East of England
LSCB Network

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Learning Together
Self Harm and Suicide in Adolescence

3 June 2019

Rowley Mile Racecourse

Newmarket

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Welcome & Introductions

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Vulnerable Adolescents: Learning from serious case reviews

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Vulnerable adolescents: Learning from serious case reviews (2011-2017)

Dr Penny Sorensen

(part of UEA team led by Professor Marian Brandon)

HNS East of England, LSCB East of England Network & Public Health England, Newmarket

3 June 2019

crcf Centre for Research on Children & Families

UEA University of East Anglia

Overview of presentation

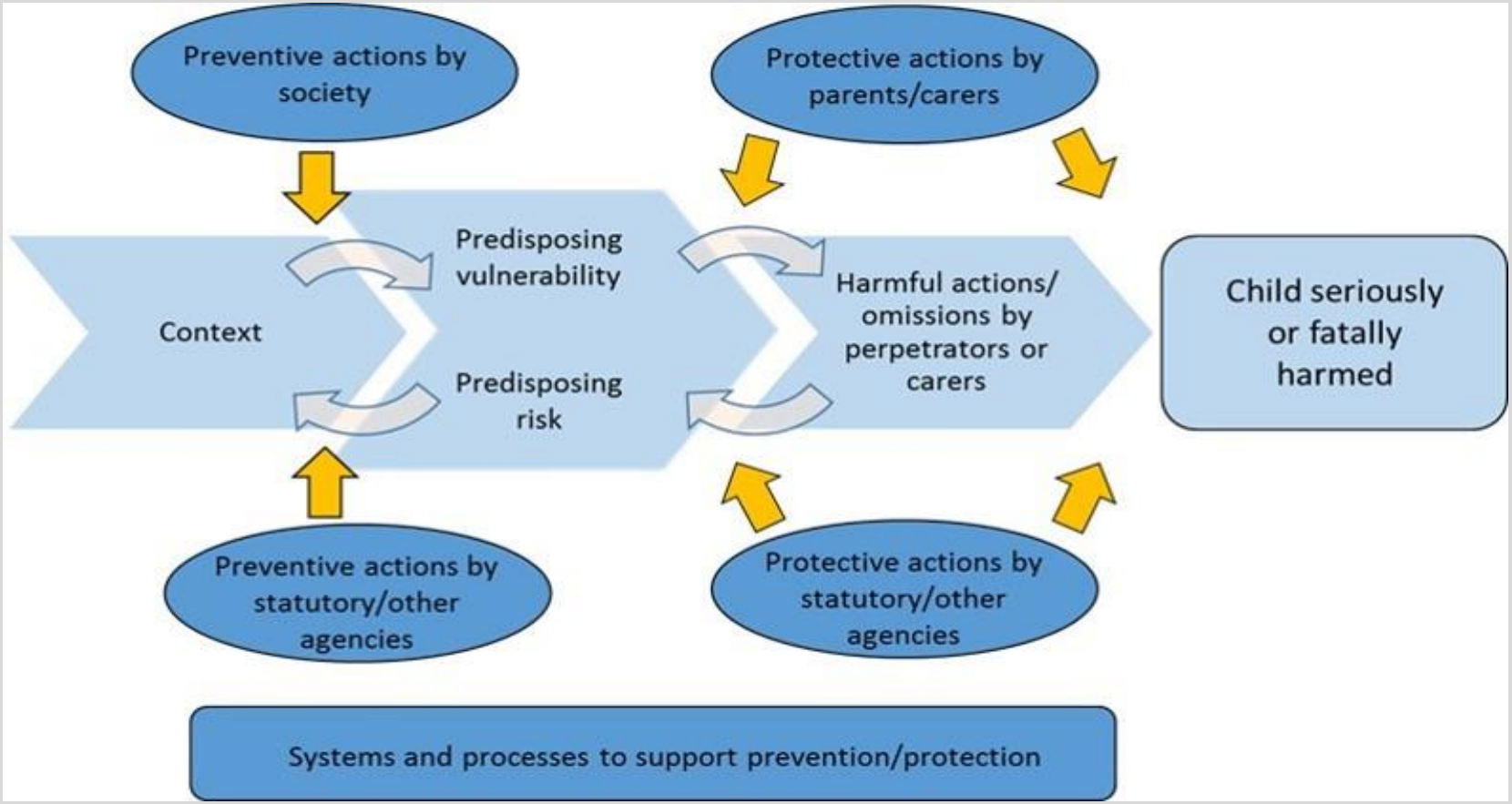
- Methodological frameworks for qualitative analysis
- Suicide risk factors from the literature
- Suicides in serious case reviews (SCRs) 2011-14
- Adolescent vulnerabilities in SCRs 2014-17
- Some policy and practice implications
- The Triennial Review launch conference

Understanding vulnerabilities in context

- Using an ecological-transactional framework to explore opportunities for protecting vulnerable adolescents*:
  - Carer's own relationship history
  - Carer's state of mind
  - Caregiving environment
  - Young person's behaviour/adaptive strategies/developmental state
  - Influence of social and environmental stress
- Final SCR reports often have limited information about young people's early life experiences

*(Bronfenbrenner, 1979; Brandon et al, 2002; Cicchetti & Valentini, 2006)

Pathways to harm, pathways to protection



Sidebotham et al, (2016)

Some key suicide risk factors in the literature

Features associated with young suicide include:

- a primary diagnosis of affective disorder or schizophrenia; undiagnosed disorders (e.g. depression, ADHD)
- substance misuse
- self-harm
- residential instability
- parental separation/divorce; loss
- adverse childhood experiences; negative life events
- minority sexual orientation

Manchester Centre for Mental Health and Safety; John et al (2014)

Suicides in serious case reviews 2011-14

In the sample of 293 serious case reviews within the time frame:

- **37 children died as result of suicide**
- Aged between 9 and 17 years old
- 51% were males
- 84% known to children's social care
  - 12% on child protection plans
  - 25% in local authority care as looked after children
- Sexual abuse noted in 10 (27%) of the cases

Antecedents to suicide in the SCR population (37 children)

- Parental conflict and acrimonious separation
- Parental and/or child substance misuse
- Mental health problems, including self-harm, and involvement with children and adolescent health services
- Involvement with a youth offending team
- Bullying
- Domestic abuse
- Time spent in care of the local authority or in secure units (including Tier 4 mental health services and YOIs)
- Going missing and homelessness
- Experiences of being a young carer

Key characteristics in the suicide sub-sample of 17 serious case reviews (2011-14)

Parental conflict/ separation	MH issues;self-harm;suicide attempts	CAMHS involvement	YP substance misuse	Bullying	YOT/police involvement
X	X	X	X		X
X	X	X	X		X
X	X	X		X	X♦
X	X		X	X	X♦
X	X	X	X	X	X♦
X	X	X♦			
X	X	X	X		X
X	X	X			
X	X	X	X		X
X	X	X			
X	X	X		X	
X	X	X	X		
X	X	X			
X	X	X		X	X
X					
X	X	X		X	X
X	X	X			X

Pathways to harm - common themes

- **Rejection, exclusion and social isolation**
  - **Multiple moves**
  - **Disrupted relationships**
- Self-harm and risk-taking behaviour
- Going missing and homelessness
- Parental behaviour

…he lacked a pivotal and stable carer who would provide boundaries to give him some sense of security but, who he also knew, would 'look out for him' and 'fight his corner': in other words be a surrogate parent to him…Staff from the various agencies involved with him, and the YOS staff in particular, made considerable efforts to assist him but their input is necessarily professional and impartial. ***He had no one person with whom his relationship was special for him alone.***

Self-harm and risk-taking behaviour

- Absence of supportive networks
- Self-harm – antecedent to suicide

A psychology report in respect of [young person]*… identified "how the alcohol and drugs helped him to forget" his traumatic life experiences.*

He was threatening to jump from a motorway bridge. The police had returned him to the family home and he attempted to stab [step parent]. The police had to use a Taser gun in order to subdue him. He was seen by the duty psychiatrist at A&E and discharged from hospital to police custody as there was no evidence of affective disorder or psychosis.

Going missing and homelessness

- Repeated episodes of going missing
- Unsuitable, insecure housing

His Connexions personal advisor reported that he was very angry and low, as his housing situation was not sorted. He reported that he was not sleeping or eating and was hearing voices.

He went missing twice during May, on one occasion was found intoxicated, and on the other had participated in anti-social behaviour. He absconded from school and was reported missing again in September. On each occasion the police were involved and returned him back to the residential unit.

Parental behaviour

- Acrimonious parental relationships
- Parental substance misuse
- Rejection

[He] experienced his parents' relationship difficulties as abuse despite the fact that neither of them meant him any harm..

Mother said: *'I can't be responsible for that thing'* [a reference to her self-harming daughter and the plan that she return home].

[Young person] also disclosed some distress about father's use of alcohol and violent behaviour.

Opportunities for prevention

- Premature adult responsibilities
- Thresholds and conflicting professional opinions

The police sought advice from the mental health crisis team who felt that she might have a personality disorder but was not mentally ill; she was never diagnosed with a personality disorder according to the information given to the review.

The inability of all services to see Child as a vulnerable child rather than a troubled or troublesome young adult was a common and recurring theme. People made assumptions that Child was adult and because of their greater intelligence and verbal ability had greater resilience than a child who had come from more disadvantaged or compromised circumstances

Opportunities for protection

- Recording and sharing history and information
- Working together
- Structural and systemic issues

Poor sharing of information with school which was not aware of his suicidal ideation and had not seen any reduction in attainment therefore they had not put any strategies in place to raise alert if he came to a teacher's attention or was absent from school.

There were a number of instances of delay and lack of purpose which may have been linked to major problems of high vacancy levels across the organisation.

YOS worked well with [young person] but did not secure full involvement of other agencies – the service worked in isolation.

Vulnerable adolescents (2014-17)

Adolescent themes explored

- Going missing
- **Exploitation**
  - **Child criminal exploitation**
  - **Child sexual exploitation**
  - **Exploitation into radicalisation**
- Harmful sexual behaviour
- Sexting
- **Social media** and technology-assisted harm
- **Loneliness**

Child criminal exploitation

- Sometimes adolescents went missing *because* they were being exploited

[He] had been reported as missing from home in the early hours of the morning. Home visits established that he was growing more nocturnal in his routine and there was information that he was using cannabis and associating with offenders. This lifestyle was clearly putting him into contact with older offenders, increasing significantly his risk of re-offending and compromising his long term health and educational prospects.

Child sexual exploitation

- Continues as persistent theme
- Practitioners can be slow to recognise particularly if the victim is male
- Risks for males are no less serious than those for females

…as far as I can see it still comes under parental control as to his whereabouts…

On return from London an Inspector spoke to Jack and his mother and, according to Jack's mother, gave Jack a "dressing down" which included threatening that Jack would be removed to a "secure unit". As a direct result of this meeting Jack and his mother feared the police…The meeting served only to further alienate the police from Jack and his family.

Exploitation into radicalisation

- Practitioners can feel unprepared for working with adolescents vulnerable to radicalisation
- Opportunities for adolescents to explore their concerns without fear of criminalisation should be developed

If young people are being discouraged from sharing their views with parents and those in authority, the opportunity to identify risk, intervene and try to de-radicalise the young person, is very small.

Social media

- Exploration, education, connecting
- Extremism, pornography, gaming, criminal and sexual exploitation
- Fast moving environment, hard to keep up, education/training
- Multiple devices and accounts

The child provided details of the account and gave permission for the Constabulary to access the account. However, the child then created a new account that the Constabulary were unaware of.

Loneliness

- Affects wellbeing and associated with risk-taking behaviour and increased risk of depression
- Loss and family/social disruption can increase feelings of loneliness
- Signs of loneliness can manifest as withdrawal and lack of engagement
- Social media can increase feelings of loneliness
- Issues rarely addressed at an early stage

[Child's] views were included in the core assessment where she says that she was worried about her mother's drinking. The children felt that with their father away, they had no-one to talk to.

Opportunities for prevention

- Engaging with education/training
- Continuity and relationships

School was 'a beacon of good practice' –worked closely with parents and pupils, put in place practical measures and ensured other agencies were kept informed.

[T]he need to develop authentic and sufficiently intensive long-term relationships with young people is not fully recognised and is not yet part of the service response.

Opportunities for protection

- Suitable placements for vulnerable adolescents
- Working together and sharing information
  - Uncertainty about referral thresholds
  - Lack of challenge and escalation when decisions appear unwise
- Written agreements
  - Lack of monitoring
  - Repeat use

The school did not make referrals to CSC as they did not think the case would reach their threshold.

Practitioners become attached to their judgements and can employ strategies to ensure that challenge is not recognised or explored.

Implications for policy and practice

In the SCR population:

- **Young people's experiences travel with them**
  - Individual professional relationships
  - Multiagency suicide prevention
- **Children and young people are not adults**
  - Appropriate child-friendly mental health services
  - Timely interventions, especially at times of distress (e.g. acrimonious parental relationships)
- **Psycho-social impact of abuse and neglect**
  - Ecological view of children and young people
  - Importance of consistent, reliable social networks

SCR Triennial Review - Launch Conference

'Complexity and Challenge: a triennial analysis of serious case reviews 2014-2017' provides a rare opportunity to hear and discuss the findings from this influential, newly published Department for Education funded study carried out by Prof Marian Brandon and her team from UEA and Prof Peter Sidebotham and his team from Warwick University.

Thursday June 27th 2019, 10-4pm

Woburn House WC1H 9HQ

Cost: £35

Book: www.crcfconferences.uea.ac.uk

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Thank you for listening

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Local Context: Suicide & Self-harm in the EoE population of CYP

Sarah Robinson
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Local context: Suicide and Self-Harm (SH) in the East of England population of CYP

3rd June 2019

Stephen Yeung

Senior Knowledge Transfer Facilitator

Dr Sarah R Robinson

Patient Experience and Quality Manager

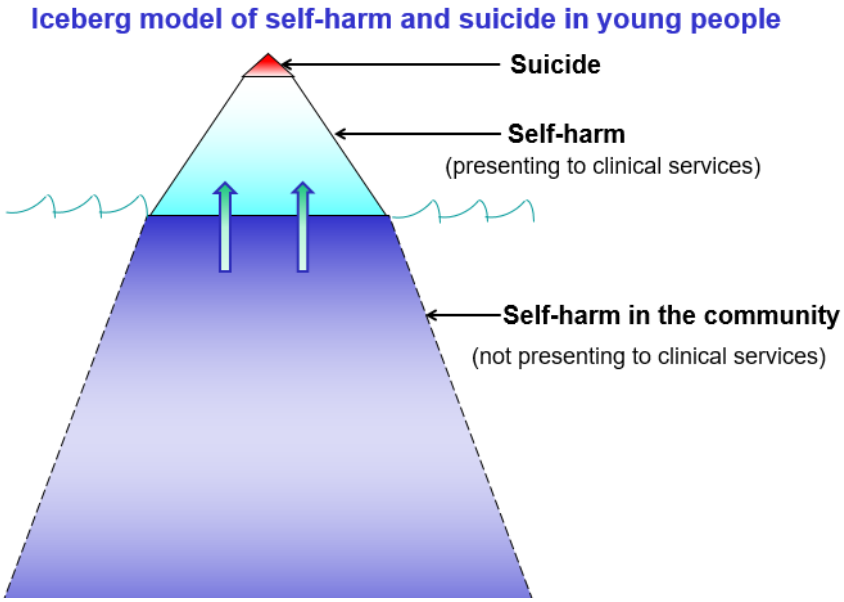
NHS England and NHS Improvement

Outcome from session

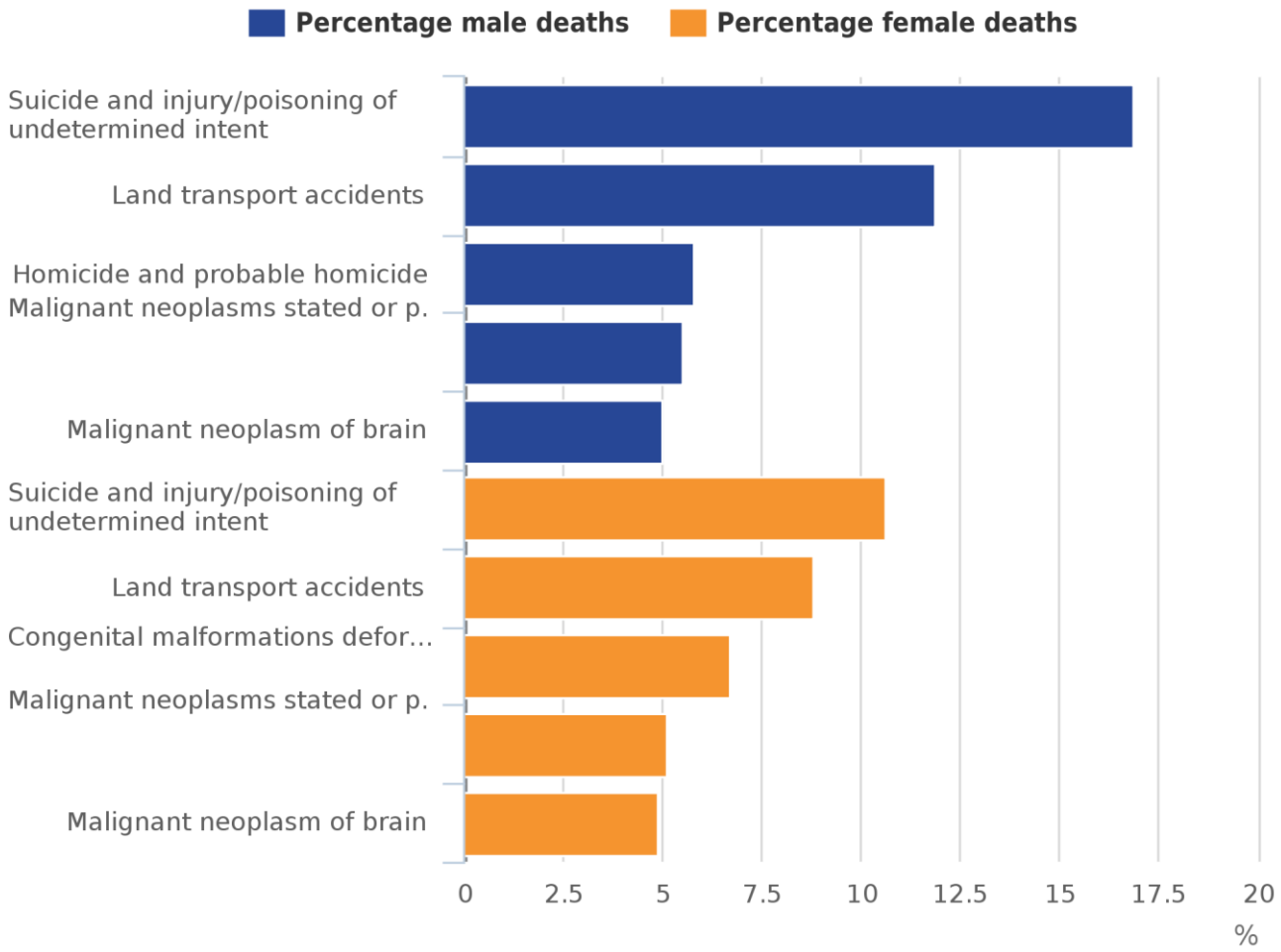
- Sense of what local data shows us
- How no ‘one-source’ of data and the difficulties because of this
- Slides developed to stand alone as a resource to take away and discuss with local teams
- Session aims to stimulate questions

Introduction to topic

- **"Suicide is the second leading cause of death among 15-29 year olds worldwide counting for 8% of all deaths In the UK, suicide is the leading cause of death in young people, accounting for 14% of deaths in 10-19 year olds and 21% of deaths in 20-34 year olds"** Suicide by children and young people, National Confidential Inquiry
- Statistics show that **suicide**, in children and young people, is on the **increase** across England and Wales (NSPCC 2018).
- Over the past few years there has also been a **increase** in the number of **self-harm** incidents amongst children and young people (NSPCC 2018: Public Health 2018).
- However, self-harm does not necessarily lead to suicide but in some cases, it is an attributed factor.



Top 5 leading causes of death for 5 to 19 year olds, 2015, England and Wales



Source: Office for National Statistics

Introduction to data

	Advantages	Disadvantages
Fingertips Self harm admission data	• Across LA • Sophisticated analysis	• Only captures SH leading to admission, not presenting at GP, A&E only without an admission • Not indicator of the amount of SH happening in community • Time delays
Patient Safety data	• Real time • Focus on lessons learnt	• Only captures suicide of those receiving MH services (NHS funded)
Child Death data (CDOP)	• Depth of analysis • Assurance re: notification of deaths	• Delay between death and review • Threshold for CoD set by coroner

PHE Fingertips data

https://fingertips.phe.org.uk/profile/child-health-profiles

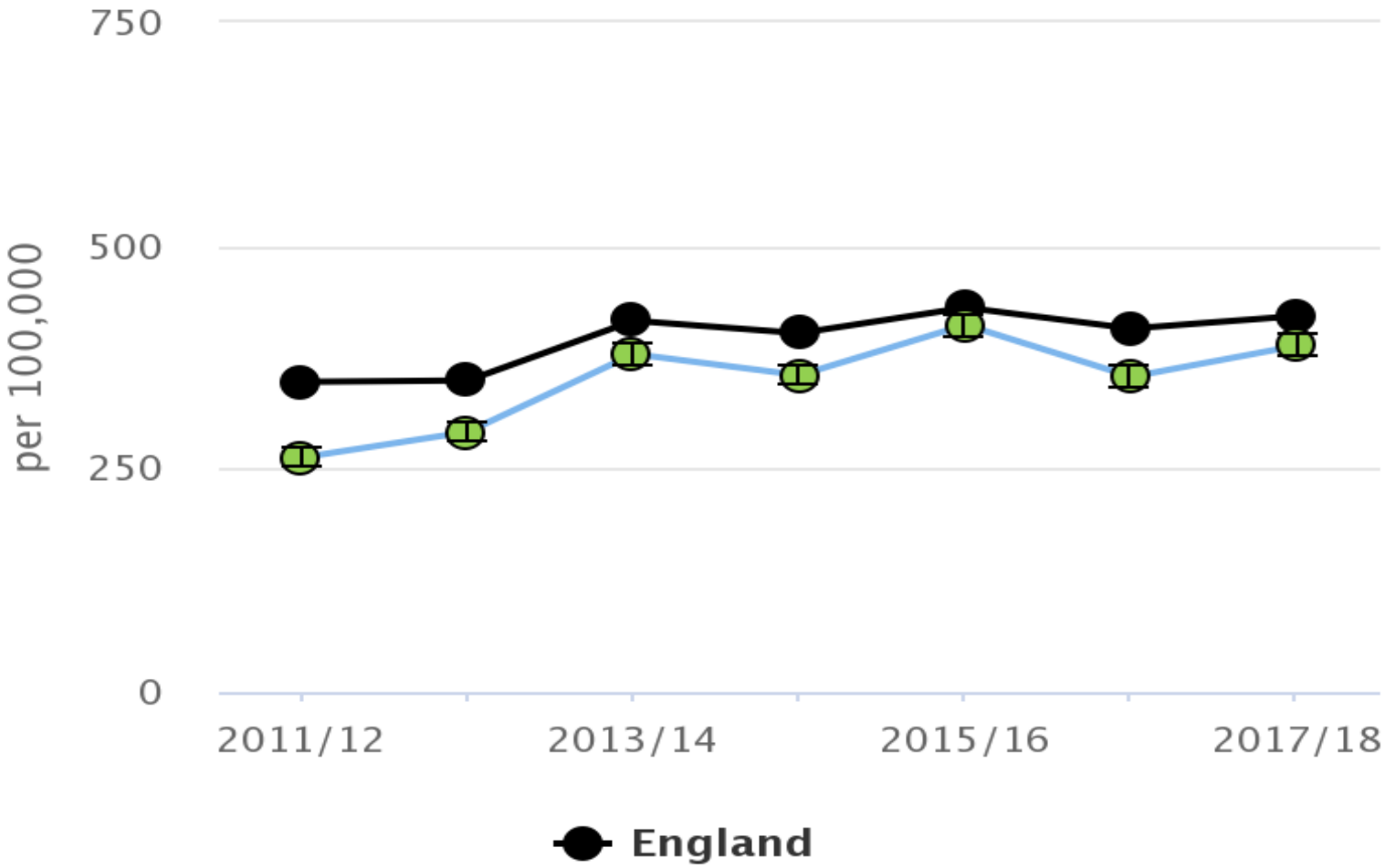
Coding:

- green is significantly better,
- orange is of similar (therefore no statistically significant difference),
- red is a significantly worse performance

All have been extensively statistically analysed, full details are on the site but essentially if there is a difference noted then the assumption that this is true, there is only a 5% chance of it being down to an error in data.

