



Staffordshire Safeguarding Children Board (SSCB)

Section 4U

Children and Young People who Self Harm or

Disclose Intent to Die by Suicide

Introduction

Data collected by the NSPCC¹ over a 3 year period reports on the alarming rise in the number of children admitted to hospital as a result of self-harming. Figures have seen a rise of 14% to nearly 19,000 children, most of who are between the ages of 13-15. It is reported that there were 150,000 Hospital attendances for Self Harm 2014/2015, 1:10 young people carry out self-harm this varies with age and is more common in children with mental health illness. 149 children and young people aged 10 -19 in England committed suicide in 2014, almost 3 children every week (Public Health England 2016). Other survey's published by the Priory, a private sector provider which treats mental health problems and addictions, found that as many as one in five girls between the ages of 15 and 17 had self-harmed and just under one in five adolescents, both boys and girls, has considered self-harm.

Self-harm has a huge impact on the day-to-day life of those who do it. It is something people often do in secret, about which they almost always feel enormously guilty, and which they go to great lengths to conceal. This can mean that many people who self-harm find it difficult to have close physical relationships. Also, people who self-harm often feel unable to talk either about their self-harm or about the reasons why they are doing it.

¹ <https://www.nspcc.org.uk/what-we-do/news-opinion/rise-children-hospitalised-self-harm-thousands-contact-childline/>

Public Health England (2016) The mental health of children and young people in England . London .PHE publications

The majority of children and young people who self-harm have no intention of ending their life and do it to manage their feelings. For many it's a coping mechanism used to survive – not die. Self-harm doesn't automatically mean children and young people are suffering a mental illness either. Although there is a relationship between self-harm and suicide, many more people self-harm than kill themselves – it's the feelings behind the stress they want to get rid of. However, some people who self-harm also have suicidal feelings, or are not sure if they want to live or die as a result of an episode of self-harm. In addition, some forms of self-harm can lead to accidental death.

Definitions

Clear definitions of self-harm, self- injurious behaviour and suicidal intent are inherently problematic and understanding the function of these phenomena is an emerging area of research.

Self-harm is used in this document to describe a spectrum of behaviours from self-injury or NSSI (Non Suicidal Self Injury) such as cutting or hair pulling on one hand to self- harm including overdosing and inflicting serious injuries on the other.

- Non Suicidal Self Injury (NSSI) is self-injury without suicidal intent. Hawton (2010).
- Attempted suicide is self-harm with intent to take life, resulting in nonfatal injury.
- Suicide is self-harm, resulting in death.

The Mental Health Foundation Truth Hurts Report (2006) describes self-harm as wide range of damaging actions that people inflict on themselves in a deliberate and usually hidden way.

They may include:

- Cutting, burning or scalding
- Banging or hitting the head or other parts of the body
- Hair pulling, including eye lashes
- Inserting things into the body
- Swallowing harmful things or substances, including taking overdoses
- Tying something tight around the body.

Professionals should also consider that self-injurious abuse of drugs and alcohol by young people and the effect of serious eating disorders and extreme risk taking behaviour by the child or young person as potential threats or attempts to self-harm or may increase the risk of suicide.

In assessing a child or young person the focus should be on the intent rather than the lethality of the method and checking on each occasion if that intent has shifted from self-injury or self-harm to that of contemplating suicide.

Significant Harm

Self-harm and suicide threats put the child or young person at risk of significant harm and should always be taken seriously. They may also indicate that the child or young person is at risk of physical, sexual, emotional abuse or chronic neglect which would in itself constitute significant harm.

Any child or young person who self-harms or expresses thoughts about this or about suicide has to be taken seriously and there should be no delay in taking action and offering appropriate help and intervention.

Sharing Information

Consent to share information should be sought if the child or young person is competent. If consent to share information is refused or cannot be sought, it should still be shared where there is reason to believe that not sharing information is likely to result in significant harm to the child or young person. It should also be shared if the risk is sufficiently great to outweigh the harm or prejudice to anyone which may be caused by doing so.

Where a child or young person is not considered competent, an adult with parental responsibility should give consent unless the conditions for sharing without consent are met.

For more information on information sharing see Part 2 (a) SSCB Procedures.

