Scottish Journal of Residential Child Care: An international journal of group and family care experience

Volume 21.2

Self-Harm in Residential Care: A consideration of the evidence and the implications for practice

Lily Burnand and Dan Johnson

Abstract

Young people in residential care settings are disproportionately affected by self-harm. This has an impact on other residents and care staff as well as the young people engaging in self-harming behaviours. Research into the efficacy of care strategies in these contexts is scarce, which makes developing and implementing effective practice challenging. This paper reviews the existing literature to identify important themes for young people and residential care staff in relation to self-harm support and management, and to outline potential areas for further research and policy development.

Keywords

Self-harm, young people, staff, interventions, relational supports, practical support, talking support, professional support

Corresponding author:

Dan Johnson, Clinical Director, Kibble, Dan.johnson@kibble.org

Introduction

Self-harm is a growing healthcare concern in the U.K. generally, exacerbated by the COVID-19 pandemic and subsequent lockdowns (Farooq, Tunmore, Ali & Ayub, 2021). Although estimates of its prevalence vary, children and young people in residential care are known to be substantially more at risk than the general population (Johnson, Ferguson & Copley, 2017). Adverse childhood experiences and trauma are strongly associated with the development of self-harm and suicidal behaviours (Huntley et al., 2019), and many young people in care have experienced neglect, abuse, and other forms of maltreatment (Wadman et al., 2017).

Within care settings, incidents of self-harm have practical and emotional repercussions for the individual engaging in self-harm, and for the staff and other residents who work and live with the individual (Mendes, 2020). At the same time, staff attitudes and responses play an important part in the experience of the self-harming young person. A comprehensive framework of care that takes into account the needs of everyone impacted by self-harm is therefore crucial.

Definitions and scope

Self-harm is defined in the U.K. as an act of deliberate self-injury, regardless of intent (NICE, 2013). This reflects the fact that while self-harm is a strong predictor of suicidal ideation and suicide attempts, it is not always a precursor to suicide. The most common form of self-harm is cutting; other methods include burning, self-hitting, swallowing or inserting objects, and self-poisoning (NICE, 2013).

For the purposes of this study, the term ‘young people’ has been defined as people aged 11-21. This is because the development of self-harming behaviours largely begins in adolescence, and most young people leave residential care between 18 and 21 years of age (Wadman et al., 2017). Outside of the care setting, there is evidence that the experience and prevalence of self-harm differs

within and between groups, according to, for instance, race, gender, neurodivergence, cultural background, LGBTQI+ identification and socioeconomic status (for examples, see Cawley et al., 2019; Sharifi, Krynicki, & Upthegrove, 2015). Existing studies generally treat care-experienced young people as a homogenous group, limiting this article's ability to comment on differences between groups. How these differences manifest within residential care settings is undoubtedly an area in need of further research.

Much of the research regarding self-harm in young people focuses on the reasons, motivations, and functions behind self-harm, which are numerous and complex. While it is important for those supporting young people in residential care environments to remain up to date on this understanding, the implications for practice are essential if children are to receive quality care. The focus therefore of this review is on the practical support and organisational processes that can be implemented in a residential care setting.

Residential care encompasses the accommodation services provided to young people when they are unable to live in their own home. This includes care settings for young people whose parents are deemed unable to look after them, secure settings for young offenders, and residential schools.

Method

A literature search was conducted, and articles were included based on their relevance to the purpose of this review. Articles were deemed relevant based on the following criteria: young people with residential care experience in the UK; young people with experience of self-harm; care staff in the UK with experience of caring for young people who engage or have engaged with self-harm; published between 2000 and 2021.

Articles with relevant titles were read and included or excluded based on overall quality and relevance. The initial literature search identified five studies that had care-experienced young people as participants, two that had residential care staff as participants and one with both young people and care staff. Four reviews of the literature were identified as relevant and included in this review.

The initial search criteria were then expanded to include articles that would give useful context and comparison points to the main body of literature. Relevant articles that included young people in other care placements, such as kinship care and foster care, have been included; articles that looked at experiences of older people in residential care, and care staff experiences with older people in residential care were also included as a point of comparison.

Key findings

Research into the impact of supports for young people who self-harm in residential care settings is scarce. Across the studies that do exist, ambivalent and contradictory findings make it difficult to draw meaningful conclusions that can be used to inform effective care strategies. There is a lack of consistent findings in the evidence at individual, group, and institutional levels. These inconsistencies relate to both the processes surrounding incidents of self-harm and the responses to these processes. This perhaps demonstrates that the needs of those who engage in self-harm are nuanced and varied and therefore so must be the responses.

The types of effective supports that emerge most frequently from the existing literature can be grouped according to four key themes: relational, practical, discursive, and professional. This review will examine these themes from the perspectives of both young people and residential care staff, thereby suggesting potential courses of action and areas for further research.

Relational supports

The importance of interpersonal relationships as a protective factor and source of support for young people experiencing self-harm is a predominant theme in the existing literature. This coincides with the established understanding that social isolation is a risk factor for self-harm and suicide, and developing trusting relationships is an important means of reducing self-harm (Epstein & Ougrin, 2020). Strong personal relationships established in a care setting are a crucial element of effective support.

