PARENT & CARER TOOLKIT - LITTLE BRAINS SC055724

Understanding self-harm

A compassionate, psychology-informed and medically grounded guide to supporting children and young people

By Louise Keegan, Founder of Little Brains Inclusive Wellbeing

Over the years, I have frequently been approached by parents and carers looking for advice on how to support a child or young person who is self-harming. It is a subject I have always found particularly difficult to put into words. Not because I don't understand it, but because I understand just how complex, personal and emotionally challenging it can be, both for the young person experiencing it and for the people who love them.

My understanding of self-harm comes from several different perspectives. Firstly, I was once the young person who self-harmed. I understand what it can feel like to be on the other side of those conversations. I remember the responses that helped, the ones that didn't, and the things I wish the adults around me had understood at the time.

Secondly, I have spent over 15 years working with children and young people, including those experiencing emotional distress, mental health difficulties and complex personal circumstances. Throughout that time, I have supported young people and families navigating situations very similar to those I experienced myself.

My perspective is also informed by previous studies in psychology, my current studies in childhood and child development, and a basic understanding of medical care. I have always been particularly interested in understanding not just what children and young people do, but why they might do it, and how the responses of the adults around them can influence their experiences.

This toolkit is not medical advice, nor is it intended to replace professional mental health support, medical assessment or treatment. It is a combination of personal experience, professional practice, academic learning and reflection.

It comes from having been the child, remembering what helped and what caused further hurt, and then spending much of my adult life working alongside children and young people facing their own difficulties. I recognise that my experiences are not everyone's experiences. Self-harm is complex, and there is no single explanation, response or approach that will work for every young person.

My hope is that this toolkit will help parents and carers approach self-harm with greater understanding, confidence and compassion. Not by providing all the answers, but by encouraging us to think more deeply about the questions we ask, the words we choose and the way we respond. Because sometimes, the difference between a young person feeling judged and feeling understood begins with how we respond in the very first moment they need us.

YOU DO NOT NEED ALL THE ANSWERS- NOBODY HAS THEM

“There's no manual that comes with a child” is something we often hear. But we pick it up as we go along- doing our best, learning from our own childhood experiences and watching others.

This one is not something you talk about in parent toddler groups or at school pick up though- this one is scary and isolating. It hurts, your job is to protect the child and this can feel like failing. But you are here, looking on all the corners of the Internet for support and guidance - that is not failure, that is not bad parenting!

Your first and hardest job is to notice- its not often a young person will disclose this straight away.

Next is to respond to physical and emotional safety, and help your child access appropriate care - we will discuss severity and actions to take for individual circumstances.

Self-harm deserves support, not punishment. I often hear “they are doing it for attention”, and this may well be true on a level - it may be the only way they can express that they need help, there are many reasons a young person self-harm's and this can look different for each person.

Once you have addressed the medical need, it is really important to put a calm plan in place that makes the young person feel supported and valued.

Please do not worry if you have already come across this situation and did not handle it well, what matters is that you are trying to understand and support- I am presuming you have been a parent for a good few years now, definitely smacked their head off a car door or tripped them over as a toddler- they forgive you!

LITTLE BRAINS - DISCLAIMER

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For families, carers and trusted adults | November 2026

This resource is educational, not a diagnosis, first-aid certificate or substitute for individual medical/mental health care. If there is immediate danger or suspected overdose, call 999.

READ THIS PAGE FIRST

Recognising the signs of self-harm.

Self-harm is not always easy to recognise. Some children and young people go to considerable lengths to hide their injuries or emotional distress, while others may show subtle changes in their behaviour, relationships or daily routines.

Self-harm can take different forms, and it is important to understand that not all self-harm leaves visible marks.

There is no single set of warning signs, and noticing one or more of the following does not necessarily mean a child is self-harming. However, recognising changes in behaviour can help parents identify when their child might need additional support.

Physical Signs

- Unexplained cuts, scratches, burns or bruises.

- Injuries that appear repeatedly or at different stages of healing.

- Frequent explanations such as being clumsy or having accidents.

- Wearing long sleeves, trousers or layers of clothing even in warm weather.

- Reluctance to change clothes around others or participate in activities such as swimming.

- Frequently using plasters, bandages or dressings without a clear explanation.

- Bloodstains on clothing, bedding or towels.

Emotional Signs

- Increased sadness, anxiety, irritability or emotional overwhelm.

- Expressing feelings of worthlessness, guilt, shame or self-hatred.

- Becoming unusually critical of themselves.

- Difficulty talking about emotions or explaining how they feel.

- Sudden changes in mood or emotional responses.

