Rationale /Background
Safety is at the centre of all good health care. Clinical risk management is integral to the co-ordination and delivery of effective and safe care. The Black Country Partnership NHS Foundation Trust (hereafter referred to as the Trust) expects the principles of best practice in clinical risk management to be used in all of its service areas.

Self-harm is poorly understood in society and people who self-harm are often subject to stigma and hostility. Even people who regularly encounter cases of self-harm through the course of their working lives - whether as school teachers, social workers, housing officers, police, prison officers, pastors and even nurses or doctors - may find the care of people who have harmed themselves particularly challenging. Yet (in contrast to the trends in completed suicide) the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is among the highest in Europe. This is a worrying situation in our society and a particular cause of concern for psychiatrists and other mental health professionals.

It is acknowledged that risk cannot be completely eliminated; indeed some risks are difficult or even impossible to predict. The Trust, however, advocates a systematic approach to clinical risk management which is underpinned by effective communication and record keeping skills. Such a systematic approach would maximise the chances of managing risk as effectively as possible given the resources available.

These guidelines present clinical staff working with individuals who engage in self-harm behaviours, guidance on conducting risk assessments and the formulation of care plans that both promote recovery and maximise safety of the individual.

“For many people self-harm is an essential coping mechanism and we have no right to demand that people stop it, unless we have something better to offer them.’

Purpose of the Guideline
Management of self-harm behaviours remains a difficult and emotive aspect of giving care and therefore poses many professional challenges. The absence of clear guidelines can create a vacuum in which inconsistent practices can occur, including different patients receiving different responses when they harm themselves, inconsistencies in how teams manage behaviours associated with self-harm from shift to shift and differences in how different treating teams manage these behaviours.

This guidance will consider both the proactive and reactive management of self-harm behaviour which is used by an individual to relieve or alleviate psychological distress.

Underpinning Principles
Principles outlined below are indicated within National Institute of Clinical Excellence (NICE) Clinical Guidelines 133: Self-harm: longer term management (2011). They
should be considered at all times when working with an individual who is using harm to self as a way of coping with distress:

- 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 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

In addition to the above principles, the five guiding principles that underpin the Mental Health Act Code of Practice must also be adhered to:

- Least restrictive option and maximising independence
- Empowerment and Involvement
- Respect and Dignity
- Purpose and effectiveness
- Efficiency and Equity

The following Trust guidelines will offer a framework for working with self-harm for those staff working with service users who harm themselves. A framework is required as opposed to a prescriptive policy, due to the need for practitioners to make ethical and professional decisions alongside each individual service user. Also the need for formulations and care plans to be reviewed quickly at times. It is the overarching framework that guides sound formulation rather than a list of “must dos”.

**Explanation of Terms used in this guideline**

**Self-Harm**

Self-harm is a broad phrase which is commonly used to describe behaviours in which an individual engages that result in detriment to the individual's physical condition. Most common types of self-harm reported by individuals include:

- Cutting
- Burning
- Self-poisoning (with medications or with other substances, some of which are not intended for human ingestion)
- Tying ligatures around the throat to limit breathing capacity
- Not managing physical health conditions whilst having the capacity to do so
- Excessive consumption of alcohol or recreational drugs
- Starvation, whether arising from difficulties associated with anorexia nervosa or not
- Severe self-neglect.

For the purpose of these guidelines the following definition will be used throughout.

“Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting”
Self-harm is often associated with a range of other symptoms and disorders such as:

- Borderline Personality Disorder (BPD)
- Impulse-control disorders not elsewhere classified
- Anxiety disorders
- Post-traumatic Stress Disorder (PTSD)
- Major depressive disorder
- Obsessive Compulsive Disorder (OCD)
- Eating disorder (anorexia, bulimia)
- Substance use disorders (alcohol, drug abuse)
- Dissociative disorder: Depersonalisation disorder, Dissociative Identity Disorder (DID) (formerly Multiple Personality Disorder), Dissociative Disorder Not otherwise specified (DDNOS)

Biopsychosocial Assessment

Biopsychosocial model is a conceptual model that assumes that psychological and social factors must also be included along with the biological in understanding a person's medical illness or disorder.

Biopsychosocial assessments should be completed with all patients who self-harm. A central purpose of a biopsychosocial assessment is to identify a patient’s needs and the risks to themselves and to devise a care plan or a management plan to address these issues.

The biopsychosocial assessment should be completed within a multidisciplinary forum.

Therapeutic Relationship

A therapeutic relationship is the relationship between a mental health care professional and an individual. It is the way in which a worker and the individual hope to work with one another to bring about meaningful and safe change for the individual. It is not a relationship in which one colludes with the other but a relationship in which interactions take place in a safe and open way and in which the individual can talk about those things that are causing them a degree of distress. It is also a space in which it is acceptable and emotionally safe for the worker to challenge the individual to promote recovery.

Process of Risk Management

The process for clinical risk management is determined by the nature of the service. Recognising possible indicators for self-harm behaviours are contained within ‘Sainsburys’ and ‘Skills Based Training on Risk Management’ (SToRM) risk assessments. There are clear stages to each risk management plan which must be followed:

- Initial assessment/ screening
- Initial risk management plan
- Comprehensive risk assessment
- Comprehensive risk management
- Positive risk taking
- Risk review
Risk Assessment Process
Department of Health (2007) states that risk assessment can be defined as the gathering of information through working with the service user, to help estimate how likely it is a negative event will occur, how soon it is expected to occur and how severe the outcome will be if it does occur for the patient relative, carer or the public.

Positive Risk Taking
Positive risk taking involves striking a balance between the sustainability of protective factors and existing risk factors between the likelihood versus the consequences of actions. It is a process, not a definitive action and this is supported by multi-disciplinary discussions and decisions. On occasion, staff actions can externally reinforce the self-harm behaviours and inadvertently increase self-harm, so it may be appropriate to take positive risks by adapting staff responses.

Person Centred Care
The patient/service user is central to the risk management process and must be involved as much as possible, from decisions about what to do to prevent self-harm or reduce the impact, as well as how the individual would prefer incidence of self-harm behaviour to be managed.

Best Available Evidence
NICE recommends that a comprehensive assessment and plan is completed which adheres to the process outlined above, with the overall aim being to:

- Prevent escalation of self-harm
- Reduce harm arising from self-harm or to reduce or stop self-harm
- Reduce or stop other risk related behavior
- Improve social or occupational functioning
- Improve quality of life
- Improve any associated mental health conditions

Self-harm is prominent within the public health agenda, advocates for a national strategy across all health and social care sectors and that evidence based risk assessment tools are routinely used as part of a biopsychosocial assessment and not as a separate exercise.

Royal College of Psychiatrists published ‘Self-harm, Suicide and Risk: Helping people who self-harm’ in 2010 which supports the generic guidance published by NICE but also reports the management within primary care settings.

Who does this Guideline apply to?
These guidelines apply to all staff within the Multi-Disciplinary Team working with those with a current or an actual risk of displaying self-harm behaviours within in patient settings.

Special consideration should be given to individuals over 65 years due to the increased risk of suicide following self-harm.

