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FAMILIES OVERVIEW AND SCRUTINY COMMITTEE AGENDA

Thursday, 22 October 2015 at 1.30 pm at the Bridges Room - Civic Centre

From the Chief Executive, Jane Robinson

Item	Business
1.	**Apologies for absence**
2.	**Minutes** (Pages 1 - 10) The Committee is asked to approve as a correct record the minutes of the last meeting held on 10 September 2015
3.	**Performance Improvement Update - Children Presenting at Hospital as a result of Self Harm** (Pages 11 - 52) Report of Director of Public Health
4.	**OSC Review - Child Protection in Gateshead - Evidence Gathering** (Pages 53 - 68) Report of Strategic Director, Care Wellbeing and Learning
5.	**Collaborative Commissioning of CAMHS Service** (Pages 69 - 74) Report of Strategic Director, Care Wellbeing and Learning
6.	**Monitoring Report - OSC Review - Role of the Council in Supporting Educational Outcomes** (Pages 75 - 78) Report of Strategic Director, Care Wellbeing and Learning

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Date: Wednesday, 14 October 2015

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE

10 September 2015

PRESENT: Councillor Malcolm Brain

Councillors: J Graham, McCartney, S Craig, Hawkins, Oliphant, Turnbull, Thompson and Robson

CO-OPTED MEMBERS: Malcolm Brown, Ray Tolley and John Wilkinson

F9 Apologies for Absence

Apologies for absence were received from Councillors Caffrey, Adams, McNally and Clelland and co-opted members, Sasha Ban, Jill Steer and Carolyn Duffy.

F10 Minutes

RESOLVED - The minutes of the meeting held on 18 June 2015 be approved as a correct record.

Matters Arising
It was confirmed that, following the issues raised around LAC achievement in education results, a meeting has been planned regarding REALAC team funding.

It was requested that officers provide additional information to the Committee around what work is being done in schools to raise awareness that 'sexting' is illegal.

F11 Children Looked After and Safeguarding – Role of Health Services in Gateshead

The Committee received a report which provided a progress update following the unannounced CQC Inspection for Safeguarding and Looked After Children in Gateshead.

It was reported that a number of organisations were involved in the inspection including; QE Hospital, CCG, NHS FT, GP's, Health Visitors, LAC Services, Drug and Alcohol Service, Family Nurse Partnership, Maternity Services, Sexual Health Services and School Nurses.

The inspection focused on the voice of the child, in particular looking into the experiences and views of children and their families. The key line of enquiry was looking at the quality and effectiveness of safeguarding arrangements in health. Focused in particular on; assessing need and providing early help,

identifying and supporting children in need and the quality and impact of child protection arrangements.

It was confirmed that safeguarding was found to be solid and that significant progress had been made since the last inspection. Partnership working, governance and leadership arrangements were also seen as areas of good practice. In addition, there was found to be good reporting of child protection issues at A&E, good examples of specialist support being available in maternity services and information sharing between GPs, midwives and health visitors. There was also found to be good evidence of achievement relating to professional staff training at all levels.

It was reported that areas for development have been compiled into an action plan. Actions include; development of a perinatal mental health pathway in midwifery services, routine inquiries around domestic violence at each midwifery contact. Two teenage pregnancy specialist midwives are in post to support the work of the Family Nurse Partnership. A GP Report Writer administrator has been appointed to strengthen GP's contributions to Child Protection Conferences, this has improved contributions from 27% to 54%. Information sharing links to NTW NHS Foundation Trust have improved with lists of children on Child Protection plans being frequently shared. Training has been held with Health and Children Services around alcohol and substance misuse impact on children. The Committee was advised that an audit on LAC assessments has been carried out and will be held on an annual basis.

The Committee was advised that outstanding actions include; strengthening the GP multi agency information sharing meetings and supporting the new designated Dr Safeguarding Children in her new role from October 2015. In addition an audit will be carried out on the quality of GP contributions to Child Protection reports.

It was queried as to the role of the Designated Dr. It was confirmed that the Dr is employed in this role by the CCG for one day per week. The role includes looking at training and governance arrangements, dealing with queries from GPs around concerns about children they have seen.

It was questioned whether any work is underway to identify child carers and what is done to ensure their care hours are not exceeded. It was confirmed that this was not a key line of enquiry so information is not clear about this. The point was made that organisations, such as Crossroads, support these children which shows that there are large numbers of young carers within Gateshead.

It was queried what the issues were around LAC assessment quality. It was acknowledged that there are variable amounts of contributions to LAC assessments, for example from school nurses, GPs and health visitors, therefore training for contributors has been enhanced.

It was questioned whether any review has been carried out on waiting times for CAMHS. It was confirmed that this has been picked up and is monitored through the Children and Young People Service. There are no recent figures from NTW but this will be picked up in the future.

It was queried what mental health support was available within midwifery services. It was confirmed that five additional midwives have been appointed, as well as two teenage pregnancy champions, and work is ongoing to develop a perinatal mental health pathway.

The point was queried that nearly half of GPs are not contributing to Child Protection Conferences. It was acknowledged that within safeguarding representatives have 10 days to provide information which is a short timescale by which to respond. It was noted that as GPs are very busy and demands are such that there is limited contribution and quality is not always of a good standard. The point was made that it was hoped that this time next year the position would be improved. It was confirmed that this is not an unusual position as this is a challenge in all areas, however there is a unique pilot in place to tackle this.

The Committee agreed that the contribution to Child Protection Conferences from all agencies, including Health Services, should be looked at further. It was agreed that this would be picked up during the Committee's current Child Protection review.

The Committee also agreed that a letter should be written to the CQC to suggest inclusion of young carers support in its future inspections. It was pointed out that within the Single Inspection Framework of Ofsted this issue would be looked at.

RESOLVED - (i) That the Committee would suggest the CQC look at young carers support in any future inspections.

(ii) That the Committee was satisfied with the progress made against the action plan.

F12 Annual Report on Complaints and Representations – Children

The Committee received the annual report on Children's Services complaints and representations. For complaints received during 2014/15 two key themes were identified; quality of service and disputes around Social Work reports.

It was acknowledged that generally families want reports changed, sometimes this is to delay the process and an attempt to stop action. It was noted that there has been a 32% increase in complaints since last year, it was suggested that this could be due to safeguarding issues being more in the media and some historic complaints have been received. It was also noted that regionally there has been an increase in complaints as people are more aware of their rights.

During 2014/15 there were no complaints received in relation to staff conduct. Five complaints were received around breach of confidentiality and work is underway with Information Officers from legal services to prevent this happening in the future. 4% of the complaints were received from representatives of the BME communities, however in those cases there was no evidence of racial discrimination.

It was reported that 42% of the complaints received were not upheld and 44% were partially upheld. The Committee was advised that when complaints move to stage two there are financial implications for the service as there is a requirement to provide an independent person to oversee the complaint.

It was noted that learnings from every complaint is used to drive improvements within the service and identifies where things can be improved. It was acknowledged that usually communication is a key issue and is addressed by team managers. It was also noted that a number of compliments were received during the year, 37% of representations made were compliments.

It was queried why half of complaints were not resolved within the 20 working day timescale. It was stated that when an internal investigation starts at stage one the investigator will contact the complainant to try and work with them and if there are a number of services involved it is difficult to resolve within the timescale. If the investigating officer keeps in contact with the complainant and keeps them updated they will generally be happy. If the complainant is unhappy with the timescale they can move their complaint to stage two, however it was noted that this does not often happen. It was recognised that generally complainants wish to have a thorough investigation rather than rushed to meet timescales.

It was questioned whether additional resources are needed in support of Social Workers as quality of service is a key issue coming out of the complaints. It was confirmed that safeguarding care planners get the most complaints and team managers are involved with each complaint at stage one. It was also noted that if issues with a particular Social Worker are received more than once this would be flagged with the Service Manager.

RESOLVED - (i) That the Committee's comments on the annual report are noted.

(ii) That the Committee was satisfied with the performance of Care Wellbeing and Learning in responding to complaints and ensuring that this results in continuous service improvement.

F13 Gateshead Child Health Profile

The Committee received an overview of the current Child Health Profile that was released in June 2015. The profile was produced by Public Health

England and looks at performance relating to child health and wellbeing in Gateshead in comparison to national performance.

The key findings were identified as;

- Child poverty in Gateshead is worse than the national average with 22% of children aged under 16 living in poverty.
- Obesity rates are above the national average
- Immunisation uptake in Gateshead is above the national average
- Increase in hospital admissions as a result of self harm for 10-24 year olds.

Indicators showing improvement since last year include; increase in immunisation to children in care, increase in breastfeeding and reduction in child poverty. Indicators not showing improvement were also highlighted, these included; increase in infant mortality, substance misuse, hospital admissions due to asthma and self harm. It was noted that some measures will be changed for next year, this includes the children in poverty measure.

A breakdown of immunisation rates was provided, which showed that Gateshead is performing above the national average, this includes rates for looked after children. GCSE attainment, including English and Maths, remains above the national average, however there is currently no data for looked after children's attainment.

In terms of obesity rates it was noted that in 10-11 year olds this is above the national average. Similarly, under 18 conception rates are worse than the England average, although within Gateshead there has been a reduction in under 18 conception rates.

It was reported that there has been a reduction in under 18 hospital admissions due to alcohol specific conditions, however this still remains higher than the national average. It was acknowledged that hospital admissions due to substance misuse is significantly higher than the national average, therefore this would need to be monitored in order to examine trends.

Mothers smoking at time of delivery remains above the England average rate. Rates of breastfeeding initiation are below the national average, however regionally Gateshead is performing well.

A&E attendances of 0-4 year olds has increased over the last three years and is currently higher than the national average. In particular there has been an increase in hospital admissions due to asthma.

It was noted that the Committee has previously raised its concerns around self harm and substance misuse figures and felt that no progress had been made on this issue. It was acknowledged that next years figures would likely increase further to reflect the increase in use of legal highs. It was noted that drug and substance misuse and legal highs remain a regular issue and

education sessions are being held. It was also suggested that there needs to be some distinction between intentional self harm and those incidents of young people taking legal highs. It was confirmed that there are clear definitions of what is included in the figures and it was noted that an update on self harm is programmed for the next meeting of the Committee.

It was queried as to why there is an increase in hospital admissions due to asthma. It was confirmed that this is usually as a result of emergency admissions and there has been an increase in respiratory problems which needs to be looked into further.

It was questioned whether there is a taskforce in place to address the whole body of issues. It was confirmed that there is no taskforce as such, however there is a Programme Board with an overview and Public Health look at this overall in terms of advances in Gateshead. This is also reported to the Health and Wellbeing Board.

It was questioned why not all LAC were reported on in terms of immunisation. It was noted that this may be to do with the age of the cohort but would be checked and confirmed.

It was also questioned as to whether the number of young people using vaporisers instead of smoking cigarettes is recorded. Committee was advised that this information is not currently being recorded.

RESOLVED - (i) That the comments of the Committee are noted.

(ii) That the Committee is satisfied with performance to date.

F14 Ofsted Inspections / School Data – Progress Update

The Committee received a report outlining the position of Gateshead schools in relation to Ofsted inspections for spring and summer 2015 terms.

It was reported that St Anne's Catholic Primary School is the lowest performing primary school in Gateshead and was found to 'require improvement' at its recent inspection. It was noted that the school has lost its Headteacher and Deputy Headteacher and Council officers are continuing to work with the Catholic Diocese to overcome the problems of the school.

It was noted that Winlaton West Lane Primary School were previously found to 'require improvement' although its leadership was judged to be good. However, at its recent inspection the school was still found to require improvement but its leadership was no longer classed as good. Work is continuing with the school as the improvement that was expected has not yet been made.

Lobley Hill Primary School was judged as 'good', although there was a dip in SATS results Ofsted still recognised the school's achievements.

It was reported that Kibblesworth Primary Academy was previously judged as 'outstanding' but was found to 'require improvement' at its most recent inspection. It was noted that Council officers previously had limited contact with the school after it became an academy, however since the inspection a support package has been put in place.

It was noted that Birtley East Primary School was initially found to require improvement, however, the school and officers disagreed with this finding and it was subsequently changed to good.

Ofsted found that Kingsmeadow School required improvement but recognised that its leadership was good. It was noted that this was a disappointing result and was due to a weakness in their data.

In relation to Ryton Junior School it was put into special measures and it was looking likely that the school would need to convert to an academy. HMI visited the school in the summer and advised that it would not be converted until Ofsted returned to inspect, in order that sufficient time was given for the school to improve. However, if at that time the school was found not to be good enough it would be converted to an academy.

RESOLVED - That the Committee noted the position of schools in relation to Ofsted inspections.

