Enfield Safeguarding Children Board
...because safeguarding children is everybody's business

Self-Harm Protocol

For all agencies who work with children and young people

Authors	Deborah Perriment (Trust Lead for Safeguarding) Dr Mark Nathan (Named Doctor for Safeguarding) / Nicholas Clarke (Consultant Clinical Psychologist) Suzy Francis (Principal Educational Psychologist, LBE)	Classification	OFFICIAL - PUBLIC	Date of First Issue	
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1. Protocol Scope and Aims

This protocol is for all professionals working in Enfield with children and young people under 18 years of age to support them both in the prevention and response to incidents involving self-harm:

- To support agencies to manage self-harm in a timely way, as it arises
- To improve responses to the presentation, disclosure or suspected signs of self-harm
- To improve the quality of support, advice and guidance, offered by all workers.

The protocol sets out a framework for multi-agency response; it does not aim to replace individual agency guidance where this already exists. The protocol is in line with the guidance of the London Child Protection Procedures[1] and the recently reviewed guidance for health professionals form the National Institute of Clinical Excellence (NICE) Short Term management and Prevention[2] and Long Term Management[3] guidance

2. Background

Self-harm is a serious public health problem and is the reason for many admissions to accident and emergency departments every year. Following learning from a recent serious case review, the LSCB identified a need for a detailed, multi-agency self-harm protocol. Self-harm and suicidal threats by a child/young person puts them at risk of significant harm, and should always be taken seriously and responded to without delay. In Enfield we will deliver timely, consistent, proportionate and safe responses to presenting self-harm concerns.

3. Definitions and context

Self-harm can take many different forms and includes self-injury or self-mutilation. It is the act of deliberately causing harm to oneself either by physical "injury or self-poisoning irrespective of the apparent purpose of the act"[2]. It may also be linked to putting oneself in dangerous situations and/or self-neglect. "Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm themselves"[2]

Self-harm is a way of coping with difficult or overwhelming situations or emotional states and not always linked to suicidal thoughts. However, some individuals that self-harm may go on to attempt suicide.

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, banging, hair pulling;
- Self-poisoning including overdoses of tablets or medicines;
- Not looking after their needs properly emotionally or physically;
- Direct injury such as scratching, cutting, burning, hitting yourself, swallowing or putting things inside;
- Staying in an abusive relationship;

[1] London Child Protection Procedures 5th Edition 2016 http://www.londoncp.co.uk/chapters/self_harm_suic_behv.html
[2] NICE Clinical guideline 16: Self-harm in over 8s: short-term management and prevention of recurrence (2004 with 2016 updates) https://www.nice.org.uk/guidance/cg16
[3] NICE Clinical guideline 133: Self-harm in over 8's Long Term Management (2011 with 2016 updates) https://www.nice.org.uk/guidance/cg133

- Taking risks too easily;
- Eating distress (anorexia and bulimia);
- Addiction for example, to alcohol or drugs;
- Low self-esteem and expressions of hopelessness.

Self-harm is common, especially among younger people. A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year. For all age groups, annual prevalence is approximately 0.5%. Self-harm increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above the rest of the population in a 12-month period. A wide range of psychiatric problems are associated with self-harm.[3]

Any child or young person, who self-harms or expresses thoughts about this or about suicide, must be taken seriously and appropriate help and intervention, should be offered at the earliest point. Any practitioner, who is made aware that a child or young person has self-harmed, or is contemplating this or suicide, should talk with the child or young person without delay[1].

4. Responding - taking protective and supportive action[1]

A supportive response demonstrating respect and understanding of the child or young person, along with a non-judgmental stance, are of prime importance in developing a trusting, engaging relationship with young people. It is also important to ensure that people are fully involved in decision-making about their treatment and care and to try to ensure continuity of the professionals involved whenever possible.

Many children and young 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. Assumptions should not be made about the reasons for self-harm and each episode needs to be treated individually.

It is important that accurate contemporaneous records, of what the young person says and the actions that you take, are kept in line with your agency policies. Self-harm is always a safeguarding incident.

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.

Be honest with the young person and tell them you will have to discuss this with your colleagues; this will include your child protection lead in an educational or youth setting but say that you will let them know what is going to happen. Encourage them to remain in the setting until you have discussed the incident with your manager or the Child Protection Lead.