In a recent study that explored what young people who self-harm find most useful, care-experienced young people named friends and pets as two of the most useful sources of support, while A&E and social services were two of the least useful (Holland et al., 2020). In the same study, non-care-experienced young people identified siblings as a useful source of support and expressed a desire for support from people who have been through similar experiences. Interestingly, Child and Adolescent Mental Health Services (CAMHS) were cited as both the most and the least useful service. Free-text responses allowed the authors to draw some limited inferences about the reasons behind these results, and they suggest that the range of services provided by such a large organisation leads to differing experiences for service users. They also attribute positive experiences to positive interactions with individuals, rather than the organisation or service itself. In keeping with this interpretation, their findings indicate that for young people, the most useful sources of support are the individuals who immediately surround them, and who are not associated with professional organisations. This is an important finding for residential care staff, whose role within the care setting is both immediate and professional.

These findings resonate with earlier evidence that young people find positive relationships with staff to be a more significant source of support than interactions with healthcare professionals. Piggot, Williams, McLeod and Barton (2004) found that young people identified internal members of staff who listened, empathised, and got to know the young person and their history of self-harm as the basis for effective support. One young person from this study explicitly credits the perseverance of a particular member of staff with helping to reduce her self-harm, and others mention talking, listening, and demonstrating genuine care – for instance, staying on beyond the end of a shift to talk – as helpful and supportive. By contrast, medical professionals, external psychologists, and social services were associated with inappropriate responses and negative experiences, such as jargonistic language, a lack of compassion or understanding of the emotional needs of the young person and feeling judged. Piggot and colleagues infer that the emotional distress that arises from negative interactions can increase the secrecy of self-harming behaviours, which inhibits the young person’s ability to access and receive the right support, therefore

making further self-harm more likely. A more recent study on self-harm disclosure describes this cycle as 'help negation' (Haskings, Rees, Martin & Quigley, 2015). The authors suggest that when self-harm disclosure is met with fear, discomfort or misinterpretation, this reinforces the avoidance of support services. The study also found that adolescents who self-harm are more likely to confide in a friend (67%) than an adult (32%), reiterating the importance of social connectedness as a feature of engaging with support networks. The authors conclude that informal support such as family and friends can act as a pathway to seeking help from formal sources of psychological support, which suggests that help-seeking is an incremental process that begins with reaching out to people who are socially important but have low professional or psychological expertise.

Social connectedness often exists between peers in the care setting, as well as between staff and young people, and seeking support from friends can be a stepping-stone in the process of seeking professional psychological help. When developing a self-harm care plan, it is therefore important to include support for both staff and young people in their knowledge and understanding of self-harming behaviours in others. Providing all young people with knowledge about self-harm and how to seek support for this may help those who harm themselves, those who do not but are exposed to it, and those who are in relationships with these young people.

The positive outcomes of social connectedness are complicated by the potential for contagion of self-harming behaviours in care settings. There is amassed evidence that having family or close friends who have self-harmed increases the likelihood of young people engaging in self-harm (see Hasking et al., 2015). The same study also indicates that exposure to self-harm content can increase assumptions about its prevalence in others. Over-estimating the prevalence of a behaviour within your social group is a known factor for increasing the likelihood and frequency of a type of behaviour within that group (Bicchieri, 2005). Studies that looked at residential groups and close-knit communities demonstrated that similar methods of self-harm (and suicide) exist within groups, suggesting that these methods are 'transmitted' (see Cheng, Li, Silenzio

& Caine, 2014). Though causal factors are almost impossible to delineate, greater understanding of what contagion constitutes within a care setting would help practitioners and staff support groups of young people living with an individual or individuals who self-harm. For instance, contagion is often framed as the result of social influence (Insel & Gould, 2008). In such cases, identifying socially influential individuals within a group and addressing their behaviour can be a useful means of addressing group behaviour. On the other hand, self-harm behaviours 'spreading' in a care setting could be indicative of compounding factors such as the heightened stress on all residents of living with traumatised young people, combined with reduced inhibitions (Wadman et al., 2017). In these cases, the supports and interventions discussed in this article all apply.

Practitioners and care staff should also be wary of using terminology associated with disease, as this promotes the idea that self-harm is something which young people need to be 'cured' of (Cheng et al., 2014). As discussed later in this article, indicating to young people that they need to stop self-harming can result in greater emotional distress and increased self-harm.

Research into the experiences of residential care staff similarly highlights the importance of building strong personal relationships. Piggot and colleagues' (2004) study found that moving staff between houses within a care setting was regarded as detrimental to providing effective care, as it inhibited staff from developing their knowledge of individual young people. A more recent study corroborates these findings, indicating that staff attribute their ability to provide effective care to knowing individuals on a personal level, and being familiar with aspects of their behaviour and experiences (Evans, 2018). Staff in this study perceive self-harm to be a method of communication, and their understanding of the individual engaging in self-harm contributes to their ability to interpret what is being communicated. By contrast, the insights of external healthcare professionals can be seen as limited in this respect. Likewise, care staff reflected that self-harm can be a means to influence relationships, regarding this as operating on an individual interpersonal level within the care setting, rather than on a systemic level. An example of this is that staff reported individuals only engaging in self-harm when a particular member of staff was on duty, which was

interpreted as a sign that they felt they would get the desired care from that person (Evans, 2018).