F15 OSC Review – Child Protection in Gateshead – Evidence Gathering

The Committee took part in the first evidence gathering session of the review into how the child protection system operates in Gateshead. The Committee received an overview on the legal framework of the child protection system and the roles and responsibilities of multi agency working.

It was reported that the Children Act 1989 governs child protection functions and the Children Act 2004 strengthened the previous Act by enforcing a duty on a range of organisations to promote the welfare of children.

Working Together to Safeguard Children Guidance was published in 2013 and provided statutory guidance for interagency working to safeguard and promote the welfare of children. The guidance took on the recommendations from the Munro Review to focus more on the individual needs of the child and clarified the procedure for a single assessment, which Gateshead established. The guidance was updated in 2015 and included referral of allegations to the LADO and emphasised the multi agency nature of safeguarding, reasserting the principles of a child centred approach.

In terms of the process it was noted that the Referral and Assessment Team decides in one day how to handle the referral. Options to be looked at at this

point include; whether the child requires immediate protection, usually police would be involved at this point, whether the child is in need, whether there is cause to suspect the child is suffering or is likely to suffer significant harm and should be assessed under section 47. At this time the team would also look to see if any services are required by the child and whether further specialist assessments are required.

If a Child in Need Assessment is needed this must be determined within 45 days, it will be done with the consent of parents. However, if during the assessment it becomes apparent that there is cause to believe the child may be at risk of significant harm, a multi agency strategy meeting will be called. This will bring together information on the family and it will then be decided whether a Child Protection investigation (section 47 enquiry) should be started. It was noted that this can be done without parental consent and therefore frees up organisations to release information.

A Social Worker will lead assessments under section 47 and will work with organisations namely; police, health professionals and teachers. The assessment will take in the views of the family, the child and professionals and the information will be evaluated and risk analysed. The enquiry will reach a view following, if it is not substantiated the case will return to a Child in Need Plan. If the referral is substantiated an initial Child Protection Conference will be called within 15 days.

The Initial Child Protection Conference (ICPC) is a multi agency meeting, including the family and the child, and is chaired by an Independent Reviewing Officer (IRO). The IROs operated outside of the operational line of responsibility. The ICPC reaches a conclusion as to whether it meets the threshold for a Plan, it points to actual harm or is based on professional judgement that there is the potential for future harm. Immediately following the ICPC an outline plan is put in place, this sets out what and by who it should be done. The Plan articulates the actions required and identifies the core group, which then meets the family monthly.

A Review Child Protection Conference (RCPC) is held at the three month point and then six monthly thereafter. It was confirmed that only a RCPC can stop a plan, a core group cannot.

A breakdown of child protection figures was provided, it was noted that figures were high at 2013/14 however 2014/15 figures are not yet available. It was pointed out that last year the number of plans decreased, however this year there are currently 220 but there is a corresponding increase in the number of LAC. It was noted that this is likely to be a similar picture nationally and regionally as authorities move to single assessments.

Committee was advised that in Gateshead there is a higher number of unborn babies being subject to child protection plans, this has been seen as good practice as it provides a long period through which to work with families. The

low numbers of children becoming subject to plans for a second time shows that the right decisions regarding plans are being made in the first place.

It was confirmed that those section 47 enquiries that are not progressed are currently being dip reviewed and the outcome of this will be reported during the review.

It was questioned whether economic factors play a part in the increased number of plans as a result of neglect. It was confirmed that Ofsted did carry out a thematic inspection and did find an impact of poverty on neglect. The authority is now seeing this more broadly than just a single issue.

RESOLVED - (i) That the views of the Committee on the evidence presented was noted.

(ii) That the Committee agreed the proposals for the next evidence gathering session.

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
22 October 2015

TITLE OF REPORT: **Self Harm – Children and Young People Update 2015**

REPORT OF: **Carole Wood, Director of Public Health**

SUMMARY
The purpose of this report is to provide the committee with an overview of Self Harm incidents within Gateshead, to outline any trends in the performance data and provide an update of the work achieved within the Self Harm Sub Group over the last 12 months.

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1. Background

The Child Health Profile produced annually by Public Health England (previously the Department of Health) presents a picture of child health and wellbeing for each Local Authority area. The 2015 profile was published in June of this year and presented to Cabinet in September 2015. The profile demonstrated a number of areas for concern including a high number of hospital admissions as a result of self Harm for 10-24 year olds.

2. Defining Self Harm

Self Harm can be defined in a number of ways. Self-harm is defined as self-poisoning or injury, irrespective of the apparent purpose of the act (National Institute for Clinical Excellence - NICE – 2004).

Self harm can occur in many forms including;

- Cutting
- Burning
- Punching
- Inserting or swallowing objects
- Head banging
- Pulling out hair or eye lashes
- Inhaling or sniffing harmful substances
- Ingesting toxic substances or objects
- Engaging in risk taking behaviour
- Eating disorders

Reasons for people engaged in self harm are often a symptom of underlying emotional problems, used as a way of coping. Self harm is usually not

triggered as a result of one isolated event but rather as a set of circumstances leaving young people overwhelmed and unable to manage their emotions.

3. Key Findings

3.1 Child Health Profile

- Gateshead Child Health Profile stated for the period 2013/14 showed 214 young people (626.5 per 100,000 population) aged 10 – 24 years were admitted to Hospital as a result of self harm. This was an increase from the previous year 170 (491.7 per 100,000). It is unclear as to what is the reason behind the increase however, one reason could be more young people and professionals being aware of self harm and as a result, better reporting of incidents and those seeking help could explain the increase.

- Nationally we know common mental health disorders are increasing for children and young people, with 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder. This means in an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder. It is estimated that 1 in 10 of 5-16 year olds, will experience a mental health problem at some point in their lives.

3.2 Hospital analysis 2012/13 and 2013/14

At the time of writing this report, A&E admittance data was not yet available. It is hoped that the data will available for presentation at the OSC meeting on 22nd October.

3.3 CAMHS service information 2014/15

- Data available to the self-harm group demonstrated that out of 353 children and young people seen by the Tier 2 CAMHS service in 2014/15, 23 of those were coded as self-harm. Out of those 23 referrals, 5 were referred onto specialist CAMHS provision (CYPS). The 23 referrals also showed a gender split of 21 females to 2 males.
- In relation to the age of females referred it ranged from 11-17yrs with the average age being 13 years. For males the age range span 16-17 years, with the average age being 16-17 years.
- Sources of referrals for the 23 young people primarily came from GP's (15) followed by Schools, other health professionals including School nurses and Tier 3 CAMHS service and self-referrals from parents.
- Assessments for Children who were admitted into Gateshead QE hospital as a result of self harm seen by the ICTS in 2013/14 included a total of 77 children under the age of 18 years.

3.4 Summary

- As a result of the data analysis Gateshead continues to have a higher rate of admissions as a result of Self Harm compared to the North East region. The gender differences for the data shows that females are more likely to self harm than males. Nationally and regionally mental health problems and self harm rates are increasing for young people. Further work is required for Gateshead to be confident that increasing rates of self harm data are not due to coding issues but reflect accurate rates of self harm for young people. The increase in rates of self harm could be due to the focus and awareness on self harm in Gateshead for professionals and as a result, better reporting of incidents and those seeking help.

4. Actions to address Self Harm

4.1 Action Plan

- To address the gaps in provision for self harm prevention and support the sub group have developed an action plan. The action plan covered the following areas:
    - Training
    - Data
    - Development of a policy/protocol
    - Opportunity to ask self harm related questions within the school health survey
- Washington Mind and the LSCB continue to offer self harm training to schools and professionals from within the children's workforce. In addition to this, the Emotional Wellbeing Team also continue to deliver and develop a general Mental Health awareness training programme to provide an overview of all mental health conditions which is included as part of the schools training directory.
- The Gateshead Self Harm Protocol has now been developed and has been shared with relevant groups such as CAMHS, LSCB and Designated Persons Safeguarding meetings. Comments and feedback have been received and any necessary changes have been made to the protocol which has generally been well received. The protocol borrowed heavily from the protocol that was developed by Nottingham as well as other areas in the UK. The next step is to disseminate this via relevant groups to professionals working with children and young people. The referral pathways that are to be included in the protocol are currently being finalised.
- Due to the low take up of schools that had signed up to participate in the last Health Related Behaviour Survey – the deadline for schools to participate in the survey was extended to the end of the 2014/15 academic year. Unfortunately no secondary schools signed up to complete the survey and as a result no information has been collected in terms of young people's thoughts, attitudes and feedback in relation to self-harm. Anecdotal reasons as to the low take up are that the survey was only offered to schools to

complete electronically as opposed to traditional paper based questionnaires due to the cost and also last year schools were having to work to a new curriculum that impacted on time.

- Following the publication of the Royal College of Psychologists Report – 'Managing self-harm in young people' CR192, October 2014, the self-harm sub group adopted the 14 recommendations laid out in the report that local areas should be adopting in order to manage self-harm in children and young people. The self harm sub group reports into the Gateshead CAMHS Partnership.

5. Summary

- Gateshead has a high proportion of hospital admissions as a result of self harm compared to the North East region. The highest proportion of those admissions occurs in the 20-24 year olds, with females more likely than males likely to self harm.
- Although there has been an increase in the numbers of young people presenting to A&E as a result of self-harm, there remains a large number of self-harm incidents that occur in the community and do not present to clinical services.
- The development of the Gateshead Self Harm Protocol along with greater awareness and sign up to training, will give professionals working with children and young people a greater awareness and more confidence in identifying, addressing and supporting incidents of self-harm in the future

6. Recommendations

- The committee is asked to note the content of the report and to provide comments on the information provided, and suggested areas for development.
- Agree to receive an update in 12 months following the implementation of the protocol, and to share the findings of the Health related behaviour questionnaire.

Contact: Emma Gibson Ext: 2845

Self Harm Protocol and Guidance

Children & Young People

Autumn 2015

Acknowledgements

Many thanks to the Gateshead CAMHS group and all our partners for their contributions in the production of this document.

Acknowledgement is given to Nottingham City Safeguarding Partnership who have given permission for us to use some of the material in their Inter-agency Practice Guidance.

Sections

- **Aims & Objectives**
- **What is Self Harm?**
- **Working with Self Harm**
- **Key Contacts**
- **Useful Websites**
- **Training**
- **Additional Documents:**

  - Assessment Form
  - Referral Pathway
  - Q.E. Hospital Referral Pathway
  - Care Pathway
  - Key Recommendations
  - Further Reading

Aims, Principles & Objectives

Aims

- To improve the quality of support, advice and guidance offered by staff working with children and young people who may be self harming or at risk of doing so.
- To support agencies communicating with children and young people in a way that encourages and enables engagement with support services.
- To support agencies in assessing and minimising harm for children and young people they are working with, with support from specialist services.
- To support agencies and young people working towards reducing self harming behaviours with less self risk taking behaviours and potentially life threatening coping strategies.

Principles

- Every young person should be treated as an individual.
- It is important for children and young people to be made aware of the confidentiality policy and implications around disclosure.
- Those working with young people need to recognise that dealing with the disclosure of self-harming behaviour requires them to exercise their existing core professional skills.
- Recognition of self-harm as a serious and sensitive issue with the focus being on working towards harm minimisation and supporting coping strategies.
- Intervention and support negotiated openly and honestly including speaking to the child/young person, professionals, parents and carers.

Outcomes

The key purpose of this guidance is to improve the understanding of, and services to, children and young people who self-harm. This will be achieved through:

- An improvement in the quality and consistency of response children and young people may receive from agencies when self-harming behaviour is disclosed.

- Improved support to children and young people in communicating their feelings and factors that have contributed to self-harming behaviour.
- Increased awareness by agencies and understanding of self harm including appropriate identification of risk and harm minimisation strategies.
- An understanding of the care pathway and where agencies, children, young people, parents and carers can go for support.

What is Self Harm?

Despite the fear and anxiety self-harming behaviour provokes, it is a comparatively common problem particularly among children and young people. Based on the local and national needs assessment, as detailed below, it is likely most people, either in their personal or professional life, will have come into contact with someone who self harms.

Working with children and young people who self harm can evoke a wide range of emotions including anger, frustration and sadness which often reflect the emotions of the child or young person who is self harming. One key message is that it is possible to recover from a pattern of self-harming behaviour and to learn other ways of coping with support from a range of professionals as well as friends and family.

Contrary to some beliefs self-harm is not generally about getting attention. It is often a very secretive problem and a young person can self-harm for a number of years before anyone notices or the young person finds the courage to tell someone.

