Local Policy 71

Policy for Management of Deliberate Self Harm

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Introduction

These guidelines are intended to inform staff responding to self harm incidents in a long term inpatient setting and as such include the following:

- Information about self harm.
- Guidance on responding to an incident of self harm.
- Information about strategies that can help reduce or prevent self harm.
- Information about the need for staff to seek support to help them deal with self harm incidents.

These guidelines are not intended as a treatment manual for self harm. Treatments for self harm involve specific psychological therapy approaches. There is some evidence to support the use of particular psychological interventions in treating self harm behaviour but such treatments should follow from a detailed assessment and formulation of the individuals treatment needs and should be conducted by a suitably qualified professional.

What is self harm?

Self harm is any act that involves the purposeful infliction of pain, injuries or wounds to oneself. The most common form of self harm is cutting, usually of the arms and wrists, although other areas of the body may be cut, including the face, abdomen, genitals, legs or torso. Other methods of self harm include biting, picking, gouging, scratching one’s skin, burning with cigarettes, setting fire to oneself, pulling one’s hair out including eyelashes and eyebrows, tying ligatures to attempt to hang or strangle oneself, punching, hitting or kicking oneself, head banging, inserting foreign objects into wounds or orifices, overdoses of medication, swallowing foreign objects such as batteries or pins, drinking toxic substances such as bleach or weedkiller.

Self harm is relatively common in mental health settings. Around half of women in secure mental health settings have some experience of self harm. The reason for this is that self harm is often used as a way of dealing with painful and distressing feelings and it is particularly common amongst people who have difficulty regulating their emotions and who experience frequent, frightening episodes of extreme distress.

Why do people self harm?

People harm themselves for many different reasons and an individual may harm themselves at different times for different reasons. Sometimes there is no one reason for an episode of self harm and there may have been an accumulation of relatively small events that have gradually increased the level of distress the individual is experiencing.

People who harm themselves have usually experienced difficult or painful events or circumstances in their lives that continue to cause major distress. Self harm can be a way of coping with these experiences.
People who self harm often have had particularly traumatic experiences in childhood. This can include severe emotional or physical neglect, loss or frequent changes in caregivers, sexual abuse, living with parents with significant substance misuse or mental health difficulties or other forms of victimisation.

Self harm may also be a response to traumatic events in adulthood such as domestic abuse, sexual abuse or assault, losses and separations.

People who harm themselves often say it brings relief from overwhelming feelings; others say it is a way of releasing tension or reaching a state of feeling soothed; others say it is a way of putting into action feelings they don’t have words for; some say that turning emotional distress into physical pain somehow makes things easier to deal with. At times self harm may seem the only way a person has of gaining some control over some aspect of their lives, or may be a way to punish themselves at times of feeling overwhelmed by feelings of guilt or shame. For people who feel numb or dead inside, self harm can make them feel aware of themselves and alive. For people who feel dirty or contaminated inside self harm may feel like a cleansing.

There are very many reasons why people self harm. The important thing to remember is that each person has their own story and for some people, who cannot easily communicate that story, self harm can show us something of the pain and distress they feel inside.

**Are people who self harm trying to kill themselves?**

There is a strong link between self harm and suicidal behaviour. Self harm is often associated with suicidal thoughts and feelings and people who have histories of self harm are at increased risk of suicide. However, there is often a crucial difference between acts of self harm and attempted suicide. People who self harm and especially those who do it regularly often use it as a way to reduce suicidal feelings and to cope with their distress. Often there is no intent to kill themselves. However, some self harm behaviours could be inadvertently lethal and people’s motivations may change over time. Therefore it is important that we try to understand the person’s needs and motivations when they self harm and to understand what may result if self harm behaviour is not attended to promptly. Whenever a person is expressing thoughts of self harm, has recently engaged in an act of self harm or has a history of repeated self harm suicide risk should be monitored.

**Indicators of suicidal intent**

- The person expresses the wish to die or the intention to kill themselves.
- The person expected the act to cause death (even if the self harm was not in fact lethal).
- The person is disappointed to be alive. This increases the risk that the person will try to kill themselves again in the near future.
- The person made concrete plans (e.g. left a note or arranged for their possessions to be dealt with after death).
- The person took precautions not to be found.
- The person planned the act for at least several hours.
• The person feels hopeless about the future and believes things can’t get better.

If a person is clear that their self harm was an attempt to deal with their problems and that they did not intend suicide, and particularly if the method of self harm is not likely to be lethal then it may not be appropriate to place the person on close observations following an episode of self harm. However, it is important to provide support to try to understand the reasons for the self harm, manage any further crisis and attempt to find strategies to help the person avoid self harm. And, suicidal intent will need to be reassessed at appropriate intervals.

