Surrey Safeguarding Children Partnership

Self-Harm Protocol

Multi-Agency Practice Guidance for Dealing with Incidents of Self-Harm

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Introduction

This protocol is for managers and practitioners setting out the key roles and responsibilities in supporting children who may be at risk of self-harm or who have engaged in acts of self-harm. This protocol has been developed in accordance with *Working Together 2018*, *Keeping Children Safe In Education 2020*, *NICE Quality Standards* and learning from Local Child Safeguarding Practice Reviews. The aim of this protocol is to ensure the effective coordination of multi-agency responses to incidents of self-harm across Surrey.

Who is the Protocol For?

This protocol is for anyone who works directly with children and young people in Surrey. This includes but is not limited to statutory and non-statutory services, universal services, targeted services and specialist services; maintained schools, including academies, free schools and alternative provision academies, further education providers of children aged 16-18 years of age, it also includes voluntary organisations and charities who provide services to children and young people.

Background

Self-harm is a serious public health concern and is the reason behind many admissions to accident and emergency departments every year. The Surrey Safeguarding Children Partnership identified a need for a detailed, multi-agency self-harm protocol which would provide guidance to frontline staff in the management of incidents of self-harm. Self-harm and suicidal threats by a child/young person, places them at risk of significant harm, and should always be taken seriously and responded to without delay. Our commitment in Surrey is that we will deliver timely, consistent, proportionate and safe responses to presenting self-harm concerns.

Self-harming is **NOT** attention seeking behaviour; it is a clear indication of emotional distress and that support is needed. Self-harm is a way of coping with difficult or overwhelming situations or emotional states.

Definitions

Self-Harm

Self-harm is when a person intentionally hurts or harms themselves as a means of coping with or expressing emotional distress. Many describe their self-harm as a way to release overwhelming emotions. Some people plan it in advance, others act on the spur of the moment. Though some people self-harm only once or twice, others do it regularly – and it can become hard to stop.[1]

Types of Self-harm

The types or methods of self-harm can be divided into two broad groups:

1. ***self-poisoning:*** this form of self-harm usually involves an overdose of prescribed or over-the-counter medication. A small additional percentage will have intentionally taken a dangerously large amount of an illicit drug or have poisoned themselves with some other substance.
2. ***self-injury:*** this form of self-harm is more common than self-poisoning in the population, perhaps by a ratio of 2 to 1 in teenagers. Cutting is by far the most common means. Less

[1] This definition is adapted from the definition provided by the Royal College of Psychiatrists. See https://www.rcpsych.ac.uk/mental-health/problems-disorders/self-harm

common methods include burning, hanging, stabbing, swallowing objects, inserting objects, shooting and jumping from heights or in front of vehicles[2]

People self-harm for several reasons, including:

- **to feel better:** Self-harm can release pent-up feelings such as anger and anxiety, or, people who feel numb use self-harm as a way to feel "something"
- **to communicate their emotional pain:** Those who self-harm for this reason will obviously display their wounds as a way of reaching out for help.
- **to feel a sense of control:** People who self-harm may feel powerless and lack self-esteem. Self-harm may be used as a way to regain control. This is particularly common for those who have suffered abuse. There is often a pronounced feeling of powerlessness, self-loathing, and an absence of self-esteem.
- **to punish themselves:** People who self-harm may lack self-esteem and think they are at fault for the way they feel.[3]

Warning Signs[4]

How can you tell if someone is self-harming? People who self-harm may:

- appear withdrawn, or quieter or more reserved than usual;
- stop participating in their regular activities;
- have rapid mood changes;
- get angry or upset easily;
- have had a significant traumatic or distressing event in their lives, e.g. a breakup with a significant other; family breakdown including parental separation, etc.
- suffer poor academic/school performance when they usually do very well;
- exhibit unexplained cuts or scratches;
- wearing clothes that are inappropriate for the weather, e.g. wearing long sleeves on a hot day. (see also appendix H for signs and symptoms)

Indicators of High-Risk Self-harm

- Low mood
- Significant changes in behaviour
- Expressing hopelessness
- Low self-esteem and self-destructive thoughts
- Lack of family support
- Expressing suicidal thoughts
- Previous self-harm
- Possible abuse including neglect and sexual abuse
- Criminal and sexual exploitation
- Bullying including online bullying through social media
- Substance misuse including alcohol

[2] Self-Harm; The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care; NICE Guideline 16; 2004

[3] (CSP, 2014; Klonsky and Muehlenkamp, 2007; Hasking, 2010)

[4] Hasking, P.A., et al., Brief report: *Emotion regulation and coping as moderators in the relationship between personality and self-injury*, Journal of Adolescence (2010), doi:10.1016/j.adolescence.2009.12.006

- Recent history of self-harm or suicide in the friendship group
- Bereavement, especially a recent loss

The overwhelming emotional issues that may lead someone to self-harm may be caused by:

- **Psychological causes**–such as experiencing mental health problems, including depression, stress, anxiety, borderline personality disorder and eating disorders;
- **Neurodevelopment difficulties**–Children with ASD, ADHD, or learning difficulties can sometimes experience impulsive behaviour or difficulty controlling emotions which can lead to an increased risk in self-harm;
- **Children Looked After**–Children in care are at increased risk of hurting themselves as a result of a range of adverse childhood experiences (e.g. abuse and/or neglect) and continuing stress. Young adults who have left the care system at 18 years are also vulnerable;
- **Issues/difficulties with Peers** –such as being bullied, having difficulties at work or school(particularly around exam periods), 'copycat' behaviour, peer/ social media pressure, having difficult relationships with friends or family, money worries, loneliness, low self-esteem and low confidence, sadness, numbness, lack of control over their lives, parental mental health, parental alcohol and substance misuse;
- **Identity**–coming to terms with their sexuality if they think they might be gay or bisexual, gender identity, or coping with cultural or religious expectations, such as an arranged marriage.
- **Trauma**–such as physical or sexual abuse, the death of a close family member or friend (death from suicide specifically can increase the risk of self-harm), being in contact with the criminal justice system, exposure to domestic violence, or having a miscarriage.

These issues can lead to a build-up of intense feelings of anger, guilt, hopelessness and self-hatred. The person may not know who to turn to for help and self-harming may become a way to release these pent-up feelings.

Understanding Self-Harm and Suicide

Self-harm is often thought to be linked to suicide. For some people, self-harm is a coping mechanism rather than a suicide attempt. However, some individuals that self-harm may go on to complete a suicide attempt and it is therefore important not to dismiss such behaviour as attention seeking or a way of coping with difficult emotions; self-harm is an indication of emotional distress, and that attention and support is needed.

