Safeguarding Today: What you need to know

20 May 2021 9:00 - 13:30

Learning Aim: Increase understanding of emotional health and wellbeing and the impact on children and young people

EVENT SCEHDULE

9:15 - Introduction
Gillian Ming, SCSP Business Manager

9:35 - Learning from Reviews

Learning from Domestic Homicide Reviews - **Debbie Smallman,**
Domestic Abuse Incidents Review Coordinator,
SMBC Domestic Abuse Team

Learning from Serious Adult Reviews - **Charmaine Stephens,**
Lead Officer Protection and Audit
Sandwell Safeguarding Adults Board

10:10 - Reflection and Key Messages from Child Death Overview Panel

Jaki Bateman,
Black Country Child Death Coordinator

10:35 - Sandwell Public Health - Crisis Support Pathway

Kate Hickman,
Vulnerable Children and Young People Project Manager,
Public Health

Sandwell Children's Safeguarding Partnership

Safeguarding Today: What you need to know

20 May 2021, Learning Aim: Increase understanding of emotional health and wellbeing and the impact on children and young people

11:15 - CAMHS

Nicky Mountford, Service Manager and Clinical Lead CAMHS

NHS Black Country Healthcare NHS Foundation Trust

11:40 - Murray Hall Community Trust

Emma Broughton, Creative Therapeutic Service, Breaking Silence Project Lead

mh murray hall community trust BUILDING BRAVER MINDS

12:00 - Drug Education, Counselling and Confidential Advice (DECCA)

Jon Bull, DECCA Team Manager

Sandwell Children's Trust

12:20 - Supporting Young People's Well-being and Mental Health

Colette Soan & Helen Tyson, Educational Psychologists

Sandwell Metropolitan Borough Council

Sandwell Children's Safeguarding Partnership

Safeguarding Today; What you need to know

Thursday 20 May 2021

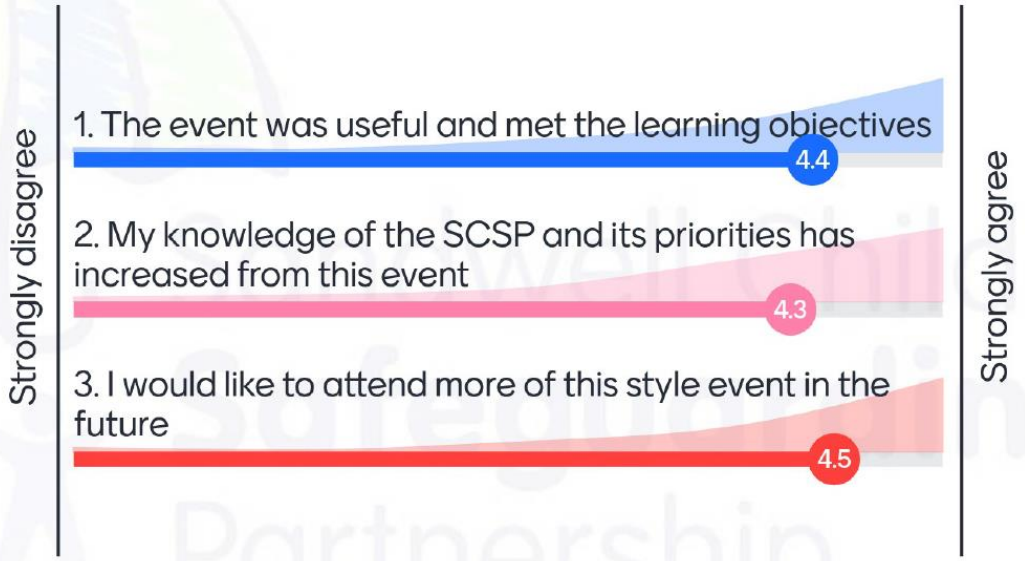
09.00 - 13.30

Delegate Information Pack Contents:

1. Event Schedule
2. Contents of Delegate Pack
3. Mentimeter feedback from January Event
4. Covid 19 Practice Guidance
5. Promoting Children & Young Peoples emotional health & Well Being – info for schools and colleges
6. Manchester Suicide Study
7. Working Together December 2020 Update 7 Minute Briefing
8. Safe Sleeping Practices for Babies 7 Minute Briefing
9. Regional Safe Sleep Campaign – Sofa Poster
10. Child to Parent Violence and Abuse – 7 Minute Briefing (DASP)
11. Safeguarding Adult Reviews; Information for Individuals (SSAB)
12. Training Needs Analysis - Supporting Young People's Well-Being & Mental Health
13. Be Brave Poster (Murray Hall)
14. Building Brave Minds Flyer – Professionals (Murray Hall)
15. Building Brave Minds Flyer – Young People (Murray Hall)
16. DECCA Service Overview (SCT)
17. Trusted Adult Training Poster – wider workforce

Feedback on mentimeter at the last event from 90 participants.

Vast majority agreed that the event met its learning objectives and would like to attend more of this style of event so this is the second of four 'Safeguarding Today – What you need to know' events.



What worked well…

I feel more informed on a variety of subjects and able to not only challenge but work with and support families better

A very enlightening session on Hidden Men today. I will ensure our new Health Visiting students attend the training event on the subject to help them achieve a comprehensive assessment of the families they meet.More conferences like this needed

The courses have been amazing, this one in particular has been so informative and I will take a lot from it and will also share with my colleagues. Virtual sessions I find are easier to attend and I think they have worked really well. Thank you all

It has keeps awareness and understanding up to date and enabled me to inform my staff team and develop and strengthen our practice and support to families

being new to the role it has made me more aware of issues that surround us today and look forward to more training

The study day was very well put together, and provided valuable updates through all the talks. Particularly the scope of DASP, evidence and practice implications around Hidden Men, and Horizons work was very useful. Important perspective on neglect

In general it's been really beneficial, to have an update to reinforce the importance of our job roles and how vital we are in being primary responders in recognising possible warning signs and dealing with them etc (I work in a school)

The excellent training has improved my knowledge which in turn improves the support I provide to the families I work with.

It has been great to have a more in depth discussion around DHR's and CSPR'S etc. It means having a greater understanding of the subjects discussed and the wealth of knowledge passed onto us from each individual, can be fully imbedded by all.

I work with drug and alcohol users and my eyes have been opened today to some new to me services out there working with children.

As a commissioner it is really useful to attend SCSP training to ensure that safeguarding remains at the heart of the services we commission and informs best practice & high quality services

GCP2 - this has changed the way I view positives, even the smallest of things that are working well are celebrated and acknowledged. Not just in cases of Neglect but in all the work I do.

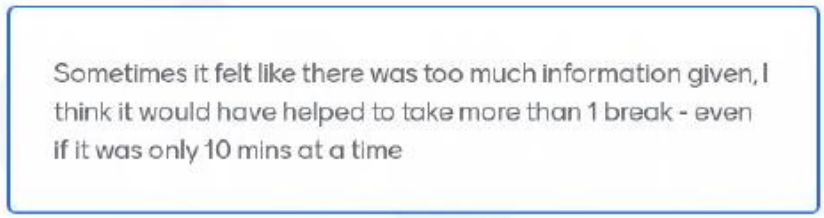
Even better if…

Training is provided to reflect issues in Sandwell and current trends which supports the work we do with children and families. It can sometimes be difficult to book onto training as they book up very quickly.

In response to the above … If a course is full please register on the waiting list and select – 'notify me of future occurrences'. We don't know there is demand if there isn't a waiting list, when we put more sessions on you will get an email from the system to let you know if you select the notify button.

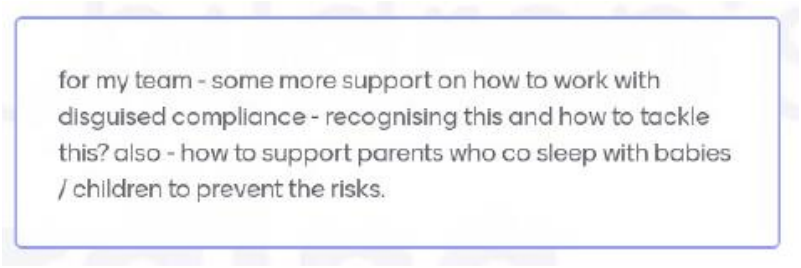
I'd like the sessions to be more interactive and also have time to ask questions as we go.

In response to the above … Awkward – sorry! We actually managed to go less interactive this time on 'Teams Live' but this system allows for more delegates to attend. We do however have a Q&A system this time where you can ask questions! These sessions are intended to be a way for us to share information with lots of people, we have included a delegate pack this time which will be emailed out prior to the event - this will give more information on the topics the speakers are discussing, their services and if relevant, any referral forms.



In response to the above … There is a lot of information being shared at these events, we are trying to pack a lot in as there is so much learning around these topics and positive work being done in Sandwell by many agencies, so we try to include as many as possible! Much of the information is then covered in further training and hopefully the delegate pack this time will help to reinforce messages.

Due to timing we only have one break, but the session will be recorded this time and shared so if you need a break please take one and come back to us, then anything you may have missed can be viewed on the recording of the session.



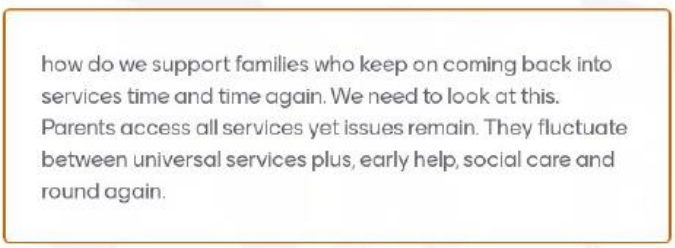
In response to the above … We are now offering a training session called 'Why wouldn't families want to work with us? Working with Resistance and 'Disguised Compliance' – bookings can be made on the SCSP booking system.

There is a 'Dog, Duck and Cat' resource on safer sleeping:
https://www.dogduckandcat.co.uk/stories-0-4/safer-sleeping-and-careful-cuddles/

In the delegate pack you will find a 7 minute briefing on safer sleeping practice, a poster campaign and there are two videos on our YouTube channel:

Been out for a drink – who's in charge
Staying in for a drink – who's in charge

SCSP are not responsible for any further links or videos that may be shown after these video. Please always remember to practice selfcare, some of the content in the video may be upsetting, take time out and seek support where you need to.