Building on these findings, Jennings and Evans (2019) found that the emotional investment of their work is an important aspect of how residential care staff self-identify in the context of their job. The authors noted a contrast between staff depictions of their own role, which emphasised the importance of experiential expertise and the complex understanding they have of the young people they work with, and the role of clinicians and psychiatrists, which was perceived to be founded on academic expertise, but empathetically limited and impersonal.

Nonetheless, establishing and maintaining personal relationships is a challenging aspect of care workers' roles. There is a growing body of research supporting the anecdotal evidence that managing self-harm in residential care settings is extremely emotionally demanding for staff, with consequences that impact their work and their personal lives. Asarnow and Mehlum (2019) hypothesise that practitioners may experience secondary traumatic stress when working with children and young people at risk of self-harm and suicide, and that a trauma-informed approach to supporting staff (as well as young people) is essential. Similarly, Brown and colleagues (2019) identify aspects of staff experiences that mirror the isolation and coping difficulties experienced by those they are caring for. Their study indicates that staff experience primary traumatic stress following self-harm incidents, as they report invasive thoughts and flash-back memories that are characteristic of post-traumatic stress disorder. In addition to this, staff describe the difficulty of engaging with young people on an emotional level, instead adopting automated responses to help them comply with self-harm protocol. At the same time, coping strategies that include 'switching off' emotionally or distancing oneself from the reality of the event inhibit care workers' long-term ability to provide compassionate support in the care setting.

Research into strategies for supporting staff is limited, and the existing literature is filled with contradictions. In residential settings for adults, emotional debriefing for staff after an incident of self-harm is often negatively received, as it brings unpleasant emotions to the surface (Mendes, 2020). Some researchers suggest that time off for staff in response to the increased strain of managing a

young person's self-harm is essential to avoid burn out and maladaptive coping mechanisms (Mendes, 2020). Conversely, there is also evidence to suggest that care workers find the intimacy of the care setting, where other staff have similar experiences, offers better emotional support than going home. For example, in Brown and colleagues' (2014, p.13) study, one participant described the team of social workers as 'like a family', with switching back to normal life being seen as challenging.

The evidence above has numerous implications for practice. It is important that residential care staff can identify who is socially significant for individuals experiencing self-harm and to nurture the social (over the professional) nature of these relationships. This lends support to the key carer or key worker model seen in many residential care settings where a named carer who is a good personal match for the individual leads the child's care and attempts to build a particularly strong relationship.

Given the similarities between the experiences and demands on both staff and young people, support structures that employ similar mechanisms may be beneficial to both groups. As suggested by Asarnow and Mehlum (2019), a person-centred and trauma-informed approach to staff support plans is a potentially fruitful means of improving their ability to cope in a high-stress work environment. Increased support for individuals who are working closely with at-risk young people needs to occur at three levels: practical, to reduce the strain of working at or beyond capacity; psychological, to help them process emotional stress and traumatic events; and continuous, to avoid crisis development and to create a proactive rather than reactive care structure for both young person and staff member. Support processes that are adaptable to the needs of the individual, and simultaneously consider the impact of their work on colleagues and residents, are likely to be most effective. For instance, it is important to prioritise care responses that encourage engagement and processing of events, and empathy between care staff and young people. For some, this might entail taking time off, whereas others might benefit from being around their colleagues and continuing to engage with their work.

There is a clear need for further research into the impact on residential staff of caring for someone who engages with self-harm. Several studies exist on this topic as it applies to parents and nurses and indicate that it takes a significant toll on their jobs, marriages, families, and their own resilience (see Brown et al., 2019). Greater understanding of how to support residential staff would be hugely beneficial.

Talking supports

A distinctive feature of the research into what young people would find helpful as a means of managing self-harm is the opportunity to discuss their needs with the carers and psychologists who interact with them. Experiences of self-harm are known to be varied and complex, and both young people and residential care staff indicate that they would benefit from talking about the historic and present experiences of the young person engaging in self-harm. Open and non-judgemental discussion is likely to strengthen relationships and improve engagement with support services.

In a study into the efficacy of care strategies in a residential setting, young people identified that staff who showed an interest and understanding in their lives and backgrounds were most able to provide effective care (Johnson, Copley & Ferguson, 2017). Discussing care needs with staff was seen to have a positive impact both long- and short-term. The authors of this study recognised that young people interpreted staff taking the time to talk to them about their personal experiences as demonstrative of 'genuine' care, which was conducive to developing trusting relationships. As well as being a step in the direction for seeking and engaging with professional psychological support, trusting relationships are an established protective factor for young people engaging in self-harm (Bryant et al. , 2021).

