Child Protection and Safeguarding: Protocols for the management of students who self-harm, display suicidal behaviour or express suicidal thoughts.

We want all staff to feel confident, informed and able to respond to young people who self-harm, display suicidal behaviour or express suicidal thoughts. We strongly encourage all staff to read more about self-harm, suicidal behaviours and suicidal thoughts (please see references) and provide regular training as part of our termly safeguarding INSET.

This document should be read in conjunction with the school's Child Protection and Safeguarding Policy.

Any child or young person, who self-harms, expresses suicidal thoughts or displays suicidal behaviour must be taken seriously, and appropriate help and intervention should be offered at the earliest point. Any member of staff who is made aware that a child or young person has self-harmed, displayed suicidal behaviour or expressed suicidal thoughts should talk with the child or young person without delay.

"If staff have a mental health concern that is also a safeguarding concern, immediate action should be taken, following the school's child protection policy and speaking to the designated safeguarding lead or a deputy" (Keeping Children Safe in Education 2021. Page 12, Paragraph 45.)

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

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

- If they have taken any substances or injured themselves;
- The location of the child or young person;
- Find out who they are with – if anyone;
- Find out what is troubling them;
- Explore how imminent or likely self-harm might be;
- Find out what help or support the child or young person would wish to have;
- Find out who else may be aware of their feelings;
- Find out what they would like to happen - their hopes and expectations.

And 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, abuse and sexual orientation issues?
- What other risk-taking behaviour have they been involved in?
- What have they been doing that helps?
- What are they doing that stops the self-harming behaviour from getting worse?
- What can be done in school or at home to help them with this?
- How are they feeling generally at the moment?

- What needs to happen for them to feel better?

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;
- Feel that you need to manage this alone. Seek support, advice and guidance as required. (if you need to gain further information or support, advise the young person of the timeframe for when you will be in touch again and agree the preferred contact details).

1. Definitions

The World Health Organisation (WHO) defines self-harm as:

- when somebody injures or harms themselves to cope with or express extreme emotional distress and internal turmoil. They do not generally intend to kill themselves, but the results can be fatal. Examples of self-harm include trying to poison oneself by taking too many tablets (medicines or something harmful), cutting or burning, banging head against objects, punching or hitting yourself against something hard. Usually, people who self-harm do not intend to kill themselves;

For the purposes of this policy, suicidal thoughts include:

- **Passive suicidal ideation –** wishing you were dead or that you could die or having abstract thoughts about ending your life or feeling that people would be better off without you but without any plans to take your own life.
- **Active suicidal ideation** – thinking about methods of suicide or making clear plans to take your own life.

Suicidal behaviours, including attempted suicide, are defined for the purposes of this policy as:

- acts of self-harm with the potential to take life, regardless of intent;

Keeping children safe relies on adults using language with clarity to ensure concerns and the level of risk are clearly communicated. Staff must therefore be familiar with these terms and use them accurately when reporting and recording concerns.

2. Risk Factors

Risk factors for self-harm include:

- Age — self-harm rates peak in 16 to 24-year-old women and 25 to 34-year-old men. Suicide rates are highest in both men and women aged 45–49 years.
- Socio-economic disadvantage.
- Social isolation.

- Stressful life events, for example relationship difficulties, previous experience in the armed forces, child maltreatment, or domestic violence.
- Bereavement by suicide.
- Mental health problems, such as depression, psychosis or schizophrenia, bipolar disorder, post-traumatic stress disorder, or a personality disorder.
- Chronic physical health problems.
- Alcohol and/or drug misuse.
- Involvement with the criminal justice system (with people in prison being at particular risk).

