



Understanding and Responding to Children and Young People at risk of Self-Harm and Suicide

A guide for adults who work with young people in Fife

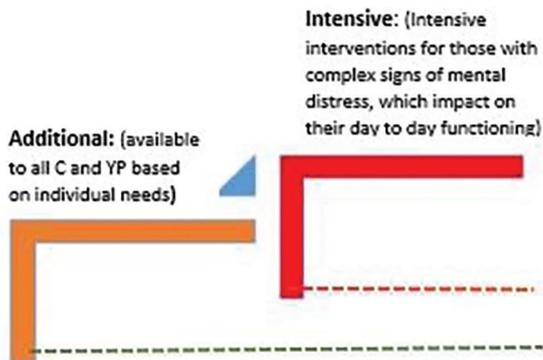


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Introduction

Who is this Document for and Why?

This document is for all staff in statutory and voluntary agencies that are working and supporting young people in Fife. For example, GPs, CAMHS practitioners, Educational Psychologists, Teachers, Social Workers, Public Health Nurses, Residential Child Care Workers and Voluntary Sector project staff, either paid or voluntary as well as carers.

The most recent UK figures document a dramatic increase in admissions to hospital due to self-harming over the last 10 years.

Figures collated by NHS Digital show the number of girls treated as inpatients after cutting themselves increased by 285% since 2005-2006.

Far fewer boys ended up in hospital than girls after cutting themselves; however, there was still a rise of 186% ¹

There were 392 referrals to the Fife CAMHS Service, for self-harm over a 12-month period between Oct 2015 and Nov 2016. That is an average of 21 referrals per high school. The actual number of young people who have self-harmed over that period is likely to be much higher.

There is a view amongst professionals that more young people are experiencing serious psychological distress in recent years because they are under unprecedented social pressures.

The good news is that research suggests that family and wider networks of support can make a big difference to help alleviate distress for young people and stop self-harming. ² This document aims to support professionals to support families and young people in that task.

The guidance applies to children and young people generally of school age, and most likely high school age, but up to 18 and beyond if a care leaver. However, much younger children can experience signs of depression, anxiety, self-harm and suicidal thoughts and we know that some groups of young people are at more risk of self-harm and suicide than others.

Aims

This guidance aims to support partnership working with children, young people, parents, carers and professionals to share information and organise support to reduce the risk of suicide and self-harm. It aims to provide all professionals with a shared framework for understanding, identifying, assessing and helping young people at risk of self-harm or suicide. The principles of GIRFEC are fundamental to supporting young people to flourish in Fife. The [“Getting it Right in Fife Framework”](#) explains how Universal, Additional and Intensive services can work effectively as single agencies, jointly or within an integrated approach to help develop and promote children and young people’s wellbeing. Whilst the Framework describes - universal, additional and intensive service, in fact the provision of services to children, young

people and their families is a continuum where services respond in a flexible and proportionate way depending on needs and risks. A fundamental principle that underpins the framework is that of minimum intervention, where as far as possible children, young people and families are supported within universal services. Support builds on to the universal provision dependent on individual needs, risks and circumstances of the child or young person within the context of the [Child Wellbeing Pathway](#) process.

[Our Minds Matter](#): A framework to support Children's and Young People's emotional wellbeing in Fife is also available to provide an overview regarding services for children and young people for all issues around mental health and wellbeing.

Key messages from the Scottish strategy for prevention of suicide³:

Suicide is preventable, it is everyone's business and collaborative working is the key to successful suicide prevention. Adults need to feel confident and skilled in responding to suicide and self-harm.

How to use this guidance

Whilst it is important to take time to read the entire document, each chapter is also readily accessible when required via the links below. Please use sections of this guide as a support when working with a young person faced with these issues. The guidance is there to support your own professional judgement and your organisation's existing policies. Remember, there should be no "wrong door" when it comes to a young person asking for help on this issue.

Acknowledgements

In creating this document, the authors have benefitted from a number of similar documents written by other areas in Scotland and the UK. The authors are grateful to the following organisations for allowing inclusion of aspects of their self-harm guidance for children and young people: Tayside, Argyll and Bute, Glasgow, Lanark, Trafford, and Cambridgeshire.

Understanding Self Harm

Definition

There are a variety of definitions of Self-Harm, however it is usually considered to be: **any act which involves deliberately inflicting pain and/or injury to oneself but without suicidal intent.** Substance abuse, eating disorders, piercing and tattooing, whilst frequently referred to in the wider debate about self-harm, are excluded from the definition of self-harm as relevant to this guidance

Public Attitudes and Awareness

Self-harm is the number one issue that young people are concerned about among their peers, in a list that includes bullying, drug use, and binge drinking.

Two in three teachers, parents, and young people think they would say the wrong thing if someone turned to them for help with self-harm.

Almost half of GP's say they do not understand self-harm, and three in five say they do not know what language to use when talking to a young person about self-harm.

Teachers feel helpless and unsure what to say; 80% want clear practical advice and materials that they can share directly with the young person.

Nearly 4 in 5 young people say they do not know where to turn with questions relating to self-harm

97% of young people feel that self-harm should be addressed in schools with two in three feeling it should be part of lessons. ⁵

The Statistics

Although statistics are provided at the beginning of this document, it is almost impossible to say with accuracy how many young people in Scotland self-harm. This is because it can be such a hidden behaviour and very few teenagers tell anyone what is going on. Whilst recent figures suggest that there has been a significant increase in the number of young people admitted to hospital for self-harm, **we also know that most self-harm occurs in the community and the majority of young people do not go to hospital for treatment of self-harm.**

In a Scottish study ⁶ in 2009:

13.8% of 15-16 year olds reported they had self-harmed in their lifetime (of whom 71% have done so in the past 12 months).

Girls were three times more likely to report self-harm than boys.

Smoking, bullying, worries about sexual orientation, self-harm by family and anxiety were factors associated with self-harm in both sexes

In addition, drug use, physical abuse, serious boy/girlfriend problems, self-harm by friends and low levels of optimism were also associated with female self-harm.

The study concluded that despite markedly different national suicide rates, the prevalence of self-harming in Scotland is similar to that in England.

Important Things we know about Self-Harm

In most cases a friend, family member or teacher notices a change in the young person.

A supportive friend, family member or teacher can significantly improve a young person's situation.

Self-harm may be an indicator of a range of serious problems that include mental health difficulties, psychological distress due to family problems, bullying, friendship or relationship stressors, physical and sexual abuse.

Each person who self-harms does so for individual reasons and as a result of a complex interplay of stressors. Each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode.

Social Media and Self-Harm

In 2016, Childline reported an 88% increase in the need for counselling about online bullying over the previous 5 years, with it featuring prominently for the 12-15 and 16-18 age groups ⁷

Parents and professionals are playing catch up in terms of understanding the role of social media in relation to the emotional health and wellbeing of children and young people. There is an emerging concern; evident to many parents and childcare practitioners that social media use can become hugely addictive for some young people. The pressures of Social Networking can leave young people feeling more isolated and alone.

Online Bullying

The impact of bullying can be amplified online for a number of reasons. Not being face to face with the person being bullied can make it easier for young people to distance themselves from the impact of what they are saying and justify it as a "joke". Online peer pressure to join in can also normalise bullying. "Liking" a cruel and hurtful comment or sharing it with others, can merely require the click of a button. Bullying can often happen later at night when parents assume young people are "safe" in their rooms. It can be incredibly difficult for young people who are being bullied to "turn off" and ignore online bullying, as often not knowing what is said about them online can feel more terrifying than knowing.

Online information about self-harm

Young people feel comfortable seeking support for self-harm online but believe they should be going to parents, teachers or GP's for help ⁵

The range of information online can vary from supportive to dismissive, from inciting self-harm to mocking and ridiculing those who do it. When a young person seeks or inadvertently comes across information, they have no way of knowing whether that information will be measured and helpful or part of an extreme negative view. There are a number of websites providing information to young people on *how to self-harm*.

Young people can also feel stressed and anxious about how to support friends on social media in relation to requests for advice about self-harm.

Positive Support Online

The YoungMinds report ⁵ concluded that organisations and professionals that offer support **need to be present in online spaces that young people feel comfortable going to**.

In a survey of young people who got in touch with Childline about self-harm, suicide and mental health issues, 78% chose to do so online instead of on the phone.

“I really value the independence of online help – it’s such a non-threatening way of getting advice. If I hadn’t used the internet when I was ill, I’m not sure I would have got through. You’re making the first step, you’re just getting the information to help you decide what to do next, so you don’t have to be anxious about what people say.”

www.themix.org

Always ask about a young person’s internet and social media use in relation to their self-harm. Do they talk to anyone about their problems online? Do they access websites about self-harm? What kind of advice are they getting?

If you are concerned about the type of advice or information a young person is receiving online; let them know, take time to show them positive support sites (listed in the resource section). If you are concerned about online bullying, Take Action.

The Relationship between Self-Harm and Suicide Attempts

The relationship between self-harm and suicide is complex. Many people who die of suicide will have a history of self-harm, but most people who self-harm will not go on to die by suicide. Suicide risk is elevated in those repeating self-harm. The risk of completed suicide among young people who cut themselves is higher than among those who have taken an overdose.

However, for the majority of young people, self-harm is not the same as a suicide attempt. In fact, it is often something very different: an attempt to cope and to stay alive in the face of emotional pain. Young people who self-harm usually do not wish to die, only to rid themselves of unbearable feelings. Even so, sometimes an individual may feel confused about their own motivation for hurting themselves. They may need to talk through what has happened and what led up to it before they can clarify for themselves whether their intention was to die or to try to deal with their feelings.

The difference between self-harm and a suicide attempt may not be apparent to others, since often the same sort of injury (such as cutting of the wrist area) could be interpreted in either way. However, most people who self-harm, if asked, are clear about their intention.

The difference between a suicidal behaviour and self-harm is about the intention. The severity of the injury is not necessarily an indicator of intent. When working with a young person who has engaged in self-harm, it is important to establish at an early stage whether there is suicidal intent or not. This is important in determining the level of risk.

