Self Harm Practice Reference Guide

NCERCC

Researched and written by Robyn Kemp

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Contents

1. Introduction

This paper is designed to guide Residential Child Care practitioners through a process of developing an understanding of the issues related to working with children and young people who self harm through using research evidence to inform and guide practice. Throughout there are references to the many publications that have informed and influenced the guide: practitioners are advised to read the relevant publications in full when trying to gain insight into the needs of a particular child/young person or group of children/young people in order to plan their care and reasonably justify care, support and interventions in the most empowering way possible.

2. Executive Summary

This guide is intended for all Residential Child Care settings and is divided into 3 main sections:

- what is self harm?
- who self harms and why? and
- how to help

Self harming behaviours serve many functions and these will vary for each person. It is understood to indicate a significant level of emotional distress and increasingly it is understood to be a form of a coping mechanism, albeit a self destructive one, and one which carries inherent risks and considerable concerns. The relationship between self harm and suicide is discussed and a tool for assessing intent is included.

There is no typical person who self harms, and the behaviours are many and varied and serve different purposes for every child or young person. Whilst not all self harm indicates a significant mental health problem, research evidence shows that between 72% and 90% of children and young people in Residential Child Care have mental health needs so it can be assumed that addressing self harming behaviours is likely to be a feature of RCC practice. The following risk and vulnerability factors are discussed:

a) Age
b) Black and Minority Ethnic children and young people
c) Child abuse, trauma and stressful life events
d) Children and young people in care
e) Children and young people in secure care or Young Offender Institutions
f) Family discord, dysfunction and social factors
g) Gender
h) Goth youth subculture
i) Learning disabilities
j) Lesbian, gay, bisexual and transgender young people
k) Mental health and conduct disorders

Helping and supporting children and young people who self harm is divided into three sections

1. ***Primary prevention*** – creating and developing a positive service culture

2. ***Secondary prevention*** – developing a strong knowledge base and targeting those known to be at risk
3. ***Intervention*** - provide well thought out support and/or treatment after self harming events to both young people, their families and practitioners, holding the long view in tandem.

1. Creating and developing a positive culture in the 'Home', as with all areas of RCC practice, is a significant factor in helping children and young people to express the difficult emotions they may seek to manage through self harm. Suggestions for a staff team's collective exploration of what constitutes their positive culture are made and it is acknowledged that this should be a continual process as cultures are frequently challenged.
2. Staff teams and practitioners are urged to develop and maintain a strong knowledge base on self harm and understand the risk and vulnerability to self harm factors so that they are prepared, both practically and emotionally, to effectively support children and young people affected. Information and evidence on assessment, attachment, creative processes, understanding groups, group contagion and warning signs are discussed.
3. Intervention supports and treatments are acknowledged as specific to the individual (there are no universal solutions) and are explored with information and advice on behaviour support interventions, law, confidentiality and risk, the importance of partnership working, "safer" self injury and support for staff.

In conclusion, NCERCC acknowledges that this guide is not exhaustive and that there are gaps, and reaffirms that practitioners are advised to read the referenced publications to gain further insight. A comprehensive list of useful organisations and web sites is included, as is a bibliography and further reading list.

3. What is self harm?

Self harm is also known as 'deliberate self harm (DSH)', 'deliberate self injury (DSI)', 'self-mutilation', 'parasuicide', 'self damaging behaviour', 'attempted suicide', 'self poisoning', 'suicide attempt', 'self injury', 'self injurious behaviour (SIB)', 'self wounding'[1] [2] (Yazdani, 1998; Babiker & Arnold, 1997)

The National Institute for Clinical Excellence (NICE)[3] defines self harm as:

"self-poisoning or injury, irrespective of the apparent purpose of the act"

and the National Self Harm Network (NSHN) describes it further as:

"the act of deliberately causing harm to oneself by causing a physical injury, by putting oneself in dangerous situations and/or self neglect"[4].

Furthermore, it is described as "a powerful, silent language"[5], and "the expression of, and temporary relief from overwhelming, unbearable and often conflicting emotions, thoughts or memories, through a self-injurious act that [the self harmer] can control and regulate"[6].

Self harm can be understood as *direct* self harm e.g.

- Cutting, burning, biting
- Head banging, hitting
- Over-dosing and self poisoning
- Face-slapping/striking face and chest with knees*
- Head slapping, rubbing or banging against surfaces*
- Trichillotomania (pulling out your own hair)*
- Self-induced vomiting or vomiting and re-ingesting*
- Hand-biting*
- Eating inedible substances (pica), eating faeces (corprophagia)*
- Skin-picking/picking at wounds*
- Gouging of ears, mouth, nose, eyes, rectum and sexual organs*
- Kicking or hitting body parts against hard surfaces*[7]

*more prevalent with people with learning disabilities

and *indirect* self harm (self-destructive behaviours) e.g.

- Alcohol and/or substance misuse

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[1] Yazdani A, *et al*. (1998) *Young Asian women and self-harm: A mental health needs assessment of young Asian women in Newham, East London. A Qualitative Study.* Newham Innercity Multifund and Newham Asian Women's Project

[2] Babiker G & Arnold L (1997) *The Language of Self injury: comprehending self-mutilation*. BPS Books, Leicester

[3] NICE (2004), Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, National Clinical Practice Guideline Number 16, Royal British Psychological Society and Royal College of Psychiatrists

[4] National Self Harm Network (2008), *What is self harm? Leaflet,* retrievable online at http://www.nshn.co.uk/upload/What_is_Self_Harm.pdf

[5] Motz A Ed. (2009), *Managing Self Harm: psychological perspectives,* Routledge, London

[6] Spandler H and Warner S, Eds (2007), *Beyond fear and control; working with young people who self harm,* PCCS books, Ross-on-Wye

[7] Paley (2007) *Fact sheet – self-injurious behaviour*, BILD, Kiddeminster

- Taking personal risks (e.g. absconding, being aggressive, engaging in abusive/exploitative/dangerous relationships, risky sexual behaviour)
- Neglecting oneself
- Eating disorders (known as anorexia nervosa, bulimia nervosa, binge eating disorder/behaviour, compulsive eating disorder/behaviour, or eating disorder not otherwise specified (EDNOS))

Research on eating disorders by b-eat, a voluntary organisation for people with eating disorders and their families (www.b-eat.co.uk), shows that it takes on average 6 years to fully recover from an eating disorder and that young people are vulnerable to relapse after reaching their 'normal' weight – important messages for Residential Child Care practitioners.

Relationship between self harm and suicide:

Walsh (2006) notes that "… self-injury is not about ending life but about reducing psychological distress. Self-injury is often a strangely effective coping behaviour, albeit a self-destructive one"[8]. There is a common understanding amongst practitioners and researchers that self harming behaviours tend not to be about ending life. However, some of the behaviours can lead to accidental death and research by the Samaritans has shown that of those 15-19 year olds who commit suicide, up to 10% have self harmed in the previous year[9]. Therefore self harm must be taken very seriously, whatever the circumstances. While it is important not to assume that self harm is intended or likely to result in suicide, it is equally important not to assume that somebody who repeatedly self harms will never attempt suicide.

Walsh designed the table below differentiating suicide attempts from self-injurious behaviour. While the table is a useful and quick guide to understanding the difference between self injurious acts and suicidal acts, it cannot be used as a stand alone method for determining whether a young person's act was suicidal or not and practitioners should seek further clinical advice. Further exploration of each area is undertaken in Walsh's book referenced below.

Assessment Focus	Suicide attempt (Shneidman, 1985)	Self-injury (Walsh & Rosen 1988)
1. What was the expressed and unexpressed intent of the act?	To escape pain; terminate consciousness	Relief from unpleasant affect (tension, anger, emptiness, deadness)
2. What was the level of physical damage and potential lethality?	Serious physical damage; lethal means of self harm	Little physical damage; non-lethal means used
3. Is there a chronic, repetitive pattern of self-injurious acts?	Rarely a chronic repetition; some overdose repeatedly	Frequently a chronic high rate pattern
4. Have multiple methods of self-injury been used over time?	Usually one method	Usually more than one method over time
5. What is the level of psychological pain?	Unendurable, persistent	Uncomfortable, intermittent
6. Is there constriction of	Extreme constriction; suicide as	Little or no constriction; choices

[8] Walsh B (2006), *Treating self-injury a practical guide,* The Guilford press, London & New York
[9] Samaritans (2004), Young Matters 2000 – A Cry for Help, Slough, Samaritans.

cognition?	the only way out; tunnel vision; seeking a final solution	available; seeking a temporary solution
7. Are there feelings of hopelessness and helplessness?	Hopelessness and helplessness are central	Periods of optimism and some sense of control
8. Was there a decrease in discomfort following the act?	No immediate improvement; treatment required for improvement	Rapid improvement; rapid return to usual cognition and affect; successful “alteration of consciousness”
9. What is the core problem?	Depression, rage about inescapable, unendurable pain	Body alienation; exceptionally poor body image in clinical populations

Warning signs

It can be very difficult to identify someone who is self-harming, particularly if the young person is trying to keep the behaviour secret, leaving the onus on the practitioners to create and maintain the conditions in which children and young people can express their difficult emotions without judgement. Here are some signs that may indicate that someone may be self-harming:

- Poor functioning at school
- Unexplained, frequent injuries
- Keeping the skin covered (arms and legs especially) at all times
- Appearing lonely, isolated, withdrawn or uninterested
- Low self-esteem
- Difficulty handling emotions
- Elusive, evasive or secretive, especially if asked about injuries
- Carrying razors, lighters or sharp objects that are not normally needed
- Difficulty handling feelings
- Misuse of alcohol or drugs
- Engaging in risky behaviours
- Eating disorder behaviours
- Engaging in abusive relationships
- Any major change in behaviour of any kind

4. Who self harms and why?

There is no typical person who self harms and each person's self harming behaviours will vary in terms of how and why. The majority of the research in this area has been carried out with adults although there are some significant publications/papers on self harm and issues relating to self harm among children and young people and a few on self harm and children in care in particular. Researchers largely agree that the majority of those who self harm report that they do it in order to relieve *too much* emotion, and that a minority report that they do it to relieve *too little* emotion or states of dissociation.[10]

Young people who self-harm have often had very difficult or painful experiences or relationships.

Other young people may start to self-harm as a way of dealing with the problems and pressures of everyday life. Pressure can come from family, school and peer groups to conform or to perform well (for example in getting good exam results). Young people can be made to feel angry, frustrated or bad about themselves if they cannot live up to other people's expectations. Young people who self-harm often have low self-esteem. For some this is linked to poor body image, eating disorders, or drug misuse.

