Joint Protocol – Nottingham City Children's Social Care & Child and Adolescence Mental Health Service (CAMHS)

Contents

Contributors;

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1. Introduction

This Protocol aims to promote effective joint working between Nottingham City Children's Social Care, the Targeted Child & Adolescent Mental Health Service's (CAMHS), the CAMHS Children Looked After Team and Nottingham healthcare trust's Community CAMHS and CAMHS Crisis team, to ensure a coordinated approach to self-harm where there are also Child Protection or Safeguarding concerns (e.g. domestic violence).

1.1 Services Involved:

This Protocol will apply to staff working within

- Nottingham City Children's Social Care
- Whole Life Disability Team.
- Nottingham Targeted CAMHS (previously known Tier Two service)
- Nottinghamshire Healthcare NHS Trust Community CAMHS (previously known as Tier Three service) and the CAMHS Crisis Team
- Nottingham City Council and Nottinghamshire Healthcare Trust CAMHS Children Looked After Team

1.2 Purpose of the Protocol:

- The main aims of the Joint Protocol are to
- Strengthen the quality of support, advice and guidance offered to children and young people who self-harm, or may be at risk of suicide
- Ensure the needs of children and young people who self-harm are routinely considered for joint assessments undertaken by both Children's Social Care and the most appropriate CAMHS team in partnership.
- Ensure the needs of the child/young person are fully considered by way of a joint assessment / joint visit / professionals meetings.

1.3 The Joint Protocol provides a clear framework outlining to staff what is expected:

- From them as an individual Practitioner
- From their practice when they are working jointly

- From their service.
- In their practice staff adhering to the Joint Protocol must ensure that they refer to Nottinghamshire and Nottingham City Safeguarding Children Board Safeguarding Children Procedures, the Boards Children and Young People who Self-Harm Interagency Practice Guidance and the Family Support Pathway.

1.4 **This document provides some definitions and updated guidance of the risks associated with self-harm/suicidal behaviours.**

2. **Definitions of Self-Harm:**

The definition of Self-harm adopted by the National Institute for Health and Clinical Excellence 2004 guidelines: Self-harm is 'self-poisoning or self-injury, irrespective of the apparent purpose of the Act'

Examples of Self- harm includes the following behaviors:

- Burning using cigarettes or caustic agents
- Cutting
- Scalding
- Punching and bruising
- Breaking bones
- Inserting or swallowing objects
- Head banging, pulling hear or scratching the body
- Pulling out hair or eyelashes
- Overdosing/self-poisoning (tablets, medicines, chemicals)
- Inhaling or sniffing or ingesting harmful substances
- Asphyxiation, attempted hanging or strangulation

NB Although self-harming behaviour can be an attempt to cope and manage and may not be accompanied by suicidal intent, it must be recognised that the emotional distress that leads to self-harm can also lead to suicidal thoughts and actions.

3. Suicide:

3.1 Suicide is the act of intentionally causing one's own death.

3.2 Suicidal intent is indicated by evidence of premeditation (such as saving up tablets), taking care to avoid discovery, failing to alert potential helpers, carrying out final acts (such as writing a suicide note) and choosing a violent or aggressive means of self-harm allowing little chance of survival.

3.3 The vast majority of children and young people who self-harm are not trying to kill themselves, however many people who die through suicide have self-harmed in the past, and for that reason each episode whether planned, accidental or spontaneous needs to be taken seriously and assessed and treated in its own right.

4. Responding to Self-ham in Primary Age Children:

Where information comes to the attention of practitioners, which suggests that a primary age child has self-harmed, serious consideration must be given to whether there are other underlying factors, including child abuse. **All children under 10 years old, with this presentation, should be seen by a Social Worker and a CAMH's Practitioner/professional under the guidelines of this Joint Protocol.**

- Avoid using the label 'self-harm' in a primary age child as you would, with a young person of any age and instead reframe a child's behaviour as the demonstration of emotional distress and/ or **help seeking behaviours**
- Use chronologies and genograms to provide clarity to all involved of the extent, pattern and severity of concern and to support referrals to Children's Social Care
- Keep accurate records of what 'self-harm' the child is alleged to have done, how frequently and the impact this has had
- Be mindful that if child abuse is occurring, rather than self-harm, that a child may have been coached to say they are self-harming
- Keep clear records of what the child is reported to have done, how often, any injuries they have sustained, rather than simply saying the child 'self-harms'. Seek clarification from other practitioners who use the term to find out exactly what they mean

- Maintain professional curiosity - and look for the evidence to support or disprove potential hypotheses, triangulate evidence and add example
- Be aware that what may have started as a hypothesis can become fact along the way - reflect on and analyse historical records and assessments to understand whether or not a different hypothesis may be a better fit. Usereflective supervision processes to help support this process.

5. Vulnerabilities related to Self-harm and or Suicide Risk:

5.1 The following table lists behaviours and situations that could indicate risk of self-harm or suicide in young people. This list is offered as a guide and not as a diagnostic tool. Whilst protective factors can reduce risk, their absence clearly increases vulnerability to self-harm. Developing protective factors is an important means of reducing risk.

