

- A key preventative strategy for self-harm should be cross-department working to improve social and economic life circumstances (R. Coll. Psych, 2010).

Multi-agency framework

- Protocols for referral, support and early intervention are agreed between all agencies (DfES, 2004).
- The needs of children and young people with complex, severe and persistent behavioural and mental health needs are met through a multi-agency approach, with joint responses, protocols and contingency arrangements between education, social care and health agreed at senior level (DfES, 2004).

Service Users as Stakeholders

- Strategic Health Authorities, Primary Care Trusts (and the equivalent organisations in the new NHS structure), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm. (NICE 2004)

Risk assessment

- Actuarial and structured risk assessment tools *per se* have really limited and short term ability to predict risk, reduce engagement and empathy (Appleby et al, 2012, RCPsych, 2010). This practice is contrary to recommendations in the NICE clinical guidelines (2011). Senior cross departmental directives to discourage the development and use of such tools and adherence to the NICE clinical guideline recommendations is required.

Operational Implementation

- Continuity of care for young people discharged from hospital or in transition to adult services must be ensured by use of the 'care programme approach'.
- Work force output rates/capacity modelling needs to account for time for engagement as a prelude to psychological treatment, rather than estimated average length of psychological treatment alone.
- Non attendance of children and families at clinical services should trigger a review of needs and care provision rather than case closure. In older children (16+) with capacity to consent to treatment, this process needs to be distinguished from young people who are withdrawing consent to treatment in an informed way.

Complex cases

- Consideration of development of distinct services for young people who repeatedly self-harm over a long period.
- This group's needs are potentially distinct from the wider population and they are at significantly increased risk of suicide and application of a diagnosis of borderline or emotionally unstable personality disorder, with the stigma and risk that such a label brings. Underlying difficulties are less likely to be mental illness *per se* and therefore mainstream specialist Camhs provision in its current form may not meet their needs (Royal Coll. Psychiatry, 2010).
- For complex cases, there is also emerging evidence from work with young people with persistent conduct problems alongside multiple other psychological and social difficulties regarding clinical efficacy of individualised multi-systemic treatment programmes, built from a range interventions, based on understanding of the issues for each individual that work across all domains of difficulty and system, rather than focusing on issue of self-harm alone (Wolpert, Fuggle et al, 2006).
- The group described above and also young people who present for the first time with self harm or suicidality, accompanied by a disclosure of abuse, are at particularly high risk of their needs remaining unmet due to threshold, administrative and legal process divides between health and social care agencies (DfES, 2008). This situation has a concomitant risk of serious untoward incident or suicide inherent within it.

Cross-agency (Health & Social Care) assessment procedures following hospital presentation and identified suicide attempts could be considered as a means of addressing this issue (Souter and Kraemer, 2004).

- A systemic culture of reflective practice and learning from experience needs to be embedded into organisational practice, not just team or individual clinical practices (Appleton et al, 2012; Royal Coll. Psychiatry, 2010).

Measuring Outcomes

- Historically, mechanisms for measuring clinical success of interventions and treatment programmes has lent heavily upon frequency of repetition and severity of self harm. The body of research evidence and clinical practice guidelines currently available clearly show the limitations of this approach. In fact, focusing solely on the behaviour leads to interventions which are overly controlling and fail to engage with the complexity of self-harm and actually risk doing more harm than good (Mental Health Foundation & Camelot Foundation, MHF:CF 2006).
- Given this, it is important to acknowledge the part that self-harm has played in the young person's life but to refrain from using it as an outcome measure unless this is something that the individual sees as useful (Allen, 2007).

- To achieve this, ways to gauge progress using the goals and measures formulated by the young person themselves are important and likely to lead to a more meaningful interpretation of progress (Allen, 2007).
- In relation to service user satisfaction, patient reported measures derived from service user information regarding the principles and characteristics of helpful care provision, contained within section 5 of the report are most likely to provide a valid benchmark upon which the quality of provision across the locality can be evaluated.
- These can be further enhanced through utilisation of the findings of the qualitative research project currently being undertaken with children, young people and carers across the Knowsley locality, who have experiences of self harm or suicidality.

8. Project Outputs

Output	Who?	When?
A comprehensive practice focused literature review	University of Salford	November 2012
Easy Read Summary of Literature Review and Recommendations	University of Salford	January 2013
Training and Education Standards	University of Salford	November 2012
In-house tailored package of training for self harm to support practitioners. This will link with the workforce development activity running within the Salford commissioned work and sit within the Knowsley Multi-Agency Training Pool.	Knowsley Locality	Development complete Spring 2013 Roll out of training delivery expected May 2013
Staff Consultation Event to establish work force needs and preferences in relation to information about self harm	University of Salford	October 2012
The production of a best practice/effective practice resource	University of Salford in consultation with Knowsley Project Steering Group and Practice Implementation Board	Production complete March 2013 Final sign off for Printing and Dissemination 3 rd May 2013
Training of Locality Based Reflective learning Set co-facilitators	University of Salford	December 2013
Facilitation of time limited reflective learning sets (3 sets, each attending 4 sessions with 8 attendees)	University of Salford	January 2013 – 27 th March 2013
Thematic analysis of outputs from sets	University of Salford	
Provision of certificated CPD record	University of Salford	
Evaluation of first run of RLS	University of Salford	
Debrief and planning meeting to support co-facilitators with continuing to run further sets	University of Salford in conjunction with Glenys Hurst-Robson c/o Knowsley Council	
Operational and logistical support and infrastructure to enable marketing, recruitment and running of the reflective learning sets	Glenys Hurst-Robson c/o Knowsley Council	
Support to Children & Young People and Public Health Commissioning Team and steering group to implement recommendations.	Collaborative partnership between University of Salford, Knowsley Commissioning Team, Project Steering Group & Practice Implementation Group	January –April 2013
Facilitation of the practice implementation board to begin development of multi agency protocol for children & young people who self harm who are identified as having complex needs and at high risk.		March- April 2013
Key note address and workshop facilitation at a local conference/dissemination event	Knowsley Council. Salford University to contribute to event	17 th September 2013

9. Next Steps for Knowsley

The Knowsley Children & Young people and Public Health Commissioning Team have undertaken a full locality self evaluation, against the recommendations as outlined. In addition to the outputs detailed above, a further action plan for the implementation of remaining recommendations has been developed and submitted to the Knowsley Safeguarding Children Board and the Knowsley Children and Family Board. This is contained within chapter 4 of the full report.

The actions have been developed across 7 domains:

1. Policy
2. Protocol
3. Practice
4. Development of workforce knowledge
5. Provision of Psychological Appropriate Psychological Interventions
6. Pathway operating procedures for complex & high risk cases
7. Service users as Stakeholders

Agreement has been obtained for the project's practice implementation group to remain in place for the following 12 months, acting as the forum for driving implementation of the agreed actions.

The group will report progress to the Knowsley Children Young People Emotional Wellbeing Strategic Group, the Knowsley Children and Families Board and the Knowsley Safeguarding Children Board as required.

Full Report

Chapter 1. Practice Focused Literature Review

1. Introduction

1.1. Purpose and scope of report

This document reports on the findings of a comprehensive practice-orientated literature review undertaken by the Knowsley Self Harm and Suicide Amongst Young People workforce project team at the University of Salford, commissioned by Knowsley DCFS, as part of a wider undertaking to improve services in relation to self harm and suicide amongst children and young people in Knowsley.

This literature review relates specifically to the evidence base and multi-agency workforce development domains, in line with DH/DfES (2004) expectations:

“That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.” (pg, 4)

It is the first component and foundation of a 3 part workforce development project that the University of Salford has been commissioned to provide, in collaboration with practitioners within the Knowsley locality.

The following report is based on a review and synthesis of a comprehensive search and critical review of quantitative and qualitative research, in the field of self-harm and suicide in children and young people, with specific and related policies, clinical guidelines, expert clinical opinion and relevant organisational briefings. The review includes judicious extrapolation of relevant adult focused enquiries, due to the limits and gaps of currently available research specifically relating to children and young people. Where available it privileges qualitative studies that construct understanding from service user perspectives.

This will lead to an integrated narrative of commissioner, service and practitioner level expectations, points of consensus and contested ground and good practice markers and recommendations for future work. It is intended that the summary of recommendations, standards and principles will be used as a locality self assessment of current practice, form the basis of the practitioner resource to be developed and, in conjunction with the research component of the project, to inform future service development.

The authors wish to caution the reader and highlight the general limitations of research evidence and published literature in the field of child and adolescent mental health. The issue of clinical efficacy may be limited by the fact that research is usually conducted on populations defined by operational, adult-derived, diagnostic criteria and the actual clinical population does not adhere to such neat boxes (Wolpert, Fuggle et. Al, 2006). As such we would urge research to be used to assist systematic decision making, alongside, but not instead of, understanding the individual and family's predicament, priorities and preferences.

1.2. Use of Language and operational definitions within the report

It is important to note that within the published literature, guidelines and evidence, there is no universally agreed or accepted definition of self-harm or other associated concepts such as self injury and suicidal behaviour. Issues of language, definition and the sensitive application of these have been identified as important precursors to effective organisational strategies for addressing the issue of self-harm and suicide (R. Coll. Psych., 2010; Allen 2007). For the purpose of this report the definition adopted in the NICE clinical guidelines for the management of self-harm (2011; 2004) will be utilised:

“An expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion and should not be presumed to be the same.” (p. 8)

It is also important to note that whilst this definition assumes that self-harm is related to distress in all cases, a number of reports and studies exploring the meaning of self-harm for children and young people have identified that it can serve a positive and worthwhile function for some, and therefore is not always a product of distress (Bywater and Rolfe 2005; Smith, 2002).

Within this report, self-harm and suicide are understood and named as primarily different but a conceptually linked phenomena. This is in line with the emerging consensus within studies that seek to understand service user views on this issue (MHF;CF, 2006; Yip, 2005; SCIE, 2005; Spandler, 1996; Solomon and Farrand, 1996). The relationship, overlap and differences in the function and meaning of these acts will be explored in more detail in a later chapter of the report.

The terms 'deliberate' and 'self-harmer' do not appear in the text of this report, although it needs to be acknowledged that many of the published studies about self-harm that were reviewed for the report do continue to use these terms. The prefix 'deliberate' has been identified as both a redundant and potentially pejorative term (R. Coll. Psych., 2010; Prymachuk & Trainor, 2010; Allen 2007). Similarly the term 'self-harmer' is a potentially dehumanising objectification of an individual whose identity is defined by far more than their relationship with self-harm. (Mental Health Foundation & Camelot Foundation, MHF:CF 2006). This can create facilitative spaces for discrimination and oppression.

A more detailed analysis of the issues relating to language and nomenclature, and its impact upon therapeutic practice with individuals who self-harm can be found in Allen (2007).

2. Context of Issue

Issues of prevalence and epidemiology in relation to self-harm and suicide in children and young people are complex. While there have been many studies published over the last twenty years seeking to establish accurate rates of occurrence, problems with differing definitions, criteria for inclusion, recruitment process and ways in which sample groups are selected, make aggregating data, difficult. Additionally, data regarding rates of prevalence and associated risk factors have only very limited use in respect of developing services and workforces that respond helpfully to individual needs.

Knowsley M.B.C. has already undertaken a significant amount of work collating and interrogating local data in this field (Refer to 'Knowsley Health & Wellbeing: Improving Lives. Suicides and Self Harm' Holford, 2011). As such, only key messages from 2 of the most recent and comprehensive studies in this field will be briefly summarised and discussed in relation to specific questions asked by the project steering group. A detailed description of the range of studies concerning prevalence, demographic and epidemiological correlates of self-harm in young people up until the current date can be found in Hawton, Saunders and O'Connor (2012).

The report into the National Inquiry into Self-harm in Children and Young People (MHF:CF, 2006) concluded that an estimated prevalence rate of between 1 in 12 and 1 in 15 young people could be assumed. The most recent assumptions made by the research team at the Oxford Centre for Suicide Research are that prevalence across the full age range of children and adolescents, both male and female, can be estimated at 10% (Hawton, Saunders and O'Connor, 2012). To highlight the complexities of establishing definitive rates, some

international studies completed more recently have much higher estimate rates (up to 45%) depending on the definition adopted (Nock, 2010).

Madge et al., (2008) undertook a seven country pan-European collaborative investigation of self-harm in young people (The CASE study). This used anonymised self report by questionnaire in school and community samples. It is the largest systematic research study of this kind to date. The total sample group was 30476 young people across 7 European countries, including a UK sample group of 5987 young people.

The age range of the study was 14-17 years, however, the final sample group was disproportionately made up of 15 and 16 year olds. This means that caution needs to be applied if generalising results across all phases of adolescence.

The study found that in the UK, an estimated 16.7% of girls and 4.8% of boys reported an episode of self-harm across their lifetime. This compares to prevalence in the total pan-European sample of 13.5% of girls and 4.3% of boys. When participants were asked about experiencing thoughts of self-harm as opposed to episodes in which they had acted on their thoughts, the rate in the total sample group rose to 12.5% of boys and 30.4% of girls.

Just over half of the participants reported more than one episode of self-harm across their lifetime. Only 12.4% of young people reported seeking help or presenting at hospital for treatment following their self-harm.

The CASE study adopts a definition of self-harm that does not distinguish between episodes of a suicidal nature and those without associated intention to die, so it is not possible to extrapolate from the reported episodes, the number of suicide attempts. However, the participants were asked to identify the reason for their self-harm and 59% identified 'I wanted to die' as a reason (although not necessarily exclusively). Of these, overdose/self-poisoning was the method of self-harm most commonly reported by participants (Madge et al, 2008).

Given the makeup of the locality of Knowsley M.B.C. and the particular context that led to this report being commissioned, it may be of relevance to highlight that some work has begun researching possible differences in population profiles in urban and rural areas. Harriss & Hawton (2011) recently reported a study of comparative prevalence and patient characteristics in urban and rural areas within the same locality, using hospital presentation data of individuals aged 15years and over. Findings indicated that reported rates of self-harm were lower in rural areas (speculatively associated with higher levels of deprivation in urban areas and potentially lower access to services in rural areas, leading to lower

reporting rates). However, the reported level of suicidal intent in individuals from rural areas was substantially higher than those in the urban sample group. As this is a preliminary single locality study in the south of England, definitive comparisons cannot be made, but analysis of further research as it emerges may be of value to the M.B.C to inform future workforce planning and service delivery.

2.1 Age

The commissioners of this report specifically asked that the issue of age and the phenomena of self-harm and suicide in younger children were reviewed.

Average age of onset of self-harm and suicidality is 12 years old and rates of self-harm across the life course peak in adolescence (Moran et. Al. 2012; MFH, 2006). As a result, most published research studies focus on populations of twelve years old and above. Any reports that did include data regarding younger children aggregated this with the data for older children meaning. As such, any distinctions based on age could not be interrogated in any detail. Self-harm and particularly suicide in younger children is a tragic but relatively speaking rare event, making design of studies from which generalisations can be drawn highly problematic. All studies found in this review that did relate to younger children focused exclusively on quantitative data and prevalence rates. This adds further support to Knowsley M.B.C.'s decision to ask that the qualitative research component of the commissioned project include interviews with children younger than 12.

The findings of a population based research study tracking the progression of self-harm rates across adolescence (Moran et. Al., 2012) have concurred with earlier research indicating that the onset of self-harm is associated with the onset of puberty, both its physical and psychological characteristics (Nock, 2010; Patton, 2007). This finding may offer a theoretical explanation for the anecdotal report of increases in episodes of self-harm in younger children, in that the average age of onset of puberty has been shown to be decreasing over time (Pierce & Hardy, 2012).

Moran et. al.'s (2012) study shows the peak rate of self-harm to be in the latter phase of pubertal development in late adolescence, which is then followed by a tapering off of self-harm rates in early adulthood. This is in contrast to figures for completed suicide which peak in early adulthood (25-34 years) and again in later life (Hawton and Harriss, 2008; NICE 2004, 2011).

Evidence presented by young people to the National Inquiry into self-harm, identified the earliest age of onset as 5 years old. However, service user evidence submitted to another qualitative research study reported the earliest age of onset as 3 years old (Warm et al, 2002). Onset as young as this is likely to be uncommon as highlighted by a national survey of more than 10,000 children which calculated the prevalence of self-harm among 5-10 year-olds as 0.8% among children without any mental health issues. The rate for children who were diagnosed with an anxiety disorder was 6.2% and 7.5% if the child had a diagnosis of conduct, hyperkinetic or other less common mental disorder (Meltzer et. Al., 2001).

More recently, Hawton and Harriss (2008) reported on a 26 year retrospective analysis of data on under 15 year olds presenting at hospital following episodes of self-harm. They found 710 cases of children under 15 years meeting their inclusion criteria. Most commonly reported precipitants were relationship problems with family or peers and school related worries. The long term risk of completed suicide in this sample was calculated as 1.1% (where N=5).

Children aged 5-10 have been calculated to be between 3 and 15 times more likely to self-harm if they had experienced either 3 or more, or 5 or more stressful life events respectively (SCARE, 2005a).

2.2. Gender

Quantitative studies over the last decade have repeatedly reported the frequency of self-harm to be much higher in young women, particularly in relation to self cutting, estimating rates to be up to 4 times higher (Hawton, Saunders et al, 2012; Madge et. Al, 2008). However, the gender profile of children and young people who self-harm or who are experiencing thoughts of suicide are likely to be much more complex than this which should be held in mind when considering statistics of this kind. There are significant issues in relation to how and what is reported as self-harm. This means that more diverse forms of self-harm other than cutting and overdosing, potentially more frequently adopted by young men, such as instigating assault from others, may not be recorded as self-harm.

Participant recruitment strategies for particular research methodologies can also lead to over or under representation of a particular gender. For example, in contrast to the findings of the CASE study (Madge et al, 2008) which used self-report questionnaires, a large scale consecutive sample of 516 young people and adults attending a general hospital for treatment of skin cutting, found no gender differences. 48% of the sample were women and 52% were men (Marchetto, 2006). Similarly a gender analysis of self-harm in a population of

people with symptoms and characteristics associated with a diagnosis of borderline personality disorder, found that head banging and losing a job on purpose were forms much more likely to be adopted by men. However, no other gender differences were apparent in the other forms of self-harm investigated, including self-cutting (Sansone et. Al., 2010).