Understanding why young people self-harm involves knowing as much as possible about their lives and lifestyles. Peer pressures may occasionally be the most important reason for self-harm, especially for those in group living environments. Young people may find themselves among friends or other groups who self-harm and may be encouraged or pressurised to do the same, or feel that this is normal.

Extreme feelings of fear, anger, guilt, shame, helplessness, self-hatred, unhappiness, depression or despair can build up over time. When these feelings become unbearable, self-harm can be a way of dealing with them. Reasons for self-harm include:

- *"Pain makes you feel more alive when you feel numb or dead inside"* (Jay)
- *"I deliberately disfigured myself in certain ways to make myself so ugly that it was easier for people to dislike me or have relationships with me"* (Faye)
- "*Self harm involves all of us at some level. We may all punish, distract or numb ourselves as a way of dealing with difficult feelings or situations"* (MIND)
- When the level of emotional pressure becomes too high it acts as a safety valve - a way of relieving the tension and reducing psychological distress
- A form of communication about one's deep unhappiness - a way of saying one needs help
- Physical pain
- Punishing oneself may relieve unbearable feelings of shame or guilt
- Self-harm is something one can control when other parts of one's life may seem out of control

Prevalence:

Figures on he prevalence of self harm among children and young people are unreliable as much of it will not come to the attention of services or professionals and most research has been carried out

[10] Favazza, 1987; Walsh & Rosen, 1988; Alderman, 1997; Conterio & Lader, 1998; Brown, 1998, 2002; Brown, Comtois & Linehan, 2002; Conterio & Lader, 1998; Shapiro & Dominiak 1992, Simoen & Hollander, 2001

with adults. However, the figures do show that in the UK rates of self harm amongst young people have risen dramatically in the last five years. A 2006 inquiry[11] by two charities found that 1 in 15 young people in the UK are thought to self-harm, most commonly by cutting. The inquiry looked specifically at the 11 to 25 year old age group and identified that self-harm was a symptom of an underlying problem relating to 'an emotional or psychological trauma'.

A recent government report on mental capital and well being noted that 45% of all children in care and 72% of young people in residential child care have a diagnosed mental health problem[12] and further research noted that "fewer than 1 in 10 children looked after by Local Authorities have positive mental health... [there is a] strong association with psychiatric disorders and care related variables"[13], meaning that the care experience itself (i.e. not necessarily the care system, but the events leading to being taken into care, and the process of that happening) can create, cause or exacerbate mental health problems.

Given the above information, prevalence of self harm amongst young people in care can be assumed to be an active potential and, as for the rest of the population of young people too, it will often be hidden and potentially can go un-noticed, thus carers, practitioners and managers at all levels should ensure that self harm is understood, responded to sensitively and that children and young people in care are given opportunities to express their views, opinions and difficult emotions in a wide variety of ways. The culture of a home will have a direct effect on whether young people feel able and safe enough to talk about their difficult feelings and address their self harming behaviours, and this is discussed in more detail later in this paper.

Increased risk / more vulnerable groups:

Some groups of young people are more vulnerable to self harming than others but this is not to say that research has been able to identify that some groups are not vulnerable to self harm. Each person who self harms does so for their own reasons, reasons that some may not be able to articulate or even understand themselves and every person who self harms is different from another. It is important that those working with young people understand and work with the fact that oppression, racism, homophobia and other forms of discrimination can either be a cause of or a contributing factor to children and young people self harming.

Research discussed in this paper informs us that some factors or indicators may increase vulnerability to self-harming behaviours than others and they include (in alphabetical order):

a) Age
b) Black and Minority Ethnic children and young people
c) Child abuse, trauma and stressful life events
d) Children and young people in care
e) Children and young people in secure care or Young Offender Institutions
f) Family discord, dysfunction and social factors
g) Gender
h) Goth youth subculture

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[11] Camelot Foundation & MHF (2006), *Truth Hurts,* MHF

[12] Foresight Mental Capital and Wellbeing Project (2008), *Final Report*, Government Office for Science

[13] Ford, T., Vastanis, P., Meltzer, H., *et al* (2007*) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households*. British Journal of Psychiatry, 190, 319 –325

i) Learning disabilities
j) Lesbian, gay, bisexual and transgender young people
k) Mental health and/or conduct disorders, alcohol and drug abuse

The following section discusses the research and practice evidence of the above is divided alphabetically.

a) Age:

Most researchers in this subject agree that self harm is more likely to begin during adolescence but some children begin self harming at an earlier age, and it can begin or continue during adulthood. Research by Meltzer[14] et al published in 2001 found that, according to parents, approximately 1.3% of 5-10 year olds had tried to harm, hurt or kill themselves. Looking into this statistic further, the researchers found that the rate of self harm increased from 0.8% among those with no mental disorder, to 6.2% of children with an anxiety disorder and to 7.5% of those who had a conduct disorder, hyperkinetic disorder (e.g. ADHD) or a less common mental disorder.

The same study found that 2.1% of 11-15 year olds had tried to harm, hurt or kill themselves and that the highest rate (3.1%) was found among girls aged 13-15. Further analysis showed that the rate of self harm or suicidal ideation was 1.2% among those with no mental disorder, and increased to 9.4% of those with anxiety disorders, 18.8% of those diagnosed with depression, 12.6% of those who had a conduct disorder and 8.5% among those with a hyperkinetic disorder. Greenwood (2005)[15] cites that Gilligan (1996)[16] "has underlined the role of shame as a catalyst for violence. Adolescence is a time when feelings of shame can be at their height as physical and emotional changes often seen to threaten any sense of equilibrium."

b) Black and Minority Ethnic children and young people:

There is scant information on self harming behaviours among black and minority ethnic communities. Indeed the NICE 2004 self harm clinical guidance states that 'there is no good evidence to suggest that incidence of self harm varies between different ethnic groups, apart from Bhugra's study in 1999'. A specific diversity perspective has not always been included and research has frequently omitted gathering such information. That there is little research should not lead readers to assume self harm is not present in the BME population.

In her discussion of self harm and black identity, Martins[17] urges us to acknowledge and engage with both the political and social context of self harm, and with this to understand the development of black identity. Cultural, institutional and individual racism play a significant role in identity development and as such, within the sphere of self harm, racism is ignored at all our peril. She says

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[14] Meltzer H, Harrington R, Goodman R, & Jenkins R (2001), *Children and adolescents who try to harm, hurt or kill themselves: a report of further analysis from the national survey of mental health of children and adolescents in Great Britain in 1999,* HMSO

[15] Greenwood L ed (2005), *Violent Adolescents – understanding the destructive impulse,* Karnac (Books) Ltd: London

[16] Gilligan J, (1996), *Violence,* London: Jessica Kinglsey

[17] Martins V (2007), Working with self harm and black identity. In Spandler H & Warner S (ed.), *Beyond Fear and Control: working with young people who self harm,* PCCS Books: Ross on Wye

"…what is the difference between a young black person scrubbing their skin raw or even bleaching it and a white young person who cuts him or herself? In many ways, it is not the 'action' itself that is different but the values and explanations we attach to it. Raising issues of identity more directly invites us to consider these values and explanations. Although it doesn't give us any easy answers, thinking about identity helps us to reintroduce notions of abuse and racism (or other oppressive and discriminatory acts) into discussions of self harm because it moves the focus from the harm young people do to themselves, to the oppression that may underlie it."

Bhugra's 2002 study[18] on attempted suicide in South Asian women found the social and cultural factors influencing these rates of self-harm were: gender: self-harm is more likely in females; gender-role expectations; alienation from culture, especially one's own but also from that of the majority population; family conflict, e.g. with parents, partner; domestic violence: by male members; alcohol use in the family: by male members; cultural conflict: liberal views *v.* traditional setting; psychological distress expressed in the individual's alienation and rejection of cultural values; and poor self-esteem.

A 2006 study by Hussain et al[19] found that South Asian women aged 16-24 were significantly more likely to self harm than white women; these women were generally younger, likely to be married and less likely to be unemployed or use alcohol or other drugs. They reported more relationship problems within the family. South Asian women were said to be less likely to attend A&E departments with repeat episode since they held the view that mainstream services do not meet their needs. Hussain et al note:

"South Asian women are at an increased risk of self harm. Their demographic characteristics, precipitating factors and clinical management are different than whites. There is an urgent need for all those concerned with the mental health services for ethnic minorities to take positive action and eradicate the barriers that prevent British South Asians from seeking help. There is a need to move away from stereotypes and over-generalisations and start from the user's frame of reference, taking into account family dynamics, belief systems and cultural constraints".

This last sentence is advice useful not only for those working with South Asian women but also with children and young people.

c) Child abuse, trauma and stressful life events:

Hawton notes that child abuse, trauma and other stressful life events are associated with self harm[20], and this is supported by a great number of other researchers (Van der Kolk et al, 1991; Meltzer et al, 2001; Spandler & Warner, 2007). However, it does not follow that having experienced

[18] Bhugra D & Manisha D (2002), *Attempted suicide in South Asian women,* Advances in Psychiatric Treatment, Vol 8, pp 418-423

[19] Hussain M, Waheed W & Hussain N (2006) *Self Harm in British South Asian women: psychosocial correlates and strategies for prevention.* Anals of General Psychiatry 2006 5:7n

[20] Hawton, K., Rodham, K., Evans, E., *et al.* (2002) Deliberate self-harm in adolescents: self report survey in schools in England. *BMJ, 325*(7374), 1207–1211.

abuse, trauma or other stresses in life a child or young person will adopt self harming behaviours. Van der Kolk et al's study[21] showed that those participating in the study who had histories of childhood sexual and physical abuse were more prone to self-cutting and suicide attempts. The nature of the trauma and the child's age at the time of the trauma affected the nature and the severity of the self-destructive behaviour.

In an important observation for Residential Child Care they concluded that childhood trauma contributes to starting self harming behaviours, but lack of secure attachments helps to maintain it. Hawton and Rodham (2006)[22] note a clear link between abuse and suicidal phenomena occurring during childhood and adolescence. They also note that other factors such as low self esteem may play a mediating role in the relationship between abuse and suicidal phenomena.

In addition to sexual and physical abuse, neglect, emotional abuse, domestic violence, bereavement, bullying, experiencing a lack of support or communication, experiences of discrimination, sexual exploitation, oppression and war etc can be factors associated with self harm. As previously mentioned, much of what the child/young person has experienced and which has precipitated acts of self harm may be difficult or even impossible for them to articulate - practitioners are therefore compelled to work alongside the child/young person, develop supportive and genuine relationships and respond to their needs in way which are acceptable and meaningful for them.

d) Children and young people in care:

By virtue of being in care, children and young people will have in their social history adverse childhood experiences, and that these experiences, as discussed in the previous and in subsequent sections, can be seen as some of the predictors for the potential to adopt self harming behaviours.

