



Cardiff Local
Safeguarding Children Board

Bwrdd Lleol
Diogelu Plant Caerdydd

CHILDREN WHO SELF HARM PROTOCOL

Cardiff Local Safeguarding Children Board would like to acknowledge the work undertaken by Swansea Safeguarding Children Board on which this Protocol is based.

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1. INTRODUCTION

The aim of this Protocol is to safeguard and promote the welfare of children and young people up until their 18th birthday when there are concerns that they are involved in self harm and para-suicide (i.e., a failed suicide attempt – see section 4 for definition).

Workers need to be aware of other vulnerable children who may be closely associated with a victim of suicide or para-suicide and significantly affected by that behaviour and therefore may also require consideration and action based on this guidance.

Workers may experience considerable anxiety when identifying aspects of self harm in children and young people. There is often a fear that working on issues will lead to an escalation of self harming behaviour. However, children involved in self harming behaviour are among the most vulnerable and have been largely invisible to those services charged with safeguarding their welfare. All agencies working with children and young people in Cardiff should work to this Protocol.

Suicide and deliberate self harm have significant personal, social and economic consequences. Whilst there seems to be a broad consensus that many suicide deaths are preventable, there is no clear way to predict which individuals are likely to die from suicide and there is no research that demonstrates how suicide can be prevented in any individual.

“Young people who self harm are 100 times more likely to commit suicide than those who do not. Childline believes self harm, where young people deliberately inflict injury – such as cutting or burning – on themselves, should be taken as seriously as suicide attempts”. (Saving Young Lives, 2001)

It should, however be recognised that although rates of self harm are rising (there were 2727 admissions in the UK for self harm with a sharp object among the under 25's in 2008/09 compared with 1758 in 2004/05) the vast majority of young people who self harm do so to enable them to cope with intense emotional pain.

2. SCOPE

For the purposes of this Protocol it is essential to clarify the current Mental Health service provision across Cardiff as set out in WHC (2002) 125.

The Child and Adolescent Mental Health Services have responsibility for all children up to School leaving age and also include responsibility for 16 –

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18 years olds who are still in School and within the responsibility of the Education support services.

The Mental Health services for adults have responsibility for young people from 16 years of age who are attending college or no longer in education.

This Protocol applies to all children and young people up to 18 years of age who come to the attention of the agencies who are represented on Cardiff Local Safeguarding Children Board and who have self harmed or attempted suicide. This Protocol applies to the following key agencies who work with children within the City and County of Cardiff:

- Local Authority
- Health Services
- South Wales Police
- Cardiff Youth Offending Services
- National Probation Service
- Voluntary and Outreach Services

The Protocol will be available through the key agencies' lead officers for Safeguarding Children.

All agencies and organisations represented on the Local Safeguarding Children Board will be expected to sign up and adhere to this Protocol.

3. AIM

The Protocol describes principles that all the agencies should adopt in order to safeguard and maximise children's health and wellbeing in such circumstances, and also provides a general flow chart which reinforces and supports any potential referral pathway.

Agencies and organisations should develop their own strategies in order to implement this Protocol giving due regard both to the content of the Protocol and in particular to primary, secondary and tertiary prevention when developing them.

Primary Prevention

This would involve all young people to create a better understanding of self harm, the reasons for it and to encourage mental health wellbeing.

Programmes in Schools covering these topics have reduced the incidence of self harm.

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Secondary Prevention

The early identification of those who may self harm/identification of those at greatest risk e.g. the early identification of those children who suffer from depression, low self esteem and a feeling of hopelessness.

Tertiary Prevention

Treatment of self harm to prevent long term consequences.

4. DEFINITIONS

The term self harm is used to describe the episode/s when a child or young person injures or harms themselves deliberately rather than by accident.

Examples of self harm include hitting, cutting, banging, skin picking and hair pulling, burning, scalding, self strangulation and overdosing of illicit, prescribed or over the counter drugs.

It can also include the use of illicit drugs, excessive amounts of alcohol and eating disorders.

Self harm covers behaviours with no suicidal intent through to taking ones own life.

The above should not be considered an exhaustive list.

