Kent and Medway
NHS and Social Care Partnership Trust

Forensic and Specialist Service Line (KSSL)

Self-harm Guidelines

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DOCUMENT TRACKING SHEET

Self Harm Guidelines

Version	Status	Date	Issued to/approved by	Comments
v.01	Draft	20/06/16	TGU Patient Safety Meeting	Need to clarify when positive risk management strategies will be overridden in light of increased risk or change in risk.
v.02	Draft	18/07/16	TGU Patient Safety Meeting	Inclusion of staff debrief following self-harm incidents and staff training on positive risk management.
v.03	Draft	15/08/16	TGU Patient Safety Meeting	Dr Kingham to seek advice from Jill Leighton (KMPT Lead Resuscitation Officer) in regards to ligature tying and positive risk management.
v.04	Draft	12/09/16	TGU Patient Safety Meeting	In light of advice given, ligatures to be excluded as a form of self-harm that can be positively risk managed. Appendix to include zero tolerance on ligature tying. Guidelines ratified at local level following Trust level patient safety meeting agreement.
v.05	Draft	24/01/17	Trust Wide Patient Safety Meeting	Change from Policy to Guidelines. Highlight procedure when there is a change in risk. Add that all self-harm incidents are reportable.
V1.0	Authorised	19/06/17	Trustwide Patient Safety & mortality Group	Authorised virtually

REFERENCES

Aldridge D (1998) "Looking back I definitely wanted to die". *Nursing Times* 93(45): 27.

Cadman L and Hoy, J (2009) Cutting the Risk: Self Harm Minimisation in Perspective: Teaching an learning guidelines. National self harm minimization group.

Klonsky ED (2007) The functions of deliberate self-injury: A review of the evidence. Clinical Psychology Review;27(2):226-239.

Cutliffe J R & Barker P (2002) „Considering the care of the suicidal Patient and the case for „engagement and inspiring hope" or „observations". *Journal of Psychiatric and Mental Health Nursing* 9: 611-621.

Pembroke, L, R (2007) „Harm minimisation: limiting the damage of self-injury" In Warner, S and Spandler, H (eds.) *Beyond fear and control: working with young people who self- harm* PCCS Books: Herefordshire.

Department of Health Self-Harm Expert Reference Group on Self-Harm (SHERG) (2012)
Safe and Secure: Working constructively with people who self-injure – a guide for staff working in secure mental health services.

Shaw, C and Shaw T (2007) A Dialogue of Hope and Recovery in Warner, S and Spandler H *Beyond Fear and Control – working with young people who self-harm* (Ross-on-Wye: PCCS Books)

Winnard J, Devlin S: Self-help for self-injury. Lancashire, England, Lancashire Care NHS Foundation Trust, 2011.

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

National Institute for Health and Clinical Excellence (2011). Self-harm: Longer term management. National Institute for Health and Clinical Excellence.	
National Institute for Clinical Excellence (2004) Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guide 16: NICE: London	
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	
Equality Act (2010)	
Clinical risk assessment and management of service user Policy	KMPT Clig.009.
Supervision Policy for all clinical staff working in clinical settings	KMPT Clig045.
Privacy, Dignity and Respect Policy	KMPT.2013

CONTENTS

1 GUIDELINES

1.1 The purpose of these guidelines is to guide and establish best practice for the management of self harm within the secure units within the Forensic and Specialist Service Line (FSSL).

1.2 The aim of this guideline is to make good practice points to guide and support staff working with individuals who represent a risk to themselves in positive risk taking by establishing standard procedures. These guidelines can be adapted to the various FSSL settings (e.g. inpatient (non-secure) and community) and other Service Lines across the Trust.

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2 RESPONSIBILITIES

2.1 All employees working with secure units within the FSSL who have a role in this procedure must ensure that they have a working knowledge and work in accordance with these guidelines. All members of the multi-disciplinary clinical team are responsible for including self-harm assessment procedures. The procedures for ensuring risk management plans are carried out are the responsibility of nursing staff, as set out below. The responsibility for imposing restrictions on leave in relation to self harm is shared by the multi-disciplinary clinical team. It is essential that every member of staff responding to self-injury in secure mental health facilities is fully aware of the NICE guidelines (2011) and its provisions.