For some, self harm may start following being placed in care as the reasons for placement, together with their experience of loss and separation from their family and the difficulties in assimilating into a new group (whether in foster or residential care), may be too difficult to bear, for others it may have started beforehand.

For all, the risks of starting or continuing self harming behaviours whilst in care should be seen by practitioners as a potential requiring close observation, a sound level of understanding and early intervention strategies to be implemented.

Meltzer et al[23] found that 39% of young people living in residential care had self harmed compared with 18% of young people living with their birth parents, and 14% of young people in foster care, and that the self harm frequently began whilst in residential care. Self harming behaviours can be the reason given for the breakdown of a placement leading the young person to experience yet more trauma in having to move, thereby compounding the problems which led them into the care system

[21] Van der Kolk B, Perry J, & Herman J (1991), *Childhood origins of self destructive behaviour*, American Journal of Psychiatry, 148(12): 1665-1671

[22] Hawton K, Rodham K & Evans E (2006), *By their own young hand. Deliberate self harm and suicidal ideas in adolescents.* London: Jessica Kingsley

[23] Meltzer H & Lader D (2005), *The General Health, Social Networks and Lifestyle Behaviours of Young People Looked After by Local Authorities in Scotland,* Scottish Journal of Residential Child Care Vol 4 no 1 Feb/Mar

in the first place and, likely, exacerbating their self harming behaviours and ideation. Cowan's[24] 2008 study of the case files of 12 young people with experience of care and who had committed suicide found that withdrawal from work or education, superficial or negative peer relationships, severe family disruption, a number of adverse personal life experiences including abuse, low self-esteem, and risky sexual health behaviours were all factors affecting the young people prior to their deaths. Most significantly for this paper, 7 of the 12 had expressed a desire to commit suicide and 10 had self harmed.

Piggot et al's 2004 paper[25] which sought the views of young people and of staff in Glasgow, negative and judgemental staff attitudes towards self harm were seen as unhelpful and contributed to keeping the behaviour secret.

e) Children and young people in secure care and Young Offender Institutions:

Whilst there are obvious differences in judicial and care & welfare settings the following section may provide a perspective for reflection on practice in Residential Child Care with practitioners taking active measures to ensure the conditions for self harming behaviours to occur and thrive are minimised or eliminated.

The UK has more children in secure settings (welfare, health and justice) than any other European country. There is little research regarding self harm within these settings. With some caution at conflating two populations, we may learn something from looking at adult statistics where compared to other population groups, incidence rates of self harm are highest in prison and psychiatric services. Whether this is mainly due to the individual's personal history or the incarceration, or whether a combination of the two are precipitating influences to self harming behaviours is not evidenced by research currently. Women are disproportionately more likely than men to display self harming behaviours within these settings[26]. In environments where control is taken away from individuals there is a greater likelihood for self harm. Service users and commentators offer origins of the self harming behaviours in such settings as stemming from being powerless and helpless, feeling controlled rather than helped, resulting in individuals being more likely to express protest via self harm. McQueen (2007)[27] argues that our society and penal systems create the environment where self harm can thrive. High numbers of young people in such settings have mental health problems, experiences of trauma and almost 40% of prisoners under 21 have been in the care system. There are considerable tensions and dilemmas for those working with young people in secure care or YOIs since the systems are highly controlled and controlling by both formal (by officers or staff) or informal (by other 'inmates') systems. Writing about children's settings McQueen notes "*The consequent environment is one of fear and aggression in which both staff and prisoners have to find a way to survive*". She notes that sometimes self harm can be a way to survive, to resist, to protest, a release, and "*sometimes an avowal of life in the midst of much*

[24] Cowan C (2008),*Risk factors in cases of known deaths of young people with experience of care: an exploratory study,* Scottish Journal of Residential Child Care, Vol 7. No 1 Feb/Mar

[25]Piggot J, Williams C, McLeod S and Barton J (2004), *A Qualitative Study of Support for Young People who Self-Harm in Residential Care in Glasgow,* Scottish Journal of Residential Child Care Vol 3 No 2 Aug/Sep

[26] Grocutt E, Self harm cessation in secure settings. In Motz A (2009), *Managing Self Harm: psychological perspectives,* Hove: Routledge

[27] McQueen, C (2007) Weaving Different Practices: working with children and young people who self harm in prison. In *Beyond Fear and Control: working with young people who self harm,* Ross on Wye: PCCS Books

inhumanity". Short et al's study[28] suggest that prison staff see women who self harm as either genuine or non-genuine and that those they viewed as non-genuine were seen as manipulating their circumstances to achieve particular ends. The staff also reported feeling ill-equipped to understand, manage or support women who self harmed.

Lawday (2009) warns in her chapter 'Self harm in women's secure services'[29] that re-traumatisation may occur in secure settings and examples of institutional practices that have this potential are "*organisational processes (e.g. restraint procedures and the use of seclusion and observations), therapeutic processes (e.g. enforced medication, physical examination, 'interrogative' interviewing), and systemic processes (lack of choice, control and power)"*.

Perry (2009)[30] has recently designed and tested a psychometric instrument for assessing vulnerability to risk of suicide and self harm behaviour in offenders (SCOPE) which some practitioners may find useful.

f) Family and social factors:

Children and young people from all social groups have been known to self harm, this in itself is not a predictor however, it will come as no surprise that children of families from social group 5 are more prevalent in the self harm population than those in social group 1[31]. Meltzer[32] notes factors which may have a bearing but are more likely to be one element of a wider group of factors for each individual include:

- children and young people from families where there is a high level of punishment
- children and young people from families who do not own their own house
- children and young people from families with 5 or more children
- children and young people from families with step children

children and young people from lone parent familiesResidential Child Care workers might like to consider this list in relation to the characteristics of the social histories of young people in their residential settings. Of other family factors which are significant among children and young people who self harm Kerfoot[33] notes several other social disadvantage factors: reliance on welfare benefits; family history of delinquency; family history of deliberate self harm; increased contact with

[28] Short V, Cooper J, Shaw J, Kenning C, Abel K, & Chew-Graham C (2009), *Custody vs care: attitudes of prison staff to self harm in women prisoners – a qualitative study,* Journal of Forensic Psychiatry & Psychology, Online early view

[29] In Motz A (2009), *Managing Self Harm; psychological perspectives,* Hove: Routledge

[30] Perry A (2009), *A new psychometric instrument assessing vulnerability to risk of suicide and self-harm behaviours in offenders: Suicide Concerns for Offenders in Prison Environment (SCOPE),* International Journal of Offender Therapy and Comparitive Criminology, Aug 2009; vol.53: pp. 385-400

[31]National Statistics Socio-economic Classification (NS SEC): Class 1 Managerial and professional occupations; Class 2 Intermediate occupations; Class 3 Small employers and own account workers; Class 4 Lower supervisory and technical occupations; Class 5 Semi-routine and routine occupations

[32] Meltzer H, Harrington R, Goodman R, & Jenkins R (2001), *Children and adolescents who try to harm, hurt or kill themselves: a report of further analysis from the national survey of mental health of children and adolescents in Great Britain in 1999,* HMSO

[33] Kerfoot M (2000). Youth Suicide and Deliberate Self Harm. In Aggleton P et al, *Young People and Mental Health,* Chichester: John Wiley and Sons.

social welfare agencies. Van der Kolk[34] found that major disruptions in parental care were reported by 89% of self harmers.

The following is instructive for Residential Child Care directly as attachment problems also feature in the studies on self harm. Gilbert et al's study[35] found that anxious attachment was significantly linked to striving to avoid inferiority and that when people feel insecure in their social environments, it can focus them on a hierarchical view of themselves and others, with a fear of rejection if they feel they have become too inferior or subordinate, and we can assume that this may have implications for understanding and responding to self harming behaviours.

g) Gender:

Women and girls are four times more likely to self harm than men and boys according to reported figures but the rate of reported self harm in men and boys and in girls and women is increasing. Males are more likely to undertake acts which could appear to be that they have had an accident, a fight or have been attacked. However, Meltzer et al (2001) found that of the 5-10 age group, the lowest rate (0.4%) was found among 5-7 year old girls and the highest (2.1%) among 8-10 year old boys; and of the 11-15 year old age group, the highest rate (3.1%) was found among 13-15 year old girls.

The 2009 Psychiatric Morbidity Survey showed that nearly 12 per cent of all (not just Looked After Children) women aged between 16 and 24 admitted to self-harm – a rise of 80% since 2000. Whether the rise in reported self harm in both males and females is partly due to better understanding of self harm and improved access to more sensitive services is hard to determine but should be considered and would be an interesting research topic.

h) Goth Youth Sub culture

Young et al (2006)[36] conducted research into the prevalence of self harm and attempted suicide in Goths in the west of Scotland which found that at age 19, identification as belonging to the Goth subculture was strongly associated with lifetime self harm (prevalence 53%) and attempted suicide (prevalence 47%) respectively among the most highly identified group although they also note that they did not look at identification with other youth sub-cultures . They note that *"Self harm could be a normative component of Goth subculture including emulation of sub-cultural icons or peers who self harm (modeling mechanisms). Alternatively, it could be explained by selection, with young people with a particular propensity to self harm being attracted to the subculture."* The role of practitioners here, rather than primarily seeing the sub culture as the problem, would be to determine and understand what led the young person to identify with a sub-culture that is seen as maybe 'miserablist', where self harm is a verbalised and accepted form of self-expression.

