Procedure for the Management of Self Harm and or Suicidal Behaviour in Children & Young People

Document control and record of amendments

Version	Reason for amendment	Date
1	New procedure - approved	May 2013
2	Annual review and update	May 2014
3	Annual review and update	May 2015
4	Reviewed and updated	January 2016

Who is this document for?

It is primarily for use by front line staff working with:

- young people who identify themselves as using self-harm as a coping strategy;
- young people when they require access to specialist Children & Young Peoples Service (CYPS) as a result of disclosing self-harm, suicide ideation and/or attempted suicide
- Children and young people of whom adults are aware that have considered or engaged in suicidal behaviour or ideation

Principles underpinning this procedure

- Safeguarding the child or young person is of paramount importance
- Recognising self-harm as a real and sensitive issue
- Each young person to be treated as an individual
- Ensure the implementation of equal opportunities
- Young people to be made aware of the local Confidentiality & Information Sharing policy
- To work towards minimising harm and give coping strategies where appropriate
- Recognising the young person may be part of a family unit
- Support to be offered to families
- Where staff feel intervention is necessary, this will be achieved through ongoing communication with the young person

The Aims of this procedure

- To ensure the child or young person is kept safe
- To improve the quality of support, advice and guidance offered to young people who self-harm, or maybe at risk of attempting and or completing suicide.
- Offer consistent support to children and young people no matter what point of contact, to standardise the response of agencies regardless of what type of agency.
- To increase knowledge, skills and competence of staff to recognize and respond appropriately when working with a young person who self-harms, and/or knows of someone who self-harms.
- To meet a locally identified need by service providers & commissioners.

Definitions to support this procedure

Suicide
Suicide is an intentional, self-inflicted, life-threatening act resulting in death from a number of means.

Suicidal intent
This 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 will) and choosing a violent or aggressive means of deliberate self harm allowing little chance of survival.

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

- cutting
- burning
- scalding
- hitting or scratching
- breaking bones

- hair pulling
- swallowing toxic substances or objects

(Mental Health Foundation 2016)

Self-injury is any act which involves deliberately inflicting pain and/or injury to one's own body, but without suicidal intent.
(Working with self-injury: A Practice Guide L.Arnold & A.Magill, 1996)

The term self-harm is often used as an all encompassing term referring to suicidal ideation and attempted suicide.

The Risk Assessment Process

First Contact – Baseline Risk Assessment Stage
A child, a peer or a parent may directly contact a member of staff. Equally a worker may notice a change in the child's behaviour or appearance that leads to a cause for concern. Either way, an early baseline assessment should take place to ensure that the child or young person gets timely and appropriate support.

All key contacts need to feel confident to make an early baseline assessment via a number of basic but important questions – See below – r*isk factors outlined on page 6 should be considered when completing baseline risk assessment.*

Baseline Risk Assessment: Questions and Guidance

Initial questions
•What has been happening?
•Have you got any injuries or taken anything that needs attention consider emergency action?
•Who knows about this?
•Are you planning to do any of these things – consider likely or imminent harm?
•Have you got what you need to do it (means)?
•Have you thought about when you would do it (timescales)?
•Are you at risk of harm from others?
•Is something troubling you? – family, school, social, consider use of child protection procedures.
Responses
•If urgent medical response needed call an ambulance
•Say who you will have to share this with (e.g. designated teacher) and when this will happen
•Say who and when the right person will speak with them again to help and support them
•Check what they can do to ensure they keep themselves safe until they are seen again e.g. stay with friends at break time, go to support staff.
Give reassurances i.e. its ok to talk about self harm and suicidal thoughts and behaviour
Setting up the contract with the child or young person
•Discuss confidentiality child protection if necessary
•Discuss Child Protection if necessary
•Discuss who knows about this and discuss contacting parents
•Discuss who you will contact
•Discuss contacting the GP
Further Questions
•What if any self-harming thoughts and behaviours have you considered or carried out? (Either intentional or unintentional – consider likely / imminent harm)
•If so, have you thought about when you would do it?
•How long have you felt like this?
•Are you at risk of harm from others?
•Are you worried about something?
•Ask about the young person's health (use of drugs / alcohol)?
•What other risk taking behaviour have you been involved in?
•What have you been doing that helps?

