

***DELIBERATE SELF-
HARM AND SUICIDE:
SAFEGUARDING
CHILDREN AND
YOUNG PEOPLE***

**Safeguarding Children and Young People
North East England
Regional Inter-agency Procedures**

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PREFACE

Status of the Document

The procedure in this document applies to all staff of agencies represented on the Area Child Protection Committees (ACPCs) and Local Safeguarding Children Boards (LSCBs) in the North East of England. Staff of these agencies should:

- Comply with the procedures contained in this document, unless there are exceptional reasons, which should be recorded.
- Take account of the rest of the contents.

ACPCs/LSCBs and their constituent agencies should ensure that any other inter-agency or internal procedures/guidance/protocols are consistent with this document.

Principles

- All children and young people should be safe and able to develop to their full potential.
- The needs of the child or young person are paramount and should underpin all work to safeguard children.
- All children and young people deserve the opportunity to achieve their full potential.
- All children and young people have the right to be safeguarded from harm and exploitation whatever their:
 - Race, religion, nationality, first language or ethnicity
 - Gender or sexuality
 - Age
 - Health, physical or learning disability
 - Location or placement
 - Criminal behaviour, where this applies
 - Political or immigration status.
- Responsibility for the protection of children and young people must be shared because they are safeguarded only when all relevant agencies and individuals accept responsibility and co-operate with one another.
- Statements or allegations about abuse or neglect, made by children and young people, must always be taken seriously.
- The wishes and feelings of children and young people, which are vital elements in assessing risk and formulating protection plans, must always be sought and given weight, according to the level of understanding of the child or young person.
- No child or young person should be allowed to feel responsible for actions taken by professionals, nor for the outcomes.
- During enquiries, the involvement and support of those who have parental responsibility for, or regular care of a child or young person, should be encouraged and facilitated, unless doing so compromises that enquiry or the immediate or long term welfare of the child or young person.

“The basic requirement that children are kept safe is universal and cuts across cultural boundaries. Every child living in this country is entitled to be given the protection of the law, regardless of his or her background. Cultural heritage is important to many people, but it cannot take precedence over standards of childcare embodied in law. Every organisation concerned with the welfare and protection of children should have mechanisms in place to ensure equal access to services of the same quality, and that each child, irrespective of colour or background, should be treated as an individual requiring appropriate care.”

Victoria Climbié Inquiry Report 2003

1. LEGISLATION - MAIN ACTS

Children Act 1989 Section 17

Children Act 1989 Section 47

Mental Health Act 1983

See Appendix 1 for further information.

2. INTER AGENCY PROCEDURES

Any child or young person who self-harms or expresses thoughts about this or about suicide has to be taken seriously and appropriate help and intervention offered at that point.

2.1 Definitions Deliberate Self-harm and Suicide

Definitions from the Mental Health Foundation (2003) are:

- Deliberate self-harm is self-harm without suicidal intent, resulting in non-fatal injury.
- Attempted suicide is self-harm with intent to take life, resulting in non-fatal injury.
- Suicide is self-harm, resulting in death.

The difference between suicide and deliberate self-harm is not always so clear. For example, deliberate self-harm is a common precursor to suicide, also children and young people who deliberately self-harm may kill themselves by accident.

2.2 Information Sharing and Consent

Informed consent to share information should be sought if the child or young person is competent unless:

- The situation is urgent and there is not time to seek consent.
- 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

Parents should be kept informed and involved in decisions about sharing information even if the child is competent or over 16. However if the competent young person wishes to limit the information given to his parents or does not want them to know it at all, the young person's wishes should be respected unless the conditions for sharing without consent apply. Where a child or young person is not deemed competent, a person with parental responsibility should give consent unless the circumstances for sharing without consent apply.

For further information, matters of information sharing, confidentiality and data protection are covered in the Government guidance 'What to do if you're worried a child is being abused' (and in the summary version of the same document).

2.3 Responding to the Child or Young Person

In every case, the practitioner who is made aware that a child or young person has self-harmed, or is contemplating this or suicide, should talk with them without delay and:

- **Ascertain if they have taken any substances, including tablets, or injured themselves (if so, the child or young person should receive urgent medical**

attention, even if they appear well, as harmful effects can sometimes be delayed).