Preferred mechanisms for help-seeking may also contribute to the development of a skewed picture. It has been noted that The Samaritans consistently take more calls from men than women (R. Coll. Psych., 2010). The profile of reported rates of self-harm amongst young men and young women also change as adolescents get older, with the situation inverting in young adulthood, where young men are reported to have the highest rates of self-harm (MHF:CF, 2006).

Face value acceptance of trends in data, with such a high level of variation and limitation inherent within it, presents risks for both young women and young men. Shaw (2002) has argued that the historical and current narrative around self-harm and women mimics the patriarchal objectification and violence to which girls and women continue to be subjected.

It also serves to foreclose opportunities for understanding the experience of boys and young men who self-harm: all of the qualitative research studies talking to young people about their personal experience of self-harm, identified for the purpose of this report were with young women exclusively.

2.3 BME issues

Rates of self-harm have been shown to be disproportionately high among young Asian women aged 15-35 years, in comparison to general population prevalence figures (Bhardwaj, 2001). This is a difficult statistic to make use of in child and adolescent mental health services, as the sub population identified encompasses both adolescents and adults. Other than this, there is no difference in prevalence between adolescents from white, black or ethnic minority communities. However, Bhugra, Thompson, Singh and Fellow-Smith (2004) indicate that some of the factors involved in self-harm may be different between cultures. For example, South Asian adolescents were more likely to have problems at school, experience cultural and intergenerational conflict at home, report greater feelings of isolation, but were less likely to feel depressed, than their white counterparts

2.4 Statistically Associated Risk Factors

Through quantitative research studies much is now known about the bio-psychosocial factors and characteristics that are statistically associated with an increased risk of self-harm and future suicide in children and young people. The evidence in relation to these has been summarised in figure 1 as follows.

It can be seen from the list provided that the risk factors associated with self-harm are almost the same as the factors associated with an increased risk of developing most mental health problems common to children and adolescents. There is consensus within clinical guidelines and systematic reviews of clinical evidence that due to low specificity and predictive value, knowledge of these risk factors does not serve to sensitively distinguish children at high risk of self-harm or predict future acts of self-harm or suicide and should not be used to try and do so. (Appleby et.al., 2012, 2006, 2001; NICE, 2011; R. Coll. Psych., 2010; MHF:CF, 2006).

Suicide and self-harm are multi-determined acts in which a complex range of experiences come together in a way that is unique for the individual and the particular occasion (RCPsych., 2010; Underwood, 2009; Hawton & James, 2005). This means they have limited use in informing care pathways or individual care plans, which require establishing a therapeutic rapport with a young person in order to understand and respond to their particular unique combination of factors and subjective experience.

These risk factors do however highlight one very important issue. Self-harm and suicidality in children and young people is often/mostly a psychosocial issue, often requiring a non-psychiatric, pragmatic resolution of the precipitants and triggers, e.g. the experience of bullying, discrimination or maltreatment or social adversity (Webb, 2002, Crowley et. Al 2003)

Two of these factors are particularly important in relation to informing strategies for prevention. There is a clear and direct relationship established between self-harm and suicide in children and young people with both childhood abuse and bullying (MHF: CF, 2006)

A study examining data across 21 countries has shown that childhood abuse (particularly sexual and physical abuse) is consistently the strongest predictive risk factor for future suicide. (Bruffaerts et. Al, 2010). In a sample of 516 young people and adults attending hospital for treatment of self-injury, 84% reported a history of trauma and 60% reported childhood abuse and/or neglect (Marchetto, 2006).

This has serious implications for local health and social care authorities looking to implement strategies to reduce incidents of self-harm and suicide in the longer term. Suggesting that strengthening the reach, resource and efficacy of safeguarding and child protection procedures to reduce the level of exposure of children to maltreatment, combined with collaborative work between mental health and social care departments, may have the most significant impact.

Standard nine of the children's national service framework (DH/DfES, 2004) specifically identifies the need for interventions to tackle bullying as a central component of child mental health promotion and prevention strategies. A systematic review of 37 research studies indicates that children who are victims or perpetrators of bullying have a significantly increased risk of experiencing suicidal thoughts (Kim and Leventhal 2008). This highlights the commonalities and shared vulnerabilities that can exist between children who bully and who are bullied (Polmear, 2004). In response to the strength of evidence submitted to the National Inquiry into self-harm in young people, a recommendation for anti-bullying strategies as part of a whole school approach to mental health for all was made.

Figure 1. Factors statistically associated with increased risk of self harm and suicide in children and young people.

- Mental health problems (hopelessness and depression, anxiety, impulsivity inc. ADHD)
- Adverse family circumstances (e.g. parental mental health difficulty, criminality and/or family poverty);
- Disrupted upbringing (periods of local authority care, parental marital problems such as separation or divorce);
- Family relationship problems.
- Close friend or family member attempting suicide or harming themselves
- Low self-image or self esteem
- Isolation (social, family and or rural)
- Drug use and or alcohol use
- Experience of bullying (victim or perpetrator)
- Stress and worry around academic performance, education or occupation
- Bereavement
- Unwanted pregnancy
- Experience of abuse or maltreatment (sexual, physical, emotional, neglect, domestic violence)
- Problems associated with sexuality
- Problems to do with race, culture or religion
- Perceived loss, rejection or separation in interpersonal relationships

Usually complex range of experiences, not one event or factor (risk is not directly associated with number of factors present) **Summarised From: Hawton, Saunders & O'Connor, 2012; Underwood, 2009; Madge et al, 2008; MHF:CF, 2006; Skegg, 2005; Hawton & James, 2005; Fox & Hawton, 2004;**

3. Continuum, Functions and Meaning of Self-harm

Establishing a shared understanding of the function and meaning of self-harm with a young person at each particular time constitutes the foundation of all assessment, response and intervention recommendations (NICE, 2011, 2004; Nock, 2010; Skegg, 2005) and therefore warrants a detailed analysis. There are a wide range of functions and meanings associated with the use of self-injury in the literature. These will now be discussed in turn.

Klonsky (2007), when reviewing the evidence for the functions of self-injury or self harm using quantitative research, described the following areas; emotional regulation, dissociation, suicide prevention, interpersonal boundaries, interpersonal influence, self-punishment and sensation seeking. These purposes have also been supported in other literature and correlate with the list of functions identified by young people participants in the CASE study (Madge et. Al, 2008). Here we have included dissociation and self-punishment as methods of managing emotions, rather than as separate entities. Other ideas from qualitative research and literature written by experts by experience have also been added.

3.1 Intrapersonal functions

Functional understandings of self-injury embrace the idea that it helps the person cope with negative life events. Although this idea has been useful for people who have experienced these events, there are also other people who have not had these experiences. This dominant discourse has been helpful for professionals in looking at reasons for self-injury and therefore has made the behaviour an understandable coping strategy. The most commonly reported experiences are surviving childhood sexual abuse, loss and coping with depression.

The most frequently reported past experience for people who self-injure is childhood sexual abuse or trauma. Authors have linked child sexual abuse with self-harm in women, men, young people and children. (Bruffaerts et. Al, 2010; MHF:CF, 2006; Babiker&Arnold, 1997; Van der Kolk,1989; Miller,1994). Indeed McAllister, (2003) emphasises this by stating that the vast majority of people who self-harm have a history of child and/or adult sexual abuse as well as abandonment and neglect. Currently there is an emerging awareness of many people who self-injure who do not engage with health service provision and are therefore usually not represented in health and social care service research (Adler and Adler, 2007). Thus assumptions cannot be made about their experiences of abuse. Nevertheless childhood sexual abuse is often considered to be a precursor to self-injury by many authors. Van der Kolk et al (1996) found evidence that severe trauma may alter the structure and

chemistry of the brain and other body systems involved in the regulation of stress. These may be irreversible if the child is traumatised before the central nervous system is fully developed. Van der Kolk (1989) suggests that self-harm is a method of repeating, communicating or symbolizing earlier trauma. If people are unable to forget the trauma, but they are unable to speak out about this, then they are obliged to remember this by acting it out. Calof (1995) describes this as a method of “telling without telling” the story of the original abuse.

Collins (1996) suggests that if a child experiences loss and deprivation, there is a lack of relationships and therefore a profound sense of internal emptiness. Due to this there is a lack of introjects (internalised objects). In this case, self-injury could be understood as an attempt to live with an inside that feels deprived, empty and unfillable. People may describe how they self-injure to convince themselves that they really are alive, because they feel dead and empty. In terms of loss the person may also self-injure as an attempt to hold onto something that once existed but is now lost.

Depression has also been one of the most commonly reported reasons why people self-injure (Babiker & Arnold, 1997; Harrison, 1994) and highly correlated with self-harm in adolescents in particular (Moran, 2012; Prymachuk & Trainor, 2010). It is argued that self-injury gives some short-term relief, only for the depressive feelings to return when they view the damage (Smith, 2002). This can be a method of gaining some control over the physical self or internal feelings. The feelings of helplessness and hopelessness associated with depression have also been frequently reported as reasons for self-harming behaviour (Souter & Kraemer, 2004; Harrison, 1994; Babiker and Arnold, 1997; Arnold, 1994).

As self-harm is such a multi-factorial issue, experiences of depression, childhood sexual abuse or loss are rarely the only reason that a person will injure themselves. However, the despair associated with these events may be the key to understanding self-injury. The feelings of helplessness, hopelessness and feeling trapped that underpin these experiences also exist in all of the difficult life experiences linked to self-injury. In addition to these prior life events the following intrapersonal functions have been documented.

3.1.1. Coping with thinking and not thinking

Ideas relating to thinking and not-thinking have been viewed as causes of self-injury. People have reported self-injuring in order to cope with thinking, or as a method of diversion away

from their thoughts to stop thinking (Babiker and Arnold, 1997). In a study exploring suicidal adolescent's relationships with their bodies, in the context of their attachment experiences, a sub group of suicidal young people identified coping styles expressly aimed at 'not thinking' about emotional experiences, in which suicidal and injurious acts against their bodies constituted a foreclosing relatedness to others for this purpose (Wright et al, 2005).

Fonagy (1991) has emphasised self-harm as one aspect of the psychic functioning of people with "borderline personalities". Whilst this paper was not specifically about self-injury, it is one of the behaviours that the above people may present, alongside many interpersonal problems. In addition, young people who repeatedly self-injure and who come into contact with secondary mental health services are at significant risk of having the diagnosis of borderline or emotionally unstable personality disorder applied to them as they approach 18 (Fonagy et al, 2011). The main focus of this theory is that people with a borderline personality do not develop a theory of mind and therefore have severe problems understanding what other people may be thinking (Mentalization). People who have difficulties mentalizing struggle to label emotions and therefore understand them as being transient (Fonagy, 1991). They may have difficulties with overwhelming emotions and also struggle to recognise emotions and thoughts in other people. Self-injury can be understood within this context as being a method of coping with the overwhelming emotions.

3.1.2. Being Different

Some professionals focus on theories to understand the differences that are thought to exist in people who self-injure (Speckens & Hawton, 2005; Evans et al, 2000). Not surprisingly these theories do not often feature in "expert by experience" explanations of why they self-injure. However, they appear to help the professionals by creating a split between staff and client and locate the problem in the client (Procter, 2004). Within these theories there is a notable absence of staff reactions or attitudes to the person and the self-injury, thus the focus remains on the client.

One of the professional theories of why people self-injure is because they are more impulsive than other people. Disorders in children and young people that are characterised with increased impulsivity, e.g. hyperkinetic disorders, have been associated with higher rates of self-harm (Underwood, 2009). Evans et al (2000), in their research paper, interviewed people presenting after "deliberate self-harm" to one Accident and Emergency department. Participants were interviewed and asked to complete the I-V-E impulsiveness

questionnaire, (Eysenck & Eysenck, 1991), the Hospital Anxiety and Depression scale (Zigmond & Snaith, 1983) and the State-Trait Anger Expression inventory (Spielberger, 1988). This was the first study to relate specific genes to the personality trait of impulsiveness. It was found that there was no significant relationship between TPH intron 7 polymorphism and a standardised impulsiveness score. However, they did find a significant relationship between impulsiveness and the 5-HT2c genotype. Evans et al found no difference between impulsiveness scores in people who repeated self-harm and people who did not. So conclusions could not be made about people who use self-harm more than once being more impulsive than people who only did this once. Unfortunately, the inclusion and exclusion criteria were not clearly specified, and the term “deliberate self-harm” was only vaguely defined. It would have been useful to know how many people in the sample had taken overdoses, cut, burnt or tried to hang themselves. The study found that people who self-harm were more impulsive than “normal people”, but did not state how they self-harmed, nor who these “normal people” were. This article concludes that impulsiveness plays a role in whether a person self-harms, but may have no influence on repetition.

Unfortunately, without a clear definition of methods of “deliberate self-harm”, it is unclear whether it was people who cut. Similarly a recent study into the factors that contribute to some young people acting on thoughts of self-harm rather than just thinking about it, has concluded that children who act on their thoughts are likely to be more impulsive and concurrently experience more life stressors than those who do not act (O'Connor et. Al, 2012). However, it is not possible to distinguish the level of individual contribution that impulsivity and the experience of life stressors make. An assumption is made here in both cases, that people are either impulsive or not impulsive. But in reality people can be impulsive at times and not impulsive at other times according to context. For children and adolescents, levels of impulsivity are tethered to developmental stage and exacerbated by the experience of stress.

There is evidence to suggest that children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) are at an overall increased risk of acting on thoughts of self harm and of experiencing suicidal thoughts and impulses (Manor et al, 2010; James et al, 2004). Some estimations are that up to 18% of children with a diagnosis of ADHD have self harmed (Green et al, 2005). However this increased risk has also been attributed to the secondary effect that symptoms of ADHD can have on the severity of depressive illnesses and conduct problems, rather than primarily as a result of the hyperkinetic symptoms themselves (Hawton et al, 2012).

Other professionals conjecture that there is a genetic contribution to impulsiveness (Eysenck & Eysenck, 1991). One part of this theory is that there is a variation in serotonin function, i.e. decreased serotonin levels in people who self-harm. This gives rise to another theory that the act of self-injury serves to increase the serotonin levels in people who have a deficiency. Reduced serotonin levels have also been linked with impulsiveness, aggression and people who have histories of childhood abuse (Cocaro et al, 1989, Van der Kolk et al, 1996). Although co-existence was supported in these research papers, the causative relationship required was not “proved”, so a deficiency in serotonin has not yet been proven to trigger repetitive self-injury.

The literature surrounding Borderline Personality Disorder (BPD) focuses on physiological differences in the brain. Meares et al (1999) found a localised neurophysiological dysfunction in the brain of people with BPD. Meares et al state that cognitive and memory deficits in BPD may be the result of severe trauma. However, this theory assumes all people with this diagnosis have experienced severe trauma. Brenner et al (1995) suggested that a reduced hippocampal volume found in people with BPD is a correlate of memory defects. Pre-frontal brain activity has been linked with higher order modulation of affective expression (Schore, 1994). Evidence presented by Schore supports the possibility of a cascade of descending inhibitory tracts emerging from the frontal and prefrontal areas of the brain. Insufficient development of these areas will lead to dysregulation of emotional experience and expression. This has been a commonly reported issue not only in BPD, but also with people who self-injure. This theory has been supported by Van der Kolk et al (1993) who found this to be an effect of psychological trauma in children and adults. Thus people who self-injure may experience overwhelming emotions that they cannot cope with, or verbalise, due to these differences in the physiology of the brain. They may then need to self-injure in order to cope with these emotions.

A pre-occupation with, and exaggerated awareness of, somatic sensation is also often associated with BPD (Meares et al, 1999). This may also be important for people who self-injure as they might use the cutting to stimulate somatic sensation or physical pain. This may be due to a disturbance in attentional focus (Meares, 1997). This disturbance is thought to be a result of disruption of the activity of a notional cascade of neural loops emanating from the prefrontal region of the brain. These are concerned with attention and thus are different to those involved in the regulation of emotion. If selective inattention does not develop, the person cannot “screen out” or “turn off” redundant stimuli and the person will be unable to focus on meaningful stimuli (Meares et al, 1999). As with people diagnosed with somatization disorder, it could be argued that some people who self-injure have failed to develop adequate systems of stimulus intensity control. Hence the person self-injures to cope with intense stimulation.

BPD as a diagnosis has been useful to help some professionals explore what this means and describe and categorise client experiences. However when a label is attached to the person it depersonalises and removes context (Procter, 2004). This can then result in “signs and symptoms” being seen, but the person overlooked. Additionally any staff reactions would be detached from the patient and therefore may also be overlooked.

3.1.3. Preventing suicide: ensuring survival

Self-injury has been understood as an externalised representation of an unconscious wish to end life (Tantam & Whittaker, 1992). However, Babiker & Arnold, (1997) and Harrison, (1994) report that many people believe that self-injury is a way of coping with life rather than ending it. The initial view is contentious because, by definition, people would not be consciously aware of their unconscious motivation. More recently, psychoanalytically orientated therapists such as Nathan (2004) have agreed with Babiker and Arnold and regard self-injury as different than suicidal behaviour. The use of self-harm as an alternative to suicide or for the preservation of life has begun to emerge strongly with the small body of literature examining young people’s own understanding of their actions (NSPCC, 2009; MHF:CF, 2006; Yip, 2005; SCARE, 2005; Spandler, 1996).

The corollary to this is agreeing that self-injury at the level of a lived experience, is not consciously destructive, but is a survival mechanism to deal with overwhelming problems. This concept highlights the survival nature of self-injury and the potential role that an

unconscious wish to die may or may not play within it. Again these views can decontextualize from the clients' reported reasons for self-injury.

Fenichel (1945) suggested that self-harm could be explained as the person (or animal) sacrificing one part of their body in order for the rest to survive. This would also be similar to people finding themselves in a situation where they feel they have no other way of coping. Here self-injury can be understood in terms of sacrificing a part of their body in order to enable both their body and mind to survive, and may include the body, or parts of the body, becoming unconsciously and concretely identified with hated or disturbing aspects of the self, significant others and relationships, or lost objects (Lemma, 2009; Polmear 2004, Bell, 2000). This may be considered a particularly helpful explanation along with the others already mentioned.