Definitions of Self-Harm

The term self-harm is used to describe a range of things that children and young people do to themselves, some of which may be hidden. Self-harm is defined as self-poisoning or injury, irrespective of the apparent purpose of the act (National Institute for Clinical Excellence - NICE - 2004).

Self-harm is a serious public health problem and is the reason behind 142,000 national admissions, for the whole population, to accident and emergency

departments every year. Most of these are a result of self-poisoning. Self poisoning involves overdosing with a medicine or medicines, or swallowing a poisonous substance. The majority of people who attend accident and emergency departments have taken over the counter medication. The definition within the practice guidance or the NICE guidance does not apply to self-harm caused by other methods such as smoking, recreational drug use, excessive alcohol consumption over eating or food restriction. Some methods of self-harm are:

- Cutting
- Burning
- Scalding
- Banging or scratching the body
- Breaking bones
- Hair pulling
- Overdose
- Ingesting toxic substances or objects.
- Attempted hanging or strangulation

Of these, cutting is the most common method with few children and young people seeking medical attention or support.

Local Context-Gateshead

A local audit with a variety of professionals from the children and young people workforce in Gateshead highlighted a need for more awareness and training around deliberate self harm, results here:-

Deliberate Self Harm(DSH)-Consultation-Gateshead CH/YP Workforce 2013

1) **Do you have a policy/protocol for managing self-harm?**

21% ☑ Yes 79% ☑ No

2) **Do you have any screening/recording tools?**

34% ☑ Yes 66% ☑ No

3) **Do you have a process for informing parents/carers regarding incidents of self-harm?**

53% ☑ Yes 47% ☑ No

4) **Would a standardised policy/procedure/training for managing self-harm be helpful?**

96% ☑ Yes 2%☑ No-Nursery Age 2%☑ Probably

Local and National needs

Self-harm rates are much higher among children and young people than adults, with the most common age of onset around 12 years. It is estimated that nationally 25,000 children and young people aged 12–25 years are admitted to hospital every year for self-harm, most as a result of overdoses or cutting.

In the vast majority of cases self-harm is hidden and secretive with most children and young people making great efforts to conceal signs of self-harm. Research indicates that parents and carers are often completely unaware of incidents of self-harm.

Considering all the available research data a prevalence rate of between 1 in 12 and 1 in 15 is indicated in the 12–25 age groups. It is probable that two children and young people in every secondary school classroom have self harmed at some point.

The rates are four times higher for girls than boys, but it is also a serious problem in young men and can be disguised by hitting themselves or breaking bones as though they have been involved in a fight or been attacked. Groups of children and young people more vulnerable to self-harm include:

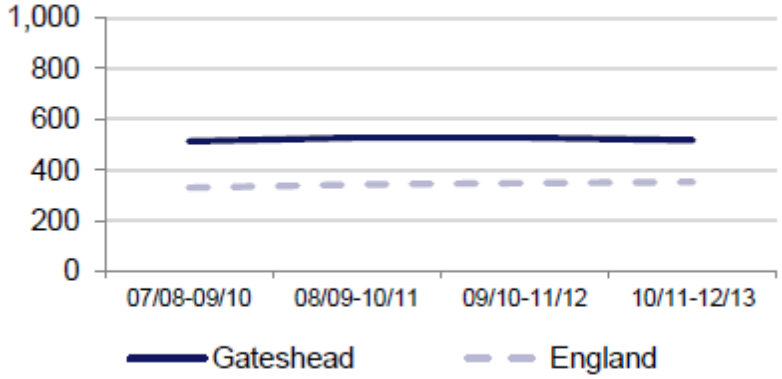
- Children and young people in residential settings.
- Lesbian, gay, bisexual and transgender young people.
- Young Asian women.
- Children and young people with learning disabilities.

Children and young people under the age of 20 years make up 22.5% of the population of Gateshead. 7.3% of school children are from a minority ethnic group. The health and wellbeing of children in Gateshead is generally worse than the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is worse than the England average with 23.8% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average.

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher

than the England average. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)



*Information about admissions in the single year 2012/13 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

Reasons for self-harming behaviour

It is often difficult to understand why children and young people self harm. Children and young people describe that by hurting themselves they are temporarily able to change their state of mind to better cope with painful feelings.

Self-harm provides a mechanism for dealing with intense emotional pain. However, with it comes the burden of emotional guilt and secrecy, which can have an affect on a child or young person's ability to build and maintain relationships. It can also quickly establish a pattern of addictive behaviour.

Some reasons indicated for self-harm include:

- Being bullied.
- Not getting on with parents.
- Stress and worry about academic performance and examinations.
- Parental separation or divorce.
- Bereavement and loss.
- Unwanted pregnancy.
- Experience of abuse including sexual abuse.
- Difficulties with sexuality.
- Low self-esteem.
- Feelings of being rejected or not fitting in.

The vast majority of children and young people who self-harm are not trying to kill themselves, rather they are trying to cope with difficult feelings by engaging in behaviour which temporarily relieves stress and anxiety but which can become very addictive. It is a method of distraction from painful feelings that children and young people then come to rely on. However many people
who complete suicide have self-harmed in the past, and for that reason each episode needs to be taken seriously and assessed and treated in its own right.

Working with Self Harm

Some indicators of self-harming behaviour

It is not always easy to tell if someone is self-harming and children and young people may find it difficult to approach services for support. This is partly because children and young people may feel ashamed and guilty about their behaviour. The stigma associated with self-harm can prevent children and young people getting the support and information they need to establish better
ways of coping. It is therefore important to be alert to the needs of children who are experiencing difficult or stressful circumstances, particularly when there are multiple factors present at the same time.

Front line staff dealing with disclosure

Many people who harm themselves have concerns about getting help. They may feel that professionals do not understand why they have harmed themselves and why their behaviour may still continue even when offered support. If self harm is revealed it is important to treat the child or young person with respect at all times and not to judge, but to listen and support. Assumptions should not be made about the reasons for self-harm and each episode needs to be treated individually.

Those working with young people (youth work, social work, health and education) need to recognise that dealing with the disclosure of self harming behaviour requires them to exercise their existing core professional skills. However, workers need to have a good awareness of the issues of emotional and mental well-being and self-harming behaviour in particular and managers
should ensure that they and their staff have received up to date training in this regard. Support to universal services is provided by tier 2 CAMHS Health and Well-being Teams.

As the child or young person who is self harming is likely to be experiencing problematic issues in a number of areas in their life the professional should discuss with the child or young person the possibility of undertaking a Common Assessment Framework (CAF) and/or, having a multi agency
meeting to identify the young persons needs.

Management of Self Harm Acts

If the self-harm act has occurred recently - within the last 48 hours and involved ingestion, serious burns or serious lacerations (with one or more large cut, or multiple minor cuts) – the child should attend the Emergency Department of the local hospital.

When an overdose is revealed the child or young person will need to be looked after in hospital.

- It is very important that the details about what has been taken and when are given to the hospital.

- It is important not to give anything to the child or young person to make them sick or make them want to go to the toilet or flush out their stomach or bowels.

What to expect in hospital

Whilst in hospital the child or young person will initially have their physical health needs dealt with and then they will also be given the opportunity to be seen by Specialist Mental Health Workers to look at their emotional well being.

The child or young person will then be offered further treatment depending upon what kind of medication has been taken and when or what type of injury they have.

Generally a young person under the age of 16 who attends the hospital with self harm will be offered an overnight stay to be looked after by the paediatric team. They will then be given the opportunity to talk to somebody from the child and adolescent mental health service (CAMHS) in more detail about:

- How they are feeling.
- What might have caused them to harm themselves.
- Their circumstances at home, at school, with friends.
- Their thoughts they may have had about suicide.
- To work out with them what help and support may be appropriate.

Young people aged 16 and over may be seen by someone from adult services.

If a young person refuses admission, the Emergency Department staff should undertake a risk assessment, contact Tier 3 Child & Adolescent Mental Health Services (CAMHS) - Children & Young Peoples Service (CYPS) Newcastle & Gateshead. CAMHS will arrange assessment/follow-up for the young person according to need. Please refer to the Queen Elizabeth Hospital, Gateshead Referral pathway in the Additional documents section.

If the self harm act has occurred after 48 hours –

- **Involving ingestion**
- **Serious burns**
- **Serious lacerations**

Urgent medical attention/ advice should be sought from Childs' GP or attend the Emergency Department of the local hospital.

Medical management of the self-harm act may still be necessary therefore medical advice is essential.

When self harm / or the intention to self harm is revealed (that is not in the above categories requiring medical attention) it is still important to take the young person seriously.

It is important to give them time to talk and space in order to explore some of the difficulties that may have occurred. Staff then need to be aware of the type of help and support that may be available or needed. It is also important to acknowledge that self harm is not automatically an indicator of mental illness. Therefore, not all incidents of self harm need to be dealt with by a referral onto Specialist Child and Adolescent Mental Health Services. For further details
please refer to the care pathway set out in the Additional documents section of this document.

Risk assessment

It is recognised that someone who has self-harmed is at greater risk of suicide than the general population. However, this does not mean that everybody that has self-harmed is an immediate suicide risk.

Consideration may need to be given to the completion of a risk assessment. If a person is referred to specialist mental health services this will be completed as part of a mental health assessment by a specialist mental health professional such as a specialist nurse, mental health practitioner or
psychiatrist.

Any assessment will be completed in relation to the whole person and their circumstances, including the self-harm.

One of the factors that should influence any risk assessment is whether the young person, and where relevant their parents/carers, is willing to engage with support services. If not this will potentially increase the level of risk. Where a family is referred for support by another agency but refuse to engage that agency should be contacted to discuss how best to respond to this. Agencies will need to consider all available options to manage such circumstances. In very serious situations this would include considering whether the threshold for an application for secure accommodation on welfare grounds should be made. The criteria for this are that the Local Authority must be able to demonstrate that the young person has:

A history of absconding and is likely to abscond from any other description of accommodation
AND
If s/he absconds s/he is likely to suffer significant harm
OR
If s/he is kept in any other description of accommodation s/he is likely to injure her/himself or other persons.

If a child/young person is in hospital and perceived to be at risk of significantly harming themselves or others then they should not be discharged until a plan has been agreed to try to manage this.

It is important that staff involved in making decisions regarding issues such as this seek the support of colleagues with sufficient seniority/experience to assist with the decision making process.

The Care Pathway set out at the end of this guidance provides a framework to enable workers to identify the types of services/tools that may be appropriate to deal with particular forms of behaviour.

Looked after Children

Young people who are looked after are a high risk group with regard to self harm, staff involved in their care should always seek appropriate support from their line management and should not manage self harm risks alone. Support should be sought from the Children & Young Peoples Service (CYPS) Newcastle & Gateshead. A formal plan should be drawn up and recorded and it should address:

- Actions to be undertaken including the planned assessment process
- Who needs to be informed
- The need to breach confidentiality – who to, how and in what circumstances
- How risk will be managed in different situation, e.g. during contact, any change of placement.

Consent, Competence and Confidentiality

Taking into account age and understanding, workers should always involve children and young people in discussion and decision making about their treatment and care.

Similarly there should be clear explanation about what is going to happen and the choice and rationale for certain treatments. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves.

Younger children who fully understand what is involved and can weigh up the information needed to make a decision can also give consent to their own treatment, although their parents will usually and ideally be involved. In other cases, someone with parental responsibility must give consent on the child's behalf. Information may be required from parents and carers or friends but in most cases the young person's agreement would be required before information is shared Information would only be shared without consent when:

- They are at risk of harm from other people.
- They require urgent medical treatment.
- They present a risk of harm to others

- They are at risk of serious injury to themselves.

Further advice and support can be obtained from individuals with a designated safeguarding and/or with reference to organisational protocols.

Child Protection

Self-harming behaviours can be a way of coping with an abusive relationship including a sexually abusive relationship, at home or in the community. Therefore, all staff working with children and young people need to be sensitive to the possibility that a young person may disclose abuse at the time of talking about what has led to their self harming behaviour. In such circumstances the Inter-agency Safeguarding Children Procedures should be followed.

Children and young people can be helped by:

- Recognising signs of distress and finding a way of talking to the young person about how they are feeling.
- Listening to their worries and feelings, and taking them seriously.
- Staying calm.
- Being clear about the risks but making sure they know that with help it is possible to stop self-harming.
- Using the Care Pathway to make sure they get the right help as soon as possible.

Additionally some children and young people may benefit from the use of alternative coping strategies. (Pg. 18)

Managing Self Harm

What Works Well - Principles for Practice

Managing a young person who self-harms in different environments

- In addition to this guidance there may also be practice guidance supplementing these developed for your specific area. These may be different according to the context/service. for example school, residential homes and health services may work to different parameters.
- It is also essential that each young person is assessed, managed, treated and cared for according to their specific individual needs – these needs should be clearly documented in health/social care plans.

