Inverclyde Alliance

AGENDA ITEM NO: 13

Report To:	**Inverclyde Alliance Board**	**Date:**	**17 June 2019**
Report By:	**Corporate Director Education, Communities & Organisational Development**	**Report No:**	
Contact Officer:	**Brian Young Health Improvement Lead Inverclyde HSCP**	**Contact No:**	**01475 715283**
Subject:	**Multi-agency Guidelines for Responding to Self-harm and Suicide in Children and Young People (Inverclyde Alliance)**		

1.0 PURPOSE

1.1 The purpose of this report is twofold –

I. To bring to the attention of the Inverclyde Alliance Board, the Multi-agency Guidelines for Responding to Self-harm and Suicide in Children and Young People and developments to support children and young people who may be at risk of self-harm and suicide.

II. To request the Inverclyde Alliance Board to support the proposed direction of travel, which is adopting a community planning approach.

2.0 SUMMARY

2.1 Both a national and local priority is to sustain and improve the mental health and wellbeing of children and young people, along with safeguarding, forming a key commitment that is an integral part of ongoing priorities for Inverclyde.

2.2 Recent high-profile cases, and subsequent reports and policy guidance, such as:
The fatal accident inquiry into the deaths on the Erskine Bridge (2012); the SCSWIS Practice Guide on Suicide Prevention for Looked After Children & Young People (2011); and Responding to Self-Harm in Scotland Final Report (2011), have contributed to begin to establish best practice in responding to self-harm and suicide.

With particular regard to the Erskine Bridge Fatal Accident Inquiry (2012) – *'Local authorities should commission a set of guidelines for staff working with looked after and accommodated children about recognising and mitigating suicide risk in this client group. These guidelines should include the requirement to develop a detailed management protocol*'.

2.3 A multi-agency writing group, with membership drawn from Inverclyde Council's Education Psychology, Specialist Children's Services, Social Work, Health Visiting and Health Improvement, was established to devise a draft of the guidance, utilising best practice from the guidelines already published in other areas and adapting for an Inverclyde context.

In addition, a freelance writer was independently commissioned to develop the guidelines.

3.0 RECOMMENDATIONS

3.1 That the Inverclyde Alliance Board notes the content of this report and approves the publication of the guidelines and associated implementation.

Ruth Binks
Corporate Director
Education, Communities and Organisational Development

4.0 BACKGROUND

4.1 Over the years, several policy drivers have considered the aspects of improving the mental health of children and young people. The latest Scottish Government's 10-year mental health strategy places children and young people at the heart of the early intervention and prevention agenda. Moreover, other policy drivers, such as the 5-year Strategy for Mental Health Services in Greater Glasgow and Clyde 2018-2023 are informed by a range of documents including the Scottish Government's Mental Health Strategy and the Healthy Minds 2017 report by NHS GG&C's Director of Public Health.

4.2 Given the directive outlined above from the Erskine Bridge Fatal Accident Inquiry, there was a responsibility placed on local areas to develop guidelines, a multi-agency approach was adopted locally.

4.3 The multi-agency guidance has been created to support staff and specifically ***frontline responders***, across all partner services, to provide a caring and appropriate response to children and young people experiencing emotional distress and who may be at risk of self-harm or have thoughts of suicide.

The document encompasses guidance for staff for both self-harm and suicide in a single document. This may infer an inevitable link and may cause concern, as self-harm and suicide are distinctly different behaviours, with very different intent and motivations.

Creating a document that includes but separates the two behaviours is the most effective way to ensure staff are capable of responding appropriately to young people experiencing suicidal ideation as well as the small proportion of young people who move from self-harm to suicide and the larger numbers whose self-harm does not lead to suicide.

In addition, this format will help to dispel the myths around the two behaviours and clarify the distinct features of each.

4.4 Noteworthy, is the extensive and robust consultation processes that the document has had, including discussions with several key professional stakeholders in social work, education services, 3rd sector agencies and young people themselves. As is evident in the guidelines, their voices have been pivotal in the document's construction, along with valuable input from Inverclyde Council's Legal Services.

4.5 Scrutiny of the guidelines has been mainly through the Joint Children's Services Plan Group and the Inverclyde Child Protection Committee.

Future governance arrangements are being recommended to the Inverclyde Alliance Board as the Joint Children's Services Plan Group.

5.0 CURRENT POSITION

5.1 In terms of the implementation of the guidelines, there are planned training/up skilling workshops that will be delivered on a multi-agency basis and the further creation of easy reference leaflet that captures the main points of the guidelines that will be used by the first responders.

5.2 The final draft of the guidelines, contained in Appendix 1, is an illustration of the content and for the Alliance meeting, there will be printed copies made available at the meeting.

6.0 IMPLICATIONS

Finance

6.1 None.

Legal

6.2 None

Human Resources

6.3 None

Equality and Diversity

6.4 Appendix 2 (attached) details an Equality Impact Assessment that addresses this aspect of the report.

Repopulation

6.5 None

Inequalities

6.6 The guidelines have a focus on addressing inequalities, which has also been considered in the attached Equality Impact Assessment (Appendix 2).

7.0 CONSULTATIONS

7.1 There were several consultations carried out with a range of stakeholder that included young people, to ensure their views were central to the final construction of the guidelines.

8.0 CONCLUSIONS

8.1 The ECOD Directorate presents this report and associated guidelines for the final sign-off by the Inverclyde Alliance

9.0 BACKGROUND PAPERS

9.1 A final draft of the guidelines is contained in Appendix 1.

9.2 An Equality Impact Assessment is detailed in Appendix 2.

Inverclyde Multi-Agency Guidelines for Responding to Self-harm and Suicide in Young People

Foreword

Councillor Stephen McCabe, Leader of Inverclyde Council and Chair of Inverclyde Alliance

On behalf of the Inverclyde Alliance, I am pleased to introduce the Inverclyde Alliance Multi-Agency Guidelines to Support Children and Young People at Risk of Suicide and Self-harm.

This development has been part of an extensive piece of work that firmly commits the Community Planning Partnership to sustaining and improving the emotional wellbeing and mental health of children and young people, as a local priority. This is augmented by the need to ensure there is adequate and effective support for children and young people with mental health problems and that they have early access to the help they require.

These guidelines have been created to support staff and specifically ***frontline responders***, across all partner services, to provide a caring and appropriate response to children and young people experiencing emotional distress and who may be at risk of deliberate self-harm or have thoughts of suicide. This document encompasses guidance for staff for both self-harm and suicide in a single document.

Creating a document that includes but separates the two behaviours is the most effective way to ensure staff are capable of responding appropriately to young people experiencing suicidal ideation as well as the small proportion of young people who move from self-harm to suicide and the larger numbers whose self-harm does not lead to suicide.

In addition, this format will help to dispel the myths around the two behaviours and clarify the distinct features of each.

The guidelines have been constructed following a number of consultations, quality assurance and scrutiny processes, ensuring these are robust for use in the context of supporting the outcomes for the children and young people of Inverclyde.

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PART 1 Introduction

1.1 Purpose of Guidance

These guidelines are intended for all staff working or in contact with children and young people in Inverclyde. They are the result of a process of collaboration and consultation with staff in statutory and voluntary services in Inverclyde as well as parents, carers and young people. It has utilised the latest research on responding to self-harm and suicide and is consistent with the principles and models of responding recommended by ASIST (Applied Suicide Intervention Skills Training) and 'What's the Harm' Self-harm Awareness and Skills Training (See Part 5 Resources and Training).

The purpose of this document is to ensure that all agencies working in Inverclyde provide a consistent, caring and appropriate response to children and young people who have been using self-harm as a coping strategy and/or are experiencing thoughts of suicide.

These guidelines should be read in conjunction with other relevant guidelines that are currently in place within each service or agency, e.g. GIRFEC which is briefly discussed in section 1.4 below:

When young people do access social, healthcare and other services, they need do so without fear, stigma and safe in the knowledge that they will be given strong and appropriate support[1].

This document is not intended to be a definitive or exhaustive guide to all aspects of self-harm and suicide. Neither should it be considered as a training package, it is recommended that you make every effort to attend the training that is outlined in Part 5 (Resources and Training).

In addition to the overall aim above, it is intended these guidelines will help to:

- Maximise consistency of response across agencies.
- Build upon and strengthen the knowledge and skills of staff in recognising and responding appropriately to young people who self-harm or are experiencing suicidal thoughts or behaviours, based on the latest research and government policy recommendations.
- Develop and maintain the quality of support, advice and guidance offered to young people who self-harm and or are experiencing suicidal thoughts or behaviours.
- Ensure that the first line response is appropriate and provides interim management even when referral is considered appropriate.
- Create clarity on the appropriate pathways when referral to another agency is required.
- Contribute to an environment within services which is nurturing and supportive and challenges the myths and stigma associated with both self-harm and suicide, so helping to promote the health and happiness of our young people.

How to use these Guidelines

It is suggested that these guidelines are supported by a smaller accessible leaflet (Responding to Distress: Self-harm leaflet and Responding to Distress: Suicide leaflet) for responding to Self-harm and Suicide. These A5 leaflets are designed to provide an at a glance guidance to responding to a young person, including a flowchart containing guidance on 'How to Help'.

This main document can be used as a reference when a practitioner requires more in-depth guidance on the rationale behind the leaflet.

1.2 Definition of Child or Young Person

There are several differing definitions of a 'child' in Scottish legislation[2] and the United Nations Convention on the Rights of a Child framework defines a child as being under 18 years of age.

However , it is also intended that these guidelines will apply to young persons over 18 years of age and in some circumstances up to , and including , the age of 25 years .Certainly , in terms of the Children and Young People (Scotland) Act 2014 , Local Authorities have a duty towards children who have been looked after and accommodated until they reach their 26th birthday .

Some of the services involved with children and young people have different age criteria. When seeking advice or making referrals , please ascertain with the agency the age range for which they provide support and help .Consideration should be given to vulnerability and whether adult or child protection processes apply for those children between the ages of 16 – 18 years.

1.3 Rationale for Separating Self-harm and Suicide

For this document, it is necessary to separate self-harm from suicide, whilst acknowledging that there may be links between the two behaviours. This is consistent with the approach taken in 'What's the Harm' Self-harm Awareness and Skills Training delivered throughout Greater Glasgow and Clyde.