In response to the above… very good question – how do we? Working together, sharing information, right support at the right times, listen to what children are telling us!

Following the event you said your next steps were….

If you are the owner of one of these actions and you've completed it, get in touch and let us know!

SCSP_Business@sandwell.gov.uk

Our school to promote how we can include fathers, for example, fathers groups advertised on school website, have more posters around school of fathers reading with their children.

Moving forward i will take care of the language that i use more and implement professional curiosity more and ask those important questions.

Access graded care profile

Will help inform the review of our safeguarding training strategy in housing

Look at the bigger picture - don't be afraid to ask questions and challenge -ensure that the child remains at the centre of everything we do

We are going to interpret more workshops to the male roles for our families, following the hidden man slides

Interested in the hidden men and will relook at our organisation and practices to check we are welcoming and include the men in our children's families.

I will use this information to inform my assessment and interventions. I will also complete further reading.

Awareness of disguised compliance.Signposting to relevant research for additional learning

Thank you for your feedback – please continue to let us know 'what's working well' and 'even better if….'

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Supporting vulnerable children and families during COVID-19

Practice Briefing

December 2020

About this publication:

enquiries: www.education.gov.uk/contactus

download: www.gov.uk/government/publications

This practice briefing from the Child Safeguarding Practice Review Panel sets out key findings and recommendations from a thematic analysis of Rapid Reviews relating to serious child safeguarding incidents reported to the Panel during the initial COVID-19 outbreak between March and September 2020.

Our analysis shows that COVID-19 presents a situational risk for vulnerable children and families, with the potential to exacerbate pre-existing safeguarding risks, and bring about new ones. The learning from this analysis is intended to support leaders and practitioners as they continue to respond to the challenges presented by COVID-19.

Background

In its role in identifying and sharing learning that can help safeguarding partners promote the welfare of children, the Child Safeguarding Practice Review Panel commissioned a thematic analysis of Rapid Reviews relating to serious safeguarding incidents occurring during the COVID-19 outbreak and national lockdown. The remit for the thematic analysis was to:

- review other published commentary on the impact of COVID-19 on children's social care to inform the identification of themes or patterns in practice
- identify patterns in practice in cases notified
- consider the impact of school closures or other service restrictions in the circumstances leading to serious safeguarding incidents
- identify lessons for national or local government should there be a further period of lockdown restrictions

Supporting vulnerable children and families during the COVID-19 outbreak

The safeguarding duties of statutory partner organisations remained unchanged during the COVID-19 outbreak period. Local authorities and Safeguarding Partners established clear processes for risk assessment, the prioritisation of cases, and implementation of COVID-safe practice.

DfE guidance in March 2020 (updated in June 2020) set out expectations for local authorities, schools, colleges, and partner organisations to identify vulnerable children and young people. They were to determine whether continued school attendance was appropriate, encourage good attendance and follow up absences. They were to consider the best way to support children remotely and on-site.

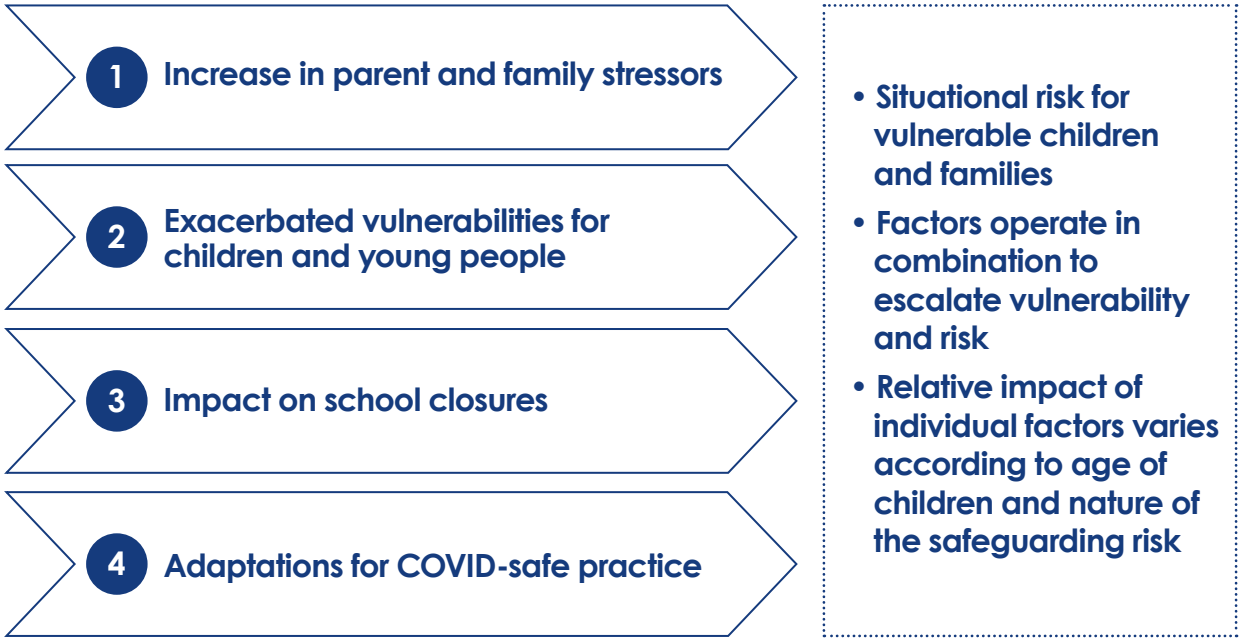
The Adoption and Children (Coronavirus) (Amendment) Regulations 2020 allowed 'virtual visits' by phone or video link where a face-to-face visit was not possible, subject to risk assessment.

Standard operating procedures, with similar flexibilities, applied for NHS practitioners.

Methodology

- An analytical framework was developed, based on published research, to evaluate the impact of COVID-19 factors in serious child safeguarding incidents reported to the Panel between 1 March and 30 September 2020.
- The reviewers devised a bespoke audit tool, linked to the analytical framework. They completed audits of 44 Rapid Reviews where COVID-19 was cited as a factor and audited a control group of 40 Rapid Reviews selected from more than 300 serious child safeguarding incidents over the same period.
- An 'impact analysis' assessed the overall impact of COVID-19, with an evaluative commentary.

A framework for analysing the impact of COVID-19 in serious safeguarding incidents



The impact of COVID-19 on families and services – evidence from published commentary / stakeholder research

An increase in parent and family stressors

There were increased pressures on families as a result of disrupted routines and behaviours; overcrowding; isolation from family support networks; and financial pressures. Tensions in family relationships resulted in an escalation in domestic violence.

Exacerbated vulnerabilities for children and young people

An extended period out of school, away from friends and trusted adults outside the home, exacerbated children and young people's vulnerabilities during the COVID-19 outbreak. There were concerns about 'children below the radar' who may have become vulnerable during lockdown and were not currently known to any service.

Impact of school closure: identification, contact with and support for vulnerable children and young people

Government guidance in March 2020 set out a framework for supporting vulnerable children and young people, with an expectation that they would continue to attend school. In practice, for a variety of reasons, school attendance by vulnerable pupils was very low). during the early stages of the first lockdown [1] Evidence suggests there were significant variations in the extent to which schools were in contact with and supporting vulnerable children and families.

Impact of adaptations for COVID-safe practice

Local authorities put in place innovative arrangements for 'virtual' home visits, supervision, and team meetings. Face-to-face home visiting continued for priority cases. Research evidence has highlighted opportunities for different and more effective engagement with vulnerable children and families as a result of these adaptive changes. There were nevertheless concerns that 'virtual visits' were not always effective in assessing changing risk and need. During COVID-19 a number of specialist services were limited or unavailable, thus reducing the scope for, and impact of, coordinated multi-agency support for children and families.

1 According to DfE figures in June 2020, school attendance by pupils identified as vulnerable was 10%.

Impact analysis

No COVID impact

Risks and decisions taken in responding to risk predated COVID-19 outbreak or not affected by COVID factors.

COVID-related impact

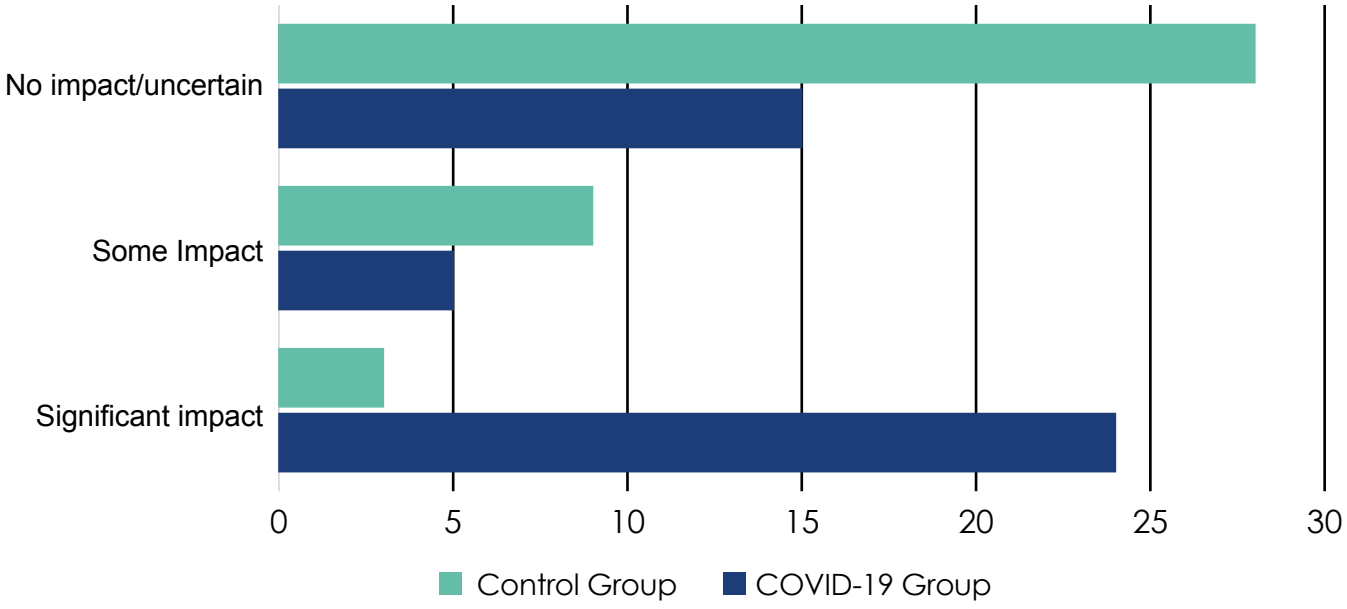
COVID factors contributed to new or escalating risk and/or affected action by partner agencies to identify and reduce risk.