Areas covered in this document:

- Working with people who self-harm and/or are at risk of suicide.
- Understanding self-harm and suicide.
- What works well – some key points
- Alternative coping strategies

Working with people who self-harm and/or are at risk of suicide.

1. **Spend time talking with and listening to the young person.** People who self-harm may not be emotionally articulate and may need help in identifying and describing what they feel but talking and feeling understood is important.

2. **Self harm may be a means of expressing what is on the inside and bringing it out:**

‘How will you know if you cannot see my pain?
‘I wear on my body what words can’t explain.’

Recovery involves identifying what is on the inside and building a working relationship with the young person to enable them to understand this.

3. **Get to know the person.** In order to assess risk and understand distress you need to know the person and understand their individual triggers.
4. **Encouraging young people to talk is important for recovery.** When people start to face their difficulties things can often feel worse before they feel better; this does not mean that we, as professionals are doing harm, but is a natural part of the process of recovery. Timing is often an essential stage of recovery for someone that self harms; people may not always be ready to face their problems, or in a stable place in their lives where this is safe to do. We need to consider
this when encouraging a young person to open up about their problems.

5. **The process of recovery can be slow;** however the sooner young people come forward for help, usually, the faster their recovery.

6. **Complete recovery is possible.** Maintain a sense of hope and hold it for the person as they will often feel hopeless.

7. **Self-harm is rarely attention-seeking, but can be a way of seeking help.** Empower young people to seek help in different ways and help them to recognise if they are starting to notice the drive to harm themselves. Seeking help when the distress first surfaces is more constructive.

8. **Regarding experiences of physical, sexual, emotional abuse or neglect,** it is not only the nature and severity of the experiences a young person has but the level of emotional impact that this has caused for the individual.

9. **Characteristics of high risk young people include: distress, isolation, feeling overwhelmed, lack of control and hopelessness**. Aim to work with the young people to talk through distress and isolation. Give hope and go through what can be tackled one at a time,
acknowledge what can't, give options and choices and be realistic and honest.

10. **Identify protective factors with the young person.** Who are their close/supportive peer relationships? What are their hobbies/interests/social

connections? Do they have positive self esteem? Do they have any hopes for the future – looking forward to events? Do they want help and support? Do they have cultural/religious beliefs that support self-preservation? How effective are their problem solving and conflict resolution skills?

11. **Adolescence is a period of rapid physical and emotional change characterised by stresses and tensions as the young person strives to establish an individual identity.** Some young people may be struggling with their sexuality and identity, it is important to be non-judgemental and allow them to talk without fear of prejudice.
12. **Try and avoid asking - why did you self-harm?** Remember they might not know or have the words to describe this; you could ask them to describe what happened, or what led up to the self-harm?

13. **Sometimes positive emotional states can precede an episode of self-harm-** perhaps they fear it won't last, or they don't deserve to feel positive things, or they find the extremity/intensity of emotions confusing and too difficult to handle and cope with.

14. **Be aware that whilst praise and encouragement are important, some young people find hearing praise difficult.**

15. **Ten minutes well-spent with the young person can make all the difference;** it can enable them to ride out the storm without turning to self harm and can be used to distract and support them.

16. There are **no 'magic solutions'** and **no 'alternative resources'** and no one person has **'all the skills required.'** Every person in the young person's life has their part to play in helping with their recovery.

Understanding self-harm and suicide

17. **Self-harm can be a coping strategy.** It can therefore be about coping and ultimately about staying alive by managing the difficult emotional states that a person is experiencing.

18. **It is important to assess the purpose of the self-harm**, if the young person expresses a wish to end their life, it may need to be managed and treated differently, but understanding this will enable you to think about how to help and which way to turn.

19. **A better predictor of suicide is the level of distress experienced.** This might not correlate to our perception of the level of trauma an individual has experienced, for instance, it may be precipitated by an incident of bullying or a body image crisis. It is important to understand
the individual impact that these experiences has on the person.

20. **Depression is a high risk factor for suicide.** If the young person has a mental health problem, this will need to be treated in its own right.

21. **Encourage the young person to sort out their own First Aid to separate the physical from the emotional care.** Instead focus on the distress and trying to engage them to talk about what has happened, this will demonstrate that we care about their difficulties and not just
that they have harmed themselves.

22. **A history of self-harm is a high risk factor for suicide, but most people who self-harm do not kill themselves.** For this reason it is essential to **acknowledge the distress and its**
causes, rather than only focus on the harm itself.

23. **Another risk factor for suicide is social isolation.** Helping a young person with this area of their lives is important to increase protective factors. What community or social contact does this young person have and can this be improved?

24. **Suicidal thinking doesn't always equate to suicidal intention.** Suicidal thinking and talking might be 'I have these thoughts sometimes'. Suicidal intent is the actual planning to end life. 'As long as there is life there is hope'; encourage a person to talk about their thoughts and feelings about suicide to understand where they are coming from.

25. **Planning suicide increases the risk of completing suicide, but so does impulsivity -** be aware of the triggers and risk factors for the individual and when these may increase, observe more closely, spend time with the young person.

26. **Where possible and safe, give responsibility and choice to the young person.** This is particularly important as they may feel powerless and out of control; encouraging the young person to take responsibility for themselves can help to give this control back and encourage resilience.

27. **Involve the young person in developing their own risk assessment.** What do you think increases your risk? How would you like people to respond? This will help them to feel in control but also develop their understanding of their own problems which can be instrumental in recovery.

28. **Involve the young person in discussions about managing their safety.** As a minimum keep young people informed and involved in decision making, giving reasons for decisions; be honest and clear wherever possible.

29. **Self-harm can be competitive so risks may be heightened through contact with others who self-harm.**

30. **Ten minute rule – An effective strategy for some young people who want to reduce/stop cutting.** Get them to agree with themselves that they will postpone cutting for 10 minutes (or another set period of time). Then fill those 10 minutes with a distracting activity. They may choose to go ahead following this or postpone again for a little longer.
The intention is that the young person learns to sit with distress, and builds their resilience. They own the decision-making.

What Works Well? – Some Key Points

Positive Relationship

- A key person that cares.
- Listen, don't always try to solve, encourage them to talk.
- Inject hope… overcome your own feelings of being overwhelmed.
- Explore and support professional help, but don't underestimate your importance.
- Empower and support them to take control of their decisions.
- Your support and care is more important than what you say: You can say the wrong thing in the right way!

Constancy

- 'Being there' for someone is more important than any skill –research evidence about people achieving change. (Harmless crisis consultation showed that above all else the thing that people found most helpful in reducing distress and risk associated with suicide was being listened to, not judged and feeling cared about – echoes work of Nock)
- Often we may feel overwhelmed and want to refer 'the problem' onto 'specialists' that we imagine have more time and skills in this area, when often these ideals probably don't exist. You may know and understand the young person better than most and are in the best possible position to help them if you are who they have chosen to turn to.
- Plan and advocate for consistent responses across all professionals.

Prepare and Plan

- Draw up a multi-agency plan agreed by the young person, based around their risks and needs, informed by a CAMHS consultant/clinician.
- Involve the young person in planning and decision making where possible.
- Involve the family according to needs of young person, e.g. reducing the causes of distress may reduce the incidence of self-harm.
- In reducing suicide risk, practical resources such as the availability of ligature cutters with appropriate staff training are paramount.

Alternative Coping Strategies

A number of young people report that they find alternative coping strategies techniques useful. However it is extremely important to recognise the need for individual techniques as otherwise this approach will not work. Some of the most useful alternative coping strategies used by a range of young people include:

Distraction Techniques	**Positive Emotional Techniques**
Cleaning and/or Tidying Washing clothes Playing games – cards/board games/ computer Sports exercise – walking/running/dance Gardening/plants Visiting a friend Telephoning a friend Paint or draw pictures/posters/cards Write letters Puzzles Watch TV/video Listen to music/Walkman Cinema Shopping Hobbies – sewing, knitting, collecting	Read old letters Look through old photos Listen to emotional music Watch funny/heart-warming film Read joke book Say positive statements to self Make an emergency bundle Read your list of assets or strengths Self-voice tape
Emotional Focusing	**Alternative 'Safer' Forms of Self-Harm**
List emotional triggers Write poetry/prose regarding feelings Paint/draw emotions Write a diary Discuss feelings with another person Rainy Day letter	Hold ice in hand Squeeze rubber ball Listen to very loud music Rubber band on wrist Throw things/scream, punch cushions Body paint Stand under very hot/cold shower Break sticks
Comforting Techniques	**Relaxation Techniques**
Hold a safe object Sit in a safe place Listen to soothing music Sing favourite songs Use perfume/hand cream Spray room fragrance Hug someone Buy fresh flowers Eat a favourite food Have a soothing drink Have a bubble bath Soak your feet Change the sheets on your bed Stroke your pet Wear comfortable clothes	Guided fantasy dreamtime Focus solely on breathing/breath deeply Count your breaths Focus on the position of your body Relax each muscle individually Listen to relaxation music Listen to guided relaxation on tape Meditation Yoga Massage hands, feet, head etc.

Key Contacts

Local Contact Details

Queen Elizabeth Hospital Accident & Emergency Dept. – **Tel: 0191 445 2171 or 0191 445 5930**.

Newcastle & Gateshead Children and Young People's Service (CYPS) – Tel: **0191 246 6913**

Gateshead Emotional Wellbeing Team – **Tel: 0191 283 4560**

Gateshead LSCB - **Tel: 0191 433 8010**

Gateshead Referral & Assessment Team - **Tel: 0191 433 2653**

National Support Organisations

Child Line

A confidential 24-hour helpline for children and young people.

Tel: 0800 11 11 www.childline.org.uk

Samaritans

Confidential, non-judgemental helpline offering support 24 hours a day.

Tel: 08457 90 90 90 Minicom: 08457 90 91 92

Email: jo@samaritans.org www.samaritans.org.uk

Useful Websites

Harmless - 🕸 www.harmless.org.uk/

National Self Harm Network - 🕸 www.nshn.co.uk/

Young Minds

🕸www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm

Epic Friends - 🕸 http://epicfriends.co.uk/self-harm

Self Injury Support - 🕸 www.selfinjurysupport.org.uk/

The Site

🕸www.thesite.org/healthandwellbeing/mentalhealth/selfharm

Mental Health Foundation

🕸www.mentalhealth.org.uk/help-information/mental-health-a-z/S/self-harm

Health Talk – Self Harm Advice

🕸www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

LifeSIGNS – User-led Self Injury Charity

🕸www.lifesigns.org.uk/

Mental Health and Deliberate Self Harm TRAINING Available in Gateshead

SCAMHP (Short Child and Adolescent Mental Health Programme)

All schools and settings

Aim: This course is an introduction to:

- ★ Mental health, risk and resilience
- ★ Children's development and mental health
- ★ Mental health problems
- ★ Interventions and what helps

Area/subject: Covers a range of basic child and adolescent mental health information

Who is it for?: This training is suitable for anyone working with children and young people in Tier 1/Universal settings i.e. schools, children's centres, education and voluntary sector.

For more information please contact Emotional Wellbeing Team-Gateshead CAMHS on Tel: 0191 283 4560

Mind Ed – Mental Health Awareness E-learning

Working with children and young people can be complicated. When problems arise, you need to have information that you can trust at hand to give you the confidence to swiftly make the right decision for those in your care.

But there is so much information available these days; it's hard to know where to begin or where to turn for a definitive answer. Understandably this can create uncertainty which can delay or prevent action. The evidence shows,

however, that when mental health problems are identified early, outcomes are improved. This is where MindEd can help.

MindEd provides free practical e-learning sessions including self-harm when and wherever they're needed, quickly building knowledge and confidence to identify an issue, act swiftly and improve outcomes for children and young people.

Start using MindEd now, it's free and easy to use. Visit
http//:www.minded.org.uk

Gateshead LSCB Training - Young People Who Self Harm

Aim: To increase awareness and confidence of professionals who work with young people who self harm.

Learning objectives:
At the end of the sessions the delegates will be able to:

- List the main forms of self-harm
- Identify significant risk factors for self-harm
- Describe how young people who self-harm are assessed and managed
- Look at the impact self-harm has on children, young people and their families
- Identify what support is available to parents and carers of young people who self-harm
- Identify risk factors for a worse prognosis following self-harm

Suitable for: People working with children and/or their families, and people in adult care services who work with young people who are self-harming or likely to self-harm.
Training level: 3

BOOK through Gateshead Learning & Development ONLINE Booking :-
http://www.gateshead.gov.uk/Learning/home.aspx

MIND - Understanding Self Harm Training Workshop

Aim: Self injury/harm is far more common than is generally realised. This half day training course is for frontline staff and volunteers who wish to increase their knowledge and raise their awareness and understanding of the difficult issue of self –harm.