- Try to find out what may be troubling them.
- Explore to what extent self-harm is likely or imminent or planned.
- Ascertain what help or support the child or young person would wish.

A supportive attitude, respect and understanding of the child or young person, along with a non-judgmental stance, is of prime importance. Note also that a child or young person who has a learning disability will find it more difficult to express their thoughts.

See also Appendix 2 which gives suggested questions which can be asked and additional guidance.

2.4 Child or Young Person Requiring Hospital Treatment for Physical Harm

Where a child or young person requires hospital treatment in relation to physical self-harm, practice should be as follows, in line with the NICE 2004 guidance:

- Triage, assessment and treatment for under 16's should take place in a separate area of the Emergency Department.
- There should be overnight admission to a Paediatric or Adolescent ward with detailed assessment the following day, with input from the CAMHS service.
- Assessment should be undertaken by healthcare practitioners experienced in this field.
- Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, family history and child protection issues.
- Initial management should include advising 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.

Any child or young person who refuses admission should be reviewed by a senior Paediatrician in Accident and Emergency and, if necessary, their management discussed with the on-call Child and Adolescent Psychiatrist.

2.5 Multi-agency Response

SEE FLOW CHART

2.6 Family Court Proceedings

Where the child or young person is currently the subject of Family Court Proceedings, whether public or private law, the Court must be informed of any self-harm or attempted suicide incident.

3. INFORMATION FOR GOOD PRACTICE

3.1 Definitions and Meanings

Suicide: Self-harm, resulting in death.

Attempted Suicide: Self-harm with intent to take life, resulting in non-fatal injury.

Deliberate Self-harm/Self-harm: Definitions and meanings vary.

(Young People and Self-harm: A National Inquiry First Interim Report 2004) "In its broadest sense, self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way, which are damaging." For the purpose of the Inquiry however, the focus is:

- Cutting behaviours
- Other forms of self-harm, such as burning, scalding, banging, hair pulling
- Self-poisoning.

(MIND) Self-harm as a broad term for many acts that cause personal harm, ranging from someone:

- Not looking after their needs properly emotionally or physically.
- Direct injury such as scratching, cutting, burning, hitting yourself, swallowing or putting things inside.
- Staying in an abusive relationship
- Taking risks too easily
- Eating distress (anorexia and bulimia)
- Addiction (for example, to alcohol or drugs).

The different meanings affect research results, as studies use different parameters. They also have implications in terms of the breadth of services set up locally for children and young people, in relation to self-harm.

3.2 Reasons for Self-harm Given by Children, Young People and Adults

The National Inquiry (First Interim Report) heard accounts from children, young people and adults.

"I am a survivor of both sexual abuse and self-injury. I no longer self-injure, but it has been a long struggle to try to acknowledge and work through emotions that once felt overwhelming in their power."

"Self-harm is not a phenomenon known only to a few like me, who have inflicted injury on our bodies. Self-harm involves all of us on some level. We may all punish, distract or numb ourselves, as a way of dealing with difficult feelings or situations."

"I am twenty years old, presently attending a day hospital and rebuilding my life, which I once believed had been destroyed."

"Anorexia and cutting for last 9 years. Afraid and insecure at home, no room of own, scared of brother who had beaten me up from a young age."

"Eating disorder on and off for last 14 years, started cutting due to frustration of no help with eating disorder."

“Was abused by mother for approximately 13 years – abuse was physical, emotional, psycho-sexual.”

“Eating disorders, depression, paranoia, and obsessive-compulsive behaviour since age of 12 years, sexually abused by brother when younger.”

“Low self-esteem, depressive, suicidal thoughts, difficulties associated with being gay, inability to express myself.”

“Bullied by peers because I was ugly, fat, and I didn’t fit...I knew that I didn’t fit in from a very young age. I don’t like people. I don’t feel comfortable around people. I’m pretty sure I was clinically depressed as a child.”

“Being constantly rejected, or feeling rejected in my life.”

Support line organisations, such as Childline, reported that many children and young people who self-harm spoke about:

- Family problems
- Bullying
- General unhappiness and depression
- Abuse.

The National Inquiry Second Interim Report contains details of a large-scale study of pupils who self-harmed and found that the most common motive for self-harm, from the perspective of the children and young people was “to get relief from a terrible mind state”.

