Understanding and responding to children and young people at risk of suicide

Guidance for staff working with and supporting children and young people in Fife

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Introduction

This guidance is for all staff in statutory and voluntary agencies that are working with and supporting children and young people in Fife and should be used to support your own professional judgement and your organisation's existing policies. There should be no "wrong door" when it comes to a young person asking for help.

This guidance supports the UN Convention on the Rights of the Child (UNCRC), particularly in relation to the following articles:

- ***Article 3:*** *Best Interests of the Child*
- ***Article 6:*** *Every child has the right to life, to grow up and reach their potential*
- ***Article 12:*** *Every child has the right to be listened to and taken seriously*
- ***Article 16:*** *Right to Privacy*
- ***Article 24:*** *Every child has the right to good healthcare*

The United Nations Convention on the Rights of the Child (UNCRC) places a strong emphasis on the protection of children's privacy and the careful handling of their personal information. When it comes to sharing confidential information, especially in sensitive contexts like disclosures of suicidal ideation, the principles of the UNCRC must be carefully balanced with the need to ensure the child's safety and well-being.

This document was developed by a multiagency group and brings together information identified within various guidance documents and is based on current service provision in Fife. We have created a Wakelet for practitioners using this document which signposts to useful website and information related to the guidance. We have also signposted to other Wakelets for children and young people and parents/carers at other points in the document. Links to all Wakelets and other examples of useful information are provided within the appendix at the end of the document.

Aims

This guidance aims to:

- *reduce the risk of suicide in children and young people in Fife*
- *support partnership working with children, young people, parents, carers and professionals*
- *increase staff confidence*
- *support you to understand your role and boundaries by providing a shared framework for understanding, identifying, responding, assessing and working with young people at risk of suicide.*

Acknowledgements

This guidance was developed by a multiagency group of partners including:

- *Barnardo's*
- *Children & Adolescent Mental Health Services (CAMHS)*
- *Children and Families and Justice Social Work*
- *Child Protection Committee*
- *Education Service*
- *Educational Psychology*
- *Health Promotion Service*
- *School Nursing Service.*

Understanding Suicide and Suicidal Behaviours

The vision within the Scottish Suicide Prevention Strategy "Creating Hope Together" is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide. The aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope. To achieve this, all sectors must come together in partnership, and we must support our communities so they can become safe, compassionate, inclusive, and free of stigma[1].

In Fife, we are supporting this national vision through Fife's Children's Services Partnership which is committed to promoting, supporting and safeguarding the wellbeing of all children and young people in Fife. At the heart of this work is our shared ambition as a Children's Services Partnership: 'Making Fife a place where every child and young person matters'. Further information can be found in the Children's Services Plan 2023-2026.

Definition

The Scottish Government defines suicide as 'death resulting from an intentional, self-inflicted act' and that 'Suicidal behaviour comprises both deaths by suicide and acts of self-harm that do not have a fatal outcome, but which have suicidal intent.[2]'

Suicide rates in young people

Suicide among young people in Scotland: A report from the Scottish Suicide Information Database (ScotSID)[3] identified that between 2011 and 2020, probable suicides were the leading cause of death among 5–24-year-olds, accounting for a quarter of all deaths (25.7%) compared to accidental poisonings (14.1%) and land transport accidents (10.1%).

There were significant differences in the proportion of all deaths attributed to probable suicide between the subgroups composing the 5-24 age group: 10.6% of deaths were attributed to suicide among 10-14-year-olds, 26.4% among 15-19-year-olds, and 31.1% among 20-24-year-olds.

Hanging, strangulation and suffocation were the most commonly used method overall. The use of these methods were significantly more prevalent among 5-24-year-olds (63.9% of deaths) than among people aged 25 and over (45.9% of deaths).

An infographic of the key findings from this report can be viewed here.

National Records Scotland is responsible for producing statistics on Scotland's population and produce the official annual suicide data release. The most recent data release can be accessed here.

1: Creating Hope Together (2022) Our understanding of suicide, and our approach - Creating Hope Together: suicide prevention strategy 2022 to 2032 - gov.scot (www.gov.scot)

2: Every Life Matters (2018) Definitions - Suicide prevention action plan: every life matters - gov.scot (www.gov.scot)

3: Scottish Suicide Information Database (2022) Suicide among young people in Scotland - A report from the Scottish Suicide Information Database 6 September 2022 - Scottish suicide information database - Publications - Public Health Scotland

Who is most at risk?

The Scottish Suicide Prevention Strategy "Creating Hope Together" states suicide in Scotland is a significant public health issue which affects all age groups and communities. Although no-one is immune from suicide, some individuals are at greater risk. Our understanding of the factors that make people more or less likely to be affected by suicide has evolved in recent years. The Academic Advisory Group for Creating Hope Together has undertaken research to develop a greater understanding of risk and protective factors for suicide. The high-level findings are[4]:

- *age and sex should be considered when other risk factors of suicide attempt are present, for example, self-harm history, impulsivity, and feeling of entrapment*
- *specific risk factors include: poverty, employment status, a sense of defeat, hopelessness, and challenging relationships*
- *perceptions of relationships should be considered, for example, feelings of burdening others.*

It is often a combination of risk factors (including life events) which can lead to suicidal behaviour. Understanding these risk and protective factors helps us put inequalities at the heart of our approach – so we can reach and connect with people who are most at risk.

Signs that someone you know may be at risk:

- *Previous deliberate self-harm or suicide attempt*
- *Talking about methods of suicide*
- *Problems out with their control*
- *Making final arrangements such as giving away prized possessions*
- *Hints that "I won't be around" or "I won't cause you any more trouble"*
- *Unresolved feelings of guilt following the loss of an important person or pet (including music or sports idols).*

Marked changes in usual behaviour patterns can also be a sign of risk

- *Change in eating or sleeping habits*
- *Withdrawal from friends, family and usual interests*
- *Violent or rebellious behaviour, or running away*
- *Drinking to excess or using drugs*
- *Feelings of boredom, restlessness, self-hatred*
- *Failing to take care of personal appearance*
- *Becoming over-cheerful after a time of depression*
- *Physical signs, for example weight loss or gain or muscular aches and pains.*

The Integrated Motivational-Volitional (IMV) Model (O'Connor 2011 and O'Connor & R.C, & Kirtley 2018) is a tripartite model that proposes that suicidal behaviour results from a complex interplay of factors, such as biology, psychology, environment, and culture. Further information can be found in the appendices section of this document.

4: Creating Hope Together (2022) Our understanding of suicide, and our approach - Creating Hope Together: suicide prevention strategy 2022 to 2032 - gov.scot (www.gov.scot)

Common myths about suicide

There are a number of commonly held myths about suicide which may stand in the way of providing assistance for those at risk of suicide:

***Myth:** Young people who talk about suicide never attempt or complete suicide*

Talking about suicide can be a plea for help and it can be a sign in the progression towards a suicide attempt. Talking about suicide is one of the factors suggesting a risk of attempted suicide.