- Expressing hopelessness or feeling like a burden to others.

- Appearing emotionally withdrawn or disconnected.

Behavioural Signs

- Spending significantly more time alone or withdrawing from family and friends.

- Becoming unusually secretive about injuries or personal activities.

- Avoiding situations where their skin might be visible.

- Changes in sleeping or eating patterns.

- Losing interest in previously enjoyable activities.

- Difficulties concentrating or changes in school attendance.

- Increased risk-taking or other behaviours that may cause harm.

Social and Relationship Changes

- Pulling away from friendships or family relationships.

- Increased conflict or sensitivity to criticism.

- Becoming uncomfortable with physical affection or closeness.

- Avoiding social events or activities they previously enjoyed.

- Difficulties communicating their needs or asking for support.

These signs can also occur for many other reasons, including bullying, bereavement, anxiety, trauma, physical illness or ordinary developmental changes. They should be treated as reasons to check in with your child, rather than proof of self-harm.

Other Signs Parents May Overlook

Sometimes there are no obvious injuries. Other warning signs can include taking medication in unsafe amounts, deliberately hurting oneself in ways that are less visible, pulling out hair, or significant changes in eating behaviours. These behaviours can have different underlying causes and do not automatically establish that a child is self-harming.

For neurodivergent children and young people, it is especially important to consider changes from their usual behaviour rather than assuming withdrawal, emotional dysregulation or sensory-related behaviour necessarily indicates self-harm.

Look for changes, not just injuries.

A child who self-harms may still laugh, enjoy friendships, do well at school and appear happy. Their distress may not be obvious to those around them. The aim isn't to become a detective in your child's life. It is to remain emotionally available, recognise when something may be wrong and create an environment where your child feels safe enough to ask for help.

Remember, discovering or suspecting self-harm can be frightening, but your child's behaviour is not a reflection of your worth as a parent.

If you have identify the sign's and feel worried- start here: safety comes first

Support the person and attend to the medical situation. You do not have to determine whether an injury was “serious enough” before asking for help.

Situation	What to do
Suspected overdose, poisoning, severe bleeding, serious injury, unconsciousness, breathing difficulties, or an immediate suicide danger	Call 999 or go to A&E immediately. Do not wait for symptoms of poisoning. Follow emergency call-handler advice.
Worry about immediate safety, escalating self-harm urges or suicidal thoughts, but no obvious life-threatening injury	Stay with the child if there may be immediate danger. Contact GP / existing mental health team urgently; outside hours, call NHS 24 on 111 and choose mental health.
Self-harm disclosed but no immediate danger or serious injury	Respond calmly. Arrange GP review promptly, including injury review if needed; ask about thoughts of suicide rather than assuming either way.
Child is withdrawn and will not answer safety questions	Do not interpret silence as reassurance. Seek urgent clinical advice when concerned and use 999 if you cannot keep them safe.

If an episode has just happened

1. Move to a calmer, more private place; use a steady voice and stay near them.

2. Check whether urgent medical attention is needed. If an overdose or poisoning is suspected, call 999 even if they seem well.

3. Ask directly about current thoughts of suicide and immediate safety. (This does not encourage suicidal behaviors or plant a seed).

An example of how this could be said- “I am really worried that you might do something else to hurt yourself or end your life, is this something you think about? Not being here anymore?”

4. Get appropriate medical and mental health assessment; make a short-term plan for tonight and the next day.

WHAT PARENTS CAN SAY

“I am glad you told me. I am not angry. I care about keeping you safe. We will get through the next step together.”

EVIDENCE NOTE NHS inform; NHS 24; NICE NG225 [1–3].

A GUIDE, NOT A TEST

How to use this toolkit

Read the emergency page first- they are the ones that contain the information you can use immediately. Then choose the sections relevant to your child. The printable worksheets near the end are meant to be completed together and adapted, not imposed or used to monitor or interrogate.

What you will find

Understand	Respond	Plan
What self-harm is and what it can mean The psychology of distressBrain, body and medical needs Neurodivergence and younger children	Noticing changes First conversations Medical care and suicide questions Professional treatment School and family conversations	Immediate-response checklist Collaborative safety plan Pattern-and-needs map School support agreement Appointment planner

Four important principles to carry throughout

1. Safety before explanation. A child does not have to tell you why they harmed themselves to deserve care.
2. Connection before correction. Feeling understood often helps a young person engage with support.
3. Curiosity without assumption. The same behaviour can serve different functions at different times.
4. Small, repeated actions. Recovery is rarely linear and should never be judged only by the absence of visible injuries.