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[34] Van der Kolk B, Perry J, & Herman J (1991), *Childhood origins of self destructive behaviour*, American Journal of Psychiatry, 148(12): 1665-1671

[35] Gilbert P, McEwan K, Bellew R, Mills A & Gale C (2009), *The dark side of competition: How competitive behaviour and striving to avoid inferiority are linked to depression, anxiety, stress and self-harm,* Psychology and Psychotherapy: Theory, Research and Practice, Volume 82, Number 2, June 2009, pp. 123-136

[36] Young R, Sweeting H, & West P (2006), *Prevalence of deliberate self harm and attempted suicide within contemporary Goth youth subculture: longitudinal cohort study,* BMJ 2006; 332: 1058-1061; 13thApril

i) Learning Disability:

Caring for young people with a learning disability who display self harming behaviours can be extraordinarily difficult. Apart from the harm caused and distressing effects on the worker, the range of intervention and treatment options may be smaller than for those without a learning disability. Paley[37] has produced a useful factsheet which can be downloaded from www.BILD.org.uk

With regards to those with learning disabilities Wolverson[38] notes that prevalence here is influenced by individual characteristics – "sensory deficits, profound learning disability, autism, limited expressive communication skills and ambulatory difficulties can all increase likelihood of [self harm] development". Some genetic conditions associated with learning disability increase the likelihood that the individual with that condition will exhibit self harm; these include Prader-Willi syndrome (85% of those with this condition display self injurious behaviour), Fragile X syndrome, Tourette's syndrome, Smith-Magenis syndrome, Cornelia de Lange syndrome, and Lesh-Nyhan syndrome and Riley Day syndrome (Gates, 2003; Clarke, 1997; Murphy, 1999) . Some conditions may benefit from the use of particular medication that is related to adjusting the pain threshold to reduce the self injurious behaviours, but most children and young people with learning disabilities will benefit from social and behavioural rather than pharmacological interventions. In fact, double blind placebo trials of psycho-tropics show they are not helpful and in the case of underlying medical conditions their administration may mask pain or SIB used to block pain.

Paley[39] notes that Guess and Carr (1991)[40] describe a three-stage interpretation to describe the development and maintenance of self injurious behaviour. "Stage 1: A child with learning disability begins to display self-regulatory, communicative or coping behaviours such as rhythmic rocking, which are interpreted as an inevitable consequence of the learning disability; Stage 2: These behaviours begin to provide self-stimulatory arousal and become more intense; Stage 3: Finally, the behaviours become self-injurious resulting in stigmatisation, social isolation and negative labelling – all of which make self injurious behaviour more likely to become functional to the person".

Oliver et al[41] conducted research on the association between an increase in the early development of self injurious behaviour (SIB) and observed characteristics of child–adult interactions that conform to a mutual social reinforcement paradigm. The learning here is that those caring for or working with the child will pay attention to those behaviours that are most worrying to them. They may therefore reinforce, at an early stage, the child's self injurious behaviour and thus the child is more likely to repeat or increase their SIB over time. The authors note that this has significant

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[37] Paley S (2007), *Fact sheet – self-injurious behaviour*, BILD, Kiddeminster

[38] Wolverson M (2006), *Self injurious behaviour and learning disabilities,* retrieved August 2009 at http://www.naidex.co.uk/page.cfm/link=83

[39] Paley S (2007), *Fact sheet – self-injurious behaviour*, BILD, Kiddeminster

[40] Guess D, Carr E (1991), *Emergence and maintenance of stereotype and self-injury,* American Journal of Mental Retardation 106(2) 299-319.

[41] Oliver C, Hall S, Murphy G, (2005), *The early development of self-injurious behaviour: evaluating the role of social reinforcement,* Journal of Intellectual Disability Research, Vol 49, part 8, pp 591-599, August 2005

implications for early intervention, especially when SIB is a known factor with a particular condition. Although this research is confined to children with learning disabilities, it is likely to have significance for all children. Other conditions likely to increase the likelihood or risk of SIB include chronic pain and underlying health conditions leading to low mood e.g. reflux, constipation, ear infections; repetitive behaviours, deficits in functional communication, problems with adaptation and low registration sensory profile.

j) Lesbians, Gay, Bisexual and Transgender young people:

Roen's 2007 study[42] of lesbian, gay, bisexual and transgender young people suggested a strong link between experiencing homophobia and self destructive behaviours. They suggest that "where young LGBT people are unable to find ways to resist the 'shaming' of homophobia, they may be more vulnerable to engaging in self-destructive behaviours". Clearly, discrimination can play a significant part for those LGBT young people who self harm.

k) Mental Health and Conduct Disorders

A theme of mental health problems as a contributing or significant factor in those who self harm emerges through most of the research, although MIND's leaflet[43] for young people points out that "just because someone self harms, it does not mean they have mental health problems". However, and as previously mentioned, Meltzer's 2001 study showed that the rates of self harm in children and adolescents increase with diagnosis of anxiety disorders (e.g. posttraumatic stress disorder, panic disorder, obsessive compulsive disorder), mood disorders (e.g. depression, major depressive disorder, bipolar disorder), conduct disorders (e.g. oppositional defiance disorder, and hyperkinetic disorders. NICE guidance alerts us that most of those who attend an emergency department following an act of self-harm will meet criteria for one or more psychiatric diagnoses at the time they are assessed. Those with phobic or psychotic disorders are strongly associated with self harm, especially those diagnosed with schizophrenia – of whom about one half will have harmed themselves at some time.

Some of those who self harm are diagnosed with having Borderline Personality Disorder (BPD)[44], and this diagnosis is most frequently applied to those who were sexually abused as children. It should be noted that there remains considerable debate on what the specific characteristics of BPD are.

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[42] Roen K (2007), *The cultural context of youth suicide: identity, gender and sexuality,* retrieved August 2009 http://www.ontheedge.lancs.ac.uk/details.htm

[43] Retrievable from www.mind.org

[44] Babiker G & Arnold L (1998), *The Language of Injury. Comprehending self-mutilation,* The British Psychological Society: Leicester

5. How to help

There appear to be two main schools of thought on how to help children and young people who self harm:

1. those who view their task as primarily to control, manage and stop the behaviour (more frequently these are hospital services, some of which may have 'no self harm' policies or contracts with their service users which mean that treatment is withdrawn if the self harming behaviour is active), and
2. those who view their task as primarily to support the young person in their daily lives, in expressing their difficult emotions, gaining an understanding of their behaviour, learning alternative coping strategies leading to cessation, and doing this within their own time and frames of reference.

People who have accessed the former type of approach have reported keeping their self harming behaviours secret in order to continue to access a service, and this has been noted to compound their problems, especially if the child's self harm is related to previous sexual abuse, abuse which may have been doused in secrecy and mistrust. Listening to children and young people and coming from a perspective based on the rights of the child[45], the latter approach is viewed as more congruent with Residential Child Care practice and needs of young people in most residential settings and provides the context the context of this paper. Each child or young person will need help responses to be tailored to their individual circumstances, needs and wishes.

Piggot et al's qualitative study[46] has some important messages from young people about what helps:

> *"Listening… that is the biggest support you can give. I think it is important that you do not just listen, and you actually do hear what is being said.*

…Young people acknowledged that when they were not engaged with the people providing the support then they did not perceive the support as helpful… They wanted care staff with more knowledge of self harm who would continue to offer helpful support even after they had refused it.

> *She must have kept coming back for six months… I think she got a 'hello' out of me… but she kept persevering.*

Young people considered that when they did engage with support it was often helpful.

Kirk's[47] experience led him to understand that in the early stages of engaging with young people, being clear that is it OK for them to speak out about these issues is crucial: "I'm not going to freak out, or judge them or tell them what to do, and the focus will be on establishing the young person's

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[45] Under the UN Convention on the Rights of the Child, articles 2, 3, 6 and 12 place a duty on those working with the child to act non-discriminately (2), in the best interests of the child (3), to promote and nurture survival and development (6) and to ensure they actively participate in decisions that affect them (12)

[46] Piggot J, Williams C, McLeod S & Barton J (2004), *A Qualitative Study of Support for Young People who Self-Harm in Residential Care in Glasgow,* Scottish Journal of Residential Child Care, Vol 3 No 2 Aug/Sep

[47] Kirk E (2007), Edges and Ledges. Young people and informal support at 42nd Street. In Spandler & Warner eds., *Beyond fear and control: working with young people who self harm,* PCCS Books: Ross on Wye

wants, needs and priorities." He hereby demonstrates his understanding of the issues, and a commitment to seeing the young person as the expert in their own life.

The following is divided into three sections:

1. ***Primary prevention*** – creating and developing a positive service culture
2. ***Secondary prevention*** – developing a strong knowledge base and targeting those known to be at risk
3. ***Intervention*** - provide well thought out support and/or treatment after self harming events to both young people, their families and practitioners, holding the long view in tandem.

A pedagogic key thinker from the 17th century, John Amos Comenius, saw the role of carers/teachers not as sculptors, moulding the child into an acceptable form, but rather as gardeners, thereby creating and maintaining the holistic conditions for the child to grow and thrive. [It is imperative here to clarify that the interpretation of Comenius's analogy is *not* about comparing children with plants, but rather that those in a caring, supportive or educative role could benefit both the child and themselves from seeing the child in context with their social environment rather than just as an individual whose needs are to be met. It is important to see young people as active decision-makers and experts in their own lives, and to help those who self harm through developing strong, authentic, valuing relationships, as well as being able to offer treatment and intervention supports for self harm].

Using this gardening analogy, the task of supporting young people who self harm can be seen as three-fold, each working in tandem with the others:

1) Design a good "garden", understand the types of weather conditions of the area, know the type of soil and feed it, know about the eco-culture of the garden, understand what will grow best in the environment – ***Primary Prevention***
2) Develop knowledge of specific types of "plants" and their particular horticultural requirements – ***Secondary Prevention***
3) Address specific needs of individual "plants" and address growing difficulties – ***Intervention***

1) Primary prevention – create and develop a positive service culture

> *"There is a level of consistency around working with self harm and suicidal feelings within 42nd Street, which is embedded in its ethos: that it is OK for young people and workers to talk about these issues openly."*
>
> *Eamonn Kirk, Suicide and Self Harm Worker, 42nd Street*

Primary prevention here concerns promoting the well-being of children and young people in general, and how promoting positive self worth and emotional well being is actually *demonstrated* by staff to young people, their families, significant others, between staff, and by and between other professionals. Clough et al[48] describe culture within children's homes as the 'feelings and messages'

[48] Clough R, Bullock R and Ward A (2006), *What works in residential child care: a review of the research evidence and practical considerations,* NCERCC/NCB: London

a visitor to a children's home picks up. These feelings and messages picked up by those first entering a home or while living within in it are all important to children and young people, and can mean the difference between engaging with staff, other young people and their environment and withdrawal.

Massachusetts Department of Mental Health (MDMH), USA, is committed to eliminating the use of restraint and seclusion in its facilities and programmes and recognised that changes in the culture of their clinical and physical environments were required if this policy shift was to be successful. MDMH have produced a valuable resource guide on Creating Positive Cultures of Care which can be requested by emailing dmhinfo@dmh.state.ma.us The guide includes sections on leadership, strength-based treatment (moving from control to collaboration; giving people a voice, choice and role; and valuing families), trauma-informed care (nurturing interventions; safety tools), sensory approaches (touch; the importance of the physical environment), and 'promising practices'. All of which can be immensely helpful when looking at the whole experience of being cared for away from home.

