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Practice Guide

Suicide prevention for looked after children and young people

Improving Practice in Scotland

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Acknowledgements

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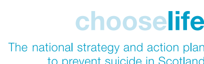

Protection in partnership

Protection and partnership in keeping young people safe – helping young people, carers and staff

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Opening words from young people

We begin the guide with the voices of some of the young people who have lived at Edinburgh Secure Services.

"We want to be safe and know where we are. Moving can be really difficult. How far are we from home? When am I going to see my family? What is the new place like, who lives here, what are the staff like?"

"We tell the staff that treating us fairly matters a lot, we feel protected when staff are fair."

"We know we test out the staff by what we say and do, but we always want to be taken seriously."

Introduction

This practice guide is written to protect ‘looked after’ children and young people who are a small but significant group in Scotland. For a variety of reasons these children and young people are looked after by local authorities. Suicide amongst looked after children and young people is a tragic but very rare event. This guide was requested by people in the field of social care and social work who care professionally for children and young people.

We asked young people who had experience of secure care to give their views on the contents of the guide and they told us that adults who care for them should read it. They told us that the guide would help adults think about how best to protect them from suicide. That is the purpose of this guide.

In 2010 the Scottish Government set out the following definition:

> *Suicide is death resulting from an intentional, self-inflicted act.*
>
> *Suicidal behaviour comprises both completed suicide attempts and acts of self-harm that do not have a fatal outcome, but which have suicidal intent.*[1]

Scottish Ministers have a legal duty to review and report on the deaths of all looked after children. This was delegated to the Social Work Inspection Agency (SWIA)[2]. In June 2009 SWIA held a joint seminar with Choose Life, NHSScotland and the Children’s Hospice Association Scotland for social work and health practitioners and managers to review practice issues raised in the SWIA annual

1 Throughout this guide we have used Choose Life’s recommended term ‘complete suicide’ rather than use the word ‘commit’.

2 The Social Work Inspection Agency ended and its work was taken over by Social Care and Social Work Improvement Scotland (SCWIS) on 1 April 2011. Reviews of the deaths of looked after children were delegated by Scottish Ministers to SCSWIS.

report. This led to requests by practitioners, foster carers and managers to provide guidance on suicide prevention and ways in which they can help looked after children and young people.

The term 'looked after' includes children who are subject to supervision and live with family members as well as looked after and accommodated children who live with foster carers or in residential schools or care homes. We recognise that these are not discrete groupings, children move between them. They have different needs and some experience additional discrimination by virtue of their race, disability and sexual orientation. Those children who are looked after and accommodated have experienced the trauma of being separated from their birth parents. In addition, many of them have experienced neglect, abuse and rejection or the early effects on their development of parental substance misuse.

Some looked after children and young people have suicidal thoughts and are at risk. People who care for them are often aware that the children and young people in their care are feeling angry and sad and they want to find ways to help them keep safe.

Protecting children and young people from contemplating suicide is not an isolated activity; it needs to be part of a holistic approach to their overall care and development. We need to be able to speak about suicide with children and young people and to dispel myths for all concerned.

We recognise that councils and organisations have developed extensive procedures and guidance to support and protect children in their care[3]. This guide is not a substitute for them but is complementary to them.

Every child and young person is unique and special. Some contributors to our consultation events asked why we needed a guide for looked after children and young people, why not one for all?

3 These are our Bairns – A guide for community planning partnerships on being a good corporate parent, Scottish Government, 2008, www.scotland.gov.uk/Publications

Whilst we hope the guide will be relevant to all in this age group we consider it is important to identify the additional risks and challenges to staff and the young people they care for in trying to keep them safe. These will include foster carers, social workers, health care staff and support staff in schools and residential settings.

We recognise that many different people care for children and young people including their mothers and fathers, brothers and sisters, grandparents, friends, foster carers, short break carers and professionals in health, social work, social care and education. To avoid repetition we refer to families and carers except where it is relevant to identify a particular group.

We have used practice examples provided by a number of practitioners. These bring together a range of factors which illustrate the challenges experienced by many looked after children. The children and families described cannot be identified. The stories are based on the real experiences of a number of children young people and their carers, but the actual characters are fictional. We have also included some practice discussion points which are all set within the context of current legislation, child protection guidance both from Scottish Government and the relevant local authority. They are not practice guidance. They are intended to indicate some of the issues we have identified and to create opportunities for discussion between people who care for looked after children and young people.

Appendix 1 sets out a range of current websites and resources which may be helpful. Appendix 2 describes some training resources.

1 Myths about suicide

Suicide happens in all societies and is often surrounded by fears, myths and beliefs. Choose Life have found in their work that many of these myths are still circulating and we begin with some myth busting about suicide.

There are a number of inaccurate but commonly-held beliefs regarding suicide. These myths can act as a barrier to providing much needed help for those at risk. By removing the myths, staff, carers and friends will be better able to recognise children and young people who may be at risk and provide the support they desperately need.

MYTH: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

Serious talk about suicide does not create or increase risk; it can help to reduce it. The best way to identify the possibility of suicide is to ask directly. Openly listening to and discussing someone's thoughts of suicide can be a source of relief for them and can be key to preventing the immediate danger of suicide.

MYTH: People who talk about suicide never attempt or complete suicide.

People who talk about their suicidal thoughts do attempt suicide. Many people who complete suicide have told someone about their suicidal feelings in the weeks prior to their death. Listening and supporting a person in these circumstances can save lives.

MYTH: If a person has made previous attempts they won't do it for real.

Those who have attempted suicide once are at increased risk of attempting again. They need to be taken seriously and given support towards finding a resolution for their suicidal thoughts and actions.