Para-suicide is self harm with intent to take life resulting in non fatal injury.

Suicide is self harm resulting in death.

5. UNDERSTANDING SELF HARM

It is often difficult to understand why children and young people self harm. Children and young people describe that by deliberately hurting themselves they are temporarily able to change their state of mind to better cope with painful feelings. Self harm provides a mechanism for dealing with intense emotional pain. However, with it comes the burden of emotional guilt and secrecy which can have an affect on a child or young person's ability to build and maintain relationships. It can also quickly establish a pattern of addictive behaviour.

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Some reasons indicated for self harm include:

- Being bullied
- Not getting on with parents
- Stress and worry about academic performance and examinations
- Parental separation or divorce
- Bereavement and loss
- Unwanted pregnancy
- Experience of abuse including sexual abuse
- Difficulties with sexuality
- Low self esteem
- Feelings of being rejected

The vast majority of children and young people who self harm are not trying to kill themselves, rather they are trying to cope with difficult feelings by engaging in behaviour which temporarily relieves stress and anxiety but which can become very addictive. It is a method of distraction from painful feelings that children and young people then come to rely on. However, many people who commit suicide have self harmed in the past, and for that reason each episode needs to be taken seriously and assessed and treated in its own right.

6. RISK INDICATORS

Risk factors associated with deliberate self harm and suicide can include one or more of the following (Hawton, Rodham and Evans 2006):

- Gender - 4 times more common in adolescent girls (completed suicide is commoner in males).
- Ethnicity - More common to find deliberate self harm in white females than Asian females, no difference in males. However the suicide rate amongst young Asian women (aged 15-34) is twice as high as their white counterparts. (Soni Raleigh & Balarajan 1992)
- History of depression and anxiety in both males and females.
- Lack of self esteem – males more so than female.
- History of drug use, alcohol use.
- Problems keeping up with school work.
- Problems keeping friends and having arguments.

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- History of coercive sexual activity (adolescents who had been forced verbally or physically to engage in sexual activities against their will).
- Sexual orientation problems.
- Having friends who self harm.
- Being influenced by media portrayal of suicide.

A more comprehensive list of risk indicators is attached at Appendix A.

7. PRINCIPLES

- 7.1 Each practitioner should be aware of and follow internal guidelines in respect of the management of self harm. Children and young people who present, following self harm should be listened to in an empathic, non judgemental manner.
- 7.2 All organisations that provide services to children and young people should ensure that systems are in place to ensure that:
- Every practitioner is accountable for his/her professional judgement and s/he has the appropriate professional competence.
 - Every practitioner should access and have access to supervision and training.
 - Every practitioner has the responsibility to assess, manage and to follow up the child or young person, commensurate with their role.
 - Every practitioner has the responsibility to consider and to ensure the appropriate liaison, referral and disclosure of information to another practitioner / agency if relevant.
 - No practitioner is unsupported or isolated in dealing with issues of self harm.
- 7.3 Practitioners should ensure there is appropriate documentation of the concerns and decisions made.
- 7.4 Primary preventive information that promotes mental health and well being and signposts children and young people to mental health support should be readily available, both via the voluntary agencies (e.g Childline) other agencies / organisations (e.g Schools, Youth Courts, Social Services waiting areas) and also through providers of unscheduled care (e.g GP practices, A&E departments etc).

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- 7.5 Any episode of self harm should be taken seriously.
- 7.6 In order to prevent escalation of the behaviour, it is essential that those young people who self harm are identified at the earliest stage in their self harming behaviour.
- 7.7 On going risk assessment is integral to appropriate management. The level of intervention will depend on the circumstances of the self harm, the frequency and severity.
- 7.8 A child or young person who is self harming should be referred to Children's Services if there are Child Protection or Child in Need concerns. Other services are listed in Appendix 3. In many situations when children or young people self harm, some form of intervention will be necessary. In some cases this may be as a Child in Need or as a child in need of protection.
- 7.9 At all stages practitioners should work with and involve the young person in the process.
- 7.10 All information sharing should be considered in the context of legal guidance and consent should be sought from the child/young person where appropriate.
- 7.11 Wherever possible information should be shared, taking into account the view and consent of the young person.
- 7.12 In order to safeguard the young person, and irrespective of the young person's views, practitioners may need to share information taking into account the need for proportionality (i.e is the proposed disclosure a proportionate response to the need to protect the child?) seeking advice from Child Protection leads within the organisation if necessary and the guidance set out within Chapter 14, Safeguarding Children: Working Together under the Children Act 2004.
- 7.13 Where there is refusal to provide consent or it is unreasonable to seek consent (e.g due to immediate action being required to safeguard a child) practitioners should be aware of the law and professionals' codes of conduct and that these rarely provide a barrier to disclosure where information sharing is considered essential for the purpose of safeguarding and promoting the welfare of children.

