

Suicide Prevention Pathway

for Children and Young People in Sheffield

March 2017



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“ There is no evidence that asking a young person whether they are having suicidal thoughts will put the thought into their mind if it were not there before. There is, however, a great deal of evidence to suggest that being able to talk to clients about suicide is extremely important in providing a safe space for them to explore their feelings. ”

Rudd (2008), Barrio (2007)

Foreword

Jane Haywood, Chair of Sheffield Safeguarding Children Board

Young people have told us that mental and emotional health difficulties are a major issue for our young people in Sheffield. We believe that keeping our children and young people safe should be at the heart of our city, our communities and our services. Our partners are clear that supporting those children and young people at risk of suicide is a vital element of our work.

The document helps us to understand the risks of suicide and the impact on young people. It tells us that:

- 1 in 10 suicides are of young people aged 15 – 24;
- 44% of LGBT young people have considered suicide;
- 1 in 4 young people experience suicidal thoughts;
- Young men are at higher risk than young women;
- Children who have been in care and care leavers are most at risk.

We know that an effective multi agency response can make a difference to those most at risk so this document sets out how we will work in partnership to reduce the risk and support those most in need. Our strategy will:

- Ensure that young people will receive the information and advice they need to support them through schools, the Youth Information, Advice and Counselling Services (YIACS) and a range of services and professionals.
- Provide learning and development so that our colleagues have the skills and knowledge to provide support at the right time and in the right way.
- Provide a systematic approach to identifying and assessing need, risk guidance, a care pathway and a wide range of supporting information and guidance.

As we move forward we will be working with young people to develop additional young people friendly materials and support and our YIACS provision will provide a safe space for young people experiencing mental and emotional health difficulties and social isolation, as part of a one stop shop where young people can receive a range of support.

I am confident that our partners and colleagues in Sheffield will do all they can to deliver this strategy. I hope that you are able to work with us to help keep the children and young people of Sheffield safe from the risk of suicide.

Introduction and Vision

Suicide is the leading cause of the death of young people aged 20-34 in the UK (Papyrus, Mental Health Foundation); it represents a major gender and social inequality and is a devastating event for families and communities. Evidence informs us that men are 4 times more likely to complete suicide than women because they are less likely to seek help. Talking about suicidal thoughts is still stigmatised and can be a difficult but lifesaving conversation for children and young people affected by depression and anxiety.

Sheffield Suicide Prevention Pathway for Children and Young People outlines our commitment to work together to reduce suicide by ensuring that the workforce are trained and equipped to assess and respond to need, and that children and young people can access support and advice. It is aligned to the emerging Sheffield Suicide Prevention Strategy.

Suicide is defined by the World Health Organisation (WHO) (www.who.int/topics/suicide/en/) as:

“The act of deliberately killing oneself. Risk factors for suicide include mental disorder (such as depression, personality disorder, alcohol dependence, or schizophrenia), and some physical illnesses, such as neurological disorders, cancer, and HIV infection. There are effective strategies and interventions for the prevention of suicide.”

In 2016, the suicide definition was revised to include deaths from intentional self-harm in children aged 10 to 14. The number of deaths from intentional self-harm in 10- to 14-year-olds is very low, as is the number of deaths where the intent was undetermined. Nationally there were 24 child suicides in 2014, which is the highest since 2007 when there were 25. (Office for National Statistics (ONS), National Records of Scotland and Northern Ireland Statistics and Research Agency).

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In the UK, a coroner is able to give a verdict of suicide for those as young as 10 years old. However, rates per 100,000 are provided by the ONS for ages 15 years and over. This is because of the known subjectivity between coroners with regards to classifying children's deaths as suicide, and because the number in those aged under 15 tends to be low and their inclusion may reduce the overall rates.

Suicides by 10 to 29 year olds increased throughout the mid-1980s up until the late 1990s before showing a steady decline until 2005. Since then, the rate has remained relatively stable. This age group has consistently had the lowest suicide rate since 2001. (ONS 2014)

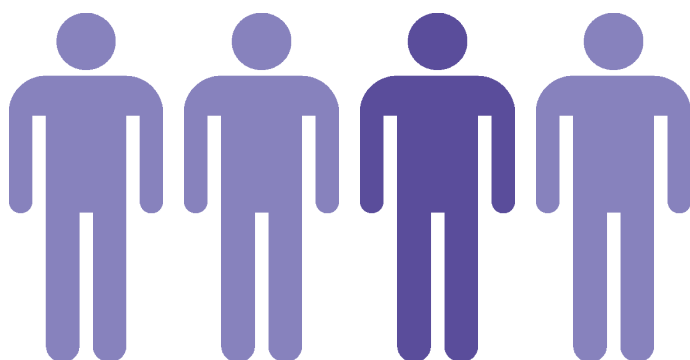
There has been a decreasing trend in the UK suicide rate until around 2007. Since 2007 there has been a general increase and suicide in the UK is now again at the level it was in 2004. It is widely accepted that the rate of suicide is under reported due to the difficulty in establishing intent in cases of death by road traffic accident or in cases of long term illness, and also due to the stigma in relation to child deaths and some cultural and religious attitudes towards death by suicide.

Reducing and preventing suicides means reaching more people who may be at risk which can only be achieved by understanding which groups of individuals are particularly at risk of suicidal thoughts and behaviours.

A related area for concern is maternal mental health problems during the perinatal period, which may have the potential to affect a child's relationship with their parents, and their emotional health and well-being. In tragic cases which result in a maternal suicide the effects on the family can be devastating.

Effective and timely support in the perinatal period can significantly improve outcomes for both mothers and infants thus minimizing the long term impact on a child's emotional and cognitive development. Sheffield has developed an integrated perinatal care pathway to respond to these needs in a timely and effective way which is part of a wider approach to improve mental health services in the ante-natal and post-natal period. This work includes drawing on the skills and expertise of professionals working across sectors alongside specialist provision, with the common aim of providing timely interventions and preventing needs from escalating.

1 in 10
suicides in the UK are
by 15-24 year olds.
Samaritans suicide statistics report 2014



One in four young
people experience
suicidal thoughts.

The Princes Trust Maquarie Youth Index 2014

The following information is taken from the Young Minds website:

- One in 10 suicides in the UK are by 15-24 year olds (Samaritan suicide statistics report 2014)
- One in four (26%) of young people experience suicidal thoughts (The Princes Trust Maquarie Youth Index 2014)
- Over 34,500 counselling sessions were delivered by Childline UK with suicidal young people in 2013-14, over 100% increase from 2010-11 (Childline 'On the Edge' Report 2014)
- Looked After Children and care leavers are between 4- 5 times more likely to attempt suicide in adulthood (Children and Young People's Health Outcome Forum)
- 44% of LGBT young people have considered suicide, often directly related to bullying (Youth Chances Survey Metro Charity and University of Greenwich 2014)
- Asian women aged 16-24 are 3 times more likely to die by suicide than their white counterparts (Self-harm and Suicide amongst Black and Minority Ethnic Women BEMIS Report)
- 34% of young people in gangs have attempted suicide ('A Need to Belong' Centre for Mental Health 2013)
- Young offenders, homeless young people, young people with disabilities and NEET are all vulnerable to increased risk of suicide.
- Up to 160 young people under the age of 20 die by suicide each year, 60-70 are under 18. Only 14% of under 20's who died by suicide were in contact with mental health services. (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013)
- It is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women take their own lives (Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office).
- In the study 'Suicide by Children and Young People in England – May 16 conducted by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) it was found that of deaths by suicide during the period of the study 'Under 18s more often had mental illness, substance misuse or domestic abuse in their family.'
- SafeLives Young people and interpersonal violence: final data report from the young people's programme 2015 (review of young people receiving IDVA support) found that Mental health issues were a concern for the majority of young people supported, yet few accessed specialist support. Two in three young people supported were experiencing depression or anxiety. Many young people disclosed self-harm, sleep problems or eating disorders.
- Emotional well-being was the most frequently recorded area of concern at both case engagement and case closure. Case holders supported the majority of young people with their health and well-being. A minority of young people accessed help from specialist mental health services. Of all young people whose cases had closed, one in four were referred for counselling and fewer than one in ten were receiving support from Child and Adolescent Mental Health Services (CAMHS) at the point of case closure. 11% of the case load had planned or attempted suicide.