Rouski and colleagues' (2021) recent study similarly suggests that participants seek genuine care through their self-harming behaviours. The authors of this study identified the need to be understood as a key theme, as young people highlighted the importance of acknowledging that their lives, experiences, and current context contribute to their engagement in self-harm. As in Johnson and

colleagues' (2017) study, participants reflected that young people have idiosyncratic care needs, and expressed a desire for more opportunities to discuss these needs with staff. For instance, some participants described staff 'checking in' as demonstrative of genuine care, while others felt it was an invasion of personal space. Young people also associated being understood with emotional containment, which is seen as an important factor in managing and reducing self-harm. Staff who are familiar with the individual and their behaviours are less likely to respond with panic, fear or uncertainty, and consequently young people feel more accepted and more able to trust those who are looking after them.

Effective care strategies differ between individuals, and also over time for the same individual, further highlighting the importance of open and frequent conversations about the needs of the individual. Wadman and colleagues (2017) looked at the differences between young people's first engagement with self-harm and their most recent. Many reported feeling better after their first episode, but this was not a significant motivating factor for those who continued to engage in self-harm. Instead, the perception that they could not tell anyone how they were feeling was cited most frequently for care-experienced young people who had recently engaged in self-harm. This study also revealed, through pre- and post-study emotional state ratings, that discussing the topic of self-harm was not emotionally detrimental to participants. The authors conclude that interventions which prioritise sharing emotional distress and communicating feelings are likely to be effective in a residential care setting, corroborating the above findings that young people would benefit from more opportunities to discuss their experiences.

Taken together, these findings indicate that communication is central to effective care strategies for self-harm. Young people can identify what care processes work for them, and staff benefit from increased confidence when they know they are delivering the care that the young person in question finds helpful. In line with the desires expressed in these studies, incorporating space for young people to talk to staff about their historical and current experiences with self-

harm is likely to strengthen relationships and improve engagement with a variety of support services.

This is already reflected in the practice of many residential care settings and forms an important part of individual care plans. Having a culture of open dialogue between young people and staff (and within each of these groups) would facilitate even greater adaptability of care plans, ensuring that the care the young person is receiving remains helpful and relevant. Furthermore, increasing the number of people that a young person feels able to talk to would increase the number of trusting relationships they are able to establish, which is doubly beneficial as a protective factor for self-harm, and as a means of relieving pressure and responsibility for individual members of staff.

Practical supports

There is a scarcity of research into the impact of specific care processes designed to manage self-harm in residential settings. Ethical concerns and logistical obstacles limit the number of appropriate methodologies for conducting research in this area. Many of the existing studies have small sample sizes and produce data that relates to a highly specific context. Nonetheless, it is useful for practitioners to understand the individual procedures as well as the broader themes that contribute to effective care, given the nuanced and potent emotional triggers for young people in care.

A recent study by Cliffe and colleagues (2021) looks specifically at the usefulness of harm minimisation techniques for young people who engage in self-harm in secondary mental health care. Harm minimisation constitutes using actions that in some way emulate the act of self-harm, but in a way that reduces the potential physical harm to the person. Some examples include snapping an elastic band against the skin to create short, sharp pain without creating an incision in the flesh, or drawing with a red pen on the skin to create the visual impact of cutting. Their results indicate that of the participants who use these methods, 92% found them to be helpful in reducing self-harm. Specifically, harm minimisation was cited as an effective way to reduce the negative outcomes of self-harm without aggravating the emotional distress brought on by stopping

altogether or imposing unrealistic expectations on young people to stop. The authors note that there are barriers to implementation that include ensuring staff are well-trained and comfortable with the use of the techniques, as well as a necessity for further research using cohort studies. Their findings, for instance, contradict those of Holland and colleagues (2020), who reported that one-third of participants found harm-minimisation techniques actively helpful, while one-third found them actively unhelpful. Research into staff attitudes towards harm minimisation is a necessary first step in developing training programs for staff and would yield insights about barriers to implementation from the perspective of people with direct experience of caring for at-risk young people.

A similarly ambivalent body of evidence surrounds the efficacy of direct interventions. Johnson and colleagues (2017) found that processes that were understood to protect the safety of residents were perceived by young people as necessary even when experienced as unpleasant. Participant responses generally endorsed systematic care processes such as room checks and removal of means, while also giving suggestions about how to mitigate unhelpful consequences. These suggestions focused on minimising the emotional distress that arises because of invasive practices and limiting interventions to what is practical rather than punitive. One young person, for instance, mentions the importance of keeping photographs of family and loved ones in her room; another suggests returning items to their room once they have calmed down. Furthermore, improper implementation of these processes is perceived to directly contribute to the emotional distress of the young person, thereby increasing their drive to self-harm, rather than reducing it. Young people mention careless slamming of doors and showing little respect as particularly distressing.

Rouski and colleagues (2021) similarly found that young people demonstrated ambivalent feelings about direct interventions. Room checks and observation routines were described as ‘unnerving’ (Rouski et al., 2021, p. 424) and served as a reminder that they were not at home, which exacerbated risk factors of self-harm, such as losing control and social isolation. Likewise, some found that the depersonalised aspect of routine care was emotionally distressing, while others found that consistency within and between individuals’ care routines was

a key factor in eliminating the need to test boundaries through self-harm. Young people in this study also described the danger of boredom that arises from restrictions, which on the one hand eliminates distractions from negative thoughts and on the other hand builds frustration in response to having limited freedom.