3 DEFINITIONS

3.1 It is important to make a clear distinction between *self-harm* and *attempted suicide* as much self-harm behaviour is not motivated by suicidal intent and serves a very different purpose. Many people who harm themselves do also experience suicidal ideation, and may have attempted suicide but they can make a distinction in their own minds between behaviours which are suicidal in nature, and other self-harming actions.

3.1.1 *Self-harm* is the umbrella term for self-injurious behaviours, and *self-poisoning*. This can include taking an over-dose of medication or taking other substances, cutting wrists or other parts of the body, burning, attempted hanging and strangulation.

3.1.2 Self-injury can be understood more specifically as “the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned.” (Klonsky and Muehlenkamp, 2007)

3.1.3 Attempted suicide may be used where there was a definite attempt to take one’s life, and parasuicide when the degree of suicidal intent of the act is not clear.

3.1.4 Suicide is the taking of one’s life.

3.2 It is important to understand that there is no simple relationship between the behaviours that people use to harm themselves and whether the person is self-injuring or suicidal. Put another way, people can use highly lethal means to self-injure without intending to kill themselves and can use non-lethal methods even though they feel a desire to end their lives. It is not safe to make inferences about what a person intends through the method they choose to self-injure. There are several reasons for this, which are particularly relevant to secure services, including the individual may adapt their usual method of self-harm to

the restrictions of the secure environment. In addition, they may not understand how potentially lethal a method is (Safe and Secure, 2012).

3.3 Methods of self-harm can include both direct and indirect methods.

3.4 Direct methods concretely and immediately hurt the body. For example:

Cutting
Burning
Hitting
Scalding
Hair pulling
Ingesting toxic substances
Poisoning
Biting
Venesection
Swallowing or inserting objects
Head banging
Breaking bones
Tying ligatures
Suffocation
Scratching
Interfering with wound healing
Medication excess

3.5 Indirect methods can be accumulative or deferred and may be unintentional effects of other behaviours or might involve denial of the harm that is being done. For example:

Sexual risk taking (e.g. unprotected sex with strangers)

Situational risk taking (e.g. absconding, hitch hiking alone)

Physical risk taking (e.g. walking in high speed traffic)

Eating disorders

Alcohol and drug misuse

4 FUNCTIONS OF SELF-HARM

4.1 Self-harm is understood to have a number of possible functions. These functions vary between people who self harm and across time and situations for an individual. They include:

Emotional regulation

Self-soothing or tension reduction

Distraction
Expression of repressed anger
Provides sense of autonomy and control
Management of dissociation and depersonalisation
Attainment of physical care

As testimony to denied, ignored or minimized past trauma – to signify courage and suffering

Rarely, to replicate or re-enact past trauma or abuse.

Expression of self-loathing
Rid self of contamination or 'badness'
To communicate pain and suffering when unable to voice directly

(Cadman & Hoy, 2009)

5 POSITIVE RISK MANAGEMENT

5.1 This is an approach to risk management that aims to improve the patient's quality of life and plans for recovery, while remaining aware of the safety needs of the patient, their carer and the public. It involves being aware that risk can

never be completely eliminated, and that management plans inevitably have to include decisions that carry some risk.

6 HARM MINIMISATION

6.1 This is an approach to helping people who self-harm by accepting the need to self-harm as a valid method of survival until survival is possible by other means. **The approach does not condone or encourage self-injury**. It emphasises facing the reality of maximizing safety in the event of self-harm (Pembroke, 2007).

6.2 Safer self-injury can be seen as a sub-category of harm minimisation (which describes a wider theoretical and ethical as well as practical approach), and means enabling people who are self-injuring to modify their behaviour to reduce physical damage (Safe and Secure, 2012).