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8. PROCEDURE

Each agency is required to have internal guidance in place to ensure that staff are clear about their role in respect of children and young people who self harm (See Appendix 1). This should include where relevant expectations with regard to identification, assessment, support and ongoing referral pathways.

CAMHS Primary Care Workers are available by telephone to offer confidential consultation to staff from all agencies.

MULTI-AGENCY PROTOCOL FOR SAFEGUARDING CHILDREN

a. Cases of attempted suicide – asphyxiation, drug overdose, serious cutting

A referral to Intake and Assessment Team, Children’s Services should be made immediately. The All Wales Child Protection Procedure” should be applied and a strategy discussion/meeting should be arranged with the Child and Adolescent Psychiatrist and Paediatrician.

If the level of concern does not warrant a child protection response which will be determined by the severity and context of the incident, a multi-agency referral form must be completed and parental consent sought and that of the young person (if appropriate). This is not necessary if the referral is deemed to be child protection. The key issue is that professionals meet together to agree and plan for the welfare of the child/young person. For all children that are admitted onto the ward a discharge plan as per the LSCB Joint Protocol for Discharge from Hospital should be in place.

b. Cases of alcohol abuse or solvent abuse if a child loses consciousness.

The cases of alcohol excess/abuse, in young people is an increasing problem. The cases where the child or young person has been admitted unconscious or becomes unconscious must be viewed seriously and in most circumstances as a child protection issue.

The same issue applies if the child or young person has become unconscious because of substance misuse. The All Wales Child Protection Procedures will apply and should be followed.

c. Child or young person presented as intoxicated or under the influence of substances.

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All children and young people presenting in these circumstances should be assessed. The Welsh Assembly Government suggests the Drug Use Screening Tool (DUST).

The protection of children and young people from harm must be the overriding concern.

Care of children and young people who misuse substances should be in accordance with Welsh Assembly Government guidance and should take account of medical, social, emotional and educational needs.

All cases of multiple ingestion should be referred to Children's Services.

d. Child or young person discloses that they have self harmed in the recent past.

For young people who disclose that they have recently harmed themselves but are not in any immediate danger, referral to the Children's Services Intake Team should be considered. As with the above, the decision to refer will depend upon the circumstances of the case. For example a young person may disclose to a teacher or youth worker that the previous weekend he / she took a small amount of tablets. You need to assure yourself that the young person is not in any immediate danger as with some medicines such as paracetamol, any symptoms may take a few days to emerge. If so, the referral should be directly to Children's Services. If you are in doubt ensure that the young person seeks medical treatment.

9. CONSENT AND INFORMATION SHARING

Guidance on Sharing Information related to Self Harming Behaviour

There is concise and consistent guidance for sharing recorded information about children who harm themselves or are perceived to be at risk of self harm including suicide.

At no point in the process should there be any delay in making an appropriate referral where a child or young person is displaying psychotic behaviour or has initiated self harming behaviour that is life threatening.

9.1 Purpose of Sharing Information

The purpose of sharing information is to ensure children in need and in particular children who harm themselves or are perceived to be at risk of self harm including suicide are given the help and support they are entitled to.

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9.2 Consent

Partner agencies when appropriate will use a Consent Form to record the competent child's consent to share recorded information. Fresh consent should be sought when appropriate, if the existing consent does not cover the proposed sharing or there has been a break in involvement. The child should be told what information may be shared and why it would be shared and the consequences of sharing.

