NCASP
NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP

Procedure for the management of self-harm and/or suicidal behaviour in children & young people

Document control and record of amendments		
Version	Amendment	Date
1.0	New procedure	December 2019
2.0	Refresh following advice from mental health services	August 2020
3.0	Review and update - learning from 3 case reviews	August 2022

CONTENTS

INTRODUCTION

WHO IS THIS DOCUMENT FOR?

It is primarily for use by front line staff working with:

- young people who identify themselves as using self-harm as a coping strategy;
- children and young people of whom adults are aware have considered or engaged in suicidal behaviour or ideation
- young people who may require access to service from universal (school health) targeted (PMHW) and specialist mental health services (Children & Young Peoples Service (CYPS) or crisis (universal Crisis Children and Young people's pathway) as a result of disclosing self-harm, suicide ideation and/or attempted suicide.

PRINCIPLES UNDERPINNING THIS PROCEDURE

- Safeguarding the child or young person is of paramount importance
- Recognising self-harm as a real and sensitive issue
- Each young person to be treated as an individual
- Ensure the implementation of equal opportunities
- Young people to be made aware of the local Confidentiality & Information Sharing policy
- To work towards minimising harm and give coping strategies where appropriate
- Recognising the young person may be part of a family unit
- Support to be offered to families
- Where staff feel intervention is necessary, this will be achieved through ongoing communication with the young person

THE AIM OF THIS PROCEDURE

1. To ensure the child or young person is kept safe
2. To improve the quality of support, advice and guidance offered to young people who self-harm, or maybe at risk of attempting and or completing suicide
3. Offer consistent support to children and young people no matter what point of contact, to standardise the response of agencies regardless of what type of agency
4. To align services and promote joint working
5. To increase knowledge, skills and competence of staff to recognize and respond appropriately when working with a young person who self-harms, and/or knows of someone who self-harms
6. To meet a locally identified need by service providers & commissioners

DEFINITIONS TO SUPPORT THIS PROCEDURE

Suicide

- Suicide is an intentional, self-inflicted, life-threatening act resulting in death from a number of means.

Suicidal intent

- This is indicated by evidence of premeditation (such as saving up tablets), taking care to avoid discovery, failing to alert potential helpers, carrying out final acts (such as writing a will) and choosing a violent or aggressive means of deliberate self-harm allowing little chance of survival.

Self-harm

- Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered.
- ***Self-harm can involve:***
  - cutting
  - burning
  - scalding
  - hitting or scratching
  - breaking bones
  - hair pulling
  - swallowing toxic substances or objects

Self-injury

- Self-injury is any act which involves deliberately inflicting pain and/or injury to one's own body, but without suicidal intent.

The term self-harm is often used as an all-encompassing term referring to suicidal ideation and attempted suicide

THE RISK ASSESSMENT PROCESS

First Contact – Baseline Risk Assessment Stage

A child, a peer or a parent may directly contact a member of staff. Equally a worker may notice a change in the child's behaviour or appearance that leads to a cause for concern. Either way, an early baseline assessment should take place to ensure that the child or young person gets timely and appropriate support.

All key contacts need to feel confident to make an early baseline assessment via a number of basic but important questions – See below – *risk factors outlined on page 7 should be considered when completing baseline risk assessment.*

BASELINE RISK ASSESSMENT: QUESTIONS AND GUIDANCE

Initial questions

- What has been happening?
- Have you got any injuries or taken anything that needs attention consider emergency action?
- Who knows about this?
- Are you planning to do any of these things – consider likely or imminent harm?
- Have you got what you need to do it (means)?
- Have you thought about when you would do it (timescales)?
- Are you at risk of harm from others?
- Is something troubling you? – family, school, social, consider use of child protection procedures.