7 PRINCIPLES AND VALUES

7.1 The principles and values which underpin this guideline include:

7.1.1 A philosophy of care that is explicitly patient focused and acknowledges that people who have self-harmed should be treated with the same care, respect and privacy as any other person currently using inpatient services (NICE 2004).

7.1.2 The provision of services that are safe, optimal and appropriate.

7.1.3 The provision of therapeutic approaches to enable individuals to develop an improved quality of life, while learning the necessary skills for surviving emotional crises, regulating emotions and improving interpersonal effectiveness.

7.1.4 The provision of services and an environment that remain within the framework of the law.

7.1.5 Any staff training needs to be focused with a specific emphasis on patient and carer participation, structured engagement, purposeful evidence based interventions and whole system care co-ordination.

7.1.6 To ensure that services offered to those who self harm are delivered in accordance with the Equality Act (2010) and the Trust's Privacy, Dignity and Respect policy by being non-discriminatory, promoting tolerance and valuing difference.

8 BRINGING IT TOGETHER: POSITIVE RISK MANAGEMENT, ENGAGEMENT AND HARM MINIMISATION

8.1 In caring for those who have required admission to a secure unit within the FSSL there will always be circumstances where the patient's immediate safety is the primary concern. Problems such as severe psychopathology, non-adherence to necessary treatment, lack of capacity and lack of insight can all affect the patient's ability to critically assess the implications of their actions or collaborate in decisions about care and risk management. In these circumstances, the mental health act provides an appropriate framework for the management of risk but collaboration and positive risk management should be the ultimate aim in all cases.

8.2 Managing risk in the care of people who self-harm is not just about intervening in restrictive, controlling ways in an attempt to eliminate opportunities. When balancing the potential benefits and potential risks of care plans it is important to recognise that strategies that rely too heavily on observation and control can, in some circumstances, paradoxically increase the risk. Self-injury that takes place in an 'out of control' manner because of the methods used and because of the need for secrecy and urgency, can be potentially more damaging (Shaw and Shaw, 2007; Safe and Secure, 2012). A person's sense of worthlessness and hopelessness may be increased by a care regimen that emphasises close or continuous observation, but at the same time neglects pressing psychosocial needs. There is recognition that the nursing care of people who are at risk of self-harm should focus on a more engaging form of care and support, rather than upon tightening up the policing strategy of observation (Cutliffe & Barker, 2002), which is recognised to do little to address the root cause of the person's difficulties and is highly stressful for participant nursing staff. In addition, there is evidence that the removal of choice and freedom from patients can contribute to increased feelings of shame and powerlessness and have a negative effect on trust and communication with staff (Cadman & Hoy, 2009).

8.3 Positive risk management provides a suitable framework for delivering care that is collaborative, respectful and which recognises the strengths of the individual who self-harms. It involves making decisions about risk management that aim to improve the patient's quality of life and plans for recovery, while remaining aware of the safety needs of the patient, their carer and the public. It involves being aware that risk can never be completely eliminated, and that management plans inevitably have to include decisions that carry some risk. Positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners (DoH, 2007).

8.4 Given the complex nature of self-harm, unsurprisingly there is no 'singular' treatment or intervention that appears to address the problem. However, there is evidence that two linked, basic interpersonal processes appear to be key in providing care for this patient group: *engagement* and *inspiring hope*.

8.5 Engagement is concerned with forming a relationship, which conveys the message of care and value of the patient, and is concerned with listening, hearing and understanding without prejudice. There is an abundance of evidence that indicates hopelessness is a key element in determining whether a person will commit suicide rather than merely consider it (Aldridge, 1998). The clinician's engagement must therefore be dedicated to understanding the nature of that hopelessness, and to develop the means to instil hope.