You are more likely to have to deal with self-harm than suicide prevention.

Types of Self Harm

Self-harm is generally a response to overwhelming emotional distress. Self-poisoning (often medication overdose) and self-injury (often cutting) are the most common methods of self-harm. However young people can also engage in other forms of self-harm such as burning, biting, hair pulling and picking at old wounds.

Overdose: There are no safe overdoses and all young people who have taken an overdose must be referred for medical assessment

Young people who have taken an overdose are at risk of taking another overdose. As many as 10% will come back to A&E within 1 year with another overdose.

Who Self-Harms?

The average age of onset for self-harm is 12 years old. Self-harm occurs in all sections of the population but it is more common among people who are disadvantaged in socio-economic terms⁸. Cultural differences also seem to have an impact: within England and Wales Asian women aged between 15-35 are 2-3 times more vulnerable to suicide and self-harm than their non-Asian counterparts⁹.

Other groups thought to be at greater risk of self-harming include young people who:

- have eating disorders, mood disorders, anxiety or other mental health issues
- are involved with drug and alcohol misuse
- are involved in anti-social behaviour and offending
- are in local authority care
- are living with parental illness/substance abuse
- are lesbian, gay, bisexual and transgender people
- are living in isolated rural settings
- have a friend who self-harms
- are in some subcultures who tend to self-harm
- have learning disabilities
- have experienced neglect, physical, emotional or sexual abuse
- are not in education, training and employment
- are caught up in family disharmony
- are homeless

Why do Young People Self-Harm?

Young people told the Truth Hurts Enquiry (2004)¹⁰ that there are often multiple triggers for their self-harm, often daily stresses rather than significant changes or events. These might include feelings of isolation, academic pressures, not getting on with parents, a suicide or self-harm by someone close to them, difficulties with peer relationships, re-location of family home,

low self-esteem and poor body image. However some young people have had significant life experiences such as trauma and abuse, and this can be associated with self-harm^{11,12}. Some young people may find that inflicting physical pain changes their mood, which can become habit forming¹³

Given the complexity around this topic and the multiple triggers and factors associated with self-harm, the act of self-harm could be considered as a way of coping with and responding to difficult day to day and significant life experiences.

The most common event precipitating self-harm is interpersonal conflict.

The reasons young people give for self-harming are varied and include:



Drawing by Christina Plaka

- Self-harm temporarily relieves intense feelings, pressure or anxiety.
- Self-harm provides a sense of being real, being alive – of feeling something other than emotional numbness.
- Harming oneself is a way to externalise emotional internal pain – to feel pain on the outside instead of the inside.
- Self-harm is a way to control and manage emotional pain – the physical pain of self-harm can be easier to manage.
- Self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions
- Self-harm can be a means of communication
- Self-harm can be a way the young person punishes themselves for things that are going wrong in their lives

Myths about Self Harm

Unfortunately, recent public attitude surveys still indicate that there is no balanced understanding of self-harm⁵. It can be seen as either too serious or too trivial to prompt action. The research suggests that adults (including professionals) can equate it with suicidal behaviour, this can make them reluctant to talk to the young person about it as they feel out of their depth. At the other end of the spectrum is the perception that it is trivial or “selfish” behaviour, that it’s a fashion, a fad or a way to manipulate people.

Such negative stereotypes around self-harming can make young people feel like they do not want to come forward for help and advice. They fear they will be judged, not taken seriously or labelled as “mad”.

Myth: Self-harming is attention seeking

People who self-harm often go to great lengths to cover up their injuries. The attention that self-harming does bring is often negative and does not help to relieve distress.

“Self-harming was never a cry for help, I just wanted people to understand that I was hurting,”
www.themix.org

Positive attention, such as **lending an ear and listening**, can help somebody who is experiencing distress and dealing with the pressures of everyday life.

Some young people harm themselves in a way that can be noticed by others as a way of asking for help when they cannot find the words, or when they do not know why they are experiencing difficulties. It is preferable to acknowledge that the young person has needs and may be trying to communicate them, rather than labelling them at this time. It can also be a means to exert some level of control over their lives, to elicit care and love when that is not expressed by caregivers at other times.

Myth: Self-harm is a failed suicide attempt

People who self-harm do not usually intend to die, although some self-harm may be a failed suicide attempt. Self-harm can also be a strategy which some young people consider makes it possible for them to continue with life. Sometimes people who self-harm may also attempt suicide, but they can often clearly differentiate between the two different intentions.

Myth: Self-harm is a group activity

Self-harm sometimes happens in groups. Self-harm should not be ignored in any young person. Self-harm is usually a sign that something is wrong, should not be minimised on the basis that it occurs in a group and warrants further exploration.

Myth: Only girls self-harm

Self-harm is often thought to be more common among girls and women than among boys and men. However, research shows that boys also self-harm but it may be harder for them to ask for help.

Myth: It is best not to mention self-harm

Talking and emotional support is helpful. Self-harm indicates a young person is experiencing difficulties and could be ready to talk about the issues with someone who can provide support and is a good listener, such as a trusted adult or a friend.

Myth: People who self-harm have a mental illness

Self-harm is not a mental illness; it is likely to be a sign of distress. Some young people who self-harm may have mental health problems

The majority of young people who self-harm require emotional support to help them seek alternative coping strategies and to address the underlying problem.

Young People's Words

"It's like there's all this pain inside me and it can't come out. When I see a wound on me it's like I'm showing how I really feel inside."

"If I've got a burn or something on my arm, it takes the focus off what I'm feeling. It hurts, but lets me stop feeling the hurt inside me, which is worse"

"I've always had to do what suited other people- different foster parents, children's homes, schools. Nobody ever asked me what I wanted"

"I hit myself because I'm so angry with myself - for being so stupid and pathetic, for being the sort of person bad things happen to."

"The badness I feel becomes unbearable. I can't take it anymore so I cut. The relief is instant. It's like I've got what I deserve. The badness just drains away."

"I like looking after my cuts. It's the one time I can be really nice to myself. Then I curl up in bed and just snuggle down and go to sleep."

"People always think I'm happy and together. Even if I say that I'm down they think it's not serious. In the end I took tablets - not to die, but to prove I wasn't ok."

Children and Young People with Learning Disabilities

Although young people with severe learning disabilities can display what are perceived by others as self-harm behaviours, there may be other functions of the behaviour to consider e.g. to achieve certain sensory stimulation. It is not uncommon for a young person with severe learning disabilities to hit or bite themselves when feeling frustrated or not understood. Or, it may be to enlist help e.g. physical pain such as an ear infection may be expressed by hitting their ear. It is therefore important to find out what is being communicated with this behaviour.

Warning Signs

Self-harming is usually a secretive behaviour but some signs may include:

- Wearing long sleeves at inappropriate times
- Spending more frequent or longer periods of time in the bathroom
- Unexplained cuts or bruises, burns or other injuries

- Razor blades, scissors, knives, plasters have disappeared
- Low mood – seem unhappy or depressed
- Changes in mood – anger, sadness
- Low self-esteem
- Feelings of worthlessness
- Losing friendships
- Withdrawal from activities that used to be enjoyed
- Abuse of alcohol and or drugs, or changes in the use of alcohol or drugs
- Spending more time on their own, becoming more private or defensive

Protective Factors

Studies have examined whether multiple environments of the adolescent including peers, school and neighbourhood might function as protective factors against self-harming behaviour during adolescence. Findings indicated adolescent/parent interaction and adolescent experience of the school culture and their neighbourhood were associated with reduced likelihood of self-harming behaviours during adolescence.^{14, 15}

Interventions that address the issues within these multiple environments, may offer an effective means of reducing the levels of self-harm.

Factors associated with reduced risk of self-harm in adolescence

- **Ease of communication with a parent or caregiver**
- **Sense of school belonging**
- **Sense of neighbourhood belonging and safety**

These findings emphasise the importance of strengthening protective factors gained from schools, the home and local communities, and shows they can make an important contribution to improving emotional health and preventing self-harm. It highlights the need for protective adult relationships during adolescence and the need for a holistic understanding of the young person's life.

School connectedness has been found to reduce a range of adverse outcomes in addition to self-harm and suicide in young people. These include: substance abuse, absenteeism, early sexual initiation, violence and poor educational outcomes. School connectedness is defined as the belief by young people that adults in the school care about their learning as well as about them as individuals. Studies indicate that a young person's feeling of being connected to school is influenced by their peers as well as by adults and thus the definition has been expanded to include a perception that their peers care about them.

Ways to support a sense of school connectedness¹⁶

- **Engage young people in extra-curricular activities (especially physical activity)**
- **Use positive class room management strategies**
- **Effective relationships and behaviour policies**
- **Ensure young people feel safe in school**
- **Support positive peer relationships**

What Are the Effects of Self Harm?

A teenager who self-harms can face various other outcomes, which can impede their health and wellbeing in the longer term. These effects might include shame and guilt, depression and social isolation. [One study](#) of young people between the ages of 16 and 21 years found that at 5 year follow up, those who had reported Self Harm at any age up to 16 were substantially more likely than those with no history of Self Harm to reported repeated Self Harm, have current mental health problems (mainly anxiety and depression), difficulties with substance misuse and lower levels of educational attainment.

As outlined above self-harm has been identified in several studies as a risk factor for suicide. There is also a risk of accidental death from self-harm even if it was not intended. ¹³

Understanding Suicide and Suicidal Behaviours

This chapter is designed as an introduction to some of the key issues relating to suicide risk. It should be read in conjunction with Chapters 4 and 5 which provides guidance on assessing and responding to self-harm and suicide risk in young people.

Definition

The Scottish Government defines suicide as 'death resulting from an intentional, self-inflicted act' and that 'Suicidal behaviour comprises both deaths by suicide and acts of self-harm that do not have a fatal outcome, but which have suicidal intent'⁴

The Statistics

The good news is that the overall suicide rate for Scotland has fallen significantly over the past 10 years, and the number and rate of suicides fell in 2015 for the fifth consecutive year¹⁷. The suicide rates in Fife are consistent with this national decrease.