These findings highlight the importance of explaining the reasons behind care procedures, and the scope and extent of the procedure, so that young people understand what is happening and know what to expect. Lack of control and autonomy are known risk-factors for young people engaging in self-harm and developing these skills in young people is a foundational aspect of trauma-informed care approaches. Similarly, procedures that are structured around positive emphasis, for instance goal-based procedures, are more likely to be effective and to cause minimal emotional distress than punitive processes that have little or no practical benefit, like removing non-harmful belongings from a young person's room. As Wadman and colleagues (2017) identify, punitive and restrictive interventions conflict with the goal of creating as normal a setting as possible for the young person to feel at home and accepted in.

This relates, too, to implicit or explicit indications that young people need to stop self-harming. Young people have expressed the difficulty of stopping (Rouski et al., 2021), and there is evidence that the combination of adults imposing unrealistic expectations on young people and removing their tool for emotional regulation causes emotional distress in the young person (Cliffe et al., 2021). This can lead to increased secrecy around self-harming behaviours, and the breakdown of trusting relationships between adult and young person, all of which inhibit help-seeking. The notion that self-harm is something 'wrong' insinuates a lack of acceptance. Rejection of all kinds is associated with increased prevalence of self-harm (Cawley et al., 2019), which implies that young people feeling safe to freely be and express themselves – even if that is through self-harm – is an important step towards emotional resilience. Balancing the competing implications for the long- and short-term safety of young people in care settings is a complicated and persistent challenge, but it is essential that

policies consider the long-term psychological effects of the immediate practical interventions implemented to protect the physical safety of the young person.

Practical training for care staff is crucial both when new to a care setting, and regularly to maintain a high standard of implementation. Additionally, providing young people with a channel for communication, where they can voice their experience of specific procedures, without fear of criticising individuals or the organisation as a whole, is also likely to contribute to greater efficacy and understanding across the care setting. This is particularly challenging and important in the context of self-harm, as people who engage in self-harm often struggle to articulate what they find distressing or helpful. Co-designing procedures and regularly reviewing these will be challenging but likely to result in much more effective supports.

Distraction is used increasingly as a short-term intervention for self-harm, with the aim of breaking the chain of thoughts, emotions or habits that lead to self-harm (Walker et al., 2016). Distraction techniques include engaging in activities such as gardening, exercise, crafts, or puzzles (Harrison and Sharman, 2005). In a study comparing care-experienced and non-care-experienced young people, Holland and colleagues (2020) found that distraction was effective for young people who are not in residential care, whereas fewer care-experienced participants reported using it. The authors of this study note the efficacy of distraction as a time-targeted and immediately accessible intervention, which implies that it would be easy to implement in a care setting; however, caution should be used if encouraging young people to try this or any other technique. Distraction may be a helpful technique, but practitioners should be mindful of proportionality i.e., it is unclear whether distraction would be effective in the face of significant distress.

Wadman and colleagues' (2017) analysis of the timeline of self-harm incidents gives an insight into the important factors that immediately precede an act of self-harm. They note that impulsivity and a reduced fear of death, combined with social isolation and having access to means, can be interpreted as warning signs. Wadman and colleagues suggest that time-targeted interventions could be

an effective way of addressing the varied and changing factors that lead to self-harm.

Holland and colleagues (2020) also found that care-experienced and non-care-experienced participants reported differing engagement with external support services, family members, and medication. The study did not identify whether these differences were a result of different preferences between the groups, or of accessibility differences. Identifying where accessibility to desired strategies of self-care management could be improved for care residents would be a useful follow-up to this study. As highlighted by Wester and Plener (2020), reinforcing help-seeking behaviours in young people before they engage in self-harm is a robust means of reducing the amount and severity of self-harm, making this an important behaviour for residential care staff to understand and nurture.

The way interventions are carried out also impacts staff well-being. Across several studies residential care staff indicate that having clear protocols surrounding self-harm gives them confidence and reduces fear of being blamed for failing to prevent instances of self-harm. Piggot and colleagues (2004) found that staff were apprehensive about the responsibilities attached to working with young people who engage in self-harm. Staff expressed a desire for greater training to help their decision-making abilities in moments of crisis, and indicated that they lacked knowledge and understanding of the legal implications of incidents of self-harm in a residential care setting, which contributed to their uncertainty and reluctance to take responsibility. Despite improvements in the training and support care staff receive since 2004, a recent study (Brown et al., 2019) indicates that staff still feel undertrained, and this impacts their approach to working with young people. The authors found that staff would avoid working closely with at-risk young people out of a fear of blame, which was coupled with feelings of ineptitude in their own training and the available support.

Staff responding with fear and uncertainty has been identified as something that exacerbates young people's emotional distress, making this a doubly important area to address. Most importantly, staff need to be informed of the legal framework in which they are working, with clarity of roles and responsibilities and clear channels of communication between staff levels. Additionally,

implementing response processes that minimise decision-making for staff following incidents of self-harm would be beneficial both for staff, in that they can respond effectively with confidence, and for young people, whose experience of care will be improved. Finally, it is crucial that care settings avoid blame culture, and frame incidents of self-harm as an indication that something needs to be learnt or changed systemically, rather than as the result of an individual failing.