Suicide risk factors:

- A recent or serious loss. This might include the death of a family member, a friend or a pet. The separation or a divorce of parents, or a breakup with a boyfriend or a girlfriend, can also be felt as a profound loss, along with a parent losing a job, or the family losing their home.
- A psychiatric disorder, particularly a mood disorder like depression, or a trauma– and stress-related disorder.
- Prior suicide attempts increase risk for another suicide attempt.
- Alcohol and other substance use disorders, as well as getting into a lot of trouble, having disciplinary problems, engaging in a lot of high-risk behaviors.
- Struggling with sexual orientation in an environment that is not respectful or accepting of that orientation. The issue is not whether a child is gay or lesbian, but whether he or she is struggling to come out in an unsupportive environment.
- A family history of suicide is something that can be really significant and concerning, as is a history of domestic violence, child abuse or neglect.
- Lack of social support. A child who doesn't feel support from significant adults in her life, as well as her friends, can become so isolated that suicide seems to present the only way out of her problems.
- Bullying. We know that being a victim of bullying is a risk factor, but there's also some evidence that kids who are bullies may be at increased risk for suicidal behavior.
- Access to lethal means, like firearms and pills.
- Stigma associated with asking for help. One of the things we know is that the more hopeless and helpless people feel, the more likely they are to choose to hurt themselves or end their life. Similarly, if they feel a lot of guilt or shame, or if they feel worthless or have low self-esteem.
- Barriers to accessing services: Difficulties in getting much-needed services include lack of bilingual service providers, unreliable transportation, and the financial cost of services.
- Cultural and religious beliefs that suicide is a noble way to resolve a personal dilemma.

Staff responses

Staff should apply the following principles in all situations.

Risks:

- The child is injured or has ingested any substances and requires medical attention;
- The child goes home with an injury that has not been seen by a first aider;
- The child hurts themselves or puts themselves at risk either in school or at home;

- Other children are aware of, or have witnessed a peer or friend's self-harm, suicidal behaviour and/or suicidal thoughts.

Confidentiality:

- Reassure the child that they do not need to share how the injury happened – the priority is to make sure they are OK;
- Explain to the child that you care for them and are worried about them and that you may need to involve some other adults to help keep them safe. Only people who need to know will be told. This includes parents. We encourage children to talk to their parents and support them to do so, but we will not talk to parents without at least discussing this with the child first.

Recording and Reporting:

- If a peer or friend is affected by self-harm, suicidal thoughts or suicidal behaviours, record this as a new concern and send to the **COMPASS referral** notification group.

Actions

1. First Aid.

Follow the normal first aid procedures to treat any injuries. If staff believe first aid is required, but the child refuses to see a first aider, staff should make every effort to encourage the student to see a first aider. This may include informing the child's LSA and asking them to encourage the child. If the child continues to refuse first aid attention, this should be treated as a safeguarding concern requiring immediate action and be brought in person to the DSL or a Deputy DSL.

2. Ask and check.

Ask the child if they have already spoken to a member of staff in their tutor team about self-harm or suicidal thoughts. Praise them if they have. Check who they have spoken to and tell them that you will go and speak with this member of staff to share your worries. Ask the student if there is anything the child would like you to say to the tutor team. Ensure tutor team staff are aware of concerns.

3. Record and Report

- Self-harm

If the self-harm is superficial **AND** the child sees a first aider, **AND** the concerns are already known to a member of the tutor team, then staff do not need to start a new concern. Instead:

  - Tutor team staff should either add to the chronology of an open concern **OR** add a profile update.
  - First aider to notify parents/carers following normal first aid protocols;

If the self-harm is superficial **AND** the concerns are **NOT** already known to a member of the tutor team, then:

  - the member of staff should start a new concern on MyConcern and send to the **DSL notification group;**

- Tutor team to contact parents/carers before the child gets home.

- **Suicidal behaviours**

If the self-harm is NOT superficial, then:

- the member of staff should immediately report their concerns in person to the DSL or a Deputy DSL. The DSL or Deputy DSL will help staff to identify an appropriate course of action and will direct staff to start a new concern on MyConcern and send to the **Safeguarding Concern Requiring Immediate Action** notification group;
- DSL or Deputy DSL to contact parents/carers.