Self-harm and suicide attempts are different. Suicide is an attempt to end one's life, although the distinction between the two acts may not always be clear cut. For example, a person might take an overdose of prescribed medication to get some sleep or respite from current problems but may not be too bothered if they don't wake up. They don't plan to kill themselves, but they're too tired to think through the consequences.

How is self-harm different from suicidal ideation and behaviour? From the table below (adapted from the work of Klonsky, May & Glenn, 2014),[5] self-harm differs from suicide attempts in frequency, methodology, severity and purpose

[5] *Self-harm and Suicide Centre for Suicide Prevention* https://www.suicideinfo.ca/resource/self-harm-and-suicide/ccessed

	Self-harm	Suicide attempts
Frequency	Incidents tend to be very frequent	Attempts happen less frequently
Methodology	Cutting, burning, self-hitting	Self-poisoning
Severity	Less severe	Much more severe, sometimes lethal
Purpose	Done to avoid suicidal impulses	Done with the intent to die

The majority of those who engage in acts of self-harm do not have suicidal thoughts when self-harming. Although self-harm is not the same as suicide, self-harm can escalate into suicidal behaviours. The intent to die can change over time. One study found that almost half of people who self-harm reported at least one suicide attempt (Klonsky, 2011).

Dealing with Self-Harm In Surrey

The approach to supporting children at risk of self-harm in Surrey is based on the following core principles

- The safety and well-being of children and young people is paramount
- The child and their family are at the centre of all we do
- Effective early help and support prevents risks and possible harm to children from escalating
- Our approach to self-harm will be based on an effective assessment of need and level of risk.
- Self-harm requires an effective multi-agency response which includes all agencies working together with children and families to ensure the safety of children and young people. This involves all key agencies
    - Being proactive in sharing information appropriately, with consent, with services supporting the child (such as the child's GP, school, Child Emotional Well-being and Mental Health Services (EWMHs), Children's Services) so that the child is safeguarded and supported.
    - Working in partnership with children, young people and their families
    - Working effectively with voluntary organisations who support children and young people in Surrey
- Schools and education providers play a key role in safeguarding children and promoting their welfare and are an essential part of the team around a child and their family.
- Schools need to know if a child in their care is experiencing emotional distress and is at risk of self-harm and should be informed at the earliest possible opportunity, with appropriate consent from the child and their parents/carers

Workers dealing with Self-Harm

Many children and young people who harm themselves have concerns about getting help. They may feel that professionals do not understand why they have harmed themselves and why their behaviour may continue even when offered support.

If self-harm is disclosed it is always important to treat the child or young person with respect and not to judge, but to listen and support as needed. Assumptions should not be made about the reasons for self-harm and each episode needs to be treated with sensitivity, seeking to understand the circumstances and triggers for self-harming behaviours.

Many children and young people who end their lives by 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.

Dealing with Disclosures

When a worker becomes aware of concerns regarding a child or young person who is self-harming or who has expressed suicidal ideation, it is important that

- The worker records, reports and discussed the information with their line manager/designated safeguarding lead (DSL) immediately
- The appropriate worker should assess the level of risk using the information and evidence available and makes a decision regarding the appropriate course of action to safeguard the child and any other children who may be affected
- In situations where children and young people are competent to give consent, consent to share information should be sought. The worker should outline the reasons why the information needs to be shared, explaining with whom the information will be shared and how the information will be used to support the child or young person.
- If consent is not given, an assessment of the level of risk must be taken and if the decision is made to share information without consent, for the purpose of safeguarding the child or young person, this must be recorded, with a clear rationale for overriding consent.
- The appropriate worker should normally contact parent/carers unless it would increase the risk of harm. If parents/carers are not informed this should be clearly recorded with the reason why.
- Along with informing the child's parents, the worker should inform the child's school, so that the child and other children can be safeguarded and supported. If the decision is taken not to inform the school, this should be clearly recorded with the reason/s why.

Please see the risk assessment flowchart on the following page

Assessing Risks Relating to Self-Harm

Level 3 Medium Risk
(incidents of self-harm are medium risk: i.e. Children with complex needs)

For example, a one-off incident that caused harm and/or expression of intent for further self-harm.

Always

- Contact EWMH SPA or PMHT in schools

If there are safeguarding concerns, where there are other factors around parenting capacity, environmental factors, complex emotional needs, developmental factors

- Contact the C-SPA (obtain consent where possible; where consent is not possible information may be shared but you must record the reason for sharing)
- The child's school should be informed with consent

Level 4 High Risk (children in acute need)

Children are at risk of significant harm, if one of the below applies

- The child's actions could result in their death, or serious injury requiring admission to hospital
- Support and interventions have failed to reduce the risk of self-harm and suicidal ideation
- Evidence and risk factors suggest that the level of emotional and psychological distress, including environmental factors form part of the self-harm or suicidal behaviour (including neglect or abuse at home, peer abuse, bullying or trolling online, exposure to self-harm or suicidal ideation online, criminal or sexual exploitation etc.)

Always contact CAMHS SPA

Contact the C-SPA where there are other factors, around where there are other factors aroundparenting capacity, environmental factors, complex emotional needs, developmental factors:

Contact the C-SPA (obtain consent where possible; where consent is not possible information may be shared but you must record the reason for sharing)

The child's school should be informed

FLOWCHART FOR ACTIONS WHEN A CHILD/YOUNG PERSON HAS SELF HARMED AND CSPA NOTIFIED

If a child is thought to be in immediate danger, a request should be made to the Children Single Point of Access and other relevant agencies. Where a notification has been received via Request for Support Form (RFS) into the CSPA and has been allocated to either the Early Help Hub or Multi-Agency Partnership services this flowchart will be followed (see Appendix A for managing incidents of self-harm when the child has an allocated social worker)

Where a concern has been identified in relation to self-harm and allocated to EHH/MAP a manager will review and confirm an initial threshold of need.

If on review the information is considered to meet Level 4 of the threshold of need this will be escalated immediately to the relevant assessment team.

The advisor within MAP or EHH will:

- Request a Daily Discussion with CAMHS (10am daily) and provide an oversight of the situation and request additional information to support a decision for the child.

The allocated advisor (working in either MAP or EHH) will:

- Carry out the enquiries requested by the manager and record the advice provided by professionals within the Daily Discussion.
- The advisor will establish that the child is safe and well.
- The advisor will seek to gain consent from the parent or child (where appropriate to share the information with school).

Where consent has been gained to share:

- The advisor will email the DSL a self-harm notification (see template). This will include a brief outline and any action taken by the EHH or MAP.
- The email will be copied into the main body of the contact.

Every attempt to gain consent will be made, this will include outlining the importance of sharing with school to enable support to be provided.

If consent has not been gained to share the advisor will record the reason within the body of the contact.