***Myth:** People who threaten suicide are just seeking attention*

Do not dismiss a suicide threat as simply being an attention-seeking exercise. It is likely that the young person has tried to gain attention and this connection is needed.

***Myth:** Talking about suicide encourages it*

Responsible talk about suicide does not encourage people to attempt suicide. Cambridge University has published research in support of this which can be viewed here.

***Myth:** If a person attempts suicide and survives, they will never make a further attempt*

A suicide attempt is regarded as a probable indicator of further attempts.

***Myth:** If someone has decided to kill themselves there is nothing anyone can do about it*

If appropriate help and support is offered to the person with suicidal thoughts and they are willing to accept this help their risk of suicide can be reduced.

***Myth:** People who are suicidal want to die*

The majority of people who feel suicidal do not actually want to die; they just want the situation they're in or the way they're feeling to stop. The distinction may seem small, but it is very important.

***Myth:** Talking therapy doesn't work for people who feel suicidal*

The research is very clear that accessing appropriate support, reduces suicide risk substantially and for a substantial amount of time.

***Myth:** Suicide is caused by a single factor*

Suicide is complex and individuals who feel suicidal are often dealing with a range of issues which is causing them to feel crisis and despair. Often, feeling actively suicidal is temporary, even if someone has been feeling low, anxious or struggling to cope for a long period of time. Getting the right kind of support at the right time is so important.

Samaritans and Papyrus provide further detail on common suicide myths and facts.

Self-Harm and Suicide

This guidance is specifically for identifying and responding to suicide risk, however, it is important to acknowledge self-harm. It is important to recognise that suicide and self-harm are very different, and often have very different objectives behind them.

Self-harm is when somebody intentionally damages or injures their body. It can be a way of expressing deep emotional feelings, or a way of coping with traumatic events. Self-harm is an expression of personal distress, rather than an illness, although it can be linked to other mental health conditions[5].

We know self-harm can be a risk factor for suicide and for some people, the line between a suicide attempt and an act of self-harm is blurred. Some people may not be sure of the outcome they intend, or their desired outcome may change either over time or even within a single episode. However, for many people, self-harm is a way to manage difficult emotions and circumstances and they do not have suicidal intent[6].

We all have a role to play in supporting young people who self-harm. Scotland's Self-Harm Strategy and action plan sets out a vision for people who have self-harmed or are thinking of self-harm, to receive compassionate, recovery-focused support, without fear of stigma or discrimination. The Self-Harm Strategy was informed by the diverse expertise of people with lived experience of self-harm and recognises the complex nature of self-harm. The varied reasons someone might self-harm means there should be a range of support and services available to meet diverse needs[7]:

- ***informal support:*** *when individuals seek help for self-harm, many want to be supported by someone they know and trust, who can listen to them, validate their feelings, and work alongside them to find ways to improve their wellbeing – all at their own pace. For many people this valuable support would be given by a family member, partner, friend, or other trusted person.*
- ***community-based support:*** *this can include responses and support given by staff in education, youth work, housing, criminal justice, social work or third sector organisations. Developing communities' and services' knowledge and confidence in responding to self-harm will be set within the broader context of the Time, Space, Compassion approach and supporting people experiencing poorer mental health, trauma or distress.*
- ***healthcare support:*** *for those looking for healthcare support for self-harm, their GP should be the first point of contact. However, the principle of 'no wrong door' means that irrespective of the service, a person seeking support should be guided to the right place.*

5: NHS Inform, Self Harm https://www.nhsinform.scot/illnesses-and-conditions/mental-health/self-harm/#introduction

6: Scottish Government, Self-Harm Strategy and Action Plan 2023-27 https://www.gov.scot/publications/scotlands-self-harm-strategy-action-plan-2023-27/pages/6/

7: ibid

Talking to a Young Person about Suicide

The skills you need to engage with a young person who is expressing thoughts of suicide are the same skills you would use with any young person in distress. Children and young people are less likely to express or advocate for their needs if they think we're too busy, overwhelmed or sending signals that we're short on time. Recognising something isn't right, listening and supporting them at this stage has a huge potential to change their expectation of being listened to. Research and experience shows us that asking children and young people for their perspective, what they know works for them and respecting and valuing their perspective on the support they need, are all key[8].

Children and young people will choose carefully who they speak to. They will speak to an adult they trust, who doesn't overreact, who will respect confidentially and can get more support if needed. This may not be the people or services we have put in place to offer crisis support. It's widely recognised that this first point of contact when the child or young person reaches out is critical, no matter what our role is[9]. All staff are encouraged to use their colleagues for support.

Time Space Compassion is an approach which can be implemented within all sectors and across our communities. The principles, practices and underpinning values support those engaging in conversations around crisis, distress and suicide to offer a response rooted in human connection and compassion.

The suite of "Ask Tell" animations explore mental health, suicide and young people and provide advice on how to initiate conversations with a young person:

- *What is Mental Health? Understanding the factors that influence mental health and resilience in children and young people.*
- *How to talk about Mental Health. Engaging proactively with children and young people about mental health.*
- *Self-Harm and Suicide Prevention. Self-harm and suicide: How to recognise the signs and when to seek help to support children and young people.*

You might also find tools such as Decider Skills helpful to assist conversations. Further information can be found in the appendices section of this document.

In any conversation with a young person, it is important to remember to:

- *follow your service/organisational policy or protocol*
- *use the support available to you - e.g. manager, colleagues, supervisor*
- *contact other agencies for advice or to refer on where appropriate*
- *liaise with all involved in line with guidelines on confidentiality and consent*

Do not:

- *assume someone else is helping the young person*
- *ever make agreements that you cannot keep*
- *tell them to stop or make ultimatums.*

8: Youth Advisory Group https://childreninscotland.org.uk/young_advisory_group_creating_hope_together/

9: First Point of Contact https://www.digitallearningmap.nhs.scot/first-point-of-contact/

The following is from Papyrus Disclosure of suicidal thoughts | Papyrus UK | Suicide Prevention Charity (papyrus-uk.org):

If someone tells you that they are suicidal, the following tips can help you open a dialogue with them and offer support in an appropriate and sensitive manner:

- *Firstly, it is important that you try to stay calm and listen to the young person – hear them out. Avoid judgement, regardless of what's going on. Suicide should always be taken seriously. Ask open questions to get an understanding of what is happening for them and how it is making them feel. Remember that, regardless of what has happened or your opinion on this, it is making a young person think about ending their life. So, it's important to listen and take them seriously.*
- *Don't judge, offer platitudes ('things will pick up', 'Life's too short' etc.) or try to fix everything. It has taken that young person a lot of courage to be open and honest with you, it is important that you take what they say seriously and without judgment.*
- *Also, empathic listening is key here – ask open and honest questions and show that you're listening by reflecting on what they say and clarifying what they mean. Don't jump in with solutions – allow them to express their problems first.*
- *Don't minimise their feelings by saying it's 'just a phase', 'you'll grow out of it' or 'why is that even bothering you?' Take time to imagine what it's like for that person, focus on their feelings and their experiences – not your own.*
- *Give them space and time in the moment or, if they feel unable to speak at that time, acknowledge the importance of what they've said and arrange a time to talk. As hard and as painful as it might be to listen, you need to hear their reasons for wanting to die before you can focus on reasons for living.*
- *It's absolutely ok to not know what to say! You're a human being too and what you're hearing might be terrifying for you, as well as the individual. If you don't know what to say – be honest and tell that person. Reassure them that you are glad they told you – this can be far more empowering and genuine than making something up. If you're honest with them, they'll be honest with you.*