Refusal to see a first aider

If the child refuses to see a first aider, then:

- the member of staff should immediately report their concerns in person to the DSL or a Deputy DSL. The DSL or Deputy DSL will help staff to identify an appropriate course of action and will direct staff to start a new concern on MyConcern and send to the **Safeguarding Concern Requiring Immediate Action** notification group;
- DSL or Deputy DSL to contact parents/carers.

- **Suicidal thoughts**

If staff believe the child has suicidal thoughts, or the child is expressing suicidal thoughts, then:

- The member of staff should engage in conversation with the child or with the child's tutor team to determine whether the thoughts are Passive Suicidal Ideation or Active Suicidal Ideation;

If the suicidal thoughts are Passive **AND** the concerns are already known to a member of the tutor team, then staff do not need to start a new concern. Instead:

- Tutor team staff should either add to the chronology of an open concern **OR** add a profile update.
- Tutor team to contact parents/carers before the child gets home.

If the suicidal thoughts are Passive and **NOT** already known to a member of the tutor team, then:

- the member of staff should start a new concern on MyConcern and send to the **DSL notification group;**
- Tutor team to contact parents/carers before the child gets home.

If the suicidal thoughts are Active:

- the member of staff should immediately report their concerns in person to the DSL or a Deputy DSL. The DSL or Deputy DSL will help staff to identify an appropriate course of action and will direct staff to start a new concern on

MyConcern and send to the **Safeguarding Concern Requiring Immediate Action** notification group;
- DSL or Deputy DSL to contact parents/carers.

Scenarios – Additional actions for ALL staff in the following situations.

Scenario 1: A child is in the act of self-harming, is expressing suicidal thoughts or displaying suicidal behaviours is.

In this scenario, the priority is to minimise physical harm, and provide immediate emotional support.

1. Minimise Physical Harm

    - Assess the risk – Don't overreact if the risk is minimal; Don't underreact.

    If you believe the child is behaving in a way that could lead to serious injury or death, then you may take the decision to use force.

    Use of force is not an appropriate response where children are displaying superficial self-harm. Taking away an object that a student is using to rub their skin sore or holding a student to prevent them picking their skin may lead to a student adopting more harmful methods and/or damage the trust between themselves and staff. Using words, for example telling a student to stop, can have the same effect.

2. Emotional Support

    - Co-regulate

    Encourage the child to copy your breathing: Count the breath in; Count the pause; Count the breath out. Use a low, calming voice. Keep your language simple. Remind them that these feelings will pass. Tell them you are here to help and want to keep them safe.

    - Distract

    If a child is using an object to hurt themselves with, you might simply say, "That looks a bit dirty. I don't want you to get an infection. Why don't we go and give it a wash and then see how you feel about it?" The mindfulness of washing the object and their skin, along with the caring messages may be enough to break the cycle. Going for a walk or engaging in an activity like mindful colouring can also help.

    - Supervise the child

    When the child is ready, they can be in class. Any decision to return a child has has self-harmed, displayed suicidal behaviours or has expressed suicidal thoughts, must take into account the safety and welfare of peers as well as the child. Being in class may be part of the distraction, and as long as the child has received first aid if necessary then being in class is probably the safest way to ensure supervision. If you are not staying with the child, make sure someone in the room is aware, being mindful of confidentiality.

    If a child is unable to return to class, then COMPASS or a sensory room would be the most appropriate place for a child to be to access support and ensure supervision.

Some children may have a safety plan in place that identifies agreed safe places. If a child is accessing their safe place then supervision must still be in place.

It is the responsibility of the staff member who first encountered the child to ensure appropriate supervision is in place before leaving the child.

A child who has self-harmed, displayed suicidal behaviours, or expressed suicidal thoughts cannot be left unsupervised unless the DSL, a Deputy DSL or the child's case owner have agreed to that.