Local findings of the Child Death Overview panel

In Sheffield there have been very few suicides by children and young people under 18. Data collected by the Child Death Overview Panel over the last 7 years reflects that the majority of these were of males with interpersonal difficulties, a history of self-harm and substance misuse. Some of these children and young people had diagnosed mental health disorders and/or parents with mental health disorders. A family history of suicide was a factor in a minority of cases, as was loss. Parental separation or divorce was a feature of the lives of the majority of these young people. Abuse and minority sexual orientation were cited in one case.

Impulsivity was considered to be a factor in some cases, as were adverse childhood experiences, limited educational attainment, low socio-economic status and homelessness. This reflects the broad spectrum of experiences which could contribute to thoughts or attempts of suicide in a minority of children and young people, and which are part of the life experience of many more. It reinforces the importance of addressing the broader risks and inequalities that underlie a sense of powerlessness and entrapment that can tip children and young people into suicidal thoughts and behaviour.

Reducing risk for children in care and young people leaving care, BAME, new arrivals and unaccompanied asylum seekers

Children in care experience multiple vulnerabilities which increase the risk of suicide. Around 60% of looked-after children and young people have emotional and mental health problems and a high proportion experience poor educational, health and social outcomes after leaving care. One-third of children and young people in contact with the criminal justice system have been looked after ('Children looked after in England, including adoption' NICE 2014).

Interventions that focus on increasing the ability to have meaningful relationships, attachment figures and a sense of belonging will reduce risks. The NICE/Scie guidance (2010) and the Quality Standard for the health and well-being of looked-after children (2013) emphasise the need for warm and nurturing care in order to achieve long-term physical, mental and emotional well-being. Stable education built on high aspirations is also essential to promoting the quality of life for looked-after children and young people whose transition to adulthood can often be traumatic. Without access to services to support this transition young people can end up unemployed, homeless or in custody, experiencing a downward spiral of rejection. NICE Guidance states that health and social care services include dedicated services to promote the mental health and emotional well-being of looked-after children and young people, and to support young people in the transition to independence. Services should be designed to help children and young people with particular needs, including those from black and minority ethnic backgrounds, unaccompanied asylum seekers and those with disabilities.

A disproportionate number of children and young people in care are from black and minority ethnic backgrounds and have particular needs. There are also other groups of looked-after children and young people, such as unaccompanied asylum seekers or those who are LGBT, who have particular needs. Services should be sufficiently diverse and sensitive to meet the needs of these groups.

The strategy ensures that carers have training and support to identify and respond to risk and that services are available to children in and leaving the care system with key priorities:

- Commissioning of services up to the age of 25 that support young people's transition leaving care.
- Providing access to a range of health and practical support for independent living.
- Developing opportunities for care leavers to engage in education, training and employment.

The NICE pathway contains recommendations about providing flexible and accessible mental health services and support for looked-after children and young children (including those from Black, Asian and Minority Ethnic (BAME) groups and unaccompanied children and young people who may be seeking asylum).

The Local Vision

The Samaritans Suicide Prevention Strategy 2015-21 states that:

“Ensuring that there is an effective local multi-agency response will be an important part of suicide prevention in the years to come and we will continue to advocate for investment and action in this area. National suicide prevention strategies are in place in England, Scotland, Wales, Northern Ireland and the Republic of Ireland but it is essential that these strategies are fully implemented through local action plans.

These local plans can include measures known to reduce the risk of suicide, such as:

- *Suicide prevention training*
- *Improved follow-up support for people attending A&E after self-harm or*
- *A suicide attempt*
- *Safety measures at high-risk locations for suicide*
- *Local specialist suicide bereavement counselling/support groups”*

The Sheffield vision for suicide prevention and care for children and young people at risk, is to ensure that through making information and support available to young people and training and resourcing those supporting them that they can cope with suicidal thoughts and feelings.

We will endeavour to ensure that all children and young people in Sheffield are aware and able to access support and information through schools and communities, targeting the most vulnerable groups, and commissioning services that support direct access to comprehensive care pathways.

We will provide training and resources to professionals in schools and children’s services to identify and respond to need at an early stage, supporting resilience and preventing suicide amongst children and young people.

“Improved services for self-harm and access to CAMHS are crucial to addressing suicide risk but the antecedents identified in this study make clear the vital role of schools, primary care, social services, and youth justice.”

“Agencies that work with young people, especially in health, social care and education, as well as families and young people themselves, can contribute to suicide prevention by recognising the pattern of cumulative risks and “final straw” stresses, e.g. relationship problems or exams, that leads to suicide.”

Manchester University, 2016. ‘Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).’

Healthy Minds Framework

The government task force report Future in Mind 2015 highlighted the need for transformation of emotional well-being and mental health support for children and young people, with more emphasis on early intervention and prevention to stop emotional well-being needs developing into mental health disorders, placing less demand on resource intensive mental health services.

Identification of risk, prevention and early intervention work takes place in schools through pastoral support, completion of Family Common Assessment Framework (FCAF) and access to support through Multi-Agency Support Team (MAST). Information about the Emotional Health and Well Being (EHWB) offer from statutory and voluntary sector providers will be available on the Learn Sheffield website and in the Let's Talk Directory for schools to access or commission in response to need. The Healthy Minds Framework will be introduced in a phased roll out across the city during the 2016/17 academic year, using the model developed by the CAMHS school link pilot.

The Healthy Minds Framework is a whole school emotional well-being approach, which enables CAMHS staff and schools to work closely together to improve mental health support in school. The framework is split into three levels – bronze, silver and gold. The bronze and silver levels focus on workforce development and support to enable schools to deliver evidence based interventions. The gold level focuses on vulnerable children and young people with identified mental health needs, schools which achieve the gold level are able to refer directly into CAMHS.

Youth Information Advice and Counselling Service

The development of a Youth Information Advice and Counselling Service (YIACS) is part of the Future in Mind transformation plan to provide a one-stop-shop provision for young people through a central hub of co-located services. It is a partnership between voluntary and statutory organisations, managed by Sheffield Futures, including:

- Emotional well-being and counselling support;
- Substance misuse advice and treatment;
- Benefits advice;
- Education, training and employment information;
- Sexual health services;
- Independent living support;
- Access to CAMHS and Adult Mental Health Services;
- Addressing the needs of vulnerable groups including: young offenders, children in care and care leavers, LGBT and children and young people not in education, employment or training;
- Bridging support to other services;
- A safe café space as part of the crisis concordat;
- Open to young people up to the age of 25 to support transition to adult services.

Development of an Emotional Health and Well-being (EHWB) offer

In addition to the Healthy Minds Framework, counselling support and workforce development training has been delivered in a schools pilot and some co-commissioning arrangements are in place between the local authority and schools. The Targeted Mental Health in Schools (TaMHS) tool kit has been refreshed to provide current knowledge and referral information to support staff in schools who can access training to accompany the tool kit. Mental Health First Aid, Flower 125 (emotional well-being support for primary school students) and attachment training is being delivered to schools as part of the Local Transformation Plan.

The development of a digital offer to make counselling accessible to young people who may be unable to access support through school or a central location is being explored. This would include young people with depression and social anxiety, young carers and young people at risk of being bullied, including LGBT.

Support for families, friends and those affected by children and young people's suicide

The families and friends of children and young people who die by suicide need support, and bereaved siblings may be at increased risk of suicide. Part of the vision is to ensure that there is support available and accessible to families and friends at this most difficult time.

This document includes websites, contact numbers and information to both prevent suicide and support those affected.

Sheffield Educational Psychology Service (EPS) has for many years provided a response to critical incidents, some of which have been related to suicide—an unsuccessful attempt or one that has led to a death. Educational Psychologists (EPs) are skilled at supporting adults who work with children and young people, addressing the challenges of complex situations and what these might mean to the individuals involved. *“When someone is bereaved by suicide or other sudden, traumatic death, friends, work colleagues and teachers often want to help but aren't sure of the best way to go about it”* (Hawton et al, 2016). EPs can provide the emotional space to explore this kind of issue with adults and young people.

In the past the EPS has been contacted by the Head Teacher of the school or from a city council worker involved in the critical incident response team. Each school will have the details for contacting the EPS in their own Critical Incident Procedures.