9.3 Sharing without Consent

Informed consent should be sought when appropriate from the competent child to share recorded information unless;

- The situation is urgent and there is not time to seek consent, or
- Seeking consent is likely to cause serious harm to someone or prejudice the prevention, detection of serious crime.

If consent to sharing information is refused by the competent child, or can/should not be sought from the child, information should still be shared in the following circumstances;

- There is reason to believe that not sharing is likely to result in serious harm to the child or someone else or is likely to prejudice the prevention of detection of serious harm, and
- The risk is sufficiently great to outweigh the harm or prejudice to anyone that may be caused by the sharing, and
- There is a pressing need to share the information.
- There should always be documented evidence of a discussion with the child about his/her consent and the outcome of such discussion clearly recorded.

9.4 When is a child “competent” to give Consent?

Anyone under the age of 18 is a child. A judgement must be made as to whether a particular child in a particular situation is competent to consent or 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.

9.5 Sharing Information

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Partner agencies who request or refer information should state:

- What the information is and why it should be shared.
- Whether there is informed consent and any limits to it.
- If there is no consent, why they believe the information should be shared without consent.
- The proposed method of sharing and storage of the information.
- The period of time for responding to the request or referral.

Partner agencies who refuse or cannot comply with a request or referral should say why and what could be done to secure their agreement to share information. Local Authorities, Education Authorities and Health Boards/Trusts must comply with requests for information from Social Workers carrying out an S47 inquiry unless it would be unreasonable to do so.

9.6 Families

Partner agencies 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 his/her 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.

9.7 The Mental Capacity Act 2005

Practitioners may need to take account of the Mental Capacity Act 2005 that affects young people over 16 years of age. The Act applies to everyone who works in Health and Social Care in England and Wales. It sets out the statutory framework for making all decisions on behalf of people over 16 years of age who lack capacity to make decisions themselves. Any decision made under the Act for or on behalf of the young person who lacks capacity must be done in their best interest and should be the least restrictive of their basic rights and freedoms.

10. TRAINING

Cardiff Local Safeguarding Children Board will have in place a Training package based on this Protocol.

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11. REVIEW

Cardiff Local Safeguarding Children Board will review the progress of this Protocol after 12 months. The Board will also consider the merit of any associated communications campaigns for the community of Cardiff in relation to this Protocol.

The Board will also assess how data and performance information relating to this Protocol can be maintained by each agency and incorporated into the overall Safeguarding Children Board Performance Management Framework.

