George Stephenson High School

POSITIVE MENTAL HEALTH POLICY

Governance	Curriculum Committee Governing Body
Policy Officer	Deputy Headteacher
Re-Adopted Date	May 2019
Review Date	October 2021
Next Review Date	October 2024

Policy Statement

> *Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (World Health Organization)*

At our school, we aim to promote positive mental health for every member of our staff and student body. We pursue this aim using both universal, whole school approaches and specialised, targeted approaches aimed at vulnerable students.

In addition to promoting positive mental health, we aim to recognise and respond to mental ill health. In an average classroom, three children will be suffering from a diagnosable mental health issue. By developing and implementing practical, relevant and effective mental health policies and procedures we can promote a safe and stable environment for students affected both directly and indirectly by mental ill health.

Scope

This document describes the school's approach to promoting positive mental health and wellbeing. This policy is intended as guidance for all staff including non-teaching staff and governors.

This policy should be read in conjunction with our Supporting Students With Medical Conditions policy in cases where a student's mental health overlaps with or is linked to a medical issue and the SEND policy where a student has an identified special educational need.

The Policy Aims to:

- Promote positive mental health in all staff and students
- Increase understanding and awareness of common mental health issues
- Alert staff to early warning signs of mental ill health
- Provide support to staff working with young people with mental health issues
- Provide support to students suffering mental ill health and their peers and parents or carers

Lead Members of Staff

Whilst all staff have a responsibility to promote the mental health of students, staff with a specific, relevant remit include:

- Kathryn Williams – pastoral lead and designated lead for safeguarding & child protection
- Rebecca Ronan - Mental Health Lead
- Louise Dunn – Deputy designated lead for safeguarding & child protection
- Rebecca Bennett – SENDCO
- Alison Miller and Catherine Patrick– Mental Health First Aiders and Family Liaison Worker
- Sarah Graham – Family Liaison Worker
- Kelly Bailey - CPL lead
- Catherine Patrick and Eleanor Little - Heads of PSHE
- Kelly McNally and Sarah Fitton – Mental Health First Aiders for Staff

Any member of staff who is concerned about the mental health or wellbeing of a student should speak to the mental health lead in the first instance. If there is a fear that the student is in danger of immediate harm then the normal child protection procedures should be followed with an immediate referral to the designated lead for safeguarding & child protection, the head teacher or the designated governor. If the student presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the first aid staff and contacting the emergency services if necessary.

Where a referral to CAMHS is appropriate, this will be led and managed by the relevant Guidance Manager and/or the school's SENCO. Guidance about referring to CAMHS is provided in Appendix F.

Individual Care Plans
It is helpful to draw up an individual care plan for pupils causing concern or who receive a diagnosis pertaining to their mental health. This could take the form of a Risk Assessment, Pastoral Support Plan, SEND Pupil Passport and should be drawn up involving the pupil, the parents and relevant health professionals. This can include:

- Details of a pupil's condition
- Special requirements and precautions
- Medication and any side effects
- What to do and who to contact in an emergency
- The role the school can play

Teaching about Mental Health
The skills, knowledge and understanding needed by our students to keep themselves and others physically and mentally healthy and safe are included as part of our developmental PSHE curriculum.

The specific content of lessons will be determined by the specific needs of the cohort we're teaching but there will always be an emphasis on enabling students to develop the skills, knowledge, understanding, language and confidence to seek help, as needed, for themselves or others.

We will follow the PSHE Association Guidance[1] to ensure that we teach mental health and emotional wellbeing issues in a safe and sensitive manner which helps rather than harms.

Signposting
We will ensure that staff, students and parents are aware of sources of support within school and in the local community. What support is available within our school and local community, who it is aimed at and how to access it is outlined in Appendix D.

We will display relevant sources of support in communal areas such as the staff room, tutor rooms and toilets and will regularly highlight sources of support to students within relevant parts of the curriculum. Whenever we highlight sources of support, we will increase the chance of student help-seeking by ensuring students understand:

- What help is available
- Who it is aimed at
- How to access it
- Why to access it
- What is likely to happen next

Warning Signs
School staff may become aware of warning signs which indicate a student is experiencing mental health or emotional wellbeing issues. These warning signs should **always** be taken seriously and staff observing any of these warning signs should communicate their concerns with Kathryn Williams, our mental health and emotional wellbeing lead.

Possible warning signs include:

- Physical signs of harm that are repeated or appear non-accidental
- Changes in eating or sleeping habits
- Increased isolation from friends or family, becoming socially withdrawn
- Changes in activity and mood
- Lowering of academic achievement
- Talking or joking about self-harm or suicide
- Abusing drugs or alcohol

[1] Teacher Guidance: Preparing to teach about mental health and emotional wellbeing

- Expressing feelings of failure, uselessness or loss of hope
- Changes in clothing – e.g. long sleeves in warm weather
- Secretive behaviour
- Skipping PE or getting changed secretively
- Lateness to or absence from school
- Repeated physical pain or nausea with no evident cause
- An increase in lateness or absenteeism

Managing disclosures
A student may choose to disclose concerns about themselves or a friend to any member of staff so all staff need to know how to respond appropriately to a disclosure.

If a student chooses to disclose concerns about their own mental health or that of a friend to a member of staff, the member of staff's response should always be calm, supportive and non-judgemental.

Staff should listen rather than advise and our first thoughts should be of the student's emotional and physical safety rather than of exploring 'Why?' For more information about how to handle mental health disclosures sensitively see appendix E. Appendix G can also help when deciding how to handle incidents of self-harm.

All disclosures should be recorded in writing on a Record of Concern form and held on the student's confidential file in CPOMS and in the Deputy Headteacher's office in line with the GSHS Child Protection and Safeguarding Policy. This written record should include:

- Date
- The name of the member of staff to whom the disclosure was made
- Main points from the conversation
- Agreed next steps

This information should be shared with the DSL, Kathryn Williams who will store the record appropriately and offer support and advice about next steps. See appendix F for guidance about making a referral to CAMHS.

Confidentiality
We should be honest with regard to the issue of confidentiality. If it is necessary for us to pass our concerns about a student on, then we should discuss with the student:

- Who we are going to talk to
- What we are going to tell them
- Why we need to tell them

We should never share information about a student without first telling them. Ideally we would receive their consent, though there are certain situations when information must always be shared with another member of staff and / or a parent for any student up to the age of 18 and who is at **immediate risk of danger or harm.**

It is always advisable to share disclosures with a colleague, usually the DSL, Kathryn Williams. This helps to safeguard our own emotional wellbeing as we are no longer solely responsible for the student, it ensures continuity of care in our absence; and it provides an extra source of ideas and support. We should explain this to the student and discuss with them who it would be most appropriate and helpful to share this information with.

Where students are not at immediate risk of danger or harm, students may choose to tell their parents of mental health issues they are experiencing themselves. If this is the case, the student should be

given 24 hours to share this information before the school contacts parents. We should always give students the option of us informing parents for them or with them.

If a child gives us reason to believe that there may be underlying child protection issues, parents should not be informed, but the designated lead for safeguarding & child protection (Kathryn Williams) must be informed immediately.

