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evidence summaries to support
social services in Scotland

June 2013

understanding suicide and self-harm amongst children in care and care leavers

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Key points

- Children in care and care leavers are at increased risk of hurting themselves as a result of adverse backgrounds and continuing stress.
- Self-harm helps manage distress whereas suicide attempts to stop distress by ending life. Young people self-harm or contemplate suicide for many reasons and every individual's motivation will be different.
- Young people hurt themselves in many different ways. These may be completely invisible to those around them.
- Responding to underlying distress is more important than focusing on stopping the self-harm. Excessive control and the removal of implements may make things worse.
- Professionals and carers should be alert for suicidal thinking or plans.
- Responding to suicidal or self-harming young people is the responsibility of several agencies. Multi-agency policies, guidance and recording should be in place.
- Mental health services may respond best by enabling adults closest to young people to help them understand and manage their distress.
- Self-harm and suicidal behaviour should be taken seriously. Assessment is essential but should focus on the needs of young people as well as their current level of risk.
- Opportunities to address the impact of suicide and self-harm should be available to all those affected, including other young people.

Introduction

Self-harm and suicide are complex issues which arouse difficult and distressing emotions both within people who hurt themselves and those who love and care for them. When children hurt or try to kill themselves, adults responsible for them often feel confused, powerless and overwhelmed. If these children are looked after away from their families then all the professionals involved with them must be able to provide them with the understanding and support they require. Examining the research and literature about self-harm and suicide is an essential element in developing understanding. Many important studies reported in this paper are quantitative or have been undertaken from a medical perspective but in reviewing them it is important to maintain a focus on the pain and emotional complexities for all involved.

Definitions of suicide and self-harm

The challenge of understanding and responding to self-harm and attempted suicide is exacerbated by the number of different terms describing the phenomena and the lack of precision with which they are used. Clearly the act of 'suicide' involves a deliberate intent to end life but other forms of self-harm are not consistently defined. Until recently any serious non-fatal act of self-harm was often perceived as a failed suicide attempt. Self-harm is intrinsically more difficult to define than suicide.

An important factor in understanding an act of self-harm is to establish the underlying intent but most terms do not distinguish among acts where the individual has a fixed determination to die, where there is ambivalence about survival and where self-harm is a way of regulating negative emotions. The term 'Non Suicidal Self Injury' (NSSI) is an attempt to differentiate about intent but it fails to include self-harm through overdosing. There is sometimes a lack of agreement about which behaviours should be included within the category of deliberate self-harm. Some studies or policy initiatives only include self-poisoning or self-injury (such as cutting, burning, hitting) and others may include both. Other types of behaviour such as eating disorders, drug or alcohol misuse or 'risky behaviour' can also sometimes be conceptualised as deliberate self-harm.

This lack of precision makes it difficult to identify clearly risk and protective factors for different forms of self-harm and appropriate ways to support people. Calculating the prevalence of self-harm accurately is difficult partly because of these definitional difficulties but also because self-harm is measured and reported in a variety of ways.

The definition adopted here is that used by the Royal College of Psychiatrists: non-fatal self-harm is 'an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent' (Royal College of Psychiatrists, 2010:6). This definition echoes that of the National Institute for Clinical Excellence (NICE) Guidelines (National Collaborating Centre for Mental Health, 2011) and the most recent Scottish Government work on responding to self-harm (Scottish Government, 2011). This definition recognises that there may be many different motives for self-harm and that a wish to die is not the only or central one.

Policy Context

Self-harm and suicide in Scotland

In the year 2009/2010 almost 13,000 admissions took place to acute hospitals in Scotland to treat self-harm (Information Services Division, 2012). Community surveys, however, suggest that only a fraction of people who deliberately hurt themselves attend hospital Accident and Emergency departments, so this figure does not represent the true level of distress within the community. One such community survey, a study based on anonymous questionnaires completed by 15 and 16 year old pupils in Glasgow and Stirling, found high levels of self-harm, with almost a fifth of girls acknowledging that they had hurt themselves or taken an overdose in order to manage difficult feelings at least once (O'Connor et al, 2009).

In the early 2000s it became clear that Scotland had a much higher suicide rate than the rest of the UK, and that the rate of increase in suicide was higher than for other European countries. As a result Choose Life, the national suicide and self-harm action plan was launched[1]. During the last decade Choose Life has organised numerous suicide prevention training programmes such as Applied Suicide Intervention Skills Training (ASIST). Based on three-year rolling averages there was a 17 per cent fall in suicide rates between 2000-02 and 2009-11 but around two people per day still die from suicide in Scotland. Although the initial focus of Choose Life's work was suicide, in 2009 the National Self-harm Working Group was established. This group emphasised that self-harm reflects an underlying distress and that helping people to manage distress in alternative ways can prevent them adopting self-harm as a strategy or enable those who do hurt themselves to reduce or stop their self-harm.

