

CRI92

Managing self-harm in young people

COLLEGE REPORT

Organisations endorsing the report

The following organisations have endorsed this report

- YoungMinds
- The Royal College of Paediatrics and Child Health
- The Royal College of Nursing



College report CR192

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Contents

Acknowledgements	2
Executive summary	3
Background	4
Commissioning services	5
Risk factors	7
Young people's experiences of services	8
Community presentation of self-harm	10
Assessment and interventions for acute presentation to hospital	14
Joint protocols for the management of self-harm	17
Acute presentation to hospital: roles and responsibilities of involved staff	18
Liaison services for acute presentations to hospital	22
Self-harm and the internet	23
Appendix of online resources	25
References	27

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Consultation commentary

We received a broad range of contributions from within the Royal College of Psychiatrists (RCPsych) and from external organisations.

External contributions were received from the Royal College of Paediatrics and Child Health, the Royal College of General Practitioners and the Royal College of Nursing.

From the RCPsych, there were contributions from: the jurisdictions of England, Wales, Scotland and Northern Ireland; the Paediatric Liaison Network; the Faculty of General Adult Psychiatry; members of the Patient Safety working group; and many other individuals, particularly from the Executive Committee of the Faculty of Child and Adolescent Psychiatry.

Young person contributions came from two sources: Very Important Kids (VIK), which was part of YoungMinds; and Surrey CAMHS Youth Advisors, who made substantial contributions to the final draft.

Executive summary

Suicide remains the second most common cause of death among young people. Self-harm is an important signal of distress, so it needs sensitive responses with careful handling. Our actions are important. Our actions can make a difference for young people and turn lives around. Our actions can save lives.

This report has been written by psychiatrists, but it is intended for a broad readership. As evidenced in the consultation process, opinions of many other professional groups have been included. The endorsements by YoungMinds, the Royal College of Paediatrics and Child Health and the Royal College of Nursing provide firm evidence of this. The intended readership is mainly professionals working with young people, although young people and families may also find the report useful, particularly in understanding how services should work together.

As there is much written on the subject of self-harm, this report does not attempt to cover all areas of management. In line with the previous version of this report (Royal College of Psychiatrists, 1998), this report focuses on service-level issues, particularly the roles of professionals and interservice relationships.

Fourteen recommendations are highlighted throughout the report. There are additional good practice points included throughout the text. Some key focuses include: courage and compassion in asking about self-harm, from community to hospital settings; reduction of stigma and the importance of treating young people who have self-harmed in a non-judgemental and respectful manner; high-quality assessment at all levels of service.

One key recommendation relates to admission of 16- and 17-year-olds attending acute hospital. The report recommends that routine admission is not expected, but if there is doubt about the safety of the young person, the arrangement or the quality of assessment, then admission to an acute hospital is to follow.

Patterns of self-harm in children and young people are evolving with the explosion of digital communication. Our understanding of the impact of this revolution in communication is growing. We have included a section at the end of the report summarising positive and negative aspects of the online world and some tips for professionals and parents.

We trust that you will find this report helpful.

Background

Outline of the report

This report replaces CR64 (Royal College of Psychiatrists, 1998). It provides updated guidance on managing self-harm in young people up to the age of 18 (up to their 18th birthday), in line with the children's National Service Framework (Department of Health, 2004). This includes young people who have an intellectual disability (termed learning disability in the UK health services).

Self-harm can be considered as a spectrum of behaviour ranging from occasional self-scratching, to taking an overdose with an intent to die, to completed suicide. In synchrony with National Institute for Health and Care Excellence (NICE; 2004, 2011) guidance, this report does not cover broader aspects of self-harming behaviour such as harmful drinking, other types of risk-taking behaviour or self-injurious behaviour (a term typically used in the field of intellectual disability, referring to behaviours such as head banging or self-biting).

Rather than focusing on professional responses to clinical need, this report primarily addresses broader matters such as professional roles and links and pathways between professionals. It also addresses service arrangements and links between services. It does not cover the management of self-harming behaviour in in-patient psychiatric settings.

The report is built on the available evidence base. Given that there are fewer studies looking at service configurations or links, this report is founded more heavily on opinion. It remains important to help services and professionals to work effectively together in the complex task of helping young people who present with self-harm, and this report aims to do this.

This report sits among several other reports, including NICE guidance on self-harm (NICE, 2004,

2011), the national suicide prevention strategy (Department of Health, 2012), best practice in risk management (Department of Health, 2007), advice on discussing self-harm with young people (Cello & YoungMinds, 2012), a College Report on helping people who self-harm (Royal College of Psychiatrists, 2010) and the implications for public health practitioners of self-harm by young people (NSPCC Inform, 2009).

This report is aimed at commissioners and providers of services, local authorities, as well as members of the Royal College of Psychiatrists (child and adolescent psychiatrists and adult psychiatrists), paediatricians, general practitioners (GPs) and professionals in other disciplines.

Self-harm and suicide

Suicide is the second most common cause of death for young people, but globally the most common cause of death for female adolescents aged 15–19, and yet it is preventable. The UK has one of the highest rates of self-harm in Europe (at 400 episodes per 100 000 population) (Hawton *et al*, 2012a).

Self-harm is common. A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year. Self-harm increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above that for the rest of the population (Hawton *et al*, 2003; Owens *et al*, 2002).

By carrying out careful risk assessment and care planning, we can make a difference to the young people presenting to services. A joined-up approach between services is needed in which presentations are taken seriously, stigma is avoided and follow-up is carefully planned.

Commissioning services

Arrangements across jurisdictions of the UK

England

In England, commissioning responsibilities are divided between clinical commissioning groups (CCGs) and NHS England, and in the latter it is delegated to local area teams. Ten of these teams have been given lead commissioning responsibility for all in-patient child and adolescent psychiatric beds (Tier 4) in England, both public and private.

Most of the acute hospital services are commissioned by the CCGs covering the hospital population. Frequently there is more than one CCG involved. Therefore, there is a matrix of commissioners covering acute hospitals.

CCGs commission community child and adolescent mental health services (CAMHS) in Tier 3 (multidisciplinary specialist services) and Tier 2 (unidisciplinary specialist services), often with one CCG taking the commissioning lead across an area.

Local planning is channelled through health and wellbeing boards, which typically oversee safeguarding procedures and increasingly have an influence over commissioning community health services. The local authority in which the hospital sits is responsible for safeguarding incidents arising within the establishment.

Scotland

In Scotland, CAMHS delivery and development are the responsibility of the Scottish Government CAMHS Implementation and Monitoring Group. This group includes members who are commissioners, managers and clinicians.