Professional supports

The professionalism of staff is a prominent issue in the care sector that emerges from research across a variety of themes. Historically, care roles have been associated with non-professional nurturing roles such as parenting, and there is some evidence that this remains apparent in the care sector in the form of the inadequate renumeration and training that care workers often experience (Jennings & Evans, 2020). Young people, care staff and practitioners have identified a lack of clarity around care workers' roles and responsibilities, and insufficient training or experience as barriers to effective care and the development of new care approaches (see Rouski et al., 2021).

There is a persistent tension in the existing body of evidence between staff expressing a desire for increased professionalism – through training, responsibility, and acknowledgement – and critiquing other professionals in the care system. In Piggot and colleagues' (2004) study, residential care staff express a desire for more accessible information on self-harm for both young people and care staff, as well as increased levels of training for staff. This is expressed alongside ambivalence towards external organisations, who are perceived as having the means to provide effective care but being difficult to reach in a moment of crisis. Increased expertise for staff can be understood in this context as a way of reducing dependency on external support and improving internal staff ability to cope with instances of self-harm.

In the same study, young people also recognise the importance of staff training and expertise as it impacts their experience of support services (Piggot et al., 2004). Young people indicated that internal staff are the most salient source of

support within the care setting and highlighted that staff responses to incidents of self-harm impact the young person's emotional containment in the moment. Almost twenty years later, young people's experience of care is still affected by insufficient staff training and experience. Rouski and colleagues (2021) found that participants recognised fear or panic in staff responses to self-harm, and this leads to emotional instability for the young person in the short-term and a lack of trust in the staff's ability to do their job in the long-term (Rouski et al., 2021).

Evans (2018, p. 946) refers to care staff as 'corporate parents', encapsulating the tension involved in occupying a statutory role that also demands the intimacy and emotional investment inherent in nurturing a child. A key theme that emerges from this study is the demarcation of responsibility according to severity and type of self-harm. Residential care staff associate 'hidden' self-harm with biomedical issues that are the remit of psychologists and clinicians, while 'visible' self-harm is seen as a relational issue that tests and reifies the social dynamics within the care system (Evans, 2018). Although these differences map onto existing literature, there is no corresponding demarcation of responsibility that functions across the care system, nor is there a national minimum standard of training for care workers, despite the complex and demanding nature of their job (Brown et al., 2019). One concern regarding these systematic grey areas is that the lack of clarity could translate into young people's experience of care, leaving them unsure as to from whom and where support will come, and reinforcing the use of self-harm to test existing channels.

Jennings and Evans' (2020) study corroborates the above findings. Their results suggest that care staff undergo an effort of legitimisation when working with external organisations and feel disenfranchised in the context of healthcare professionals with formal qualifications. At the same time, they express an aversion to increased professionalism of their role, which the authors of this study interpret as a wariness that increased professionalism will come with increased scrutiny and culpability should something 'go wrong'. This ambivalence reappears in participant responses regarding medical professionals. While their attitude towards self-harm is regarded as lacking in understanding and

compassion, their role in the care process is acknowledged as essential and distinct from that of care workers, because of their technical expertise.

By contrast, care workers see their role as providing them with a unique perspective because of their close relationship with the young person, and they place value in experiential over academic expertise (Jennings and Evans, 2020). Participants in this study mentioned that excluding care workers from the decision-making process of a young person's care plan means that valuable insights are lost. At the same time, staff describe how they often experience poor treatment as a direct result of their close relationships with young people. Participants in this study reflected on several situations in which they experienced negative interactions with medical professionals, including the assumption that they are underqualified to support children with complex needs as a result of past trauma, being associated with 'problem patients' in hospitals, and consequently being treated with exasperation, and in some cases receiving blame for failing to prevent or even contributing to a young person's engagement in self-harm.

There is a clear need for increased knowledge among care staff. Standardised training across the care sector would help to distinguish care workers from non-professional roles, and to ensure a consistent level of knowledge and ability throughout the sector. Moving between care units can be emotionally distressing for young people, and this is exacerbated by the inconsistency of care provision available within different units (Brown et al., 2019). Sector-wide consistency in the kind of practical, medical, and psychological support that is available internally and externally to a care organisation, as well as similar standards and expectations upheld by staff, would help to reduce the stress involved in moving to a new care setting. Training should be coupled with access to information resources that are designed with both staff and young people in mind. The insights from young people that staff responding to instances of self-harm with fear and panic is actively unhelpful indicates that scenario-based training could be a useful way of preparing staff for situations that are highly emotional. Additionally, collaborative training programs whereby staff share their experiences, perspectives and support would help to create consistency as well

as strengthening bonds between staff and helping individuals to develop coping mechanisms when faced with high-stress situations.

There is also a need for clear distinctions between the responsibilities of residential care workers and those of medical and psychological practitioners, which should match the level of training and capacity of each group. Acknowledging the progression of training and responsibility through formal qualifications would be a useful means of ensuring consistency and legitimising the work of care staff in the eyes of organisations both within and outwith the care sector. The studies above indicate that distinguishing between biomedical issues and the relational functions of self-harm could be a useful framework for establishing different responsibilities. For instance, residential care staff indicate that they consider it their responsibility to create an environment that promotes the general safety and emotional resilience of the young person, while it is the responsibility of specialist services to manage their immediate medical and psychological needs following instances of self-harm. Communicating these distinctions to young people in residential care means that they know who can and will provide what kind of support, reducing the need to test these limits.