	Vulnerabilities	**Protective Factors**
Characteristics of the individual child	• History of self-harm (increases risk of suicide, specifically self-harm by cutting) • Low self esteem • Increasing age • Asylum & Refugee • Child has a disability including ASD, ADHD or other • Poor coping skills • Perfectionism • Hopelessness • Difficult temperament • Mental distress or illness, e.g. anxiety/depression • Alcohol/substance misuse	• High self esteem • Outgoing personality • Good coping skills • Positive school experience • Secure attachment • Resilience • Knowledge of where to seek support • Good problem solving skills

	• Stress or worries about school work or peers • Past or current experience of abuse • Feeling isolated • Recent bereavement • Identifies as Lesbian, Gay, Bi Sexual, Transgender (LGBT) • Adolescence • Being male (increased risk of suicide) • Being female (increased self-harm)	
Features of the immediate context	• Access to means of causing self-harm • Isolation • Social exclusion • Using alcohol and drugs • Negative social networking • Anti-social behavior/involved in crime • Child sexual exploitation • Exposure to others who have completed suicide • Child looked After	• Access to social support • Social inclusion

	• Young Carer	
Family Factors	• Family members who self-harm or have attempted or **completed suicide** (high risk factor) Insecure Attachments • Family conflict • Parental separation and divorce • Not living with both biological parents • Family Parental illness (physical/mental) • Parental alcohol/drug misuse • Emotional Harm • Neglect • Sexual/physical abuse • Poverty/financial distress • Domestic abuse/violence • Pressure from family to achieve at school	• Supportive adult relationship • Harmonious family relationships • Low level of material or social hardship • Good role models within family
Peer group	• Arguments with friends • Bullying/cyber bullying	• Stable and secure friendship group

	• Friends who self-harm • Loss of a friend	
School/college	• Pressure from school to perform well • Transition/move to another school • Poor relationships with adults. Poor attendance/ school refusal • Poor achievement	• Good attendance • Supportive adult • Inclusive/incorporative ethos • Strong commitment to PSHE mental health promotion • Establishment of peer support systems
Wider culture and community	• Minority status • Problems in relation to race, culture or religion • Problems regarding sexual orientation or identity • Media portrayals glamorise self-harm or suicide ‘victims’ and elicit ‘copy-cat’ responses by vulnerable children and young people	• Access to social support

6. Assessment of Risk and Interventions:

6.1 An early assessment of self-harm should take place to ensure that the child or young person gets timely and appropriate support. Practitioners need to be aware that risk factors are not, nor can they ever be, tools for prediction. The risk indicators provide a guide for Practitioners to assess the nature and severity of the problem to minimise risk, increase safety and ensure appropriate access to services. Practitioners need to be mindful that any risk assessment can only be valid at the moment at which it is carried out and therefore might need to be repeated at regular intervals according to professional judgment or advice.

6.2 Self-harm can be a symptom of distress which in not always related to a mental illness. In a self-harm assessment, unless a child or young person refuses they should be seen alone. If they refuse to be seen alone, work is needed to be undertaken to understand why this is the case, for example they could have they been told to say this by an abuser?

The assessment should be holistic gathering information from other sources, such as parents or carers, other significant adults, peers, and other professionals. It should take into account any parenting capacity issues for the parents/carer (i.e. mental health, substance misuse, domestic abuse etc.) and how this impacts on the child(ren) and whether:

- The parenting being provided is adequate to meet the needs of the child(ren) and keep them safe
- The parenting is having an impact on the young person's self-harm behaviour.

7. Consent:

7.1 If a young person is deemed to need support from other professionals the worker supporting the individual will:

- Seek consent from the young person to share information
- Tell the young person what information will be shared, why it should be shared and the consequences of sharing.
- Ensure privacy notice and consent information is clearly shared with them and they understand this process and where to find this information

7.2 Sometimes concerns of significant harm may lead to a referral being made without consent. However, it is highly recommended to seek consent where possible.

8. Levels of Risk and Suggested Intervention:

8.1 The order of the factors in the list below is not necessarily significant, as they are all worthy of consideration. When assessing risk Practitioners need to consider the duration of the thoughts and if the young person has planned/researched methods.

Level of risk	Risks	Actions
Low Risk	• Superficial, minor self-harm in stable social context. Suicidal thoughts are fleeting and soon dismissed • No intention to act on thoughts • No plan • Current situation felt to be painful but bearable. • No alcohol or substance misuse • No signs of psychosis (delusional thoughts and behaviours)	• Ease distress as far as possible. Consider what may be done to resolve difficulties • Alternative coping skills. • Complete safety plan with young person, family & network • Link to other sources of support • Make use of line management or supervision to discuss particular cases and concerns • Review and

		reassess at agreed intervals. • Consider completing a Common Assessment Framework (CAF)/ Priority Family Assessment
Medium Risk	• Suicidal thoughts are frequent • No specific plan or immediate intent • Emotional distress impacting on wellbeing • Situation felt to be painful, but no immediate crisis • History and / or current self-harm	• Ease distress as far as possible. Consider what may be done to resolve difficulties • Harm minimization strategies • Complete safety plan with young person, family & network Consider universal and early intervention services i.e. Kooth, School counselling, school mentor, harmless or base 51 • Consider safety