Scotland has 14 regional NHS boards, which are responsible for the protection and improvement of the population's health and for the delivery of front-line healthcare services. Each board allocates

a budget to CAMHS and includes a child health commissioner who advises on commissioned services. CAMHS professionals have a voice in shaping local services by taking issues to the health board, such as requests for additional funding for the development of specialist services.

CAMHS in Scotland are delivered in line with *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (Scottish Executive, 2005). This specifically outlines the elements of an integrated approach to children and young people's mental health across a range of settings.

The Mental Health Strategy (Scottish Government, 2012) sets out further aspirations, and health improvement, efficiency, access and treatment (HEAT) targets have been set for access to CAMHS and to psychological therapies. Challenges remain in relation to Tier 4 services in the absence of secure in-patient care and a low bed/population ratio.

Wales

In Wales, the seven local health boards (LHBs) are responsible for commissioning primary and secondary healthcare in close conjunction with their partners in local authority departments. Specialist services, including all Tier 4 CAMHS and planning of Tier 3 (multidisciplinary specialist teams) and Tier 2 (unidisciplinary teams, usually primary mental health teams) CAMHS, are commissioned nationally on behalf of health boards by the Welsh Health Specialised Services Committee (WHSCC).

Most areas of Wales have a specialist CAMH out-of-hours service, but the comprehensiveness of these services varies from nursing cover to consultant cover. In most LHBs the children and young people presenting with self-harm out of hours are usually admitted to the paediatric ward in the local acute hospital, where telephone advice is available from the on-call consultant child and adolescent psychiatrist. Young people are assessed by the

local CAMHS team on the following working day. Paediatric in-patient care varies across Wales, some services admitting young people up to 16 years of age, others up to 18.

Northern Ireland

In Northern Ireland, regional commissioning responsibilities lie with the five health and social care boards (HSCBs), although most local decision-making is devolved to local commissioning groups (LCGs) representing each of the five health and social care trust areas. Although commissioning arrangements differ from those in the rest of the UK, the principle of developing clear and collaborative care pathways equally applies.

The HSCBs need to ensure that regional services such as in-patient CAMHS adequately meet the needs of the population.

In 2011, a regional review focusing on moving care from hospital to the community (Health and Social Care, 2011) led to the establishment of integrated care partnerships (ICPs). These are made up of representatives from health and social care providers. Their purpose is to ensure that delivery is consistent and coordinated. Together, the LCGs and ICPs will need to ensure an effective community-based multi-agency response to self-harm.

Commissioning in relation to self-harm

Local commissioners should ensure that the significance of self-harm in young people is

fully recognised in their plans, notably any CAMHS-related joint strategies, thus involving the local authority. Community and multi-agency responses to self-harm should be made clear. They should also set down requirements for service providers to plan and negotiate adequate local services to support the activities described in this report.

Recommendation 1

For self-harm presenting to the acute hospital, commissioners need to be mindful that multiple services are involved. Therefore, service specifications for all relevant services should include recognition of the importance of self-harm in young people.

Recommendation 2

Commissioners need to stress the importance of collaborative working between the acute hospital, mental health services and the local authority in responding to a young person's self-harm. Commissioners need to prevent fault lines developing between services, where possible. Pressing for joint protocols and agreed pathways is a good way of promoting collaborative working.

Adequate in-patient psychiatric beds for children and adolescents need to be commissioned. These beds need to be readily accessible to prevent young people staying on acute medical wards for long periods, and pathways promoting strong community links and facilitating early return to the community should be set down.

Risk factors

Self-harm can be broadly grouped into self-poisoning (with prescription medication or other chemicals) and self-injury (Horrocks *et al*, 2003). The latter most commonly includes self-cutting, but may also involve behaviours such as stabbing, jumping or hanging.

Self-harm may be an indicator of a range of serious problems that includes mental illness, dysfunctional family relationships, substance misuse, bullying and physical and sexual abuse.

Research (Hawton *et al*, 2012a) indicates that the following factors are most likely to be associated with a higher risk of completed suicide by adolescents who self-harm:

- individual factors:
 - male gender
 - older age
 - presence of mental disorder such as depression or attention-deficit hyperactivity disorder (ADHD)
 - alcohol and substance misuse
 - previous attempt and previous self-harm
 - psychiatric history (especially in-patient treatment)
 - high ongoing suicidal intent
 - medical severity of the act
 - violent methods (hanging, jumping, etc.)
 - hopelessness
- family/social factors:
 - parental separation/divorce or death
 - family history of suicidal behaviour
 - parental mental disorder
 - interpersonal difficulties
 - restricted educational achievement
 - low socioeconomic status
 - adverse childhood experiences
 - social contagion.

For the whole-age population, physical ill health, unemployment and living alone are risk factors. These are less relevant to the adolescent population, but poor support or indeed care breakdown, such as being a looked after child, is highly pertinent.

About 25% of young people self-harm on one occasion, most commonly by self-cutting (Wright *et al*, 2013). Recurring self-harming is less common, with 9.5% of young people self-harming on more than four occasions (Plener *et al*, 2009). Some commentators have coined the term non-suicidal self-injury, but this is thought to be potentially unhelpful as it might encourage professionals to view people who cut as at low risk of suicide. In fact, the risk of completed suicide among young people who cut themselves is ultimately higher than among those who have taken an overdose (Hawton *et al*, 2012b).

People who frequently self-harm comprise a small but important group of patients. Their patterns of repetition and other characteristics may differ and this needs to be considered in planning care.

The risk factors for self-harm are similar to those for completed suicide, although with some exceptions:

- suicide is more common among males, whereas self-harm is more common among females
- suicide is more likely to be associated with major depressive disorder, whereas self-harm is more likely to be associated with anxiety disorders
- family dysfunction is more likely to be associated with suicide.

Young people's experiences of services

Young people should be involved in the planning and monitoring of self-harm services.

Findings from the Talking Taboos campaign (Cello & YoungMinds, 2012) highlight professional gaps in knowledge and the need for a deeper understanding of how to support young people who self-harm. In that research almost half of GPs did not understand the reasons why young people self-harm and three out of five were concerned that they did not know what language to use when talking to a young person about self-harm. Similarly, teachers felt 'helpless' and unsure of what they can say; 80% wanted clear practical advice and materials that they can share directly with young people. Most young people turn to online support instead of their GPs, teachers or parents.

Communications are generally strained between front-line professionals, families and young people, given the lack of understanding and the amount of shame and guilt involved. Parents may also struggle with knowing what to do, sensing stigma as well as shame or blame. In the Talking Taboos study, a third of parents said that they would be reluctant to seek help, partly for these reasons, but also for fear of making things worse for their daughter or son.