Increased professionalism, however, should be carried out with caution, as there are several potential negative outcomes linked to staff and young people's perceptions and experiences of professional organisations. Crucially, care workers perform an important social role in young people's lives (as discussed above), which risks being obscured by increased professional status. Training that prioritises personal engagement, empathy and the social aspect of care roles is likely to be most effective in managing self-harm. Young people themselves have indicated that incorporating perspectives of people with care experience and histories of self-harm would increase empathy and understanding, and thereby improve relationships between young people and staff (Rouski et al., 2021). Furthermore, it is important that changes to roles, responsibilities or qualifications are carefully accounted for and clearly delineated, to avoid confusion for young people and to ensure that staff remain clear as to the remit of their job. This includes clarity on the legal implications, as well as the escalation processes within the care setting.

Conclusions

Across the existing literature on self-harm among young people in residential care settings, the importance of positive relationships between staff and residents emerges as a predominant theme for both groups. This is consistent with existing evidence that social factors play a significant role in young people's experience of and engagement with self-harm (Bryant et al., 2021). Developing and maintaining these relationships is a complex and challenging aspect of care workers' roles. Connecting emotionally with young people who have histories of trauma, and who struggle to trust and engage with adults, is draining and can lead to secondary trauma. Witnessing self-harm incidents, particularly when the person self-harming is in your care, can cause traumatic stress for the staff. Young people who form close relationships within the residential setting are also likely to experience emotional distress as a result of their friends' self-harming behaviours, which can lead to an increased likelihood of them engaging in self-harm.

The importance of positive relationships is further reflected in conceptualisations of the role of residential care staff, both in how they perceive their duties, and in how they are perceived within the care sector and more broadly by society. The nurturing aspect of their role, which is crucial to the delivery of effective care, is contingent on understanding the individual and developing a trusting relationship. At the same time, this dynamic is often what causes residential care staff to be overlooked and disenfranchised with regards to their professional status within the care sector. There is a notable lack of training across the care sector in the U.K., coupled with a lack of clarity about residential care staff's duties, which can translate into a lack of clarity for the young people they are caring for.

Greater levels of training pertain to carrying out individual processes, as well as increased professionalism in general. Young people express ambivalence towards certain processes that aim to protect their safety, often because of negative interactions or poor delivery from staff. Looking beyond residential care to incorporate methods that are effective for young people experiencing self-harm is necessary to ensure that care-experienced young people are provided with

every opportunity to take their mental and physical safety into their own hands, and benefit from available support services. Approaching self-harm management in a way that helps young people to feel accepted and safe in their environment furthers the goal of care settings to provide a 'normal', stable, and nurturing home for young people.

Finally, at every level, talking and having open discussions has been highlighted as a crucial aspect of developing care processes. Young people have indicated that there is a need for more opportunities to discuss their histories of self-harm with staff, and to be listened to and understood by external healthcare professionals. Staff acknowledge this, though admitting that it can be emotionally challenging, and that their shift patterns often don't allow the time to properly engage with a young person. Both staff and young people have also indicated that talking about what care requirements the young person has in moments of crisis and more broadly makes for positive interactions. Young people feel heard and can build autonomy, while staff are able to deliver the right care with confidence.

References

Al-Sharifi, A., Krynicki, C. R., & Upthegrove, R. (2015). Self-harm and ethnicity: A systematic review. *International Journal of Social Psychiatry*, *61*(6), 600-612. https://doi.org/10.1177%2F0020764015573085

Asarnow, J. R., & Mehlum, L. (2019). Practitioner review: Treatment for suicidal and self-harming adolescents – advances in suicide prevention care. *Journal of Child Psychology and Psychiatry*, *60*(10), 1046–1054. https://doi.org/10.1111/jcpp.13130

Bicchieri, C. (2005). *The grammar of society: The nature and dynamics of social norms*. Cambridge University Press. http://dx.doi.org/10.1017/CBO9780511616037

Brown, A. M., Chadwick, R., Caygill, L., & Powell, J. (2019). One moment you're covered in blood and next it's what's for tea? An interpretative phenomenological analysis of residential care staff's experiences of managing self-harm with looked after children. *Scottish Journal of Residential Child Care*, *18*(3). https://core.ac.uk/download/pdf/322327939.pdf

Bryant, L. D., O'Shea, R., Farley, K., Brennan, C., Crosby, H. F., Guthrie, E., & House, A. (2021). Understanding the functions of repeated self-harm: A Q methodology approach. *Social Science & Medicine 1982*, *268*, 113527–113527. https://doi.org/10.1016/j.socscimed.2020.113527

Cawley, R., Pontin, E., Touhey, J., Sheehy, K., James Taylor, P. (2019) What is the relationship between rejection and self-harm or suicidality in adulthood? *Journal of Affective Disorders*, *242,* 123-134. https://doi.org/10.1016/j.jad.2018.08.082