Learning Objectives:

- What is self-harm?
- Statistics of self-harm
- Why do we self-harm?
- The Cycle of Self Harm
- How to support someone who self-harms
- Signposting and support services.

For more information please contact Washington Mind by Telephone: 0191 4178043 or Email: **training@washingtonmind.org.uk**

Training around the Digital Lives of children/young people

Safeguarding Children & Young People in the Digital Age – Gateshead LSCB Training

To provide staff who work with children and young people with an understanding of the key risks posed by the use of digital technologies such as internet access, mobile phones and digital photography and strategies that can be put in place to manage these risks. The session will also look at the responsibility upon staff to act as positive role models regarding the use of digital technology. www.gateshead.gov.uk/Learning/Course-description/Safeguarding-Children--Young-People-in-the-Digital-Age.pdf

Children and Young People's Digital Lives - MindEd Online Training FREE

This session is aimed at a universal audience and will describe how the use of digital and online technologies is a major part of children and young people's lives, outlining some of the risks they may encounter and what to do in relation to them. It will also highlight the importance of professionals and parents showing an interest in and talking on an everyday basis to children and young people about their digital usage and online experiences. www.minded.org.uk/course/view.php?id=164

Digital Media and Young People – MindEd Online Training FREE

This session is aimed at more experienced/specialist worker and develops ideas from Children and Young People's Digital Lives to give some understanding in a rapidly changing field of the developing interactions as children grow up in a digital world. It also examines the impact of this world on children and young people vulnerable to, or suffering from, mental health disorders. www.minded.org.uk/course/view.php?id=277

Additional documentation / information

NTW Children and Young Peoples Service (CYPS) - Service Leaflet

NTW Children and Young Peoples Service (CYPS) - Information for Referrers Leaflet

NTW Children and Young Peoples Service (CYPS) - Referral Form

Gateshead Out of Hours Support – Information leaflet

Local Contact Details

Gateshead Emotional Wellbeing Team – **Tel: 0191 283 4560**

Children & Young Peoples Service (CYPS) Newcastle & Gateshead – **Tel: 0191 246 6913**

Queen Elizabeth Hospital Accident & Emergency Dept. – **Tel: 0191 4452171 or 0191 4455930**.

Gateshead LSCB – www.gateshead.gov.uk/lscb/home.aspx

Gateshead Safeguarding Nurse (Health): **0191 283 1374**

Gateshead Council's Children's Social Care: **(0191) 433 2653** (office hours, Mon-Fri 8:30am-5:00pm)

or **(0191) 477 0844** (out of office hours at night, at weekends and bank holidays)

Gateshead Self Harm Care Pathway
What to do if you are concerned about a young person self-harming

Tier 1 – Universal Services	Tier 2 – Targeted Services	Tier 3 – Specialist Services	Tier 4 - Highly Specialist Services
Low level risk self-harm Superficial, minor self-harm in stable social context. Some indicators of good emotional health, functioning well. No evidence of suicidal intent. Good support networks.	**Repeated & more worrying self-harm behaviour.** More frequent or severe self-harm. More pervasive stressors, poorer coping strategies and fluctuating mental health. SH that presents alongside mild-moderate MH problems e.g. depression	**Persistent & severe self-harm**. More complex, frequent, high risk behaviours – concerns re isolation, substance misuse, suicidal intent. SH that presents alongside moderate- severe MH problems e.g. depression and trauma. Poor support/ protective factors.	**High risk suicidal behaviour** Concerns about severe mental health disorder, where risk cannot be managed in the community.
What action should you take?			
Promotion of healthy ways of expressing emotions. Talk to YP, ideally encourage parental involvement. Self-help information, coping strategies. If situation deteriorates seek consultation and support from Tier 2 and possible referral via CAF	Continue working with YP, gather info, involve network around the YP. Assess & monitor risk. If situation deteriorates inform YP worried – may need additional support, consultation, joint working or referral to Tier 3 via single point of access. Access consultation via CYPS	Work with YP on agreed plan, access clinical supervision & MDT support. Monitor risk & review progress. If situation deteriorates consider Tier 4 assessment.	Assess & develop management plan for mental health & suicidal behaviour. Involve & transfer to Tier 3 when risk reduced assessment/ treatment complete.
Services and help available			
Tier 1 – Universal Services School nurse, youth workers, GP, Schools, Colleges	Tier 2 – Targeted Services Emotional Wellbeing Team, Children & Young Peoples Service(CYPS)	Tier 3 – Specialist Services Children & Young Peoples Service(CYPS)	Tier 4 - Highly Specialist Services Inpatients

Monitor & document concerns, seek appropriate supervision and involvement of line manager.
IN THE CASE OF AN EMERGENCY REFER YOUNG PERSON TO THEIR GP OR HOSPITAL EMERGENCY DEPARTMENT IMMEDIATELY
YP under 16 who attend emergency department for self-harm will be admitted & assessed by Tier 3 CAMHS. 16 & 17 year olds will be assessed by Adult Mental Health Services and referred to CAMHS (EDT) for follow-up.

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Key Recommendations

CR192 **Managing self-harm in young people**

RCPSYCH College Report. October 2014

Commissioning in relation to self-harm

Recommendation 1 - For self-harm presenting to the acute hospital, commissioners need to be mindful that multiple services are involved. Therefore, service specifications for all relevant services should include recognition of the importance of self-harm in young people.

Recommendation 2 - Commissioners need to stress the importance of collaborative working between the acute hospital, mental health services and the local authority in responding to a young person's self-harm. Commissioners need to prevent fault lines developing between services, where possible. Pressing for joint protocols and agreed pathways is a good way of promoting collaborative working.

The role of all front-line Professionals

Recommendation 3 - Asking about self-harm does not increase the behaviour. It is important that all front-line professionals become familiar with asking about self-harm when talking with young people who are struggling with changes in their lives.

It is important that the young person is clear about confidentiality, with limits outlined right at the outset of a conversation. This does not discourage young people from disclosing their difficulties.
When a young person presents with an episode of self-harm it is important to establish whether there is a risk of self-poisoning or other physical health risks because of suicidal ideation. Asking the questions does not increase the likelihood of harm coming to the young person. Every encounter with a suicidal person is an opportunity to intervene to reduce their distress and, potentially, to save a life.

These points can be summarised as follows.
Try to avoid:

- reacting with strong or negative emotions:
    - alarm or discomfort
    - asking abrupt or rapid questions
    - threatening or getting angry
    - making accusations, e.g. that the young person is attention-seeking
    - frustration if the support offered does not seem to be making a difference

- too much focus on the self-harm itself:
    - engaging in power struggles or demanding that self-harm should stop
    - ignoring other warning signs

- promising to keep things a secret.

It is helpful:

- when talking to the young person to:
    - take all self-harm seriously
    - listen carefully, in a calm and compassionate way
    - take a non-judgemental approach and try to reassure them that you understand that the self-harm is helping them to cope at the moment and that you want to help

- make sure they understand the limits of confidentiality
- if there are safeguarding concerns, follow local safeguarding procedures#
- help the young person to identify their own coping strategies and support network
- offer information about support services

- when talking to others to:
  - control contagion – look out for impact on the young person's peer group
  - offer support to peers as needed.

If a young person has self-harmed through self-poisoning, attendance at an emergency department is necessary. This is because it is often hard to quantify the risk involved following ingestion of a substance, so a cautious approach needs to be exercised. Emergency department attendance will help with evaluating both physical health and mental health risks. In self-injury the physical health risks may be more easily quantifiable since the result may be visible, as in cutting. This means that emergency department attendance to evaluate physical harm may not be necessary. However, the front-line professionals must pay attention to mental health and safeguarding risks, evaluate them in line with their training and expertise and act accordingly. A mental health risk assessment may also be needed.

Recommendation 4 - Front-line professionals should be able to carry out the basics of a mental health risk assessment.

This should include asking about the history of self-harming behaviour as well as trying to understand the part it plays in coping. It is critical to ask about suicidal ideation and any continuing suicidal intent. Basic family and social information should be gathered if not already known. It is worthwhile screening for characteristics known to be associated with risk, notably depression and hopelessness.
In some instances, a more extensive mental health risk assessment will be needed. If this is the case, there are various options, such as referral to an emergency department, referral to specialist CAMHS or consulting with colleagues. This must be decided on a case-by-case basis.

Input from schools

Recommendation 5 - Many school staff feel unskilled and unsupported in dealing with pupils' self-harm, so it is important that schools prioritise the self-harm training needs of their staff along with other mandatory training. This support is crucial for staff to feel confident in supporting young people in an effective, non-judgemental manner.

Collaboration between schools and statutory and voluntary agencies is crucial in the ongoing support of young people who self-harm, so that knowledge improves, service access is maintained and services build towards better outcomes for these individuals.

Roles of specialist CAMHS

Recommendation 6 - Young people who self-harm should be involved in the planning and delivery of training.

Emergency departments should seek the help of mental health service colleagues in training their staff.

All Tier 2 and Tier 3 staff should be trained in the assessment of children and young people who self-harm. This training should include knowledge of the Mental Health Act 1983 as well as capacity and consent. Training should include the impact of the stigma surrounding self-harm.

A number of useful publications and online resources are listed in the Appendix, in particular:

- MindEd e-learning modules, which offer free training about a broad range of mental health problems in children and adolescents, including self-harm; they are written with a general rather than a professional audience in mind, so are intended to have a wide reach
- general mental health resources include the *Toolkit for GPs* (Freer, 2013), about the mental health consultation in general practice
- *Mental Health in Emergency Departments– A Toolkit for Improving Care* (College of Emergency Medicine, 2013)
- Connecting with People's 4 Areas Assessment (Cole-King *et al*, 2011) gives a useful framework for assessing risk following self-harm.

Assessment and interventions for acute presentation to hospital

Recommendation 7 - In line with NICE guidance, young people under the age of 16 seen in the emergency department following acute self-harm presentations should be admitted. Admission should be to a paediatric, adolescent or medical ward or to a designated unit. This is indicated regardless of the individual's toxicological state so that comprehensive physical and psychosocial assessments can occur and management/crisis intervention can be planned and initiated.

Recommendation 8 - For 16- to 17-year-olds, a developmentally sensitive and risk-proportionate approach should be taken. The objectives continue to be detection of difficulties and high-quality mental health assessment and planning, focused on the most vulnerable young people. If these objectives can be met and safe discharge planned, then it is suggested that a young person aged 16–17 seen in the emergency department following an acute self-harm presentation does not always need to stay overnight. However, if in any doubt, admission should follow.

Mental health risk assessment and planning

Recommendation 9 - Where concerns arise about care quality or significant harm, joint assessment by social care and health services staff should be arranged, with local procedures to reflect this.

Joint protocols for the management of self-harm

Recommendation 10 - It is recommended that a consultant paediatrician (local lead) and a consultant child and adolescent psychiatrist be nominated as the joint service leaders. They should work together to ensure that protocols for assessing, caring for and treating young people who harm themselves are negotiated with and agreed between their employing trusts or directorates, where they are different. Additionally, they should press for the resolution of operational difficulties and delivery of appropriate training to paediatric ward and emergency department staff.

Acute presentation to hospital: roles and responsibilities of involved staff

Recommendation 11 - All professionals involved in the assessment and management of young people who self-harm, should ensure that good-quality care is provided in a non-judgemental, confidential manner, respecting the young person and their family with a view to emotionally supporting recovery and treatment. At all stages, unhelpful critical comments can raise barriers to future help-seeking and should be strictly avoided.

Liaison services for acute presentations to hospital

Recommendation 12 - An essential component of liaison provision is for arrangements to be in place for young people to be assessed on all days of the year, including weekends and Bank Holidays.

Professional engagement in digital lives

Recommendation 13 - It is critical for professionals to include an assessment of a young person's digital life as part of clinical assessments, especially when there are concerns about self-harm.

Parental involvement and supervision

Recommendation 14 - It is important for parents to be interested and engaged in their children's digital lives as early as possible.

Further Reading

HM Government. Preventing suicide in England: Two years on
Second annual report on the cross-government outcomes strategy to save lives. February 2015.

Mental Health Foundation.The truth about self-harm for young people and their friends and families. 2012.

Mental Health Foundation. Truth Hurts: Report of the National Inquiry into Self-harm among Young People. 2006.

NICE Clinical Guidance 16. Self-harm. The short-term physical and psychological management and secondary prevention of self harm in primary and secondary care. July 2004.