MYTH: If somebody wants to end their life, they will, and there is nothing anybody can do about it.

Most people contemplating suicide do not want to die; they just want to end the pain they are experiencing. Although there are some occasions when nobody could have predicted a suicide, in many cases if appropriate help and support is offered to a person and they are willing to accept this help, a tragic outcome may be averted.

MYTH: Some people are always suicidal.

Some groups, sub-cultures or ages are particularly associated with suicide. Whilst some groups, such as young men seem to be at increased risk, suicide can affect all ages, genders and cultures. Many people think about suicide in passing at some time or another. There isn't a 'type' for suicide, and whilst there may be warning signs, they aren't always noticed. Whilst those who have made an attempt on their own life in the past can be at increased risk of completing suicide, people can and do move on in their lives.

MYTH: When a person shows signs of feeling better, the danger is over.

Often the risk of suicide can be greatest as depression lifts, or when a person appears to be calm after a period of turmoil. This can be because, once a decision to attempt suicide is made, people may feel they have a solution however desperate it may be.

MYTH: When a young person harms themselves or threatens to do so, this is attention-seeking behaviour which is not serious.

Self-harming for some people in distress is a way of coping with difficult or frightening feelings. It is a risk factor and should never be dismissed out of hand.

2 Why might a looked after child or young person contemplate suicide?

First we consider factors which may affect all young people. Many people experience times when they feel sad, lonely, depressed, and unpopular or a failure. Young people may feel they cannot cope with these feelings and may feel angry or helpless about the future. It may be the first time that a young person or teenager has found themselves facing these sorts of problems and they may not know what to do or who to turn to for support. They may feel intense pain and upset, which won't go away, leading them to think that suicide is the only answer.

Suicidal thoughts can be very confusing and frightening. The young person may feel they want to die, but they may also want a solution to their problems and for someone to understand how they feel. They may be anxious about having such mixed feelings and be unsure of what to do for the best.

Below we set out some of the factors which can increase or decrease the risks to children and young people. A range of factors should be taken into account together with knowledge of the child or young person's background and individual circumstances.

Factors that can increase risk

- Loneliness and a lack of trusted friends
- Substance misuse and alcohol problems within the family
- Previous suicide attempts and self-harm (including a family history of suicide)
- Experience of abuse which could be sexual, physical and or emotional
- Low self-esteem, lack of confidence
- Not achieving educational potential and lacking life and interpersonal skills
- Life crises such as bereavement or issues relating to sexual orientation
- Mental health disorder, such as depressive disorder, obsessive compulsive disorder or a psychotic illness
- Inability to access appropriate services and support at times of need
- Late evenings and night times are times when looked after children and young people especially may contemplate suicide
- Hearing about or knowing another child or young person who has completed suicide

Factors than can help protect

- Evidence of having coped well with earlier difficulties
- A sense of hopefulness, reasons for living and optimism
- A sense of having positive health and participation in sporting activity
- Close and healthy family relationships and peer support
- A supportive school environment and relationships
- Good social support
- Religious faith and spirituality
- Access to, and involvement in, health treatment(s)
- Limited access to means (medicines, places and so on)
- A safe caring relationship
- A trusted adult who is available at night as well as during the day

Looked after children, whether at home or in another setting, may have additional risk factors as a result of their life experiences. Young people may be more vulnerable to suicidal thoughts and

feelings if they do not feel able to solve the difficulties in their lives. Looked after young people face particular challenges. They can face discrimination and the stigma of being looked after. They often feel rejected by their families and have to move to new neighbourhoods where they do not feel part of the community.

In the practice example Ben and his sister experience the risk factors from loss and bereavement.

Practice example: Ben aged 13 and Samantha aged 9

Ben and his younger sister Samantha live in foster care. He has been in several foster homes due to their mother Nicola having serious alcohol problems. Nicola tried to offer a more settled life for them but slipped back into alcohol misuse. She could not sustain her good intentions. Although she loved her children very much she was unable to provide them with consistent care. Sometimes they were locked out of the flat when they came home from school. Ben set the kitchen on fire trying to make baked beans on toast when he was 8.

Ben felt responsible for his sister and knew how upset she was when their mother came to contact sessions having been drinking heavily. At a contact session he told his mother that if she came drunk again he and Samantha would refuse to come to contact. At the next session Nicola had clearly been drinking and the following contact time Ben refused to go and persuaded Samantha also to refuse. Two days later Nicola had completed suicide by taking a large overdose of paracetamol.

Ben's social worker, Martin, recognised that the risk of suicide, especially to Ben, had increased with his mother's death.

Ben became angry and aggressive and his foster carers who had two very young children asked for him to be moved. Samantha stayed on and she and her brother were separated.

Practice discussion points

Ben and his sister have a higher risk of suicide because they have a relative or friend who has completed suicide. In this example, Ben has experienced a great loss. He will have had feelings about his mother's addiction and anger that she has 'chosen' alcohol over him and his sister. He may also be feeling responsible for his mother's death. At the same time he is separated from his sister and feels rejected by his foster carers for being unable to manage his anger.