However, *suicide deaths still occur disproportionately amongst people in certain groups such as men, the middle aged, those who do not have a partner, and those who live in areas of socio-economic disadvantage. Many of these deaths will have occurred among people with acute psychiatric needs but who have not received specialist mental health treatment.*

Suicide Rates in Young People

The actual numbers for attempted suicide by young people in Scotland are unknown. This is partially due to the methods of recording deaths of children and young people and lack of studies in this area

A study in 2014¹⁸ reported that there had been no reduction in rates of death from intentional injury (suicide and assault) among 10 to 18 year olds in the UK in three decades. In the four years to 2010, just over 34% of injury deaths among boys were intentional as were nearly 38% among girls. Injury resulting in death among adolescents often occurs when there are coexisting chronic conditions, for example injuries accounted for nearly 70% of deaths among 15 to 18 year olds with psychological or behavioural problems.

The same study reported that many children who died from suicide had not had any contact with mental health services, and there were reportedly problems with services failing to follow up patients who had been referred but not turned up for appointments.

When young people fail to attend mental health appointments, and health providers have been unable to contact the young person or their parent/carer, and where there may be ongoing concerns about the young person's wellbeing, it is important for the health provider to consider use of the [Child Wellbeing Pathway](#).

Who is Most at Risk?

Misusing alcohol or drugs and mental health problems

Even young people who are using substances “casually” can be at increased risk of suicide, they can be particularly vulnerable in the “come down” phase.

Research shows that substance misuse may cause or increase symptoms of mental illness.

Mental ill health may also lead someone to abuse substances. They may want to block out their symptoms or the side-effects of medication. They may have difficulties in sleeping, feel lonely or simply wish to boost their self-confidence. People with mental health problems and who are also using substances are at increased risk for self-harm and suicide¹⁹.

Other Vulnerable Groups of Young People

- Looked after children and young people/children in residential units/care leavers
- Young men
- People with mental health problems
- Recently bereaved
- Living in rural/isolated communities

Factors Most Likely to be Associated with a Higher Risk of Completed Suicide by Adolescents who Self-Harm

Individual	Family	Social
<ul style="list-style-type: none"> • Previous suicide attempt • Previous self-harm over a long period of time • High ongoing suicidal intent • Have utilised violent methods (hanging, jumping) • Difficulty sleeping, feeling hopeless, not seeing a positive future, no plans for the future 	<ul style="list-style-type: none"> • Parental separation/divorce or death • Have a relative or friend who tried to kill themselves or completed suicide • Parent mental health problems • Adverse childhood experiences • Harsh discipline • Family conflict 	<ul style="list-style-type: none"> • Educational underachievement • Have been in young offender institute/prison • Homeless • Socially isolated

Protective Factors for Reduced Risk of Suicide in Adolescence

Individual	Family	Social
<ul style="list-style-type: none"> • Problem solving confidence • Physical activity and health • Reasons for living 	<ul style="list-style-type: none"> • Parental warmth • Familial connectedness 	<ul style="list-style-type: none"> • Social connectedness • Adult caring • School safety • Supportive schools • neighbourhood safety

19, 20, 21, 22

It is important to develop multi-faceted strategies to strengthen these factors, such as increasing problem-solving capabilities in individuals whilst promoting the development of supportive family and school environments.

"I was really depressed, panicky all the time. I thought no-one liked me. I didn't know what was happening - I thought it was all my fault. I couldn't see any future."

"Trying to kill myself was a lot to do with my sexuality. I thought when people found out I was gay, my life wouldn't be worth living. Also I couldn't cope at school and I couldn't keep covering it up."

"After my mum died, I couldn't bear going on without her. It felt so empty and pointless. Also I felt what right did I have to go on living when she couldn't? I thought I should go and keep her company."

Why do Young People Attempt Suicide?

A stressful event or life crisis nearly always precedes suicide in young people. In vulnerable children and adolescents, recent destabilising life events can result in high *perceived* threats to self-esteem. Examples of precipitating events include a) reputation loss b) exam failure c) broken romance d) intimidation e) rejection f) loss of face with peers

Conflicts or arguments with family members/peers can often precede a suicide attempt and more recently conflicts or humiliation on social media have been associated with suicide attempts in young people. Bereavement or traumatic grief can also be a factor in suicide attempts.

The young person's intention is often to end their life because they cannot live with or see an end to the pain they are experiencing, or a solution to the situation they are dealing with. Sometimes the young person has shown no previous signs of emotional distress. Sometimes they young person has had serious problems, for example with the police, their family or school for a long time. These are the young people who are most at risk of further attempts. Some will already be seeing a professional e.g. CAMHS, Social Work. Others may have refused help or found it difficult to engage with support which is available.

Many of the risk factors associated with suicide can also be part of normal teenage behaviour. Many young people live with some or many of the factors listed above but it does not automatically mean they will consider suicide. Their response to difficulties depends on many factors such as their resilience, support networks and access to information. Some young people may have one risk factor but have difficulty coping, while other young people may live with many risk factors and cope well. Some acts of self-harm may result in death where this was not intended.

Signs that someone you know may be at Risk

- Previous deliberate self-harm or suicide attempt.
- Talking about methods of suicide.
- Dwelling on insoluble problems.
- Making final arrangements such as giving away prized possessions.
- Hints that *"I won't be around"* or *"I won't cause you any more trouble"*.
- Unresolved feelings of guilt following the loss of an important person or pet (including music or sports idols).

Marked Changes in Usual Behaviour Patterns can also be a Sign of Risk

- Change in eating or sleeping habits
- Withdrawal from friends, family and usual interests
- Violent or rebellious behaviour, or running away
- Drinking to excess or misusing drugs
- Feelings of boredom, restlessness, self-hatred
- Failing to take care of personal appearance
- Becoming over-cheerful after a time of depression.
- Physical signs, for example weight loss or gain or muscular aches and pains

Common Myths about Suicide

There are a number of commonly held incorrect beliefs about suicide. These myths about suicide may stand in the way of providing assistance for those who are in danger.

Myth: Young people who talk about suicide never attempt or complete suicide

Talking about suicide can be a plea for help and it can be a sign in the progression towards a suicide attempt. Talking about suicide is one of the factors suggesting a risk of attempted suicide.

Myth: People who threaten suicide are just seeking attention

Do not dismiss a suicide threat as simply being an attention-seeking exercise. It is likely that the young person has tried to gain attention and this attention is needed. The attention may save their lives.

Myth: Talking about suicide encourages it

Responsible talk about suicide does not encourage people to attempt suicide. If you are noticing warning signs chances are the person has already thought about suicide.

Myth: If a person attempts suicide and survives, they will never make a further attempt

A suicide attempt is regarded as a probable indicator of further attempts. It is likely that the level of danger will increase with each further suicide attempt.

Myth: If someone has decided to kill themselves there is nothing anyone can do about it

If appropriate help and support is offered to the person with suicidal thoughts and they are willing to accept this help their risk of suicide can be reduced.

Suicide Methods

- More young women take overdoses of drugs.
- More young men (20-24 years) use violent methods, e.g. hanging, strangulation or poisoning.
- Men in rural areas have higher numbers of deaths from firearms, deaths from drowning and deaths from car exhausts.
- Between 80% and 90% of adolescents who are referred to hospital after suicide attempts have taken overdoses.

A large proportion of attempted suicides are by an overdose of commonly available drugs such as aspirin, paracetamol, anti-depressants and minor tranquillisers, often in conjunction with alcohol. Such overdoses can result in death, or long-term physical damage.

Suicide Prevention

It is estimated that 90% of young people who attempt suicide make some attempt to communicate their intentions²³. **However**, young people are more likely to tell a friend than a parent or professional if they are contemplating suicide, but few young people said that they would tell an adult if a friend had confided their suicidal intent to them.

Measures that can be taken to reduce risk of suicide (Minded.org.uk)

- Making it harder to get hold of drugs and alcohol
- Not reporting specific details of suicide, not glorifying suicide or sensationalising it in the media
- Making sure young people cannot get hold of tablets or other means of suicide
- Educating professionals in depression recognition and treatment
- Reduce the stigma of mental health problems amongst young people and acknowledge the importance of personal help seeking
- Encourage caring attitudes in schools and help seeking on behalf of a friend
- Consideration of some of the principles and approaches outlined in [evidence-based school suicide prevention programmes](#)

Talking to a Young Person about Self Harm and Suicide

The skills you need to engage with a young person who is self-harming are the same skills you would use with any young person in distress and all staff are encouraged to use their colleagues for support. It's important not to shy away from talking to a young person you feel may be at risk - you may be the person that they feel safe to reach out to.

Reasons young people gave for not asking for help with self-harm

- I feel ashamed
- My parents think this is just a phase I am going through
- They will say I am attention seeking, which makes me feel even worse!
- No one will understand or help me
- I don't want to stop; it makes me feel better/in control
- I just want people to leave me alone
- My friends self-harm too. I talk to people online about it
- My parents will be blamed: I might be taken into care
- It's the only way my parents take notice that something is wrong

Initial Response

Young people report that telling someone about self-harm or suicidal feelings can initially make their situation worse. It may set off a chain of events that the young person had not anticipated, leading to more worry and distress. Young people often worry about the reaction they will get from a professional and the effect it will have on relationships with family and friends, this can prevent them seeking help. They may fear being labelled an 'attention seeker' or placing burdens on those around them, or else their concerns being dismissed. They will have concerns about what happens next and who else will be told. ²⁴

It can therefore take a lot of courage to make a disclosure of self-harm or thoughts of suicide to an adult. This could be the first time they have told anyone so your reaction is very important. Never ignore self-harm, there is always a reason behind it.

All professionals working with children from infancy onwards should recognise that their capacity to listen to children, to tune in to their emotional state and to help ensure that their needs are met, are essential elements in the reduction of self-harm and the prevention of suicide.