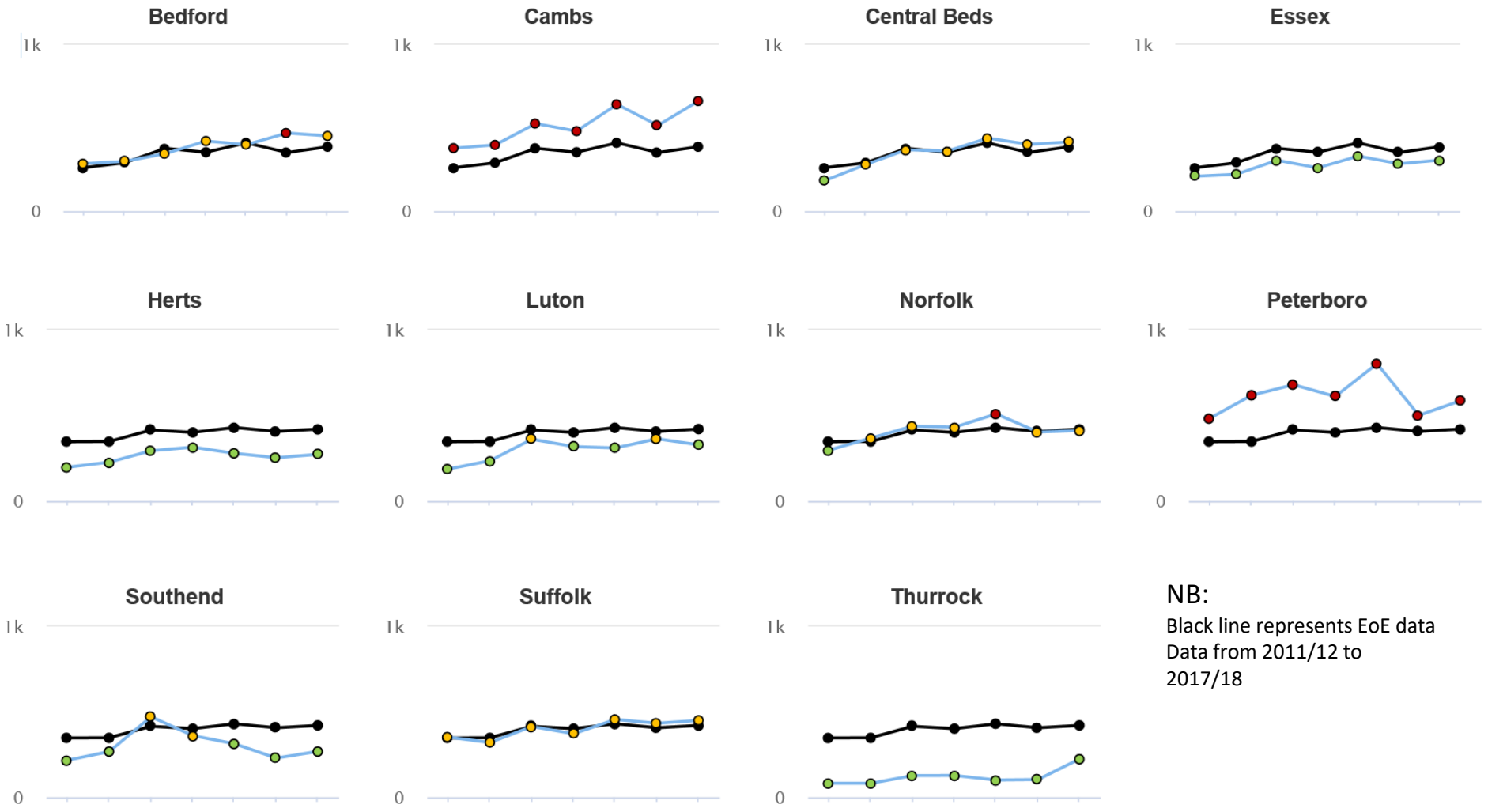
Following graphs report acute admissions for self-harm - acute Hospital Episode Statistics (HES) - Number of finished admission episodes in children aged between 10 and 24 years where the main recorded cause (defined as the first diagnosis code that represents an external cause (V01-Y98)) is between X60 and X84 (Intentional self-harm)

PHE Fingertips data
Hospital admissions for Self-Harm per 100,000 population aged 10-24



Hospital admissions as a result of self-harm (10-24 years)

Directly standardised rate - per 100,000



NB:

Black line represents EoE data

Data from 2011/12 to 2017/18

PHE Fingertips data
17/18 Hospital admissions for Self-Harm per 100,000 population aged 10-24

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	–	-	41,218	421.2	417.1	425.3
England	–	-	41,218	421.2	417.1	425.3
East Midlands region	–	-	3,787	436.2	422.4	450.4
East of England region	–	-	3,971	387.9	375.9	400.1
London region	–	-	3,134	209.1	201.9	216.6
North East region	–	-	2,174	458.0	438.9	477.7
North West region	–	-	6,321	488.8	476.8	501.0
South East region	–	-	7,394	467.6	457.0	478.4
South West region	–	-	5,893	621.0	605.3	637.1
West Midlands region	–	-	4,196	388.7	377.0	400.6
Yorkshire and the Humber region	–	-	4,081	404.4	392.0	417.0

PHE Fingertips data
17/18 Hospital admissions for Self-Harm per 100,000 population aged 10-24

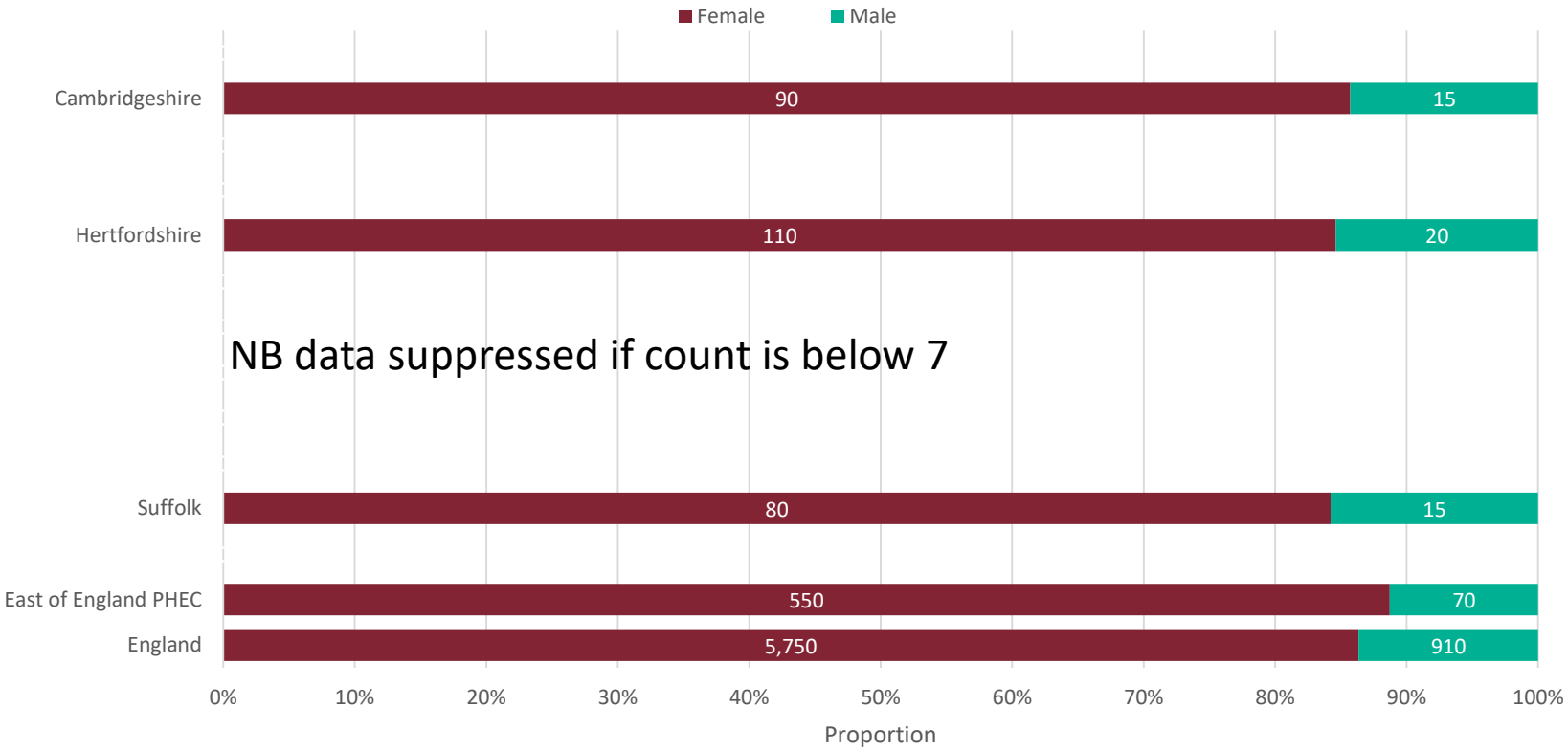
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	–	-	41,218	421.2	417.1	425.3
East of England region	–	-	3,971	387.9	375.9	400.1
Bedford	–	-	130	453.0	378.1	538.3
Cambridgeshire	–	-	777	662.7	616.9	711.0
Central Bedfordshire	–	-	178	416.6	357.3	482.8
Essex	–	-	735	307.6	285.7	330.7
Hertfordshire	–	-	546	273.7	251.1	297.7
Luton	–	-	131	328.9	274.9	390.3
Norfolk	–	-	602	412.7	380.4	447.1
Peterborough	–	-	197	587.2	507.9	675.3
Southend-on-Sea	–	-	77	269.3	212.4	336.7
Suffolk	–	-	534	450.8	413.3	490.8
Thurrock	–	-	64	225.3	173.4	287.8

PHE Fingertips data
17/18 Hospital admissions for Self-Harm per 100,000 population aged 10-24

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	–	-	41,424	407.0	403.0	410.9
East of England (East) NHS region	–	-	-	-	-	-
NHS Basildon And Brentwood CCG	–	-	190	416.4	359.2	480.0
NHS Bedfordshire CCG	–	-	292	377.7	335.6	423.7
NHS Cambridgeshire and Peterborough CCG	–	-	973	565.3	530.3	602.0
NHS Castle Point And Rochford CCG	–	-	75	242.2	190.4	303.6
NHS East And North Hertfordshire CCG	–	-	271	262.3	232.0	295.5
NHS Great Yarmouth And Waveney CCG	–	-	179	469.3	403.1	543.3
NHS Herts Valleys CCG	–	-	285	276.2	244.9	310.4
NHS Ipswich And East Suffolk CCG	–	-	267	411.2	363.2	463.8
NHS Luton CCG	–	-	129	297.6	248.4	353.6
NHS Mid Essex CCG	–	-	163	261.5	222.8	304.9
NHS Milton Keynes CCG	–	-	157	329.6	279.9	385.6
NHS North East Essex CCG	–	-	220	349.2	304.4	398.6
NHS North Norfolk CCG	–	-	96	391.8	317.3	478.6
NHS Norwich CCG	–	-	163	387.1	328.3	453.1
NHS South Norfolk CCG	–	-	109	284.5	233.5	343.3
NHS Southend CCG	–	-	62	205.9	157.8	263.9
NHS Thurrock CCG	–	-	65	216.1	166.8	275.6
NHS West Essex CCG	–	-	101	205.9	167.7	250.4
NHS West Norfolk CCG	–	-	160	620.9	528.4	724.9
NHS West Suffolk CCG	–	-	220	589.5	514.0	672.9

PHE Local Knowledge & Intelligence Service (East)

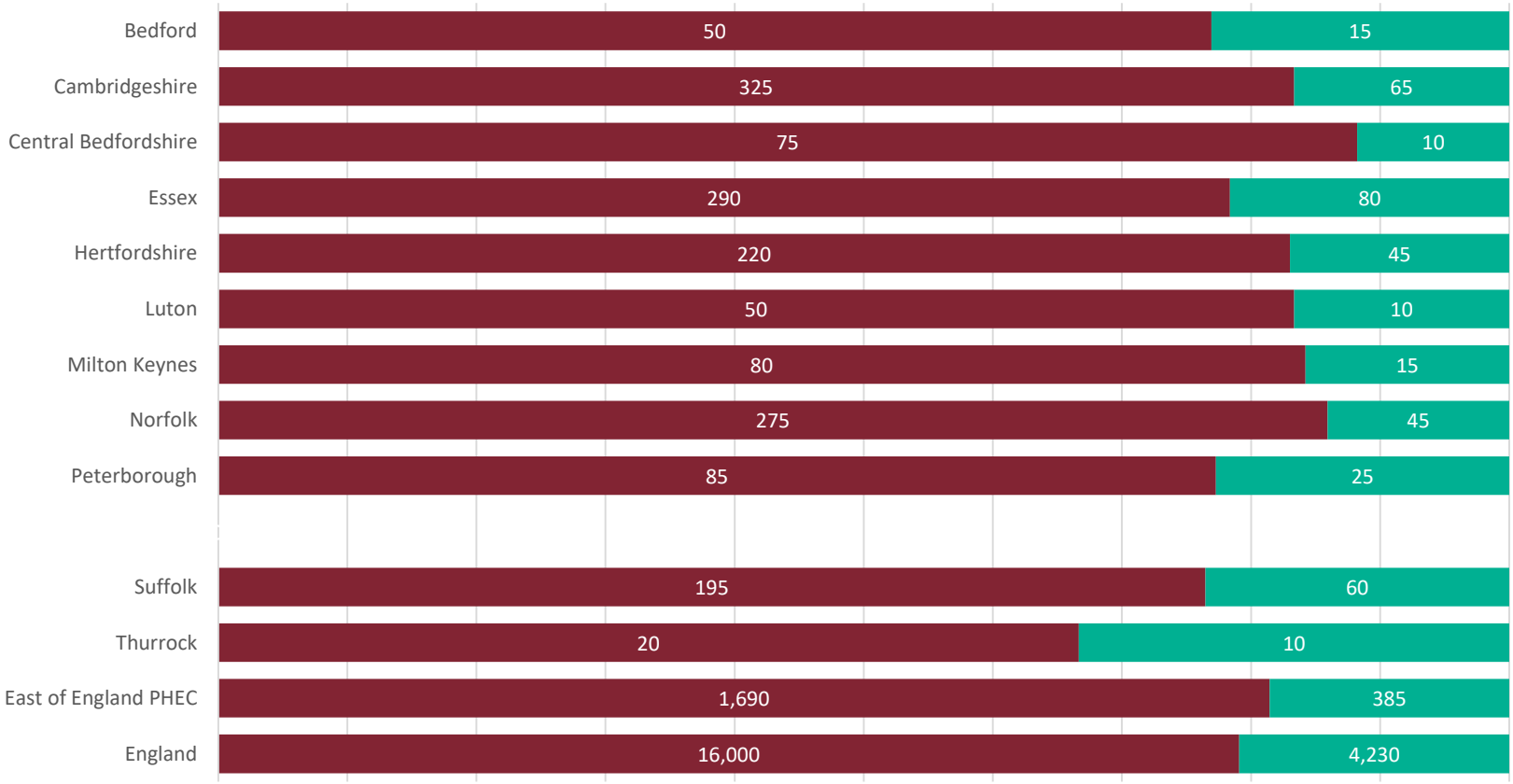
Episodes by gender, 10 - 14 yrs, 2017/18



NHS England and NHS Improvement

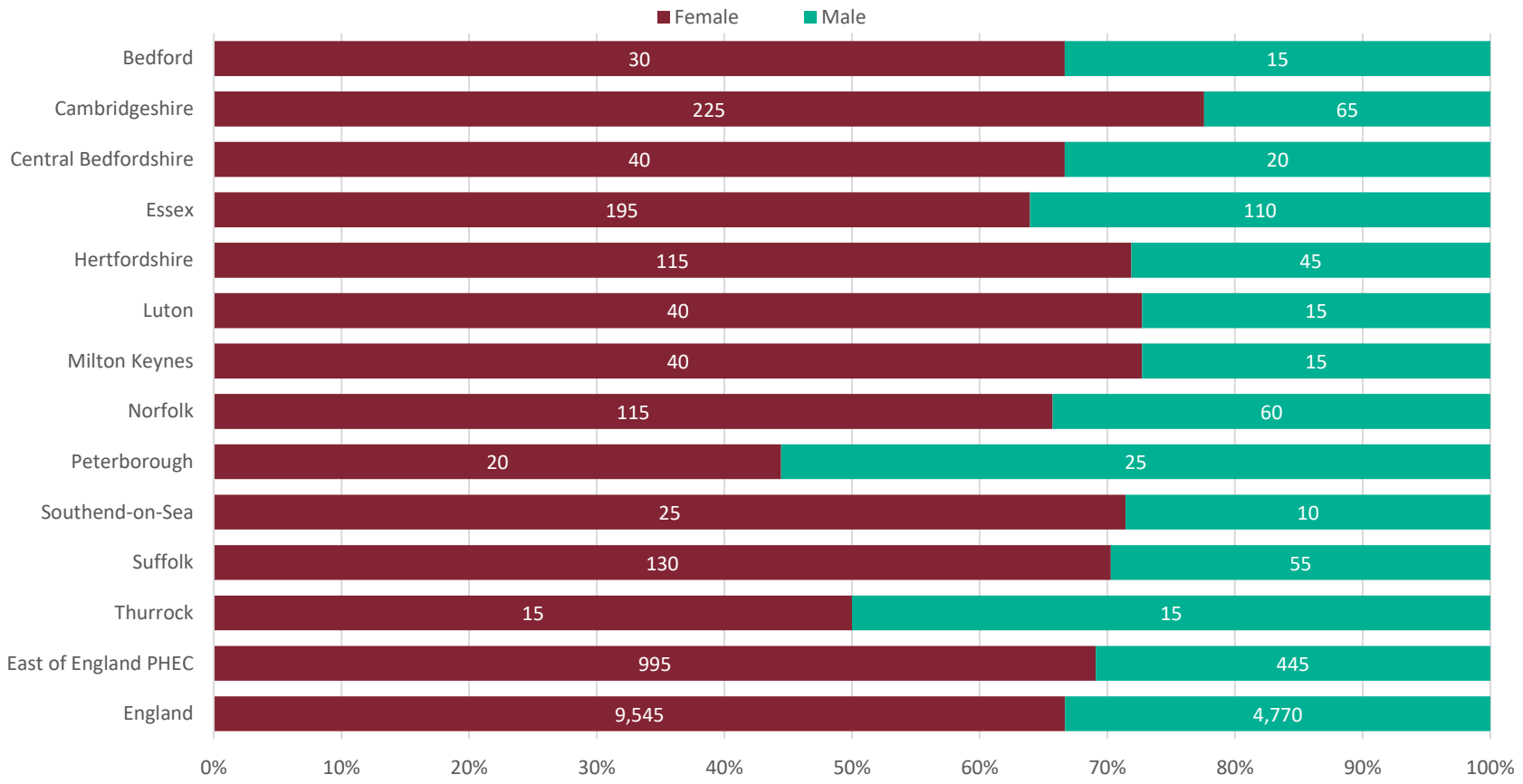
PHE Local Knowledge & Intelligence Service (East)

Episodes by gender, 15 - 19 yrs, 2017/18



PHE Local Knowledge & Intelligence Service (East)

Episodes by gender, 20 - 24 yrs, 2017/18



LKIS cont

- Although not shown due to small numbers there were self-harm admissions in the 0-9 age group
- More females are admitted for acute treatment following self-harm than males in all age groups, but the proportion of male admissions for self-harming increases with age.
    - Although there was a lot of suppression at LA level for the 10-14 data, including it would nevertheless show that males only accounted for 1 out of every 9 episodes.
    - By 15-19 years, this increases to 1 out of every 5 episodes,
    - By 20-24 years, males account for 1 out of every 3 episodes.
- Key issues:
    - The self-harm indicator is only the tip of the iceberg – many self-harm episodes will not result in a visit to GP, emergency presentation let alone hospital admission
    - We don’t know how much of the variation in self-harm admissions is due to variation in actual self-harming, variation in clinical practice or variation in how self-harm admission episodes are coded – this also needs to be considered when looking at the episode to patient ratio
    - We also haven’t talked about repeat admissions, and some of this data is skewed by repeat attenders

Child Death Overview Panel data

Deaths summarised her are defined as suicide by local CDOP team and not finalised view taken by coroner

17/18	Essex	Cambridge	Norfolk	Suffolk	Total
0-17 population (N)	302,000	206,404	169,100	187,000	864,504
Suicides (N in 12 month period)	10	4	3	2	19
Age	13-17 (mode = 16)	13-17	15-16 (mode = 16)	15-15	13-17 (mode = 16)
Gender	5 males 5 females	2 males 2 females	1 male 2 female	1 male 1 female	9 males 10 females
Gender Ratio	(1:1)	(1:1)	(1:2)	(1:1)	(4.7 : 5.3)
Method – Hanging	10 (100%)	4 (100%)	1 (33%)	2 (100%)	17 (89.5%)
Method – Overdose			2 (66%)		2 (10.5%)
Known to social care	2 (20%)	1 (25%)	3 (100%)	1 (50%)	7 (36.8%)
Known to CAMHS	5 (50%)	1 (25%)	3 (100%)	2 (100%)	11 (57.9%)
History of self-harm	7 (70%)	1 (25%)	2 (66%)	0 (0%)	10 (52.6%)
Substance-abuse history	5 (50%)	2 (50%)	1 (33%)	0 (0%)	8 (42.1%)
Alcohol misuse history	6 (60%)	1 (25%)	1 (33%)	0 (%)	8 (42.1%)
Breakdown of parental relationship	8 (80%)	2 (50%)	2 (66%)	2 (100%)	14 (73.7%)
Breakdown of interpersonal relationship	4 (40%)	2 (50%)	3 (100%)	0 (0%)	9 (47.4%)
Disclosure of suicidal feelings	6 (60%)	1 (25%)	1 (33%)	2 (100%)	10 (52.6%)
Suicide note left	4 (40%)	1 (25%)	0 (0%)	1 (50%)	6 (31.6%)
Assessed by professionals as high risk of suicide	2 (20%)	1 (25%)	0 (0%)	0 (0%)	3 (15.8%)

STEIS data

- This is data drawn from a NHS reporting database, where all serious incidents within NHS funded services are reported where harm has occurred and care or service delivery problems need to be investigated
- Whilst it is upto providers and commissioners to decide on which incidents reported, generally well assumed that all suspected self-inflicted deaths for people who have been referred, who are being seen, or have recently within 6 months been discharged will be reported.
- This data thus looks at those aged 18 and under who were being under the care of NHS funded services in Cambridgeshire, Norfolk, Suffolk and Essex, Hertfordshire and Bedfordshire
- Small numbers so care must be taken in both over extrapolating but also presenting identifiable information
- Primarily process of SI reporting and investigation is about health learning

STEIS data East of England

	2017/2018	2018/2019
Total number of suicides	11: under 18	7: under 18
Inpatient suicides	3	1
Methods	7 hanging 2 overdose/self-poisoning 5 other	3 hanging 3 overdose/self-poisoning 1 other

STEIS causes & learning for health (East DCO geography only)

Health Root Cause Analysis: Risk factors / Triggering events

- Childhood trauma (abuse and/or neglect) – Safeguarding
- Bereavement (death of family member)
- Parental separation
- Bullying
- Pressure of school coursework and exams / Poor school attendance / Moving schools / not being in education
- Friendship difficulties, arguments or relationship breakdown
- Physical health condition worsening; e.g. IBS, infections
- Drug and alcohol use

Health Root Cause Analysis: Themes of key areas for improvement

- **Risk assessments:** to include full risk history screen
- Paper work – need for electronic recording system
- Care-coordinator allocation
- **Information sharing:** with family members / carers; between services
- Multi-agency working & access to client formulation
- Engagement and contact
- **Transition between services:** to adult services / other services – communication and completed in timely fashion

NB Bold represents recurring themes

Serious Case Review findings

- Across East of England a number of deaths resulting from suicide have resulted in Serious Case Reviews and a number of LSCBs have completed thematic reviews. Some of the pertinent recommendations from these SCRs and thematic reviews are set out below:

Raising the profile of suicide, getting help, and resilience

- The need to consider how to facilitate conversations about teenage suicide (and emotional health issues) within families, with friends, within peer groups and **how best we can help families and professionals listen to and respond to vulnerable young people**. Exploration of what would help enable peer mentoring to be part of the support to young people - what skills would peer mentors need
- Delivery of workshops in schools and other settings for young people focusing on maintaining positive emotional health, managing social media, managing relationships and peer pressures, and addressing self-harming and drug/ alcohol use. **Young people need more immediate access to information about emotional and mental health** - such as online resources, Young Minds, Samaritans, YouTube videos, Kooth, etc.
- Consideration of how we can best ensure that young people are supported through separation, loss and bereavement, and the consequences of such events.
- Recognition that the issues in relation to emotional health and well-being, and self-harming, are increasingly being seen in primary- age school children, so this **work needs to begin in primary schools**. Need to look at how to build ‘resilience’ in schools for teachers and young people

Serious Case Review findings

Service development recommendations

- **Multi-agency training** to enable early interventions and conversations with young people about suicidal thoughts and about emotional & mental health, and supporting young people who have been told by their friends they are having suicidal thoughts.
- Consideration of the idea of having Emotional Literacy Support Assistants (ELSA's) in all schools, or other models of having mental health workers or teams in primary/secondary schools to enable vulnerability issues to be addressed at a much earlier stage (such as the Barnsley model)
- Consideration of multi-agency and multi-disciplinary meetings when specific risk thresholds are met - to share information, **consider collaborative actions /plans whereby each agency knows what the safety plan looks like**
- **Involvement of young people more in the design of emotional and mental health and well-being services**
- Explore how to work with '**Impulsivity**' in **young people**. Consideration of "drop-in" resources for young people experiencing emotional health crises.