Responses

- If urgent medical response needed call an ambulance
- Say who you will have to share this with (e.g. designated safeguarding lead) and when this will happen
- Say who and when the right person will speak with them again to help and support them
- Check what they can do to ensure they keep themselves safe until they are seen again e.g. stay with friends at break time, go to support staff.
- Give reassurances i.e. its ok to talk about self-harm and suicidal thoughts and behaviour

Setting up the contract with the child or young person

- Discuss confidentiality child protection if necessary
- Discuss Child Protection if necessary
- Discuss who knows about this and discuss contacting parents
- Discuss who you will contact
- Discuss contacting the GP

Further Questions

- What if any self-harming thoughts and behaviours have you considered or carried out? (Either intentional or unintentional – consider likely / imminent harm)
- If so, have you thought about when you would do it?
- How long have you felt like this?
- Are you at risk of harm from others?
- Are you worried about something?
- Ask about the young person's health (use of drugs / alcohol)?
- What other risk taking behaviour have you been involved in?
- What have you been doing that helps?
- What are you doing that stops the self-harming behaviour from getting worse?
- What can be done in school to help you with this?
- How are you feeling generally at the moment?
- What needs to happen for you to feel better?

Dos

- Make first line assessment of risk
- Take all suicide/self-harm gestures seriously
- Be yourself, listen, be non-judgmental, patient, think about what you say
- Check associated problems such as bullying, bereavement, relationship difficulties, abuse, and sexuality questions
- Ask about parental conflict including domestic violence and abuse
- Check how and when parents will be contacted
- Encourage social connection to friends, family, trusted adults
- Implement initial care pathway
- Implement support/contact with young person
- Seek further risk assessment from appropriate service to meet need as per the graduated response
- Make appropriate referrals
- Set up a meeting to plan the interventions based upon understanding of the risks and difficulties
- Refer to Children's Social Care triage to identify appropriate pathway (CSC, Early Help, universal services)
- Provide opportunities for support, strengthen existing support systems
- Consider Risk Factors outlined on page 7

Don't

- Jump to quick solutions
- Dismiss what the children or young person is saying
- Believe that a young person who has threatened to harm themselves in the past will not carry it out in the future (past history of self-harm, regardless of severity, should be considered a factor)
- Disempower the child or young person
- Ignore or dismiss people who self-harm
- See it as attention seeking
- Assume it is used to manipulate the system or individuals
- Minimise risks of threats to self-harm, if in the past they have not carried out previous threats to self-harm

At this stage it is strongly recommended that discussion should take place with other agencies involved with the child to ensure communication of any new risks or changes in the young person's life and clarify what work or care plans are in place.

Responses to the risk assessment questions together with an assessment of the appearance and behaviour of the child or young person will lead to some or all of the following:

- Referral to children's social care for triage and assessment. If no role is identified for Children Social Care, refer to Early Help.
- An increased awareness of the child's or young person's needs and an on-going support and potential re-assessment system being put in place locally, or

- A recognised need for the child or young person to be referred on for a more in- depth assessment and support.

LOOKED AFTER CHILDREN

If a child /young person is looked after then the *Looked After Health Team* should also be notified if a child has self-harmed (though this should not replace contact with mental health services and should be in addition to notification of child's social worker).

CONSENT ISSUES

The best assessment of the child or young person's needs and the risks they may be exposed to requires useful information to be gathered in order to analyse and plan the support services. In order to share and access information from the relevant professionals the child or young person's consent will be needed. Consent also needs to be sought from the parent/s (unless there is a safeguarding concern).

Professional judgement must be exercised to determine whether a child or young person in a particular situation is competent to consent or to refuse consent to sharing information. Consideration should include the *child's chronological age, mental and emotional maturity, intelligence, vulnerability and comprehension of the issues*. A child at serious risk of self-harm may lack emotional understanding and comprehension and the Gillick competency and Fraser guidelines should be used.

Informed consent to share information should be sought if the child or young person is competent. Advice should be sought from a Child and Adolescent Psychiatrist if use of the mental health act may be necessary to keep the young person safe. Consider the implications of the Mental Capacity Act 2005 for young people over the age of 16.