PRIVACY WITH SAFETY LIMITS

Invite your child to decide who needs to know where possible, but explain clearly that you may need to involve a clinician or safeguarding professional to protect them. Never promise absolute secrecy.

EVIDENCE NOTE NICE NG225 and NHS self-harm support [1,4].

PSYCHOLOGY + MEDICINE

Understanding self-harm

Self-harm means intentionally injuring or poisoning oneself, regardless of apparent purpose. It is a behaviour, not a diagnosis or character flaw. Some young people use it to cope with distress; some experience suicidal thoughts; and intent may change from one episode to another.

What self-harm can be communicating

“My feelings are too intense and I need the intensity to change.”

“I feel numb, disconnected, ashamed or unable to put this into words.”

“I need control when other parts of my life feel unpredictable.”

•“I need another person to understand that I am struggling.”

“I do not know exactly why; the urge arrives quickly.”

These are possible experiences, not a checklist. Some children cannot articulate a clear motive. A request for connection is a genuine need, not “attention seeking” in a dismissive sense.

What self-harm does not tell you

It does not automatically mean...	But you should still...
The child wants to die	Ask about suicide thoughts and safety directly.
The child has a particular mental health diagnosis	Seek an individual assessment of distress and physical health.
A parent caused the problem	Consider pressures across home, school, relationships, health and environment.
The child is manipulating others	Respond to unmet needs and safety rather than attributing bad motives.

CLINICAL DISTINCTION

Repeated head banging, biting or similar self-injurious behaviour in some younger or disabled children may differ from intentional self-harm. It still deserves assessment, including pain, sensory needs, communication and safety.

UNDERSTANDING BEHAVIOUR WITHOUT BLAME

Why self-harm can become a cycle

One useful psychological model is that behaviour can be reinforced when it quickly changes an unbearable feeling. This is called negative reinforcement: something unpleasant temporarily decreases, making the response more likely to recur. It is not a conscious choice to become unwell, and it will not explain every child.

A possible pattern - not a universal formula

Before	During	After
Stress, conflict, bullying, pain, overwhelm, self-criticism or numbness	A fast-growing urge; it may be difficult to think flexibly or ask for help	Brief relief or change in feeling; later shame, secrecy, worry or further distress

Sometimes the scariest part is not knowing what to say in this situation. This is a completly normal response when someone you love is hurting themselves- you might feel shocked/helpless/frustrated. You want to help the child , you want to understand, you just do not have the tools yet to cope with this situation.

Five questions that can reveal the need beneath the behaviour and open the conversation:

Before you get to this point: the child or young person needs to know that they are not alone. If you need too- take a minute to breath and regulate yourself. Words like “I am here”, “We will work through this” and “You are not alone” can reassure the young person that you are not angry, they do not need to feel ashamed and you will take control of this situation as an adult.

When the child is ready, these questions can help you identify what is going on.

What was happening just before the urge?

What did your body feel like - tense, numb, hot, restless, exhausted?

What did the urge seem to promise: relief, a feeling, control, escape or help?

What happened afterwards, emotionally and physically?

What response from me would feel safe or useful next time?

A child may say “I don’t know”. That answer is information too. Explore together later, when calmer, rather than interrogating in the moment.

The psychology of shame

Fear of punishment or upsetting adults can increase secrecy. Secrecy may delay treatment of injuries and make distress feel harder to share. A non-judgemental response supports disclosure, but does not remove the need for clinical assessment.

TRY A NEEDS-BASED REFRAME

Instead of “Why are you doing this?”, try: “What was your mind or body trying to get away from, or what did you need more of?”

EVIDENCE NOTE NICE NG225; YoungMinds; Oxford parent guide [1,5,10].

THE MEDICAL AND PSYCHOLOGICAL PICTURE

Brain, body and distress

Stress changes what feels manageable

During acute distress, the body's threat-response systems can increase arousal: faster breathing or heartbeat, tense muscles, racing thoughts, and a narrowed focus on escaping discomfort. Some young people instead become shut down, detached or numb. These are descriptions of stress responses, not diagnostic tests.

When highly distressed, it may be harder to plan, name feelings, remember coping skills or process lots of speech. That is why a calm presence, a short sentence and a quieter environment may help more than a lengthy discussion.

What may be contributing

Mental health difficulties such as depression, anxiety, trauma-related symptoms or eating problems.

Pain, poor sleep, medication issues, neurodevelopmental differences or sensory overload.

Bereavement, bullying, discrimination, family stress, relationship changes or online experiences.

High self-criticism, feeling trapped, difficulties with emotional awareness or communication.