- **Often adults are reluctant to discuss funeral arrangements with young people and assume they do not want to be involved. Asking Ben may be important for him.**
- **It is important to keep talking openly with Ben and Samantha. This will help and reassure them at the time of their mother's funeral and afterwards. As a first stage both should have the opportunity for counselling and support.**
- **Good joint work with their schools will be crucial in making sure they are supported and do not suffer bullying or teasing.**
- **Longer-term plans need to be put in place to provide bereavement counselling for both children when they are ready.**
- **Ben is going to be moved to another care setting and it is vital that a clear account of his mother's death is communicated to his next carers.**
- **Ben and Samantha should have regular contact with each other and, if appropriate, the possibility of some joint counselling sessions should be considered.**

3 Transitions and loss

In this section we recognise that when a child or young person moves from home or from one placement to another their risk of suicide can increase. Looked after children and young people are much more likely than others to have these transitions, which invariably involve loss. We discuss how carers can help to make moves safer for children and young people, both by recognising how they may be feeling and also by working in partnership with their families and other professionals.

In the practice example, Ben's behaviour has become so aggressive that he has had to be moved from the foster home for the safety of younger children. For all sorts of different reasons, looked after children and young people often have to move from one placement to another. Sometimes this occurs at short notice as in the practice example; at other times there is a planned move with time to support the young person through it.

Whatever the reason for the move, the child or young person will have strong and perhaps confused feelings about leaving their previous home, which may include a sense of personal failure or rejection. Unless they can be helped with these thoughts and feelings they may find it hard to settle in their new placement.

These transitions represent increased risk but also opportunities. A well-planned transition to a more suitable placement which meets a young person's needs is likely to reduce the risk to them but a poorly-managed transition may increase the risk. Young people who have frequent moves in care will often have had to change school. They will have to build new relationships with those caring

for them and the other young people living with them. They may distance themselves from people close to them or fear losing touch. Children or young people who have had many moves may never get past the level of superficial relationships with those around them. At a time when the young person may be feeling rejected and excluded, those caring for him/her will just be starting to build the relationship.

Carers are often aware of the potential risks at this point for the child but may not always feel confident in how to help. Being able to value and recognise the child or young person's history can be important in helping them to express sadness for their losses. Leaving home or a foster home does involve losing family members, friends, a favourite teacher, and for some children pets as well.

Extraordinary Lives concluded that:

> *Adults who care for children and young people consistently underestimate the children's feelings towards them and often do not appreciate the trauma that can be caused by moving a child from one family or unit to another. Children and their carers who contributed to the Adoption Review (Adoption Policy Review Group 2005) told how they were distressed and unsettled by moving from one placement to another. Denial of the depth of children's feelings by adults lies partly because children and teenagers in particular, often do not show their true feelings directly, sometimes expressing them through aggression. Working with distressed children is emotionally very demanding and to survive the experience adults sometimes protect themselves by denying the strength of their and the children's feelings.* (*Extraordinary Lives,* SWIA, 2005: 37)

In the next practice example Zak struggles with many complex feelings brought about by change and loss in his life.

Practice example: Zak aged 15

Zak is 15 and has recently become looked after as his adoptive parents decided they could no longer cope with his behaviour. Zak was placed for adoption at the age of 7 after his father was convicted of murdering his mother. His two younger sisters were placed for adoption with another family who two years ago moved abroad.

Zak has been smoking cannabis and drinking alcohol. He formed a relationship with an 18-year-old boy at his school. The boy has now gone away to university and apart from a few texts, Zak has not heard from him. There were many rows at home, Zak's parents objected to his relationship on religious grounds. Zak wants to train as a vet and at home he had pet rabbits, a dog and tropical fish.

Zak is living in a children's unit and is being taunted by another boy about his sexuality. His social worker has arranged for him to go to a Lesbian, Gay, Bisexual and Transgender (LGBT) Youth forum but Zak is worried that he will be bullied and is becoming depressed. His social worker also arranges for Zak to become a volunteer at the local animal rescue centre on Saturdays and he enjoys that but is always very sad about missing his own dog when he comes back.

Zak's key worker is newly in post and does not feel confident about talking with Zak about his losses and he tries to cheer him up by suggesting they watch football together on TV.

Zak ran away from the unit and was found unconscious in a doorway late at night. He had been drinking and told the police he wanted to 'end everything'.

The social work called an urgent meeting and invited a youth worker from LGBT Youth and a social worker from the local child and adolescent mental health team to discuss with the care staff and Zak's guidance teacher how best to help him.

Practice discussion points

There are underlying root causes for Zak's risk of suicide, past life experiences, loss of his birth mother, sisters and now his adoptive parents, and also possibly feelings about his sexual orientation. There are also exacerbating factors, substance misuse, bullying and a previous suicide attempt which indicate a heightened risk of suicide.

- **Zak has a risk of suicide due to his misuse of drugs and alcohol.**
- **Zak was being bullied and if this was not tackled by staff the risk to him could increase[4].**
- **Zak's cumulative losses have overwhelmed him and his key worker felt unable to help him, he lacked confidence and feared he would make Zak upset by talking about his feelings.**
- **The manager of the unit provided training and support for Zak's key worker and as part of the team around Zak he was able to help him.**
- **The social worker's interventions were helpful but in the early stages were in isolation from the work of the unit.**
- **LGBT Youth were a valuable resource and as well as helping Zak they were able to advise staff in the unit and in Zak's school. The worker also offered to go and see Zak's parents but they were unwilling to meet him.**
- **The local Child and Adolescent Mental Health Service (CAMHS) team[5] had a policy of flexible approaches to engaging with young people and were willing initially to meet Zak in his unit to try to engage with him.**
- **The team around Zak set up an effective communication system of sharing information about Zak.**

4 Scottish anti-bullying charity Respectme offers a range of training and guidance resources at www.respectme.org.uk/

5 CAMHS teams vary in how they work.

Appendix 1 sets out a range of current websites and resources which may be helpful.

Zak has no family contact at present although his social worker is trying to encourage his parents to phone, text or write to him to begin to build a bridge between them.