Dealing with incidents of self-harm

Self-harm must always be treated as a complex need (level 3) which requires targeted support in accordance with the *Effective Family Resilience Model*. In some cases, self-harm will also be a safeguarding issue requiring specialist support (level 4).

If a worker is aware that a child or young person, has self –harmed they must:

1. Listen calmly (**Assess**)

2. Seek first aid treatment if necessary (**Manage**)

3. Encourage the young person to speak to parents/carers as soon as possible (**Inform**). Workers are expected to inform the child or young person's parents or carers as soon as possible, unless there is a good reason not to do so (for example, informing the parents/carers would place the child at additional risk of harm). If the decision taken not to inform the child or young person's parent/carers this must be recorded along with the reasons for not sharing this information. Please note the points above regarding seeking consent.

4. Incidents of self-harm which result in severe, significant harm may need medical treatment and should be referred to the C-SPA and Emotional Well-being and Mental Health Services for on-going therapeutic support.

5. Contact other professionals for advice. This should include the child or young person's school and may include Emotional Well-being and Mental Health Services (EWMH SPA or PMHT in schools), the School Nurse, and/or the Children's Single Point of Access (C-SPA). (**Assess**)

6. Work with students and their families to ensure appropriate support is in place to address both the self-harming and the underlying issues. (**Manage**)

7. Monitor the situation and communicate regularly with parents/carers. (**Inform**)

8. Support other children and young people who may be affected (**Assess**)

9. If the self-harm incident has involved ingestion, do not to give anything to the child or young person to make them sick or make them want to go to the toilet or flush out their stomach or bowels, the child or young person will need to be assessed in hospital. Details about what has been taken and when must be shared with medical staff.

Information Sharing: A Proactive Approach

The Surrey Safeguarding Children Partnership is committed to ensuring that all agencies work together so that children who experience self-harm receive appropriate help and support at the earliest possible opportunity. Learning from local child safeguarding practice reviews demonstrate how important it is for services to share information effectively and in a timely way. Effective early help and support requires that all workers and agencies are skilled to confidently gain consent and are able to share information appropriately so that needs, and risks are identified, support is offered, and children and young people are safeguarded.

Concerns about information sharing and confidentiality must not be a barrier to the effective safeguarding of children. *Working Together 2018* chapter 1, paragraph 26 reminds us that,

> Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern.[6]

In Surrey, the multi-agency threshold document, *'Effective Family Resilience Surrey - Every Child in Surrey Matters Surrey'* highlights, where consultation is required when working with and sharing information with other services:

> 'Information should be shared in the spirit of openness, transparency and honesty between practitioners, the child and their family; however it is important that you have due regard for the principles of confidentiality and parental consent[7]

In situations where there are indications that early help or targeted support is needed to address current concerns and prevent further incidents, *Effective Family Resilience Surrey - Every Child in Surrey Matters Surrey,* notes, that

> Where the family needs other services to support them, the agency must seek consent from the family and then contact can either be made directly to the other agency or, using the Early Help Hub, advice can be sought about the other services that can be approached'.
>
> Parents should always provide written consent for any referrals and for practitioners to share information. In the spirit of openness and respect it is important that we ask young people who demonstrate understanding and competency[8], especially those aged over 15, to also give their consent.[9]

And

> New referrals for service and referrals on closed cases should be made by completing the Children & Families Multi Agency Request for Support Form attaching copies of the Early Help Plan (where completed) and emailing to the Children's Single Point of Access secure email address: cspa@surreyccgov.uk
>
> 'Unless there is immediate risk of significant harm, the family should be consulted by the referrer and informed of the referral'[10]

Statutory guidance, *Working Together To Safeguard Children 2018*, states that

> Wherever possible, you should seek consent and be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared. You should seek consent where an individual may not expect their information to be passed on. When you gain consent to share information, it must be explicit, and freely given. There may be some circumstances where it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put a child's or young person's safety at risk.[11]

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[6] Ibid

[7] December 2020 *'Effective Family Resilience Surrey - Every Child in Surrey Matters Surrey',* section 5, p. 14

[8] Although Gillick competence is primarily a Health tool, using the same measures, one can assess the young person's competency to consent to an assessment

[9] December 2020 *'Effective Family Resilience Surrey - Every Child in Surrey Matters Surrey',* section 5, p. 14

[10] ibid

[11] HM Government, July 2018, *Working Together To Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, p. 20, Crown Copyright

The Surrey Effective Support Screen should be used by practitioners to describe risk and need and inform decision making and information sharing.

Please see the referral form in Appendix B.

It is always good practice to seek agreement to share information from the child and/or their parents/carers. If a child is at risk of significant harm as a result of self-harm, then information **MUST** be shared with key agencies who are part of the team around the child including, but not limited to

- The parents/carers (except in cases where sharing this information would place the child at additional risk)
- Children's social care
- The school or educational setting (see below)
- The GP
- The School Nurse
- Emotional Well-being and Mental Health services (CAMHS)
- Other identified agencies that play a key role in safeguarding the child and promoting their welfare, who may be part of the safety plan to protect the child,

Self-Harm in Schools: The Essential Role of Schools in Safeguarding

Schools are in *loco parentis*. This is a legal term meaning that schools and education providers are in the place or position of parents when pupils are left in their care. The Children Act 1989 provides that teachers have a duty of care towards the children under their supervision, as well as a role in promoting the safety and welfare of the children in their care. The level of this duty of care is measured as being that of a 'reasonable parent.'

The Role of the Designated Safeguarding Lead (DSL) in Schools

Every school and college should have a designated safeguarding lead who will support staff to carry out their safeguarding duties and who will liaise closely with other services such as children's social care.[12]

All staff should be aware of indicators of abuse, harm and exploitation, which may signal that children are at risk from, or are involved with serious violent crime. These may include increased absence from school, a change in friendships or relationships with older individuals or groups, a significant decline in performance, signs of self-harm or a significant change in wellbeing, or signs of assault or unexplained injuries.[13] The DSL (and any deputies) are most likely the most appropriate person to advise on the school's or college's responses to safeguarding concerns.

The following principles underpin the school's response to self-harm:

- Duty of care is, as always, paramount.
- The child or young person is central to the whole process and should be given appropriate priority by all involved.
- All school colleagues will adhere to a consistent response to and understanding of self-harm.
- The emotional wellbeing and mental health of the child and young person must be supported, and harm minimised.

[12] Keeping Children Safe in Education 2021
[13] Keeping Children Safe in Education 2021

- The child or young person will be supported to access service(s) which will assist the child or young person with opportunities and strategies for hope and recovery from the effects of self-harming and the risk of future harm minimised.

It is reasonable that in incidents of self-harm, that schools have sufficient information to enable them to safeguard the child who has experienced self-harm and to safeguard the other children in their care.

