Safeguarding Children and Young People who self-harm: A Multi-agency approach

Newcastle Self-harm Care Pathway January 2020

1. Introduction

The UK has the highest self-harm rates of any country in Europe. A recent UK study looked at trends in reports of self-harm among young people aged 10 to 19 since 2001.[1] It found annual rates of self-harm of 37 per 10,000 girls and 12.3 per 10,000 boys. The study reported a 68% rise in rates of self-harm amongst girls aged 13 to 16 since 2011, something that was not seen in boys or any other age group in girls. Many cases involved drugs or alcohol. The study also highlighted a social divide with higher rates of self-harm in more deprived areas.

Non-fatal self-harm is also the strongest risk factor for subsequent suicide, which is the second most common cause of death among 10-24-year olds worldwide after road traffic incidents. In the United Kingdom, suicide rates amongst adolescents aged 15-19 years have increased from 3.2 to 5.4 per 100 000 between 2010 and 2015, respectively. Half of adolescents who die by suicide have a history of self-harm. Approximately three quarters of young people who die as a result of suicide are male and the most common methods of suicide are asphyxiation by, for example, hanging, followed by overdosing.

It is therefore imperative that all professionals coming into contact with children and young people have the skills to be able to identify young people who are at risk and refer to appropriate services. This Guidance aims to provide professionals with information surrounding self-harm in children and young people with reference to

NICE Guidance and a proposed pathway for referral to Children's Social Care for those individuals where a multiagency assessment is deemed to be needed.

2. Definitions

Self-harm as defined in NICE Guidance refers to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation.

Attempted suicide is defined as Self-harm with intent to take life, resulting in non-fatal injury

Suicide is defined as self-harm resulting in death.

3. Why do children and young people self-harm?

The phrase 'self-harm' is used to describe a wide range of behaviours. Self-harm is often understood to be a physical response to an emotional pain of some kind and can be very addictive. The most common activities include cutting and taking overdoses although there are many other forms such as hitting, burning, pulling hair, picking or scratching at the skin, swallowing things which are not edible or inserting objects into the body. Other behaviours identified include eating disorders, drug and alcohol misuse and risk-taking behaviours. It is therefore often more helpful to focus on how someone is feeling rather than what they do to themselves.

Self-harm often happens during times of anger, distress, fear, worry, depression or low self-esteem in order to manage or control negative feelings. Self-harm can also be used as a form of self-punishment for something someone has done, thinks they have done, are told by someone else that they have done, or that they have allowed to be done to themselves.

In the majority of cases self-harm remains a secretive behaviour that can go on for a prolonged period before it is discovered. Less than a quarter of children and adolescents who self-harm are believed to present to healthcare services. Current figures, based largely on hospital data, likely underestimate the incidence of self-harm. People who self-harm and present to general practitioners alone are not captured and only half of self-harm presentations to secondary care result in hospital admissions.

Some of the reasons that young people report as triggers or reasons that lead them to self-harm include:

- difficulties at home (abuse, domestic abuse, conflict with parents)
- bereavement
- arguments or problems with friends/ relationships

- Bullying (including cyber bullying)
- depression.
- anxiety.
- trauma.(including experience of abuse in earlier childhood)
- low self-esteem.
- Difficulties associated with sexuality
- transitions and changes, such as changing schools.
- Stress and worry about academic performance/ exams
- alcohol and drug use.

A wide range of mental health problems are associated with self-harm, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders.

Although there are no “typical” groups of people who self-harm there are identifiable groups who we know are at higher risk with girls being up to four times more likely to self-harm than boys. Other vulnerable groups include:

- Young people with pre-existing mental health problems
- Young people with substance misuse problems
- Young Asian women
- LGBT young people
- Young people with learning disabilities
- Young people in residential care / residential settings including boarding schools, armed services, hostels, prison
- Young people who miss appointments and go off the radar

4. Identifying children and young people who are self-harming

Self-harming behaviour is often hidden, and a young person may feel ashamed or guilty of their actions and therefore how a professional responds to their self-harming behaviour is crucial in determining the likelihood of them engaging with services and support.

Warning signs that a child or young person is self-harming include observable changes in behaviour such as:

- Physical marks or scarring

- Internet use (looking at suicide related sites)
- Changes in mood
- Becoming withdrawn/isolated from friends and family
- Changes in eating / sleeping behaviour
- Reluctance to get undressed / expose specific parts of body
- Drug / alcohol misuse
- Lowering of school grades
- Expressions of suicidal ideation (especially to peers)

5. Responding to the child or young person who self-harms

NICE Guidance[2,3] provides standards of care for children and young people who present with self-harm. It is recommended that "All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment."

When a practitioner has identified self-harming behaviour, it is important to gather further information sensitively from the young person to identify whether they have taken any substances or injured themselves in order to decide whether the person needs urgent medical attention. If urgent medical attention is required, then this should be arranged without delay.

If urgent medical attention is not required, then it is appropriate for the practitioner to gain further information about the self-harming behaviour from the young person to decide whether further referral to a specialist service is needed. Informed consent to share and access information from relevant professionals should be sought if the child or young person is competent unless the situation is deemed to be urgent and there is no time to seek consent or seeking consent is likely to cause serious harm to someone. If consent has not been able to be sought or a young person refuses consent but there are concerns about the risk of serious harm, then information should be shared (See Information Sharing Guidance)

Such questioning should include:

- How long have they been feeling like this?
- Are they worried about something in particular?

- Are they at risk of harm from others?
- How long have they felt like this?
- What other risk-taking behaviour are they involved in?
- Ask about general health including drug and alcohol use
- What have they been doing which helps?
- What are they doing that stops the self-harming behaviour from getting worse?
- What needs to happen for them to feel better?