Helpful Tips for Responding to a Disclosure of Self-Harm

- Try to be clear about the limits of confidentiality as early as possible in the conversation
- Acknowledge their distress and show concern. For example: "That sounds very frightening. Let's see what we can work out together to help."
- Listen to what is being said and check you understand the meaning
- Talk at their pace and give them time to talk
- Try to understand the sequence of events that led them to self-harm, don't focus solely on the self-harm
- Be non-judgemental
- Present yourself as confident and in control (however you may feel inside). For example: "Let's work through this together to find a way forward."
- Be realistic about what you can and can't do but don't avoid talking about self-harm. Talking about it won't make matters worse but ignoring it may make the young person feel alone and unheard
- Be interested in them as a person and not just as someone who self-harms
- Talk to them about the key adults in their lives and develop a sense of who supports them. (If there is a suspicion that there are adults who are unsafe and potentially damaging/dangerous talk to your Child Protection Coordinator promptly)
- Ask the young person what they want to do and plan the next steps together.
- Be strength focussed – e.g. "I admire the way you have been able to talk about such difficult things"
- Try to end by offering HOPE and a problem solving approach. Things can change and get better. What seems overwhelming now can feel very different in a few weeks' or months' time.
- Agree what the follow up plans will be.

Remember to:

- Be aware of the limitations within your professional role
- Follow your service/organisational policy or protocol
- Use the support available to you - e.g. manager, colleagues, supervisor
- Contact other agencies for advice or to refer on where appropriate
- Liaise with all involved in line with guidelines on confidentiality and consent

Do not:

- Assume someone else is helping the young person
- Ever make agreements that you cannot keep
- Tell them to stop or make ultimatums.

Unless things have reached a critical level, your concern for the young person and interest in her/his well-being are likely to have reduced some of their distress and sense of isolation.

By offering to see the young person again within a specified time frame, you show that you have time for them and can be approached if the situation deteriorates.

Make sure that the plans you put in place actually happen; for example, check they have been contacted/seen by the counsellor, or have seen their GP.

Talking with Young People about Self-Harm

There is no one right way to work with a young person as everyone is an individual and will have different needs. It is natural to assume that the best outcome for the young person is for them to stop harming themselves, however this isn't always the young person's goal. For this reason, it is important to listen to them and work together so you can reach a shared understanding of what you are working towards achieving.

The young person may wish to develop strategies other than harming themselves, to manage triggers and painful emotions. It can be helpful to understand how thoughts and feelings affect behaviour as this will help you explore with the young person new ways of managing difficult situations.

There are specific strategies that young people who self-harm have said they find useful when they feel the urge to self-harm, such as distracting themselves or talking to someone. These help the young person to minimise harm when they feel unable to stop completely. *Further links provided in the resource section.*

Sometimes when things are feeling difficult it can be hard to recognise aspects of life that are going well. Therefore, it is useful to identify and use strategies that already help them feel better about themselves and the world around them. Support the young person to see they are not alone and encourage positive support networks through friends, family, or professionals. Identifying triggers and high risk situations is essential. Even the best strategies do not work in all situations and so it is helpful to develop a range of strategies the young person can use when they are struggling.

Understanding the Drivers of Self-Harm

As well as talking to the young person about their self-harm it is important to try and understand the underlying issues that led to them self-harming. It is important to consider your wider understanding of the young person. What are the protective and risk factors? Do they have a positive support network? Are there clear changes in their presentation? Have there been changes in behaviour, grades or attitude? What is the family context? [The GIRFEC National Practice Model](#) and resilience matrix can help practitioners and agencies to gain a more complete understanding of a young person's needs, the strengths and pressures on them and consider what support they might need. It is also a way for all agencies and workers who support children, young people and their families to begin to develop a common language within a single framework enabling effective inter and intra-agency working.

Assessing / Understanding Self-Harm Risk

- Find out how the young person has been feeling.
- What do they think is going well in their life, what is not going so well?
- What are the underlying difficulties? Check for:
 - Bullying, school stressors, relationship issues, difficulties at home,
 - Are they misusing alcohol or substances?
 - Worries about their weight/how they look
 - Worries/problems with their sexuality
 - A recent death of a friend or family member
 - Mental health problems such as depression and/or eating disorders
 - Issues with sexual or gender identity

- Problems with race, culture and/or religion
 - Self-harm or suicide by someone close to them
 - Sexual, emotional, physical abuse or neglect
- Has the Self-Harm been triggered or maintained by any of these issues?
 - How long have they been self-harming and what was the sequence of events that first led to their self-harm?
 - What measures have been taken by others to address these underlying issues? Have they helped?
 - Are there times when they can use other coping strategies? What other strategies do they have?
 - Regarding self-harm – when does it happen? How often? Who knows about it? Has it changed over time i.e. increased in frequency, severity or type?
 - What do they feel would help right now?
 - Have they ever felt that life is not worth living?

Many young people who self-harm do so in a way that is controlled and so that they do not, for example, cut deeply or harm themselves in a way that requires medical attention. However, it is important to recognise that, as with all maladaptive coping strategies, self-harm can become a usual response to daily stresses and can therefore escalate in severity.

Sometimes practitioners can become complacent where the same child or young person presents with self-harm on a regular basis, but it is very important to reconsider risk *each time*, as there are situations or factors that increase the level of potential risk to someone's safety. When working with young people it is essential to develop an understanding of the level of risk that they present to themselves and to remember that this can change over time - the meaning or intent may change depending on the young person's mood or circumstances.

It is important to talk with young people about these issues - it will not make things worse.

Factors that Increase Risk Relating to Self-Harm Include;

- The use of alcohol or drugs when self-harming. This can make an individual more reckless and impulsive
- The young person feeling hopeless about life, whether it be not caring whether they harm themselves or actively wanting to die
- Methods of self-harm where there is a higher risk of accidental or unanticipated severe harm e.g. frequent small overdoses may cause long-term harm
- An increase in frequency of self-harm or a feeling that they have to do more to feel the benefits.

Should a Worker Ask to See a Young Person's Injuries?

This can be a difficult dilemma for a worker; on the one hand you might want to ensure that the young person is safe and establish whether or not they require medical attention. Some young people may be seeking practical advice to care for wounds and scars. On the other hand, we know that someone who has recently harmed themselves may be upset and vulnerable and a request to see their injuries may cause anxiety and compound possible feelings of guilt and shame. There are no definitive guidelines to getting it right. However, if you suspect or are aware of recent injuries it is compassionate to show concern for these. The fact that the young person has caused the wound themselves does not mean it will not hurt, or be frightening or shocking to them. Concern for them gives them a message that they matter and deserve care.

It is important to respond sensitively and respectfully. If you have concern that an injury may need first aid, gently requesting to see the injury makes sense, and if first aid or other medical attention is required then you should offer support to them in arranging this. It is important that the young person maintains a sense of control of their situation and is made to feel involved in decision making around their care and treatment.

Requesting to see a young person's injuries should not be considered as a routine practice or motivated by curiosity alone. The request should be made from knowledge that there may be an injury that requires first aid or other medical attention. For young people who are disturbed by the appearance of scars which have resulted from self-harm, there is help available via the NHS to help [camouflage such scars](#).

Working with Young People and their Families

Young people and their families may have different views and feelings regarding self-harm and may struggle to understand each other's' experience. For the professional trying to help it is often difficult to achieve a balance and support everyone involved. Don't feel you need to manage this by yourself. It is not unusual for more than one person to provide support. Self-harm within families can make people feel helpless and it is therefore important to help them to explore these feelings in a safe way. It is important for all involved to remain open-minded, non-judgemental and to respect the views of all family members in order to reduce feelings such as blame, guilt or shame being directed at any one individual. It is important that family members have a sense of urgency in terms of understanding the triggers to a young person's self-harm and doing what they can address these issues. At the same time, it is important to convey a sense of hope that if everyone works together then these issues can be successfully addressed and change is possible.

It is also worth remembering that brothers and sisters may be affected as well and their needs should also be considered.

Other Young People Who May be Affected by Self-Harm

- Encourage all young people to raise worries they may have about friends who seem depressed.
- If a young person is self-harming, be alert to the possible impact on their peer group, especially if it is a friend who has come forward to pass on concerns about the self-harming. Reassure them that they have done the right thing and you will handle what they have told you sensitively. Let them know that their role is to be the young person's friend and that adults will take key responsibility for acting on the concerns they have passed on.
- In some instances, a young person self-harming can be unsettling to other vulnerable young people. Be aware of this and offer support and guidance when needed.

How to Talk about Suicide

“Protecting children and young people from contemplating suicide is not an isolated activity; it needs to be part of a holistic approach to their overall care and development.” (SCSWIS 2011)

- Talk openly about suicide and don't avoid the issue.
- Don't be sworn to secrecy. Do seek support.
- Be willing to listen and accept the individual's feelings.
- Be non-judgemental and don't debate the rights and wrongs of suicide.
- Be there for the person and be involved.
- Don't dare them to do it.
- Try not to appear shocked.
- Offer hope that alternatives are available.
- Take action by removing any means they may have to commit suicide; your own safety is paramount.

Take Action / Get assistance from appropriate support agencies

If the young person is expressing a wish to die and says that they have a plan of what to do **you must** ensure that they are seen urgently by CAMHS or attend the local Emergency Department who will access mental health services as appropriate. Accessing emergency services takes priority over maintaining confidentiality in these circumstances. If you feel that the young person has experienced or is at risk of experiencing significant harm, then it is necessary to follow your organisation's child protection procedures. For advice regarding such concerns your organisation's identified child protection lead.

Assessing Risk of Suicide

In terms of talking to a young person who may be having suicidal thoughts and feelings much of the advice in the previous section is relevant, however when entering into a dialogue, it can be helpful to gather information on the following areas, in order to accurately assess risk and pass necessary information on to the relevant professional.

Thoughts Have they ever thought about suicide? How often do these thoughts come into their mind? Are these thoughts that they can ignore? Are there things that they can do to take their mind off these thoughts? Do they ever hear these thoughts as voices telling them to harm themselves? Do they feel hopeless about their future?

Intent Do they feel that they would act on these thoughts? Are they worried that they might act on them? Do they feel safe right now? What stops them from acting on these thoughts?