Each school should have in place guidance to staff for dealing with incidents of self-harm.

Each school should ensure that their Home School Agreement with parents/carers includes the expectation that information regarding anything that significantly affects the child's physical and emotional well-being must be shared with the school. The school should also provide parents/carers with assurances that such information will be used sensitively and appropriately to safeguard their child and the other children at the school. The school's response to self-harm should be developed in accordance with the Healthy Schools Approach.

Confidentiality is very important to young people; however, staff must remember that they cannot promise total confidentiality, in line with statutory guidance and their institution's safeguarding policy. Staff should respect wishes around confidentiality if possible, but young people's health, safety and welfare are paramount. If, as a teacher, you become aware that a student is self-harming, you are obliged to share this with your school's designated safeguarding lead. This information would usually be shared with parents/carers too, unless sharing this information would pose a risk of greater harm to the child (e.g. where there is possible abuse at home).

It is important for the DSL to discuss the need to tell parents/carers and other services (e.g. Children's Services) with the child or young person and to listen carefully to any fears they may have. The DSL should explain why the information needs to be shared, how information will be used to support the young person, how they will be involved in the process and seek consent for this information to be shared. A decision should be made in line with the school's safeguarding policy and statutory guidance. Students should be informed when the school contacts parents or carers about self-harm. Self-harm can be a way of feeling in control; by not involving the child the school may exacerbate the student's distress. It may be helpful to invite the parents or carers into school to talk with staff and the student together to try and make sense of the self-harming behaviour and think about ways of supporting the young person. Parental involvement is essential because parents/carers need information so that they can support their son or daughter and access further help and support.[14]

The Role of the School Nurse

School Nurses and their teams have an important role to play in supporting the emotional and mental health needs of school age children and are equipped to work in the community, family and individual levels. Their skills cover identifying issues early, determining potential risks and providing early intervention to prevent issues escalating. Student feedback indicates how much they value the trusted adult role, face to face intervention and other support provided through school nursing teams (PHE 2015).

The school nursing service in Surrey's maintained schools is provided through the 11 borough 0-19 teams. Every school can access their school nurse through their local 0-19 team. If schools are

[14] ibid

unclear of who their school nurse is, they can contact the 0-19 advice line on 01883 340922 who will provide contact details.

Most secondary schools facilitate a school nurse 'Drop In' service. This school nurse contact provides an opportunity for ad hoc 'Drop In' appointments or a more structured booked appointment system. Nurse visits to individual schools may vary in length of time from a lunch hour to a school day. This is dependent on the needs of the school and accommodation that school can provide.

The Drop-In service provides an opportunity for the school nurse to contact students who may have self-referred or been referred by school staff, other professionals or parents. The majority of students present with emotional well-being issues, which may include self-harming behaviours. School nurses who run the Drop-In clinics receive regular emotional/mental health updates and are assessed to deliver this service under the 'School Nurse Drop In Competency Framework'.

Please see the Appendix F: School Nurse Support Pathway

Self-harm at school: what to do?

To be used in conjunction with the school's safeguarding policy

See to **immediate medical needs**

Follow first aid guidelines for cuts, wounds or burns

Contact emergency service for overdoses

Don't panic

Speak to the young person to see how they are feeling and provide support

Listen to what they have to say

Speak to Head of Year, School Nurse, school Counsellor or designated safeguarding lead

Think about **confidentiality**
Should the self-harm be reported to parents/carers?
Make sure the young person knows what will be said and to whom

Think about **circumstance** and **potential risks**
Risk of mental health problems, e.g. depression and anxiety,
Risk of potential abuse
Risk of other students self-harming
Risk of further self-harm
Risk of suicide

Higher concerns

Discuss with CAMHS PMHT or SPA
Involve parents/carers
Initiate referral for specialist care
Consult with CAMHs
Continue with supportive listening while waiting for referral
Refer to C-SPA if immediate risk

Lower concerns

Provide a listening ear
Suggest distraction or emotional release techniques
Help the young person think of more effective coping mechanisms
Consider how stresses at school can be reduced

The Role of Primary Care – GP Surgeries in Assessing and Treating Self-Harm

Primary care has an important role in the assessment and treatment of people who self-harm. Careful attention to prescribing drugs to people at risk of self-harm and their family could also help in prevention.

When a child presents in primary care following an episode of self-harm, healthcare professionals should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the young person.

In the assessment and management of self-harm in primary care, healthcare professionals should refer young persons for urgent treatment to an Emergency department, if assessment suggests there is a significant risk to the individual who has self-injured.

In most circumstances, children who have self-poisoned and present to primary care should be urgently referred to the nearest Emergency department, because the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned, making accurate risk assessment difficult.

If there is any doubt about the seriousness of an episode of self-harm, the general practitioner should discuss the case with the nearest Emergency department consultant, as management in secondary care may be necessary.

Consideration should be given to the child's welfare during transportation to any referral organisation and, if necessary, this should be supervised by an appropriate adult where there is a risk of further self-harm or reluctance to attend other care centres, or the child is very distressed.

Information Sharing for General Practitioners[15]

Confidentiality is central to the trust between doctors and patients and an essential part of good care. Without assurances about confidentiality, children and young people, as well as adults, may be reluctant to get medical attention or to give doctors the information they need to provide good care.

As noted above, young people may be particularly concerned about keeping confidential information from their parents, schools, children's services, the police and other statutory agencies. Young people, parents and other adults receiving psychiatric care, and other vulnerable people might have similarly increased concerns about sharing confidential information.

However, sharing information appropriately is essential to providing safe, effective care, both for the individual and for the wider community. It is also at the heart of effective child protection. It is vital that all doctors have the confidence to act on their concerns about the possible abuse or neglect of a child or young person.

[15] Confidentiality and sharing information - GMC (gmc-uk.org)

Confidentiality is not an absolute duty. GPs can share confidential information about a person if any of the following apply.

a. You must do so by law or in response to a court order.
b. The person the information relates to has given you their consent to share the information (or a person with parental responsibility has given consent if the information is about a child who does not have the capacity to give consent).
c. It is justified in the public interest – for example, if the benefits to a child or young person that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential.

When an urgent referral to an emergency department is not necessary

If an urgent referral to an Emergency department is not considered necessary for children who have self-harmed in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services.

Assessment of the young person's needs should be comprehensive and should include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current intent and hopelessness, as well as a full mental health and social needs assessment.[16]

Self-Harm in Acute Trusts and the Emergency Departments

Acute Trusts should follow NICE guidance in managing incidents of self-harm.