•What are you doing that stops the self-harming behaviour from getting worse?
•What can be done in school to help you with this?
•How are you feeling generally at the moment?
•What needs to happen for you to feel better?

A document (appendix) has been developed which may help you complete the baseline risk assessment.

Do's and Don'ts

Do's
•Make first line assessment of risk
•Take all suicide/self-harm gestures seriously
•Be yourself, listen, be non-judgemental, patient, think about what you say
•Check associated problems such as bullying, bereavement, relationship difficulties, abuse, and sexuality questions.
•Check how and when parents will be contacted
•Encourage social connection to friends, family, trusted adults
•Implement initial care pathway
•Implement support/contact with young person
•Seek further risk assessment from GP safeguarding lead or other health professional eg CYPS, .
•Make appropriate referrals
•Set up a meeting to plan the interventions based upon understanding of the risks and difficulties (consider Early Help or Child Protection Process)
•Provide opportunities for support, strengthen existing support systems
•Consider Risk Factors outlined on page 6
•Consider completion of **Vulnerability Check List (VCL)**

Don'ts
•Jump to quick solutions
•Dismiss what the children or young people are saying
•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 people who self-harm
•See it as attention seeking
•Assume it is used to manipulate the system or individuals
•Trust appearances

At this stage it is strongly recommended that the professional should ask the young person who else is aware of the young person's circumstances or has been involved to avoid risk assessment duplication.

Responses to the risk assessment questions together with an assessment of the appearance and behaviour of the child or young person will lead to some or all of the following:

- Referral to children's social care for initiation of child protection procedures
- An increased awareness of the child's or young person's needs and an on-going support and potential re-assessment system being put in place locally, or
- A recognised need for the child or young person to be referred on for a more in-depth assessment and support.

Looked After Children - if a child /young person is Looked after then The Looked After Health Team should also be notified if a child has self harmed (though this should not replace contact with Mental Health services and should be in addition to notification of child's social worker)

Consent Issues
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

It is highly recommended to seek consent where possible, however, If there are concerns about harm then a referral should be made with or without consent. The harm may not appear 'significant' but even superficial cuts can be a sign of significant emotional distress and be the visible part of harm which is hidden.

Child Protection
After the baseline risk assessment, or at any stage of this care pathway, if a professional is concerned that the child is in need of protection, the usual child protection procedure should be followed whereby a section 47 enquiry / core assessment will be carried out by Children's Social Care in consultation with the police and other agencies. Children's Social Care should always allocate cases involving the attempted suicide of a child to an experienced social work practitioner who has completed relevant training in this field and who is well acquainted with this pathway

Further Risk Assessment Stage

At the Further Risk Assessment stage a number of key workers will be in a position to offer a more in-depth risk assessment and thus determine whether the child or young person needs further support.
Assessment at this stage using the proforma below will lead to one of the following outcomes:

Low risk – An increased awareness of the child's or young person's needs but no further action

Moderate risk – An increased awareness of the child's or young person's needs and an on-going support and potential re-assessment system being put in place

High risk – Identification of a **high risk** of need leading to either emergency admission or referral to any of those stipulated in the **Referral Routes** box within the pathway diagram.

This staged risk assessment approach ensures that practitioners are supported where uncertainty arises, and that children and young people receive timely and appropriate support and assessment.

Child Protection
At any stage, if a professional is concerned that the child is in need of protection, the usual child protection procedure should be followed whereby a section 47 enquiry / core assessment will be carried out by Children's Social Services in consultation with the police and other agencies. Children's Social Care should always allocate cases involving the attempted suicide of a child to an experienced social work practitioner who has completed relevant training in this field and who is well acquainted with this pathway

Further Assessment of Risk to determine referral

Second level questioning:

Please remember that risk factors are **not**, nor can they ever be, tools for prediction.
Also, any risk assessment can only be valid for the moment at which it is carried out and so may need to be repeated at suitable intervals according to professional judgement or advice.
Risk of self-harm is **not** the same as risk of mental illness, and one does not need to be mentally ill to self-harm, although there may be links (see below).

Bear in mind that some information can be obtained from the young person, but not all, which may need to come from other sources, such as parents or carers, peers, or other professionals.
The order of the factors in the list is not necessarily significant, as they are all worthy of consideration.

