GUIDANCE ON RECOGNISING AND MANAGING SELF-HARMING AND SUICIDAL BEHAVIOUR

Introduction

Research, carried out as part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, showed that there were 1,722 adolescent and juvenile deaths by suicide in the UK between 1997 and 2003, which represents 4% of all suicides in that time period. The majority of young people were aged 15-19 (93% of the sample), and overall, the most common methods of suicide were hanging, followed by self-poisoning. 142,000 young people are admitted to accident and emergency departments each year as a result of self-harm.

The difference between suicide and deliberate self-harm is not always clear. Deliberate self-harm is a common pre-cursor to suicide and children and young people who deliberately self-harm may kill themselves by accident.

Although completed suicide is a rare occurrence, episodes of self-harm and/or suicidal behaviour are not. Early intervention can help to address underlying problems that can lead to such behaviour. Many people who self-harm do not come to the attention of health services and when they do, many do not return or cannot be followed up. Those who do receive services often describe contact as being characterised by ignorance, negative attitudes and sometimes punitive behaviour by professionals towards people who self-harm. As the risk of suicide is considerably higher among people who have self-harmed it is crucial that practitioners are best equipped to give the most helpful initial response in such circumstances.

This guidance is intended to help professionals to identify the types of behaviour that may give cause for concern and to promote awareness of appropriate intervention and sources of support.

Definitions of Self-Harm and Suicide

- Self-harm is self-harm without suicidal intent, resulting in non-fatal injury
- Attempted suicide is self-harm with intent to take life, resulting in non-fatal injury
- Suicide is self-harm resulting in death

Mental Health Foundation 2003

The difference between suicide and deliberate self-harm is not always clear but deliberate self-harm is a common precursor to suicide. In addition, children and young people who deliberately self-harm may kill themselves by accident.
Self-Harm

Research indicates that 1 in 15 young people in Britain have harmed themselves. This probably means that there are probably two people in every secondary school classroom who have done it at some time. Most young people who harm themselves are between 11 and 25 years. Most people start at around 12 years of age but some children as young as 7 have been known to do it.

Although there are no typical groups of people who self-harm, about four times as many girls as boys do it. When boys do self harm they may hit themselves or break their own bones to make it look as if they have been involved in a fight or been attacked.

The groups of children and young people who may be more vulnerable to self-harm can include:

- Young people in residential settings such as the armed services, prison, sheltered housing, hostels and boarding schools
- Lesbian, gay, bisexual and transgender young people
- Young Asian women (one study found that the suicide rate in women aged 16–24 years was three times higher in women of Asian origin than in white British women)*
- Young people with learning disabilities
- Young people with existing mental health problems
- Young people with substance misuse problems
- Vulnerable young people who miss appointments and go off the radar

There are many types of self-harm but these can include:

- Cutting
- Burning
- Scalding
- Banging head and other body parts against walls
- Hair-pulling
- Biting
- Swallowing things that are not edible
- Inserting objects into the body
- Self-poisoning
- Scratching, picking or tearing at skin causing sores and scarring

Responses to self-harm

Self-harm is always a sign of emotional distress and poorly developed coping skills. Whilst it is ultimately damaging and may be dangerous, for many people it provides a method for coping with life. Taking away a person’s means of self-harm can increase the emotional distress and make the situation worse.
The initial reaction that anyone who self-harms receives has a major impact on whether or not they are able to go on to get help. They require understanding, care and concern for their injuries as well as encouragement to talk about the underlying feelings or situations that have led to the self-harm. It is important to try to avoid taking control as many people who self-harm do so in order to have some control over their lives. You can offer to make a referral for support e.g. to the GP, CAMHS, a counsellor or a therapist, but unless you consider the situation one in which the young person is likely to suffer significant harm then an immediate safeguarding referral to Surrey Children’s Service is not likely to result in a positive outcome for the young person. A CAF should be completed to gain a better overall assessment of the young person’s situation and to identify any unmet needs. This should only be undertaken with the consent of the young person and, the parents, where appropriate.

For many young people stopping or reducing self-harm is a long and slow process. There is information on websites that they can be directed to and the Camelot Foundation has collated a list of substitutes for self-harm that young people have found to be successful.