Learning from past events

- Gathering of learning from young people who have previously attempted suicide but had not died.
- In future discussion of suicide cases, it would be useful to note the difference between historical bullying and current bullying; given that both were significant factors recognised in this review

Concluding thoughts

- No ‘perfect’, real time data that looks at whole region
- Limitations in all the data presented within pack
- Data from PHE for hospital admissions and national info indicates SH is increasing in CYP
  - Within East of England there is variance in where and how people receive physical treatment for SH
  - There is no means of capturing therapeutic treatment for SH
- Data on deaths from suicide gathered from STEIS and CDOP indicates fewer under 18s died from self-inflicted methods in 2018/19 than 2017/18
  - Don’t have comparative data to understand what this tells us
  - Will be a while before national NCI data is released to compare what we have seen in 18/19

Thank you for your attention

- Enjoy the rest of the stimulating presentations
- sarahrobinson@nhs.net

East of England
LSCB Network

Public Health England

NHS

Table Top Discussion

NHS England and NHS Improvement

Table top discussion AM

- Introduce yourself and identify a note taker (bullet points)
- Reflecting on the national and local presentations of data and learning

	Your organisation	Locally (STP/ LA)	Regionally
What resonated for you ?			
What data /evidence would be helpful to you			

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NHS

Refreshment Break & Networking

NHS England and NHS Improvement

East of England
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Public Health England

NHS

Voice of Children & Young People

Chantelle Keen

NHS England and NHS Improvement

East of England
LSCB Network

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Norfolk & Suffolk NHS Foundation Trust Youth Council

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Bedfordshire & Luton CAMHS

Aliza Rizvi

NHS England and NHS Improvement

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NHS

Themes, Children & Young People Videos

Dr Tim Clarke

Children & Young People Clinical Adviser

NHS England & NHS Improvement

East of England
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Voices of Families

Verity Bramwell

Ollie Foundation

NHS England and NHS Improvement

The OLLIE Foundation

As a parent what we wished you knew and wished we knew

Suicide and mental illness

When there is emotional crisis, not mental illness

SUICIDE BY CHILDREN AND YOUNG PEOPLE IN ENGLAND 2017

Under 20s

"Families will sometimes say that a suicide occurred "out of the blue". We confirmed that a proportion of the young people who died had not talked about suicide and had low rates of key stresses."

"A diagnosis of mental illness was reported in less than half (41%) of under 20s."

"Eighty-four (29%) had never expressed suicidal thoughts nor previously self-harmed."

SUICIDE BY CHILDREN AND YOUNG PEOPLE IN ENGLAND 2017

20 – 24 year olds

"A diagnosis of mental illness was reported in less than half (47%) of 20-24 year olds."

"Thirty-seven (35%) 20-24 year olds had never expressed suicidal thoughts nor previously self-harmed."

OLLIE's Founders

All three parents say there was no diagnosed mental illness. Their sons were not known to services, nor waiting to be seen. Instead their sons had a very bad day/s which resulted in emotional crisis and overwhelm. They did not have the resilience or problem solving skills to be able to cope with it. So they made a spontaneous choice that suicide was the solution.

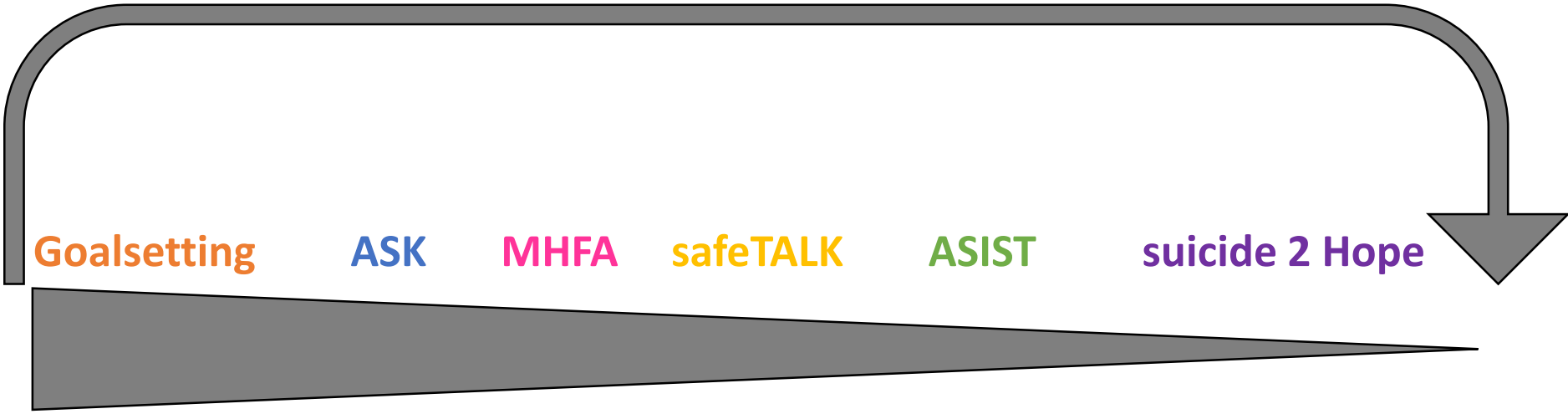
So what do we do when there is no mental illness?

When CAMHS isn't set up to support resilience and life skills, where do young people who end up in crisis go for the support they need?

What we did

safeTALK ASIST suicide 2 Hope

What we do



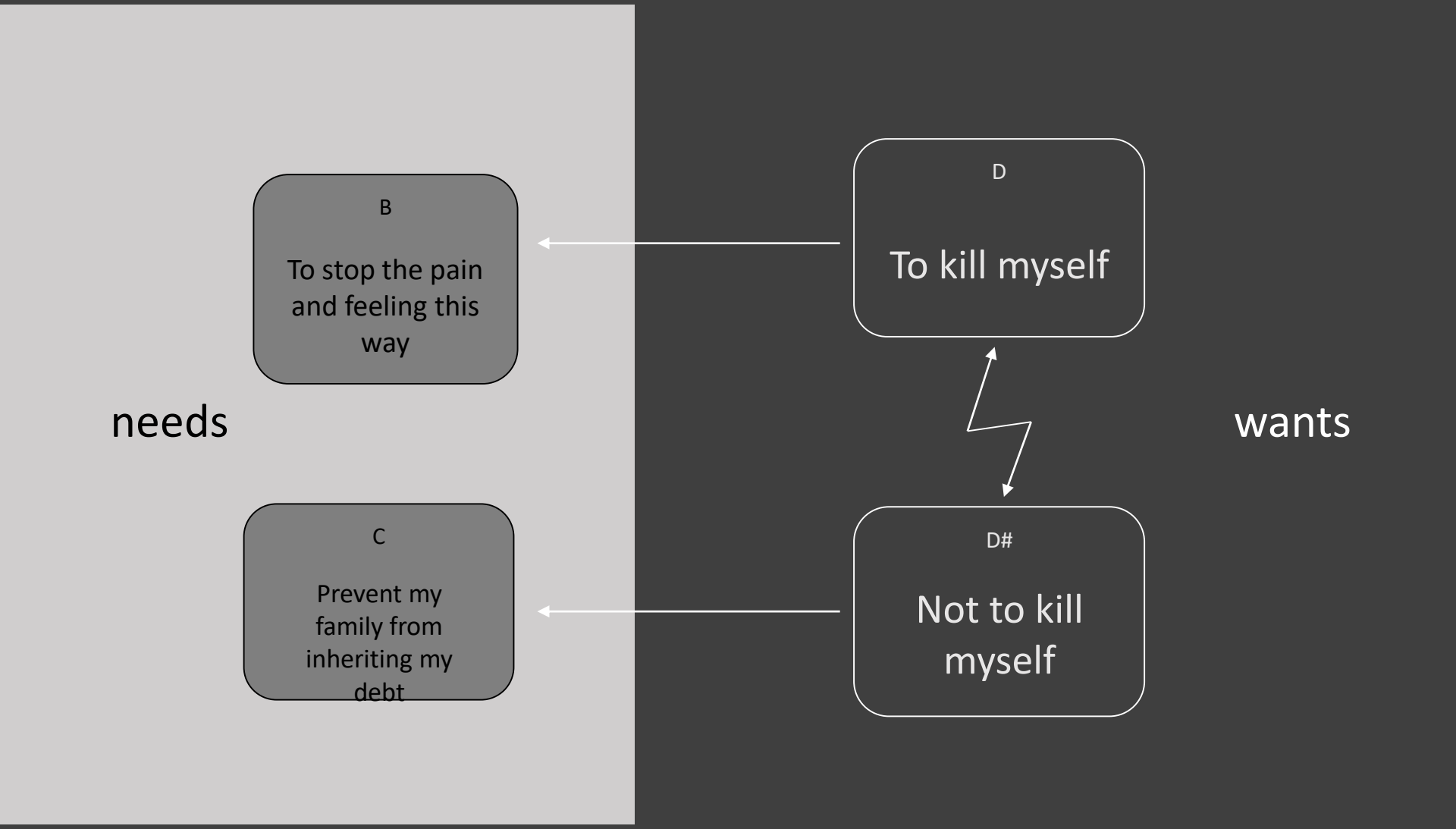
Our mental health teams

Do you know what they all are?

- CMHT — Community Mental Health Team
- CRHT — Crisis Resolution and Home Treatment Team
- CAT — Crisis Action Team
- HTRRT — Home Treatment Rapid Response Team
- PICU — Psychiatric Intensive Care Unit
- ESTEP — Essex Support & Treatment for Early Psychosis
- RAID — Rapid Assessment Interface & Discharge Team
- CCATT — Children's Crisis Assessment & Treatment Team

Other services

- Citizens Advice Bureau
- District Council Advisors
- Debt Collectors
- Job Centre


B
To stop the pain and feeling this way
D
To kill myself
needs
wants
C
Prevent my family from inheriting my debt
D#
Not to kill myself

Where to go in a crisis?

GP

A&E

999

THE OLLIE FOUNDATION

ONE LIFE LOST IS ENOUGH

Take away messages

Suicide sometimes has absolutely nothing to do with mental illness, but everything to do with emotional crisis. How do we work to prevent those suicides which tend to be seen as spontaneous with fewer warning signs?

We need to educate professionals AND public about what our mental health teams do to ensure expectations are realistic and to reduce disengagement.

Our professionals which we signpost people in crisis to, don't have mandatory mental health training. Why?

East of England
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Public Health England

NHS

Self-harm and Suicide Prevention

Jess Sharp

Programme Manager

NHS England & NHS Improvement

Self-Harm and Suicide Prevention

Jessica Sharp,

Children and Young People's Mental Health National Team

May 2019

What we will cover today

1. Brief policy and strategy overview
2. Self-harm and suicide – what is the problem?
3. What do we know ?
4. What are we doing ?
5. Looking ahead.

CYP Mental Health in England

21st Century Living

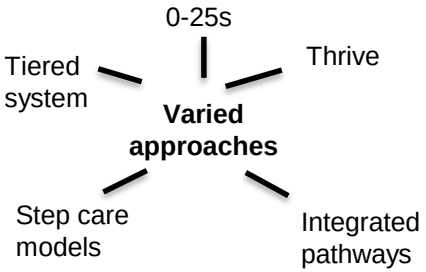
- Rising Prevalence
- Rising awareness and concern
- Changes in stigma
- Recognition of overlap with physical Illness
- Health inequalities
- Adverse Childhood Experiences
- Social Media

Infrastructure/resources

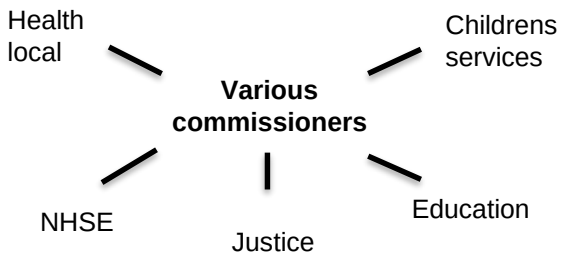
- High numbers of referrals
- Variable waiting times
- Variation in delivery
- Limited workforce capacity
- Need to improve productivity

Investment

- Failing to support CYP early - high personal cost to individuals and families as well as to society
- Low costs of intervening early
- CYP MH spend 9% of total NHS MH spend (2017/18)
- CYP ED community spend 2017-18 £46.7m
- CYP MH community (exl ED and LD) spend 2017-18 £640.5m



CYP IAPT change programme (from 2011) worked with services across England to embed and improve access to evidence based and outcomes focused care and interventions, building partnership and collaboration with CYP and their parents.



Current NHS programme builds on the learning from previous programmes and strategies going back to 2004 e.g. the National Service Framework, Every Child Matters, Choice and Partnership Approach, Targeted Mental Health in Schools, Children and Young People's Improving Access to Psychological Therapies Change programme.

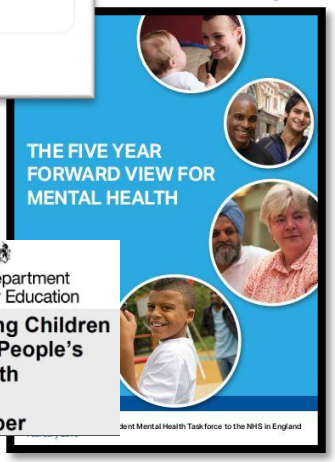
Accelerating change

"We can give the mental wellbeing of our children the priority it so profoundly deserves."

Political drive

Leadership

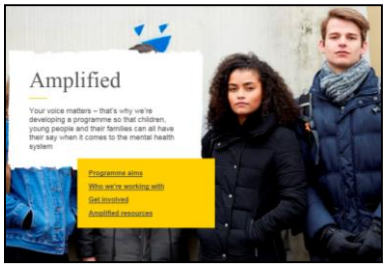
Policy



Vision

Understanding need

YOUNGMiNDS



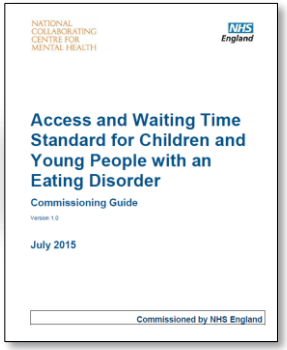
Engagement

Progress

Local Transformation Plans for Children and Young People's Mental Health and Wellbeing

Enablers

Stepping forward to 2020/21: The mental health workforce plan for England



Where we are now

	FYFV MH	
Access	70,000 more CYP accessing CYPMH services	**On track for 70,000 more children and young people to be seen by 2020/21**
Eating Disorders	95% of those in need of eating disorder services seen within 1 week for urgent cases and 4 weeks for routine cases	**CYP eating disorders on track for 95% access target by 2020/21**
Crisis Care	Improved crisis care for all ages, including places of safety	**Second national survey (2018) shows increase in comprehensive offer (crisis assessment, brief response and intensive home treatment) being commissioned, as well as significant growth in services operating 24/7 or over extended hours**
Finance	All CCGs to deliver the mental health investment standard	**Mental health investment standard met in all CCG plans 2018/19**
Workforce	3,400 existing CYPMH staff trained in evidence based teams 1,700 new qualified therapists working in CYPMH services	**CYP IAPT rolled out across 100% of the country and is now business as usual with existing and new staff trained to deliver evidence-based therapies**
Inpatient beds	Inappropriate placements to inpatient beds for CYP will be eliminated: including both placements to inappropriate settings and to inappropriate locations.	**Re-distribution of inpatient beds to provide more beds across a range of needs and in places where previously there were no beds**

Five Year Forward View for Mental Health commitments by 2020/21

NHS England

70,000 more children and young people accessing CYP MH services

1,700 newly qualified therapists working in CYP MH services

3,400 existing CYP MH staff trained in evidence based treatments

Improved Crisis Care for all ages, including places of safety

95% of those in need of eating disorder services seen within 1 week for urgent cases & 4 weeks for routine cases

Improved access to and use of Inpatient Care, having the right number and geographical distribution of beds to match local demand with capacity, and an overall reduction in bed usage

Suicide reduction: specific commitments

- 10% reduction in suicide rates, backed by £25m investment
- In addition, in 2018, the Secretary of State announced ***zero suicide ambition*** for mental health inpatients
- £1.8m to support the Samaritans helpline up to 2022.

NEXT STEPS: CYP MH Programme Priorities 2019/20 *Transitional Year*

Policy Development & System Support	▪ Support development of **Long Term Plan National Implementation Framework** and subsequent **National Implementation Programme** ▪ Continue links to other programme e.g. SEND and Transforming Care
National and Regional Support	▪ Support local area development of **1-year 'transitional' operational plans** for 2019/20 and future planning ▪ Continue to improve access to CYPMH services - target by 20/21 70,000 more CYP per annum ▪ System support: CYP MH Improvement teams in Clinical Networks ▪ Next phase Commissioner Development Programme and tools e.g. system planning model ▪ Pilot and report on proposed CYPMH currencies for payments ▪ Continue to develop national data/MHSDS/dashboard of metrics/outcomes monitoring ▪ Continued CYP and parent participation - Amplified (Young Minds)
Workforce Development	▪ CYP IAPT: now BAU but continued focus on increasing workforce capability of existing staff and achieve the 3,400 target of staff trained in evidence based interventions by 2020/21. ▪ Support provision of new workforce for improved access and Green Paper
Eating Disorders	▪ Continue to Improve access by dedicated community ED teams to meet standards
Crisis Care	▪ Develop tools and resources to support spread of 24/7 emergency response pathways for CYP ▪ Second National audit of crisis and intensive community support services
Specialised Commissioning	▪ Recommissioning of CYP MH (tier 4) inpatient beds ▪ Continue to support collaborative commissioning through New Care Models
Vulnerable Groups	▪ Continue to implement forensic CAMHS complex needs service and pathway ▪ Specialised framework of integrated care across YOIs, SCHs etc. ▪ Health and justice collaborative commissioning networks and JSNAs ▪ Test Personal Budgets for looked after children ▪ Improve CYP experience of Transition
Implement green Paper	▪ Continue to support development of Trailblazer sites ▪ Support HEE curriculum development and workforce implementation ▪ Data specification for outcome and output monitoring for schools and WT pilots ▪ Waiting time pilot

HM Government

Suicide Prevention

NHS England

Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives

Published January 2019

National Suicide Prevention Strategy Priorities (Jan 2019)

1. Working in partnership with local government to embed their local suicide plans in every community;
2. Delivering our ambition for zero suicide in mental health in-patients and improving safety across mental health wards and extending this to whole community approaches;
3. Addressing highest risk groups including middle aged and other vulnerable groups such as people with autism and learning disabilities, and people who have experienced trauma by sexual assault and abuse;
4. Tackling societal drivers of suicide such as indebtedness, gambling addiction and substance misuse and the impact of harmful suicide & self-harm content on line;
5. Addressing increasing suicides and self harm in young people and,
6. Improving support for those bereaved by suicide

Suicide attempts and self harm

- **Steady increase between 2000 and 2014** in suicidal thoughts, suicide attempts and self-harm for 16 to 24 year olds.
- **25.7% of women aged 16 to 24 had self-harmed** - twice the next highest age cohort (13.2% of 25 to 34 year olds). (APMS, 2014)