How to talk about suicide

Asking about suicide saves lives but it can be hard to know where to start or how to help. Below are some example conversation starters if you are worried about someone. The practitioners Wakelet also provides examples of conversations starters from Papyrus. It can be scary, hard or painful to talk about suicide – but we need to. Suicidal feelings don't have to end in suicide. Many young people feel really isolated with their thoughts of suicide and do not feel that they are able to tell anyone. **Evidence shows that talking about suicide does not make it more likely to happen – it reduces the stigma and is often the first step in a person's recovery.**

Ask them directly:

- *"Are you thinking about suicide?" By using the word suicide, you are telling the young person that it's OK to talk openly about their thoughts of suicide with you.*
- *"Sometimes, when people are feeling the way you are they think about suicide. Is that what you're thinking about?"*
- *"Are you telling me you want to kill yourself? End your life? Die? Die by suicide?" "It sounds like you're thinking about suicide, is that right?" "It sounds like life feels too hard for you right now and you want to kill yourself, is that right?"*

If someone is suicidal, listen to them and allow them to express their feelings. They may feel a huge sense of relief that someone is willing to hear their darkest thoughts:

- *"It sounds as though things are really hard at the moment.... Can you tell me a bit more?"*
- *"Things must be so painful for you to feel like there is no way out. I want to listen and help."*
- *"Take your time and tell me what's happening for you at the moment."*
- *"I am so sorry you're feeling this way. Can you tell me more about how you are feeling?"*
- *"Can you tell me more about why you want to die?*
- *"What has brought you to this place/ to feel this way?" "It's hard and scary to talk about suicide but take your time and I will listen."*

Reassure them that they are not alone and you can look for support together. You can refer to the children and young persons Wakelet to help you do this.

- *"It's not uncommon to have thoughts of suicide. With help and support many people can work through these thoughts and stay safe." "There are organisations that offer support like PAPYRUS HOPELineUK, I can help you find their contact details."*
- *"You've shown a lot of strength in telling me this. I want to help you find support."*
- *"There is hope. There is help available and we can find it together".*

Unless things have reached a critical level, your concern for the young person and interest in their well-being are likely to have reduced some of their distress and sense of isolation. By offering to see the young person again within a specified time frame, you show that you have time for them and can be approached if the situation deteriorates. Make sure that the plans you put in place actually happen; for example, check they have been contacted/seen by the service you have connected them with, or have seen their GP.

Working with Young People and their families

Young people and their families may have different views and feelings regarding the risk of suicide and may struggle to understand each other's experience. For the professional trying to help it is often difficult to achieve a balance and support everyone involved. Don't feel you need to manage this by yourself. It is not unusual for more than one person to provide support to the young person and their family. Risk of suicide within families can make people feel scared and helpless and it is therefore important to help them to explore these feelings in a safe way. It is important for all involved to remain open-minded, non-judgmental and to respect the views of all family members in order to reduce feelings such as blame, guilt or shame being directed at any one individual.

It is important that family members have a sense of urgency in terms of understanding the triggers to the young person's risk of suicide and doing what they can to address these issues. At the same time, it is important to convey a sense of hope that if everyone works together then these issues can be successfully addressed, and change is possible.

Not all parents/carers have the knowledge, resources, or emotional capacity to offer support and guidance. They may also ignore or minimise concerns. Children might not always feel able to communicate openly with their parents due to fear of judgment or misunderstanding. If assessment indicates that parents/carers are not a protective factor, alternative strategies and support systems must be considered to ensure the young person's safety and well-being. It is also worth remembering that siblings may be affected as well and their needs should also be considered.

There is a useful Wakelet for parents and carers which you may find helpful in your conversations with the parents and carers to support them to identify the right support.

If there is already multi agency support in place for the child or young person then it is important to consider how this concern is integrated alongside any other information. It may be that existing supports are enough to address any contributing factors identified in your conversations with the child or young person.

Deciding what information to share: Confidentiality and Consent

Explain the limits of confidentiality, emphasising that their safety is the priority and that you may need to inform parents/carers to ensure they get the support they need. Inform them that due to legal requirement you may need to inform parents/carers if their safety is at risk.

Risk Assessment

In terms of talking to a young person who may be having suicidal thoughts and feelings much of the advice in the previous section is relevant. However, when entering into a dialogue, it can be helpful to gather information on the following areas in order to accurately assess risk and share information, as required.

Thoughts: Have they ever thought about suicide? How often do these thoughts come into their mind? Are these thoughts that they can ignore? Are there things that they can do to take their mind off these thoughts? Do they ever hear these thoughts as voices telling them to harm themselves? Do they feel hopeless about their future?

Intent: Do they feel that they would act on these thoughts? Are they worried that they might act on them? Do they feel safe right now? What stops them from acting on these thoughts?

Planning: Have they ever made any plans to take their own life? What did they plan to do? Do they have a plan at this time? Have they thought about when this might happen? Have they ever researched

methods or spoken to anyone else about ways to die?

Access to lethal means: Do they have anything that they would use to harm themselves such as pills etc.? Where are they kept?

History: Have they ever tried to kill themselves in the past? What happened? What stopped them? Did they go to someone for help? Do they feel the same right now?

What to do next: If suicidal thinking is fleeting, with no clear intent or planning and is contextual to a wider issue, consider access to primary support e.g., school nurse, counselling service or Primary Mental Health Workers. Are parents aware? If not, what are the young person's concerns about telling them? If there is clear risk, you will need to inform them. If you are unsure about the level of risk or how to make sense of the information you have gathered, it is important that you seek appropriate consultation. When considering next steps, returning to the five GIRFEC questions will help contextualise the risk and support your next steps. Where clear risk is apparent, you need to consider your safety plan.

1. *What is getting in the way of the child/ young person's wellbeing?*
2. *Do I have all the information I need?*
3. *What can I do to help?*
4. *What can my agency do to help?*
5. *What additional help may be needed?*

Refer to the GIRFEC national practice model for further information.

Responding to risk and the use of Safety Plans

Any response to a young person who is experiencing suicidal ideation or distress should be informed by the level of risk. A plan to support the young person's wellbeing may be appropriate or a box which could be filled with things to help the young person feel better, it could include items to help a young person self-soothe or include a list of phone numbers or support service that can be used if they would like to talk to someone about how they are feeling. This resource from Papyrus may be helpful for you to use: https://www.papyrus-uk.org/wp-content/uploads/2018/09/HOPEBOX-resource.pdf

A safety plan is a collaborative agreement including the young person, family and relevant practitioners and is more likely to be used where there is a raised or high risk of harm. An immediate safety plan can be "here and now" and can be reviewed once the young person has accessed any additional supports. Refer to the practitioners wakelet for a safety plan example.