8.6 Within this collaborative engagement, clinicians can help the person to understand the functional value of their self-harm and seek to assist them manage the risks whilst exploring alternative ways of meeting their needs. This is not the negligent avoidance of professional responsibility for providing directive and restrictive care where a person is unsafe. It is care that respects the dignity and the rights and responsibilities of individuals to confront the problem of living and to face the reality of human suffering within a supportive therapeutic system.

9 GUIDELINES FOR MANAGING SELF-HARM

9.1 All staff will be provided with training around positive risk management with self-harm. This training should be delivered by a qualified clinical psychologist. The

training will outline the theoretical underpinning of positive risk management, and guidelines for managing self harm within this framework.

9.2 For new admissions, a self-harm assessment should be made at the earliest opportunity, preferably by a clinician with specialist knowledge in self-harm (e.g. psychologist, psychiatrist, nurse). The patient's self-harm will be assessed in terms of history, methods, severity, function, triggers, and impulsivity. It is essential that the relationship with self-harm and suicidal intent is established at assessment.

9.3 All new admissions with self-harm histories will be provided with a leaflet about the approach of the FSSL to self-harm at the earliest opportunity. Where appropriate, patients will also be provided with harm minimisation and safer self-injury information, which can form the basis of initial discussions around self-harm with primary nurses. Harm minimisation strategies should not be offered for people who have self-harmed by poisoning or tying ligatures (please see appendices). There are no safe limits in self-poisoning or ligature tying. In addition, due to the possibility of carotid sinus reflex death ligature tying will not be managed within positive risk management framework (clinical teams may override this where there is a clear formulation). Harm minimisation strategies include:

9.3.1 Providing information on how to recognise and respond to signs of infection

9.3.2 Providing first-aid supplies, such as Steristrips, so that individuals can take care of minor injuries.

9.3.3 Advice on long-term aftercare, such as scar reduction

9.3.4 Information on the consequences of overdoses

9.3.5 Flexible, creative and person-centred ideas for the reduction of risks involved in any individual's self-harm. For example, wearing a hat when head-banging, wearing gloves when biting hands, or setting time limits when punching.

Alternatives to self-injury include:

9.3.6 Flick rubber bands

9.3.7 Scream into your pillow

9.3.8 Hold ice

9.3.9 Drawing on yourself with washable red pen

9.3.10 Bite into a lemon

9.3.11 Suck toxic waste sweets

9.4 Following a thorough assessment, and in consultation with the multi-disciplinary team, the patient's self-harm will be collaboratively formulated (i.e. ensuring the patient is involved in this process) within an evidence-based psychological formulation (e.g. Cognitive Behaviour Therapy, Cognitive Analytic Therapy, Schema Therapy, Behavioural Therapy). This formulation will highlight the function of a patient's self-harm, its possible triggers, and provide an appropriate framework for positive risk management. **This care plan will also highlight at**

what point positive risk management strategies are overridden and restrictive practices are implemented This may be modified during the patient's progress within KFSS.

9.5 It is important to acknowledge any changes in an individuals risk and how this impacts on positive risk management strategies. Where risks change (i.e. receipt of upsetting information; suspicion of drug or alcohol use; mental state deterioration), restrictive practices may be adopted pending MDT discussion. Restrictive practices will always be considered as an alternative if clinical opinion is that there has been a change in risk.

9.6 Positive risk management will be promoted by:

9.6.1 Accepting that for some, self-harming behaviour may continue during an episode of inpatient care.

9.6.2 Working collaboratively with at-risk patients and their family/carers in assessing needs, risk factors and planning care.

9.6.3 Engagement in open exploration of self-harm ideation – the frequency, intrusiveness, planning and motivation.

9.6.4 Engagement in therapeutic conversation that facilitates the safe discharge of distress and the identification of underlying issues and concerns.

9.6.5 Negotiation of a safety care plan with patients and their family/carer and seeking the person's ideas about what is likely to work.

9.6.6 Weighing up the potential benefits and harms of choosing one action over another.

9.6.7 Being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk.

9.6.8 Being clear to all involved about the potential benefits and the potential risks.

9.6.9 Developing plans and actions that support the positive potentials and priorities stated by the patient, and minimise the risks to the patient or others.