- Using a red felt tip pen to mark where you might usually cut
- Hitting a punch bag to vent anger and frustration
- Hitting pillows or cushions or having a good scream into a pillow or cushion
- Rubbing ice across your skin where you might usually cut or holding an ice cube in the crook of your arm or leg
- Getting outdoors and having a fast walk
- All other forms of exercise – really good for changing your mood and releasing adrenaline
- Making lots of noise either with a musical instrument or just banging on pots and pans
- Writing negative feelings on a piece of paper then ripping it up
- Keeping a diary
- Scribbling on a large piece of paper with a red crayon or pen
- Putting elastic bands on wrists, arms or legs and flicking them instead of cutting or hitting
- Calling and talking to a friend (not necessarily about self-harm)
- Collage or art work – doing something creative
- Going online and looking at self-help websites

### Suicide

The most accurate predictors of suicide are previous attempts and mental health problems. In studies of young men a previous suicide attempt was the strongest predictor of suicide and for young women there was a prior episode of depression. This indicates that any mental health problems in young people need to be taken seriously and that those who have tried to commit suicide need appropriate monitoring and follow-up.
Myths

Myth 1: People who talk about suicide never attempt or complete suicide

People who talk about their suicidal thoughts do attempt suicide. Many people who complete a suicide have told someone about their suicidal feelings in the weeks prior to their death.

Myth 2: If somebody wants to end their life they will and there is nothing that anyone can do about it

Most people contemplating suicide do not want to die but they do want to find a way to ease the pain. Although there are some occasions when nobody could have prevented a suicide, in most cases, if appropriate help and support is offered to a person they are willing to accept this.

Myth 3: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts

Serious talk about suicide does not create or increase risk; it can help to reduce it. The best way to identify the possibility of suicide is to ask directly. Openly listening to and discussing someone’s thoughts can be a source of relief for them and can be key to preventing the immediate danger of suicide.

Myth 4: Some people are always suicidal

Some groups, subcultures or ages are particularly associated with suicide. Whilst young men seem to be at increased risk, suicide can affect all ages, genders and cultures. Those who have made an attempt on their own life in the past can be at increased risk of completing suicide but people can and do move on in their lives.

Myth 5: When a person begins to feel better the danger is over

Often the risk of suicide can be greatest as depression lifts when a person appears to be calm after a period of turmoil. This can be once a decision to attempt suicide is made, people may feel that they have a solution, however desperate it may appear to be.

Myth 6: Most suicides happen in the winter months

Suicide is more common in the spring and summer months.

Myth 7: People who threaten suicide are just attention seeking and shouldn’t be taken seriously.

People may well talk about their feelings because they want support in dealing with them. The response of those close to a person who has attempted suicide can be important to their recovery and giving them the
attention they need may save their life. A suicide attempt should always be taken seriously.

Myth 8: People who are suicidal want to die

The majority of people who feel suicidal do not actually want to die but they do not want to live the life they have. Offering emotional support and talking through other options can help people come through a suicidal crisis and make the difference between them choosing to live or deciding to die.

**Recognition**

Things that seem insignificant or even trivial to adults can be of monumental importance to young people who may get them totally out of proportion. However, the issues may also be of extreme significance and affect other young people. Early identification of signs of emotional distress can include:

- Bullying
- Break up with boy or girlfriend
- Bereavement
- Family stress
- Mental health problems
- Developing a mental illness
- Using drugs and/or alcohol
- Physical, sexual or emotional abuse
- Difficulties with sexual identity
- Fear of under-achievement

This may manifest itself in a number of ways including:

- Changes in usual behaviour
- Anger and/or hostility
- Tearfulness
- Being very quiet and withdrawn
- Disruptive behaviour
- Difficulty concentrating
- Missing school
- Loss of appetite
- Sleep problems

**Responses**

In every case, the practitioner who is made aware that a child or young person has self-harmed or is contemplating this or suicide should talk with them without delay and:

- Ascertain whether they have taken any substances, including tablets, or injured themselves (if so, the child or young person should received
urgent medical attention, even if they appear well as harmful effects can sometimes be delayed)

- Make an initial assessment of risk
- Try to find out what may be troubling them
- Explore to what extent self-harm is likely or imminent or planned
- Ascertain what help or support the child or young person would wish

A supportive attitude, respect and understanding of the child or young person along with a non-judgemental approach is of prime importance. It is also important to remember that a child or young person with a learning disability may find it more difficult to express their thoughts. You may wish to ask them to rate their risk on a scale of 1-10.