Procedure

- 1. If information is received which suggests that a child or young person has self-harmed or that they have expressed suicidal thoughts it must be taken seriously and all practitioners should consult immediately with their Team or line Manager and if appropriate their named or designated child protection lead

2. The context of the information should be considered along with any other known information relating to the young person and their circumstances, taking into account risk factors and risk indicators. **See Appendix A**
3. Not all incidents of self-harm require specialist Child and Adolescent Mental Service (CAMHS) involvement. Low level self-harm can be appropriately managed by School Nurses, Local Support Team etc. However, attempted suicide, overdose requiring hospital treatment and persistent self-harm are issues that would normally fall within CAMHS criteria. **See Appendix A**
4. The outcome of the consultation should be recorded on a key decisions sheet or the agency equivalent.
5. A decision should be made on immediate risk and any action which may be required to protect the child or young person under child protection procedures. Some children and young people threatening or disclosing intent to die by suicide will be considered at high and immediate level of risk. This will depend upon the context and circumstances. The duty worker within the local Child and Adolescent Mental Health Service (CAMHS) should be contacted for further advice and guidance.
6. In all cases the parent or primary carer for the child or young person should be notified, unless it would pose a risk to the child or young person to do so, and they should be fully engaged in the subsequent assessment process.
7. If the child or young person has a physical injury that requires medical attention or may have ingested a substance in the last 48 hours, arrangements should be made for them to attend the Emergency Department (ED) as a matter of urgency and in all cases to inform the child or young person's GP.
8. All children who are received in the E.D following an overdose, or are otherwise considered to have attempted suicide should be admitted to the local children's ward where there is then an agreement with the local specialist CAMHS service that an assessment is completed and follow up care is arranged prior to discharge.

These assessments allow for face to face contact with the young person and family members and will usually conclude with a 7 day follow-up appointment at CAMHS whether the young person is already known to CAMHS or not. A central role will be to determine the context to the overdose and assess risk and protective factors.

It is important to note that these assessments are to determine whether a young person can be safely discharged home from the ward and as such any advice or guidance from other professionals involved can be vital and contribute to a discharge plan. Hospital staff will have already assessed the medical risk prior to a CAMHS ward assessment.

9. Regardless of the need for any treatment a parent or other responsible adult should go with the child or young person to the Emergency Department.

10. If the overdose took place longer than 48 hours medical attention, or advice, and a general medical assessment is still necessary. This should be sought from the child or young person's GP in the first instance who may refer to the A&E department or the local CAMHS team.

11. Once any immediate actions are completed, a holistic assessment of the child's needs should be carried out and professional judgement applied. If it is deemed that there are on-going risks or additional needs an Early Help Assessment or Team Around the Child (TAC) meeting should be considered with a view to:

- Referral to universal or other support services
- Initiating a early help assessment plan
- Referral to the First Response Team (FRT)

12. If a child is under 16 years of age, the school nurse should always be invited to any support planning meetings in addition to the child or young person's GP. If the child is over 16, the school nurse may attend if the child was known to them prior to being 16.

13. If abuse of alcohol or other substances is indicated advice should always be sought from the CRI -T3 Staffordshire worker (see page 6 for contact details).

Children Requiring Hospital Treatment

Where a child or young person requires hospital treatment in relation to self-harm, practice should be as follows, in line with the NICE (2015) guidance:

1. The child or young person should be offered a psychosocial assessment at triage to determine their mental capacity and their willingness to remain for further assessment.

2. Assessment should be undertaken by healthcare practitioners experienced in this field and should follow the same principles as for adults who self-harm, but should also include a holistic assessment of the family, their social situation, family history and any potential child protection issues.
3. Assessment and treatment for under 16's should always take place in a separate area of the A&E department.
4. All children or young people who are received in E.D following an act of self-harm (this specifically means overdose or if they are otherwise considered to have attempted suicide) should be admitted to the local children's ward where there is then an agreement with the local specialist CAMHS service that a mental health assessment and risk assessment (**this is not a Mental Health Act Assessment – see page 6**) is completed and follow up care is arranged before discharge.
5. If assessment indicates that there are child protection concerns, hospital staff should follow their Trust's safeguarding procedures and consult with their nominated or designated child protection adviser as appropriate.
6. Any child or young person who refuses admission should be assessed in terms of risk and advice sought from a senior paediatrician and, if necessary, the appropriate mental health professional.
7. Initial management should include advising parents and carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed.
8. Discharge from hospital should involve co-ordinated planning with community health services, CAMHS, drug and alcohol services CRI – T3 Staffordshire, and/or children's services as appropriate.