Children who have displayed suicidal behaviours or expressed suicidal thoughts may not be safe to remain at school. The the Head Teacher, DSL or a deputy DSL may make this decision. If a child is deemed unsafe to be in school, then the Head Teacher, DSL or Deputy DSL may take one of two courses of action:

- Arrange for parents to collect the child. In this scenario, parents should be advised to consult with medical professionals, either by contacting their GP, a CAMHS professional if CAMHS are involved, or by going to Children's Emergency (Under 16), or Adult Emergency (Over 16) at Leicester Royal Infirmary.
- Arranging for school staff to take the child to Children or Adult's Emergency and meeting parents/carers there.

If a child is deemed unsafe to be in school because they have displayed suicidal behaviours or expressed suicidal thoughts, the DSL or a Deputy DSL should seek permission from parents/carers to make a referral for Early Help via a MARF. The rationale not to make such a referral should be recorded on MyConcern. Reasons to not refer for Early Help might include: A recent referral has already been made; Social Care and Health services are already involved.

Scenario 2: You are supervising a student who has recently self-harmed, displayed suicidal thoughts or expressed suicidal behaviours.

In this scenario, staff play 3 crucial roles: Ensuring physical safety, providing a safe space for the child to regulate their emotions and to talk, and keeping the child informed about what is going to happen next.

Actions

- Ensuring physical safety

    - Supervision

    The balance is to provide safe supervision whilst also giving the child enough space. Staff will need to use professional judgment to move between close, direct and remote supervision whilst always maintaining visual observation as a minimum.

    It is OK for staff to say that they are here to listen when a child is ready to talk, and then allow the child to do some mindful colouring, listen to music, or engage in sensory play.

    After an appropriate period of time, staff may need to initiate the conversation: "Can we talk about what happened?" is a simple way to begin.

- Safe space

From the outset, supervising staff should be clear about their role:

- "I've been asked to keep you safe, so I need to be able to see you at all times until someone tells me I can stop doing that.";
- "I am here to listen to you so we can work out the best ways to keep you safe.";
- "It's my job to make sure you know and understand what is happening now and what is going to happen next."

Staff should explicitly talk about confidentiality and what this means:

- "I will have to share information because this will help keep you safe";
- "I don't have to share information with lots of people and I will make sure you know what is going to be shared and with whom";
- "I will not share information with people who don't need to know"; and
- "You will not talk about self-harm or suicidal thoughts with peers or friends in school. Your friends have learning difficulties as well and it is not fair to expect them to be able to deal with with this. Your friends will care and worry but won't necessarily know how to help."

Once ready to talk, students should be given the tools and support to communicate in a way that is useful to them. You cannot have this conversation with other students in the room – this conversation needs to be confidential.

Staff should ask open questions and spend most of their time listening. It is OK to talk openly about suicide and self-harm. This is not a checklist of questions, and staff may decide it's not appropriate to ask some or any of them, but they are included here to acknowledge that these questions, or similar questions may be asked:

- "Have things got so bad that you've thought about hurting yourself or ending your life?"
- "Sometimes when people feel the way you do right now, they start to have thoughts about suicide. Has this ever happened to you?"
- "What kinds of thoughts have you been having?"
- "How long have you been having these thoughts? When did they first start?"
- "How long have you been having these thoughts? When did they first start?"
- "Do you have a plan for how you would kill yourself?"
- "Have you thought about any other methods?"
- "In the next 24–48 hours, on a scale of 1-10, how likely is it that you will act on your suicidal plan?"

Whilst a record on MyConcern is likely, staff should not be making meticulous notes whilst the child is talking. Staff may say to a child:

- "I might make a few simple notes as we go along so that I don't forget anything important."

- "I will show you my notes and read them to you when we are finished so that you know what I've written."
- "I might keep the notes and put them on MyConcern."

Start a safety plan. Use the safety plan to facilitate a conversation about how staff and the child can work together to keep them safe.