Working with Parents
Where it is deemed appropriate to inform parents, we need to be sensitive in our approach. Before disclosing to parents we should consider the following questions (on a case by case basis):

- Can the meeting happen face to face? This is preferable.
- Where should the meeting happen? At school, at their home or somewhere neutral?
- Who should be present? Consider parents, the student, and other members of staff.
- What are the aims of the meeting?

It can be shocking and upsetting for parents to learn of their child's issues and many may respond with anger, fear or upset during the first conversation. We should be accepting of this (within reason) and give the parent time to reflect.

We should always highlight further sources of information and give them leaflets to take away where possible as they will often find it hard to take much in whilst coming to terms with the news that you're sharing. Sharing sources of further support aimed specifically at parents can also be helpful too, e.g. parent helplines and forums.

We should always provide clear means of contacting us with further questions and consider booking in a follow-up meeting or phone call right away as parents often have many questions as they process the information. We aim to finish each meeting with agreed next steps and will always keep a brief record of the meeting on the child's confidential record.

Working with All Parents
Parents are often very welcoming of support and information from the school about supporting their children's emotional and mental health. In order to support parents we will:

- Highlight sources of information and support about common mental health issues on our school website
- Ensure that all parents are aware of who to talk to, and how to go about this, if they have concerns about their own child or a friend of their child
- Make our mental health policy easily accessible to parents
- Share ideas about how parents can support positive mental health in their children through our regular information evenings
- Keep parents informed about the mental health topics their children are learning about in PSHE and share ideas for extending and exploring this learning at home

Supporting Peers
When a student is suffering from mental health issues, it can be a difficult time for their friends. Friends often want to support but do not know how. In the case of self-harm or eating disorders, it is possible that friends may learn unhealthy coping mechanisms from each other. In order to keep peers safe, we will consider on a case by case basis which friends may need additional support. Support will be provided either in one to one or group settings and will be guided by conversations with the student who is suffering and their parents with whom we will discuss:

- What it is helpful for friends to know and what they should not be told
- How friends can best support
- Things friends should avoid doing or saying which may inadvertently cause upset
- Warning signs that their friend may need help (e.g. signs of relapse)

Additionally, we will want to highlight with peers:

- Where and how to access support for themselves
- Safe sources of further information about their friend's condition
- Healthy ways of coping with the difficult emotions they may be feeling

Training

As a minimum, all staff will receive regular training about recognising and responding to mental health issues as part of their regular child protection training to enable them to keep students safe.

Training opportunities for staff who require more in depth knowledge will be considered as part of our performance management process and additional CPD will be supported throughout the year where it becomes appropriate due developing situations with one or more students.

Where the need to do so becomes evident, we will host twilight training sessions for all staff to promote learning or understanding about specific issues related to mental health.

Suggestions for individual, group or whole school CPL should be discussed with Kelly Bailey, our CPL Coordinator, who can also highlight sources of relevant training and support for individuals as needed.

The Charlie Waller Memorial Trust provide funded training to schools on a variety of topics related to mental health including twilight, half day and full day INSET sessions. For further information email training@cwmt.org or call 01635 869754.

Policy Review

This policy will be reviewed every 3 years as a minimum. It is next due for review in October 2024.

Additionally, this policy will be reviewed and updated as appropriate on an ad hoc basis. If you have a question or suggestion about improving this policy, this should be addressed to Rebecca Ronan our mental health lead via email rronan@gshs.org.uk or by telephone on 0191 2161115.

This policy will always be immediately updated to reflect personnel changes.

Appendix A: Further information and sources of support about common mental health issues

Prevalence of Mental Health and Emotional Wellbeing Issues[2]

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.
- Nearly 80,000 children and young people suffer from severe depression.
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.
- Over 8,000 children aged under 10 years old suffer from severe depression.
- 3.3% or about 290,000 children and young people have an anxiety disorder.
- 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society.

Below, we have sign-posted information and guidance about the issues most commonly seen in school-aged children. The links will take you through to the most relevant page of the listed website. Some pages are aimed primarily at parents but they are listed here because we think they are useful for school staff too.

Support on all these issues can be accessed via Young Minds (www.youngminds.org.uk), Mind (www.mind.org.uk) and (for e-learning opportunities) Minded (www.minded.org.uk).

Self-harm
Self-harm describes any behaviour where a young person causes harm to themselves in order to cope with thoughts, feelings or experiences they are not able to manage in any other way. It most frequently takes the form of cutting, burning or non-lethal overdoses in adolescents, while younger children and young people with special needs are more likely to pick or scratch at wounds, pull out their hair or bang or bruise themselves.

Online support
SelfHarm.co.uk: www.selfharm.co.uk
National Self-Harm Network: www.nshn.co.uk

Books
Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2012) *A Short Introduction to Understanding and Supporting Children and Young People Who Self-Harm*. London: Jessica Kingsley Publishers

Depression
Ups and downs are a normal part of life for all of us, but for someone who is suffering from depression these ups and downs may be more extreme. Feelings of failure, hopelessness, numbness or sadness

[2] Source: Young Minds

may invade their day-to-day life over an extended period of weeks or months, and have a significant impact on their behaviour and ability and motivation to engage in day-to-day activities.

Online support
Depression Alliance: www.depressionalliance.org/information/what-depression

Books
Christopher Dowrick and Susan Martin (2015) *Can I Tell you about Depression?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Anxiety, panic attacks and phobias
Anxiety can take many forms in children and young people, and it is something that each of us experiences at low levels as part of normal life. When thoughts of anxiety, fear or panic are repeatedly present over several weeks or months and/or they are beginning to impact on a young person's ability to access or enjoy day-to-day life, intervention is needed.

Online support
Anxiety UK: www.anxietyuk.org.uk

Books
Lucy Willetts and Polly Waite (2014) *Can I Tell you about Anxiety?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2015) *A Short Introduction to Helping Young People Manage Anxiety*. London: Jessica Kingsley Publishers

Obsessions and compulsions
Obsessions describe intrusive thoughts or feelings that enter our minds which are disturbing or upsetting; compulsions are the behaviours we carry out in order to manage those thoughts or feelings. For example, a young person may be constantly worried that their house will burn down if they don't turn off all switches before leaving the house. They may respond to these thoughts by repeatedly checking switches, perhaps returning home several times to do so. Obsessive compulsive disorder (OCD) can take many forms – it is not just about cleaning and checking.

Online support
OCD UK: www.ocduk.org/ocd

Books
Amita Jassi and Sarah Hull (2013) *Can I Tell you about OCD?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Susan Conners (2011) *The Tourette Syndrome & OCD Checklist: A practical reference for parents and teachers*. San Francisco: Jossey-Bass

Suicidal feelings
Young people may experience complicated thoughts and feelings about wanting to end their own lives. Some young people never act on these feelings though they may openly discuss and explore them, while other young people die suddenly from suicide apparently out of the blue.