In most instances, prolonged lack of communication promotes the progression of self-harm into vicious downward spirals. Self-harm is a sensitive issue and is a symptom of the complex interplay of stressors that vary in each young person's life. Young people need help and support from family, friends and the community. Talking about the issues in a sensitive and calm way with compassion and some curiosity is often a good place to start.

Consultation with young people

In 2013, the YoungMinds Very Important Kids (VIK) focus group discussed self-harm. We outline here key messages from this discussion.

Young people remain concerned with the attitude of front-line professionals who lack understanding of self-harm. Unacceptable attitudes and comments of professionals have a negative effect on the ways in which young people access help and support.

Hurdles to healthcare

- Critical comments that the young people cited ranged from underestimating the seriousness of self-harm to simple ridicule: 'Oh it's only superficial', 'Oh my God, what did you do?', 'It's just a phase', 'A teenage hormonal thing', 'You're just here to get attention', 'This is stupid', 'What do you want out of this?', 'You're wasting our time'. Criticisms such as these can raise barriers to recovery.
- Lack of privacy, confidential matters discussed in open areas and the lack of respect for young people seeking help in emergency departments were common themes.
- Young people felt out of place on paediatric wards, with long waiting times to see psychiatric professionals and reduced input at the weekend. Families were left out and were not always supported.
- One young person was suspended from school for self-harming; such punitive measures can have a detrimental impact and may encourage secretive self-harming.
- There was inconsistency in levels of support offered by CAMHS, and young people were more likely to be prioritised if their self-harm

was severe. This led to frustration and feelings of not being taken seriously.

- Contradictory messages such as 'Do it safely' and 'Don't do it at all' left young people confused.

Building bridges and breaking barriers

- Young people uniformly reported good services from CAMHS liaison teams. They felt understood and they appreciated the consistent approach that reduced the need for emergency help.

- Young people valued collaborative working which balanced power, leading to trusting relationships that facilitated therapeutic sharing of responsibility.
- Young people thought that emotional aspects of self-harm management were more important than the medical and physical aspects of treatment.
- Young people highly valued clear communication and a fuller understanding of self-harm, with a caring and sensitive approach from all professionals.

Community presentation of self-harm

Most self-harm occurs in the community. In the Child and Adolescent Self-harm in Europe (CASE) study, 87.4% of young people did not seek help from an acute hospital (Hawton *et al*, 2009). In most instances, a friend, family member or teacher notices a change in the young person. Most young people feel a sense of relief when people in their day-to-day lives are supportive and non-judgemental. A supportive friend, family member or teacher can significantly improve a young person's situation.

The role of all front-line professionals

It is crucial that front-line professionals involved with a young person who self-harms are open minded and compassionate (Cole-King *et al*, 2013). Young people benefit from a non-judgemental approach from a person who is able to listen to them, foster a good relationship with them and encourage them to establish positive relationships with services. That person might be anyone who comes into contact with the young person in any setting – perhaps a parent, friend, teacher, counsellor, GP, nurse or CAMHS professional.

Basic understanding of self-harm should extend to all tiers of service. Compassion and promotion of positive communication, as well as simple advice about maintaining safety, should be available at all tiers. Self-help resources, such as those listed in the Appendix, may help support this.

Recommendation 3

Asking about self-harm does not increase the behaviour. It is important that all front-line professionals become familiar with asking about self-harm when talking with young people who are struggling with changes in their lives.

It is important that the young person is clear about confidentiality, with limits outlined right at the outset of a conversation. This does not discourage young people from disclosing their difficulties.

When a young person presents with an episode of self-harm it is important to establish whether there is a risk of self-poisoning or other physical health risks because of suicidal ideation. Asking the questions does not increase the likelihood of harm coming to the young person. Every encounter with a suicidal person is an opportunity to intervene to reduce their distress and, potentially, to save a life.

These points can be summarised as follows.

Try to avoid:

- reacting with strong or negative emotions:
 - alarm or discomfort
 - asking abrupt or rapid questions
 - threatening or getting angry
 - making accusations, e.g. that the young person is attention-seeking
 - frustration if the support offered does not seem to be making a difference
- too much focus on the self-harm itself:
 - engaging in power struggles or demanding that self-harm should stop
 - ignoring other warning signs
- promising to keep things a secret.

It is helpful:

- when talking to the young person to:
 - take all self-harm seriously
 - listen carefully, in a calm and compassionate way
 - take a non-judgemental approach and try to reassure them that you understand that

the self-harm is helping them to cope at the moment and that you want to help

- make sure they understand the limits of confidentiality
- if there are safeguarding concerns, follow local safeguarding procedures
- help the young person to identify their own coping strategies and support network
- offer information about support services
- when talking to others to:
 - control contagion – look out for impact on the young person’s peer group
 - offer support to peers as needed.

If a young person has self-harmed through self-poisoning, attendance at an emergency department is necessary. This is because it is often hard to quantify the risk involved following ingestion of a substance, so a cautious approach needs to be exercised. Emergency department attendance will help with evaluating both physical health and mental health risks.

In self-injury the physical health risks may be more easily quantifiable since the result may be visible, as in cutting. This means that emergency department attendance to evaluate physical harm may not be necessary. However, the front-line professionals must pay attention to mental health and safeguarding risks, evaluate them in line with their training and expertise and act accordingly.

A mental health risk assessment may also be needed.

Recommendation 4

Front-line professionals should be able to carry out the basics of a mental health risk assessment.

This should include asking about the history of self-harming behaviour as well as trying to understand the part it plays in coping. It is critical to ask about suicidal ideation and any continuing suicidal intent. Basic family and social information should be gathered if not already known. It is worthwhile screening for characteristics known to be associated with risk, notably depression and hopelessness.

In some instances, a more extensive mental health risk assessment will be needed. If this is the case, there are various options, such as referral to an emergency department, referral to specialist CAMHS or consulting with colleagues. This must be decided on a case-by-case basis.

Input from schools

It is important to promote resilience in young people. Schools should promote a nurturing environment that actively discourages bullying and encourages inclusion at every stage, as well as encouraging students to be supportive to their peers.

A school policy on self-harm and related confidentiality should be in place.

Recommendation 5

Many school staff feel unskilled and unsupported in dealing with pupils’ self-harm, so it is important that schools prioritise the self-harm training needs of their staff along with other mandatory training. This support is crucial for staff to feel confident in supporting young people in an effective, non-judgemental manner.

Collaboration between schools and statutory and voluntary agencies is crucial in the ongoing support of young people who self-harm, so that knowledge improves, service access is maintained and services build towards better outcomes for these individuals.