It is common for those unfamiliar with self-harm to assume that it is a suicide attempt or gesture.

'While suicide attempts are undertaken with some intent to end life, Non-Suicidal Self Injury is undertaken with the intention of self-integrating and preserving life'[3].

(See section 2.1. for an explanation of the use of the terms self-harm self- injury and non suicidal self injury)

Several authoritative studies have indicated that young people are clear about the difference in intent between self-harm and suicide: self-harm is about staying alive and suicide is about dying. However, given that there is a view that both self-harm and suicide are underpinned by distress it can be assumed that there is a link between the two behaviours, and there is some evidence that for some, suicide may become an option when self-harm is no longer an effective coping mechanism for an individual's distress[4].

'The relationship between self- harm and suicide is complex. Many people who die by suicide will have a history of self- harm, but most people who self- harm will not go on to die by suicide. As such self- harm is a clear risk factor for suicide, but it is also a phenomenon that we need to understand and address in its own right.'[16]

However, given the apparent prevalence of self-harm in young people, estimated at 1 in 12 [8] to 1 in 15 [2] secondary pupils, it is clear that the majority of young people do not go on to attempt or complete suicide.

'That said, it is important to note that individuals with a history of self-injury are at higher risk for suicide thoughts, gestures, and attempts and, because of this, need to be assessed for suicide risk'[15]

For this reason, the guidelines would always recommend ensuring that the young person is always asked directly about the intent behind their harming behaviour and that the lethality of the method is taken into account. (See 'Self-harm How to Help' and 'Suicide How to Help').

1.4 Parental Support

1.4(i) Involving parents

Whenever we work with young people and we ensure there is a relationship of trust, we also have to make them understand that there may be occasions when we may need to share information with other people, including their parents.

While we want to ensure a comprehensive support system is in place for young people at risk of self-harm or suicide, we also need to listen to young people if they tell us they live with parents who may have mental health issues, substance misuse problems or are verbally, physically or emotionally abusive to them.

We need to recognise that we could make an already difficult family situation worse or risk the child or young person from disengaging with us. Therefore, it is very important to identify whether the child or young person wants their parent(s) to be a source of support for them. ***They may prefer to identify another adult family member or even an older brother or sister to be their support.*** What is important is that the child or young person's feelings are documented and that all staff engaged with the young person are aware of their circumstances so decisions can be made in the best interests of the child or young person.

1.4(ii) Information to support parents to support their child

From a parent's perspective it can be very difficult supporting their child in relation to self harm or suicide. The following information may be useful:

***In relation to Self –Har*Guidance from the National Self-harm network for family/friends and carers is available at this link:**

http://www.nshn.co.uk/downloads.html

Leaflets include:

Basic First Aid Distractions that can help

Advice for friends family and carers of young people who self harm

Advice for Young People Self harm: The Myths

Guidance from Lifesigns: Self Injury Guidance and Network Support offers downloadable leaflets:

www.lifesigns.org/downloads.html

Leaflets include

Parents and Guardians Factsheet Friends Factsheet

For People who self injure factsheet

Young Minds provide a parents helpline:

Call 08088025544
(Mon to Fri 9.30-4.00pm)

Parentline can be contacted:

Call: 08000 28 22 23).
Email: parentlinescotland@children1st.org.uk

Text: 07860022844

Webchat also available

In relation to Suicide

Guidance for family, friends, carers and the young person is available from Papyrus and it's associated helpline HOPElineUK (0800 068 41 41). Papyrus materials are available at this link:

http://www.papyrus-uk.org

Provide information leaflets, including:

Thinking of ending it all Not just a cry for help Coping with Exams

Listen to me Conversation starters (About Suicide)

HOPELineUK is a confidential support and advice service run by Papyrus for:

- Young people under the age of 35 who may be having thoughts of suicide
- *Anyone concerned a young person may be having thoughts of suicide*., including parents and guardians

HOPELineUK can be contacted:

Call: 08000 68 41 41

Text :07786209697

Email: pat@papyrus-uk.org

Parentline Scotland:

Call: 08000 28 22 23

Young Minds provide a parents' helpline:

Call: 08088025544

(Mon to Fri 9.30-4.00pm)

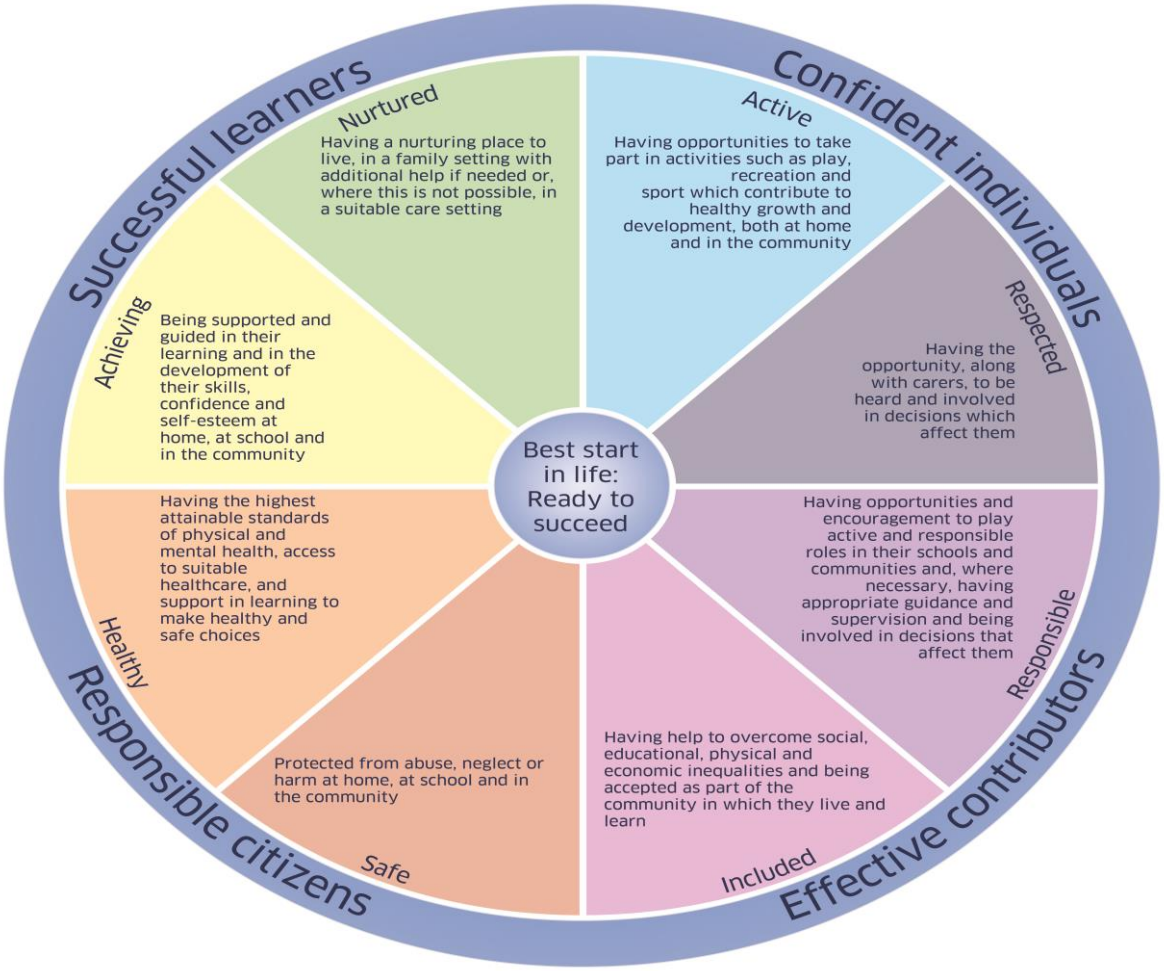
1.5 Getting It Right for Every Child (GIRFEC)

Getting it right for every child (GIRFEC) is the national approach in Scotland to improving outcomes and supporting the wellbeing of children and young people by offering the right help at the right time from the right people. The GIRFEC approach should be used as a way to identify needs, outcomes and solutions for individual children or young people at risk as a result of self-harm or suicide. It supports them and their parent(s) to work in partnership with the services that can help them.

The Getting It Right for Every Child approach ensures that anyone providing support places the child or young person and their family at the centre. Practitioners need to work together to support families, and where appropriate, take early action at the first signs of any concern.

The Wellbeing Indicators

To ensure that children get the best start in life practitioners use the eight indicators to assess a child or young person's overall wellbeing and identify strengths and any concerns. The indicators offer a consistent approach and language which helps organise what we know about a child or young person. If you work with children and young people, and you record information about them, you and your organisation should organise that information based on the wellbeing indicators in line with this National Practice Model.



Find out more about GIRFEC: www.gov.scot/Topics/People/Young-People/gettingitright

Wellbeing is broader than child protection and how we tend to think about welfare. When considered together the different elements of wellbeing give the whole picture of a child's or young person's life at a particular point in time. A child's or young person's wellbeing is influenced by everything around them and if we don't consider the bigger picture and work together our support can be less effective.

Concern for a child's wellbeing may arise as a result of an event, a series of events, attributes or circumstances which affects how they progress and do well now and in the future, for example, missing appointments for health checks.

Below are the five key questions every practitioner should ask themselves when they are concerned about a child or young person:

What is getting in the way of this child's wellbeing?

Do I have all the information I need to help this child?

What can I do now to help this child?

What can my agency do to help this child?

What additional help, if any, may be needed from other agencies?

Where concerns are identified action must be taken and a child's plan put in place. It is important to liaise with your supervisors and at this stage you must consider if a multi-agency approach is necessary.

The Named Person

Most children and young people get all the help and support they need from their parent(s), wider family and community, but sometimes, perhaps unexpectedly, they may need a bit of extra help.

Children and young people from birth to 18, or beyond if still in school, and their parents will have access to a Named Person to help them get the support they need.

This is to ensure that every child or young person has a clear point of contact if they or their parents want information or advice, or if they want to talk about any worries and seek support

A Named Person will normally be the health visitor for a pre-school child and a promoted teacher - such as a head teacher, or guidance teacher for a school age child.

A Named Person will be available to listen, advise and help a child or young person and their parent(s), provide direct support or help them access other services. They will also be a point of contact for other services if they have any concerns about a child's or young person's wellbeing.