In relation to adolescence this is a developmental stage in which the use of the body to solve psychological conflict tends to predominate (Briggs, 2002). This is due to the whole developmental focus of this stage being on psychophysical integration, prompted by the onset of puberty. Wright et al (2005) found that suicidal acts for young people in their study, were akin to an attempt to regulate a body/self/context that felt out of control, and to defend against the feelings of hopelessness that were associated with this experience. Ensuring survival and preventing suicide has become a widely accepted method of understanding self-injury when professionals work collaboratively with the client to create meaning (Babiker and Arnold, 1997; Harrison, 1994; Connors, 1996).

3.1.4. Coping with emotions

Within professional and service user publications, this is the dominant explanation of why people self-injure. A commonly reported reason is to “release tension” (Harrison, 1994; Babiker and Arnold, 1997). ‘Relief from a terrible state of mind’ was the most commonly cited reason by young people participating in the CASE study (Madge et al, 2008). This reason alongside self-punishment, were also the reasons most likely to be cited by young people in this study who reported repeated self-harm.

Wegscheider Hyman (1999) reports guilt, anger, anxiety, disgust, frustration, hate, depression, helplessness and fear of loss as emotions prior to self-injury. She states that any emotion that is considered negative and/or overwhelming could actually be experienced prior to self-injury. McAllister (2003) emphasised guilt, blame and shame particularly if

people had experienced childhood sexual abuse and had started to self-injure to cope with these emotions. Expression of emotional pain is also regarded as a function of self-injury (Harris, 2000), so feeling emotional pain or sadness could also be an emotion experienced prior to self-injury.

Shame has been recognised as an emotion occurring prior to and following self-injury (Connors, 1996). Shame can be regarded as a physical sensation that occurs as a response in a socio-cultural context (Crowe 2004a). If individuals transgress social norms, feelings of shame are usually experienced. This implies judgement and exclusion by others. Lewis (1971) identifies that the main difference between guilt and shame is that guilt is an evaluation of the behaviour, but shame is an evaluation of the self. Shame is accompanied by a sense of shrinking or of “being small” and a sense of worthlessness and powerlessness. Therefore, when people feel shame they are more likely to feel observed by others and are more concerned with others opinions of them and thus feel more isolated (Crowe, 2004a). This has been a response commonly reported by people who self-injure, but not necessarily expressed using the word shame (Pembroke, 1994; Babiker and Arnold, 1997).

Authors such as Klonsky (2007) describe the function of self-injury as “affect regulation”, but do not elaborate which emotions the person is attempting to regulate. A focus on relieving stress, rather than shame appears to be a more socially acceptable function. However, the role of shame prior to self-injury has been recognised by some authors. Huband and Tantam (2004), for example, make the emotions explicit by stating that guilt, shame and anger are experiences prior to self-injury. However, they did not explicitly name these as reasons or triggers for self-injury, but just state that they occur prior to the behaviour.

Shame has been explicitly linked with other issues associated with self-injury. Andrews (1998) has stated that shame is a mediator between childhood sexual abuse, depression, eating disorders and post-traumatic stress disorder (PTSD), but did not link this with self-injury. However links between childhood sexual abuse, depression, eating disorders and self-injury have been prevalent in other literature (Farber, 2000; Babiker and Arnold, 1997). Miller (1994) has also linked self-injury with these issues and also PTSD.

The diagnosis of Borderline Personality Disorder (BPD) has also been linked with shame and “never being good enough” (Crowe, 2004a P327, 2004b P335). She advocates that the characteristics of BPD are better understood as a chronic shame response. She states that

shame is difficult to articulate in words and thus may be conveyed to others through the body and gives an example of self-harm. She describes self-harm as an expression of shame.

Milligan and Andrews (2005) found a significant relationship between shame, anger, childhood abuse, suicidal behaviour and self-harm. This was statistically significant in their research with women who have offended. However this was in a group of women where 60% of the sample was both suicidal and also self-injured. They found a significant correlation between experiences of shame and anger following self-injury, but did not record any reports of this prior to self-injury. They found that women who expressed suicidal or self-harming behaviours also expressed shame about their behaviour, character, body and appearance.

Understanding the role of shame in the dynamics of self-injury is particularly important given the strong evidence given by young people to the national inquiry into self-harm, that adult responses to disclosures of self-harm could often compound feelings of shame (MHF:CF, 2006). Rissanen et al (2009) also found that experience of shame and guilt actively inhibits children and young people from seeking help for their self-harm and associated problems. Issues of shame and guilt may also go some way to making sense of the potency of the experience of bullying or of being bullied, as a risk factor for self-harm and suicide in children.

Self-injury can be used as a method of helping the person avoid emotions and thoughts. This may be achieved by dissociation or a diversion of focus. The focus may be shifted to the external chaos for other people, or rituals for the person before or after the self-injury. Dissociation is a method of splitting off parts of a personal experience from the self, to avoid at all costs the integration of thoughts, feelings, memories and bodily sensations (Pearlman & Saakvitine, 1995). There are different levels of dissociation linked to self-injury (Connors, 1996). Some people describe being dissociated from the pain and have a sense of control over the self-injury (Smith 2002). Other people have reported that pain is experienced but that a dissociated part of the self is inflicting the pain. Miller (1994) describes how people may use self-injury to cope with dissociation. By experiencing physical pain, the person once again regains a sense of themselves within their own body. Connors (1996) describes self-injury as having a central role in the management and maintenance of the dissociative process. She describes self-injury as causing or coinciding with a switch to an altered state, thus helping the person to disconnect from current distress. She also views self-injury as a

method of preventing or halting dissociation. Thus self-injury can be conceptualised as a method of ending or preventing dissociation, but also a method of facilitating the same process.

Masking could be regarded as a type of dissociation. This is where the person may cope with unbearable feelings by self-injuring so that the physical pain masks the emotional pain (MHF:CF, 2006; Miller, 1994). This acts as a distraction from the emotional pain and provides a focus for healing and relief. In addition to masking being an intra-personal strategy of moderating mood, for some people it can also become an interpersonal strategy whereby these emotions may also be avoided by the external pandemonium caused by the self-injury.

Rosenfield (1971) stated that destructive impulses could lure people who self-injure into an ideal world where need was absent, quick solutions are provided and psychic pain would not have to be faced. This produced a “Nirvana” like state where they feel nothing, have no conflict and are liberated from need or pain.

3.1.5 Creating emotions

Emotions may be created by using self-injury. This may be to avoid the numbness or lack of emotion, or alternatively can be used to avoid other emotions. Sensation seeking has been a function reported by some people who self-injure. Predominantly this seems to be understood as a euphoric experience, but there are some theories that self-injury induces an analgesic effect, which avoids sensation, this could also be understood as dissociation. For example, painful stimulation has been demonstrated to result in increased release of endorphins (Farber, 2000,). It has also been found that intrusive thoughts trigger an endorphin response that release natural opiates found in the body and provides a form of analgesia (Strong, 2000). People who self-injure have been found to have high enkephalin (a natural opiate) levels when they are self-injuring. These reduce when they stop self-injuring. It is unclear yet whether it is the intrusive thoughts or the act of self-injury that result in an increase in enkephalin levels or any of the natural opiates. Increased catecholamines (dopamine, adrenaline and nor epinephrine) are also thought to trigger the hyper aroused state experienced when people who cut become agitated and feel the compulsion to cut (Strong, 2000). Again this is a theory that is used by professionals, rather than people who self-injure and locates the “difference” with the person who self-injures.

3.1.6 Self-punishment

Self-punishment was the second most cited reason for self-harm by young people taking part in the CASE study (over 30,000 respondents to an anonymised self-report questionnaire). In addition it was highly correlated with repeated use of self-harm and self-cutting in particular (Madge et. Al, 2008).

Ferenczi (1956) suggested that self-injury occurred when murderous wishes have been redirected from the objects in the external world towards the self. Freud (1917) theorised that some of the verbal attacks of his clients on themselves (such as being worthless, stupid, weak), were also reported to have been used against their loved ones in the past or present. Freud believed that, instead of attacking the external objects (or people), his clients had become the object and thus could violently attack themselves from this safer perspective. Contemporary theorists have applied Freud's theory both to the dynamics of self-harm and suicide, and to the process of mourning inherent within adolescence (Polmear, 2004; Bell, 2000)

People who self-harm can be perceived as sado-masochists. Collins (1996) explains that, by definition, masochism is about satisfaction or pleasure in experiencing pain. Thus it is the pain, rather than the consequences, that brings relief. This may be true for some people who self-injure that enjoy physical pain. However, many people describe the sense of relief that follows self-injury, rather than enjoying pleasure from feeling pain. A sadist gains satisfaction from the infliction of pain. Thus in the latter case, the person who self-injures by cutting the skin would be sadistic in relation to parts of themselves. This may occur when the person sees the skin or body part as not belonging to themselves. A person may experience satisfaction from experiencing self-inflicted pain with or without also believing that they should be punished. Collins (1996) conceptualises self-injury as a method of self-punishment, as described above. She emphasises expressions of "I don't deserve any better", "I need to be punished" and guilt and responsibility in terms such as "I'm to blame" when people self-injure. However she does not explicitly link these expressions to shame before self-injury, but only describes shameful experiences accompanied with disgust and guilt, following the behaviour.

3.1.7. Externalisation

Self-injury can externalise the internal emotions and thoughts onto the body, or onto other people or objects. Babiker and Arnold (1997) have reported the idea that people can understand physical pain more than emotional pain.

Self-injury can also have a function of regulating emotions by externalising them onto others or objects. Object relations analysts regard the self-injury as a method of eliminating the bad object/self that has polluted the body (Nathan, 2004). Here the conscious wish is to preserve the body rather than to destroy it. This is illustrated when people talk of the need to get the “bad, evil blood” out of their system and has been reported specifically in the few studies in which young people are invited to explore the meaning of their self-harm (Smith, 2002). This may be a useful explanation for some people who self-injure.

3.1.8 Communicating to the self

Many psychosocial theories would support the idea that self-injury is a method of communicating feelings. This may be a communication to the self or to other people. McAlister (2003) refers to self-injury as a symbolic method of crying. As with crying, the person may not have the words to describe why they cut, but just know that it helps. Strong (2000) also likens self-harm to crying and labels this as a “bright red scream”.

Within psychoanalytic theory, self-injury has been linked with regression (Hibbard, 1994). This is where the person returns to an earlier developmental stage to cope with difficult feelings. Thus, self-injury can be understood as a method of self-satisfaction that is characterised as reacting in childish, self-centred ways in which immediate gratification is sought.

Some theorists focus on the importance of the skin in the earliest mother-child relationship. This is where the first emotions are communicated, from tenderness and warmth to disgust and hate (Pines, 1980). Pines suggested that individuals can safely regress to regain the most primitive form of maternal comfort. This is a repeat of their infantile experience of a mother who could care for the body, but not the feelings. The skin is also the first site of physical or sexual abuse and therefore is the first assault on the person’s boundaries, so could be used as a method of punishing the skin or re-enacting the abuse. These ideas can be useful for professionals in theorising about people who self-harm, but could be offensive

to the person who self-harms if ideas of infantile regression are discussed openly. However, the suggestions about the skin seem very important as many people who self-injure will say that they are using the skin to communicate, or alternatively, may be seeking the skin soothing described earlier.

Self-injury can also be understood in terms of an existential statement, a means by which the person is able to confirm their existence and boundaries between being alive and dead. Babiker and Arnold (1997) wrote of an adaptive function of pain that can help people determine whether they are alive or dead. Thus self-injury may be used when a person is feeling depersonalised, (a process of being dissolved or losing one's identity) as a way of finding one's person again, or reintegrating.

Self-injury clearly has many functions and meanings to the self. The person may experience many of these each time they self-injure. These have been discussed at length. However when other people observe self-injury or the after effects of this behaviour interpersonal functions occur. Staff may assume that the person who self-injures intends these interpersonal effects to occur, but this is often not the case.

3.2 Interpersonal functions

The intrapersonal functions above may describe the functions if the self-injury occurs in private. However if the self-injury enters into the public domain, functions take on an interpersonal element whether the person intended this or not. Sometimes this results in the observing other feeling responsible in some way for the self-harm or the person doing it (Rayner et al, 2005). This may be a conscious or unconscious process and is reflected in staff and/or family and friends feeling that they are being “manipulated”, or that they did something wrong and therefore are to blame. There are various functions when self-injury moves into the interpersonal domain.

3.2.1. Communication with others

Self-injury has also been described as a vehicle for the expression of feelings, including rage, frustration, guilt and shame (Connors, 1996). This strategy can be effective if people need to communicate these emotions while attempting to protect other people from their

effects. Connors also links these emotional responses of guilt and shame to a sense of being “needy” or requiring help.

Machioian (2001) reports on interviews with adolescent girls with a trauma history, in which they identify that cutting themselves elicits a response from others, when others do not listen to their speaking voices. Machian (2001) posits a potential developmental pathway for young people, in which cutting starts as an effort to communicate psychological distress and make a connection with an other, but if not responded to helpfully, may become a form of regulating unbearable emotions, such as has been outlined in earlier sections.

3.2.2. Maintaining interpersonal boundaries

Self-injury can be used as a response when the person is feeling rejected, but it can also be used to encourage people to reject them to prevent a close relationship occurring and further rejection (Farber, 2000). In addition, it can be used to test relationship boundaries with people. This may be in terms of how far they can be pushed, and also to get others involved in acting out interpersonal issues or re-enactments. It may be used as a retaliative behaviour, in order to get someone in trouble or to express frustration, anger and helplessness (Madge et al, 2008). Here, self-injury is conceptualised as a method of acting out intra-personal difficulties due to past experiences of rejection. This has frequently been reflected in anecdotal evidence from clients in a variety of clinical settings and is a strong theme in the literature. However, it should be noted that in literature pertain to self-reported reasons by young people, this function is one of the least commonly cited reasons, alongside seeking attention. It is also more likely to be associated with one off episodes of self-harm in young people (Madge et al, 2008).

3.2.3. Initiation/ritual

When focusing on groups of people it has been observed that self-injury has a role in initiation or ritual. Ross & McKay (1979) noted that some women in their research group self-injured as an act of initiation rite, which took place within many other ritualistic behaviours such as chanting and sitting in a circle. Self-harm as a ritual or initiation rite is not uncommon, and certainly links into some religious rituals (Favazza, 1996). It may also be used within institutions to gain status and recognition, especially among peers in an anti-establishment culture. It can become a learned way of coping with life and a way of maintaining status in a very difficult institution. Many people self-harm for the first time when

locked up in institutions (Ross and McKay, 1979). If self-harm were understood as a response to feelings of helplessness and being trapped, it is not surprising that being locked in a secure environment may exacerbate the need to self-harm for some people (Solomon and Farrand, 1996).

3.2.4. Interpersonal influence

The short span of attention in institutions often becomes plentiful following self-injury (Ross & McKay, 1979). Lovaas and Simmons (1969) stated that this attention exacerbated self-injury. This can become a way of drawing attention to oneself if all other methods fail. Other people cannot ignore self-injury. This is a traditional theory within health services and can be expressed by staff when they believe that the person is “manipulative” or “attention seeking” (Rayner et al, 2005). It is important to note that the most comprehensive survey of young people’s motives for self-harm indicates that seeking attention or other interpersonal influence is the least likely reason for young people to self-harm. In addition it is the function that is most associated with one-off episodes of self-harm, rather than young people who utilise self-injury on a repeated basis (Madge et. al, 2008).

Within this function, self-injury can be understood as a method of gaining control externally of the body or other people when the person feels out of control within. This would also link in to the behavioural concept that self-mutilation is an operant response, a behaviour which is acquired and maintained by rewarding responses, such as attention (Davies et al, 1998). Here, self-injury is more than just an intra-personal coping strategy; it is also a method of stimulating interpersonal or environmental change.

3.2.5. Re-enactment

Re-enactment of abuse is predominantly a method of intra-personal communication that is documented mainly in the psychoanalytic literature (Farber, 2000). Re-enactment of abuse is also common where the victim may duplicate physical damage to the body that was previously committed by the abuser, such as mutilating breasts. Stone, (1987) suggests that a process exists, whereby a person may use his or her own skin as a symbol for an offending person. As such, the person who self-injures may take the role in re-enactment of the abuser or the victim interchangeably. Although essentially this is an intra-personal coping strategy, inter-personal effects may also occur, such as the need to be rescued being fulfilled.

3.2.6. Problem Solving

Much has been made in the child and adolescent literature of the relationship between problem solving and self-harm (Hawton et. Al, 2012; Prymachuk & trainor, 2010; Speckens & Hawton, 2005). This is concerned with the potential deficits in problem solving ability and problem solving training as a helpful intervention.

Evans et. al (2005) asserted a difference in the help seeking, communication and coping styles of children and young people who self-harm, in a sample of 15 and 16 years. Those who self-harm were identified as finding it harder to talk to others, less focused on their problems and more likely to use avoidant behaviours to manage problems, than their non-self-harming counterparts. It should be noted that within the study design young people had to choose from a closed list of coping strategies that privileged particular kinds of strategies as more adaptive, meaning that more diverse or creative coping strategies used by the young people in the study may not have been captured.

A systematic review of the literature in problem solving and suicide in adolescents determined that whilst there was a consensus regarding impairment of problem solving in suicidal young people, it was not clear if this was related to the impact of depressive symptoms and feelings of hopelessness, rather than an inherent characteristic in young people (Speckens and Hawton, 2005).

Souter and Kraemer (2004) challenge the conception of self-harm in children and young people as help seeking, asserting that it is often an active attempt to find a solution to a problem when help is not available or other solutions have failed.

The pragmatic value of self-harm as a problem solving strategy for children and young people, in the context of not yet fully developed coping skills, has also been highlighted. Nock (2010) reminds us that young people have far more limited access to other more adult-accepted strategies for coping with emotional and social difficulties (e.g. alcohol and drugs). Whereas, self-harm is readily available to young people and can be undertaken quickly, quietly and in almost any setting.

Self-injury has many intrapersonal and interpersonal functions and meanings. These are also varied within the context of each individual episode of self-injury. Due to the multifactorial nature of self-injury there are often many functions occurring at the same time for each episode of self-injury (Rayner et al, 2005). These functions may be complementary or competing at the same time. The functions described here can be a useful method to

assist in the understanding of why people self-injure particularly for practitioners working with children and young people who may not always be able to easily articulate the meaning of their experiences without support. In addition some authors (Yip, 2005 and Nock, 2010) have presented conceptual frameworks for trying to understand how different factors, functions and responses may come together for an individual. However, the inherent limitations of trying to circumscribe and generalise causes, functions and meanings of self-harm cannot be overstated (Turp, 2002) and should never be used as an alternative to taking the time to come to a shared understanding of the unique subjective experience of each young person on each occasion.