Figure 12G: Self-harm ever by sex among 16-24 year olds; 2000, 2007 and 2014

Base: adults aged 16–24 and living in England

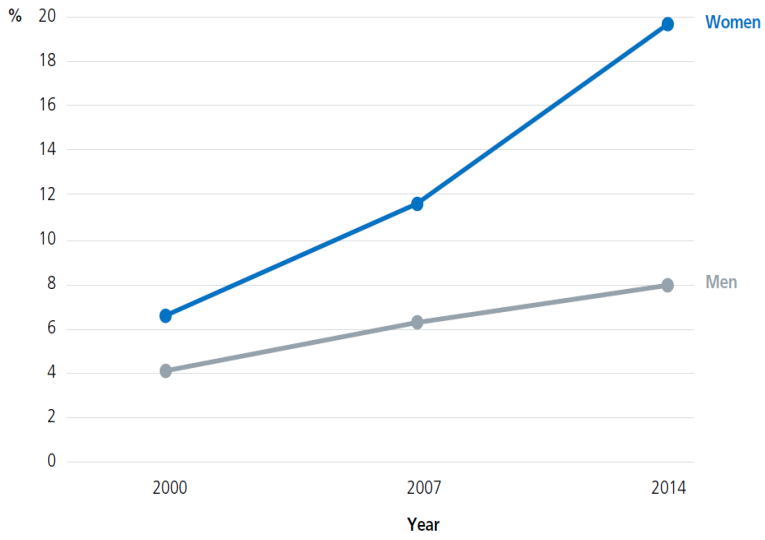
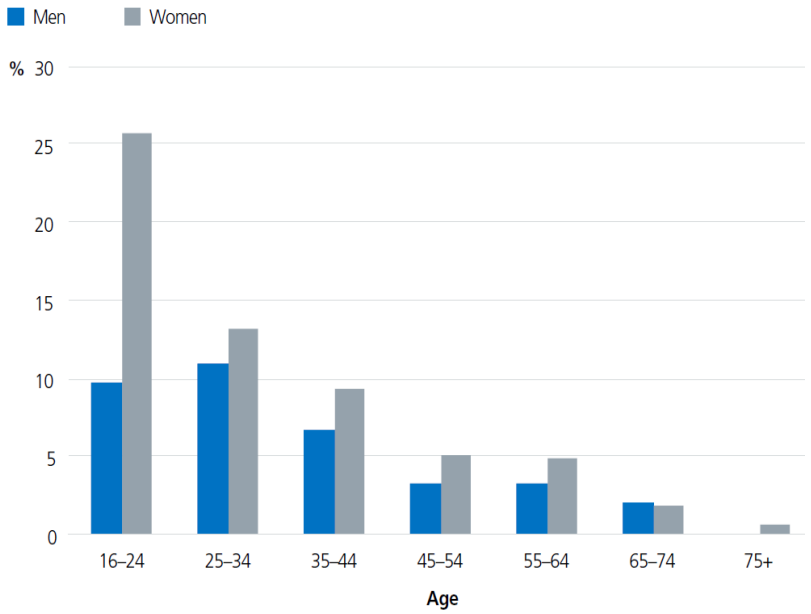


Figure 12C: Self-harm without suicidal intent ever, by age and sex

Base: all adults

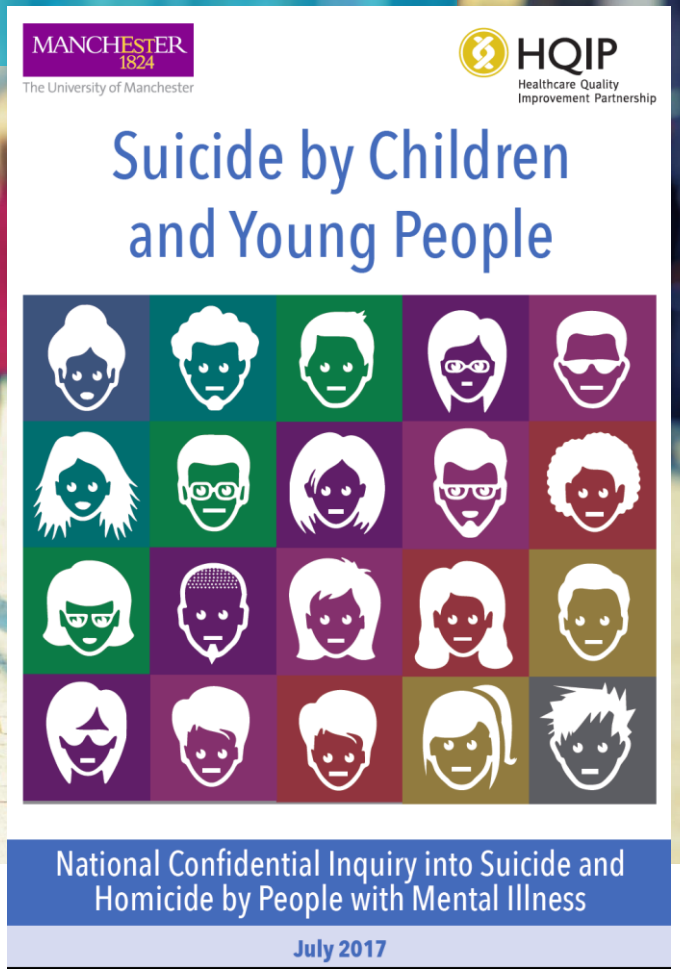


Suicide attempts and self harm: CYP

- 5% of 11 to 16 year olds, and 14% of 17 to 19 year olds had attempted suicide at some point.
- 25% of 11-16 year olds with a mental disorder vs 3% of those without a disorder were likely to have self-harmed or attempted suicide at some point. (APMS, 2014)
- Half of 17 to 19 year old girls with a mental disorder reported self-harm or suicide attempt (NHS Prevalence Survey, 2017)
- 52% of suicides under 20 had self harmed (NCISH 2017)
- 89% of female suicides under 25 had self harmed (NCSIH 2018)
- 52% of 16 to 24 year olds did not seek professional help after a suicide attempt or self-harming incident (APMS, 2014)

National Confidential Inquiry into Suicide and Safety in Mental Health

The National Confidential Inquiry into Suicide and Safety in Mental Health



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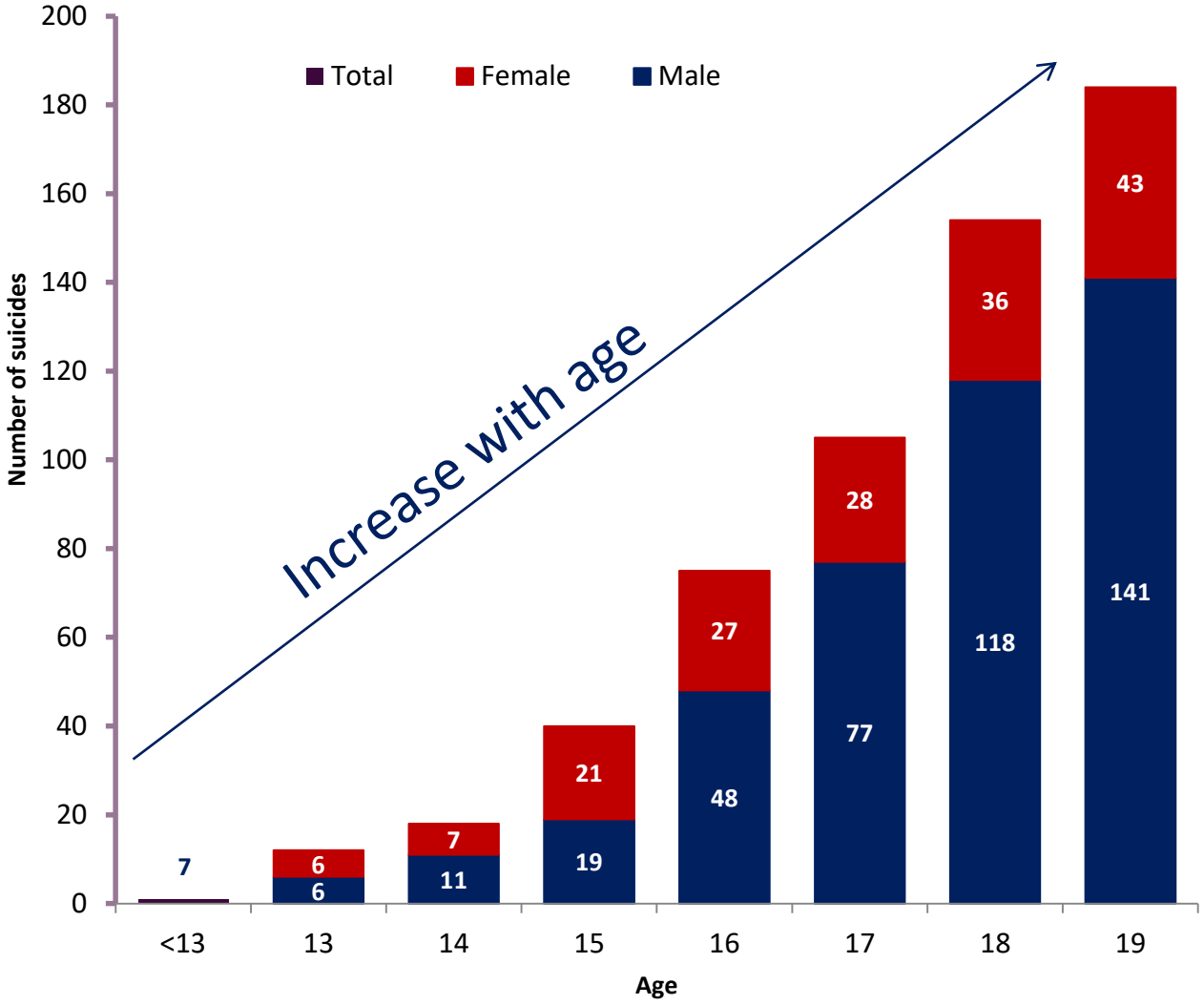
Suicide in children young people aged <20



Suicide rate increases steadily with age, esp. in mid-late teens

Mainly males (71%)

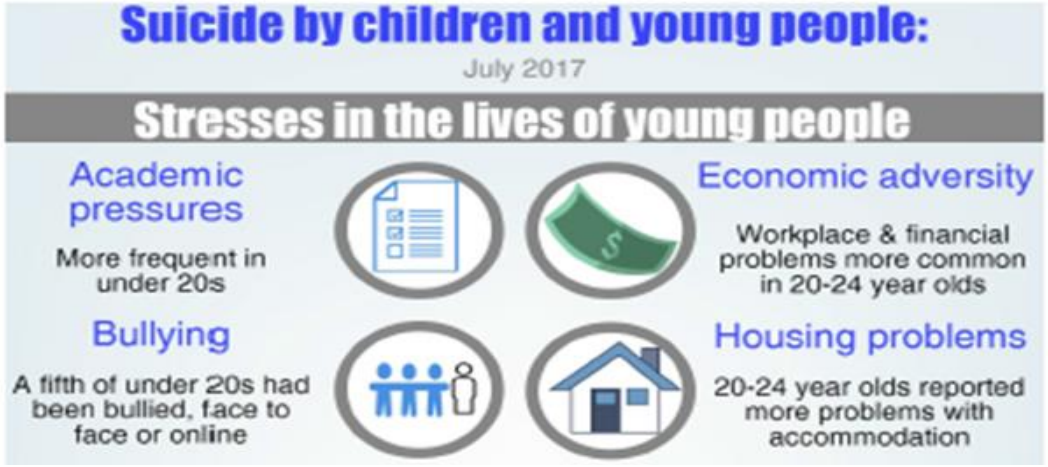
Hanging the most common method

18 suicides of U18s in inpatient settings since Jan 2013 (PHE)

www.england.nhs.uk

Important Themes for Suicide Prevention

10 common themes
Family factors such as mental illness
Abuse & neglect
Bereavement & experience of suicide
Bullying
Suicide-related internet use
Academic pressures, especially related to exams
Social isolation or withdrawal
Physical health
Alcohol & illicit drugs
Self-harm & suicidal ideas, mental ill-health



NHS England

Although there were many antecedents in common, there was a changing pattern reflecting the stresses experienced at different ages

Key messages:

Suicide in CYP is rarely caused by one thing: it usually follows a combination of previous vulnerability and recent events.

The stresses identified before suicide are common in young people - most come through them without serious harm

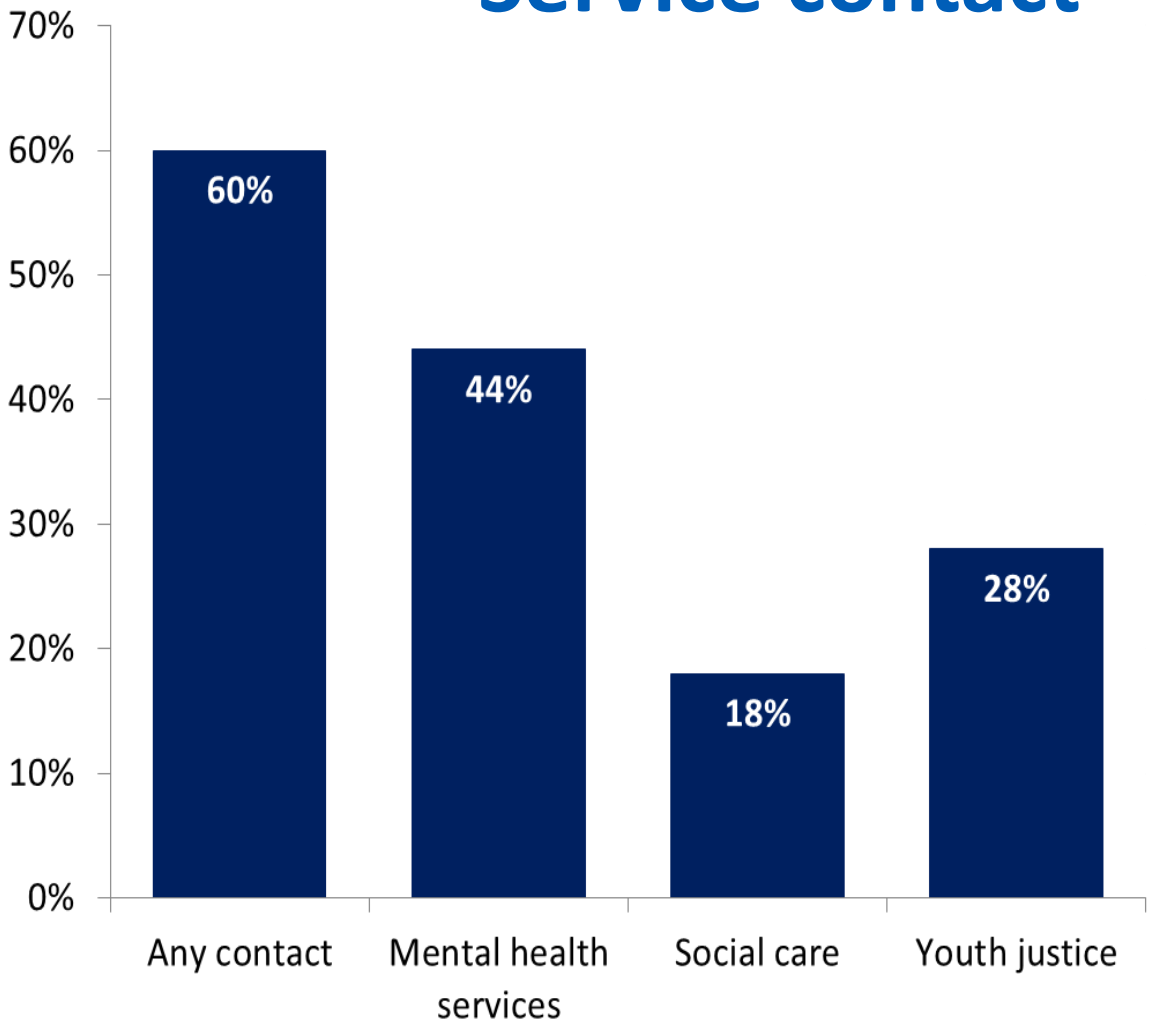
A history of self-harm was especially common, occurring in 89% of those under 25. (NCISH 2018) and 52% of U20's (NCISH CYP Report 2017)

Nearly 4 in 5 young people say they "do not know where to turn" for support for self harm,
(Young Minds and Cello report 2012)

HQIP
Healthcare Quality Improvement Partnership

MANCHESTER 1824
The University of Manchester

Service contact



40% no service contact

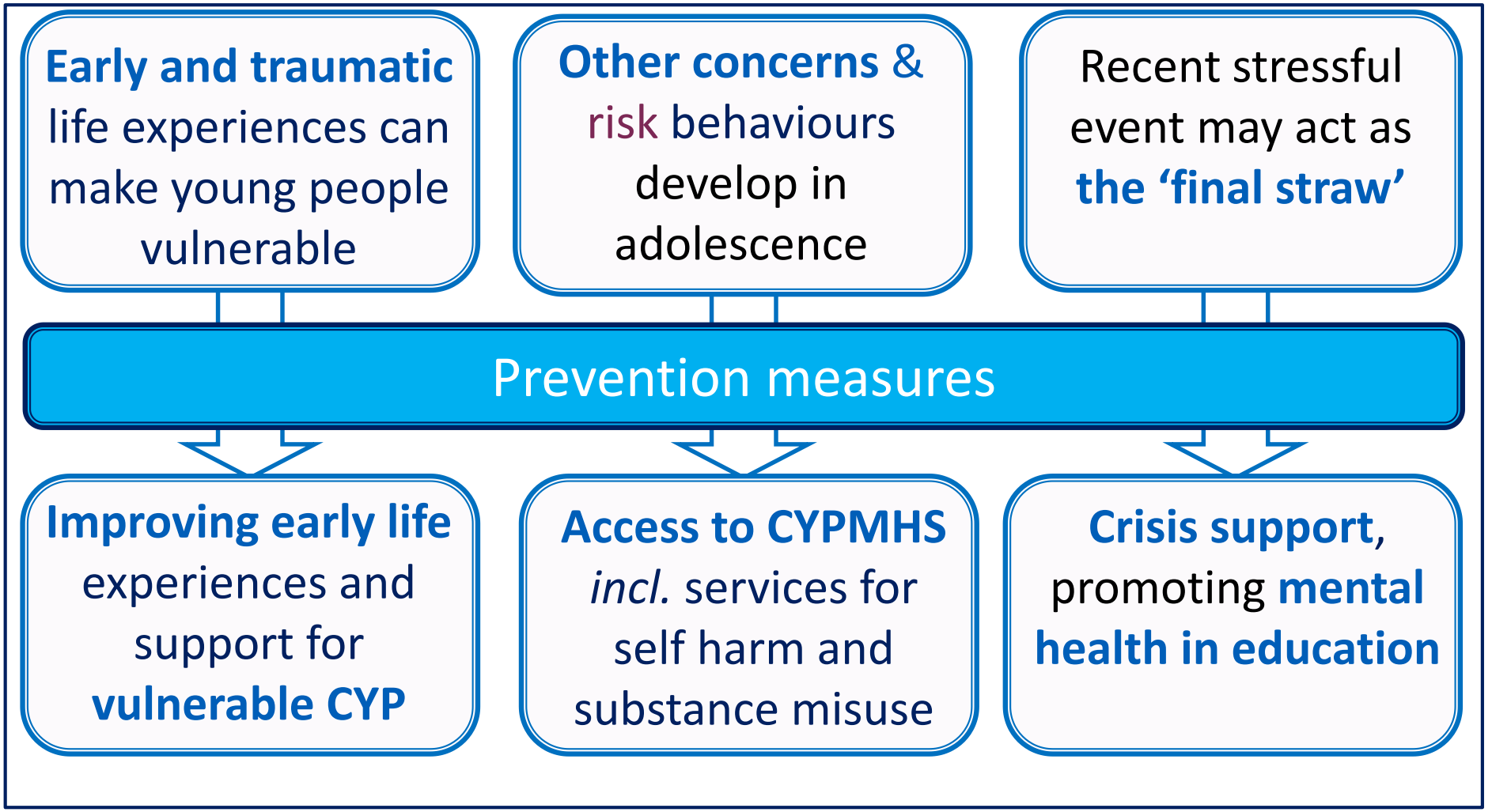
Under half in recent (<3 month) contact

Mainly mental health service contact

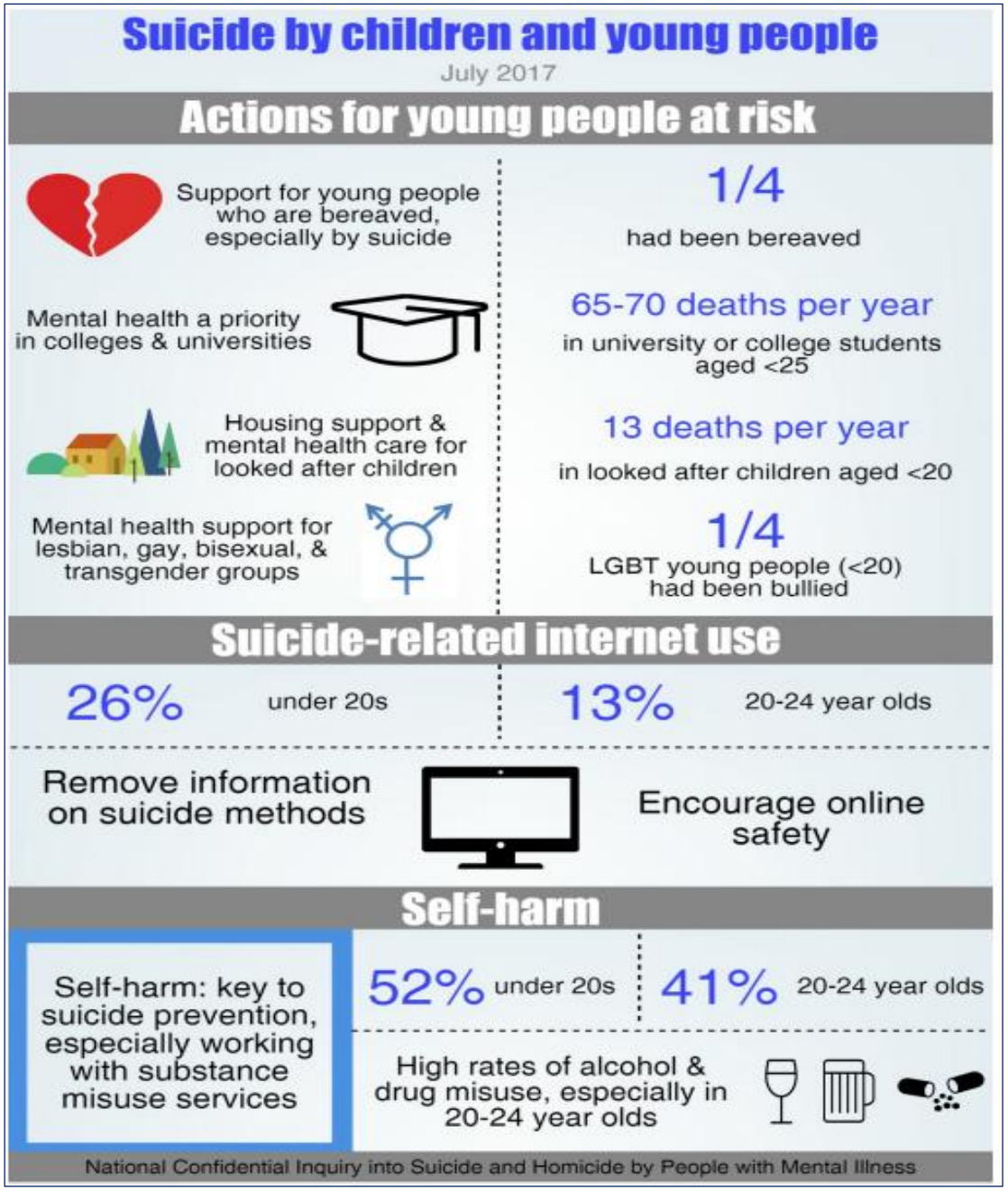
29% 'out of the blue' (no expressed suicidal thoughts or self harm)

Males more likely to have no contact

A model of cumulative risk



Suicide prevention contributed to by recognising this pattern



MANCHESTER 1824

HQIP
Healthcare Quality Improvement Partnership

NHS England

Half of LAC & care leavers group reported problems with or a recent change in accommodation

42% of under 20s reported excessive use of alcohol or illicit drug use. (NCISH 2018)

www.england.nhs.uk

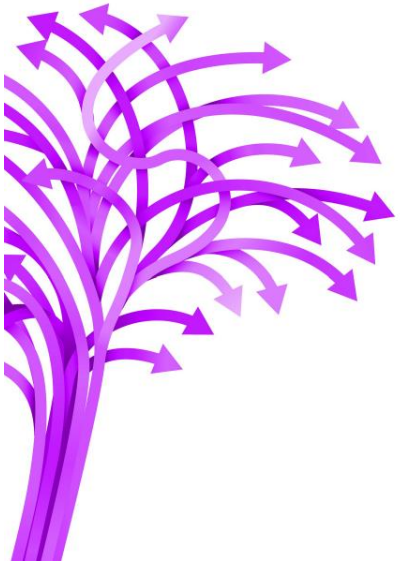
What the findings tell us

Improved online safety

Public awareness of availability of online information on suicide method

Increase online vigilance

Encourage online safety



PSHE Association

PSHE Education Programme of Study

Key stages 1-5

What the findings tell us

Shared role

Promoting mental health in education

Availability of support at times of risk, e.g. exam months

Shared role for frontline services

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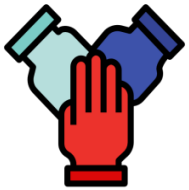
Self-harm

Good psychosocial assessment after self-harm

Access to psychological therapies - follow-up with CBT/DBT

Mental health & alcohol/ drug services working together



What are we doing?