NICE Quality Standard for self-harm. NICE quality standard 34. June 2013.

NSPCC Inform. Young People Who Self-Harm: Implications for Public Health Practitioners (Child Protection Research Briefing). NSPCC. 2009.

Royal College of Psychiatrists. CR158 Self-Harm, Suicide and Risk: Helping People who Self-Harm: Final Report of a Working Group College Report. CR158). 2010.

Royal College of Psychiatrists. CR192 Managing self-harm in young people. RCPSYCH College Report. October 2014.

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
22 October 2015

TITLE OF REPORT: **Review of Child Protection in Gateshead – Second Evidence Gathering**

REPORT OF: **David Bunce, Strategic Director, Care Wellbeing and Learning**

SUMMARY

Council has agreed that this committee should review how the child protection system operates in Gateshead. The review will examine each stage of the process and will explore the way decisions are taken, risks are managed, and the involvement of partners. The review will explore how Gateshead undertakes its safeguarding responsibilities in conjunction with partners within the policy context and legal frameworks for Child Protection.

The review will provide the committee with an overview of how the child protection process works in Gateshead and provide examples of how Gateshead children's social work service operates in conjunction with partners to ensure children's safety. It will focus in particular on the ways in which services operate collectively, review the evidence and contribute to the future development and delivery of child protection within Children's Social Care Services.

Background

1. The Committee agreed the scope of the review at its meeting on 18th June and proposed that the focus of this review will be on the specific aspects of the system which are concerned with child protection. The review will follow the potential steps for a child who becomes subject to a child protection plan.

2. It is suggested that the key issues which this review will need to address are:

a. An understanding of the child protection system, the policy context and clarity on roles and responsibilities.

b. The opportunity for improvement of systems, processes and improving efficiency.

c. The effectiveness of multi-agency working, especially around communication and information sharing.

d. The ways in which the views of children, young people and their families are used.

3. The first evidence gathering session on the 10th September provided the committee with a precis of the legislative framework and statutory guidance, and set the scene for how the child protection system is organised and delivered in Gateshead.

Second evidence gathering

4. This second evidence gathering has been developed to provide the committee with an overview of how children and young people are referred into children's social care, the thresholds that govern at what level the child and family should be assessed and how the level of support is determined to meet their needs.
5. The session will enable the committee to follow the journey of a child and their family to illustrate the steps and considerations social workers make when delivering their service from the point of referral through to the end of the **Child in Need (CIN)** assessment.

Referral and Assessment

6. **Working Together Guidance** provides the framework for interagency working and sets out specific arrangements for how children should be referred and assessed within the arena of safeguarding and promoting the welfare of children.

7. Where the criteria for child in Need (as defined by the Children Act 1989) are thought to be met, a referral should be made to the local Children's Social Care team, the Referral and Assessment Team, who will consider the need to undertake a statutory assessment. Where an assessment is deemed appropriate, a Social Worker will complete the assessment within 45 working days.

8. Local authority children's social care has the responsibility for clarifying the process for referrals. Anyone who has concerns about a child's welfare should make a referral to local authority children's social care. For example, referrals may come from: children themselves, teachers, a GP, the police, health visitors, family members and members of the public. Within local authorities, children's social care should act as the principal point of contact for welfare concerns relating to children. Therefore, as well as clear protocols for professionals working with children, contact details should be signposted clearly so that children, parents and other family members are aware of who they can contact if they require advice and/or support.

9. When professionals refer a child, they should include any information they have on the child's developmental needs and the capacity of the child's parents or carers to meet those needs.

10. Feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold to be considered by local authority children's social care for assessment and suggestions for other sources of more suitable support.

11. In Gateshead both contacts and referrals are recorded on Carefirst. During the last 4 years we experienced an unprecedented number of child referrals peaking at 2,434 by the end of March 2014. In the following year referrals declined to a level more in line with figures pre 2012. By the end of the year 2014/15 there had been 1720 referrals 93.7% of which led to a Child in Need

assessment. In the first 2 quarters of 2015/16 we have experienced a slight increase 900 referrals having been received, 886 of which went on to a CIN assessment, 98.4%. A 10% increase in the number of CIN assessments being carried out this year.

12. In 2013/14 the figures for referrals made per 10,000 of children aged under 18 years were; Nationally 573 per 10K, North East region 659.8 per 10k and 604.1 per 10k in Gateshead. Referral figures across the region fell by 12% during 2014/15 compared to the previous 12 months, in Gateshead we experienced a more significant fall of 29% however, the current picture as above is showing a moderate increase.

13. Over the last 5 years the proportion of referrals from various sources has remained fairly consistent with the majority coming from police/probation/courts as detailed below.

Referrals by referring agency		2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Anonymous	%	1.8%	1.7%	1.7%	2.2%	3.2%	3.2%
Friends/Family		11.5%	12.1%	11.4%	10.1%	9.1%	7.6%
Gateshead Department		7.8%	8.4%	8.7%	7.6%	10.1%	10.4%
Health		19.6%	18.8%	19.3%	17.9%	19.1%	20.2%
Other		10.6%	12.8%	11.4%	13.5%	11.2%	10.0%
Police/Probation/Courts		31.7%	33.2%	34.5%	34.9%	34.2%	33.2%
School/Education		14.7%	10.8%	11.4%	11.9%	11.0%	12.8%
Self		2.3%	2.2%	1.7%	1.8%	2.1%	2.6%

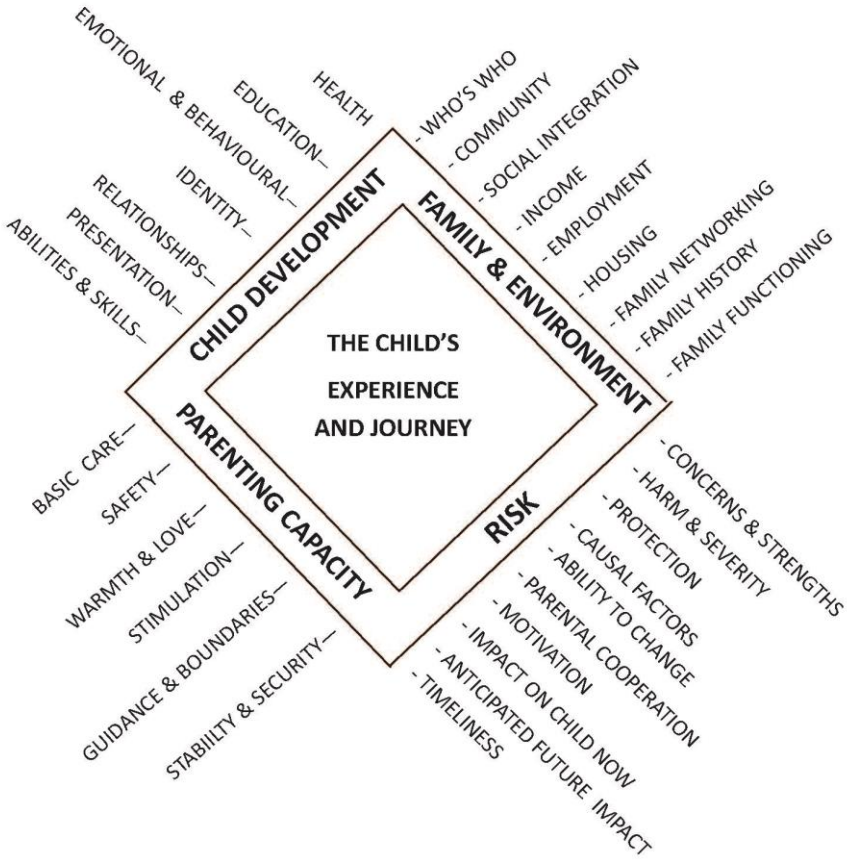
The Assessment Framework

14. In 2013 a regional assessment framework was developed to ensure that assessments across the region were compatible in terms of quality standards, style, content and timescale in order to facilitate the transfer of cases across boundaries. The work was commissioned by the regional Vulnerable Children's Safeguarding Network.

15. Whilst Working Together re-stated the traditional 3 domains of assessment;

i. Child development
ii. Family environment
iii. Parenting capacity

The regional framework added the additional domain of risk that should be considered in all assessments. The diagram below shows the areas that social workers consider under each domain.



16. The regional guidance describes assessment as the *methodical collation of information which allows the practioner to identify, through analysis and evaluation, the risks to, and the needs of, the child and family. Crucially the assessment should provide the practioner with a level of understanding about the child and the family context to enable an appropriate plan to be formulated which builds on child and family strengths and addresses the areas requiring change in order to improve the child's outcomes and keep them safe. Through this process the practioner will develop an understanding of those factors and indicators which denote the likelihood of success within a timescale appropriate for the child. The assessment process and consideration of such factors and indicators will also provide the practioner with an indication of which services are the most appropriate to be involved with the child and family to meet the identified needs*.

17. In order to ensure that assessment is completed in a timely fashion and that there are clear opportunities for management oversight clear check pints have been established which take place at the 10 day point, 28 day point and 40 day point. At each check point the social worker and their line manager should have regard to the following:

- Consider the information that has been gathered and how other agencies have or should contribute - this should include consideration of agencies or services that are currently involved in providing services to the child or family and whose involvement will need to feature in the planning for the child. This is particularly relevant where there are or have been specialist assessments under part 3 of the Children and Family Bill (when enacted in early 2014) or for example assessments undertaken within youth justice or Child and Adolescent Mental Health Services.
- Consider from the perspective of the child(ren) the current circumstances
- Consider and evaluate the level of parental engagement in the process
- Identify information that is not yet known and how this will be gathered
- Discuss on the basis of known information if services should be provided immediately to improve the outcomes for the child
- Consider if a different course of action is needed
- Discuss emerging hypotheses and how these will be tested
- Discuss and begin to formulate a proposed plan for the child
- Consider the need to hold a multi-agency meeting to discuss progress and coordinate involved specialists in the formulation of a single plan
- Agree the anticipated timescale for completion
- Record the discussion and agreed actions on the Carefirst system

18. The principles for assessment are also set out within the regional guidance stating that all assessments should adhere to the following:

- The child is at the heart of the assessment.
- The child's known or perceived experiences will form the corner stone of plans which will be designed to improve the outcomes for the child.
- A working agreement will be agreed with the family that clearly states:
- why an assessment is needed
- who will undertake the assessment
- how the assessment will be conducted and who needs to be involved
- the anticipated timescale
- what is expected and what can be expected
- Assessments will be concluded within a timescale that ensures the needs of the child are understood and are addressed in accordance with identified need.
- Assessments will be conducted openly and honestly with children and their families and will actively involve them in the assessment and planning process.
- Assessments will take due consideration of the context within which the child lives, the views and wishes of the child and their carers, and be

conducted in such a way so as to facilitate their involvement and engagement.

- Assessments will identify strengths as well as areas of concern
- Assessments will be evidence based and where appropriate reference current research in support of the conclusions reached.
- Assessments will include information from other professionals as appropriate and be integrated in approach
- Where there is more than one child the assessment process will specifically consider each child individually
- Areas of disagreement will be taken seriously and considered with the family. The child and family will have information that informs them how to make a complaint.
- Assessments will result in a single plan designed to coordinate professional intervention.
- Plans will be reviewed with the family and their effectiveness monitored.

19. In Gateshead the majority of assessments are undertaken by the Referral and Assessment team (82%). However where the support provided to is ongoing there is a need to re-assess, either when there is a significant change in circumstances or in line with our quality standards which ensure children have up to date assessments that are no older than 2 years old so that a clear and relevant picture is available to support the planning for the individual child.

20. Between April 2014 and March 2015, a total of 2010 CIN assessments were completed. Of these, 1961 (97.7%) were completed within timescales. The national figure for completion within timescale stands at 82.2% (CIN census 2013/14)

21. Between April and September 2015 a total of 1007 CIN assessments have been completed. Of these 964 (95.7%) were completed within timescales. Currently there are 322 open CIN assessments

Thresholds

22. The multi-agency thresholds document provides guidance for professionals and service users, to clarify the circumstances in which to refer a child to a specific agency to address an individual need, to carry out a Common Assessment Framework (CAF) or to refer to Children's Social Services.The Indicators of Need document describes the criteria for access to Children's Social Services/Care in Gateshead and how that fits within the wider context of multi-agency services and a range of needs. It is intended as a guide to assist practitioners in deciding, either at the initial screening stage or following an assessment, whether a child has additional needs and at what level or by what agency those needs could best be met. (The document is attached at appendix A)

Level 1: Baseline = Universal Services
Level 2 : Moderate = Targeted Services
Level 3: High = Specialist Social Care Services

External Scrutiny

23. In 2013 Ofsted undertook inspection of the Local Authority's arrangements for child protection provide they considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Gateshead's overall effectiveness was judged to be good. Ofsted noted a number of areas of strong practice including In relation to referrals they judged that:

> 'Partner agencies in Gateshead understand thresholds well and apply them consistently when making appropriate referrals to children's social care' and also that
>
> 'Historical information is effectively analysed and documented well within the contact and referral record and this informs sound decision making.'