Children who may require a Mental Health Act Assessment

1. Where there is a need for mental health expertise and there is no suitably experienced or trained social worker within the children's social care team, this may be obtained from the relevant Mental Health Team (see **Appendix A** for contact details).
2. The relevant Mental Health Team will offer support and guidance relevant to the mental health issues the child or young person may be experiencing.
3. Where there is a need for a mental health assessment under the Mental Health Act (1983) necessitating the involvement of an AMHP (Approved Mental Health

Professional - previously known as an `Approved Social Worker`) there should be a discussion with the Mental Health Team Manager responsible for the local AMHP rota.

4. Outside of normal working hours the Emergency Duty Service should always be contacted.

Substance Misuse

CRI-T3 Staffordshire work with young people aged between 10-19 who use drugs and/or alcohol. Quite often young people who access the service have complex needs, including deliberate self-harm through intoxication or overdose, CRI- T3 Staffordshire work closely with parents/carers, and partner agencies to achieve positive outcomes for such young people. CRI-T3 offer evidence based psychosocial, therapeutic and medical interventions; working to reduce harm and promote abstinence. They work on an outreach basis offering appointments within a young person's locality, encouraging engagement and offering support to those hardest to reach.

CRI -T3 Staffordshire,
Young Persons Treatment Services
Suite 1,
7-8 Mill Street
Stafford
ST16 2AJ
Phone: 01785 241393
Fax: 01785 252790

Children as 'inpatients'

1. Children and young people who require treatment as an in-patient in a mental health setting will usually be admitted on a voluntary basis, otherwise the Mental Health Act 1983 or the Children Act 1989 will apply. The admission criteria will differ, such as acute (crisis or short term), for eating disorders or challenging behaviour.

2. Age ranges can vary considerably and as a result some children and young people in the past were admitted to adult mental health settings. This practice was effectively stopped under amendments to the Mental Health Act 1983 which set a target to ensure age appropriate treatment for 16 – 17 year olds by April 2010. Catchment areas for some hospitals may cover a regional or national area depending on their specialism.

3. Where consent for treatment is required, it should be clarified by the lead professional e.g. LA children's social care, child and adolescent mental health services, CAMHS, whether this is being carried out under the Mental Health Act 1983 or the Children Act 1989.

4. If any child or young person who is considered to be Gillick competent to give consent is unwilling to remain as an informal patient, consideration should be given to use the Mental Health Act 1983. If any child under 16 considered being competent to give consent wishes to discharge him or herself as an informal patient from hospital, the contrary wishes of those with parental responsibility will ordinarily prevail. Where there is dispute consideration should be given to use the Mental Health Act. Similarly if a 16 or 17 year old deemed to have capacity to consent is unwilling to remain in hospital as an in-patient, consideration may need to be given whether he or she should be detained under the Act.

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5. Children and young people in mental health settings may need to be isolated from other patients or require control and restraint on occasions, and staff should be appropriately trained to meet their needs and safeguard their welfare. When a child or young person is admitted to a mental health setting where adults are inpatients, a risk assessment must be undertaken to avoid the child or young person being placed in vulnerable situations.

6. Children or young people admitted to mental health settings may disclose information about abuse or neglect concerning themselves or others. Disclosures may be made when the child or young person feels it is safe to talk or when the child or young person is angry, distressed or anxious. All allegations should be treated seriously and SSCB procedures followed.

7. When a child or young person already open to social care services is admitted to an 'inpatient facility' the allocated worker should ensure they attend or be represented at all relevant care planning meetings.

Risk Factors and Risk Indicators

Profile of Children and Young People who Self-Harm The National Inquiry Report – Truth Hurts (2006) suggests that many children and young people who self-harm display some significant features:

- Experience eating disorders
- Are very sensitive or self-critical

- Have low self-esteem and are lacking in confidence
- Have a great difficulty in liking or praising themselves
- Are very caring and thoughtful
- Are often highly intelligent
- Are often 'there' for other people, supporting them and hiding their own sadness

Triggers and Associated Factors

- Being bullied at school
- Not getting on with parents
- Stress and worry around academic performance and examinations
- Parental divorce
- Bereavement
- Unwanted pregnancy
- Experience of abuse in earlier childhood (whether sexual, physical, and/or emotional)
- Difficulties associated with sexuality
- Problems to do with race, culture or religion
- Low self-esteem
- Feelings of being rejected in their lives.