Choose Life works at both a national and local level and several local multi-agency guidelines and protocols for practitioners have been created throughout Scotland outlining the appropriate actions and pathways to be taken when faced with a young person who may be suicidal or self-harming. Many are based on the Tayside guidelines which were developed after a cluster of young male suicides in Dundee in 2010[2]. These include contact details for both local and national organisations that can provide support to young people and their carers.

Children in care and care leavers

Because of difficult and in many cases traumatising backgrounds, children in care and care leavers are more at risk both of hurting themselves and completing suicide. A Glasgow council study suggested that almost half the children in their residential settings had harmed themselves deliberately (Piggot et al, 2004). All deaths of children in care in Scotland must be reported to the Scottish Government. An analysis of the figures collected by the Social Work Inspection Agency (SWIA)[3] shows that at least two children in care have died from suicide every year since 2000. There is no legal requirement to report care leaver deaths but there is evidence that the number of suicides among care leavers is much higher than among those still in care (Cowan, 2008). Heightened awareness of the risk of suicide for children in care prompted SWIA and Choose Life to produce a suicide prevention guide.

Evidence from research

Although there is extensive research on self-harm and suicide, very little focuses on children in care and care leavers and this is highlighted within the Scottish Government literature review on suicide and suicidal behaviour (McLean et al, 2008). This means that it is necessary to extrapolate research findings about suicide and self-harm from the wider population to young people with a care background. Although such extrapolation can be problematic, the general risk factors highlighted within the wider population have been shown to

1 www.chooselife.net

2 http://www.pkc.gov.uk/CHttpHandler.ashx?id=1090&p=0

3 Since 2011 SWIA has been succeeded by The Care Inspectorate which has combined the responsibilities of three separate regulators; Care Commission, Social Work Inspection Agency (SWIA), Her Majesty's Inspectorate of Education (HMIE). The Care Inspectorate has taken over the responsibility of reporting on the deaths of looked after children.

exist among children in care at a higher level than their peers which justifies this approach.

Prevalence

An international study involving 30,000 young people across Europe identified high levels of self-harm among teenagers in all seven countries concerned (Madge et al, 2008). Girls were more than twice as likely to hurt themselves as boys and many young people did not seek medical assistance. High levels of self-harm were also reported by the Avon Longitudinal Study of Parents and Children (ALSPAC) birth cohort (Kidger et al, 2012).

Internationally suicide is the third most common cause of death for people aged 15-24 and 100,000 adolescents kill themselves worldwide every year[4]. In the UK, although the suicide rate in this age group is relatively low, there are signs that the reduction in the number of suicides has halted in recent years[5]. Suicide is a common cause of death in young people and more people under the age of 35 die as a result of suicide than in road traffic accidents. Completed suicides in young adult men in Scotland represent a fifth of all suicides in this age group in Great Britain which means that the suicide rate for young men in Scotland is around five times that of England and Wales.

Some research suggests that children who have experience of care are not only more likely to hurt themselves but are also at greater risk of both attempted and completed suicide than their peers (Hjern et al, 2004; Vinnerljung et al, 2006). Only a few robust studies focus specifically on these children and young people, but research that examines risk and protective factors for self-harm or suicide, indicates that the background and current circumstances of children in care and care leavers leave them very vulnerable to these behaviours.

Motivations for self-harm and suicide

In the population studies discussed above (Madge et al, 2008; Kidger et al, 2012), the connection between self-harm and suicide was complex and difficult to untangle. Most commonly self-harm was used for the relief of intensely difficult feelings and a desire for punishment, but many young people also expressed a wish to die. In the ALSPAC study (Kidger et al, 2012), however, although many young people described suicidal thoughts they were not necessarily hurting themselves with the intention to die. Moreover a few young people had experienced suicidal thoughts and had planned to kill themselves but had never self-harmed. Suicidal intent was more common among young people who took overdoses than those injuring themselves. Suicidal intent increased with the frequency of self-harm though it is not clear whether this increase was associated with greater distress or because self-harm made it easier to undertake active suicide attempts. Although the main reason given for self-harm was relief of negative emotion, this was not always successful, especially for those who had overdosed. In contrast Klonsky (2009), who studied young adults who cut themselves, reported that his participants described overwhelming sadness and frustration before self-injury and a sense of relief and calm afterwards. He postulated that the effectiveness of the release was in itself likely to reinforce the behaviour.