		of young person, including possible discussion with parents/carers or other significant figures • Seek advice through consultation • Possible mental health assessment – discussion with, for example primary mental health worker, Child and Adolescent Mental Health Service (CAMHS) or G.P. • Consider consent issues for the above • Consider increasing levels of support/professional input • Review and reassess at agreed intervals – likely to be

		quicker than if risk is low. • Promote hopefulness and build on self-confidence by engaging in future orientated conversation
Medium/ High Risk	• Evidence of current mental condition disorder, e.g. depression or psychosis • Unstable psychological situation with impending crisis • Significant drug or alcohol misuse • Previous, especially recent, suicide attempt • Current self- harm increasing in frequency, duration and severity • Change in method of act of self-harm and impulsivity of harm • Suicide thoughts more frequent and intrusive • Thinking/researching about methods of suicide • Use of drugs and alcohol when self-harming	• Harm minimization strategies • Complete safety plan with young person, family & network • Provide details of emergency and out of hours services including CAMHs crisis team number if concerns of immediate risk • Referral to CAMHS to the behavioural, emotional, mental health pathway • Work in a multiagency way including holding

	• No immediate intent to take life • Current Situation felt to be unmanageable • Feeling of hopelessness	regular meetings • Ongoing risk assessment through intervention • Use available resources (see appendix) • Increase contact with young person through phone or face to face
High Risk	• Current intent/ plan to take own life with access to potentially lethal means • Self-harm which requires medical attention or has led hospitalisation • Intrusive, frequent suicidal thoughts, which can't be dismissed • Evidence of current mental illness • Current crisis • Significant drug or alcohol use • Current situation felt to be causing unbearable pain or distress • Increased self-harm, (frequency, duration potential lethality or	• Ease immediate distress as far as possible. Consider what may be done to resolve difficulties • Do not leave the child alone • Contact CAMH's crisis team for consultation if concerns about immediate risk • Harm minimization strategies alongside alternative coping skills. • Complete safety plan with young

	both). • Complete withdrawal and isolation • If the following 5 risks factors are all currently present, male, history of self-harm, intent to take life, plans in place and hopelessness	person, family & network • Safety – discussion with parents/carers or other significant figures more likely (immediate action to secure safety) • Increase contact with young person through phone or face to face • Consider overriding any issues re consent to treatment consent issues • Consider increasing levels of support/ • professional input in the mean time • Monitor in light of level of CAMHS involvement • Promote hopefulness and build on self-confidence by

		engaging in future orientated conversation • Explore previous coping strategies • If young person requires immediate assessment or treatment ensure they seen by the Crisis team or taken to Emergency department • Seek senior guidance if confidentially or consent could be a barrier to keeping a young person safe. • Medical attention

9 Referrals to Children and Families Direct involving self-harm and Child Protection or Significant Children in Need Issues:

9.1 In the event of the Children and Families Direct receiving a call from an outside agency or a member of the public that relates to self-harm and there is either Child Protection or significant Children In Need issues and the case is not known to Children's Social Care then the referrer will be immediately put through to a member of staff for a referral to be taken. If the child has a severe and lifelong disability the call will be directed to the Whole Life Disability Team.

9.2 All open cases will be directed to the case-holding team whether that is Children's Social Care. If at point of the referral, a Children's Assessment is identified as being required and self-harm is present, the identified Social Worker can seek consultation/advice from CAMHS or request a joint visit where appropriate.

9.3 Where a case is currently open to CAMHS and a joint assessment with Children's Social Care is needed as there are coexisting safeguarding concerns including concerns that the level of self-harm is so significant they require a Children in Need or Child Protection Plan. The CAMH's Practitioner will contact the Children's Social Care Team Manager where the child resides in order to do a joint assessment. Refer to the transfer policy

9.4 A visit to the child will happen within 48 hours depending on the level of risk, the time should be appropriate for the family and young person. In extreme circumstances where it has not possible to undertake the assessment within 48 hours, or the family are not home for the visit/do not turn up as agreed, the level of risk does not reduce during this period, so there should be ongoing and regular communication to ensure that the child or young person is safeguarded, until the visit can be undertaken. If the 48 hour time scale is not met, the reasons for this should be clearly recorded in the child/young person's records and the visit that takes place should still be deemed as a joint protocol visit and assessment and not just a home visit.

9.5 Where a child has a diagnosed disability, any additional concerns/vulnerabilities need to be assessed within the context of his/her disability. When little is known or understood about the impact or consequences of a child's disability, advice, information and possibly ongoing consultation should be sought from the Whole Life Disability Team, even when a referral may not be appropriate or the child does not meet the criteria for the Whole Life Disability Team.

9.6 As two professionals will visit the home together, no shadowing from other professionals should be undertaken.

10. Referrals made by Non CAMH's Practitioners:

10.1 Duty Social Worker Responsibilities:

- Ensure that the correct information is gathered from the referrer to support their referral.
- Refer to risk indicators in Joint Protocol to aid decision making
- Consider the need for a joint approach (visit/assessment) with CAMHS. If needed contact CAMHS Single Point of Assess (SPA) to discuss telephone 0115 8764000
- In the case of a high risk suicidal behavior or severe self-harm the Duty Team contact the CAMHS Crisis Team 0115 8440560

10.2 Where the referral is accepted and it is agreed that a joint assessment with CAMHS is required the Duty Social Worker will contact the Single Point of Access (SPA) on 0115 8764000 to request a joint working arrangement.