4. Link or otherwise between Self-Harm & Suicide

The NICE (2011) guideline on longer term management of self-harm is aimed at healthcare professionals across all sectors who have direct contact with adults and young people who self-harm. In considering who self-harms, NICE (2011) states that little is known about self-harm in younger children but that available information indicates that girls are more likely to self-harm than boys. This ratio difference narrows with age and the expression of self-harm for both genders is increased with adolescence.

Many young people who self-harm will not go on to repeat this and in relation to repetition and outcome, a number of studies are cited by NICE (2011) which indicate that it is a minority of people who attend general hospital following self-harm who will harm themselves again within the following year.

This is not to say that such patterns can be endorsed without due consideration, as this does not account for people who subsequently self-harm and do not come to the attention of health care services and so it is fair to say that accurate estimates are problematic to establish.

This is also the case when suicide and self-harm are considered with NICE (2011) stating that following self-harm, the rate of suicide is increased in comparison with the general population and that this pattern is particularly related to men who self-harm. This link between self-harm and suicide is well documented in the literature with Hawton et al, (2004) stating that self-harm is the best predictor of eventual suicide and other authors finding that;

“The strong connection between self-harm and later suicide lies somewhere between 0.5 and 2% after 1 year and above 5% after 9 years” (Owens et al (2002 p193).

Yet because something is the best predictor it does not mean it is accurate and self-harm by its mere nature is a risky activity which may result in unintended consequences. An analogy to illustrate this point is that by crossing the road, one's risk of being involved in a road traffic accident may increase but that is not necessarily the intention (Allen, 2007). The statistic above suggests that the vast majority of people who self-harm do not go on to end their lives and it is notoriously difficult to identify who, within a sample of people who self-harm, will do so (NICE, 2011).

This understandably leads to anxiety when working with people who self-harm and whilst bearing the difficulties associated with quantifying self-harm within the population, it does suggest that contrary to some misconceptions the majority of people who attend hospital following self-harm do not attend again within the year and that most people do not intentionally end their own lives. As such it is imperative that when contact with healthcare services is made, the opportunity is taken to provide a service which engages with the complexity and risks in an ethical and therapeutic manner. The aim being to deliver an effective service which is not overly controlling, but equally, is not dismissive of the issues troubling the young person.

Working with a person who subsequently ends their own life has a profound effect on all involved including healthcare professionals. Whilst wishing to acknowledge this and not minimise it, it is also important to reiterate that it is a relatively rare occurrence even when people engage in activities such as self-harm (NICE, 2011). This reinforces the need to engage in a collaborative assessment which identifies the person's unique needs. To do this, risk and its management are important but equally so is an understanding of the contextual factors that have brought a young person into contact with healthcare services following self-harm.

The importance of this was identified by Bergen et al (2010) who studied 13966 people who attended emergency departments in Oxford, Manchester & Derby between 2003-2005 with a first episode of self-harm. More than half of the study participants received a psychosocial assessment and it was found that assessment actually reduced the risk of self-harm. This was particularly apparent in the group of people who had no current or previous psychiatric treatment and an additional finding, when the group were followed up, was that assessment of people with a history of self-harm still appeared effective in reducing the risk of repetition.

As such, if the inter and intrapersonal factors that relate to the person's self-harm can be explored and addressed where possible and the person supported effectively, the risk of self-harm may reduce and consequently the risk of suicide, whether by intention or accident.

In keeping with the points made above, NICE (2011) recommend conducting a psychosocial assessment which includes a comprehensive assessment of personal circumstances, social context, mental state, risk and needs following self-harm and acknowledges the importance of engaging the person in a collaborative investigation of the complex factors that led self-harm.

Such an objective is facilitated by taking a narrative approach because this avoids over reliance on checklists and enables a picture of the individual's unique circumstances to be built and understood. As such, it is not enough to rely solely on risk assessment tools as they are not sophisticated enough to determine who will repeat self-harm or die by suicide following self-harm (NICE, 2011). For a detailed list of the areas suggested to consider in a psychosocial assessment following self-harm section 6.7 in the NICE (2011) guidelines can be consulted and are summarised in Section 6 of this report.

If the link between self-harm and suicide in young people is conceptualised as a dynamic continuum along which young people continuously move up and down, some research evidence does exist regarding the kinds of emotional experiences and phenomena that may move a young person further along towards the intention to die, which can assist in the process of narrative assessment.

Evidence given to the national Inquiry into Self-harm by young people indicated that social isolation, feelings of shame and guilt and a reduction in choice and control were particular difficulties that were more likely to lead to young people attempting to end their life rather than coping using self-harm (MHF:CF, 2006). This is particularly manifest for children and young people who find themselves placed in strange or restrictive environments (such as residential care placements, hospital or secure environments).

This mirrors research in adult populations that has linked the phenomenon of suicide with the loss of structures that give personal meaning to life (Bell, 2000), and the level of intent to die with the severity of feelings of hopelessness and entrapment (Skegg, 2005).

Souter and Kraemer (2004) conceptualise both self-harm and suicide in young people as a problem solving strategy. The use of suicide is highlighted as more likely when the problem is beyond the control of the adolescent, or the solution is beyond their sphere of influence and the adolescent feels hopelessness about the prospect of getting help. In these circumstances there emerges a feeling that there is no alternative to the unbearable suffering other than death.

In line with this a research study involving children attending hospital following an episode of self-harm, found evidence to suggest carer support, combined with peer acceptance and integration, were the most significant preventative factors for moving from self-harm to suicide (Groholt, 2000)

A study comparing quality of decision making processes between a group of 40 non-suicidal and 40 suicidal adolescents found a statistically significant difficulty with learning from experience, in order to adapt or augment decision making strategies for their own benefit, in the suicidal group. This was not present in the control group (Bridge et.al 2012). Although this is a single small scale study meaning that generalisations cannot be made, it does potentially point to the importance of practitioners holding in mind that as self-harm and suicide are often a form of psychosocial problem management, children with cognitive difficulties or additional learning needs may require additional support in this domain.

5. Therapeutic responses/engagement

In a Cochrane review of psychosocial and pharmacological treatments, Hawton et al, (2009) concluded that there is considerable uncertainty about which treatments for self-harm are the most effective. Whilst the Cochrane review attributes this conclusion primarily to the way the studies reviewed were conducted, other authors have concluded similarly. Kapur et al (2005) contend that there is a scarcity of interventions following self-harm whilst Lilley et al (2008) suggest that a discrepancy exists between what people need after self-harm and what services offer.

Such findings may lead to therapeutic pessimism, however when the service user literature is consulted it becomes clear that strategies deemed to be helpful are in many cases, neither complex nor financially prohibitive. Truth Hurts (MHF:CF, 2006) emphasises in its recommendations that the most effective strategies for helping young people who self-harm are founded upon the core values of all health and social care and helping professions and therefore are within all professionals ability to provide.

The management of self-harm may or may not involve its prevention (Hume and Platt, 2007). The National Inquiry into Self-harm amongst Young People recommends that the starting point of all intervention is to understand that self-harm is not an illness and to identify underlying issues. The inquiry found direct evidence that if the focus of care is on self-harm, rather than underlying causes it can leave young people with no choice but to self-harm again (MHF: CF, 2006). Appreciation of a person's life circumstances and experiences may

help uncover some of the reasons why they may self-harm. Interventions need to target the functions that the self-injury serves and how this may help the person cope. So these need to be individualised and may cover many different interventions. Self-injury needs to be conceptualised as a method of coping, if this is the reason why the person has self-injured (Harrison, 2000 Babiker and Arnold, 1998; Rayner et al, 2005). Thus just stopping self-injury would leave the person vulnerable to being unable to cope. As there are so many varied interventions for a variety of different settings, principles will be discussed that need to underpin any intervention that is selected. For some helpers the principles will be all that is required.

5.1 Principles for working with people who self-injure

5.1.1 Reconceptualization of self-harm

Self-harm needs to be viewed by helpers as a survival strategy (McAllister, 2003, Allen 2007). If self-harm is only understood by professionals as a self-destructive method of ending life, then engagement with people who self-harm to survive is minimised. Thus the use of language is important (Allen, 2007) and defining how suicide and self-harm are different, although sometimes people may use self-harm as a coping strategy and also become suicidal. It is also important to avoid reliance on method of self-harm/suicide as a predictor of function. One behaviour can actually have a function of survival or death for the same person and have many different functions for different people. The helper can only clarify this by asking the person how the method helps them.

Connors (2000) states that self-harm needs to be conceptualised as a communication strategy. This can be to the self or to other people. If this is the case interventions can focus on what the self-harm is communicating. Alternative methods of communication can also give the person more choice about whether they self-harm or not.

McAllister (2003) suggests that professionals need to think of and describe self-harm as self-soothing and not as a symptom of an illness. This in turn can help carers to understand each other more and work together on joint understandings and methods of helping. Self-soothing is a method of calming down, meditation or self-nurture (Lindgren et al, 2011). As an intervention, other methods of self-soothing can also give the person more choice. This has been found to be useful in Dialectic Behaviour therapy (Linehan, 1993), Mindfulness (Freeman) and Compassion focused therapy (Gilbert, 2005).

5.1.2. Validation and acceptance

Clinical guidelines for the management of self-harm (NICE 2011, 2004) stress the underpinning principles of respect, dignity and choice and the pivotal nature of trusting and empathic relationships.

Humanistic principles have been deemed essential by many authors when working with people who self-injure/self-harm (Harrison, 1994, Babiker and Arnold, Pembroke). As such, responsibility remains with the client and the helper avoids judgement, is empathic and actively listens at all times. Here the client needs to determine the issues they want to work on.

Listening, in and of itself, has been identified within the literature as a mechanism for both prevention and therapeutic intervention for children and young people.(Rissanen et al, 2009; MHF;CF, 2006; Fortune 2005; Machoian, 2001). Young people have identified that anyone who knows about their self-harm can be a helper and that their view is that adults are duty bound to try and help them (Rissanen et al., 2009). Helpful listening is defined as coming from adults who make themselves accessible, within a wider context/environment that is felt to be caring, and who are interested in listening to all kinds of issues about young people's daily lives, worries and pressures not just self-harm.

Unconditional acceptance is a major part of the work and this is also a key aspect of many other therapeutic interventions that may be useful (Linehan, 1993; Bateman and Fonargy, 2006; Gilbert, 2005). Indeed Rayner et al (2005) consider the relationship essential to change, but that the therapeutic challenge is to address staff emotional reactions and thoughts in order to remain in this hopefully stable relationship.

Linehan writes of the experience of invalidating environments when working with people who self-harm. An invalidating environment is one in which communication of private experiences is met by erratic, inappropriate, or extreme responses. That is the expression of private experiences is not validated; instead it is often punished and/or trivialized and the experience of painful emotions disregarded. The individual's interpretations of their own behaviour, including the experience of the intents and motivations of the behaviour, are dismissed. In response to experiencing invalidation, when young people present for help we need to ensure service and individual responses are validating. The risks facing children and young people due to exposure to negative responses from A&E, ambulance, mental health, GP practice and police staff and from doctors, nurses and social workers, are still being reported to professional bodies (RCollPsych, 2010). Young people who self-harm more than once have been identified as particularly at risk. Cooper and Glasper (2001) argue that if

staff are less anxious and judgmental they are more able to hear the child's story and help them make sense of this.

5.1.3. Look beneath the physical self-harm to what's being communicated

Caregivers need to look beyond the self-harming behaviour and give the power back to the person (Lindgren et al, 2011). Commonly when people present for help the behaviour becomes a preoccupation with the professional. Many professional judgements are made about whether the person wanted to die, could die or may be just "attention seeking". This often occurs without actually speaking to the person who has self-harmed. Helpers need to ask about the self-harm and also assist in helping people to understand the reasons for this. Functions of self-harm need to be explored, both positive and negative aspects need to be acknowledged and analysed. Then, for example; if a function is about communicating distress exploration of other methods of coping with distress may help, alongside building resilience to distress.

5.1.4. Help the person to become more compassionate towards themselves

Compassion is key to the cycle of shame that may occur when a person self-harms (Rayner 2012). Thus a key role of the helper is to encourage the person to believe that they are not:

"A waste of space"

"Wasting services"

"Worthless" "A piece of dirt"

A person that deserves to be punished

An "attention seeker"

A "manipulative person"

"Worthless with added shame on top"

(Direct quotes from people who self-injure, Rayner 2011)

Helpers need to facilitate an environment where the person begins to think that they are valuable and a good person, worthy of receiving care from others and caring for themselves. Or as Yip (2005) states, nurturing the young person's sense self-integrity and dignity.

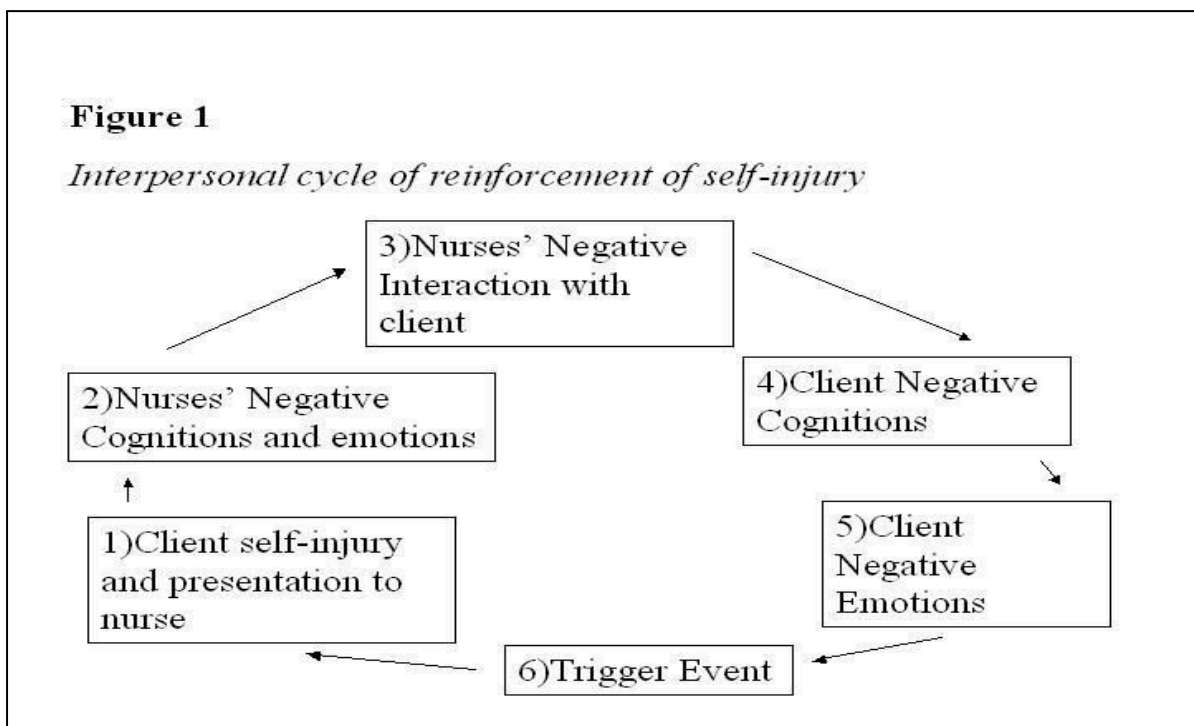
Helpers need to foster hope by offering time to meet, listen and talk and take the person seriously (Lindgren et al 2011).

5.1.5. Help the person to reflect on own thoughts & feelings – Mentalisation (Bateman and Fonagy)

Initially the helper needs to provide emotional containment when the person who self-harms talks about their experiences. They then need to help develop language or other communication methods to name and express their emotions and thoughts (Rissanen et al, 2009). Helpers are able to provide space to express emotions and also reflect on the self-injury, triggers, process and also consequences. Helpers need to be able to hold onto hope during difficult times and remain engaged with the person.

5.1.6. Recognise the impact of helpers responses

In order to work with people who self-harm we need to examine our own concepts, understanding, and reactions (Rayner et al 2005, Cooper and Glasper, 2001). An interpersonal cycle of reinforcement of self-injury may occur if the helper has negative reactions to person that self-injures. This in turn can then confirm the person's negative thoughts and emotions about themselves at a time when they are most vulnerable. (See figure 1. below Rayner et al, 2005)



Thus staff need to have some time and space to reflect on their experiences, emotions, values and beliefs relating to working with the person who self-harms. They need to be able to reflect in order to understand their own issues before they can help the other person reflect and understand what is going on for them. Cooper and Glasper (2001) support the idea that staff need to be aware of their own narratives in relation to self-harm. It is only when staff have time to reflect on their own understanding of why people self-harm that these narratives can emerge.

5.1.7. Issues relating to disclosure consent, confidentiality and information sharing

Truth Hurts (MHF/CF 2006) Identifies the importance of disclosure and immediate response as being critical in deciding whether further services are accessed by young people who self-harm.

It is identified within standard 9 of the children's National Service Framework (DfES, 2004) that fear of confidentiality being broken and lack of trust in statutory services are reasons for not accessing services that are available. This is specifically reported in relation to disclosure of self-harm (Underwood, 2009). Young people reporting to the national inquiry described losing control of how and with whom information would be shared (MHF, 2006).

Given the over-representation of children experiencing or having past experiences of maltreatment and abuse in the population that self-harm, informing parents carers might not always be in the child's best interests and could actively contribute to increasing risk to a child or young person. This is both in terms of arousing feelings of guilt, shame and stigma that can lead to escalation of self-harm and disengagement with services and the potential for increased risk of actual harm from others. Consideration what? how? and when? information about a young person is shared, in consultation with the child, is a very important issue in relation to future engagement (NICE, 2011; Underwood, 2009).

The Truth Hurts (MHF:CF, 2006) recommendations are for integrated application of Fraser/Gillick competence assessment guidelines, and the Children Act (1989), alongside the Mental Health Act and MCA (2006) where indicated. Asserting that when properly applied most children [who disclose self-harm] will be able to give informed consent and can expect confidentiality in their contact with professionals and services (MHF 2006b). The Importance of presage, i.e. giving clear information in advance of the limits of confidentiality so that children and young people can make informed choices has also been highlighted (NICE 2011).