Information can be shared without consent:

- If the situation is urgent and delaying in order to seek consent may result in serious harm to the young person
- If seeking consent is likely to cause serious harm to someone or prejudice the prevention or detection of serious crime.

If consent to information sharing is refused, or can/should not be sought, information should still be shared in the following circumstances:

- there is reason to believe that not sharing information is likely to result in serious harm to the young person or someone else or is likely to prejudice the prevention or detection of serious crime; and
- the risk is sufficiently great to outweigh the harm or the prejudice to anyone which may be caused by the sharing; and
- there is a pressing need to share the information.

Professionals should keep parents informed and involve them in the information sharing decision even if a child is competent or over 16. However, if a competent child wants to limit the information given to their parents or does not want them to know it at all; the child's wishes should be respected, unless the conditions for sharing without consent apply.

Where a child is not competent, a parent with parental responsibility should give consent unless the circumstances for sharing without consent apply.

SAFEGUARDING / CHILD PROTECTION

At any stage, if a professional is concerned that the child is in need of protection, the usual child protection procedure should be followed whereby a referral to Children's Social Care should be submitted and decisions made in consultation with the police and other agencies on how to take forward the case.

Children's Social Care should always allocate cases involving the attempted suicide of a child to an experienced social work practitioner who has completed relevant training in this field and who is well acquainted with this pathway.

FURTHER ASSESSMENT OF RISK

Please remember that risk factors are not (nor can they ever be) tools for prediction. Also, any risk assessment can only be valid for the moment at which it is carried out and so may need to be repeated at suitable intervals according to professional judgement or advice.

Risk of self-harm is not the same as risk of mental illness, and one does not need to be mentally ill to self-harm, although there may be links (see below).

Bear in mind that some information can be obtained from the young person, but not all. Information may need to come from other sources, such as parents or carers, peers, or other professionals.

The order of the factors in the list below is not necessarily significant, as they are all worthy of consideration.

Risk factors:
☐ Previous deliberate self-harm or suicide attempt.
☐ Intent – does the young person wish to die? What do they understand by death? Do they think that what they have done, or are planning to do, will kill them? N.B. it is the young person's perception of or belief in potential lethality that is important here, not what a professional think.
☐ Evidence of mental illness, especially depression, psychosis or eating disorder.
☐ Poor problem-solving skills – are problems seen as over-whelming? Does the young person see themselves as capable of solving, or coping with, problems? Have they been able to solve problems in the past? May be linked to poor communication skills.
☐ Impulsivity/planning - Were steps taken to avoid discovery? Were any preparations for death made? A tendency to impulsive behaviour may increase risk of repetition and thus the likelihood of significant harm, but evidence of planning may indicate higher levels of seriousness for any given attempt. But remember that an impulsive act can be just as damaging as a planned one.
☐ Substance use (especially important in impulsive males).
☐ Hopelessness – is there a future, or any reason to continue living? What plans for the future does the young person have? This has been described as "the missing link" between depression and suicide. It can be especially significant if there has been previous deliberate self-harm or attempts at suicide.
☐ Anger/hostility/anti-social behaviour – some research suggests conduct disorder may be a higher risk factor than depression. This may be difficult to assess, as information will be needed from sources other than the young person.

☐ Family factors – instability (this can mean more than divorce or separation and can include repeated house moves). History of suicide or mental illness, especially in first-degree relatives. History of substance use. Arguments or disputes can be important.
☐ History of abuse, whether physical, emotional or sexual, but especially the latter.
☐ Loss or bereavement – this may include such things as loss of status as well as deaths. Anniversaries of losses can be significant.
☐ Bullying or other victimisation, such as experiencing racial or sexual discrimination, and including
☐ homophobic bullying (see below).
☐ Issues of gender or sexual orientation – a very high proportion of young people who either are homosexual or think they might be self-harm or attempt suicide.
☐ Current stressors or life events.
Other considerations:
☐ Function of deliberate self-harm (other than a clear suicide attempt) – what did the young person hope the act would achieve: a sense of relief or release; punishment; purification; a desire to feel physical rather than emotional pain; a form of communication of distress or other significant matter; something else?
☐ Method of self-harm – be aware of unintended consequences, such as liver damage from repeated 'Paracetamol' overdoses, stomach ulceration from aspirin overdose, brain damage from oxygen starvation in attempted hanging, drowning or exhaust poisoning, or bone damage resulting from jumping.
☐ Time of year may be significant, especially when school-related factors are involved, such as bullying or exams. Hence the start of terms or exam periods may see an increase in self-harming behaviour.
☐ Young people may be highly ambivalent in their views of themselves and any act of self-harm.