If you have concerns for a child's wellbeing and consider that they need additional support you should consult with the child and family and with their agreement involve the child's Named Person. If the child and family are opposed to this further involvement then the child's welfare and safety must be your paramount consideration and you must consider if it is necessary, justifiable and proportionate to share this information and involve the Named Person without

their consent.

If the child and family are opposed to this further involvement then the child's welfare and safety must be your paramount consideration and you must consider if it is necessary, justifiable and proportionate to share this information and involve the Named Person, or any other agency /service, without their consent. It is imperative that you inform the child and their family of your intention to share information and the reasons why you feel this additional help is required, unless doing so would be detrimental to the child's welfare and safety.

PART 2 Responding to Self-harm

2.1 Definition of Self-harm

There are many definitions of self-harm, the definition utilised within these guidelines is:

"an act which is intended to cause injury to oneself but which is not intended to result in death. It is often described by those who self-harm as a way of coping with emotional pain and of surviving distressing experiences. It is not a suicide attempt."[9]

This is the definition used within the 'What's the Harm' Self-harm Awareness and Skills Training [9] and the 'On Edge'-learning about self-harm Resource Pack[12] .

Some of the literature quoted in this document uses the term Non-Suicidal Self Injury (NSSI) and self injury : for the purpose of this document these terms are synonymous with the term self-harm. It should be noted that self-harm, which has suicidal intent will be dealt with in the adjoining Inverclyde Responding to Suicide (Section3).

This section of the guidance has utilised research and articles which relate to self-harm and/or self-injury, which has a direct intent to cause tissue damage but is not intended to result in death.

2.2 Background and National Context

Self-harm among young people is a significant and growing public health issue[6]. On average two teenagers in every secondary school classroom will have hurt themselves in response to the pressure of growing up in an increasingly complex and challenging world[7]. Young people also say self-harm is their number one concern for their peers, above bullying, gangs, binge-drinking and drug use[7]. However, those in closest contact with young people often have limited knowledge of self-harm, which results in a poor response when a young person finally finds the courage to tell someone they need help[7] According to Truth Hurts (2006)[8], the National Inquiry into self-harm amongst young people, the response a young person receives when they first disclose self-harm will influence whether or not they go on to seek further help.

The Scottish Executive's Choose Life Strategy and Action Plan (2002, 2013-16) [17] identified children and young people as a priority risk group. It recommended that teaching staff are enabled or empowered to identify when early interventions are necessary and provide access to appropriate support and services. It is also recommended that teachers and other practitioners be equipped with the knowledge, skills and training to enable them to talk openly about self-harm to those groups most at risk and continue to develop and expand school based programmes on positive mental health and well-being. The Self-Harm Action Plan (2011)[10] sets out a series of objectives in relation to self-harm.

2.3 Prevalence of self-harm among young people

It is difficult to put a definite figure on the prevalence of self-harm, with estimations varying depending on the population studied and assessment tools used, and on the definition of self-harm.

"There are a number of reasons why it is difficult to determine the prevalence of self-harm amongst young people in Scotland. The majority of individual episodes of self-harm go unreported and yet prevalence is based on hospital treatment" [10] ***(SG, 2011).***

> Worryingly, as the hospital figures are only the tip of the iceberg, the true figure of how many children and young people are self-harming is likely to be far higher, and this is especially so for particular at-risk groups including lesbian and gay, transgender and bisexual young people, looked-after children, and young people in the criminal justice system.[7]

The Truth Hurts Report [8] estimated in 2006 that 1 in 12 young people self -harm. In 2013 Childline reported a 68% increase in the number of young people contacting them in relation to self- harm in the previous year, and intimated that they are at the greatest risk of self -harm around the age of 12 to 13.

2.4 Why young people Self-harm

Self-harm is a coping mechanism, which enables a person to regulate feelings and express difficult emotions. Young people who hurt themselves often feel that physical pain is easier to deal with than the emotional pain they are experiencing. However, the behaviour only provides temporary relief and fails to deal with the underlying issues that the person is facing.

> ***They may want attention, but the fact that they do want attention isn't because they're bad and they're an attention seeker, it's because they have another … they feel the need for affection or something like that"***
> ***Benjamin,****17* [12]

For some young people, Self-harm may last for a short time. For others, it can become a long-term behaviour. Som people self-harm, stop for a while, and return to it months, even years later in times of distress.

> **It is a response to distress. It can be a way of coping with unbearable emotional pain, feelings of powerlessness and hopelessness. These feelings may arise from events happening in a person's life right now or painful experiences in the past that left the person feeling powerless, bad about themselves, alone, hurt and betrayed'[8].**

The reasons young people gave for using self-harming behaviours are varied and are discussed below. It is however safe to assume that the behaviour is underpinned by distress of some kind.

- 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 or disassociation
- 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 pain - unlike the pain experienced through physical or sexual abuse
- Self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions, a form of emotional regulation
- Self-loathing - some young people who self-harm are punishing themselves for having strong feelings (which they may not have been allowed to express as children), or for a sense that somehow they are bad and undeserving (for example, being a victim of abuse and a belief that it was deserved)
- Self-harm followed by tending to wounds may be a way to be self-nurturing, for someone who never was shown by an adult to express self-care
- Self-harm can be a way to draw attention to the need for help, to ask for assistance in an indirect way
- Self-harm can be used to attain group membership, but this should not imply that the young person is not experiencing severe distress

Self-harm can be influenced by alcohol and drug misuse2.5 Groups who may be more at risk of Self-harm

Anyone can self-harm. This behaviour is not limited by gender, race, education, age, sexual orientation, socio-economics, or religion. However, there are some identified vulnerable 'at risk' young people.

These are:

- Adolescent females
- Young people in a residential setting
- Lesbian, gay and bisexual and transgender young people
- Young Asian women
- Children and young people in isolated rural settings
- Children and young people who have a friend who self-harms
- Groups of young people in some sub-cultures who self-harm
- Children and young people who have experienced physical, emotional or sexual abuse during childhood

2.6 Types of Self-harming behaviours

Self-harm is a response to a sense of overwhelming emotional distress and the most common ways that young people self-harm are:

- Cutting.
- Biting self.
- Burning, scalding, branding.
- Picking at skin, reopening old wounds.
- Breaking bones, punching.
- Hair pulling.
- Head banging.
- Ingesting objects or toxic substances.
- Overdosing with a medicine.
- Inserting objects

It is always helpful to check out what purpose the behaviour serves for the young person before assuming that it is harm as referred to in these guidelines. For example, for some young people with additional needs self- harm or self- injurious behaviour may have a sensory component and so the management of that behaviour would need to take account of this.

There are a variety of other risk-taking behaviours, which may also be associated with self-harm. With these behaviours, the harm is **less direct,** but could potentially be more life threatening and they might include:

- Eating disorders.
- Drug and alcohol misuse.
- Dangerous driving/sports.
- Unsafe sex/multiple sexual partners.

2.7 Indications that a young person may be using Self-harm

How can you tell if someone is self-harming? Often a person who is self-harming will take steps to hide the injuries. Here are a few things to look for:

- Unexplained or clustered scars or marks
- Fresh cuts, bruises, burns, or other signs of bodily damage
- Bandages worn frequently
- Inappropriate dress for the season, such as long shirts or long trousers worn consistently in summer
- Unwillingness to participate in events that require less body coverage (such as swimming), physical education (PE)
- Constant use of wrist bands, multiple bracelets
- Unusual or unexplainable paraphernalia, such as razor blades or other cutting implements
- Physical or emotional absence, preoccupation, distance
- Social withdrawal, sensitivity to rejection, difficulty handling anger, compulsiveness
- Falling behind in class, difficulty concentrating
- Expressions of self-loathing, shame, and/or worthlessness
- Mention of self-harm in creative writing.

'It is important to note that although many self-injurious youth do become emotionally withdrawn, not all do. There are a significant number of highly functional and socially engaged individuals who self-injure'[3].

2.8 Link to Suicide

A common misconception is that self-harm is a suicide attempt. ***'While suicide attempts are undertaken with some intent to end life, non-suicidal self-injury is undertaken with the intention of self-integrating and preserving life'***[3]. Many studies have indicated that young people are clear about the difference in intent between self-harm and suicide: self-harm is about staying alive and suicide is about dying. However, given that there is agreement that both self-harm and suicide are underpinned by distress it can be assumed that there is a link between the two behaviours, and there is some evidence that suicide may become an option when self-harm is no longer an effective coping mechanism for an individual's distress[4]. Given the apparent prevalence of self-harm (one study cites 1 in 12 adolescents will self -harm [8]), it is clear that the majority do not go on to attempt suicide: this supports the rationale for separating self- harm and suicide within this document

'

2.9 Responding to Young People who self-harm

2.9 (i) Advice for staff on initial response to a young person:

- It is crucial that you show compassion and respect
- Unless the injuries are serious or requiring immediate attention, initially focus on the young person and their feelings rather than the self-harm
- Be aware that the young person may be feeling guilty and ashamed
- Be aware of the stigma associated with self-harm and that this may be making the young person more distressed
- Refrain from telling the young person to stop as this can make it worse
- Let the young person know you are available to talk about their self-harm but avoid being too intrusive initially
- Recognise signs of distress and find a way of talking to the young person about how they are feeling
- Listen to their worries and problems and take them seriously
- Try to remain calm and reassuring, however upset you feel about the behaviour
- Help the young person to understand that talking about worries and feelings is the best way to reach a solution
- Accept your limitations and seek advice if you feel stuck or out of your depth
- When the young person is ready, work through the flowchart with them

2.9 (ii) Starting conversations about Self-harm

Encouraging open talk about self-harm

Young people who engage in self-harm can find it hard to talk about the subject and are often afraid of the reaction they may receive. Almost all of them feel guilty and ashamed.