The role of the GP

Young people who self-harm may consult their GP. The GP should try to put the young person at ease and take an initial history. This should not be exhaustive, but should aim to determine the current level of risk to the individual and to ascertain whether there are any safeguarding concerns that merit immediate attention (Roberts *et al*, 2013). Children who have been exploited or are living in violent, abusive homes or in households with adults who are unable to provide for their basic needs may present with cutting or a history of a recent overdose and need prompt referral to Social Services for further assessment.

The GP needs to assure the young person that information will be treated respectfully with limits to confidentiality outlined.

If the young person presents with a history of cutting, it is helpful to establish when the cutting started, its frequency and the usual sites (such as the arms, thighs, breasts and abdomen). It is also important to ask about associated feelings and how the cutting links to these.

Other questions that the GP might ask the young person include:

- Have they identified any triggers? Are there particular worries or problems?
- Is the cutting becoming more frequent? Is it changing (e.g. cutting deeper)? How does the young person feel after cutting? Are any other behaviours used to deal with the feelings that lead to cutting (e.g. drinking, using drugs)?
- Are they having any thoughts that life is not worth living?
- Have sleep, eating and weight patterns changed?
- What about friendships, school, family? Do they have anyone else to talk with?

Given the wider knowledge the GP may have of the family and those living at the address, the GP may know of likely triggers, such as a recent diagnosis of illness in a family member or a history of mental ill health. This puts the GP in a good position to ask about these matters.

With the young person's consent, it is important to examine any sites of scarring and also to conduct a more general physical examination where appropriate.

The consultation in general practice needs to conclude with an agreed follow-up plan and a decision as to whether the GP needs to consult with colleagues in CAMHS, often the primary mental health worker (PMHW), to establish whether further assessment of the young person's mental state is needed. Planned brief GP consultations spaced weekly or fortnightly can be supportive to young people.

Red flags signalling increased concern include:

- significant suicidal ideation

- hopelessness
- violent method used, such as hanging or jumping
- significantly escalating self-harm
- self-harm in association with likely mental disorder, notably depression, significant anxiety or eating disorder
- disengagement from services
- absence of an effective young person safety plan
- absence of effective supports.

Interventions

Many different professionals could provide care or support for the young person and their family, but this will inevitably depend on the skill of the professionals involved and the complexity of the clinical scenario. The young person might be referred onto a multidisciplinary CAMHS team (Tier 3), but other options are usually considered as well. These might include consultation with the primary mental health service (Tier 2) or the Tier 3 service, joint working and training to gain the necessary skills.

Intervention should be tailored to the young person's need and should be collaborative. The aim of the treatment should be to reduce self-harm, reduce risk and treat underlying difficulties. In the first instance, it is important that there is limited access to the means of self-harming. Both families and young people should be encouraged to dispose of sharp objects, tablets and other means of self-harm.

More formal interventions include evidence-based treatments such as 3–12 sessions of talking therapy with elements of cognitive-behavioural therapy (CBT), problem-solving therapy, psychodynamic treatments or family therapy (NICE, 2004, 2011). Dialectic behavioural therapy shows promise for repeated self-harm. Medication can be offered to treat underlying conditions.

It is often important to involve family members to facilitate the young person's recovery. It is also important to acknowledge the support needs of parents or carers since self-harm is often very stressful for the young person's family.

In some instances, family work to strengthen communication and help resolve difficulties is valuable.

A crisis plan should include coping strategies, emergency contact numbers and how to access help both during and out of service hours. Transition and ending of treatment should always be planned so that young person and the family are able to work collaboratively towards recovery.

Roles of specialist CAMHS

Specialist CAMHS teams (which include Tier 2 and Tier 3 CAMHS) provide consultation, training and direct delivery. These teams tend to become involved in more risky or complex cases, with onward referral to in-patient services of individuals with very complex problems or at very high risk. It is important to remember the supportive functions of specialist CAMHS to other services. This needs to be a two-way process, with both parties seeking and delivering support as it is needed. It is crucial that commissioners are mindful of these interservice and inter-agency relationships and consider including specific guidance where necessary.

The consultant child and adolescent psychiatrist typically takes a lead role in providing risk management support to other team members and to the wider community as needed. The consultant becomes directly involved if risk increases or if an underlying psychiatric disorder requiring medical intervention is suspected. This includes severe depression, psychosis, bipolar disorder, eating disorder, drug misuse (needing detoxification) or personality disorder.

The consultant psychiatrist may need to be involved when issues of consent and confidentiality trigger a need for a mental capacity assessment. If a Mental Health Act assessment is required, a section 12 approved mental health professional will be needed. If the young person needs to be admitted formally or informally to a psychiatric ward, the involvement of the consultant is critical in facilitating admission, discharge and follow-up.

Training

Training expectations as outlined in NICE guidance are that clinical and non-clinical staff who come into contact with people who self-harm have a sufficient understanding to provide compassionate care (NICE, 2004, 2011).

Training should teach staff how to recognise and respond to self-harm, including assessment and management approaches. It should include education about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes. Training should specifically aim to improve the quality and experience of care of young people who self-harm.

Recommendation 6

Young people who self-harm should be involved in the planning and delivery of training.

Emergency departments should seek the help of mental health service colleagues in training their staff.

All Tier 2 and Tier 3 staff should be trained in the assessment of children and young people who self-harm. This training should include knowledge of the Mental Health Act 1983 as well as capacity and consent. Training should include the impact of the stigma surrounding self-harm.

A number of useful publications and online resources are listed in the Appendix, in particular:

- MindEd e-learning modules, which offer free training about a broad range of mental health problems in children and adolescents, including self-harm; they are written with a general rather than a professional audience in mind, so are intended to have a wide reach
- general mental health resources include the *Toolkit for GPs* (Freer, 2013), about the mental health consultation in general practice
- *Mental Health in Emergency Departments – A Toolkit for Improving Care* (College of Emergency Medicine, 2013)
- *Connecting with People's 4 Areas Assessment* (Cole-King *et al*, 2011) gives a useful framework for assessing risk following self-harm.

Assessment and interventions for acute presentation to hospital

Not all acts of self-harm would be considered an acute presentation in the community. Young people who self-harm in the community may be at a range of levels of risk, from low risk to chronically high risk. The same applies to people with physical health conditions.

Attending hospital comes about since someone has considered the risk to have significantly increased. This can be from a physical perspective (commonly, risk of harm from an overdose) or a psychiatric perspective (such as acute suicidal ideation). Acute suicidal ideation may be sufficient to justify hospital attendance, despite the absence of an act of self-harm.