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 they may cover up their distress.

In a crisis situation where a child presents with a serious injury or has taken an overdose, you should ask for help from a colleague and seek immediate medical attention using usual first aid and emergency services as needed.

It is usual to refer all cases of recent self-poisoning to an emergency department as the quantity and exact nature of the substances ingested may not be known or accurately stated. The child or young person should not be encouraged to vomit. Any remaining substances should be taken to the emergency department to help identify the treatment.

A flow chart to support the action to be taken in educational or children and young people settings is included at Annex A and B and in the emergency department at Appendix C however these flowcharts are not intended to replace fuller local guidance within agencies.

Once immediate physical safety has been ensured, if there is the time and opportunity within your service, explore the following in a private environment, not in the presence of other pupils or patients 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?

Risk Assessment[1]

An assessment of risk should be undertaken at the earliest stage by an appropriately trained profession (such as the Child Protection Lead) and should consider the child or young person's:

- level of planning and intent;
- frequency of thoughts and actions;
- signs of depression;
- signs of substance misuse;
- previous history of self-harm or suicide in the wider family or peer group;
- delusional thoughts and behaviours;
- 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 support needs of other children and young people who are aware of the self-harm and the risk of associated self-harm should also be assessed and considered

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

5. Information sharing and consent

Professionals involved should work with young people and their families to ensure appropriate support is in place to address both the self-harming and the underlying issues and maintain regular communication with them. This may involve making a referral to other agencies such as their GP, Children's Social Care or the Child and Adolescent Mental Health Services (CAMHS) and a range of other services.

To assess the child or young person's needs and the risks they may be exposed to, information needs to be gathered and analysed. 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 Gillick Competency/Fraser guidelines should be used.

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

- The situation is urgent and there is not time to seek consent;
- 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.

Annex E contains further information and links to documents that children, young people and their families may find helpful.

Referral to Local Authority Social Care[1]

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 Common Assessment Framework (CAF) support service or they may be likely to suffer significant harm, which requires child protection services under s47 of the Children Act 1989[1].

This referral for an assessment of Early Help, Child in Need or Child Protection should be made through the Enfield Single Point Of Entry (SPOE) Tel: 0208 379 555 or out of hours 0208 379 1000.

A referral should be made to the SPOE if the professional or their child protection lead believes that there is a risk of harm to the child and **must** always be referred if any of the following apply:

- The child's actions could have resulted in their death or serious injury and required A&E or hospital admission.