3.3 Figures

Suicide:

- Accounts for 20 per cent of all deaths amongst young people aged 15-24 (MIND).
- Is the second most common cause of death amongst young people after accidental death (MIND).
- For every suicide recorded in the 1980s among 10-14 year-olds in the UK, three other children were deemed to have died from 'undetermined' causes or 'accidental' drugs overdoses (MIND).
- Rates for suicides amongst young men (20-34) increased between mid 1980’s and the end of the century, however, figures available in 2005 show that this trend is reversing (Reuters).
- Rates of suicide in the young vary also according to gender with 80% being male (Mental Health Update).

Self-harm/Attempted Suicide:

- More than 24,000 teenagers are admitted to hospital in the UK each year after deliberately harming themselves (National Inquiry First Interim Report)
- Most have taken overdoses or cut themselves (National Inquiry First Interim Report)
- It is estimated that 1 in 10 teenagers self-harm. (National Inquiry First Interim Report)
- Rates of reported self-harm in the UK have increased over the past decade (Mental Health Foundation)
- Between April 2002 and March 2003 Childline counselled over 3,000 children and young people (90% girls) who disclosed self-harm or were concerned they would harm themselves.

- 800 people contacted Childline because of concern about self-harm by a child or young person.

However, statistics are unreliable because:

- Many incidents of self-harm will be treated at home and will not reach the attention of services or professionals (National Inquiry First Interim Report).
- Incidents that reach A&E services are predominantly of self-poisoning and only account for a small sub-population of young people who self-harm (National Inquiry First Interim Report).
- Figures on self-harm are confusing as the definitions of self-harm used vary across different research.

The National Inquiry Second Interim Report cites a study across 41 schools in England, surveying over 6,000 pupils aged 15 and 16. Of these, based on the definition of 'cutting behaviours, self-poisoning, other forms of self-harm' over 10% of pupils reported they had self-harmed in their lifetimes, with over 6% saying this had been in the last year.

3.4 Profile of Children and Young People Involved

The National Inquiry First Interim Report gives a picture that many children and young people who self-harm:

- Experience eating disorders
- Are very sensitive and very self-critical
- Have enormous low self-esteem and lack confidence
- Have 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.

Research for the Samaritans, carried out by the Centre for Suicide Research, University of Oxford (2002) found that:

- Those who self-harm have many more problems and life events than other teenagers (for example, boyfriend or girlfriend problems, death of a close relative, and physical abuse).
- They are more likely to suffer anxiety, depression and have low self-esteem.
- They often have friends who self-harm.
- Girls who self-harm may have concerns about sexuality, boys may have suffered physical abuse.
- Those who self-harm find it difficult to cope and are more likely to blame themselves, get angry, drink alcohol or shut themselves in their room than talk things through.
- They have fewer people in whom they can confide, compared to other adolescents.

3.5 Triggers and Functions of Self-harm

Children and young people often disclose a 'trigger' or circumstance that led them to begin self-harming, such as being bullied or other incidences connected to education or schooling. Many triggers are connected to another important factor in a young person's life, that of family relationships.

The National Inquiry First Interim Report notes that self-harm can function to provide an outlet, sometimes the only outlet, for directing anger and frustration, particularly for children and young people who have been sexually abused.

It can also allow a sense of control and personal ownership. In common with other mental health problems, such as eating disorders, depression and suicidal thoughts there is a theme from children and young people who self-harm about loss of control over their lives.

3.6 Associated Factors for Suicide and Attempted Suicide

Gender: Young women aged between 15 and 19 years are the group most likely to attempt suicide, however, young men are much more likely to die as a result of their suicide attempt (MIND).

Exposure to suicide/suicidal behaviour: Young people who commit suicide are more likely than their peers to have had a friend or relative who died through suicide - exposure to suicide or suicidal behaviour of relatives and friends appears to be a significant factor (MIND).

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

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. This contrasts sharply with the suicide rates of young Asian men who appear to be far less vulnerable to suicide than young men from white British backgrounds. Asian women's groups have linked the high suicide rates amongst young Asian women to cultural pressures; conservative parental values and traditions such as arranged marriages may clash with the wishes and expectations of young women themselves (MIND). (See also 'Forced Marriage: Safeguarding Children and Young People' Regional Procedures)

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

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

Custody: Within the prison population as a whole, young prisoners are the individuals most at risk, particularly those under 21, who make up a third of the remand population. In 1995, 20 per cent of prison suicides were by people under 21, the vast majority being young males (MIND).