In the next section we consider the risks and protective factors of family contact for looked after children and young people.

4 Family contact

Young people who are looked after away from home usually have regular contact with their families. For some young people this is a positive experience and helps them to plan for an eventual return home. However, many children and young people can be upset by family contact. Sometimes parents let them down at the last minute and the young person feels rejected as a result. For others although the actual contact goes well the separation afterwards is a painful experience. Also many young people become looked after following the breakdown of their relationship with their parents and these difficulties continue during contact time.

Young people who contributed to this guide told us that when they had been in a caring role for their parent and/or brothers and sisters they felt great anxiety by being separated and unable to care for them. Without being able to 'care and protect' they experienced feelings of extreme isolation and low mood. They needed to be reassured and wanted to know how their parent or family member was getting on without them.

Family contact can therefore be fraught with difficulties and have a significant effect on the young person. Those caring for looked after young people must be aware of changes in the young person's mood following family contact. Carers should make sure that the young person's social worker is aware of any impact contact has had. Those caring for young people day to day are best placed to pick up subtle changes in their mood and behaviour. In the next practice example school staff had an important role in noticing the young person's change of mood.

Practice example: Suzi aged 14

Suzi, 14, has lived in a small children's unit for nearly two years. She became looked after following a serious incident of domestic abuse leading to her mother being hospitalised. Suzi expected to be in care for a short time and then return home but her mother became depressed and was unable to care for her. Contact between Suzi and her mother has become less and less frequent over the last year.

School staff were worried about Suzi's recent 'moodiness' and encouraged her to speak to the school counsellor. She has seen Clare, the counsellor, every week for the last four weeks. Clare is recently qualified and has worked in Suzi's school for the last two months. Suzi has talked to her about her worries about her mum and that she fears she will not be returning home.

In the course of a session with Clare, Suzi says that sometimes she wishes she was dead. In exploring this further Suzi says she has blades hidden in her bedroom. Clare suggests they talk to her key worker but Suzi says no to this. Clare suggests they talk to her guidance teacher or her social worker. Suzi is angry and says she wants no-one to know and she only told Clare because she thought their sessions were just between the two of them. Clare explains she is worried about her and so may need to talk to someone else to make sure she stays safe. Following a telephone call to her supervisor where Clare outlined her concerns and the risk to Suzi, Clare decides to go to talk to the Head Teacher. They agree that the information has to be passed on to Suzi's social worker as a matter of urgency.

Clare explains this to Suzi and tells her the exact information which has been passed on is about her personal safety and not about other areas she has discussed with her. Suzi is initially very angry and when she got home told her key worker she was never going back to school. Her key worker

asked her to give her the blades hidden in her bedroom and she agreed.

Later in the evening Suzi talks to Brenda, her favourite night care worker, about her worries about her mother and how she fears she may inherit her mother's depression. Brenda has recently attended a day course on suicide prevention[6] and she remembers the information that most looked after children and young people who complete suicide do so at night.

Brenda is concerned about Suzi when she says she is going to her bed. She offers to bring her up a hot chocolate when the staff have their midnight tea break and Suzi accepts. When she takes up the hot chocolate Suzi has settled and gone to sleep.

Practice discussion points

- **Does Suzi's care plan involve work to try and sustain her relationship with her mother?**
- **As well as encourage Suzi to meet the school counsellor did her guidance teacher tell her key worker they were concerned about her moods and unhappiness in school?**
- **Clare rightly discusses Suzi's comments about wishing she was dead and talks further with her and gains more information, for example that Suzi has got the means to harm herself or complete suicide.**
- **Clare also shares this information with Suzi but in a way which focuses on the risk and not on all the issues Suzi has discussed with her.**
- **Suzi's key worker is able to 'hold' Suzi's anger and is very honest about knowing about the blades and asking for them.**
- **Suzi seeks out her favourite member of staff, Brenda, who is an unqualified but very experienced night staff.**
- **The night care staff have all had suicide prevention training and she helps Suzi to explore her fears.**

6 See Appendix 2 for information about training courses.

- **The offer of taking up hot chocolate enables the night care worker to offer further care and also to check that Suzi is alright once in bed.**
- **The next morning Brenda makes sure that the staff coming on duty are aware of Suzi's worries.**

In the next section we explore the ways in which we can help.

5 What can be helpful?

We recognise that help can come in a number of ways, knowing what the risk factors are and dispelling some of the myths which surround suicide. This section includes key areas, focusing on being able to recognise signs, building confidence in carers, sharing information and communication, working together, and staff and carer support.

Many children and young people who are feeling suicidal signal their intent, whether it be verbally or through behavioural change. Therefore, if families and/or carers feel confident and willing to explore possible signs of suicide risk and provide support and help, this can help young people. Some adults do not want to intervene for fear of making the child's situation worse.

5.1 What are possible warning signs?

Many young people who are contemplating suicide will make an attempt to let someone know how they are feeling. Some common signs are:

- excessive sadness or moodiness
- lack of energy or apathy
- sudden calmness, especially after a period of depression or moodiness
- choosing to be alone and avoiding friends or social activities
- losing interest or pleasure in activities the person previously enjoyed
- changes in appearance, especially neglecting their physical appearance
- changes in sleep patterns

- changes in appetite, resulting in weight loss or gain; some people may develop anorexia or bulimia
- self-harmful behaviour, such as cutting, biting or burning themselves, recklessness, engaging in unsafe sex, getting into fights and increased use of drugs and/or alcohol
- making preparations, such as beginning to put his or her personal business in order; this might include visiting friends and family members, giving away personal possessions, and cleaning up his or her room or home; some people will write a note before attempting suicide
- talking about suicide[7].

