Nottinghamshire Healthcare NHS
NHS Trust
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Nottingham City Council

Joint Protocol – Nottingham City Children's Social Care and Child and Adolescence Mental Health Service (CAMHS)

1. Introduction

1.1 This protocol aims to promote effective joint working between Nottingham City Children's Social Care and CAMHS, to ensure a coordinated approach to self-harm where there are also Child Protection or safeguarding concerns (e.g. domestic violence).

1.2 Services Involved:

This Protocol will apply to staff working within;

- Nottingham City Children's Social Care
- Disabled Children's Team
- Nottingham City CAMHS (Tier two service)
- Nottinghamshire Healthcare NHS Trust CAMHS (Tier Two and Three service)

1.3 Purpose of the Protocol:

The main aims of the protocol are to;

- Strengthen the quality of support, advice and guidance offered to young people who self-harm, or may be at risk of suicide;
- Ensure the needs of children and young people who self-harm are routinely considered for joint assessments undertaken by both Children's Social Care and CAMHS. This doesn't necessarily mean both workers have to see the young person at the same time, but that both have a role to play and work to do;
- Ensure the needs of the child/young person are fully considered by way of a joint assessment / joint visit / professionals meeting.

1.4 The protocol provides a clear framework outlining to staff what is expected;

- From them as an individual practitioner;
- From their practice when they are working jointly;
- From their service.

1.5 In their practice staff adhering to the Joint Protocol must ensure that they refer to Nottinghamshire and Nottingham City Safeguarding Children Boards Safeguarding Children Procedures, the Boards Children and Young People

who Self-Harm Interagency Practice Guidance and the Family Support Pathway.

1.6 This document provides some definitions and updated guidance of the risks associated with self-harm.

2. Definitions of Self-Harm

2.1 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).

Some methods of self-harm are:

- Burning using cigarettes or caustic agents
- Cutting
- Scalding
- Punching and bruising
- Breaking bones
- Inserting or swallowing objects
- Head banging, pulling hear or scratching the body
- Pulling out hair or eyelashes
- Restrictive or binge eating
- Overdosing of tablets or medicines
- Inhaling or sniffing or ingesting harmful substances
- Attempted hanging or strangulation

NB Although self-harming behaviour can be an attempt to cope and manage and may not be accompanied by suicidal intent, it must be recognised that the emotional distress that leads to self-harm can also lead to suicidal thoughts and actions.

3. Suicide

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

3.2 Suicidal intent is indicated by evidence of premeditation (such as saving up tablets), taking care to avoid discovery, failing to alert potential helpers, carrying out final acts (such as writing a

suicide note) and choosing a violent or aggressive means of self harm allowing little chance of survival.

3.3 The vast majority of children and young people who self-harm are not trying to kill themselves, however many people who die through suicide have self-harmed in the past, and for that reason each episode whether planned, accidental or spontaneous needs to be taken seriously and assessed and treated in its own right.

4. Risk indicators of Self Harm and Suicide

4.1 The following table lists behaviours and situations that could indicate risk of self-harm or suicide in young people. This list is offered as a guide and not as a diagnostic tool. Whilst protective factors can reduce risk, their absence clearly increases vulnerability to self-harm. Developing protective factors is an important means of reducing risk.

	Risk Factors	**Protective Factors**
Characteristics of the individual child	• Low self esteem • Increasing age • Poor coping skills • Insecure Attachments • Difficult temperament • Mental distress or illness, e.g. anxiety/depression • Alcohol/substance misuse • Stress or worries about school work or peers • History of similar behaviour in the past • Past or current experience of abuse • Feeling isolated • Recent bereavement	• High self esteem • Higher ability/attainment • Outgoing personality • Good coping skills • Positive school experience • Secure attachment • Resilience • Knowledge of where to seek support
Features of the immediate context	• Access to means of causing self-harm • Being alone • Social exclusion • Alcohol and drugs • Negative social networking	• Access to social support social inclusion
Family Factors	• Family members who self-harm	• Supportive adult relationship