Consider referral to GP/CYPS/counselling

Young person presenting at hospital

For the child or young person under the age of 16 presenting to hospital following an episode of self-harm they should be admitted overnight under the care of the Paediatric team and a referral to the mental health team made (Children and Young People's service) for a mental health assessment .

The initial paediatric assessment should include sensitive questioning of the young person using the HEEADSSS tool as the basis for the history taking to ensure a thorough detailed assessment is undertaken. (HEEADSSS is a recognised interview framework tool which refers to Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicidal ideation and Safety that allows a better understanding of the young person's situation and what their specific needs may be)[5]

Any child or young person refusing admission should be reviewed by a senior paediatrician in the Emergency Department and their management discussed with the on-call Child and Adolescent Psychiatrist

For those young people between the ages of 16 and 18 years presenting to hospital a referral will be made to the Psychiatric Liaison Team and offered a full biopsychosocial assessment including risk assessment. The Psychiatric Liaison team comprises of a Consultant Psychiatrist, Doctors in training, mental health nurses and social work input. Out of hours this is staffed by nurses with input from the on-call psychiatrist. Depending on the outcome of this assessment the Psychiatric Liaison Team will refer onwards to the adolescent Crisis Team (ICTS until 10pm) or Adult Crisis Team after 10pm. All 16-18-year olds are referred to ICTS for 7 day follow up.

6. Referral to Children's Social Care

Children and young people who have committed suicide have been the subject of serious case reviews. In many situations it is not possible to predict which children and young people will go onto commit suicide but professionals working with this group of young people who are self-harming need to be aware of the risk factors. For those children presenting with self-harm there may be concerns raised by the professionals assessing the young person that a child or young person is a Child in Need of services which could take the form of an Early Help assessment. In some situations, there may be concerns about the risk of significant harm to the child or young person requiring child protection and a Section 47 investigation. In assessing the risk of harm, it is helpful to consider the following questions:

- Is there evidence that the parents/carers are failing to protect the child from harm or are they failing to diminish the risks of further attempts at harm?

- Is the child exhibiting behaviour beyond the control of their parent/carer and are they continuing to self-harm or attempt suicide?

- Is the child too young or has learning difficulties and is not able to give an explanation consistent with self-harming behaviour?

- Is the child being harmed or suspected of being harmed by another adult or child (including injury from a sibling or severe bullying by other children or situations where the child id witness to, or the subject of, domestic violence)?

- Following an assessment, is there significant concern that the child's family circumstances would continue to place them at risk of significant harm?

7. Pathway for children and young people presenting to GNCH Paediatric Emergency Admissions Unit with self-harm or suicide attempt

This pathway applies to children and young people under 16 years old presenting with the following:

1. Overdose
2. Deliberate self-harm
3. Suicidal ideation

(Young people aged 16 to 18 years will be assessed and managed by the emergency department and referred to the Psychiatric Liaison Team)

Presentation to Emergency Department

- Cause for Concern completed by triaging nurse
- If significant wounds, to be assessed by ED team
- Referred to paediatrics for assessment

Initial Assessment by Paediatric SHO/Nurse Practitioner/Registrar

- Ensure cause for concern completed
- History and examination
- Identify need for medical treatment
- HEADSS assessment completed
- Identify any urgent safeguarding concerns and make referral to Children's Social Care
- If young person is known to Children's Social Care, inform Social Worker

Medical Management

- Investigations as per TOXBASE or local guidelines (bloods, levels, ECG)
- Identify time at which the child/young person will be medically fit for discharge from hospital

Arranging CYPS Review

- CYPS contact coordinator (0191 282 9012) daily to identify patients requiring review
- For later presentation CYPS contacted by medical/nursing team for acute assessment

CYPS Review

- Risk assessment as per NICE guidelines when medically stable (this will not have been done previously)

Discharge Checklist

- Following assessment if serious or new concerns are identified refer to social services
- Is there a need for a discharge planning meeting?
- CYPS plan for follow up
- CYPS assessor to discuss with consultant paediatrician prior to discharge
- If all agreed, discharge with written information
- Ensure Cause for Concern completed
- Agree outcome

Frequent Attenders

Where patients have presented on more than one occasion, it may be appropriate for them to have an individualised plan.

- Consider if this presentation is consistent with previous presentations and are there any different/worrying new signs/concerns?
- Non-admission may be appropriate if there is an agreed safety plan in place
- Need for this to be documented electronically

Patients refusing to stay

- Review by Senior Paediatrician
- Mini risk assessment
- Management discussed with on-call Child and Adolescent Psychiatrist to agree a plan
- Acute/OOH CYPS assessment to be arranged if required

The Patient who absconds

- Contact Police to try and find the young person
- If known to Children's Social Care/Safeguarding concerns, contact Children's Social Care
- Arrange for young person to be brought back to the department

Unaccompanied Child/Young Person

There may be multiple reasons why children/young people are unaccompanied and the decision may not be the preferred decision of the child/young person but it may be the best option for the family unit. These patients will have to be cared for in an appropriate location (i.e. near a nurses' station) and will require a degree of risk

8. References

1. Morgan et al , Incidence, clinical management, and mortality risk following self-harm among children and adolescents: cohort study in primary care BMJ 2017; 359:j4351

2.NICE Self-harm in over 8s: short-term management and prevention of recurrence . Clinical guideline [CG16] Published date: July 2004

3.NICE Self-harm in over 8s: long-term management .Clinical guideline [CG133] Published date: November 2011

4. Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.

5. Doukrou M, Segal TY. Fifteen-minute consultation: Communicating with young people—how to use HEEADSSS,a psychosocial interview for adolescents Arch Dis Child Educ Pract Ed 2018;**103**:15–19. doi:10.1136/archdischild-2016-311553