Why physical assessment matters

Self-harm can cause infection, scarring, complications after burns or injuries, and poisoning that is not obvious at first. The visible appearance of an injury does not reliably measure either emotional distress or suicide risk. Medical and psychological care should happen together when needed.

AVOID OVERSIMPLIFIED BRAIN CHEMISTRY

Claims such as "self-harm always releases endorphins" or "it is caused by low serotonin" cannot explain an individual child. Brain and stress processes may be involved, but personal context and careful assessment matter more than a single chemical explanation.

EVIDENCE NOTE NICE NG225; NHS inform; NICE autism guidance [1,2,9].

OBSERVATION WITHOUT SURVEILLANCE

Preventing Self-Harm: Creating Safety Without Removing Trust

When parents discover that their child is self-harming, their natural instinct is often to remove anything they believe could cause further injury. This comes from a place of love, fear and a desperate need to protect their child. However, it is important to understand that removing access to harmful objects is only one part of preventing self-harm.

Removing Sharp Objects

Parents may feel compelled to remove every sharp object from the home. While reducing access to items that could cause injury is an important safety measure, removing everything without discussion does not necessarily remove the desire to self-harm.

For some young people, sudden restrictions may increase feelings of shame, frustration or loss of control. There is also a concern that a young person who remains determined to hurt themselves may seek out other, potentially more dangerous or unhygienic objects, increasing the risk of injury and infection.

This does not mean parents should leave dangerous objects accessible. Sharp items that present a risk should be secured, particularly when a young person is experiencing significant distress or there is an immediate concern for their safety.

Where possible, involve your child in conversations about making their environment safer. Explain that these precautions are about protection, not punishment.

The aim should be to reduce opportunities for harm while also addressing the emotional distress driving the behaviour.

Removing Access to Medication

Medication presents a different and potentially life-threatening risk. Taking medication in excessive quantities can cause serious internal damage, sometimes without immediate visible symptoms.

Securing medication is a practical and important precaution that parents can take.

Consider keeping prescription medicines, over-the-counter medication and other potentially harmful substances in locked storage. Where necessary, a responsible adult can manage and administer prescribed medication according to medical instructions.

Parents can also speak with their GP or pharmacist about safer prescribing, smaller quantities and medication storage.

Medication should never be stopped or withheld against medical advice.

Prevention Is More Than Removing Objects

It is important to recognise that self-harm is often a response to overwhelming emotional distress. Removing access to harmful items may reduce immediate opportunities for injury, but it does not automatically resolve the feelings behind the behaviour.

Longer-term prevention involves understanding what your child is experiencing, identifying potential triggers, developing safer coping strategies and ensuring they have access to appropriate professional support.

A collaborative safety plan can help children and parents agree on warning signs, ways to manage difficult moments, people to contact and practical steps to make their environment safer.

The goal is not simply to remove everything your child could hurt themselves with. It is to help them reach a point where hurting themselves no longer feels like their only way of coping.

Remember, safeguarding your child and respecting their emotional needs are not opposing approaches. Both are essential.

How to approach what you notice

Choose a private, unhurried moment. Speak about the changes you can see rather than making accusations. Ask one clear question and leave room for an answer. If your child uses AAC, texting, drawing or written responses, invite that route.

OPENING WORDS

“I have noticed you seem to be carrying a lot lately. I might have got it wrong, but I’m worried about you. Have you been hurting yourself, or thinking about hurting yourself?”

If they say no

You can say: “Thank you for telling me. I’m here if that changes.” If signs or safety concerns persist, contact a GP or appropriate service; denial alone does not rule out need. Do not search their body or belongings as a routine response. Discuss reasonable safety measures transparently.

EVIDENCE NOTE NHS inform; NHS; YoungMinds [2,4,5].

WHAT TO SAY AND WHAT TO AVOID

The first conversation

A response that strengthens connection

Regulate yourself first: pause, breathe and speak slowly. You can process your shock with another adult later.

Thank them for telling you. A disclosure often takes courage.

Ask about injuries and safety, including suicide thoughts, without expressing disgust or blame.

Listen to what is hard in their world. Resist jumping immediately to solutions.

Agree the next step: medical review, support contact and when to talk again.

Instead of... (These never have the desired effect with a disregulated child)	Try... (This opens the conversation and builds the trust)
“Promise me you’ll never do that again.”	“If the urge comes back, how can we help you get through it more safely?”
“You have nothing to be upset about.”	“I can see this feels unbearable, even if I don’t fully understand yet.”
“You’re doing this for attention.”	“Your distress matters. I want to understand what support you need.”
“Show me every injury.”	“Do you have injuries that need medical attention? We can get help.”
“Tell me why right now.”	“We can talk later if now is too much. I do need to check your safety.”