Although most people will give off warning signs or invite invitations for help, some will not. Also, carers may not be around the child or young person for long enough periods of time to assess any changes in behaviour. Asking the young person how they are feeling may help them to say how they are feeling. A carer who suspects that the child or young person may be having thoughts of suicide should ask them.

In the next practice example Shadia's family circumstances and separation are potential risk factors, but the sudden and unexpected rejection by her school friends precipitated her distress and could not have been foreseen.

7 Caring About Health: Improving the health of looked after children in Scotland, page 259. NHS Health Scotland, 2009.

Practice example: Shadia Benien aged 13 and Mrs Tyler

Shadia is 13 and has been fostered by Mrs Tyler for two years. Shadia's mother is addicted to heroin and is a sex worker. Shadia resents being with Mrs Tyler as she wants to live with her mother. Her mother's lifestyle has meant that Shadia has not been safe. She was looked after by her older brother until he was sent to prison. Three months ago he hanged himself in prison.

Shadia was invited to a party and was very excited. She has difficulty making friends and was thrilled to be invited; Shadia and Mrs Tyler went into town and bought a new dress and shoes. Shadia left for the party with her new clothes as the girls were all going to get ready together at a friend's house. Mrs Tyler arranged to collect her at 11pm. At 9pm the police phoned Mrs Tyler to say that Shadia had swallowed most of a bottle of vodka and was unconscious in A and E.

Mrs Tyler went to the hospital, a staff member greeted her as Mrs Benien and was very abrupt saying they were tired of spoilt kids drinking too much. They were planning to discharge Shadia as soon as they could. Mrs Tyler felt initially that she would be betraying Shadia if she said she was in foster care. She tried to phone the out of hours service but could not get through.

She phoned the mother of one of the girls who had been at the party and discovered that the girls had refused to let Shadia get changed with them. Shadia had brought a bottle of vodka to try and make herself popular and when she was rejected she drank most of it in the park.

Mrs Tyler decided to approach a staff nurse and explained her worry that Shadia may be contemplating suicide and may have taken tablets. The staff nurse was very busy and was called to a road accident.

Mrs Tyler sat beside Shadia who would not speak to her. Eventually a doctor came and told Mrs Tyler to take Shadia home. Mrs Tyler followed him

into the corridor and explained that she was unwilling to take Shadia home and she asked for the duty psychiatrist. She asked the doctor to call her Mrs Tyler and explained that there was more to Shadia's circumstances than getting drunk at a party. Shadia was kept in overnight and saw the duty psychiatrist the next morning. He referred her as an emergency to the local child and adolescent mental health team and Shadia responded well to the help that was offered. She was also referred to a Seasons for Growth programme[8].

Practice discussion points

- **The death of Shadia's brother increased the risks to her safety.**
- **Her foster carer should have been offered advice and support in how to help Shadia if there were problems out of hours.**
- **Shadia's guidance teacher was aware of her background and was supporting her. She did not know that some girls were taunting her about her mother being a sex worker.**
- **Mrs Tyler had done her best to check out the party but could not have foreseen the sudden rejection by a group of girls.**
- **Mrs Tyler was unable to contact the out of hours service and to begin with was rather at a loss to know what to do. She needed a support contact and a phone number where she could get advice.**
- **Mrs Tyler should have been aware of the importance of sharing with health staff that Shadia was a looked after child.**
- **The hospital was very busy and Mrs Tyler acted appropriately eventually, in insisting that Shadia obtained special help.**

8 Seasons for Growth is a loss and grief peer-group education programme for young people aged 6-18 years and adults. www.seasonsforgrowth.co.uk

Some care settings have links with their local Accident and Emergency department so that if a young person injures themselves intentionally an appropriate response to the risks can be shared. It can be difficult for staff to decide when to get more help. As risk and danger increase, then services are likely to be required. A CAMHS team which has a good working relationship with a residential unit would be able to offer more protection than a situation where residential staff have to phone for advice in emergencies.

In the next section we consider the importance of people who care for children and young people working together and sharing information.

5.2 Working together and sharing information

We recognise the complexity facing families and carers and staff when many different agencies are involved. Effective services are those which are joined up and communication works well between professionals and with the child, family and carers. Such approaches have provided the building blocks for a national approach in Scotland, 'Getting it right for every child' (GIRFEC)[9].

As part of the GIRFEC programme, all children with two or more agencies involved should have a multi-agency child's plan, designed to meet all of their needs. A lead professional is identified from within the lead agency, to co-ordinate the child's plan, integrate the assessments of those involved, and monitor the effectiveness of the plan.

Where there is concern or a recognised risk that a child or young person is contemplating suicide staff and/or carers must immediately find ways to work well together. No time must be wasted in making sure those in regular contact with and caring for the child know of these risks and how to respond to the child. There can often be complex issues concerning communication and confidentiality which must not get in the way of keeping a child safe.

The practice example below gives a glimpse of the importance and the sensitivities of information sharing when young people are in

9 GIRFEC is a Scottish Government programme that aims to improve outcomes for all young people in Scotland. www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec

distress. Staff or carers must take great care to discuss with the child or young person what information is being shared and the reasons for this. Where at all possible the agreement of the child or young person should be obtained. If information is shared without their consent the reason for this should be explicitly stated and the child or young person should know the content of that information.

Practice example: John aged 15

John, 15, attends the 'drop in' at his local youth centre. During the evening one of his pals, Tom, approaches one of the youth workers, Mary, and tells them that John said he took some tablets earlier on after a row with his parents. Mary knows John has a difficult home life and that he is on social work supervision. Mary takes John aside and has a chat with him and tells him what Tom told her.