When should the Guideline be applied?
Self-harm indicators are included within Sainsbury's and STORM and this should indicate the need for further exploration and planning for incidences of self-harm. However, risk is dynamic and an individual's clinical presentation and their emotional health can change suddenly and at any time.
**Putting the Guideline into Practice**

Robust risk assessment, the formulation of plans and continual review is vital to ensure consistency of care of the individual. This will provide the context in which positive risk taking can be actioned. This, in conjunction with the multidisciplinary nature of the risk assessment process will hopefully alleviate, to some degree, any staff concerns.

‘Self-Harm Discussion’

The following five questions offer a framework for discussing self-harm with the individual. It is imperative that a thorough and empathic discussion occurs so that a robust and effective care plan can be implemented.

- What type of self-harm do you engage in?
- What area of the body is harmed?
- Do you use any particular item to self-harm with?
- What type of situations is the self-harm likely to occur?
- Have you ever tried to conceal medication (with a view of taking excessive amounts)?

Please see Appendix 1 for a solution focused framework that staff may find useful to explore people’s individual experiences of self-harm behaviours.

Staff should empathically discuss self-harm with the individual with a view to understanding the function of the harm. It is also important that the individual feels comfortable with telling staff when they have self-harmed in order that individuals can be supported to take responsibility for their emotional and physical health at an appropriate pace. The individual should not think they will be judged and chastised when reporting this as it may reduce the likelihood that they will seek out support to manage their distress when they need this. This is especially important when dealing with repeated incidences, particularly of stored medication; what may be viewed as a relatively small amount of medication can still prove fatal.

Closed questions (questions that can be answered with a yes or no answer, or with a one word answer) should be avoided as these do not facilitate effective information gathering. The conversation about self-harm should not be hurried and staff should be allowed to give time and space for the individual to engage without any external pressures.

Discussions must also include education about:

- Not re-using anything that has been used to cause harm (for example, using the same blade more than once) due to infection control risk
- Safe disposal of anything used to harm self (again due to infection control issues but also in case other patients find and use these items)
- Reporting any spillages of body fluids associated with self-harm (this is due to infection control risk as well as issues pertaining to dignity and privacy of service users)

**Biopsychosocial Assessment**

The Biopsychosocial assessment should work synergistically with the completion of the evidence based tool (Sainsburys/STORM/SOAP). It is imperative that the keyworker initiates this on the point of admission with the involvement of the multidisciplinary team as soon as possible. The process is an ongoing one and should utilise various forums,
for example: handovers, multidisciplinary reviews (e.g. ward reviews, business meetings), professionals meetings, case conferences and reflective practice sessions.

The table below details thorough aspects of a robust biopsychosocial risk assessment. It is not intended to be a mere tick list or a quantitative exercise that will dictate the frequency or severity of the self-harm behaviours. Staffs need to carefully consider each factor to assess the significance of the said factor for the individual.

For example, an individual could have poor physical health (a risk factor for harm to self) that is then quickly stabilised on the ward (resulting in a reduction of impact). An individual may have a supportive network of family and friends (a protective factor for self-harm) but this support is then limited whilst on the ward (reduced access to protective factor). Or an individual may access their place of worship frequently (protective factor), but whilst on the ward access is limited (reduced access to protective factor).

Therefore a change in only one factor may have a significant impact on the overall presentation of risk of harm to self. The interplay between these factors will give rise to a clinical formulation of risk of self-harm and thus allow for evidencing of robust risk assessment, the formulation of plans and continual review in light of positive risks taken.

Please note that some factors listed as protective may actually also be risk factors at different times for the individual and that what may be a protective factor for one person will not be for another person:

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
<th>Other factors that may indicate increasing risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Current difficulties</td>
<td></td>
<td>- Anniversaries, significant events</td>
</tr>
<tr>
<td>- Social situation (living arrangements, work, social isolation)</td>
<td>- Actively practising religion</td>
<td>- Potential lethal method – tying a ligature, for example</td>
</tr>
<tr>
<td>- Financial problems (debt)</td>
<td>- Supportive family and friends</td>
<td>- Denying or minimising serious previous behaviours</td>
</tr>
<tr>
<td>- Family network</td>
<td>- Effective problem solving skills</td>
<td>- Procuring the means to harming self, for example, purchasing rope</td>
</tr>
<tr>
<td>- Personal relationships outside of the family</td>
<td>- Effective interpersonal skills</td>
<td>- Detailed plan/tested out when to harm self with minimal intervention from others</td>
</tr>
<tr>
<td>- Perception of being a burden</td>
<td>- A healthy and sustainable sense of meaning and purpose</td>
<td>- Recently made a will</td>
</tr>
<tr>
<td>- Diversity characteristics (age, race, faith, gender, disability, sexual orientation)</td>
<td>- Responsibility for others (caring role, although this may also be a risk factor so be mindful)</td>
<td>- Written a suicide note</td>
</tr>
<tr>
<td>- Physical ill health</td>
<td>- A sense of hopefulness that things can be different</td>
<td>- Sold or given away possessions</td>
</tr>
<tr>
<td>- Recent life events</td>
<td>- A sense of belonging</td>
<td>- Sudden change in mood (including a</td>
</tr>
<tr>
<td>- Psychiatric history (diagnosis, previous difficulties, previous treatments whether they have been deemed helpful or not)</td>
<td>- Maintained good mental and physical health</td>
<td></td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Protective Factors</td>
<td>Other factors that may indicate increasing risk</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>behaviour (types, frequency, patterns, relapse signature)</td>
<td>these protective factors can be supported and maintained as much as possible whilst an inpatient. Consideration must also be given when planning an individual’s discharge</td>
<td>sense of relief or happiness</td>
</tr>
<tr>
<td>• Current self-harming behaviour and its implications to self or others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current alcohol &amp; substance misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Coping resources and available support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Concern expressed by others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current mental state examination (psychiatric disorder, mood, psychosis, hopelessness, helplessness, ambivalence about risk to self from self-harm-possible suicide, ambivalence about seeking help, ambivalence about getting help to recover)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Service user’s willingness and engagement with assessment &amp; treatment (past and present; patterns in this)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enduring psychological characteristics associated with self-harm</td>
<td></td>
<td></td>
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<tr>
<td>• Function of self-harm behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Detailed account of the circumstances leading to and motivation for, self-harm</td>
<td></td>
<td></td>
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<tr>
<td>• Service user receiving abuse or the victimisation of others</td>
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</tbody>
</table>

Depending on the individuals’ answers, staffs need to consider what is deemed acceptable to the individual; what is ‘normal’ or ‘day to day’ behaviour for them). This will assist staff in assessing the level of risk that behaviours may pose. For example, an individual may regularly cut on the thigh; if the same individual starts cutting themselves on another part of their body, this indicates a change in ‘normal’ behaviour and therefore a possible increase in risk.

Any changes in ‘typical’ behaviour will need further exploration by the team.
Care Plans and Management Plans
All individuals with a current risk of self-harm must have a care plan that addresses the self-harm behaviours.

Ideally, if the individual is able and willing to engage with this process then the standard care plan template is to be used.