Evidence from young people already known to self-harm expands our understanding of the functions of self-harm. Research undertaken by NCH (Bywaters and Rolfe, 2002) identified reasons given by young people to explain why they began or continued harming themselves. These fell into three categories: managing events; managing emotions; and contextual factors. Several interviewed had a care experience during childhood or adolescence. Many young people described past abusive and traumatic experiences that they were still struggling to manage, while others were experiencing extreme stress or difficulties in their current lives. Some were clear that self-harm was, for them, a way of dealing with stress and acted as a safety valve that could at times prevent suicide. Young people also described using self-harm as a way to regulate difficult feelings. Many described the sense of release involved in letting all the badness out of their bodies or converting unendurable emotional distress into a more manageable physical pain. Others felt that they could achieve a brief escape through the self-harm. Profound feelings of self-hatred led some young people to hurt themselves because they believed they deserved punishment. Where young people had experiences in which they had been unable to exercise control over their own lives or bodies, they sometimes used self-harm to take back a sense of control. When professionals had attempted to prevent them engaging in self-harm by removing implements or undertaking intrusive monitoring, these young people had reacted by hurting themselves in covert ways in order to regain control.

For some, the experience of self-harm was not only associated with reducing negative feelings but also with enjoying positive ones. Some described an adrenaline rush or high when they hurt themselves; others talked about the warm soothing feeling of blood on their skin after cutting. For a few young people there was an acknowledgment that their

4 www.iasp.info
5 www.poverty.org.uk/37/index.shtml

self-harm had become a habit and that it was escalating in severity. Self-harm was generally described as an intensely private activity and certainly not attention-seeking or manipulative. Some explained, however, that at times it could communicate the distress they were experiencing when they could not put this into words.

Contextual factors also played a part in initiating or maintaining self-harm. Some felt that within residential settings self-harm had become routine or normal and an acceptable way to express distress or to communicate needs. Others felt that being with friends who self-harmed prevented them adopting alternative ways of dealing with stress. Social factors also contributed to some self-harm, particularly when an identity based on ethnicity, disability or sexuality evoked negative responses from others.

Barton-Breck (2010) argues that self-injury (direct damage to bodily tissue) is a multi-functional behaviour. In adolescence the primary functions of self-injury are to relieve emotional distress, or to alter or reduce dissociation, and for some people to achieve a balance between these two opposite but distressing states. He also suggests that prolonged and established use of self-injury, particularly as adulthood approaches, can lead to more generalised secondary functions, such as increasing concentration by removing distracting thoughts or gaining empowerment and control.

Many of his participants had tried alternative problematic methods for dealing with distress, such as alcohol or drugs, but had returned to self-injury as it was more effective for them. Even when their situations improved and they adopted more socially acceptable methods of regulating their negative emotions, some participants chose to continue to self-injure though at a reduced level.

Suicide is often associated with mental health difficulties, particularly mood disorders, but it is still important to understand the message behind suicidal behaviour and the processes leading to completed suicide. Granello (2010) suggests that, although every individual has a unique set of personal motivations, it is possible to identify three core categories: avoidance; communication and control. Suicide may be perceived as a rational and realistic option to avoid ongoing overwhelming distress or to avert impending intolerable experiences. It may also be an attempt to convey to others the depth of pain or despair the individual is experiencing. Finally it may be a way of taking control in a powerless situation – whether the attempt is to control others or to regain control of one's own destiny. Joiner (2005) suggests an interactive model to explain how people are able to overcome the drive for self-preservation and attempt or complete suicide. He outlines the notion of 'perceived burdensomeness', where people believe their death will benefit those close to them, and 'thwarted belongingness' where there is a sense of alienation and no close connections. He believes, however, that these distressing states are not sufficient to overcome the commitment to life unless people have acquired the capacity for 'lethal self-injury'. One way this can occur is through repeated episodes of self-harm which can both reduce fear and inure individuals to pain. Exposure to others killing themselves may work in a similar way and this certainly appears to increase risk for young people (Hawton et al, 2012). In some well publicised cases the suicide of friends or of other young people within the care system appears to have influenced some young people in care to attempt or complete suicide.