Respect, understanding and choice[17]

Children who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training

Clinical and non-clinical staff who have contact with children who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed. Emergency departments should make training available in the triage and brief risk assessment of mental health needs and the preliminary management of mental health problems, for all healthcare staff working in that environment.

Procedures at Accident and Emergency Department (ED)

1. Emergency admissions to hospital if appropriate and any necessary treatment will take precedence before the initiation of a self-harm referral pathway.

2. If a child/ren who presents to a Surrey Emergency Department following an episode of self-harm and is assessed as being at risk of significant harm a referral must be made within 24 hours to the C-SPA with or without consent in accordance with the Level 4 Specialist level of need in accordance with The Surrey Effective Support Windscreen document. The expectation is that If a decision is made to convene a strategy discussion information will be shared with

[16] Self-harm in over 8s: short-term management and prevention of recurrence (CG16) © NICE 2020. All rights reserved. Subject to Notice of rights (https://www.nice.org.uk/terms-andconditions# notice-of-rights).
[17] Self-harm in over 8s: short-term management and prevention of recurrence Clinical guideline Published: 28 July 2004 www.nice.org.uk/guidance/cg16, © NICE 2020. All rights reserved. Subject to Notice of rights.

the designated safeguarding lead within the child/ren's school so that they are able to fulfil their statutory duty to safeguard children and promote their welfare.

3. When a child presents to an Emergency Department as a result of self-harm, and the level of support required is assessed as Level 3 of the Surrey Effective Support Windscreen the expectation is that consent is sought so that appropriate information is shared sensitively and confidentially with the school so that the school is able to fulfil its duty to safeguard and promote the welfare of the child and other children in its care by offering early or targeted help Emergency Department Staff should proactively seek consent from the child/young person and their family to share this information. A leaflet will be provided to parents and young people explaining the need to give consent to share information and how this information would be used by the school.

4. However, if consent is not given, an assessment of the level of risk to the child must be made and a decision should be taken regarding sharing this information, without consent. If the decision is made not to share this information with the school, this is to be recorded along with the reason/s why this information was not shared.[18]

5. Emergency Department staff should take a proactive approach to seeking consent to sharing information confidentially with the child or young person's school so that the school can provide support and ensure that the child or young person and other members of the school community who could be affected are safeguarded.

6. Children presenting with self-harm will be directed to the appropriate department (Adult or Paediatrics) according to local Hospital policy.

7. Initial assessment will then be carried out by an appropriately trained triage nurse.

8. the child will then be seen by the Emergency Department medical team (as determined by age criteria described above).

9. As a general guide children less than 16 years presenting with high risk mental health needs should be admitted to hospital for observation and assessment. This might not always be possible or appropriate and should be guided by the appropriate mental health trained professional.

10. Children under 18 who present to Emergency Departments with self-harm can be admitted to the paediatric ward (dependant on local hospital policy) if admission is deemed safe and appropriate (In accordance with NICE Guidance regarding young people and self-harm).

11. Psychiatric assessment will take place by child Emotional Well-being and Mental Health services / Paediatric mental health liaison nurse in Emergency Department during working hours and within 24 hours of attendance.

12. The exception to this is cases where low risk is identified. The decision to discharge the young person should only be made in conjunction with EWMH crisis team or the Paediatric mental health liaison nurses or the Emotional Well-being and Mental Health services consultant

[18] This is in accordance with statutory guidance Working Together 2018, chapter 1, paragraph 26, bullet point 3

psychiatrist on-call and follow local hospital policy. The assessing clinician will request a full risk assessment from community services after discharge if the child is not admitted. The completed risk assessment and triage details should be sent with a referral form to rxx.camhscommunitycrisis@nhs.net requesting community triage.

13. Before discharge there must be a risk assessment and a safety plan developed with the child or young person and their carers using local services offers for support. This should be uploaded onto the hospital Medical records as well as Emotional Well-being and Mental Health services records. (See appendix E)

Young people in settings have the right to request the support of a mental health advocate.

The role of the medical and Paediatric teams if the child or young person is admitted to hospital[19]

- To take lead medical responsibility for initial assessment and treatment until the patient is accepted and assessed by another team.
- To treat all children in a respectful and non-stigmatising way.
- To support engagement of children and families, particularly by explaining process in a clear and sympathetic fashion.
- To complete a physical assessment and begin any appropriate treatment.
- To identify any safeguarding issues and refer to Childrens Services if indicated.
- To gather initial psychosocial risk-related history, which should include information about the reasons for self-harm; history of self-harm; a description of mood; the degree of suicidal intent; family circumstances.
- To alert the Paediatric mental health Liaison nurses or CAMHS community crisis team to each child's attendance and need for assessment.
- To consult with emotional well-being and mental health service (EWMH) colleagues as necessary.
- To decide appropriateness of admission to a paediatric ward for 16- and 17-year-olds.
- To declare the patient medically fit and complete discharge paperwork within an appropriate time frame
- Before discharge there must be a risk assessment and a safety plan developed by EWMH community crisis team/Paediatric Mental health liaison nurses or EWMH consultant psychiatrist on-call with the child or young person and their parent/carers.
- For local leads to work in strategic partnership with local service providers to review and plan for the provision of support and management of patients who self-harm.
- For local leads to identify the necessary staffing levels and communicate this to local managers/commissioners; this should include provision for mental health assessments at weekends

Emotional well-being and Mental Health (EWMH) Services[20] formerly known as Child and Adolescent Mental Health Services

[19] Managing self-harm in young people, Royal College of Psychiatrists College Report 192 2014

[20] Self-harm in over 8s: short-term management and prevention of recurrence Clinical guideline Published: 28 July 2004 www.nice.org.uk/guidance/cg16,

Emotional well-being and mental health practitioners involved in the assessment and treatment of children and young people who have self-harmed should:

- be trained specifically to work with children and young people, and their families, after self-harm
- be skilled in the assessment of risk
- have regular supervision
- have access to consultation with senior colleagues who have been trained to level 3 of the intercollegiate framework.

Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed.[21]

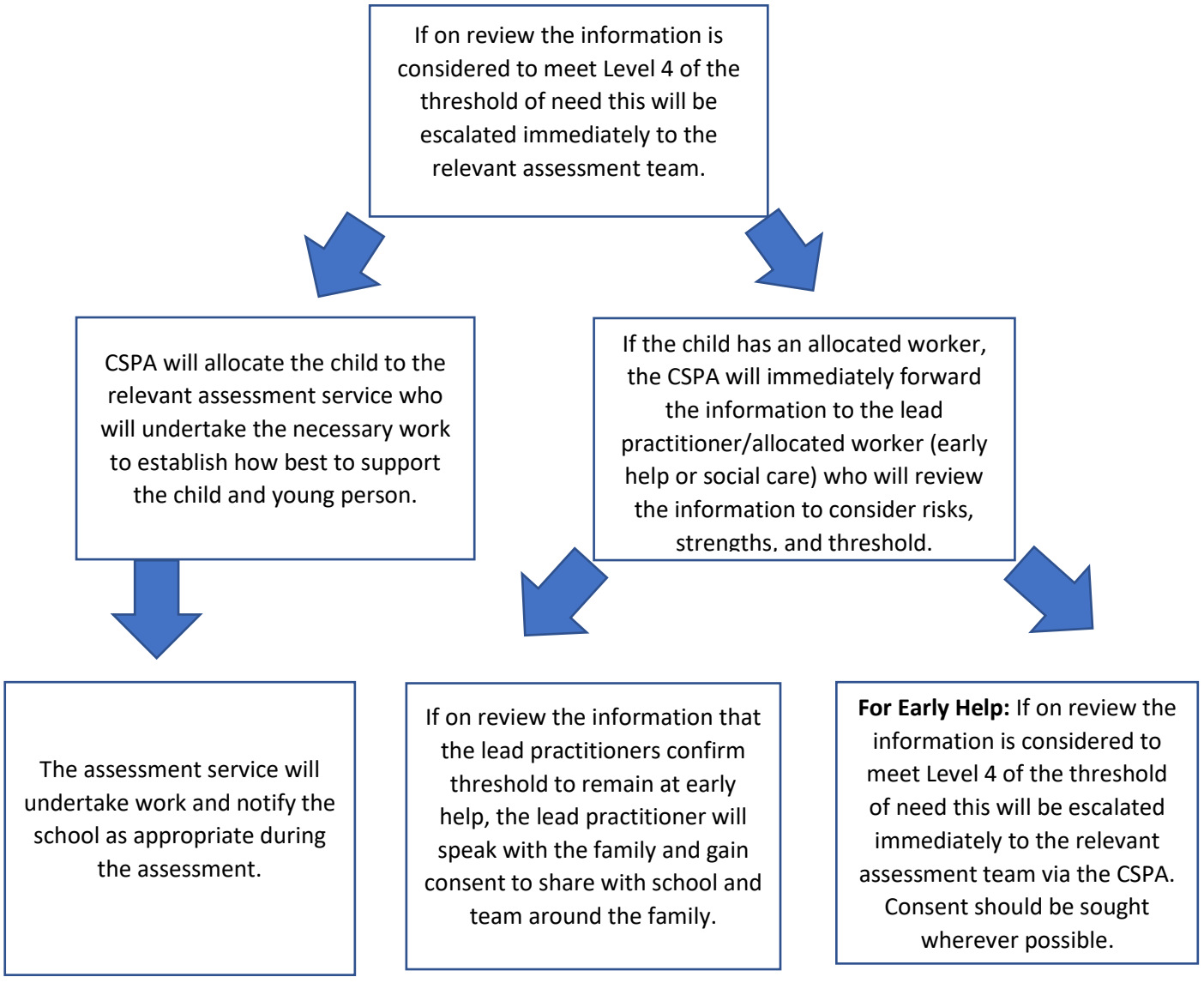
Call EWMH Practitioners Single Point of Access
Call 0300 222 5755. Open 8am - 8pm Monday to Friday and 9am -12pm Saturday.

Crisis Support (non-referral)

[21] Self-harm in over 8s: short-term management and prevention of recurrence Clinical guideline Published: 28 July 2004 www.nice.org.uk/guidance/cg16,

Appendix A: Flowchart for Actions When A Child/Young Person Has Self-harmed and the Child/Young Person Has an Allocated Worker

(This flowchart should be read in conjunction with Surrey's Self Harm Protocol.)



Appendix B: Self-Harm Notification Form

FOR THE ATTENTION OF THE Designated Safeguarding Lead

SELF-HARM NOTIFICATION

ICS NUMBER:

CHILDS NAME:

The CSPA have received notification from (REPORTING SERVICE) that the child named above, who attends your school, has been reported following an incident of self-harm.

REPORTING SERVICE:

INCIDENT DATE:

INCIDENT REPORTED:

SUMMARY OF INCIDENT:

ACTION TAKEN:

All children where a request for support has been submitted have been triaged and support as appropriate. The final outcome is (INSERT OUTCOME).

Appendix C: Initial Response and Gathering Information

Initial information gathering/assessment

(Information that is useful to have so you can discuss the incident with the Child Protection Lead)

1. Be honest with the child and tell them you will have to pass this on to the Child Protection Lead, but you will let them know what's going to happen.

2. Encourage them to remain in the setting until you have discussed the incident with the Child Protection Lead

3. Try to ensure that if they are around in the setting for the rest of the day that they have someone they can come and talk to if necessary.

It is important to write down what the young person says (not always in front of them) as you want to have a record, but it also helps you inform the Child Protection Lead.

SELF-HARM

You have come to me and told me that you have self-harmed…….

Are you willing to show me what you have done? (it may need medical attention) OR

What have you done? Tell me about it? (Different types of self-harm-cutting, hitting, burning) How did this make you feel?

Have you done it before?

Do you plan to do it again?

Have you told anyone else, your parents or carers?

What are you planning to do the rest of the day/ weekend?

This is to check out if they have any support at home or are, they going to be alone?

Now this is out in the open this is what we need to do to support you.....

Mood scale - If you were to think about how you are feeling what number would you be?

1 – Feeling: 'I can't cope'. Or 10 – Feeling: "happy and content."

How would you like to feel?

SUICIDAL thoughts.

You have come to me and told me that you have had these thoughts….

Have you tried to do anything to harm yourself?

Have you made any plans to end your life?

What are you planning to do for the rest of the day or weekend (as above)?

Use the mood scale above.

Appendix D: Supporting Parents

Parents may suspect that their child is self-harming. Parents are worried, they should be alert to the following signs:

- unexplained cuts, burns, bite-marks, bruises or bald patches
- keeping themselves covered; avoiding swimming or changing clothes around others
- bloody tissues in waste bins
- being withdrawn or isolated from friends and family
- low mood, lack of interest in life, depression or outbursts of anger
- blaming themselves for problems or expressing feelings of failure, uselessness, or hopelessness

It can be difficult for parents to know what to do or how to react if they find out that their child is self-harming. UK children's mental health charity, Young Minds, suggests the following things that can really help:

1. Avoid asking the child lots of questions all at once.
2. Keep an eye on your child but avoid 'policing' them because this can increase their risk of self-harming.
3. Consider whether the child is self-harming in areas that can't be seen.
4. Remember the self-harm is a coping mechanism. It is a symptom of an underlying problem.
5. Keep open communication between parent and child and remember they may feel ashamed of their self-harm and find it very difficult to talk about.
6. Parents should talk to their child but try not to get into a hostile confrontation.
7. Keep firm boundaries and don't be afraid of disciplining your child. It is helpful to keep a sense of normality and this will help your child feel secure and emotionally stable.
8. If parents feel confident, they can ask if removing whatever they are using to self-harm is likely to cause them use something less sanitary to self-harm with, or whether it reduces temptation. This can be a difficult question to ask and if you are not confident to ask this seek professional advice.
9. Seek professional help. The child may need a risk assessment from a qualified mental health professional. Parents should talk to their GP and explore whether the child needs to be referred to EWMHs SPA.
10. Discovering and responding to self-harm can be a traumatic experience – it's crucial that parents seek support for themselves. It's natural to feel guilt, shame, anger, sadness, frustration and despair – but it's not parents' fault.[22]

[22] Adapted from Young Minds guidance for parents, https://youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-self-harm/

Appendix E: Model Safety Plan

Here are some other coping methods which young people tell us they find helpful.