Never discuss the consequences of their potential death as they are likely to already feel guilty and you may add to this burden of self-loathing and worthlessness.

**Staff and Volunteer Support**

All staff and volunteers should ensure that they have the support of their manager or supervisor to agree their response to any potential risk and to record what actions have been planned.

One of the most complicated issues around a suicide is attempting to understand the reason for it and the perceived failure of those around the deceased to spot the signs. Anyone involved with a suicide should try be aware of their own coping abilities and seek support however well they believe that they are coping.

CAMHS (Child and Adult Mental Health Service) can be contacted at any time for telephone advice if a professional has concerns. See appendix 3 for Surrey CAMHS contact details.
### Possible questions to ask:

- What is it that troubles you?
- What other concerns do you have about your health and well-being (e.g. drug/alcohol misuse / pregnancy / relationships / bullying / bereavement or loss)
- What happened, including thoughts / feelings that led up to the last incident?
- Who knows about the things that trouble you or how you are harming yourself?
- Where would you put yourself on a scale of 1-10 (10 being high risk)
- Where are you now
  - Thinking about harming yourself – consider questions about frequency, pattern, escalation and triggers
  - The behaviours likely to happen again
    - What is the range of harmful behaviours, intentional / unintentional have you carried out?
    - Ask about other risk-taking behaviour
  - Mood generally
  - What would a 10 be like? What would be happening if you were a 10?
  - Ask about having the means to do this. Have you thought about when you would do this?
  - How long have you felt like this?
  - How do you see the future?
- What have you been doing that helps?

### Risk is high when:

- There is an escalating pattern of self-harm – increases in frequency and severity
- Current situation experienced as causing unbearable pain
- Significant drug and alcohol misuse
- Indicators of mental ill-health

### Risk is raised when:

- Suicidal thoughts are frequent but generally fleeting
- There is a clear plan / intent
- There are indicators of mental ill-health e.g. panic attacks, anxiety, depression, psychosis
- Significant drug or alcohol misuse
- Experiences which are painful with no impending crisis
- Feeling of failure, uselessness, lack of hope and loss of self-esteem
- Dwelling on problems which seem to have no solution
- Being isolated, lonely, withdrawn and unable to relate

### Risk is low when:

- Suicidal thoughts are fleeting and soon dismissed
- There is no plan or intention
- There is little indication of depression
- No indicators of psychotic mental illness
- Experiences which are painful but not unbearable
**Appendix 2 References and Resources**


<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The relationship between child maltreatment, sexual abuse and subsequent suicide attempts</td>
<td>NSPCC, May 2009</td>
</tr>
<tr>
<td>Papyrus – A national charity for the prevention of young suicide</td>
<td></td>
</tr>
<tr>
<td>The Site.org – advice for young people on self-harm and recovery</td>
<td></td>
</tr>
<tr>
<td>Samaritans</td>
<td></td>
</tr>
<tr>
<td>Centre for Suicide Research</td>
<td></td>
</tr>
<tr>
<td><strong>Ashford &amp; St. Peter's Hospital CAMHS</strong></td>
<td><strong>East Elmbridge CAMHS</strong></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Tel: 01932 722561</td>
<td>Tel: 020 8224 7878</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Buryfields Clinic CAMHS (Guildford)</strong></th>
<th><strong>Epsom CAMHS</strong></th>
<th><strong>Farnham Hospital and Centre for Health - CAMHS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel: 01483 783330</td>
<td>Tel: 01372 204120</td>
<td>Tel: 01483 783330</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Frimley CAMHS</strong></th>
<th><strong>Mole Valley CAMHS</strong></th>
<th><strong>Redhill/Horley CAMHS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel: 01483 782900 / 782919</td>
<td>Tel: 01306 502708</td>
<td>Tel: 01737 277701</td>
</tr>
</tbody>
</table>

**Primary Mental Health Work Service:**

- **North west Surrey advisory line**
  Tel: 01784 884 817

- **South west Surrey advisory line**
  Tel: 01483 783 344

**North east and south east Surrey CAMHS**

- East Elmbridge. Tel: 020 8224 7878
- Epsom and Ewell. Tel: 01372 203 301
- Leatherhead and Dorking. Tel: 01305 502 708
- Tandridge. Tel: 01883 388 303
- Redhill and Reigate. Tel: 01737 287 002