Stopping self-harm

In many cases self-harm may be a short-term response to transient difficulties (Young et al, 2007) or it may be an age limited behaviour which stops as young people move into adulthood (Hawton et al, 2012). In one Scottish study some young people explained that stopping was associated with gaining purpose or in realising the impact their behaviour had on others and feeling uncomfortable or "stupid" about it (Young et al, 2007). Among a group of hospital patients three explanations were offered for their cessation of self-harm. Many explained that as their chaotic lives improved they no longer needed to self-harm. Some found that abstaining from alcohol had reduced the urge to self-harm, while others had recognised the importance of their own mental health difficulties, particularly depression, and having medical treatment had resolved their self-harm (Sinclair and Green, 2005). In most studies, help from health professionals that focused on self-harm had limited impact on the decision to stop. There was, however, some evidence that having space and time from trusted friends or adults to talk and feeling accepted were often key to enabling people to stop self-harm.

Understanding risks

People who harm themselves and people who attempt suicide share the experience of emotional distress. They may have suffered similar difficult backgrounds and be struggling with comparable stresses in their daily lives. There is considerable evidence that certain adverse experiences, particularly in childhood, are associated with a higher risk of both self-harm and suicide for young people (Hawton et al, 2012). Childhood abuse, family discord, loss, exposure to suicide or self-harm within the family and homelessness all increase the risk of young people hurting themselves or attempting suicide. Current stressors such as relationship breakdowns, bullying and social isolation also increase the risk of self-harming and suicidal behaviour. Hawton et al (2012) also emphasised that some young people who hurt themselves were unable to develop alternative adaptive problem solving skills or achieve well educationally and demonstrated high impulsivity and aggression. Excessive alcohol consumption

and smoking are also associated with greater risk for self-harm and suicidal behaviour. These risk factors are all common among children in care and care leavers, whose backgrounds typically include severe trauma and family difficulties, and whose experiences growing up, both at home and in the care system, can limit opportunities for healthy emotional, social and cognitive development.

Self-harm is not in itself a mental disorder, and indeed may be an adaptive response to severe distress. Nevertheless, the level of diagnosable mental disorders among young people with self-harming and suicidal behaviours is elevated and there is clear evidence that this is true for children in care too (Meltzer et al, 2004). This poses a further risk to children in care and care-leavers, particularly as we know that mental health problems increase as young people face the difficulties of leaving care and moving towards independence (Stein and Dumaret, 2011).

In their review of adolescent suicide and self-harm, Hawton et al (2012) identify three groups of young people who may go on to complete suicide: those whose previous life problems and developmental difficulties have placed them at risk; those living with what would be categorised as major mental disorders; and those for whom suicidal behaviour is a response to a more immediate stressor. The backgrounds, mental and emotional difficulties and current life experiences of many children in care and care leavers, mean that they could fit in to one or all these groups.

Risk factors for self-harm and suicide cannot reliably predict either which young people will self-harm or those who will go on to complete suicide. Further, there is evidence that the level of suicidal intent involved in self-harm may vary quite significantly for individuals within a short space of time (Granello, 2010). The most significant risk factor for suicide is previous self-harm and this is not limited to episodes of overdosing but also includes behaviour such as cutting. The complex relationship between suicide and self-harm, and the fluidity that is evident in suicidal intent, means that assessment should never be confined to simple risk tools nor should assessment at one point in time be assumed to be valid even shortly afterwards (Granello, 2010; Royal College of Psychiatrists, 2010).

There is therefore no reliable, simple screening tool for suicide. There are, however, additional warning signs to be aware of, particularly in a high risk group such as children in care and care leavers. Some of these signs may also be indicative of depression such as feeling hopeless, changes in sleep or appetite, loss of interest in previously important activities, reductions in self-care and social withdrawal. Others may include talking or writing about suicide or death which may include a fascination about people who have killed themselves, giving away important personal possessions or finishing off important emotional or practical business. None of these automatically signal suicidal intent and indeed some young people may attempt suicide without giving any indication of their internal distress, but it is estimated that 90% of adolescents make some attempt to communicate their intentions (Granello, 2010). Adolescents are more likely to tell a friend than a parent or professional if they are contemplating suicide, but few young people said that they would tell an adult if a friend had confided their suicidal intent to them.

Protective factors

Some protective social factors have been found to mitigate risks of suicidal behaviour (Mclean et al, 2008). Positive family experiences, strong connectedness to school and good peer relationships can protect young people who may otherwise be at risk of suicide. In addition, the emotional and cognitive skills possessed by young people themselves can help them to manage adversity more effectively, without engaging in self-harming or suicidal behaviour. Problem solving skills such as self-control, self-efficacy and positive future thinking can be protective. This information can provide staff and carers with a potentially helpful starting point in supporting young people, but many children and young people enter care with few of these protective factors and, for some, their experience of care does little to change this. For many care leavers their accelerated transition to independence rips away the social connectedness they may have achieved during their time in care and exposes them to challenges that overwhelm their problem solving skills.