LEVELS OF RISK AND SUGGESTED ACTION:

Low risk:

- Suicidal thoughts are fleeting and soon dismissed
- No plan
- Few or no signs of depression
- No signs of psychosis
- Superficial harm
- Current situation felt to be painful but bearable.

Action:

- Ease distress as far as possible. Consider what may be done to resolve difficulties
- Link to other sources of support.
- Make use of line management or supervision to discuss particular cases and concerns
- Review and reassess at agreed intervals.
- Consider completing an Early Help Assessment or Multi-agency referral form (MARF)
- Consider safety of young person, including discussion with parents/carers or other significant figures
- **Consider consent issues**

Moderate risk:

- Suicidal thoughts are frequent but still fleeting
- No specific plan or immediate intent
- Evidence of current mental disorder, especially depression or psychosis
- Significant drug or alcohol use
- Situation felt to be painful, but no immediate crisis
- Previous, especially recent, suicide attempt
- Current self-harm

Action:

- Ease distress as far as possible. Identify what needs to be done immediately
- Consider safety of young person, including possible discussion with parents/carers or other significant figures
- Seek specialist advice and/or possible mental health assessment – discussion with, for example primary mental health worker, CYPS or G.P.
- **Consider consent issues for the above**
- Consider increasing levels of support/professional input
- Review and reassess at agreed intervals – likely to be quicker than if risk is low.
- Consideration of child protection processes
- Consider Multi-Agency referral form

High risk:

- Frequent suicidal thoughts, which are not easily dismissed
- Specific plans with access to potentially lethal means
- Evidence of current mental illness
- Significant drug or alcohol use
- Situation felt to be causing unbearable pain or distress
- Increasing self-harm, either frequency, potential lethality or both.
- Current suicide attempt

Action:

- Ease distress as far as possible. Consider what may be done to resolve difficulties
- Safety – discussion with parents/carers or other significant adults
- Referral to children's social care for child protection procedures
- CYPS referral
- **Consider consent issues**
- Consider increasing levels of support/professional input in the meantime
- Monitor in light of level of CYPS involvement.

NOTE: at any time during assessment and review emergency medical treatment may be found to be necessary or child protection concerns may be raised.

It is highly recommended to seek consent where possible, however, if there are concerns about harm then a referral should be made with or without consent

DIRECT REFERRAL ROUTE TO SPECIALIST OR EMERGENCY CARE

Some practitioners at the 'Baseline Risk Assessment Stage' might decide to directly refer to the professionals in the 'referral route' box. For example, a General Practitioner may refer directly to the Children and Young Peoples Service or the Universal Crisis team – children and Young people's pathway (0-18yrs)

It is also possible that the first time any community health or education professionals learn of a child or young person in need may be after attempted suicide or deliberate self-harm that has resulted in assessment in Accident and Emergency or admission to hospital. Where a child/young person has been deemed to need an assessment it is essential that we follow the correct procedures, make appropriate referrals and do not lose sight of that person post assessment.

A referral to Children's Social Care for every child and young person who attends A&E after attempted suicide or deliberate self-harm will enable an informed assessment of risk and vulnerability.

Children's Social Care will be able to assess any previous or ongoing involvement with the child or family, ensuring that available information is considered within the context of the child's attendance at A&E. Children's Social Care will then determine if the child/family require additional support and seek assurance the referral has been received. Agencies should feedback to CSC the outcome of the referral (to specialist or emergency care).