“It is very important that professional staff understand that a young person disclosing self-harm needs to know that the fact they have been able to disclose shows strength and courage. It is equally important that people hearing a disclosure allow the young person to take the discussion at their own pace, foster trust and respect the right of the young person to act on their own judgement as to what and how much to say.” (MHF:CF, 2006, pg 46)

Understandably, given the relationship with childhood abuse, self-harm can often be conceptualised as a safeguarding issue. Anecdotally, there is evidence that the conflation of self-harm with the potential for causal child protection issues to be underlying, has led to practice, at both individual and organisational levels, that assumes by the very act of self-harm, children and young people have given away their right to confidentiality. NICE (2011) advises that safeguarding and child protection procedures and plans should be implemented as per usual practice, but in relation to the identified child protection issue, rather than the act of self-harm per se.

This is a complex and challenging area as the clinical need for careful adherence to principles of confidentiality for individuals can be in contrast to recommendations from public inquiries into Safeguarding practice, for organisational policy to ensure greater levels of cross-agency information sharing across the board. Practitioners need coherent strategic agreement between agencies in this regard, if they are to be supported to avoid potentially damaging all or nothing approaches.

5.1.8. Recommendations from people who self-harm

The following direct quotes are taken from interviews with people who self-harm and can be considered as principles and recommendations (Rayner, 2011).

“See the person not just the self-harm”

Be kind, caring and firm “Matter of fact type interaction”

Calm and accepting

Help them to talk

View each self-injury separately

Focus on the solution not the problem

“Recognise the person’s strengths and limitations”

What young people have said helps:

- Listening and hearing what is being said
- Being human & honest (but holding on to more negative feelings)
- Acknowledging self-harm & taking it seriously
- Clear boundaries, guidelines & agency responses (esp. Confidentiality and information sharing).
- Giving information about self-harm and help that is available
- Exploring triggers and meanings
- Help to learn how to talk about self-harm and emotions generally
- Helping with other kinds of problems
- Seeing the whole person, not just the self-harm

Things that young people have identified as actively unhelpful:

- Experiences of others that arouse feelings of shame, guilt
- Silence about self-harm or unresponsiveness of others.
- All or nothing responses (over estimation or minimising).
- Being left with no intervention
- over estimations about own capacity to help self-unaided,
- Negative emotional reactions from others.

Taken from: Rissanen, Kylma and Laukkanen, 2009; MHF:CF, 2006; Spandler 1996.

Ideas about ways of delivering helping services to young people submitted by young people to the National Inquiry into Self-harm (MHF:CF, 2006)

- 1:1 support/counselling
- Group support/drop-in
- Self-help group (facilitated)
- Creative Initiatives
- Multimedia/internet access
- Information point
- Outreach team
- Family support
- Self-help (no facilitator)

6. Issues of assessment, decision making and risk management

Clear, summarised evidence based clinical guidelines regarding the assessment and treatment of children and young people who present to general hospital or secondary mental health services following self-harm are already available in the NICE clinical guidelines for the short term and longer term management of self-harm (NICE, 2004; 2011). These will already have been incorporated into secondary care policy and procedures. In addition disciplines responsible for undertaking this work have their own standard and expectations covered in core pre-qualification training. As such these will not be repeated here.

However, key aspects of the clinical guidelines for all practitioners working with children and young people, and addressing the interface between primary and secondary care, integrated with specific research findings relevant to how to talk to young people about their self-harm are summarised in Boxes 2 & 3.

Box 2. Guidelines for Assessing/Talking to Children and Young People About Their Self Harm

Assessing/ finding out about self harm should focus on gathering an integrated knowledge of needs and risks for purpose of understanding and engaging the individual. The focus should be on person centred care and establishing a trusting therapeutic relationship (Nice, 2011; 2004; Royal Coll Psych., 2010; Skegg, 2005) and should include:

- Development of a shared understanding of the function and meaning of the act of self harm (whether a 'one off' or part of more habitual coping response) with both the young person and (with the young person's agreement) their carers. Taking into account:
 - each person who self-harms does so for individual reasons, and
 - each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode.
- Identification of underlying problems
- coping strategies, skills, strengths and assets
- signs of mental health problems & physical health problems or disorders
- Social, developmental, education/occupational circumstances, functioning and problems, any recent and current life difficulties, including interpersonal and financial problems
- 'Inside' factors (e.g. low self worth, perfectionism, high self criticism) impacting on the young person's mood, mental state, experience of distress, concept of self and other & level of functioning within their wider system,
- Potential wider risks to young people, e.g. bullying, child protection issues (abuse, neglect), high levels of deprivation, social adversity/vulnerability which indicate the young person is a 'child in need' necessitating an assessment as such by social services.
- the need for psychosocial or psychological intervention, social care and support, occupational rehabilitation, and treatment for any associated conditions
- the needs of carers and any dependent children.

Specific risks should be collaboratively identified with the individual (NICE 2011) taking into account:

- current and past suicidal intent/expressed wish to die
- Assessment of parent/carer ability to understand their young person's experience and respond in a helpful way to keep them safe (Souter and Kraemer, 2004)
- Symptoms of anxiety or depression (for primary care staff: expression of hopelessness and loss of enjoyment, repetitive, intrusive or disturbing worries)
- any psychiatric illness and its relationship to self-harm
- the personal and social context and any other contributing specific factors before during or after self-harm, such as specific unpleasant states of mind or emotions and changes in relationships (Nock 2010)
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- immediate and longer-term risks.

DONTS:

- Do not use method of self harm as an indicator of intent, risk or severity of difficulties – it is not a reliable measure (Wolpert et al 2006)
- Do not use level of premeditation/planning as a measure of seriousness of intent. Research indicates that over half of children who self harm decide to do so less than 1 hour before the event, regardless of their level of intent to die (Madge, 2008)
- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm (NICE, 2011; RCollPsych, 2010; Appleton et al 2010)
- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged

Do's

- Place an equal importance on the treatment of young people who self harm without any underlying suicidal intent or mental disorder as those with (Appleton et al 2010; MHF:CF, 2006)
- Be clear with the individual about the limits of confidentiality and issues of information sharing before you start (NICE 2011)
- Ask directly and openly about self harm, thoughts of wanting to die and suicidal behaviour – research shows this **does not** increase risk of a child enacting self harm or suicidal behaviour. It provides relief and modelling that difficult issues can be talked about (Nock 2010; Souter & Kraemer 2004)
- Encourage young people to explain their feelings and understanding of their own self-harm in their own words, actively listening and validating their experiences (NICE 2004; Machoian, 2001).
- Communicate to young people their strength and courage for disclosing and proceed at a pace led by them (MHF:CF, 2006)
- Avoid adult-orientated appraisals of severity or impact of perceived losses that children report (e.g. relationship break ups) – establish their view of it (Souter & Kraemer, 2004)
- Ask children you come across who are anxious or experiencing low mood, about thoughts or episodes of self harm or suicide (Hill, Castellanos et al 2011)

Box 3. Initial responses to disclosures of self harm decision making about what to do next

- All work with people who self harm should be underpinned by the principles of dignity, respect and choice (NICE, 2004)
- Health and social care professionals working with people who self-harm should:
 - aim to develop a trusting, supportive and engaging relationship with them
 - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental empathic approach
 - ensure that people are fully involved in decision-making about their treatment and care
 - aim to foster people's autonomy and independence wherever possible
 - maintain continuity of therapeutic relationships wherever possible
 - ensure that information about episodes of self-harm is communicated sensitively to other team members. (NICE, 2011)
- Where it is indicated, and if the young person consents, involve parents and carers, giving support, information and advice to help them understand their children's situation.
- Self harm is not an illness and mental health interventions are not always the first line response. Using the information the young person gives about the meaning of their self harm, work directly with them to respond to underlying problems identified, wherever possible (e.g. bullying, worries about home or school) (MHF:CF, 2006)
- Indicators that you may need to make a referral to secondary/specialist camhs services include:
 - levels of distress are rising, high or sustained
 - the risk of self-harm is increasing or unresponsive to attempts to help
 - the person requests further help from specialist services
 - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. (NICE, 2011)
- Following an identified suicide attempt (clear intent to die at time of act), children and young people should always be assessed by specialist CAMHS (Wolpert et al, 2006)
- Children and young people who present in primary care settings with an episode of self poisoning or overdose should always be referred to nearest emergency department to ensure they receive the right physical health care treatment. (NICE 2004)

7. Evidence Base for Psychological Interventions

7.1 Suicide Prevention Strategies

The 2012 Suicide Prevention Strategy for England (DH, 2012) should be referred to for detailed recommendations regarding evidence based suicide prevention across the population.

With regards to suicide reduction in children and younger people, the following additional recommendations have been derived from the review of child specific evidence:

- Suicide prevention interventions are not likely to be successful if there are underlying comorbidities (e.g. depression) the focus of risk reduction in this case needs to be on treating the underlying issue (Wolpert, Fuggle et al, 2006).
- There is emerging quantitative evidence that more access to robust treatment of mental health disorders in adolescents who self-harm, actively contributes to reduction in suicide rates of young adults (Moran et al, 2012)
- Preventative/ promotion strategies in school have been demonstrated to improve peer attitudes to disclosure and awareness. However there is no evidence of impact upon help seeking in higher risk groups of young people (Wolpert, Fuggle et. Al, 2006)
- The dominant mitigator of suicide risk in children and young people is their social and financial circumstances and levels of associated deprivation. Interventions to improve the material and physical circumstances of young people's lives should therefore be prioritised (R.Coll. Psych., 2010; Crowley, Kilroe & Burke, 2004)

7.2 Interventions for young people who self-harm

A series of systematic reviews of trials aiming to test efficacy of specific psychological interventions in relation to self harm have been undertaken over the last decade (Fonagy et al, 2002; Webb, 2002) , Burns, Dudley, Hazell & Patton, 2005; Wolpert, Fuggle et al, 2006; Hawton et al, 2009). The outcomes of all of these are that there is currently no evidence clearly demonstrating the benefit of one psychological intervention over another, or over routine care.

This has been largely accounted for due to research methodology problem in trials conducted to date: differences in age ranges, selection criteria and outcome measures. The predominant outcome measure utilised in large scale quantitative studies of this kind have been rates of repetition of self harm and/or self reported suicidal ideation and depression

symptoms. Other quality of life measures of improvement have often been missing and in addition self harm and attempted suicide are often merged in these trials.

In relation to longitudinal benefits, observations has been made that interventions that effectively reduce rates of self-harm do not reduce associated issues of depression, hopelessness and suicidal ideation. Conversely, those which do impact these issues do not act to reduce rates of self harm (SCARE, 2005b)

Skegg (2005) concludes that it is unlikely that a single specific treatment will fair better against treatment as usual in controlled trials, as treatment as usual whilst not necessarily being evidence based is individualised. The service user evidence already outlined points to interventions being most likely to be effective, if they are informed by understanding of the individuals underlying difficulties and the function and meaning of their self harm. In addition, evidence across the life course highlights the quality of the relationship with the helper as the most pivotal contributor to outcome (Skegg, 2005).

From a pragmatic service design perspective, the central issue is that if self-harm is understood as a coping response rather than an illness, secondary to a diverse range of other issues and difficulties, it should be anticipated that there will not be a single advised treatment for all. A range of approaches and interventions need to be available to meet the needs of a heterogeneous population (Hulme & Platt, 2007)

Based on this the Royal College of Psychiatry recommendation is that Commissioner's need to ensure range of evidence based psychological therapies are available based on the number of therapies that have shown effectiveness for some people, rather than all people (Royal Coll. Psych., 2010).

7.2.1. Problem Solving Interventions and Training

Brief problem solving interventions, post suicide attempt have been shown to improve adolescent feelings of depression and suicidality and improve maternal attitudes towards treatment (Hawton, 2012; Prymjachuk & Trainor, 2010; Wolpert, Fuggle et al, 2006; Skegg, 2005). More broadly across the life course, there is a moderate amount of evidence demonstrating that problem solving interventions are of benefit to populations of people self harm more than once (McAuliffe et al, 2006; Townsend, 2001)

Problem solving training is direct, easy to understand, can be used in a range of settings, has a low risks/contra indications profile and can be extended to the family (Hawton, 2012;

Prymachuk & Trainor, 2010). From a staff development perspective, it requires low intensity training, building on core skills of practitioners across a range of disciplines and agencies. As a result problem solving interventions are likely to have good cost benefit value as first line interventions in primary care, education and non statutory settings.

7.2.2. Interventions for young people requiring secondary or specialist CAMHS care provision

There is single study evidence for brief family interventions, often with a focus on problem solving, reducing suicidal ideation in some young people (Wolpert, Fuggle et al, 2006; Burns et al, 2005)

Dialectical Behaviour Therapy (DBT) is a multi modal structured treatment for repeated self injury associated with problems of emotional regulation and interpersonal difficulties, in the context of complex relational trauma. It has been predominantly tested in relation to populations of adults with a diagnosis of personality disorder. Preliminary studies have shown outcomes of reduced feelings of depression and hopelessness in samples of adolescents receiving both individual and group therapy, but not on the actual rate of enactment of suicidal thoughts.(James et al, 2008; Rathus & Millar, 2002). Publication of the results of a larger scale Randomised Control Trial is expected later in the year.

A Single large cohort study has shown benefit in the addition of developmental group therapy to care as usual, in reducing self-harm rates in some adolescents who repeatedly self-harm (Wood et. Al, 2001). Although, subsequent studies have failed to replicate this result (Prymachuck & Trainor, 2010). This model of intervention is an integrated approach influenced by CBT, DBT, and psychodynamic group psychotherapy and framed by a focus on recovery and development (Prymachuck & Trainor 2010)

In cases of repeated self injury when it is not possible or indicated to try and stop or reduce self injury, clinical guidelines advise that information on harm minimisation techniques and advice on wound management should be made available (NICE, 2004).

Given the relationship with underlying mental health disorders for a sub group of the population of young people who self harm, secondary service design should also include access to the range of psychological treatments shown to be helpful in address underlying mental health conditions in young people (i.e. depression, anxiety and trauma).

These should include:

- Cognitive Behavioural Therapy (Wolpert, Fuggle et al, 2006)
- Brief psychodynamic therapy (DIT) (Lemma et al, 2011; Dubinsky, 2004)
- Interpersonal Therapy (Wolpert, Fuggle et al, 2006; NICE, 2005)

For complex cases, there is emerging evidence from work with young people with persistent conduct problems alongside multiple other psychological and social difficulties regarding clinical efficacy for individualised multi-systemic treatment programmes, built from above list and based on understanding of the issues for each individual that work across all domains of difficulty and system, rather than focusing on issue of self-harm alone (Wolpert Fuggle et al,2006). It is likely that there will be examples of the practice already occurring in secondary care within the locality of Knowsley and neighbouring areas. A recommendation for future work is the identification and evaluation of case by case good practice examples of this kind.

8. Service design/ characteristics of quality service delivery

An aggregated summary of organisational and service delivery good practice markers and expectations, drawn from national policy, reviews and professional body reports and briefings, is presented across the themes of the multi-agency framework, service user as stakeholder, operational implementation, risk assessment and complex cases.

8.1.1. Multi-agency Framework

- Protocols for referral, support and early intervention are agreed between all agencies (DfES, 2004)
- The needs of children and young people with complex, severe and persistent behavioural and mental health needs are met through a multi-agency approach (DfES, 2004)
- Joint responses and protocols between education, social care and health agreed at senior level for complex persistent emotional and behavioural disorders (DfES, 2004)
- Contingency arrangements are agreed at senior officer levels between health, social services and education to meet the needs and manage the risks associated with this particular group (DfES, 2004).
- A key preventative strategy for self-harm should be cross-department working to improve social and economic life circumstances (R. Coll. Psych, 2010)

8.2. Service Users as Stakeholders

- Strategic Health Authorities, Primary Care Trusts (PCTs), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm. (NICE 2004)

8.3. Risk Assessment

- Risk assessment tools per se have really limited and short term ability to predict risk (Appleby et al, 2012). A Royal College Psychiatry Working Group (2010) concluded that evidence submitted to them indicated that locally developed risk assessment tools that lacked validity, “encouraged a tick-box mentality, distracted staff from their work with vulnerable people, devalued engagement and impaired empathy”. This practice is contrary to recommendations in the NICE clinical guidelines (2011). Senior cross departmental directives to discourage the development and use of such tools and adherence to the NICE clinical guideline recommendations is required.

8.4. Operational Implementation

- When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the ‘care programme approach’.
- Work force output rates/capacity modelling needs to accounting for focus on and time for engagement as prelude to psychological treatment, or actually as the psychological treatment in itself, rather than estimated average length of psychological treatment alone.
- Non attendance of children and families at clinical services should not trigger closure of episodes of care, but concern regarding the meaning of non attendance and a review of the offer of care against identified needs. (in older children (16+) with capacity to consent to treatment this process needs to be distinguished from young people who are withdrawing consent to treatment in an informed way)

8.5. Complex cases

- Consideration of development of distinct services for young people who repeatedly self-harm over a long period. This group’s needs are potentially distinct from the wider population and they are at significantly increased risk of suicide and application of a diagnosis of borderline or emotionally unstable personality disorder, with the

stigma and risk that such a label brings. Underlying difficulties are less likely to be mental illness *per se* and therefore mainstream specialist Camhs provision in its current form may not meet their needs (Royal Coll. Psychiatry, 2010)

- The CAMHS Review identified that *“administrative and legal processes, unhelpful thresholds for access to services and some entrenched professional views can ‘parcel up’ children into individual services and prevent their needs being met in a holistic, flexible and responsive way or leave their needs unaddressed”* (DCSF, 2008, p. 9).

This is particularly likely to apply to the group described above and also young people who present for the first time with self harm or suicidality, accompanied by a disclosure of abuse. Cross-agency assessment procedures following hospital presentation and identified suicide attempts could be considered as a means of addressing this issue (Souter and Kraemer, 2004).