In 2018/19 NHS England,

Identified and allocated resources to STPs with high rates of suicide

Designed and commissioned a National Quality Improvement offer delivered by *National Confidential Inquiry into Suicide and Safety in Mental Health* (NCISH) and RCPsych

Allocated funding to regions for joint NHS England-Public Health England regional suicide prevention leads, and to support STPs not in receipt of priority funding

Preventing Suicide in England (2012)

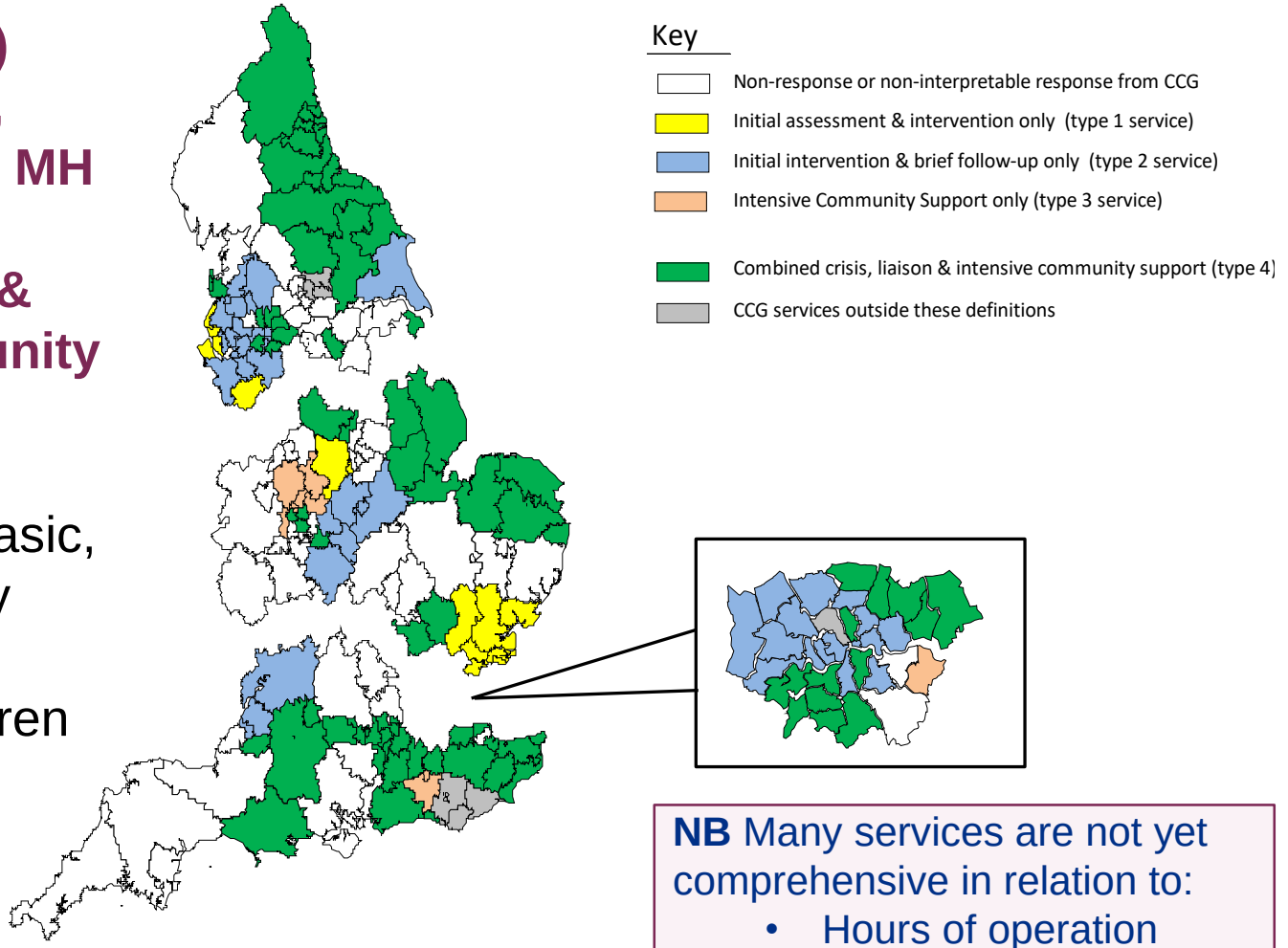
Identifies children and young people, including those who are vulnerable such as looked after children, care leavers, and children and young people in the youth justice system for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced.

CYPMH UEC Survey Findings 2017
Most comprehensive service type by CCG

NHS England

Most areas (52%) with a dedicated, staffed CYP UEC MH service offer combined crisis & intensive community support.

All areas offer a basic, on-call emergency mental health response for children and young people



NB Many services are not yet comprehensive in relation to:

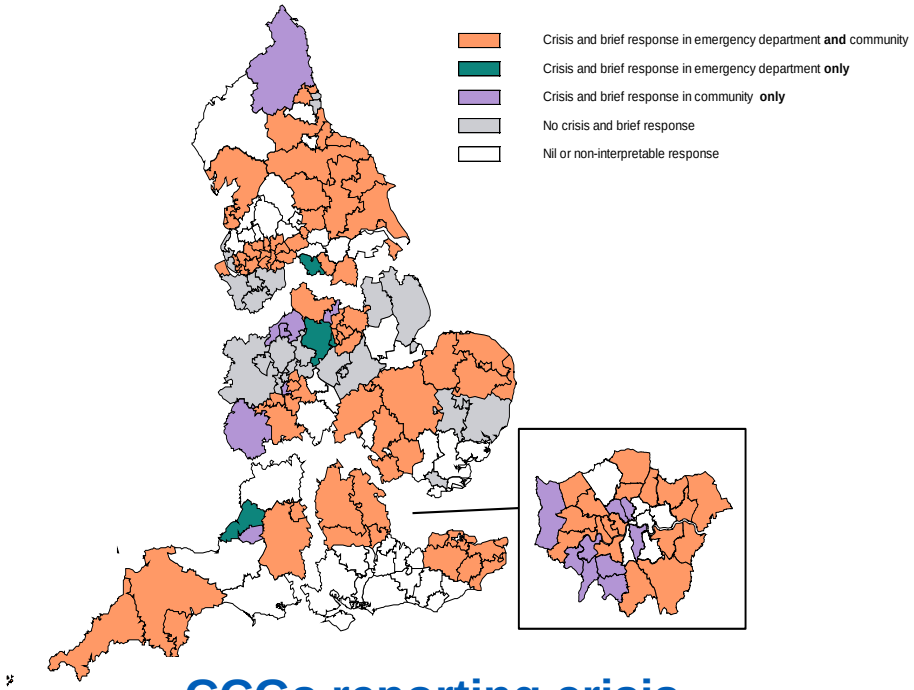
- Hours of operation
- Age range
- Staffing

CYPMH UEC Survey Findings 2018

Summary comparison of CYP Urgent & Emergency Mental Health services reported in 2017 and in 2018

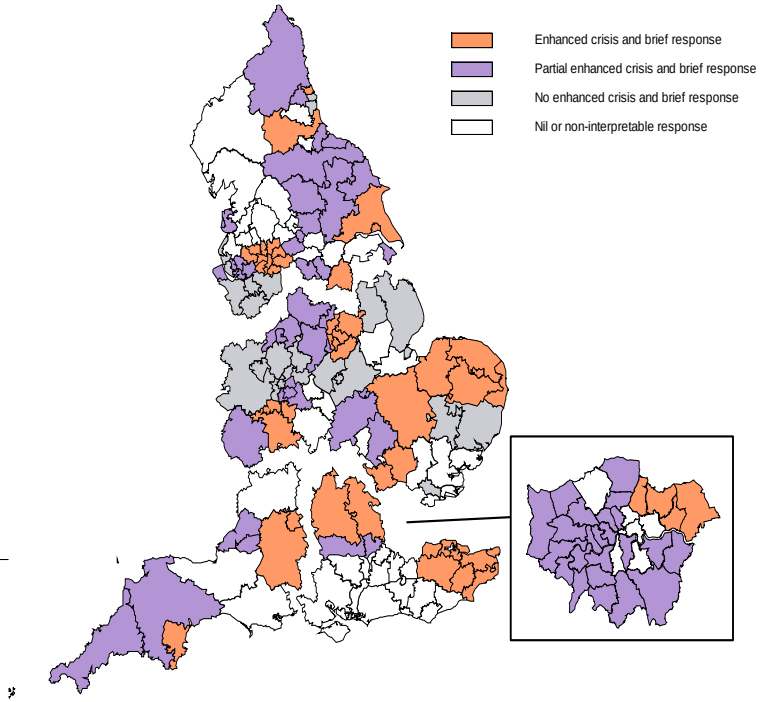
Survey analysis	Percentage of CCGs reporting	
CYP Mental Health Urgent & Emergency Care Offer	**2017**	**2018**
Crisis assessment in the emergency department and/or in community settings, plus brief intervention and support	80%	82%
Intensive home treatment	57%	74%
Crisis, brief response and home treatment	52%	57%
Hours of operation		
24/7 or extended hours	62%	93%

CYPMH UEC Survey Findings 2018



CCGs reporting crisis assessment and brief response (as per 2017)

'Step-up analysis' for *enhanced* CYP crisis response service

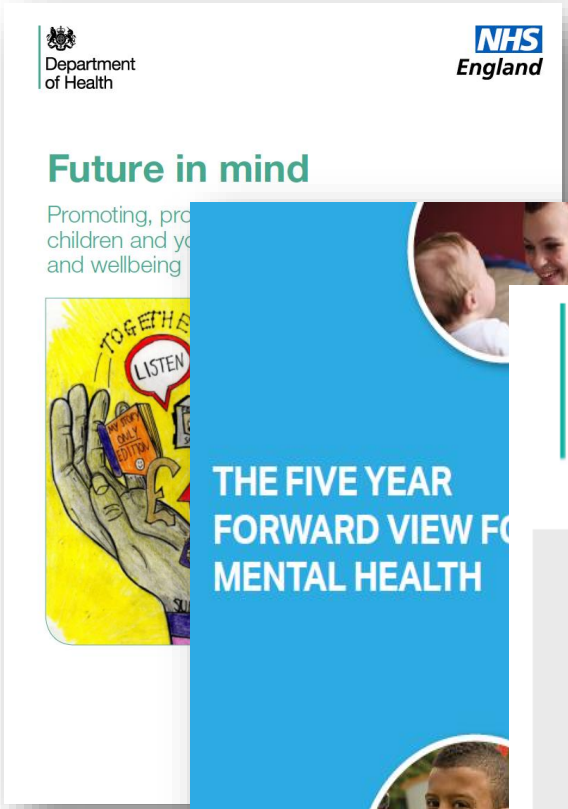


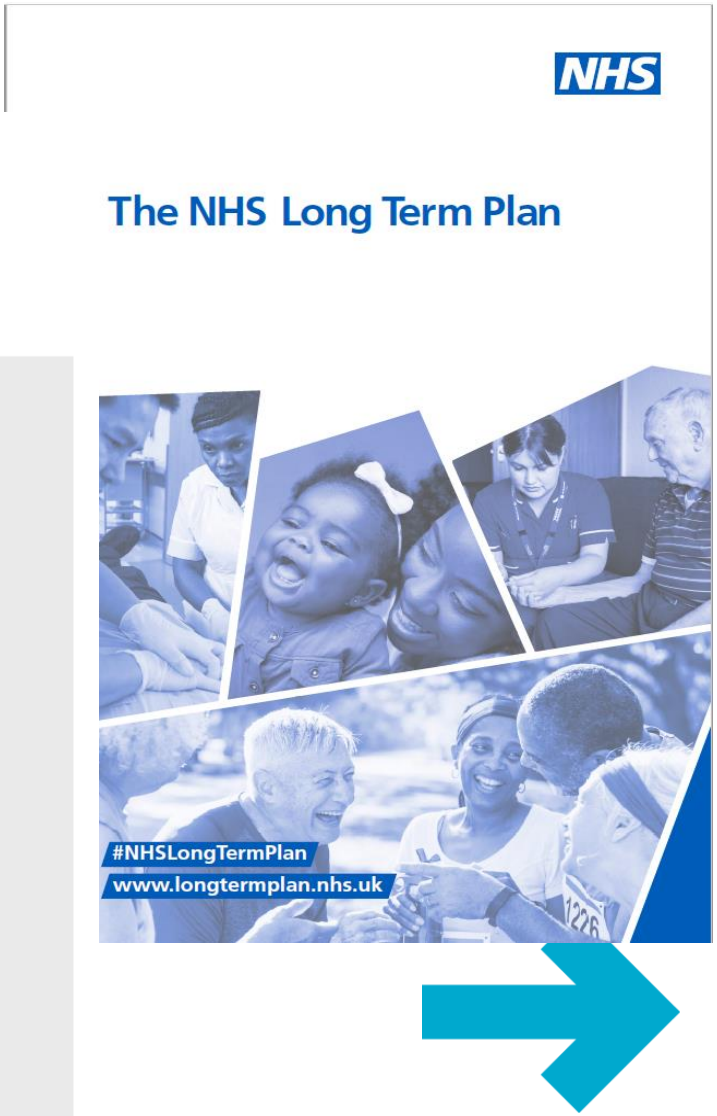
CCGs reporting enhanced crisis assessment and brief response

Step-up analysis for *enhanced* service

- Assessment and brief response in **both** emergency departments and community settings
- Extended hours (8.00 a.m. – 10.00 p.m.) on weekdays or 24 hrs
- children and young people **aged 0 up to their 18th birthday.**

Policy





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Transforming CYP MH Provision: a Green Paper

NHS England

Commitment to three core deliverables:

1. **Designated Senior Lead for Mental Health** (DfE lead): Schools and colleges to identify a **DSL** to oversee the approach to mental health and wellbeing. All NHS CYPMHS to identify a link for schools and colleges to provide rapid advice, consultation and signposting.

2. **Mental Health Support Teams**, (NHS Lead) **supervised by NHS CYPMH staff,** to provide extra capacity for early intervention. Work managed jointly by schools, colleges and the NHS. Teams provide evidence based interventions to support those with mild to moderate needs and support the promotion of good mental health, wellbeing and whole school approaches.

3. **Trial a four week waiting time** (NHS Lead) in a limited number of areas for access to specialist NHS community CYPMHS.

Mental Health Support Teams

Each 'trailblazer' CCG selected must have a minimum of two mental health support teams (MHSTs), each covering a population of c.8,000 children of school age.

Core interventions for mild to moderate MH issues

New teams carry out interventions alongside established provision such as school nurses, SENCOs, school counsellors Place2B and educational psychologists.

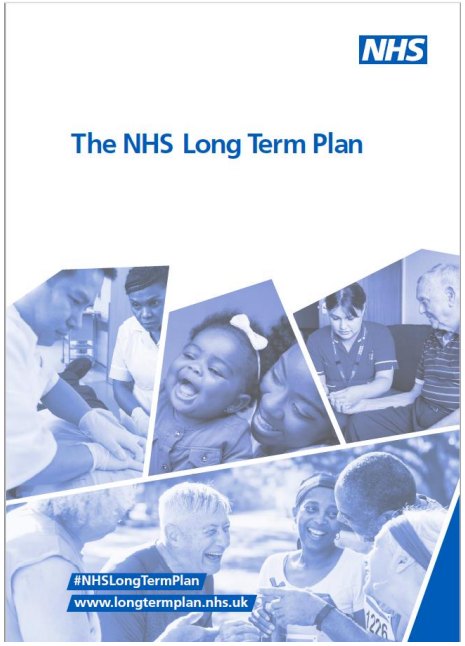
- **Face to face work:** for example, effective brief, low-intensity interventions for children, young people and family systems experiencing anxiety, low mood , friendship difficulties and behavioural difficulties, based on the most up to date evidence
- **Group work** for pupils or parents such as drop ins and group CBT for young people for conditions such as anxiety and self-harm.
- **Group parenting classes** to include issues around conduct disorder, communication difficulties.

Mental health in the Long Term Plan

Headline ambition is to deliver ‘world-class’ mental health care, when and where children, adults and older people need it.

The NHS Long Term Plan published on 7 January 2019 commits to grow investment in mental health services faster than the overall NHS budget. This creates **a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24**. Further, the NHS made **a new commitment that funding for children and young people’s mental health services will grow faster than both overall NHS funding and total mental health spending**. This will support, among other things:

- Significantly **more children and young people from** 0 to 25 years old to access timely and appropriate mental health care. NHS-funded school and college-based Mental Health Support Teams will also be available in at least one fifth of the country by 2023.
- People with **moderate to severe mental illness** will access better quality care across primary and community teams, have **greater choice and control** over the care they receive, and be supported to lead fulfilling lives.
- We will **expand perinatal mental health care** for women who need specialist mental health care during and following pregnancy.
- **The NHS will provide a single-point of access and timely, age-appropriate, universal mental health crisis care for everyone, accessible via NHS 111.**



NHS Long Term Plan and suicide prevention and reduction ambitions (by 2023/24)

Suicide reduction

- Reducing suicide will **remain an NHS priority.**
- Full coverage across the country of the existing **suicide reduction** programme.
- Further supported by the design and roll out of a **Mental Health Safety Improvement Programme** with a focus on suicide prevention and reduction for mental health inpatients.
- Building on the work of the Global Digital Exemplar (GDE) programme, we will use **decision-support tools and machine learning** to augment our ability to **deliver personalised care and predict future behaviour, such as risk of self-harm or suicide**.

Bereavement support

- **Bereavement support** for families and staff who are bereaved by suicide, who are likely to have experienced extreme trauma and are at a heightened risk of crisis themselves will be rolled-out to all areas of the country.

Self harm

- A new approach to the **longer-term management of self harm.**

Further work

In 2019/20, NHS England plans to:

- **Fund suicide and self harm reduction in more STPs** with high rates of suicide, trailblazers (sites of good practice and innovation) and postvention bereavement services (including central hub of resources)
- Continue with National Quality Improvement offer and Regional Support

NICE Quality Standards for Suicide Prevention (pub Sept 2019)

The Department for Education (DfE)

Health education – including mental health education will be made compulsory in English schools from September 2020.

Includes primary and secondary schools addressing

- Relationships – family and friends,
- Staying safe on line,
- Building mental resilience – as well as how to recognise when their peers are struggling with mental health issues.
- Lessons also focus on topics such as consent and LGBT+ issues.

Thank you

Any questions?

Resources

March 2019

NHS England – CYP MH Team

References

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- Adult Psychiatry Morbidity Survey (2014)
- Mental Health of Children and Young People in England – Prevalence Survey (2017)
- NHS Long Term Plan (2019)
- Transforming Children and Young People's Mental Health Provision: A Green Paper
- Preventing Suicide in England – a cross-government outcomes strategy to save lives (prepared by Department of Health, 2012)
- Saunders, K. and Smith, K. (2016). Interventions to prevent self-harm: what does the evidence say? *Evidence Based Mental Health, 19*(3), 69 – 72
- Young Minds and Cello Health PLC joint report – Talking Self-Harm (2012)
- Patton, G., Coffey, C., Sawyer, S., Viner, R., Haller, D., & Bose, K. et al (2009). Global patterns of mortality in young people: a systematic analysis of population health data. *The Lancet, 374* (9693), 881 – 892
- Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2016. www.manchester.ac.uk/ncish/reports/
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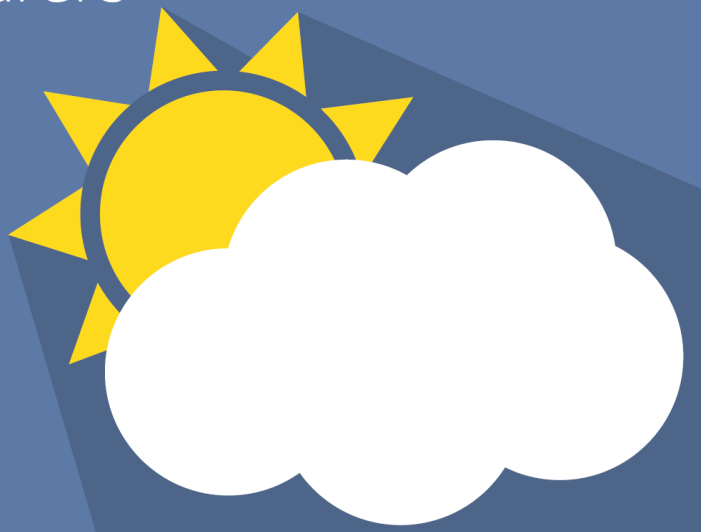
Coping with self-harm

A Guide for Parents and Carers



DEVELOPED BY RESEARCHERS AT THE UNIVERSITY OF OXFORD

NHS England

About this guide

This guide was developed from talking to parents and carers of young people and is aimed at helping parents, carers, other family members and friends cope when a young person is self-harming. It includes information on the nature and causes of self-harm, how to support a young person when facing this problem and what help is available.

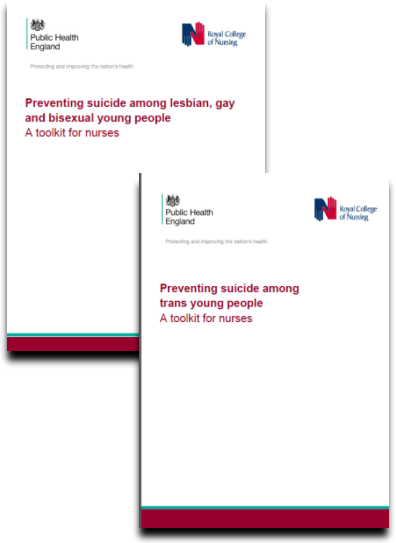
What is self-harm?

Self-harm is behaviour that is done deliberately to harm oneself. At least 10% of adolescents report having self-harmed. Self-harm can include, for example:

- self-cutting
- taking an overdose
- hitting or bruising
- intentionally taking too little or too much medication
- burning
- hanging
- suffocation

Although some people who self-harm may be suicidal, self-harm is often used as a way of managing difficult emotions without being a suicide attempt. However, self-harming can result in accidental death.

All PHE suicide prevention resources and guidance can be accessed here:



https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance#history

Primary Care

Royal College of General Practitioners recently launched an online educational resource

Suicide in Children and Young People: Tips for GPs

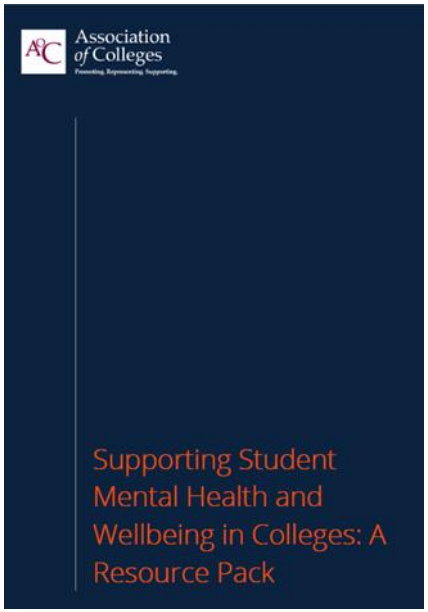
Top tips for GPs when consulting with a young person at risk of suicide:

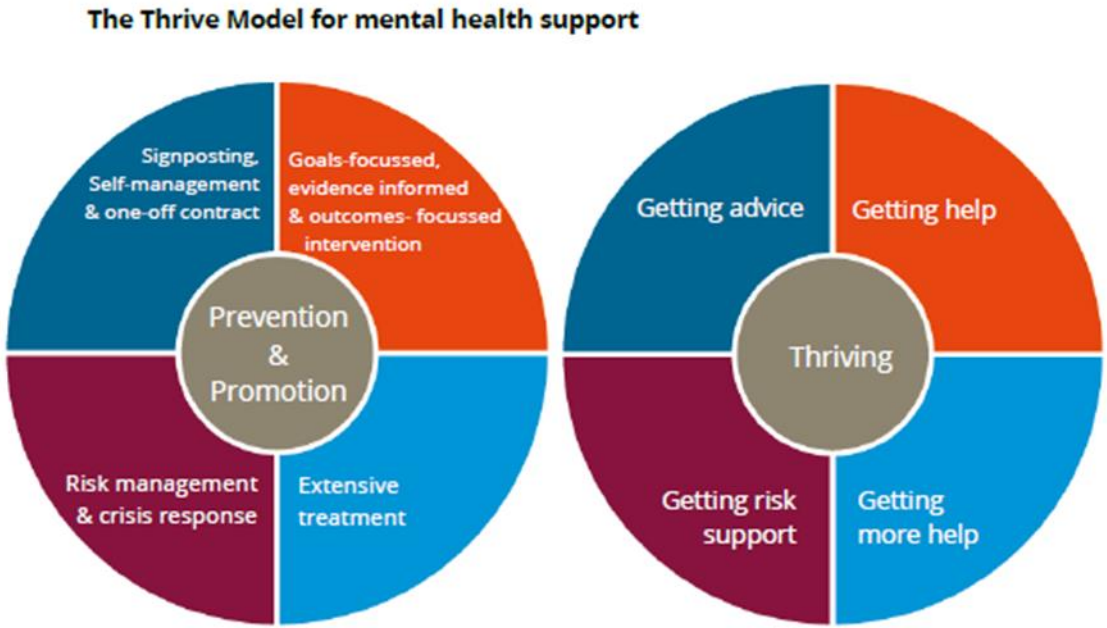
1. **Communicate effectively**
   Allowing young people to express their feelings and their concerns, listening intently, and responding with empathy and compassion is important in establishing therapeutic alliance and a trusting continuing relationship.

2. **Ask about suicidal ideation directly**
   It is important to emphasise that there is no evidence to suggest that talking about suicide or self-harm increases risk. On the contrary, open communication and direct questioning about suicidal ideation could facilitate disclosure and provide young people with the platform to express their feelings and thoughts.

3. **'What could keep young people safe'**
   Agreeing in partnership with the young person a brief safety plan including coping strategies, restricting access to means, identifying social support (e.g. family, friends) as well as ensuring follow-up by booking the next appointment directly with the young person could reduce suicide risk and support young people and their families

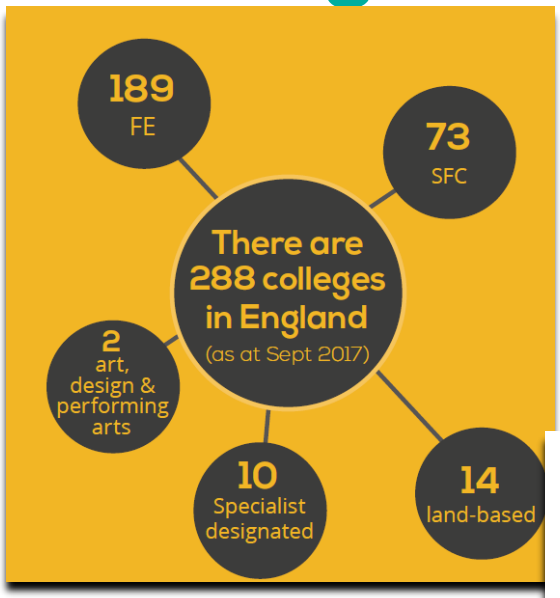
Association of Colleges Resource Pack

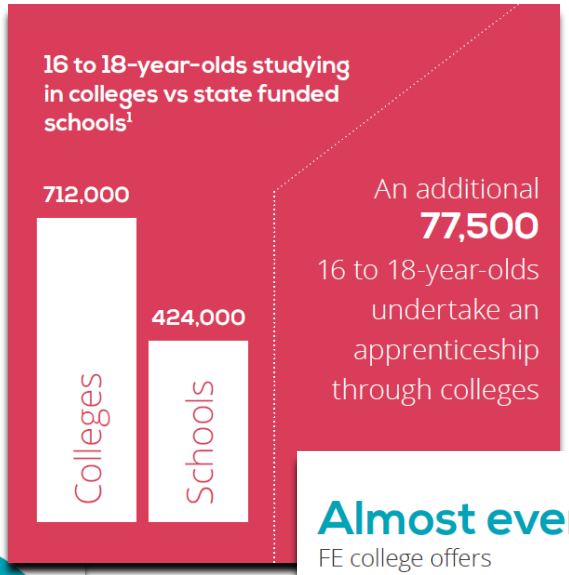


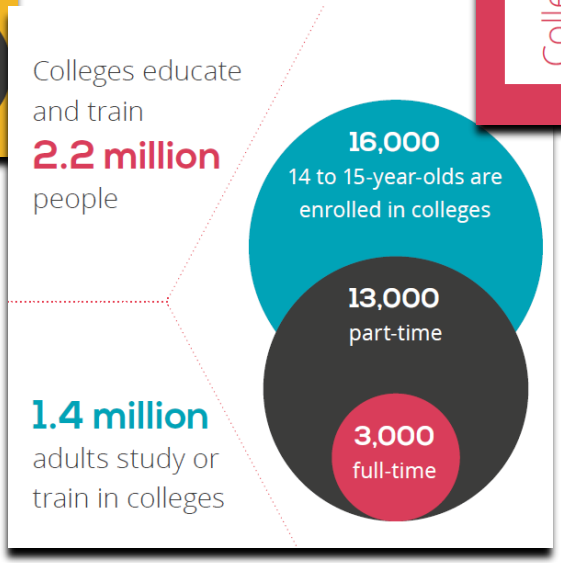


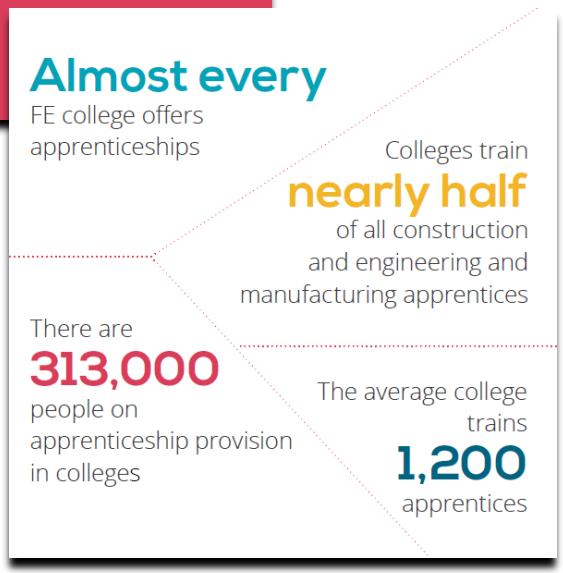
https://www.aoc.co.uk/sites/default/files/Supporting%20Student%20Mental%20Health%20and%20Wellbeing%20in%20Colleges%20-%20A%20Resource%20Pack_0.pdf

College Settings





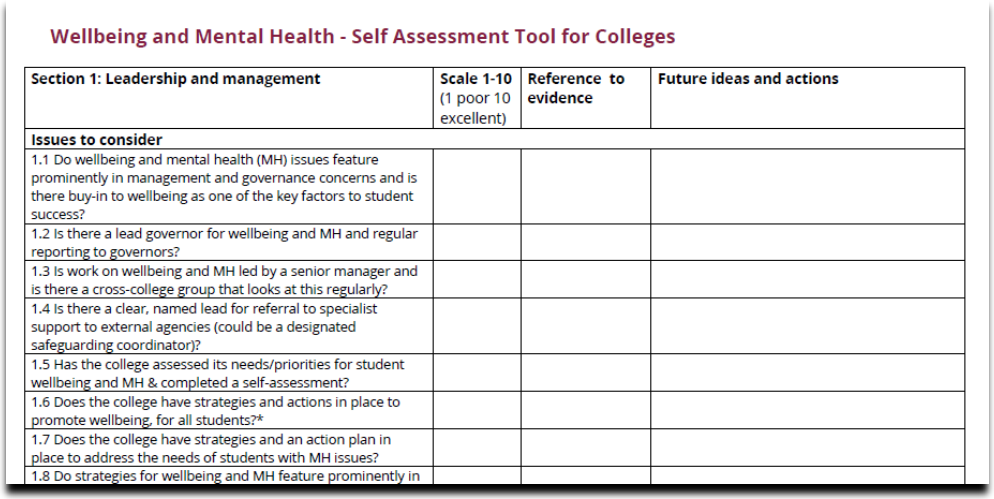




https://www.aoc.co.uk/sites/default/files/AoC%20College%20Key%20Facts%20201718%20%28web%29.pdf

Self Assessment Tool

1. Leadership and Management
2. Ethos and Environment
3. Curriculum
4. Student voice
5. Staff development and support
6. Targeted support
7. Parents and carers
8. External partnerships
9. Audit and evaluation
10. Set of case studies and guide to further resources



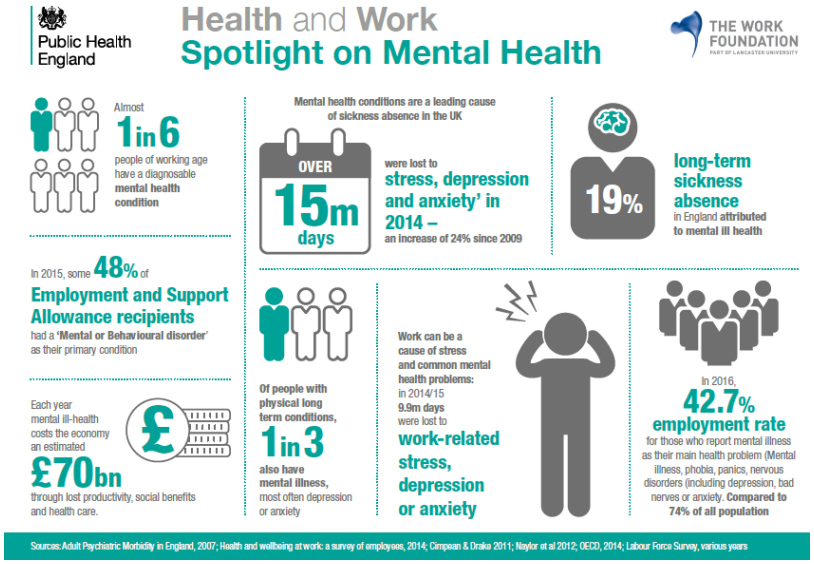
Wellbeing and Mental Health - Self Assessment Tool for Colleges

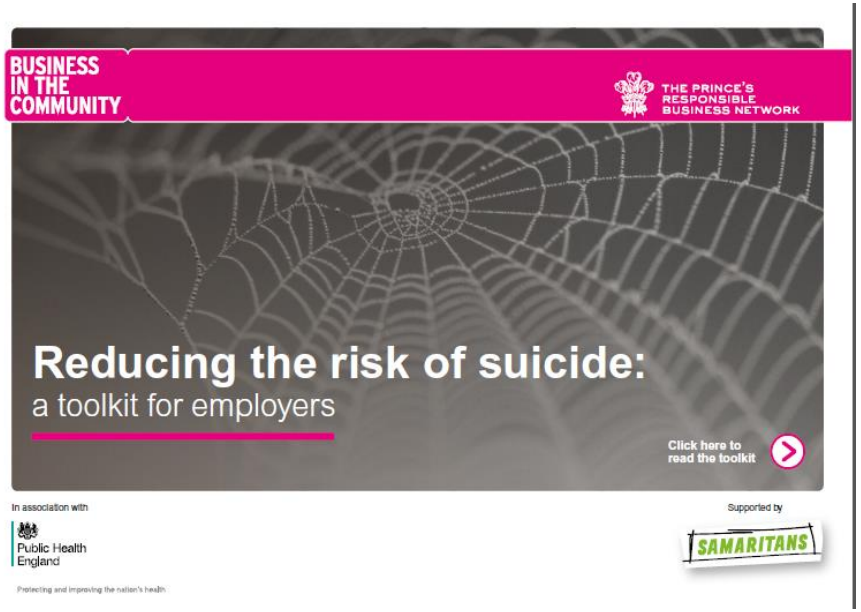
Section 1: Leadership and management	Scale 1-10 (1 poor 10 excellent)	Reference to evidence	Future ideas and actions
Issues to consider			
1.1 Do wellbeing and mental health (MH) issues feature prominently in management and governance concerns and is there buy-in to wellbeing as one of the key factors to student success?			
1.2 Is there a lead governor for wellbeing and MH and regular reporting to governors?			
1.3 Is work on wellbeing and MH led by a senior manager and is there a cross-college group that looks at this regularly?			
1.4 Is there a clear, named lead for referral to specialist support to external agencies (could be a designated safeguarding coordinator)?			
1.5 Has the college assessed its needs/priorities for student wellbeing and MH & completed a self-assessment?			
1.6 Does the college have strategies and actions in place to promote wellbeing, for all students?*			
1.7 Does the college have strategies and an action plan in place to address the needs of students with MH issues?			
1.8 Do strategies for wellbeing and MH feature prominently in			

Not by Degrees: Improving student mental health in the UK's universities

https://www.ippr.org/research/publications/not-by-degrees

Whole school/college additional resources





https://www.gov.uk/government/publications/health-and-work-infographics

https://wellbeing.bitc.org.uk/sites/default/files/business_in_the_community_suicide_prevention_toolkit_0.pdf

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NHS England and NHS Improvement

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NHS

Thematic Review of Teenage Suicide in Essex

Paul Secker

Head of Essex Safeguarding Board

NHS England and NHS Improvement

Thematic Review of Teenage Suicide in Essex

Essex Safeguarding Children Board

The Context of the Essex Review

- There were 9 teenage suicides between April and November 2017 in Essex (and there were 4 teenage suicides in 2018)
- To place this in context-previously in Essex there had been 9 teenage suicides in the preceding 8 years (2009-2016)- so many questions asked (why so many, were there any links between these deaths, could we have done anything differently)
- All the deaths where the young person was under 18 would have had a multi-agency response meeting, an Inquest, Child Death Overview panel scrutiny and a Serious Incident Investigation where EWMHS (CAMHS) involved
- None of these deaths warranted a Serious Case Review or Partnership Learning Review-no clear concerns re neglect/abuse within the families involved

Context of the Thematic Review (2)

- The review was one strand of different workstreams/initiatives in relation to teenage suicide, including a series of learning events and the intention to set up an Emotional Well-Being and Mental Health Strategic Board
- Before these deaths by suicide, it had become clear that as a multi-agency partnership, we needed to look at our overall preventative approach;
    - Who owns it
    - What does it look like; where had it been agreed
    - Who needs to implement it; what do we need to do differently?
    - How do we measure effectiveness
- In essence there had been no coherent preventative strategy in place, despite the initiatives/good work undertaken by different agencies

The Focus of the Thematic Review

- To understand the circumstances of each young person's death
- To identify any common themes in respect of vulnerability, stress factors and indicators of risks associated with these young people
- To consider whether anything could have been done differently which may have helped to prevent such tragic outcomes/whether there could have been any different interventions
- To help inform new guidance across Southend, Essex and Thurrock for young people themselves, their families and for professionals working with young people. (The previous guidance had a stronger focus on what to do after a teenage suicide, rather than what preventative strategies/early interventions would help potentially vulnerable young people)

Thematic Review – Key Findings

- 8 of the young people were under 18 (all White British), and 1 was just over 18 (dual heritage)

- 4 were aged 16, 2 were aged 17, one was aged 15, one was aged 13, and one was aged 18 and three weeks

- 4 of these young people were male and 5 were female (this is different to national figures)

- 8 of these young people hanged themselves (the 18 year old jumped in front of a train)

- 4 of these young people were known to EWMHS, 2 were known to Social Care and 1 was known to both
- <u>There was no known link/connection between any of these teenage suicides.</u>

In our study we also looked at:

- Whether the young person themselves had experienced a recent relationship breakdown - 3/8 (37.5%)
- Whether the young person's parents were separated or not - 7/8 - (87.5%)
- How many young people had left suicide notes 4/8 - (50%)
- How many of these young people had been assessed by professionals as being "high-risk of suicide" 3/8 - (37.5%)
- How many of the young people had told anyone about their suicidal thoughts (professionals, parents and peers) 6/8 - (75%)

Vulnerabilities and the Manchester Research Study (2016)

- We looked at the Manchester research study-considered to be very credible research study (922 suicides of young people under 25, of whom 133 were under 18)
- Manchester study identified the most frequently known vulnerabilities/themes/factors in the teenage suicides they studied
- We applied the vulnerabilities in their study to our Essex young people
    - 5/8 Essex young people were socially isolated, withdrawn, low self-esteem, difficult peer relationships
    - 4/8 parental factors such as mental health, substance misuse, alcohol misuse, domestic abuse
    - 8/8 had a history of self harm
    - 7/8 had shown little or no indication that they were soon to take their own lives (and theories around this)

Assessing the risk of suicide in adolescence

- We looked at a number of research studies/a range of thinking about teenage suicide
- We looked at how suicidal ideation/behaviours are seen in the psychiatric field
- We looked at a research study where young people discussed some of their feelings at the point of trying to take their own lives
    - Negative emotions towards themselves (isolation, depression, lack of meaning to their lives)
    - The need for control(because their lives were out of control-and felt impossible to change)
    - Inter-personal difficulties (an impasse in family relationships)
    - Communication (the only way to send a message to the world about how they felt)
    - No future (unable to see a future, feeling trapped)

Assessing the risk of suicide in adolescence

- We looked at neurological development of the teenage brain, and what this meant for young people (their capacity for reflection, impulsive behaviour, ability to read emotional cues, increased self-consciousness etc)
- There is a general acceptance that teenage suicide is not usually the consequence of a single event but a combination of multiple factors, a set of circumstances that leave the young person feeling overwhelmed, unable to manage their feelings, and that suicide appears to be a way of responding even controlling such pressures
- For many young people in this situation, longstanding issues/pressures/stresses seem to be followed by a difficulty in an area of their life which has specific emotional significance for that young person

Assessing the risk of suicide in adolescence

- **This generates a situation of cumulative risk factors (sometimes referred to as ‘stacking’) and then a ‘final straw event’ (may be a relationship breakdown, academic pressures, social media pressures etc)**

- I think the logical thing to conclude is that there is no straightforward way of assessing the risk of suicide for nearly all of our children

Critical questions emanating from the Review

The review panel considered that these were some of the critical questions to be considered, and each attendee was asked to respond to the following questions.

1.Were there any specific missed opportunities for intervention which may realistically have made any difference?

2.If we were to develop a more meaningful response to young people with suicidal thoughts, what would this look like; what would it need to include; what might help young people themselves, their families and professionals working with such young people?

3.How can we make sure that young people themselves are more aware of the issues surrounding teenage suicide.

4.How can we help young people develop impulse control, build resilience and help young people at high risk from self-harming/suicide feel listened to?

Were there missed opportunities / could we have made a difference?

- This is very difficult to judge
- It is very difficult to predict what may have been the proverbial “last straw” what might have caused it and when this might have taken place.
- It is very difficult to single out one factor that indicates a missed opportunity with any degree of certainty.
- It could be said that there were missed opportunities in relation to five of these young people (4 professional responses, 2 family responses), albeit at different levels, and clearly we will never know whether different responses may have prevented the young person’s death, both at the specific time or in the future
- These potential missed opportunities are not in any way conclusive, they are just areas where things could have been different.

Were there missed opportunities / could we have made a difference?

- Whether a family had picked up on a change of the young person's behaviour
- Whether the risk assessment was as thorough as might have been expected
- Whether an earlier offer of therapeutic support may have made a difference to the young person
- If there had been an earlier referral to Social Care
- If the school had identified risk factors earlier

These are not overly striking factors – these are not "if only we had done that" factors

Critical Questions-our thoughts

- We need to be able to have conversations about very difficult emotional issues-including teenage suicide and self-harming; open conversations within families, within school settings and other settings where we work with young people

- Professionals need to have a greater understanding of potential risk indicators, ‘stacking’ and ‘final straw’ factors and how to respond to such situations (and to be helped to have those conversations with young people)

- We all have a role and responsibility in working with vulnerable young people about their emotional health (not just schools)

Critical Questions-our thoughts

- Equally no-one is saying that any of this is straightforward

- We really need to think through the impact of social media on children and young people-and the impact of the digital world on attachments, relationships, families and meal times

Key Findings from this Review

1. No obvious linking between the 9 young people who took their own lives
2. Clear shift in the method being used by young people to take their own life
3. 5 female and 4 male deaths is not consistent with national/historic ratios
4. All these young people had a number of specific vulnerabilities, as emphasised by the Manchester Research Study- as do many young people through adolescence- we need though to emphasise the importance of identifying such vulnerabilities and responding appropriately to them.
5. All the young people had a history of self harming
6. 7 out of 8 had shown little or no indication to friends/family that they were soon to take their own life

Key Findings from this Review - 2

7. 6 out of 8 had told someone about their suicidal thoughts
8. Only 3 out of 8 had been identified by professionals as being a “high suicide risk” but 5 had not.
9. 7 out of 8 came from families where the parents had separated (but the young person was in contact with both parents) - how stressful are the issues of divided loyalties for children / young people / how do they deal with different parenting styles / different boundaries /the introduction of new partners (and to what extent do we have these conversations with our children about these issues)
10. 7 out of 8 had experienced separation, loss, or break up of a relationship, or more than one of these.
11. 5 out of 8 young people were socially isolated, withdrawn, experienced difficulties with peer relationships, had low self esteem etc.

Summary

- Whilst this review focused upon teenage suicide, this study has equally been about reflecting upon the emotional health and well-being of our young people, and how we can support them through their adolescence.
- Young people are having to cope with the ever-increasing pressures of adolescence – whether this be managing social media and its 24 hour a day impact, online relationships, peer pressures, fragmented family life for some, the potential to be exploited, gangs, academic pressures etc .
- Overall, there needs to be a considerable culture shift – changing the fact that suicide is a taboo subject and one we find very difficult to talk about. We need to be able to have the difficult conversations – about suicide, self harm, emotional health and well-being

Summary

- We need a co-ordinated and collaborative multi-agency preventative approach which depends upon a greater society-wide awareness of potential risk factors, the need to recognise patterns of cumulative risks and “final straw” stresses, and helping young people to develop both impulse control and increased resilience.

- Young people need to be listened to, and to be heard and understood. We need adults not to be shocked or unable to cope with the intensity of what young people say. We need to understand that young people need to have a degree of control, and need to have awareness of the developmental stages they themselves will go through as they go through adolescence.

Recommendations (1)

1. We need to be able to have conversations about teenage suicide, within families, with friends, within peer groups – suicide is still a taboo subject

   We need to consider how such conversations can be facilitated.

2. There needs to be meaningful and helpful guidance for young people themselves, for parents for professionals, e.g.
   - What should a young person do if they are feeling overwhelmed / that life is not worth living, etc
   - How does a professional respond to a young person when they say they feel like taking their life
   - What should a young person do if their friend tells them they are having suicidal thoughts, but asks them to promise not to tell anyone.

   (schools have a critical role, but this is not exclusively about schools, we all have a responsibility towards vulnerable young people and their emotional health and well-being)

Recommendations (2)

3. Multi-agency and multi-disciplinary meetings should always be considered when specific risk thresholds are met to share information/consider action plans.
4. Young people themselves need more immediate access to information about mental health – online resources, Young Minds website, Samaritans, Kooth, Youtube videos.
5. We need to involve young people more in the design of emotional health and well-being services.
6. We need to prioritise the delivery of workshops in schools and other settings focusing on maintaining positive emotional health, managing social media, managing relationships and peer pressures - these are all critically important areas.
7. We need to rethink how we can ensure young people are supported through loss or separation, and the consequences of such events.

Recommendations (3)

8. We need to gather the learning from young people who have previously attempted suicide but had not died. This is potentially invaluable learning which needs to be incorporated into our thinking.
9. There needs to be recognition and focus that the issues in relation to emotional health and well-being, and self-harming, are increasingly being seen in primary age school children, so this work needs to begin in primary schools.
10. There needs to be multi-agency training to enable early interventions and the difficult conversations with young people about suicidal thoughts, self-harm, about emotional health issues, about supporting young people told by their friends they are having suicidal thoughts.
11. Consideration to be given to the idea of having Emotional Literacy Support Assistants (ELSAs) in all schools, and other models of having mental health workers or teams in primary/secondary schools to enable vulnerability issues to be addressed at a much earlier stage (e.g. the Barnsley model)

And finally……

- This presentation has tried to cover the complexities of this subject
- There are no straightforward solutions, but that is not to say that we cannot begin to seriously address these issues
- We need to have **systemic change** in respect of how we support our young people, and their emotional health and well-being
- We need to work differently with children, young people and their families, and we need to support those professionals who are undertaking this work
- Thank you for listening-if you would like us to send you a copy of the report, please email: escb@essex.gov.uk

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Public Health England

NHS

CYP Suicide prevention activities Norfolk Schools

Norfolk Training, Guidance & Support

Dr Bianca Finger-Berry

Critical Incident Lead Officer
Norfolk Children's Services

NHS England and NHS Improvement

Suicide prevention activities children/young people – schools Norfolk

Dr Bianca Finger-Berry

Critical Incident Lead Officer (Norfolk Children's Services)

bianca.finger-berry@norfolk.gov.uk

Norfolk County Council

Educational Psychology & Specialist Support

Critical Incident Service - Norfolk

Part of the Educational Psychology Service, based in Norfolk Children's Services

Funded by schools funding, subscription model for academies, funded provided centrally for EY settings

Support in a Critical Incident

Consultation

Training for staff

Local Authority Work

Since 2018 – Funding from Public Health for suicide prevention work with schools

2015 – 2016 Multi-Agency Review

- Concerns raised at CDOP following another child death through suicide
- Limited national data available at the time of the review, some information available from adult reviews or localised ones
- Review of 9 children between May 2010 and May 2015 (CDOP: suicide or self-inflicted harm), aged 12-17
- Representatives from health, public health, children's services and police

Recommendations

Raising resilience in children and young people

Most children who experience negative life events do not take their own life and only few will develop mental health problems. Resilient children and young people will be better placed at successfully manage the challenges they face in adolescence and deal with the ups and downs of life.

All agencies should support children's health, including their mental health, and well-being and use effective ways to raise resilience.

Providing for the long-term needs of children and young people who have experienced bereavement

Children who experienced a bereavement when they were younger will revisit this as they enter their teenage years.

Schools should have a bereavement policy, they need to understand the long-term needs of bereaved children and review them, in particular when they have concerns about children's mental health.

All agencies working with children need to consider the long-term needs of bereaved children and consider re-offering support.

Training for schools on supporting bereaved children (one whole day/in school twilights)

Sample bereavement policy

Guidance for staff

Clear guidance for staff in relation to self-harm/suicide ideation should be developed. This should include information on how and when to refer, including clear guidance on how to assess for suicide risk so that referrals can be made with all the necessary information. This should include details about consultation services offered by CAMHS.

There are good examples published by some other authorities.

It would be helpful to develop a sample self-harm policy for schools to use if they wish.

NSCB policy – published Sept 2017, part of safeguarding training

NSCB Policy: What to do if you believe a child might be at risk of suicide

- Introduction
- Principles and Values

- Definitions
- Identifying risk factors

- Referral pathway including sample safety plan

- Important things to remember
- Young people who do not engage
- Engagement with parents and carers
-
- Appendix 1 Information Gathering Conversation and Flowchart

- Appendix 2 The links between self-harm and suicide

- Appendix 3 Guidance on sharing information

- Appendix 4 Roles and responsibilities
- Appendix 5 Useful national organisations/websites

Information gathering conversation

If a young person's presentation/behaviour causes concern that they may have suicidal thoughts or intent, have an **information gathering conversation**. Feel free to adapt the questions appropriate to the young person's needs, and ask other relevant questions.

- Tell me, is something troubling you (home, family, school, friends)? Or: I am aware that you have talked about xxx, tell me a bit more… how is this making you feel?
- How often have you had these thoughts?
- Are other people also worried about you? Who, why?
- Have you ever felt like hurting yourself? Have you ever hurt yourself?
- Have you ever felt like ending your life?

Then, suicide specific questions if appropriate.

Further questions.

General questions

Do safety plan – agree what will happen next

Sample safety plan

It is best to have someone complete this before a crisis so they can refer to it as a protective measure.

- **1. Warning signs of crisis**
- **2. Coping strategies – what I can do to take my mind off it**
- **3. Who or what is good in my life**
- **4. Contact details of someone who I trust to get help**
- **5. Contact details of agencies I can get help from**
- **6. What makes life worth living**

Review of the guidance (questionnaire)

Most useful:

Questions template, risk categories, referral information, reminder to look after myself, warning signs, roles & responsibilities, safety plan, questionnaire (pupils responding exceptionally positive to being asked direct questions)

Least useful:

Definitions, referral not accepted by CAMHS

Most staff commented that everything was useful

Other comments:

‘We have no way of telling if this pupil is serious about taking her own life’; ‘Have used the training to work with parents and staff, too’, ‘Questionnaire in particular is invaluable’, ‘Useful guide, possibly add more re. national organisations and helplines’

Future plans

- Review guidance following comments received
- Sample self-harm policy for schools (Meeting with young people completed, meeting with agencies planned, then meeting with schools)

Training for Tier 1 staff to support children with self-harm/suicide ideation

With comprehensive guidance, consistent training should be offered to all staff. The training should give staff the confidence to support children with self-harm issues and apply any newly developed guidance.

Suicide prevention should be part of safeguarding training, this applies in particular, but not exclusively to school staff with a direct responsibility for pastoral care and safeguarding.

Multi-agency briefing sessions were offered when the guidance was launched.

Training sessions for school staff were offered, funded through suicide prevention funding.

Understanding self-harm and suicide prevention

- This academic year 123 staff attended training, with three more training sessions to be delivered this term

Increased confidence supporting children who self-harm						4.71	8.27
Increased confidence in responding to and supporting children who express suicidal thoughts						4.96	8.4

- Staff have found useful:

Practical ideas

Leaflets and where to find support

Safety plan

Young person's video

Don't forget to support friends, too.

Learning it's okay to ask a child about suicide

Reasons and signs

Everything was really useful and I will definitely be more pro-active

Before the end of term I am planning to do the following:

- Update support information on website
- Cascade learning to other staff
- Plan assembly
- Look at mental health policy
- Create guidance for staff
- Go on mental health champion course
- Complete a mental health strategy for the school
- Have conversations with children who self-harm
- Put in safety plans for students who are self-harming
- Encourage children to talk about how they feel

Mental health awareness for children and young people

Friends are often aware of children's self-harm and suicide ideation, some talked to parents or school staff.

We need to raise young people's awareness of mental health issue and give them clear guidance on when and how to access support for themselves or others, especially when they are concerned about suicide ideation.

There is some limited evidence from school based prevention programmes. We recommend to trial a programme, ideally at a school where a high level of self-harm has already been identified. Any pilot programme needs to be effectively evaluated.

A number of schools are running initiatives relating to mental health and it would be useful to collate all information including evaluations and share information about successful projects.

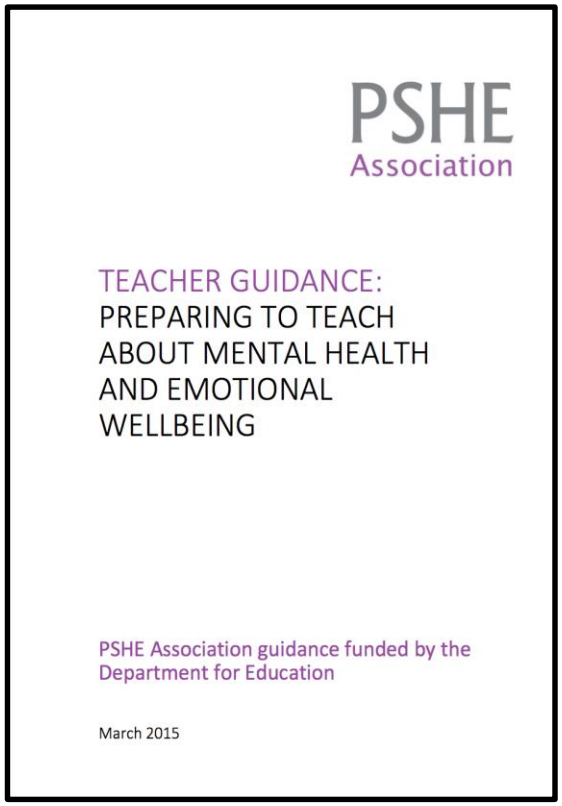
Children's commissioner: children's voices (October 2017)

- Children conceptualise mental health in highly stereotyped, negative and limited terms
- Children's help-seeking behaviour is affected by their lack of knowledge and inability to relate the information they have to their own mental health
- Children are unaware of the availability and purpose of mental health services, including in their own school

PSHE Association: Teaching about mental health and emotional well-being

57 staff trained in 2018/2019

12 staff planning to teach Y7's
16 staff planning to teach Y8's
21 staff planning to teach Y9's
21 staff planning to teach Y10's
17 staff planning to teach Y11's



Norfolk County Council

Educational Psychology & Specialist Support

Norfolk County Council

Educational Psychology & Specialist Support

Teaching about mental health and emotional well-being (PSHE Association)

In a small-scale study with two Norfolk secondary schools

'I think it's good to talk about mental health and well-being because you can always go and see someone and get help to get through it.'

90% of young people said that their peers should learn about mental health through this programme

- Increased knowledge about mental health
- Mental health as a taboo subject
- Help-seeking behaviour
- Components of a helpful teaching programme

Increased knowledge about mental health

- Fewer children reported they knew ‘nothing’ or a ‘a little’ after the programme
- More young people reported they knew ‘quite a bit’ or ‘a lot’

Very helpful to know this information if you ever go through it or you could help a friend.

Mental health as a taboo

- Young people discussed mental health more with their friends
- Young people talked more about their own mental health issues with others, in particular school and friends
- Fewer children said they didn’t have any mental health difficulties to share

I like it because it will help people get help and feel like they are not the only one.

Help-seeking behaviour

- The proportion of young people who reported they had sought help from parents, friends and school increased significantly
- The proportion of young people who said they hadn't accessed any help, or where the question was not applicable, had also decreased
- *I think it's good to talk about mental health and well-being because you can always go and see someone and get help through it.*

Components of a helpful PSHE teaching programme

- Teachers who show understanding, are attentive and have a positive relationship with students
- Staff need to be mindful of young people with mental health difficulties (there needs to be an opportunity before the programme for students to identify themselves if they need support)
- Classroom behaviour needs to be managed appropriately
- Consistent teachers (not supply)
- The programme needs to be delivered in an engaging way

- **Better information sharing and gathering information about ‘near misses’**

- **Regular reviewing of child deaths – suicide or self-inflicted harm**

New review : 6 young people died following their own actions 2016 – 2019 (none in 2018)

What next?

- New review
- Continued training
- More schools to teach about mental health and emotional well-being (hopefully supported by new government legislation re. new PSHE teaching requirements)
- Engagement with all agencies working with schools and children and young people and mental health
- Self-harm policy
- World Mental Health Day (Suicide)
- Any new evidence – what works???

Dr Bianca Finger-Berry

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www.norfolkepss.org.uk

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Suicide and self-harm prevention in Bedfordshire & Luton CAMHS

Dr Cathy Lavelle
Clinical Director, Children's Services

Matt Sparks
Clinical team Lead, CAMHS Crisis Team

NHS England and NHS Improvement

East London NHS Foundation Trust

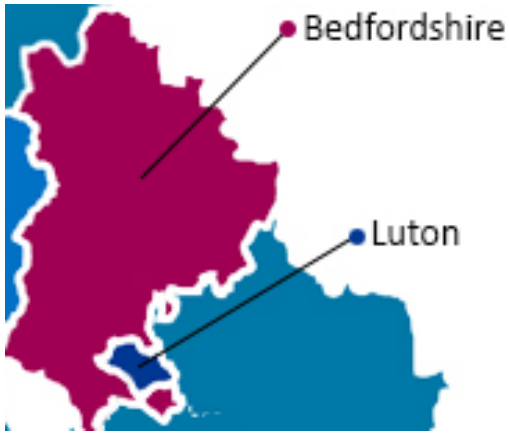
Suicide Prevention in Bedfordshire CAMHS

Dr Cathy Lavelle
Clinical Director, Children's Services
Matt Sparks
Clinical team Lead, CAMHS Crisis Team

Introduction to Bedfordshire

One County

3 Local Authorities



2 CCG's

Bedfordshire CCG

Bedford Borough:

Population: 170,000

41,000 Under 18's

Central Bedfordshire:

Population: 274,000

59,600 Under 18's

Suicide prevention plan

- Whole service approach
- Focus on crisis, awareness raising and training
- Population Health
- Increasing resilience
- Joint working with partner agencies

5 part suicide prevention plan:

1. Raise awareness & improve early intervention across the system with external stakeholders / partners.
2. Provide appropriate levels of crisis support when/where needed.
3. Ensure high risk cases are monitored.
4. Ensure all staff are skilled to recognise signs of mental health distress at varying levels, including non-clinical staff.
5. Ensure easy access for vulnerable groups

1. Raise awareness & improve early intervention system wide with external stakeholders & partners.

- Local FilmProject: event held by service users promoting their stories and breaking the stigma-open to all external agencies / families / carers.
- “Teenage Misadventure” training delivered via LSCB workshops
- Quarterly CAMHS Stakeholder Events promote services and deliver training to key stakeholders.
- Local Workforce shadowing agreement encouraging staff to gain workplace experience in any of the agencies (ie: Local Authority, Safeguarding, Education, Police, Health, CAMHS).
- Series of webinairs arranged for local GPs and LA staff to share CAMHS referral pathways (including crisis response).
- Universal training offer developed in partnership with tier 2 Partners to ensure standardised training across the patch.

Raise awareness & improve early intervention system wide with external stakeholders & partners.

- CAMHS School team deliver school assemblies with service users to break the stigma and raise awareness.
- “Mental Health Toolkit” to be rolled out across all schools within Bedfordshire.
- Primary Care Liaison Workers linked to GP Clusters delivering training, rapid assessment, consultation and direct work to yp presenting with mild /moderate mental health needs
- Embedded CAMHS Practitioners in LA early help teams.
- Crisis staff deliver training to acute hospital staff & care plan /risk assessment guidance used in acute hospitals to support management of young people on acute wards.
- Crisis guidance developed and shared with GPs to help identify and manage high risk presentations.

"We really appreciate having you both as part of the team and our schools' link workers. You provide great knowledge about what is going on in schools and in the local community and have supported us on some tricky cases. It is a great example of joined up working across the service" Feedback from CAMHS staff

The CAMHS Practitioners in every secondary school are proving to be a strong source of early help and support, both to students in building resilience, and to school staff who have benefitted from the uplift in skills and knowledge." CQC Thematic Review September 2017

2. Provide appropriate levels of crisis support when/where needed.

- Dedicated CAMHS crisis team
  - Mon-Friday 9am-9pm & Weekends 10am-2pm
  - All receive 7 day follow up
  - On call consultant
  - Use of crisis and safety plans
  - Care plans shared with key agencies
  - Under 18 care pathway shared with external colleagues

- DBT service:
  - evidence based and aiming to develop resilience
  - rolling programme over 12 weeks providing individual, group and telephone support.

3. Ensure high risk cases are monitored.

- All referrals screened for risk on a daily basis: COD
- Urgent cases offered same day assessment by the crisis team
- Duty Consultant Psychiatrist available:
- AMHT have a daily morning handover including all crisis cases, risks rated accordingly.
- Joint escalation protocol drafted for use in acute settings where local authority support is required
- Caseloads all RAG rated and entered on RiO. All red rated cases discussed at weekly MDTs.
- Caseload supervision undertaken in clinical supervision, robust supervision structures in place in all teams.
- CTL role in monitoring

4. Ensure all staff are skilled to recognise signs of mental health distress at varying levels, including non-clinical staff.

- STATMAN training mapped to roles and disciplines, monitored via team meetings and supervision.
- Whole staff quality away days to share learning from events.
- CPD sessions available within all teams.
- Journal club offering clinicians the opportunity to debate current research relevant to practice.
- Staff PDPs undertaken and reviewed 6 / 12 – identified learning needs form the Service wide Training Needs Analysis.
- CYP IAPT training places secured and staff are encouraged/ supported to undertake – including external partners
- Debrief protocol available (to include all staff) in the event of an SI.

5. Ensure easy access for vulnerable groups

- LAC team
  - embedded sessions at both LA's- offering consultation, complex case panels regarding placement suitability, training (to staff and foster carers) and assessment preventing placement breakdown.
- Behavioural Improvement Team
  - YP at risk from offending and excluded from school. Linked to PRU's
- YOS CAMHS worker
  - provides training, consultation & assessment. Linked to AMHT
- QI Project
  - to increase BME attendance within CAMHS
- Schools team

Population Health Project

- Part of the Trust's Triple Aim QI project, supported by the Institute for Health Improvement in USA
- Triple Aim: Improved patient experience, Improving population health, Value for money,
- To reduce self harm in 14-16 year olds
- In a single school initially and then learning to be spread.
- Key stakeholders identified
- Data collection complete
- Led by CAMHS but aiming to generate a range of interventions, across all areas of the community.

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NHS

Resilience & Role of Education

Nick Boddington
Subject Specialist
PHSE Association

NHS England and NHS Improvement

PSHE Association

Resilience and Safeguarding

The contribution of Schools

Nick Boddington BA(Hons) MEd MSc
PSHE Association Subject Specialist

What is 'resilience?'

PSHE Association

The process of effectively **negotiating**, **adapting to** or **managing** significant sources of stress or trauma

Assets and resources within the individual their life and environment facilitate this capacity for adaption and 'bouncing back' in the face of adversity.

Gill Windle 2011

If resilience is not one 'quality' but is dependent on acquiring different 'components' can we develop these in young people through education?

What are these ‘assets and resources’?

PSHE Association

- **I have** factors – support and resources that promote resilience – e.g. trusting relationships
- **I am** factors – personal attributes that contribute to a positive self concept – e.g. optimism or hope
- **I can** factors – social and interpersonal skills that support the prevention and management of adverse situations – e.g. prediction, perspective, problem solving and communication skills

Grotberg 1995

Taught or caught?

PSHE Association

- Schools are only part of child's overall experience and our ability to influence that wider experience is limited…
- 'However within a 'whole school approach' the taught curriculum and especially PSHE education lessons provides an ideal opportunity for explicit and implicit learning by building resilience'

Public Health England UCL Institute of Health Equity 2014

‘I have’ factors

PSHE Association

Helping pupils

- Build healthy relationships
- Manage or leave unhealthy relationships
- Exploring..
  - *‘Who are my ‘special people’? What do they say or do that helps me feel special?*
  - *‘How do I help my special people to feel special?’*
  - *‘What am I looking for in a healthy relationship – how would I recognise one?’*
  - *‘What could I say or do if I thought a relationship was not so healthy?’*

‘I am’ factors

PSHE Association

Providing opportunities for young people

- to take real responsibility and achieve
  - academically
  - in sports
  - in creativity
  - socially
- to reflect on their own unique qualities
- to develop a strong locus of control (Newman 2002)
- to learn from ‘failure’ – to see it as new learning not a personal failing (Willis 2016)

‘I can’ factors

PSHE Association

- Emotional literacy – a comprehensive ‘language of feelings’
- Empathy
- Problem solving skills
- Negotiation skills and conflict resolution
- Self regulation and self control – the ability to ‘stop, think, think a bit more, act.’
- Risk management – identification, evaluation, decision making and action.
- Having a ‘growth mind set’ (Dweck 2014)

PSHE Association

Conversations with an alien….

An alien has come down from another world.
They have heard about something called….. but they don't know what it is.
How would you explain it to them?

‘A growth mindset’

PSHE Association

- Teachers model a ‘growth mindset’ themselves.
- Focus on small goals - setting and achieving small goals in class helps boost students’ self-confidence
- Praise effort, not outcome
- Recognise learning is a process – demonstrating and exploring multiple strategies to work out an answer
- Teach ways to cope, to embrace challenge
- Provide ‘assessment for learning’ opportunities during the lesson to give students time to reflect on the growth they have experienced

Bromfords School Wickford – from Ofsted ‘special measures’ to ‘good’

‘Whole school climate or ethos’ –

PSHE Association

- ‘How we do things here’,
  - How we talk to one another,
  - How we behave towards one another,
  - How the procedures of the school,

  enhance rather than limit pupils sense of self worth
- All the ‘micro interactions’ that we notice ‘unconsciously’ – the learning we take on through modelling.
- The concept of the ‘health promoting school’

The taught curriculum

PSHE Association

- The contribution made through the way learning is generally offered to pupils.
  - Does it offer appropriate challenge?
  - Is it relevant and engaging?
  - Does it offer pupils opportunities to take responsibility for their learning?
  - Does it offer opportunities for success?
  - Does assessment encourage new learning (the feeling of the ‘Ah-ha’ moment!)
- The contribution of learning in specific subjects, for example English, Drama, Religious education and activities such as ‘mindfulness’.

Personal, Social, Health and Economic Education

PSHE Association

- The subject in the curriculum where we look in depth at issues such as relationships broken down into
  - Knowledge – what do I know?
  - Understanding – how is what I know relevant to me in my life?
  - Values and beliefs – how do I and others feel about this and how do these feelings influence my choices and behaviour?
  - Skills and strategies – what are my options and can I act on them?
  - Vocabulary and language – what can I *actually* say?
  - Rights and responsibilities – my own and others?

PSHE education is

PSHE Association

- a planned, developmental programme of learning matched to the readiness and grounded in the real life experiences of pupils.
- based around 3 core themes -
  - Health and Wellbeing
  - Relationships
  - Living in the wider world

From September 2020 the *knowledge* components of relationships and sex education, physical and mental health will gain statutory status.

See here - https://www.pshe-association.org.uk/curriculum-and-resources/resources/mapping-pshe-association-programme-study-new

The link with digital resilience

PSHE Association

- Life in increasingly experienced ‘on-line’ and this will continue and ‘digital literacy’ and ‘digital optimism’ can boost resilience.
- It is important not to over-differentiate between digital and ‘real’ – children and young people do not make that distinction – resilience is not context dependent – it’s how you are *feeling* not the medium.
- Being put under pressure (‘overt and insidious’) in the real world and under pressure in the digital world both require the ability to recognise and manage pressure and ‘pressure’ comes in many forms.
- 24 hours, 7 days a week, perceived ‘social norms’ sent directly to your pocket
- Being asked to do something risky in the real world and something risky in the digital world both require risk management.
- It is about a broad approach to resilience and helping young people to see the inter-connections.

PLEASE download this!!! (It's free!)

PSHE Association

https://www.gov.uk/government/publications/education-for-a-connected-world

Life comes at us in ‘moments’ not ‘topics’

PSHE Association

- Some are ‘mundane’
- Some are ‘critical’
- Some are ‘crunch’
- Some are predictable
- Some ‘blind side’ us

Living is a ‘performance art’, some we can ‘script in advance’ with the help of others, some we have to ‘improvise’ on the spot

PSHEe is not simply *‘teaching about’* – it is *‘teaching how to manage’* and resilience is closely tied to context, risks and consequences.

Resilience is not simply ‘putting up with’ or ‘enduring’ – sometimes it’s being able to scream help loudly and run – we need to recognise which to choose!

Considering someone experiencing or fearing abuse

PSHE Association

- You need to know and understand the *concept* of abuse
- You need to understand that what is happening to you is abusive
- You need to *know* that it is wrong – you need to *believe* that it is wrong
- You need to *know* you have a right for it to stop – you need to *believe* you have a right for it to stop
- You need to *believe* telling someone won't make things ten time worse – you need to *trust* them to know how to help you
- You need to know who to tell, and how to attract someone's attention to let them know something is wrong
- You need the vocabulary and language to explain what's happening to you
- You need to have that 'inner something' that allows you actually get the words out your mouth
- You need to have those 'inner resources' that enable you to keep on telling until someone listens

Or the bystanders who need….

PSHE Association

- to recognise what is happening to someone they care about is abusive
- to know that it is wrong
- to know that they have a responsibility to help and be willing to act
- to believe telling someone won't make things ten time worse
- to weigh up damaging a friendship – especially if someone has asked or even made them promise not to make a fuss.
- to know who and how to attract someone's attention to let them know something is wrong – and to keep doing it if they need to!
- the language to explain what's happening

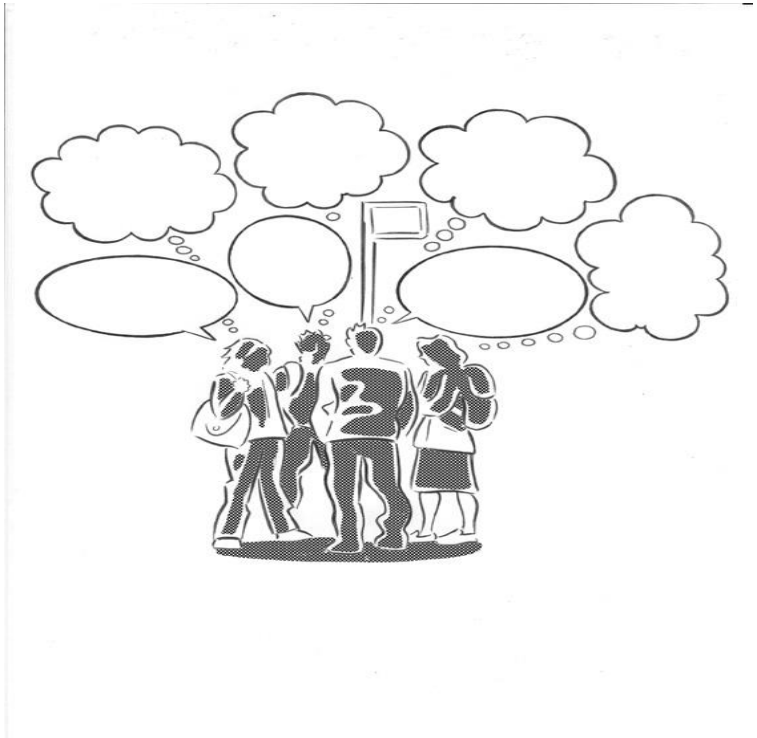
…..and all this takes time – no single lesson or 'event' will provide all this, but a planned PSHEe programme might.

Bus stop people….

PSHE Association

A group of young people about your age have meet at the bus stop. They are talking about ‘a healthy relationship’ – what do you think they are saying?

- what do you think they are thinking?



A ‘moment’….

PSHE Association

During a conversation you over-hear two people your age talking…

‘When we first met Alex was lovely but Alex has changed. It must be something I have done. I know we still really care about each other.’

‘I know Alex puts me down at lot when we are out with our friends, but it’s just Alex mucking about. Alex always is lovely when we are together.’

‘Everyone’s relationships have ups and downs – its just how the way things are and its better to have someone than be on your own.’

‘Yes, Alex has hit me once…well…more a slap really… and only a couple of times but I suppose deserved it. Alex was so sorry and upset afterwards. Alex promised it would never, ever happen again.’

‘NO! Please don’t say anything to anyone, you’ll only make things worse! Promise me you won’t!’

Deconstructing the present

PSHE Association

- What do you think they are thinking right now?
- What do you think they are feeling right now?
- Could they be having different feelings? Conflicting feelings – 'pushing and pulling' feelings?
- Might what they are saying be different from what they are feeling?
- Is anyone being put 'under pressure'?
- Listening to this what are you feeling?
- How do you feel about

  'Everyone's relationships have ups and downs – its just how the way things are and its better to have someone than be on your own.'
- Imagine the world suddenly stops – each person turns to you and asks you for your advice – what would you say to them?
- Would it be easy to accept your advice? Why? Why not?
- Would it be easy to act on your advice? Why? Why not?
- How could they be supported to act on your advice? In themselves? By others?

Exploring the future?

PSHE Association

Imagine they have not heard your advice.

- What do you think might happen next?
- Tomorrow? Next week? Next year?
- Is the future good or not so good?
- What are the chances of Alex's behaviour changing?
- Might there be wider risks, perhaps for their ambitions, hopes, dreams?
- Might anyone not presently involved be at risk in the future?
- Who is responsible for what happens next? (They begged you not to tell anyone.)

Exploring the past

PSHE Association

- What might have stopped these events happening?
- What could people have said or done differently?
- Who? What might have encouraged them? What might have held them back?
- Are we responsible for our own choices or behaviour?
- Are we responsible for protecting others?
- Imagine you could have talked to these people yesterday, a week ago, a month ago, a year ago – what would you have said?
- Would it have been easier to address this earlier rather than now?

Only now do we add the ‘knowledge’

Once the students are engaged and can see the relevance we can add the ‘content’…

- What if you knew…..
- What if you were aware of….

Opportunities for reflection - Have I…

PSHE Association

- **increased my knowledge?** *(Before I only knew…Now I also know….)*
- **increased my understanding?** *(I always knew… but now I can see how it connects to… and now I can see how I could use this in my life)*
- **changed or reconfirmed a belief?** *(I used to feel… but now that I understand …I now feel…)*
- **enriched my vocabulary?** *(Before I would have said.. but now I can say…)*
- **increased my competence in a skill?** *(Before I knew how to do/be… but now I know how to do/be…)*
- **increased my confidence?** *(Before I could/would say and do…but now I feel I am able to say and do…)*

and perhaps;

- **new questions?** *(Before I thought I knew…now I realise I need to think a bit/ find out more about….)*

Through PSHE education pupils practice

- perseverance in the face of challenges
- positive mindset about the situations presented and a person's capacity to manage those situations
- flexibility and adaptability when responding to challenges
- differentiation between worthwhile challenges and those which are unhelpful, unfair or unsafe and how to ask for help when needed
- the ability to manage emotional responses to change, challenge and adversity
- the recognition that mistakes and perceived failures are opportunities to grow and learn;
- the ability to reframe failure and bounce back from disappointments

[PSHE Association, 2016]

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Interventions & Resource Pack - Resources for Professionals

Hannah Crook

Trainee Clinical Psychologist

University of East Anglia

NHS England and NHS Improvement

Resources for Professionals

3rd June 2019

Hannah Crook

Trainee Clinical Psychologist

NHS England and NHS Improvement

Introduction

- In 2017, there were 223 deaths by suicide in the UK in the 10-19-year-old age range.
- This increases to 590 when we consider a 10-24 range
- Suicide and self harm in children in young people is receiving increasing recognition and is, rightly, high on the agenda.
- The aim of this toolkit is to present a range of materials to help clinicians support children and young people who present with suicidal ideation and self-injurious behaviours.
- This is not an exhaustive list and it should be treated as a toolkit to aid a clinician's normal approach to treatment. Every effort has been made to ensure the materials have been collated from credible resources based on evidence.

Literature overview

Are psychosocial interventions effective for the treatment of self harm and suicidal ideation in CYP?

- Cox & Hetrick (2017). Couldn't recommend one treatment over another. Highlighted that face to face therapy dominates and suggest a need for novel and innovative approaches.

- Ougrin et al (2015). Suggested that CBT, DBT, and MBT are effective in preventing self harm but there is a weaker effect when interventions for attempts to take own life are considered.

- Hawton et al (2015). Little support for group therapy for adolescents who have engaged in self harm. No clear evidence that any therapeutic approach, apart from mentalization, were effective in managing self harm.

Overview of tool-kit

- 1. Helpful Apps, Websites and Videos
- 2. Guidelines and Competencies
- 3. Professional Information
- 4. Interventions

Helpful Apps, Websites and Videos

Apps recommended by the NHS Apps library

Bluelce (free) – Specifically for young people

Bluelce is an evidenced-based app to help young people manage their emotions and reduce urges to self-harm.

It includes a mood diary, a toolbox of evidence-based techniques to reduce distress and automatic routing to emergency numbers if urges to harm continue.

MeeToo (free) – specifically for young people

The MeeTwo app provides a safe and secure forum for teenagers wanting to discuss any issue affecting their lives.

You can anonymously get advice from experts or other teenagers going through similar experiences in areas such as mental health, self-harming, relationships and friendships.

CalmHarm (free)

Calm Harm is an app designed to help people resist or manage the urge to self-harm. It's private and password protected.

distract (free)

The distrACT app gives you easy, quick and discreet access to information and advice about self-harm and suicidal thoughts.

The content has been created by doctors and experts in self-harming and suicide prevention.

Helpful Websites

www.hubofhope.co.uk

This website allows you to enter your postcode and find local mental health support services.

www.papyrus-uk.org

A national charity dedicated to prevention of young suicide

www.theolliefoundation.org

The OLLIE Foundation (One Life Lost is Enough) is a registered charity funding suicide prevention skills training for any individual or community that wants it, especially those interacting with young people, or young people themselves.

www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/self-harm-in-young-people-for-parents-and-carers?searchTerms=self%20harm

This leaflet looks at why young people self-harm and offers advice about what to do to help.

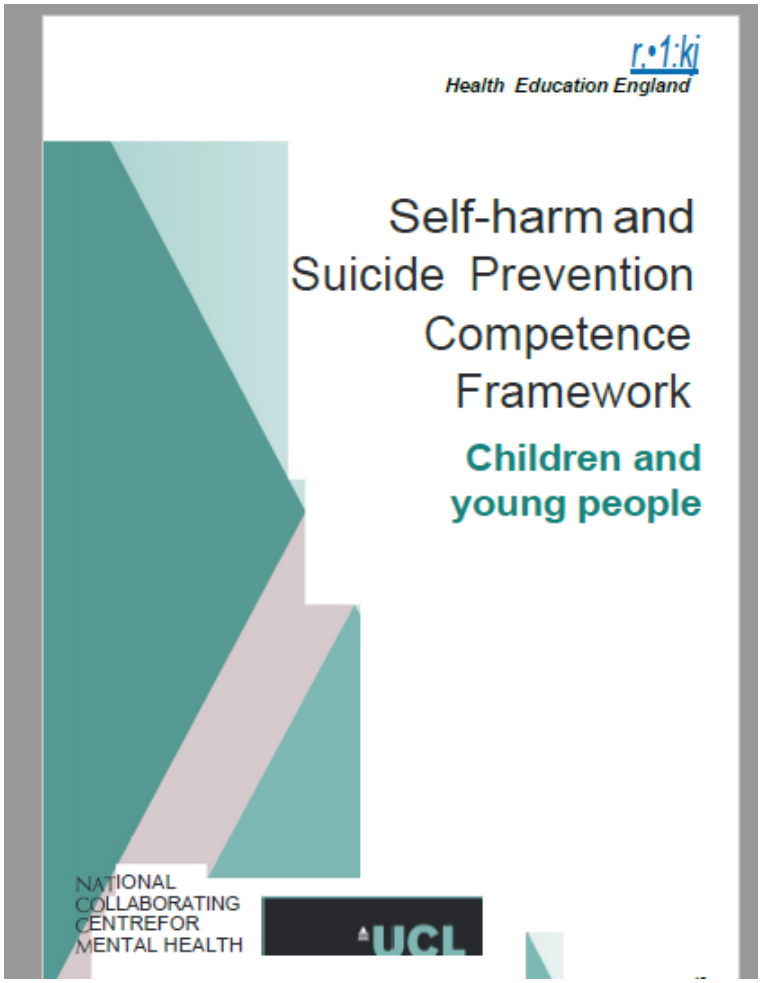
Guidelines and Competencies

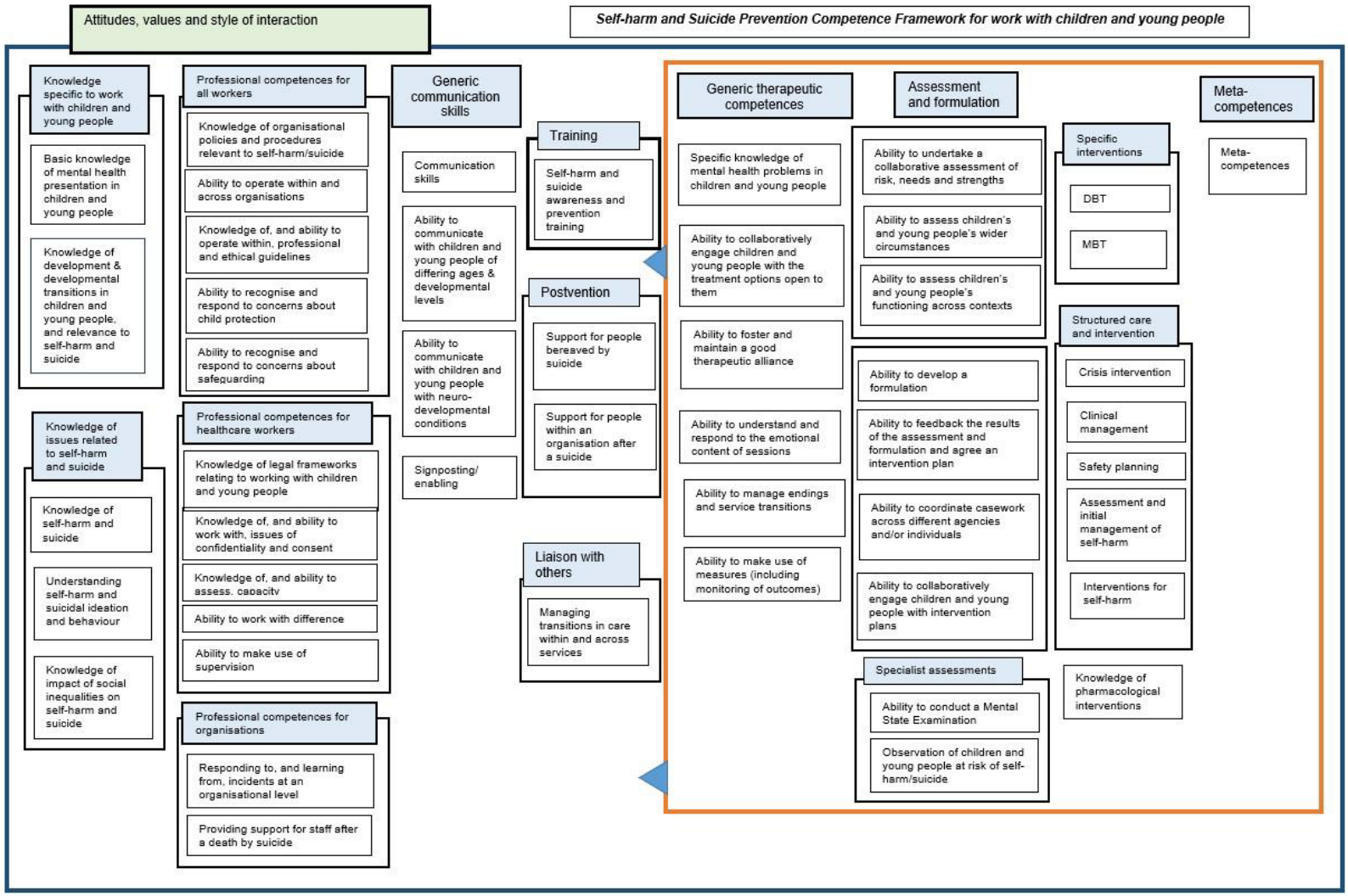
NICE National Institute for Health and Care Excellence

NICE guideline

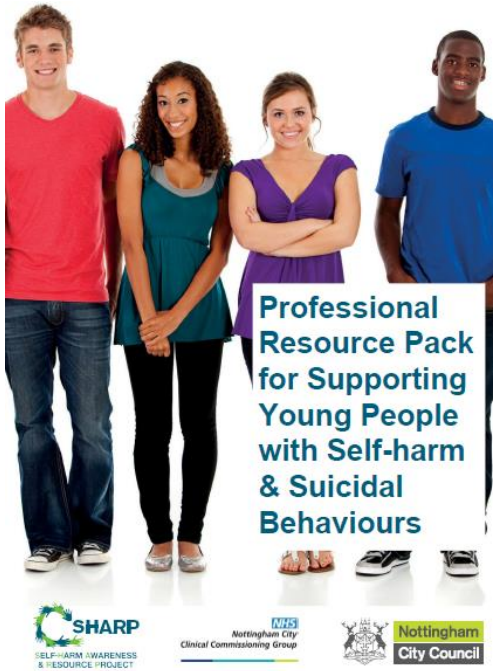
Self-harm in over 8s: short-term management and prevention of recurrence

Clinical guideline
Published: 28 July 2004
nice.org.uk/guidance/cg16




Attitudes, values and style of interaction
Self-harm and Suicide Prevention Competence Framework for work with children and young people
Knowledge specific to work with children and young people
Basic knowledge of mental health presentation in children and young people
Knowledge of development & developmental transitions in children and young people, and relevance to self-harm and suicide
Professional competences for all workers
Knowledge of organisational policies and procedures relevant to self-harm/suicide
Ability to operate within and across organisations
Knowledge of, and ability to operate within, professional and ethical guidelines
Ability to recognise and respond to concerns about child protection
Ability to recognise and respond to concerns about safeguarding
Generic communication skills
Communication skills
Ability to communicate with children and young people of differing ages & developmental levels
Ability to communicate with children and young people with neuro-developmental conditions
Signposting/ enabling
Training
Self-harm and suicide awareness and prevention training
Postvention
Support for people bereaved by suicide
Support for people within an organisation after a suicide
Liaison with others
Managing transitions in care within and across services
Knowledge of issues related to self-harm and suicide
Knowledge of self-harm and suicide
Understanding self-harm and suicidal ideation and behaviour
Knowledge of impact of social inequalities on self-harm and suicide
Professional competences for healthcare workers
Knowledge of legal frameworks relating to working with children and young people
Knowledge of, and ability to work with, issues of confidentiality and consent
Knowledge of, and ability to assess, capacity
Ability to work with difference
Ability to make use of supervision
Professional competences for organisations
Responding to, and learning from, incidents at an organisational level
Providing support for staff after a death by suicide
Generic therapeutic competences
Specific knowledge of mental health problems in children and young people
Ability to collaboratively engage children and young people with the treatment options open to them
Ability to foster and maintain a good therapeutic alliance
Ability to understand and respond to the emotional content of sessions
Ability to manage endings and service transitions
Ability to make use of measures (including monitoring of outcomes)
Assessment and formulation
Ability to undertake a collaborative assessment of risk, needs and strengths
Ability to assess children's and young people's wider circumstances
Ability to assess children's and young people's functioning across contexts
Ability to develop a formulation
Ability to feedback the results of the assessment and formulation and agree an intervention plan
Ability to coordinate casework across different agencies and/or individuals
Ability to collaboratively engage children and young people with intervention plans
Specialist assessments
Ability to conduct a Mental State Examination
Observation of children and young people at risk of self-harm/suicide
Specific interventions
DBT
MBT
Structured care and intervention
Crisis intervention
Clinical management
Safety planning
Assessment and initial management of self-harm
Interventions for self-harm
Knowledge of pharmacological interventions
Meta-competences
Meta-competences

Professional Information



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

Teenage Suicide - No-one saw it coming
Strategic Learning Event
26th June 2018

The purpose of this event is to share the learning from the thematic review on teenage suicides in Essex

Essex County Council

Essex Safeguarding Children Board

Interventions

What makes me feel bad? What does this feel like?
HINT: Has something happened to make you feel this way? What do you currently feel?

How can I keep myself safe right now?
HINT: Do you need to speak to someone for some help? Are there things around you that make you feel unsafe? Can being somewhere else make you feel safer?

What might make it harder for me to stay safe right now and what can I do about this?
Do I use any drugs, alcohol or medication to cope? These can make it harder to stay safe if they make me more impulsive or lower my mood. What can I do to make these safe?

If I have acted on thoughts of suicide before, what makes it harder to stay safe that I might need to consider while staying safe today?

CONVERSATION STARTERS

Asking about suicide saves lives but it can be hard to know where to start or how to help. Below are some example conversation starters if you are worried about someone.

It can be scary, hard or painful to talk about suicide – but we need to. Suicidal feelings don't have to end in suicide. Many young people feel really isolated with their thoughts of suicide and do not feel that they are able to tell anyone. Evidence shows that talking about suicide does not make it more likely to happen – it reduces the stigma and is often the first step in a person's recovery.

Talking about suicide does not make it more likely to happen.

Ask them directly 'Are you thinking about suicide?' By using the word suicide, you are telling the young person that it's OK to talk openly about their thoughts of suicide with you.

"Sometimes, when people are feeling the way you are they think about suicide. Is that what you're thinking about?"

"Are you telling me you want to kill yourself? End your life? Die? Die by suicide?"

"It sounds like you're thinking about suicide, is that right?"

"It sounds like life feels too hard for you right now and you want to kill yourself, is that right?"

PHYSICAL DISTRACTIONS

Go out doors - take your pet if you have one

Use a punch bag or hit a pillow to release some frustration

Find some space and scream and shout

Go to the gym, an exercise class or for a swim. Yoga is particullary good for strengthening the connection between your body and mind

Sit in the garden, outside in the park or on the beach and listen to the sounds of nature

Try and do some cleaning and tidying

Play with a stress toy

Ball up your socks and throw them at a wall

Dance around and burn some energy.

How to access…

- https://www.dropbox.com/s/kiyy88qdl33zb7h/CYP%20Self%20Harm%20and%20Suicide%20Resources%20Pack%20PDF%20final.pdf?dl=0

Thank you for listening!

Hannah.crook@uea.ac.uk

East of England
LSCB Network

Public Health England

NHS

Round Table Discussion

How can we better support & safeguard Children & Young People?

NHS England and NHS Improvement

Table top discussion PM

How can we better safeguard and support children and young people ?

1. What actions will you take away for your organisation ?
2. What actions need to be developed locally ?
3. What can /should the role be of LSCB's and the NHS in supporting practice ?

East of England
LSCB Network

Public Health England

NHS

Conference Closing Summary

Vijay Patel
Strategic Business Manager
Luton Safeguarding Adult and Children's Board

&

Fran Pearson
Independent Chair Luton LSCB and Luton LSAB

NHS England and NHS Improvement