Online support
Prevention of young suicide UK – PAPYRUS: www.papyrus-uk.org

On the edge: ChildLine spotlight report on suicide: www.nspcc.org.uk/preventing-abuse/research-and-resources/on-the-edge-childline-spotlight/

Books

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Terri A.Erbacher, Jonathan B. Singer and Scott Poland (2015) *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention*. New York: Routledge

Eating problems

Food, weight and shape may be used as a way of coping with, or communicating about, difficult thoughts, feelings and behaviours that a young person experiences day to day. Some young people develop eating disorders such as anorexia (where food intake is restricted), binge eating disorder and bulimia nervosa (a cycle of bingeing and purging). Other young people, particularly those of primary or preschool age, may develop problematic behaviours around food including refusing to eat in certain situations or with certain people. This can be a way of communicating messages the child does not have the words to convey.

Online support

Beat – the eating disorders charity: www.b-eat.co.uk/about-eating-disorders

Eating Difficulties in Younger Children and when to worry: www.inourhands.com/eating-difficulties-in-younger-children

Books

Bryan Lask and Lucy Watson (2014) *Can I tell you about Eating Disorders?: A Guide for Friends, Family and Professionals*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2012) *Eating Disorders Pocketbook*. Teachers' Pocketbooks

Appendix B: Guidance and advice documents

Mental health and behaviour in schools - departmental advice for school staff. Department for Education (2014)

Counselling in schools: a blueprint for the future - departmental advice for school staff and counsellors. Department for Education (2015)

Teacher Guidance: Preparing to teach about mental health and emotional wellbeing (2015). PSHE Association. Funded by the Department for Education (2015)

Keeping children safe in education - statutory guidance for schools and colleges. Department for Education (2014)

Supporting pupils at school with medical conditions - statutory guidance for governing bodies of maintained schools and proprietors of academies in England. Department for Education (2014)

Healthy child programme from 5 to 19 years old is a recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Department of Health (2009)

Future in mind – promoting, protecting and improving our children and young people's mental health and wellbeing - a report produced by the Children and Young People's Mental Health and Wellbeing Taskforce to examine how to improve mental health services for children and young people. Department of Health (2015)

NICE guidance on social and emotional wellbeing in primary education

NICE guidance on social and emotional wellbeing in secondary education

What works in promoting social and emotional wellbeing and responding to mental health problems in schools? Advice for schools and framework document written by Professor Katherine Weare. National Children's Bureau (2015)

Appendix C: Data Sources

Children and young people's mental health and wellbeing profiling tool collates and analyses a wide range of publically available data on risk, prevalence and detail (including cost data) on those services that support children with, or vulnerable to, mental illness. It enables benchmarking of data between areas.

ChiMat school health hub provides access to resources relating to the commissioning and delivery of health services for school children and young people and its associated good practice, including the new service offer for school nursing.

Health behaviour of school age children is an international cross-sectional study that takes place in 43 countries and is concerned with the determinants of young people's health and wellbeing.

Appendix D: Sources or support at school and in the local community

School Based Support:

- Guidance Managers, Family Liaison Workers (Guidance Managers make referrals) Student Well-Being Team, Learning Support Centre can be accessed by all students.
- Information about each of these sources of support is accessed via– via form tutors, assemblies, tutor notice boards, information displayed in the hall, Student Well-Being Team etc.
- TRAX Outreach Programme in school – therapeutic and talk therapies available.
- For more specialist support, school can signpost students and parents to charities and external services best placed to support.

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Local Support

Sign Directory for North Tyneside specific services: https://services.northtyneside.gov.uk/sign/

Rethink (has search engine for local services)
https://www.rethink.org/home

Anna Freud Centre Youth Wellbeing Directory (search engine for local services)
https://www.annafreud.org/on-my-mind/youth-wellbeing/

Pages on NTC website that list summer holiday and leisure activities etc:
https://www.activenorthtyneside.org.uk/

NHS Choices
https://www.nhs.uk/livewell/youth-mental-health/pages/Youth-mental-health-help.aspx

Moodzone
www.nhs.uk
Practical information, interactive tools and videos from the NHS to help you look after your mental health and avoid common problems like depression, anxiety and stress.

On My Mind – self care information
https://www.annafreud.org/on-my-mind/self-care/

Mood Juice – self help
http://www.moodjuice.scot.nhs.uk/
From the site you are able to print off various self-help guides covering conditions such as depression, anxiety, stress, panic and sleep problems. In the site you can explore various aspects of you life that may be causing you some distress and at the click of a button obtain information on organisations, services and other self-help materials that can offer you support and information to help yourself.

Appendix E: Talking to students when they make mental health disclosures

The advice below is from students themselves, in their own words, together with some additional ideas to help you in initial conversations with students when they disclose mental health concerns. This advice should be considered alongside relevant school policies on pastoral care and child protection and discussed with relevant colleagues as appropriate.

Focus on listening

> *"She listened, and I mean REALLY listened. She didn't interrupt me or ask me to explain myself or anything, she just let me talk and talk and talk. I had been unsure about talking to anyone but I knew quite quickly that I'd chosen the right person to talk to and that it would be a turning point."*

If a student has come to you, it's because they trust you and feel a need to share their difficulties with someone. Let them talk. Ask occasional open questions if you need to in order to encourage them to keep exploring their feelings and opening up to you. Just letting them pour out what they're thinking will make a huge difference and marks a huge first step in recovery. Up until now they may not have admitted even to themselves that there is a problem.

Don't talk too much

> *"Sometimes it's hard to explain what's going on in my head – it doesn't make a lot of sense and I've kind of gotten used to keeping myself to myself. But just 'cos I'm struggling to find the right words doesn't mean you should help me. Just keep quiet, I'll get there in the end."*

The student should be talking at least three quarters of the time. If that's not the case then you need to redress the balance. You are here to listen, not to talk. Sometimes the conversation may lapse into silence. Try not to give in to the urge to fill the gap, but rather wait until the student does so. This can often lead to them exploring their feelings more deeply. Of course, you should interject occasionally, perhaps with questions to the student to explore certain topics they've touched on more deeply, or to show that you understand and are supportive. Don't feel an urge to over-analyse the situation or try to offer answers. This all comes later. For now your role is simply one of supportive listener. So make sure you're listening!

Don't pretend to understand

> *"I think that all teachers got taught on some course somewhere to say 'I understand how that must feel' the moment you open up. YOU DON'T – don't even pretend to, it's not helpful, it's insulting."*

The concept of a mental health difficulty such as an eating disorder or obsessive compulsive disorder (OCD) can seem completely alien if you've never experienced these difficulties first hand. You may find yourself wondering why on earth someone would do these things to themselves, but don't explore those feelings with the sufferer. Instead listen hard to what they're saying and encourage them to talk and you'll slowly start to understand what steps they might be ready to take in order to start making some changes.

Don't be afraid to make eye contact

> *"She was so disgusted by what I told her that she couldn't bear to look at me."*

It's important to try to maintain a natural level of eye contact (even if you have to think very hard about doing so and it doesn't feel natural to you at all). If you make too much eye contact, the student may interpret this as you staring at them. They may think that you are horrified about what they are saying or think they are a 'freak'. On the other hand, if you don't make eye contact at all then a student may interpret this as you being disgusted by them – to the extent that you can't bring yourself to look at them. Making an effort to maintain natural eye contact will convey a very positive message to the student.

Offer support

"I was worried how she'd react, but my Mum just listened then said 'How can I support you?' – no one had asked me that before and it made me realise that she cared. Between us we thought of some really practical things she could do to help me stop self-harming."