Planning Have they ever made any plans to take their own life? What did they plan to do? Do they have a plan at this time? Have they thought about when this might happen? Have they ever researched methods or spoken to anyone else about ways to die?

Access to lethal means Do they have anything that they would use to harm themselves such as pills etc.? Where are they kept?

History Have they ever tried to kill themselves in the past? What happened? What stopped them? Did they go to someone for help? Do they feel the same right now?

What to do next If suicidal thinking is fleeting, with no clear intent or planning and is contextual to a wider issue, consider access to primary support e.g. school nurse, counselling service or Primary Mental Health Workers. Are parents aware? If not, what are the young person's concerns about telling them? If there is clear risk you will need to inform them. If you are unsure about the level of risk or how to make sense of the information you have gathered, it is important that you seek appropriate consultation. Where clear risk is apparent, you need to consider your safety plan.

Safety Planning for Suicide Risk

A safety plan is a collaborative agreement including the young person, family and relevant practitioners. An immediate safety plan can be "here and now" and can be reviewed once the young person has accessed any additional supports. It should include;

The warning signs for distress Triggers? Situations?

What actions the young person will take to maximise safety? Letting someone know, staying in public areas, focusing on a distraction task, 'safe pain' techniques, talking to positive friends etc.

What actions will family take? Remove access to lethal means, agree frequency of checks, keeping room door open, and spend time with the young person engaging in distraction, time to talk or listen, plan activities. Ensure the family has contact details for emergencies and a clear plan of action if they feel unable to keep the young person safe.

What actions others will take? Provide a safe space in school. Identify a named adult to talk to, to give encouragement to engage in lessons and activities, to address underlying issues and to review timetable as appropriate. Provide access to counselling or school nurse. All involved to build confidence and self-esteem through positive activity and responsibility. For school-age young people, when indicated, share an understanding of their wellbeing needs through a co-ordinated plan, using the Wellbeing Pathway.

Other Risks to Consider:

Risk of suicide is not the only risk that needs to be considered when a young person may be so distressed that they are feeling suicidal. It is important to consider whether the young person is at risk of harm from others, including family, peers, online contacts or other adults. It is also important to consider if the young person is so distressed by their situation that they are a risk to others, using violent methods.

All organisations must follow their respective protocols for responding to a critical incident.

Multi-Agency Pathway for Self-Harm & Suicidal Behaviour

Working together

It is important to be able to communicate effectively and develop working relationships with other practitioners and professionals to safeguard and promote the welfare of young people. This involves understanding the role of other practitioners and agencies in supporting and advising young people and families. It also involves knowing how and when to share information using GIRFEC tools such as the [Child Well Being Pathway](#)

Deciding How Best to Meet the Identified Needs of the Young Person

You may continue working with a young person. You may also decide to refer them on to another service or professional. This decision will depend on the identified needs of the young person based on you and/or others' assessment, including the level of risk the young person presents. It will also depend on your role and whether you feel another service is better placed to provide the help the young person needs.

If you are continuing to work with the young person you may want to consider the following: The skills you have that will support the young person, the time commitment that is needed and how this fits with your role. Who will you consult for advice and who can provide support your own wellbeing as you work directly with the young person? Have you taken the young person's views into account? There are a range of universal services you might wish to consider in the first instance including primary health care services such as School Nurses, Primary Mental Health Workers, GPs or non-statutory counselling services. Consulting with other additional support services can also be valuable (and essential if they are already part of the team around the young person) e.g. Educational Psychology.

You may find the risk chart (low, raised, high risk) in this chapter helpful in guiding your assessment. In terms of the staged intervention approach, broadly the levels correspond with the Universal, Additional and Intensive continuum of services outlined in the Getting it Right in Fife Framework. Do remember though, that risk assessment is more than just a matter of listing risk factors or ticking boxes. The interplay between risk factors and outcomes is complex and the impact of each factor varies from person to person - this means that understanding why one young person is more at risk than another can be complicated. It is also important to recognise that risk fluctuates depending on the mood and circumstances of a young person at any one time, so it will be necessary to revisit risk assessment regularly.

If in doubt, please ensure that you consult with specialist mental health services. You may also find the checklist in Appendix 2 a useful way of recording decision-making and actions for incorporating into your organisations confidential records.

Seeking Help from Specialist Mental Health Services

Once you have engaged with the young person and have assessed the issues underlying the self-harm it is appropriate to seek advice from mental health professionals if you are concerned. Within the school setting this may be via the Primary Mental Health Worker or if risk is high then seek an urgent CAMHS consultation direct 01334 696250.

This applies to all young people up to the age of 18 years (pathway for care leavers below). Information to consider including in your referral, if available:

- Presenting concerns and the background for these as discussed with the young person
- Description of their mood, and in particular any changes over recent weeks
- Thoughts of hopelessness; and/or an expressed wish to die
- Any plans to harm themselves
- Changes in behaviour, such as social withdrawal, school refusal or anti-social behaviours
- Level of drugs or alcohol use
- Changes in sleeping patterns or appetite
- A description of the family situation and relationships including other support networks
- A description of any help the young person currently receives, what they want further help with and whether they are fully aware of and in agreement with the referral
- Your current involvement and capacity to stay involved
- The parents understanding of the young person's difficulties.

Sometimes, if there is not enough information in a referral letter to consider whether specialist CAMHS is the most appropriate service to meet the young person's mental health needs, they may seek further information before offering an assessment. An assessment may lead to further treatment or signposting to alternative, more appropriate services.

If you have significant concerns regarding a young person's immediate safety as a result of serious self-harm or suicidal intent an emergency assessment can be arranged. In these circumstances, the young person should be seen by their GP or the local Emergency Department who will access an urgent CAMHS assessment as needed. Appendix 3 details the care pathway for young people who present with Self Harm/suicidal behaviour at the Emergency Department.

If it is not practicable for the young person to be seen by their GP and you require urgent advice, please contact CAMHS Monday to Friday 9am-5pm, or outside these hours and at weekends arrange for the young person to attend the local Emergency Department. If there are immediate health concerns resulting from self-harm (e.g. an overdose) the young person will need help from the Emergency Department in the first instance - not specialist CAMHS.

Remember: The 16 to 17 year old age group is at greater risk for completed suicide

Young people aged 16 and 17 are also vulnerable to falling into gaps in services. All 16 and 17 year olds presenting with self-harm in either Emergency Department, GP or educational setting (including Further Education) require mental health assessment and planning. The same processes and pathways should be followed as for younger adolescents.

Case Examples

Universal

Available to all



Megan's Situation

Megan aged 14, went to see her guidance teacher following a few incidents of bullying by fellow pupils. She was distressed, scared and reported that a few pupils had been calling her unpleasant names and laughing at her. This had been going on for a few weeks. She disclosed that she had cut her arm the night before whilst crying in her bedroom.

Alongside listening and easing Megan's distress the guidance teacher asked if she had any further plans to harm herself. Megan stated she didn't and reassured her guidance teacher that her cuts were superficial and did not require any first aid treatment. There were no other obvious concerns. They agreed that her parents would be called and this information shared with them. Following this a meeting was arranged with Megan, her mum and the guidance teacher. The guidance teacher reassured Megan that the school would take the appropriate action re the bullying and discussed what ongoing supports would be appropriate for Megan. It was agreed that Megan would check in with her guidance teacher to monitor the bullying situation. The guidance teacher, as Megan's Named Person, kept a written record of these meetings.

Additional

Available based on individual needs



Karen's Situation

During a recent immunization clinic, the school nurse noticed that Karen aged 15 had several scars and newer cuts on her left forearm. The school nurse asked if she would return after the clinic for a longer chat and Karen agreed. Karen reported that she had been self-harming for around 6 months and was using a razor blade to cut her arms every few nights. Her mood has been low and she is having problems sleeping. Karen's parents separated a year ago following incidents of domestic violence at home. There was no violence towards Karen but she was witness to several incidents. She states the self-harm helps her release feelings of anger and sadness. The school nurse asked if she has had any thoughts of suicide and Karen admitted that at times she has thought about overdosing but had no specific plans to do this.

They discussed together what should happen next and Karen was not keen for her mum to be informed as she didn't want to worry her. The school nurse explained that due to the extent of her cutting and her ideas of overdosing that she needed to involve mum at this time. Karen reluctantly agreed alongside agreeing to a referral to CAMHS. The school nurse contacted

mum and arranged a meeting the following day, the guidance teacher was also invited with Karen's consent. At this meeting it was agreed that Karen would check in with her guidance teacher on a set time once a week to see how she was doing and discuss supports in school. It was also agreed that she could approach her guidance teacher or school nurse at any time if needed. They spent time discussing ways of staying safe and thinking about what supports were available to her in her own life. Mum agreed to accompany her to the CAMHS appointment and stay in regular touch with the school.

The school nurse completed the referral to CAMHS and informed the Guidance Teacher, Karen's Named Person of these actions. It was agreed that a wellbeing meeting was arranged. All actions were documented.

Intensive

Intensive interventions for those with complex issues and emotional distress which impact on their day to day functioning



Adam's Situation

Adam aged 17 has been meeting with a local drug and alcohol service due to problems with alcohol and substance misuse. He left school over a year ago and has been unemployed since. He has a history of self-harm and previous overdosing largely related to difficult home circumstances and past sexual abuse. He was previously seen by CAMHS but stopped attending last year. He has charges against him for assault and he has sought support for his drinking and drug use following advice from the police.

At his recent appointment his worker noticed that he had several recent lacerations to his arm. The worker enquired about his mood any thoughts about suicide. He stated that he has been very low for a few months and has frequent thoughts of hanging himself. Through further questioning the worker discovered that Adam had a rope under his bed and has been close on a few occasions recently to hanging himself. These thoughts were ongoing and he could give little reassurance about his ongoing safety.