Initially John denies having taken tablets and says he was only joking. Mary knows one of John's uncles completed suicide.

Mary considers the risks and decides she needs to seek medical help for John whether or not he agrees with this. She talks to John about why he told Tom and explains that she will go with him to Accident and Emergency. John storms out swearing and Mary tells the manager what has happened. They are discussing what to do next when Mary sees that John is sitting on the wall outside the centre smoking a cigarette. She goes out to speak to him, he tells her he took three paracetamol and shows her the rest of the packet which he gives to her.

Mary and John talk about how he is feeling and who there is at home he could talk to. John then decides to go to his Gran's for the night. They go back into the office and John phones his mum to tell her he is going to his Gran's and also phones his Gran to confirm he can come.

Practice discussion points

- **Mary was correct in taking the comments seriously and following them up with John.**
- **Mary helps John to think about where he would feel safe and whether there is a family member he can turn to.**
- **Next day Mary and her manager discuss how Mary might have managed things a little differently, by spending longer with John, finding out what he had taken, why and why he was telling her, before making a decision to get medical help.**
- **They also discuss the importance of telling John's social worker and how to make sure that John is included.**

All looked after young people should have a care plan which should be developed with the young person and their family. The plan should be regularly updated and be useful for staff involved in day to day care. Recording of daily events and observations can be crucial in keeping an up-to-date picture of the child or young person's progress. At our consultation events we heard from a group of residential social workers about the care and attention which they put into regularly updating the young person's care plan. The young people were always involved in these changes and were able to contribute their own ideas to the plans.

Comprehensive, up-to-date information about the young person; their likes and dislikes, their feelings, experiences and previous responses to difficulties must be passed on to the new carers immediately. Any move may make a young person more vulnerable and there could be a heightened risk if key information is not passed on to new carers of family members.

Sometimes when a child or young person moves from one placement to another this will have implications for the provision of specialist services, for example CAMHS. Some services have strict geographical catchment areas and if the young person no longer lives in that area this can affect the continued involvement of the child or young person in that service. It is essential that any

evaluation of suicidal intent or self-harm risk is passed on to the new placement. Each placement will want to review the risk to the child in their care and always take into account the detail of what has happened before.

Staff and carers told us how difficult they found it to cope and continue to care effectively for others after a young person had attempted suicide. They had a responsibility to help the young person but also to the other children or young people in their care. When a placement is arranged there need to be clear written plans about what is expected of staff and carers who support young people in crisis. The child or young person should expect to have a clear support plan in place which takes account of their needs and wishes.

There is an important role for managers and social workers who support foster carers in making sure that support at times of crisis in readily accessible and is helpful. Residential staff told us that they felt their views about young people were not always taken seriously by other professionals. It is important that professionals, care staff and foster carers listen to each other's views and concerns about a young person and, if need be, act on this information. All concerned should value each other's experience and knowledge of the young person.

There should always be an explicit statement of what each agency/professional and/or carer can expect from each other when supporting young people who have attempted or threaten suicide.

Any agreed actions must link to the young person's care plan.

There are two crucial aspects to information sharing; both collecting accurate data and interpreting it. Good risk assessments will consider both static/historical factors and current factors relating to the person concerned. The second key aspect of information sharing is making sense of the information. We have recognised in this guide that previous life events, for example the death of a parent, the suicide of a brother or sister, together with

behaviour such as running away, self-harm or threatening suicide can be crucial in determining the level of risk for the child or young person. A chronology of the young person's key life events can be crucial in identifying risks and should be updated regularly[10].

5.3 Where does support come from?

Resources are provided by a wide range of services from health education and the voluntary sector. Sometimes adults can feel that there must be an 'expert out there' who can solve the young person's problems. Sometimes staff and carers underestimate their own skills in helping a young person. Significant skills are needed to get young people to use these resources if they are able to access them. For example in SWIA reviews of the circumstances of the deaths of looked after children we found examples of young people who refused to attend CAMHS and or other services in the community.

Other valuable resources are those which may meet the particular needs of a child or young person, for example if they are unsure or reflecting on their sexual orientation. For example if they are coming out:

> *"**Coming Out:** This is the phrase used to describe the process that someone goes through when they decide to be open and honest about their sexuality and/or transgender status. For lesbian, gay and bisexual people it is often a life-long process because people assume that everyone is straight. LGB people may not be 'out' at work or college, but might be at home or to a few close friends. For transgender people coming out is both an emotional and physical process where family, social and work spaces are negotiated at the same time. This can often lead to higher levels of anxiety and distress in anticipation of rejection or discrimination. Individuals usually go through a period of coming out to themselves, where they accept their own sexuality, before coming out to other people."*[11]

10 Chronologies – a Practice Guide (SWIA 2010) A practice guide on compiling and using chronologies can be found on SCSWIS Website.

11 www.lgbtyouth.org.uk/

Without effective support this experience may place a young person at greater risk. Young people can be helped by being in contact with either a local or national group.

In our consultations with staff and carers we heard about the worries and concerns of staff who were caring for children and young people who may be contemplating suicide. Staff who work together in a residential unit/school or secure accommodation or mainstream school are ideally placed to support and help each other, but we know that this does not always happen naturally. Managers have a key role in helping staff to communicate and feel confident in their work with young people.

Effective joint working depends on practitioners appropriate sharing of information with other agencies. Practitioners should be open and honest with the person (and/or their family where appropriate) from the beginning about why, what, how and with whom their information will, or could be shared. Practitioners must seek people's agreement to share[12].