When considering the use of safety plans, it can be helpful to gather information on the following areas:

The warning signs for distress: What are the triggers? What are the situations?

What actions the young person will take to maximise safety? Letting someone know, staying in public areas, focusing on a distraction task, 'safe pain' techniques, talking to positive friends etc.

What actions will family take? Remove access to lethal means, agree frequency of checks, keeping room door open, and spend time with the young person engaging in distraction, time to talk or listen, plan activities. Ensure the family has contact details for emergencies and a clear plan of action if they feel unable to keep the young person safe.

What actions others will take? Provide a safe space in school. Identify a named

adult to talk to, to give encouragement to engage in lessons and activities, to address underlying issues and to review timetable as appropriate. Provide access to counselling or school nurse. All involved to build confidence and self-esteem through positive activity and responsibility. For school-age young people, when indicated, share an understanding of their wellbeing needs through a co-ordinated plan, using the Wellbeing Pathway.

Other Risks to Consider

Risk of suicide is not the only risk that needs to be considered when a young person may be so distressed that they are feeling suicidal. It is important to consider whether the young person is at risk of harm from others, including family, peers, online contacts or other adults. It is also important to consider if the young person is so distressed by their situation that they are a risk to others, using violent methods.

The Integrated Motivational-Volitional (IMV) Model (O'Connor 2011 and O'Connor & R.C, & Kirtley 2018) is a tripartite model that proposes that suicidal behaviour results from a complex interplay of factors, such as biology, psychology, environment, and culture. Further information can be found in the appendices section of this document.

Working with children and young people at risk of suicide can be a complex area often requiring multi agency working / risk management approaches / clinical interventions. All organisations must follow their respective protocols for responding to a critical incident. Multiagency pathways for responding and managing risk should be used to support young people and their families.

Other young people who may be affected

Encourage all young people to raise worries they may have about friends. If a young person is expressing thoughts of suicide, be alert to the possible impact on their peer group, especially if it is a friend who has come forward to pass on their concerns. Reassure them that they have done the right thing and you will respond sensitively. Let them know that their role is to be the young person's friend and that adults will take key responsibility for acting on the concerns they have passed on.

In some instances, a young person expressing thoughts of suicide can be unsettling to other vulnerable young people. Be aware of this and offer support and guidance when needed. A shared strategy or approach across your colleagues can often be helpful to provide a consistent and predictable response.

Responding to suicide risk

Fife multi-agency protocol - updated September 2023 (18 years and under)

Talking to someone about suicidal thoughts and feelings can be extremely difficult. If you are unsure whether someone is suicidal, the best way to find out is to ask them if they are thinking about suicide. This shows you care and they are not alone. It allows the other person to talk about their feelings and plans - the first step to getting help.
Communicating suicidal intent can sometimes be a way of communicating distress.

Using the principles of Time, Space, Compassion; children and young people can be moved from a high or raised risk of concern to a lower risk with identified supports in place.

When a child or young person is expressing distress

Step 1: Create a compassionate space to pause and reassure

Step 2: Start a conversation

A helpful way to start the conversation is by checking in on them:
"I'm really worried about you, it must have been hard to share this with me, thank you."
"I wanted to check in with you because you haven't seemed yourself lately."
"I am really worried about you and need to ask you if you have been thinking about suicide."

Step 3: Enquire to inform level of distress

Sometimes people can say things like:
"I've had enough"
"I can't take this any more" or
"I wish I didn't feel like this any longer"

This can be an expression of despair without intending or thinking about self-harm or suicide.
If someone does not have any active suicidal thoughts, it is still important to offer support and referral services.

Questions to assist assessing presence of active suicidal thoughts:
Are you thinking about attempting suicide?
Do you have a suicide plan?
Have you identified a method?
Have you identified when you might act on a suicide plan?
If the person answers YES to any of the above, determine low, raised or high risk and take appropriate actions.

Step 4: Reflect/confirm - consider whether you have the answer to the 5 GIRFEC questions

LOW

Link to indicators in case study document
Risk factors may be present
This is an opportunity for early intervention
Listen compassionately, ease distress
Consider additional support or therapeutic intervention
Complete documentation/assessment
Consider with child or young person who needs to know - UNCRC
Child Wellbeing Pathway
Follow up conversation
CAMHS bookable consultation system
email: fife.camhs-pmhw@nhs.scot
If appropriate, a consultation slot will be offered within 2-3 weeks (approx)

RAISED

Active suicidal thoughts are present.
No clear plan, method or timeframe.
Consider individual risk and protective factors.
Consider other services that can support in the area eg third sector organisations
Choosing the right support alongside the child or young person.
Consider
Child Wellbeing Pathway
If you need immediate help call **111** and select the mental health option.
You may be able to speak to a trained mental health professional over the phone.

HIGH

Active suicidal thoughts are present. This may include a plan, method and timeframe.
Consider individual risk and protective factors
Submit completed referral forms via email to Fife.camhsreferrals@nhs.scot
include URGENT in the email heading
Submit CAMHS referral form
Safety planning - supported by parents/carers (if appropriate) and informed by
Child Protection Procedures
If young person continues to have active suicidal behaviours phone 999 or take them to A&E

Step 5: Check back and review

LOW RISK

No suicidal thoughts, or if so, vague, reactive, fleeting.

- No plan in place.
- Self-harm that is known and managed.
- Any mood changes are transient.
- Able to articulate future life plans.
- Current concerns were managed appropriately.

POSSIBLE ACTIONS

Actions to consider

Discuss plan to support wellbeing, self-help tools eg distraction plans.

- Provide advice on appropriate care of any injury.
- Inform parents/carers with young person's consent.
- Arrange meeting with parents/carers to discuss.
- Inform the named person with consent and link to sources of support in school.
- Single Agency Support Plan as per GIRFEC.
- Consult with relevant services eg Ed Psych, school nurse (drop in model), Primary Mental Health Worker, CAMHS consultation appointment. Consider referral to counselling or other support services.

RAISED RISK

- Talking about suicide, thoughts are more frequent but still fleeting.
- May have considered method but no specific plan or immediate intent.
- Previous suicide attempts.
- Previous history of overdose or other significant self-harm.
- History of impulsivity.
- Current self-harm with raised safety risk, eg deeper/more frequent cutting.
- Significant drug/alcohol use.
- Experience of trauma has been considered.
- Young person has significant other wellbeing concerns eg truancy, conflict at home or with peer group, offending.
- Current concerns are managed appropriately.
- Care experienced child/young person.