- A systemic culture of reflective practice and learning from experience needs to be embedded into organisational practice, not just team or individual clinical practices (Appleby et al, 2012; Royal Coll. Psychiatry, 2010)

9. Implications for Measuring Outcomes & Service User Satisfaction

The purpose of delivering any intervention is to effect change for the better and to demonstrate this it is crucial to identify agreed outcome and satisfaction measures. Attempts to do this in relation to caring for people who self-harm have used frequency and/or severity of the act as a measure of success or otherwise and are reported in the literature. To illustrate this, Bateman and Fonagy’s (2001) study can be drawn upon which uses hospitalisation, incidents of self-harm and attempts at suicide as outcome measures. Yet Turp’s (2003) urge to consider the underlying state of mind behind acts of self-harm would be neglected in this way. Particularly as it is important to be mindful that for children and young people self-harm can serve a positive and worthwhile function and therefore is not always a product of distress (Bywater and Rolfe 2005; Smith,2002).

Further comment regarding the use of self-harm as an outcome measure may be found in Allen (2007) where it is argued that someone who has sought therapy may experience an increased frequency and/or severity of self-harm due to the exploration of difficult material,

but this does not mean that undergoing therapy is not a positive step in the long term. It is also pertinent to reflect on personal experience of working with people who use services and which illustrate how self-harm may manifest in other ways, for instance limiting nutritional intake rather than cutting (Allen, 2007).

To further progress this point, where self-harm is prevented, for instance when experiencing in-patient care, it may be possible to conclude that this has been an effective strategy if focus is placed on the incidence of self-harm. However, if a loss of control and disempowerment are the by-products of this it can be argued that the intervention has clear limitations.

This is not the only issue to bear in mind here, evidence given to the national Inquiry into Self-harm by young people indicated that social isolation, feelings of shame and guilt and a reduction in choice and control were particular difficulties that were more likely to lead to young people attempting to end their life (MHF:CF, 2006). Additionally, the inquiry found direct evidence that if the focus of care is on self-harm, rather than underlying causes it can leave young people with no choice but to self-harm again (MHF: CF, 2006).

As such, interventions which are overly controlling and fail to engage with the complexity of self-harm risk doing more harm than good and focusing on the self-harm risks the dehumanising objectification of an individual whose identity is defined by far more than their relationship with self-harm. (Mental Health Foundation & Camelot Foundation, MHF:CF 2006).

Given this it is important to acknowledge the part that self-harm has played in the young person's life but to refrain from using it as an outcome measure unless this is something that the individual sees as useful (Allen, 2007). To achieve this ways to gauge progress using the goals and measures formulated by the young person themselves are important and likely to lead to a more meaningful interpretation of progress (Allen, 2007).

This is particularly important when considering the experiences reported by people who use or have used services;

“Psychiatric hospitalisation only compounded my need to harm myself, and the response from staff was frequently angry and hostile...One doctor would stitch wounds which extended to the bone of my arm with just a skin suture, not bothering to repair the underlying layers. As the verbal humiliation and hostility increased with each visit to A&E, I became

increasingly reluctant to attend for fear of the response I would get.” (Pembroke, 2007 p163).

Warm et al (2002) evaluated levels of service satisfaction received by people who self-harm and found that medical personnel were rated most poorly, whilst self-harm specialists were deemed to be the most satisfactory. That said it may not be unreasonable to suggest that it is the response of the worker that is crucial as opposed to the nature of the service. This was argued by Skegg, (2005) who stated that the quality of the relationship with the helper is the most pivotal contributor to outcome.

With this in mind, Allen (2007) urges an individualised approach which was also stressed by Webb (2002) and Crowley et. Al (2003) who contend that self-harm and suicidality in children and young people is often/mostly a psychosocial issue, often requiring a non psychiatric, pragmatic resolution of the precipitants and triggers. It is therefore not unreasonable to suggest that by embracing such an approach, a positive outcome and satisfaction may be experienced and benefit the young person.

Such thoughtful reactions are important when it is borne in mind that adult responses to disclosures of self-harm can compound feelings of shame (MHF:CF,2006). This may impact on accessing services as described by Rissanen et al (2009) who found that shame and guilt actively inhibits children and young people from seeking help for their self-harm and associated problems.

Containing the young person's worries and concerns is only possible if the worker is also contained. As such, any focus on outcome and satisfaction that neglects the worker in this process would be remiss. With this in mind, outcome and satisfaction measures should also be applied to those who have worked directly with young people who self-harm. Rayner, et al (2005) make the case for workers to have a place to air their concern and success and where the issues stirred up as countertransference may be explored and relived thereby enabling the worker to remain resourceful. As such, the need to remain engaged and thoughtful is only possible if the worker is supported and in nurturing a positive outcome and satisfaction for the benefit of the young person, should also include the workers evaluation as one component in the overall delivery of a quality service.

10. Training and Education Issues for Primary Care Staff and the Interface between Primary and Secondary Care Services

10.1 Standards and Content

NICE (2004) advises that all people who come into contact with people who self-harm should have access to training to support them with this issue. The National Camhs Support Service has made recommendations for a minimum standard of knowledge in staff working with children and young people:

“All those working with children and young people need to be able to

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

(NCSS, 2011, pge1.)

In addition the National Inquiry’s (MHF:CF, 2006) recommendations for core content of universal training were:

- A basic understanding of what self-harm is,
- Why young people do it, how to respond appropriately
- How to respond to disclosures helpfully,
- What other support and services are available.
- A clear understanding the legal framework in relation to consent, competence, capacity and safeguarding

Stressing the importance of competent practice being based on reconnection with core skills and values of caring professions and providing responses that are rooted in these (MHF:CF, 2006).

The importance of developing theoretical understanding of the symbolic, emotional, psychological and physical functions and meaning of self harm has been stressed by multiple authors, as pivotal in reducing an over focus on physical manifestation of self harm and in challenging staff assumptions regarding controllability, which have been shown to underpin negative attitudes towards individuals (Cook & James, 2009; Mackay & Barrowclough, 2005)

For professionals in universal or primary care services, practical advice on how to support and help children and young people alongside guidance about when and how to refer on to more specialist agencies should be provided, both for pragmatic purpose, but also to help

reduce feelings of helplessness which again can give rise to hostile attitudes or frustration within professionals (Cook & James, 2009; Crawford, 2003)

The Royal College of Psychiatry (2010) have highlighted the importance of training for primary care (non mental health) staff on the signs and symptoms of commonly encountered mental disorder (particularly anxiety and depression) coupled with understanding of the difference between mental illness and expected reactions of distress. This needs to be simple and translated into information that primary care staff feel confident to ask about. For example, feelings of hopelessness and lack of enjoyment for life have been shown to be reliable indicators for the possible presence of depressive illness in young people, and relatively easy for non mental health staff to ask about or make judgements about based on their experience of being with a young person (Souter & Kraemer, 2004).

The efficacy and impact of any training and development strategy regarding self harm and suicide requires a whole system approach, with training delivered jointly across disciplines, departments and agencies (Appleby et al, 2012; Skegg, 2005). The changing nature of the developing knowledge and research in the field, combined with the emotional content of the work, means that regular updates for all staff should be embedded into the strategy. The recommendations from the most recent national confidential enquiry into suicide are that this should be an at least 3 yearly basis (Appleby et al, 2012).

NICE (2004; 2011) clearly advocates for the involvement of people who self harm in the planning of training specifying that:

- The aim of any training should be to specifically improve the quality and experience of care for people who self-harm.
- The efficacy of any training of this kind should be assessed using service-user feedback as an outcome measure.

10.2 Developmental Issues:

The common nature of the phenomenon of self harm and suicidal feelings in young people is strongly associated with the particularities of the developmental task of adolescence (Moran et al 2012). Consequently, knowledge and skills for working with adolescents are an important part of the wider skill set required to intervene with this problem in a helpful way. Practitioners not used to working with adolescents need to be helped to have reasonable developmental expectations regarding relationships, boundary testing and frequent changing states of mind, alongside confidence to provide the elements of care that are shown to bring

about change in this age group: emotional containment, support, structure, involvement and validation (Ramritu, 2002).

Although these elements are core skills common to all professional helpers, the intense and sometimes disturbing nature of the inherent emotionality of adolescence can mean that adults become subject to being 'swept up by the culture of adolescence' (Briggs et al, 2009). This can lead to reactive and impulsive action rather than strategic thinking, particularly when facing decisions around risk, and stir up psychological defences that aim to try and protect the worker from the adolescent's distress, rather than engaging with it to try and help.

Building in support and supervision systems at an organisational level that hold this 'adolescent' formulation in mind can help to sustain practitioners capacity to 'think about' the meaning of those elements of young people's behaviour that are actively serving to render their usual strategies for helpfully responding to distress and risk useless (Foster, 2009). This needs to include help to understand the interpersonal cycles that occur between the young person and the helper, including the impact of the helper upon the young person (Rayner & Allen, 2005).

These supervisory mechanisms are a common and accepted part of specialist mental health service practice, but are much less likely to be so in education and universal or primary care, despite the fact that these agencies are increasingly coming into contact with and being expected to intervene with young people who self harm.

10.3 Supervision & Reflective Learning

Royal College of Psychiatry (2010) has stated that the needs of those working regularly with complex cases extend beyond regular access to training and supervision and require provision of safe frameworks in which reflective practice can occur, supported by others (2010).

The clinical impact of such support networks and regular supervision is clearly defined within the published literature. A study by Crawford (2003) found a direct association between staff perception of their own efficacy and confidence and reduced negative attitudes towards children and young people who self harm.

Cook & James (2008) identified the importance of training strategies that focus on experiential learning, and embedding new knowledge in practice through reflection for school nurses. They concluded that more didactic and traditional teaching strategies evaluate poorly and results in requests for further training on the same subject. The use of small group reflective work discussions are particularly indicated for effecting change in practice with adolescents (Briggs et al, 2008).

11. Directory of Freely Available Online Resources

Barnardos. 'About Self Harm'. A free to download booklet, written for young people from the age of 13yrs upwards, their friends and family. Developed in partnership the charity MIND it provides easy to access explanations about self harm and how to access information, help and support. <http://www.barnardos.org.uk/about-selfharm/publication-view.jsp?pid=PUB-1301>

Camhs Evidence Based Practice Unit. Jointly held by the Anna Freud Centre and University College London. Provides accessible integrated information on evidence based interventions for commonly encountered problems in child and adolescent mental health, including self harm and associated mood disorders. <http://www.ucl.ac.uk/clinical-psychology/EBPU/>

Centre for Mental Health. Provides a range of information on mental health issues differentiated for children and young people
www.centreformentalhealth.org.uk/info/mental_health_information.aspx

Child and Maternal Health Observatory. Comprehensive repository of policy, guidelines, resources and data on all issues related to child and adolescent mental health. <http://www.chimat.org.uk/resource/view.aspx?QN=CAMHS>

Choosing what's best for you. Young people's website jointly developed by Young Minds and the CAMHS Evidence Based Practice Unit. Providing information in a range of mental health issues and types of treatment available to young people, in order to help them make informed decisions about their care. Also a very useful website for professionals who do not work in mental health services.
<http://www.youngminds.org.uk/publications/all-publications/choosing-whats-best-for-you>

Cochrane Library

Full library of systematic reviews, randomised controlled trials and other rigorous and quantitative research studies, on all aspects of health and social care. Full text versions of the 3 systematic reviews investigating effective treatments for self harm can be found here. www.thecochranelibrary.com/

Department of Health Suicide Prevention Strategy for England 2012
<http://www.dh.gov.uk/health/2012/09/suicide-prevention/>

'EveryBody's Business' Tier 1 CAMHS E-learning Resource. Free to use, developed by National CAMHS Support Service. <http://learning.camhs.org.uk>

Mental Health Foundation; Camelot Foundation (2006b) *Young People and Self-Harm: A Legal Perspective*. Mental Health Foundation.
www.mentalhealth.org.uk

National CAMHS Support Service Workforce Programme/CERNIS (2011) *Self Harm in Children and Young People Handbook*. NCSS/CSIP.

Available at: <http://www.chimat.org.uk/resource/view.aspx?QN=CAMHS>

National Institute of Clinical Excellence (NICE)

- National Institute for Clinical Excellence, NICE. (2011) *Self Harm: Longer term management*. (NICE Clinical Guideline 133). London: NICE
- National Institute for Clinical Excellence (2004) *Self-harm The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16*
<http://www.nice.org.uk/nicemedia/live/10946/29422/29422.pdf>

National mental health development unit: Legal aspects of caring for children and young people with mental disorder. Easy to use downloadable book that helps with navigating the interaction between key legislative frameworks that apply to children and young people with mental health problems

<http://www.nmhd.org.uk/silo/files/the-legal-aspects-of-the-care-and-treatment-of-children-and-young--people.pdf>

National Self Harm Network. Aims to support, empower and educate those who self-harm, their families and those who support them. <http://www.nshn.co.uk/index.html>

NSPCC. Hosts Child Line telephone line for Children and Young people. Also hosts a 24 hour telephone line for adults who are concerned about the welfare and safety of children. Website holds some public information and publications regarding self harm in children. <http://www.nspcc.org.uk/>

Oxford Centre for Suicide Research. Highly prolific National research Centre that has produced much of the statistical and epidemiological research into the prevalence of self harm and suicide amongst young people. Website holds a repository of free to access full text versions of the published articles and papers by this research group. <http://cebmh.warne.ox.ac.uk/csr/>

Papyrus. National Charity that Supports young people (35 years and under) at risk of suicide and those concerned about them. Runs a free phone helpline: **Hope Line UK 0800 684141**

Monday-Friday 10am-5pm and 7pm-10pm; 2pm - 5pm weekends. www.papyrus-uk.org

Royal College of Psychiatry Youth Info. Information on a range of mental health problems and subjects, including self harm for children, young people and their carers <http://www.rcpsych.ac.uk/expertadvice/youthinfo/youngpeople.aspx>

Samaritans. Provides confidential emotional support by telephone and email. <http://www.samaritans.org/>

Also run a programme to support schools help children cope with the aftermath of peer suicide – ‘Step by Step’ Programme. <http://www.samaritans.org/your-community/supporting-schools/step-step>

SANE. Mental health Charity that commissioned its own self harm research project (not in relation specifically to children)

<http://www.sane.org.uk/Research/SelfHarmIntro>

Social Care Institute Excellence (SCIE). Holds a range of e-learning modules on child and family mental health and 2 comprehensive briefing papers on self harm in children and young people

www.scie.org.uk

The Site. Young person’s guide to the real world, including mental health and self-harm.

<http://www.thesite.org/>

Young Minds. National charity dedicated to promoting the mental health and emotional wellbeing of children and young people. <http://www.youngminds.org.uk/>

Chapter 2: Practitioner Resource Development

Process of development and agreement

Following consultation with key stakeholders to determine the requirements, the project team were given the task of collating information that would be useful for a universal level service provider when working with a young person who self harms or is feeling suicidal. The key themes collated for a series of work force consultation events are presented below. These were used as a framework around which the structure of the resource was developed.

The resource was developed using the available evidence base and included a section on implementing good practice guidelines and a resource to help the service provider remain engaged with the young person. A problem solving cycle was presented as an easy to use resource with a favourable evidence base when applied to working with a young person who self harms or is feeling suicidal. Guidance was also included with regard to when Child and Adolescent Mental Health Service input may be required, or safety concerns about the young person's wellbeing are raised.

This was presented to key stakeholders (identified in the introduction) and through a process of negotiation the resource was agreed and is due for distribution to key universal service providers.

Staff Consultation Event: Collated themes

On the 4th October 2012 Celeste Foster and Gillian Rayner facilitated three one hour consultations with staff. 15 members of staff attended from the following settings;

Rights and participation
Community colleges
CAMHS
Youth offending services
Family First
Self assessment team
Social care
CID
KOOH

Staff were encouraged to network and this seemed a really important aspect of the sessions as they were able to spend time with staff from other services that they may be referring

young people to. The staff were asked about their experiences working with young people who self harm and any challenges or dilemmas. Then they were also asked about which information would be useful to themselves and their teams and also which format this could take and if there were any other issues they would like to discuss.

Box 4. Key Themes from Practitioner Consultation Events

- Staff thought that generally young people and staff needed to understand that self harm was "nothing to be ashamed of" and that they were "not alone"
- Staff need to recognise the importance of being the first person that the young person may have spoken to about this issue, regardless of workplace setting. They also need to be confident that they can listen and talk to the person without making things worse. They need to understand when they need to refer on and when they can just help in their current relationship.
- Staff need to understand why people self harm and which questions to ask using the correct language. Some clear questions to ask would be useful.
- Staff need help with decision making, what to do next.
- Staff need to understand that self harm and suicide are different and how to work out if the person is suicidal.
- Staff need to understand what services are available and also what an appropriate referral is for that service. They need to understand that self harm doesn't mean that the person has a mental illness or needs to be referred to CAMHS services. Staff need to know what a mental illness and personality disorder is and which services will help. They need clear referral routes and to understand the health Tier systems.
- Staff need to know definitions of self harm, examples and also what the research/ literature recommends.
- Staff need to be able to understand that repetition of self harm is not personal or means that the service has failed, but that this is the persons coping strategy. Also repetition does not mean that the person has a mental illness.
- Staff need supportive compassionate management who do not immediately blame the staff. The staff need space to reflect on their reactions and think about future interventions or responses.
- The staff need to know if to involve parents or not.
- Staff need a phone line to CAMHS where they can ask questions about referral and also hopefully gain some support on managing risk in other services.
- Staff would like some "top tips" and "myth busting"

Format

The staff consulted all agreed that a pocket sized laminated z card would be useful. They would also like a web resource but recognised the problems with this. They compromised on having an emailed version of the card that could be printed out in future. They also liked the idea of having further reading, such as a summary of the literature review and suggested further reading. This could also be emailed around to the staff.

Chapter 3: Reflective Learning Sets

1. Why?

In addition to access to appropriate training and supervision, those working regularly with people who self harm require provision of safe frameworks in which reflective practice can occur, supported by others (Royal Coll, 2010). This is to ensure that good practice principles are embedded into everyday work and to build practitioner confidence and their sense of helpfulness (Crawford, 2003).

A direct association has been shown between staff perception of their own efficacy and confidence and reduced negative attitudes towards children and young people who self harm (Crawford, 2003).

The use of small group reflective work discussions are particularly indicated for effecting change in practice with adolescents, where the intense and sometimes disturbing nature of the inherent emotionality of adolescence can mean that workers become subject to being 'swept up by the culture of adolescence' (Briggs et al, 2009).

What?