The reaction a young person receives when they disclose their self-harm can have a critical influence on whether they go on to access supportive services. Young people who have self-harmed want responses that are **non judgemental and** ***which are caring and respectful. Professionals working with young people e.g (youth work, social work, health and education) need to recognise that dealing with disclosure requires them to exercise their existing core professional skills, not to have a completely new set of skills[8].***

Since the adult's initial reaction to the young person disclosing self-harm is so crucial these guidelines recommend striving to be a '***compassionate witness'*** where the initial goal is to hear the young person and give them a safe space to share some of their distress, rather than

focussing initially on actions to be completed, ***unless you believe their life to be in immediate danger.***

The term 'compassionate witness' encompasses not only what someone does but also their value base. The compassionate witness realises that listening to an individual with empathy and without judgement can be a way to help the person release their emotions and gain some clarity about the meaning of those emotions. The compassionate witness holds their own discomfort in relation to the other's behaviour by containing their own emotions, and trusts that the other person is doing the best they can with the resources they have at the time. The value base of the compassionate witness is underpinned by respect for the other person and belief that listening to the other person can at times be as important as acting.

If you are concerned about broaching the subject directly with a young person then there are **two** possible courses of action:

Report your concerns to an appropriate member of staff e.g.

Pastoral care / Manager / Team Lead /Supervisor and work within your organisational policies

or

Approach the young person if you consider this is appropriate to your role or relationship with them and ensure that you are in a place that protects the privacy of the young person by choosing an appropriate time and place

1. ***Tentatively*** **ask directly about what you are observing and saying something like:**

   'I notice that you have wounds or scars on your arms and know that this can be a sign of self-harm. Are you deliberately hurting yourself?'

   'I've noticed you've been wearing bandages on your arm for some time now and have wondered if you are hurting yourself?'

   'I've noticed you've been upset recently and covering up your arms despite the warm weather and I'm wondering if...'

2. ***If the answer is yes, try to respond with calm concern, rather than with shock or emotional displays.*** Walsh (2012)[3] suggests '***respectful curiosity'*** – asking simple questions that allow you to gather important information and provide an opening for sharing. The following questions are ***suggestions and not a script*** as a child centred response needs to be tailored to each individual

   'Do you want to talk about this?'

'Where on the body do you tend to hurt yourself?'

'Do you want to talk about what happened that made you hurt yourself?'

'What do you use to hurt yourself?'

'Are you taking care of your wounds/burns/cuts?'

3. ***Establish if the young person needs help to tend to their wounds or if medical attention is required.***

'Is there anything I can do to help you take care of your cut/ burn/bruise?'

'Do we need to get immediate medical attention?'

4. Don't assume what the young person needs and wants or take any action without discussing it and agreeing it with them. Be sure that the young person is comfortable with the way forward, **unless you believe their life is in imminent danger.**

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See the Flowchart Self-harm How to Help' Page 26

2.9 (iii) Ethos of approach: Harm Minimisation

These guidelines advocate a harm-minimisation approach to self-harm whenever practicable. ***'Harm minimisation is just that - minimising the damage you are doing to yourself'***[15].

> **'If we take this at face value understanding that those who self-harm are using it as a survival strategy has significant implications for how we can help. It would not be helpful to tell the person that they should stop self-harming. Doing that is the equivalent of taking a life jacket off a drowning man. No rational person would do this: we would use our common sense and get the man out of the water first. The same is true for those who self-harm'**[14]

This approach stems from acceptance that self-harm is a coping strategy and indeed may be keeping the person alive: removing their coping mechanism will exacerbate their distress and could precipitate a suicide attempt. The initial goal (unless wounds are serious or life threatening) is to listen to the young person and ensure our response is calm and non-judgemental so that we help them contain their distress.

Harm Minimisation is consistent with a Recovery based approach, where the individual decides the process and definition of their own recovery. (See Glossary P.52 for explanation of Recovery approach). Concentrating on the self-harm rather than underlying issues is more likely to be counterproductive, exacerbating the behaviour rather than reducing it.

Eventually the young person may be ready to focus on their self-harm. At that point a ***harm minimisation*** approach would involve encouraging the young person to put measures in place to reduce the harm caused by the behaviour, (such as cleaning wounds, using clean/safer implements, not using alcohol or drugs at the same time), until such time as the underlying distress can be managed by other means. Note that initially at least it may not be about putting something in place of the harm (alternative coping strategies) but about reducing the impact of the behaviour post harm. A harm minimisation approach has proven efficacy in the fields of sexual health and substance misuse. Encouraging ***positive risk management*** (see Glossary p.68) by the individual is consistent with the "*10 Essential Shared Capabilities for Mental Health" (See Glossary P 68)*

Encouraging alternatives to self-harm should be facilitated with extreme care, given the alternative has to relate to the function of the self-harm. For example, if it is important for a young person to see blood, then suggesting they ping their wrist with an elastic band is likely to be irrelevant at best. However, if the purpose of the self-harm is to feel pain then the elastic band ***may*** be a suitable alternative.

2.9 (iv) Harm Minimisation and Young People

- Supports young people to take responsibility for their own behaviour, unless that behaviour is life threatening
- Enables young people to gradually develop more healthy ways of coping
- Increases young people's self-esteem
- Increases young people's assertiveness in a positive way
- Encourages young people to take control of their lives (reducing risk taking behaviours).

The caveat to adopting a harm minimisation approach would be where the young person did not have the capacity to engage in harm minimisation, or where the means of harm was in itself very lethal[9]

2.9(v) SafePlan for Self Harm

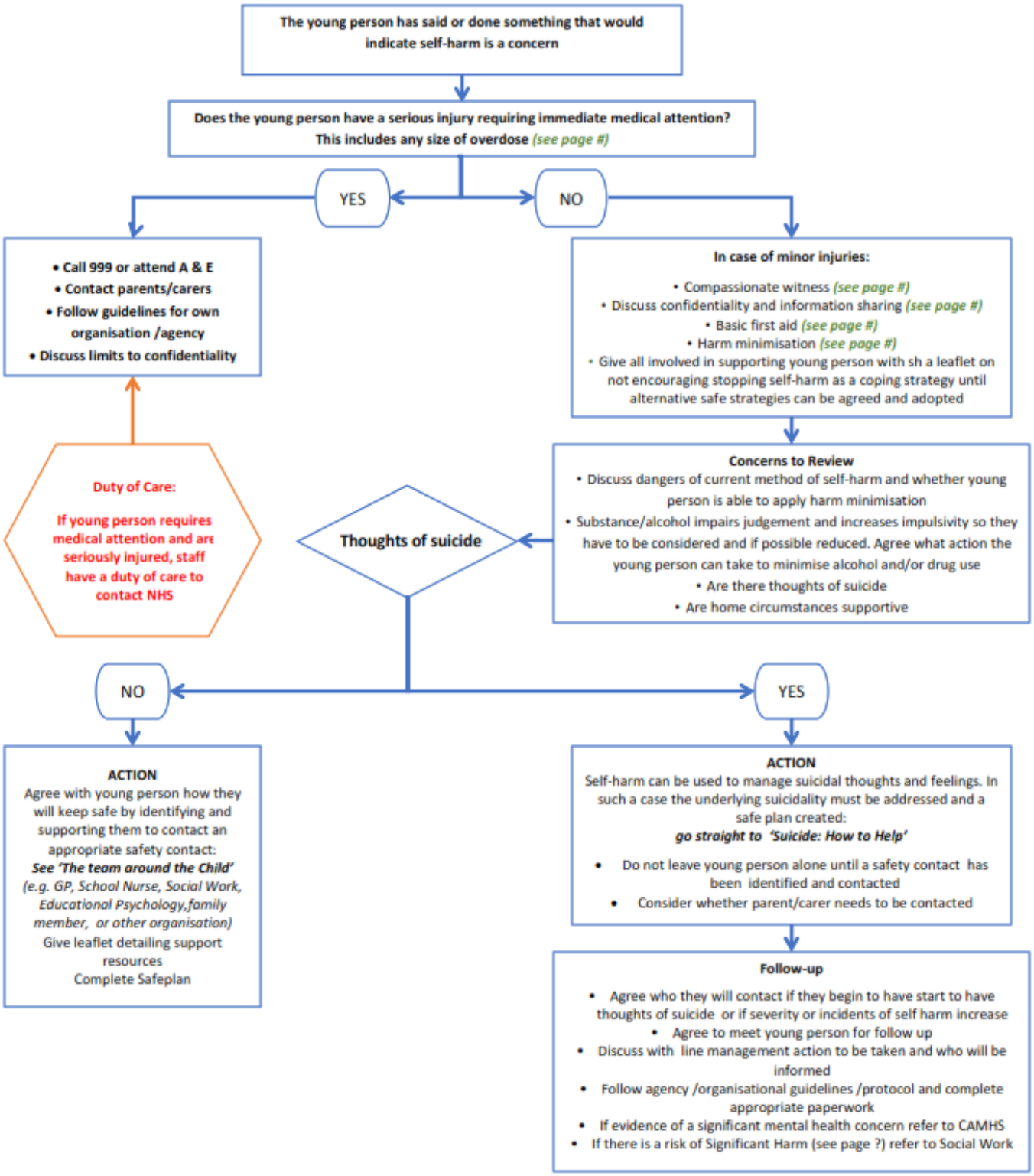
NAME MY SAFEPLAN

Need to ensure this is not just a tick box exercise

(Space for Young Person's Name) **states they are unable to agree to a Safeplan** **Activate 24-hour monitoring**	My 24-hour safety contacts are: Daytime: Night-time:
Agree who are their safety contacts: Daytime: Evening: Night-time: Ensure individuals who are safety contacts are aware and agree to this responsibility	My safety contacts are: Daytime: Evening: Night-time:
Agree how they will keep safe from alcohol and drugs	I will keep safe from alcohol and drugs by
Agree what they will do in event of an incident of self harm	If I self harm I will do the following to take care of my wounds:
Agree what they will do if incidents of self harm increase or if they become more serious	If I begin to self harm more often or hurt myself more I will do the following:

Discuss the situations that cause them distress (e.g. being on their own, going on Facebook etc.) and how they can avoid them	I will try to avoid the following upsetting situations:
Helplines and other resources	Detail resources here

2.9 (vi) Taking Action: 'Self-harm How to Help' Flowchart



2.10 Addressing Contagion

Social contagion refers to the way in which a behaviour such as Self-harm can spread among members of a group.

Contagion or the spread of self-harm is a concern for many working with young people. Some organisations and individuals are wary of discussing self-harm with young people as they fear they may promote contagion. This has prevented them from talking openly about self-harm. This approach has been challenged as it increases the stigma attached to the behaviour and discourages help seeking, often resulting in young people seeking support from unsuitable sources, especially online. Not talking about self-harm may be counterproductive, but the context and way in which it is discussed should be considered carefully.