If a community presentation does not include an acute medical, acute psychiatric or acute safeguarding need, then hospital attendance would be unlikely.

The purpose of hospital attendance is to assess the situation, reduce the risk where possible and engage necessary follow-up services. This applies to physical health conditions as well as psychiatric conditions. Hospital attendance is only one of many pathways for achieving these purposes.

At the stage of acute presentation, emergency physical assessment and treatment is undertaken in an emergency department. This should be accompanied by an initial assessment of the patient's mental state, and initial mental health risk assessment and assessment of safeguarding needs.

Under-16s

Recommendation 7

In line with NICE guidance, young people under the age of 16 seen in the emergency department following acute self-harm presentations should be admitted. Admission should be to a paediatric, adolescent or medical ward or to a designated unit. This is indicated regardless of the individual's toxicological state so that comprehensive physical and psychosocial assessments can occur and management/crisis intervention can be planned and initiated.

The clinical purpose of hospital admission following an acute presentation of self-harm is to allow mental health assessments to be undertaken in a calm and considered manner, by staff experienced in assessing young people and their families. Assessments can be lengthy, requiring separate interviews of the young person alone, together with the parents and sometimes also of the parents alone, so it is important not to rush them. Private space off the main ward is needed to help discussion of personal matters that may cause distress. It is also important to take the opportunity to contact other agencies. This helps with both the completion of a thorough assessment and the formulation of a good-quality discharge and care plan.

The mental state of young people can vary significantly from one day to the next, and 'waiting to see' often brings a fuller picture. Relationships with parents/carers are often tense after an acute presentation of self-harm, so an overnight

hospital stay has a respite function and will allow for emotional cooling off. This will enable more accurate assessment and more reliable care planning.

Extended stays in hospital are not desirable. In particular, a system should be in place to allow high-quality mental health assessment and discharge planning to take place over weekends and public holidays.

16- and 17-year-olds

For 16- and 17-year-olds, guidance has been less clear. To clarify the rationale for Recommendation 8 below, the arguments for and against routine admission are presented here.

Arguments for routine admission

In an unpublished Royal College of Psychiatrists survey that we conducted, 80% of child and adolescent psychiatrists thought that the same approach should be applied across the full age range of 0–18 – advising admission regardless of physical health needs. This is in keeping with responsibilities of the Children Act 2004, with safeguarding responsibilities and with the National Service Framework for children (Department of Health, 2004), meaning that there is a consistent approach across the age range. The response also matches CAMHS arrangements.

The 16- to 17-year-old age group is at greater risk of completed suicide. Further, impending transition to adulthood makes the group particularly vulnerable, and taking a careful and caring approach provides a critical opportunity to punctuate the life course of a young person in crisis. Young people aged 16–17 are vulnerable to falling into gaps in services. These gaps may result in pressure to admit young people to acute psychiatric beds inappropriately, or else take risks by discharging young people late at night in a fragile state.

Arguments against routine admission

Under the Mental Capacity Act 2007, 16- and 17-year-olds have presumed capacity and may legally refuse intervention. Further, developmental

changes mean that they are more likely to give a clear and consistent account of their mental state and intentions, so there is less reliance on the reports of others.

The issue of self-cutting also requires consideration. About 10% of adolescents self-cut on several occasions (Plener *et al*, 2009). However, self-cutting usually presents less of an acute physical risk and most self-cutting does not result in attendance at an emergency department at all. This form of self-harm increases significantly from the age of 14 through to 18. Although short-term admission and comprehensive assessment of all young people may be desirable, this may not be possible because of existing resources. It may also have the unintended effect of deskilling non-specialist staff in the community at Tiers 1 and 2.

Recommendation 8

For 16- to 17-year-olds, a developmentally sensitive and risk-proportionate approach should be taken. The objectives continue to be detection of difficulties and high-quality mental health assessment and planning, focused on the most vulnerable young people. If these objectives can be met and safe discharge planned, then it is suggested that a young person aged 16–17 seen in the emergency department following an acute self-harm presentation does not always need to stay overnight. However, if in any doubt, admission should follow.

The details of resources needed and pathways to be followed to facilitate this must be negotiated locally. CAMHS must be involved as well as hospital medical staff. Involvement of adult mental health services and/or psychiatric liaison services as well as children's services is likely to be needed.

Mental health risk assessment and planning

Conducted well, a mental health risk assessment can be an important intervention that, in itself, can aid recovery (Kapur *et al*, 2013). It should include assessments of the family, social situation, education and safeguarding issues. Assessment should cover matters specific to the act of

self-harm and also consider wider psychological and social triggers and needs. It should include identification of the main clinical and demographic features, and as well as characteristics known to be associated with risk, notably social isolation, depression, hopelessness and continuing suicidal intent. Particular attention should be given to children and young people from Black and minority ethnic groups.

Staff should always try to get the young person's permission before involving family and members of their network.

Although standardised risk assessment tools are useful additions to the assessment process, they should not be used to decide whether a young person is discharged or offered treatment/intervention. Nor should they be used to predict future risk of self-harm.

The young person and family should be given written information about self-harm, with names and contact details of relevant agencies, including out-of-hours services.

Self-harm may be the route by which child abuse or severe failures of childcare come to light, particularly for people presenting at younger ages. The continuing risk of acting on self-damaging or suicidal impulses may be a direct function of the parental and/or social care provided for a young person. Similarly, exposure to domestic or other

violence, exploitation and trafficking may come to light. Local safeguarding boards should ensure that this is reflected in safeguarding training of staff. Indeed, some boards include an expectation in safeguarding policy that the local authority should receive notification of a safeguarding concern for all young people presenting with self-harm to a hospital.

Recommendation 9

Where concerns arise about care quality or significant harm, joint assessment by social care and health services staff should be arranged, with local procedures to reflect this.

NICE guidance recommends using the Common Assessment Framework (CAF) in these circumstances (NICE, 2004). Securing a young person's safety may require recourse to a statutory order and/or alternative care arrangements to be made by the relevant local authority Social Services department.

Self-harm may be an indication of major psychiatric disorder requiring admission to a specialist in-patient treatment unit. The pathway to accessing in-patient beds will be shaped by local agreement. A smooth process and pathway needs to be in place so that all parties can follow the required steps. It may be necessary for staff of each relevant trust to advise their service commissioners appropriately so that arrangements can be adjusted/improved as necessary.

Joint protocols for the management of self-harm

It is essential that all providers of healthcare, including NHS trusts, primary care trusts and local health groups ensure that a protocol for the management of self-harm is agreed between the professional staff and managers of the following departments:

- CAMHS
- adult psychiatric services, including liaison
- emergency departments
- paediatrics and child health (including community child health) services
- general medical services
- substance misuse services
- learning disability services.