The reflective learning sets will be broadly based on the process of Action Learning, but will also draw heavily from a type of discussion based learning called 'Work Group Discussion'. This approach has a focus on thinking about the meaning of the young person's behaviour (Foster 2009) and on understanding the interpersonal cycles that occur between the young person and the helper, including the impact of the helper upon the young person (Rayner & Allen, 2005).

Using this model 'Actions' may well be working to understand something through discussion and reflection, or thinking about issues raised in the session and how they will inform practice

How?

Each participant will join a group who will in the first instance be offered 4 reflective learning sessions on the following dates:

- Group A January 22nd; February 5th; March 6th and March 25th **2:30-4pm** (plus 1/2/hour for facilitator debrief)
- Group B January 24th; February 7th; March 7th and March 27th **10-11:30** (plus 1/2/hour for facilitator debrief)
- Group C Same dates as either Group A or Group B, but at the opposite time

- Each group will last 1 ½ hours. A maximum of 8-10 people per group. A ½ hour debriefing session will take place for the facilitators at the end of each session
- Group participants need to make a commitment to attendance. Ideally 3 out of 4 sessions attended, but not less than 50%.
- The facilitator will be responsible to enabling discussion and managing the frame of the group. Participants will be expected to bring material or an issue from their practice that they would like the rest of the group to help them think through (they will get some information about this during the first session)
- At the end of the each group key themes and any actions for individuals to take forward between sessions will be summarized and agreed by the group. We discussed that collation of these very broad themes may provide the basis of some kind of certificate of attendance/learning for attendees, for CDP purposes
- The first group in January will begin with an introduction to the group aims and structure including agreeing boundaries regarding confidentiality, ground rules (including responding to distress and to disclosures of unacceptable practice) and attendance. A simple evaluation tool will be administered at this point to use as a baseline at the end of the sessions.
- Administration arrangements for the group will be co-ordinated by the Children's Workforce Strategy Manager. This in relation to email contacts for staff for alerting to any changes and disseminating information between group members as well as some information being held centrally re: employer organization and manager contact details in case of having to escalate any issues raised
- Attendance will be certificated, for CPD purposes, including a summary of key learning undertaken.

2. Developing Co-facilitator Capacity

6 practitioners were identified from within the locality workforce, who had been trained in the process of facilitating action learning and who expressed an interest in facilitating this component of the project. A half day briefing session was developed and delivered with the aim of supporting practitioners apply their transferable action learning skills to the process of

reflective learning sets which develop the process of action learning to incorporate a focus on emotional content and interpersonal processes (Jackson, 2008). The training session was supported by development of written learning resources, made available to the practitioners electronically, alongside access to support and advice by email.

2 practitioners were then allocated as co-facilitators for each reflective learning set. A University of Salford practitioner acted as the lead facilitator within the learning sets, working collaboratively with the co-facilitators to enable their increasing participation in the facilitation over the course of the programme, in order to develop their confidence and skills to be able to lead future learning sets. A debrief session for facilitators at the end of each set, was built into the programme, to further support development.

To support sustainability of delivery of the reflective learning sets on an ongoing basis beyond the life cycle of the project, agreement was sought from the Tier 2 CAMHS brief intervention and assessment service to provide ongoing advice, subject expertise and supervision for facilitators, as part of this service's remit to strengthen mental health capacity within universal children's services.

3. Emerging Content Themes from Reflective Learning Sets

There were a total of 27 participants who attended all or some of the four scheduled sessions across the three groups, 2 people only attended the first session. Participants attended for up to 6 hours. Themes were collated and agreed at the end of each group's session and then aggregated together.

Understanding

- Consideration of the function of expression of wanting to be dead as communication in younger children
- The importance of identifying the underlying issues from the child's perspective. (This helps move the focus from just the self-harming behaviour that helpers can feel more confident to intervene with)
- Understanding the function of self-harm for the person and using this to make right decisions (e.g. urgency, keep working or refer?)
- The significance for some children and young people of loss and separation in understanding their self-harm and suicidal feelings
- The use of psychological theories to help with understanding e.g., use of body based coping strategies to manage feelings or distract self, self-punishment, re-enactment of previous trauma
- Understanding controlling behaviour as a way of surviving

Developmental issues

- As adults we need to understand what it is like to be a teenager today (not when we were teenagers) – seeing it through their eyes.
- Care/action/ treatment planning – working with knowledge about where individuals are at developmentally, rather than where they ‘should’ be at chronologically, as the basis for this.

Communication

- The importance of thinking about what may be being communicated indirectly by more challenging or anxiety arousing behaviours in young people - what might we be being given a taste of (projective identification and transference), and how to communicate our understanding of this to young people
- Using non directive or developmentally appropriate types of engagement for younger children e.g. use of stories play and activities to help with emotional expression

Responding

- The importance of quality trusting relationships with adults and nurturing responses to children’s concerns
- Recognising and exploring the use of core skills which are used well with children to respond helpfully and applying these to self harm and suicidal feelings
- Seeing the person amongst everything else (not just the self-harm or the problems)
- Managing boundaries sensitively with children and avoiding judgement
- Persistence, hope and praise as therapeutic tools to help children and young people.

Service responses

- The importance and value of services co-ordinating themselves and sharing information and managing transition between services – when it works well it makes so much difference to outcomes
- Young people not always fitting the services currently provided
- Uneven allocation of resources (e.g. offending = greater service availability)
- The disengagement and rejection cycle – between young people and services
- Managing limitations and constraints within disciplines and roles

Interpersonal Processes

- Working with and capitalising on existing helpful relationships that the child has
- Focus on relationships as central to both understanding and responding to self-harm in children across the age range
- Self-harm as means of managing feelings and of feeling in control
- How children and young peoples’ understanding of themselves and beliefs about their worth are shaped by formative relationships – ways of help young people reflect on connections with the past relationships and experiences.
- Renurturing to empower children & young people
- Transference of blame within work systems and society at large

- The therapeutic value of sensitively validating the painful realities that children live in, rather than trying to fix it or reframe it positively

Feelings

- The emotional component of care – not always needing to “do” an intervention – listening, validating, responding compassionately all can be agents for change in themselves and are often exactly what the child or young person actually wants/needs
- Managing difficult feelings within ourselves
- Feeling sad
- Naming feelings and hearing what is being communicated by the self-harm or thoughts of wanting to be dead

Thoughts

- Staff often thought that ‘we should be doing something’ or “I’m not good enough” or “I’m not qualified”, moving into a referral to other specialists, rather than recognising how much they were doing already.
- Staff recognizing when they could not stop the person self-harming. “they are in control, I can’t stop them” and thus feeling out of control.
- Dealing with our own frustration
- Trying to develop a compassionate approach to ourselves not just the people we are working with – working towards accepting that what you have done is ‘good enough’ , avoiding prefix’s such as ‘ all I did was...’, ‘I only...’, ‘I just...’, as it might accidentally reduce our confidence and sense of being good enough to help.

Optimum Conditions for Work

- Safety for all – Children, Young People, carers and staff
- Emotional containment
- Importance of support networks (for child, family and professional)
- Importance of clarity of understanding role and purpose of different agencies, to enable effective co-working
- Access to information, knowledge of evidence and of available support services for signposting on to build confidence to approach and intervene
- Access to clinical supervision and debrief and support post incident for staff

Professional care and support needs

- The need for specific support for practitioners in the aftermath of suicide or traumatic self-harm. Staff need to know how to access this.
- Space for exploration of shared concerns within the group about whether one is doing enough, know enough or whether trying to do something could inadvertently cause harm

- A space to reflect on the emotional component of working with children who have thoughts of wanting to be dead, or who self-harm. This could be the reflective learning sets or supervision groups and may be for a variety of challenging issues not just self-harm and suicide.
- The impact of working with young people with such high levels of distress and disturbance – how to try and value whatever impact you make, when the harms they have suffered can't be undone
- Building confidence in own skills, validation of current good practice
- Dissemination of information about Staff hotline for support 'Listening Ear' - 24hr service run by Knowsley MBC run by counselling team

Specific Issues related to working in Safeguarding

- Exploration of the young people's experiences of care, and how this relates to vulnerability to exploitation
- Deprivation (materially and psychologically) - seeking that which is missing e.g. kindness, affection, food, gifts etc.
- In cases where children have previous sexually transgressive or abusive experiences, their vulnerability to seduction and misunderstanding of the intention of the other
- Emotional difficulties for the work force thinking about how something of the young person's internal world contributes to risks – feeling dangerously close to allocating culpability to a young person who is clearly vulnerable and needs protecting
- Specific demands upon staff working in safeguarding making it difficult to engage with the harm or damage done to the young person and how that then leads to responses: employment of defences to cope and manage self
- Managing the balance between being able to listen and take in and be moved by children's sadness and pain, without being either overwhelmed by it, or numbed to it
- The importance of supervision forums with focus on emotional impact
- The challenges of reflecting on feelings in a professional culture which can accidentally associate talking about feelings with an indication of not being able to cope
- Thinking about feelings aroused by work as a very important source of information that will help one do their job more effectively

4. Measuring Impact of the Reflective Learning Sets

2 methods were utilised to evaluate the impact of the learning sets upon attendees practice. A structured questionnaire was administered pre-attendance at the reflective learning sets and again at the end of the learning set programme. The Attitude to Deliberate Self Harm Questionnaire (ADSHQ) is a 33 item scale that has been specifically developed to evaluate attitudes and beliefs in relation to working with self harm and has been extensively tested and evaluated (McAllister et. al., 2002). It centres around key issues of perceived confidence and effectiveness in assessment and working with self harm, empathy towards those who

self harm, perceived ability to cope and understanding of the issues relating to self harm. An attitudinal scale was utilised to evaluate impact as evidence indicates that negative attitudes towards children and young people who self harm are highly correlated to levels of practitioner knowledge, skill and confidence (Crawford et. Al., 2003).

The second method of evaluation was a qualitative semi structured participant evaluation form. This included questions designed to encourage participants to reflect on changes they made as a result of their learning (see results below).

24 participants completed pre ADSHQ questionnaires and 14 completed post ADSHQ questionnaires, enabling us to analyse a total of 14.

Results of the Attitude to Deliberate Self Harm Questionnaire

Question 1: sense of control when working with people who self harm

6 participants identified an increase in their satisfaction with the control they had in dealing with children and young people who self harm. 6 participants showed no change in this domain. 2 participants indicated that they felt a reduction in their sense of control when working with people who self harm.

Collation of the themes discussed in the learning sets highlights development of increased understanding amongst practitioners that self harm as often correlated to issues of control for the children and young people, rather than being something that professionals have control over. This may well account for the negative change in 2 of the participants responses and reflect a more realistic of accurate position from which to work.

Question 2: perception of ability to help solve the problems of people who self harm

8 participants identified that they felt able to help solve the problems of children and young people who self harm before they attended the learning set and maintained this position after their participation in the learning set. 3 participants reported an increase in their perceived ability to help children and young people who self harm, with one of these participants moving from originally rating themselves as unable to help at all to feeling that they could help to solve the problems of the children and young people who self harm at the end of the learning set process. 3 participants rated a decrease in their belief that they could solve the problems of children and young people who self harm. This may relate to the themes explored in some of the learning sets about the relationship between self harm and the experience of childhood abuse and trauma for some children.

Question 3: Feeling used by people who self harm

7 Participants disagreed with the statement that they sometimes felt used by people who self harm in both their pre and post questionnaires. 3 participants showed an increase in the strength with which they disagreed with the statement, demonstrating a positive attitudinal shift. 3 participants agreed with the statement that they sometimes felt used by people who self harm in their pre-questionnaire and demonstrated no change in their post questionnaire.

1 participant moved from a position of disagreeing with the statement to agreeing that they sometimes felt used.

It is important to note that the learning environment of the reflective learning sets explicitly encourages openness about difficult feelings that may be aroused by working with individuals who self harm, within a supportive environment in which these feelings can be explored and understood. It is possible therefore that some respondents may have felt increased confidence to reflect honestly on their feelings in the post-questionnaire.

Question 4: There is little I can do to help people who self harm change many of the events that take place in their lives

8 participants disagreed or strongly disagreed with the statement that there was little they could do to help in both their pre and post questionnaires. 4 respondents showed a positive improvement in their post questionnaires in terms of the degree to which they believed they could help change the events that take place in the person's life. 2 participants showed no change in their belief that there was little they could do to change the events in people's lives and 1 participant moved from a belief that they could make changes in the events of people's lives to feeling that this was not always achievable. This result reflects the individual nature of beliefs that inform working practice in relation to self harm. Some individuals started off as very hopeless about their ability to be helpful, becoming much more positive through the course of the learning sets, Whilst other participants demonstrated moving to a more realistic position of understanding that not all events in a child's life to within the control or influence of professionals.

Question 5: Feelings of helplessness/helpfulness

9 participants moved to feeling helpless to a position of feeling helpful in relation to self harm. 3 participants who felt they could be helpful in their pre questionnaires increased their sense of helpfulness further in their post questionnaires. 2 participants rated themselves as feeling more helpless in their post questionnaires.

Question 6: Feeling used by the professional health and social care system

7 participants disagreed with the statement that they sometimes feel used by the system in both the pre and post questionnaires. 5 participants felt this statement was not applicable or declined to answer. 2 participants reported having feelings of being used by the system.

Question 7: Sense of self-determination/efficacy in their role

5 participants reported an increase in their sense of self efficacy. 3 participants rated themselves as having a sense of agency in their pre-questionnaires and this was maintained in their post-questionnaire. 4 participants showed no change or a small decrease in their responses to this item and 3 participants declined to answer.

Question 8: Sense of usefulness when working with people who self harm

9 participants responded that they felt useful when working with people who self harm and 2 showed an increase in their feelings of usefulness. 3 participants showed no change on this item and 1 participant showed a small decrease in their feelings of usefulness.

Question 9: The way the system works encourages repetition of self harm

6 respondents felt this question was not applicable to them or did not answer. 6 participants did not agree with this assertion in both their pre and post questionnaire responses. 2 participants agreed with this statement in the pre-questionnaires and moved to disagreeing with it in their post-questionnaires.

Question 10: Having sufficient knowledge of first aid skills

8 participants felt they had the requisite first aid skills to help people who self harm. 3 participants showed a positive improvement in this domain. 5 participants identified that they did not feel that they had the requisite first aid skills. This skill set was not addressed as part of the reflective learning set aims and objectives and may represent a continuing professional development need for some components of the locality workforce.

Question 11: Beliefs about people who self harm ‘clogging up’ the system

All participants disagreed or strongly disagreed with the statement ‘people who self harm clog up the system’ in their pre-questionnaires. All participants maintained this position in their post questionnaires with 2 respondents rating an (positive) increase in the strength of their disagreement.

Question 12: Knowledge of referral sources is important

Aside from 1 person whose post reflective learning set stated this question was not applicable, all 13 other responses showed that there was no movement to the question that knowledge of referral sources is important in relation to self-harm. Of the 13 who responded at pre and post reflective learning, 12 either agreed or strongly agreed with this, 1 person disagreed.

Question 13: Assessing future risk is an important skill to have

1 person disagreed that assessing risk of future self-harm was important to them, all other respondents agreed or strongly agreed with this and for 7, their strength of agreement stayed the same, for 4 people this shifted to strongly agree whilst 2 shifted from strongly to agree. This probably reflects the diversity of group members with some being in management roles which are not directly involved in risk assessment of young people who self-harm and for others a space to evaluate the part that risk assessment has in their role

Question 14: Dealing with people who self-harm is a waste of Health Care Professionals time

In answer to the question that dealing with people who self-harm is a waste of health care professionals’ time, 10 respondents consistently disagreed or strongly disagreed with this. Interesting 1 person went from strongly disagreeing to agreeing at the final session, 1 person remained consistent in strongly agreeing and 2 people went from strongly agree to strongly disagree. It seems fair to say that this is a mixed response and conjecture suggests that for 2 people the reflective learning group may have helped to reframe the positive impact a helper can have in relation to self-harm. For those who showed a more negative response it would be useful to clarify this but that opportunity is not available and any speculation for the reasons behind this response may include that gaining an overview of the complexities of working with people who self-harm can evoke or that the entries were a mistake given the scoring system on the questionnaire reverses for that question.

Question 15: I deal effectively with people who self harm

Dealing effectively with people who self-harm was consistently agreed with pre and post sessions by 4 people, 2 people did not give an answer on the second occasion, 3 people consistently disagreed with this whilst for 5 there was a positive move either from disagree to agree or agree to strongly. It seems reasonable to suggest that on the basis of this response, the reflective learning set probably played a part in supporting existing or enhancing the perception of respondents' ability to work with young people who self-harm.

Question 16: The hospital system impedes my ability to work effectively

3 respondents left this blank or stated it was not applicable, this reflects the diverse range of work contexts represented by members of the reflective learning set given that the question posed relates to the hospital system impeding the ability to work effectively with people who self-harm. Of those who answered 9 consistently disagreed or strongly disagreed with this, 1 person consistently agreed and 1 person moved from agree to disagree. This may reflect effective multiagency working and for a minority an increased understanding of the role agencies may play in supporting young people who self-harm.

Question 17: People who self harm have been hurt in the past

7 respondents consistently strongly or agreed that people who self-harm have been hurt in the past, 1 moved from disagree to strongly agree, 1 person did not know pre session but agreed by the last group, 2 from disagree to agree, 2 people moved from agree to disagree and 1 consistently disagreed pre and post learning group. As such the vast majority of the group concurred with this statement by the end of the 4 sessions and is probably explained by the content of presentations brought by respondents to stimulate thought and discussion.

Question 18: I actively use strategies to discourage further contact

The use of actions to discourage contact with people who self-harm was not fully answered for 5 respondents, of those who did, 8 either disagreed or strongly disagreed with this and interestingly 1 person went from strongly agreeing to strongly disagreeing with this statement, possibly showing a more positive response to young people who self-harm than before.

Question 19: Ongoing education and training would be useful

The potential for on-going education and training to help when working with people who self-harm was consistently agreed or strongly agreed with for all 14 respondents.

Question 20: Risk assessment is an important skill for me to have

13 respondents agreed or strongly agreed that risk assessment is an important skill, the remaining person went from strongly disagreeing to strongly agreeing with this statement and perhaps this indicates an increased awareness of this.