The following measures are recommended:

- Utilising the 'On Edge' – learning about self-harm resource pack with pupils [12]
- Encouraging staff to attend What's the harm? Developing Self-Harm awareness and Skills Training' [9]
- Provide young people with information on support resources that treat the subject of self-harm responsibly (The National Self-harm Network leaflets or Lifesigns Leaflets)
- As part of the response to young people who are using self-harm, if it's thought to be an issue, consider discussing a responsible '***etiquette***' about showing their wounds to other young people.[3] This would have to ***be balanced with*** responding in a way which acknowledges the possible purpose of showing wounds (e.g. to communicate distress) with helping the individual understand the possible impact this may have on others. Note that the majority of young people who self-harm do so in a hidden manner, but for a small number showing their wounds may have a significant purpose which should not be dismissed.
  'In light of the complexity of the current research in this area, it is recommended that students be asked to cover wounds, due to school health requirements concerning any potential contamination by blood which applies to all cuts and wounds; secondly it should be explained to students that there is some evidence that the viewing of wounds by those who are still struggling with their recovery around self – injury could be triggering'[22]

PART 3 Responding to Suicide

3.1 Definition of Suicide

For this document, suicide is defined as **'the act of deliberately killing oneself**', which has been taken from the report the World Health Organisations 'Preventing Suicide: A Global Imperative' (WHO,2014)[17].

Suicidal behaviour refers to a range of behaviours that include thinking about suicide (ideation), planning for suicide, attempting suicide and suicide itself. The inclusion of ideation in suicidal behaviour is a complex issue about which there is meaningful ongoing academic dialogue.

The rationale to include ideation (i.e thinking about suicide) in suicidal behaviour is so that staff are clear they should respond to thoughts of suicide even when no plan is in place. There is a diversity of research included in these guidelines which have different views on whether ideation should or should not be included in suicidal behaviour.

3.2 Background and National Context

The Choose Life Strategy and Action Plan (2002)[16] identified children and young people as a priority risk group. For preventing suicide in children and young people, these guidelines advocate that staff working with young people are enabled to recognise when early interventions are necessary and provide access to appropriate support and services. It is also recommended that staff be equipped with the knowledge, skills and training to enable them to talk openly about suicide to those groups most at risk and continue to develop and expand school based programmes they do receive such a response.[16]

3.3 Prevalence

The Suicide Statistics Report (2015)[18] stated that the overall rate for suicide among 15 to 19 year olds in 2013 was 9.6 per 100,000, translating to 66 deaths in this age group for Scotland.

The Scottish Public Health Observatory (ScotPHO) do not produce a rate per 100,000 for 0 to 15 age group due to small numbers that may identify the young person. However, it is important not to be complacent and assume that suicide does not occur in the under 15 age group.

The World Health Organisation (2014)[17] state that suicide is the second leading cause of death amongst young people aged between 15 and 29 years old.

The reliability of the statistics on suicide across all age groups is affected by several factors including the multiple definitions of suicide and the stigma associated with suicide impacting on the decision to record a death as a suicide

3.4 Common Misconceptions

There are many common misconceptions surrounding suicide as detailed in the publication 'Art of Conversation'.[19]

"People who talk about suicide never attempt or complete suicide"	People who talk about suicidal thoughts may also attempt suicide. Many people who complete suicide have told someone about their suicidal feelings in the weeks prior to their death. Listening to and supporting people in these circumstances can save lives.
"Talking about suicide or asking someone if they feel suicidal will encourage a suicide attempt"	Serious talk about suicide does not create or increase risk; it can help to reduce it. The best way to identify the possibility of suicide is to ask directly. Openly listening to and discussing someone's thoughts of suicide can be a source of relief for them and can be key to preventing immediate danger of suicide.
"If somebody wants to end their life they will"	Most people contemplating suicide do not want to die; they want to end the pain they are suffering. Although there are some occasions when nobody could have predicted a suicide, in many cases a tragic outcome may be averted if appropriate help and support is offered to a person and they are willing to accept this help.
"Some people are always suicidal"	Some groups, sub-cultures or ages are particularly associated with suicide. While some groups, such as young men, seem to be at an increased risk, suicide can affect all ages, across gender and cultures. Many people think about suicide in passing at some time or another. There isn't a 'type' for suicide, and while there may be warning signs they aren't always noticed. While those who have made an attempt on their own life in the past can be at increased risk of completing suicide, with appropriate help and support, people can and do move on in their lives.
"If a person has made attempts they won't do it for real"	Those who have attempted suicide once are at increased risk of attempting again. They need to be taken seriously and given support and help to find a safe resolution for their suicidal thoughts and actions.
"When a person shows signs of feeling better, the danger is over"	Often the risk of suicide can be greatest as depression lifts, when a person appears calm after a period of turmoil. This can be because once a decision to attempt suicide is made; people may feel they have found a solution; however desperate they may be.

3.5 Factors which may precipitate suicidal behaviour in young people

Suicide attempts in young people nearly always follow a stressful event or life crises, such as:

- Inter-personal loss such as relationship problems
- Bullying/cyber bullying
- Bereavement or traumatic grief
- Family break-up
- Homelessness
- Issues relating to sexual orientation
- Unexpected exam results or unemployment

Sometimes the young person will have shown no previous signs of mental health problems. In order to feel suicidal a young person does not have to be experiencing a mental health issue, their feelings may be a manifestation of distress.

Sometimes, the young person will have had serious problems (e.g. with the police, their family or school) for a long time. It is these young people who are most at risk of further attempts. Some young people will already be seeing a Counsellor, Psychiatrist or Social Worker. However, others may have refused these forms of help, and appear to be trying to escape from their problems.

Expressing feelings of hopelessness are common in those who have attempted suicide.

3.6 Who is at risk?

Anyone is at risk but there are some specific 'vulnerable groups' amongst young people:

- Young people who are misusing drugs or alcohol are at risk of death by suicide. This is not just linked to those with a substance misuse habit but includes casual recreational users too. Young people can be particularly vulnerable in the 'come down phase ' (see Glossary P.52)
- Looked after and accommodated children and young people
- Young men
- Lesbian, gay, transgendered young people or other marginalised groups

There are other groups of people who are at risk of suicide, and young people can fall into these categories:

- Young people with mental health problems (in particular those in contact with mental health services and those with a severe mental illness such as young people with severe depression or severe anxiety disorders)
- Young people who have attempted suicide before
- A young person who has a relative or friend who attempted or completed suicide
- Young people who have been in young offender's institute/prison
- Young people who have been recently bereaved
- Young people in isolated or rural communities
- Young people who have recently lost employment.
- Young people who are homeless.

3.7 Some ways in which people Suicide

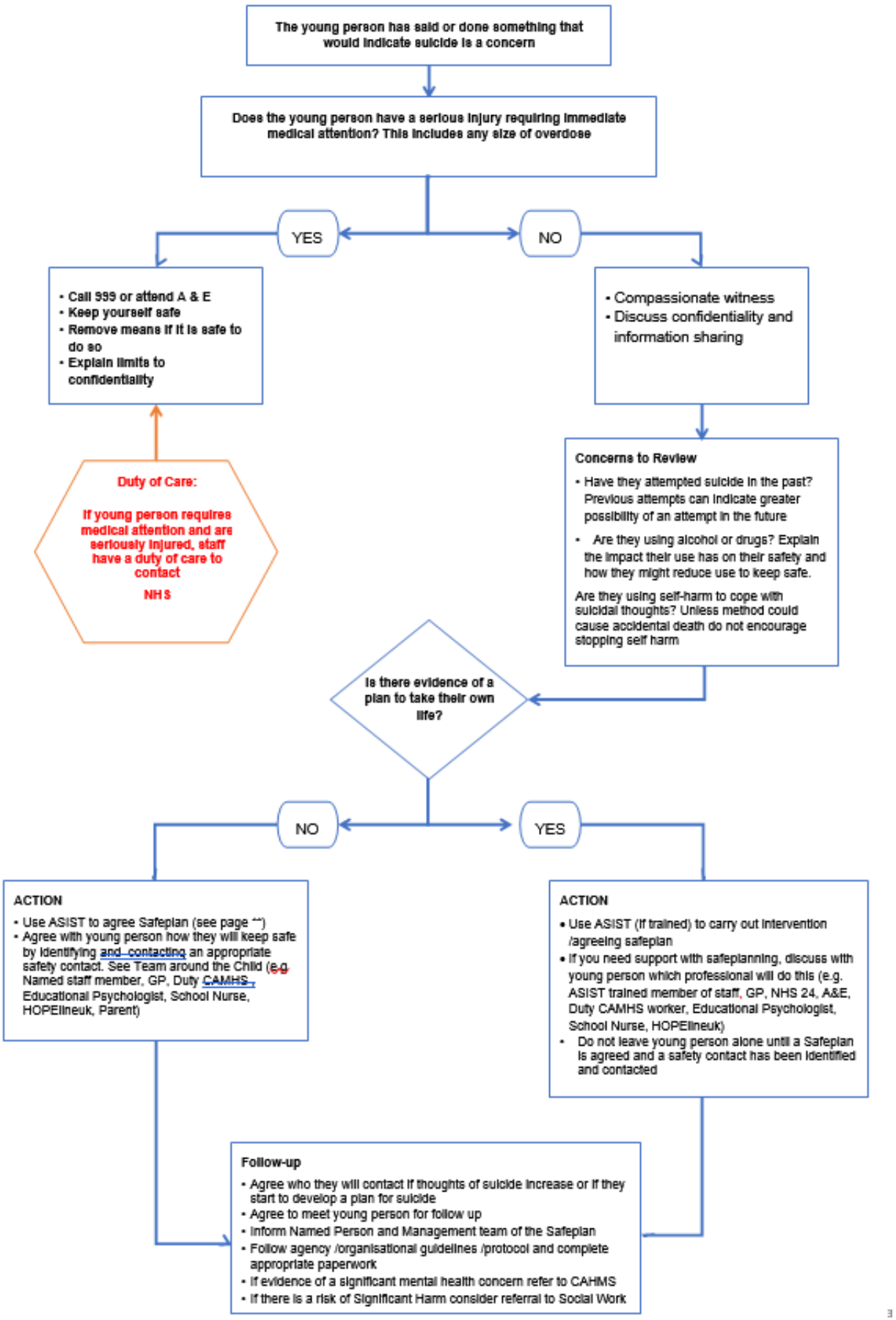
- More young females take overdoses of drugs
- More young males use methods such as hanging, strangulation or poisoning
- Between 80% and 90% of adolescents who are referred to hospital after suicide attempts have taken overdoses
- A large proportion of attempted suicides are by an overdose of commonly available drugs such as aspirin, paracetamol, antidepressants and minor tranquillisers, often in conjunction with alcohol. Such overdoses can result in death, or long term physical damage, even if the suicidal intent may have been small

3.8 Some indications that a young person may be feeling suicidal, thinking about Suicide

- Previous deliberate self-harm or suicide attempt
- Talking about methods of suicide
- Dwelling on insoluble problems
- Giving away possessions
- Hints that “I won’t be around” or “I won’t cause you any more trouble”
- 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
- Unresolved feelings of guilt following the loss of an important person or pet (including music or sports idols)
- Expressing feelings of hopelessness

This list is not exhaustive, and sometimes we just notice something different about a young person that we are unable to pinpoint. Always act on your instincts and open the conversation about whether the young person is ok.