The multi-disciplinary team will work collaboratively with the individual to develop a better understanding of the use of self-harm. The team must also use clinical judgement to categorise the level of risk of actual caused by the self-harm activity. This will inform the care plan and staff actions to particular behaviours.

However, in some situations, the individual may not agree with the proposed staff actions to manage self-harm. This may be dependent on the actual driver of the self-harm and the individual's motivation to change behaviour. Staffs are to use clinical judgement to assess this. In this situation a standard care plan is still to be used but will only address how to manage the individuals' needs before and after the self-harm event. How staff will manage the actual event will be detailed in a self-harm management plan. This will be referenced within the management plan.

The 4ps model of understanding difficulties can be used to formulate management plans. As such, comprehensive management plans should consider:

- Problem to be addressed
- Precipitating factors
- Perpetuating factors
- Protective factors

Problem to be addressed: This is the target behaviour for which we are generating the management plan. It will also be helpful to consider the emotions that are associated with the behaviour in the short description. For example: “When Stacey is worried or angry she often ties a piece of clothing around her neck”.

Precipitating factors: These are things that have triggered and may continue to trigger the behaviour in question. Remember, the triggers will often give rise to an emotion that individuals may not be able to identify or articulate and the behaviour may be more obvious in the first instance. For example triggers to Stacey tying clothing around her neck include:
- When her mum misses a visit
- When the ward review is running late
- When she does not have any texts from her friends
- When someone doesn’t open the office door straight away

Perpetuating factors: These are things that are either maintaining the current behaviour or making it worse. Please note that this might include things that the individual, family, friends and staff do to try to control the problem. See page 7 for further details of “risk factors” that may be maintaining the behaviour or making it worse. For example:
- In the past, when Stacey tied clothing around her neck, she got extra time with staff and has learned that this may be a way to get extra one to one time
- Stacey spends a lot of time in her room and so it’s hard to assess what’s happening for her
- Stacey will often tell staff she is ok so that she can be alone
- Stacey continues to make contact with her mum even though she thinks her mum lets her down a lot

Protective factors: These are things that stop the behaviour from getting worse or that help it to resolve. These are sources of resilience and strength for the individual. See page 7 for a list of potential protective factors. Please note this list is not exhaustive.

For example:
- Stacey has some non-harmful coping strategies such as drawing, watching TV and playing Candy Crush on her phone
- Her boyfriend is very supportive and visits every evening
- This is Stacey’s first admission to the ward and she has been able to cope with her feelings in the past without hurting herself
- Stacey is open to doing things differently but she admits that when she is really worried or angry she “can’t think straight” and will ignore attempts to distract herself
- Stacey has a good relationship with her keyworker and her keyworker is working with other staff on the ward and encouraging Stacey that she can speak to anyone who is on shift, when she gets worried or angry

The use of a management plan will ensure that staff responses are therapeutic and consistent based on both evidence based and practice based evidence. It is hoped that this will avoid splitting of treating teams in terms of how self-harm is managed for any given individual at any given time. All plans will be reviewed on a regular basis (minimum weekly) and incidences of self-harm examined to ascertain if there is evidence of harm minimisation. If this is not evident then a comprehensive review of the management plan should be undertaken as soon as possible. The review will also include any changes in self-harm behaviour, including frequency, severity and type of self-harm.

Please see Appendix 2 for an example of a care plan with full engagement from individual.

Please see Appendix 3 for an example of a care plan with partial engagement from individual.

Please see Appendix 4 for an example of a Self-harm management plan.

The associated risk factors and the protective risk factors outlined above should aid in the clinical decision making. It is imperative that all types of interventions are considered to minimise risk and that this is done in as therapeutic a way as possible.

Things to consider:
- Daily protected time with the individual, ideally with their key or co-worker or any staff where there is a therapeutic relationship. This can help with problem solving and developing healthy coping strategies for distress
- Use of psychological PRN to manage distress and thus avoid the need to use self-harm. This may also help with the communication of emotional needs
- Time off ward. This can be in the Extra Care Areas, multifaith areas, or anywhere else that is deemed useful and safe by the service user. Often the ward environment is very stimulating and can be somewhat overwhelming and a lower stimulus environment can reduce levels of emotion, to such a level where service users can use psychological skills to manage how they feel
Level of observations to monitor activity levels and engage with the service user proactively
Removal of objects that can be used to harm (for example CDs for cutting behaviour)
Use of medication PRN to manage distress and thus avoid the need to use self-harm. When an individual asks for PRN medication this is a great opportunity to engage the service user in solution focussed discussion about how best to manage their distress without the use of medication (if possible)

NICE recommends that teams should consider offering psychological intervention that is specifically structured for people who self-harm with the aim of reducing self-harm. Across the male and female wards within acute care in the Trust, a number of transdiagnostic groups, with potential benefits for individuals who are self-harming are offered, including:
- Managing emotions group
- Mindfulness group
- Problem solving group

In addition, there are various groups across the inpatient units that can offer distraction activities. One to one sessions are also available for people who self-harm. These sessions are tailored to individual need and include solution focused, cognitive behavioural and problem-solving elements. One to one sessions can be offered by any member of the multidisciplinary team, dependent upon the need of the individual and guidance from the multidisciplinary team. In accordance with NICE, drug treatment is not offered as a first line treatment for the reduction of self-harm.

All staffs working with self-harm are provided with opportunities to reflect on their practice through reflective practice, clinical supervision, management supervision and peer supervision.

**Self-Harm – Harm Reduction Strategies**
The following table lists possible alternatives to destructive self-harm that could be discussed with the individual and included in their care plan.

| Using a red felt to draw on the area normally ‘cut’ (to replicate blood) | Take a cold shower |
| Using small ice cubes on the skin. These could even be made up with red food dye (this would release a small amount of adrenalin, the red food dye would mimic blood flow) | Listen to music and dance! |
| Flicking elastic bands onto an area of the body | Exercise (to release endorphins) |
| Write it down and rip it up! (when the individual feels the urge to self-harm, to write down negative feelings onto paper and then destroy the paper) | Phone someone |

Take the ‘5 minute’ test (when an individual feels the urge to self-harm, to engage in another activity, ideally seeking support, for five minutes, in the hope that the urge will pass)

Hit/throw pillows and scream into them

For further information on drivers and positive alternatives please see Appendix 5.
Actions Following Self-Harm
Following an episode of self-harm, the management of such should be indicated within the care plan. It should include (1) physical first aid, (2) maintaining safety and (3) emotional first aid. For example:

Physical first aid:
- Will staff give the individual appropriate tools to clean and dress the wound?
- Will the staff be present when doing so?
- Depending on severity or location of wound is there a need for a further medical review?
- Depending on wound/item does the individual need a tetanus injection?
- If staff are to clean and dress the wound then this should be done following tissue viability guidance
- If staff are to clean and dress the wound then this should be done with minimal conversation and if conversation is to be had it will be helpful to be about circumstances leading to harm and what can be done differently in future

Maintaining safety:
- If an item was used to injure where is it now?
- Is a search of the individual or environment necessary to retrieve the item or to reduce the presence of further items?
- Is there a need for changes in clinical observation?
- Staff need to consider/attempt to complete MRSA screen in line with current Trust policy regarding MRSA

Emotional first aid should focus on:
- Circumstances that lead to the use of self-harm (remember triggering events, thoughts and feelings)
- How the person felt in the lead up to self-harm
- What did they want to achieve when they harmed themselves?
- Did it work?
- What did they try to do to manage distress before they harmed themselves?
- Did these things work (even if for a few minutes)?
- What made it easier to use those things that worked?
- What support do they need from others around them or their environment to focus on those things that work for them to manage distress more safely?
- Will the staff talk about the behaviour and if so when is the best time to do this, during cleaning and dressing the wound or a while after the event?
- Does the individual want protected time to talk with a familiar staff?
- Is this the best time for staff to therapeutically remind the individual of agreed alternatives to self-harm?