Never leave this kind of conversation without agreeing next steps. These will be informed by your conversations with appropriate colleagues and the schools' policies on such issues. Whatever happens, you should have some form of next steps to carry out after the conversation because this will help the student to realise that you're working with them to move things forward.

Acknowledge how hard it is to discuss these issues

"Talking about my bingeing for the first time was the hardest thing I ever did. When I was done talking, my teacher looked me in the eye and said 'That must have been really tough' – he was right, it was, but it meant so much that he realised what a big deal it was for me."

It can take a young person weeks or even months to admit to themselves they have a problem, themselves, let alone share that with anyone else. If a student chooses to confide in you, you should feel proud and privileged that they have such a high level of trust in you. Acknowledging both how brave they have been, and how glad you are they chose to speak to you, conveys positive messages of support to the student.

Don't assume that an apparently negative response is actually a negative response

"The anorexic voice in my head was telling me to push help away so I was saying no. But there was a tiny part of me that wanted to get better. I just couldn't say it out loud or else I'd have to punish myself."

Despite the fact that a student has confided in you, and may even have expressed a desire to get on top of their illness, that doesn't mean they'll readily accept help. The illness may ensure they resist any form of help for as long as they possibly can. Don't be offended or upset if your offers of help are met with anger, indifference or insolence; it's the illness talking, not the student.

Never break your promises

"Whatever you say you'll do you have to do or else the trust we've built in you will be smashed to smithereens. And never lie. Just be honest. If you're going to tell someone just be upfront about it, we can handle that, what we can't handle is having our trust broken."

Above all else, a student wants to know they can trust you. That means if they want you to keep their issues confidential and you can't then you must be honest. Explain that, whilst you can't keep it a secret, you can ensure that it is handled within the school's policy of confidentiality and that only those who need to know about it in order to help will know about the situation. You can also be honest about the fact you don't have all the answers or aren't exactly sure what will happen next. Consider yourself the student's ally rather than their saviour and think about which next steps you can take together, always ensuring you follow relevant policies and consult appropriate colleagues.

Appendix F:: What makes a good CAMHS referral?[3]

If the referral is urgent it should be initiated by phone so that CAMHS can advise of best next steps

Before making the referral, have a clear outcome in mind. What do you want CAMHS to do? You might be looking for advice, strategies, support or a diagnosis, for instance.

You must also be able to provide evidence to CAMHS about what intervention and support has been offered to the pupil by the school and the impact of this. CAMHS will always ask 'What have you tried?' so be prepared to supply relevant evidence, reports and records.

General considerations

- Have you met with the parent(s) or carer(s) and the referred child or children?
- Has the referral to CMHS been discussed with a parent or carer and the referred pupil?
- Has the pupil given consent for the referral?
- Has a parent or carer given consent for the referral?
- What are the parent or carer and pupil's attitudes to the referral?

Basic information

- Is there a child protection plan in place?
- Is the child looked after?
- Name and date of birth of referred child/children
- Address and telephone number
- Who has parental responsibility?
- Surnames if different to child's
- GP details
- What is the ethnicity of the pupil / family?
- Will an interpreter be needed?
- Are there other agencies involved?

Reason for referral

- What are the specific difficulties that you want CAMHS to address?
- How long has this been a problem and why is the family seeking help now?
- Is the problem situation-specific or more generalised?
- Your understanding of the problem or issues involved.

Further helpful information

- Who else is living at home and details of separated parents if appropriate
- Name of school
- Who else has been or is professionally involved and in what capacity?
- Has there been any previous contact with our department?
- Has there been any previous contact with social services?
- Details of any known protective factors
- Any relevant history i.e. family, life events and/or developmental factors
- Are there any recent changes in the pupil's or family's life?
- Are there any known risks, to self, to others or to professionals?
- Is there a history of developmental delay e.g. speech and language delay

[3] Adapted from Surrey and Border NHS Trust

- Are there any symptoms of ADHD/ASD and if so have you talked to the educational psychologist?

The screening tool on the following page will help guide you as to whether or not a CAMHS referral is appropriate.

For further support and advice, our primary contacts are:

Main telephone number is 0191 2196685
Consultation Line is 0191 2196700

There are no email addresses, initial contact needs to be made via telephone.

INVOLVEMENT WITH CAMHS	
	Current CAMHS involvement – **END OF SCREEN***
	Previous history of CAMHS involvement
	Previous history of medication for mental health issues
	Any current medication for mental health issues
	Developmental issues e.g. ADHD, ASD, LD

DURATION OF DIFFICULTIES	
	1-2 weeks
	Less than a month
	1-3 months
	More than 3 months
	More than 6 months

*** Ask for consent to telephone CAMHS clinic for discussion with clinician involved in young person's care**

Tick the appropriate boxes to obtain a score for the young person's mental health needs.

MENTAL HEALTH SYMPTOMS		
	1	Panic attacks (overwhelming fear, heart pounding, breathing fast etc.)
	1	Mood disturbance (low mood – sad, apathetic; high mood – exaggerated / unrealistic elation)
	2	Depressive symptoms (e.g. tearful, irritable, sad)
	1	Sleep disturbance (difficulty getting to sleep or staying asleep)
	1	Eating issues (change in weight / eating habits, negative body image, purging or binging)
	1	Difficulties following traumatic experiences (e.g. flashbacks, powerful memories, avoidance)
	2	Psychotic symptoms (hearing and / or appearing to respond to voices, overly suspicious)
	2	Delusional thoughts (grandiose thoughts, thinking they are someone else)
	1	Hyperactivity (levels of overactivity & impulsivity above what would be expected; in all settings)
	2	Obsessive thoughts and/or compulsive behaviours (e.g. hand-washing, cleaning, checking)

Impact of above symptoms on functioning - circle the relevant score and add to the total

Little or none	Score = 0	Some	Score = 1	Moderate	Score = 2	Severe	Score = 3

HARMING BEHAVIOURS		
	1	History of self harm (cutting, burning etc)
	1	History of thoughts about suicide
	2	History of suicidal attempts (e.g. deep cuts to wrists, overdose, attempting to hang self)
	2	Current self harm behaviours
	2	Anger outbursts or aggressive behaviour towards children or adults
	5	Verbalised suicidal thoughts* (e.g. talking about wanting to kill self / how they might do this)
	5	Thoughts of harming others* or actual harming / violent behaviours towards others

*** If yes – call CAMHS team to discuss an urgent referral and immediate risk management strategies**

Social setting - for these situations you may also need to inform other agencies (e.g. Child Protection)			
	Family mental health issues		Physical health issues
	History of bereavement/loss/trauma		Identified drug / alcohol use
	Problems in family relationships		Living in care
	Problems with peer relationships		Involved in criminal activity
	Not attending/functioning in school		History of social services involvement

	Excluded from school (FTE, permanent)		Current Child Protection concerns

How many social setting boxes have you ticked? Circle the relevant score and add to the total