POSSIBLE ACTIONS

Actions to consider

- As per Low Risk action points.
- Arrange wellbeing meeting.
- Link to sources of support in school/notify named person and other relevant professionals.
- Discuss need for increasing level of support.
- Refer to relevant agencies and agree multiagency Child's Plan.
- Consider safety and support plan and who should be part of this.
- Review and assess at agreed intervals.
- Complete checklist/document decision making.
- Consider how to access your own support needs.

HIGH RISK

- Frequent suicidal thoughts which are persistent, clear and unrelenting.
- Strong desire to die, indicates hopelessness.
- Specific/detailed plans in place.
- Increasing self-harm with significant safety risk, frequency, severity, or both.
- Previous history of suicidal behaviour, attempts, family history of suicide.
- Evidence of current mental health problem.
- Significant drug or alcohol use (including binge drinking).
- History or evidence of impulsivity.
- Situation felt to be causing unbearable distress.
- Lack of protective factors.
- Care experienced child/young person.

POSSIBLE ACTIONS

Actions to consider

- Consider access to trained people in your organisation (eg ASIST trained).
- Stay with the young person. Do not send home alone.
- Listen compassionately and ease distress as far as possible.
- Consider together what may be done to resolve difficulties.
- Provide advice on appropriate care of any injury.
- Discuss immediate plan to stay safe.
- Submit completed CAMHS referral form via email, include URGENT in the email heading.
- Inform parents/carers (unless this will increase present risk).
- Discuss immediate Safety & Support plan with parents/carers.
- Notify services as appropriate (eg GP, Social Work).
- Decide on ongoing level of monitoring, increased support and by whom.
- Meeting/Child's Plan Review arranged - risk management processes may be required.
- Complete checklist/document decision making.
- Assess immediate risk and consider 999/ A&E if urgent attention is required.

Contributory Risk Factors

Fife Children's Services Partnership recognise that the children, young people and families of Fife have experiences, needs and aspirations that are many and varied. This recognition is underpinned by the importance of valuing diversity and challenging of discrimination. Within this context it is recognised that some groups of young people experience additional vulnerabilities and challenges which may increase risk of suicide as a result. It remains crucial to understand any identified vulnerabilities within the wider context of the young person's circumstances using a Time Space and Compassion approach and GIRFEC.

This section outlines some of the contributory factors which may increase the risk of suicide, however it is not exhaustive. The assessment carried out during a discussion with the individual will be central to identifying, understanding, and responding to potential risks.

Care Experienced Children and Young People

Young people looked after away from home are particularly vulnerable to an increased risk of self-harm and suicide. They are much more likely to have had adverse/traumatic early experiences and can experience high levels of stress during adolescence. They are also likely to have far fewer protective factors and positive support networks than their peers. Looked After Children experience "significantly poorer mental health than the most disadvantaged children outside the care system"[10].

There is evidence to suggest that children in care and care leavers are more at risk both of hurting themselves and completing suicide, than those who are not care experienced. It is important to investigate and act upon any evidential links between adverse childhood experiences, suicide and these groups.[11]

The roots of adolescent suicide can often be found in the early trauma experienced by young people.[12] These risks continue into adulthood and may well be implicated in much self-harm and many suicides later in life.[13] Traumatic experiences prior to and in care have an adverse impact well into adult life. Many care experienced young people are likely to have several of the risk factors associated with suicide. This can create difficulties in maintaining a balance between responding to transient, though intense distress which may be manageable, and under reacting to more subtle but serious difficulties where young people may need professional help and protection. Careful assessment and intervention are required as a result.

In recognition of this increased risk for children and young people who are care experienced, the following Care Inspectorate resource is recommended: Suicide Prevention for looked after children and young people.
A further resource may also be useful: Understanding suicide and self-harm amongst children in care and care leavers.

10: IRISS https://www.iriss.org.uk/resources/insights/understanding-suicide-self-harm-children-care-leavers

11: ibid

12: Still Vulnerable: A Review of the Impact of Early Childhood Experiences on Adolescent Suicide and Accidental Death - Queen's University Belfast https://pure.qub.ac.uk/en/publications/still-vulnerable-a-review-of-the-impact-of-early-childhood-experi

13: Listen up! Adult care leavers speak out: the views of 310 care leavers aged 17-78 https://strathprints.strath.ac.uk/27410/

Supporting Care Experienced Children and Young People

The key principles of Time, Space, Compassion remain the main components to any conversation or planned approach with any care experienced young person who is communicating signs of suicidal crisis. Many of the supports and interventions that will address the risk of suicide are key tasks for social workers, residential care workers and foster carers. Using their existing skills and working confidently, caringly, and competently with young people helps address their underlying distress and difficulties. Training and support specific to the practitioners who support children in these contexts are critical and Fife offers a tiered approach of training to meet this need, as well as access to more specific training for Fife Council Foster Carers.

Important Points

- *Young people can form genuine and secure attachments to adults caring for them which provide opportunities to resolve some of the underlying chaos and distress that impacted their earlier lives.*
- *Supporting positive peer relationships, both within their care setting and at school or work, combats the social isolation often associated with self-harm and suicidal behaviour.*
- *Success at school is a protective factor and so helping young people to attend regularly and achieve their full potential both academically and socially is essential.*
- *Supporting young people to manage and improve their relationships with their families is a key role for carers and workers.*
- *Relationships with the other young people with whom they share their living space can be very powerful. Adults can encourage the reciprocal responsibility of relationships among young people. This is particularly important as we know that young people contemplating suicide are most likely to confide their intentions to a peer. Creating a positive culture where distress is talked about and understood by everyone can prevent some of the dangers of contagion within residential settings.*
- *A sense of connectedness and belonging is protective against both self-harm and completed suicide. Children in care and care leavers often experience a massive amount of turbulence in their living arrangements. When change and transitions, whether planned or unplanned, disrupt important and comforting relationships this can greatly increase the risk that young people will hurt themselves.*

Pathway for Children and Young People who are Looked After in Fife

Fife is committed to delivering The Promise ensuring that children, young people and their families can access the support they need, where and when they need it. Considering the likelihood of increased complexity of presentation of children who are in care and at risk of self-harm or suicide, the use of existing planning and review processes continue to be important. This supports the shared analysis of any presenting risk factors and how this can be integrated alongside other known assessment information. This may include Looked after Children (LAC) core groups, LAC reviews or the use of multi-agency risk management processes.

In Fife, CAMHS support is offered through an enhanced pathway, reducing the need of any waiting time for planned mental health assessment and support. For those children and young people who are Looked After and Accommodated within foster or residential care placements, the child's social worker should consider as a second step, making a referral to the Springfield Project (for children in local authority placements) The Beeches (children in purchased placements within Fife) or The Willow Project (children in Kinship care) service for a therapeutic service.

The stability of the young person's placement is of upmost importance, and it may often be appropriate for CAMHS professionals to offer external consultancy to those directly caring for the young person, even or especially if that young person feels unable to accept individual therapeutic support. Targeted CAMHS provision has greater flexibility in overcoming such barriers to support young people and can use a range of geographical locations across Fife.