History of Abuse: Research by Evans, Hawton and Rodham (2005) looking at findings from ten studies found evidence to suggest that adolescents with a more severe history of sexual abuse and physical abuse are more likely to experience suicidal phenomena than those with a less serious abuse history.

Availability of Methods: Evans, Hawton and Rodham and others point to the link between easy access to means of self-harm or suicide and the actual event. The Government put the recent downturn in suicides by young men as due to the fact that paracetamol and aspirin are no longer sold in the same packaging as previously.

Coping Styles: Evans, Hawton and Rodham bring attention to 'coping styles' as another factor that contributes to suicidal phenomena.

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 (MIND).

Bullying: Individual case histories of children and young people who have killed themselves suggest a link with being bullied.

3.7 Associated Factors for Deliberate Self-harm

Individual accounts from children, young people and adults are that self-harm such as cutting behaviour is undertaken in order to 'feel alive' or 'be in control' and that the behaviour is not intended to be suicidal.

Nonetheless, as highlighted by MIND, there is a strong association between deliberate self-harm and subsequent suicide. Also, the associated factors for suicide and attempted suicide (above) show a marked similarity with those for self-harm, given below:

- Previous deliberate self-harm
- Mental illness
- Drug and alcohol abuse
- History of abuse
- Being in custody
- Personal knowledge of someone who self-harmed or committed suicide.
- Family dysfunction
- Relationship problems.

(Mitchell and Stowell 2002)

3.8 Additional System and Practitioner Risks

Mitchell and Stowell give additional risks, as listed below. Although their focus is on young offenders, their points could be applied to other children and young people.

Risk is increased when:

- Systematic assessment of risk is not carried out.
- Risk indicators are denied or minimised by responsible professionals.
- Information is not passed from one professional to another.
- Clinical responsibility is not clearly defined or transferred inappropriately.
- There is inadequate community support (includes family and friends as well as community-based services).
- Carers are unaware of services available locally.
- Provision of resources is inadequate.
- Management has failed to introduce a risk strategy appropriate to local circumstances, which includes policies and procedures for clinical risk assessment, risk management, induction training for new staff, continuous training for established staff and serious incident review.

3.9 Assessment and Management of Risk

The first response to any particular child or young person should be as given in 2.4 of the 'Inter-agency Procedures Section'.

The Mental Health Foundation is clear that children and young people who have self-harmed or attempted suicide need to be assessed for the degree of risk they pose to themselves and that this should be conducted by specialist mental health staff. They continue that evidence should be drawn from as wide a range of sources as possible, so

that all those involved in the care and education of children and young people can be expected to contribute to this process, which should involve:

- Assessment of risk, including mental state and substance use patterns
- Agreement and documentation of crisis/contingency plans
- Nomination of a named Care Co-ordinator
- Dissemination of crisis/contingency plans to those involved in child/young person's care/education
- Pro-active use of relevant referral pathways.

The Foundation stresses that prevention of suicide and self-harm in the young is not the exclusive responsibility of any one sector of society. They say that significant contributions can be made by a range of organisations and individuals, for example:

- School Nurses/student counsellors creating cultures in which young people feel it is healthy to talk through emotional and other difficulties.
- GPs restricting the number of tablets prescribed to those at risk of overdose and educating parents/guardian on availability of medicines in the home.
- GPs ensuring that relevant referral pathways are used.
- Accident and Emergency staff ensuring all young people who have attempted suicide receive a specialist mental health assessment.

3.10 Some Experiences of Children and Young People

(Source National Inquiry Second Interim Report)

One young male told a guidance teacher when he was 14 years old about his self-harm and he reports that the teacher told him to “do it better next time”. The young male felt that the teacher was trying to be funny and possibly making him feel at ease, which left him wishing he had not sought help. There was no follow-up or referral to other individuals or organisation for support. The young male never spoke to anyone else at school after this incident – although there were other times when teachers were aware of his self-harming (e.g. cut arm badly and required stitches, remained at school, with evident blood soaking through shirt sleeve) but no-one approached him.