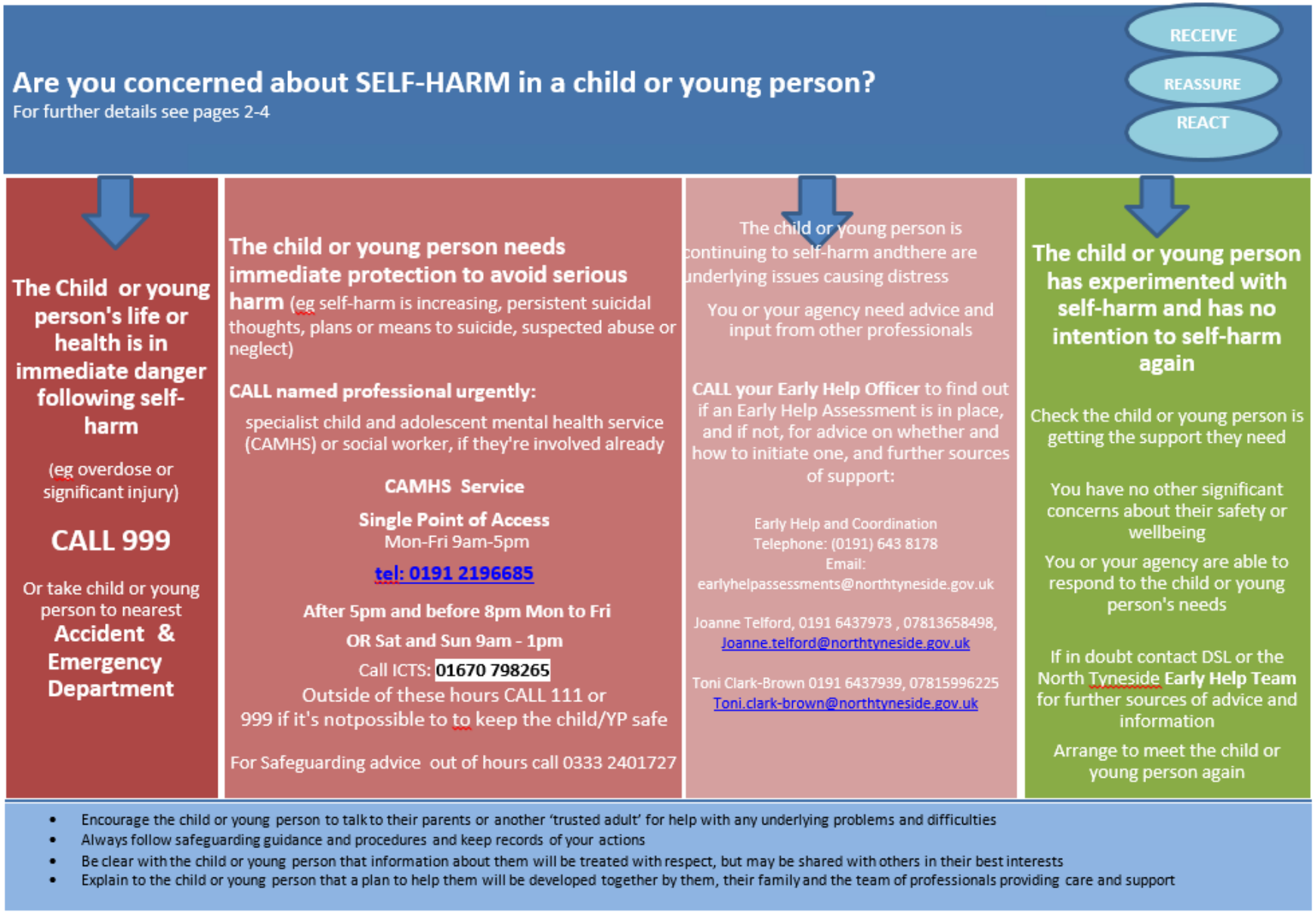
0 or 1	Score = 0	2 or 3	Score = 1	4 or 5	Score = 2	6 or more	Score = 3

Add up all the scores for the young person and enter into Scoring table:

Score 0-4	Score 5-7	Score 8+
Give information/advice to the young person	Seek advice about the young person from CAMHS Primary Mental Health Team	Refer to CAMHS clinic

***** If the young person does not consent to you making a referral, you can speak to the appropriate CAMHS service anonymously for advice *****

Appendix G – GSHS Guidance for Professionals Working with Children and Young People who Self-harm



This guidance aims to help you identify *what to do*, *who to contact* and *where to get help* when you have concerns about self-harm in children and young people. Self-harm can occur in childhood but it becomes increasingly common from early adolescence; for this reason,this guidance uses the term 'young people' as shorthand.

SOME SIMPLE GUIDANCE – Receive, Reassure and React

RECEIVE: although self-harm is often a hidden behaviour, the child or young person may give subtle signs that they want help. As a trusted adult, learn to be alert to these signs and respond to these invitations by being "***helpfully nosey".*** Here are some simple tips for conversations about self-harm:

- Take all self-harm seriously
- Treat the child or young person with respect and empathise: get across that you care, and that you want to understand and to help
- Take a non-judgemental approach: reassure that you understand that self-harm may be helping the child or young person to cope at the moment
- Make sure the child or young person understands the limits of confidentiality.

Avoid:

- Reacting with strong or negative emotions: alarm or discomfort; asking abrupt or rapid questions; threatening or getting angry; making accusations, e.g. that the young person is attention-seeking; frustration if the support offered does not seem to be making a difference
- Too much focus on the self-harm itself: engaging in power struggles or demanding that self-harm stop; ignoring other warning signs; promising to keep things secret…
- Commenting, advising, or attempting to solve all their issues (in that first instance).

REASSURE: make yourself fully available at that moment in time when a child or young person seeks you out or responds to an invitation to talk further:

- Listen carefully in a calm and compassionate way
- Have your eyes, ears and body language open to what the young person has to say, without judging, or being shocked
- Show the young person they can trust that you will first **hear** what they have to say, and later **support** them if another professional needs to be involved.

REACT: in some instances you/your agency may be able to respond to the child or young person's needs. This includes encouraging the child or young person to talk to their friends, their parents and other trusted adults about their thoughts and feelings. In other circumstances, you will need to help the child or young person get additional support.

For more information about ***what to expect from health services for children and young people who self-harm*** click here.

In making decisions about how best to support children and young people who self-harm, it's important to take into account: ***physical harm, safeguarding risks,*** and

mental health. Ask yourself which of the following circumstances best describes the young person's current situation:

- The child or young person's life or health is in **immediate danger** following self-harm
- The child or young person needs **immediate protection** to avoid serious harm
- The child or young person is **continuing to self-harm** and there are underlying issues causing distress
- The child or young person has **experimented with self-harm** and has no intention to self-harm again

The child or young person's life or health is in immediate danger following self-harm

If there is immediate danger to the life or health of the young person, then they need to go to their local accident and emergency department immediately for assessment and treatment. As a trusted adult, consider accompanying the child or young person to the nearest hospital, or ***call 999*.**

Remember there are no safe overdoses: all children and young people who have taken an overdose must be referred for urgent medical assessment and management.Children and young people with self-inflicted injuries may also need urgent referral to hospital.

The child or young person needs immediate protection to avoid serious harm

When deciding how best to support children and young people who self-harm, or who are at risk of self-harm, three kinds of risk questions need to be borne in mind:

- What is the risk this young person poses **to themselves**?
- What is the risk the young person might pose **to other people**?
- What is the risk **from other people** to the young person?