Risk factors:

- Previous deliberate self-harm or suicide attempt.
- Intent – does the young person wish to die? What do they understand by death? Do they think that what they have done, or are planning to do, will kill them? N.B. it is the young person's perception of or belief in potential lethality that is important here, **not** what a professional thinks.
- Evidence of mental illness, especially depression, psychosis or eating disorder.
- Poor problem-solving skills – are problems seen as over-whelming? Does the young person see themselves as capable of solving, or coping with, problems? Have they been able to solve problems in the past? May be linked to poor communication skills.
- Impulsivity/planning - Were steps taken to avoid discovery? Were any preparations for death made? A tendency to impulsive behaviour may increase risk of repetition and thus the likelihood of significant harm, but evidence of planning may indicate higher levels of seriousness for any given attempt. But remember that an impulsive act can be just as damaging as a planned one.
- Substance use (especially important in impulsive males).
- Hopelessness – is there a future, or any reason to continue living? What plans for the future does the young person have? This has been described as "the missing link" between depression and suicide. It can be especially significant if there has been previous deliberate self-harm or attempts at suicide.
- Anger/hostility/anti-social behaviour – some research suggests conduct disorder may be a higher risk factor than depression. This may be difficult to assess, as information will be needed from sources other than the young person.
- Family factors – instability (this can mean more than divorce or separation and can include repeated house moves). History of suicide or mental illness, especially in first-degree relatives. History of substance use. Arguments or disputes can be important.
- History of abuse, whether physical, emotional or sexual, but especially the latter.
- Loss or bereavement – this may include such things as loss of status as well as deaths. Anniversaries of losses can be significant.
- Bullying or other victimisation, such as experiencing racial or sexual discrimination, and including homophobic bullying (see below).
- Issues of gender or sexual orientation – a very high proportion of young people who either are homosexual or think they might be self-harm or attempt suicide.
- Current stressors or life events.

Other considerations:

- Function of deliberate self-harm (other than a clear suicide attempt) – what did the young person hope the act would achieve: a sense of relief or release; punishment; purification; a desire to feel physical rather than emotional pain; a form of communication of distress or other significant matter; something else?
- Method of self-harm – be aware of unintended consequences, such as liver damage from repeated 'Paracetamol' overdoses, stomach ulceration from aspirin overdose, brain damage from oxygen starvation in attempted hanging, drowning or exhaust poisoning, or bone damage resulting from jumping.
- Time of year may be significant, especially when school-related factors are involved, such as bullying or exams. Hence the start of terms or exam periods may see an increase in self-harming behaviour.
- Young people may be highly ambivalent in their views of themselves and any act of self-harm.

Levels of risk and suggested action:

Low risk:

- Suicidal thoughts are fleeting and soon dismissed
- No plan
- Few or no signs of depression
- No signs of psychosis
- Superficial harm
- Current situation felt to be painful but bearable.

Action:

- Ease distress as far as possible. Consider what may be done to resolve difficulties
- 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 an Early Help Assessment or making a referral to the Early Help Hub
- Consider safety of young person, including discussion with parents/carers or other significant figures
- Consider completion of **Vulnerability Check List (VCL)**

Moderate risk:

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

Action:

- Ease distress as far as possible. Identify what needs to be done immediately
- Consider safety of young person, including possible discussion with parents/carers or other significant figures
  Seek specialist advice and/or possible mental health assessment – discussion with, for example primary mental health worker, CYPS 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.
- Consideration of child protection processes
- Consider completion of **Vulnerability Check List (VCL)**
- Consider referral into the Early Help Hub

High risk:

- Frequent suicidal thoughts, which are not easily dismissed
- Specific plans with access to potentially lethal means
- Evidence of current mental illness
- Significant drug or alcohol use
- Situation felt to be causing unbearable pain or distress
- Increasing self-harm, either frequency, potential lethality or both.
- Current suicide attempt

Action:

- Ease distress as far as possible. Consider what may be done to resolve difficulties
- Safety – discussion with parents/carers or other significant adults
- Referral to children's social care for child protection procedures
- CYPS referral

- Consider consent issues
- Consider increasing levels of support/professional input in the mean time
- Monitor in light of level of CYPS involvement.
- **Vulnerability Check List (VCL)** to be completed

N.B. at any time during assessment and review emergency medical treatment may be found to be necessary or child protection concerns may be raised.