Remember, it is not the emotional experience that is the problem – it is the way in which the individual is managing the emotional experience that is problematic and harmful!

Operational Considerations
Clear and accurate record keeping is vital. This helps to review any progress or deterioration in behaviours and informs the risk assessment. In relation to wound management it is staff responsibility to keep a track of current wound sites. Using body maps, signs of possible infection etc.
A Datix needs to be completed if the self-harm is unexpected, the severity of the injury is unexpected or if the individual needed to access external medical assistance (accident and emergency).

**Safeguarding, Mental Capacity and Duty of Candour**

Duty of Candour is only applicable if the self-harm behaviours result in moderate harm. One of the key indicators for moderate harm is the necessity of medical treatment via the local Accident and Emergency department. If moderate harm has occurred as a result of the self-harm behaviours then the duty of candour field must be indicated within the Datix.

Self-Harm is not regarded as requiring a referral to the Adult safeguarding team; this is primarily due to the fact that there is ‘no secondary individual implicit to the actual self-harm behaviour’. However, consideration must be given to any impact of the self-harm behaviour on any child and family member within the household. Advice should be sought from the children’s safeguarding lead nurse to ensure that consideration to the ‘think family’ approach is applied.

Through implementing these guidelines and undertaking robust assessments and the formulation and regular review of robust care plans and management plans, the patient’s capacity regarding the actual self-harm behaviours is very much incorporated. Any fluctuation in capacity should be fully documented and amendments made to care plans and management plans.

When addressing issues of capacity the five guiding principles within the Mental Health Act Code of Practice (2015) must be adhered to.

**Staff Wellbeing and Debrief**

When a patient harms themselves, no matter the situation, it can be incredibly stressful. Whether staff witnessed the patient harming themselves, responded to the concerns of the patient or others, or found the patient harming themselves or responded to an alarm, it can have an impact on how we think and feel about the patients, our job, ourselves and our family and friends.

It is vitally important that all staff access the emotional support they need post-incident of self-harm. Whether this is via individual supervision, reflective practice, a debrief session or through speaking to Staff Support, it is imperative that staff look after their own emotional needs. Repeated exposure to self-harm behaviours can also become overwhelming and staff should never be concerned about the implications of talking about the self-harm they have observed or helped to manage.

It will be important to take time on shift to have a break and eat and drink regularly. Furthermore, checking in with colleagues at the end of the shift can also ensure that any issues from the shift are ascertained and any support needs identified at an early stage.

**Where do I go for further advice or information?**

For self-harm specific information:
- [http://www.rcpsych.ac.uk/healthadvice/problemdisorders/self-harm.aspx](http://www.rcpsych.ac.uk/healthadvice/problemdisorders/self-harm.aspx)
  This is a user friendly simple guide to self-harm which details self-harm strategies.
- [https://www.nice.org.uk/guidance/cg133](https://www.nice.org.uk/guidance/cg133)
  This link provides the guidance from National Institute of Clinical Excellence, Self-Harm; longer term management.
- [https://www.rcpsych.ac.uk/pdf/PS03-2010x.pdf](https://www.rcpsych.ac.uk/pdf/PS03-2010x.pdf)
This link provides the summary into the final report of ‘Self Harm, suicide and risk: helping people who self-harm report undertaken by the Royal College of Psychiatrists in 2010.

  This is a user friendly simple guide to self-harm which details self-harm strategies.

### What overarching policies the guideline links to?

- Clinical Risk Management Policy
- Searching of Inpatients Policy
- Resuscitation Policy
- Clinical Observations Policy
- Wound Management Policy (pending)
- Supervision Policy
- Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- Children’s Safeguarding Policy

### References


### Training

Staff may receive training in relation to this guideline where it is identified in their appraisal as part of the specific development needs for their role and responsibilities. Please refer to the Trust’s Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies.

### Monitoring/review of this guideline

In the event of new evidence or a planned change in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this guideline will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

### Equality impact assessment

Please refer to overarching policy

### Data Protection Act and Freedom of Information Act

Please refer to overarching policy
Appendix 1 - Possible Framework for Discussion about self-harm

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
<th>Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital:</td>
<td>Ward:</td>
<td>Named Nurse:</td>
</tr>
<tr>
<td>OASIS/MH No:</td>
<td>NHS Number:</td>
<td>Staff involved:</td>
</tr>
</tbody>
</table>

General questions

What do you see as the ‘good things’ of self-harm?
- How does it help you in your life?
- Does it come with any benefits?

What do you see as the ‘bad things’ of self-harm?
- What does it stop you from doing that you’d like to do?
- Does it affect your relationships with others?

Would you like to stop self-harming?
- If yes, what have you tried in the past to stop?
- If no, what would need to be different for you to think about stopping?

What do you consider you would gain by stopping?

What do you consider you would lose by stopping?

Would you describe self-harm as addictive?
- If yes, in what way?
- If no, how would you describe it?

Are there any strategies that have helped you not to self-harm? (e.g. ‘phoning somebody, going for a walk, taking a shower, engaging in something physical to release tension)?

What age were you when you started self-harming? Please describe what led to the use of self-harm.

How long have you been self-harming? Have there been any gaps when you haven’t hurt yourself, or hurt yourself as much? What was different then?

How often do you self-harm? Does the frequency ever change? If so, when?

What is your ‘preferred method’ of self-harming? (For example, cutting, tying, burning, other)?