The worker spent time with Adam reassuring him that help could be provided and he agreed to a further urgent referral to CAMHS alongside the worker contacting his Mum and his GP. The worker stayed with Adam until his Mum came to the project. CAMHS was contacted and an urgent assessment appointment was arranged the next day. CAMHS gave advice to the worker, agreeing safety plans for that night. Adam agreed to abstain from alcohol that night and mum agreed to stay with him until the appointment with CAMHS the next day, Adam also agreed that he would hand over the rope to his Mum. The worker also telephoned the GP and Named Person to inform them of the situation and documented all these actions. Adam was seen by CAMHS the following day and a treatment programme was put in place. A multiagency meeting was also arranged to discuss ongoing risk and support.

Self-Harm/Suicidal Thoughts or Behaviours: Guidance on Levels of Risk

Low Risk

- No Suicidal thoughts or if so vague, reactive, fleeting and soon dismissed
- No real desire to die
- No plan in place
- Self-harm leading to minimal safety risk, e.g. superficial cutting, no overdose
- Any mood changes are transient
- Able to articulate future life plans
- Sensible attitude to experimentation with drugs and alcohol
- No indication of past or present abuse
- Current problem situation felt to be distressing but bearable

Raised Risk

- Talking about suicide, thoughts are more frequent but still fleeting
- May have considered method but no specific plan or immediate lethal intent
- Possible past attempts
- Previous history of overdose or other significant self-harm,
- History of impulsivity
- Current self-harm with raised safety risk, e.g. deeper/more frequent cutting
- Significant drug or alcohol use
- Indications of possible abuse or significant traumatic experience
- Indications of current mental health problem
- Current problem situation felt to be distressing but no immediate crisis
- Young person has significant other wellbeing concerns e.g. truancy, conflict at home or with peer group, offending
- Looked After Child or Care Leaver

High Risk

- Frequent suicidal thoughts which are not easily dismissed
- Strong desire to die
- Specific/detailed plans in place
- Indicates hopelessness/sees no other option
- Increasing self-harm with significant safety risk, frequency, severity, or both
- Previous history of overdosing or other significant self-harm, family history of suicide
- Evidence of current mental health problem
- Significant drug or alcohol use (including binge drinking)
- History or evidence of impulsivity or violence
- Situation felt to be causing unbearable distress
- Impaired problem solving skills, isolated from support
- Looked After Child or Care Leaver

Self-Harm/Suicidal Thoughts or Behaviours: Management

Low Risk

Possible Actions

- Listen compassionately/ease distress (see guidance)
- Consider together what may be done to reduce difficulties
- Discuss plan to stay safe
- Provide advice on appropriate care of any injury
- Inform parents/carers with young person's consent
- Arrange meeting with parents/carers to discuss
- Inform the named person & link to sources of support in school
- Single Agency Support Plan as per GIRFEC
- Consult with relevant services e.g. Ed Psych, school nurse, Primary Mental Health Worker, consider referral to counselling or other support services
- Agree on follow up arrangements
- Complete documentation, including decision making

Raised Risk

Possible Actions

- As per Low risk action points 1-7
- Refer to CAMHS for further assessment. Link to sources of support in school/ notify Named person and other relevant professionals
- Arrange Wellbeing Meeting
- Discuss need for increasing level of support
- Refer to relevant agencies and agree multiagency Child's Plan
- Review and reassess at agreed intervals
- Complete checklist/document decision making

At any time during assessment prioritise any first aid or medical concerns.

Always consider if any child protection concerns need to be acted upon.

Consider issues of consent throughout. Confidentiality needs to be balanced against the safety of the young person.

High Risk

Actions

- Assess immediate risk and consider A&E if urgent attention is required
- Stay with the young person, do not send home alone
- Listen compassionately and ease distress as far as possible
- Consider together what may be done to resolve difficulties
- Provide advice on appropriate care of any injury
- Discuss immediate plan to stay safe
- Urgent referral to CAMHS 01334 696 25
- Inform parents/carers (unless this will increase present risk)
- Discuss immediate Safety & Support plan with parents/carers
- Notify services as appropriate e.g. GP, SW
- Decide on ongoing level of monitoring, increased support and by whom until Wellbeing Meeting/Child's Plan Review arranged
- Complete checklist/document decision making

Children in Care and Care Leavers

Looked-after children and care leavers are between four and five times more likely to attempt suicide in adulthood

Young people in care are particularly vulnerable to an increased risk of self-harm and suicide. They are much more likely to have had adverse/traumatic early experiences and experience high levels of stress during adolescence. They are also likely to have far fewer protective factors and positive support networks than their peers. Looked After Children experience “significantly poorer mental health than the most disadvantaged children outside the care system”²⁵

The roots of adolescent suicide can often be found in the early trauma experienced by young people²⁶. These risks continue into adulthood and may well be implicated in much self-harm and many suicides later in life. Traumatic experiences prior to and in care have an adverse impact well into adult life²⁷.

In recognition of this increased risk for children and young people who are in care, SWIA and Choose Life [produced a Suicide Prevention Guide](#), available online (a recommended resource for all carers and professionals working with this group).

Supporting Young People in Care (adapted from Furnivall 2013) 28

Many of the interventions that will address the risk of self-harm are key tasks for residential care workers and foster carers. Using their existing skills and working confidently, caringly and competently with young people helps address their underlying distress and difficulties.

- Young people can form genuine and secure attachments to adults caring for them which provide opportunities to resolve some of the underlying chaos and distress that plagued their earlier lives.
- Supporting positive peer relationships, both within the care setting and at school or work, combats the social isolation often associated with self-harm and suicidal behaviour.
- Success at school is a protective factor and so helping young people to attend regularly and achieve their full potential both academically and socially is essential.
- Supporting young people to manage and improve their relationships with their families is a key role for carers and workers.
- Relationships with the other young people with whom they share their living space can be very powerful. Adults can encourage the reciprocal responsibility of relationships among young people. This is particularly important as we know that young people contemplating suicide are most likely to confide their intentions to a peer. Creating a positive culture where distress is talked about and understood by everyone can prevent some of the dangers of contagion within residential settings.
- A sense of connectedness and belonging is protective against both self-harm and completed suicide. Children in care and care leavers often experience a massive amount of turbulence in their living arrangements. When change and transitions, whether planned or unplanned, disrupt important and comforting relationships this can greatly increase the risk that young people will hurt themselves. Young people should remain in the same placement wherever possible; if movement is unavoidable staff, carers and other young people should be able to remain closely in touch with the young person who has had to move.

Self-Harm Pathway for Children and Young People who are Looked After in Fife

In light of the likelihood of increased complexity of presentation of children who are in care and at risk of self-harm or suicide, Fife CAMHS support is offered through an enhanced pathway, avoiding the need for any waiting time, which is especially detrimental for this group. The stability of the young person's placement is of utmost importance and it may often be appropriate for Child and Adolescent Mental Health professionals to offer external consultancy to those directly caring for the young person, even or especially if that young person feels unable to accept individual therapeutic support. Young people report that accessibility and perceived stigma are key issues in accessing specialist mental health support and targeted CAMHS provision has greater flexibility in overcoming such barriers in order to support young people. The availability of local access without the need to travel long distances is valued by both young people and the adults who are supporting them.

- For those children and young people who are Looked After and Accommodated within foster or residential care placements, the child's social worker should consider as a second step, making a referral to the Springfield Project (for children in local authority placements) or to The Beeches, CAMHS LAC service (children in purchased placements within Fife) for a therapeutic service.
- For Fife young people resident out with Fife, at present, carers are required to access CAMHS support via their local GP service or according to local CAMHS self-harm pathway arrangements. If young people who are self-harming and the staff who work with them are not able to access appropriate therapeutic support and consultancy over self-harm and the related issues in a timely manner then this should be a priority concern for the young person's Lead Professional (Social Worker). There can be a lack of continuity in terms of mental health support for vulnerable young people who move frequently between placements, and working arrangements across health board boundaries can require clarification.

Carer Support

The impact of supporting a young person who is self-harming in residential or foster care can be traumatic to both staff and other children and young people. All staff and carers require adequate support, training and reflective supervision in order to remain resilient in the face of such difficult circumstances and enable them to continue to support the young person and the other young people living in the same environment. De-briefing after an incident of self-harm should be regular practice. The impact of a youth suicide on foster families and residential communities can be devastating. The grief that is experienced is complicated by the fear of scrutiny and criticism felt by staff and the profound anxiety of young people that they and the adults caring for them are no longer safe. It can be helpful for residential child care or foster care providers to develop a crisis plan to follow in the event of a suicide ²⁸

Care Leavers

[The Children and Young People \(Scotland\) Act 2014: Part 10](#) has changed the legal definition of a 'care leaver'. From April 2015 any young person who ceases to be looked after on or after their

16th birthday will be classified as such. All looked after children can become 'care leavers', including young people who were classified as 'looked after at home' and in formal kinship care. The 2014 Act extends eligibility to aftercare services to care leavers aged 21 to 25.

[The Scottish Care Leavers Covenant](#) ²⁹ was written to support the implementation of Part 10 of the Act. It supports corporate parents to deliver changes in action and practice to bring improvement and consistency to the care of these young people. It offers clear guidance on how to meet the needs of young people who are often disadvantaged as a result of their care experiences.

The Covenant outlines a range of actions and practice changes across key policy themes, which need to be delivered consistently by all relevant corporate parents across Scotland, at national and local level. One of the policy themes is "Health and Wellbeing" and it states a range of actions, one of which is that corporate parents will ensure that care leavers are given priority access to specialist services (***including Self Harm Services***) and improved access to adult mental health services. It also specifies that each local authority and health board has a named contact with specific responsibility for care leavers' health and for promoting and coordinating actions to reduce health inequalities, these being made explicit within Corporate Parenting Plans.

The section of the Self Harm guidance will be updated as Fife develops its specialist pathways of mental health care for Care Leavers.

Staff Support, Supervision and Training

Policies, Procedures and Guidelines

Each organisation will have a range of policies, procedures and guidelines to support staff in managing situations that involve a risk to young people's emotional wellbeing. These may include Child Protection Policy and Guidance, Traumatic Incidents Guidance, Exclusion from School Policy and support planning guidance, including the Child Wellbeing Pathway.