3.9 Working with young people who are suicidal (i) Taking Action 'Suicide How to Help Flowchart



Section 3.9.(ii) Initial response to a young person who is suicidal

Ask the young person if they are thinking about suicide/ending their life/taking their life. Ask them clearly and directly. For example, *'Are you thinking about suicide?'* *'Are you thinking about ending your life?'* *'Are you thinking about killing yourself?'* **If the answer is Yes – go to the suicide flowchart.** Talking about suicide does not make it more likely to happen. Try to be patient if they are angry or refuse to talk. It may be that writing things down is an easier way for them to communicate with you.	***Put*** the young person down or do things that might make them feel worse. Do not ask them in a way which implies criticism e.g. 'You're not thinking of doing anything stupid/silly are you?'
Listen – this is the most important thing you can do. Treat the young person with respect and try not to be judgemental or critical. See the glossary – how to be a good listener	***Abandon*** or reject the young person in any way. Help, support and attention are vital if they are to begin to feel that life is worth living again. Don't assume that the danger is over just because they seem to be better; they may be at risk for quite a while.
Empathise – by showing that you really are trying to understand from their point of view.	***Nag –*** although it may be well meant, nobody wants to be pestered all the time. Don't intrude or be hyper-vigilant – try to balance being watchful with a respect for privacy.
Reassure the young person that desperate feelings are very common and can be overcome. Things can and do change, help can be found and there can be hope for the future. People ***MAY*** get better.	***Ignore*** any signs of distress
Try to give practical support, **always agree a safeplan** that is explicit about what they will do to keep themselves safe.	***Criticise*** their actions - however you may be feeling about their thoughts of suicide; try to remember the pain and turmoil that underpins these thoughts. Don't take their behaviour personally – it is not necessarily directed at you.

3.9(iii) Starting conversations about suicide

Don't tell – ask

The best way to help is to ask questions. That way you leave the young person in control. By asking questions, the young person you are talking with finds his or her own answers.

Here are some questions which can lead conversations into useful areas:

When: 'When did you realise?'

Where: 'Where did that happen?

What: 'What else happened?'

How: 'How did that feel?'

All of these questions effectively ask the young person you're talking with to examine, honestly, the problems they are experiencing. The only question to avoid is 'why?' – it can sound challenging and judgmental and may result in the young person becoming defensive

If you discover someone in the act of trying to take their own life:

- Keep safe - do not endanger your own life
- If the person's life is in danger, phone 999 immediately or take the person directly to A&E
- Perform first aid if it is necessary and if it is safe to do so
- Remove the means if possible
- If the person is drinking alcohol or taking drugs, try to get them to stop

3.9 (iii) Safeplan

The purpose of a safeplan is to help a young person keep themselves safe from suicide. Even when referral to clinical services or other services is being undertaken, ***It is important to create a simple safeplan for interim management unless clinical services are seeing the child immediately.***

In the event of lower levels of concern and even when a plan for suicide is not present, a basic safeplan is still required. Having a safeplan in place that can help guide a young person through difficult moments can make a difference and helps to keep them safe. During the night can be a difficult time for young people, it is at this time, young people need to know what action to take or who to contact.

A safe plan should be developed with another person; this person will help the young person by writing down the actions and contacts that have been discussed with the young person. **The commitment to the safeplan needs to be explicit in order to keep the young person safe from suicide.**

No matter what the level of concern a safeplan is still recommended.

3.9 (iv) Suggested Paperwork for Safeplan for Suicide

NAME MY SAFEPLAN

Need to ensure this is not just a tick box exercise

(Space for Young Person's Name) **states they are unable to agree to a Safe plan** **Activate 24-hour monitoring**	My 24-hour safety contacts are: Daytime: Night-time:
Agree how long they can keep themselves safe	I can keep myself safe until:
Agree who are their safety contacts: Daytime: Evening: Night-time: Ensure individuals who are safety contacts are aware and agree to this responsibility	My safety contacts are: Daytime: Evening: Night-time:
Method planned - Will be disabled by: Doing: Who will help them do it: When will they do it: How will they do it	I agree to disabling my plan by : Doing: Who will help me do it: When will I do it: How will I do it
Agree how they will keep safe from alcohol and drugs	I will keep safe from alcohol and drugs by

Discuss the situations that make them upset (e.g. being on their own, going on Facebook etc.) and how they can avoid them	I will try to avoid the following upsetting situations:
Helplines and other resources	Detail resources here

3.9(v) How to respond to a Crisis

This is an example of what is currently being used in Education, however given this is a Multi Agency Guidance you should always follow your own Agency Protocols

The young person has said or done something that would indicate suicide is a concern (refer to section 3.9 (i) in guidelines and flowchart).

If the young person has a serious injury requiring immediate medical attention and this includes any size of overdose:

- CALL 999 or attend A & E
- Keep yourself safe
- Remove means if it is safe to do so
- Attend to immediate care needs using First Aid if required , and if it is safe to do so
- Explain the limits to confidentiality (including informing your line manager)
- Be compassionate and listen
- Given that there is a threat to life the parent/carer is advised of the current situation, when safe to do so. The young person is informed that this is the action that is being taken.

If there is no serious injury requiring immediate medical attention but there is evidence that the young person may be planning to take their own life:

- Be compassionate and listen
- Use ASIST (if trained) to agree a Safeplan
- If you need support writing a Safeplan, discuss with the young person which professional will do this (e.g. ASIST trained member of staff, GP, NHS 24, A&E, Duty Social Worker, CAMHS, Educational Psychologist, School Nurse and member(s) of the Team around the Child as appropriate)
- If there is a requirement to convene a Team Around the Child do so immediately
- Do not leave the young person alone until a Safeplan is agreed and a safety contact has been identified and contacted
- Inform your line manager
- Given that there is an immediate threat to life the parent/carer is advised of the current situation, when safe to do so. The young person is informed that this is the action that is being taken.

PART 4 – Supporting Information

4.1 (i) Confidentiality and Information Sharing

The basis for information sharing can be found across National guidance, regional procedures and local protocols both in single and multi-agency settings e.g.: Protecting Children and Young people: Framework for Standards (2004); Sharing Information about children at risk of abuse or neglect: A brief guide to good practice (2004); and The Data Protection Act (1998).

Many local Data Sharing Partnerships also have local Sharing Information protocols. Also there is Health guidance for sharing information contained within the General Medical Council guidance (for 0-18 year old's) and the NHS Caldicot Guardian's information on confidentiality and information sharing. Guidance can also be found at:

www.scotland.gov.uk/Topics/People/ Young-People/gettingitright/informationsharing

The Inverclyde Guidance on Information Sharing is available at

https://www.inverclyde.gov.uk/education-and-learning/girfec/practitioners

It is important that you:

- Understand the legislative, policy and practice context parameters when sharing personal and/or sensitive personal information;
- Understand the limitations and constraints of confidentiality and consent; and
- Understand that you are empowered to share personal and/or sensitive personal information, if you are worried and/or concerned about a child or young person's wellbeing and nothing whatsoever prevents you from doing so.

Following a conversation with a child/ young person, you may pass on information given by them when:

- They have given their explicit agreement and you are sure they have understood what will be shared, with whom and why. OR
- The information they have given us means that you must act to keep them or someone else safe. Refer to your own organisation for child protection procedures. OR
- You feel that they are at risk of seriously harming or killing themselves you must act. (Details are given in the example flowcharts and 'Risk of Significant Harm' is defined on P 52).It is imperative that each professional supporting a young person makes clear the reason and nature of their involvement and the support they can or will be providing, including gaining the young person's consent for actions.

It is also vital to make explicit:

- Why you would wish to share information
- With whom information would be shared
- What information would be passed to or available to others e.g. shared case notes
- Any recommendations you will be making and to whom
- Any actions that you will be taking

Within this context, you should be making young people aware that you have to ensure their safety and that of other children, young people or vulnerable adults. Therefore, you should be explicit in letting them know that you may be required to let others know.

Our primary responsibility is to keep the young person or other young people safe

Evidence supports an approach and strategies that recognise that:

- Ensure the young person is safe and risk to them is minimised 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 from e.g. abusive parents. In addition, we have to be aware that the young person may wish to be protective of e.g. a parent who has mental or physical health problems.

Legally and professionally, we have to listen to, respect, and where appropriate, accept and work with their decisions rather than those of their parents

- We are not acting “in loco parentis”, even when we are fulfilling our duties as a corporate parent. Rather, 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.

- Self-harm and similar behaviours are coping mechanisms, necessary for surviving personal problems and traumas. While we will be working with young people to find and use less harmful coping strategies, the priority is to address their primary problems and enable them to better cope with them

These young people are very 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 them 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 so that the self-harm and suicide behaviours increase and become riskier.

4.1 (ii) Assessing likelihood of harm

It is paramount to ensure that the child or young person is safe at all times and that risk to them is minimised. In the case of a medical emergency take immediate action by calling 999.