Many services base their response on the principles of Psychological First Aid. This practical approach aims to enhance coping and control. Although counselling might be identified some time later should people become 'stuck' in the natural process of grieving, this is not a helpful first step especially in the initial first stages that accompany the shocking news of a suicide or attempted suicide.

Sheffield EPS has a range of useful material some of which is used to support staff and young people following a suicide. Often a useful first step after first contact with the school is to share these resources with the Head Teacher. EPs might then typically visit the school and work with the senior leadership team to listen to their concerns and offer advice in relation to practical matters such as telling the school community and supporting the staff and young people.

Experience of Abuse

There are a number of life experiences which evidence shows increase the risk of suicidal ideation and/or attempts - including physical, emotional, sexual, domestic abuse and neglect. Sheffield has developed a Young People and Domestic Abuse / Peer on Peer Abuse Traffic Light Tool to support practitioners working with young people affected by domestic abuse which can be found at <http://sheffiddact.org.uk/domestic-abuse/resources/children-young-people/> and is included in the Safeguarding Children Board procedures.

This refers to a young person feeling suicidal as a red risk factor. Professionals using the tool are advised that Section 47 investigations should be initiated for all under 16s – whether they are a victim or a young person causing harm (and for over 16s where necessary). Whole family assessment should follow where possible and all over 16s should also be DASH risk assessed – as the definition of domestic abuse starts at age 16. Workers are advised to remember to consider the ages of the young people involved in terms of the legal age of consent. They should also refer to the Young People and Domestic Abuse pathway which can be found at <http://sheffiddact.org.uk/domestic-abuse/resources/local-strategies/>

Self-Harm

Self-harm can take lots of physical forms, including cutting, burning, bruising, scratching, hair-pulling, poisoning and overdosing. There are many reasons why children and young people try to hurt themselves. And once they start, it can become a compulsion. That's why it's so important to spot it as soon as possible and do everything you can to help and respond at the earliest stage.

Self-harm isn't usually a suicide attempt or a cry for attention. Instead, it's often a way for young people to release overwhelming emotions. It's a way of coping. So whatever the reason, it should be taken seriously. Self-harm is the fourth most common concern that children and young people contact Childline about. There were over 19,000 Childline counselling sessions about self-harm in 2014/15 (NSPCC website).

The exact reasons why children and young people decide to hurt themselves aren't always easy to work out. In fact, they might not even know exactly why they do it. There are links between depression and self-harm. Quite often a child or young person who is self-harming is being bullied, under too much pressure to do well at school, being emotionally abused, grieving or having relationship problems with family or friends. Often, the physical pain of self-harm might feel easier to deal with than the emotional pain that's behind it. It can also make a young person feel they're in control of at least one part of their lives.

Sometimes it can also be a way for them to punish themselves for something they've done or have been accused of doing. Schools and GPs can help with supporting young people who self-harm and accessing specialist support if needed.

Strategic Context

The Suicide Prevention Pathway is an integral element of our local Future in Mind Transformation plan to improve emotional well-being and mental health support and services for children and young people. It is aligned to the work of the Sheffield Suicide Prevention Group.

Locally we have written a comprehensive transformation plan which identifies our priorities and areas for improvement. This follows the completion of a detailed Emotional Well-being and Mental Health Needs Assessment which has highlighted the increases in emotional health and well-being issues and clarified areas where we need to make changes.

www.sheffield.gov.uk/caresupport/health/future-in-mind-transformation.html

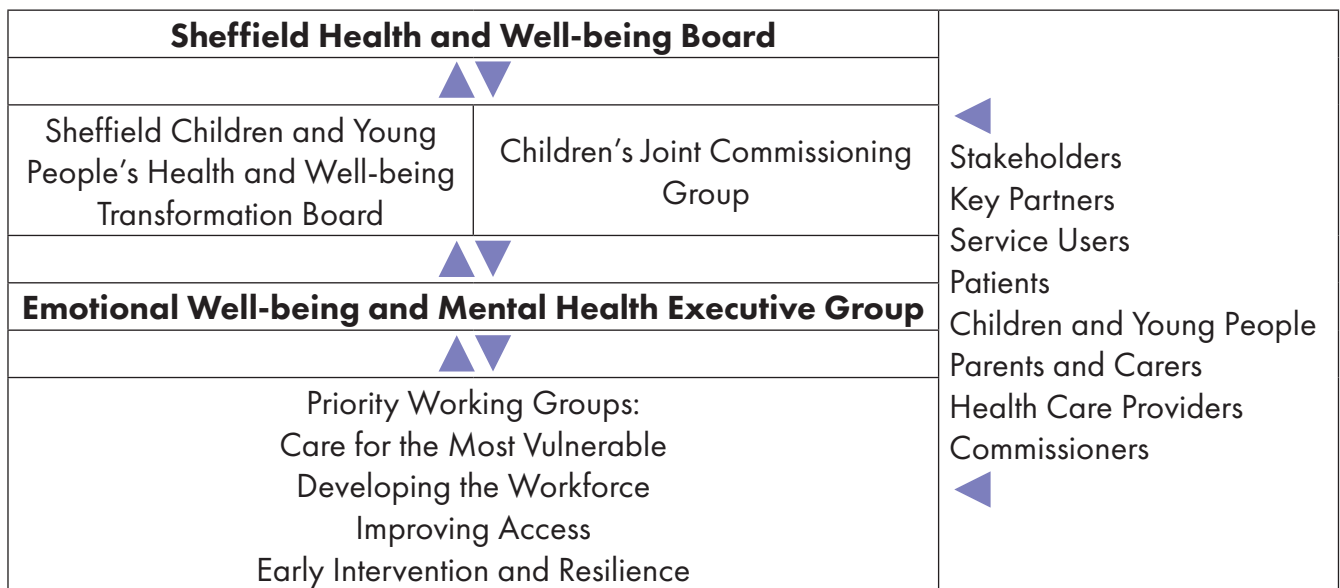
In order to ensure a joined up partnership approach across organisations to implement these changes a governance structure has been developed to provide strategic oversight and direction at citywide level. The Sheffield Children's Health and Well-being Transformation Board identifies emotional well-being and mental health as a priority work stream; this means that there is a citywide commitment from all strategic partners to implement redesign across mental health and well-being services.

The Emotional Well-being and Mental Health Executive Group has lead and oversight of our local transformation and reports progress and outcomes to the Children's Health and Well-being Transformation Board. The diagram below provides an outline of the governance arrangements.

These Boards and work streams are responsible for ensuring that the Suicide Prevention Pathway is integrated into services and implemented locally. They will monitor how the pathway is used and the overall delivery of the strategy. Through this Pathway, we are aiming to make it easier for professionals to get help for young people when they need it - through the introduction of a single phone line where young people can be triaged regardless of age, supporting the transition into and out of specialist services.

The development of this strategy and pathway has been agreed through the Care for the Most Vulnerable Work Stream.

Sheffield Future in Mind Transformation Plan Governance Structure



Aims

- Standardise the response of agencies and workers to young people who exhibit suicidal thoughts and behaviours.
- Equip workers with the practice guidance and tools needed to deal with these issues - from early intervention through to complex and 'at risk of serious harm' situations.
- Establish the necessary support mechanisms for workers dealing with suicidal thoughts and behaviours.

Objectives

- A systematic approach to identifying and addressing the needs of children and young people at risk of suicide.
- Risk assessment guidance, early intervention questions and initial assessment.
- A care pathway flowchart for workers to follow.
- Additional supporting information and guidance.

Who is this document for?

It is primarily for use by front line workers in contact with:

- Young people who are identified as being at risk from suicidal thoughts or behaviours.
- Young people who need referral to, and support from, specialist services as a result of disclosing suicidal thoughts and/or attempted suicide.

Principles Underpinning the Suicide Prevention Strategy and Care Pathway

- Recognition of the challenges facing front line workers dealing with these issues.
- Recognition of suicidal thoughts and behaviour as a real and sensitive issue for young people.
- That each young person should be treated as an individual. Recognition that young people should not be stigmatised or discriminated against because of suicidal thoughts or behaviour.
- Young people to be made aware of the agency's Confidentiality and Information Sharing policy.
- To work towards minimising harm and promoting young people accessing support to help them cope with issues that might lead to them having suicidal thoughts or behaviours.
- Recognition that young people may be part of a family unit and that support should be offered to families, parents/carers and significant others. Where workers assess that an intervention is necessary the aim should be to work in partnership with the young person.