Do you have a ‘preferred’ item to hurt yourself with? Why is this preferred?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| Do you self-harm in private?                                           | - If yes, what is it about being in a private place that means you self-harm?  
  - If no, what influences your decision as to where to hurt yourself? |
<p>| What other feelings/emotions do you experience when hurting yourself?  | - Feeling overwhelmed? Out of control? Angry? Frightened? These are common feelings and emotions reported, but everyone’s experience is different. |
| <strong>Ascertaining motivation</strong>                                            | <strong>Why do you think you self-harm?</strong> |
|                                                                        | <strong>What do you think triggers the urge to self-harm?</strong>                     |
|                                                                        | <strong>Can you delay the urge to act? If so, for how long? What helps to do this?</strong> |
|                                                                        | <strong>Can you explain in your own words what you hoped to achieve when you harm yourself? Is there anything else that has ever served a similar function?</strong> |
|                                                                        | <strong>Does the self-harm link to anything from the past? If so, please explain as best you can.</strong> |
| <strong>During self-injury</strong>                                                 | <strong>Did you experience any pain during self-harming?</strong>                      |
|                                                                        | <strong>Did you experience a sense of detachment? (As if you were looking in on yourself harming yourself).</strong> |
|                                                                        | <strong>Did you feel in control of what you were doing?</strong>                      |
|                                                                        | <strong>How did you know when to stop?</strong>                                      |
| <strong>After self-injury</strong>                                                  | <strong>How did you feel after self-harming? Common feelings reported are feeling numb, calm, relieved, relaxed, more in control. Again, people’s experiences are different. Can you name the feelings you experienced? Or can you talk about what you felt like doing afterwards?</strong> |
|                                                                        | <strong>Were you surprised or shocked by the level of harm you had done to yourself?</strong> |
|                                                                        | <strong>Were you kind to yourself after self-harm? (some people describe it as an opportunity for self-soothing). Did you do anything that was self-nurturing after you hurt yourself?</strong> |</p>
<table>
<thead>
<tr>
<th>Did you attend to your own wounds or was it necessary to seek treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severity of self-harm</strong></td>
</tr>
<tr>
<td>How would you describe your self-harm?</td>
</tr>
<tr>
<td>- Superficial? (little blood loss with minimal scarring)</td>
</tr>
<tr>
<td>- Moderately severe? (more blood loss with permanent scars)</td>
</tr>
<tr>
<td>- Other? (please specify)</td>
</tr>
<tr>
<td>Does the severity of your self-harm vary according to the trigger/situation/level of stress/anxiety etc.? If so, please describe.</td>
</tr>
<tr>
<td>What happens if your ‘preferred’ item is not available to you when you need to self-harm?</td>
</tr>
<tr>
<td><strong>Methods used to self-harm</strong></td>
</tr>
<tr>
<td>Do you/have you used multiple methods to self-harm? If yes, how do you decide which one to use at any given time?</td>
</tr>
<tr>
<td>If you cut and burn, do they serve different functions for you? Can you explain?</td>
</tr>
</tbody>
</table>
**Appendix 2**

**MDT care plan - Mental Health Group – Inpatients (1)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date: 23rd April 2015</th>
<th>Consultant: Dr. Young</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Ward: Dale</td>
<td>Named Nurse: Jo Smith</td>
</tr>
<tr>
<td>OASIS/CARE Notes No:</td>
<td>NHS Number:3834056</td>
<td>Care Plan lead: Lee Wilson</td>
</tr>
<tr>
<td></td>
<td>1111</td>
<td></td>
</tr>
</tbody>
</table>

Team involved in care plan.
- Dr. Young, Sara Mall (psychologist), Jo Smith, Lee Wilson, Mac Earl (OT)

**Area of Need:**
I frequently hurt myself by cutting, burning and using ligatures. When I harm myself I find it difficult to tell others and usually try to hide my injuries.

**I sometimes describe my self-harm as:**
- Impulsive and unplanned.
- Something that helps me to manage painful feelings and to feel more in control.
- A way of releasing tension.

**Self-harm behaviours include:**
- Breaking CDs and cutting the tops of my thighs.
- Tying material tightly on the top of my arm to cause pain and numbness.
- Digging at old scabs - this is literally ‘opening up old wounds’. Various wound sites have historical emotional significance.

**The following are identified as triggers for my self-harm:**

Periods of increased stress such as:
- CPA meetings, ward rounds, certain visitors (my mum).
- The anniversary of my index offence (12/01/06).
- My daughter’s birthday (06/05).
- My late father's birthday (09/10).
- Flashbacks of traumatic life events such as: sexual abuse and abandonment.
- Difficulties in relationships on the ward i.e. arguments with fellow patients.
- Not feeling safe and feeling unsupported by my primary and/or team nurses.
- A sense of being out of control and unable to pinpoint what I am feeling and why.

**Goal:**
To maintain my safety

To increase mine and the nursing teams understanding of my self-harming behaviour

To develop therapeutic relationships with me that enable me to feel safe and supported and become more able to inform nursing staff when I have harmed myself or when I feel like harming myself.

**Long term:**

To assist me in increasing my ability to express my feelings of distress, reduce my impulsivity around self-harm and provide increased empowerment through choice.

To help me gradually move away from self-harm and find alternative coping strategies.
**How are we going to help you achieve this?**

**What can you do to help yourself achieve this?**

1. I will have weekly one-to-one sessions with my named nurse (Jo) for the next 6 weeks to explore my self-harm and try to reach a better understanding of it. We will also discuss my progress in relation to this current care plan, making any changes as I need to.

2. I will meet each shift with my named nurse or other nominated member of staff, to make sure I feel safe and supported as well as help me to develop more open and trusting relationships with nursing staff.

3. Where possible, before I self-harm, I will try and approach staff to try and identify an alternative to self-harm (see list of helpful alternatives below).

4. I have identified the following alternative strategies as helpful when I feel like self-harming:

   - Cleaning/tidying my room.
   - Washing my clothes.
   - Playing board games with nursing staff/other patients.
   - Completing puzzles.
   - Playing sports/exercising.
   - Telephoning friends and family.
   - Listening to really loud music on my stereo.
   - Flicking a rubber band on my wrist.
   - Spending time with other people that I know won’t judge me.

5. If I continue to present a risk to myself, I should consider and be encouraged to hand in risk items; and/or having restricted access to my bedroom alone; and/or the use of PRN medication and the use of increased levels of observation.

6. Nursing staff should clearly and accurately document any changes in risks, all risk assessments and interventions they have implemented and ensure this information is handed over accurately.

**Wound care:**

Provide sensitive and compassionate wound care:

- Ensure pain relief is appropriate.
- Maintain high levels of cleanliness so that I don’t get an infection.
- Adhere to tissue viability guidance.

**Patient’s views of care plan:**

I will clean my wound myself so you need to give me the correct stuff so I can do this. I want to do this on my own but if I need the staff to help me, please don’t look at me, just do it as quick as possible. I don’t want to talk to staff at this time about what I have done, but don’t ignore me either. Talk about something else, something good. I need an hour or so, a cigarette and some quiet time before I will feel ready to talk to you about what happened. You can talk to me then.

I don’t understand why I sometimes can’t go into my room, just let me go there and I’ll promise to leave the door open.

I don’t like being on higher obs., it doesn’t give me quiet thinking time. It makes me feel as if staffs are waiting for something to happen, so I might as well do it. I understand that staffs sometimes have to do it if I’m really stressed out about something, just don’t stare at me... Do something with me if I want to!

**Date for review**
First review on 30.4.15 and then subsequently weekly (at a minimum).

I have received a copy of this care plan and it has been explained to me.

Signature of patient: Declined to sign Date: 23.4.15

Signature of Named Nurse: Jo Smith Date: 23.4.15

Signature of relative: (If required) Permission to disclose not given by Kate (23.4.15).