If you consider that a child is likely to significantly harm themselves as a result of their self-harming or suicidal behaviours then they should not be left alone, social services should be informed and they will commence a multi-agency risk assessment and put a risk management support plan in place as soon as possible.

How do we define significant harm?

"Harm" means the actual or potential ill effect, or the impairment of the health or development

of the child, In this context, "development" can mean physical, intellectual, emotional, social or behavioural development and "health" can mean physical or mental health.

Whether the harm suffered, or likely to be suffered, by a child or young person is "significant" is determined by comparing the child's health and development with what might be reasonably expected of a similar child.

4.1 (iii) Involvement of Parents/Carers

Parents and Carers may often but not always be important sources of support for young people

Evidence supports an approach and strategies that recognise that: When we ask young people to involve their family/carers, we have to be ready to respond to three reactions: 1. They will agree and may even be keen and relieved that their family/carers will be involved. 2. They will be reluctant. 3. They will refuse to have their family/carers contacted, let alone be involved.

- ***Agreeable In most cases***, we will be able to receive 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.

- ***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. 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.

- ***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 long-term intensive multi-agency work with the whole family before it is safe and appropriate to explicitly consider the young's person's self-harm and/or suicide behaviours. 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 a major reason for self-harming and suicide behaviours in young people is 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.

e.

f. ake steps to support family members/carers to understand the young person's behaviour and then give them appropriate help to support their child.

4.2 Looked After and Accommodated Children and Young people

In terms of the Children and Young People (Scotland) Act 2014 , Corporate parenting duties have been placed on a range of publicly funded organisations in respect of Looked after children and care leavers , increasing the breadth and depth of support available .Part 10 of the Act extends eligibility to after care assistance up to an individual's 26th Birthday while Part 11 introduces " continuing care " for Looked After and Accommodated children .

For more complete discussion see 'Understanding suicide and self-harm amongst children in care and care leavers ' IRISS insights, no 21:

http:// www.iriss.org.uk/resources

A copy of the Practise Guide 'Suicide Prevention for looked after children and young people' can be found at:

http://www.anguschildprotectioncommittee.org.uk/pdfs/Suicidepreventionguide.pdf

This practise guide has some useful discussions that will help to inform responses not only to a young person who is at risk of suicide but also of self -harm.

4.3. Support for Staff

Managing Feelings

Staff members need to monitor and care for their own mental wellbeing on an ongoing basis.

Talking to young people who self -harm or are suicidal is challenging and rewarding but it can also provoke uncomfortable feelings in ourselves such as anxiety, fear, confusion, sadness, frustration, hopelessness and powerlessness. It is important for the staff member involved to be aware of their own mental health and to acknowledge any distress they may feel. Regardless of your particular relationship with that young person you will need to consider how to look after yourself so that you are in the best position to help.

Managing your feelings is important in maintaining your own emotional health and well-being, as well as preventing it affecting your work with the young person. It is essential you access some form of supervision and take the opportunity to reflect on the work and its impact.

Line managers also need to be careful that staff members feel they access appropriate support whenever they need it, but particularly when dealing with these kinds of incidents.

TrainingConsider whether you need to seek additional training to improve your skills, knowledge and confidence in helping young people who self-harm or are suicidal. See Section 5 on Resources and Training.

Be honest about your limits

If supporting the young person becomes too much of a burden it may affect your relationship with them. It is rarely helpful to become a young persons' sole source of support. They will benefit more from developing or identifying a wider support network.

Finally:

- Accept the fact that you can't always be there for them when they are distressed and thinking about self-harm or suicide. This is why a robust Safe Plan needs to be developed to help them manage their safety and utilise other supports.
- Accept that you are not responsible for their behaviour

Managing stress

This straightforward approach to managing stress was developed by Saakvitne and Pearlman[20].

Awareness • Be alert to one's needs, limits and emotions. • Pay attention to all aspects of your experience including thoughts and feelings. • It helps to have quiet time and space for positive self-reflection.	**Balance** • Maintain a balance and diversity of activities at work. • Balance your energies between work and play, between activity and rest, between focus on self and focus on others. • Balance provides stability and helps us be more resilient when faced with high levels of stress.
Connection • Connection to oneself and to others decreases isolation and increases hope. • Connection is supported by open communication. • Connection with others, both personally and professionally is essential. • Connection with others enables us to be empathetic and to provide effective support. • We cannot do this work alone or unsupported • When we look after ourselves, we are better able to care and support others.	**Additional Resources**: National Helplines such as Breathing Space and Samaritans may be useful for times of extreme distress (see section 5.2(iii) Helpline Details) Local Resources: Mind Mosaics: Counselling and Therapy Tel: 01475 892208 The Spark Counselling Port Glasgow for Relationship Counselling. Tel: 08088020050

PART 5 – Resources and Training

5.1Responding to Self-harm

5.1(i) Educational Resources

Positive Mental Attitudes Curriculum pack that addresses young people's emotional and mental well-being	http://mindreel.org.uk/video/positive-mental-attitudes-%E2%80%93-schools-curriculum-pack
On Edge – learning about self-harm Resource pack for teachers and professionals working with young people	http://mindreel.org.uk/video/edge-learning-about-self-harm-millies-story

5.1(ii) Advice Sites

The Basement Project Offers publications and resource packs that can be purchased as well as free downloadable factsheets	www.basementproject.co.uk
The National Self-harm Network Offers downloadable leaflets and posters	www.nshn.co.uk
Mind Offers resources that can be purchased	www.mind.org.uk
LifeSIGNS **Self-Injury Guidance and Network support** Offers an online Support forum and extensive information for those who self injure and those who wish to support them. Offers downloadable Factsheets :	www.lifesigns.org.uk

• For people who self-injure Factsheet • Parents and Guardians Factsheet • Males Factsheet • Teachers and Lecturers Factsheet • Friends Factsheet	
Free downloadable resource: **OUT OF HARM.TOOLKIT.** If you are a young person who is self-harming and would like to have a conversation with an adult you trust, you could give them this. It also provides a useful guide for an adult wishing to discuss self- harm with a young person	www.confab.org.uk/uploads/images/fullToolkit.pdf

5.1(iii) Helplines/Details

Childline ChildLine is a private and confidential service for children and young people up to the age of 19.	0800 11 11 www.childline.org.uk
Samaritans Samaritans is a private and confidential telephone helpline	116 123 jo@samaritans.org www.samaritans.org
Get Connected Get Connected is the UK's free, confidential and multi-issue helpline service for young people under 25 who need help, but don't know where to turn.	0808 808 4994 80849 (text) www.getconnected.org.uk

5.1(iv) Training

Lanarkshire Lifelines Online training and information on self-harm	http://www.selfharmlifelines.org.uk/register.html
What's the harm? Developing Self-harm Awareness and Skills Training	

5.2 Responding to Suicide

5.2 (i) Educational Resources

Papyrus - Prevention of Young Suicide Provide information leaflets including: Thinking of ending it all Not just a cry for help Coping with Exams Listen to me	https://www.papyrus-uk.org/

5.2 (ii) ADVICE SITES

Support for Parents/Carers

HOPELineUK run by PAPYRUS **A confidential helpline to support anyone supporting a young person with suicidal thoughts**	0800 0684141 Confidential Helpline 10am-10pm weekdays, weekends 2pm till 10pm Confidential text advice 07786209697 Confidential e mail advice pat@papyrus-uk.org Also provide useful leaflets
ParentLine Scotland 0808 800 222 **www.parentlinescotland.org.uk**	

5.2(iii) Helpline Details

Childline ChildLine is a private and confidential service for children and young people up to the age of 19.	0800 11 11 www.childline.org.uk
HOPELine UK HOPELineUK is a confidential support and advice service for: • Young people under the age of 35 who may be having thoughts of suicide • Anyone concerned a young person	08000 68 41 41 https://www.papyrus-uk.org/help-advice/about-hopelineuk

may be having thoughts of suicide.	
Samaritans Samaritans is a private and confidential telephone helpline	116 123 jo@samaritans.org www.samaritans.org
Get Connected Get Connected is the UK's free, confidential and multi-issue helpline service for young people under 25 who need help, but don't know where to turn.	0808 808 4994 80849 (text) www.getconnected.org.uk
Breathing Space (16+) Breathing Space is a free, confidential phone and web based service for people in Scotland experiencing low mood, depression or anxiety.	0800 83 85 87 http://breathingspace.scot/

(iv) Training

SafeTALK **(Suicide Alertness for Everyone)** 3-hour (face to face)	safeTALK is training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. Most people with thoughts of suicide invite help to stay safe. Alert helpers know how to use these opportunities to support that desire for safety. As a SafeTALK-trained suicide alert helper, you will be better able to: • move beyond common tendencies to miss, dismiss or avoid suicide • identify people who have thoughts of suicide • apply the *TALK* steps *(Tell, Ask, Listen* and *KeepSafe)* to connect a person with suicide thoughts to suicide first aid, intervention caregivers. Powerful video clips illustrate both non-alert and alert responses. Discussion and practice help stimulate learning. Learn steps that contribute to saving lives.
ASIST **(Applied Suicide Intervention and Skills Training)** 2 days (face to face)	The ASIST workshop is about **suicide first-aid;** about helping a person at risk stay alive and seek further help. The ASIST workshop is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Evaluations have shown that the workshop increases knowledge and confidence to respond to a person at risk of suicide, that intervention skills are retained over time and that they are put to use to save lives.

HOPELineUK 0800 0684141

'How to talk so kids will listen & listen so kids will talk' Adele Faber and Elain Mazlish

ParentLine Scotland 0808 800 222

www.parentlinescotland.org.uk

PART 6 – In the event of a completed suicide : PostventionSamaritans' Step by Step service is there to support organizations working with young people so that they can respond effectively following the suspected or attempted suicide of someone from within their community; taking practical steps to reduce the risk of further deaths in the area.

PART 6 In The Event of a Suicide About Step by Step

Samaritans has offered the Step by Step service across the UK since 2010 and have recently expanded to support schools and Youth-reach Centres in the Republic of Ireland.