Suicide Prevention Pathway for Children and Young People in Sheffield

Risk Thresholds for Action for Front-line Staff

A young person's life is in danger because they have caused serious self injury, or have taken an overdose, or express suicidal thoughts and have an immediate plan they intend to act on:

- Contact emergency services to ensure the young person receives emergency medical treatment
- Stay with the young person until they are in the care of emergency services
- Contact the parent(s)/carer

A mental health assessment will be undertaken by CAMHS/Adult Mental Health Team (AMHT) through A&E and access to specialist services will be offered once the young person is safe.

A young person has suicidal thoughts but no plan to act on this, but thoughts are not easily dismissed, has previously attempted suicide, has increasing self-harming behaviour, experiences low mood, significant anxiety or depression, has significant or increasing drug or alcohol use:

- Consider risk factors – Guidance (1)
- Ask initial concern questions – Guidance (2)
- Complete baseline risk assessment – Guidance (3)
- If young person has self-harmed and needs medical attention, inform parent(s)/carers and take to Emergency Department or arrange for parent/carer to do this
- If working in MAST or Community Youth Teams (CYT) consult with Primary Mental Health Worker
- Contact Community CAMHS for a consultation with a CAMHS Clinician
- Draw up a safety plan with young person/parent(s)/carer, to include resilience factors – record in line with your safety procedures
- Do not agree to keep suicidal thoughts a secret
- Listen, do not judge and keep communicating, this young person has chosen to trust you, take them seriously
- Share concerns with any other professionals involved and consider referral to MAST.

A young person has suicidal thoughts that are fleeting and soon discussed and has not planned suicide, shows no signs of depression or psychosis, uses self-harming behaviour occasionally, but causes very little self injury and is in a difficult situation but feels this is bearable:

- Consider risk factors
- Ask initial concern questions
- Complete base line risk assessment
- Consider referral to MAST
- Draw up a safety plan with young person/parent(s)/carers, record in line with your agency procedures
- Listen to young person and those around them

IN ALL SITUATIONS, COMPLETE A WRITTEN RISK ASSESSMENT AND DISCUSS WITH YOUR CLINICAL SUPERVISOR/LINE MANAGER

Pathway for Universal Workers

Responding to concerns that a child or young person is at risk of suicide



¹ Multi-Agency Psychological Support (MAPS)

Guidance Notes 1: Risk Factors to Consider

Personal history and external factors	Please tick
Has there been previous self-harm, suicide thoughts or suicide attempts?	
Is the young person taking alcohol or drugs on a regular basis?	
Is there a known mental health problem?	
Has the young person recently experienced loss or bereavement or had a recent relationship break-up?	
Is there a history of abuse?	
Are there any current stresses in the young person's life?	
Is there a family history of suicide or mental illness?	
Are there any issues around gender and sexual orientation?	
Is the young person homeless or struggling financially?	
Is the young person experiencing domestic abuse in their relationships or witnessing domestic abuse at home?	
Are they being bullied?	

Personal functioning	
Are there any significant changes in behaviour e.g. increased anxiety, loss of interest in things they previously enjoyed doing?	
Change in appearance, sleeping or eating habits or concentration?	
Do they run away from home?	
Is there anger or hostility or anti-social behaviour?	

Verbal warning signs	
For example "I'm going to top myself, nobody cares about me."	

Non verbal warning signs	
Showing signs of withdrawal or isolation	
Showing symptoms of depression- low mood, loss of interest, lack of motivation	
Exhibiting changes to their personality	
Making a will, giving away possessions	
Struggling to communicate	
Fascination with death	
Sudden weight loss	

Guidance Notes 2: Suggested Initial Concern Questions

- Is something troubling you? (Home, family, school, friends)
- Can you tell me what this is?
- How is this making you feel?
- How often have you had these thoughts?
- Have you ever felt like ending your life?
- Have you ever tried to hurt or kill yourself? (e.g. taking tablets)
- Are you currently thinking about hurting or killing yourself?
- Do you have a plan?
- What has stopped you acting on your thoughts so far?
- Who can you talk to about how you are feeling?
- Who can you call at any time if you need to talk?
- Do you have the contact details for Childline and Samaritans?
- What gets you through when you are having thoughts about suicide?
- Who can help you make a safety plan?

Guidance Notes 3: Suggested Initial Assessment Questions

Baseline Risk Assessment (SP 2) - Young person admits to suicidal thoughts	Please tick
How often do you think about suicide?	
How long have you been having suicidal thoughts?	
When did you last think about suicide?	
What makes you think of suicide (e.g. worries, fears, loss)?	
What stops you acting on these thoughts?	
Have you ever made a suicide attempt?	
Have you thought of how you would kill yourself (having a plan)?	
Is anyone aware that you think about suicide (family, friends, professionals)?	
Are you at risk of harm from others (bullying, threats, abuse)?	
Is there anyone else at home who is at risk of harm from others (bullying, threats, abuse)?	
Do you have access to means of killing yourself (e.g. tablets, weapons)?	
Do you use drugs / alcohol – does this make you feel better or worse?	
Have you ever tried to hurt yourself (e.g. cutting self, overdosing)?	
What other risk taking behaviour have you been involved in?	
What helps you to not think about harming yourself or suicide?	
What helps you stop your self-harming behaviour from getting worse?	
Are you getting support with your feelings (from family, friends or professionals)?	
How are you feeling generally at the moment (mood, health, social life)?	
What do you think needs to happen for you to feel better?	

Guidance Notes 4: Levels of Risk

Low risk:

- Suicidal thoughts are fleeting and soon dismissed
- No plan of how they would complete suicide
- Few or no signs of depression
- No signs of psychosis
- No self-harming behaviour
- Current situation felt to be painful but bearable.

Raised risk:

- Suicidal thoughts are frequent but still fleeting
- No specific plan or immediate intent
- Evidence of current mental disorder, especially depression or psychosis
- Significant drug or alcohol use
- Situation felt to be painful, but no immediate crisis
- Previous, especially recent, suicide attempt
- Current self-harm

High risk:

- Previous suicide attempt(s); this is sufficient reason to assess and take steps outlined in the Care Pathway
- Frequent suicidal thoughts, which are not easily dismissed
- Specific plans with access to potentially lethal means. Plans may be detailed with time, location and method. Choosing a place where the plan is unlikely to be disrupted is a very high risk factor.
- Evidence of current mental health problems
- Significant or increasing drug or alcohol use
- Situation felt to be causing unbearable pain or distress
- Increasing self-harm, either in frequency or potential lethality or both.

Guidance Notes 5: Consent; Information Sharing; Child Protection

Consent issues

- If a young person is assessed as needing support from other professionals the worker supporting them must seek consent from the young person to share information
- Ideally the young person should consent to the disclosure of sensitive personal information
- If they will not consent, the duty of care, or paramountcy of the child's welfare under the Children Act 1989, must be considered. If the young person is at risk of significant harm this overrides the wishes of the young person (see Child Protection below)
- However, there may be circumstances (such as the young person threatening to harm themselves if information is shared) which will require careful consideration so that the agencies or worker's actions do not put the young person at greater risk
- Tell the young person what information will be shared, why it should be shared and the consequences of sharing (see Appendix 1 – Concise Guidance on Sharing Information).

Information sharing

If you are asked, or wish to share information, you must use your professional judgment to decide whether to share or not and what information it is appropriate to share; unless there is a statutory duty or a court order to share.

If consent is withheld, or there are good reasons not to seek consent to share confidential information, you must consider whether there is a sufficient public interest to share the information (to prevent harm occurring to a service user or member of the public).

The Government's 'Information Sharing: Pocket Guide' can be accessed at www.education.gov.uk/publications/standard/publicationdetail/page1/DC_SF-00807-2008

Child protection

- If information comes to light that the young person, or other people, are at risk of significant harm, discuss with your Line Manager or the Initial Contact Team (Emergency Duty Team if "out of hours"). Do not delay in having this discussion. You must share relevant information from the Early Interventions Questions and/or the Baseline Risk Assessment.
- If the young person is at immediate risk of significant harm (e.g. has disclosed overdose) seek emergency help – this overrides any consent issues.

Always follow your own agency's Child Protection Procedures.