<table>
<thead>
<tr>
<th>Date</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.4.15</td>
<td>There has only been one incident of self-harm during the past week. This was minor and although Kate wasn’t able to seek staff out before the event, she did engage with staff following it. She says this was because her mother failed to bring her daughter to visit as she had promised. Self-harm occurred following her mom’s visit. Wound on right hip cleaned and dressed by Kate. Care plan continues, staffs have now provided Kate with a diary to record events, thoughts and feelings around the time when she has the urge to self-harm. Kate thought this would be a good idea and something to focus on when stressed or feeling out of control. This diary will be used in her weekly sessions with her primary nurse. Kate is happy for this to be discussed with Sara Mall (psychologist) but at the moment doesn’t want to talk to her directly.</td>
</tr>
</tbody>
</table>
### MDT care plan - Mental Health Group – Inpatients (2)

<table>
<thead>
<tr>
<th>Name: Lucy Neal</th>
<th>Date: 1.5.15</th>
<th>Consultant: Dr Sharma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: Hallam</td>
<td>Ward: Oak</td>
<td>Named Nurse: Amy Clarke</td>
</tr>
<tr>
<td>OASIS/CARE Notes No: 582985</td>
<td>NHS Number: 570257</td>
<td>Care plan lead: Sheila Meakin</td>
</tr>
</tbody>
</table>

**Team involved in care plan**
- Dr Sharma
- Amy Clarke
- Sheila Meakin
- Ross Button (psychologist)

**Area of Need:**
I often hurt myself by tying stuff around my neck. I do this as a way of getting attention from staff so that I know I am cared for and important to other people. I hate talking to people about how I feel.

This care plan also goes with care plan number 7 which talks about protected therapeutic engagement time with me. It also goes with my PCPiP.

**Goal:**
To maintain my safety.
To encourage me to adopt positive coping strategies to minimise the frequency of self-harm and to help me to communicate more positively any negative or difficult emotions.

**Long term:**
To encourage me to develop positive strategies that will fulfil my emotional need.

**How are we going to help you achieve this? What can you do to help yourself achieve this?**
- I will use my protected time with my keyworker so I can have quiet time with it just being her and me.
- I will try and attend all of the activities that I have signed up for.
- When I am feeling stressed I will try and speak to staff but I will need staff to give me time when I need it.
- I will try to take myself off to my room when I feel stressed and there is no one I can talk to. I will try and shout and scream into my pillow. I may even rip up my bedding, but I won’t use this to tie around my neck. Staff shouldn’t tell me off if I have done this ‘cos I do it out of frustration and it’s better than hurting myself.
- I know I sometimes tie stuff around my neck, but I won’t cut myself. I don’t like the sight of blood.

**Patient’s views of care plan:**
- If I rip up sheets, sometimes the staffs say I am damaging NHS property but this is what helps me. It’s better to rip up a sheet than to hurt myself.
- Staffs are sometimes too busy to spend time with me and that’s when my emotions build up.
Staff should be able to stop what they are doing and have a cup of tea with me somewhere quiet.

I don’t want to sign it. It’s all in my head, I understand what we have talked about and I don’t understand why I have to sign it.

**Date for review**  
7.5.15

I have received a copy of this care plan, it has been explained to me

Signature of patient:                         Refused to sign                                   Date:

Signature of Named Nurse:               Amy Clarke  Date: 1.5.15

Signature of relative: (If required)                               Date:

<table>
<thead>
<tr>
<th>Date</th>
<th>Evaluation</th>
<th>Signature</th>
</tr>
</thead>
</table>
| 7.5.15 | Lucy has thrown furniture around in an uninhabited area of the ward (though broke nothing) and staff responded by observing her and allowing her to complete this, calm down and leave, before wordlessly tidying up the pod. She did this a couple of times, saw that she was not eliciting any other response from staff and then stopped.  
It was mentioned in reflective practice that this behaviour continued for about 10 minutes before she realised that she was not getting the desired response and came up to the ward shared space calmly.  
There has been one incident of ligature tying (4.5.15). Lucy used a torn pillow case; this was managed as per attached management plan with good effect. Protected time given to Lucy following the incident to reflect.  
Care plan to continue. | |

**Next review date 15.5.15**
Appendix 4

MDT Self-Harm Management Plan - Mental Health Group - Inpatients

<table>
<thead>
<tr>
<th>Name: Lucy Neal</th>
<th>Date: 1.5.15</th>
<th>Consultant: Dr Sharma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: Hallam</td>
<td>Ward: Oak</td>
<td>Named Nurse: Amy Clarke</td>
</tr>
<tr>
<td>OASIS/CARE Notes No: 582985</td>
<td>NHS Number: 570257</td>
<td>Management plan lead: Sheila Meakin</td>
</tr>
</tbody>
</table>

Team involved in care plan
Dr Sharma, Amy Clarke, Sheila Meakin, Ross Button (psychologist).

Area of Need:
Lucy already has a care plan (one above and number 7) regarding her self-harm behaviours. Therefore this management strategy compliments the care plan. Staff must be familiar with all. Management strategies have not been incorporated into the care plan due to the significant risk of encouraging an escalation in behaviours and Lucy actively trying to disrupt the effectiveness of staff responses.

Current problem:
This management plan provides staff with a consistent approach with the actual tying of ligatures. This is the only type of self-harm behaviour that Lucy has demonstrated.

Precipitating factors:
Ross Button (psychologist) and the rest of team have identified that the main driver for Lucy tying ligatures around her neck is the need for her to feel that she is worthy. This is usually triggered by her perception that other patients are getting more time or that her family don’t care about her (so, after interactions with family that she finds difficult she often feels anxious and needs confirmation that people do care about her).

Perpetuating factors (things that maintain the problem):
An increase in staffs’ interactions with Lucy, following self-harm which positively reinforces the behaviour (i.e. staff will speak to her, be around her and negotiate with her when she has harmed herself).

Lucy is likely to assault staff when they do physically intervene to remove the ligature. This result in MAPA physical holding skills being utilised which further positively reinforces the behaviour (i.e. Lucy gets more attention and care when she is more aggressive).

Lack of other ways of having meaningful interactions with staff.

Lucy finds it difficult to talk about how she feels so may be more likely to continue using self-harm to get her emotional needs met.

Protective factors (things that stop the problem from getting worse and that may also help to resolve the problem):
In the past, when Lucy has activated the alarm and then proceeded to tie the ligature in the time it takes staff to respond, staffs have treated the incident as an emergency situation. Her self-harm attempts need to be viewed in the context of her situation: that this behaviour has escalated whilst being on the ward (even in A&E) and that she does so having called staff first. This tells us that she has ‘traditionally’ self-harmed in a public place or has raised the alarm...
immediately before self-harming and thus the risk of longer term harm to self could be seen as reduced.

Lucy is aware of why she harms herself and so has spoken to some staffs whom she trusts.

All staffs are in agreement with this management plan and it will be reviewed if it does not reduce the frequency/severity of incidents.

Overall risk
There is no evidence on the available history or current assessment of any significant risk of suicidality. Therefore each episode of self-harm must be judged individually. Therefore, the following has been agreed;

If Lucy pushes the alarm button and requests something then that should be handled like any other patient, i.e. she should be encouraged to act independently and appropriately.