Residential care staff told us that monitoring young people who display suicidal tendencies can be difficult. Managers need to acknowledge this with care staff and be prepared for the emotional needs of all concerned. Additional staff resources may also be required to support young people and staff and managers must consider these when caring for young people who have attempted or threaten suicide.

Foster carers told us about how they could feel isolated especially in the evenings and weekends when sources of support were restricted or non existent. Out of hours services were not on the whole seen as a helpful source of support with emotional problems of children and young people. One foster carer told us:

> *"Our foster child is 14 and she is often unsettled at night, we put limits on her use of her computer after 11pm as we worry she can get upset by messages on Facebook. There has been some bullying at school by texts as well. Her social worker told us we*

12 On the Record, SWIA, 2010.

were restricting her rights. But we want to keep her safe. We phoned standby once when she was threatening to jump out the window, but they didn't help. They said they would phone back and it was hours before they did."

Some foster carers told us about the help which can come from help lines, one foster carer encouraged the young person to phone Childline and talk to a counsellor which was very helpful. Childline provides a wallet of information about their services which can be given to all carers and young people. Phoning Childline even from a mobile is free. Another told us they had phoned the Samaritans who had listened but not provided advice, which had helped the foster carer to work out their own solution.

Childline told us that many children contacted the helpline to talk about the distress of being bullied. The impact of bullying on a child or young person should never be underestimated and always tackled immediately by staff and/or carers.

When one young person attempts or completes suicide in a residential unit or foster home, this has immediate and longer term implications for other children they live with. Other young people and staff must always be given the opportunity to talk about it to someone with whom they feel comfortable. However, children shouldn't be forced to talk. A protocol should be in place to provide a support plan for all residential units and school care accommodation. This needs to include explicit arrangements for an external manager's involvement.

Likewise, support structures need to be in place for foster carers and for kinship carers.

Conclusion

This guide is about a partnership approach to protecting children and young people where at all possible from attempting or completing suicide. As we saw in the practice example of Shadia unforeseen events which deeply distress a child cannot necessarily be predicted or avoided. But many risks can be identified by effective joint working and information sharing. Assessing the level of risk should be a shared activity between staff and with the child and young person.

We are learning all the time about how to improve practice and evaluate risks. The key messages of this guide are: keep learning, keep asking, keep sharing and above all, keep listening.

Appendix 1

Resources and references

Each agency will have resources for looked after children, as well as procedures and guidance to help children who are self-harming or who are at risk.

There is also extensive Scottish Government guidance on the care of looked after children which can be located on the Scottish Government website.

This guide is not a substitute for these.

We include examples of resources – these are there for carers to select – we do not recommend them.

www.papyrus-uk.org: resources and support for those dealing with suicide, depression or emotional distress – particularly young persons and young adults.

www.samaritans.org.uk: Samaritans offer 24-hour support for people in distress or despair, including those feeling suicidal. They have branches all over the UK and Ireland and most branches are able to offer services via telephone, email, letter and face to face.

www.breathingspacescotland.co.uk: this website has a number of sections, some of which are 'Your Mood', 'Your Problems', 'Self-help Toolkit' and a section if you are concerned about someone. There is also a free, confidential number to call for those who are feeling down or stressed. There is a very extensive 'Links' section that contains details of many organisations.

www.chooselife.net: a national strategy and action plan to prevent suicide in Scotland. The website contains information about suicide, for those that are suicidal and for those bereaved by suicide. There is an extensive 'Links' section that covers a number of areas relevant to mental health.

www.lookokfeelcrap.org: This is a self-help website which provides advice and access to other resources.

www.crusescotland.org.uk: Cruse Bereavement Care Scotland is a registered charity which offers free bereavement care and support to people who have experienced the loss of someone close.

www.dascot.org: Depression Alliance Scotland is the national charity for people with depression in Scotland.

www.headsupscotland.com: Heads Up Scotland is a national project for children and young people's mental health. This site contains a links section which provides access to other sites of relevance to young people.

www.lifelink.org.uk: LifeLink provides free support and advice to people in crisis, who self harm and are at risk of suicide in the North Glasgow area.

www.lgbtyouth.org.uk: LGBT Youth Scotland work to improve the health and wellbeing of LGBT youth and LGBT communities in Scotland.

www.respectme.org.uk/: Scottish anti-bullying charity provides training, information, advice and other resources to help tackle bullying.

www.samh.org.uk: the Scottish Association for Mental Health (SAMH) provides local community support services offering practical and emotional support, social activities, advice on employment and education and help with personal care and health issues.

SAMH has published a valuable guide: After suicide.

www.wellscotland.info: mental health information site with priority areas, news and research information. It contains a section 'Useful Contacts' that provides details should you need immediate help and a Directory (A-Z) of organisations and agencies throughout Scotland.

www.livinglifetothefull.com: this is a free online life skills resource. It aims to help users change the ways in which they think, and to respond in new ways to the challenges faced in life. **Please note:** the website is not an appropriate substitute to seeing a practitioner if you feel very distressed or are actively suicidal.

www.mentalhealth.org.uk: the website of the Mental Health Foundation outlines the charity's work in research, policy, service development and service user involvement. The site offers information and publications to download on research, good practice in services and on mental health problems and key issues. It provides a daily mental health news service and directories of organisations, websites and events. Website visitors can use forums and bulletin boards, join a mailing list and find out how to support the organisation.

www.ukselfhelp.info: this website provides links to many self-help and support groups across the UK.

www.getconnected.org.uk: free confidential help for young people.

www.youth2youth.co.uk: Youth2Youth – The UK's first National Young Person's helpline, run by young people, for young people.

www.youngminds.org.uk: YoungMinds promotes child and adolescent mental health and mental health services and has information for children, young people and parents.