These departments may not lie within a single trust or, in the case of larger generic trusts, within the same clinical directorate. Therefore, it is

essential that service agreements are developed between trusts and across the relevant clinical directorates to enable a seamless service to be provided regardless of the corporate or physical boundaries of individual providers and/or their clinical directorates or departments.

Recommendation 10

It is recommended that a consultant paediatrician (local lead) and a consultant child and adolescent psychiatrist be nominated as the joint service leaders. They should work together to ensure that protocols for assessing, caring for and treating young people who harm themselves are negotiated with and agreed between their employing trusts or directorates, where they are different. Additionally, they should press for the resolution of operational difficulties and delivery of appropriate training to paediatric ward and emergency department staff.

Acute presentation to hospital: roles and responsibilities of involved staff

Recommendation 11

All professionals involved in the assessment and management of young people who self-harm, should ensure that good-quality care is provided in a non-judgemental, confidential manner, respecting the young person and their family with a view to emotionally supporting recovery and treatment. At all stages, unhelpful critical comments can raise barriers to future help-seeking and should be strictly avoided.

The composition and structure of departments varies between trusts so the roles described below may not fit local service arrangements exactly. Positive experience quotations are included after each section, as special contributions from young people who have used services.

The role of the emergency department medical team

- To take lead medical responsibility for initial assessment and treatment until the patient is accepted and assessed by another team
- To treat all children and young people in a respectful and non-stigmatising way
- To support engagement of children, young people and families, particularly by explaining processes in a clear and sympathetic fashion
- To complete a physical assessment and immediate treatment

- To identify any safeguarding issues and refer to Social Services if indicated
- To gather initial psychosocial risk-related history, which should include: information about the reasons for self-harm; history of self-harm; a description of mood; the degree of suicidal intent; family circumstances
- To ensure that every young person under 16 years of age is routinely admitted
- To request a full risk assessment, if the young person is not admitted for some reason
- To consult with CAMHS colleagues as necessary.

Young person's positive experience

'The ED team helped me by giving me the opportunity to talk things through and were able to let me know what support I would be able to receive. I was able to tell them I didn't feel comfortable to be left alone and they were able to find someone to wait with me.'

The role of the paediatric team

- To take lead medical responsibility following referral from the emergency department; throughout their admission, young people should remain in the overall care of a paediatrician

- To treat all children and young people in a respectful and non-stigmatising way
- To support engagement of children, young people and families, particularly by explaining processes in a clear and sympathetic fashion
- To treat the physical sequelae of the self-harm episode
- To clarify the history of the self-harm episode
- To identify any safeguarding issues and refer to Social Services if indicated
- To decide appropriateness of admission to a paediatric ward for 16- and 17-year-olds.
- To obtain agreement for the psychiatric assessment from the parent(s) or other adult(s) with parental responsibility for the young person, and seek their full involvement in this process
- To alert the staff of the child and adolescent mental health service to each young person's need for assessment
- To declare the patient medically fit and complete discharge paperwork within an appropriate time frame
- For local leads to work with staff of CAMHS, emergency departments and other units to develop, implement and monitor local protocols for assessing and managing young people following self-harm
- For local leads to identify the necessary staffing levels and communicate this to local managers/commissioners; this should include provision for mental health assessments at weekends
- For local leads to identify specialist training required to provide a comprehensive service for young people who harm themselves: training should cover engagement and basic risk assessment skills and encourage positive attitudes to the children and young people.

Young person's positive experience

'The paediatrician I saw was very upbeat and as I wasn't feeling too great, this really helped me to cheer up a little! I was quite worried and anxious but they looked after me well. This made me feel supported and less alone.'

The role of the duty liaison/psychiatric team

This role does not exist in all services, but it is worthy of mention for the sake of completeness. The functions are very similar to those described under CAMHS duty worker/out-of-hours worker below. The duty liaison team, however, will consult with the CAMHS duty worker and other members of the wider team as specified in local protocols.

In some areas, adult consultant psychiatrists are asked to provide advice to duty workers. They may feel that this is outside their usual expertise. If this is the case, there should be local planning to ensure that either the relevant skills are obtained or protocols are adjusted so that consultant cover is provided by a CAMHS consultant.

The role of the CAMHS duty worker/out-of-hours worker

- To clinically assess the young person and the family and to offer consultation to the paediatric team, and possibly staff of the Social Services and education departments following initial treatment in the emergency department
 - Often, a more comprehensive psychiatric and psychosocial assessment will be more useful if conducted the day after admission, while the individual is still a hospital in-patient; this allows time for reflective thinking, risk reduction and the possibility of obtaining collateral information from other professionals involved to assist with assessment and management
 - The assessment should be comprehensive, including a risk assessment, an assessment of the young person's overall mental health and development, psychosocial and family situation and the ability of the adults responsible for the young person to ensure their safety

- To be aware that self-harm may cause considerable anxiety for the family and a number of agencies, such as the young person's school
- To advise on handling issues of confidentiality and consent that can arise; these matters should be the focus of training and supervision for the professionals who undertake the specialist psychosocial assessments
- To identify any safeguarding issues: it is best practice that joint Social Services and CAMHS assessments are undertaken
- To take account of the opinions of medical and nursing staff
- To consult with the consultant child and adolescent psychiatrist
- To develop a management plan, either in the emergency department or on the ward, and liaise closely with paediatric and other multi-disciplinary staff regarding its implementation
- To recommend any specific arrangements thereafter and arrange for further assessment and treatment of the young person and their family as appropriate
- To complete written records and promptly communicate onwards in writing.

This work is highly skilled and can be stressful. Therefore, these staff should have had training specifically oriented to working with young people and their families after self-harm and they should be skilled in risk assessment. They should also have consultation and supervision available to them. This role is not restricted to medical staff but access to psychiatric opinion and consultation is essential. If assessments are carried out by personnel who are not from the staff of a specialist CAMHS, arrangements must be in place for consultation with the CAMHS.

Young person's positive experience

'The duty worker met with me the following morning after I was admitted. I got a chance to speak with them about what was going on for me. As I'd had time to rest it was useful to talk to someone about what had happened. They reassured me about what support I was going to receive and I was able to ask them questions.'