If a child prefers not to speak

Offer a message, yes/no questions, drawing, sensory breaks, a walk, or a trusted professional. Do not mistake limited eye contact or a flat expression for a lack of distress.

RELATIONSHIP REPAIR

If you reacted strongly, you can come back and say: “I was frightened and I did not respond the way I wanted. I am sorry. You deserve care, and I am here to listen.”

MEDICAL CARE WITHOUT STIGMA

Responding after an episode

In the first minutes

IF APPLICABLE check responsiveness, breathing and the immediate environment; call 999 for serious injury, severe bleeding, suspected poisoning or overdose, or immediate danger.

For minor injuries, seek advice from a GP or NHS 24 if needed; an injury can be significant even when the young person minimises it.

Do not delay emergency care to work out why it happened or whether it was “really” self-harm.

For suspected poisoning, do not make them vomit. Tell emergency clinicians what may have been taken and follow their instructions.

Physical aftercare

A clinician can assess wound care, infection risk, burns, possible complications, need for further treatment, and whether tetanus vaccination needs checking. New or increasing redness, swelling, discharge, fever or worsening pain needs clinical advice. Avoid presenting self-care as a substitute for proper assessment.

The emotional follow-through

When the immediate medical risk has been addressed, ask about suicidal thoughts and agree who will stay nearby and how to reach help. Do not use threats, punishment, humiliating checks or forced confessions. The child should be offered a psychosocial assessment following self-harm.

IMPORTANT MEDICAL POINT

An overdose can cause serious harm before obvious symptoms appear. If you suspect one, call 999 rather than waiting to see how they feel.

EVIDENCE NOTE NHS inform; NHS urgent mental health; NICE NG225; NHS poisoning [1–3,11].

CLEAR LANGUAGE CAN SUPPORT SAFETY

0Asking about suicide

Self-harm and suicide are not identical, but they overlap, and intent can change. Asking directly about suicide does not “put the idea in a child’s head”. A child’s answer should guide urgent support, not be used as the only measure of risk.

Questions you can ask calmly

“Have you been thinking about dying or ending your life?”

“Have you thought about doing anything to end your life?”

“Do you feel you might act on those thoughts now, or soon?”

“Is there anything nearby that worries you or could make it harder to stay safe?”

“Can we stay together and contact someone who can help us now?”

How to respond

If there is current intent, a plan, access to means, an attempt or you cannot keep the child safe, call 999 or attend A&E. Stay with them while help is arranged.

If there are suicidal thoughts without obvious immediate danger, seek urgent professional advice the same day through GP / mental health team or NHS 24 (111).

Do not rely on a “promise not to self-harm”, a numerical risk score, or a label of low risk. NICE advises against predictive risk scales and risk categories.

Work together on practical safety steps, including securing medicines and other potentially dangerous items; use the least restrictive approach that still protects safety.

HELPFUL RESPONSE

“Thank you for trusting me. I am taking this seriously because you matter. We are going to get support together.”

EVIDENCE NOTE NICE NG225; NHS 24; Oxford Health [1,3,12].

ASSESSMENT AND EVIDENCE-INFORMED CARE

Getting professional support

Start with a GP or existing care team

Ask for an assessment of both mental health and any physical injury. Explain if the behaviour is new, repeated, escalating, associated with suicidal thoughts, or affecting school, sleep or daily life. Ask how to access local CAMHS or other appropriate child/young-person services. Families can use NHS 24 (111) for urgent out-of-hours mental health needs.

What a good assessment explores

- The young person's own account and what matters to them.
- Emotional distress, current safety, past episodes and possible suicidal thoughts.
- Home, school, friendships, social media, physical health, neurodevelopment and safeguarding.
- Strengths, preferences, communication needs, family support and a collaborative care plan.

Treatments parents may hear about

Approach	Purpose and evidence-based place
DBT adapted for adolescents (DBT-A)	NICE suggests considering it for young people with frequent self-harm and significant emotional dysregulation.
CBT-informed / other psychological care	May help with thoughts, feelings, coping and problem-solving, tailored to assessed needs; the clinician selects the approach.
Family involvement	Supports communication, safety and consistency, with the young person included where appropriate.
Medication	Not prescribed specifically to reduce self-harm. It may be used for an assessed coexisting condition under appropriate clinical care.

ASK THE CLINICIAN

"What is your understanding of what is driving the self-harm? What is our plan for the next difficult evening? Who do we contact if things worsen?"