Guidance Notes 6: Parental Consent

- In most cases it would be expected that parents/carers would be informed of suicidal intent and become part of the assessment process
- Informing parents/carers can be very stressful for the young person and a difficult decision for the worker to make (the young person may require support through this process) however, often parental/carer involvement can be the solution to the problem
- If the young person does not wish their parents/carers to be informed explore the reasons for this; workers should discuss any concerns they have with their line manager/supervisor.
- If the young person has disclosed that their self-harm or suicidal thoughts/intent is in response to alleged abuse from their care givers workers should consult both their line manager/supervisor and the Initial Contact Team (EDT if 'out of hours') for guidance on how to proceed

Refer to consent issues below.

Guidance Notes 7: Young Person Reluctant to Work with Specialist Services

- Some young people who are assessed by CAMHS after a suicide attempt are not keen to attend follow up appointments. This may be because they are embarrassed or because they just want to forget about it all as it's a very painful time to be reminded of.
- How CAMHS would work with this would be to offer alternatives - perhaps suggesting they just use the time to talk through broader issues and not focus on suicidal thoughts. CAMHS will keep a check on whether they are feeling suicidal.
- CAMHS can talk to young people in very practical terms about what school/parents/carers/friends can do to be helpful in times of stress - either alone or with a supportive relative or friend if that helps them. Even then young people and families sometimes decline this offer.
- CAMHS can only work with people with their consent and would therefore look to anyone else that was engaging with the young person and their family to let them know what has been offered and the response. CAMHS may offer to keep in touch with that teacher/social worker/support worker for example and help them to work with the family and young person if there are concerns.
- CAMHS would consider any child protection concerns in respect of a young person's decision to decline the service.
- If there were real concern that the young person is unable to make decisions for themselves by virtue of a mental disorder, then recourse to law to recommend they be detained in a hospital for their safety, assessment and/or treatment could be undertaken.

Appendix 1: Do's and Don'ts in Suicide Prevention

DO's:

- Make an assessment of risk
- Take suicide gestures seriously
- Be yourself, listen, be non-judgemental, patient, and think about what you say
- Check associated problems such as bullying, substance use, bereavement, relationship difficulties, abuse and sexuality issues
- Check how and when parents will be contacted
- Encourage social connection to friends, family, trusted adults
- Ensure support/contact with young person is in place
- Seek risk assessment from GP. Check School Nurse's opinion.
- Make appropriate referrals
- Set up a meeting to plan the care pathway interventions based upon understanding of the risks and difficulties.
- Provide opportunities for support, strengthen existing support systems - consider protective factors
- Make sure you record your assessment, concerns and actions in line with your agency's procedures

DON'Ts:

- Do not promise absolute confidentiality
- Do not make assumptions or react without considering all of the risks
- Do not dismiss what the child or young person is saying
- Do not presume that a young person who has threatened to harm themselves in the past will not carry it out in the future
- Do not dis-empower the child or young person
- Do not ignore or dismiss people who self-harm
- Do not view self-harm or suicidal thoughts as attention seeking
- Do not assume self-harm or suicidal thoughts is used to manipulate the system or individuals
- Do not trust appearances¹

¹ One recent report (Manchester University, 2016) indicates that *"Many children and young people who die by suicide have not expressed recent suicidal ideas. Suicidal ideas are important when present but their absence cannot be assumed to show lack of risk."*

Appendix 2: Concise Guidance on Sharing Information

Purpose of Sharing Information

The purpose of sharing information is to ensure young people who are at risk from suicidal thoughts and behaviour receive help and support appropriate to their level of need.

Seven Golden Rules for Information Sharing

(Information Sharing: Pocket Guidance - Every Child Matters)

- 1. Remember that the Data Protection Act** is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately
- 2. Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could, be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- 3. Seek advice** if you are in any doubt - without disclosing the identity of the person if possible
- 4. Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.
- 5. Consider safety and well-being:** base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions
- 6. Necessary, proportionate, relevant, accurate, timely and secure:** ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion and is shared securely.
- 7. Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

If you answer 'not sure' to any of the questions, seek advice from your supervisor, manager, nominated person within your organisation or from a professional body.

Appendix 3: Relevant Legislation

1. Children Act 1989 Section 17

A child is defined as 'in need' by Section 17 of the Children Act (1989) if:

- He or she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services or;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services or;
- S/he is disabled.

2. Children Act 1989 Section 47

Where a local authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

'Harm' is defined as ill treatment, which includes sexual abuse, physical abuse and forms of ill-treatment which are not physical, for example:

- Emotional abuse or;
- Impairment of health (physical or mental) or;
- Impairment of development (physical, intellectual, emotional, social or behavioural);
- This may include seeing or hearing the ill treatment of another (s120 Adoption and Children Act 2002).

3. Mental Health Act 1983

The Mental Health Act (MHA) is the law under which someone can be admitted, detained and treated in hospital against their wishes.

Its full name is the Mental Health Act 1983 and it was amended recently by the Mental Health Act 2007.

To be detained or 'sectioned' under the MHA someone must be suffering from a mental disorder which requires assessment or treatment and this needs to be given in hospital in the interests of their own health or safety or to protect other people.

Mental disorder is defined as 'any disorder or disability of mind'. This definition includes conditions such as schizophrenia, depression, bipolar disorder, anxiety disorder, obsessive-compulsive disorder, eating disorders, personality disorders, autistic-spectrum disorders, organic disorders such as dementia, behavioural changes due to brain injury and mental disorders due to drug use.

This definition includes learning disability only where it is associated with abnormally aggressive or seriously irresponsible behaviour.

A person cannot be detained if they have drug or alcohol dependency alone, but can be detained if they have drug/alcohol dependency and another form of mental disorder.

When a person is assessed under the MHA three people must agree to the detention in hospital (there are exceptions in urgent situations). Usually, the three people would consist of an Approved Mental Health Professional (AMHP) or nearest relative as specified by the Act, a doctor who has received special training, and a registered medical practitioner. If possible, one of the doctors should already know the person.

There are different sections of the Mental Health Act that have different powers to determine the time period of detention.

Anyone detained must be told their rights, including the right to appeal and the right to the assistance of an advocate.

When someone is discharged from hospital they should receive community after care usually from health and social care departments.

Appendix 4: Definitions to Support the Care Pathway

- **Acute** in relation to an illness, means arising suddenly with intense severity of relatively short duration.
- **Affective Disorders** are conditions which affect mood; see also manic depression.
- **Affective Psychosis** is a major mental disorder in which there is serious emotional disturbance; see also manic depression.
- **Aggressive behaviour** is verbal and/or physical actions or serious intentions, the consequences of which are likely to cause actual damage and/or distress.
- **Alcohol abuse** means reliance on alcohol to a harmful extent.
- **Anxiety State** includes:
 - Panic attacks i.e. a rapid build-up of anxiety, producing a rapid heartbeat, sweating, breathlessness and feelings of impending danger;
 - Phobias i.e. exaggerated fears;
 - Obsessions i.e. repetitive thoughts which keep on intruding without good reason;
 - Compulsive behaviour e.g. acting on obsessions, an uncontrollable impulse to do something repeatedly.
- **Anorexia Nervosa** is an eating disorder characterised by refusal to eat.
- **Appropriate adult** needs to be present when a mentally disordered person is interviewed by the police; an appropriate adult may be:
 - A relative, guardian or a person responsible for their care;
 - Someone who has had experience of dealing with mentally disordered people, e.g. an approved social worker, or
 - Some other responsible adult who is not employed by the police.
- **Assessment** is the gathering and appraisal of information in order to identify a person's needs.
- **Bi-Polar Disorder** see manic depression.
- **Bulimia Nervosa** is an eating disorder characterised by eating binges and vomiting.
- **Challenging behaviour** is behaviour of such intensity, frequency or severity that the physical safety and emotional well-being of the person or others is likely to be placed in serious jeopardy.
- **Counselling** aims to help people develop insight into their problems and identify resources within themselves which they can use to cope more effectively with their situation.
- **Depression** is an intense long-term lowering of mood, including:
 - Lack of energy (apathy)
 - A sense of hopelessness
 - Sad miserable thoughts
 - Slowed down physical movement and speech
 - Anxiety, often without obvious cause
 - A loss of appetite for food
 - Agitation and even panic attacks
 - Guilt
 - Suicidal thoughts
 - Difficulty in sleeping

- **Disability** is defined in the Disability Discrimination Act, 1995 as “A physical or mental impairment which has a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities; “mental impairment” includes “mental illness”.