Assessing risk

Only a small fraction of young people who harm themselves will eventually complete suicide. Similarly very few young people who think about killing themselves will go on to do so. Nevertheless all those concerned with caring for, or working with, traumatised and distressed young people are faced with assessing the risks that they pose to themselves, in particular permanent disability or death.

The research outlined above provides considerable information about the risks, protective factors and warning signals that are associated with suicide. Moreover there are other social factors such as age, gender, ethnicity, employment status or sexual orientation that also affect the risk of completed suicide. None of this, however, enables professionals to decide in individual cases whether a person will attempt suicide. Several risk assessment tools exist but all professional guidance counsels against the simplistic use of such tools and recommends that a full bio-psycho-social assessment be undertaken for all people presenting at emergency departments for self-harm. This should include an assessment of need as well as risks and protective factors (National Collaborating

Centre for Mental Health, 2011; Royal College of Psychiatrists, 2010). An assessment of need can lead to a therapeutic approach which addresses the pain and distress behind the self-harm and can help the individual develop more effective problem solving capacities and a more positive experience of life. A focus solely on risk might reduce the immediate danger of suicide but does not address the underlying difficulties and may make suicide more likely by increasing the sense of alienation and disconnection.

Granello (2010) points out that effective suicide risk assessment is a complex, collaborative and ongoing process. Ambivalence about living or dying often confuses assessment of risk, although it does provide a therapeutic opportunity to strengthen life-choosing motivation. Involving other people to ensure the safety of the individual and to provide a fuller picture of their external circumstances and internal world can be very important. Failure to listen carefully to the concerns of those close to young people is often apparent in Fatal Accident Inquiry reports. Consultation with colleagues may also enhance assessment and provide a useful corrective for practitioners to their own theoretical or therapeutic tunnel vision. Granello (2010) also emphasises the importance of asking direct, if difficult, questions about the desire to die and taking any expressions of suicidal intent very seriously. Importantly she recognises that any assessment should in itself be the beginning of support and treatment and can be a therapeutic experience. In addition she strongly recommends a rigorous recording process that ensures quality of assessment and also provides accurate information for any future professionals working with the individual. Failure to record self-harm and suicidal behaviour rigorously has frequently been commented on both in formal enquiries and in retrospective research after the suicides of young people (Cowan, 2008).

Many children in care and care leavers are known to self-harm and to have several of the risk factors associated with suicide. This can create difficulties in maintaining a balance between over reacting to transient though intense distress which may be manageable and under reacting to more subtle but serious difficulties where young people may need professional help and protection. Many practitioners report that even when young people are supported to seek medical help, they may be perceived as already being in receipt of a professional service and be discharged more readily than their community based peers.

Balancing support and protection

Research undertaken in Canada (Ranahan, 2011) identified a powerful dynamic that emerged when child and youth care workers were faced with the possibility of a suicidal young person. This involved trying to manage a tension between emotional and physical proximity to the young person and engaging in more distant behaviours located at the perimeter of the service, which involved attempting to appraise risk and seek out protection from others for the young person. A series of practices were identified that ranged along a continuum from close emotional connection to distant defensive protection:

- *being with* - maintaining an engaged, attuned and closely connected involvement with the young person
- *building supports* - practitioner and young person working together to identify and strengthen supports among significant people
- *detecting* - actively using pre-existing knowledge about the young person and of risk and warning signs to ascertain if suicide was an issue
- *appraising* - using protocols or tools to determine the seriousness of risk
- *flooding the zone* - communicating concerns about the young person to managers and other external professionals usually unknown to the young person
- *watching* – monitoring, with the purpose of intervening to prevent the young person hurting themselves

The struggle to maintain a balance between these caring and defensive practices was often ineffective. A number of factors including the level of support from supervisors, the workers' own arousal, agency policies and suicide-specific training moved them towards the perimeter end of the continuum where they focused on preventing harm rather than on their relationship with the young person. It is clearly important to create a protective plan for a potentially suicidal young person which involves appropriately qualified professionals. Losing sight of the importance of caring responses such as being with and building supports, however, can risk rupturing relationships with the young person. Rather than protecting them this can leave them feeling dangerously isolated and abandoned and can increase rather than alleviate the risk of suicide.