CO-REGULATION, NOT QUICK FIXES

Building coping options

Self-harm urges may rise quickly and fluctuate. The aim is to create options for managing distress and reaching people - not to demand a coping trick as proof that someone is safe. Strategies are an addition to clinical care, never a replacement.

Choose by the need, not by a generic list

If the need seems to be...	Gentle alternatives to explore together
To calm overload	Quiet room, less talking, soft lighting, familiar music, comfortable blanket or preferred sensory item.
To release restless energy	Movement, stretching, walking, dancing, or a brief task chosen by the child.
To reconnect when numb or detached	Name five things visible in the room, feel feet on floor, hold a textured object, sip water.
To feel heard	Text a trusted adult, use a feelings card, sit alongside someone without pressure to talk.
To regain predictability	A visual plan, a choice between two small options, clear next steps, reduced demands.

Make a “support menu”

Ask the child to choose two options they might actually use and one person they would contact. Test the ideas when calm. Some sensory or breathing exercises feel unpleasant to particular children; offer choices and stop if they make things worse.

AVOID PAIN-BASED SUBSTITUTES

Do not suggest snapping elastic bands, deliberately causing pain, or using extreme temperatures as a standard alternative- In my experience, they are not effective and can lead to the child feeling like their replacement strategies are “stupid”.

Choose non-injuring strategies and seek professional help for persistent urges.

EVIDENCE NOTE NICE NG225 harm-minimisation guidance; YoungMinds [1,5].

AN INDIVIDUALISED, ACCESSIBLE RESPONSE

Neurodivergence and younger children

Autistic and ADHD young people may have overlapping mental health needs, and their communication and sensory experiences may change how distress appears. However, do not assume neurodivergence explains away self-harm or reduces suicide risk.

What to consider

- Sensory overload: noise, light, touch, crowding and the need for decompression.
- Interoception and alexithymia: recognising body signals or naming emotions may be difficult for some children.
- Communication: speech may be hard during distress; offer AAC, symbols, texting, drawing or response options.
- Demand, masking and change: school exhaustion, social misunderstanding, uncertainty and transitions may add to stress.
- Physical factors: assess pain, constipation, dental problems, sleep difficulties, medication side effects or other illness as possible contributors, especially if there is repeated head banging, biting or hitting.

Intentional self-harm vs repetitive self-injury

Repeated self-injurious behaviour in younger children or children with learning disabilities may occur in response to pain, sensory differences, frustration or communication needs. It requires careful medical and developmental assessment, a functional understanding of situations, and safety planning. NICE NG225 explicitly treats repetitive stereotyped self-injury separately.

A USEFUL QUESTION

“What was different in the environment, body, expectations or communication just before this happened?” - while still checking for injury, distress and safety.

Adjust, do not exclude

Ask services for reasonable adaptations to communication, waiting times, sensory environments and appointment structure. Neurodevelopmental conditions should not be used to deny appropriate self-harm treatment. [1]

LOOK AT THE WHOLE ENVIRONMENT

Home, school and safeguarding

Consider the pressures around the child

Self-harm may coexist with bullying, peer rejection, identity-related discrimination, grief, abuse, family conflict, academic pressure, exclusion or unsafe online experiences. Do not assume one explanation. Ask about school and online life without treating technology itself as the sole cause.

Working with school

Ask who the named contact is (for example, guidance/pastoral staff or an appropriate safeguarding lead).

Share necessary safety information sensitively, ideally with the young person involved; agree what is confidential and who must know.

Ask for practical adjustments: trusted adult, quiet space, check-ins, flexible deadlines or attendance support as appropriate.

Agree how the school will respond to incidents and how parents will be informed.

Review bullying, harassment, additional support needs and peer dynamics without exposing the child's private story widely.

When safeguarding concerns arise

If there may be abuse, exploitation or neglect, seek professional safeguarding advice promptly and follow local child-protection pathways. Listen and record the child's words accurately; do not investigate or promise secrecy. Where immediate danger exists, call 999.

Boundaries in a community setting

Little Brains can signpost and support connection but is not an emergency mental health service. Staff and volunteers should follow organisational safeguarding procedures and not attempt clinical risk categorisation or wound treatment beyond their training.

WORDS FOR SCHOOL

"We're supporting our child following self-harm concerns. Could we agree one trusted contact, sensible adjustments and a clear route for urgent communication while preserving their dignity?"

EVIDENCE NOTE NICE NG225 school recommendations; NICE autism guidance [1,9].

KEEP RELATIONSHIPS BIGGER THAN SELF-HARM

Recovery and family wellbeing

What progress can look like

Your child tells someone sooner when distress increases.