- **Domestic Abuse** is defined as ‘any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

‘Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.’

The Government definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

- **Drug dependence** is where users of street drugs rely on them or are addicted to them.

- **Eating disorder** is a phrase that describes conditions in which individuals engage in disordered eating. Eating disorders are not simply poor eating habits but are recognised mental health disorders in which emotional issues manifest in harmful eating habits.

The three most common eating disorders are anorexia nervosa (anorexia), bulimia nervosa (bulimia), and binge eating disorder. Though each of these disorders results in different eating behaviours, each occurs when sufferers cannot separate their emotions from their eating habits and this skews the way, and the amount, that they eat. Eating disorders can strike young or old, male or female, any race and any income level. However, eating disorders are, by some estimates, eight times more likely to affect women than men and are also more frequently found among younger women.

- **Hypomanic** is where someone is mildly manic (high) which may include the following characteristics:

- Tremendous activity and energy levels
- An inability or unwillingness to sleep
- A rapid flow of ideas
- Rapid speech and movement
- Inflated self-esteem
- Impulsive decision-making
- Irrational spending of money
- Lack of inhibition
- Bizarre behaviour
- Intense insights not normally experienced.

- **Learning Disability** is a state of arrested or incomplete development of mind.
- **Manic Depression** is the name given to an illness which causes excessive changes in mood from extreme depression to hypomania.
- **Mental disorder** is defined in the Mental Health Act as including any of the following:
 - Mental illness
 - Severe mental impairment i.e. severe learning disability
 - Mental impairment, i.e. learning disability
 - Psychopathic disorder.
- **Mental health** is emotional, psychological and spiritual well-being.
- **Mental illness** is an illness affecting thoughts, mood and/or behaviour, including the following specific diagnosed conditions:
 - Anxiety
 - Dementia
 - Depression
 - Manic depression
 - Schizophrenia.
- **Mental Impairment** see learning disability.
- **Obsessions** see anxiety state.
- **Panic Attacks** see anxiety state.
- **Personality Disorder** is a disorder of the development of personality, including a range of mood, feeling and behavioural disorders.
- **Psychosis** the word “psychosis” is used to describe conditions that affect the mind, in which there has been some loss of contact with reality. Hallucinations, delusions (false beliefs), paranoia and disorganised thoughts and speech are symptoms of psychosis. These symptoms can seem so real that often the person does not realize that they are experiencing psychosis. Psychosis also affects feelings and behaviour.

Psychotic episodes are periods of time when symptoms of psychosis are strong and interfere with regular life. Although the duration of these episodes varies from person to person, and may only last a few hours or days, psychosis is most likely to continue for weeks, months or even years unless the person is given proper treatment.

The experience of psychosis varies greatly from person to person and individuals experiencing psychosis may have very different symptoms.

Unfortunately, at this time there are many theories about what causes psychosis, but no definite answers. Psychosis occurs in a variety of mental and physical disorders; therefore, it likely has multiple causes. Biology, stress and drug use are three of the most common theories.

Approximately 3% of people will experience a psychotic episode at some stage in their life, although a first episode usually occurs in adolescence or early adult life. Psychosis occurs across all cultures and levels of socioeconomic status and affects males and females equally.

Psychosis is treatable and people can recover.

- **SAD - Seasonal Affective Disorder** is a form of depression that follows a seasonal pattern. People with SAD usually have symptoms of depression as winter approaches and daylight hours become shorter. When spring returns and the days become longer again, they experience relief from the symptoms and a return to a normal mood and energy level. Like other forms of depression, the symptoms of SAD

can be mild, severe, or anywhere in between. It's the seasonal pattern of SAD — the fact that symptoms occur only for a few months each winter (for at least 2 years in a row) but not during other seasons that distinguishes it from other forms of depression. About 6 in every 100 people (6%) experience SAD. Although it can affect kids and young teens, it's most common in older teens and young adults, usually starting in the early twenties. Like other forms of depression, females are about four times more likely than males to develop SAD, as are people with relatives who have had depression. Individual biology, brain chemistry, family history, environment, and life experiences also might make certain people more prone to SAD and other forms of depression.

- **Self-harm** describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered. Self-harm can involve:

- Cutting - often to the arms using razor blades, or broken glass
- Burning using cigarettes or caustic agents
- Punching and bruising
- Inserting or swallowing objects
- Head banging
- Hair pulling
- Restrictive or binge eating
- Overdosing

(Mental Health Foundation 2006)

Self-harm is a coping strategy. The risk of suicidal thoughts or behaviour can be raised if young people stop self-harming without either the original stressors being resolved or other coping strategies being put in place.

- **Serious** is important and demands consideration.
- **Severe** relates to 'extreme' and 'making great demands upon'.
- **Severe Mental Impairment** is a severe learning disability.
- **Suicide** is an intentional, self-inflicted, life-threatening act resulting in death from a number of means.
- **Suicidal ideation (thoughts)** means having thoughts of ending your life. These thoughts can be occasional, regular or frequent and should be explored in any risk assessment. The young person may be thinking of a plan to complete suicide but not actually taking steps to do so.
- **Suicidal intent** is indicated by:
 - Evidence of premeditation (such as saving up tablets);
 - Taking care to avoid discovery;
 - Failing to alert potential helpers;
 - Carrying out final acts (such as writing a note/leaving a message/giving away possessions);
 - Choosing a violent or aggressive means of suicide - allowing little chance of survival.

For a more comprehensive list and more detailed information go to: www.rethink.org

Family Common Assessment Framework (FCAF)

The FCAF is a key part of delivering front-line services that are integrated, and are focused around the needs of children and young people. The FCAF is a standardised approach to conducting assessments of children's additional needs and deciding how these should be met. It should be used by practitioners across children's services in England.

The FCAF promotes earlier, more effective identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development. Practitioners are then better placed to agree with children and families about appropriate modes of support. The FCAF also aims to improve integrated working by promoting coordinated service provision through Team Around the Child (TAC) meetings. For Sheffield Local Authority children and young people in care under 18, the pathway would be for the social worker to contact MAPS (Multi-Agency Psychological Support) to access mental health support and the Team Around the Child integrated approach.

Appendix 5: Training

- **The CAMHS multi-agency training service** offers a comprehensive programme of child and adolescent mental health training, including Working with Self-Harming Behaviour. Training is provided free of charge and available to all those working with children, young people and their families across education, social care, health and the voluntary sector. The emphasis is upon development and application of child and adolescent mental health awareness and skills.

Full details of the multi-agency training programme are available at:

www.sheffieldchildrens.nhs.uk/refer-to-us/camhs/multi-agency-training/mats-training-days.htm

- **Sheffield Safeguarding Children Board** also provides a broad programme of free training and learning events open to all practitioners working with children young people and their families in Sheffield. Understanding and working with self-harming behaviours, alongside other child and adolescent mental health issues, is to be included in the SSCB lunchtime seminar programme on a continuing basis.

Full details of the SSCB multi-agency training programme are available at:

www.safeguardingsheffieldchildren.org.uk/multi-agency-training

- Practitioners are also encouraged to access **online training** via the **Mind Ed** website. Funded by the Department of Health and built by a consortium of organisations including Royal College of Paediatrics and the Royal College of Psychiatrists, it offers a range of free e-learning modules to inform about the mental health of children and young people, what goes wrong and what can be done to help. It provides a wealth of information on child development, how problems show and gives practical insights into when to be concerned, what to do and when to refer on to specialists. Modules are available to suit the needs of both experienced health care professionals and other practitioners and volunteers from across the children's workforce.

www.minded.org.uk

- **Emotional Well-being and Mental Health (EWBMH) training** for early intervention and prevention is available to the children and young people's workforce, see **Sheffield Clinical Commissioning Group** and **Learn Sheffield** websites for the current programme:

www.sheffieldccg.nhs.uk and www.learnsheffield.co.uk

- **Suicide prevention training** can also be accessed through **PAPYRUS** as a traded service, details on their website:

www.papyrus-uk.org

Appendix 6: Helplines and Websites for Confidential Advice and Support

Support for children and young people

Big White Wall: www.bigwhitewall.com

A safe, online, anonymous service for people over the age of 16. Get the support of others who feel like you, 24/7, and learn ways to feel better and how to get on top of your own troubles.