11. Referrals (Duty Team and Whole Life Disability Team) and requests made to Children's Social Care (Community Fieldwork Teams) or Whole Life Disability Team by CAMHS Practitioners:

11.1 Where it has been identified that there are potential safeguarding or complex concerns in relation to self-harm, any subsequent visits or assessments should be undertaken by the Social Worker or a WLDT worker and a Citywide CAMH's Practitioner. Duty have up to 45 days working days from the date of the referral in which to conduct, populate, review and complete the Children's Assessment. As part of the joint assessment, the CAMH's Practitioner should undertake a self-harm risk assessment. On completion of the assessment the CAMH's Practitioner will make recommendations for further intervention and safety planning.

Where a child/young person has presented at hospital due to self- harm or suicidal behaviors, a Self-harm Assessment will be undertaken by the CAMHS Crisis Team or by the on call Doctor. Where it is identified within the hospital assessment that there are safeguarding issues Children's Social Care will be notified and a discharge planning meeting will be held to consider the immediate and medium term safety plans to ensure the child/young person remains safeguarded once they have left hospital. The hospital safeguarding practitioner may often be invited to a Discharge Planning Meeting.

11.2. **Practitioner and Social Worker's Responsibilities**

It is the joint responsibility of the CAMH's Practitioner and Social Worker to agree

where a case requires a joint approach. This is most likely to include a joint visit, a joint assessment or a professionals meeting. Where this is not possible there needs to be good communication between professionals and a clear plan with clear roles.

11.3 It is expected that the referring practitioner will share with the Duty Worker:

- Risks / concerns / safety factors/strengths;
- Any relevant care plans and risk assessments, including self-harm assessments, CAF, Priority Family Assessments and safety plans;
- Any previous history that would aid the referral including any known self-harm including severity/duration and risk of this.

11.4 Requests by WLDT, CAMHS or Children's Social Care for a joint approach will be responded to positively by all practitioners and their Team Managers who will support such joint working initiatives by agreeing the most appropriate response i.e. a joint assessment, a joint visit or attending a professionals meeting.

11.5 The Duty Team/ Whole Life Disability Team Manager and /CAMH's Specialist/ Manager will:

- Identify a worker to complete a joint visit / joint assessment or a professionals meeting **within 48 hours of the referral being received.**
  NB this may require Team Manager agreeing an immediate response due to the levels of risk or need involved.

11.6 Where a referral has been accepted by Children's Social Care and a joint assessment / joint visit / professionals meeting has been agreed:

The allocated Social Worker will:

- Call the Nottingham City Council CAMHS Single Point of Access to confirm the date, time and venue of the joint assessment / joint visit and practitioner. Once the CAMH's Practitioner has been identified the Social Worker will contact the CAMH's Practitioner ensuring that they are both fully briefed and are clear of their roles and responsibilities when completing this task
- Start a Children's Assessment at which point the allocated Social Worker becomes the lead professional and holds case responsibility
- Ensure that there is a written agreement at this point about how the self-harm is to be managed and who is overseeing and updating the safety plan.

The CAMH's Practitioner will:

Share existing and historic assessments/current safety plans, and any interventions with Children's Social Care

- Ensure CAMHs contribute to any other processes already in place such as Child Protection Reviews
- Contribute fully to any Children's Social Care assessment or processes as required
- If there is an appropriate and on-going role for CAMHS, CAMHS will undertake any therapeutic work or consultation depending on:
    - If the family/YP consent and are willing to engage with CAMHS
    - It is therapeutically safe to do so
    - Identification of the appropriate level of CAMHS support required, i.e. Targeted or Community, and what type of intervention is appropriate, in consultation with the child, young person and family and the professionals involved

11.7 Children's Social Care and Whole Life Disability Team will lead on assessing the needs of all of the children within the family. The CAMHS Practitioner will help to inform the assessment around self-harm/mental health needs and support the Social Worker to identify the therapeutic needs of the child/young person. The Social Worker will complete the Children's Assessment within 45 working days of the referral being accepted.

11.8 For cases open to Community Social Work Teams the request for joint working will be made to the allocated Social Worker.

12 Requests made by Children's Social Care/ Whole Life Disability Team to CAMHS to jointly work a case:

12.1 Where a Duty Social Worker, a Community Social Worker or a Whole Life Disability Worker find that a self-harm case they are involved in requires Joint Protocol with CAMHS, if the case is known to CAMHS the allocated CAMHS Practitioner will arrange a joint visit or consultation depending on the current situation. If the case is not known, the case needs to be referred to CAMHS via the Single Point of Access (SPA) where the case will be allocated

12.2 Where there is a more serious mental health/self-harm presentation the CAMH's

Practitioner or Manager will discuss the case with Community CAMHS SPA Representative.

13. Children in Care

If a child/young person is in Local Authority Care and the Social Worker has identified mental health needs, they can access the Children Looked After CAMHS Service. The team can offer consultation to the practitioner, foster carer or residential worker and/or offer direct work to the child/young person. (Please see Appendix) If a Joint Protocol response is required, the allocated CAMHS CLA practitioner/duty worker will undertake the assessment with the allocated LAC Social Worker within the agreed 48-hour timescale. We know from research (as detailed in section 5) that being child/young person in care can be a significant risk factor that can lead to self-harm/suicidal behaviours. It is therefore very important that the professional networks involved in child in care services understand this protocol and have training to ensure the protocol is followed correctly.