If she pushes the call button and is harming herself when staff attend:

1. Nursing staff to stand off, verbally de-escalate and **not de-escalate by using hands on**.

2. The focus of verbal de-escalation should be on the **feelings she is experiencing, not the behaviour that she is manifesting**.

3. Nursing staff to observe physical effects of self-harm and observations.

4. If her ligature tying leads to respiratory distress or other physical symptoms then the plan is as follows:
   - MAPA team to be unobtrusively assembled.
   - Staffs remove the ligature using appropriate equipment.
   - Staff is only to apply MAPA physical holding skills if she becomes assaultive and verbal de-escalation has failed. MAPA skills to cease as soon as the ligature is removed and staff are to withdraw.

Following the incident:

**Physical first aid:**

Staffs are to offer Lucy the appropriate wound care equipment so she can tend to any wounds. If she refuses to do this, staffs are to complete wound care. Staffs are not to make any reference to why she self-harmed at this point, but to use empathic body language but make no verbal reference to the incident. If Lucy is experiencing pain and discomfort this can be verbally acknowledged. The task should be completed as quickly and efficiently as possible.

**Maintaining safety:**

Staffs are to ask Lucy what she used to harm herself and to ascertain if she still has access to the item, or to similar items. Staffs are to consider if a search is clinically justified, especially if Lucy refuses to hand over the item or similar items.

**Emotional first aid:**

Following the above two actions, staff are to reiterate to Lucy that she can speak to staff at any time. This may involve discussing the lead up to the incident, the incident itself, or providing her with some general therapeutic time. If Lucy does choose to talk about the incident, then the...
positive coping strategies as outlined in her care plan should be discussed and explored as to what worked and what didn’t.

<table>
<thead>
<tr>
<th>Date</th>
<th>Evaluation</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5.15</td>
<td>There has been one incident of ligature tying (4.5.15). Lucy used a torn pillow case; this was managed as per care plan with good effect. Protected time given to Lucy following the incident to reflect. Management plan to continue.</td>
<td></td>
</tr>
</tbody>
</table>

**Next review date**

15.5.15
### Appendix 5 - Alternative Coping Mechanisms

<table>
<thead>
<tr>
<th>Goal of harm to self</th>
<th>Healthy alternatives</th>
<th>Safe alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To feel better</strong></td>
<td><strong>DISTRACTION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Seeing blood</strong></td>
<td>Use red marker pen on arm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use food colouring on arm (be wary of stains!)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Red ice blocks (coloured with food colouring)</td>
<td></td>
</tr>
<tr>
<td><strong>Feeling blood flow from the body</strong></td>
<td>Use something that will simulate that same feeling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(e.g. hot shower)</td>
<td></td>
</tr>
<tr>
<td><strong>The pain</strong></td>
<td>Physical activities, activities that require physical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interaction with self or environment (for example,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>elastic band on wrist, punch bag)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carry safe things that can be accessed to manage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>distress when needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chew on something that has a strong flavour (e.g.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>raw onion, ginger)</td>
<td></td>
</tr>
</tbody>
</table>

| **To feel better**                                        | **EXPRESS FEELINGS**                                      |                                                       |
| **To punish oneself**                                    | Distress tolerance skills:                                |                                                       |
| **To make emotional pain clearer and more tangible**     | - Self soothe skills                                      |                                                       |
|                                                           | - Wise mind ACCEPTS                                       |                                                       |
|                                                           | Mindfulness                                              |                                                       |
|                                                           | Emotion regulation skills                                |                                                       |
|                                                           | Hitting the pillow/screaming at the pillow. Sometimes     |                                                       |
|                                                           | doing this with a patient can be really validating      |                                                       |
| **Problem solving**                                      | - ABC charts/thoughts and emotion diaries/records.       |                                                       |
|                                                           | Other communication of feelings (traffic light system,    |                                                       |
|                                                           | drawing, writing letters, key worker sessions)           |                                                       |
|                                                           | Chew on something that has a strong flavour (e.g. raw    |                                                       |
|                                                           | onion, ginger)                                            |                                                       |

**Notes:**
- **DISTRACTION**
  - Make your mind work in some way (e.g. crossword, word search, reading)
- **EXPRESS FEELINGS**
  - Distress tolerance skills:
    - Self soothe skills
    - Wise mind ACCEPTS
  - Mindfulness skills
  - Interpersonal effectiveness skills
- **RELEASE NEGATIVE EMOTIONS AND TENSION**
  - Distress tolerance skills:
    - Self soothe skills
    - Wise mind ACCEPTS
  - Mindfulness
  - Emotion regulation skills
  - Hitting the pillow/screaming at the pillow. Sometimes doing this with a patient can be really validating
how else can the situation be remedied? Develop a compassionate dialogue or a compassionate image that can be used in times of distress

<table>
<thead>
<tr>
<th>To end dissociation</th>
<th>Grounding techniques, particularly those that involve physical stimulation of the body</th>
</tr>
</thead>
</table>
| To get a rush or high | Strenuous activity  
Another (less harmful) activity that the person enjoys/finds rewarding |
| To communicate to themselves/other people | Provide validation of thoughts and feelings  
Consider ways in which someone can validate their own experiences  
Other communication of feelings (traffic light system, drawing, writing letters, key worker sessions) |
| To stop a painful thought or memory | Mindfulness  
Grounding techniques  
After developing a “safe place” image when not distressed, go to this |
| To stop from committing suicide | Any of the techniques |

Overall, it can be helpful to help patients to think of ways to:
- Get out of emotional mind
- Distract themselves
- Soothe themselves
- Connect with someone who can help
- Do something fun
- Give themselves encouraging messages

(From Healing the Hurt within by Jan Sutton)

It can also be helpful to develop a “self soothe” toolkit – a box of things that an individual can use as alternatives to self-harm or as a reminder of the alternatives to self-harm (e.g. photos, stress balls, elastic bands). People can then take these away with them on discharge from hospital to continue with their recovery.
Appendix 6 - Case Studies

Juliet
I have been self-harming on and off for about five years. It was something I ‘learnt’ while in hospital with anorexia. I resented not having control over food anymore and hated the fact that I was getting larger instead of disappearing. Initially I began to cut myself on my chest, arms and thighs. The cutting was fuelled by the repulsion I felt at my body and was directed particularly at areas giving me femininity. I was being forced to become an adult woman again and it frightened me. The self-harm lessened for a year or so as the anorexia came back but then worsened again as I recovered from anorexia. It began to be closely linked with bingeing and other times when I felt very low or isolated. When my parents found out they were horrified and refused to talk about it. It was something that couldn’t be happening in our family and as such I felt terrible about it.

There have been whole months where I haven’t self-harmed; at other times it can be two or three times a week. It helps by providing a release for me – I can’t cry so my arm cries instead. I feel much more able to cope immediately afterwards, however within an hour or two I realise I’ve failed again and the shame and guilt thoughts and feelings set in.