The role of the consultant child and adolescent psychiatrist

- To consult to the assessing professional
- To provide medical advice to hospital staff and to undertake a psychiatric assessment if required, particularly in cases involving a high degree of complexity and risk
- To refer the young person to an in-patient unit for children and adolescents where this is indicated
- To oversee psychiatric management of the young person while remaining on the ward/unit
- To advise commissioners and local authorities about appropriate aftercare services within the context of comprehensive child and adolescent mental health services
- To work with staff of child health and emergency departments and other units to develop, implement and monitor local protocols for assessing and managing young people following self-harm
- To identify the staffing levels and specialist training required to provide a comprehensive service for young people who harm themselves, including assessments at the weekends
- To advise on and be involved in training and supervision of staff of the paediatric, emergency, CAMHS and Social Services departments in order to ensure that young people receive excellence in immediate care and aftercare.

Young person's positive experience

'My psychiatrist was a significant part of my recovery. I felt able to be open and talk with them about what was going on for me. Over time this led to me feeling more positive and reducing the amount I self-harmed. They also supported me in getting the right medication, and always checked in with me to see how I was doing.'

The role of acute hospital nursing staff

- To liaise with CAMHS and the young person's family about assessment arrangements
- To liaise with hospital medical staff on the appropriate levels of observation required if the young person is admitted to the ward
- To create a safe environment through actions that include: removing sharp or hazardous objects; nursing on the main ward; establishing clear ground rules for behaviour; a clear explanation of care plans
- To support the young person as appropriate and pass on information regarding behaviour, oral intake, sleep, relationships with visitors, etc. to the paediatric and CAMHS teams.

Young person's positive experience

'I found the nursing staff really helpful as they were at hand for me to speak with, they were great listeners and they provided me with company, which made a difference.'

Liaison services for acute presentations to hospital

Mental health liaison services are now much more common across the country. Older-age services and working-age adult services have seen a particular increase, with a notable prompt from the rapid assessment interface and discharge (RAID) model that originated in City Hospital, Birmingham. Sadly, services for young people have been left behind.

Approximately two-thirds of CAMHS surveyed in 2011 reported providing a paediatric liaison service. Of these, around one-third had a dedicated paediatric liaison service, the majority being provided by in-reach from CAMH Tier 3 services. Specialist centres and children's hospitals were more likely to provide dedicated paediatric liaison services (P. Hindley & F. Mohamed, personal communication, 2012). A substantial majority of services were commissioned as part of CAMH Tier 3 services, mainly by primary care trusts. When acute trusts or services were the commissioners, they were far more likely to commission a dedicated paediatric liaison service.

There are some excellent dedicated liaison services for young people in the UK. Although it is desirable

that all areas should aspire to and achieve the best, this process is inevitably incremental. Fully developed paediatric liaison services should provide the following:

- management of acute emergency presentations, notably self-harm, possible psychosis and severe depression
- management of ward emergencies and acute out-patient presentations
- dedicated links to specific teams
- intervention for chronic physical conditions/ services, including services such as paediatric neurology, diabetes, renal services and cystic fibrosis, with dedicated team members attached to teams and part of the paediatric liaison service
- out-reach and preventive interventions.

Recommendation 12

An essential component of liaison provision is for arrangements to be in place for young people to be assessed on all days of the year, including weekends and Bank Holidays.

Self-harm and the internet

Young people and digital technology

Digital technology, particularly social media platforms such as Facebook, Tumblr and Twitter, is now a central part of young peoples' lives, for information, entertainment and communication. The use of apps and accessing the internet on mobile devices have become a way of life, so people can share, connect and communicate with each other instantly and spontaneously. Young people use a range of social media and congregate within an array of online forums. Some of the services offer blogging facilities to share images, comments and other media. Mobile apps such as WhatsApp, Whisper, Yik Yak and We Heart It are quickly gaining popularity with young people owing to the easy sharing, the anonymity offered by some of the services and the geolocation features. This enables them to connect to others locally about their interests, feelings, questions and events.

Although anonymity features can be associated with bullying, these sites allow young people to share and explore difficult issues that they are experiencing in their lives, such as anxiety, self-image concerns and relationships away from the eyes of adults. They may also share thoughts and feelings concerning self-harm and suicide.

Professional engagement in digital lives

Recommendation 13

It is critical for professionals to include an assessment of a young person's digital life as part of clinical assessments, especially when there are concerns about self-harm.

When enquiring about this, it is important to recognise that there may not be predictable patterns of digital activity and each young person's use will be different. It is likely that they will have their own specific interests and activities online, such as where they go and what they do, and this could relate to self-harm.

Information available on the internet

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

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

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

- Selfharm.co.uk is a moderated site where young people can post video footage or stories about their life and self-harm; the overall aim is to support others in helping recovery
- self-injury.net includes a discussion forum, but the context is US based and may not accurately reflect evidence-based treatments

and approaches in the UK; also, descriptions of what happens during emergency department attendance are not particularly encouraging.

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

Social media and microblogging

There are many different ways for young people to express themselves and communicate with each other using social media. This can include social media platforms such as Facebook and Twitter and other microblogging sites such as Tumblr. Services like Tumblr allow users to upload images, videos, poems and music, which can be very popular with those who self-harm, as they can share and connect with each other and express themselves creatively.

Owing to the vast number of people using these sites there is huge variation in the content. A number offer support and useful information, but some of this may cause distress and possibly trigger self-harm.

It is important to understand the young person's experience of different types of content and engagement with others and to not make simple assumptions about how harmful or helpful it is.

A further aspect of social media is that the individual may be 'followed' by hundreds, if not thousands, of others. This could affirm their identity as someone who self-harms, thus impairing recovery.

There are many online experiences, which may relate to self-harming behaviour, including humiliation, harassment, threats, sexual extortion, body-image problems and fear of exposure. It is important to understand what is specifically uncomfortable or distressing for the particular patient.

Parental involvement and supervision

Recommendation 14

It is important for parents to be interested and engaged in their children's digital lives as early as possible.

Recognising the benefits of the online world will often help a young person feel more comfortable when talking about difficult online experiences such as bullying or feeling uncomfortable about something they have seen or have been involved with. Given the rapidly evolving nature of the online and digital world, trust and communication are likely to be more helpful to the young person than attempts at surveillance, especially given young people's use of mobile devices.

Understanding the online world, particularly what may be harmful and distressing, is a complicated and challenging part of a young person's life. Discussing their concerns with educational, health and social care professionals can help young people to work out the difficulties and identify the best ways forward.