13.1 Following completion of joint assessment/visit/meeting:

When a joint assessment / joint visit / professionals meeting has been completed the Children's Social Worker and CAMHS practitioner will:

- CAMHs' Practitioner will complete the self-harm risk assessment paperwork and a safety plan and send to the Social Worker
- The Social Worker will complete the Children's Assessment and share with the CAMH's Practitioner
- Ensure the assessment completed is shared between both services and recorded / filed in Liquid Logic and any relevant network member is informed. This could be a combined report that is co-authored by both Practitioners
- Jointly consider any parenting capacity issues for the parents/carer and how this impacts on the child(ren) including the implementation of any safety plan i.e. is the parenting being provided adequate to meet the needs of the children / how does the parent's needs (mental health, substance misuse, domestic abuse) impact on the child/young person? Assessments should include discussions with agencies involved with the parents to understand any concerns that they might have, what support is currently being offered and whether the parent is engaging with their service. This will need to be recorded and analysed in the joint assessment

- Plan and review jointly ongoing work, actions and decisions for the case and record them within each service.
- Ensure plans are SMART (specific, measurable, achievable realistic and time-bound) and have timescales following the joint assessment/ joint visit/professionals meeting and this should be made readily available to staff within both services
- Supply the young person with support/resources such as the Harmless website; Kooth, Crisis Card
- Contribute fully to relevant meetings (Child Protection conferences, reviews, consultations etc)
- Share their findings and provide reports

14. Disagreements/escalation

Where there is a disagreement over the appropriateness of a case being jointly worked, or the level of risk, **the issue must be resolved within 48 hours**. This will involve the Social Worker or CAMHS practitioner (depending on who is raising the disagreement) referring the case to the relevant Service Manager for resolution within 24 hours. If this cannot be achieved, the case must be referred to the relevant Heads of Service for resolution within a further 24 hours.

15. Harm Reduction:

National Institute for Health & Clinical Excellence (NICE 2011) defines harm-minimisation as not condoning or encouraging self-harm but aims to maximise safety at a time when stopping is not immediately attainable. Harm-minimisation approaches accept that someone may need to self-harm at a given point and focus instead on supporting the CYP to reduce the risk and damage inherent in their self-harm. However, currently there is no robust empirical evidence supporting the use of harm minimisation. Data is in the process of being publishing suggesting that young people may actually start using these techniques as self-harm, which is of concern. Certainly, these strategies should never be offered in the absence of other clinical supports and in conjunction with interventions addressing their underlying distress/needs. So, if needed/indicated it is a short-term plan/intervention. The capacity to engage in harm-minimisation might vary. The level of risk must be reviewed regularly and the safety plan should be altered accordingly.

Harm minimisation strategies should not be offered for people who have self-

harmed by poisoning. There are no safe limits in self-poisoning.

- Reinforce existing coping strategies and develop new strategies as an alternative to self-harm, where possible
- Advise the young person that there is no safe way to self-poison (medication/chemical/fluids)
- Provide the young person with basic anatomical information about bodily structures (please see body map activity)
- Discuss with the young person how to access medical attention
- Discourage the use of cutting with the same implement time after time, as this can cause infection. Instead discuss the following; using clean implements, keeping wounds clean and having access to a first aid kit and medical care
- Where service users have significant scarring from previous self-injury, consideration should be given to providing information about dealing with scar tissue

16. Safety and Risk Management:

NICE (National Institute for Care Excellence)
https://www.nice.org.uk/guidance/qs34/resources/selfharm-pdf-2098606243525

A risk management plan can help people who self-harm reduce their risk of self-harming again. It should be based on a risk assessment and developed with the person who has self-harmed, who should have joint ownership of the plan. They should fully understand the content of the plan, including what can be done if they are at risk of self-harming again and who to contact in a crisis.

A risk management plan should:

- address each of the long-term and more immediate risks identified in the risk assessment
- address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
- include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
- ensure that the risk management plan is consistent with the long-term treatment strategy

Safety planning:

Safety planning is fundamental when working with self-harm and suicidal behaviours. Safety plans are designed to help keep the child or young person safe by raising awareness of warning signs and promoting coping strategies, safety and access to support.

All plans need to be collaborative and involve the child or young person and family at the centre.

Safety plans should be individual, taking account of the child or young person and family's needs and risks, as well as the network.

SHARP have developed a safety plan template for your use. Please see appendix.

Safety plans do not replace treatment and they should be used in line with appropriate support plans for the child or young person.