9.6.10 Clarity about a patient's responsibility for his/her own safety within the context of the care plan.

9.6.11 Ensuring that the patient, and involved others who might be affected are fully informed of any decisions, reasons and associated plans.

9.6.12 Regular Clinical Supervision of **all** staff (both qualified and unqualified).

9.6.13 Consulting to specialist staff where the risk is unacceptably high or not well understood.

9.7 Providing opportunities to discuss the subject of self-harm and to be heard and supported are essential in managing self-injury. Safe and Secure (2012) offer the following ways that these skills can be constructively applied:

9.7.1 Never dismiss self-injury as unimportant, attention-seeking or time-wasting even if wounds appear superficial – there is often no relation between the type of injury engaged in and the depth of feeling motivating the behaviour.

9.7.2 Even if self-injury appears to be a strategy for changing a person's circumstances or getting emotional needs met, this still indicates a significant need for help: it may be more helpful to think of such actions as 'attention needing' rather than attention seeking.

9.7.3 Listen to the person's experience without being critical, judgemental or blaming. Try not to panic or overreact; a calm, empathic approach works best.

9.7.4 Give the person the space and time to talk about their feelings but recognise that they may not be able to (or not able at that moment). Remember, self-injury can be a response to an inability to use words to articulate feelings. Try to encourage the person to talk at their own pace in a place of their choosing.

9.7.5 It is not unprofessional to be honest if you find it difficult to hear what the person is saying – conveyed in an appropriate way, this may be perceived as a more authentic response, leading to the building of genuine rapport. However, it is important not to convey incomprehension, disgust, revulsion or rejection.

9.7.6 Don't just focus on the injuries – try to convey to the person an attitude of professional care for the whole person. Try to emphasise the person's inherent value to help develop and support their own sense of self-worth.

9.7.7 Never assume that a person self-injures repeatedly will always maintain the same pattern. People can and do change their behaviour – each episode needs to be considered in its own right.

9.7.8 Wherever possible, try to involve the person in dialogue about approaches to managing the self-injury and their care. Participation in such a dialogue may be an important act of empowerment leading to positive change.

9.8 It is essential that no staff member independently implements safer self-injury strategies such as the provision of sterile blades etc (note that the provision of sterile blades would not be acceptable on a medium secure unit). These approaches need to be based on carefully considered and formulated risk management plans, taking into account the nature of individuals forensic histories (i.e. risk to others).

9.9 Providing all self-harm episodes are managed as set-out within the patient's care plan, no individual staff member will be held accountable should an adverse event occur. However, where a staff member has deviated from the agreed care plan this will be investigated and considered within appropriate competency frameworks

9.10 All episodes of self-harm regardless of severity must be reported by entering the information on to DATIX.

9.11 In the **absence of a self-harm care plan**, the standard response to a self-harm episode must adhere to NICE (2004) Guidelines for Self-harm in over 8s: short-term management and prevention of recurrence, and ensure that the following treatment guidelines are followed:

9.11.1 People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.

9.11.2 Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.

9.11.3 Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

9.11.4 When a patient has self-harmed a qualified nurse should assess the need for possible medical intervention immediately.

9.11.5 If urgent medical intervention is needed due to significant threat to the patient's physical health an ambulance should be requested immediately. Staff must escort the patient to the hospital, and the number of escorts depends on the patients risk at that immediate time. However a minimum of 2 staff should escort.

9.11.6 If medical intervention is needed at A&E but the qualified nurse feels it is safe for staff to escort, this should be arranged, as soon as possible via a unit vehicle. The number of escorts depends on the patients risk at that immediate time. However a minimum of 2 escorts should escort.

9.11.7 If medical intervention is required that can be carried out within the ward environment, and staff are trained to apply the intervention this should happen e.g. dressing a wound. The ward Doctor or Duty Doctor (out of hours) must also be contacted to come and assess the patient at the soonest opportunity.