Question 21: People who self harm are attention seekers

1 person was unsure whether people who self-harm are attention seekers, 12 respondents consistently disagreed or strongly disagreed with this and 1 person moved from agree to strongly disagree, this possibly represents an increased understanding of the complexities involved.

Question 22: When all else have failed I feel the need to go to extremes

Feeling the need to go to extremes when all actions have failed was deemed not applicable or left blank for 3 respondents. Of those who did respond to this question 1 person went from strongly disagreeing to strongly agreeing with this, 1 person consistently agreed, and 9 people consistently disagreed or strongly disagreed with this.

Question 23: I have the requisite knowledge and skills to help

Feeling confident in having the knowledge and skills to work effectively with people who self-harm was consistently disagreed or strongly disagreed with by 9 respondents, 1 person consistently strongly agreed, 1 person moved from agree to strongly agree, 2 consistently agreed and 1 moved from disagree to agree. This indicates a mixed response and again may be due to a diverse range of experience and work contexts in the groups, it also reinforces responses to question 19.

Question 24: Referral of deliberate self harm patients to external services for further assessment is an effective course of action.

6 participants identified an increase in their agreement to referral on to other services. 0 identified a decrease in disagreement and 5 participants showed no change in this. This could relate to the discussions we had in the learning sets about who to refer on to for further help. Generally this increased awareness of other services available.

Question 25: people who self harm are just using ineffective coping mechanisms.

6 Participants identified an increase in their agreement with this, 3 Participants identified a decrease and 4 showed no change. This could relate to the many discussions that occurred within the learning sets of how self harm can be a coping strategy that also has longer term negative consequences.

Question 26: I feel as though I have the requisite knowledge in communication skills to help people who self harm

4 Participants identified an increase in their knowledge and 0 participants identified a decrease in knowledge. 9 participants showed no change, although 8 of these were in agreement anyway. Overall 13 out of the 14 questionnaires analysed had agreed with having the knowledge and communication skills required.

Question 27: I feel sorry for people who self harm

4 Participants identified an increase in feeling sorry for people who self harm. 2 Participants identified a decrease and 5 showed no change. This question uses a sympathetic approach, rather than using empathy. Within the learning sets empathy was encouraged rather than “feeling sorry” for the person.

Question 28: Providing information about community support groups is a good idea

3 participants identified an increase in having community support groups and 2 participants identified a decrease in this belief. 8 participants showed no change. Community support groups were only explicitly discussed in one of the learning sets.

Question 29: People who self harm are victims of some other social problems

3 participants identified an increase in agreement with this statement. 3 participants identified a decrease and 7 showed no change. The word “Victim” in this statement may have caused people to disagree with this. Within the learning sets many of the themes

described were relating to some of the social problems that children and young people may experience.

Question 30: People who self harm are in desperate need of help

3 participants identified an increase in agreement with this. 0 participants identified a decrease and 9 showed no change. 2 people disagreed with this statement pre and post questionnaire. 12 people agreed with this statement pre and post. So generally participants did agree that people who self harm are in desperate need of help.

Question 31: The legal system impedes my ability to work effectively with people who self harm

2 participants identified an increase in agreement with this statement and 0 participants identified a decrease. 7 people showed no change. 5 did not answer this question or stated that they didn't know. This gives a mixed message but as participants in the learning sets were from a wide variety of work environments they would also have different legal obligations.

Question 32: I feel that people who self harm are treated less seriously by the medical staff than patients who present with serious medical problems

3 participants identified an increase in this belief. 1 participant identified a decrease and 5 showed no change. 4 didn't answer or didn't know. 6 people disagreed with this statement and 8 agreed with this. Within the learning sets there were some discussions around who was suitable to be referred to CAMHS services for mental health provision and there were many ideas expressed that people who self harm did not necessarily have a mental health issue. In addition to this there were some personal experiences expressed about children and young people who had experienced some negative responses from staff in health care settings.

Question 33: Sometimes people self harm because their cultural beliefs condone this.

2 participants identified an increase in this belief and 1 participant identified a decrease. 5 showed no change. However, 5 people disagreed with the idea that self harm relates to cultural beliefs that condone it. This may be due to limited discussion on cultural beliefs within the learning sets.

Summary of Overall Trends

There was some clear evidence of some positive changes and learning for each participant. However, elements of change were unique to each individual and this reflects the diversity of the groups' attending the learning sets. The following areas of change were most apparent for the participants of the learning sets;

- An increase in sense of control when working with people who self harm.
- An increase in perception of their ability to help solve the problems of people who self harm.
- An increase in feelings of helpfulness and a decrease in feelings of helplessness.

- An increased sense of usefulness and a decreased sense of uselessness.
- An increased belief that assessing future risk is an important skill to have.
- An increase in recognition that people who self harm may have been hurt in the past.
- A decrease in participants actively using strategies to discourage further contact.
Thus a possibility of increased contact with services and less experiences of rejection.
- An increase in the belief that ongoing education and training would be useful.
- A decrease in the belief that people who self harm are "attention seekers".
- An increase in agreement that they had the knowledge and communication skills to work with people who self harm.
- An increase in the belief that people who self harm are in desperate need of help.

All of these areas of change point towards a more engaging, empowered and responsive level of help in the services that took part in the learning sets. Staff now seem able to have more confidence in their ability to help, have less negative attitudes towards people who self harm and also recognise the background and context that self harm may occur within. This is echoed in the comments from the qualitative evaluation (overleaf), in which participants have been able to articulate clear benefits and changes in their practice from engaging in the learning set process.

For some of the less positive responses in the questionnaire, a more in depth, mixed methods training programme, such as the Self-harm module at the University of Salford, would have covered these areas in more depth. However, as a reflective learning set method, in which content is governed by the participants, was utilised in this project some of the themes did not emerge from the participants who discussed their work in the learning sets. Thus it is an consideration that the reflective learning sets should be linked to other training methods that include delivery of core concepts and information, alongside the opportunity to reflect on emotional and interpersonal processes. This questionnaire was developed to use pre and post a taught self harm module in Australia and thus not designed for use within a reflective learning set experience, so does have some limitations for this project.

5. Attendee Qualitative Evaluation

16 attendees completed the qualitative evaluation form at the final reflective learning group on which this evaluation derives.

1. What has been most useful about the group?

- Being made to think
- More specialised knowledge /gaining insight from the group sessions x3
- Listening to and sharing experiences x12
- Networking
- Shared struggle realising it's not just me that finds this difficult
- Learning there is more than one way to help x6
- Facilitation x2
- Learning about psychological theory to help understanding
- Challenging own thoughts about suicide and self-harm
- Application to practice x5
- Being with other practitioners and hearing their desire to do everything possible to help children and young people
- Getting support x4

2. What has been least useful about the group?

- Nothing x6
- None attendance by group members x2
- Not having a fixed day of the week for the session
- Personally being unable to attend all sessions
- The number of sessions, 4 meant just getting used to each other and the format, would have preferred 6 sessions across 6 months

3. As a result of participating in the group has anything changed for you?

- Understanding the issue of self-harm & suicide
- Understanding how things look and feel for frontline practitioners who are working with these issues on a regular basis
- More mindful of how these issues can impact on the staff I manage and have built this into supervision
- Thinking about feelings and emotions in my work
- Thinking about support for myself and others x2
- Aware of more resources x2
- Personal efficacy
- New contacts and meeting other people
- Improved confidence x2
- Increased awareness of what helps x4
- Good to know you are not on your own
- Greater awareness of the underlying issues faced by young people
- Knowledge of the self-harm strategy
- Anticipate changes in the future due to service reconfiguration leading to more contact with young people who self-harm

- Confirmed the need for reflective learning sets x2

4. As a result of participating in the group have you done anything different when meeting a young person who self-harms and or is suicidal, their carers or a professional?

- Has informed how I will work in the future
- Presenting the issue helped in the management of the case x3
- Using new approaches to understanding what is being communicated by the young person, being attentive to indirect communication x2
- Avoiding over reacting to self-harm
- Have the confidence to offer support and advice
- Considered the young person's wider picture and experiences

5. As a result of participating in the group have you introduced any new initiatives to support a young person who self-harms and or is suicidal, their carers or a professional

- Shared experiences with other professionals
- Trying ensure I have appropriate support
- Not yet but plans to x5... and feel confident I will not panic x1, plans for multiagency working x1
- Raised the issue of the need for supervision at a higher level x2
- Encouraged/enabled young person to share their self-harm with at least one other person
- Informed the development of training and building links with case workers

6. Any other issues to feedback

- Thanks x2
- 😊
- Really useful and powerful process that I will encourage other staff to participate in the future
- Informal and relaxed which is conducive to good learning
- More reflective groups rolled out to the borough x3
- Really enjoyed the sessions
- The importance of participants being multiagency rather than discipline specific.



Chapter 4: Recommendations for Implementation & Intended Further Actions Developed by the Knowsley Commissioning team

Themes:

1. Policy
2. Protocol
3. Practice
4. Development of workforce knowledge
5. Provision of Psychological Appropriate Psychological Interventions
6. Pathway operating procedures for complex & high risk cases
7. Service users as Stakeholders

Theme	Recommendation	Already completed (c) /Underway (u)	Intended Actions/Outcomes
1. Policy	Borough wide strategies aimed at improving the social and economic life circumstances of CYP & families as the key preventative strategy for self-harm.	<ul style="list-style-type: none"> • Range of strategies in place aimed at improving the context for children, young people and families including the Borough Strategy, Joint Health and Wellbeing Strategy, Children and Families Plan, Child Poverty Plan, Stronger Families etc. (c) 	<ul style="list-style-type: none"> • Assess progress of preventative strategies through monitoring and evaluation.
2. Protocol	<p>Ensure that safeguarding and child protection procedures reflect the link between abuse and self harm & suicide, and the need for collaborative work between mental health and social care departments.</p> <p>Ensure that responses to bullying include the needs of perpetrators.</p>	<ul style="list-style-type: none"> • Development of the High Risk Protocol (u) • Anti-bullying Strategy (c) • Health Related Behaviour Questionnaire in schools to be changed to include more in-depth bullying questions (u) 	<ul style="list-style-type: none"> • Agencies to have a common/shared understanding of thresholds (Implementation Group) • Safeguarding training will reflect self harm/suicide (Workforce Strategy Group) • Monitor effectiveness of anti bullying strategies (Anti-Bullying Group) • Align with domestic abuse workstreams

Theme	Recommendation	Already completed (c) /Underway (u)	Intended Actions/Outcomes
<p>3. Practice</p>	<p>Risk Assessment & Management</p> <p>Assessment should focus on the child's journey & a narrative approach to needs /risks to aid understanding & engagement of the young person</p> <p>Whole System understanding & informed management framework for front line staff including reflective supervision/ multi- agency supervision</p> <p>Strategic cross agency policy to discourage use of actuarial risk assessment checklists re assessing severity of need</p> <p>Joint Health & Children Social Care assessment on hospital presentation/ where complex issues</p> <p>Planning</p> <p>Review continuity of care procedures for young people discharged from hospital or in transition to adult services using a Care Programme Approach / similar model</p> <p>Service Flexibility re planning to address the gaps in service when young people do not meet thresholds /require greater level of support</p> <p>Acknowledgement of need for greater time allocation when planning staff workloads/</p>	<ul style="list-style-type: none"> Recommendation to CCG T3 CAMHS review (u) 	<ul style="list-style-type: none"> Evaluate through thematic file audit of cases involving self harm (KSCB) Peer Challenge means of disseminating and embedding good practice Share good practice of narrative assessment templates (e.g. in CAMHS/YOS) (Implementation Group) Assess model of multi agency supervision (Implementation Group)

Theme	Recommendation	Already completed (c) /Underway (u)	Intended Actions/Outcomes
	<p>managing case loads</p> <p>Young people & families involved in planning interventions & also in service development planning</p>		
<p>4. Development of workforce knowledge</p>	<p>Ensure the workforce have consistent understanding of function and meaning of self harm and suicidality in children & young people and that it is often/mostly a psychosocial issue, often requiring a non-psychiatric, pragmatic resolution of the precipitants and triggers.</p> <p>Clinical and policy guidance for professionals regarding the effective response to disclosure, triaging and assessment</p> <p>Ensure the workforce respond therapeutically in context of their own role and understand the process of & thresholds for referrals, signposting onto specialist services as appropriate.</p> <p>Access to supported reflection on practice, peer support and supervision.</p> <p>Ensure managers across agencies are aware of current good/evidence based practice to support front line staff.</p>	<ul style="list-style-type: none"> • Development & circulation of practice focused review of literature and evidence, easy read summary and directory of online resources to workforce (c) • Development of training and education standards to inform workforce training content & strategy (c) • <i>Introduction to self harm</i> - awareness raising training for all workforce (u) • Training regarding general assessment skills (c) • Continue to facilitate access to STORM training for practitioners in appropriate roles needing advanced assessment training (u) • Development of practitioner resource (c) • Training of reflective learning set facilitators (c) 	<ul style="list-style-type: none"> • Evaluate Reflective Learning Sets to feed into this recommendation and inform next cohort. • Self harm awareness raising training to be monitored and evaluated by Integrated Workforce Strategy Group and outcomes reported to the Safeguarding Board. Consideration for this training to become mandatory for all partner agencies. • Wider programme of multi-agency safeguarding training to be reviewed to reflect these recommendations. • Further development of the capacity for wider practice support in Tier 2 CAMHS contract • Use of Multi Agency Thematic Audit Process to review pertinent cases • Liaison with relevant managers from partner agencies to feed into work stream on effective / reflective supervision practice.

Theme	Recommendation	Already completed (c) /Underway (u)	Intended Actions/Outcomes
		<ul style="list-style-type: none"> • Reflective Learning Sets Programme (u): • Use of practice implementation and steering group for dissemination across life of the project (u) • Multi agency staff consultation (c) • Practice Implementation Board (u) 	<ul style="list-style-type: none"> • Provide opportunities for practitioners to network and support each other outside of training and reflective learning sets – internet based groups and blogs subject to available capacity and resource
<p>5. Provision of Psychological Appropriate Psychological Interventions</p>	<p>System of support to include the following:</p> <ul style="list-style-type: none"> • Use of problem solving techniques across Universal Services • Counselling & Emotional Support Services to be provided at Primary Care level • Advice, Consultation, Brief intervention to be provided at the Primary & Secondary Care Interface <p><i>T3 CAMHs (secondary care)</i></p> <ul style="list-style-type: none"> • Brief family Interventions with a focus on problem solving • Dialectical Behaviour Therapy • Developmental Group Psychotherapy • Psycho education on harm minimisation techniques and wound management 	<ul style="list-style-type: none"> • Incorporate into toolkit for practitioners (u) • Review of the T2 emotional health and wellbeing pathway to ensure that there are a range of appropriate services offered (u) • CAMHS Brief intervention and assessment service (u) • Pilot of therapeutic group using dialectical behavioural skills for young people who self harm but do not meet threshold for T3 CAMHS (u) <p>Provided by T3 CAMHs:</p> <ul style="list-style-type: none"> • DBT outreach service for YP with difficulties indicative of Emerging Personality Disorder secondary to developmental trauma written into specification of T3 CAMHS (u) • Practitioners in T3 CAMHS trained to provide Developmental Group Psychotherapy although not currently 	<ul style="list-style-type: none"> • Problem solving training to be included in <i>Introduction to Self Harm</i> awareness raising training • Recommendation to LA/PH/Schools to ensure appropriate services/interventions in place • Review outcomes of pilot (July 21013) • Recommendation to CCG Commissioners • Recommendation to CCG/Specialist Commissioning

Theme	Recommendation	Already completed (c) /Underway (u)	Intended Actions/Outcomes
	<p><i>Evidence based treatments for underlying mental health disorders commonly associated with self harm (depression, anxiety and trauma):</i></p> <ul style="list-style-type: none"> • Cognitive Behavioural Therapy (CBT) • Interpersonal therapy (IPT) • Brief psychodynamic therapy (DIT) Consideration of development of distinct service provision for young people who repeatedly self harm over a long period. 	<p>running this.</p> <ul style="list-style-type: none"> • CBT & IPT part of core T3 CAMHS offer (c) • Practitioners trained to provide psycho dynamic therapy and mentalisation therapy – though not specifically commissioned within service specification currently 	
<p>6. Pathway</p> <p>Operating procedures for complex & high risk cases</p>	<p>Ensure that the needs of children and young people with complex, severe and persistent behavioural and mental health needs are met through a multi-agency approach, with joint responses, protocols and contingency arrangements between education, social care and health agreed at senior level</p> <p>Joint Health & Social Care assessment procedures following hospital presentation and identified suicide attempts (to address risks for CYP whose self suicidality is correlated with safeguarding issues or disclosure of abuse)</p> <p>Non attendance of children and families at clinical services should trigger a review of needs and care provision rather than case</p>	<ul style="list-style-type: none"> • A number of characteristics identified in recommendations are already in place e.g. use of CPA within T3 CAMHS, 7 day follow-up post discharge from hospital (u) • Development of a high risk protocol (u) • Agreed operational procedure / protocol for cross agency working for young people with high risk and complex needs to complement the Emotional Health & Wellbeing Pathway (u) 	<p>High Risk Protocol to address the following:</p> <ul style="list-style-type: none"> • Characteristics of the group of young people the protocol would focus on • A MARAC type approach focusing on high risk/vulnerable young people • Sign up/accountability • Address the gaps in thresholds/service provision where young people require flexibility/ different provision to keep them engaged/supported • Spot Commissioning • Multi- agency supervision arrangements. <p>Review progress (Implementation Group)</p> <p>Recommendation for CCG Commissioners</p> <p>Develop consistent methodology for</p>

Theme	Recommendation	Already completed (c) /Underway (u)	Intended Actions/Outcomes
	<p>closure</p> <p>Review current indicators and develop measures of progress & outcomes based on collaborative goal planning with CYP</p>		<p>outcome goal planning (EHWG)</p>
<p>7. Service users as Stakeholders</p>	<p>Learning from service user experience/ evaluation of services</p> <p>Development of service user satisfaction benchmarks from above</p> <p>Involvement of people who self-harm are in the commissioning & planning of service delivery</p>	<ul style="list-style-type: none"> • Commissioned qualitative research with CYP and parents/carers re: experience of multi agency service provision (u) 	<ul style="list-style-type: none"> • Findings from research will be available May 2013. Implications for action plan be reviewed at this point

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