The Step by Step team aims to:

- Provide information and support to help the school community come to terms with what has happened and prevent stigma and isolation in the school community;
- Support school communities to reduce the risk of further suicide;
- Reach out to high risk people and communities to reduce the risk of further suicide

Specialist support

The service is run by a team of trained volunteers, called Postvention Advisors, who can offer practical support, guidance and information on addressing the impact of a suspected or attempted suicide on the school community. The team is experienced in working proactively with schools and local authorities to prevent further suicides. The specialist knowledge and skills of the volunteers is based on research and best practice developed through Samaritans' experience, learning from the communities we have supported.

As every situation is different, Postvention Advisors can tailor the support offered depending on the needs of the school or group

Contact the team by e mail:

stepbystep@samaritans.org

or call:

0808 168 2528

The Resource 'After A Suicide' is available from SAMH and gives detailed information and advice for those affected by a completed suicide

PART 7– Additional Information

7.1 Glossary of Terms

- Reference to 'come down' Page 30 or 'crashing' is the deterioration in mood that happens as a psychoactive drug is decreasing or clearing from the blood
- Reference to 'the Recovery Model' on Page 22. ' Recovery is about building a meaningful and satisfying life, whether or not there are recurring or ongoing symptoms or mental health problems'. Mental Health Foundation
- Reference to 'positive risk management' Page 22

  Positive risk management is: 'weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes'. (Steve Morgan, risk consultant, 2004) quoted in **http://arcuk.org.uk/scotland/files/2013/05/2.0_Positive-Risk-Management-June-2011.pdf**
- Reference to the '10 Essential Shared Capabilities for Mental Health' on Page 22

The 10 Essential Shared Capabilities (ESC) were originally developed and published by a partnership involving the Department of Health, the Sainsbury Centre for Mental Health, the National Institute for Mental Health in England and the NHS University in 2004. It is important to note that these organisations worked closely with service users and carers to develop the ESCs to ensure that they reflected their priorities.

The 10 ESCs are listed below:

1. Working in partnership
2. Respecting diversity
3. Practising ethically
4. Challenging inequality
5. Promoting recovery
6. Identifying people's needs and strengths
7. Providing service user-centred care
8. Making a difference
9. Promoting safety and positive risk taking
10. Personal development and learning

The 10 ESCs:

- are about attitudes, behaviours, expectations, and relationships
- describe the values and principles that should be demonstrated in the way mental health services are commissioned, planned and delivered
- are derived from, and reflect, how people who use mental health services and those who support them want to be treated, and the way they expect to be treated
- outline values and principles that should influence the actions and outcomes that people working in mental health services should be seeking to achieve

Five steps to active listening from 'The Art Of Conversation' Published by NHS Health Scotland www. Healthscotland.scot

Open Questions	Rather than asking questions which only require a yes or no answer, try to ask open questions. For example, instead of saying 'Has this been going on for a long time?' ask 'How long has this been going on?' That way, instead of closing the conversation down into a yes or no response, you open it out and encourage the other person to keep talking.
Summarising	It helps to show that you've listened to, and understood, what's been said. You can do this by summarising. For example, 'So you've fallen out with your partner and you are finding it very difficult?
Reflecting	Repeating back a word or phrase can encourage people to go on. If someone says, 'So it's been difficult recently', you can keep the conversation going simply by reflecting on this and saying, 'It sounds like it's been really difficult for you.'
Clarifying	We all skirt around or gloss over the most difficult things. If we can avoid saying them, we will. If the person you're speaking with glosses over an important point, try saying 'Tell me more about....' or '....sounds a difficult area for you'. This can help them clarify the point, not only for you, but for themselves.
Reacting	You don't have to be completely neutral. If whoever you're talking with has been having an absolutely dreadful time, some sympathy and understanding is vital. 'That must have been difficult' or 'You've had an awful time' can be helpful things to say'.

7.3 Sources of Information

(i) Information uoted in the document

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7.3 Acknowledgements

Inverclyde council

Equality Impact Assessment

This document should be completed at the start of policy development or at the early stages of a review. This will ensure equality considerations are taken into account before a decision is made and policies can be altered if required.

SECTION 1 - Policy Profile

1	**Name/description of the policy, plan, strategy or programme**	Multi-agency Guidelines for Responding to Self-harm and Suicide in Children and Young People (Inverclyde Alliance)
2	**Responsible organisations/Lead Service**	Children's Services Plan Group
3	**Lead Officer**	Brian H Young, Health Improvement Lead, Inverclyde HSCP
4	**Partners/other services involved in the development of this policy**	Multi-agency writing group formed to oversee the developments. Membership was drawn from Inverclyde Council's Education Psychology, Specialist Children's Services, Social Work, Health Visiting and Health Improvement. Additional scrutiny was undertaken by the Inverclyde Child Protection Committee.
5	**Is this policy:**	New ✓ Reviewed/Revised ☐
6	**What is the purpose of the policy (include any new legislation which prompted the policy or changes to the policy)?**	The guidelines have been developed following a directive from the Erskine Bridge Fatal Accident Inquiry (2012) – *'Local authorities should commission a set of guidelines for staff working with looked after and accommodated children about recognising and mitigating suicide risk in this client group. These guidelines should include the requirement to develop a detailed management protocol'.* Over the years, several policy drivers have considered the aspects of improving the mental health of children and young people. The latest Scottish Government's 10-year mental health strategy places children and young people at the heart of the early intervention and prevention agenda. Moreover, other policy drivers, such as the 5-year Strategy for Mental Health Services in Greater Glasgow and Clyde 2018-2023 is informed by a range of documents including the Scottish Government's Mental Health Strategy and the Healthy Minds 2017

	report by NHS GG&C's Director of Public Health.
7 What are the intended outcomes of the policy?	The multi-agency guidance has been created to support staff and specifically frontline responders, across all partner services, to provide a caring and appropriate response to children and young people experiencing emotional distress and who may be at risk of self-harm or have thoughts of suicide. The document encompasses guidance for staff for both self-harm and suicide in a single document. Creating a document that includes but separates the two behaviours is the most effective way to ensure staff are capable of responding appropriately to young people experiencing suicidal ideation as well as the small proportion of young people who move from self-harm to suicide and the larger numbers whose self-harm does not lead to suicide. In addition, this format will help to dispel the myths around the two behaviours and clarify the distinct features of each. The document is not intended to replace current organisational policies or protocols and instead is to be used to complement existing resources. This plan will support delivery of Equality Outcome 2 – Inverclyde's children, citizens and communities are able to access our services and buildings with ease and confidence.
8 Geographical area (Inverclyde wide or a specific location)	Inverclyde wide
9 Is the policy likely to have an impact on any of the elements of the Council equality duty (if yes, please tick as appropriate)?	• Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010 • Advance equality of opportunity between people from different groups • Foster good relations between people from different groups

10	**Will those who may be directly or indirectly affected by this policy be involved in its development?**	There have been extensive and robust consultation processes carried out, including discussions with several key professional stakeholders in social work, education services, 3rd sector agencies and parents and young people themselves. As is evident in the guidelines, their voices have been pivotal in the document's construction, along with valuable input from Inverclyde Council's legal services. Future governance arrangements will be the responsibility of the Joint Children's Services Plan Group.

SECTION 2 – Impact on Protected Characteristics

Which of the protected characteristics will the policy have an impact upon? (see guidance for examples of key considerations under each characteristic)						
	Impact					
Protected Characteristic	Positive		Neutral	Negative		Reason/Comments
	High	Low		High	Low	
Age	Y					N/A for young people up to the age of 18 (not Equality Act 2010)
Disability		Y				Young people with disabilities form a very small part of the developments but the intention is to cover this in other areas.
Gender reassignment		Y				No known correlation.
Marriage and civil partnership		Y				N/A
Pregnancy and maternity			Y			
Race			Y			
Religion or belief	Y					
Sex (male or female)	Y					
Sexual orientation	Y					
Other groups to consider (please give details)						

SECTION 3 – Evidence

What evidence do you have to help identify any potential impacts of the policy? (Evidence could include: consultations, surveys, focus groups, interviews, projects, user feedback, complaints, officer knowledge and experience, equalities monitoring data, publications, research, reports, local, national groups.)	
Evidence	**Details**
Consultation/Engagement (including any carried out while developing the policy)	As mentioned above, extensive and robust consultation took place on the devising of the Guidelines, including discussions with several key professional stakeholders in social work, education services, third sector agencies and young people. Input was also sought from Inverclyde Council's Legal and Property Services.
Research	The guidelines contain a widespread approach to evidence-based research and resources.
Officer's knowledge and experience (including feedback from frontline staff).	As per above (see Section 1.4)
Equalities monitoring data.	Forms part of the Council's Equality Mainstreaming Reporting
User feedback (including complaints)	Extensive consultation has been undertaken by young people's groups with positive feedback.
Stakeholders Other	Key stakeholders throughout Inverclyde participated in focus groups, as part of the development of the guidelines. The feedback has been used to fully inform the final document.

What information gaps are there?	Local data is not available on the number of suicides for young people aged 15 – 24, which is mainly due to low numbers and this type of data being made available publicly would run the risk of identifying individuals who had taken their own lives. As a proxy measure, reference could be made to national data, which would be sourced from the national Scottish Suicide Information Database (ScotSID) reporting and the next update due in December 2019.

SECTION 4 – CONSEQUENCES OF ANALYSIS

What steps will you take in response to the findings of your analysis? Please select at least one of the following and give a brief explanation.		
1. Continue development with no changes		
2. Continue development with minor alterations	Y	The guidelines will be subject to ongoing monitoring and amendments carried out, subject to pertinent updated information becoming available, such as statutory measures and appropriate resources being developed.
3. Continue development with major changes		
4. Discontinue development and consider alternatives (where relevant)		

How will the actual effect of the policy be monitored following implementation?

As above

When is the policy due to be implemented?

Following approval by the Inverclyde Alliance on 17th June.

Additionally, arrangements have been made to deliver training/upskilling workshops on a multi-agency basis. An easy reference leaflet will also be created

that captures the main points of the Guidelines (to be used by first responders).
When will the policy be reviewed?
On an annual basis
What resources are available for the implementation of this policy? Have these resources changed?
In kind support

Name of Individual(s) who completed the Assessment Name(s): Brian Young Position: Health Improvement Lead, Inverclyde HSCP Date: 12th May 2019
Authorised by Name: Position: Date:

Please send a copy of all completed forms to Karen Barclay, Corporate Policy Officer at karen.barclay@inverclyde.gov.uk