- Talk to someone you feel comfortable with.
- You can ring or text one of our recommended helplines.
- Do something you enjoy e.g. drawing, writing, dancing or watching a film.
- Do some light exercise e.g. going for a walk.
- Listen to music.
- Do some relaxation/mindful techniques.

www.sabp.nhs.uk/mindsightsurreycamhs/resources/CYP-help-sheets

Here is a link to some apps that you may want to explore

w ww.nhs.uk/apps-library/category/mental-health/

Useful helplines and websites:

Local to Surrey

CYP Haven www.cyphaven.net for over 10s

Extended Hope via the Emergency Duty Team 01483 517898 – 5pm-11pm every day for over 11s

National

ChildLine 0800 1111 www.childline.org.uk

Family Lives 0808 800 2222 www.familylives.org.uk

Samaritans 116 123 (24/7) www.samaritans.org

Beat 0808 8010 677

www.beateatingdisorders.org.uk

NHS 111

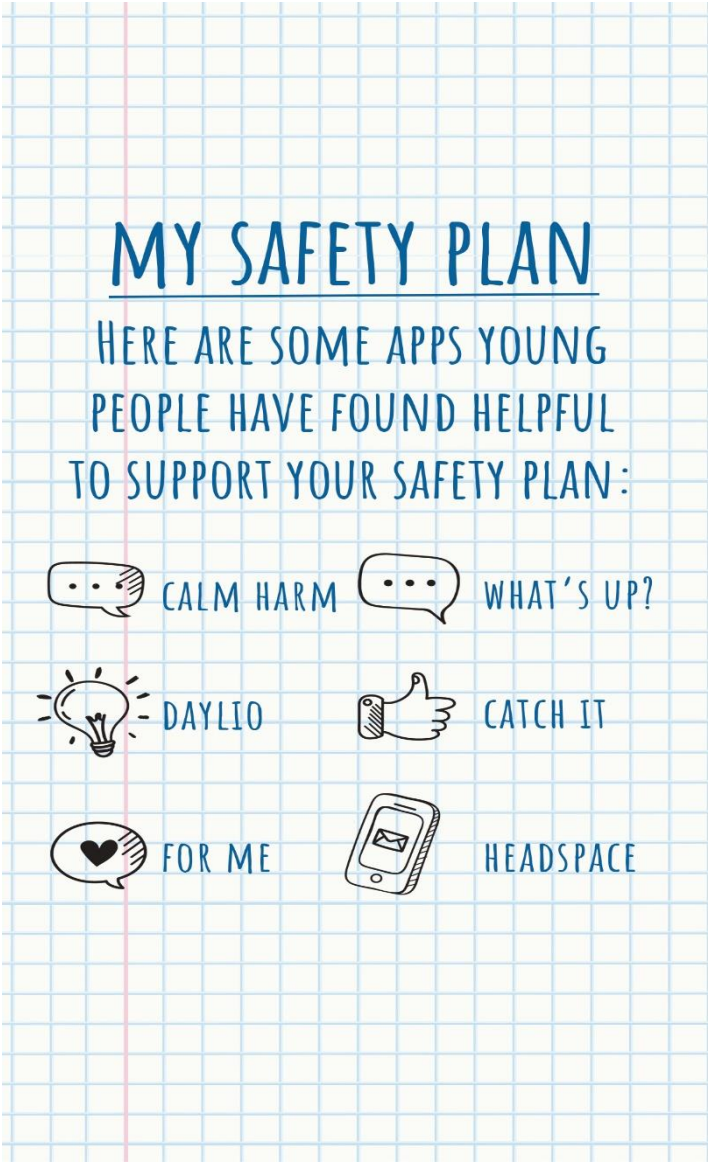
Catch22 08006226662 www.catch-22.org.uk

Young Minds Crisis Messenger text YM to 85258 (24/7)

Papyrus 0800 068 41 41 Text 07786 209697
E-mail pat@papyrus-uk.org
Offering support and guidance on the prevention of suicide

Kooth www.kooth.com
Online support weekdays 12noon–10pm

Weekends and bank holidays 6pm-10pm



Name of young person:
NHS Number:
Date:

If you sometimes struggle or feel distressed, it can be helpful to create a plan. to keep yourself safe when your thoughts feel overwhelming.