Relative impact of COVID-19 factors

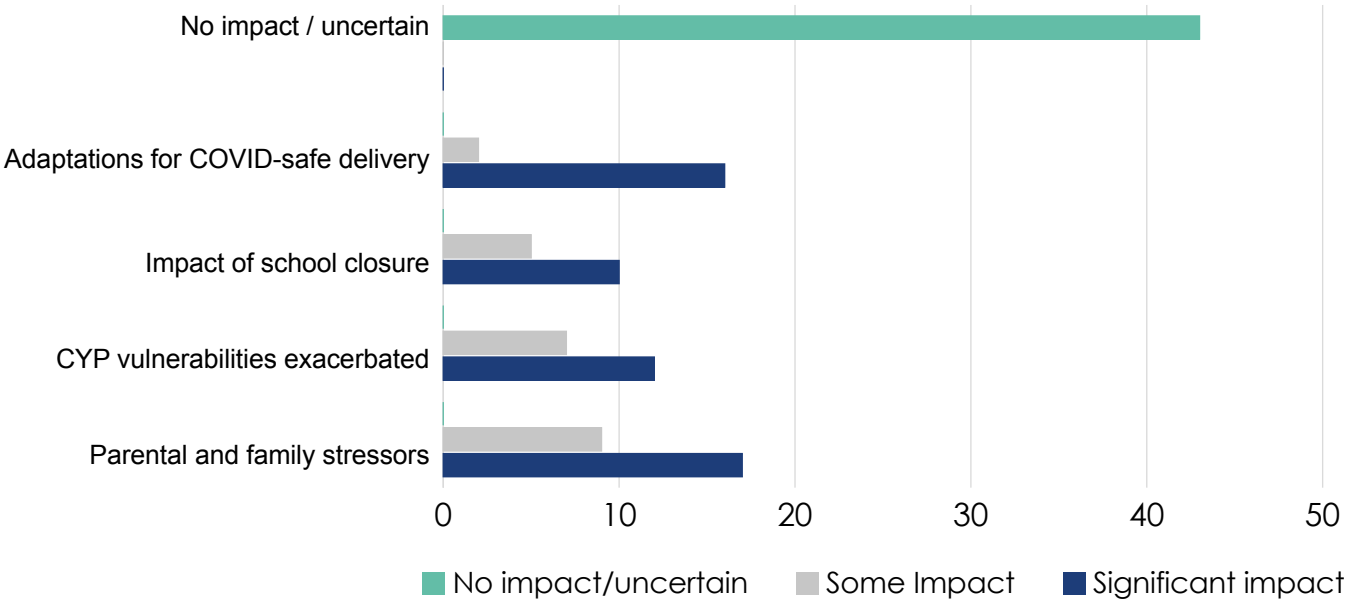
Significant = Strong and direct link between circumstance of lockdown and the serious safeguarding incident.

Some = An association between the circumstances of lockdown and the serious safeguarding incident, affecting capacity for agencies to respond to changing risk and need.

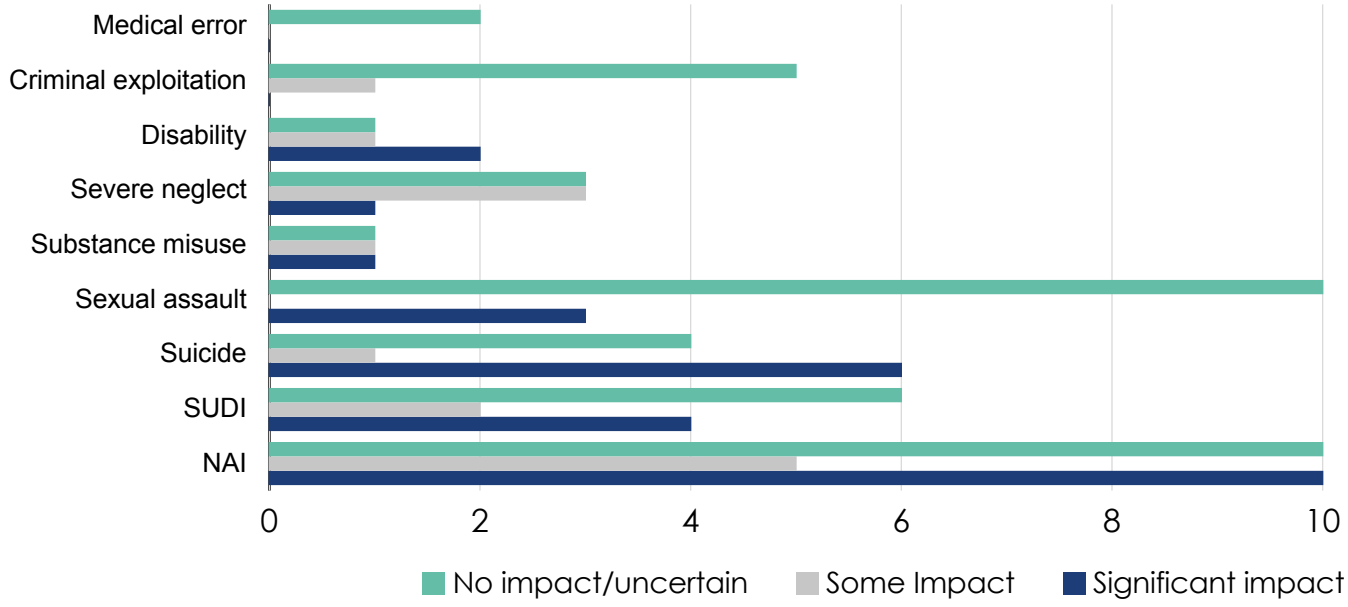
Audit of Rapid Reviews: COVID-19 impact analysis



Relative impact of COVID-19 factors across all cases audited



Impact of COVID-19 factors by case theme



Relative impact of COVID-19 factors – case profiles

The hypothetical case profiles below are based on case audits and show the way in which COVID-19 factors act in combination to escalate vulnerability and risk.

The graphs show the relative impact of the COVID-19 factors overall, and by case theme. The most significant factors were parental and family stressors, and COVID-safe adaptations.

Case 1 – Baby B – Non-accidental injury

Baby B was the mother's second child. At the first antenatal visit, she disclosed previous domestic abuse by Baby B's father, but said that he had since left the home. She also disclosed feeling anxious and depressed and gave a history of previous self-harm. She was referred to the Perinatal Mental Health Team (PNMHT). The assessment could not be completed, as mother and baby were discharged early from the ward due to COVID-19 protocols. PNMHT maintained contacts by video and telephone. The Health Visitor contacted the mother by telephone for the initial visit; the mother reiterated that father was not in the home and said that she was struggling to cope with Baby B. In fact, Baby B's father had moved back into the home at the time of lockdown, but this was not disclosed, or known, to health professionals. There were no further Health Visitor or Midwife contacts. The maternal grandmother, who had been a great support to the mother, was shielding and unable to visit the home. Four weeks into lockdown, Baby B was found pale and lifeless in his cot by his mother in the early hours of the morning. Hospital examination revealed injuries consistent with inflicted head trauma.

Case 2 – WM – Suicide

WM was a 13-year old male who was living with his single mother and his 11-year old sister at the time of lockdown. He was being assessed for possible learning difficulties, autism and attention-deficit hyperactivity disorder (ADHD). He had been started on medication by CAMHS. CAMHS involvement was variable and WM was discharged due to lack of parental engagement. School continued to monitor his progress. At the start of lockdown, he was engaged in his learning and had a wide circle of friends. WM did not continue to attend school as he was not considered vulnerable. He became steadily withdrawn and ceased his ADHD medication. This led to sudden, unprovoked episodes of rage and violence. WM's mother contacted school, who re-referred WM to CAMHS. One month later, a home visit was arranged but cancelled due to lack of appropriate PPE. Three months into lockdown, WM was found in the backyard by his mother, lifeless, with a ligature around his neck. He was pronounced dead by the ambulance crew at the scene.

Summary of findings

Practitioner working

There were good examples of Safeguarding Partnerships taking the learning from Rapid Reviews to make immediate changes in COVID-19 protocols for practitioners. For example, local authorities, working with Safeguarding Children Partnerships, established clear frameworks for risk assessment, identifying and sharing information about vulnerable children. Practitioners were also enabled to engage remotely with families and in working with one another.

Parental and family stressors

These were major factors across the full range of cases involving COVID-19. Increasing domestic violence and mental health concerns were key features across the Rapid Reviews. The lack of contact with extended family members during lockdown meant the loss of a key protective factor in some cases. In others, family dynamics changed where a new partner joined the household to avoid lockdown contact restrictions. Reviews highlighted pressures and tensions as a result of disrupted routines and overcrowding.

Harm to babies under 12 months old

Babies under 12 months old continue to be the most prevalent group notified, and there were a high proportion of cases involving non-accidental injury and sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk. In some of the cases, face-to-face visits had been replaced with telephone or video contact. It is important that families with newborns during lockdown have at least one face-to-face visit from a midwife and health visitor.

Young people's mental health

Being away from the support of friends, trusted adults and school appeared to have a particular impact on children and young people's mental health, and was evident in all cases of suicide. Reviews highlighted incidents of self-harm, exposure to sexual abuse and online bullying.

School closures

Rapid Reviews provided mixed evidence of the impact of local authorities and schools in identifying and supporting vulnerable children and young people.

There were some good examples where schools had maintained contact, promoted study support and other activities, and adapted their approach in line with evolving national guidance and expectations. However, many vulnerable children who were entitled to attend school were kept at home by parents fearing risk of COVID-19 infection. This meant children lost structure and routine where parents' capacity to provide home schooling was limited. Additionally, children at home full-time was an added pressure for the parents, particularly for carers with disabled children. School was not available as a source of support or as a trusted environment for children to disclose concerns; as a result, some vulnerable children remained 'below the radar'. In any future lockdown period, it is essential that schools remain open for all

children, with clear messaging for parents about COVID-safe learning environments, and expectations of normal attendance.