In addition, the following may be used as guidance to support the safety of a child or young person:

- Give the family and CYP SHARP Crisis Card and contact details for out of hours services i.e. EDT, 111, Samaritans, ChildLine.
- Give information about support services available. i.e. school mentor, support worker, youth services, after school activities, Kooth, Childline, Harmless, NSPCC, www.ru-ok.org, NGY, thesite.org, family support, children centres, specialist support services.
- Give parent/carer information about what self-harm is and provide them with information about what we know to be helpful and unhelpful to CYP ('Advice for friends, family and carers' leaflet is available from the National Self-Harm Network).
- Share information/leaflets with CYP about self-harm.
- Give information about alternatives to self-harm including distraction techniques and coping strategies.
- Identify and encourage family and CYP to have positive activities/events planned to look forward to.
- Discuss safe storage of medications and household chemicals with parents/carers. Consider on a case by case basis whether the removal of implements would be beneficial. Consider a referral to CAMHS.

ALL SOCIAL CARE AND TARGETED CAMHS STAFF MUST COMPLETE THE JOINT PROTOCOL TRAINING SESSION (dates available through the Learning Zone)

17. Support Services

SHARP (Self Harm Awareness & Resource Project)

The team is part of service offered by CAMHS:

- Professional face-to-face consultations
- Professional telephone consultations in working hours
- Individual therapeutic support
- SHARP 4Parents (parent support group)
- School self-harm Clinics in Nottingham City Secondary Schools
- Training (self-harm, suicide, mental health)
- Resources available at http://www.eduserve.co.uk/additional-needs/sharpe-self-harm-awareness-and-resource-project/about-sharpe/
- Contact T **0115 8764000** E:Camhs.sharp@nottinghamcity.gov.uk

National Self Harm Network have a range of helpful resources including distractions techniques, first aid leaflet, advice for friends and family. These can be found at www.nshn.co.uk

Coping with suicidal thoughts booklet available at www.getselfhelp.co.uk

Harmless

Harmless is a user led organisation that provides a range of services about self-harm and suicide prevention including support, information, training and consultancy to people who self-harm, their friends and families and professionals and those at risk of suicide.

The Tomorrow Project offer a suicide crisis pathway for care, as well as a suicide bereavement pathway. Our intention is not to replicate the great services already working around Nottingham, but to provide a service that addresses a gap in current provisions of suicide care. Often we encounter people who have had difficulty accessing other services due to things like not having a diagnosed mental health difficulty, or by virtue of their suicidal thoughts or behaviours are ineligible for accessing a service. Currently, we support people who are ineligible for primary and secondary care services

E**:info@harmless.org.uk**

www.harmless.org.uk

Kooth

Face to face and online counselling / emotional well-being support service for children and young people

www.kooth.com

Childline

Free, private and confidential help for young people through online chat, telephone and email

T:**0800 1111**

www.childline.org.uk

Samaritans

A charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide.

T:**116 123**

E:**jo@samaritans.org**

HOPELine

HOPELineUK is a confidential support and advice service for children and young people who are worried about how they are feeling and for anyone concerned about a young person.

T**:0800 068 41 41**

E:**pat@papyrus-uk.org**

SMS:**07786 209697**

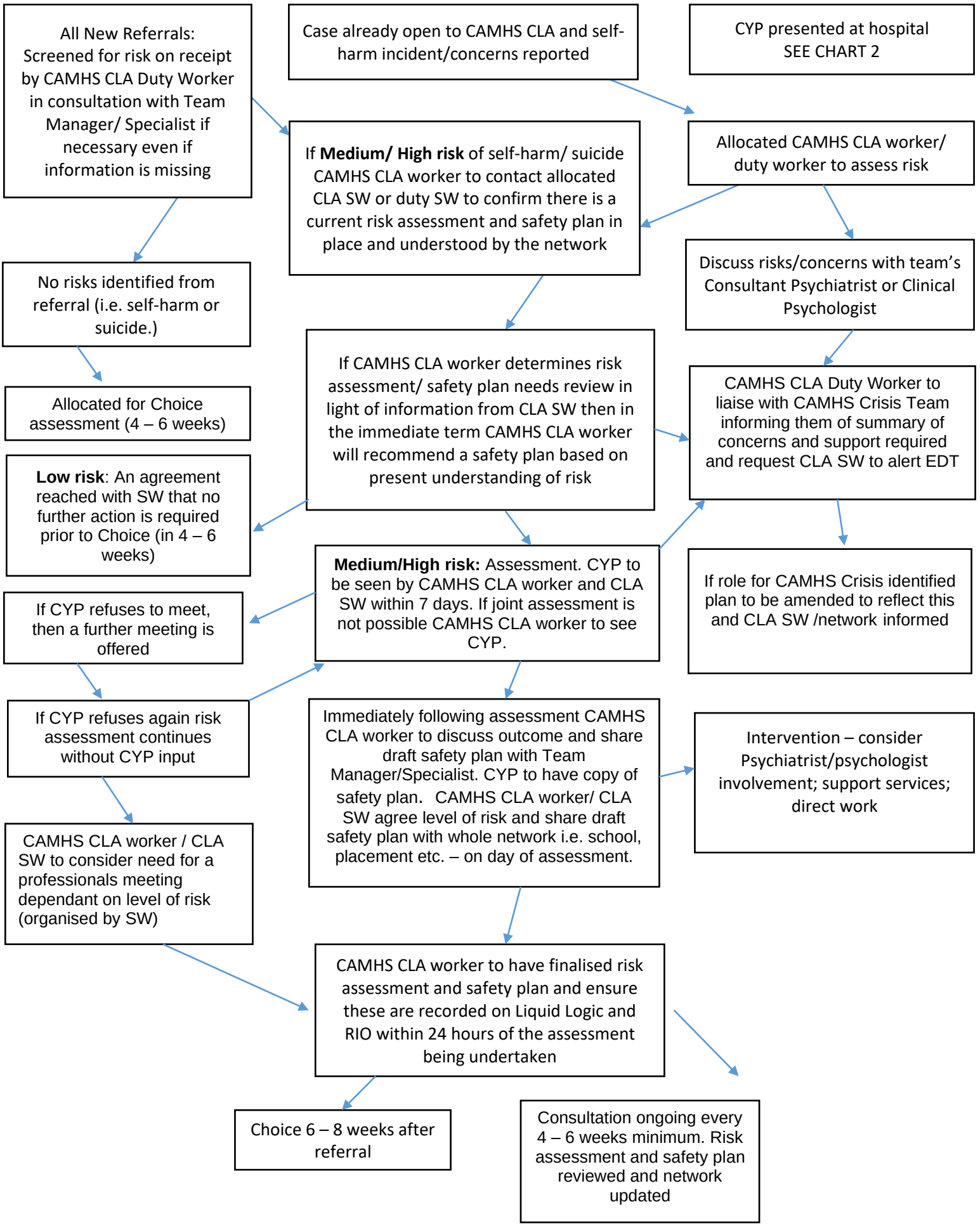
Opening hours: Mon-Fri: 10am-10pm, weekends: 2pm-10pm & bank holidays: 2pm-5pm

