Thematic learning summary on serious self-harm and risk of death by suicide

Background:

Oxfordshire Safeguarding Children Board have undertaken this thematic learning summary to highlight the findings and learning from local reviews relating to serious self-harm and risk of death by suicide, and to consider common themes with national reviews.

Its purpose is to highlight strengths in practice, areas for improvement and gaps in provision for children requiring preventative and residential mental health provision.

Key Findings

- The importance of identifying and responding to concerns early on to reduce the impact of trauma on children
- Understanding and addressing the underlying factors of a child or young person's self-harming behaviour to ensure responses are informed, appropriate, and focused on the needs of the child
- All agencies involved with children have a responsibility to share safeguarding information as per the OSCB multi-agency information sharing protocol
- Building good relationships with parents, carers and other practitioners involved with children, is integral to partnership working and ensuring work is child focussed
    - There should be a single professional with oversight and authority to manage work where children and families have multiple and/or complex needs
    - There should be joint meetings/supervision to explore and challenge hypotheses where concerns are escalating, or where there are differences of opinion either across agencies or between agencies and the parents or child
- Complex and high-risk behaviours often involve many agencies and require a formal planning and review structure. Child Protection processes provide such a structure, though reviews have highlighted the limitations of these processes, when working with extra familiar risk and harm to children
- Where a child has been identified as being at risk of death by suicide plans should include a specific suicide prevention plan and residential/care providers should undertake environmental assessments to minimise risk
- Supporting & involving children and young people in decision making should be central to everyone's practice

Strengths in practice:

- There were examples where referrals to agencies were responded to in a positive and timely manner, and information sharing between the agencies was good
- There was evidence of good partnership working with schools, children's homes and hospitals to provide continuity of care and to communicate with a range of services involved
- Respectful and effective working relationships with families helped to instil trust and confidence in parents, that their child's needs were understood and being met
- Risk assessment, planning, and the involvement of local services (when needed) contributed towards positive and successful home visits
- Multi-agency plans were in place at discharge from hospital
- Practitioners showed sensitivity and care in their work with children and young people

Common themes from local and national reviews:

- Early intervention is key to minimising the impact of adverse childhood experiences
- Effective partnership working and information-sharing is essential to see the full picture
- The importance of building good working relationships with families
- Hearing children's voices in assessments, observations, meetings and decision making
- Management oversight in complex situations or where there are professional disagreements
- Plans that identify preventative measures, harm minimisation and ligature assessments when working with serious self-harm and risk of suicide
- Placement insufficiency

Learning points for practitioners:

Effective multi-agency working, information sharing and recording

- Ensure that you are familiar with, and follow, the OSCB information sharing protocol and early help guidance when concerns are first highlighted
- A full multi-agency assessment should be undertaken, including whole family history, dynamics and stresses, parental resilience and skills, and support needs to understand and address a child's self-harming behaviours and underlying factors
- Multi-agency discussions, assessment of risk and decision making, should be recorded in detail

Building strong relationships to work in partnership with agencies and families

- Consider whether you have spoken to everyone you need to
- Time and care must be taken in responding to queries from parents/carers about their child's treatment and progress

Understanding a child's world

- Act on early concerns, using the Strengths and Needs Form (SNF) to better understand what is going on and to decide the best way forward
- All observations and assessments should capture the child's world in their own words, including how they see themselves and what they think about their day-to-day life, their feelings, wishes and beliefs, what they do and don't like
- Ensure children and their families are able to be involved in Child in Need, Child Protection and Child in Care meetings and decision-making processes and are supported and prepared for such meetings to encourage their participation before, during and after the key decisions are taken
- Inclusion in meetings and planning should be age appropriate and parental concerns and needs to protect their child/ren, should not preclude information being shared directly with children. If there are reasons not to include children, these should be recorded

Take the time to reflect ….

Has a full multi-agency assessment been undertaken that includes:

- A full family history - dynamics and stresses, parental resilience and skills, and support needs
- Child's history, past trauma, identified risk and what the child needs as a consequence
- Have all children's voices been heard and recorded in their own words?
- Have all relevant agencies been involved to take a co-ordinated approach?
- Have you considered the use of relevant multi-agency tools to inform the child's assessment or plan?
- Are assessments and plans purposeful and SMART so that progress can be measured?

Learning point for managers:

Management oversight

- Feedback and /or complaints from parents and carers should be listened to and responded to in a timely manner to allow frontline staff to focus on direct work with children
- In complex situations, a lead professional with sufficient experience and authority should assume overall case management to work across professional boundaries and communicate with the parents and where appropriate, referrals made to relevant forums and panels, e.g. Children Missing and Exploited Panel, Complex Child Panel
- Professional disagreements may occur when working with complex situations, and should be managed and resolved in a professional and respectful way, refer to the OSCB Resolving Multi-Agency Disagreements and Escalation Policy

Learning points for the safeguarding system including education settings:

Effective multi-agency working, information sharing and recording

- Where there is repeated and serious self-harming and a risk of dying by suicide, plans which identify preventative measures to reduce risks, including ligature assessments where appropriate, must be clearly documented and shared, and reviewed and updated as a priority
- The OSCB should further promote the Resolving Multi-Agency Disagreements and Escalation Policy so that it is widely known across organisations and publicised as part of a culture of healthy debate and challenge when safeguarding and protecting children and young people

Learning points for commissioners:

Unmet needs and insufficient service provision

- The importance of commissioning staffing levels that meet the needs and risks of children, including experienced specialist mental health nurses and carers

National learning

Placement insufficiency both nationally and locally resulted in:

- There are few specialist therapeutic placements available in the country
- Not being close to home and local services adds to vulnerability, possible isolation and has a negative impact on family contact and relationships
- Given the complexity of the children's needs and high-risk behaviours in these reviews, the suitability of placement and therapy specification should always involve CAMHS

Did you know? The following links offer useful further information and guidance:

- ✓ Use the OSCB multi-agency tools and resources to improve practice and inform assessments and plans (for use by any practitioner or volunteer working with children, young people and families) e.g., Threshold of Needs, Early Help Assessment tools and resources, Multi-Agency Chronologies
- ✓ Refer to the OSCB multi-agency procedures manual for policies, procedures, guidance and local resources such e.g., information sharing and escalation
- ✓ OSCB suicide & self-harm webpage for information on local self-harm networks, external resources including short videos and free training
- ✓ Complex child panel terms of reference, sets out the function and responsibilities of the panel, criteria for referral and intended outcomes
- ✓ Research in Practice: Hearing Children's Voices
- ✓ CAMHS good advice pages, info and advice on mental health and wellbeing including self-harm and suicidal thoughts
- ✓ NSPCC guidance on self-harm
- ✓ Coping with self-harm: A Guide for Parents and Carers
- ✓ Free online suicide awareness training

If you do one thing……

Working with complex and high-risk situations needs effective partnership working, and good management oversight. Invest in building effective relationships with children, their families and one another across the partnership. Keep the focus upon working WITH and not doing to or for others, ensuring everyone's views are heard and recorded in their own words, differences in opinion are discussed respectfully, and plans worked out together.