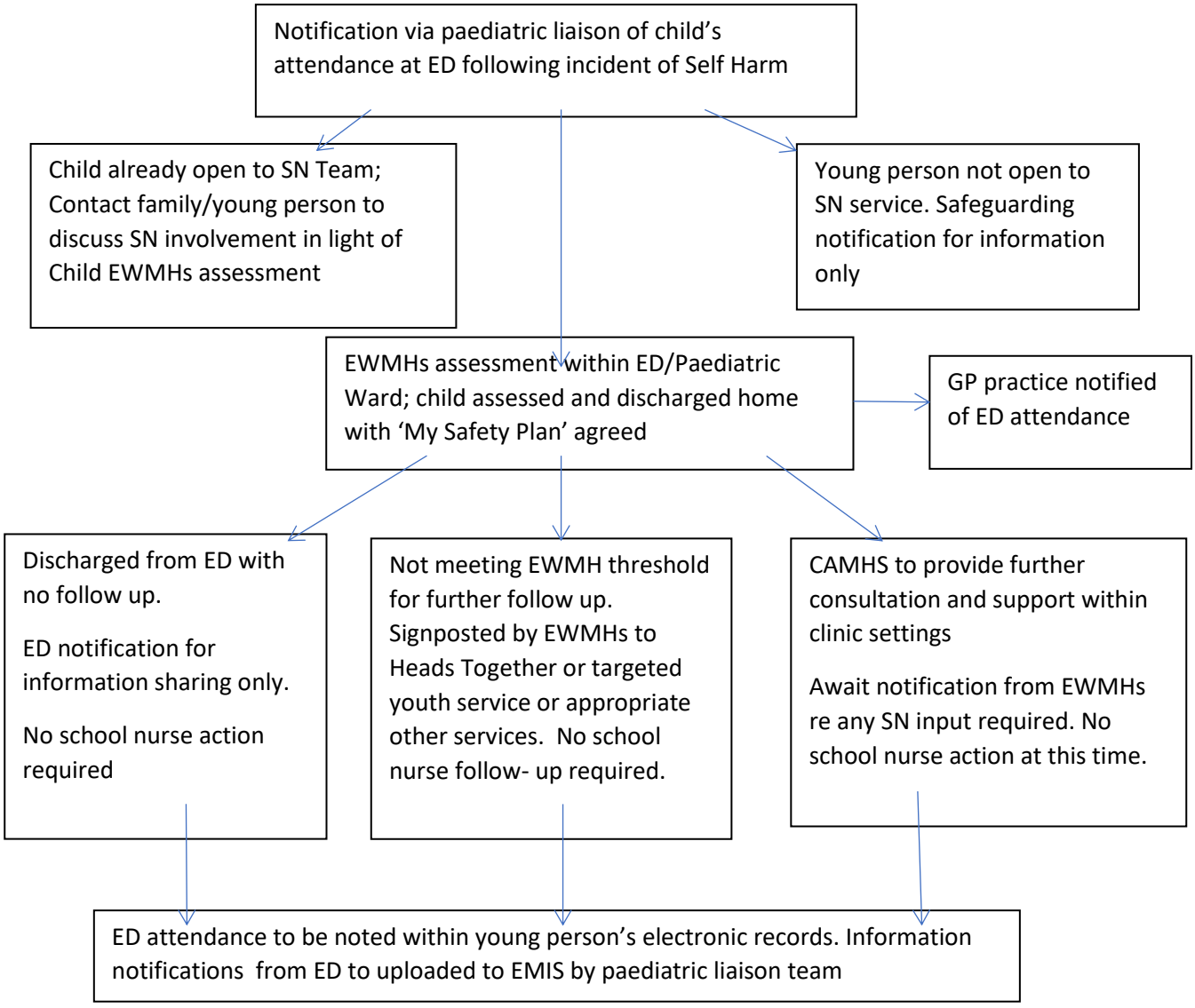
1. These things cause me distress;

2. When I am distressed, this is what you'll see;

3. When I am distressed, I will try these things (what would you tell a friend to do who was feeling this way?)

4. When I am distressed, this is how you can help me;

Appendix F: The School Nurse Support Pathway



Surrey Wide Self Harm protocol to be ratified and distributed June 2021, with further multi-agency training available, including multi-agency use of 'My Safety Plan'

Parental responsibility to share information with school staff following ED attendance and share young person's 'my safety plan' with key school pastoral staff.

Appendix G: Substitutes for Self-Harm

Young People have shared successful techniques with professionals. These include:

- Using a red felt tip pen to mark where you might usually cut.
- Hitting a punch bag to vent anger and frustration.
- Hitting pillows or cushions or having a good scream into a pillow or cushion.
- Rubbing ice across your skin where you might usually cut or holding an ice-cube in the crook of your arm or leg.
- Getting outdoors and having a fast walk.
- All other forms of exercise – these are really good at changing your mood and releasing adrenaline (but not obsessively).
- Making lots of noise, either with a musical instrument or just banging on pots and pans.
- Writing negative feelings on a piece of paper and then ripping it up
- Keeping a journal.
- Scribbling on a large piece of paper with a red crayon or pen.
- Putting elastic bands on wrists, arms or legs and flicking them instead of cutting or hitting.
- Calling and talking to a friend (not necessarily about self-harm).
- Collage or artwork – doing something creative.
- Getting online and looking at self-help websites.
- Using PVA Glue to cover appropriate areas and peel off.

Appendix H: Signs and Symptoms

Self-harm can take many different forms and as an individual act is hard to define. However in general self-harm (also known as self-injury or self-mutilation) is the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and/or self-neglect.

Physical harm can take many forms. It could include:

- Cutting,
- Burning,
- Biting
- Substance abuse
- Excessive exercising
- Inserting objects into the body
- Head banging and hitting
- Taking personal risks
- Picking and scratching
- Neglecting oneself
- Pulling out hair
- Eating disorders
- Overdosing and self-poisoning

Situations that can trigger self-harm:

- Relationship problems with partners, friends or family
- Pressures e.g. school- work and exams, sporting performance, family issues
- Bullying
- Trying to fit in (some social groups are more accepting of self-harming behaviours)
- Feeling bad about one's self (guilt, shame, worthlessness)
- Physical, emotional or sexual abuse
- Feeling depressed
- An illness or health problem
- Confusion about sexuality
- Bereavement
- Financial worries
- Young people may be more likely to self-harm if they feel:
- That people don't listen to them
- Hopeless or worthless
- Isolated, alone
- Out of control
- Powerless – it feels as though there is nothing, they can do to change anything
- Unable to experience emotional pain even for a short period of time.

Appendix I: The role of Emerge Advocacy within acute hospitals

Emerge Advocacy is a registered charity (1171851) (www.emergeadvocacy.com) which provides support for young people (up to the age of 25) attending acute hospitals because of self-harm, suicidal ideation or emotional crisis. Emerge is a complementary service that works alongside and adds value to the care provided by NHS and statutory partners, benefitting the patient experience and alleviating pressure on NHS staff. Emerge's role is to offer non-clinical support and befriending to young people, reducing anxiety and encouraging them to engage effectively with clinical professionals. Emerge also offers follow up support to young people after they leave hospital. The team is there to ease the young person's journey through a mental health crisis admission and help them engage as fully as possible with statutory services so they can get the best care and help going forward.

Operational details and procedures

Emerge teams operate within Standard Operating Procedures and Safeguarding Policies which are signed off by Clinical Leads within each hospital trust where Emerge works. The team are comprised of staff and volunteers who are suitably trained and experienced. Emerge Advocacy appoints a staff member as Project Lead for each hospital trust, who delivers the project alongside a team of volunteers who they train, oversee and support. The teams come under the governance of the Trust's Voluntary Services Department, undergoing Enhanced DBS, Occupational Health clearance and all relevant training through the Trust, in addition to specific training delivered by Emerge Advocacy.

Emerge teams escalate safeguarding concerns as per the Trust's policies and procedures when operating within the Trust and escalate concerns directly through the Single Point of Access when engaged in follow up work.
The team are available in hospital from 7pm – 11pm on the agreed evenings of operation and operate an open referral policy, accepting referrals by phone on 07534 331 455 or in person.