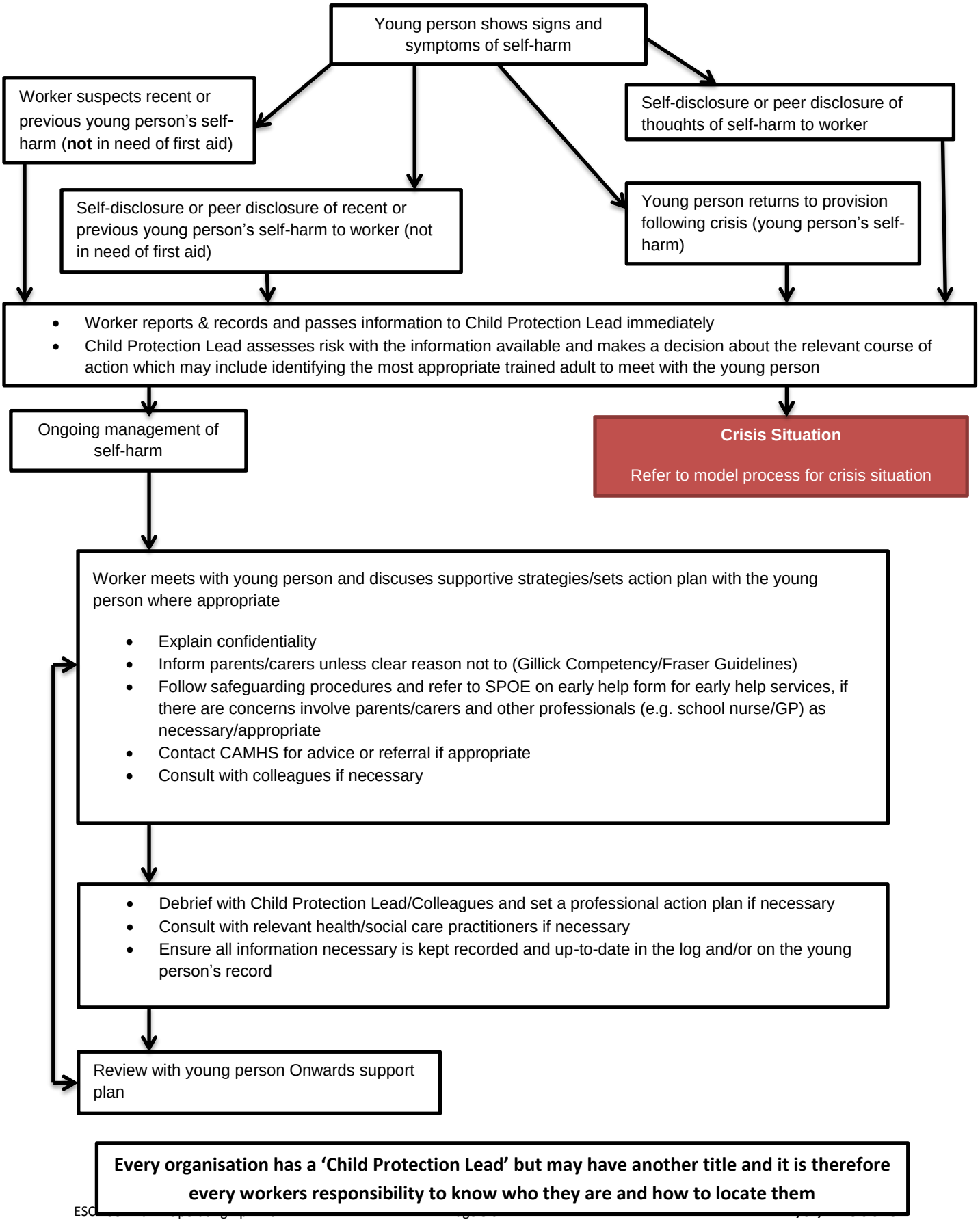
- The intervention and support work with a child or young person is failing to reduce the risk of self-harming behaviour.

- Evidence and risk factors suggest child protection issues may form part of the motivation for self-harm. This includes bullying, and abuse within gangs and child sexual exploitation.

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[1].

Dr Mark Nathan - Named Doctor for Enfield

6. Annex A: Model process for managing self-harm (if NOT in need of urgent medical treatment) (in education and similar settings)



7. Annex B: Model process for managing self-harm in a crisis situation) (in education and similar settings)

Worker suspects young person has self-harmed and is in need of immediate medical attention

- Assess immediate risk
- Call for help from colleague/Emergency Services
- Administer First Aid
- Keep calm and give reassurance – to the individual young person and to all those who might be affected by witnessing self-harm (adults and young people)

- Contact emergency services if injury is life-threatening or if young person is suicidal
- If the child/young person is taken to hospital, emergency protocols for treatment and care will be implemented and a CAMHS referral will be activated by the hospital
- *On young person's return to provision, refer to process for managing recent/historical self-harm*

- Report and record injury and inform Child Protection Lead as per procedure
- Complete a children's services referral form with consent if possible risk for the medium term
- Explain confidentiality to workers and young people involved

Still has concerns

Practitioner refers to Social Services, following up electronically in writing within 48 hours

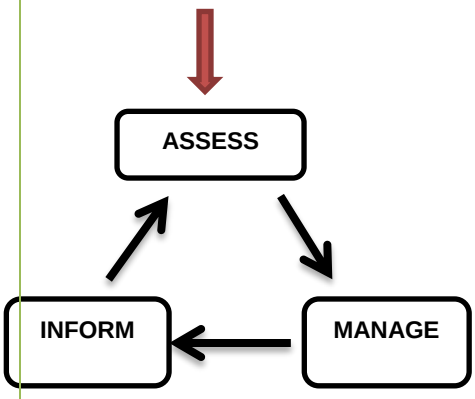
Social Worker and Manager acknowledge receipt of referral and decide on next course of action within 1 working day