12. REFERENCES

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Mental Health Act 2007

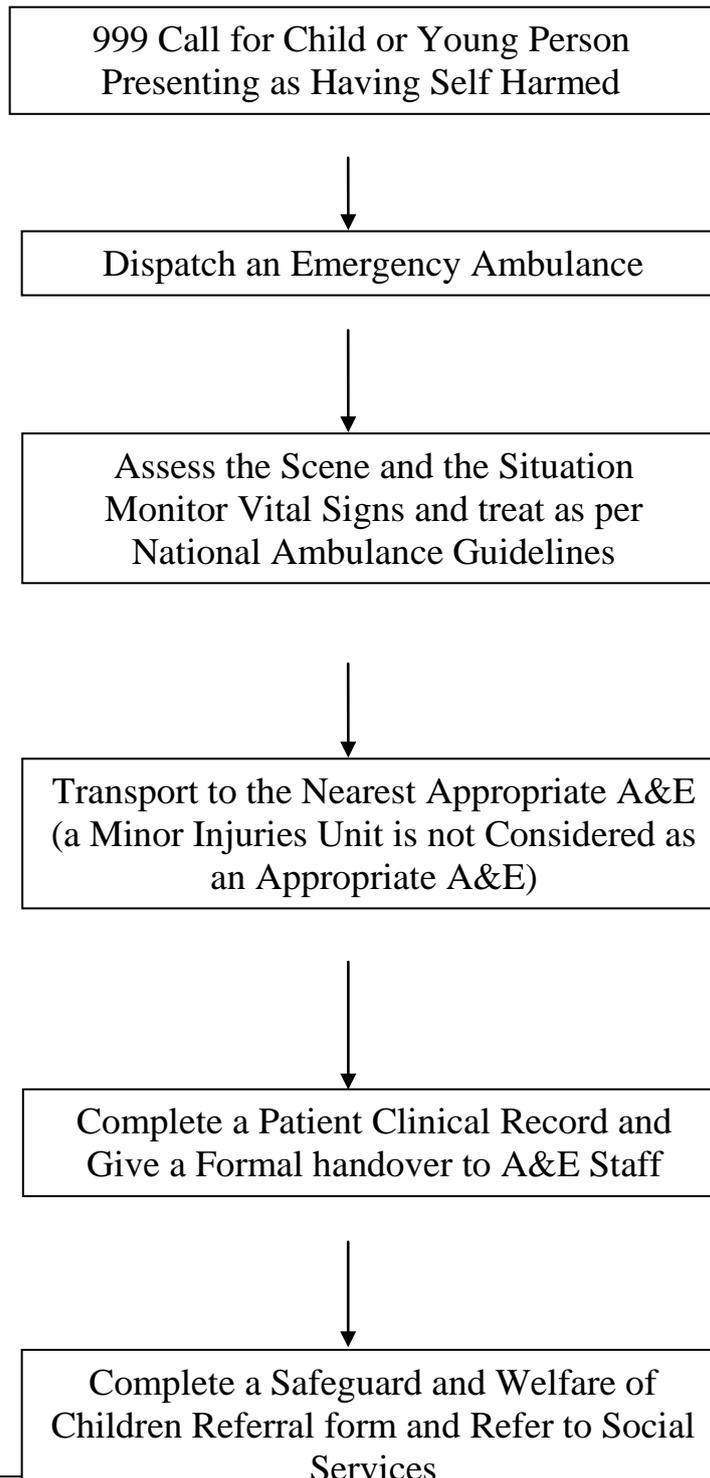
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Welsh Ambulance Services NHS Trust Flowchart for Children and Young People who Have Self Harmed



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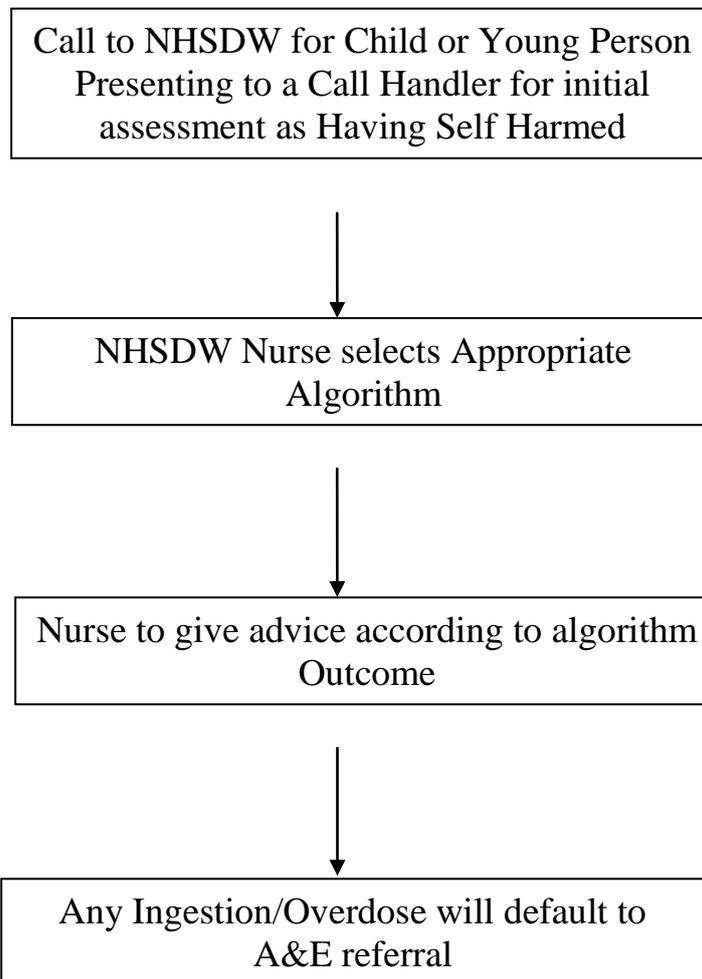
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NHSDirect Wales Flowchart for Children and Young People Who Have Self Harmed



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APPENDIX 2

Multi-Agency Self Harm Pathway (Education)

A child / young person tells you that they have self harmed or expressed suicidal thoughts.
The primary Mental Health Team offer telephone consultation at this point.