- Keeping the child informed

Supervising staff should act as an advocate for the child. They should be kept informed about what is going to happen next and they should ensure the child is aware of any plans. Children are likely to be anxious about the following:

- Parents/carers finding out or being told

If the DSL or Deputy DSL consider the child to be at further risk then parents will need to be told. In an ideal world, school staff provide appropriate support for the child to be able to inform their parents/carers about what has happened. However, the world is often far from ideal. Sometimes to safeguard a child, the DSL or a Deputy DSL has to inform parents without the child's consent. In this scenario, the supervising staff can help to explain why this decision has been made.

- Being sent home

The Head Teacher, DSL or a Deputy DSL may decide that the child is unsafe to remain in school. Supervising staff can help to explain this decision to make it clear that this is not a punishment for bad behaviour but simply a decision to keep them and others safe and ensure they access the help they need.

- Going to Children or Adults' Emergency

The Head Teacher, DSL or a Deputy DSL may decide that the child needs to attend Children or Adults' Emergency. The child may be taken directly there by school staff and met by parents/carers, or parents/carers may collect the child from school and then make their way there. In either case, this is likely to make children anxious. Supervising staff should explain what will happen and ensure that the child is comfortable with the arrangements.

Scenario 3: You suspect a child whose MyConcern team you are not a member of, has or may have self-harmed, or you are concerned they may be displaying suicidal thoughts or have suicidal behaviour.

In this scenario, you will not have access to the child's chronology on MyConcern and therefore you will not be privy to the full picture. In this case, you may not be aware of what is already in place. You do still have a duty of care to ensure the child is safe.

Actions

- First Aid
- Ask and check.

- Record and Report

Scenario 4: You suspect a child whose MyConcern team you are a member of, has or may have self-harmed, or you are concerned they may be displaying suicidal thoughts or have suicidal behaviour.

In this scenario, you will have access to the child's chronology on MyConcern and therefore you will not be privy to the full picture. In this case, you will know if the behaviours displayed are new behaviours, an escalation of behaviours, or a repetition of behaviours. You do still have a duty of care to ensure the child is safe.

Actions

1. First Aid
2. Ask and check.

   In this scenario, staff are a member of the tutor team. As such, you should be **asking yourself**, and other members of the tutor team whether the behaviours displayed are in-line with previous, known behaviours, or if the behaviours represent an escalation. If the behaviours represent an escalation, then record as a new concern and speak to the DSL or a Case Owner if the child has one.

   As a member of the tutor team, you should always ensure that systems are in place within the tutor team are in place to support children who self-harm, display suicidal behaviours or express suicidal thoughts.

   At Wave 1, tutor teams should have in place some or all of the following:

   - Regular contact with parents to explicitly discuss self-harm, suicidal behaviours and/or suicidal thoughts;
   - Regular opportunities to talk openly and confidentially with a trusted member of the tutor team;
   - Regular use of emotional regulation tools (Chirpy; Zones of Regulation etc);
   - Individual safety plan, including positive strategies, trusted adults, safe places, and out of hours signposting;
   - A class worry box;
   - Whole-class signposting to internal and out of hours support

3. Record and Report

   In this scenario, staff need to assess whether the information is best recorded as an update on an existing, open concern, or as an update on the child's profile chronology, or if the child's presentation and displayed behaviours warrant a new concern.

Where the behaviour is known and part of an established pattern of behaviour, it is likely that the child will have been assigned a case owner. Case owners are DSL trained and can provide an additional level of support and advice to the tutor team.

Risk Assessment

The DSL or a Deputy DSL will decide if a child requires an individual risk assessment. If required, 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 thoughts;
- 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 some risks may remain static whilst others may be more dynamic such as sudden changes in circumstances within the family or school setting.

The level of risk may fluctuate and a point of contact with a backup should be agreed to allow the child or young person to make contact if they need to.

The 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 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.