If a child or young person presents at A&E with issues relating to alcohol and or substance misuse, a referral to SORTED must also be made. A&E will share the Children's Social Care referral with SORTED (as stated in the 'Northumberland Care Pathway for children presenting at A&E with issues relating to alcohol and or substance misuse').

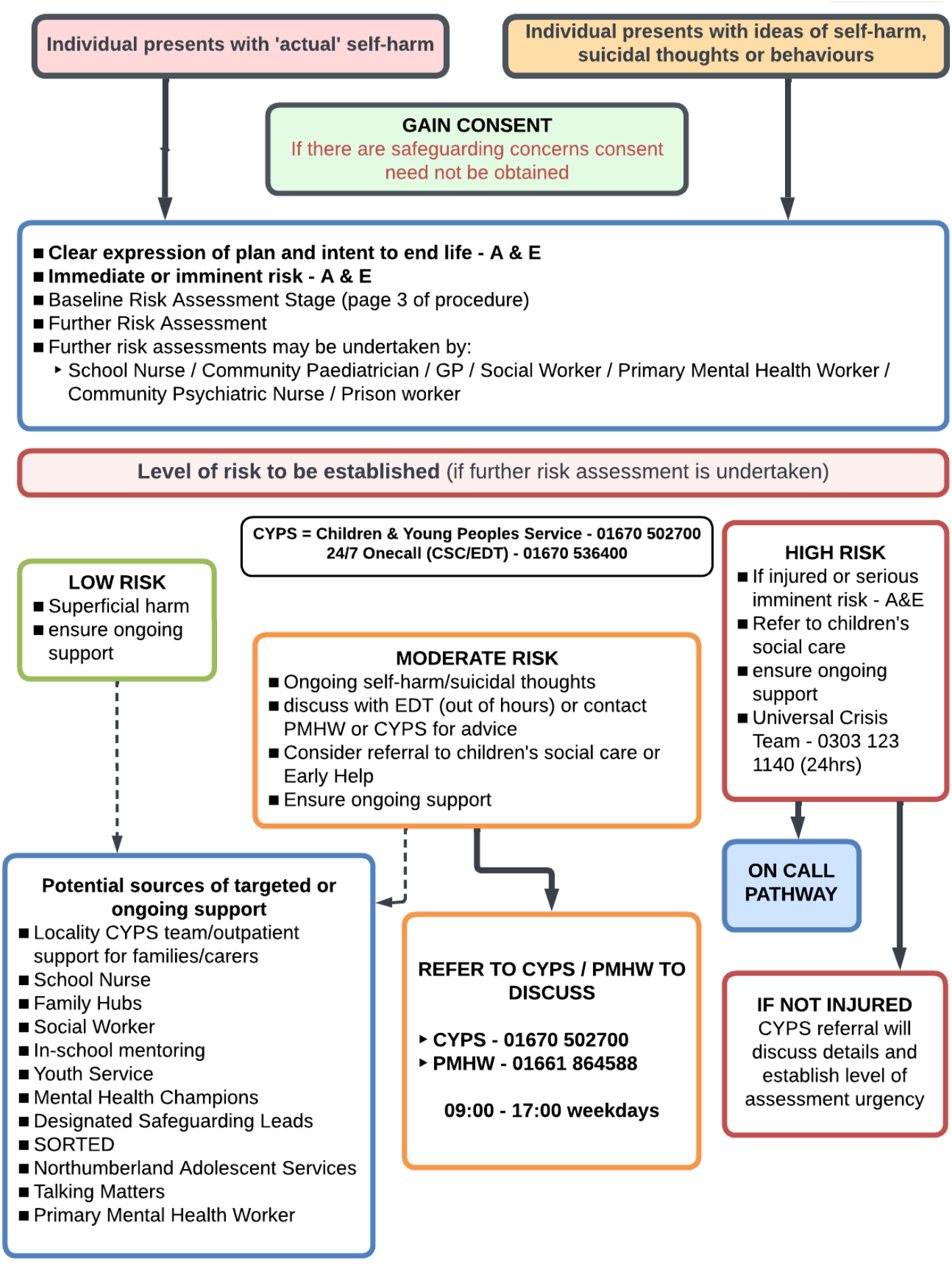
Early Help or other multi- agency planning processes may also be implemented to support the child/young person, including Early Help Assessment.