Amongst people with histories of repeated serious self harm and suicidal behaviour, suicide risk is increased when the intensity of support is reduced. There is evidence that ongoing support reduces suicide risk in such individuals. Therefore plans to reduce supervision observation levels or intensity of support should include a formulation of the reduced risk of self harm and what contingency plans are in place to ensure subsequent increases in risk of self harm are to be monitored and responded to.

What should you do when someone self harms?

1. First actions need to be about immediate safety
   This is both for yourself and for the person who has self-harmed. Check the immediate environment. For example:
   • Is there blood around?
   • Is there a weapon visible?
   • Is there a live electrical source? Etc.

   Call for assistance before you do anything else.

2. Intervening to prevent an act of self harm
   A patient should not be physically restrained to prevent an act of self harm. In exceptional circumstances it may be considered necessary in order to preserve life. Any physical intervention should follow these general principles:
   • It is safe for staff, the patient and other people in the vicinity, to make a physical intervention AND.
   • There are sufficient numbers of trained staff available to safely intervene AND THEN ONLY IF.
   • The self harm behaviour is likely to have immediate lethal or extreme consequences if you did not intervene OR.
   • The self harm is frenzied or repetitive and occurs outside of the patients known pattern of behaviour, OR.
   • In exceptional circumstances the patient may have a care plan that indicates the use of physical intervention to prevent self harm. In such
cases physical intervention should follow the specific guidelines contained in the care plan.

3. **Immediate crisis management**
   At all times the patient should be treated with respect and care. They should be treated as someone communicating distress and not as someone who is attention seeking, being manipulative or wasting staff time.

   It is vital to talk to the person who has self-harmed. Even if they appear to be unconscious they may be able to hear your voice. Try to be reassuring and calm; if appropriate, ask if they have done anything else that is not immediately visible. When injuries are severe and life threatening referral to A and E would normally be required.

   If there is any danger to life, resuscitation should be carried out ensuring that airways are clear, breathing is taking place, circulation is adequate, there is no excessive bleeding, there is no immediate risk from flames, and that burns (whether from heat or chemicals) are irrigated with cold water. Death from asphyxiation from a ligature around the neck can occur very quickly or may take several minutes. Resuscitation, oxygenation, and heart massage should commence in all cases even if rigor mortis has developed and must continue until a medical officer states otherwise or the patient is taken to hospital by paramedic staff.

   For infected wounds the use of antibiotics should be kept to a minimum with good hygiene and antiseptic dressings instead where possible.

4. **First Aid**
   Being prepared and able to take speedy action really can save lives.

   Preparation is the key to success. It is essential that you:
   - know where basic first aid equipment is kept
   - know how to use it
   - ensure that the equipment is in full working order
   - ensure that the equipment is easily and quickly accessible.

   Recommended minimum equipment:
   - Disposable rubber gloves (good supply)
   - Safety glasses
   - Face mask with non-return valve
   - Dressing packs and pads
   - Ligature cutting tool.

   Ligature cutting tools should be kept securely, in a prominent position, in an area easily accessible to all staff.

   Keep your Hepatitis B inoculations up-to-date. Blood borne viruses can be contracted whenever an open sore or cut on your hand or other part of your body comes into contact with the blood or bodily fluids of another person. This is true whether the person bleeding is a nurse, patient or a bishop! However, some people’s lifestyles make them particularly at risk of contracting such infections. For example, people
who inject drugs are much more likely to contract Hepatitis B or C than those who don’t. So it is essential to keep your inoculations up-to-date and also that you wear gloves before treating someone who is bleeding.

5. **Know your ABC – airway, breathing, circulation**
The top first aid priority is to maintain the individual’s airway, breathing and circulation

Where an individual is not breathing, artificial respiration should be commenced and continued until the patient is breathing unaided or transferred to hospital.

This is most commonly needed in cases of hanging and self strangulation, but may be required for any method of self harm. Even in cases of severe external bleeding, attention should not be diverted from the ABC though efforts to staunch the bleeding should be made by applying pressure to the wound and elevating the wound if possible.

Place the individual on a flat surface; check that their airway is clear. Wearing gloves, feel in the mouth and remove anything (false teeth, food) blocking the airway with a finger. Then check that they are breathing by observing for rise and fall of chest as well as feeling for any expired air from the mouth. Check to see if there is a pulse either at the wrist or the neck. Where there is no sign of breathing and/or pulse, start cardio pulmonary resuscitation until specialist assistance arrives or the individual is declared dead by a member of medical staff.

6. **Call for help immediately but do not leave the scene**
In an emergency, you need to balance maintaining your own safety with the immediate needs of maintaining life.

Before entering a patient’s room consider what actions you need to take:

- Calm down. It is important that, when you talk to the individual (or to staff in the individual’s hearing) you avoid being judgemental or dismissive.
- Talk to the individual, if conscious, and attempt to get him/her to agree to your help.

Do not leave a distressed, self harming individual alone even to summon help (shout if necessary) as he or she may attempt further injury if left unattended.