It is highly recommended to seek consent where possible, however, If there are concerns about harm then a referral should be made with or without consent.

Direct referral route to Specialist or Emergency Care
Some practitioners at the 'Baseline Risk Assessment Stage' might decide to directly refer to the professionals in the 'referral route' box. For example, a General Practitioner may refer directly to the Children and Young Peoples Service.

It is also possible that the first time any community health or education professionals learn of a child or young person in need may be after attempted suicide or deliberate self-harm that has resulted in assessment in Accident and Emergency or admission to hospital. Where a child/young person's has been deemed to need an assessment it is essential that we follow the correct procedures, make appropriate referrals and do not lose sight of that person post assessment.

A referral to Children's Services for every child and young person who attends A&E will enable an informed assessment of risk and vulnerability. Children's Services will be able to assess any previous or ongoing involvement with the child or family, ensuring that available information is considered within the context of the child's attendance at A&E. Children's Services will then determine if the child/family require additional support f and/or make appropriate referrals to other agencies.

If a child or young person presents at A&E with issues relating to alcohol and or substance misuse, a referral to SORTED must also be made. A&E will share the Children's Services referral with SORTED (*as stated in the **'Northumberland Care Pathway for children presenting at A&E with issues relating to alcohol and or substance misuse'***)

Early Help or other multi-agency planning processes may also be implemented to support the child/young person, including Early Help Assessment.

On-going support systems need to be put in place irrespective of the level of risk based on the notion that the level of perceived risk could change at any time.

Ongoing support may take many forms and may be offered via numerous sources and will be dependent on the child or young person's needs and wishes.

Where the baseline assessment does not lead to referral for more in depth assessment it is essential that communication with the young person remains strong and that an appointed professional remains in contact with the young person on a regular basis.

If a young person has been admitted to hospital the Children and Young Peoples Service might continue to offer support, but equally the school nurse, the child's GP, or in some cases the child's social worker, may be best placed to offer ongoing support. One key worker should be named and identified to offer an ongoing point of contact for that child, with an alternative person stipulated should the key worker not be available. This needs to be agreed locally between key professionals and in consultation with the family and young person. A planning meeting may need to be convened for this purpose, and further review meetings where requires.

It is also acknowledged that parents / carers, staff and other pupils may require support themselves when supporting young people at risk of self harm. Key contact numbers for staff are available within Appendix 5.

Risk management group

The Risk Management Group is a multi-agency group that works with young people to develop a consistent approach to risk management.

A tool, the Vulnerability Check List (VCL), has been developed and the assessment covers a range of risk and protective factors, including emotional health, physical health, sexual health, social and environmental factors, substance misuse, offending behaviour and whether a young person has been reported missing to the police. The VCL is attached as appendix 2.

The risk management process can be used for any adolescent considered to be at high or very high risk due to their own behaviour. The practitioner undertakes an assessment of the risks based on a scoring matrix.

APPENDIX 1 Northumberland Self Harm Pathway for Children and Young people

Individual presents with 'actual' self harm

Individual presents with ideas of self harm, suicidal thoughts or behaviours

Gain consent
If there are safeguarding concerns consent need not be obtained

- **Clear expression of plan and intent to end life – A & E**
- **Immediate or imminent risk – A & E**
- Baseline Risk Assessment Stage (page 3 of procedure)
- Further Risk Assessment Stage or completion of Vulnerability Check List (VCL) (if appropriate)
- Further risk assessments may be undertaken by: School Nurse/Community Paediatrician/GP/Childcare Social Worker/Primary Mental Health Worker/CPN/Prison

Level of risk to be established (if further Risk Assessment in undertaken)

Low Risk
- Superficial harm
- Ensure ongoing support

Moderate Risk
- Ongoing self harm/suicidal thoughts
- Discuss with EDT or contact CYPS (01670 394256) for advice
- Consider referral to children's social care or in to Early Help Hub
- Consider VCL
- Ensure ongoing support

High Risk
- If injured or serious and imminent risk– A&E
- **Refer to children's social care**
- Ensure ongoing support
- Consider VCL

Potential Sources of targeted or ongoing support
- Locality CYPS Team/Outpatient Support for Families/Carers
- School Nurse
- Children's Centres
- Social Worker
- In-School Mentoring
- Youth Service
- Teenage Pregnancy Team
- Locality Inclusion Support Team (LIST)
- SORTED
- Northumberland Adolescent Services

