Self-Harm and Suicidal Behaviour in Children

SCOPE OF THIS CHAPTER

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 make every effort to talk with the child or young person without delay.

Contents

1. Definition

Definitions from the Mental Health Foundation (2003) are:

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

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

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

Some young people harm themselves as a coping mechanism, but not all. There are other reasons for example, copying the behaviour of others, a cry for help or occasionally a genuine belief at the time that they can end their life.

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

Self- injury is any act which involves deliberately inflicting pain and/or injury on the body, but without suicidal intent. Self -injury is seen as a coping mechanism with the aim of relieving emotional distress.

2. Indicators

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

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

- Cutting behaviours;
- Other forms of self-harm (self-injury), such as burning, scalding, head banging, hair pulling;
- Self-poisoning;
- Not looking after their needs properly emotionally or physically;
- Direct injury such as scratching, cutting, burning, hitting yourself, swallowing or inserting objects;
- Staying in an abusive relationship;
- Eating distress (anorexia and bulimia);
- Excessive use of substances, for example, to alcohol or drugs;
- Low self-esteem and expressions of hopelessness.
- Engaging in risk taking relationships/behaviours (exploitations)

3. Risks

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

- Level of planning and intent;

- Frequency of thoughts and actions;
- Signs or symptoms of a mental health disorder such as depression;
- Evidence or disclosure of substance misuse;
- Previous history of self- harm or suicide in the wider family or peer group;
- Delusional thoughts and 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 the level of risk may fluctuate. Some risks may remain static whilst others may be more dynamic such as sudden changes in circumstances, for example, within the family or school setting.

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

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

4. Protective and Supportive Action

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

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

- If they have taken any substances or injured themselves;
- Find out what is troubling them;
- Explore how imminent or likely self-harm might be;
- Find out what help or support the child or young person would wish to have;

- Find out who else may be aware of the way that they are feeling;
- Whether the child or young person has prepared a suicide plan.

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

- How long have they felt like this?
- Are they at risk of harm from others?
- Are they worried about something?
- Ask about the young person's health and any other problems such as relationship difficulties?
- Confused about their own sexuality/difficulty in accepting it/not being able to disclose their sexuality?
- Do they have any thoughts/plans to harm themselves/contemplating carrying out final acts such as writing a suicide note (suicide intent)?
- What other risk- taking behaviour have they been involved in?
- What have they been doing that helps?
- What can be done in school or at home to help them with this?
- How are they feeling generally at the moment?
- What needs to happen for them to feel better?

Do not:

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

Referral to the Initial Response Team, Children and Families Division.

The child or young person may initially be assessed as having additional needs and potentially require the support of agencies. A referral could be made to the Early Help and Support Services (EHAS) with involvement of the Child and a parent who will need to consent to support being provided. The Child with Additional Needs Coordinator (CwAN) will assist with bringing together the agencies who are involved with the child or young person to ensure the necessary support and advice is provided. The support from EHAS is only provided on a short- term time limited basis. However, if support is required on a longer- term basis, then there will need to be a review to establish whether the support could be extended.

If during the course of EHAS intervention concerns grow in severity then consideration should be given to stepping up the level of intervention, especially if the child or young person may be likely to suffer significant harm, which requires a child protection response under Section 46 of the Children and Young Person's Act 2001.

The information that should be shared to inform Section 46 enquiries should include all information about the background history and family circumstances, the community context and the specific concerns about the current circumstances, if available.

Where hospital care is needed:

Where a child or young person requires hospital treatment in relation to physical self-harm, triage and assessment should be carried out by skilled practitioners who are trained to work with children and young people who are experiencing poor mental health and crisis. (Insert link for hospital flowchart)

Special attention should be given to:

- Confidentiality;
- Young person's consent (including Gillick competence);
- Parental consent;
- Child protection issues;
- Use of the Children and Young Persons Act 2001;
- Admission process to hospital for the child or young person.

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

Alternative placements may be needed, depending on:

- Age;
- Circumstances of the child and their family;
- Time of presentation;
- Child protection issues;
- Physical and mental health of the child or young person;
- In exceptional circumstances suite 132 in Mannanan Court may be used but there is no specific adolescent psychiatric ward available on the Isle of Man for regular use.

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

During admission, the CAMHS team should:

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

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

5. Issues – Information Sharing and Consent

The best assessment of the child or young person’s needs and the risks requires information to be gathered in order to analyse and plan the support services.

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 medical treatments or sharing information. Consideration should include the child’s chronological age, whether they have any learning difficulties/disabilities, their 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. Gillick competency guidelines should be taken into account. When assessing Gillick competency if there are any concerns about the safety of the child or young person there should be a check whether previous child

protection concerns have been raised and explore any factors that could place them at risk.

Advice should be sought from a Child and Adolescent Psychiatrist if use of the Mental Health Act is thought to be necessary to keep the young person safe.

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

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

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

- 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.

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; 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.

Further Information Available

Isle of Man Children's Services Partnership – Self Harm Guidelines (Information, Guidance and Suggestions 1 March 2015.

Self-harm in Young People: Information for Parents, Carers and Anyone Who Works with Young People, Royal College of Psychiatrists

The Truth About Self-harm, The Mental Health Foundation

Suicide Prevention: Resources and Guidance, GOV.UK

Websites:

Young Minds – fighting for young people's mental health 2021-2022

The Mix - Essential Support for Under 25s

National Self Harm Network