On-going support systems need to be put in place irrespective of the level of risk based on the notion that the level of perceived risk could change at any time. Ongoing support may take many forms and may be offered via numerous sources and will be dependent on the child or young person's needs and wishes.

Where the baseline assessment does not lead to referral for more in depth assessment it is essential that communication with the young person remains strong and that an appointed professional remains in contact with the young person on a regular basis.

It is also acknowledged that parents / carers, siblings, staff and other pupils may require support themselves when supporting young people at risk of self-harm.

Appendix 1: Northumberland Self Harm Pathway for Children and Young people



Children Act 1989 Section 17

- A child is defined as 'in need' by Section 17 of the Children Act (1989) if:
- he or she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services or
- his/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services or
- s/he is disabled.

Children Act 1989 Section 47

- Where a local authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.
- 'Harm' is defined as ill treatment, which includes sexual abuse, physical abuse and forms of ill-treatment which are not physical, for example:
- emotional abuse or impairment of health (physical or mental) or impairment of development (physical, intellectual, emotional, social or behavioural)
- This may include seeing or hearing the ill treatment of another (s120 Adoption and Children Act 2002).

Mental Health Act 1983

- The Mental Health Act 1983 is the principal Act governing the treatment of people with mental health problems in England and Wales. The Mental Health Act covers all aspects of compulsory admission and subsequent treatment.
- Besides these emergency procedures, there are other sections of the Act under which a person can be detained in hospital without their consent. (In November 1999 the Government issued a White Paper called 'Reforming the Mental Health Act', which was intended to act as the basis for a new Act. In June 2002 this was superseded by a draft Mental Health Bill).
- The Mental Health Act of 1983 covers the detention of people deemed a risk to themselves or others. **It covers four categories of mental illness: *severe mental impairment*, *mental impairment*, *psychopathic disorder*** and ***mental illness.***
- Severe mental impairment and mental impairment are generally interpreted as people with learning difficulties who have aggressive tendencies.
- Psychopathic disorder relates to people who have a "persistent disorder or disability of the mind" which leads to aggression.
- Mental illness itself is not defined by the Act. However, it does state what it does not cover, which includes people who may be deemed to be mentally ill "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".
- The Act allows people considered to be mentally ill to be detained in hospital and given treatment against their will. They do not have to commit a crime or have harmed anyone. They are usually detained because it is considered in their interests and for their own safety, but they may be held because they are deemed a risk to others.

Appendix 3 - Useful Organisations/Contacts

National Self Harm Network (NSHN)

The lead UK charity offering support, advice and advocacy services to people affected by self-harm directly or in a care role.

- What is Self-Harm?
- Advice for Friends, Family and Carers
- Advice for Young People
- Basic First Aid
- Common Misconceptions
- Distraction Lists

These leaflets and posters are available to download free of charge and can be printed and given out to children and their families and/or displayed in public areas. Further information and resources are available on the National Self Harm Network website.

NSHN Support Helpline: *0800 622 6000 (7pm-11pm Thursday-Saturday, 6.10pm-10.30pm Sunday)*

Childline 0800 1111 www.childline.org.uk

British Association for Counselling and Psychotherapy (BACP)
BACP House, 35–37 Albert Street, Rugby CV21 2SG tel. 0870 443 5252, minicom: 0870 443 5162. email: bacp@bacp.co.uk web: www.bacp.co.uk

Kooth
Kooth is an online mental wellbeing community. Access free, safe and anonymous support
https://www.kooth.com/

Mind
tel. 0845 766 0163
Mind is the leading mental health organisation in England and Wales, providing a unique range of services.
https://www.mind.org.uk/

Samaritans http://www.samaritans.org/ Phone: 08457 909090
Befriending service for anyone going through a personal crisis who is at risk of suicide.