You understand their early warning signs better, or conflict becomes easier to repair.

They attend an appointment, try a support strategy or ask for a break.

They reconnect with a safe activity, friend, routine or interest.

Episodes may still occur. Recovery is not invalidated by a setback.

What parents can maintain

Protect ordinary family life where possible. Shared meals, interests, sleep opportunities, predictable contact and moments of humour can help a child feel like more than a problem to solve. Treat routines as supports, not as moral tests.

If it happens again

Return to the same sequence: medical care, current suicide/safety questions, calm connection, professional follow-up and review of the safety plan. Avoid the phrase “back to square one”. Examine whether stressors, support access or the plan need to change.

Support for you matters

Parents may feel shocked, frightened, angry, guilty or exhausted. Seek your own support from another trusted adult, GP or parent service. Do not ask the child to manage your emotions. Shared safety responsibility can prevent one adult from becoming constantly on alert.

A SENTENCE TO REMEMBER

“We can take this seriously without treating our child as the behaviour.”

EVIDENCE NOTE NHS support for others; Oxford parent guide; NICE [1,4,10].

A PAGE TO RETURN TO

Quick facts: common myths

Common myth	What the evidence supports
“They are just looking for attention.”	Visible distress or a wish to be noticed still deserves care, and many young people hide self-harm.
“Self-harm always means suicide.”	Not always; assess suicidal thoughts and injury separately because risk can overlap and change.
“Talking about suicide gives people ideas.”	Asking sensitively and directly does not create suicidal thoughts.
“Small injuries mean low risk.”	Injury appearance does not reliably indicate emotional or suicide risk.
“Removing every choice will make them safe.”	Collaborative, proportionate safety measures are preferable when possible; act decisively in danger.
“Medication is the treatment for self-harm.”	NICE advises against medication specifically for reducing self-harm; treat assessed coexisting conditions.
“A setback means we failed.”	Needs and circumstances change; plans require review rather than blame.
“Autistic self-injury and adolescent self-harm are always the same.”	They may differ in function and require different assessments; both deserve care.

What matters most

Notice without judgement. Ask about physical injury and suicide. Arrange clinical care. Build a collaborative plan. Return to connection again and again.

FOR PARENTS AND CARERS

Worksheet A - First 48 hours

Use this as a prompt, not a diagnostic assessment. Call 999 for emergency warning signs at any point.

Now: safety and health

- ☐ Emergency care considered / 999 called if appropriate
- ☐ Physical injuries reviewed or advice sought
- ☐ Direct question about suicidal thoughts and immediate safety
- ☐ A trusted adult agreed to stay nearby if needed
- ☐ Medicines and other potentially dangerous items secured collaboratively

Next: access to help

- ☐ GP / existing mental health team contacted
- ☐ NHS 24 111 used if urgent or out of hours
- ☐ School or other trusted support contact considered, with privacy respected
- ☐ A short collaborative safety plan started
- ☐ Parent has arranged support for themselves

Who will contact which service, and when?

_____

_____

What needs to change tonight to help this child feel and be safer?

_____

_____

IF SAFETY CHANGES

Do not wait for this worksheet to be complete. Use 999 for life-threatening emergencies or NHS 24 111 for urgent mental health support.

COMPLETE TOGETHER WHEN CALM

Worksheet B - Our joint safety plan

Keep a copy somewhere accessible to the child and the adults involved in their care. Review with clinical professionals.

My early warning signs (thoughts, feelings, body signals or behaviours):

_____

_____

What situations tend to make things harder?

_____

_____

Two things that may help me feel safer without injury:

_____

_____

One person I can contact; the easiest way to communicate with them:

_____

_____

What I would like a parent or carer to do (and not do):

_____

_____

What we will change at home to reduce access to dangerous items:

_____

_____

My professionals / out-of-hours contacts:

_____

_____

If I might act on suicide thoughts, cannot stay safe, or there is serious injury or poisoning, we will seek emergency help on 999. For other urgent mental health needs in Scotland, NHS 24 is 111.

NEEDS AND PATTERNS MAP

Worksheet C - What is happening for me?

Only use when the child wishes to engage; it is a reflection tool, not evidence gathering or a demand for disclosure.

What was happening around me?

_____

_____

What I noticed in my body or thoughts:

_____

_____

The feeling or need that was hardest to manage:

_____

_____

What helped a little (even for a minute)?

_____

_____

What made the situation worse?