- Inform parents/carers unless clear reason not to

- Where young person is not taken to hospital, seek advice and refer to CAHMS where appropriate
- Refer process for managing recent/historical self-harm

Refer to ongoing management of self-harm

ALWAYS



Every organisation has a 'Child Protection Lead' but may have another title and it is therefore every workers responsibility to know who they are and how to locate them

8. Annex C: Managing Acts of Self-Harm – Attendance at Emergency Department (ED)

I. If the self-harm act has occurred and involved ingestion, serious lacerations or an excessive dose /omission of prescribed medication, the child or young person should attend the ED Department.
II. When an overdose is revealed 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.
III. If the self-harm incident has involved ingestion, **do not** give anything to eat or drink.

The clinical care of a child or young person in the care of an emergency health service including the ambulance services, an A&E or an ED Department will be guided by the current evidence base. This is outlined in the NICE Clinical guideline 16: Self-harm in over 8s: short-term management and prevention of recurrence (2004 with 2016 updates) https://www.nice.org.uk/guidance/cg16

The following outlines the structure of health service involvement

Procedures at Accident and Emergency Department (ED)

I. Emergency admissions to hospital and related care will take precedence before the initiation of a self-harm protocol.
II. All children and young people who attend ED must be **referred by ED** to SPOE as soon as possible and within 24 hours of being assessed at ED.
III. Children and young people presenting with self-harm will be directed to the Paediatric ED department up to their 16th birthday. Thereafter they will usually be directed to the general (adult) ED.
IV. Initial assessment will then be carried out by an appropriately trained triage nurse.
V. The child or young person will then be seen in a timely fashion by the ED medical team (as determined by age criteria described above).
VI. As a general guide ALL children less than 16 years presenting with self-harm should be admitted to hospital for observation and assessment.
VII. Young people aged 16 years up until their 16th birthday who present with self-harm can be admitted to the paediatric ward if admission is deemed safe and appropriate.
VIII. 16 year olds requiring admission for ongoing medical treatment will be referred to the on call medical team and admitted to an adult medical ward. Psychiatric assessment will take place once medical treatment is complete. If ongoing medical treatment is not required they will be assessed by Liaison Psychiatry in ED. If there is a delay then they will be admitted to the observation ward.
IX. The exception to this is cases where no increased or ongoing risk is identified. This decision should only be made in conjunction with the CAMHS on call consultant.
X. Before discharge there must be a risk assessment and a Crisis and Contingency Plan developed with the child or young person and their carers.

9. Annex D:

It is best not to ask questions in a scripted check list form as they may appear impersonal but these questions may help you to plan your discussions.

10. Annex E: Supporting Guidance and Advice

For professionals

http://www.londoncp.co.uk/ London Child Protection Procedures

http://www.londoncp.co.uk/consultation/self_harm_suic_behv.html

NICE Clinical guideline 16: Self-harm in over 8s: short-term management and prevention of recurrence (2004 with 2016 updates) https://www.nice.org.uk/guidance/cg16

NICE Clinical guideline 133: Self-harm in over 8's Long Term Management (2011 with 2016 updates) https://www.nice.org.uk/guidance/cg133

www.nhs.uk/conditions/Self-injury/Pages/Introduction.aspx

For young people and their families

www.rcpsych.ac.uk/healthadvice/parentsand youthinfo/youngpeople/ucancope.aspx

http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/self-harm.aspx

www.mentalhealth.org.uk/help-information/mental

www.youngminds.org.uk

www.mind.org.uk

www.nshn.co.uk

www.childline.org.uk Childline 0800 1111

www.samaritans.org.uk Samaritans 08457 909090

www.beatbullying.org

www.anti-bullyingalliance.org.uk

https://www.bigwhitewall.com/landing-pages/landingv3.aspx?ReturnUrl=%2f

http://www.rcpsych.ac.uk/expertadvice/youthinfo.aspx

http://www.rcpsych.ac.uk/usefulresources/publications/books/titlesbyspecialty/childandadolescent.aspx

http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingoverwhelmed.aspx

http://www.rcpsych.ac.uk/press/pressreleases2012/feelingontheedgeleaflet.aspx