Clearly and consistently identifying and demonstrating the shared values of the staff team on which practice is underpinned helps young people to feel and know that they are valued, and that they are in a safe environment where they can share and address issues affecting them within a non-judgemental atmosphere of sensitivity and understanding. It also provides a useful base line for staff practices on which the team can develop their understanding of their task, and constructively challenge each other with a view to eliciting learning and developing as individuals and as a team.

Having gained some understanding through the previous sections of this paper, on what self harm is, who may be more vulnerable to it and why, we begin to understand what elements of culture will be helpful to those with higher risk of self harming behaviours. Focussing on Carl Rogers' core conditions of congruence, empathy and unconditional positive regard may help teams develop a deeper sense of how to create and develop their service culture. Other helpful starting questions for teams to explore together so that their shared environment may be more sensitive to those who self harm may be:

- What is important about how supportive relationships are developed, nurtured and understood and about how we communicate with children and young people, with each other and with others? How will we demonstrate the positive adult role model, what are the key elements of this?
- What do we mean by 'respect' and 'empowerment' and how will these be demonstrated in both times of calm and times of difficulty? How will anti-discriminatory and anti-oppressive practice be demonstrated?
- What do we mean by 'listening to children' and 'participation', and how is this demonstrated throughout the service, the day and within the all the contexts of the child?
- What do we mean by 'emotional well being', 'self worth' etc, and how will they promote and develop this with individuals and the group? How will resilience[49] be encouraged and developed? How do we help young people to recognise their stress triggers and to recognise and regulate their emotions?

[49] Useful resources on resilience can be obtained from the NCERCC website: http://partner.ncb.org.uk/Page.asp?originx_8199xe_66484128288485n39x_20091155215y

- What types of creative outlets and processes for expressing emotion do we have available to children and young people and what can we do to improve this?
- How do we promote children and young people's enjoyment of and engagement with education, training and/or employment?
- How do we understand the dynamics of the group and what do we do to promote a good dynamic?
- What support services or processes are available to young people and to us, and how can we improve this?

This is not an exhaustive list and these are the types of questions that need to be asked at regular intervals. Children and young people's needs change with time and events, meaning that our emphases as practitioners may need to change and develop with them. Including children and young people in answering some of or all these questions may help them to feel that they have greater control over their situation and environment, loss of which can lead to self harm for some.

2) Secondary Prevention – develop knowledge base and target those at risk

Developing the knowledge base

> "*We need to see the problems coming and understand them and understand where the young person is coming from… rather than dealing with crisis all the time."*
>
> *Residential Child Care Worker*

Developing a strong knowledge base on the wide range of issues around self harm will aid the assessment and intervention processes no end. The previous sections on the what, who and a little to answer why, provide a starting point for practitioner's development of their understanding about self harm and who may be more vulnerable. Further training, qualification and development opportunities, including *time* to research particular issues affecting individuals or groups and to reflect on the learning, are essential for all practitioners.

Frequent placement moves is a significant factor in those who self harm. Beck's study[50] of 747 children and young people looked after by one inner London local authority (excluding those where there were ongoing care proceedings) found that 30% had a probable psychiatric diagnosis, 11% had moved placement three or more times in the last year and that these children were significantly more likely to report self harm in the last 6 months than those who had moved placement less frequently. 59% of these young people believed their social worker was not aware of their emotional or behavioural problems. Placement instability can be therefore assumed to reinforce psychological and social functioning.

She argues for screening those particularly at risk for targeted outreach, interventions that specifically aim to stabilise placements, and far greater partnership working between social care and mental health services. CAMHS teams can, and indeed should, provide advice and guidance to those caring for children and young people, even if the child/young person does not wish to take up an offer of service; in helping practitioners with developing their knowledge base and a range of useful

[50] Beck A (2006), *Addressing the mental health needs of looked after children who move placement frequently,* Adoption and Fostering, Vol 30, No 3, Autumn

practice tools, CAMHS and care teams together can increase the likelihood of a placement becoming or remaining stable.

Children and young people, astute observers, are often acutely aware that some (or all) of those caring for or supporting them have little awareness of self harm and can be moved to withdraw from developing relationships with them. As one young person put it in Piggot's earlier mentioned research,

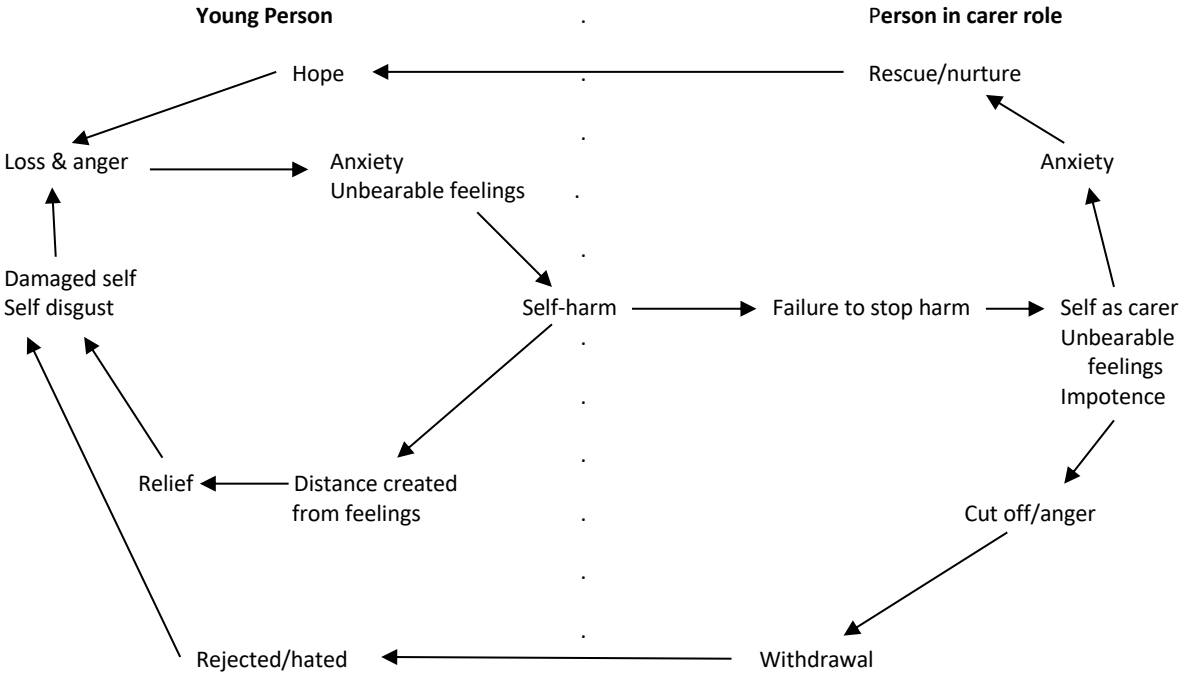
> *"… I did not tell the staff… there was no point telling them… know what I mean?"*

For practitioners, key prevention strategies are to develop personal and collective awareness of the factors which may compound the difficult emotions self harming behaviours are 'coping' with, or which force the young person further away from those who may help them. Within the development of knowledge on this subject is a need to understand one's own responses to self harm. Norris & Maher[51] note

> *"Carers who have not experienced the behaviour before may feel highly anxious and frightened by the behaviour, often linked to a fear of death… Over time, and as repeated incidents occur, a sense of confusion and impotence may emerge, with carers describing feeling 'cut off' and at times feeling angry with, and persecuted by, the young person."*

These are highly powerful feelings, the intrapersonal discourse of which needs to be brought out, understood and addressed. For many, self harm will be a hugely difficult area to empathise with as hurting oneself appears utterly incongruent with coping, and our initial reactions may be to stop the harm. Our responses to those who self harm are likely to be influenced by this and may make matters worse for the child as Oliver's previously mentioned research on socials interactions with children with learning disabilities reveals. Norris and Maher provide a diagram below which illustrates the intra- and interpersonal cycles that may develop in self harming behaviour.

[51] Norris V and Maher M, The trap: children in care. In Motz A (ed) (2009), *Managing Self Harm; psychological perspectives,* Routledge: Hove



They argue that the feelings are inevitable, and this in itself is likely to cause further pain and confusion to the child, inducing them to recall their loss of others who they wanted to care for them. So, a deeply complex set of intra- and interpersonal situations, and appropriate responses will be determined on a high number of factors, not least of which is understanding one's own inner reactions to self harming behaviours.

Targeting those at risk

Assessment: In addition to developing a greater understanding of the increased risk factors and more vulnerable groups discussed in section 4, practitioner understanding of individual young people is aided by assessment. Barbara Dockar-Drysdale, founder and director of the Mulberry Bush School and consultant psychotherapist, said 'all needs assessments, must in my view be made by a group, never by an individual collecting information or depending upon interview procedure', and she held the view that while pre-placement assessments were useful, the in-placement needs assessment she designed could only be useful if carried out by a group of residential workers who had lived with the child for at least 3-4 weeks.

Attachment history: Knowing about the child's early life can help us to understand where they are at now, why they respond to their world as they do and what may help to address their difficulties. Insecure or anxious attachment is known for some who self harm to be a factor in maintaining the behaviour. Child development and attachment theories from Bowlby, Dockar-Drysdale, Erickson, Klein, A Freud, Piaget, Skinner, Stern, Winnicott and others provide useful perspectives on the development of the child and what may have influenced the self harming behaviours. NCERCC has a number of useful papers on child development and attachment which can be downloaded from www.ncb.org.uk/ncercc

Creative processes and outlets: Many of the young people who have engaged with researchers have used creative processes, whether that is art in its many forms, drama, music, poetry, dance etc, to help find a language for their self harm, and the evidence shows that they have found it helpful.

> *"There were the ones that did try to help… tried to get you in drama and stuff… stuff to get you to talk out. Eventually that is what I did do… now I don't shut up!"*
>
> *Young Person in Residential Care*

Csikszentmihaliyi[52] notes that 'creativity does not happen inside people's heads, but in the interaction between a person's thoughts and socio-cultural context'. It is within that interaction that young people who self harm may be able to express previously unspeakable pain, or difficult emotions. Nickerson[53] promotes the value of creative processes for all, not just the 'arty', and provides a summary of the various creativity techniques that have been proposed by both academia and industry and which may help practitioners to think about how to use creative processes in their work with young people who self harm.