Refer to CYPS to discuss

CYPS – 01670 394256

08.00 – 21.00 weekdays
08.00 – 18.00 weekdays

Please note CYPS will discuss referral information and will decide required urgency of appointment

On call pathway

If not injured
CYPS referral will discuss details and establish level of assessment urgency

CYPS = Children & Young Peoples Service – **01670 394256**
YOS = Youth Offending Service - **01670 852225**
EDT = Emergency Duty Team - **0845 600 5252**

Appendix 2 – Vulnerability Check List (VCL)

This document is to be used to identify the level of vulnerability of a young person referred to the Northumberland Risk Management Group (RMG). The purpose of the checklist is to identify strengths and risks in relation to a young person and to ensure that a multi-agency coordinated plan is developed to meet their identified needs.

The checklist contained in the document is not exhaustive and should be used to summarise the information held by different agencies involved with a young person. It is intended to assist with decision making and does not remove the need for professional judgement which should take account of factors such as the age and maturity of the young person.

Personal Details of Young Person

First Name:		
Family Name:		
Also known as:		
Address:		
DoB / Age:		
ICS No:		
Case Status (Eg. CIN or CP)		
Legal Status:		

Agencies Involved

Children's Social Care		Education	
Police		TAS - SORTED	
TAS -YOS		Health	
CYPS		Other (name Agency)	

Risk Matrix

Score using the following scale:

Score		
0	No apparent risk	No history or evidence at present to indicate current likelihood of risk from behaviour.
1	Low apparent risk	No current indication of risk but young person's history indicates possible risk from identified behaviour.
2	Medium apparent risk	Young person's history and current behaviour indicates the presence of risk but action has already been identified to moderate risk.
3	High apparent risk	The young person's circumstances indicate that the behaviour may result in a risk of serious harm without intervention from one or more agency.
4	Very high apparent risk	The young person will commit the behaviour as soon as they are able and the risk of significant harm is considered imminent.

Vulnerability and Protective Factors

Section 1:

Emotional Health

Section 3:

Substance Misuse

Low Self Esteem	
Low Mood	
Depression	
Self-Harm	
Severe Paranoia / Anxiety	
Suicidal Intent	
Suicidal Ideation	
Diagnosed Mental Health Difficulties, i.e., ADHD psychosis, OCD, schizophrenic	
Eating Disorder	

Physical Health

Major (under consultant care) (3)	
Moderate (regular GP involvement) (2)	
Minor (self-managed or with support of carer) (1)	
No Physical Health Issues (0)	

Sexual Health

Early onset of sexual activity	
Having sex with multiple partners	
Engages in unsafe sexual behaviours which could result in contracting a sexually transmitted infection	
Has much older partner	
Wants to become pregnant/is pregnant/is a young parent	
History of abuse	
Inappropriate use of pornography/social networks	

If scoring high – complete sexual health referral form

Section 2:

Social and Environmental

Looked After Child / Leaving Care	
Family/Relationship Difficulties	
Non School Attendance	
Homelessness	
Unsuitable Housing	
Social Isolation	

Alcohol	
Amphetamine	
Cannabis	
Cocaine/Crack	
Heroin	
Ecstasy	
Benzodiazepines	
Solvents/Gas/Aerosols	
Other (state)	
Poly Drug Use	
Frequency - Regular - Occasional	
Injecting - No - Yes/Previously	
Contact with Substance Users - No using friends - Some using friends - All friends using	
Family Substance Users - No family users - Known close family users - Significant family misuse	
Risk of Overdose	

Section 4:

Offending Behaviour

Involvement in Criminal Justice System	
Risk of Custody	

Section 5:

Absconding (reported missing to Police)

Frequency of Absconding	
Risk of Harm	
Risk of Sexual Exploitation	
Length of Abscond Episodes	

If scoring high key worker to liaise with Social Worker for Missing Children

The check list above should be completed using the scoring matrix on page 1 and the total score used to identify an indicative risk using the scale on page 3. The identification of the level of risk should take into account the age and level of functioning of the child as well as professional judgement.