One young female had been self-harming since she was 14 but only spoke about it at college to her form tutor with whom she had a good relationship and perceived to be ‘different from the rest’ of the staff. Although the form tutor was identified as being an incredible source of support at the time, the young female explained that when she changed courses she subsequently moved form groups and was not allowed to have the same access to old form tutor – she explained how this caused her great frustration, anxiety and feelings of abandonment.

Approximately half of the young people (who reported to the Inquiry) said that they had confided in friends at school and that their friends had in turn disclosed to teachers. The majority talked about their “lack of control” in this “private” situation, and their lack of knowledge over who had then been told about their self-harm (e.g. their parents, other teachers, other staff, other professionals).

However, one young female, who had taken an overdose at school, talked about her friend telling a teacher, her teacher then phoning her parents, being taken to hospital and being referred immediately to the CAMHS whom she saw straight away. When she returned to school she saw her guidance teacher once a week, which was found to be really helpful, and felt that the teacher listened to her without judgment.

Additionally, those offered support within the school setting were given no information on support agencies or services outside of school and that the support within school “ended at

the school gate". It was pointed out "support at school was okay, as far as it went, but outside of school hours and over summer, you're just cut off, left to drift on your own".

Counselling services within educational settings were typically accessed when young people's difficulties became severe. It was felt that had the counselling staff been introduced to the young people as part of their induction tour, accessing the service would have been less daunting and therefore would have occurred earlier. "Not knowing staff, or being familiar with their roles was off-putting, and leaflets just aren't the same as being introduced to people".

On the whole, the counselling was felt to be very helpful; the young people felt listened to and supported, and were able to access support as and when needed, in addition to weekly sessions. However, access and support was restricted again to only the college times, within term time.

3.11 What is Wanted

The Mental Health Foundation, whilst recognising the challenge presented to practitioners, urges that those who provide care and education to children and young people need to incorporate a proactive awareness (of the growing problem of self harm and risk of suicide) in their work. The Foundation says that the attitudes shown by practitioners can influence what happens, so, for example, isolation can be reinforced by a judgmental approach in which their behaviour is viewed as manipulative or selfish.

The National Inquiry Second Interim Report stresses that taking young people's experiences and thoughts into account, when investigating what services and support should be offered, is essential in future development work around training staff, building services and policy recommendations. The Inquiry points to a large number of young people who report negative experiences when they have tried to engage with services for support, as well as a large number of those who cannot find the appropriate support they require.

The National Inquiry First Interim Report gives what young people have said they would like, which includes:

- Self-harm to be tackled in schools and educational settings (one group said they could not think of anywhere else where there could be so much access to so many young people).
- Presentations from outside organisations and professionals, discussion groups with peers, peer support/mentoring groups, also leaflets and posters in schools in accessible places.
- Some form of comprehensive training, whether internal or external, to ensure that teachers can not only talk about self-harm but also know how to look out for the signs of someone self-harming and how to approach them.
- Similar training and information to be made available to parents through parent/teacher groups.
- The subject to be addressed within the school setting but not by a teacher, rather a counsellor available at school but one that is independent of the school system.
- Other settings with information about self-harm such as community youth projects or cafes or drop-in centres.

3.12 Government Expectations

When looking at what young people say they would like, this would appear to link with Government initiatives. For example, the National Healthy School Standard includes in its definition of a "healthy school" one which:

- Promotes physical and emotional health by providing accessible and relevant information and equipping pupils with the skills and attitudes to make informed decisions about their health.
- Understands the importance of inviting in Health to assist in the process of raising levels of pupil achievement and improving standards

Under the 'Change for Children Programme', one outcome is to 'Be Healthy'. Where the mental and emotional health of children and young people is concerned, there is a target for a reduction in the death rate from suicide and an improvement in access to Child and Adolescent Mental Health Services. The DOH also highlights that some children in special circumstances have greater needs regarding their mental health.

- Looked after children are five times more likely than their peers to have a mental health disorder.
- Children and young people with significant learning disabilities are three to four times more likely to have a mental disorder
- At least forty per cent of young offenders have been found to have a diagnosable mental health disorder.