Adaptations for COVID-safe practice

Adapting practice was an important factor across the full range of cases involving COVID-19. Typically, this related to circumstances where face-to-face home visits or booked appointments were replaced by telephone contacts or virtual visits. However, service closures, deferred appointments and delays in decision-making were also evident. On occasion, visits were delayed or cancelled owing to a lack of Personal Protective Equipment (PPE). Rapid Reviews highlighted examples of the effective use of 'virtual home visits' by video link. Where these worked well, practitioners were able to observe children and adult-child interaction, assess the home environment, and use focus questions to assess changing risk and need. Practitioners would benefit from the development of practice guidance and best practice standards for virtual visits, as local authorities and partner agencies anticipate moves to a more blended approach to contact with children and families.

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Public Health England

Children & Young People's Mental Health Coalition
hosted by mental health foundation

Promoting children and young people's emotional health and wellbeing

A whole school and college approach

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

About the Children and Young People's Mental Health Coalition

The Children and Young People's Mental Health Coalition (CYPMHC) comprises 14 charities who come together and speak as one on behalf of children and young people's mental health.

About this resource

This resource was commissioned by PHE and content was written by Paula Lavis on behalf of Children and Young People's Mental Health Coalition, and Claire Robson, PHE.

We thank the staff from the schools who agreed to share their practice (Samuel Rhodes Primary School in Islington; Hitchin Girls School in Hertfordshire; Kings Hedges Education Federation in Cambridgeshire; Framwellgate School Durham; Epsom Downs Primary School and Children's Centre in Surrey; The Harbour School in Portsmouth; Wellington College in Berkshire; Smithy Bridge Primary School in Rochdale, The Haven at Budehaven Community School in Cornwall, and Bacon's College in London). We also thank everyone who contributed as part of the consultation process, and Katharine Smith who provided editorial support.

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Contents

Introduction

It is widely recognised that a child's emotional health and wellbeing influences their cognitive development and learning[i, ii] as well as their physical and social health and their mental wellbeing in adulthood.[iii, iv, v]

This document sets out key actions that headteachers and college principals can take to embed a whole school approach to promoting emotional health and wellbeing. These actions are informed by evidence[iv, v, vi, vii] and practitioner feedback[1] about what works. They build on what many schools and colleges are doing across the country but, if applied consistently and comprehensively will help protect and promote student emotional health and wellbeing. We pose one key question in each chapter aimed at helping the reader to reflect on implications for practice, and we give some examples of local practice.

Our hope is that this document will also be useful to school and college governing bodies, school nurses, local public health teams, academy chains and others whose role it is to promote the health and wellbeing of children and learners. The document signposts to practice examples and resources to support implementation. It also highlights action taken by schools and colleges to promote emotional health and wellbeing link with Ofsted inspection criteria.[2]

This document should be read alongside statutory guidance on 'Keeping children safe in education',[viii] 'Supporting pupils at school with medical conditions'[ix] and existing advice on targeted approaches for supporting pupils with, or at risk of developing mental health problems including:

- statutory guidance on 'Promoting the health and wellbeing of looked after children'[x]
- advice for school staff on 'Mental health and behaviour in schools'[xi]
- advice on 'Counselling in schools'[xii]

Other supporting documents include guidance from the PSHE Association to support schools in teaching about mental health safely and effectively and 'Resilience and results'[xiii] which outlines how schools can work with external agencies to commission additional support for pupils with behavioural and emotional difficulties.

[1] In 2014 the Children and Young People's Mental Health Coalition consulted with a sample of teachers, public health and other relevant professionals to test their understanding and application to practice of the term 'whole school approach.' The principles as advocated by 'Healthy Schools' or 'health promoting schools' approaches were considered to be relevant and consistent with effective whole school educational practice

[2] References are made to the school inspection handbook published in January 2015. A new inspection framework will be introduced from September 2015. This will include a new judgement on 'personal development, behaviour and welfare' from September 2015

Rationale

In an average class of 30 15 year-old pupils:

- 3 could have a mental disorder [xiv]
- 10 are likely to have witnessed their parents separate [xv]
- 1 could have experienced the death of a parent [vi]
- 7 are likely to have been bullied [vi]
- 6 may be self-harming [xvi]

The Department for Education (DfE) recognises that: "in order to help their pupils succeed; schools have a role to play in supporting them to be resilient and mentally healthy".[xi] There is good evidence to support this assertion[i] and Ofsted has highlighted that children and young people themselves say that they want to learn more about how to keep themselves emotionally healthy.[xvii] Moreover schools have a duty to promote the wellbeing of students.[xviii]

The National Institute for Health and Care Excellence (NICE) advises that primary schools and secondary schools should be supported to adopt a comprehensive, 'whole school' approach to promoting the social and emotional wellbeing of children and young people.[iv,v] Such an approach moves beyond learning and teaching to pervade all aspects of the life of a school, and has been found to be effective in bringing about and sustaining health benefits.[ix]

DfE also identifies a whole-school approach to promoting good mental health as a protective factor for child and adolescent mental health.[xiv] The report of the Children and Young People's Mental Health and Wellbeing Taskforce (2015) [xix] identifies a national commitment to "encouraging schools to continue to develop whole school approaches to promoting mental health and wellbeing" (page 19).

Although schools and colleges play a significant and valuable role in helping to promote student emotional health and wellbeing, their contribution should be considered as one element of a wider multi-agency approach. The Healthy Child Programme[xx] (2009) from 5 to 19 year-olds sets out the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing.

Eight principles

Figure 1. Eight principles to promoting a whole school and college approach to emotional health and wellbeing

The following diagram presents 8 principles to promote emotional health and wellbeing in schools and colleges. Each of these principles will be outlined in the following chapters along with a key question and examples of local practice relating to each principle.

Leadership and management

Support from the senior leadership team is essential to ensure that efforts to promote emotional health and wellbeing are accepted and embedded. [iv,xxi] Having a governor with knowledge and understanding of emotional health and wellbeing issues is highly desirable in championing organisation-wide practices.

To ensure actions are integrated, sustained and monitored for impact it is important that a commitment to addressing social and emotional wellbeing is referenced within improvement plans, policies (such as safeguarding; confidentiality; personal, social, health and economic (PSHE) education; social, moral, spiritual and cultural (SMSC) education; behaviour and rewards) and practice.[iv] It is also important to involve pupils, staff and parents in developing these policies so that they remain 'live' documents that are reviewed and responsive to the evolving needs of the school community.

In addition to leadership from senior management, feedback from practitioners highlights the importance of having a champion who will promote emotional health and wellbeing across the organisation. Such champions do not have to be senior managers, but they do need the support of the senior management team and governors in order to take work forward in a way that is embedded across the school.

School leaders have an important executive role in advocating for the needs of children and learners within the context of wider local strategic planning and in influencing local commissioning arrangements**.** The Children and Young People's Mental Health and Wellbeing Taskforce recommends that schools assign a lead on mental health issues who would be responsible for linking schools with expertise, identifying issues and making referrals. It also recommends that local mental health commissioners and providers assign a point of contact in specialist children and young people's mental health services for schools as well as in GP practices who would be responsible for advising on the management of specific cases.[xix]

Key question: How is the school or college providing visible senior leadership for emotional health and wellbeing?

Links with the Ofsted inspection framework:

One of the 4 key Ofsted judgements is "the quality of leadership in, and management of the school".[xxii] Schools have to demonstrate how effectively leadership and management enable all pupils to overcome specific barriers to learning, for example through effective use of the pupil premium and sports premium, and the extent to which leaders and managers create a positive ethos in the school. The framework also specifies that schools should demonstrate capacity for further improvement, for example by working in partnership with other schools,

early years providers, external agencies and the community; as well as by engaging with parents.

NICE guidance recommends that head teachers, governors and teachers should demonstrate a commitment to the social and emotional wellbeing of young people. They should provide leadership in this area by ensuring social and emotional wellbeing features within improvement plans, policies, systems and activities. These should all be monitored and evaluated.[iv]

Practice examples:

At Samuel Rhodes Primary School the head teacher is a champion for promoting emotional health and wellbeing and is an integral part of a multidisciplinary team who support children, parents and staff. This arrangement helps to ensure a good fit between the work of the multi disciplinary team and the leadership priorities for the school.

At Bacon's College the head teacher provides strong leadership in recognising that the emotional health and wellbeing of all pupils, supported by a strong commitment to sport and physical activity, is a pre-requisite for their capacity to learn.

Hitchin Girls School is developing a whole school approach to emotional wellbeing which it calls Re:mind*me*. Its psychology teacher champions the work but has established a working group with representation from staff and students to steer the work forward. Support from the head and senior staff is helping to ensure effective implementation. An integral part of the approach has involved staff being encouraged to think about their own emotional health and wellbeing and how they can be role models for the students.

The Harbour School is a special school in Portsmouth that has established a whole school approach through strategic and systemic planning reflected in their school development plan. There are 5 key strands in this plan which are systematically and robustly reviewed:

- attendance
- social and emotional progress
- behaviour, exclusions and reintegration
- curriculum achievement and attainment
- outreach services based on one of their school sites

School ethos and environment

The physical, social and emotional environment in which staff and students spend a high proportion of every week day has been shown to affect their physical, emotional and mental health and wellbeing as well as impacting on attainment.[xxiii]

Relationships between staff and students, and between students, are critical in promoting student wellbeing and in helping to engender a sense of belonging to and liking of school or college.[xxiv]

Key question: How does the school or college's culture promote respect and value diversity?

Links with the Ofsted inspection framework:

When judging behaviour and safety Ofsted looks for evidence of a positive ethos that fosters improvements in the school as well as the promotion of safe practices and a culture of safety.[xxii]

As part of the inspection process inspectors will ask to see records and analysis of bullying, including racist, disability and homophobic bullying and will ask young people about their experiences of learning and behaviour in the school, including bullying. The school will be judged on the effectiveness of its actions to prevent and tackle all forms of bullying and harassment.[xxii]

NICE guidance recommends that:

- primary eduction providers
    - create an ethos and conditions that support positive behaviours for learning and for successful relationships
    - provide an emotionally secure and safe environment that prevents any form of bullying or violence
- secondary education providers
    - foster an ethos that promotes mutual respect, learning and successful relationships among young people and staff. Create a culture of inclusiveness and communication that ensures all young people's concerns can be addressed (including the concerns of those who may be at particular risk of poor mental health)
    - provide a safe environment which nurtures and encourages young people's sense of self-worth and self-efficacy, reduces the threat of bullying and violence and promotes positive behaviours

Practice examples:

Framwellgate School Durham sees emotional wellbeing as a key factor in enabling students to achieve their full educational potential and to become responsible individuals well prepared for life beyond school. It has peer mentoring schemes and anti-bullying ambassadors. It has commissioned a social enterprise to run inspirational workshops with the students which focus on personal, social and employability skills. Evaluation of the work demonstrates that it has

helped students gain an insight into why they behave in the way they do, and has made them more confident, and more empathic.