In relation to assessment they reported that:

> 'Assessments are timely; child focused and routinely consider historical information, clearly identifying risk and protective factors. The quality of analysis is good and leads to recommendations which coherently address identified needs. Assessments of unborn babies are undertaken at an early stage and appropriately identify potential risks and strengths… The assessment process supports effective case planning and results in targeted interventions to reduce risk and the provision of appropriate support'

24. In July 2014 Gateshead took part in a themed inspection of assessment carried out by Ofsted the subsequent report was published in August 2015. In their feedback to senior managers Gateshead inspectors reported that assessments were of good quality and were rich in information and that they had seen evidence of the positive change to social workers' approach to analysis.

Evidence gathering continued

25. It is proposed that future evidence sessions will review the following aspects of the child protection system:

- 3 December 2016 – third evidence gathering report – Strategy discussions, meetings and S47 investigations
- 21 January 2016 – fourth evidence gathering report – Child protection conferences, plans and reviews

Recommendations

26. Committee members are invited to:

i. Comment on this second evidence gathering;
ii. Outline any additional information / evidence they wish to have included in the review at this second evidence gathering stage.

Appendix A

THRESHOLD DOCUMENT

Delivering a Continuum of Integrated Support: Indicators of Need and Service Response

1. Introduction

The foundation of the Indicators of Need and Service Response is based on Gateshead's Common Assessment Framework (CAF) Protocol. The Protocol states that every child and young person in Gateshead, whatever their circumstances, will have the support they need to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

Effective multi-agency working and the Lead Practitioner role are key elements of improving outcomes for children and young people through the provision of integrated support. Team Around the Family (TAF) is a framework for joint and multi-agency working for all children, and young people and families with additional needs.

All children and young people with additional needs, and particularly those who require integrated support from more than one practitioner, should experience a seamless and effective service. This includes the lead practitioner taking overall responsibility for coordinating support and services through a written CAF / TAF plan that achieve agreed outcomes.

2. Aim

Gateshead Council and partners recognise that early intervention and preventative work with children, young people and their families can reduce the risk of abuse, family breakdown and social exclusion. It is Gateshead's aim to reduce and attempt to eliminate the extent to which vulnerable children and young people are at significant risk of harm and/or their life chances are impaired through a co-ordinated approach to the CAF, TAF and support plans by universal, targeted and specialist services.
Working Together to Safeguard Children 2013 asks professionals to be alert to the potential need for early help for a child who:

- Is disabled and has specific additional needs
- Has a special educational need
- Is a young carer
- Is showing signs of engaging in anti-social or criminal behaviour
- Is in family circumstances presenting challenges for the child, such as substance misuse, adult mental health, domestic violence and or
- Is showing early signs of abuse and or neglect

Using the Indicators of Need

Professionals and partners from a variety of agencies, particularly health, education and community services, are often in the best place to identify whether a child or their family are experiencing difficulties and have additional needs. The indicators of need framework is intended as a guide to assist practitioners in deciding, either at the initial screening stage or following an assessment, whether a child has additional needs and at what level or by what agency those needs could best be met:

- **Level 1: Baseline = Universal Services**
- **Level 2 : Moderate = Targeted Services**
- **Level 3: High = Specialist Social Care Services**

These indicators of need are not prescriptive and are designed to assist practitioners in using their professional judgement to gauge what level of intervention will be most appropriate.

Level 1: Baseline = Universal Services

If a child's needs are being met in accordance with this baseline level, this would indicate that the child is making good progress across all areas of their development and there would be no need for any additional supports other than those accessed through universal services.

If a child's needs are mostly being met in accordance with this baseline but there are one or two needs identified in Level 2 below, this would indicate that overall the child is making good progress across most areas of their development but may need additional support from a single agency to maximise life chances. A CAF may help to focus the support needed and the strengths within the family to maximise future resilience.

Level 2: Moderate = Targeted Services

If some of a child's needs are being met in accordance with the baseline (Level 1), but there is a cluster of needs identified in Level 2, this would indicate that they have some significant needs that are not being met and without intervention or support their health and wellbeing will be impaired. If ignored, these issues could develop and lead to adverse outcomes where risks increase over time leading to statutory intervention.

These children will require a co-ordinated multi-agency response. The interim lead practitioner would undertake a CAF assessment to identify the needs and initiate a Team around the Family meeting bringing together practitioners from the services required to meet the identified needs, develop a single multi agency support plan, and identify the most appropriate person to undertake the lead practitioner role.

Tools for undertaking a CAF assessment and initiating a TAF are available here:

http://www.gateshead.gov.uk/childrenstrust/Training/Training.aspx

Level 3: High = Specialist Services
If a child's needs are mainly clustered in level 3 (or have a number of needs clustered in level 2, with some needs identified at level 3) a referral to the Social Care Referral and Assessment Team would be appropriate. A decision will then be made within 1 working day as to whether a child in need assessment is necessary.

The purpose of the assessment is to gather important information about the child and family, analyse their needs, risks and protective factors and decide if the level of need identified would indicate that they are a Child in Need under section 17 Children Act 1989 and or at serious risk of significant harm or are suffering significant harm. Enquiries under section 47 of the Children Act 1989 may need to be instigated; this decision would be made at a strategy meeting/ discussion by a social care manager, police and health professional following a referral or as the outcome of an assessment.

Following enquiries it may be necessary to remove a child from their home to a safe
place this can either be under a voluntary agreement with parents (section 20 Children Act 1989) or through initiating legal orders. The Local Authority will always take legal advice before making these decisions.

The children who have needs identified at this level are our most vulnerable children and need a multi-agency response led by a Social Worker. During the assessment process a care team meeting may be organised to enable the child, family and professionals to share information and contribute to the outcome of the assessment. Further information about how to make a referral to social care is available here: http://www.gateshead.gov.uk/lscb/Worried-for-a-child/Worriedforachild.aspx

4. Professional judgement

Professional judgement should be used at all times; the indicators of need are not exhaustive and children's needs do not always clearly fit into specific levels. Therefore if the needs are spread across the levels, a judgement should be made as to where the greatest need lies and an assessment should be undertaken to analyse these needs, drawing on the strengths of the family and protective factors to balance risk and determine the best way to support the family.

Needs change over time and therefore the service response is expected to be used flexibly so that the child and their family are supported by a range of professionals through a continuum of seamless integrated working.

If professionals feel they need support or advice in making a judgement they should

discuss this with their line manager and / or contact the following service for advice from a Social Worker ;**Referral and Assessment Team Duty on 0191 4332653 or 4332349 or 4332505.**

5. Planning

Effective planning requires agencies and professionals to work in partnership with each other, the child and their family; this will ensure support is appropriate, co-ordinated and tailored to the assessed needs. At the conclusion of a CAF or CIN assessment where the assessor has identified further support would be beneficial an interagency team around the family meeting or outcome meeting should be held. The purpose of the meeting will be to draw together the findings of the assessment and formulate any plan required, including a contingency plan, identify who would be most appropriate to lead the plan and agree timescales for review.

6. Specialist Services - Referral and Assessment Team

The role of all professionals working with vulnerable children is to safeguard and minimise risk of harm, promote positive lifestyles, and develop resilience for children to maximise life chances. However, where there are clear concerns that a child is in need of protection you should contact the Referral and Assessment Team immediately, including in the following situations:

• A child with an unexplained or suspicious injury.
• Observed injury or suspicious bruising.
• A child who has alleged physical or sexual abuse.
• A child who is suffering specific incidents of emotional abuse or neglects that is harming, or likely to harm their health and/or development (including non-organic failure to thrive).
• A child who is physically injured in an incident of domestic abuse (even inadvertently).
• A child living in a household where a person deemed to be a risk to children has moved or has plans to move or there is regular contact.
• Suspected induced or fabricated illness.
• Serious concern about the risk of significant harm to an unborn baby or where children have been previously removed or adopted.
• A young/vulnerable child left alone (if the child is known to be alone the police should be contacted immediately at that time).
• Sexual activity in children under the age of 13.
• Concerns about sexual exploitation or trafficking.

The following children are also entitled to a CIN assessment:

• Unaccompanied asylum-seeking children.
• Young carers.
• Homeless 16 and 17 year olds.
• Disabled children

LEVEL 1: BASELINE Universal (Single agency)

Health	Education	Emotional and Behavioural Development	Identity	Family and Environmental	Parenting Capacity
Appropriate height and weight for age Physically healthy Developmental and medical checks up to date Adequate and nutritious diet Regular dental and optical care Good state of mental health No misuse of substances	Enjoys and participates in educational activities and school life No concerns around cognitive development Regular school attendance Access to books, toys as appropriate Good links between home and school	Good quality attachments/ relationships Demonstrates appropriate responses in feelings and actions Able to adapt to change Able to demonstrate empathy	Positive sense of self and abilities Demonstrates feelings of belonging and acceptance by family / peer group No experience of bullying due to ethnicity, sexual orientation, disability, or poverty	Adequate income with resources used appropriately to meet child's needs Accessing universal services in neighbourhood Accommodation has basic amenities and appropriate facilities Good family networks and friendships outside of the family unit Good relationships with siblings	Protection from danger / significant harm in the home and community Shows warmth, praise and encouragement No substance misuse issues Supportive relationship between parents, including when separated / divorced

Notes:
These indicators are intended to assist practitioners in making a decision regarding a child / family's needs. They are not exhaustive and no single indicator should be taken out of context.

If a child's needs are being met in accordance with this baseline above, this would indicate that the child is making good progress across all areas of their development and there would be no need for any additional supports other than those accessed through universal services.

If a child's needs are mostly being met in accordance with this baseline but there one or two needs identified in Level 2 below,, this would indicate that overall the child is making good progress across most areas of their development but may need additional support from a single agency to maximise life chances.

A CAF may help to focus the support needed and the strengths within the family to maximise future resilience.

LEVEL 2: MODERATE Targeted (CAF team around the Family)

Health	Education	Emotional and Behavioural Development	Identity	Family and Environmental	Parenting Capacity
Not registered with a GP/Dentist Preventative health measures not taken, e.g. dental checks, vision, hearing, immunisations. Some missed health Appointments Medical advice and treatment not consistently adhered to Inadequately nutritious Diet Speech, language and communication delay Developmental delay Unexplained wetting and Soiling Experimental alcohol and substance misuse Risky sexual activity (under 16 years)	Under stimulated - lack of positive interaction through play Lack of parental encouragement to learn Not reaching education/learning potential. Low aspirations Poor links between home and school Often late for school; tired during lessons impacting on ability to learn Often hungry at school/nursery Poor attendance	At risk of involvement in criminal activities and anti social behaviour or involved in low-level offending Lack of self control in response to change or challenge Low-level self-harming Challenging behaviour in home and community Disruptive behaviour and inability to control anger Withdrawn	Experiences of bullying and discrimination due to ethnicity, sexual orientation, disability, or poverty Low self image, doesn't feel valued Low self-esteem Difficulties in relating to peers Poor hygiene and / or inappropriate clothing leading to alienation from peers	Some level of poverty or debt impacting on household and child Lack of family support Isolated in the Community Home in poor repair with lack of some basic amenities Threat of eviction Stressful family Relationships Child's clothing is regularly unwashed and frequently ill-fitting Child is a young carer	Inconsistent Parenting Parents critical and show inconsistent warmth, praise and affection Inexperienced parent who needs support. No family network Domestic disputes No effective Boundaries Problematic alcohol and substance misuse Some concerns regarding attachment to child Significant or enduring physical or mental health issues

Notes:

• These indicators are intended to assist practitioners in making a decision regarding a child / family's needs. They are not exhaustive and no single indicator should be taken out of context.

• If some of a child's needs are being met in accordance with the baseline (Level 1), but there is a cluster of needs identified in Level 2, this would indicate that they have some significant needs that are not being met and without intervention or support their health and wellbeing will be impaired. If ignored, these issues could develop and lead to adverse outcomes where risks increase over time leading to statutory intervention. These children will require a co-ordinated multi-agency response (CAF/TAF).