CALM: Campaign Against Living Miserably: www.thecalmzone.net

Tel: 0800 585858

Offers help via the website and a helpline for men aged 15-35 who are feeling depressed or down. Callers are offered support and information. Calls are free, confidential and anonymous. The helpline is open from 5pm – midnight, Saturday, Sunday, Monday and Tuesday, every week of the year.

ChildLine: www.childline.org.uk

Tel: 0800 1111

ChildLine offers support online and over the phone for any issues and can be accessed 24/7. ChildLine has trained counsellors who can help young people to talk about the emotions they may be feeling and which may be their triggers to self-harm.

Connecting with People: www.connectingwithpeople.org/ucancope

'U Can Cope' film is designed to help young people develop the ability to cope with the difficulties in their lives. The Connecting with People website has information for young people coping with suicidal thoughts including real life experiences of people surviving suicidal thoughts.

Doc Ready: www.docready.org

Doc Ready helps to prepare people to talk about mental health to the GP.

Feeling Overwhelmed Leaflet: www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingoverwhelmed.aspx

Have I Got a Problem: www.haveigotaproblem.com

Free counselling support, videos and diagnostic tools.

Local Let's Talk Directory: www.sheffieldccg.nhs.uk

If you're a young person, a parent or carer or someone who works with young people, this guide will help you find the right advice and support and see what services are available in Sheffield.

Heads Above the Waves: <http://hatw.co.uk/>

Online resource for young people suffering from depression and self-harm.

Maytree

If you are worried about yourself or someone else you can contact Maytree on: 020 7263 7070 or email: maytree@maytree.org.uk

NHS Choices

24 hour national helpline providing health advice and information, and access to out-of-hours GP call free on: 111

PAPYRUS: www.papyrus-uk.org

HOPELineUK: 0800 068 41 41 (Open Monday to Friday 10am – 5pm; 7pm – 10pm and Weekends 2pm – 5pm). PAPYRUS aims to prevent young people taking their own lives. Their professionally staffed helpline provides support, practical advice and information both to young people worried about themselves, and to anyone concerned that a young person may harm themselves. PAPYRUS has a range of helpful resources including HOPELineUK contact cards or call: 01925 572444 or fax: 01925 240502 for a sample pack.

Patient: www.patient.co.uk

Details of UK patient support organisations, self-help groups, health and disease information providers, and more. Each entry is cross-referenced and details are checked annually.

Samaritans: www.samaritans.org

Free phone: 116 123 (Open 24/7); email: jo@samaritans.org

A 24/7 helpline service which gives a safe space to talk about what is happening in young people's lives, how they are feeling, and how to find their own way forward. Samaritans volunteers are ordinary people from all walks of life who know how difficult it can be for young people to talk to their families and friends, and that very often, with some time and space, people are able to find their own solution within themselves.

Stay Alive

Suicide Prevention App can be downloaded from Apple Store or Google Play.

YoungMinds: www.youngminds.org.uk

YoungMinds is committed to improving the emotional well-being and mental health of children and young people. Their website has many resources for children and young people, parents and professionals.

Support for parents / carers

Alliance of Hope: www.allianceofhope.org

Support and resources for survivors of loss by suicide

Survivors of Bereavement by Suicide (SOBS): www.uk-sobs.org.uk

Helpline: 0844 561 6855 (Open 9am – 9pm daily)

SToRMS: www.stormsdmc.org

SToRMS stands for "Strategies To Reduce Male Suicide" and is a small grass routes organisation based in Sheffield with events and resources to promote young men's emotional well-being and help prevent suicide.

Young Minds Parent's Helpline

Tel: 0808 802 5544 (free for mobiles and landlines) open 9.30am - 4.30pm Monday to Friday

Offers free, confidential online and telephone support, including information and advice, to any adult worried about the emotional problems, behaviour or mental health of a child or young person up to the age of 25.

Support for experience of self-harm

The Mix: www.themix.org.uk

Tel: 080 8808 4994 (Freephone for one-to-one conversations and support.) The Mix offers help by telephone and email for young people (under 25) for mental health and other issues.

NSPCC Helpline

You can call NSPCC's experienced counsellors whenever you need to on: 0808 800 5000. They're used to dealing with the effects of self-harm and your call can be made anonymously.

RecoverYourLife: www.recoveryourlife.com

Online self-harm support community, it also provides support for any emotional problems, in addition to self-harm.

Self Harm UK: www.selfharm.co.uk

Website for young people aged 11 to 19 affected by self-harm. Email: info@selfharm.co.uk

Support for experience of bereavement

Child Bereavement UK: <http://childbereavementuk.org/>

Supports families and educates professionals when a baby or child dies or is dying, or when a child is facing bereavement.

Cruse Bereavement Care: www.cruse.org.uk

Helpline: 0844 477 9400; email: helpline@cruse.org.uk. Provides emotional support to people who have been affected by a death. Services are free and confidential, and open to all, no matter when a death occurred. One section of the site provides information for professionals who work with bereaved people, and anyone who needs to know more about their services or bereavement in general, during the course of their work. www.cruse.org.uk/sheffield-branch-map

Winston's Wish: www.winstonswish.org.uk

Set up in 1992 to meet the needs of bereaved children, young people and their families.

Support for experience of bullying

Beatbullying: www.beatbullying.org

Works with children and young people across the UK to stop bullying. They help young people to support each other.

Support for experience of depression and mental illness

Depression Alliance: www.depressionalliance.org.uk

Tel: 0845 123 23 20 email: information@depressionalliance.org. Information, support and understanding for people who suffer with depression, and for relatives who want to help. Self-help groups, information, and raising awareness for depression.

Depression UK: www.depressionuk.org

A national mutual support group for people suffering from depression. Email: info@depressionuk.org

Mind: www.mind.org.uk

Infoline: 0300 123 3393 (Open Monday - Friday 9am – 6pm). Provides information in a range of topics including types of mental distress, where to get help and advocacy. They are able to provide details of help and support for people in their own area. Email: info@mind.org.uk

SANE: www.sane.org.uk

SANEline: 0845 767 8000 (Open 6pm – 11pm) Emotional support and specialist information to anyone affected by mental illness, including families, friends and carers. SANE offers 1:1 support via helpline and email services and peer support via an online Support Forum where people share their feelings and experiences of mental illness, as well as exchanging information about treatment and support options.

Support for substance misuse

Alcohol Service

Tel: 0845 345 1549

Drinksmarter: www.drinksmarter.org

Helpline: 0800 7 314 314. Call free and at any time to talk to someone in confidence.

Change, Grow, Live Substance Misuse Service

Change, Grow, Live (The Corner) accept referrals from young people aged 10-18, parents/carers and professionals for advice, support and treatment. Tel: 0114 275 2051. Email: thecorner.sheffield@cgl.org.uk

Sheffield Health and Social Care Adult Substance Misuse Treatment Services

Opiate Service: 0114 305 0500 or: 0845 245 0370

Non-Opiate Service: 0114 272 1481

UK National Drugs helpline

Tel: 0800 77 66 00. UK National Drugs helpline is a 24/7 service offering free and confidential telephone advice and information for anyone who is concerned, or has questions, about drugs.

Appendix 7: Children's Services Key Contacts in Sheffield

If an urgent referral is required then this should be directed to the Child's GP, CAMHS or Children's Social Care. In the case of self-inflicted injuries needing treatment or when a substance or tablets have been ingested then an emergency referral to A&E would be required, usually via a 999 call for an ambulance.