Cheng, Q., Li, H., Silenzio, V., & Caine, E. D. (2014). Suicide contagion: A systematic review of definitions and research utility. *PloS one*, *9*(9), e108724. https://doi.org/10.1371/journal.pone.0108724

Cliffe, C., Pitman, A., Sedgwick, R., Pritchard, M., Dutta, R., & Rowe, S. (2021). Harm minimisation for the management of self-harm: A mixed-methods analysis of electronic health records in secondary mental healthcare. *BJPsych Open*, *7*(4), e116–e116. https://doi.org/10.1192/bjo.2021.946

Epstein, S., & Ougrin, D. (2020). Self-harm and suicidality in children and adolescents. In: E. Taylor, F. Verhulst, J. Wong, K. Yoshida & A. Nikapota (Eds.) *Mental health and illness of children and adolescents* (Mental Health and Illness Worldwide). Springer. https://doi.org/10.1007/978-981-10-0753-8_45-1

Evans, R. E. (2018). Survival, signaling, and security: Foster carers' and residential carers' accounts of self-harming practices among children and young people in care. *Qualitative Health Research*, *28*(6), 939–949. https://doi.org/10.1177/1049732318759935

Farooq, S., Tunmore, J., Ali, W., & Ayub, M. (2021). Suicide, self-harm and suicidal ideation during COVID-19: A systematic review. *Psychiatry Research*, *306*, 114228–114228. https://doi.org/10.1016/j.psychres.2021.114228

Hasking, P., Rees, C. S., Martin, G., & Quigley, J. (2015). What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC public health*, *15*(1), 1-9. https://doi.org/10.1186/s12889-015-2383-0

Holland, J., Sayal, K., Berry, A., Sawyer, C., Majumder, P., Vostanis, P., Armstrong, M., Harroe, C., Clarke, D., & Townsend, E. (2020). What do young people who self-harm find helpful? A comparative study of young people with and without experience of being looked after in care. *Child and Adolescent Mental Health*, *25*(3), 157–164. https://doi.org/10.1111/camh.12384

Huntley, C., Shah, N., Hobart, C., Evans, N., Adams, N., Pinder, R., Abrar, S., McMullen, I., & Polling, C. (2019). Adverse life experiences and triggers for self-harm in young people aged 12–26 years in inner south London: A retrospective

observational study. *The Lancet (British Edition)*, *394*, S57–S57. https://doi.org/10.1016/S0140-6736(19)32854-5

Insel, B., & Gould, M. (2008). Impact of modeling on adolescent suicidal behavior. *Psychiatric Clinics of North America*, *31*, 293–316. https://doi.org/10.1016/j.psc.2008.01.007

Jennings, S., & Evans, R. (2020). Inter-professional practice in the prevention and management of child and adolescent self-harm: Foster carers' and residential carers' negotiation of expertise and professional identity. *Sociology of Health & Illness*, *42*(5), 1024–1040. https://doi.org/10.1111/1467-9566.13071

Johnson, D. R., Ferguson, K., & Copley, J. (2017). Residential staff responses to adolescent self-harm: The helpful and unhelpful. *Clinical Child Psychology and Psychiatry*, *22*(3), 443–454. https://doi.org/10.1177/1359104516689378

Mendes, A. (2020). Supporting residents at risk of self-harm and suicide. *Nursing & Residential Care*, *22*(11), 1–3. https://doi.org/10.12968/nrec.2020.22.11.4

NICE (2013). *Self-harm: NICE quality standard* [QS34]. Manchester.

http://www.nice.org.uk/guidance/qs34/resources/selfharm-2098606243525.

Piggot, J., Williams, C., McLeod, S., & Barton, J. (2004). A qualitative study of support for young people who self-harm in residential care in Glasgow. *Scottish Journal of Residential Child Care*, *3*(2), 45-54.

Rouski, C., Knowles, S. F., Sellwood, W., & Hodge, S. (2021). The quest for genuine care: A qualitative study of the experiences of young people who self-harm in residential care. *Clinical Child Psychology and Psychiatry*, *26*(2), 418–429. https://doi.org/10.1177/1359104520980037

Wadman, R., Clarke, D., Sayal, K., Armstrong, M., Harroe, C., Majumder, P., Vostanis, P., & Townsend, E. (2017). A sequence analysis of patterns in self-harm in young people with and without experience of being looked after in care. *British Journal of Clinical Psychology*, *56*(4), 388–407. https://doi.org/10.1111/bjc.12145

Walker, T., Shaw, J., Hamilton, L., Turpin, C., Reid, C. & Abel, K. (2016), Supporting imprisoned women who self-harm: Exploring prison staff strategies, *Journal of Criminal Psychology*, *6*(4), 173-186. https://doi.org/10.1108/JCP-02-2016-0007

Westers, N. J., & Plener, P. L. (2020). Managing risk and self-harm: Keeping young people safe. *Clinical Child Psychology and Psychiatry*, *25*(3), 610–624. https://doi.org/10.1177/1359104519895064

About the authors

Lily Burnand is a researcher at Social Value Lab and volunteer researcher for Kibble. Dan Johnson is the Clinical Director at Kibble.