SELF HARM AND SUICIDAL BEHAVIOUR

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1. DEFINITION

Definitions from the Mental Health Foundation (2003) are:

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

The term self-harm rather than deliberate self-harm is the preferred term as it a more neutral terminology recognising that whilst the act is intentional it is often not within the young person's ability to control it.

Self-harm is a common precursor to suicide and children and young people who deliberately self-harm may kill themselves by accident.

Self-harm can be described as wide range of behaviours that someone does to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered. Many children and young people may struggle to express their feelings in another way and will need a supportive response to assist them to explore their feelings and behaviour and the possible outcomes for them.

2. INDICATORS

The indicators that a child or young person may be at risk of taking actions to harm themselves or attempt suicide can cover a wide range of life events such as bereavement, bullying at school or a variety of forms of cyber bullying, often via mobile phones, homophobic bullying, mental health problems including eating disorders, family problems such as domestic violence and abuse or any form of child abuse as well as conflict between the child and parents.

The signs of the distress the child may be under can take many forms and can include:

- Cutting behaviours.
- Other forms of self-harm, such as burning, scalding, head banging, hair pulling.
- Self-poisoning.
- Not looking after their needs properly emotionally or physically.
- Direct injury such as scratching, cutting, burning, hitting yourself, swallowing or ingesting foreign objects.
- Staying in an abusive relationship.
- Taking risks too easily.
- Eating distress (anorexia and bulimia).
- Addiction for example, to alcohol or drugs.
- Low self-esteem and expressions of hopelessness.

3. RISKS

An assessment of risk should be undertaken at the earliest stage and should enquire about and consider the child or young person's:

- Level of planning and intent.
- Frequency of thoughts and actions.
- Signs or symptoms of a mental health disorder such as depression.
- Evidence or disclosure of substance misuse.
- Previous history of self-harm or suicide in the wider family or peer group.
- Delusional thoughts and behaviour.
- Feeling overwhelmed and without any control of their situation.

Any assessment of risks should be talked through with the child or young person and regularly updated as some risks may remain static whilst others may be more dynamic such as sudden changes in circumstances within the family or school setting.

The level of risk may fluctuate and a point of contact with a backup should be agreed to allow the child or young person to make contact if they need to.

The research indicates that many children and young people have expressed their thoughts prior to taking action but the signs have not been recognised by those around them or have not been taken seriously. In many cases the means to self-harm may be easily accessible such as medication or drugs in the immediate environment and this may increase the risk for impulsive actions. A plan for safe storage of medication in the household and other potential items which may be used by young people to self-harm should be made with all at risk young people and their parents/carers. GP's should be aware of risk of self-harm when prescribing medication for the young people who self-harm and their family. Whilst no medication is safe taken in this context, certain medication may pose a much greater risk of harm, or death, and this should be considered when prescribing to at risk young people and others in the household.

If the young person is caring for a child or is pregnant the welfare of the child or unborn baby should also be considered in the assessment.

4. PROTECTIVE AND SUPPORTIVE ACTION

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

Practitioners should talk to the child or young person and establish:

- If they have taken any substances or injured themselves.
- Find out what is troubling them.
- Explore how imminent or likely self-harm might be.
- Find out what help or support the child or young person would wish to have.
- Find out who else may be aware of their feelings.

And explore the following in a private environment, not in the presence of other pupils or patients depending on the setting:

- How long have they felt like this?
- Are they at risk of harm from others?
- Are they worried about something?
- Ask about the young person's health and any other problems such as relationship difficulties, abuse and sexual orientation issues?
- What other risk taking behaviour have they been involved in?
- What have they been doing that helps?
- What are they doing that stops the self-harming behaviour from getting worse?
- What can be done in school or at home to help them with this?
- How are they feeling generally at the moment?
- What needs to happen for them to feel better?

Do not:

- Panic or try quick solutions.
- Dismiss what the child or young person says.
- Believe that a young person who has threatened to harm themselves in the past will not carry it out in the future.
- Disempower the child or young person.
- Ignore or dismiss the feelings or behaviour.
- See it as attention seeking or manipulative.
- Trust appearances, as many children and young people learn to cover up their distress.