Staff Support

There are a number of safeguarding procedures that organisations must provide which will help staff in response to a completed suicide or suicide attempt and to reduce the risk of workers themselves becoming overburdened or distressed.

Organisations have a duty of care towards their staff, to provide them with appropriate guidance and support to enable them to carry out their functions. This is particularly important where these functions involve providing support to some of the most vulnerable young people. There are a number of safeguarding procedures that organisations must provide which will help staff in response to a completed suicide or suicide attempt and to reduce the risk of workers themselves becoming overburdened or distressed.

All staff working with children and young people have a responsibility to promote positive wellbeing as part of their role. As part of this responsibility, they have a responsibility to monitor their own emotional wellbeing, acknowledge any distress they are experiencing and seek appropriate support.

Organisations should proactively create an environment where there is an understanding that working with vulnerable young people is a collaborative effort where team work is valued, where the provision of support is a given, and where seeking support is an expected part of ongoing professional development.

It is normal for frontline staff who support young people who are self-harming and/or presenting suicidal risks to experience a range of emotions. These may include:

- Shock – this is common when first working with young people who have self-harmed or attempted suicide. It can be very upsetting to see or hear about a young person's wounds or scars
- Fear and anxiety – for example, about any wounds or scars, or about what a young person may do next
- Distress and sadness – for example, about the level of distress a young person is experiencing, and also perhaps about any personal unresolved pain and sadness
- Incomprehension – staff may find it difficult to understand why someone would hurt themselves or try to take their own life
- Anger and frustration – this can be in response to shock or fear. It can be difficult to acknowledge these feelings but it is important to do so in order that they can be effectively managed. Otherwise this anger could lead to staff minimising the self-harm or reframing the behaviour as being attention seeking or manipulative rather than evidence of distress. Staff may also feel angry at the people in the young people's life who have caused them such distress.

- Powerlessness and inadequacy – for example, staff may feel that their input has little effect and may begin to think that the young person cannot be helped, or that they themselves do not have the skills to help them. Staff may also feel pressure from the young person’s family or other professionals that they should be able to stop the young person from harming themselves

Managers should be aware of these risks and be vigilant in order to identify when staff may be in need of additional support. They should be clear with staff what support is available.

In addition to formal supervision and training, workers may find some of all of the following helpful:

- **Offloading:** Opportunities to “let off steam” and discuss difficult issues and feelings in a safe environment
- **Recognition:** Acknowledgement and appreciation of the challenges of the work and for efforts and progress made
- **Sharing Ideas:** The chance to discuss the work with others, sharing ideas and gaining insights
- **Support in the work itself:** at times young people and their families require an intensive level of contact. It can be helpful if colleagues can “share the load” ³⁰

Supervision

Staff need support and supervision to work confidently, professionally and effectively with vulnerable young people and their families. The safety and wellbeing of young people and members of staff are paramount.

Supervision is a system which enables individual members of staff to have access to a supportive relationship with an identified professional colleague. Effective supervision is an essential aspect of supporting staff welfare and ongoing learning and development.

It is characterised by opportunities to debrief and for reflection, and should provide the chance within a confidential professional relationship for self-evaluation and identifying individual development needs.

Organisations should provide a supervision system for staff who are engaged in supporting young people at risk. This can be a key element of staff support when dealing with young people who self-harm or engage in suicidal behaviours, as any unresolved issues and concerns experienced by staff may limit their ability to respond effectively to young people in an ongoing and consistent manner.

For example, there will be a supervision system in place for the Named Person Service which is specifically designed to support Named Persons’ own welfare and to promote individual professional learning.

Training

Ensuring staff are confident to intervene and provide support for children and young people in distress, including self-harm and risk of suicide requires training. It is recommended that all staff who work directly with young people complete at least one of the Level 1 training opportunities outlined in the table below. At an additional level, staff may seek further training from a range of professionals to deepen their knowledge and expertise in relation to specific areas, such as self-harm and/or suicide.

The training listed below specifically relates to suicide risk but as emphasised throughout this document, using the skills you have to support social and emotional wellbeing (and thus address the underlying concerns that are resulting in the self-harm behaviour) is crucial. MindEd (www.minded.org) provides free, high quality educational resources containing advice, guidance and information on managing a wide range of mental health issues in children and teens. Their curriculum ranges from Core content (aimed at all adults working as professionals or volunteers with children and young people) up to topics for targeted and specialist CAMHS.

General awareness raising training for school staff on self-harm and suicide can be delivered by Fife Council Educational Psychology Service. Schools can contact their link Educational Psychologist to negotiate this input.

Training	Duration	Course details	Delivered	Available to	Cost	Additional information
LEVEL 1 TRAINING						
MindEd e-learning	40 mins	Self-harm in children and teenagers, common associated conditions optimal approach to management. Info to help undertake a basic risk assessment awareness of red flags. Explain best course of action when faced with an adolescent who is at risk	Online	All staff	free	https://www.mindEd.org.uk
Self-harm e-learning module	40 mins	Provides an overview of self-harm and how those who self-harm can be supported	Online	All staff	free	www.selfharmlifelines.org.uk
Introduction to Fife Self-Harm guidance and pathway	Half-day	Provides an overview of the Fife Multi-agency self-harm guidance and pathway	Fife Council CAMHS	All staff	free	Book via CLMS if Fife Council and if NHS via Playfield Institute
LEVEL 2 TRAINING						
Understanding and Responding to Self-Harm	One day	Learning outcomes: shared and discussed professional and personal dilemmas; viewed self-harm in a broader context; identified life events underlying self-harm; furthered their understanding of 'how it works' for people; shared and promoted ideas on helpful and unhelpful responses to self-harm	CAMHS at Playfield Institute	Anyone who comes into contact with young people who may self-harm	free	www.healthyfife.net
Applied Suicide Intervention Skills (ASIST)	2 days	A 2 day intensive interactive and practice dominated course aimed at enabling people to spot the risk of suicide and provide immediate help to persons at risk	Fife Health and Wellbeing Alliance	frontline services where suicide prevention and risk assessment skills are required	free	
Safe Talk	Half day	A four hour session aimed at giving participants the skills to recognise that someone may be suicidal and to connect the person to someone with suicide prevention skills	NHS Fife Health Promotion		free	
Scotland's Mental Health First Aid (Young People)	14 hrs	Aimed at supporting a better understanding of young people's mental and to learn mental health first aid skills. Contains information around suicide risk intervention and self-harm	NHS Fife Health Promotion		free	Blended learning Part 1: self-study – 3hrs Part 2: Face to face training – 7 hrs Part 3; Self-study – 4 hrs

Information Sharing and Confidentiality: Best Practice and Legal Frameworks

If a child is considered to be at risk of harm, relevant information must always be shared

When disclosing personal information about a child or another living individual, the laws relating to privacy and confidentiality must be considered and complied with. As a result, disclosure of personal information will be conducted within the legal framework of UN Convention on the Rights of the Child (1989); the Human Rights Act 1998; the Data Protection Act 1998; the common law of confidentiality and in compliance with Professional Codes of Conduct.

In order to assist the sharing of information relating to children, Fife Children's Services Information Sharing Protocol (ISP) was developed and agreed between the relevant partner organisations in 2013. Therefore, every practitioner must ensure that they read and fully understand the terms of the ISP and implement the procedure set out within the ISP when sharing personal information.

The ISP sets acknowledges that in most cases the legal basis for sharing personal information will be consent. The ISP also acknowledges that: *"Where circumstances exist such that consent may not be appropriate, for example where an assessment under the wellbeing principles raises concerns, the Data Protection Act 1998, provides conditions to allow sharing of this information, such as 'for the exercise of any other functions of a public nature exercised in the public interest by any person' or 'in the legitimate interests of the data controller, or the third party to whom the data is disclosed so long as it is not prejudicial to the child'"*

The ISP also makes it clear that:

"Staff should not hesitate to share personal information in order to prevent abuse or serious harm, in an emergency or in life-or-death situations. If there are concerns relating to child or adult protection issues, the relevant organisational procedures must be followed."

Subsequent to the Supreme Court judgement regarding the **Named Person scheme**, the Information Commissioner's Office (ICO) has issued a statement to Local Authorities, Health Boards and Police Scotland. It stressed the following points:

- Over-riding the duty of confidentiality owed by GIRFEC partners to children and young people by sharing their personal data without their consent should *only occur* where such sharing may be carried out on the basis of an appropriate condition for **fair and lawful processing under the DPA (see above)**. The failure to identify appropriate conditions for such sharing may amount to a breach of the DPA as well as a breach of the Article 8 rights of the individual (Human Rights Act).
- The sharing of personal data without the consent of the individual is likely to take place only in very particular and clearly justified circumstances rather than as common practice. It should be exceptional for this to take place for sensitive personal data of children.

Clearly record your decision to share or not to share, and outline your reasons

We know that this is an extremely sensitive issue for young people and balancing confidentiality against the overall welfare needs of the child can be complex. If you have any queries regarding the sharing of personal data in these circumstances then you may wish to contact your Line Manager in the first instance or the Data Protection Teams within your organisation. For Fife Council staff, the relevant email address is: dataprotection@fife.gov.uk. For NHS Fife staff, the relevant contact is: Data Protection Office, NHS Fife, Lynebank Hospital.

Explaining to Children and Young People the Need to Share Information

- *It is crucial to build trust with the child/young person by explaining what information you are required to share, who you will share it with, and why*
- *Always listen to the young person's views on sharing information. Do they have any fears with regard to the information being shared?*

Evidence supports an approach and strategies that recognise that:

- It is paramount to ensure the young person is safe and risk to them is minimised: this has priority over a commitment to contact parents.
- The young person may be very accurate in their appraisal of their situation and risks of contacting their parents. There could be the potential for an increase in the risk to them, for example from abusive parents. In addition, we have to be aware that the young person may wish to be protective of a parent who has their own vulnerabilities, for example mental or physical health problems.
- We are required to fulfil our professional responsibilities as set out in any Council or Service policies, our professional codes of practice or legislation. This will include discussing events with other lead professionals.