At Epsom Downs Primary School, the children are taught to embrace and value difference and this is incorporated into the curriculum wherever possible. The school takes an active role in anti-bullying week and children from across the key stages take part in workshops and activities to teach them to address diversity in a positive way.

The first wave of the Social and Emotional Aspects of Learning (SEAL) programme[xxv] delivered in England focussed on creating an ethos and climate in schools to promote social and emotional skills. The evaluation found 50% of teachers perceived that pupil listening skills had improved and 44% perceived that pupil concentration levels had improved. Factors identified as contributing to the programme's efficacy included the commitment of senior management, sufficient time allocated for staff to develop an understanding of the programme and to plan for its implementation, appointing a designated coordinator and adopting a whole school approach.

Curriculum, teaching and learning

School-based programmes of social and emotional learning have the potential to help young people acquire the skills they need to make good academic progress as well as benefit pupil health and wellbeing.[i, xxvi]

Opportunities exist to develop and promote social and emotional skills through both a dedicated Personal Social Health and Economic education (PSHE) curriculum and the wider curriculum. The PSHE Association has published advice for teachers on preparing to teach about mental health and emotional wellbeing.

Pupils and students are more likely to engage in lessons that focus on emotional wellbeing if they are of practical application and relevant to them. There are a range of ways of getting insights into pupil need ranging from validated assessment tools (see pages 17 to 18) to feedback from existing fora such as school councils or local area youth councils. Assessment of learning is important and both teachers and pupils will want to know that what has been taught has been learnt, and that learning is progressing.

There may be stages during the academic year that provide opportunities for a specific curricular focus, for example learning skills for coping with transition periods or learning skills for coping with the pressures of studying for exams. There may also be times when it will be appropriate for a focus to be given to a locally topical issue.

Key question: What focus is given within the curriculum to social and emotional learning and promoting personal resilience, and how is learning assessed?

Links with the Ofsted inspection framework:

The quality of teaching in the school is a key Ofsted judgement area. The inspection criteria states that the role of teaching is to promote learning and the acquisition of knowledge by pupils and to raise achievement, but also to promote the pupils' spiritual, moral, social and cultural development.[xxii]

NICE guidance recommends that:

- primary education providers
    - include a curriculum that integrates the development of social and emotional skills within all subject areas (these skills include problem-solving, coping, conflict management/ resolution and understanding and managing feelings)
- secondary education providers
    - provide a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying. This can be achieved by integrating social and emotional skills development within all areas of the curriculum. Skills that should be developed include motivation, self-awareness, problem-solving, conflict management and resolution, collaborative working, how to understand and manage feelings and how to manage relationships with parents, carers and peers
    - tailor social and emotional skills education to the developmental needs of young people. The curriculum should build on learning in primary education and be sustained throughout their education, reinforcing curriculum learning through, for example, extra curricular activities

Practice examples:

The Penn Resilience Programme[xxvii] (PRP) is an 18-lesson curriculum for 11 to 13 year-olds, which supports young people to develop skills such as emotional intelligence, flexible and accurate thinking, self-efficacy, assertive communication and problem solving. The programme is intended to empower young people to be more resilient in dealing with setbacks and make the most of opportunities both inside and outside of school. Three local authorities in England piloted the programme. The evaluation found the programme had a positive impact on pupils application of skills to real life situations, a short term improvement in depression symptom scores, school attendance rates and academic attainment in English and greater impact for the most vulnerable groups.

How to Thrive provide training for teachers who want to teach the Penn Resilience Programme (PRP) lessons. How to Thrive provide a 5-day programme that provides the skills and knowledge required to teach the PRP curriculum to children and young people. This training allows participants to develop their own personal resilience and then apply this insight to

teaching the curriculum to young people. The PRP is a licenced model and only those who have received training through an accredited body such as How to Thrive can legitimately teach the PRP curriculum. How to Thrive are currently leading a national project called Healthy Minds that is training teachers in 32 schools to deliver a 4-year curriculum (including the PRP).

Wellington College has been teaching wellbeing lessons since 2006. PSHE lessons were overhauled in order to effectively engage students. A 60-hour programme embedded over a 4-year period has been developed focussed on enabling students to flourish. Students embark upon this course in year 9 when they arrive at the school and complete it at the end of their lower sixth form year.

The PSHE Association has produced a number of resources to help schools incorporate emotional health and wellbeing into PSHE lessons.

YoungMinds suggests some simple and practical ways of incorporating emotional wellbeing into the curriculum.

Student voice

Involving students in decisions that impact on them can benefit their emotional health and wellbeing by helping them to feel part of the school and wider community and to have some control over their lives. At an individual level, benefits include helping students to gain belief in their own capabilities, including building their knowledge and skills to make healthy choices and developing their independence. Collectively, students benefit through having opportunities to influence decisions, to express their views and to develop strong social networks.

Key question: How does the school or college ensure all students have the opportunity to express their views and influence decisions?

Links with the Ofsted inspection framework:

Ofsted Inspectors must have regard to the views of pupils.
When assessing the level of behaviour and safety in schools, inspections should look at a small sample of case studies in order to evaluate the experience of particular individuals and groups, including disabled pupils and those who have special educational needs, looked after children and those with mental health needs. [xxii]

NICE guidance recommends that secondary education providers:

- develop partnerships between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing

- introduce a variety of mechanisms to ensure all young people have the opportunity to contribute to decisions that may impact on their social and emotional wellbeing
- involve young people in the creation, delivery and evaluation of training and continuing professional development activities in relation to social and emotional wellbeing

Practice examples:

St Albans Youth Council (SAYC), which is supported by Youth Connexions, works alongside and presents its concerns to the district council. Following a number of suicides in the area, SAYC conducted a survey of 1,800 year 8 and year 10 students in 2012 from schools in the district and a follow-up survey in 2014 of 2,700 people, which included students and teachers. It identified high levels of stress in students with some requiring support for more serious mental health issues. Many of these students did not know about school-based counselling and indicated that they would approach their teacher if they needed support for a personal issue.

The SAYC was so concerned about the high levels of mental health need and the funding difficulties of a local youth counselling service that it presented a letter to the district council asking it what it was going to do to prevent suicides in local young people. As a result of this the district council set aside £15,000 of ring-fenced money to promote mental health and wellbeing. This ring-fenced money is being used to promote workshops focussed on the 5 ways to wellbeing.[3]

The Haven is an integrated health centre that is co-located and managed by Budehaven Community School. There is a student management group which has representation from young people of all ages, including sixth formers. Involving young people in this way helps to give them ownership of the centre. The student management group was involved in setting-up and running the Haven. It was heavily involved in designing the Haven and was instrumental in obtaining funds to furnish the building. This has resulted in the service being very young person friendly, which encourages students to access the service.

Staff development, health and wellbeing

It is important for staff to access training to increase their knowledge of emotional wellbeing and to equip them to be able to identify mental health difficulties in their students. This includes being able to refer them to relevant support either within the school or from external services. The report of the Children and Young People's Mental Health and Wellbeing Taskforce recommends that staff working with children and young people in universal settings, including

[3] The New Economics Foundation identified 5 key elements that have been shown to promote wellbeing: Connect; Be Active; Take Notice; Learning and Giving. These are being promoted as 'The 5 ways to wellbeing'

schools, should receive training in children and young people's development and behaviours but should not be expected to replace specialist services. [xix]

DfE has produced advice to help schools identify potential mental health problems as well as give advice on commissioning services and how to make a referral to child and adolescent mental health services (CAMHS).[xi]

The government has also funded an e-learning platform developed by experts in children and young people's mental health and emotional health and wellbeing called MindEd.

Promoting staff health and wellbeing is also an integral principle of the whole school approach to emotional health and wellbeing. Teaching and learning establishments can demonstrate a commitment to staff health and wellbeing in a number of ways. For example, by providing opportunities for assessing the emotional health and wellbeing needs of staff, by providing support to enable staff to reflect on and to take actions to enhance their own wellbeing and by promoting a work-life balance for staff. A good way of driving these changes is through the Workplace Wellbeing Charter National Standards. The standards set out action across a number of areas, including mental health and wellbeing, and provide a roadmap for driving improvements in workplace health.

Key question: How are staff supported in relation to their own health and wellbeing and to be able to support student wellbeing?

Links with the Ofsted inspection framework:

The quality of teaching is a key judgement area for Ofsted. The inspection criteria refers to the importance of ensuring that all teaching staff benefit from appropriate professional development and that performance is rigorously managed. [xxii]

When assessing leadership and management, inspectors must consider the school's use of performance management and the effectiveness of strategies for improving teaching. This should include the extent to which professional development is based on the identified needs of staff and the induction needs of newly qualified teachers and teachers at an early stage of their career.

NICE guidance recommends:

- that primary education providers:
    - offer teachers and practitioners in schools training and support in how to develop children's social, emotional and psychological wellbeing
    - train and develop teachers and practitioners so that they have the knowledge, understanding and skills to deliver a curriculum that integrates the development of social and emotional skills within all subject areas effectively. The training should include how to manage behaviours and how to build successful relationships

    - ensure teachers and practitioners are trained to identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary school children. They should also be able to assess whether a specialist should be involved and make an appropriate request
- that secondary education providers:
    - integrate social and emotional wellbeing within the training and continuing professional development of practitioners and governors involved in secondary education
    - ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing

Practice examples:

Hitchin Girls School's Re:mind*me* initiative actively encourages staff to think about their own emotional health and wellbeing.

Bristol University is undertaking a research project that is looking at the effects of providing school staff with support for their wellbeing via a peer support service, and training in supporting student wellbeing using Youth Mental Health First Aid (MHFA). The project is called Wellbeing in Secondary Education (WISE).