Childline has a special service for 'children in care' – looked after and accommodated children and young people.

Call 0800 1111 or talk online. Sand advice is also available from other young people on the ChildLine message boards.

Seasons for growth
www.notredamecentre.org.uk

Seasons for Growth is a loss and grief education programme catering for young people aged 6-18 years.

Publications

NHS Health Scotland (2009). *Caring About Health: Improving the Health of Looked After Children in Scotland*. NHS Health Scotland.

Scottish Government (2008). *These are our Bairns – A Guide for Community Planning Partnerships* on Being a Good Corporate Parent. Scottish Government.

Scottish Government (2010). *Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland: Report of the National Suicide Prevention Working Group*. Scottish Government.

Scottish Government (2010). *A Guide to Implementing Getting it Right for Every Child: Messages from Pathfinders and Learning Partners*. Scottish Government.

Social Work Inspection Agency (2005). *Extra-ordinary Lives*. Scottish Government.

Social Work Inspection Agency (2010). *On the record – getting it right: Effective management of social work recording.*

Social Work Inspection Agency (2010). *Chronologies – a practice guide*.

Appendix 2

Training resources

Training information provided by Choose Life

Training courses of various kinds can help carers to explore some of the issues and give them greater confidence in helping children and young people. We give some examples.

Suicide Prevention Training Programmes

A broad range of suicide prevention training programmes, from awareness and exploration to suicide first aid skills training, are available across Scotland. The programmes have been developed and disseminated by reputable training providers and are robustly evaluated.

suicideTALK: a short exploration and awareness-raising session. It is flexible to meet the needs of each group, and is practice orientated allowing open and honest dialogue for participants.

safeTALK: a three-hour training course which gives participants the skills to recognise when someone may have thoughts of suicide, and to connect that person to someone with suicide intervention skills.

ASIST (Applied Suicide Intervention Skills Training): a two-day workshop with two trainers, offering practical help to enable caregivers to recognise and intervene to prevent the immediate risk of suicide.

ASIST TuneUp: an interactive 3.5-hour refresher workshop with up to 30 participants, which pulls together and refines previous learning. Anyone who has completed a previous ASIST workshop can attend.

STORM: a suicide prevention training package for developing, through rehearsal, the skills needed to assess and manage a person at risk of suicide. STORM is a modular course which was developed for front-line workers in health, social and criminal justice services.[13]

Knowing what the risks are and having the confidence to recognise and discuss them can be important in protecting children and young people.

13 www.chooselife.net/training for more information.

Appendix 3

Organisations which contributed to this guide

The councils of:
Aberdeen
Aberdeenshire
Angus
Dumfries and Galloway
Dundee
East Ayrshire
East Dunbartonshire
East Lothian
East Renfrewshire
Edinburgh
Glasgow
Highland
Inverclyde
Falkirk
Fife
North Lanarkshire
North Ayrshire
Perth and Kinross
Renfrewshire
Scottish Borders
South Ayrshire
South Lanarkshire
Stirling
West Dunbartonshire
West Lothian

And staff from:
Aberlour Trust
Aberdeen Foyer
Action for Children
Airth Drive Children's Unit
Andrew Lang Unit (NHS Borders)
Association of Chief Police Officers Scotland
Barnardo's
Barnardo's Scotland Fostering
Barnardo's Hopscotch Project
Childline
Choose Life
Child Health Commissioner, NHS Lothian
Children and Young People's Specialist Services
Dept. Paediatric Psychology, Royal Hospital for Sick Children, Yorkhill
Coylton Children's Unit
Crown Office and Procurator Fiscal Service – Argyll & Clyde
East Dunbartonshire Community Health Partnership
East Renfrewshire CHCP HQ
Edinburgh Connect
Edinburgh Secure Services
Fife CAMHS
Fostering Network
Fostering and Adoption Highland council
Gartnavel Royal Hospital
Glasgow CAMHS
Good Shepherd Secure / Close Support Unit
Greenock Health Centre
Helenvale Children's Unit
Helensburgh Children's Unit
HM Young Offenders Polmont
HMP and Young Offenders Cornton Vale
Hospice Butterflies
Kibble
LGBT Youth Scotland
Lothian Mental Health and Well-Being Team NHS Lothian
Motherwell College

NHS Ayrshire and Arran
NHS Borders
NHS Dumfries and Galloway
NHS Forth Valley
NHS Grampian
NHS Greater Glasgow and Clyde
NHS Highland
NHS Tayside
NSSPCC
Onslow Drive Children's Unit
Open Secret
Penumbra
Psychological Services Woodside Primary School
Royal Hospital for Sick Children, Edinburgh
Royal Edinburgh Hospital
Young People's Department Royal Cornhill Hospital
Scottish Children's Reporter Administration
Scottish Government:

- GIRFEC Team, Safer Children Stronger Families
- Improving Outcomes for Looked After Children Team
- Secure Care – Care and Justice Division
- Child and Maternal Health Division, Healthcare Policy and Strategy Directorate
- Her Majesty's Inspectorate of Education
- Scottish Prison Service
- Social Work Inspection Agency

Scottish Institute for Residential Child Care
Shellachview
Spark of Genius
Strathclyde Police
Stratheden Hospital
The Samaritans
181 Whiteletts Road (Children's Unit)
Wallacewell Children's Unit
Western Isles Health Board
Who Cares? Scotland

This guide is available in pdf format on our website:
www.scswis.com

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