

Assessment and management of self-harm procedure

Version:	1.2
Approved by:	Executive Management Team
Date Approved:	30 April 2019
Author:	Associate Medical Director
Responsible Director:	Medical Director
Date issued:	June 2019
Review date:	April 2022
Intranet	Yes
Extranet	Yes



Contents

1	Introduction.....	3
2	Purpose	3
3	Scope.....	4
4	Definitions	4
5	Duties and responsibilities	4
6	Procedures	5
7	Training Requirements.....	9
8	Process for monitoring compliance with this procedure	9
9	References	9
10	Associated documents	9
11	Equality Impact Assessment.....	11

Assessment and management of self-harm procedure

1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health trust based in north London, providing out-patient psychological therapy services for children, young people (up to 25 years of age) their families and carers and adults, as well as providing multi-disciplinary training and education. Unlike most other mental health trusts, it has no in-patient beds or psychiatric wards. However, risk remains an important consideration in all the care provided for all our patients. Also, a number of our services are engaged in assessment rather than direct treatment, which means that they consider risk from a specific perspective and their assessment of risk determines how they start work and under what conditions.

However, certain services in the Trust will have patients more likely to present with self-harming thoughts and behaviour, and may therefore be thought of as *'high risk services'*. These include:

- Adolescent and Young Adult Service
- City and Hackney Primary Care Consultation service
- Community CAMHS
- Complex medical conditions
- Eating disorders service
- Family Drug and Alcohol Service
- Fitzjohn's unit
- Gender Identity Development Service
- Looked After Children's Assessment Service
- Pain service
- Portman Clinic
- Refugee Service
- Trauma service
- Gloucester House
- Returning Families Unit

2 Purpose

This document sets out the Trust procedure for the assessment, treatment and support of patients who self-harm. It should be read in conjunction with the Trust's procedure for clinical risk assessment and the Trust's procedure for the prevention of suicide.

3 Scope

This procedure is relevant to all clinical staff who are involved in the assessment and /or treatment of patients and to senior managers who are involved both within the Trust and with external colleagues in the planning and developing of services that could have an impact on the detection, management and support of people who self-harm.

4 Definitions

Definition of self-harm

The Trust has adopted the NICE Guidelines definition of self-harm:

'Self-harm' refers to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting.

There are several important exclusions that this term is not intended to cover. These include harm to the self-arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.

5 Duties and responsibilities

5.1 Medical Director/ Associate Medical Director (Patient Safety and Clinical Risk Lead)

The Medical Director has overall responsibility for this procedure in his role as lead for clinical risk. Working with the Associate Medical Director (Patient Safety and Clinical Risk Lead) he will ensure that: the self-harm management and prevention training provided by the Trust is valid and fit for purpose; to commission and act upon training satisfaction /evaluation processes; and report to the Management Team any gaps in the implementation of the procedure.

5.2 Directors and Associate Directors

Clinical Directors and Associate Clinical Directors will ensure that the management and prevention of self-harm training is delivered and accessed by all appropriate staff in their services; and ensure that this procedure and other relevant policies and clinical guidance are disseminated across services and used to direct practice.

5.3 Clinical Staff and Trainees

All clinical staff must be aware of what constitutes self-harming behaviour, so that they know what behaviour or actions need to be identified, reported and responded to.

6 Procedures

6.1 Assessment of self-harm

All patients who are referred or present with self-harming/injurious behaviour must be assessed using the Trust's Clinical Risk Assessment Procedure. The following risk indicators and psychosocial needs should be covered in the assessment:

- Social situation (living arrangements, debt, work etc.)
- Personal and significant relationships, either supportive or representing a threat
- Recent and current life difficulties, including personal and financial problems
- Internet/ social media interfaces e.g. cyber bullying, web communities.
- Psychiatric history (including previous self-harming, drug/alcohol use)
- Presence of mental illness, e.g. depression, psychosis
- Mental capacity
- Level of distress, consider behaviour, emotions, cognition and physical
- Willingness to engage in assessment
- Rationale behind self-harming
- Current suicidal intent and hopelessness including immediate and longer-term risks
- Skills, strengths, assets and coping strategies including protective factors and the possible reduction in previous protective factors

When assessing **children and young people**, particular attention should be paid to the following:

- Abuse (physical, emotional, sexual)
- Neglect by caregivers
- Family stressors e.g. parental separation or divorce
- Internet/ social media interfaces i.e. cyber bullying, web communities
- Bullying by peers
- History of peers who have committed suicide. This may cause trauma and guilt which increases risk
- Previous suicide attempts and if help was sought and how it was sought.

(Note: some high risk adolescents and young adults may plan in secret and minimize their difficulties when assessed)

When assessing **older adults** who have self-harmed, particular attention should be

paid to the following:

- Evidence of depression
- Cognitive impairment
- Physical ill health
- Home situation
- Recent bereavement

6.2 Changes to risk level

The risk assessment must be reviewed following an act of self-harm or when there is a sudden escalation (in frequency and severity) or changes in self-harm behaviour.

6.3 Management of self-harm principles

Clinicians working with individuals of all ages who have self-harmed should:

- 6.3.1 Aim to develop a trusting, supportive and engaging relationship with them
- 6.3.2 Maintain continuity of therapeutic relationships wherever possible
- 6.3.3 Work with the individual to establish an understanding of the meaning of self-harm for the individual
- 6.3.4 Be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
- 6.3.5 Ensure that patients are as fully involved as possible in decision-making about their treatment and care, and where this relates to a child, that their carers are involved
- 6.3.6 Aim to foster the patient's autonomy and independence wherever possible
- 6.3.7 Ensure that information about episodes of self-harm is communicated sensitively to other team members
- 6.3.8 Where possible and appropriate, and with the consent of the service user, information should be obtained and shared with carers
- 6.3.9 All clinicians working with patients who self-harm should receive regular individual and/or group supervision, which must be documented on the patient file.