For Fife young people resident out with Fife, at present, carers are required to access CAMHS support via their local GP service or according to local CAMHS pathway arrangements. A lack of continuity in terms of mental health support for vulnerable young people who move frequently between placements can be a barrier and working arrangements across health board boundaries can require clarification.

Carer Support

The impact of supporting a young person who is experiencing suicidal crisis in residential or foster care can be traumatic to both staff and other children and young people. All staff and carers require adequate support and training to remain resilient in the face of such difficult circumstances and enable them to continue to support the young person and the other young people living in the same environment.

Care Leavers

Any young person who ceases to be looked after on or after their 16th birthday will be classified as a Care Leaver. All looked after children can become 'care leavers', including young people who were classified as 'looked after at home' and in formal kinship care. The Children and Young People (Scotland) Act (2014) extend eligibility to aftercare services to care leavers aged 26. Section 58 of the Act also outlines corporate parenting responsibilities this group of young adults.

The Scottish Care Leavers Covenant supports corporate parents to deliver changes in action and practice to bring improvement and consistency to the care of these young people. It offers clear guidance on how to meet the needs of young people who are often disadvantaged because of their care experiences.

The Covenant outlines a range of actions and practice changes across key policy themes, which need to be delivered consistently by all relevant corporate parents across Scotland, at national and local level. One of the policy themes is "Health and Wellbeing" and it states a range of actions, one of which is that corporate parents will ensure that care leavers are given priority access to specialist services (including self-harm services) and improved access to adult mental health services. It also specifies that each local authority and health board has a named contact with specific responsibility for care leavers' health and for promoting and coordinating actions to reduce health inequalities, these being made explicit within Corporate Parenting Plans.

Support for 'care leavers' is provided by the Children and Family Social Work Service depending on the age they move on from their care arrangement. There are barriers to young care experienced adults in accessing the mental health support they require, including geographical accessibility and stigma. There is a further transition point between CAMHS and Adult Services that requires navigation. Pathways to access more flexible mental health advice, assessment and intervention continues to be developed. This includes a post of a Senior Mental Health Nurse who is located within the Young People's Team and can be contacted for further advice and guidance. There is also a Senior Nurse for Transitions who is located within CAMHS to support transitions to Adult Mental Health Services.

Social Media

Social media platforms are now a part of everyday life. This can provide many opportunities including: learning more about, or connecting with, others in relation to areas of shared interest; staying connected with family and friends; developing communication or technical skills; or campaigning for social good. However, like many things, social media also carries risks, such as: pressure to overshare personal information online; sending or receiving inappropriate content; cyberbullying; or developing an unrealistic sense of reality[14], all of which, could have a detrimental impact on health and wellbeing. Online platforms can also provide young people with opportunities to access harmful content disguised as support, including online forums; message boards; and groups that have been set up for people experiencing similar feelings in relation to issues such as eating disorders, self-harm or suicide[15].

LGBTQI+

LGBTQI+ people are much more likely to have experienced[16]:

- *bullying and name calling at school*
- *hostility or rejection by family*
- *danger of violence in public places*
- *rejection by some religions*
- *harassment*
- *casual homophobic/biphobic/ transphobic comments.*

Research by LGBT Youth Scotland in 2022[17] found that 50% of LGBQ young people who responded to their survey had experienced suicidal thoughts or behaviours. Research commissioned by Just Like Us, an LGBT+ young people's charity in the UK, carried out a pupil survey exploring the wellbeing and experiences of young LGBT+ people aged 11 to 18. A total of 2,934 pupils from 375 schools and colleges across the UK were surveyed, 1,140 of whom identified as LGBT+ (39%). The research found that LGBT+ young people were twice as likely to contemplate suicide than their non-LGBT+ peers[18].

Refer to the practitioner wakelet for further information.

Young Carers

Children and young people who care for someone are known as young carers. They can be as young as three or as old as 25. They may be caring for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Older young carers are also known as young adult carers[19]. For many young carers their exposure to the stress of their caring role, family illness/disability or substance use issues, coupled with other risk factors can compromise their ability to remain resilient[20] which in turn, could have a detrimental impact on their mental health.

Refer to the practitioner wakelet for information on toolkits to support young carers in relation to their mental health and wellbeing.

14: NSPCC Social Media https://www.nspcc.org.uk/keeping-children-safe/online-safety/social-media/

15: NSPCC Harmful content disguised as support https://www.nspcc.org.uk/keeping-children-safe/online-safety/inappropriate-explicit-content/promotion-self-harm/

16: LGBT inclusive mental health services – good practice guide https://www.mwcscot.org.uk/news/lgbt-inclusive-mental-health-services-good-practice-guide

17: LGBT Youth Scotland Life in Scotland for LGBT Young People in 2022 - LGBT Youth Scotland

18: Just like Us Just-Like-Us-2021-report-Growing-Up-LGBT.pdf (justlikeus.org)

19: Carers Trust, Breaking the Silence on Mental Health Toolkit https://carers.org/downloads/resources-pdfs/breaking-the-silence-on-mental-health/breaking-the-silence-on-mental-health.pdf

20: Carers Trust, Young Carer Mental Health Toolkit https://carers.org/downloads/scotland-pdfs/mental-health-toolkit.pdf

Speech, Language and Communication Needs

Many children with social, emotional and mental health needs have unidentified speech, language and communication needs (SLCN) (RCSLT, 2020), with one study identified that 81% of children with emotional and behavioural disorders having significant unidentified language deficits. Around 60% of youth offenders have an unidentified SLCN. Difficulties with speech, language and communication impacts on all areas of a young person's life including academic attainment, mental health, long-term outcomes, making and maintaining positive relationships with family and peers.

Difficulties with speech, language and communication can often be attributed to a young person having poor motivation or attitude through behaviours or the young person may have superficial skills which mask underlying difficulties. These difficulties can prevent them from being able to access mental health supports which typically require good language and reasoning capabilities.

Please refer to Promoting social, emotional and mental health leaflet for further information. E-learning modules to support understanding of children and young people with social, emotional and mental health needs and speech, language and communication needs are available: Mind Your Words – RCSLT CPD.

Neurodivergence[21]

Neurodivergent people are more likely to experience mental health issues with research showing that autistic children are 28 times more likely to think about or attempt suicide than neurotypical peers. Factors known to increase the risk of suicide in the general population are more common in those with neurodevelopmental conditions. These factors include social isolation, low mood and self-esteem, rumination, and difficulty identifying, regulating and expressing feelings and emotions. Often neurodivergent young people face language, processing and communication challenges which should be considered when using the Time Space Compassion approach. It is important to adapt language to avoid confusion. Use well-defined (short and to the point) questions to probe the specific circumstances and check understanding.