Islington CAMHS offer all schools the 'Solihull Approach Training'[xxviii] which gives school staff a framework to help them work with children and parents and gives them a better understanding of mental health issues and how they can help support their students. The training also gives schools a shared language with the CAMHS workers which helps support integrated working.

Identifying need and monitoring impact

There are a variety of tools that education settings can use as the basis for understanding and planning a response to pupils' emotional health and wellbeing needs. The tools range from simple feedback forms to validated measures which can focus on both wellbeing and mental health.

Defining pupil need on a more formal basis can help to inform commissioning decisions at school level, across clusters of schools or at a local authority level. It is equally important to be able to record and monitor the impact of any support that is put in place. Examples of validated tools that can measure mental wellbeing include:

- the Stirling children's wellbeing scale is a holistic, positively-worded scale, developed by the Stirling Educational Psychology Service, that is suitable for educational professionals looking to measure emotional and psychological wellbeing in children aged 8 to 15 years (see page 72 of the toolkit for schools and colleges)

- the Warwick-Edinburgh mental wellbeing scale (WEMWBS) is also a positively worded scale that can be used to measure wellbeing with young people aged 13 and over, and is recommended that it be used with samples of over 100 people (shorter version, which has 7 questions, can be found here, and the more comprehensive scale and advice on how to calculate a wellbeing score can be found here).

For tools, such as the strengths and difficulties questionnaire (SDQ), designed to focus more on assessing targeted and specialist mental health needs, please see DfE guidance.[xi]

Key question: How does the school or college assess the needs of students and the impact of interventions to improve wellbeing?

Links with the Ofsted inspection framework:

When inspecting the quality of leadership in and management of the school Ofsted inspectors should consider the effectiveness of monitoring and evaluation and the extent to which it is shared with governors. They should also consider how well the school meets the needs of all vulnerable groups of pupils.[xxii]

Assessing and responding to the emotional health and wellbeing needs of children and learners, and taking steps to mitigate the impact this has on their capacity to learn could provide supportive evidence in relation to all key judgement areas: the achievement of pupils at the school, the quality of teaching in the school, the behaviour and safety of pupils at the school and the quality of leadership in and management of the school.

NICE guidance recommends:

- that secondary education providers
    - systematically measure and assess young people's social and emotional wellbeing and use these outcomes as the basis for planning activities and evaluating their impact

Practice examples:

Epson Down's Primary School uses happy/sad sheets to enable lunchtime staff and class teachers to track emotional wellbeing and look for signs of bullying or withdrawal. The school provides a range of support for children from assigning them a lunchtime buddy to providing a 'Circle of Friends' intervention,[xxix] a team of support, primarily peer support around the child, and via its 'Nurture Room'[4] service.

[4] A nurture room, is a small structured teaching group for students showing signs of behavioural, social or emotional difficulties, particularly those who are experiencing disruption or distress outside of school. For more information see http://www.nurturegroups.org/introducing-nurture/what-nurture-group

Smithy Bridge Primary School in Rochdale used an adapted version of the Stirling Wellbeing Scale to measuring wellbeing in year 6 students. It used its data to evaluate how well new activities and interventions designed to improve wellbeing were actually working and whether they were worth the investment.

Framwellgate School Durham was able to demonstrate to its governors that its counselling service enhanced the motivation of students, impacted positively on their attendance and learning, and as such improved standards. This enabled the school to invest in further developing the counselling service.

Place2Be uses well-researched measures to assess how its services are improving children's emotional wellbeing. This data is used to evaluate how well a commissioned service or other intervention is working and whether it is actually helping students.

Working with parents/carers

The family plays a key role in influencing children and young people's emotional health and wellbeing.[xxx, xxxi] There is strong evidence that well implemented universal and targeted interventions supporting parenting and family life that offer a combination of emotional, parenting and practical life circumstances (combining drug, alcohol and sex education, for example) have the potential to yield social as well as economic benefits.[xxxii]

Key question: How does the school or college work in partnership with parents and carers to promote emotional health and wellbeing?

Links with the Ofsted inspection framework:

The Ofsted inspection criteria expects schools to be engaging parents in supporting pupils' achievement, behaviour and safety and their spiritual, moral, social and cultural development.

Ofsted inspectors have a duty to have regard for the views of parents. Inspectors will also take account of the results of any surveys carried out or commissioned by the school.[xxii]

NICE guidance recommends:

- that primary education providers:
    - support all pupils and, where appropriate, their parents or carers (including adults with responsibility for looked after children)
    - offer support to help parents or carers develop their parenting skills. This may involve providing information or offering small, group-based programmes run by community

    - nurses (such as school nurses and health visitors) or other appropriately trained health or education practitioners
    - give all parents details of the school's policies on promotiong social and emotional wellbeing and preventing mental health problems

- that secondary education providers:
    - work in partnership with parents, carers and other family members to promote young people's social and emotional wellbeing
    - help reinforce young people's learning from the curriculum by helping parents and carers to develop their parenting skills. This may involve providing information or offering small, group-based programmes run by appropriately trained health or education practitioners
    - ensure parents, carers and other family members living in disadvantaged circumstances are given the support they need to participate fully in activities to promote social and emotional wellbeing. This should include support to participate fully in any parenting sessions, for example by offering a range of times for the sessions or providing help with transport and childcare. This might involve liaison with family support agencies

Practice examples:

Samuel Rhodes Primary School has successfully provided parenting classes, which were delivered by the multidisciplinary team who work within the school.

Kings Hedges Primary School has commissioned a service for parents called The Red Hen Project. This project is located within the school and is provided by a local charity. The project provides home-school workers who build relationships with families, and works with the children in school and the family at home. It helps families to address issues such as attendance problems, bullying and family break-ups that may cause a barrier to learning.

The Centre for Mental Health has written a briefing for schools about the importance of parenting programmes.

How to Thrive runs evidence-based interventions in the classroom and other settings to help young people and adults learn the skills of emotional resilience and wellbeing. Parent workshops are one key aspect of How to Thrive's work, helping parents to be a role model for their children regarding how they deal with setbacks and develop resilient thinking.

Targeted support

Some children and young people are at greater risk of experiencing poorer mental health. For example those who are in care, young carers, those who have had previous access to

CAMHS, those living with parents/carers with a mental illness and those living in households experiencing domestic violence. Delays in identifying and meeting emotional wellbeing and mental health needs can have far reaching effects on all aspects of children and young people's lives, including their chances of reaching their potential and leading happy and healthy lives as adults.[xiii]

There is good advice already available from DfE that focusses on the role of schools in providing targeted support and specialist provision for pupils with particular mental health and wellbeing needs.[ix, x, xi,xii] This document, therefore, purposefully does not duplicate these existing resources.

The Children and Young People's Mental Health and Wellbeing Taskforce has proposed the introduction of transformation plans for children and young people's mental health and wellbeing. These would be developed with the contribution of schools and would articulate the local offer of services for children and young people's mental health and wellbeing.[xix]

School nurses and their teams have an important role to play in supporting the emotional and mental health needs of school-aged children[xxxiii] and are equipped to work at community, family and individual levels. Their skills cover identifying issues early, determining potential risks and providing early intervention to prevent issues escalating.[xxxiv] Student feedback indicates how much they value the trusted adult role, face to face interaction and other support provided through school nursing teams.

The Youth Wellbeing Directory helps service users and funders find high-quality services to improve the emotional wellbeing and/or mental health of children and young people directly, or by supporting their families and caregivers. The directory enables users to search for services in their area and to have the reassurance that the services being promoted adhere to quality standards.

Schools wishing to gain accreditation for the emotional health and wellbeing support they provide could work towards the AcSEED Award. This scheme was founded by young people with direct experience of mental illness. The AcSEED quality assurance mark is presented to schools that have made a substantial effort to support the mental health of their students

Key question: How does the school or college ensure timely and effective identification of students who would benefit from targeted support and ensure appropriate referral to support services?

Links with the Ofsted inspection framework:

Ofsted inspectors will be interested in how monitoring ensures that individual children or groups of children with identified needs are targeted, and appropriate interventions are secured so that children receive the support they need, including through effective partnerships with external agencies and other providers.[xxii]

NICE guidance recommends:

- that primary education providers:
    - provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems
    - schools and local authority children's services should work closely with child and adolescent mental health and other services to develop and agree local protocols. These should support a 'stepped care' approach to preventing and managing mental health problems, as defined in NICE clinical guideline 28 on depression in children and young people. The protocols should cover assessment, referral and a definition of the role of schools and other agencies in delivering diferent interventions, taking into account local capacity and service configuration
    - identify and assess in line with the common assessment framework[5] children who are showing early signs of anxiety, emotional distress or behavioural problems
    - discuss options for tackling these problems with the child and their parents/carers. Agree an action plan as the first stage of a 'stepped care' approach
    - provide a range of interventions that have been proven to be effective, according to the child's needs

- that secondary education providers:
    - ensure young people have access to pastoral care and support, as well as specialist services, including child and adolescent mental health services, so that emotional, social and behavioural problems can be dealt with as soon as they occur
    - provide young people with clear and consistent information about the opportunities available for them to discuss personal issues and emotional concerns. Any support offered should take account of local community and education policies and protocols regarding confidentiality
    - provide young people with opportunities to build relationships, particularly those who may find it difficult to seek support when they need it. This could involve developing a peer education or peer mediation approach where young people who act as peer supporters are trained and supported appropriately

Practice examples:

Samuel Rhodes Primary School is a special school in Islington that has set-up a multidisciplinary team comprising of a speech and language therapist, occupational therapist, CAMHS workers and a school support worker. This team meets regularly to share information and provide support including training for school staff.

Leeds TAMHS (Targeted Mental Health Services in Schools[6]) is a city wide project managed by the health and wellbeing service. It has built on the success of being a TAMHS pilot and

[5] Since the publication of NICE guidance on social and emotional wellbeing 'early help assessments' have replaced the former requirements of the common assessment framework

provides emotional wellbeing and mental health support in schools, including providing young people with swift and easier access to mental health professionals. Funds were made available by Leeds City Council, NHS Leeds and the Schools Forum to further develop the project after funding of the national pilot ended. The schools have seen the benefits of the service and have match funded the project following an application process.

Framwellgate School Durham has a well-established counselling service and it views this provision as part of its duty of care to its students. The counsellors are employed by the local authority and the school buys in their service under a service level agreement.