Total Score		**Risk Level**	

Section 6: Indicative Risk Continuum:

Low Risk	Medium Risk	High Risk	Very High Risk
0	40/41	60/61	70/71

0 ---------- 10

Section 7:

Protective Factors
(To include what is working well for the young person.)

Summary:

Please remember to note:

- **What is it that you are worried about?**
- **What is working well? (include strengths, exceptions, resources, goals, willingness, etc)**
- **What needs to happen to decrease risk and improve safety.**

Professional assessment of risk
Section 1: **Emotional Health:** **Physical Health:** **Sexual Health (*to consider factors associated with Child Sexual Exploitation – See guidance):***
Section 2: **Social & Environmental**
Section 3: **Substance Misuse**
Section 4: **Offending Behaviour**
Section 5:

Absconding (*to consider factors associated with Child Sexual Exploitation – See guidance)*
Danger Statement: must be simple so that the young person can understand it.
Needs to capture the seriousness of the issues (i.e. what are we worried about) and to be something the care team and the young person can achieve together. **If not scoring high on this scoring matrix is this young person assessed as high risk by any single agency using their own criteria/documentation?**

Young person's view of risk
What do you think needs to happen to make people less worried about you? What would the next steps be to help with this?

On a scale of 0 to 10, where 10 means the problem is sorted as much as it can be and zero means things are so bad you need some help, where do you see yourself at the time of the present time.
0 ----------10

Views of Parent/Carers:

Parent or carers view of risk
What do you think needs to happen to make people less worried about your child/young person? What would the next steps be to help with this?
On a scale of 0 to 10, where 10 means the problem is sorted as much as it can be and zero means things are so bad you need some help, where do you see you see your child/ young person at the present time.
0 ----------10

Does this family meet the Supporting Families criteria? Yes ☐ No ☐

Need to meet 3 or more of the criteria set out below:

1 or more under 18 has been found guilty of an offence ☐
or 1 or more member of the family has had ASB within the last 12 months

Permanent exclusion or 3 or more fixed term exclusions ☐
across the last 3 consecutive terms or PRU or alternative provision
or Not on school roll or 15% unauthorised absences across the last 3 consecutive terms

Child subject CP ☐

Teenage pregnancy ☐

Domestic violence ☐

Family are not in employment. ☐

Has this family been identified as meeting the criteria and has documentation been sent? Yes ☐ No ☐

Appendix 3 –Relevant Legislation

1. Children Act 1989 Section 17

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

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

2. Children Act 1989 Section 47

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

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

- emotional abuse or
- impairment of health (physical or mental) or
- impairment of development (physical, intellectual, emotional, social or behavioural)

This may include seeing or hearing the ill treatment of another (s120 Adoption and Children Act 2002).

3. Mental Health Act 1983

The Mental Health Act 1983 is the principal Act governing the treatment of people with mental health problems in England and Wales. The Mental Health Act covers all aspects of compulsory admission and subsequent treatment. Besides these emergency procedures, there are other sections of the Act under which a person can be detained in hospital without their consent. (In November 1999 the Government issued a White Paper called 'Reforming the Mental Health Act', which was intended to act as the basis for a new Act. In June 2002 this was superseded by a draft Mental Health Bill).

The Mental Health Act of 1983 covers the detention of people deemed a risk to themselves or others. It covers four categories of mental illness: severe mental impairment, mental impairment, psychopathic disorder and mental illness.

The first two are generally interpreted as people with learning difficulties who have aggressive tendencies. Psychopathic disorder relates to people who have a "persistent disorder or disability of the mind" which leads to aggression.

Mental illness itself is not defined by the Act. However, it does state what it does not cover, which includes people who may be deemed to be mentally ill "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".

The Act allows people considered to be mentally ill to be detained in hospital and given treatment against their will. They do not have to commit a crime or have harmed anyone. They are usually detained because it is considered in their interests and for their own safety, but they may be held because they are deemed a risk to others.

Appendix 4 - USEFUL ORGANISATIONS/CONTACTS

National Self Harm Network (NSHN)

The lead UK charity offering support, advice and advocacy services to people affected by self harm directly or in a care role.

What is Self Harm?
Advice for Friends, Family and Carers
Advice for Young People
Basic First Aid
Common Misconceptions
Distraction Lists

These leaflets and posters are available to download free of charge, and can be printed and given out to children and their families and/or displayed in public areas. NSCB would encourage you to use these resources.