	• Family conflict • Parental separation and divorce • Not living with both biological parents • Family Parental illness (physical/mental) • Parental alcohol/drug misuse • Emotional Harm • Neglect • Sexual/physical abuse • Poverty/low socio-economic status • Domestic violence Pressure from family to achieve at school	• Harmonious family relationships • Low level of material or social hardship • Good role models within family
Peer group	• Arguments with friends Bullying • Friends who self-harm • Loss of a friend	• Stable and secure friendship group
School/college	• Pressure from school to perform well • Transition/move to another school • Poor relationships with adults	• Supportive adult • Inclusive/incorporative ethos • Strong commitment to PSHE mental health promotion • Establishment of peer support systems
Wider culture and community	• Minority status • Problems in relation to race, culture or religion • Problems regarding sexual orientation or identity • Media portrayals glamorise self-harm or suicide 'victims' and elicit 'copy-cat' responses by vulnerable children and young people	• Access to social support

5. Assessment of Risk and Interventions

5.1 An early assessment of self-harm should take place to ensure that the child

or young person gets timely and appropriate support. Practitioners need to be aware that risk factors are not, nor can they ever be, tools for prediction. The risk indicators provide a guide for practitioners to assess the nature and severity of the problem to minimise risk, increase safety and ensure appropriate access to services. Practitioners need to be mindful that any risk assessment can only be valid at the moment at which it is carried out and therefore might need to be repeated at regular intervals according to professional judgment or advice.

5.2 Risk of self-harm is not the same as risk of mental illness, and one does not need to be mentally ill to self-harm, although there may be links. Wherever appropriate children and young people should be seen alone. The assessment should be holistic gathering information from other sources, such as parents or carers, other significant adults, peers, and other professionals. It should take into account any parenting capacity issues for the parents/carer (i.e. mental health, substance misuse, domestic abuse) and how this impacts on the child(ren) and whether:

- the parenting being provided is adequate to meet the needs of the child (ren);
- the parenting is having an impact on the young person's self-harm behaviour.

5.3 NB Where a child or young person refuses to engage in the assessment

or

Support, consideration needs to be given to the use of the Mental Health Act

6. Consent

6.1 If a young person is deemed to need support from other professionals the worker supporting the individual will:

- Seek consent from the young person to share information
- Tell the young person what information will be shared, why it should be shared and the consequences of sharing.

6.2 Sometimes concerns of significant harm may lead to a referral being made without consent. However, it is highly recommended to seek consent where possible.

7. Levels of Risk and Suggested Intervention

7.1 The order of the factors in the below list is not necessarily significant, as they are all worthy of consideration. When assessing risk practitioners need to consider the duration of the thoughts and if the young person has planned/researched methods.

Level of Risk	Risks	Actions
Low Risk	• Suicidal thoughts are fleeting and soon dismissed • No plan • No signs of psychosis (delusional thoughts and behaviours) • Superficial, minor self-harm in stable social context. • Current situation felt to be painful but bearable. • No alcohol or substance misuse	• Ease distress as far as possible. Consider what may be done to resolve difficulties • Link to other sources of support • Make use of line management or supervision to discuss particular cases and concerns • Review and reassess at agreed intervals. • Consider completing a Common Assessment Framework (CAF).
Raised Risk	• Suicidal thoughts are frequent but still fleeting • No specific plan or immediate intent • Evidence of current mental disorder, especially depression or psychosis • Unstable psychological situation with impending crisis • Significant drug or alcohol use • Situation felt to be painful, but no immediate crisis • Previous, especially recent, suicide attempt • Current self-harm • Change in method of act of self-harm and impulsivity of harm	• Ease distress as far as possible. Consider what may be done to resolve difficulties • Consider safety of young person, including possible discussion with parents/carers or other significant figures • Seek specialist advice • Possible mental health assessment – discussion with, for example primary mental health worker, Child and Adolescent Mental Health Service (CAMHS) or G.P. • Consider consent issues for the above • Consider increasing levels of support/professional input • Review and reassess at agreed intervals – likely to be quicker than if risk is low. • Promote hopefulness and build on self-confidence by engaging in future orientated conversation
High Risk		