LEVEL 3:HIGH Specialist (Child In Need Assessment Social Care)

Health	Education	Emotional and Behavioural Development	Identity	Family and Environmental	Parenting Capacity
Severe developmental delay, failure to gain weight or average expected rate of growth for age Unexplained or suspicious injury Multiple A&E/ Walk-In Centre attendance None compliance with medical treatment resulting in impaired health Failure to seek medical attention for significant injuries or ailments Sexual activity under 13 Years Sexual exploitation Problematic substance and alcohol misuse	Significant underachievement proportionate to child's ability None school attendance Parent encourages or colludes in absence from school Constantly late for school; tired during lessons impacting on ability to learn Constantly hungry at school/nursery	Suicidal thoughts Significant self harm or eating disorder Extreme anxiety or depression Constantly missing from home Behaviour beyond parental control – violent, abusive etc Risk to self and others	Rejected by parent, no positive relationship resulting in no sense of belonging within family No sense of individuality or positive view of themselves Feelings of self-loathing leading to deterioration in mental health	Serious poverty or debt impacting on household and child Frequent changes of living situation – transient (accommodation and household members) Home environment highly unsuitable exposing child to risk of injury or significant harm to health Failed asylum seeking family with children under 18r	Serious neglect of primary needs Inability to protect child from sexual, physical, or emotional harm Domestic violence on a regular basis witnessed by child No engagement with school or nursery Multiple carers Home alone (relevant to age) Misusing alcohol and substances when in sole care of the child which overrides their ability to meet basic needs of child No longer want to care for the child

These indicators are intended to assist practitioners in making a decision regarding a child / family's needs. They are not exhaustive and no single indicator should be taken out of context. If a child's needs are mainly clustered in level 3 (or in the level 2, but there are some needs identified at level 3) this would indicate that they may be at serious risk of significant harm or are suffering significant harm. These are our most vulnerable children and need a multi-agency response led by a Social Worker. Please refer to list of circumstances for immediate referral to the Referral and Assessment Team.

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Gateshead Council

FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
22 October 2015

TITLE OF REPORT:	**Expanding Minds, Improving Lives: an update on the work of the collaborative commissioning of children and young people's mental health services**
REPORT OF:	**David Bunce, Strategic Director, Care Wellbeing and Learning**

Summary
This report summarises the work underway to redesign children and young people's mental health services across Gateshead and Newcastle. It outlines the status of the project, emerging themes and timescales, as well as links to the Transformation Plans required by NHS England.

1. Introduction and background

1.1 In January 2015 NHS Newcastle Gateshead Clinical Commissioning Group, Newcastle City Council and Gateshead Council agreed to work together with their communities to plan what needs to happen locally to transform the emotional wellbeing and mental health provision for children and young people and their families across Newcastle and Gateshead.

1.2 Nationally, regionally and locally there is a recognition that the emotional wellbeing and mental health needs of children and young people and their families are not being met and this project aims to address this through a fit for purpose local response.

1.3 "Expanding Minds, Improving Lives" is a time-limited project which has been established to drive the transformational change in Newcastle and Gateshead. "Expanding Minds, Improving Lives" is led by a Principal Public Health Consultant and benefits from a dedicated Project Manager. A small project team, made up from representatives from each of the three collaborative partners drives the day to day work of the project.

1.4 The project's vision is that:
'*Our communities are enabled to improve the emotional health and wellbeing of children, young people and families, who will thrive through access to the right support at the right time.'*

2. Progress to date

2.1 The Advisory Group

The project has established an Advisory Group as a means for “Expanding Minds, Improving Lives” to share early thinking with key stakeholders, who have knowledge and experience of working with children and young people and mental health services, so that they may guide and influence the development of the project.

Membership of the group is broad and includes parent/carer representatives, school leaders, community and voluntary sector representatives, Healthwatch and universal, targeted, and specialist providers. The group has met three times, and will continue to meet on a monthly basis, and is very well attended.

2.2 Young Commissioners

The project has commissioned Youth Focus, a voluntary organisation based in Gateshead, to recruit, develop and support a group of young people aged 13 to 19 (or up to 25 if the young person has learning difficulties or disabilities) to become co-commissioners who will help to shape future mental health services for children and young people and their families across Newcastle and Gateshead.

Once the Young Commissioners are trained (Autumn 2015) they will act in a challenge and scrutiny role, encourage wider involvement of young people, and will have a role in decision making throughout this process.

2.3 Action!: Story

Targeted engagement with children engaged with mental health services has begun. Action: Story! delivered by Helix Arts, aims to empower young people aged 9 to 14 who access CAMHS to have a voice in the commissioning process for this service. By taking part in a film project, the young people will be given an opportunity to express how they feel about their journey within the service and how they would like to see it change. They are working with professional filmmakers and designers in workshop settings to explore and voice their experiences. The filmmakers and designers will also work separately with commissioners to explore the issues raised and feedback to the young people as an iterative process throughout the project.

A younger age range was selected for this targeted piece of work, to ensure representation from younger children outside of the scope of the Young Commissioners role.

2.4 Moving from the “Collaborative Commissioning Project” to “Expanding Minds, Improving Lives”

To make the transformation project more meaningful to children and young people and their families, a workshop with young people was held to name the project. Through this workshop the name “Expanding Minds, Improving Lives”

was developed, with the strapline “Motivating and working together to transform children and young people’s mental health”.

2.5 Baseline Positions Statement – The Case for Change

The project team has prepared a detailed baseline position statement which sets out:

- The impact of mental health on children, young people and families
- Prevalence of mental ill health
- Current service provision including performance
- Resources
- Summary of the wider services supporting children and young people (e.g. universal and targeted)
- Feedback from previous engagement

The baseline position statement will form the ‘Case for Change’ and will continue to develop as communities share their experiences of the current system.

The baseline position statement was shared with the Project Board on 17th September, and will shortly be available on the “Expanding Minds, Improving Lives” webpage on the CCG’s website.

2.6 Launch of the Listening / Pre-consultation Stage

The project has commenced the “Listening / Pre-consultation” phase of the project where stakeholders will be provided with the opportunity to share their experience of the current mental health system, and get to start to think about how any new system should be provided. The project has designed a multi-faceted engagement plan which will include stakeholder events, focus groups, surveys, and social media.

The first stakeholder events have taken place, with targeted events for school staff, including professionals working into schools e.g. school nurses. Announcements of upcoming stakeholder events will be made shortly.

The “Listening / Pre-consultation” phase will run until the middle of November when the focus of the project will shift to working with our communities to develop how services should be provided in the future.

During this phase, early engagement with the respective Health and Wellbeing Boards, Scrutiny Committees and Children’s Trusts Boards will take place to ensure members have the opportunity to influence the emerging proposals.

A timeline for the redesign process is included in Appendix 1.

3. Interface with the Local Transformation Plan

3.1 The Department of Health requires all clinical commissioning groups to submit a Local Transformation Plan to outline how mental health services for children and young people will be transformed over the next 5 years.

3.2 NHS Newcastle and Gateshead CCG are working with Newcastle and Gateshead councils to produce its Local Transformation Plan in light of the collaborative approach adopted locally.

3.3 The Local Transformation Plan is centred on “Expanding Minds, Improving Lives”, as it is the time-limited project which will drive the transformation of local services. Within the Local Transformation Plan are a number of key priorities which will be included as key lines of enquiry within “Expanding Minds, Improving Lives”.

4. Recommendations

4.1 Members are asked to note the progress of the project to date.

Contact:	Martin Gray / Emma Gibson	ext:	3919 / 2845

Appendix 1

Collaborative Commissioning – High Level Project Timescales

Stage	Description	Dates
Establishing the baseline	Getting the detail about our story - marking out what we want to change and what we don't, and why the system should transform. Developing the case for change	13 April 2015 - 31 July (16 weeks)
Pre-consultation and listening	Taking 'our story' to the community - service users, children and young people, parents and carers, families, providers and commissioners- and listening to what we hear	3 Aug 2015 - 13 November 2015 (15 weeks)
Co-producing a new model of emotional wellbeing care and support	Working together to design a new system that enables people to thrive through prevention and early intervention, and when necessary specialist support	16 November 2015- 29 January 2016 (11 weeks)
Formal Consultation	Formally consulting on the proposed new system	1 February 2016- 28 April 2016 (12 weeks)
Implementing	Putting our new system in place	May 2016 - 28 April 2017

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
22 October 2015

TITLE OF REPORT: Role of the Council in Supporting Educational Outcomes with a particular focus on Vulnerable and Poorly Performing pupils

REPORT OF: David Bunce Strategic Director - Care, Wellbeing and Learning

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Summary

Council agreed that the Committee should review how the Council supports educational outcomes in Gateshead, with a specific focus on vulnerable or poorly performing pupils. This is in recognition of the rapidly changing educational landscape, including the emergence of Academies, the increasing autonomy of schools, and the promotion of "school to school" support as the vehicle for school improvement. The review has focused on the Council's overall role, remit and approach and will, in addition, focus on vulnerable children through a focus on the use of Pupil Premium and improving the educational outcomes of Looked After Children.

This report gives an update on the progress, to date, following the Committee's and Cabinet's approval of the report.

1. Background

The Committee identified the following recommendations from the review:-

Information and transparency

a. On an annual basis, the Committee to receive a pupil performance data report that focuses upon the gap between disadvantaged and other pupils. This "closing the gap" report to show performance trend over time and to be school specific.

b. While the secondary "closing the gap" initiative is active, for Committee to receive an annual assessment of impact.

Governor's role in supporting and challenging school leaders on 'closing the gap'

c. The Governing Body Support team to review its training programme to ensure that Governors have access to a range of courses that support them in holding school leaders to account.

The strategic delivery of education services

d. Care, Wellbeing and Learning to review the implementation of the Council's Education Strategy to:

- review how support for the most vulnerable pupils is provided and funded;
- determine how a focus on school improvement can be best delivered in view of the ongoing financial constraints
- ensure the right balance between core funded services and those traded

Special schools

e. An annual conversation with special schools to include examples of innovative work to achieve outcomes.

f. The specific issues around support for pupils with complex health needs. Agree to focus a case study in the 2015/16 work programme on the issues around targeted and specialist support from the NHS for special schools. This will focus on the delivery of therapeutic support, the role of the Community Children's Nursing Team and Continuing Care.

2. What has happened since completion of the review?

The findings of the review were agreed by Committee on 2nd April and presented to Cabinet for comment on 2nd June. Officers have begun to implement the necessary changes or reviews in response to the Committee's findings.

Information and transparency

- Reports have been produced for pupil performance data that are in line with the reviews finding based on 2013/14 examination data i.e. the reports show school specific "gap data" between disadvantaged pupils and others. 2014/15 examination analysis is well advanced.

- The Headteacher of the virtual school for looked after children has produce a "data dashboard" that specially details the performance of looked after children. This dash board will be produced on an annual basis.

- An annual assessment of the impact of the secondary "narrowing the gap" project has been incorporated in to a senior officer's performance management targets.

- The Governing Body and Inspection Teams have begun to review and assess the present Governors' development programme. The key theme is supporting Governors to give robust but appropriate challenge to school leaders. The theme of developing appropriate challenge for Governors will be central to the Governing Body Team's Business/Action plan.

The strategic delivery of education services

- The strategic delivery of education services is a key part of the Council's reviews that are taking place at this time as a response to a reducing budget. To retain high quality provision and intervention that delivers excellent outcomes for children and young people at a significantly reduced cost will need highly creative and innovative thinking.

Special Schools

- Special Headteachers will welcome the opportunity to both share concerns and successes with Committee on an annual basis.

- The extension to Eslington School, on the Tyne View site, has been completed and is running. Children and staff are extremely positive about their new building.

- The Case Study exploring the issues around targeted and specialist support from the NHS for special schools has not yet been discussed with the Special Headteachers.

3. What impact has this had for users?

At this stage the data does not exist to show that there has been an impact on schools or children and young people. The work across education teams is ongoing and the findings from the Committee have begun to direct the approach.

4. What will we do next?

- Data analysis of 2014/15 Key Stage 2 SATS and GCSEs will be carried out following statistical release in line with the Committee's requirements.

- A reviewed approach/programme to developing the skills of Governors to appropriately challenge school leaders will be created and shared based on the present good practice.

- The Council will continue to assess the likely impacts of a significant reduction in funding. This will include how and want it wishes to fund in Education and all other services. This may require the development of new delivery models.

- Special Headteachers and Council officers will plan the Case Study that investigates the issues around targeted and specialist support from the NHS for special schools. This will focus on the delivery of therapeutic support, the role of the Community Children's Nursing Team and Continuing Care.

5. Recommendations

The views of the OSC are sought on:-

- Whether the OSC is satisfied with progress against actions to date?

Contact:	Steve Horne	ext 8612