7. **Cuts and lacerations: apply pressure to reduce bleeding**
Most incidents you are likely to come across will involve cuts and lacerations of the skin and underlying structures.

Minor injuries: These are superficial cuts or scratches, requiring cleaning and a simple dressing only.

Moderate injuries: Here there will be some blood loss, fairly deep incisions that require health care intervention but are not immediately life threatening. Stay calm, talk to the individual, wear gloves before you apply a secure dressing. Where there has been a loss of blood, lie the individual down and call a medic or the nurse practitioner. Don’t move the individual. Ligament and nerve damage may be present
even with relatively low levels of blood loss. This can have lasting repercussions for patient mobility and therefore medical advice should be sought.

Major injury: Here there has been a large blood loss, the individual may lose consciousness, the injury may be to an artery (blood spurting out) and the injury may be life threatening. Call for help, lay the individual flat, elevate lower limbs if upper injury. Wearing gloves, apply dressing and pressure to the bleeding points, continue to engage and talk to the individual.

8. Hanging: Support the body
   - Support the weight of the body to reduce constriction
   - With the assistance of a second person, cut the ligature, saving the knot if possible
   - Immediately remove the ligature from around the neck

9. Self-strangulation – release the noose
   Here one person can release the noose or ligature.

10. Overdose: do not make the patient vomit
    a. Where the individual has vomited, place him/her in the recovery position to prevent inhalation of vomit.
    b. Keep him/her warm and call for medical assistance.
    c. Do not attempt to dilute the ingested substances or make the individual vomit. This may cause further harm.
    d. Try to obtain information on the type and amount of substance taken, and the time of ingestion, either from the individual or from evidence in the room.

After self harm

After the immediate actions, there are some further issues to consider.

1. Talking to the person is vital
   Treat the person with respect and with humanity. You may be able to find out what is going on in their lives and why they have harmed themselves. By talking to them, you can remind them that there is another way of communicating their distress. You need to check out how they are feeling now (e.g. do they feel suicidal? relieved? ashamed?). The seriousness of the harm may not reflect the seriousness of the distress, particularly in someone who has not done it before. It is important to talk to them to find out if they are feeling suicidal now.

2. Ignoring or scolding someone can lead to further self-harm
   Treating someone in a punitive way often leads to further self-harm because the person may feel a continued need to punish themselves if they feel bad about what they have done. It will not help to break the cycle.

3. Giving attention does not increase the likelihood of further self-harm
Giving them attention is not going to increase the likelihood of further self-harm, but it may help you to find out what is going on in the patient’s life at the moment and it may lead her or him to feel that someone cares about what happens to them.
4. Do not expect to stop someone from self-harming
You are unlikely to be able to stop someone from self-harming if that has become a regular coping method, but you may be able to help them to find other ways of coping. It is important, both for yourself and for the person who has self-harmed, that you be realistic about what you can achieve.

6. Follow the guidelines in the patients care plan
Any patient with a history of self harm should have a written care plan describing what is understood about the patients self harm, what strategies are being supported and what the patient’s goals are. If such a care plan is not evident or appears out of date, highlight this with the patients clinical team.

7. Take steps to safeguard the environment, limit access to the means of self harm
In negotiation with the patient, the nurse in charge, members of the clinical team, and in line with any care plans, steps should be taken to evaluate the potential for reducing risk of further self harm by limiting access to the means to self harm. This may involve removing items from a patient’s bedroom, asking the patient to give up items they may have on their person that they might use for self harm, removing items from communal areas of the ward, increasing observation or escort levels or restricting access to certain environments. Such measures should be regularly reviewed along with reviews of the patient’s ongoing risk of self harm.

8. Incident reporting
Every episode of self harm and the interventions applied need to be accurately recorded on a Trust incident form. Forms should be presented to the patients’ clinical team to agree the recommendations for managing self harm.

9. Find ways of managing your own feelings and reactions to self harm incidents
Self harm can evoke strong feelings in people who work with those who self harm – both positive feelings of wanting to help and strong negative feelings. It is important to have somewhere to talk through your own feelings so they do not affect your attitude to the person self harming. Your feelings may well mirror those of the person who has harmed themselves and by sharing your feelings it can help you reflect on and try to understand the patients own feelings and motives. Make sure you use the support of your clinical supervisor on a regular basis, talk over the issues with colleagues on the ward and other members of the patients’ clinical team.

Duty of Care
- We have a legal duty of care towards all patients: we are required to take all positive steps to protect a patient.
- In presenting safer self-harm strategies, we may be at risk of being seen as ‘encouraging’ self-harm.
- Any perceived act of encouragement may be legally challengeable, under the Human Rights Act, as a failure to act in accordance with our duty of care
- Therefore we need to take care when giving advice about safer strategies: that they are clearly preventing or reducing risk.
- Any strategies proposed must be included in the patients’ care plan.

NB. Also be aware of Trust policies on Resuscitation and Inoculation Injuries.