Appendix of online resources

Publications

- Royal College of Psychiatrists' information leaflets (www.rcpsych.ac.uk/healthadvice/atozindex.aspx), for example:
 - *Self-harm*, which discusses help available, what individuals can do to help themselves and what friends or family can do to help
 - *Feeling overwhelmed – helping you stay safe*: for anybody struggling to cope when bad things happen in their life, this leaflet includes advice on how to make a safety plan
 - *Feeling on the edge? Helping you get through it*, for people in distress attending an emergency department following self-harm or with suicidal thoughts. This leaflet includes several links to other helpful resources
 - *Self-harm in young people: information for parents, carers and anyone who works with young people*, a mental health and growing up factsheet
- NICE clinical guidelines (www.nice.org.uk/guidance/published)
 - *The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care (CG16)*
 - *Self-Harm: Longer-Term Management (CG133)*
- *4 Areas Assessment for Patients with Suicidal Thoughts Following Self-Harm Presenting to ED*. Cole-King et al, 2011 (www.connectingwithpeople.org/resources)
- *A Toolkit for GPs: The Mental Health Consultation (with a Young Person)*. Freer, 2013 (www.cwmt.org.uk/wp-content/uploads/2014/01/GPToolkit2013.pdf)
- *Mental Health in Emergency Departments – A Toolkit for Improving Care*. College of Emergency Medicine (www.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/Clinical%20Guidelines/Mental%20Health/default.asp)
- *Suicide Mitigation in Primary Care* (factsheet). Cole-King et al, 2012 (www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf)

Websites

- Childline
Offers advice and a freephone helpline for young people up to the age of 19: www.childline.org.uk
- Connecting with People
This site includes free online training material, articles plus clinical practice tools: www.connectingwithpeople.org/resources
- Internetmatters
Guidance for parents on internet safety: www.internetmatters.org
- MIND
Advice on suicidal feelings and supporting someone else: www.mind.org.uk/information-support/a-z-mental-health/?letter=s
- MindEd
Short (20–30 minutes) online learning sessions to help adults identify mental health problems in children and young people: www.minded.org.uk
- Mindfull.org
A new service for 11- to 17-year-olds that provides support, information and advice about mental health and emotional well-being: www.mindfull.org
- NHS Choices
www.nhs.uk/conditions/Self-injury/Pages/Introduction.aspx
- Papyrus
A charity to help prevent youth suicide, with website including useful information and publications: www.papyrus-uk.org
- Samaritans
Helps people of all ages in distress, including those who are suicidal, through telephone support: www.samaritans.org (tel. 08457 90 90 90)
- Selfharm.co.uk
A young person friendly site for sharing positive experiences of coping: <http://selfharm.co.uk/home>
- TheSite
A recovery-oriented website with suggestions of support: www.thesite.org/healthandwellbeing/mentalhealth/selfharm
- YoungMinds
A charity promoting needs for young people with mental health problems, with useful information and resources: www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm

References

- Cello, YoungMinds (2012) Talking Taboos: Talking Self-harm. *Cello Group*.
- Cole-King A, Wadman S, Hughes H, *et al* (2011) *4 Areas Assessment for Patients with Suicidal Thoughts Following Self-Harm Presenting to ED*. Connecting with People (www.connectingwithpeople.org/resources).
- Cole-King A, Walton I, Gask L, *et al* (2012) *Suicide Mitigation in Primary Care*. RCGP/RCPsych Primary Care Mental Health Forum.
- Cole-King A, Green G, Gask L, *et al* (2013) Suicide mitigation: a compassionate approach to suicide prevention. *Advances in Psychiatric Treatment*, **19**: 276–283.
- College of Emergency Medicine (2013) *Mental Health in Emergency Departments – A Toolkit for Improving Care*. College of Emergency Medicine
- Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services*. Department of Health.
- Department of Health (2007) *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*. Department of Health.
- Department of Health (2012) *Prevention of Suicide in England: A Cross-Government Outcomes Strategy to Save Lives*. TSO (The Stationery Office).
- Freer M (2013) *A Toolkit for GPs: The Mental Health Consultation (with a Young Person)*. Charlie Waller Memorial Trust & Royal College of General Practitioners.
- Hawton K, Harriss L, Hall S, *et al* (2003) Deliberate self-harm in Oxford, 1990–2000: a time of change in patient characteristics. *Psychological Medicine*, **33**: 987–995.
- Hawton K, Rodham K, Evans E, *et al* (2009) Adolescents who self harm: a comparison of those who go to hospital and those who do not. *Child and Adolescent Mental Health*, **14**: 24–30.
- Hawton K, Saunders K, O'Connor R (2012a) Self-harm and suicide in adolescents. *Lancet*, **379**: 2373–2382.
- Hawton K, Bergen H, Kapur N, *et al* (2012b) Repetition of self-harm and suicide following self-harm in children and adolescents: findings from the Multicentre Study of Self-harm in England. *Journal of Child Psychology and Psychiatry*, **53**: 1212–1219.
- Health and Social Care (2011) *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*. Health and Social Care, Ireland.
- Horrocks J, Price S, House A, *et al* (2003) Self-injury attendances in the accident and emergency department: clinical database study. *British Journal of Psychiatry*, **183**: 34–39.
- Kapur N, Steeg S, Webb R, *et al* (2013) Does clinical management improve outcomes following self-harm? Results from the Multicentre Study of Self-Harm in England. *PLOS ONE*, **8**(8): e70434.
- National Institute for Health and Clinical Excellence (2004) *The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care* (NICE Clinical Guideline 16). NICE.
- National Institute for Health and Clinical Excellence (2011) *Self-Harm: Longer-Term Management* (NICE Clinical Guideline 133). NICE.
- NSPCC Inform (2009) *Young People Who Self-Harm: Implications for Public Health Practitioners* (Child Protection Research Briefing). NSPCC.

- Owens D, Horrocks J, House A (2002) Fatal and non-fatal repetition of self-harm: systematic review. *British Journal of Psychiatry*, **181**: 193–199.
- Plener PL, Libal G, Keller F, *et al* (2009) An international comparison of adolescent non-suicidal self-injury (NSSI) and suicide attempts: Germany and the USA. *Psychological Medicine*, **39**: 1549–1558.
- Roberts J, Pryke R, Murphy M, *et al* (2013) Young people who self-harm by cutting. *BMJ*, **347**: f5250.
- Royal College of Psychiatrists (1998) *Managing Deliberate Self-Harm in Young People* (Council Report CR64). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2010) *Self-Harm, Suicide and Risk: Helping People who Self-Harm: Final Report of a Working Group* (College Report CR158). Royal College of Psychiatrists.
- Scottish Executive (2005) *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care*. Scottish Government.
- Scottish Government (2012) *Mental Health Strategy for Scotland: 2012–2015*. Scottish Government.
- Wright B, Hooke N, Neupert S, *et al* (2013) Young people who cut themselves: can understanding the reasons guide the treatment? *Advances in Psychiatric Treatment*, **19**: 446–456.