Responding to the Child/Young Person

In every case, a practitioner who is made aware that a child or young person has self-harmed, or is contemplating self-harm or suicide must be spoken to without delay and should be asked:

- Was it their intention to self-harm or to take their life?
- If they have taken any substances, including tablets?
- What may be troubling them?

- What help or support they might wish?

A supportive attitude demonstrating respect and understanding of the child or young person and a non-judgemental stance is of prime importance and practitioners should also be mindful of any communication needs, or assistance the child or young person might require, in expressing themselves.

Myths about self-harming are that it is:

- Manipulative
- Attention Seeking
- For pleasure
- Only carried out by those who are interested in 'Goth' or EMO sub-culture
- A failed suicide attempt
- Evidence of borderline personality disorder

Associated Factors for Suicide and Attempted Suicide

Gender: Young women aged 15-19 are the group most likely to attempt suicide; young men are much more likely to die as a result of their suicide attempt.

Exposure to suicide or suicidal behaviour: Young people who die through suicide are more likely than their peers to have had a friend or relative who died as a result of suicide- exposure to suicide or suicidal behaviour appears to be a significant factor.

Substance Misuse: Substance abuse is thought to be a significant factor in youth suicide, alcohol and drugs affect thinking and reasoning ability and can act as depressants, decreasing inhibitions, increasing the likelihood of a depressed young person making a suicide attempt.

Race: Race and cultural background can be major influences. One study of young people of Asian origin in the UK found that the suicide rate of 16-24 year old women was three times that of 16-24 year old women of white British origin. Asian men appear to be far less vulnerable to suicide than young men from white British backgrounds. Asian women's groups have linked these factors to cultural pressures, conservative parental values and traditions such as 'arranged marriages' at odds with the expectations of young Asian women themselves.

Sexuality: Young gay men and lesbians are particularly at risk of suicide, possibly linked to their sexual orientation bringing them into conflict with their families or others.

Mental Distress: Suicide risk is raised for virtually all mental disorders and also some medical disorders related to mental disorder or substance abuse

History of Abuse: Adolescents with a more severe history of sexual abuse and physical abuse are more likely to experience suicidal phenomena than those with a less significant abuse history.

Availability and Lethality of Methods: There is a link between easy access to means of self-harm and the actual event. One reason is that suicidal behaviour is sometimes impulsive so that if a lethal method is not available immediately a suicidal act can be delayed or prevented altogether, most people will not go on to use another method.

Deliberate Self Harm: Acts of deliberate self-harm and suicide attempts do not necessarily involve an intention to die. However, there is a strong association between attempted suicide, deliberate self-harm and subsequent successful suicide so all incidents of self-harm should be treated with extreme care.

Bullying: Individual case histories of children and young people who have died through suicide suggest a link with being bullied.

Suicide Pacts: Whilst suicide is not a group activity we know from serious case reviews that the dynamic of young people who may share similar experiences or feelings is not insignificant. A pact describes the suicides of two or more individuals in an agreed-upon plan. This might be to die together, or separately and closely timed.

The trend of **Internet-related suicide pacts** is changing the way that workers need to deal with depressed and/or suicidal youngsters, and professionals should be alert to young people who have been accessing or obtaining suicide information from Internet sites, or have been talking in suicide 'chat rooms'.

CAMHS (Child and Adolescent Mental Health Services)

- The CAMHS team provides a range of specialist mental health services to children, young people and their families or carers. They can help with emotional and behaviour problems, family relationship problems, effects of traumatic experiences, bullying, eating disorders, sleeping and toileting problems and anxiety and stress.
- Child and Adolescent Mental Health Services (CAMHS) are a comprehensive range of services available within local communities, towns or cities, which provide help and treatment to children and young people who are experiencing significant