3.13 Models of Inter-agency/Inter-professional Working

The DOH cites two examples of services, one in Cornwall and one in Northampton, as models of good practice in relation to safeguarding children and young people from the risk of self-harm and suicide.

A brief description of these is given in Appendix 3, along with a developing model taking place in Northumberland, initiated by Northumberland Area Child Protection Committee.

APPENDIX 1: LEGISLATION – FURTHER INFORMATION

1. 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.

2. 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).

3. 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.

The first two 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 2: RESPONDING TO A CHILD OR YOUNG PERSON

Questions

1. What has been happening? Are you alright? Have you got any injuries or taken anything e.g. tablets/toxic substances that need attention? (Ask how much/when)
2. What, if any self-harmful thoughts have you had? (Consider asking questions about frequency, pattern, escalation and triggers)
3. What if any self-Harming behaviour (intentional/unintentional) have you carried out?
4. Have you planned/are planning any of these? (Consider likely/imminent harm)
5. If yes, have you got what it would need to do it? (Means)
6. Have you thought about when you would do it? (Timescale)
7. Ask about normal health. (Use of alcohol/drugs)
8. How long have you felt like this?
9. Are you at risk of harm from others?
10. Is there something troubling you? (Family/social/school). (If you are concerned about potential abuse follow the Child Protection Procedures).
11. How do you see the future?
12. What have you been doing that helps? (Who knows about what is troubling you and/or how you are harming yourself)
13. Where would you put on a scale of 0-10 your: (Establish what 0-10 is)
 - Thinking about harming yourself
 - Behaviours likely to happen again
 - Mood generally
14. What would 10 look like?
15. Have you ever been at 10?
16. What were you doing when you were at 10?
17. How high would you need to go for life to be ok so you would not harm yourself anymore?
18. What other risk taking behaviour have you been involved in?
19. What are you doing to stop the self-harm from getting worse?
20. If you have managed to stop the harming what are you doing instead?

General Responses

- It is okay to talk about self-harm.
- It is good that you are able to speak about this and have looked for solutions to

control this.

- I will have to contact. to help get you the right support to help you with this.
- If you don't want your family to know, the named person will talk this through with you.
- Set up contract re managing the harmful behaviour until further risk assessment/referral/ sessions have been arranged.

Do

- Make first line assessment of risk.
- Take suicide gestures seriously.
- Be yourself, listen, be non-judgmental, patient, think about what you will say.
- Check associated problems such as bullying, bereavement, relationship difficulties, abuse, sexuality questions.
- Encourage social connection to friends, family, trusted adults.
- Implement support/behaviour contracts with child or young person.
- Seek consultative support/seek further risk assessment.
- Make appropriate referrals.
- Remember healing power of therapeutic availability.
- Offer interventions based on understanding of the risk and problems encountered.
- Offer interventions designed to alter the life trajectory of young person.
- Offer interventions that set the young person on a new development course, opening new opportunities changing life circumstances and providing support.
- Offer new coping skills.
- Provide support particularly in times of crisis or stress.
- Strengthen natural support systems in the community (collect data on their effectiveness).
- Recognise that self-harming is a mechanism that is used to manage problems, feelings and experiences. It may take time to be replaced by alternatives (using rating scale - what would need to happen for it to be a 4 rather than a 5?).

Don't (Generally)

- Jump to solutions.
- Make quick judgements.
- Dismiss what the child or young person is saying.
- Believe a young person who has threatened to harm themselves in the past and not carried it out, will not carry it out now or in the future.
- Disempower the child or young person.
- Trust appearances.
- Ignore or dismiss people who self-harm.
- See it as attention seeking.
- Assume it is used by children and young people to manipulate the system or individuals.

IT IS IMPORTANT TO REMEMBER TO TREAT EACH CASE ON ITS MERITS!

APPENDIX 3: MODELS OF SERVICE DELIVERY

1. Cornwall Leaving and Aftercare Service

Provided by NCH (National Children's Homes)
Commissioned by Cornwall County Council.
National Service Framework Standard 4 - Growing up into Adulthood
Contact 01726 815005 or swnadiyah@mail.nch.org.uk

This service provides intensive support to young people leaving care whose needs are more complex than usual, focussing on developing the young person's independence skills and supporting him or her to find accommodation, working also on education, training and employment issues. Additions health, self-esteem, confidence, safe sex, contraception, healthy diets and drug and alcohol misuse. The team have developed and established robust safe care practice, including risk assessments, to respond to young people who attempt suicide or who self-harm. The project has also established a through system of evaluating the outputs and outcomes of their work. The service has been successful in helping 80% of the young people using the service into formal education, training or employment (compared with national average for care leavers of 50%).