You should take action immediately to safeguard the child or young person if the consequence of no action could lead to serious harm: in particular if you think the immediate suicide risk is high.

Remember that asking about suicide and self-harm does not increase the likelihood of harm to the young person.

- If a **specialist mental health professional** or **social worker** is already involved with the child or young person, call the named professional urgently.
- If the child or young person is not known to services, contact the **CAMHS Service Single Point of Access** Mon-Fri 9am-5pm, CALL 0191 2196685
- After 5pm and before 8pm Mon to Fri OR Sat and Sun 9am - 1pm Call ICTS on 01670 798265
- Outside of these hours Call NHS 111 or 999 if it's not possible to keep the child/young person safe for possible admission to hospital overnight

For Safeguarding advice in or out of hours CALL the **North Tyneside Front Door** 0345 2000 109 (office hours) or 0330 333 7475 (evenings and weekends)

The child or young person is continuing to self-harm and there are underlying issues causing distress

You/your agency need advice and input from additional agencies to better understand the meaning of the self-harm behaviour, and to plan action to ease distress.The North Tyneside **Early Help Assessment** process is the **best way to get this additional help.**

CALL your local **Early Help Team** officer to find out if an Early Help Assessment is in place, and if not, for advice on whether and how to initiate one:

Early Help and Coordination
Telephone: (0191) 643 8178
Email: earlyhelpassessments@northtyneside.gov.uk

Early Help Managers are:
Joanne Telford, 0191 6437973 , 07813658498, Joanne.telford@northtyneside.gov.uk
Toni Clark-Brown 0191 6437939, 07815996225 Toni.clark-brown@northtyneside.gov.uk

Early Help Assessment (EHA) allows support to be tailored to the child or young person and family's strengths as well as their needs, by a **Team around the Family** involvingrelevant agencies (Primary Child and Adolescent Mental Health Service, GP, school nurse, school counsellor, teacher, third sector organisation, other trusted adult…)

The assessment cannot proceed without either the young person or parent(s) consenting. Parental involvement should be encouraged. However if a young person agreesto an Early Help Assessment, but does not want their parents involved, they can give consent themselves if they are "Gillick" competent (see Fraser Guidelines).

The Early Help Team advisor will also be able to give advice on **appropriate further sources of local support and guidance** if a decision is reached not to initiate an EHA.

The child or young person has experimented with self-harm and has no intention to self-harm again

For some young people, self-harming can be a temporary coping mechanism; others may experiment with self-harm out of curiosity, or as a way of fitting in with peers. In these instances, and provided you have no other significant concerns about the child or young person's safety and wellbeing, y**ou/your agency may feel able to respond** to needs, based on a dialogue with the child or young person and their family.

This may include, as appropriate, helping the young person to identify their own coping strategies and support network, giving simple advice about maintaining safety, andoffering information about other sources of advice and support.

If in doubt, contact your DSL or the North Tyneside **Early Help Team** for further sources of advice and information.

Encourage the child or young person to talk to their friends, parents or another 'trusted adult' about self-harm and any other difficulties they may be having. It may behelpful to suggest making an appointment with the child or young person's GP.

Check that the child or young person is getting support and arrange to meet again, in a confidential, quiet space.

RED FLAGS: certain factors are warning signs that a young person who self-harms is at an increased risk of further, or more serious, harm. These include:

- Persistent suicidal thoughts and/or suicidal plans with access to the means to suicide
- A history of multiple episodes of self-harm, increasing self-harm, and/or self-harm through very violent means, such as attempted hanging
- Difficulty sleeping and feelings of hopelessness - not seeing a positive future, or having no plans for the future
- Feelings of entrapment, defeat, lack of belonging, and perceiving oneself as a burden
- Self-harm in association with a known mental disorder, notably depression, significant anxiety or eating disorder
- Previous admittance to a psychiatric hospital
- Misuse of alcohol and illegal drugs.

Other 'red flag' signs include: disengagement from services (consider parental as well as young person disengagement); absence of an effective young person safety planand absence of effective support mechanisms; being in transition between services; and unhelpful use of social media, including seeking ways to self-harm.

Consider asking the young person:

- Have you any particular worries or problems? Have you identified any triggers?
- Is the cutting becoming more frequent? Is it changing (e.g. cutting deeper)?
- How do you feel after self-harming?
- Are any other behaviours used to deal with the feelings that lead to self-harm (e.g. drinking, using drugs)?
- Have sleep, eating and weight patterns changed?
- What about friendships, school, family? Do you have anyone else to talk with?
- Are you having any thoughts that life is not worth living?

Risk of suicide is not the only kind of risk that needs to be considered. It is also important to think about whether the young person is at harm from others, including theirfamily, their peer group ('classmates', young people in their community or online contacts) or other adults (self-harming behaviour in a context of abuse or neglect).

Equally, it is important to consider if the young person is so distressed that they are a risk to others, especially if they are using violent methods.

The '***social transmission'*** of self-harm has been well documented, and it is important to look out for self-harm in the young person's peer group. Similarly, ***'suicide contagion'*** can follow death by suicide not only in the deceased's immediate social network, but also in people who became aware of the suicide through media or other influences, especially if they share similar characteristics (eg age, gender, social circumstances).

ABOUT THIS GUIDANCE

This guidance was developed by a multi-agency group consisting of Cumbrian GPs, teachers, early help practitioners, Child and Adolescent Mental Health professionals, staff from acute hospitals, public health doctors and members of third sector organisations. This group worked together over a period of months in response to feedback from local children and young people, their parents, professionals, and external inspections that had identified the need for a Cumbrian multi-agency pathwayfor self-harm. GSHS has adapted it for their use by updating it with North Tyneside contact and support services.

This guidance was updated in October 2018

The group's vision is that the multi-agency pathway for children and young people who self-harm will enable children and young people, parents, carers, and professionals to obtain appropriate and timely help, advice, and information from the earliest sign of need. As a result children and young people will receive the support that they need to stay safe, develop coping strategies and build their own resilience.

This guidance for professionals should be read alongside guidance for children, young people, families and friends. These draw on the best available evidence and good practice examples, as well as from the voice of young people. We are particularly grateful to the Cumbrian 6th form students who took part in two focus groups in November 2014 to inform development of the pathway.

Consistent with the recent Royal College of Psychiatrist's college report, Managing self-harm in young people, it is designed to complement ***detailed protocols for the management of self-harm between providers of health and social care***, to be agreed between the professional staff and managers of: Child and Adolescent Mental Health Services (CAMHS); adult psychiatric services, including liaison; emergency departments; paediatrics and child health (including community child health) services; general medical services; substance misuse services; learning disability services; county council children's services; and local MASH Team.

This is to enable a seamless service to be provided regardless of the corporate or physical boundaries of individual providers and/or their clinical directorates or departments. This will include the resolution of operational difficulties, and ensuring delivery of appropriate training, including to paediatric ward and emergencydepartment staff.

It recognises that practitioners from many different agencies may be involved in responding to young people who self-harm. We have a collective responsibility to workcollaboratively to prevent fault lines developing between our agencies; adopting a shared pathway is one way to enable collaborative working.