21: Autistica, Suicide and Autism https://www.autistica.org.uk/what-is-autism/suicide-and-autism

Autistica, Supporting Autistic Children and Young People through crisis https://www.autistica.org.uk/downloads/files/Crisis-resource-2020.pdf

Autistica, Personal Tragedies Public Crisis https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf

Dickerson Mayers, S, et al, Suicide ideation and attempts in children with autism https://www.sciencedirect.com/science/article/pii/S1750946712000931

National Autistic Society, Autistic People and Suicidality https://www.autism.org.uk/advice-and-guidance/professional-practice/suicide-research

Newall, V, et al, A systematic review and meta-analysis of suicidality in autistic and possibly autistic people without co-occurring intellectual disability https://molecularautism.biomedcentral.com/articles/10.1186/s13229-023-00544-7

Papyrus, Understanding Neurodiversity and the risk of suicide https://www.papyrus-uk.org/understanding-neurodiversity-and-the-risk-of-suicide/

Some neurodivergent young people may discuss plans and intent in what appears to be a 'matter of fact' way and interpret questions literally. It may be helpful to ask specific questions with timeframes such as "How many times have you thought of suicide today?", "Do you think these thoughts will be less or more over the next week?" or "What do you do when you have these thoughts?"

Neurodivergent people process information differently and adapting communication means can help e.g., writing things down, drawing things or allowing the young person to do the same. If a young person says they do not understand, rephrasing the question using specific key words and pausing between points to provide additional processing time may help. Using visual aids and tools (such as an emotion and feelings wheel) to support the young person recognise and label their own feelings and emotions, and describe the situations where they occur, could be beneficial.

Unaccompanied Asylum Seekers

All unaccompanied young people arriving in Fife through the National Transfer Scheme will be supported within the legal frameworks and guidelines of Section 25, Children of Scotland Act 1995. As a result, they will have an allocated social worker and access to the Interpreting Service if required.

Young people who have fled their country of origin and made the long journey to the UK are at risk of increased mental health problems. They are often completely isolated from everyone and everything they know, separated from their families and living alone in a country where they don't speak the language or understand the culture. Some of these young people may have suffered extreme torture or other significant trauma. Instances of Post-Traumatic Stress Disorder (PTSD) are significantly higher for these young people than in the average population. There are also elevated rates of depression and anxiety.

Whilst it is difficult for us to comprehend what these children have been through, for some of them the impact of abuse, trauma and torture on their behaviour is not always obvious. These young people often present as very resilient.

Refer to the practitioner wakelet for further information.

Support for Staff

Supporting a child or young person following a disclosure of suicide is a highly emotive and stressful situation. Staff who find themselves in this situation could be at risk of secondary trauma or vicarious trauma which can occur as a result of exposure to traumatic stories or experiences of others[22]. Vicarious trauma is not the same as post-traumatic stress disorder (PTSD) but the symptoms can be similar[23]:

- *Becoming overly involved emotionally with the young person*
- *Experiencing bystander guilt, shame, feelings of self-doubt*
- *Being preoccupied with thoughts of the young person outside of the work situation*
- *Over identification with the young person*
- *Loss of hope, pessimism, cynicism*
- *Distancing, numbing, detachment, cutting people off, staying busy. Avoiding listening to young people's story of traumatic experiences*
- *Difficulty in maintaining professional boundaries with the young person, such as overextending self (trying to do more than is in the role to help them).*

As well as supporting the young person, you may need to consider appropriate and necessary support for yourself and other staff involved. This can be either: informal, such as peer support from colleagues; processes, such as building in debrief meetings; or more formal support through supervision.

Supervision provides a structured environment where practitioners can reflect on their work, receive guidance, and ensure they are meeting professional standards and safeguarding protocols. It can be very helpful in supporting practitioners with the decision-making process. Supervision allows for the review and oversight of cases to ensure that all necessary steps are being taken to protect the child. Supervisors can help assess the level of risk to the child, ensuring that all aspects of the child's situation are considered and addressed appropriately.

22: Vicarious Trauma, Mind, https://www.mind.org.uk/media/4tybnie0/headlines-guide-to-vicarious-trauma.pdf

23: Vicarious Trauma: signs and strategies for coping, BMA, https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

If you feel you may be suffering from vicarious trauma, try following these coping strategies to reduce the risks[24]:

- *Increase your self-observation: recognise and chart your signs of stress, vicarious trauma and burnout*
- *Take care of yourself emotionally: engage in relaxing and self-soothing activities, nurture self-care*
- *Look after your physical and mental wellbeing*
- *Maintain a healthy work/life balance, have outside interests*
- *Be realistic about what you can accomplish, avoid wishful thinking*
- *Don't take on responsibility for the wellbeing of others*
- *Balance your caseload where possible with a mix of more and less complex young people to support*
- *Take regular breaks, take time off when you need to*
- *Seek social support from colleagues and family members*
- *Use a buddy system, particularly important for less experienced members of staff*
- *Use peer support and opportunities to debrief*
- *Take up training opportunities*
- *If you need it, take up time-limited group or individual therapy.*

Support is available for the range of emotions and feelings you may experience. For further information visit https://www.nhsfife.org/suicideprevention/

If you require further support, please speak to your GP.

24: Vicarious Trauma: signs and strategies for coping, BMA, https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

Training and Workforce Development

Training and workforce development is an essential way of ensuring staff have the skills, knowledge, experience and confidence to support children and young people. The aim is to build a strong and sustainable workforce who can adapt and grow and at the heart of this is ensuring they can access training opportunities which are mapped to their role and competencies to deliver better outcomes. Workforce development is not a 'one-size-fits-all' approach.

Knowledge and Skills Framework

NHS Education for Scotland's Children and Young Peoples Mental Health and Wellbeing: A Knowledge and Skills Framework for the Scottish Workforce is a national framework that provides a common language and shared understanding of the mental health and wellbeing needs of children and how this links with staff learning and development.

The framework sets out the levels of knowledge and skills required by staff, across agencies, to deliver wellbeing and mental health supports and interventions within the framework of Getting it right for every child (GIRFEC).

The framework highlights the important role that all staff (at all practice levels) have in supporting mental health and wellbeing. It helps improve clarity around required roles, skills and competencies centred around better outcomes for children & young people. It also considers how to maintain staff wellbeing as they meet the mental health and wellbeing needs of the children that they work with.

The framework can be used as a reference tool when identifying what training is needed at what level to support the wider work of the Our Minds Matter (OMM) Guidance. Three areas within the framework that directly link to the OMM guidance are:

- ***Trauma*** *– page 25*
- ***Mental Health*** *– pages 28-33*
- ***Risk of Harm*** *- pages 44-45*

It is important to acknowledge that trauma is associated with an increased likelihood of experiencing suicidal ideation, indicating the need for staff to be trauma-informed as well as having an awareness and understanding of mental health and suicide prevention.

"People who die by or attempt suicide and those who engage in self-harm have elevated rates of trauma exposure" (Asarnow et al.2020)

Training Opportunities

There are various ways staff can up skill; this can be through self-directed learning or facilitated discussion with a trained trainer. Many of the training opportunities available will indicate what level of the framework they sit within; however, it is important that staff members use the framework to consider the most suitable training required for them in relation to their role and remit and the support they offer to the children and young people they work with.