Interventions

Until fairly recently the management of self-harm involved one of two approaches. Either the self-harming individual was seen as suicidal and in need of protection and control, or the behaviour was seen as attention seeking and should be ignored or punished. Both responses focus more on stopping the behaviour than on understanding its meaning and responding to the underlying distress. Although elements of both these responses persist among practitioners and within policies, there has been a considerable shift in approach that is echoed in the professional and research literature. For example the National Self–Harm Enquiry (Mental Health Foundation and Camelot Foundation, 2006) was told of the Crisis Recovery Unit at the Bethlem hospital. This in-patient unit operates a philosophy that allows individuals to retain responsibility for their behaviour even if this involves self-harm. Whilst not condoning self-harm, this preparedness to accept therapeutic risk is based on the understanding that removing all implements that could be used for self-harm leaves young people less prepared to engage in the therapeutic process. The same report emphasises that dealing with young people who hurt themselves requires the same core values and skills that underpin all effective therapeutic work. Duffy (2009) emphasises that as there are no treatments shown to reduce self-harm the focus of intervention should be on identifying and responding to the underlying difficulties that the person experiences.

For young people who are asking for support to reduce or stop their self-harm, there are two different levels at which this needs to be approached. Longer term, support to deal with the underlying difficulties is essential but distraction techniques and cognitive behavioural methods may help young people control the immediate urge to self-harm. The Royal College of Psychiatrists has produced a useful guide that could be helpful to practitioners working directly with young people who wish to gain more control over their self-harming behaviour[6].

Many services are now adopting a harm minimisation approach which recognises that self-harm may be an effective coping mechanism for distress and focuses on reducing damage and avoiding unintended lethal outcomes. This approach poses ethical and legal dilemmas for professionals but there have been some pro-active attempts to address these. For example a handbook outlining alternatives to self-harm was developed by Selby and York Primary Care Trust which included harm-minimisation advice (Pengelly et al, 2008). The Trust consulted widely with people who had self-harmed, colleagues from other Trusts, professional associations and the legal profession. The responses they received confirmed their decision to include harm-minimisation as part of a comprehensive approach to supporting patients who self-harmed. In adopting a harm-minimisation approach, however, it is essential to communicate to people who harm themselves that there is no safe level for self-poisoning.

There is tension in working with people who self-harm between the wish to maximise their choices and respond to their distress and the pressure to protect them by controlling their behaviour. This is particularly problematic for professionals working with children and young people because their age is deemed to leave them requiring additional protection. For those caring for children away from their birth families, this tension is particularly acute as they may be open to scrutiny and criticism by regulatory bodies, media and families if they are perceived to be failing to protect children. As has been discussed above, however, removing implements and intrusive monitoring can evoke a determination from individuals to continue self-harming covertly. It can also cut them off from the opportunity to develop a therapeutic alliance with professionals in which the underlying distress can be addressed.

Even where people have been assessed as at imminent risk of suicide, there is evidence that such controlling and protective behaviours can be unhelpful. Several studies have been undertaken exploring the phenomenon of constant observation in psychiatric facilities, where patients are continuously monitored, in some cases not allowed further than an arm's length away from the professional observing them (Fletcher, 1999; Cutcliffe, 2002). These showed that far from being therapeutic and protective, many patients experienced this as frustrating, intrusive and actively encouraging the desire to self-injure. Moreover even with such close observation numerous suicides occurred while people were in-patients in psychiatric hospitals. When constant observation was dismantled and a more care orientated approach instituted, self-harm, violence and aggression all reduced and suicide levels did not increase. Although the evidence points to reducing control over people who self-harm and focusing more on alleviating distress, individual practitioners need to be supported in this approach by clear organisational policies and guidelines and robust recording mechanisms.

6 www.rcpsych.ac.uk/PDF/Self-harm Distractions and Alternatives FINAL.pdf

Suicide Prevention

Suicide is often perceived as a public health problem because it is the cause of so many preventable deaths. Efforts to reduce the suicide rate have included better identification, reducing stigma around mental illness and extensive suicide prevention training aimed both at the general public and relevant professionals. The research literature now provides information about risk and protective factors. In particular, the importance of previous self-harm as an indicator of increased risk and the strong association between mental illness and suicidality provide clear bases for improved identification of people at risk of attempting or completing suicide. Campaigns such as *See Me* in Scotland challenge negative stereotypes of people with mental health difficulties[7]. Education about suicide is rarely a core element in professional qualifying training (Ranahan, 2011) but programmes such as ASIST and SafeTALK have increased the knowledge, skills and confidence of professionals dealing with people who may be suicidal (Griesbach et al, 2008). Despite these improvements, however, there is no incontrovertible evidence that public health based suicide prevention is effective.