Further information and resources are available on the National Self Harm Network website.

NSHN Support Helpline: *0800 622 6000 (7pm-11pm Thursday-Saturday, 6.10pm-10.30pm Sunday)*

Childline 0800 1111 www.childline.org.uk

British Association for Counselling and Psychotherapy (BACP)
BACP House, 35–37 Albert Street, Rugby CV21 2SG
tel. 0870 443 5252, minicom: 0870 443 5162
email: bacp@bacp.co.uk web: www.bacp.co.uk

Mind
tel. 0845 766 0163
Mind is the leading mental health organisation in England and Wales, providing a unique range of services. http://www.mind.org.uk/About+Mind/Mindinfoline/ is Mind's helpline and information service.

Samaritans http://www.samaritans.org/
Phone: 08457 909090
Befriending service for anyone going through a personal crisis who is at risk of suicide.

Self-harm Alliance
PO Box 61, Cheltenham, Gloucestershire GL51 8YB
helpline: 01242 578 820, web: Self harm resources and publications, self-harm links and websites
A national survivor-led voluntary group

Mental heath and counselling organisations Mental health Support organisations - Health encyclopaedia - NHS Direct

YoungMinds
YoungMinds
102–108 Clerkenwell Road, London EC1M 5SA
parents information service: 0800 018 2138
web: www.youngminds.org.uk
For anyone concerned about a child's mental health

NICE
NICE guidance sets the standards for high quality healthcare and encourages healthy living. The guidance can be used by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.
Web: http://guidance.nice.org.uk/

Websites
www.selfinjury.freeserve.co.uk
www.selfharm.org.uk
www.siari.co.uk
www.self-injury-abuse-trauma-directory.info

Appendix 5 – Contact Numbers

Children's Social Care Locality Teams
Alnwick Children's Services **Tel:** 01665 626830 **Ashington Children's Services** Tel: **01670 629200** **Berwick Children's Services** **Tel:** 01289 334000 **Blyth Children's Services** **Tel:** 01670 354316 **Cramlington Children's Services** **Tel:** 01670 712925 **Hexham Children's Services** **Tel:** 01434 603582
Emergency Duty Team
Tel: 0845 600 5252
Disabled Children's Team
Tel: 01670 516131
16+ Team
Tel: 01670 712925
Children & Young Peoples Service (CYPS)
Tel: 01670 394258
SORTED
Tel: 01670 500150
Teenage Pregnancy Team
Tel: 01670 819049
Safeguarding Standards Manager & Principal Social Worker
Tel: 01670 624037
Safeguarding Unit (List of Children with a Child Protection Plan)
Tel: 01670 624888

Central Referral Unit, Protecting Vulnerable People (Northumbria Police)
Tel: 0191 2951770 extension: 45170
Designated Nurse, Child Protection
Tel: 0191 2172989
Safeguarding Team, Northumbria Healthcare NHS Foundation Trust
Tel: 01670 529279
Named GP
Tel: 07789437146
Designated Doctor
Tel: 01434 655395
Local Authority Designated Officer
Tel: 01670 623979 0845 600 5252 (out of hours)
Missing Children Social Worker
Tel: 01670 629200 **Mobile: 07770735512**
Early Help and Think Family Co-ordinator
Tel: 01670 840723
Family Support and Placement Service
Tel: 01670 626262
Children's Support Team
Tel: 01670 714246 **Tel:** 0845 600 5252 (EDT, out of hours)
Hospitals
Wansbeck General Hospital **Tel: 0344 811 8111** **Royal Victoria Infirmary** **Tel:** 0191 233 6161 0191 282 5322 **Fax:** 0191 282 0618 **Newcastle General Hospital**

Tel: 0191 233 6161

Fax: 0191 219 5037

Newcastle Freeman Hospital

Tel: 0191 233 6161

North Tyneside General Hospital

Tel: 0844 811 8111

Main switch board number

Alnwick Infirmary

Tel: 0344 811 8111

Main switch board number

Berwick Infirmary

Tel: 0344 811 8111

Main switch board number

Blyth Community Hospital

Tel: 0344 811 8111

Main switch board number

Haltwhistle War Memorial Hospital

Tel: 01434 320 225

Hexham General Hospital

Hexham

Tel: 0344 811 8111

Main switch board number