6.4 Management of acute self-harm

If the patient has recently self-harmed, either on a Trust site, or elsewhere, the acute risk to the patient should be urgently assessed. If this suggests that there is a significant physical risk to the individual who has self-injured the person should be referred to the nearest emergency department.

In most circumstances, people who have self-poisoned should be urgently referred to the nearest emergency department, because the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned,

making accurate risk assessment difficult. If there is any doubt about the seriousness of an episode of self-harm, the clinician should discuss the case with the nearest emergency department consultant, as management in secondary care may be necessary.

Where there is no acute physical risk, but there is evidence of suicidality and/or repeat serious self-harm the person should be referred to the nearest acute psychiatric unit.

In all cases where the patient requires urgent transfer this should be arranged via a 999 ambulance call in accordance with the Rapid Transfer Procedure.

6.5 Longer-term management of self-harm

Self-harm is not a diagnosis in itself and most patients will have been referred for the assessment and treatment of other mental health difficulties, in which the self-harming behaviour forms part of the overall clinical picture, and will have been assessed and referred to the specific clinical service(s) within the Trust as appropriate.

All clinicians should be aware of the following guidance from NICE regarding the care planning, risk management plans and interventions for self-harm:

<https://www.nice.org.uk/guidance/cg133/resources/selfharm-in-over-8s-longterm-management-pdf-35109508689349>

<https://www.nice.org.uk/guidance/cg16/resources/selfharm-in-over-8s-shortterm-management-and-prevention-of-recurrence-pdf-975268985029>.

6.5.1 Care plans

Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:

- 6.5.1.1 prevent escalation of self-harm
- 6.5.1.2 reduce harm arising from self-harm or reduce or stop self-harm
- 6.5.1.3 reduce or stop other risk-related behaviour
- 6.5.1.4 improve social or occupational functioning
- 6.5.1.5 improve quality of life
- 6.5.1.6 improve any associated mental health conditions.

Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year.

Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans should:

- 6.5.1.7 identify realistic and optimistic long-term goals, including education, employment and occupation
- 6.5.1.8 identify short-term treatment goals (linked to the long-term goals)

- and steps to achieve them
- 6.5.1.9 identify the roles and responsibilities of any team members and the person who self-harms
- 6.5.1.10 include a jointly prepared risk management plan
- 6.5.1.11 be shared with the person's GP.

6.5.2 Risk management plans

A risk management plan should be a clearly identifiable part of the care plan and should:

- 6.5.2.1 Address each of the long-term and more immediate risks identified in the risk assessment
- 6.5.2.2 Address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
- 6.5.2.3 Include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
- 6.5.2.4 Ensure that the risk management plan is consistent with the long-term treatment strategy.
- 6.5.2.5 Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals.
- 6.5.2.6 Where the care is of a child, the network, for example school or allocated social worker, will need to be involved in the risk management plan
- 6.5.2.7 Interventions for self-harm
- 6.5.2.8 Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:
- 6.5.2.9 The intervention should be tailored to individual need and could include cognitive-behavioural, psychodynamic or problem-solving elements.
- 6.5.2.10 Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
- 6.5.2.11 Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.
- 6.5.2.11.1 Do not offer drug treatment as a specific intervention to reduce self-harm. Provide psychological, pharmacological and psychosocial interventions for any associated conditions, e.g. alcohol and drug-use disorders, depression, borderline personality disorder, bipolar disorder and schizophrenia

6.5.3 Harm reduction

If stopping self-harm is unrealistic in the short term:

- 6.5.3.1 Consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
- 6.5.3.2 Consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
- 6.5.3.3 Advise the service user that there is no safe way to self-poison

7 Training Requirements

Training regarding self-harm will be delivered in the following way:

- Trust induction (all staff) includes an introduction to clinical risk assessment training which includes training in the assessment, management and prevention of suicide and self-harm
- On-going training and support. This will be delivered at Directorate level supervision and team meetings.

8 Process for monitoring compliance with this procedure

Compliance with this procedure will be monitored by way of analysis of reported incidents of self-harm which will be investigated to consider whether lessons can be learned and also whether this procedure has been followed. Learning from incidents will inform future reviews of this procedure

9 References

NICE Guideline No 16: Self-harm – The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (July 2004).

NICE Clinical Guideline 133: Self-harm: longer-term management (Nov 2011).

College Report from the Royal College of Psychiatrists CR192: Managing self-harm in young people. (2014).

College Report from the Royal College of Psychiatrists Cr158. Self-Harm, Suicide And Risk: Helping People Who Self-Harm (2010).

10 Associated documents¹

Trust procedure for clinical risk assessment

Incident reporting procedure

Procedure for the investigation of serious incidents

Consent to treatment procedure

Procedure for the prescribing and administration of medicines

Procedure for the rapid transfer of an acutely unwell patient

¹ For the current version of Trust procedures, please refer to the intranet.

11 Equality Impact Assessment

Completed by	Irene Henderson
Position	Clinical Governance & Quality Manager
Date	April 2019

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	Yes	No	Comment
Do policy outcomes and service take-up differ between people with different protected characteristics?			

What are the key findings of any engagement you have undertaken?			
If there is a greater effect on one group, is that consistent with the policy aims?			
If the policy has negative effects on people sharing particular characteristics,			

what steps can be taken to mitigate these effects?			
Will the policy deliver practical benefits for certain groups?			
Does the policy miss opportunities to advance equality of opportunity and foster good relations?			
Do other policies need to change to enable this policy to be effective?			
Additional comments			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources.