SAFEGUARDING CHILDREN SERVICE

Report on the Scoping Exercise: Management of Self Harm in Young People presenting to NHS Organisations in Wales

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Purpose and Summary of Document
This report presents the results of a scoping exercise on the management of self harm in young people in health settings in Wales.

The main findings are:
• Self harm by young people is an increasing problem presenting in health settings in Wales, although there is a lack of accurate data
• There is a lack of appropriate inpatient facilities for young people in Wales providing age appropriate expertise:
  o Difficulties managing young people with overt risky behaviour alongside young children in hospital.
  o The majority of young people 16 years and older are admitted to adult wards except Cwm Taf Health Board (CTUHB)
• Training on suicide and self harm is inconsistent across HBs and Trusts.
• Lack of awareness of Regional Multi-Agency Suicide Prevention Fora in some HBs
• Examples of good practice include:
  o CTUHB admit all children to Paediatric wards
The Inspire Project in North Wales has youth workers based in hospital to support young people in hospital and community settings.

Cwm Taf Regional Safeguarding Children Board has established the Suicide and Self Harm Reduction Steering Group for 0-25 years, a multi-agency partnership chaired by Head of Safeguarding CTUHB which provides in house multi-agency training.

- Talk to Me 2: Suicide and self harm prevention strategy for Wales 2015-2020 was published by the Welsh Government in July 2015. This scoping exercise provides further information to inform the action plan and aid implementation.

**Next steps**

- Feedback report to
  - All Wales Safeguarding Children NHS Network
  - National Advisory Group Suicide and Self Harm Prevention and link to Talk to Me 2 action plan
- Ensure HB and NHS Trust staff working with children are represented on Regional Multi-Agency Suicide Prevention Groups/Fora

**Distribution:**

- All Wales Safeguarding Children NHS Network
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1. INTRODUCTION AND BACKGROUND

A scoping exercise on safeguarding vulnerable adolescents presented to the All Wales Safeguarding Children NHS Network in January 2014, identified the management of children and young people who self harm in NHS Wales as a priority. The Safeguarding Children Service, Public Health Wales (PHW), was tasked by Welsh Government to lead on a national scoping exercise to better understand the picture across NHS Wales. This fell within the PHW Integrated Medium Term Plan.

Purpose

The purpose of the National Scoping Exercise was:

- To determine the management of young people who present to health settings with self harm across Wales
- To identify areas of good practice which could be shared across Health Boards
- To identify significant gaps in service provision in relation to National Institute for Care and Health Excellence NICE guidelines
- To identify multi-agency practice in relation to self harm in young people

Definition of self harm

Self harm is defined as:

‘Intentional non-fatal self-poisoning or self-injury, irrespective of the degree of suicidal intent or nature/ purpose of other types of motive.’

*Talk to Me 2: Suicide and self harm prevention strategy for Wales 2015-2020 Welsh Government 2015*

Self harm results in 5,500 admissions per year in Wales across all ages and is one of the top five causes of medical admissions. Much of this care is unscheduled. It is estimated that approximately 8 in 100 14 to 19 year olds will self harm (1). Self harm is the strongest risk factor for suicide, the second leading cause of death in the 15 to 19 year old population.(2) However, only a very small fraction of those who self harm go on to make suicide attempts or die by suicide. The risk factors for young people who self harm are consistent with other safeguarding risks such as child abuse and neglect, substance misuse, intimate partner violence and sexual exploitation.
Front line health professionals play a key role in the management of those who self harm. Often they are the first contact for the young person with support services and this has a significant impact on the outcome for the young person and future help seeking. Young people who have self harmed need to be cared for with compassion and the same respect and dignity as any service user. Unfortunately there is evidence that this does not always occur as shown in these comments made to young people by health professionals (3):

‘You’re not helping yourself by hurting yourself’

‘If you harm again we won’t treat you’

Health professionals need an understanding of self harm in order to be able to communicate appropriately with young people.

2. METHODOLOGY

An audit tool (Appendix 1) was developed to capture the NHS response to children and young people who self harm based on the NICE Guidelines (4,5).

Semi structured interviews were undertaken by the Safeguarding Children Service (SCS) with a nominee requested from the Nurse Director in every Health Board and NHS Trust across NHS Wales. The majority of interviews were conducted face to face by a member of the SCS and one was conducted by telephone with an All Wales NHS Trust.

The results were tabulated, analysed and summarised in this report

3. FINDINGS

Two NHS Trusts (Public Health Wales and Welsh Ambulance Service NHS Trust) and seven Health Boards (HB) provided a nominee to be interviewed. A range of personnel were interviewed from Women and Children, CAMHS, Adult Mental Health and the Safeguarding Team.

3.1 GUIDANCE

All Health Boards and Trusts had their own or Regional Safeguarding Children Board (RSCB) guidance or both in place. The RSCB guidance was different across one area due to the amalgamation of LSCBs into an overarching RSCB.

There was a range of guidance for children presenting to health, for example:

• Advice for practitioners when considering referral to NHS CAMHS, with specific integrated care pathway for self harm (Powys) (6)
• Standard operational procedure for managing self harm and suicidal thoughts in children under 18 in acute hospital setting (BCUHB)

• Cardiff LSCB Children who Self harm protocol 2011 (Table 1)

• Bridgend LSCB Risky Behaviour protocol 2011

**TABLE 1 Cardiff LSCB protocol 2011 identifies when to refer based on clinical presentation:**

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<tr>
<th>ACTION</th>
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<tr>
<td><strong>Cases of attempted suicide: asphyxiation, drug overdose, serious cutting</strong></td>
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<tr>
<td><strong>Cases of alcohol abuse or solvent abuse if a child loses consciousness</strong></td>
</tr>
<tr>
<td><strong>Child or young person presented as intoxicated or under the influence of substances</strong></td>
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<tr>
<td><strong>Child or young person discloses that they have self harmed in the recent past</strong></td>
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</tbody>
</table>

The protocols describe further assessment required of the young person before referral to Children’s Services, to identify if there are Child Protection or Child in Need concerns, with consideration of consent by the young person to share information. Comments were made that guidance differed as to which young people who self harmed should be referred to Children’s services.

### 3.2 TRAINING

Training was provided as single agency and multi-agency, the majority provided in house by Safeguarding Teams and CAMHS. Within Health, training is incorporated into Level 2 Safeguarding Children training and
specific Level 3 training, for example Self Harm Awareness and Suicide Prevention. The Level 3 sessions are half to a full day with no charge to participants. Mental Health professionals receive Wales Applied Risk Research Network (WARRN) Risk Awareness training. CAMHS have specialised training including supervision of Trainees for 6 months (Aneurin Bevan University Health Board), and CAMHS module from USW and Swansea University. The RSCBs offer multi-agency training on Self Harm and Suicide in their area.

Cwm Taf Health Board / RSCB have developed and deliver free Level 1 and 2 Reduction of suicide and self harm multi-agency training to a wide range of professionals including Health, Social Services, Police, Education and Foster carers. Over 800 people have received training. Level 1 lasts 1.5 hours and Level 2 a full day but it can be condensed according to the audience. Evaluation of training immediately and 6 months post course demonstrates sustained change in practice. The Project Officer identifies key groups requiring training.

External providers deliver Applied Suicide Intervention Skills Training (ASIST), a 2 day course for care givers costing £150 per person, and 1 day courses on suicide and self harm mitigation training programmes for £200 per person (7,8).

Most HBs have targeted key staff groups for training but it was acknowledged that this was ‘hit and miss’ with no clear overarching strategy. CVUHB commented on an improvement in staff attitude after training with Paediatric ward staff. ABUHB has identified new Band 6/7 post to target training for primary care, CAMHS and Emergency Department.

Overall the numbers needing training was not known by HBs and Trusts: only 3 HBs were able to provide data. Hywel Dda Health Board has centralised admissions for young people to a single ward and are able to provide bespoke training programmes. Consequently 100% of Child Health and CAMHS staff were trained and 41/150 staff in ED in 2014.

In the majority of HBs and Trusts there is no clear strategy for provision of training for Health staff. Cwm Taf University Health Board and Hywel Dda Health Board stand out. One HB commented that there was a significant gap in training for Health frontline staff. Good multi-agency training is available but it costs in both staff time and expenses.

3.3 DATA COLLECTION

Four HBs routinely audit self harm activity, although none had an audit action plan in place. BCUHB had significantly increased their workforce to deliver improved services as a result of audit against NICE guidance.
Data from ABUHB audit demonstrated a clear increase in the number of psychosocial assessments completed by CAMHS from 43 to 95 in the three month periods ending July 2012 and July 2013, most marked in 16-17 year olds.

An audit in CTHB of A&E attendances identified that the commonest reason for self harm were interpersonal issues and family breakdown, and that alcohol was often involved. Although young people presented repeatedly, many of them were not known to services.

### 3.4 ENGAGEMENT IN REGIONAL GROUPS

Four HBs were aware of their Regional Multi-agency Forum focusing on self harm and suicide, all of which have Health representation (CAMHS, Adult Mental Health, Safeguarding Team). The senior safeguarding children staff interviewed from 3 HBs were not aware of the Regional fora until this scoping exercise, although there was adult representation from health.

### 3.5 NICE GUIDELINES

All HBs felt that they were meeting NICE guidelines for short term management although limited evidence could be provided. All stated that they provided a preliminary psychosocial assessment at initial presentation and a psychosocial assessment by Specialist Mental Health professional. HBs commented on improving Paediatric staff attitudes through targeted training, regular safeguarding supervision of key groups and improving relationships between CAMHS and Child Health.

There was a clear process in place for admission of under 16s: the majority (5/7) of HBs admitted all under 16s overnight to a Paediatric ward. Some children are discussed with CAMHS and may be sent home following that discussion.

The majority of 16 and 17 year olds are assessed in adult settings and admitted to adult (5) or mixed (1) wards. Only one HB always admitted these young people to Paediatric wards and would employ agency workers to provide appropriate nursing (CTHB).

The NICE guidelines have specific guidance for children and young people under 16 years (see Appendix 2) but the management of 16 and 17 year olds is less clear.

### 3.6 GENERAL QUESTIONS

**3.6.1 Is there anything particularly challenging in the management of young people who self harm?**

**THEMES**
1. **Management of acute admission**

   High demand patients who are not seen as ‘priority’

   Increasing numbers documented although under reporting of self harm episodes

   Children on adult wards

   Young people on Paediatric wards exhibiting risky behaviour (cutting) next to sick 2 year old

   Lack of service for 16/17 year olds

   Lack of service for 18+ year olds

   Lack of lead Paediatrician managing individual children

   Impact on CAMHS service

   CAMHS comments: ‘Panic button approach’ with lack of confidence in ward staff about how to manage and support these children. Dependency on CAMHS but do all these children need to be referred to CAMHS?

   *‘Not all referrals need to go to CAMHS’*

   Children admitted to hospital waiting overnight / weekends to be assessed by CAMHS

2. **Multi-agency process**

   Perceived differences of opinion between Health and Children’s Services:

   - Lack of understanding of risk and need for planning by Social Services
   - Lack of assessment by Social Services
   - Lack of crisis placements / accommodation: demand outweighs capacity
   - Difference of understanding of thresholds between agencies

   When to refer to Children’s Services?

3. **Lack of training**

   Health professionals require training of appropriate length to their role. Available courses are lengthy and competing with other training. Frontline staff need short focused courses

   WAST only have training on symptom management not broader issue of self harm, eg understanding why young people self harm

   Need for risk management training
School teachers reluctant to address self harm and need further training

4. **Looked after children**

Placement of LAC with no robust care plan in place and service not informed of children’s needs. These children are often admitted after episode of self harm (HDUHB, Powys). The placement breaks down, disrupts support and the young person further disengages from support services.

5. **Resources**

Increasing numbers but under reported
Lack of primary mental health services
Inequity of service provision within individual HBs and between HBs

6. **Prevention agenda**

Lack of prevention services: youth services likely to be cut further

3.6.2 What do you feel the Health Board does well in relation to the management of self harm in young people? Is there anything particularly effective in your area that you would like to highlight and share?

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Examples of good practice</th>
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<tbody>
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<td>CAMHS supervision group</td>
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<td></td>
<td>Adolescent unit</td>
</tr>
<tr>
<td>ABMUHB</td>
<td>Nursery Nurse with special interest, Paediatric safeguarding liaison nurse and Band 8a self harm / ISH role</td>
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<tr>
<td></td>
<td>Proactive in support and supervision in relation to inpatients</td>
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<tr>
<td></td>
<td>SERAF assessment on all young people</td>
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<tr>
<td></td>
<td>Self Harm inpatient data is routinely sent to the Named Doctor</td>
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<tr>
<td>BCUHB</td>
<td>Inspire project provides support in hospital and community</td>
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<td></td>
<td>Aspire BCUHB 16-25 years funded by Barnardo’s</td>
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<td></td>
<td>Regional service of nurses for A&amp;E / wards to assess substance misuse and self harm assessments in North Wales</td>
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4. SUMMARY AND CONCLUSIONS

A range of health professionals were interviewed for this scoping exercise and the answers are dependent on their professional role. Therefore some respondents were fully conversant with their Regional Multiagency Suicide Prevention Groups whereas others were more aware of safeguarding issues. The results therefore have to be interpreted with this in mind.
4.1 Although the suicide rate of 15-19 year olds in England and Wales has been steadily declining since the 1980s (9), the perception is that self harm by young people is an increasing problem presenting to HBs in Wales.

4.2 Data collection is variable: 3 out of 7 HBs collected data, inpatient data is more accurate compared to Emergency Department data. Self harm is under reported. (TTM2 Priority action 8)

4.3 All HBs providing clinical management state they provide initial and CAMHS assessment consistent with NICE guidance but limited evidence was available. The majority of children 15 years and under are admitted to Paediatric wards and work is being undertaken to improve their management such as training of Paediatric staff, provision of specialist nurses and improving relationships with CAMHS. However further work is required in supporting ward staff and there have been difficulties managing young people with overt risky behaviour alongside young children. (TTM2 Priority action 8)

4.4 The management of young people 16 years and older is inadequate, with the majority of children admitted to adult wards with no age appropriate support services. CTUHB admit all children to Paediatric wards and fund the extra resource required. The Inspire Project has youth workers based in hospital to support young people across hospital and their community in BCUHB. There is a lack of inpatient facilities for young people in Wales providing age appropriate expertise. (TTM2 Priority action 8)

4.5 There is a stigma attached to suicide and self harm: children and young people may be reluctant to talk about it, nor do professionals want to listen. Training on raising awareness and understanding of self harm is essential particularly to frontline practitioners such as ambulance, A&E and primary care staff and needs to be prioritised. The recommended training is costly in terms of financial and staff time. Cwm Taf Regional Safeguarding Children Board (CTRSCB) provide in house multi-agency Level 1 and 2 training which should be considered on an All Wales basis following evaluation. Training on suicide and self harm is ‘hit and miss’, there is no overarching training strategy. Scotland Choose life has an NHS Suicide Prevention training Standard that 50% of NHS frontline staff must be trained in suicide prevention on an ongoing basis. (6) A training strategy that links professional role to training required needs to be developed and implemented as identified in Talk to Me 2. (TTM2 Priority action 1)

4.6 Staff interviewed from three HBs were not aware of their Regional multi-agency group focusing on self harm and suicide. Children
need to have more representation on these groups. The groups consider prevention of suicide and self harm and it is important that professionals working with children are represented. CTRSCB has been innovative in responding to self harm and suicide and have established a SSHSG 0-25 multi-agency partnership with focus on prevention chaired by Named Nurse and PRUDiC Plus Immediate Response Group. (TTM2 Priority action 6)

4.7 Self harm by young people is not uncommon and presents in non health settings, primary and secondary care. These children need a coordinated approach including a safeguarding risk assessment to identify those children who need referral to Children’s Services. Regional Safeguarding Children Boards have an important role in relation to children and young people who self harm. This has been recognised in the development of RSCB Risky behaviour guidance and the overlap with children who go missing, and are at risk of child sexual exploitation. This guidance needs to be updated to reflect changes in legislation and guidance. Further consideration needs to be given to identification of children most at risk, their management and effective interventions.

4.8 Talk to Me 2: Suicide and self harm prevention strategy for Wales 2015-2020 was published by the Welsh Government in July 2015. This scoping exercise provides further information to inform the action plan and aid implementation particularly in relation to training, data collection and safeguarding.

5. NEXT STEPS

5.1 Feedback report findings to
- All Wales Safeguarding Children NHS Network
- National Advisory Group Suicide and Self Harm Prevention

5.2 Ensure staff working with children represented on Regional Groups

5.3 National Training Framework to consider
- National standards to identify training required by role
- Targeted focused training for frontline health staff

5.4 When is self harm a safeguarding issue?

Clarification of safeguarding risk assessments and when to refer to Children’s services for all children and young people who self harm to ensure consistency in practice across Wales.
Updating of RSCB Guidance on risky behaviour

5.5 Accurate data collection in health

6. ACKNOWLEDGEMENTS

I would like to acknowledge the contribution of Caroline Jones, Kathy Ellaway and Rachel Shaw, Designated Nurses in the Safeguarding Children Service, and Andrea Coombes for their contribution in study design, obtaining the data and formatting the report.

7. REFERENCES


3. Cardiff Adult Self Injury Project presentation at Talk to Me 2 launch July 16 2015


5. NICE quality standard [QS34] Self harm June 2013

6. Self Harm:

7. Suicide first aid – ASIST:
   http://mindaberystwyth.org/training/suicide-first-aid-asist

8. Connecting with people:
   http://connectingwithpeople.org/courses?qt-connecting_with_people=6#qt-connecting_with_people

9. How safe are our children? NSPCC June 2015:

10. Choose Life Scotland:

http://www.chooselife.net/Training/NHSstandard.aspx
APPENDIX 1

THE MANAGEMENT OF SELF HARM IN YOUNG PEOPLE
PRESENTING TO NHS ORGANISATIONS IN WALES
A SCOPING EXERCISE

Purpose:

- To determine the management of young people who present to health settings with self harm across Wales
- To identify areas of good practice which could be shared across Health Boards
- To identify significant gaps in service provision in relation to NICE guidelines
- To determine future data sources to identify the extent of the problem
- To identify multi-agency practice in relation to self harm in young people

Definition

Young people: those aged under 18 years old
Self harm: intentional self poisoning or self injury, irrespective of the method, nature of motivation, purpose or degree of suicidal intent

1. Protocol procedures / guidance in place

1a Does the Health Board/Trust have written guidance in respect of the management of self harm in young people?  
   Yes ☐  No ☐

   If yes, please attach.

1b Does the Regional Safeguarding Board have multi-agency guidance on self harm in young people?  
   Yes ☐  No ☐

   If yes, please attach.

1c Do you have any other relevant associated guidance for children presenting to health e.g. alcohol and substance misuse or suicide?  
   Yes ☐  No ☐

   If yes, please attach.

Add comments below:

Please tick
## 2. Training of staff

**2a** What training can your staff, both clinical and non clinical access regarding the management of self harm in children and young people?

<table>
<thead>
<tr>
<th>Name of Training course e.g. Youth MHFA</th>
<th>Training provider e.g. MIND Cymru</th>
<th>Costs e.g. £500 per person</th>
<th>Duration e.g. 2 days</th>
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**2b** Have key staff groups been targeted for training in self-harm in children and young people across your Health Board/Trust?

- **i.** Emergency department (nursing and medical)
- **ii.** Child health staff (Ward staff, nursing and medical)
- **iii.** Primary care (GPs, practice nurses, nurse practitioners)
- **iv.** Paramedics (WAST)
- **v.** CAMHS (nursing and medical)
- **vi.** Adult mental health services (nursing and medical)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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**2c** How have they been targeted?
2d  How many staff need self-harm training overall (trained and untrained)?

1. Emergency Department (nursing and medical)
2. Child Health staff (Ward staff, nursing and medical)
3. Primary care (GPs, practice nurses, nurse practitioners)
4. Paramedics (WAST)
5. CAMHS (nursing and medical)

2e  How many staff have received self-harm training?

1. Emergency Department (nursing and medical)
2. Child Health staff (Ward staff, nursing and medical)
3. Primary care (GPs, practice nurses, nurse practitioners)
4. Paramedics (WAST)
5. CAMHS (nursing and medical)

Add comments below:

3.  Data collection

3a  Do you routinely audit self-harm activity for example in ED, inpatient, in young people? Yes  
No

If yes, please attach the audit

If yes, is there a self-harm action plan in place to address the audit issues? Yes  
No

If yes, please attach the action plan
4. **Engagement in Regional groups**

Are you aware of a Regional multi-agency group focusing on self-harm and suicide?  
Yes ☐  
No ☐

If so, is the group for adults/children or both?  
Adults ☐  
Children ☐  
Both ☐

Is the Health Board represented on the Regional group?  
Yes ☐  
No ☐

If yes, please state title, profession and from which service

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Add comments below:

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5. **NICE guidelines**

Is the Health Board auditing and meeting NICE guidelines for self-harm?  
Yes ☐  
No ☐  
Don’t know ☐

Do all young people have a preliminary psychosocial assessment at initial presentation?  
Yes ☐  
No ☐  
Don’t know ☐

Do all young people have a psychosocial assessment by a specialist mental health professional?  
Yes ☐  
No ☐  
Don’t know ☐

Are all under 16s admitted overnight to a paediatric ward?  
Yes ☐  
No ☐  
Don’t know ☐
Where are 16 and 17 year olds assessed?

Where are 16 and 17 year olds admitted?

Do you have any data to support your answers?  
Yes  [ ]  No  [ ]

Please list what local resources are available to support the young person

Any comments below:

6. **General comments**

   Is there anything particularly challenging in the management of young people who self harm?

   What do you feel the Health Board does well in relation to the management of self harm in young people?
Is there anything particularly effective in your area that you would like to highlight and share?

THANK YOU FOR COMPLETING THIS EXERCISE
APPENDIX 2

NICE self harm guidance: Special issues for children and young people (under 16 years) (4)

Children and young people who self-harm have a number of special needs, given their vulnerability. Physical treatments will follow similar principles as for adults.

1.9.1.1 Children and young people under 16 years of age who have self-harmed should be triaged, assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

1.9.1.2 Children's and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed.

1.9.1.3 All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary.

1.9.1.4 For young people of 14 years and older who have self-harmed, admission to a ward for adolescents may be considered if this is available and preferred by the young person.

1.9.1.5 A paediatrician should normally have overall responsibility for the treatment and care of children and young people who have been admitted following an act of self-harm.

1.9.1.6 Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person.

1.9.1.7 Staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues.
1.9.1.8 In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act.

1.9.1.9 During admission to a paediatric ward following self-harm, the Child and Adolescent Mental Health Team should undertake assessment and provide consultation for the young person, his or her family, the paediatric team and social services and education staff as appropriate.

1.9.1.10 All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm. Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues.

1.9.1.11 Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self-harmed should:

- be trained specifically to work with children and young people, and their families, after self-harm
- be skilled in the assessment of risk
- have regular supervision
- have access to consultation with senior colleagues.

1.9.1.12 Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed.

1.9.1.13 For the further management of young people who have self-harmed, see 'Self-harm: longer-term management' (NICE clinical guideline 133).