Level 1	Level 2	Level 3	Level 4
Informed	**Skilled**	**Enhanced**	**Specialist**
Support for All	Early Support in early years settings and schools	Additional Support from community services	Specialist - Support from CAMHS or Neurodevelopmental Services

For example, a 'Pupil Support Assistant' will likely only require to access Mental Health Improvement and Prevention of Self-Harm and Suicide Ask, Tell... Animations – Children and Young People Training which sits at Level 1 (informed) of the framework. Whereas a 'Guidance Teacher' may need to attend Applied Suicide Intervention Skills Training which sits at Level 2 (skilled) of the framework.

There are various organisations/services offering training support for staff related to the OMM Guidance:

- *Health Promotion Training Programme*
- *Fife Child Protection*
- *Fife Violence Against Women Partnership*
- *Scottish Women's Aid*
- *Public Health Scotland*
- *NHS Education for Scotland*

Glossary

Some important things to understand about suicide and suicidal ideation are:

Behaviour: Acting out a plan with intent to complete suicide e.g. Collecting pills, researched methods of lethality, gave away valuable, wrote a suicide note.

Completed suicide: The act of intentionally taking one's own life.

Contagion: the process whereby one suicide or suicidal act within a school, community or geographic area increases the likelihood that others will attempt or die by suicide

Ideation: Thoughts or considerations about ending life, can be fleeting or involve detailed planning.

Intent: Where there is a desire to end life, or where this desire is a way of feeling able to cope.

Preparation: There is strong intent to end life and a plan of how to do it.

Self-harm: when somebody intentionally damages or injures their body without suicidal intent.

Suicidal gesture/attempt: A non-fatal self-directed potentially injurious behaviour, with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury.

Appendices

Appendix 1: Links to Wakelets

Children and Young People's Wakelet

Parent and Carers Wakelet

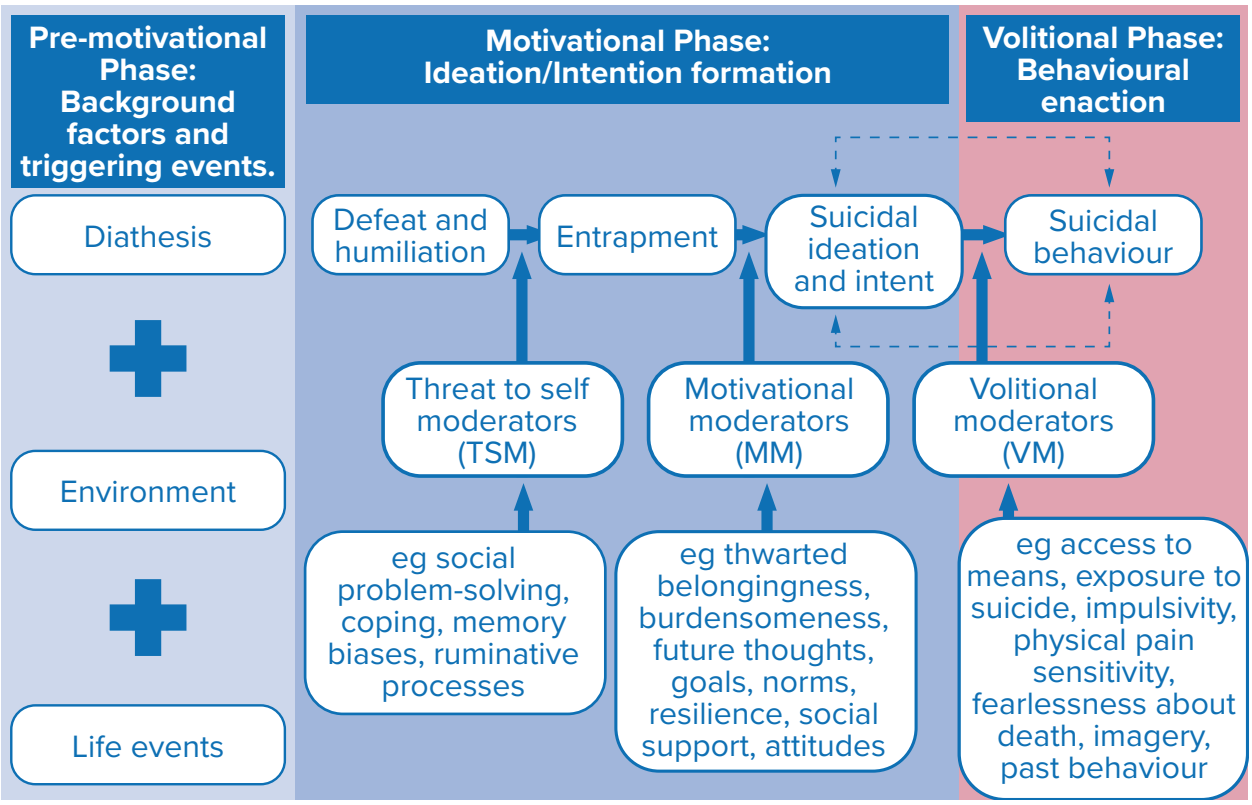
Practitioners Wakelet

Appendix 2: The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour

The Integrated Motivational-Volitional (IMV) Model (O'Connor 2011 and O'Connor & R.C, & Kirtley 2018) is a tripartite model that proposes that suicidal behaviour results from a complex interplay of factors, such as biology, psychology, environment, and culture. The three parts of the model can be summarised as follows:

- *Background factors: Pre-Motivational Phase – the context in which suicide may occur*
- *Development of suicidal thoughts: Motivational Phase – how/why suicidal thinking emerges*
- *Attempting suicide: Volitional Phase – factors associated with acting upon one's thoughts of suicide.*

A key factor to the model is intention to engage in suicidal behaviour. Intention is determined by feelings of entrapment where suicidal behaviour is seen as a potential solution to life circumstances. These feelings of being trapped are triggered by defeat or humiliation, which are often associated with chronic or acute situations. The transitions from the defeat/humiliation stage to entrapment, from entrapment to suicidal ideation/intent, and from ideation/intent to suicidal behaviour are determined by specific factors that facilitate or prevent movement between stages. In addition, background factors, such as deprivation or vulnerabilities, and life events, such as relationship or crisis, provide the broader context for suicide.



Appendix 3: Resources - the Decider Skills

The Decider Skills use Cognitive Behavioural Therapy to teach children, young people and adults skills to recognise their own thoughts, feelings and behaviours, allowing them to monitor and manage their own emotions and mental health. The skills were designed to enable participants to make effective changes to help manage distress, regulate emotion, increase mindfulness, promote effective communication and to live a more skilful, less impulsive life.

The Decider Skills are delivered in an original, fun and creative style, using role plays, props, imagery and music, that makes them easy to learn and easy to teach. The demonstrations bring the skills to life.

Resources | The Decider

Designed by Health Promotion Service, Fife Health & Social Care Partnership.
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