Every encounter with a young person who self-harms, for whatever reason, is an opportunity to intervene to reduce their distress and, potentially, to save a life… Young people benefit from a person who is able to listen to them non-judgmentally, foster a good relationship, and encourage them to get help'.

KEY FACTS ABOUT SELF-HARM AND SUICIDE IN CHILDREN AND YOUNG PEOPLE

Self-harm refers to any act of intentional self-poisoning or self-injury, irrespective of motivation or intent. It can be considered as a spectrum of behaviours ranging fromoccasional self-scratching, to cutting, pulling of hair, head banging, taking an overdose with intent to die, or completed suicide.

Reasons for self-harming behaviour vary greatly from person to person. For some young people there is strong suicidal intent; some may experiment out of curiosity, oras a way of fitting in with peers. Self-harm can become psychologically addictive. It is often described as a way to escape from intolerable distress or situations.

Self-harm is common. About 17% of girls and 5% of boys will have self-harmed by the time they leave school. Self-harm rates increase from the age of twelve years and are highest in the late teens for females and in early adulthood for males. Onset of self-harm may be related to puberty, especially late or completed puberty, rather than chronological age. Self-harm rates are higher in adolescents from lower socioeconomic groups. About 80% of those admitted to hospital have overdosed and around 15% have cut themselves. In the community, cutting is a more common way of self-harming than taking an overdose.

Self-harm is often a hidden behaviour. There is much stigma surrounding self-harm. Only about 1 in 8 adolescents who self-harm present to medical services. Young people who self-harm often say that there was no one they could easily trust to talk to about how they were feeling, leaving them feeling isolated and lonely.

Digital technology is influencing patterns of self-harm in children and young people. It is important to gain an understanding of their digital lives. Social media can be partof the problem and also the solution, for more information click here.

It is important to take self-harm seriously: as an expression of distress; because it causes body damage; and because it is linked with an increased risk of suicide. Although suicide in children and young people is very rare, it is the second most common cause of death among young people. Self-harm is one of the strongest predictorsof death by suicide in adolescence, increasing the risk of suicide about ten-fold. Risk of suicide is greater in older adolescents, and in boys and young men who self-harm.

Investigations of suicides in young people suggest they usually belong to one of three groups: those with complex, longstanding life and behavioural problems (schoolfailure, family relationship problems, childhood sexual abuse, family violence, personality problems, low self-esteem, and poor peer relationships…); those with major psychiatric disorders; and those in whom the suicidal process occurred as an acute response to life events, especially relationship problems.

Some young people who die through suicide have no history of previous self-harm/suicide attempts or previous emotional or behavioural problems. They may have felthopeless in reaction to particularly stressful events, for example a recent relationship breakdown or problems at home. They may still, in some way, have asked for help.

Asking about suicide and self-harm does not increase the likelihood of harm to the young person. It is important that all front-line professionals become familiar withasking about self-harm and suicide in an open minded, compassionate, way. Remember that self-harm may be a means of showing others how bad they feel.

Whenever possible, limit access to the means of self-harming. Families and young people should be encouraged to dispose of sharp objects, medication and other meansof self-harm, and at the same time to develop alternative strategies to cope with the underlying distress.

Most young people, parents, teachers and other professionals agree that increasing understanding of self-harm, and being more open about it, is a good thing.They want help-seeking to become more normal, accompanied by a wider acceptance that everyone

Young people report a sense of relief when people in their day-to-day lives are supportive and non-judgmental. They want parents and other adults to be better informed about self-harm so they can go to them for help. A supportive friend,

WHAT CHILDREN AND YOUNG PEOPLE SAY ABOUT SELF-HARM

National surveys: Young people say that conflicts with other people, for example, family members, siblings, teachers and boyfriends/girlfriends, are the most common reasons for self-harm. These conflicts could be about different things but they often make young people feel pushed away, left out, unfairly criticised or out of control. Young people also report that they can feel embarrassed or ashamed about self-harming themselves, and that they fear being judged by others, including professionals.

They say that it is often very difficult to know who they can talk to about their self–harming behaviour and the strong feelings that go with it, which may feel very private. This includes difficulty talk to their parents (who report, themselves, often feel guilty about their child's self-harm). Young people say they want to be able to talk to their teachers or GPs, for example, but they are not sure how to start the conversation, and may not feel encouraged by the professional. It may be easier, or less threatening, to talk to a trusted adult, for example, their football coach or youth leader, about self-harm.

Some young people have also voiced concerns with the attitudes of front-line professionals and their perceived lack of understanding of self-harm. For example, young people seeking help in emergency departments have reported lack of privacy, with confidential matters discussed in open areas, and lack of respect. Young people may feelout of place on paediatric wards, and have reported long waiting times to see psychiatric professionals and reduced input at the weekend. Some felt their families were leftout and received inconsistent support.

These attitudes and perceptions can have a negative effect on the ways in which young people access help and support; many young people report turning to their peers and/or to online support instead of their GPs, teachers or parents.

Focus groups with Cumbrian 6th formers were carried out in November 2014 to inform this self-harm pathway. Participants recognised that *'the immediate effect ofphysical pain can be better than unhappiness'*. They said that digital technology can be part of the problem and the solution. They identified stigma and difficulties accessing support as key themes. They wanted:

- **All children to learn about mental health and self-harm to remove the stigma**
- **Someone they trust and can go to when they are worried about self-harm**, who will know where to get help: *'some people just don't have anyone to talk to'*
- **Support for parents:** most participants said they would not tell their parents about self-harm, whether not wanting to upset them or to be judged
- Some felt strongly that young people should be able to **self-refer to Child and Adolescent Mental Health Services (CAMHS).**

WHAT PROFESSIONALS SAY ABOUT SELF-HARM

Research indicates that many professionals feel they need a deeper understanding of how to support young people who self-harm. They do not understand the reasons why young people self-harm and do not know what language to use when talking to a young person about self-harm. Similarly, teachers felt 'helpless' and unsure of what they can say; 80% wanted clear practical advice and materials that they can share directly with young people.

THERAPEUTIC INTERVENTIONS

Overall, there is a little evidence on which to base treatment recommendations for adolescents who self-harm.

There is no evidence that giving young people medication reduces self-harm; however, medication may still be appropriate if the young person who self-harms has otherdisorders such as depression or anxiety.

Interventions should be tailored to the young person's needs and personal goals. The aim of the treatment should be to reduce self-harm, reduce risk and address underlying difficulties. In the first instance, it is important that there is limited access to the means of self-harming. Both families and young people should be encouraged to dispose of sharp objects, tablets and other means of self-harm.

Many young people are confused about their reasons for self-harm and it is often hard for them to make sense of what they wanted to achieve by self-harming. Understanding self-harm jointly with the young person, identifying the vicious cycle that keeps self-harm going and mapping the way to break the cycle seems to instil hope and improves the chances of young people getting the help they need.

Support of young people who self-harm should ideally also involve their family members, while acknowledging that in some cases, interpersonal family relationships can contribute to self-harm. Parents may be invited to take part in psychological ('talking') therapies. It is also important to acknowledge the support needs of parents or carers since self-harm is often very stressful for the young person's family.

Self-harm can have many roots, so **collaboration and good communication between parents, teachers, school nurses, mental health professionals and other agencies** areessential.