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	• Frequent suicidal thoughts, which are not easily dismissed • Specific plans with access to potentially lethal means • Evidence of current mental illness • Unstable psychological situation with impending crisis • Significant drug or alcohol use • Situation felt to be causing unbearable pain or distress • Increasing self-harm, either frequency, potential lethality or both. • Member of a high risk group e.g. LGBT/LAC/Learning disability • Child/young person has lost a friend/family member through act of suicide	• Ease distress as far as possible. Consider what may be done to resolve difficulties • Safety – discussion with parents/carers or other significant figures more likely (immediate action to secure safety) • CAMHS referral • Consider consent issues • Consider increasing levels of support/professional input in the mean time • Monitor in light of level of CAMHS involvement • Utilise problem solving techniques • Promote hopefulness and build on self-confidence by engaging in future orientated conversation • Explore previous coping strategies

8. Referrals to Screening and Duty involving self-harm and Child Protection or Significant Children in Need Issues

8.1 In the event of the Children and Families Direct receiving a call that relates to self-harm and there is either Child Protection or significant Children In Need issues and the case is not known to Children's Social Care then the referrer will be immediately put through to Screening & Duty Children's Social Care or the Disabled Children' Team if the child has a severe and lifelong disability.

8.2 All open cases will be directed to the case-holding team whether that is Children's Social Care or the relevant team within Families and Communities. If at point of the referral a Children's Assessment is identified as being required and self-harm is present, the identified Social Worker can seek consultation/advice from CAMHS or request a joint visit where appropriate.

8.3 Where a child has a diagnosed disability, any additional concerns/vulnerabilities need to be assessed within the context of his/her disability. When little is known or understood about the impact or consequences of a child's disability, advice, information and possibly ongoing consultation should be sought from the Disabled Children's Team, even when a referral may not

be appropriate or the child does not meet the criteria for the Disabled Children's Team.

9. Referrals made by Non CAMH's practitioners

9.1 Duty Social Worker Responsibilities

- Ensure that the correct information is gathered from the referrer to support their referral.
- Consider the need for a joint approach (visit/assessment) with CAMHS Tier 2.

9.2 Where the referral is accepted and it is agreed that a joint approach with CAMHS Tier 2 is required the Duty Social Worker will contact the Single Point of Access (SPA) on 0115 8764000 to request a joint working arrangement. In the case of a high risk suicidal behavior or severe self harm the Duty Team can contact the CAMHS Tier 3 Duty Service on 0115 8440500.

10. Referrals (Screening and Duty Team and Disabled Children's Duty Team) and requests made to Children's Social Care (Community Fieldwork Teams) or disabled Children's Team by CAMHS practitioners

10.1 Where it has been identified that there are potential safeguarding or complex concerns in relation to self-harm, any subsequent visits or assessments should be undertaken by the Social Worker or DCT worker and a CAMHS Tier 2 Practitioner. Screening and Duty have 10 working days from the date of the referral in which to conduct, populate, review and complete the assessment. As part of the joint assessment the CAMHS worker could undertake a Tier 2 Self-harm and Needs Assessment. On completion of the assessment the CAMHS worker would make recommendations for further intervention. (High Risk – Tier 3 CAMH'S, Medium Risk- Tier 2 CAMHS, Low Risk –Universal Services). Where a child/young person has presented at hospital due to self harm or suicidal behaviors a Self-harm and Needs Assessment will be undertaken by the hospital Self – Harm Team or by the on call Doctor (weekends). Where it is identified that there are safeguarding issues Children's Social Care will be notified and a discharge planning meeting will be held to consider the immediate and medium term safety plans to ensure the child/young person remains safeguarded once they have left hospital.