Sometimes I don’t even know why I’m doing it – I just feel an enormous pressure building up, I get restless and edgy and something has to give. Other times it is linked directly to bingeing or desperation. Either way, I usually know a couple of hours beforehand that I will self-harm and that it’s just a case of how long I can put it off for. Part of me thinks that it doesn’t matter what I do to myself because it doesn’t affect anyone else (no one else knows about it) and I don’t like myself anyway. Another part of me knows that it isn’t a constructive way to cope and that I need to stop if only for practical reasons. I find it very addictive though and difficult to stop because it is so effective in releasing the unbearable hurt I feel at the time.

On one occasion I needed treatment for my arm when the self-harm was particularly bad about 18 months ago. Never again. I was seen by the triage nurse then deliberately kept waiting for four hours while others arriving afterwards were treated first. Eventually, the psychiatrist I saw let me go on the condition that I came back for an appointment the next day. When I came back he told me I had to come into hospital or be sectioned so I had no choice. It was one of the worst places I could imagine – I was woken in the night several times by curious patients wandering into my room, one of whom was chanting. I discharged myself first thing on Monday morning. The one amusing thing was the label the psychiatrist had given me – a ‘disorder of impulse control.’ Maybe I’m being cynical but I suspect it was more for his benefit than mine since nobody explained anything about it to me.

I found very little support available to me in either understanding or trying to stop self-harming. I believe, however, it is much more common than generally realised. There is a huge stigma associated with it – admitting to such a problem is in many people’s view tantamount to admitting madness. I have encountered reactions such as shock,
hostility, disgust and have been ignored because of it. I believe that self-harm is not seen as a high priority in the medical world because it is ‘self-inflicted’ and often seen as a cry for attention, when in fact sufferers can go to great lengths to keep such behaviour a secret. In my situation, no one knows about it except my GP.

I have been on anti-depressants for five years and have recently started having counselling once a week which I am financing myself since at least locally there is no suitable free or NHS counsellor. It is strange but in a nice way – trust is a big issue for me but I hope this will develop. It’s very healing to have a person there for me who accepts me unconditionally and I’m finding it is taking some adjusting to! We look at various issues such as expressing emotions, relationships and anything which I think is important to talk about.

What helps most is for those trying to help looking beyond self-harm to the person themselves – valuing them as they are and for who they are. However, I would like to see more help available for people who self-harm and to see health-care professionals better educated about it.

Attitudes must change in society too because criticism and condemnation only add to the shame and guilt felt already by the sufferer. With understanding, acceptance and love, the isolation felt by the individual lessens and with continued support I believe the need for self-harming patterns of behaviour can be left behind for good as new, constructive ways of coping are learnt.

**Summary of Juliet’s story**

**Motivation to self-harm**

‘The cutting was fuelled by the repulsion I felt at my body and was directed particularly at areas giving me femininity.’

‘Sometimes I don’t even know why I’m doing it – I just feel an enormous pressure building up, I get restless and edgy and something has to give.’

**Functions served by self-harm**

‘It helps by providing a release for me, - I can’t cry so my arm cries instead.’

‘I feel much more able to cope immediately afterwards, however within an hour or two I realise I’ve failed again and the shame and guilt thoughts and feelings set in.’

**Significant points**

‘I have been self-harming on and off for about five years. It was something I learnt’ while in hospital with anorexia.’

‘The self-harm lessened for a year or so as the anorexia came back but then worsened again as I recovered from anorexia.’

‘I have encountered reactions such as shock, hostility, disgust and have been ignored because of it.’

‘What helps most is for those trying to help looking beyond self-harm to the person themselves – valuing them as they are and for who they are.’
Earl

From what I remember, I began self-harming when I started secondary school at age 11. I would isolate myself and avoid food when I could. Looking back now, I know I had no understanding of what I was doing; it was just how I lived. The self-harm carried on and no one seemed to notice. By age 14, I started scratching myself. I wanted someone to see; someone to stop me but no one did. Some people did see but didn’t know what they saw or that I was asking for help. From then on, the self-injury became secretive and I didn’t want anyone to know or see what I could do to myself. I was ashamed and scared but also felt alive. I felt that this was something I could do, something I was good at and it belonged only to me.

The self-injury continued all through my GCSE years and allowed me to function through depression, lack of identity and a very low self-worth. I could separate myself from the surrounding chaos I felt and keep going. I did well in my GCSE’s despite my scars becoming numerous and my free time being taken over by self-injury.

By age 16, I was cutting and would go through phases of cutting daily to maybe a couple of times a week. This would go hand in hand with not eating as much as I should have and isolating myself from those around me. By age 17, I was using razors and my arms were covered in cuts every day. I was now self-injuring to get through the next day. It was an addiction for me, a coping mechanism, a major part of my identity; it seemed it controlled me.

At 17, I sought help from a teacher at school. This was a massive step and I guess the beginning of my fight with self-injury. This is the point where I realised it needed to stop. It was not helping me to function anymore and it was getting in the way of the rest of my life. My A-levels went badly grade-wise, but I saw a number of mental health professionals during those two years, one of which I was able to trust. I did not realise at the time that she had an important impact on my self-injury.

I managed to get into university and continued self-injuring there. Moving away from home meant there was no one to monitor my eating and no one to worry about seeing my scars. Consequently, for two years my self-injury got out of control. My recollections of university are mostly about cutting my forearms, or making certain scars. I would constantly pressure myself to stop; setting myself targets – so many cuts a day or no razors – I would always fail. By this time, I was on antidepressants and waiting for my first outpatient appointment with a psychiatrist. Life was all over the place.

After self-harming for nine years, I accepted that it had become part of me and my life and was something I couldn’t stop; that it would always be there and I had to minimise its effects, but that would be the best it could ever be.

Once I made the conscious decision, I began to look at myself more rather than focusing on my self-injury; it was now that I was able to heal. Within six months of accepting that the self-injury was never going anywhere, I was cutting less. Within a year, it had stopped. It has now been five years since I cut myself.
It has been an extremely hard road and I sometimes wonder how I made it. I know I had to let go of focusing on my self-injury and focus on myself. I know I also had to let go of the control self-injury gave me. There is one member of my family who know what I was doing to myself, but I never felt judged no matter what I put that person through – quite the opposite in fact, this person helped me learn that I was a worthwhile individual.

Since being able to look at myself, I have been able to restore healthy relationships in my family and have been able to move on with my life – I like life now. I'm a deep person; I think too much and I analyse more than I need to, but I have fun the rest of the time and things seems to balance out. I am covered in scars but that’s okay……at least I’m able to live now without causing more.

Summary of Earl’s story

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<thead>
<tr>
<th>Identified progression route of self-harm</th>
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<tbody>
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Guideline Details

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<td>Violence and Aggression Advisor</td>
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<td><strong>Committee/Group Responsible for Approval of this Guideline</strong></td>
<td>Mental Health Quality and Safety</td>
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<td><strong>Month/year Guideline was approved</strong></td>
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Review and Amendment History

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<th><strong>Version</strong></th>
<th><strong>Date</strong></th>
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<td>1.1</td>
<td>Jan 2019</td>
<td>Guideline reviewed no amendments made.</td>
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<tr>
<td>1.0</td>
<td>Oct 2015</td>
<td>New Guidelines developed for BCPFT</td>
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