9.11.8 Until a patient has been assessed by a Doctor they are to remain on, either eyesight or arms reach observations. The qualified nurse is to assess the patient's risk to decide the level of observation.

9.11.9 A full room search of the patient's room must take place with 2 staff present to remove any sharp/self-injury objects.

9.11.10 Any leave should be suspended until review by medical staff.

9.11.11 At the soonest opportunity after a self-harming episode a full multi-disciplinary clinical team discussion should take place and a care plan devised with the patient to manage any further episodes.

9.11.12 Following a self-harming episode, all staff involved in the incident should be provided a debrief session. This session should be provided by the team psychologist. In addition to any urgent debriefing, all staff working with patients that self-harm must be provided with regular individual or group supervision.

10. MONITORING COMPLIANCE WITH & EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non compliance
Self-harm episodes in KFPS	MDT discussions and minutes. Datix forms?	Clinical area managers	Ongoing	Nursing records and MDT care plans	Modern Matron to raise awareness with nursing team and authors to agenda at Clinical Governance meetings
Psychological intervention for self-harm (e.g trauma intervention/personality disorder intervention)	Attendance at intervention addressing self-harm behaviour	Psychology	Yearly	Records of Attendance / Standardised Outcome Measures	To discuss with patient's individual clinical team / Head of Psychology

APPENDIX A LIGATURE RISKS

This section is concerned with patients who tie ligatures for reasons other than suicide. Suicide prevention guidance can be found on Staffzone under *'Prevention of Suicide Homicide Group'.*

It is recognised by the Kent Forensic Service that some patients will tie ligatures around their neck with the aim not to kill themselves but for purposes including pleasure (Erotic Asphyxiation) and self-harm.

The Kent Forensic service cares for patients with enduring and complex mental health needs. Patients who choose to tie ligatures for reasons other than suicide and are reluctant to stop tying ligatures are at high risk of killing themselves or causing long term harm. Patient liberties along with recovery ideals need to be balanced with the risks posed.

Due to the high risk of serious self-harm or death the Kent Forensic Service does not believe that there is any safe process of permitting the tying of ligatures and take a zero tolerance stance.

Staff must be aware of and follow the KMPT policy *'Control of Ligatures and Ligature Points'.*

When a patient is found to be tying ligatures or expressing urges to tie ligatures a risk assessment needs to be completed along with a tool such as SAFE-T.

Any patients who are known to tie ligatures should have the risk identified in their care plan. Where a patient is actively tying ligatures or seeking to tie ligatures a care plan should be devoted to managing this.

Where a patient is found with a ligature tied around their neck nursing staff need to respond immediately to remove the ligature. Where appropriate a patient can be asked to remove a ligature but if they do not respond immediately or struggle to remove the ligature staff should cut the ligature off. It is possible that lasting damage or death can occur in a matter of seconds. In these incidences no consideration should be made to damaging the patient's property.

All staff working on inpatient units need to know where to find ligature cutters and resuscitation equipment. NHSP and agency workers must be made aware of this in their orientation to a ward.

Only the minimal amount of personal belongings that can be used as ligatures should be permitted. Clothing containing obvious ligatures should be avoided. Examples might include tracksuit bottoms with drawstrings, removing laces and wired bras.

Patients who are known to be seeking or suspected of ligature tying behaviours should be monitored on no less than 15 minute observations.

Whenever possible the bedroom a patient who ties ligatures is placed in should meet minimal ligature point specifications.

In instances where patients are assessed to be making a recovery but continue to seek non-suicidal ligature tying behaviours intermittently, they should continue to have restrictions placed on them.

In order for the patient to move away from tying ligatures it is likely they will need to replace the ligature tying with a less risky behaviour. This is likely to take time and the patient should be offered a plan of support as recommended in other areas of this protocol.

For long term ligature users who work with services to stop tying, inevitably there will be risks. At an appropriate time patients will need to retain items that can be potentially used as ligatures along with reduced observation levels.