A recent report from the Northern Ireland Commissioner for Children and Young People (Devaney et al, 2012) emphasised that the roots of adolescent suicide can often be found in the early trauma experienced by young people. The authors argue that the failure of health and social care services to intervene early enough in a child's life and the focus on managing immediate risk rather than planning for longer term outcomes, ultimately led to the deaths of young people during their adolescence. They also point out that these risks continue into adulthood and may well be implicated in much self-harm and many suicides later in life. This reinforces work on adult care leavers that showed that traumatic experiences prior to and in care had adverse ramifications well into adult life (Duncalf, 2010). Robust early and effective support for struggling families and traumatised children may be the most effective form of suicide prevention for children in care and care leavers.

The impact of self-harm and suicide on professionals and carers

The emotional impact on professionals of working with people who self-harm is considerable and it can affect the service that is offered to people in distress. Many people attending Accident and Emergency departments following self-harm report negative experiences (Warm, Murray and Fox, 2002), yet this may be their first professional contact and a route to further help. Mackay and Barrowclough (2005) explored negative reactions from staff and identified that where self-harm appeared to be in the control of the patient or where it was an entrenched behaviour staff were less sympathetic and helpful. Where self-harm was perceived as uncontrollable, it elicited sympathy whereas when it was perceived as deliberate and controlled it evoked anger. In addition staff believed a successful resolution of frequently occurring self-harm was unlikely and this reduced their willingness to provide help.

Residential child care workers and foster carers can be profoundly affected by the emotionally demanding work involved in caring for children who may be in severe distress (Furnivall et al, 2006; Colton and Roberts, 2007). The specific effects of self-harm within residential child care are identified within one study undertaken in Ireland. This highlights the potentially traumatic impact both on adults and other young people of being exposed to a young person self-injuring (Williams and Gilligan, 2011). Managing the complexity of supporting both the young person who was self-harming and others living in the residential environment was seen as very challenging. Many workers experienced adverse personal and professional effects but had insufficient access to supportive reflective supervision and debriefing and few had been offered training on self-harm.

Although the impact of suicide in schools and work places is widely recognised (Mauk and Weber, 1991), there is virtually no literature that explores the impact of suicide on carers, workers and young people with an experience of care. The devastating effects of youth suicide on families is well documented but there appears to be little awareness of the shattering effect of the loss of a child or young person in an intense, emotionally connected community such as a residential setting or foster family. Moreover the grief that is experienced is complicated by the fear of scrutiny and criticism felt by staff and the profound anxiety of young people that they and the adults caring for them are no longer safe. There is literature that provides advice about crisis planning for suicide within school communities but nothing similar exists for residential child care communities.

"Efforts to reduce the suicide rate have included better identification, reducing stigma around mental illness and extensive suicide prevention training aimed both at the general public and relevant professionals."

7 www.seemescotland.org.uk

Implications for policy and practice

Responding to young people

Central to the effective and ethical response to self-harm is the importance of focusing on the pain and distress behind the behaviour rather than concentrating on stopping the behaviour itself. The initial response to self-harm should be non-judgemental and caring and staff and carers need to attend to both the physical needs and the emotional distress the young person presents. There should be less emphasis on control and the removal of all the means of self-harm should not be an automatic response. For some young people self-harm has become a coping mechanism which they believe enables them to manage their lives rather than to end them. If young people know that disclosure of their self-harm will involve vigorous attempts to control it, they may be unwilling to share their distress and harm themselves covertly which cuts them off from potential sources of emotional support. Some young people may want to reduce or stop their self-harm and removing the means to hurt themselves may be a relief, but this should be done in discussion with young people and with their full agreement. For those young people, however, whose self-harm may be a response to coercive control from adults, for example through sexual abuse, removing their self-harm tools may exacerbate their distress.

For young people whose self-harm is an established coping mechanism, discussing harm minimisation is important. It is important, however, to explain clearly that responses to drugs are different and there are no safe levels for self-poisoning. Some organisations working with adults provide self-harm kits for people who cut themselves. This is not an appropriate response to children or young people in care, though it is important to discuss cleanliness and wound care with those who self-injure. If young people are trying to overcome the urge to self-injure, then developing more adaptive ways to deal with their distress, for example, by helping them create a comfort box holding materials to sooth or distract them, can be very helpful. Many young people also find it useful to use diaries and visual ways to begin to recognise patterns in their own behaviour and thus to begin to exert some control over it.

The literature on risks and protective factors points to longer term interventions to prevent or reduce self-harm. Most of these are actually core tasks of residential workers and foster carers and it is important for professionals to understand that using their existing skills and working confidently, caringly and competently with young people helps address their underlying distress and difficulties. Many young people need to learn the basic self-regulatory skills that small children acquire naturally through their key attachment relationships.