10.2. Practitioner and Social Worker's Responsibilities

10.3 It is the joint responsibility of the CAMHS practitioner and Social worker to agree where a case requires a joint approach. This is most likely to include a joint visit, a joint assessment or a professionals meeting. Where this is not possible there needs to be good communication between professionals and a clear plan with clear roles. The CAMHS Practitioner will also need to state the perceived level of urgency and their reasons for

requesting this multi-agency intervention.

10.4 It is expected that the referring practitioner will share with the Duty Worker:

- Risks / concerns / safety factors/strengths;
- Any relevant care plans and risk assessments, as part of CPA (Care Programme Approach) including self-harm assessments, CAF and safety plans;
- Any previous history that would aid the referral including any known self-harm and severity/duration and risk of this.

10.5 Requests by DCT, CAMHS or Children's Social Care for a joint approach will be responded to positively by all practitioners and their Team Managers who will support such joint working initiatives by agreeing the most appropriate response i.e. a joint assessment, a joint visit or attending a professionals meeting.

10.6 The Screening & Duty Team/ Disabled Children Duty Team Manager and /CAMHS Specialist/ Manager will:

- Identify a worker to complete a joint visit / joint assessment or a professionals meeting within 48 hours of the referral being received. **NB this may require Team Manager agreeing an immediate response due to the levels of risk or need involved.**

10.7 Where a referral has been accepted by Children's Social Care and a joint assessment / joint visit / professionals meeting has been agreed:

The allocated Social Worker will:

- Call the CAMHS Practitioner to confirm the date, time and venue of the joint assessment / joint visit, ensuring that they are both fully briefed and are clear of their roles and responsibilities when completing this task.
- Start a Children's Assessment at which point the allocated Social Worker becomes the lead professional and holds case responsibility.
- Ensure that there is a written agreement at this point about how the self-harm is to be managed and who is overseeing and updating the safety plan.

The CAMHS Practitioner will:

- Share existing and historic assessments/current safety plans, CPA documentation and any interventions with Children's Social Care;
- Contribute to any other processes already in place such as Child Protection Reviews;
- Contribute fully to any Children's Social Care assessment or processes as required;
- Undertake any therapeutic work or consultation where appropriate with consent.

10.8 Children's Social Care and Disabled Children's Team will lead on assessing the needs of each of the children within the family. The CAMHS practitioner will help to inform the assessment around self-harm/mental health needs and support the Social Worker to identify the therapeutic needs of the child/young person. The Social Worker will complete the Children's Assessment (CA1) within 10 working days of the referral being accepted.

10.9 For cases open to Community Fieldwork Teams the request for joint working will be made to the allocated Social Worker.

11. Requests made by Children's Social Care/ Disabled Children's Team to CAMHS to jointly work a case

11.1 Where a Duty Social worker, a Community Fieldwork Social or a Disabled Children's worker find that a self-harm case they are involved with requires joint working with CAMHS, if the case is known to CAMHS the allocated CAMHS Practitioner will arrange a joint visit or consultation depending on the current situation. If the case is not known, the case needs to be referred to CAMHS via the Single Point of Access (SPA) where the case will be allocated.

11.2 Where there is a more serious mental health/self-harm presentation CAMHS Tier 2 will request CAMHS Tier 3 support or the professional network can access self-harm consultations offered by CAMHS Tier 3.

12. Children in Care

12.1 If a child/young person is in Local Authority Care and the Social Worker has identified mental health needs they can access the Children Looked After CAMHS Tier 3 service based at Thorneywood. The team can offer consultation to the practitioner, foster care or residential worker and offer direct work to the child/young person.