Calm Harm

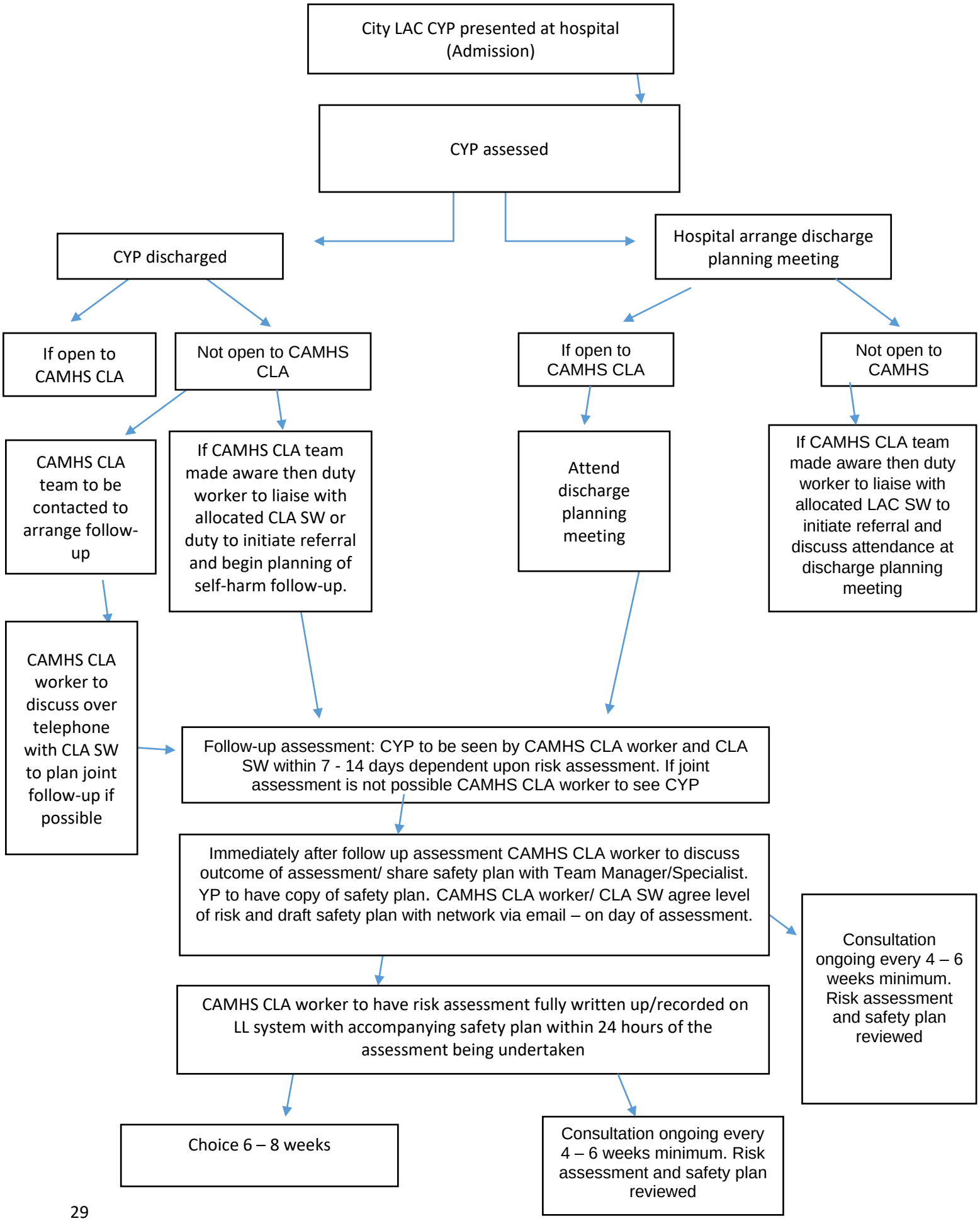
Calm Harm is a free private app that helps you manage the urge to self-harm

www.calmharm.co.uk/

CAMHS Children Looked After SELF HARM PATHWAY



CAMHS CLA SELF – HARM PATHWAY PLAN 2



CAMHS CLA SELF-HARM PATHWAY 3

City CLA CYPs placed out of area

If CYP unknown to CAMHS CLA

CYP entitled to CAMHS service locally. Referral via registered GP or SW – in emergency CYP to present at local A&E and CLA SW to consider contact with local CAMHS Crisis provision for out of hours support.