Child and Adolescent Mental Health Service: 0114 305 3218

Safeguarding Children Service: 0114 273 4934

Children's Social Care: 0114 203 9591

Community Youth Teams: 0800 138 8381

East Multi-Agency Support Team: 0114 205 3635

North Multi-Agency Support Team: 0114 233 1189

West Multi-Agency Support Team: 0114 250 6865

Youth Justice Service: 0114 228 8555

Young People's Substance Misuse Team: 0114 275 2051

Permanence and Through Care Team: 0114 203 9060

Educational Psychology Service: 0114 250 6800

Youth Information, Advice and Counselling Services: 0114 201 2800
(Operational from June 2017)

Appendix 8: Bibliography and Further Reading

Department for Education, 2015: ***'Working Together to Safeguard Children'***

Department of Health, 2000: ***'Framework for the Assessment of Children in Need and their Families'***

Department of Health, 2006: ***'What to do if you're worried a child is being abused'***

Department of Health, 2004: ***'The Mental Health and Psychological Well-being of Children and Young People: National Service Framework Standard 9'***

Department of Health, 2016: ***'National Suicide Prevention Strategy'***

National Institute for Mental Health in England, 2009: ***'National Suicide Prevention Strategy for England – Annual Report on Progress'***

Evans E., Hawton K. and Rodham K, 2005. ***'Suicidal Phenomena and Abuse in Adolescents: a Review of Epidemiological Studies' in Child Abuse and Neglect'*** 29-45-58

National Institute for Clinical Excellence (NICE), 2004: ***'Self-harm'*** <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10946>

Samaritans, 2015: ***'Working Together to Reduce Suicide Strategy 2015-2021'***

Office for National Statistics Suicides in the UK: ***'2014 Registrations'*** Released 4 February 2016

Department of Health, 2012: ***'Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives'***

Department of Education (DENI), 2014: ***'A guide to managing critical incidents in schools.'***

Hawton, K., Simkin, S., Great Britain and NHS Direct, Department of Health, 2006: ***'Help is at hand: A resource for people bereaved by suicide and other sudden, traumatic death.'***

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Manchester University, 2016: ***'Suicide by children and young people in England.'***

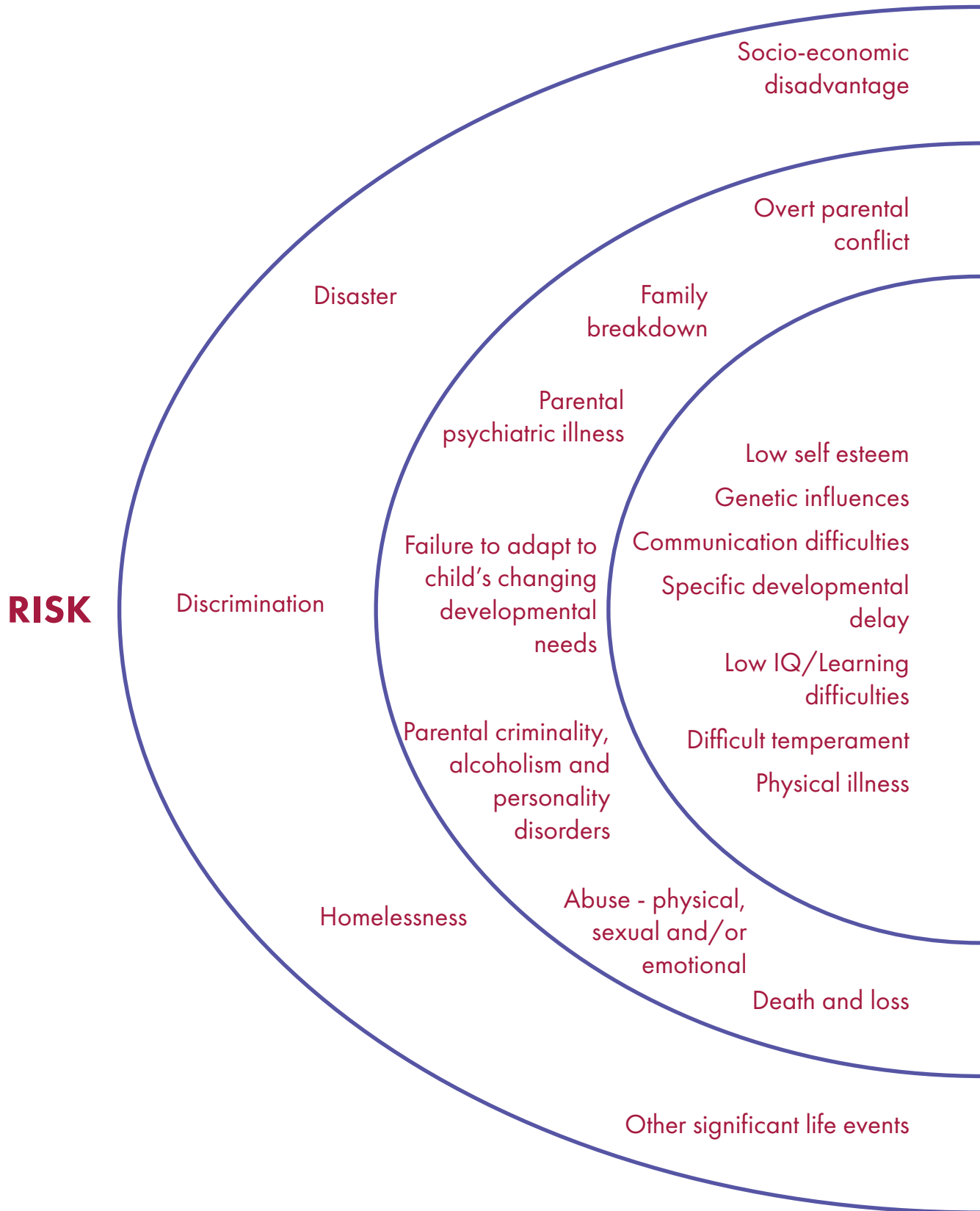
National Educational Psychological Service (NEPS) Agency, 2004: ***'Responding to critical incidents: Information pack for psychologists.'*** See also NEPS, 2007: ***'Responding to critical incidents: Resource Materials for Schools'***

NICE and SCIE Guidance, 2010: ***'Promoting the quality of life of looked after children and young people'***

NICE, 2013: Quality Standard 31 for the health and well-being of looked after children

Appendix 9: Risk and Resilience Factors

Children and young people can be at higher risk of developing mental health problems if they have certain attributes or life experiences. On the other hand there are attributes and life experiences that can help build children and young people's resilience – helping them to be mentally and emotionally stronger. The diagram below shows the factors within the child, in the family and in the environment that may create risk or resilience.

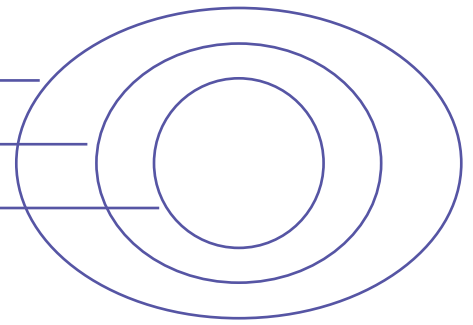


Key

Environment

Family

Self



High standard of living

Affection

Supportive network

Being female

Higher intelligence

Easy temperament in infancy

Positive attitude, problem-solving approach

Secure early relationships

Good communication skills

Planner, belief in control

Capacity to reflect

Religious faith

Humour

Clear, firm and consistent discipline

At least one good parent-child relationship

Supportive for education

Supportive long-term relationship

High morale school with positive policies for behaviour, attitude and bullying

Good housing

Absence of severe discord

Schools with strong academic and non-academic opportunities

Range of sport/leisure opportunities

RESILIENCE

Remember...

The majority of people who die by suicide are not accessing services, which means that any opportunity to intervene is potentially life-saving.

Talking to someone about their wish to end their life is part of everyone's safeguarding responsibility. Most interventions and support takes place within the young person's network of family and friends, and does not involve services. It requires skill to hold a safe space for a young person to explore their feelings of suicide and to be comfortable hearing them.

It is more helpful to avoid offering solutions and allow the young person to explore their feelings without dismissing them or making them feel guilty about how others would be affected if they made a suicide attempt. It is common for people with suicidal feelings to see themselves as a burden to those they love.

The young person has the best knowledge and understanding of their situation and what it means to them. They are the expert, and need those around them to keep listening and responding. It can help to listen to the young person's perception of themselves and their situation and explore options with (not for) them. Developing 'if...then' plans helps to generate options, for example: *If I feel like self-harming, then I will call my friend.*

Suicidal thoughts can be a response to situations that are causing distress and are perceived as unchangeable. This can cause feelings of entrapment and despair. Having positive thoughts about the future are a protective factor, the absence of positive thoughts are a risk.

Some distress is internal, and that can be difficult to change; a therapeutic relationship can be helpful. Often the distress is situational and the young person needs this to be taken seriously and for a response to help them change this.

Safeguard - share concerns appropriately.

Stabilise - stay involved with the young person where possible.

Self-care - Seek support to sustain emotional engagement.