Kings Hedges Primary School has commissioned a local charity to provide a school-based counselling service that provides one-to-one counselling and mentoring. Its work with young children uses a play and arts based approach to develop coping strategies which helps improve pupils' school performance.

There are school-based counselling services that work nationally. Place2Be, for example, provides one-to-one counselling, group work and a lunchtime self-referral drop-in for when students need a quiet place to talk to a counsellor, as well as providing support for teachers and parents.

Hitchin Girls School has prioritised self-harm as an issue they are addressing. It has been raising awareness of self-harm for students and staff through assemblies. It has been working through how to talk to parents about self-harm as part of their child protection policy. It has also brought in some online training sessions to help give students a better understanding of self-harm. The school also uses a worries box where students can post a note if they are having any problems or if they are concerned about a friend. The school's student development co-ordinator and mental health lead is responsible for the postbox but the aim is for the schools' peer mentors to help these students by listening to their concerns and signposting them to additional support if necessary.

Epsom Downs Primary School has invested in support from an external agency that delivers early intervention group support for key stage 1 children who have emotional and behavioural difficulties. This service provides support to all key stage 1 children from across the North Downs Confederation area. It also have a nurture room, which is a small structured teaching group for students showing signs of behavioural, social or emotional difficulties, particularly those who are experiencing disruption or distress outside of school. Nurture groups work with individual children or small groups and provide targeted support. This service is run by 2 specially trained and experienced emotional literacy support assistants.

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[6] Targeted Mental Health in Schools programme (TaMHS) was a 3 year funded programme that ran between 2008-2011 with the aim of helping schools deliver timely support to those with mental health problems and those at increased risk of developing them, with particular emphasis on promoting evidence based practice and interagency working

Complex cases at the Harbour School are discussed and planned in ways that better meet the individual's emotional needs. The most complex cases are referred to senior leaders on a pupil placement panel who suggest ways forward. They also work with the multi-systemic team to help some of the hardest to reach and complex families.

Budehaven Community School provides a wide range of services through its integrated health centre known as The Haven. These services include CAMHS, diabetic clinics, school nursing services and careers advice. Having services provided on the school site means that young people have easy access to the services they need with minimum disruption caused by taking time out of lessons to access the services and helping to reduce the stigma associated with accessing mental health support.

Walsall school nursing service uses the 'FRIENDS' programme, which is an evidence-based cognitive behavioural programme. School nurse teams are trained to deliver programmes in schools and other venues, targeting children and young people with anxiety or low self-esteem and confidence. Sessions are co-facilitated with school staff, helping to build the capacity of the school to offer early intervention.

Resources

Some local authority public health teams provide coordinated health and wellbeing support for teaching and learning providers. In some areas this includes helping schools to audit current whole school practice and identify priorities for continuing development, as well as helping schools to address the identified needs.[7]

There is a wide range of resources and support available to help promote children and young people's emotional health and wellbeing. The list below aims to signpost and categorise some of these sources based on insights from the Children and Young People's Mental Health Coalition as well as feedback from individual schools. The list is not exhaustive and many other useful organisations and services exist. All of the links listed below were correct at the time of publication.

To assure the quality of services aiming to improve the emotional wellbeing and/or mental health of children and young people and their families, the Youth Wellbeing Directory provides one way of promoting services that demonstrate adherence to defined quality standards. The PSHE Association also offers a quality mark relating to

[7] Healthy Schools London, for example, has an audit tool that helps schools assess how well they are implementing a whole school approach, and prepare for an awards system - http://www.healthyschoolslondon.org.uk/resources/healthy-take-aways/review-tools http://www.cypmhc.org.uk/resources/healthy_schools_london/

curriculum resources judged by schools to be useful in supporting effective delivery of the PSHE curriculum.

Government guidance and advice

Mental health and behaviour in schools (2014) is departmental advice for school staff. Department for Education.

Counselling in schools: a blueprint for the future (2015) is departmental advice for school staff and counsellors. Department for Education.

Preventing and tackling bullying (2017) advice for head teachers, staff and governing bodies. Department for Education.

Promoting the health and wellbeing of looked-after children (2015) is statutory guidance for local authorities, clinical commissioning groups and NHS England. Department of Health and Department for Education.

Keeping children safe in education (2014) is statutory guidance for schools and colleges. Department for Education.

Supporting pupils at school with medical conditions (2014) is statutory guidance for governing bodies of maintained schools and proprietors of academies in England. Department for Education.

Healthy child programme from 5 to 19 years old (2009) is a recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Department of Health.

Health visiting and school nursing programme supporting implementation of the new service offer: promoting emotional wellbeing and positive mental health of children and young people

Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing (2015) is a report produced by the Children and Young People's Mental Health and Wellbeing Taskforce to examine how to improve mental health services for children and young people. Department of Health.

Evidence

NICE guidance on social and emotional wellbeing in primary education

NICE guidance on social and emotional wellbeing in secondary education

NICE social and emotional wellbeing for children and young people pathway

Data

Children and young people's mental health and wellbeing profiling tool collates and analyses a wide range of publically available data on risk, prevalence and detail (including cost data) on those services that support children with, or vulnerable to, mental illness. It enables benchmarking of data between areas.

Health behaviour of school age children is an international cross-sectional study that takes place in 43 countries and is concerned with the determinants of young people's health and wellbeing. Publication of the England report for 2013 to 2014 is forthcoming.

Local public health teams operating from within the local authority may be able to provide insights into relevant local data sources.

Useful curriculum resources

Cross-phase

Social and emotional aspects of learning (SEAL) are materials used in primary and secondary schools to deliver a whole-school approach to promoting social, emotional and behavioural skills.

PSHE Association helps support PSHE practitioners across all phases to raise the quality of PSHE teaching and raise its status in the curriculum.

Primary age

Feeling good: promoting children's mental health are activity sheets aimed at children aged 4 to 7.

How to get up and go when you are feeling low is a booklet providing top tips for year 4 students when they are feeling upset or stressed.

Secondary age

Time to change provides a collection of resources including videos, lessons, assemblies, and toolkits for teachers and youth workers to reduce stigma and discrimination faced by people with mental health problems.

What's on your mind? is a resource pack that includes a video along with downloadable lesson plans to help teachers introduce the subject of emotional wellbeing and mental health to students. Produced by the Scottish anti-stigma programme 'See Me'.

Notes to self is a film and mental wellbeing teaching resource for use with young people at key stages 3 to 5. It helps students get a better understanding of mental health issues and why they should seek help. The film and teaching pack cost £35, but the trailer is freely available online.

Dove self-esteem workshops are for students aged 11 to 14.

Resources to support children and young people with learning disabilities, physical disabilities and chronic illness

Children and young people with learning disabilities: understanding their mental health is an information pack providing an introduction to learning disabilities among children and young people.

FRIENDS for life: learning disabilities is part of FRIENDS for Life, a group programme that teaches children and young people techniques to cope with anxiety and promote wellbeing, social and emotional skills and resilience. The FRIENDS for Life Learning Disabilities development project was adapted to be accessible for children and young people with learning disabilities.

Feeling down: looking after my mental health is an easy-read guide for people with learning disabilities from the Foundation for People with Learning Disabilities. The guide provides information and advice on how to look after oneself and get the best out of life.

I Can produces factsheets about speech, language and communication difficulties, and has a helpline for parents and practitioners.

National Autistic Society has a website that provides information about autism.

Specific issues

Ofsted has produced short videos that help illustrate what a primary school and a secondary school have done to reduce bullying:
Good practice film - Edith Neville Primary School: anti-bullying
Good practice film - Hillcrest School and Community College: bullying

Childhood bereavement network offers resources to help schools deal with a bereavement within the school.

OCD Youth website is especially for young people, their parents and teachers with information, resources, and online forums for young people with OCD.

On edge: self-harm awareness resource pack is a film and lesson plan resource pack for teachers and other professionals working with young people. Developed by NHS Greater Glasgow and Clyde.

General

Learning to ride elephants: teaching happiness and wellbeing in schools (2009) is a book about positive psychology and the teaching of wellbeing by Ian Morris who runs the Wellbeing programme at Wellington College.

Resources written by young people, for young people

Reach out north east newsletters are about mental health.

The Site provides information on a range of topics including mental health.

Training

MindEd is a portal that provides free, online bite sized chunks of 'e-learning' available on tablets, phones or computers to help adults to identify, understand and support children and young people with mental health issues. The learning materials were written and

edited by leading experts from the UK and around the world. Different learning pathways can be followed according to professional or other interests.

ADDISS is the National Attention Deficit Disorder Information and Advice Service which provides training for schools on ADHD management and information about ADHD. 'School Report: Perspectives on ADHD' illustrates what it is like to be a child with ADHD in the school system.

Alumina is an online course for young people aged 14 to 19 years and provides group and individual courses.

Bounce Forward provides training for teachers who want to teach the UK Penn Resilience Programme (PRP). Participants develop their own personal resilience and then apply this insight to teaching the curriculum to young people. The PRP is a licenced model, and only those who have received training through an accredited body such as Bounce Forward can legitimately teach the PRP curriculum.

Mental health first aid England is an educational course focussing on young people's mental health and how to identify, understand and help a young person who may be developing mental health problems.

Mindfulness in schools project offer a range of courses including " *.b,"* which stands for 'Stop, Breathe and Be,' and can be used with a range of different age groups.

National Association of Independent and Non-Maintained Special Schools (NASS) is a membership organisation working with and for special schools in the voluntary and private sectors within the UK. 'Making sense of mental health' is an e-learning resource for staff working in schools with children and young people who have complex special educational needs. The e-learning training increases staff knowledge about mental health and how this relates to children with disabilities.

Place2Be provides counselling services for children and support for teachers and parents. It also provides continuous professional development training sessions that address themes related to children's emotional wellbeing in schools, such as safeguarding, attachment, understanding risks and resilience and others. The sessions help reduce teacher and staff stress by providing practical approaches that help them deliver effective support. It also provides a range of professional qualifications around counselling in schools.

YoungMinds provides a range of support to schools, including training. It provides a varied training calendar and schools are also able to commission bespoke training packages.

Examples of organisations providing support to schools to provide emotional wellbeing support

Achievement for All (AfA) delivers a whole school improvement framework that raises the aspirations, access and achievement of vulnerable and disadvantaged pupils, including those with special educational needs and disabilities, EAL, looked-after children and children on free school meals. The programme has 4 elements: leadership, teaching and learning, parental engagement, and wider outcomes.