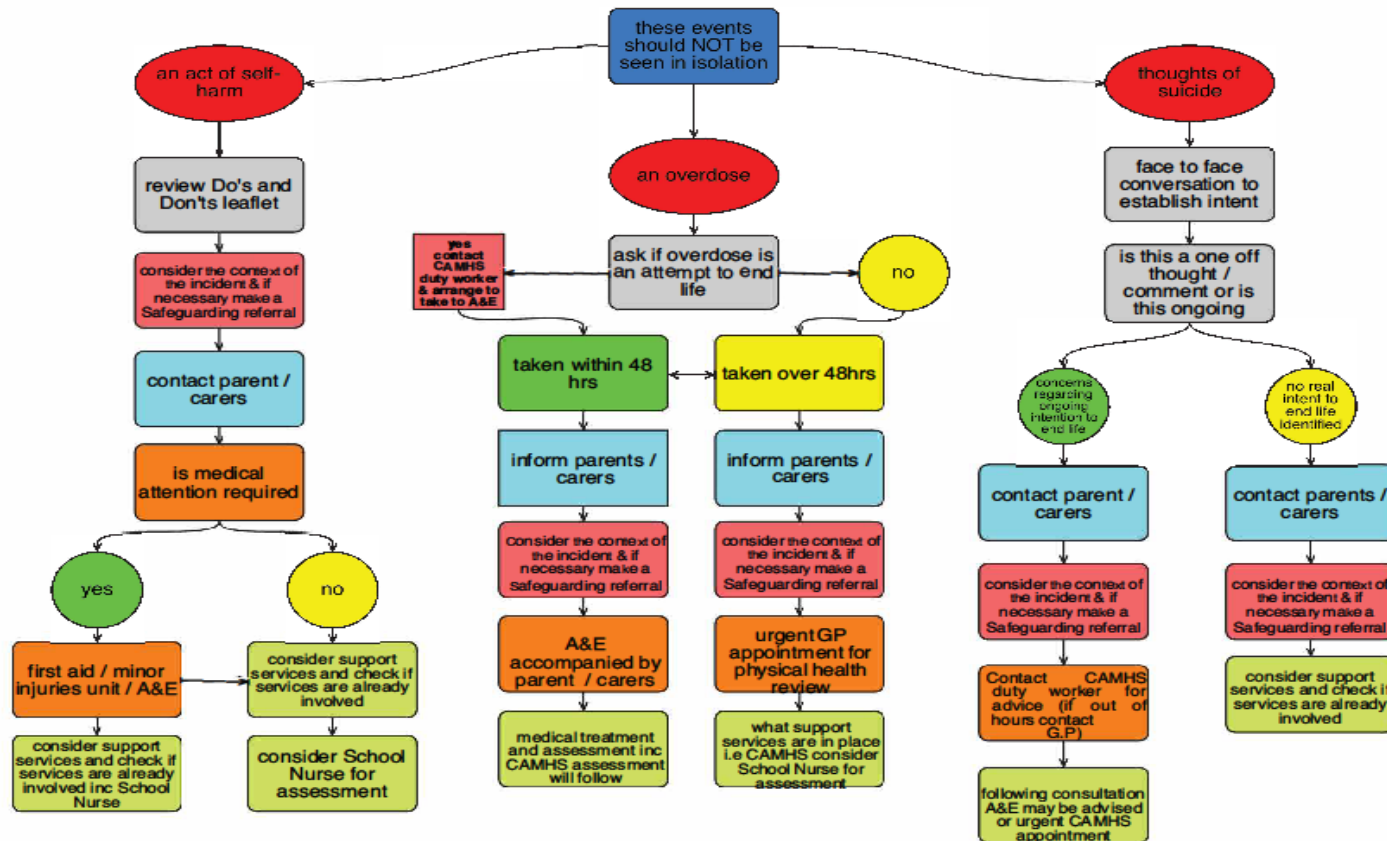
and prolonged emotional or behavioural difficulties, or mental health problems, disorders and illnesses.

- Some of these services are based in National Health Service (NHS) settings such as Child and Family Consultation Services, in-patient and outpatient departments of hospitals, in GP surgeries and health centres and in private health care. Others are based in educational settings such as schools, colleges and universities or in youth centres, walk-in centres for young people and counselling services.

- For those with concerns about a child or a young person's mental health it might be helpful to speak to any of the following: their GP, a teacher, head teacher or head of year, school nurse, health visitor, social worker or youth counselling service for advice and referral for specialist help within these services.