1. Establishing purpose and intention
2. Building basic skills
3. Encouraging acquisitions of domain-specific knowledge
4. Stimulating and rewarding curiosity and exploration
5. Building motivation, especially internal motivation
6. Encouraging confidence and a willingness to take risks
7. Focusing on mastery and self-competition
8. Promoting supportable beliefs about creativity
9. Providing opportunities for choice and discovery
10. Developing self-management (meta-cognitive skills)
11. Teaching techniques and strategies for facilitating creative performance
12. Providing balance

A young person at risk of self harm or who is self harming may usefully find that engaging in creative processes is role modelled by staff and other residents, and may therefore be more likely to feel at ease with taking it up themselves.

Groups: Understanding what is, is likely to be, or what might be happening between young people, and between staff and young people helps us to be aware of the positive and negative potential of the group. Bruce Tuckman's[54] [55] 5 stage model for group processes is a useful starting point in understanding what stage or phase a group may be in and how this may affect the members of the group, and is summarised by me as follows:

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[52] Csikszentmihaliyi M (1996), *Creativity: flow and the psychology of discovery and invention,* Harper Collins: New York

[53] Nickerson, R.S. (1999). Enhancing Creativity. In ed. Sternberg, R.J. *Handbook of Creativity*, Cambridge University Press.

[54] Tuckman, Bruce W. (1965) 'Developmental sequence in small groups', *Psychological Bulletin*, 63, 384-399. The article was reprinted in *Group Facilitation: A Research and Applications Journal* - Number 3, Spring 2001 and is available as a Word document: http://dennislearningcenter.osu.edu/references/GROUP%20DEV%20ARTICLE.doc.

[55] Tuckman, Bruce W., & Jensen, Mary Ann C. (1977). 'Stages of small group development revisited', *Group and Organizational Studies*, 2, 419- 427.

1. *Forming* (getting along with others, or trying to do so or not, sometimes known within RCC for young people as the 'honeymoon period');
2. *Storming* (working out who's who within the group, letting down the politeness barrier and trying to get down to the issues, emotions at this stage tend to be fairly anxious, this is when the 'honeymoon period' has ended);
3. *Norming* (getting used to each other and developing norms of behaviour, which hopefully includes trust, but also mistrust can be a feature of the norming stage if the forming and storming stages have not gone well);
4. *Performing* (co-operation, collaboration, trust);
5. *Adjourning* (ending the group)

Awareness of these processes helps practitioners to carefully plan new admissions to the home, helping to reduce anxiety for the new young person and for existing young people, and to plan sensitive endings. A group may become stuck at stages 1-3 and never reach the 4th stage; if a stage has not gone well it may have implications for the next stage and can reinforce and 'norm' negative behaviours.

Group contagion: Walsh[56] discusses contagion and self injury which he and Rosen define in two ways: '1) when acts of self injury occur in two or more persons within the same group within a 24 hour period and 2) when acts of self injury occur within a group in statistically significant clusters or bursts' (p231). He suggests that motivations regarding self injury and contagion are more inter-personal than intra-personal, contrary to what evidence we have about motivations for self injury in individuals, and he espouses a number of reasons for this. He sets out the inter-personal dimensions supporting contagion as:

- *Limited communication skills – desire for acknowledgement; desire to punish*
- *Attempts to change the behaviour of others – desire to produce withdrawal; desire to coerce*
- *Response to caregivers, family members or significant others – competition for caregiver resources; anticipation of aversive consequences*
- *Additional peer-group influences – direct modelling influences; disinhibition; competition*

He notes that identifying peer hierarchies helps us to understand the 'contagion' and that '"high status instigators" may play a role in the spread of self injury through a group'. He also notes that a desire for group cohesiveness may also play a part and that this desire is both inclusive and exclusive. Finally, he discusses the recent phenomena of contagion episodes that involve people who use voice mail, chat rooms, instant messaging and web sites and warns that the content on many of these sites is triggering rather than therapeutic, contrary to what the designers claim.

When there is a risk or an actuality of a group of young people self harming together, it is important to analyse the group before intervening. If not carefully thought out our responses can re-traumatise or confuse young people, or push them back into secrecy. Taking specialist advice is crucial.

Warning signs: It can be very difficult to identify someone who is self-harming, particularly if the young person is trying to keep the behaviour secret, leaving the onus on the practitioners to create and maintain the conditions in which children and young people can feel safe to express their difficult emotions without judgement. Here are some signs that may indicate that someone may be self-harming:

[56] Walsh B (2006), *Treating self injury: a practical guide,* Guilford Press: New York

- Poor functioning at school
- Unexplained, frequent injuries
- Keeping the skin covered (arms and legs especially) especially when it would be unusual to do so, e.g. in warm weather or bed time
- Appears lonely, isolated, withdrawn or uninterested
- Low self-esteem
- Difficulty handling emotions
- Elusive, evasive or secretive, especially if asked about injuries
- Carrying razors, lighters or sharp objects that are not normally needed
- Difficulty handling feelings
- Misuse of alcohol or drugs
- Engaging in risky behaviours
- Eating disorder behaviours
- Engaging in abusive relationships
- Any major change in behaviour of any kind

3) Intervention – support and treatment

Behaviour Support

Self harming behaviours may be seen by practitioners as significantly harmful and meeting the organisation's criteria for restrictive physical intervention and/or the duty of care (which requires that reasonable measures are taken to prevent harm). Colton[57] designed a checklist for assessing organisational readiness for reducing seclusion and restraint, after researching over 80 studies on the use of seclusion and restraint failed to demonstrate value in these techniques. Further research[58] has found a causal link between restraint and re-traumatisation and given that many who self harm have trauma featuring in their histories. Understanding that restraining a young person is likely to increase rather than decrease incidences of self harm will aid practitioners in finding other solutions for behaviour support concerns.

As previously discussed, supporting the young person by demonstrating a non-judgemental attitude towards them and their behaviour, through listening, dialogue, creative expression, working in partnership with specialist services, by applying first aid or seeking medical treatment, and by providing information should help reduce and even eliminate the behaviour over time.

Law, Confidentiality and Risk

Do people have a right to self harm and is this right protected under law? Warner and Ferry discuss this saying that whilst self harm can be seen as an 'intrinsically private activity that could be said to demonstrate a person's individual choice and represents their unique coping mechanisms[59], when people come to the attention of services (whether health, education or social care) the rights of young people to exercise choice and the duties or responsibilities of professionals to protect from harm can come into conflict. Sometimes young people look to caring and health professionals to help them stop self harming but intra-personally there may be conflict and confusion and expression of what they want to choose to do can be inconsistent on a day to day basis. As care professionals we need to provide clear messages that whilst we may understand, to some extent, that emotional distress, for whatever reason, causes the self harm, and that that may serve a purpose in coping with the distress, we are concerned that we do not inadvertently condone behaviours that may lead to significant harm. The boundaries of confidentiality must be explicitly explained to young people and their understanding checked out.

Warner and Ferry further note "Article 2 of the European Convention on Human Rights sets out the 'right to life'... recently a coroner's court case confirmed that service failure to prevent suicide amounted to negligence." Whether professionals working with children are openly aware of this or not, the often risk averse culture we work within sends the message that if we do not stop young people from self harming and something terrible happens, we may be held liable, and this can cloud our judgement over the right intervention for the individual. Risk assessments should also determine

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[57]Colton D, (2004), *Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint*, Commonwealth Center for Children and Adolescence Staunton, VA .

[58] Allen, D, (2008), Risk and Prone Restraint-Reviewing the Evidence. In Nunno, M., Day, D. & Bullard, L. (Eds). *Examining the safety of high-risk interventions for children and young people*. New York: Child Welfare League of America.

[59]Warner S & Ferry D, Self harm and the law. In Spandler and Warner, *Beyond fear and control,* PCCS Books: Ross on Wye

any benefits to the young person in their self harming behaviour – there may be none, but to not assess this undermines a full and transparent process. The Mental Capacity Act 2005 applies to all people over the age of 16 and places a duty on professionals to *prove* lack of capacity rather than to *assume* it as they have done under the Mental Health Act 1983. Under this act there are four statutory principles:

1. The assumption of capacity (the right to make your own decisions)
2. Individuals must be given appropriate support to make their own decisions before it is concluded that they lack capacity
3. Individuals retain the right to make what might seem to be 'unwise' decisions
4. If an individual is deemed to lack capacity, anything done on their behalf must be in their best interests, and should be the 'least restrictive alternative'

Warner and Ferry note that for young people under 16 determining capacity and its effects is slightly different. The age, understanding and intelligence of the young person determines whether s/he has the capacity to consent to medical treatment, including for mental health. Consent by a competent young person cannot be overridden by a parent's refusal, but the reverse does not apply. A young person's refusal to consent to treatment where the parent(s) give consent for treatment to go ahead must still be in the child's best interests. The Gillick ruling (a child has the right to make decisions about their life as long as they have both the age and understanding) was challenged by a young person with an eating disorder who wanted the right to refuse to be force fed. She was refused as her decision to not be fed was deemed to be not in her best interests.

With an important conclusion directly applicable to Residential Child Care practice, Warner and Ferry sum up by saying it seems that the law "works to restrict the ability of people to use self harm as a coping strategy that preserves life. This is partially because self harm is too often, in law and practice, taken to be indicative of suicidal intent. It is crucial therefore that differences of intent (between coping and suicide) are mapped, as these require different, if sometimes overlapping, strategies and interventions. Advocates and progressive lawyers and expert witnesses can help this process in legal settings by ensuring that self harm is understood as a strategy... rather than simply a symptom of mental illness or personality disorder."

<u>Partnership working</u>

The fourth of the 'four noble truths' for resilient therapists, as designed by Hart & Blincow[60], is 'enlisting'. The authors describe enlisting as 'the process of orchestrating the right people and organisations into the right place to make resilient moves when and where they need to be made'. Children's services have long found it hard to achieve this, especially when working across health, social care and education but it is an all important component of the package of support practitioners can offer to young people who self harm.

The National Child and Adolescent Mental Health Service Review (2008) raised concerns about the way in which children's homes staff, often ill equipped and generally not intended to provide mental health care, are nevertheless seen as part of the specialist network of provision along with teaching assistants, youth justice workers and newly qualified staff; 'there is concern that too often the staff with the least experience of mental health issues spend the most time with the most vulnerable

[60] Hart A & Blincow D (2007), *Resilient Therapy, working with children and families*, Routledge: Hove

children'[61]. It is of great disappointment then that the call for "highly trained and qualified professionals to be backed up by appropriately skilled staff who can support the child on a daily basis", does not call for highly trained and qualified residential staff to work alongside health professionals. Skill comes with high quality training, the process of attaining meaningful qualifications, a well thought out set of values, and experience.