13. Following completion of joint assessment/visit/meeting

13.1 When a joint assessment / joint visit / professionals meeting has been completed the Children's Social Worker and CAMHS practitioner will:

- Agree who will be responsible for writing the assessment or joint visit;
- Ensure the assessment completed is shared between both services and recorded / filed in CareFirst and Castle. This could be a combined report

that is co-authored by both practitioners;

- Fed back any issues pertaining to the mental health of a young person to the relevant Mental Health Specialist/Team Manager and have a discussion to ensure that a safety plan is in place and/or if ascertain if the case needs to be stepped up to Tier 3, or stepped down to a Tier 2 CAMHS service,
- Jointly consider any parenting capacity issues for the parents/carer and how this impacts on the child(ren) i.e. is the parenting being provided adequate to meet the needs of the children / how does the parent's needs (mental health, substance misuse, domestic abuse) impact on the child/young person? Assessments should include discussions with agencies involved with the parents to understand any concerns that they might have, what support is being offered and whether the parent is engaging with their service. This will need to be recorded and analysed in the joint report.
- Plan and review jointly ongoing work, actions and decisions for the case and record them within each service;
- Ensure plans are SMART (specific, measurable, achievable realistic and time-bound) and have timescales following the joint assessment/ joint visit/ professionals meeting and this should be made readily available to staff within both services;
- Supply the young person with support contacts such as the Harmless website;
- Contribute fully to relevant meetings (Child Protection conferences, reviews, consultations etc);
- Share their findings and provide reports.

14. Disagreements/escalation

14.1 Where there is a disagreement over the appropriateness of a case being jointly worked the issue must be resolved within 48 hours. This will involve the Social Worker or CAMHS practitioner (depending on who is raising the disagreement) referring the case to the relevant Service Manager for resolution within 24 hours. If this cannot be achieved, the case must be referred to the relevant Heads of Service for resolution within a further 24 hours.

Support Services

SHARP (Self Harm Awareness & Resource Project)
The team is part of service offered by Tier 2 CAMHS. They provide:

- Professional telephone consultations every Tuesday 9.00-11.00 am
- Family support through mediation
- Individual therapeutic support through the CAMHS referral pathway
- SHARP 4 (parent support group)
- Parent support helpline
- ME-Source (Building self esteem and resilience group for young adolescents)

NOTTINGHAMSHIRE & NOTTINGHAM CITY SELF-HARM CARE PATHWAY
What to do if you are concerned about a young person self-harming

Tier 1 UniversalServices	Tier 2 Targeted Services	Tier 3 Specialist Services	Tier 4 Highly Specialist Services
Low level risk self-harm Superficial, minor self-harm instable 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 and trauma.	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 behavior concerns about severe Mental Health disorder, where risk cannot be managed in 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 & 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 self-harm team or Tier 3 EDT (emotional disorders teams).All City CAMHS referrals except mental health emergencies come CAMHS can be transitioned to TIER 3 via SPA.	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…..			
UNIVERSAL School nurse, Youth workers, GP, Schools, Connexions PA, Harmless Base51-Counselling	**TARGETED** MALTS, EHWT, Compass, Face it, JAT (County), LD/ CAMHS Early Intervention Service Community Pediatricians, YOT's	**SPECIALIST** Self harm Team, Specialist Community CAMHS, H2H (Head2Head) CLA (Children Looked After)	**HIGHLY SPECIALIST** Adolescent unit
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.**			
RANGE OF INTERVENTIONS Family work/individual work Counseling, Group work, Assessment CAF, Liaison/signposting	**RANGE OF INTERVENTIONS** Assessments, CAF, Group work Range of therapeutic interventions. Individual and family work. Joint working with CAMHS, CEPS, BST Consultation to tiers 1 Universal services/Training	**RANGE OF INTERVENTIONS** Risk & needs assessment, Mental health assessments, Range of therapeutic interventions: e.g. individual psychotherapy, family therapy, CBT. Joint working at Tier 3 & with Tier 2 Consultation to Tiers 1& 2	**RANGE OF INTERVENTIONS** Assessment and management to suicidal risk &s elf-harm Mental Health Assessments

THIS CARE PATHWAY IS FOR USE IN CONJUNCTION WITH NOTTINGHAMSHIRE & NOTTINGHAM CITY PRACTICE GUIDANCE ON CHILDREN & YOUNG PEOPLE WHO SELF-HARM.