Supportive psychosocial care, and the role of general practice. Young people who self-harm may seek help from their GP. General practitioners are in a good position to provide initial supportive psycho-social care. The crises associated with self-harm in children and young people can often resolve quickly. Planned brief GP consultations spaced weekly or fortnightly can be supportive to young people, and give them an opportunity to explore the often complex reasons for the distress underlying the self- harming behaviour, and the part it plays in coping. Given the wider knowledge the GP may have of the family and those living at the address, the GP may also know of likely triggers, such as a recent diagnosis of illness in a family member or a history of mental ill health. They are also in a good position to ask about these matters.

It is critical that GPs, like other professionals, ask about suicidal ideation and any continuing suicidal intent; and that they screen for characteristics known to be associated with risk, notably depression and hopelessness (for more information, see Red Flags).

The GP may need to consult with colleagues either through the North Tyneside Early Help process, or specialist CAMHS, to establish whether further assessment of the youngperson's mental state is needed.

Specialist therapeutic interventions: Specific interventions may be indicated, especially when problems are severe or longstanding and where self-harm is associated with use of more dangerous methods or clear suicidal intent. These more specialist interventions include evidence-based treatments such as 3–12 sessions of talking therapy with elements of cognitive–behavioural therapy (CBT), problem-solving therapy, psychodynamic treatments or family therapy (NICE, 2004, 2011). Dialectic behavioural therapy shows promise for repeated self-harm, as does Mentalization-Based Treatment.

WHAT TO EXPECT FROM HEALTH SERVICES

Children and young people who self-harm will be treated with respect, dignity and compassion. They will be treated as individuals and not be judged by their actions.Their engagement will be encouraged, particularly by explaining health and care processes in a clear and sympathetic fashion.

Acute Hospital Services: emergency physical assessment and treatment is undertaken in **the accident and emergency department** (AED) when children and young peoplepresent to hospital following self-harm. This will be accompanied by an initial assessment of the young person's mental state, an initial mental health risk assessment and assessment of safeguarding needs, to include: information about the reasons for self-harm; history of self-harm; a description of mood; the degree of suicidal intent; and family circumstances.

Young people under the age of 16 seen in the accident and emergency department following acute self-harm presentations will be **admitted to a paediatric, adolescent ormedical ward or to a designated unit.** This is indicated regardless of the individual's toxicological state so that comprehensive physical and psychosocial assessments can occur and management/crisis intervention can be planned and initiated.

Admission is usually for an overnight stay. While on the ward, children and young people will receive appropriate medical and/or surgical treatment. Throughout their admission, young people will remain in the overall care of a consultant paediatrician. **A member of the CAMHS Crisis Assessment and Intervention Service (CAIS) will carryout a psychosocial assessment,** ideally within 24 hours, in a private and confidential way. This will involve talking about underlying issues, as well as the recent self-harm, and exploring ways of coping. The mental health professional will always speak to the young person alone first, and will ask if they would like any family members, friends or carers to be involved in the assessment.

The ***Paediatric Liaison Service*** will work in partnership to ensure effective two-way communications and sharing of information between hospital and community servicesto enable children and their parents to receive appropriate care and support.

Child and Adolescent Mental Health Services (CAMHS) teams (which include targeted (Tier 2) and specialist (Tier 3) CAMHS, and the Children and Young People's Improving Access to Psychological Therapies service (CYP IAPT), provide consultation, training and direct delivery. These teams tend to become involved in more risky orcomplex cases, with onward referral to in-patient (Tier 4) services of individuals with very complex problems or at very high risk.

MEETING YOUR TRAINING NEEDS

You may choose to complete the online 'self-harm and risky behaviour' module on the 'Mind Ed' website https://www.minded.org.uk/Catalogue/Index?HierarchyId=0_36198_36204&programmeId=36198 'Mind-Ed' has been developed in partnership with leading experts and is endorsed by the Department of Health.

As recommended by the Royal College of Psychiatrists (2014), the training programme that accompanies this pathway specifically aims to improve the quality and experience of care of young people who self-harm. It will teach our workforce how to recognise and respond to self-harm. It will include education about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes. Young people who self-harm and the frontline professionals who care for them are actively involved in the planning and delivery of this training programme.

[i]We are also working with children, young people, and their parents to pilot ways in which we can increase their understanding of self-harm, and their confidence in helping children and young people navigate their way to the help they need.

SOCIAL MEDIA AND SELF-HARM

When working with children and young people, it is important to gain an understanding of their digital lives, and their experiences of different types of content andengagement with others, without making simplistic assumptions about how harmful or helpful it is.

There are many different ways for young people to express themselves and communicate with each other using social media. This can include platforms such as Facebook and Twitter and microblogging sites such as Tumblr which allow users to upload images, videos, poems and music. These can be very popular with those who self-harm, asthey can share and connect with each other and express themselves creatively.

Owing to the vast number of people using these sites there is huge variation in the content. A number offer support and useful information, but some of this may causedistress and possibly trigger self-harm.

A further aspect of social media is that the individual may be 'followed' by hundreds, if not thousands, of others. This could potentially affirm their identity as someone who self-harms, thus impairing recovery. There are many online experiences which may relate to self-harming behaviour, including humiliation, harassment, threats, sexual extortion, body-image problems and fear of exposure. It is important to understand what is specifically uncomfortable or distressing for each individual.

New digital technologies are also being used increasingly to make available interactive support for people who self-harm: for example through online counselling services. While the evidence of effectiveness of these approaches is limited, early research findings are promising.

KEY SOURCES FOR THIS GUIDANCE

National Confidential Enquiry into Suicide by Children and Young People (2017)

http://documents.manchester.ac.uk/display.aspx?DocID=37566Royal College of

Psychiatrists (2014) Managing self-harm in young people CR 192

National Institute for Health and Care Excellence (NICE 2004) Clinical Guideline 16 : Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

The National Institute for Health and Care Excellence (NICE 2011) Clinical Guideline 133: Self-harm (longer term management)

MindEd e-learning module: self-harm and risky behaviour : MindEd offers training about a broad range of mental health problems in children and adolescents, includingself-harm. Its aim is to help adults to support wellbeing and identify, understand and support children and young people with mental health issues.

OTHER SOURCES OF ADVICE, INFORMATION AND SUPPORT

NATIONAL SERVICES

YoungMinds: provides information for young people on different mental health issues.

Royal College of Psychiatrists: provides information for

parents, carers and anyone who works with young people.

The Royal College of General Practitioners - Youth Mental

Health: provides resources about adolescent mental

health.

ChildLine: provides a free and confidential 24/7 helpline for any worries about children and young people, including self-harm. Call 0800 11 11.

HOPElineUK: Provides a telephone service to support anyone concerned that a young person they know may be at risk of suicide. Call **0800 06841 41,** email: pat@papyrus-uk.org or text 07786 209697.

The Samaritans: offers a 24/7 helpline, including for young people under the age of 18

http://www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-

experiences/topics: shares parents' experiences of self-harm.selfharmUK: provides

support to young people impacted by self-harm

National Self-harm Network: provides crisis support,

information and resources, advice, discussions and

distractions.CALM: offers support to men of any age to

prevent suicide. Call 0800 58 58 58