Child and Adolescent Mental Health staff should be key professionals in the support and treatment of young people who self harm. CAMHS teams usually consist of a range of specialisms and may be able to refer to other specialists should they not have the capacity or particular specialism required. Spinhoven et al[62]researching this specific approach rather than a comparison across approaches found that participants in their study with a reported history of childhood sexual abuse showed a significantly lower risk of repeated deliberate self harm after having Cognitive Behavioural Therapy with a focus on emotion regulation skills, than those who received treatment as usual. Other forms of therapeutic help need similar research. It is important to find treatments that the young person feels most able to engage with. Some areas may have specialist voluntary organisations able to offer advice, treatment and/or support – see section on Organisations and Web Sites for further information.

Rissanen et al's[63] small qualitative study in Finland found that parents said they were in need of information about self-mutilation as a phenomenon to be able to help their children, and that help for self-mutilating adolescents, as perceived by their parents, also includes help for the whole family. Involving the young person's family may need consent from the case manager if concerns about the family are held, and will need consent from the young person if practitioners are to promote and protect their right to participate in decisions that affect them.

Treatment for wounds may, and cases of self poisoning will, need urgent medical treatment. A&E departments, when asked to engage with children's home staff on the care of young people, are often very open to developing a partnership approach and, in terms of providing a consistent, sensitive and non-judgmental response to incidences of self harm can provide information and advice, and refer quickly to more specialist services.

"When an individual presents in the emergency department following an episode of self-harm, emergency department staff responsible for triage should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

Emergency department staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment."

Self Harm Clinical Guidance, NICE, 2004, p57

Unfortunately and frequently this is not yet representative of the reported experiences of people who have presented to A&E departments with self harming injuries, maybe partly due to the relative

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[61] Department of Health (2008) *Improving the mental health and psychological well-being of children and young people: National CAMHS Review Interim Report; 8.3.5*. London: DOH

[62] Spinhoven et al (2009), *Childhood Sexual Abuse Differentially Predicts Outcome of Cognitive-Behavioral Therapy for Deliberate Self-Harm,* Journal of Nervous & Mental Disease. 197(6):455-457, June 2009

[63] Rissanen, M Kylma J & Laukkanen E (2009), *Helping adolescents who self-mutilate: parental descriptions,* Journal of Clinical Nursing, Vol 18, Issue 12, pp 1711-1721

recentness of this publication and allowing time for this approach to bed in to every day practice, but more likely due to health staff requiring education in effective responses without which they may inadvertently act with little understanding about self harm and react in ways made familiar to us by Norris and Maher. Pembrook[64] describes verbal humiliation and hostility in her visits to the A&E department, Norris and Maher[65] say that responses are often denigatory, people widely report being called "attention-seeking" or "manipulative" and a young person in residential care said

> *"I've been called some funny things in hospital… 'time waster' and things like that… so you just stop saying anything… and dealing with things yourself."*
>
> *Young Person in RCC*

Bird & Faulkner[66]report that in adult 'psychiatric wards and secure units people may be punished for their self injury by silence, isolation or anger... the irony is that punitive responses frequently result in more self-injury.'

Cowan[67] suggests that self harm and attempted suicide should be accorded the same priority level as child protection given the likelihood for mental health problems in this group. Enlisting the support of specialist services may be made easier if the concern level was higher.

Safer self injury

There are legal, practical and ethical implications to be considered for providing service users with information about how to self injure more safely, and no method is entirely safe. Some reports from people who have self injured suggest that providing information on safer self injury would lessen damage rather than increase it[68]. Whilst they are of the opinion that they have found ways of minimising the harm they inflict on themselves through trial and error, some errors have caused life-long damage.[69]

Legally (see also, the section on law, risk and confidentiality), Residential Child Care practitioners are bound by their duty of care, and to safeguard and promote the child's welfare. Whilst practitioners may believe that the self injurious behaviour is a coping strategy for the child, making the act of self injury easier for the child by providing information and / or tools to minimise the harm may be interpreted as acting against the duty of care and the welfare of the child.

Practically, the child or young person, their social worker, parent(s) and health professionals must be in agreement before such decisions are made, and only when the Regulatory Body has been informed and agreed to such action, and training to staff has been provided, can this be acted upon.

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[64] Pembrook LR, Harm minimisation: limiting the damage of self injury. In Spandler and Warner eds (2007), *Beyond fear and control: working with young people who self harm,* PCCS Books: Ross on Wye

[65] Norris V and Maher M, The trap: children in care. In Motz A (ed) (2009), *Managing Self Harm; psychological perspectives,* Routledge: Hove

[66] Bird L & Faulkner A (2002), *Suicide and Self harm*, Mental Health Foundation

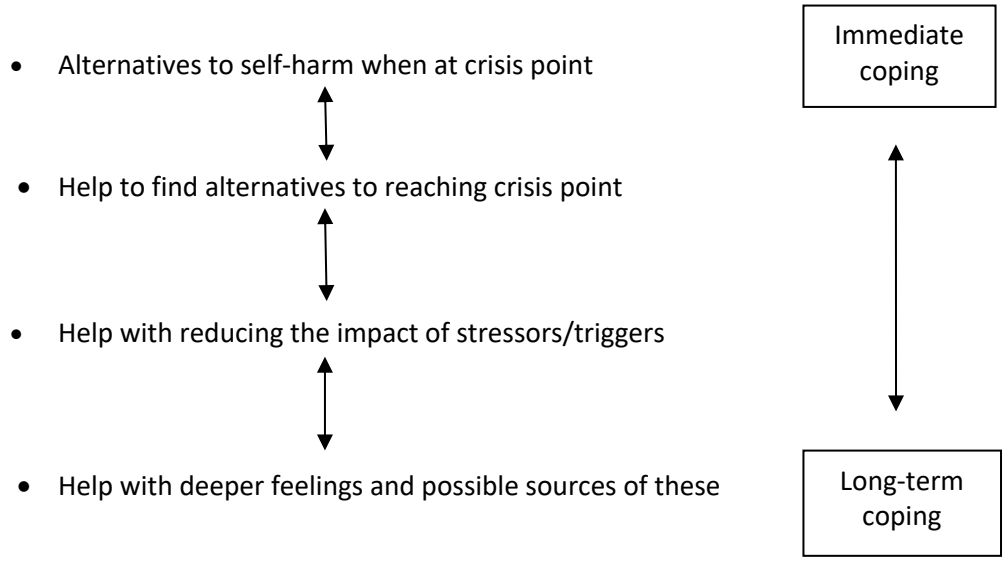
[67] Cowan, C (2008), *Risk factors in cases of known deaths of young people with experience of care: an exploratory study,* Scottish Journal of Residential Child Care, Vol 7, No 1

[68] Shaw C & Shaw T (2007) A dialogue of hope and survival. In Spandler and Warner (eds), *Beyond Fear and Control,* PCCS Books: Ross on Wye

[69] Warner S & Ferry D (2007) Self harm and the law: what choices do we really have? In Spandler and Warner (eds), *Beyond Fear and Control,* PCCS Books: Ross on Wye

Ethically, knowing when a young person is in the right emotional space to digest this type of information is extraordinarily difficult. Safer self harm information or tools may be OK one day and not OK the next. Constant assessment is required and it is likely that only very specialised settings should be undertaking such work. Such mitigation of self harm is beyond the usual self harm work of Residential Child Care, and must be seen as the exception and involve a socio-medical environment.

Kirk[70] describes a pattern of work he has 'shared with young people', the focus of which 'is on developing alternative coping strategies in the immediate and long term and, as the diagram [below] suggests, people move between different levels of work and coping strategies at different times'.



Residential Child Care practitioners can help children and young people by discussing the above four areas with both the child/young person and other professionals. There are no quick fixes to self harming behaviours and each of these areas need careful consideration by the professionals.

Support for staff

Observing self harming behaviours or the effects of self harm on a young person or a group of young people can be enormously distressing for even the most experienced of us. There is no shame in admitting negative emotional responses that may have happened, indeed it is probably a human default position to recoil from injuries or withdraw from a person who has self harmed. Practitioners need to 'unlearn' these natural responses in order to provide the best possible care and this can be achieved through individual and group supervision, supported by ad hoc and peer supervision, and through debriefing.

[70] Kirk E (2007) Edges and Ledges: young people and informal support at 42nd Street. In Spandler and Warner (ed.), *Beyond Fear and Control: working with young people who self harm. PCCS Books: Ross on Wye*

Debriefing
Sarah Leitch designed the following debriefing guidance for a large children's charity, it may need to be modified for different settings.

Debriefing in a social care setting supports constructive reflection on practice. Debriefing allows staff to talk through and reflect on a stressful incident in a confidential meeting to clarify and acknowledge any learning points. This has a positive effect on both morale and practice. It is considered to be very helpful to psychological well being to retell the story (Brown and Bourne, 1996) and develop strategies that may inform more positive outcomes. Staff need opportunities and encouragement to debrief as it may feel challenging initially.

The impact for safeguarding children, absenteeism and service standards cannot be underestimated. It encourages and aids development of open cultures where things can be discussed in a blame free environment.. It can also inform the organisation about health and safety issues that may not have come to light without this kind of analysis.

Studies show that there is a difference between cumulative work related stress and reaction to trauma. The latter is maintained internally and based on individual responses to situations. If staff experience crisis situations at work debriefing may help them to control the leakage into their home life. Interviews with staff have also shown that it reduces fear, guilt and personalisation, allowing them to move on.

Guidelines for individual staff debriefing

When – Practitioners should be encouraged to debrief when they have been involved in a stressful situation (team discussion about constitutes stressful situations may be helpful). They should also be able to request debriefing on any occasion and not have to wait until their next supervision. Debriefing should take place whenever there has been a restrictive physical intervention, a serious accident or incident (critical). If possible it should take place before the staff member leaves work if not as soon as possible after that i.e. the next time they are in work or if not possible a phone debrief can be implemented.

Who - The debriefer will need to have good listening skills as well as an ability to empathise and reassure while conducting the session as a professional appraisal of what has happened. Debriefing however is not just collusive approval; real support requires discrimination as to the value of any alternate decisions. The debriefer will also need to be able and confident to deal with safeguarding issues appropriately if they arise, a basic understanding of health and safety and a basic first aid qualification are also needed. In services where debriefing is likely to have followed a behavioural incident, some knowledge of behaviour support would be important as well as a commitment to confidentiality. Usually debrieifers are experienced senior staff who already have demonstrated these skills, although it is a good development opportunity for others and the manager may wish to recruit appropriate members of the workforce and provide mentoring support. To maintain an open, non collusive and non discriminative culture it would be expected that individuals could be debriefed by any debriefer even though they may have individual preferences. If a manager is involved directly in crisis or restrictive physical intervention they must have access to debriefing (by a line manager) as with their staff members. Services will develop their own criteria for when debriefing needs to take place but it should always be available on request. Research evidences that debriefing is most successful when conducted on a one to one basis with a more senior member of staff in a confidential and comfortable environment.