2. Northampton Integrated Pathway for Children and Young People who Self-harm

Provided by Northampton General Hospital
Commissioned by Northampton General Hospital and CAMHS
National Service Framework Standard 9 – The Mental Health and Psychological Well-being of Children and Young People.
Contact 01604 634 700

The integrated care pathway allows Hospital staff to directly refer to the Doctor on the ward a child or young person who needs treatment of self-harm. Also there is a requirement of all involved to fill in one set of notes, so that one set of paperwork accompanies the child or young person from admission to A & E until their discharge from hospital. The child or young person benefits because they stay in hospital for a shorter period because of the integrated pathway.

3. Northumberland Deliberate Self-harm and Suicide Care Pathway (Early 2005, model under development by Northumberland Area Child Protection Committee)

The Northumberland model starts from the point where concerns first arise. Children and young people may directly or indirectly disclose feelings, intentions to, or experience of, self-harm and suicide to practitioners in different agencies, as seen in the box 'Sources of Information' in the following Flowchart.

'Early Risk Assessment Designated Workers' such as School Nurses, Youth Offending Service professionals, Community Psychiatric Nurse etc. would be available to advise and support the practitioner involved. They would be 'key contact people' whose names and telephone numbers would be known to practitioners.

Risk assessment would involve asking a number of key questions (see questionnaire at end) of the child or young person and making an assessment of their appearance and behaviour. The outcome at this stage would be:

- An increased awareness of the child's or young person's needs but no further action
- An increased awareness of the child's or young person's needs, on-going support and potential re-assessment.
- The child or young person being referred for a more in-depth assessment by, for example, a specialist Child and Adolescent Mental Health service or Social Services or an emergency referral to hospital. Subsequently there would be ongoing support, from an identified professional, who may be from any agency.

Systems would be put in place to ensure the pathway of care for the child or young person, covering issues of consent and multi-agency meetings.