_____

_____

What I would like adults to understand or do differently:

_____

_____

My communication preference

□ Talking □ Texting □ Drawing □ AAC / symbols □ Sitting together quietly □ Other: _____

One small change to try this week

Our idea:

_____

_____

A SHARED, RESPECTFUL APPROACH

Worksheet D - Working with school

Named school contact / trusted adult:

_____

What the child agrees can be shared:

_____

_____

Changes that may reduce stress or increase access to help:

_____

_____

_____

How the child can ask for support privately during the school day:

_____

_____

When parents will be contacted, and who will contact them:

_____

_____

What will happen if there are urgent safety concerns:

_____

_____

Review date and person responsible:

_____

CHILD-CENTRED REMINDER

The child should not be publicly identified, punished for disclosure or required to explain personal information to multiple adults. Follow school child-protection procedures if safeguarding concerns arise.

QUESTIONS FOR THE GP OR MENTAL HEALTH TEAM

Worksheet E - Appointment and follow-up

Information I want to bring

□ Recent changes in sleep, appetite, school or relationships □ Physical symptoms and injury concerns

□ Current medication and other health needs □ Self-harm urges / episodes □ Questions about suicide / safety

□ Communication or sensory adjustments □ What helps / strengths □ Safeguarding worries

Questions worth asking

1. What physical treatment or follow-up is needed?
2. How will my child receive a psychosocial assessment?
3. What support is available while waiting for treatment?
4. Would a referral to CAMHS or another specialist service be appropriate?
5. What should we do if urges, injuries or suicidal thoughts intensify?
6. Who holds the care plan, and what information should school receive?

The clinician's advice / referrals agreed:

_____

_____

_____

Who will follow up, and by when?

_____

_____

Next review date:

_____

CONTACTS WORTH KEEPING ACCESSIBLE

Support in Scotland

Helplines support connection and signposting. They do not replace emergency medical care.

Service	Contact / when to use
Emergency	999 - serious injury, suspected overdose or poisoning, immediate danger or imminent suicide risk.
NHS 24 Mental Health Hub	111 - urgent mental health advice, all ages in Scotland, 24 hours a day.
Childline	0800 1111 - confidential support for under-19s; 24/7.
Samaritans	116 123 - confidential listening support for anyone; 24/7.
Shout	Text SHOUT to 85258 - free 24/7 crisis text support in the UK.
Self-Harm Network Scotland (Penumbra)	selfharmnetworkscotland.org.uk - support and resources for ages 12+ plus families and professionals; evening webchat and self-referral.
Breathing Space	0800 83 85 87 - for people aged 16+ in Scotland, evenings and weekends; not an emergency service.
GP / school / local services	For assessment and continuing support. Ask how to access CAMHS and any local services appropriate to your child.

This toolkit is not clinical advice, and Little Brains does not provide emergency mental health treatment.

EVIDENCE BASE

Sources and further reading

Source links checked 5 November 2026. Clinical guidance may change; check the current versions when using this resource.

[1] NICE (2022; reviewed 2024). NG225: Self-harm: assessment, management and preventing recurrence.

https://www.nice.org.uk/guidance/ng225/chapter/recommendations

[2] NHS inform. Self-harm (Scotland).

https://www.nhsinform.scot/illnesses-and-conditions/mental-health/self-harm

[3] NHS inform / NHS 24. Urgent mental health help and 111 mental health support.

https://www.nhsinform.scot/illnesses-and-conditions/mental-health/mental-health-support/get-urgent-mental-health-help/

[4] NHS. How to help someone else who self-harms.

https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/self-harm/how-to-help-someone-else/

[5] YoungMinds. Self-harm: parents' guide.

https://www.youngminds.org.uk/parent/parents-a-z-mental-health-guide/self-harm/

[6] Self-Harm Network Scotland (Penumbra).

https://selfharmnetworkscotland.org.uk/

[7] Public Health Scotland. Information for the public: mental health support.

https://publichealthscotland.scot/population-health/public-mental-health/information-for-the-public/

[8] NICE. NG11: Challenging behaviour and learning disabilities.

https://www.nice.org.uk/guidance/ng11/chapter/Recommendations

[9] NICE. CG170: Autism spectrum disorder in under-19s: support and management.

https://www.nice.org.uk/guidance/cg170/chapter/recommendations

[10] University of Oxford / Oxford Health. Coping with self-harm: a guide for parents and carers.

https://www.oxfordhealth.nhs.uk/wp-content/uploads/sites/13/2020/10/Parents-Guide-self-harm-002.pdf

[11] NHS. Poisoning: getting urgent help.

https://www.nhs.uk/conditions/Poisoning/

[12] Oxford Health NHS. Caring for someone who may be at risk of suicide.

https://oxfordhealth.nhs.uk/carers/support/self-harm/