How – A set of simple questions to be discussed for a time limited session (usually no more than 15 minutes) needs to take place as soon after the incident as is possible.

- Describe your experience:
- Describe how you feel about this:
- How do you feel now?
- Any learning?
- What happens now (immediately)?
- Other action to be taken:

These questions promote an open culture of reflective practice and can also highlight health & safety issues, training needs, as well as examples of good practice to share with the rest of the team. Individual debriefing will need a quiet private space. The debriefer will first assess the physical and emotional state of the debriefee; if injuries need attention or individuals are in shock obviously debriefing is not the priority. Debriefing usually takes about 15 minutes, the individual is gently encouraged to retell their story, describe their feelings and reflect. Open questions such as "what do you think we could do to have a better outcome next time", "do you feel you or anyone else could have done anything differently?" The suggested set of questions above could be customised to individual service use.

The debriefing also functions as an assessment and agreement of further support or action. For example a referral to a counselling service may be needed or a new risk assessment. Debriefing is not counselling but it gives an opportunity to tell the story and reflect. Debriefing should be recorded, a copy given to the practitioner and a copy given to the manager, who will sign it off and deal with any outstanding health and safety issues, follow up staff support issues, make sure risk assessments are appropriately reviewed etc and store it in the staff file.

Other types of debriefing - Some services may use group debriefing regularly, this can be very beneficial if managed well, further actions recorded and used to inform practice. However this may have some slightly different function to individual debriefing and people should have access to individual support as well. In some services there may be limited opportunities to be debriefed it may be that a phone system is arranged.

Information for managers - When first introducing debriefing take base line physical intervention rates, rates of related injuries and staff sickness absence rates and monitor these over the year to provide evidence of improvement.

Coping skills for staff
Walsh, in his chapter on reactions of therapists and other care givers, suggests that "professionals need to acquire and employ at least the following set of skills' (here summarised):

- *Physical self soothing* (breathing skills and other relaxation techniques)
- *Cognitive restructuring* (developing a non-judgemental, dispassionate, patient attitude)
- *Regulating affective responses* (recognise the occurrence of the negative emotions – anxiety, fear and related avoidant emotions; frustration, anger and related aggressive emotions; sadness, discouragement and related hopeless/ helpless emotions)
- *Managing negative behaviours* ("rules to live by" include: self injury is not about suicide and should not be treated as a suicidal crisis, reminding of this means you are more likely to remain calm, strategic and helpful; the best interpersonal approach is to employ a low-key,

dispassionate demeanour in combination with respectful curiosity; be patient in your expectations for change; to give up self injury, clients need to learn replacement skills that are at least as effective as self injury; the emphasis should be on learning new skills rather than on giving up self injury)

- *Intervening appropriately in client's environments* (interventions should generally be positive and non-intrusive)

6. Conclusion

Self harm is a considerable subject on which there are widely ranging views, an enormous amount of research evidence and considerable practice implications and dilemmas. The paper has not been able to cover all the aspects of self harm in children and young people and NCERCC is aware, and cautions the reader, that there are gaps. The purpose of this paper is to guide practitioners to evidence and to provide some useful advice stemming from this on how to support children and young people.

7. Organisations and Web sites

The following list of resource is not exhaustive and is provided for information only. Inclusion does not necessarily imply recommendation or endorsement by NCERCC.

@Ease

@Ease is a clearly written mental health resource for young people under stress or worried about their thoughts and feelings. It forms part of the Rethink website and also provides information to support friends/carers of people who self-harm.
email: advice@rethink.org
http://www.rethink.org/at-ease/self_harm.html

b-eat (beating eating disorders)

Formerly known as The Eating Disorders Association, b-eat is a voluntary organisation based in the UK providing information, help and support for people affected by eating disorders and, in particular, anorexia and bulimia nervosa.
http://www.b-eat.co.uk

Basement Project

This Project provides support groups for people who have been abused as children and for people who self-harm. It also offers training, supervision and consultation for workers in community and mental health services, undertakes research and offers a range of publications that are detailed on the website.
PO Box 5
Abergavenny
NP7 5XW
tel: 01873 856524
http://freespace.virgin.net/basement.project
email: basement.project@virgin.net

BBC: Mental health: Self harm

Section of the BBC website which provides a clearly written overview of self-harm, including the theory behind self-harm and practical advice.
http://www.bbc.co.uk/health/mental/emotional_selfharm.shtml

British Association of Counselling and Psychotherapy

Provides information on counselling and therapy. A list of local therapist can be accessed from the website or be sending an SAE to their address.
1 Regent Place
Rugby
Warwickshire
CV21 2PJ
tel: 0870 443 5252

email: bacp@bacp.co.uk
http://www.counselling.co.uk

British Institute for Learning Disabilities (BILD)

The British Institute of Learning Disabilities is a voluntary organisation working to improve the lives of people in the UK with a learning disability. The fact sheet referred to in this Guide can be downloaded from their site, together with other useful information.

http://www.bild.org.uk

Bristol Crisis Service for Women

A national voluntary organisation supporting women with emotional problems, with a particular focus on self-harm. It supports self-help groups, offers training and produces a range of publications - a number of self-help leaflets or may be downloaded from the site. They also operate a national helpline that is available to women of all ages.

PO Box 654
Bristol BS99 1XH
Helpline: 0117 925 1119. Open on Friday and Saturday evenings 9pm to 12. 30 am and Sunday evenings, 6pm - 9pm.
http://www.selfinjurysupport.org.uk/

Centre for Research into Suicide, University of Oxford

The aim of the Centre for Suicide Research is to increase knowledge about the prevention of suicide and deliberate self harm. The website includes details of the Centre's research programmes, publications and statistical information.
Department of Psychiatry
Warneford Hospital
Oxford
OX3 7JX
United Kingdom
tel 01865 226258
email: csr@psychiatry.oxford.ac.uk
http://cebmh.warne.ox.ac.uk/csr/

ChildLine

The website contains information and advice on a range of problems experienced by young people, including problems at school, relationships, bullying, and eating problems.
ChildlLine also offers a free national helpline, offering advice on all sorts of problems faced by young people.

Freepost 1111
London N1 OBR
tel: 0800 1111 available 24 hours a day textphone: 0800 400 222 available 9.30am - 9.30pm weekdays, 9.30am - 8pm weekends.

http://www.childline.org.uk

42ndStreet

Provides support services to young people living in the Manchester, Salford or Trafford areas, who are experiencing stress and mental health problems. The website contains details of its services (counselling, drop-in sessions, self-help groups) and its publications.
Second Floor
Swan Buildings
20 Swan Street
Manchester M4 5JW
Helpline: 0161 832 0170 administrative enquiries: 0161 832 0169
http://www.fortysecondstreet.org.uk

Mental Health Foundation. Children and Young People - Mental Health Programmes

A comprehensive website on mental health (and mental illness). This section of the website includes information on the national inquiry into self-harm among young people, developing mental health services for young people, policy development, research and publications.
http://www.mentalhealth.org.uk/information/mental-health-a-z/self-harm/?locale=en

MIND

MIND is a mental health charity that aims to improve the life of everyone with a mental health problem. The website provides a wide range of information on mental health issues. MIND also offer a helpline - Mind*info*Line: 0845 766 0163. Available weekdays 9.15am- 5.15pm

15-19 Broadway
London E15 4BQ
tel. 020 8519 2122
fax: 020 8522 1725
email: info@mind.org.uk
http://www.mind.org.uk

National Electronic Library for Mental Health

This specialist on-line library within the NHS National Electronic Library for Health provides evidence-based research on mental health problems. The site has sections on Child and Adolescent Mental Health and on Suicide and Self-Harm.

http://www.nelmh.org/

National Self-Harm Network

Organisation providing information and support to people who self-harm and their friends, families and carers. It also offers training for professionals on self-harm. The website includes details of its

publications and a message board offering access to a number of forums where professionals as well as people who self-harm can share their experiences.

NSHN

PO Box 7264
Nottingham NG1 6WJ.
email: info@nshn.co.uk
http://www.nshn.org.uk

PAPYRUS

PAPYRUS is a voluntary organisation aimed at preventing suicide among young people and promoting mental health and well-being. It offers advice to professionals who deal with young people experiencing suicidal tendencies, depression or distress. Information is provided on suicide prevention and emotional well-being and there is advice for young people with suicidal tendencies.

Rossendale GH
Union Road
Rawtenstall
Lancashire
BB4 6NE
tel: 800 068 41 41
fax: 01706 214449
email: admin@papyrus-uk.org
http://www.papyrus-uk.org/

Queer Youth Network

The Queer Youth Network is a national non-profit making organisation that is run by and for Lesbian, Gay, Bisexual and Transgendered (LGBT) and Queer Young People and is based in the United Kingdom

http://www.queeryouth.org.uk/community

Royal College of Psychiatrists

The link below takes you to a set of resources on self harm from the Royal College of Psychiatrists.
http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/depression/self-harm.aspx

Self Harm Alliance

A survivor-led voluntary group supporting people of all ages affected by self-harm. It runs a telephone helpline service, provides monthly newsletters and offers postal and e-mail support. The website includes information for people who self-harm and their friends and families, with links to recommended reading.

PO Box 61
Cheltenham
Gloucestershire
GL51 8YB
Helpline: 01242 578820. Available Tuesdays 6pm - 7pm, Thursdays 11am - 1pm, Sundays 6pm - 7pm.
email: selfharmalliance@aol.com
http://www.selfharmalliance.org

Samaritans

A section of the website contains information and research on self-harm. In an emergency the Samaritans offer confidential emotional support 24 hours a day. People can also visit their local branches which are listed on the website.
tel: 08457 909090
http://www.samaritans.org.uk

The Site

The Site is a voluntary organisation web based resource for young people on a wide range of subjects. The link below takes you to their information, support and advice on self harm.

http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm

Young Minds

This clearly written and informative website contains information and resources for and about young people and self-harm. Young Minds also offer Parentline, a free, confidential telephone service providing information and advice for any adult with concerns about the mental health of a child or young person. tel: 0800 018 2138.

102-108 Clerkenwell Road
London
EC1M 5SA
Tel 020 7336 8445
Fax 020 7336 8446
http://www.youngminds.org.uk/selfharm/

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