These young people can be vulnerable, often very isolated and very poorly supported, however this may not be apparent (for example, perfectionism is a major contributor to self-harm risk). They may well have needed courage and a great deal of encouragement to access and work with staff. In going against their wishes, not only may we exacerbate an already troubled or abusive family situation but put a young person at risk of withdrawing from contact with any service. Therefore, there is a risk of compounding their vulnerability and isolation, and, in so doing, increasing their stress. The likelihood becomes that the self-harm and suicide behaviours increase.

Web-Based Resources

Resource	Suitable for	Link
“Aye Mind” aims improve the mental health and wellbeing of young people – by making better use of the Internet, social media and mobile technologies. Young people aged 13 to 21 have helped create many of the resources	Separate sites for young people and professionals	http://ayemind.com
“Calm-Harm” mobile App - developed using principles from an Evidence-Based therapy called DBT. The focus is to help learn to identify and manage your ‘emotional’ mind with positive impact. The app is an aid in treatment but does not replace it.	Young people	http://www.stem4.org.uk/calmharm/
YoungMinds is a leading UK charity committed to improving the emotional wellbeing and mental health of children and young people. It provides factsheets on self-harm in addition to a series of short films (Noharmdone) for young people, parents and professionals. The 3 separate films have accompanying digital resource packs	Young people, parents, professionals	http://www.youngminds.org.uk/noharmdone
Self-injury Support is a national organisation that supports girls and women affected by self-injury or self-harm. Online Resource Hub is a collection of guidance, research and useful educational tools	Girls and women, family, friends and carers, professionals	http://www.selfinjurysupport.org.uk/resource-hub/
selfharmUK is a project dedicated to supporting young people impacted by self-harm, providing a safe space to talk, ask any questions and be honest about what's going on	Young people, parents, professionals	www.selfharm.co.uk/home
The Mix -provides free information and support to Under 25’s in the UK. Specific link for coping methods	Young people	www.themix.org.uk/mental-health/self-harm www.themix.org.uk/mental-health/self-harm/self-harm-coping-tips-and-distractions-5696.html
ON EDGE: Learning about Self Harm Scottish Online videos and lesson plans plus a short animation about self-harm made by young people at Scarborough Child and Adolescent Mental Health Service (CAMHS).	Teachers, pupils, professionals	http://mindreel.org.uk/category/self-harm
Self-Injury in Schools - a short guide for Schools and Teachers including how to write a self-injury policy	Teachers	www.scar-tissue.net/schoolsipolicy.pdf
Changingfaces - an organisation that provides professional skin camouflage clinics. Available on prescription from GP’s. Fife Clinic based at Victoria hospital	Health professionals	https://www.changingfaces.org.uk/skin-camouflage .

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Appendices

Appendix 1. Talking to Young People about Sharing Information with their Parents

Parents and carers will most often (but not always) be sources of support for their child. Guidance from the Royal College of Psychiatrists ⁴ states that: *In the first instance, it is important that there is limited access to the means of self-harming. Both families and young people should be encouraged to dispose of sharp objects, tablets and other means of self-harm.* This is one of the reasons why *if safe to do so*, it is important for family support to be garnered.

Be ready to respond to three possible reactions to asking a young person to involve their parents:

1. **Agreeable** - In most cases, it will be possible to get the young person's agreement to informing and involving their family/carers. We can then decide the best strategies to support that young person and their family/carers.
2. **Reluctant** - In other cases, the young person will be reluctant for this to happen because of anxiety, embarrassment or uncertainty about how the adult(s) will react. Here, staff will have to help both the young person and their family/carers by:
 - Reassuring and supporting the young person through this process.
 - Signposting adults in the family/carers to other sources of support and information. (See Resources)
 - It may be helpful or even essential to identify adult family members such as an older sibling, aunt, grandparent or carers to act as a bridge and longer term mediator.
3. **Refusal** - It is important to recognise that the young person's resistance to their family/carers being contacted can be realistic and appropriate. Our priorities are to ensure their safety and that they continue to seek help and engage with support staff. For some young people, we may have to respect this refusal while continuing to seek ways to encourage them to inform and involve their family/carers. In some situations, we may need to engage in intensive multi-agency work with the whole family. In a few cases, it will never be possible to inform or involve the parent/carers. In considering our course of action, it is important to:
 - a) Be alert to the fact that one reason for self-harming and suicide behaviours in young people could be abuse, physical, emotional or sexual, by family members/carers. If there is knowledge or any anxieties about this possibility, it is imperative that staff take active steps to clarify the situation and ensure the young person's safety before making the family/carers aware of the situation. The involvement of and advice from social work colleagues are likely to be central to this process.
 - b) Take steps to reassure the young person, if required, about the value of informing and involving their family/carers.

- c) Provide support to the young person while working with them to understand how they can discuss their problems and needs with their parents/carers.
- d) At the time of the discussions with the young person, they may not be ready to involve their family/carers and let them know about their self-harm or suicide behaviours through, for example, fear of their reaction or embarrassment. They may not feel emotionally and psychologically prepared, at this point, to disclose the behaviour and discuss their feelings with family members/carers. Take steps to support family members/carers to understand the young person's behaviour and then give them appropriate help to support their child.

Appendix 2. Self-Harm or Suicidal Thoughts/Behaviours: Action Checklist

This form can be used to check and record possible action steps and retain in records. You can also use it to share information as appropriate, with other agencies.

Name: School:		D.O.B: Named Person/Lead Professional:			
Concern reported by (tick)	Young Person	Peers/friends		Other (specify)	
Action		Tick if complete	Task Undertaken by	Relevant information collected (bullet points)	Date complete
Low, Raised, and High Risk					
Any immediate first aid or medical risk attended to. Emergency Services called if necessary/A&E					
Support provided to ease distress as far as possible (guidance in chapter X)					
Young person has been asked re presence of self-harm or suicidal thoughts and you have established level of risk, Low, Raised or High (as per guidance)					
Joint discussion with young person and immediate support plan agreed. Check in date within the next 3 days agreed					
Parents/carers informed (consider issues of consent). Discussion about involving parents has been extensive with young person. If complex issues around disclosure to family pass info to Named Person/Lead Professional.					
Named Person informed					
Single Agency Plan agreed: task passed to named person/date of meeting agreed. Referral to relevant support if required					
Other young people affected by incident? If yes, appropriate support offered. Named Person informed.					
Raised or High Risk					
Safety Plan agreed with the young person and their family. Parents/carers advised of the need to remove all medications or where possible other means of self-harm available e.g. sharp objects					
Well-being meeting arranged by Named Person. GP informed.					

Self-Harm or Suicidal Thoughts/Behaviours: Example Completed Action Checklist

This form can be used to check and record possible action steps and retain in records. You can also use it to share information as appropriate, with other agencies.

Name: <i>Chloe Evans</i>		D.O.B: <i>23.02.2004</i>			
School: <i>Fife High School</i>		Named Person/Lead Professional: <i>Jan Moore (named person)</i>		Date of incident: <i>26/04/2016</i>	
Concern reported by	Young Person <input checked="" type="checkbox"/>	Peers/friends		Other (specify)	
Action		Mark if complete	Task Undertaken by	Relevant information collected	Date complete
Low, Raised, and High Risk					
Any immediate first aid or medical risk attended to. Emergency Services called if necessary/A&E		<input checked="" type="checkbox"/>	School Nurse	Treatment for scratches to arm	26/04
Support provided to ease distress as far as possible (guidance in chapter X)		<input checked="" type="checkbox"/>	Jan Moore, Guidance Teacher	Young person came to my office at lunch break along with a friend who had persuaded her to speak to me.	26/04
Young person has been asked re presence of self-harm or suicidal thoughts and you have established level of risk, Low, Raised or High (as per guidance)		<input checked="" type="checkbox"/>	Jan Moore Guidance Teacher	Raised risk Conflict at home with parents Chloe's Mum has history of mental health problems and a previous suicide attempt Chloe admits drinking alcohol regularly at weekend with peers Recent incident on Facebook, photo posted of her drunk that was seen by most of young people in school Signs of scarring from previous episodes No suicidal intent disclosed Protective factors: Mum aware of Chloe's self-harming. Chloe agreed for me to contact her. Original Facebook post removed.	26/04
Joint discussion with young person and immediate support plan agreed. Check in date within the next 3 days agreed		<input checked="" type="checkbox"/>	Jan Moore, Guidance Teacher	Chloe to check in with me daily for next week Chloe to spend time in the support base at lunch time Young People who have posted abusive comments to be	26/04

			spoken to. Discussion re contacting their parents. Mum to remove easily available sharp objects and medications from home	
Parents/carers informed (consider issues of consent). Discussion about involving parents has been extensive with young person. If complex issues around disclosure to family pass info to Named Person/Lead Professional.	X	Jan Moore, Guidance Teacher		26/04
Named Person informed	X	Jan Moore, Guidance Teacher		
Single Agency Plan agreed: task passed to named person/date of meeting agreed. Referral to relevant support if required	raised risk – MA plan			
Other young people affected by incident? If yes, appropriate support offered. Named Person informed.	X	Jan Moore	Check in with Chloe's friend completed as she has some issues of her own just now. Reassured she can speak with me if required	27/04
Raised or High Risk				
Initial Safety Plan agreed with the young person and their family. Parents/carers advised of the need to remove all medications or where possible other means of self-harm available e.g. sharp objects	X		As per above.	27/04
Well-being meeting arranged by Named Person. GP informed.	X		Social Work, family invited Date: Weds 11 th May	26/04
Referral made to CAMHS and/or other agencies depending on co-occurring needs (referral made by telephone call/sending this form). Referral agreed with family/young person	X		Telephone call to CAMHS They will offer screening assessment. Updated Checklist to be forwarded Cause for concern submitted to Social Work re conflict at home and Chloe's alcohol use	27/04
Multiagency Child's Plan agreed with Safety Plan. Review meetings arranged according to Risk management guidance.	X	Kay Stewart, SW, Lead Professional		11/05