A child / young person tells you that they:

- intend to self-harm;
- you suspect that they have self-harmed or are expressing suicidal thoughts.

If the self-harm took place **within the last 48 hours** and involves ingestion, serious lacerations or excessive dose / omission of prescribed medication.

If the self-harm took place **longer than 48 hours ago** and involves ingestion, serious lacerations or excessive dose / omission of prescribed medication.

- Clarify who is best placed to talk with the child / young person.
- Find a safe and appropriate place for discussion.
- Indicate willingness to talk to child / young person about self-harm.
- Decide whether it is OK to leave the child / young person until later and act accordingly.
- See 'what to say section' (page).
- **Confidentiality:** inform children / young people who you will pass information to and how.
- Conduct risk assessment. Assess situation re. safety, mental health, context, risk and resilience factors. Use information to inform whether a referral to specialist CAMHS is appropriate. You can consult with the Primary Mental Health Team to help with this decision.
- Use information from risk assessment to decide whether it is appropriate to leave the child / young person alone.
- Inform designated child protection coordinator in school. Consider whether child protection issues are raised. If so, follow LEA child protection procedures.
- Consideration given to when / where and how to inform parents. Provide parents with helpful information (see page).
- Log incident (see proforma – page 18).
- Monitor child / young person through ongoing pastoral support. Provide child / young person with sources of external support (see useful websites / contacts on page 12/13).

- Child / young person should be taken to hospital emergency department.
- Discuss with your manager / safeguarding colleague / child protection coordinator.
- Ensure own support.
- Consider contacting parent / carer.
- Log incident (see proforma – page 18).

- Contact any of the following:
- GP;
- NHS direct;
- A & E;
- Log incident (see proforma – page 18).

Important contacts:
LEA Safeguarding Team –
School Nurse –
Educational Psychology Service – 02920 629800
School-based Counselling Service -

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If no immediate action is required, ensure that you follow up the next working day.

APPENDIX 3

SOURCES OF HELP

1. Cardiff Social Services

Intake & Assessment Team Tel: 029 20 536400

Out of Hours Duty Team: Tel: 029 20 788570

2. Child & Adolescent Mental Health Service

Tel: 029 20 536730

3. Barnardo's Cymru Caterpillar Project

The Caterpillar Project provides one to one and group support for young people aged 12 – 19 who are experiencing mental ill health, distress or unhappiness. The project can accept referrals from any agency, from families or self referrals. Staff are experienced with working across a range of issues including depression, anxiety, eating disorders, self harm, low self esteem, and phobias. Staff link with a broad range of other agencies. The project offers social and emotional support often over many months to help young people build confidence address fears, establish ways of coping with their own difficulties and to link to appropriate social networks. The project uses Barnardo's harm minimisation approach and techniques for work with young people who self harm and this can include short periods of 24 hour telephone advice and guidance at times of particular stress or crisis.

Caterpillar
Barnardo's Cymru
46 Marlborough Road
Roath
Cardiff CF23 5BX
Tel: 029 20497531
mrp@barnardos.org.uk

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4. Childline

A free 24 hour confidential service for children and young people up to 18.

Tel: 0800 1111

5. The Amber Project

Exists to support any young person (aged 14 – 25) in Cardiff and surrounding areas who has experience of self harm.

Tel: 029 20 344776

6. Samaritans

Provides confidential emotional support 24/7 to those experiencing distress or suicidal feelings.

Tel: 029 20 344022

7. Papyrus UK

Support young people at risk of suicide and those concerned about them.

Tel: 0800 068 41 41

www.papyrus-uk.org

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