If CYP open to CAMHS CLA and there are known concerns re: self-harming and CYP moves out of area

CYP entitled to CAMHS CLA service locally. Referral via SW, or CAMHS. In emergency CYP to present at local hospital A&E and CLA SW to contact with local CAMHS Crisis provision for out of hours support.

Looked After CYPs placed in Nottingham City by other local authorities

No involvement. Referrals for CAMHS to be directed via City SPA

NOTTINGHAMSHIRE & NOTTINGHAM CITY SELF-HARM CAREPATHWAY
What to do if you are concerned about a young person self-harming

Universal Services	City Targeted CAMHS & Community CAMHS	Highly Specialist Services
Low level risk self-harm (SH) Superficial, minor self-harm in stable social context. Some indicators of good emotional health, functioning well. No evidence of suicidal intent. Good support networks.	Repeated & more worrying self-harm behaviour. More frequent or severe self-harm. More pervasive stressors, poorer coping strategies and fluctuating mental health. SH that presents alongside moderate MH problems e.g. depression and trauma.	Persistent & severe self-harm. More complex, frequent, high risk behaviours –concerns re isolation, substance misuse, suicidal intent/ behaviour. SH that presents alongside moderate-severe MH problems e.g. depression and trauma. Poor support/ protective factors.	High risk suicidal behaviour, concerns about severe mental health problems, where risk cannot be managed in community.

What action should you take?

Promotion of healthy ways of expressing emotions. Talk to young person (YP), ideally encourage parental involvement. Self-help information, coping strategies. If situation deteriorates seek consultation and support from City - SHARP or County - Primary Mental Health Liaison.	Work with YP, gather info, involve network around the YP. Assess & monitor risk. If situation deteriorates, inform YP worried – may need additional support, consultation, joint working or referral to Community CAMHS via single point of access (SPA). Access consultation via Community CAMHS or CAMHS Crisis team. Work with YP on agreed plan, access clinical supervision & MDT support. Monitor risk & review progress. If situation deteriorates, consider involvement of CAMHS crisis and/or in-patient assessment.	Assess & develop management plan for mental health & suicidal behaviour. Involve & transfer to Community CAMHS when risk reduced assessment/treatment complete.

Examples of services and help available…..

GP, Schools, SHARP school clinics Healthy Families Teams 0-19 - Public Health Practitioners Youth workers NGY (Base 51) Counselling – KOOTH.com	City Targeted CAMHS (including SHARP) Community CAMHS, (Head2Head) H2H, Children Looked After (CLA), Harmless Community Paediatricians Youth Offending Teams (YOT's), Lifeline Journeys Social Care – Nottingham City and Nottinghamshire County	In-patient adolescent units (National provision)

CAMHS Primary Mental Health Workers

CAMHS Crisis Team

Monitor & document concerns, seek appropriate supervision and involvement of line manager.
IN THE CASE OF A MEDICAL EMERGENCY REFER YOUNG PERSON TO THEIR GP OR HOSPITAL EMERGENCY DEPARTMENT IMMEDIATELY
YP under 16 who attend emergency department for self-harm will usually be admitted & assessed following day or may be assessed same day by CAMHS Crisis Team. 16 & 17 year olds may be assessed by Adult Mental Health Services and referred to Targeted/community CAMHS for follow-up.
IN THE CASE OF A MENTAL HEALTH EMERGENCY CONTACT CAMHS CRISIS TEAM VIA SPA ON 8542299 (M-F) OR 8440560 (M-F 8-10 & S-S 10-6)

Examples of interventions…..

RANGE OF INTERVENTIONS

Assessment
Family work/ individual work
Counselling
Mentoring
Group work
Psycho-education
Resilience building, self-esteem
Early Help Assessment Framework
– self-harm risk reduction
NVR (Non-Violent Resistance)

Consultation to universal services & teaching

RANGE OF INTERVENTIONS

Risk & needs assessment/formulation
Mental health assessments – where appropriate diagnosis
Individual psychotherapy, Systemic/Family Therapy, CBT, DBT, EMDR, group work, support for parents
Consultation to CAMHS staff
Prescribing/medication review

Urgent assessment & intervention in response to immediate risk.
Home treatment

Urgent assessment & intervention in response to immediate risk.
Home treatment

THIS CAREPATHWAY IS FOR USE IN CONJUNCTION WITH NOTTINGHAMSHIRE & NOTTINGHAM CITY PRACTICE GUIDANCE ON CHILDREN & YOUNG PEOPLE WHO SELF-HARM.