Mental health and counselling organisations
https://www.mind.org.uk/information-support/drugs-and-treatments/talking-therapy-and-counselling/#.XefJnej7SUk

Young Minds
https://youngminds.org.uk/
102–108 Clerkenwell Road, London EC1M 5SA parents information service: 0800 0182138 web: www.youngminds.org.uk
For anyone concerned about a child's mental health

The Mix - essential support for under 25s

NICE

NICE guidance sets the standards for high quality healthcare and encourages healthy living. The guidance can be used by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.

Web: http://guidance.nice.org.uk/

FURTHER INFORMATION

The links relate to publications about self-harm and suicide with sections about children and young people as in the latest national strategy:

Self-harm in Young People: Information for Parents, Carers and anyone who works with Young People Royal College of Psychiatrists

This webpage looks at the reasons behind why people self-harm, and offers advice about what to do to help.

The Mental Health Foundation: The Truth About Self-harm (for young people and their friends and family)

This booklet aims to help you understand more about self-harm and what to do if you are worried about yourself or someone else. It explains what self-harm is, what to do if you or someone you know is self-harming, and how to get help. Self-harm is very common and affects more people than you might think.

Suicide Prevention: resources and guidance (GOV.UK)

Help for local authorities, public healthcare professionals, police forces, and others to prevent suicides in their areas.

National Suicide Prevention Alliance (NSPA)

The NSPA works with its members to share knowledge, learning and good practice in suicide prevention and they provide a range of guidance and information.

Support after Suicide Partnership is a special interest group of the NSPA. Its site contains a number of resources including Help is at Hand, and also links to additional support for people who have been affected by suicide.

Suicide in Children and Young People – NCMD Thematic Report (October 2021)

This report draws on data (from April 2019 to March 2020) from the National Child Mortality Database (NCMD) to identify the common characteristics of children and young people who die by suicide, investigate factors associated with these deaths and pulls out recommendations for service providers and policymakers.

Suicide - State of Child Health - RCPCH

The rate of young people ending their own life has increased across the UK, with trends considerably higher for young men than young women. This evidence report looks at the indicator suicide in 15-24 years old. Report highlights key findings, what children and young people are saying, what good looks like and makes policy recommendations. This indicator was published in March 2020. In May 2021 RCPCH updated graphs and charts where new data had been published, and reviewed their policy recommendations by nation (See: England report)

Suicide by Children and Young People 2017 (HQIP)

This report examines the findings from a range of investigations such as coroner inquests, into the deaths by suicide of people aged under 25 between January 2014 and December 2015 in England and Wales, extracting information about the stresses they were facing when they died. Data was collected from 922 suicides by people aged under 25 in England and Wales during 2014 and 2015. The information came from investigations by official bodies, mainly from coroners, who take evidence from families and professionals.

ZeroSuicideAlliance.com
NHS charity hosted by Mersey Care NHS Foundation Trust dedicated to preventing suicide. Works in collaboration with NHS trusts, non-profit organisations, local authorities, businesses and individuals to raise awareness of suicide and its contributing factors.

ZSA useful links:

- free suicide awareness training - how to identify, understand and help someone who may be experiencing suicidal thoughts.
- resources (interactive and evidence-based) - to support community and organisational leaders to understand the incidence of suicide in their local area, the factors that contribute to suicide and what others are doing to tackle these issues.
- Facts for Action: Suicide incidence
- Facts for Action: Children & young people
- Facts for Action: Adults
- Suicide Prevention Resource Map - find out more about suicide rates and the challenges that your community face.
- Case Study Library - a range of examples of good practice within organisations who are working towards better mental health and wellbeing care for all, including those taking proactive steps to prevent incidences of suicide from a community, service and strategic perspective.
- Resource library - provides a range of new and emerging resources.