Supporting positive peer relationships, both within the care setting and at school or work, combats the social isolation often associated with self-harm and suicidal behaviour. Success at school is a protective factor and helping young people to attend regularly and achieve their full potential both academically and socially is essential. It is not possible to remove the abuse, trauma and neglect that many young people experience. But supporting young people to manage and improve their relationships with their families is a key role for carers and workers. It is also essential, however, to recognise the relationships that exist within foster families and in residential communities. Young people can form genuine and secure attachments to adults caring for them which provide opportunities to resolve some of the underlying chaos and distress that plagued their earlier lives. Moreover relationships with the other young people with whom they share their living space can be very powerful. This can often be viewed negatively but adults can encourage the healing potential and reciprocal responsibility of relationships among young people. This is particularly important as we know that young people contemplating suicide are most likely to confide their intentions to a peer. Creating a positive culture where distress is talked about and understood by everyone can prevent some of the dangers of contagion within residential settings.

All self-harm and threats of suicide should be taken very seriously and not dismissed as attention seeking or manipulative. Even when the underlying intention of the behaviour is to communicate or potentially to influence others, the response from adults needs to be to explore the current triggers and the underlying distress rather than to punish or ignore. It is important that adults working with these young people are able to address difficult and frightening issues with them. In particular they need to be able to ask about suicidal intent and planning very directly and have a strong awareness of risk factors and warning signs. Although it is very important to communicate with others about a potentially suicidal young person, all those involved should ensure that any response does not remove the young person from close contact with trusted adults and friends. Any assessment should focus on the needs of young people as well as the risks they face and should lead to clear joint planning that includes the young person and where appropriate their family.

Stability and transitions

A sense of connectedness and belonging is protective against both self-harm and completed suicide. Children in care and care leavers often experience a massive amount of turbulence in their living arrangements. When change and transitions, whether planned or unplanned, disrupt important and comforting relationships this can greatly increase the risk that young people will hurt themselves. Young people should remain in the same placement wherever possible; if movement is unavoidable staff, carers and other young people should be able to remain closely in touch with the young person who has had to move. It is important that mental health services recognise that the transition from child to adult services is likely to coincide with moves to independence for young people in care. Appropriate planning needs to occur to ensure that young people are not faced with too many overwhelming changes simultaneously and important relationships and practical sources of support should be maintained for care leavers.

Staff and carer support

Looking after children or young people who hurt themselves or are suicidal is both frightening and emotionally distressing, and this can be overwhelming for adults both on a personal and professional level. Organisations have a responsibility to provide emotional containment for all those involved in dealing with self-harm. There should be regular training available and all adults should receive reflective supervision that addresses the impact of this work. If a young person has self-harmed a debriefing should take place as soon as possible after the event. Nobody should work in a policy vacuum around this issue and agencies should develop clear guidelines that support good practice rather than constrain it. It is helpful for residential child care or foster care providers to develop a crisis plan to follow in the event of a suicide.

"Young people should remain in the same placement wherever possible and if movement is unavoidable staff, carers and other young people should be able to remain closely in touch with the young person who has had to move."

Inter-agency working and early intervention

The responsibility for dealing with self-harm and suicidal behaviour among children in care and care leavers is shared among a number of agencies. Clear pathways and protocols should be in place so that young people receive a speedy, non-judgemental and effective response to their distress. For young people with mental disorders such as depression, early access to a responsive and supportive mental health service is essential. In some cases it may be appropriate for Child and Adolescent Mental Health teams to offer continuing external consultancy to those directly caring for the young person. Robust recording and monitoring measures should be in place, both within and across organisations. It is important to address issues of confidentiality, particularly as young people approach adulthood, but there should also be clarity about the need to protect and safeguard young people.

For most children in care and care leavers, self-harm is a reaction to intolerable distress that has its roots earlier in their childhood. There have often been multiple points at which professional intervention was inadequate or too late and children and families have been left alone to deal with trauma or overwhelming problems without support. Children encounter many adults in different professional roles as they grow up and all these adults have the capacity to recognise distress and intervene helpfully. All professionals working with children from infancy onwards should recognise that their capacity to listen to children, to tune in to their emotional state and to help ensure that their needs are met, is an essential element in the reduction of self-harm and the prevention of suicide.

"Clear pathways and protocols should be in place so that young people receive a speedy, non-judgemental and effective response to their distress. For young people with mental disorders such as depression, early access to a responsive and supportive mental health service is essential."

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Acknowledgements

This *Insight* has been reviewed by Helen Allbutt (NES), Greg Burgess (SAMH), Neil Macleod (SSSC) and Gordon Watt (Scottish Government). IRISS is very grateful to them for their input.

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