Appendix A

Referral pathway into child mental health services



Reviewed: September 2017
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 Version 6

Appendix B

Staffordshire CAMHS Contact Details

Area	Base	Address	Tel/Fax
Stafford Cannock Kinver, Wombourne, Perton Codsall/Bilbrook.	The Bridge	St Georges Parkway, off Crooked Bridge Rd Stafford ST16 3NE	01785 221665 Fax: 01785 221666
Newcastle Leek Biddulph	Dragon Square	CAMHS Bungalows2-3 Dragon Square Chesterton ST5 7HL	01782 408354
Lichfield	Holly Lodge	St Michael's Court Trent Valley Road Lichfield WS13 6EF	01543 442012 Fax: 01543 442017
Tamworth	Argyle St Clinic	Argyle Street Glascote Tamworth B77 3EW	01827 51183 Fax: 01827 312098
Burton	Cross St Clinic	Cross Street Clinic Cross Street Burton on Trent DE14 1EG	01283 505820 Fax: 01283 505818
Staffordshire	The Darwin Centre	167 Queens Road Penkhull Stoke-on- Trent ST4 7LF	0300 7900234 Fax: 01782 276 427

North Staffordshire Combined Health Care NHS Trust

<http://www.combined.nhs.uk/ourservices/CYP/Pages/default.aspx> -- delete this

South Staffordshire and Shropshire Healthcare and NHS Foundation Trust

<http://www.sssft.nhs.uk/component/seoglossary/2-main-glossary/41-camhs>

Barnardo's web page specifically designed for young people experiencing mental health issues

<https://www.upsideonline.co.uk/>

Please Note:

The Bridge provides outreach clinics at Cannock Hospital, Kinver, Wombourne, Perton and Codsall/Bilbrook.

Ashlands provides an outreach clinic in Leek (Eaton House)

Each CAMHS base has a daily duty worker (any member of the team) on rota

Additional contact details

For up to date contact details please visit

www.camhscares.nhs.uk

Further help and information

Websites that have been recommended by young people include:

www.youthnet.org

www.lifesigns.org.uk

www.childline.org.uk

www.samaritans.org.uk

www.thesite.org.uk

School Nurse contact details

Stafford and Seisden	sspnt.0-19west@nhs.net	01785 221047
Newcastle and Moorlands	sspnt.0-19west@nhs.net	0300 124 5029
Cannock and Lichfield,	sspnt.0-19east@nhs.net	01543 431586
Tamworth, Burton	sspnt.0-19east@nhs.net	01283 504426

Helpful telephone numbers:

Child Line – 0800 1111

Samaritans – 08457 90 90 90

Parent line Plus – 0808 800 2222

NSPCC – 0808 80

Appendix C

Self-Harm and Suicide Awareness

Do	Don't
Stay Calm - do not show anxiety, disapproval or disgust. Be prepared to be shocked – then ...	Panic - Unfortunately, many young people self-harm - it is a complex issue and each young person will have a different reason or story behind their behaviour – panicking will not help the young person feel safe and contained.
Listen - just being listened to can be a brilliant support and bring great relief to someone: particularly if they have never spoken to anyone about their self-harming before	Don't send the young person away - make some time for them - either help them find other ways of coping or support them in getting the right kind of support.
Listening intently - does not just require ears - Observe the young person's non-verbal clues -look at their body language - does what they say and what you see match up?	Don't be judgemental – keep an open mind about the behaviour and don't refer to it as “attention seeking / needing”.
What is the underlying mood state – is it <ul style="list-style-type: none"> • Anger? • Sadness? • Frustration? 	Don't work alone - you may still see a young person alone, but you will need to offload with an appropriate staff member or colleague from another agency.
Think carefully before you act - what is in the best interest of the young person?	Don't offer to take the young person to your home environment.
Remember - most episodes of self-harm have nothing to do with suicide. The easiest way to differentiate between suicide and self-harm is by asking the young person what was their intent behind the self-harm behaviour; Did they intend to seriously harm or kill themselves? If they did, ask what plans they had made or what their continuing thoughts of suicide are.	Don't give them your mobile number or house number – or get into texting the young person. It is more appropriate and professional for you to help the young person identify their supportive network, than for you to take this upon yourself. Self-harming behaviours can be extremely concerning, but you cannot offer objective support if you become enmeshed within the young person's difficulty.

Do Ask; The act of asking this will not increase their chances of attempting suicide in the future.	
Do refer the Young Person to your School Nurse if the child / young person attends school	
Do Treat a suicide intention as an emergency - do not leave the young person alone or in a vulnerable environment - get help and support as soon as possible and remain calm.	