Referral to Children's Social Care:

The child or young person may be a Child in Need of services (s17 of the Children Act 1989), which could take the form of an early help assessment or a support service or they may be likely to suffer significant harm, which requires child protection services under s47 of the Children Act 1989.

The referral should include information about the back ground history and family circumstances, the community context and the specific concerns about the current circumstances, if available.

Where hospital care is needed:

Where a child or young person requires hospital treatment in relation to physical self-harm, practice should be as follows, in line with the National Institute of Health and Clinical Excellence (NICE) June 2013 (see **NICE website**):

Triage, assessment and treatment should be undertaken by paediatric nurses and doctors trained to work with children and young people who self-harm in a separate area of the emergency department for children and young people.

Special attention should be given to:

- Confidentiality.
- Young person's consent (including Gillick competence).
- Parental consent.
- Child protection issues.
- Use of the Mental Health Act and the Children Act.
- Admission.

All children and young people should normally be admitted into a paediatric ward under the overall care of a paediatrician and assessed fully the following day.

Alternative placements may be needed, depending on:

- Age.
- Circumstances of the child and their family.
- Time of presentation.
- Child protection issues.
- Physical and mental health of the child or young person.
- Occasionally, an adolescent psychiatric ward may be needed.

After admission, the paediatric team should obtain consent for mental health assessment from the child or young person's parent, guardian or legally responsible adult.

During admission, the CAMHS team should:

- Provide consultation for the young person, their family, the paediatric team, social services, and education staff.
- Undertake assessment addressing needs and risk for the child (similar to adults, see assessment of needs and assessment of risk), the family, the social situation of the family and young person, and child protection issues.

For all children and young people, advise carers to remove all means of self-harm, including medication, before the child or young person goes home.

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

There should be a clear individual follow up plan for any child/young person who presents with self-harm/suicidal intent.

5. ISSUES – INFORMATION SHARING AND CONSENT

The best assessment of the child or young person’s needs and the risks, they may be exposed to, requires useful information to be gathered in order to analyse and plan the support services. In order to share and access information from the relevant professionals the child or young person’s consent will be needed.

Professional judgement must be exercised to determine whether a child or young person in a particular situation is competent to consent or to refuse consent to sharing information. Consideration should include the child's chronological age, mental and emotional maturity, intelligence, vulnerability and comprehension of the issues. A child at serious risk of self-harm may lack emotional understanding and comprehension and the Fraser guidelines should be used. Advice should be sought from a Child and Adolescent Psychiatrist if use of the mental health act may be necessary to keep the young person safe.

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

- The situation is urgent and delaying in order to seek consent may result in serious harm to the young person.

- Seeking consent is likely to cause serious harm to someone or prejudice the prevention or detection of serious crime.

If consent to information sharing is refused, or can/should not be sought, information should still be shared in the following circumstances:

- There is reason to believe that not sharing information is likely to result in serious harm to the young person or someone else or is likely to prejudice the prevention or detection of serious crime; and
- The risk is sufficiently great to outweigh the harm or the prejudice to anyone which may be caused by the sharing; and
- There is a pressing need to share the information.

Professionals should keep parents informed and involve them in the information sharing decision even if a child is competent or over 16. However, if a competent child wants to limit the information given to their parents or does not want them to know it at all; the child's wishes should be respected, unless the conditions for sharing without consent apply.

Where a child is not competent, a parent with parental responsibility should give consent unless the circumstances for sharing without consent apply.

6. FURTHER INFORMATION

The links relate to publications about self-harm and suicide with sections about children and young people as in the latest national strategy:

'Preventing suicide in England: a cross government outcomes strategy to save lives' September 2012.

Mental Health Foundation (2003) Suicide amongst children and young people

Truth Hurts: Report of the National Inquiry into Self-harm among Young People. Mental Health Foundation 2006

Hawton, K, Rodham, K and Evans, E (2006), By Their Own Hand: **Deliberate Self-harm and Suicidal Ideas in Adolescents**. London: Jessica Kingsley

Royal College of Psychiatrists Managing Self-harm in Young People (2014)

Guidance for Developing a Local Suicide Prevention Action Plan: Information for Public Health Staff in Local Authorities (2014) Websites:

National Self Harm Network

Papyrus

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