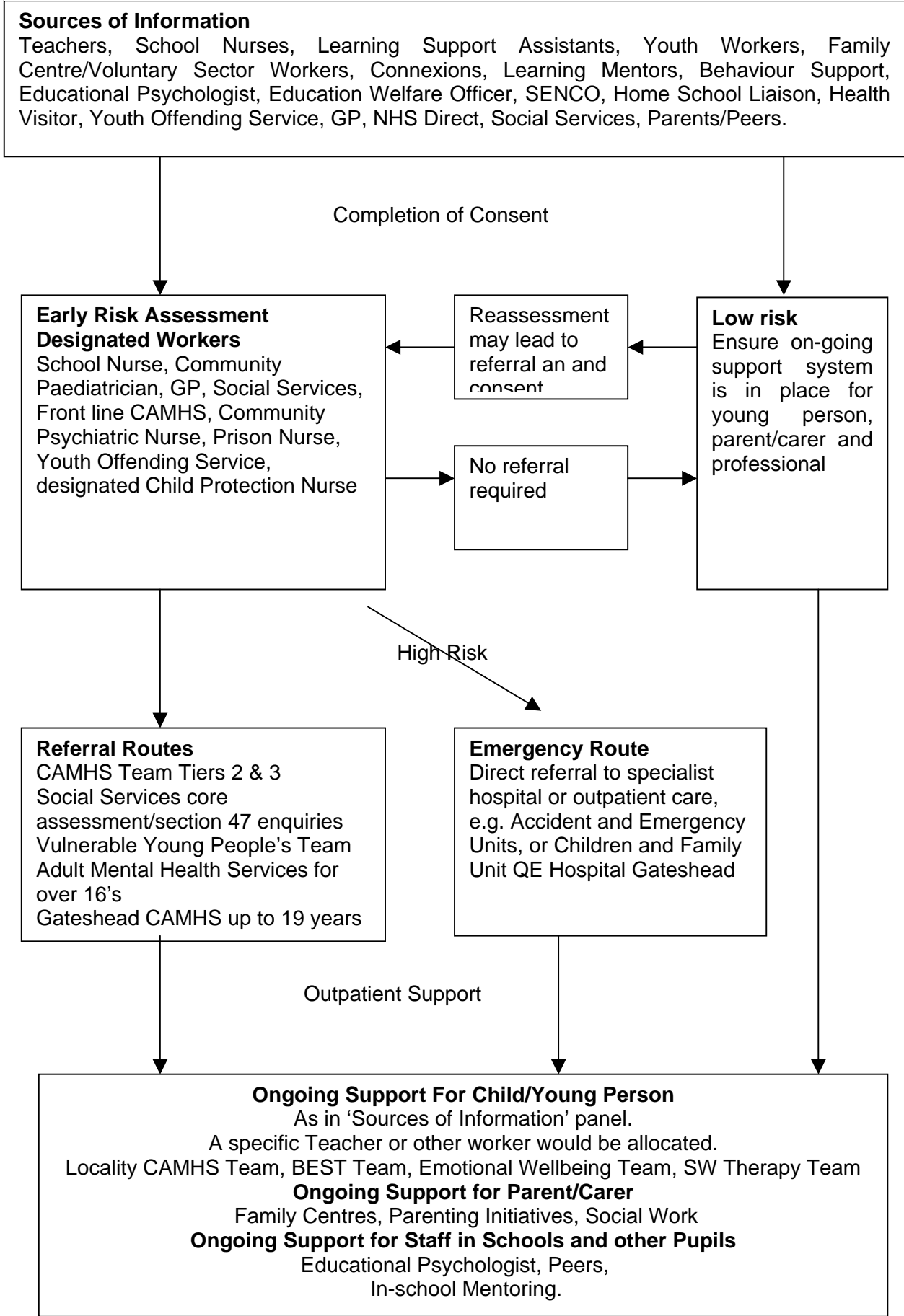
The above processes would be supported by multi-agency training and setting up local systems. A 'Deliberate Self-Harm and Suicide Pack' would be available, consisting of:

- A care pathway
- A quality standard
- Teaching programme and summary
- Risk assessment guidance, questions and proforma
- Additional supporting information.

The pack would aim to offer an informed and systematic approach to addressing the needs of children and young people at risk of deliberate self-harm or suicide. It would aim also to ensure that children and young people gain appropriate support and are assessed and referred appropriately where necessary.

See Flowchart on following page

Flowchart Proposed Gateshead Self-harm Care Pathway



APPENDIX 4: USEFUL ORGANISATIONS/CONTACTS

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

British Red Cross

9 Grosvenor Crescent, London SW1X 7EJ
tel. 020 7235 5454, web: www.redcross.org.uk
Free training in camouflaging scars

MindinfoLine

tel. 0845 766 0163
Mind is the leading mental health organisation in England and Wales, providing a unique range of services. MindinfoLine is Mind's helpline and information service.

NAPAC

42 Curtain Road, London EC2A 3NH
helpline: 0800 085 3330. web: www.napac.org.uk

National Information Service for People Abused in Childhood

National Self-harm Network (NHSN)
PO Box 7264, Nottingham NG1 6WJ
email: info@nshn.co.uk web: www.nshn.co.uk

Samaritans www.samaritans.org.uk

Phone: 08457 909090
Befriending service for anyone going through a personal crisis that is at risk of suicide.

Self-harm Alliance

PO Box 61, Cheltenham, Gloucestershire GL51 8YB
helpline: 01242 578 820, web: www.selfharmalliance.org
A national survivor-led voluntary group

Threshold Women and Mental Health Helpline

14 St George's Place, Brighton, East Sussex BN1 4GB
helpline: 0845 3000 911, email: thrwomen@gloablnet.co.uk
Information line for women with mental health problems

YoungMinds

102–108 Clerkenwell Road, London EC1M 5SA
parents information service: 0800 018 2138
web: www.youngminds.org.uk
For anyone concerned about a child's mental health

Websites

www.selfinjury.freeseve.co.uk
www.selfharm.org.uk
www.siari.co.uk
www.self-injury-abuse-trauma-directory.info

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www.dh.gov.uk

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www.dh.gov.uk

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www.nice.org.uk

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