AcSEED encourages all UK schools to achieve and maintain an acceptable threshold of support and to align on best practices that provide a common language and understanding between schools, parents, young people, and associated organisations and charities. The AcSEED initiative was founded by young people with direct personal experience of mental illness at a young age, and is entirely dedicated to supporting the emotional wellbeing and mental health of young people in schools.

ADDISS (see above on page 27)

Boing Boing is an evidence based resilience framework for parents, practitioners and young people.

Humanutopia is a social enterprise that works with schools to offer a range of workshops and courses for students that focus on personal, social development and employability skills. The workshops can help to build confidence, leadership skills, peer mentoring skills and help students overcome barriers to engaging in their own education.

Mental Health Foundation provides useful information about mental health.

Nurture Group Network promotes the development of nurture groups that are small groups of children who need short, focussed support to help address issues connected to social, emotional and behavioural difficulties. It ensures the continuing quality of delivery through accredited training programmes, research on effective practice, relevant publications and information exchange.

Place2Be (see above 28)

Rethink Mental Illness produces useful information for young people about mental health.

Royal College of Psychiatrists provides a wide range of leaflets and other information for parents, young people and professionals.

Samaritans can support schools by giving talks, providing a teaching resource called DEAL, and hosting a suicide response service to support schools following a suicide.

YoungMinds in Schools programme was funded by the Department for Education and piloted a programme of consultancy and training to 4 cluster schools in England. This YoungMinds website also provides a useful library of resources for schools.

Therapeutic story writing from YoungMinds is an approach to helping support students' emotional wellbeing whilst at the same time improving writing skills.

Academic Resilience from YoungMinds is a free resource to help schools support pupils' academic resilience and was devised by Lisa Williams and Professor Angie Hart.

Approaches to promoting emotional wellbeing in children and young people

Classroom Dinosaur Curriculum is a prevention program delivered by teachers in the classroom and includes group activities and activities for parents and children to do at home.

Social and Emotional Aspects of Learning (see above on page 25)

Therapeutic story writing from YoungMinds is an intervention that helps support students' emotional wellbeing as well as improve their writing skills.

UK Resilience Programme (Penn Resilience Programme) Bounce Forward provides expertise in the skills that allow children and young people to thrive and flourish.

Zippy's Friends is a programme that helps young children, aged 5, 6 and 7, to develop coping and social skills.

Parenting programmes

Childhood behaviour problems: briefings for professionals is by the Centre for Mental Health.

Some of the best tested and most reliable parenting programmes are Incredible Years and Triple P. In order to work best, parenting programmes need to be delivered as they were originally intended and be targeted at those with the right level of need.

Counselling

School-based counselling for all is a short paper from the British Association for Counselling and Psychotherapy.

Helplines

NSPCC Working with schools is a service that uses specially trained volunteers to talk to primary school children about abuse. The aim is to give them the skills to protect themselves and know where to go for help. There is also a free helpline for children and young people. The helpline number is 0800 1111.

Get Connected is a free, confidential helpline service for young people under 25, who need help, but don't know where to turn. The helpline number is 0808 808 4994.

Papyrus is a charity that aims to prevent young suicides. It has a helpline for young people at risk of suicide or for people worried about a young person at risk of suicide called HOPELineUK. The helpline number is 0800 068 41 41.

Relate provides local counselling services for all ages including young people. It also has an online emotional support and advice resource called IRelate which provides information and access to an online counsellor.

Rise Above helps 11 to 6 year-olds build emotional resilience by equipping them with knowledge and skills to deal with pressures they may face. It also provides an online platform through which young people can converse with peers alongside professional support.

YoungMinds Parents' Helpline is a free, confidential helpline for any adult who is concerned about the emotional problems, behaviour or mental health of a child or young person up to the age of 25. The helpline number is 0808 802 5544.

Youth Access offers a directory of local youth information, advice and counselling services for young people aged 14 to 25.

Youth Health Talk provides advice and support on mental health issues from young people for young people

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Suicide by Children and Young People

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

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The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. HQIP's aim is to promote quality improvement, and it hosts the contract to manage and develop the Clinical Outcome Review Programmes, one of which is the Mental Health Clinical Outcome Review Programme, funded by NHS England, NHS Wales, the Health and Social Care Division of the Scottish Government, the Northern Ireland Department of Health, and the States of Jersey and Guernsey. The programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. More details can be found at: www.hqip.org.uk/national-programmes/a-z-of-clinical-outcome-review-programmes/

The interpretation and conclusions contained in this report are those of the authors alone.

SUICIDE IN CHILDREN AND YOUNG PEOPLE: SUMMARY

THE STUDY

We carried out this study to find the common themes in the lives of young people who die by suicide. We wanted to identify possible sources of stress and to examine the role of support services.

We collected information on 922 suicides by people aged under 25 in England and Wales during 2014 and 2015. The information came from investigations by official bodies, mainly from coroners, who take evidence from families and professionals.

MAIN FINDINGS

The number of suicides at each age rose steadily in the late teens and early 20s. Most of those who died were **male** (76%), and the male to female difference was greater in those over 20.

Although under 20s and 20-24 year olds had many antecedents in common, there was a **changing pattern,** reflecting the stresses experienced at different ages. Academic pressures and bullying were more common before suicide in under 20s, while workplace, housing and financial problems occurred more often in 20-24 year olds.

We confirmed in this larger study our previous findings of **10 common themes** in suicide in under 20s (see Table 1, page 4).

We found **bereavement** to be common in both age groups, 25% of under 20s and 28% of 20 -24 year olds, equivalent to around 125 deaths per year. **Suicide bereavement**, i.e. the death of a family member or friend, was more common in the under 20s (11% v 6%).

21% of under 20s and 14% of 20-24 year olds were university or college **students** equivalent to around 75 deaths per year in this age group. Suicide in students under 20 occurred more often in April and May, conventionally exam months. Only 12% were reported to be seeing student counselling services.

9% of under 20s who died had been "**looked after children"**, 14 deaths per year in this age group. They had high rates of housing problems and suicidal ideas. Almost all had recent contact with at least one service but a third were not in recent contact with mental health care.

6% of under 20s and 3% of 20-24 year olds were reported to be lesbian, gay, bisexual, or transgender (**LGBT**) or uncertain of their sexuality, equivalent to 18 deaths per year. A quarter of LGBT under 20s had been **bullied**; most had previously self-harmed.

We found **suicide-related internet use** in 26% of deaths in under 20s, and 13% of deaths in 20-24 year olds, equivalent to 80 deaths per year. This was most often searching for information about suicide methods or posting messages with suicidal content.

Self-harm was reported in 52% of under 20s and 41% of 20-24 year olds who died, equivalent to around 200 deaths per year.

Families will sometimes say that a suicide occurred **"out of the blue"**. We confirmed that a proportion of the young people who died had not talked about suicide and had low rates of key stresses.

Around 60% in both age groups were **known to services**. Around 40% had been in recent contact—in only 26% this was mental health care. Interagency collaboration was variable and risk recognition appeared poor.

KEY MESSAGES

Suicide in young people is rarely caused by one thing; it usually follows a combination of previous vulnerability and recent events.

The stresses we have identified before suicide are common in young people; most come through them without serious harm.

Important themes for suicide prevention are support for or management of family factors (e.g. mental illness, physical illness, or substance misuse), childhood abuse, bullying, physical health, social isolation, mental ill-health and alcohol or drug misuse.

Specific actions are needed on groups we have highlighted: (1) support for young people who are bereaved, especially by suicide (2) greater priority for mental health in colleges and universities (3) housing and mental health care for looked after children (4) mental health support for LGBT young people.

Further efforts are needed to remove information on suicide methods from the internet; and to encourage online safety, especially for under 20s.

Suicide prevention in children and young people is a role shared by front-line agencies; they need to improve access, collaboration and risk management skills. A later, more flexible transition to adult services would be more consistent with our finding of antecedents across the age range.

Services which respond to self-harm are key to suicide prevention in children and young people, and should work with services for alcohol and drug misuse, factors that are linked to subsequent suicide.

BACKGROUND

Rates of suicide and self-harm in young people

Suicide is the second leading cause of death among 15-29 year olds worldwide accounting for 8% of all deaths[1].

In the UK, suicide is the leading cause of death in young people[2], accounting for 14% of deaths in 10-19 year olds and 21% of deaths in 20-34 year olds[3]. The UK has a relatively low rate of suicide by children and young people compared to other countries[1], but there has been a recent increase, reversing a decline over the previous 10 years. Rates also vary between UK countries, a previous NCISH report showing higher suicide rates in young people in Scotland and Northern Ireland[4].

Over half of young people who die by suicide have a history of self-harm[5]. Self-harm has risen in the last 15 years—in 2014, one in five young women reported having ever self-harmed, twice the rate in young men and three times higher than reported 15 years ago[6]. Recent self-harm has become more common as an antecedent of suicide in patients of mental health services over the last 20 years[4]. A report, to be published in 2018, on the patterns of contact between primary and secondary services by children and young people with mental health disorders, including self-harm, will focus on trends in service presentation, recognition and treatment[7].

Policy context

Improving the mental health and wellbeing of children and young people is a Government priority. In 2015 the Department of Health and NHS England published Future in Mind, with proposals on prevention, access to help and support, and mental health services[8].

In January 2017, the Prime Minister announced a number of pledges to help those, particularly young people, with mental health conditions. These included a revised national suicide prevention strategy, highlighting self-harm and the mental health of children and young people[9]. A Green Paper on child and adolescent mental health services is planned for later this year.

A national study to investigate suicide by children and young people

We have established a national study combining multiple sources of information to investigate antecedents of suicide in children and young people.

In phase one of our study we reported initial findings about suicide by people aged under 20[5]. In this phase we report on a two year sample of people aged up to 24 and explore the changing patterns of suicide risk in childhood, early and late adolescence, and early adulthood.

Key messages from phase one

Our previous report[5], examining suicides by children and young people aged under 20 in England, cited ten common themes (Table 1).

Table 1: Ten common themes in suicide by children and young people

Family factors such as mental illness
Abuse and neglect
Bereavement and experience of suicide
Bullying
Suicide-related internet use
Academic pressures, especially related to exams
Social isolation or withdrawal
Physical health conditions that may have social impact
Alcohol and illicit drugs
Mental ill health, self-harm and suicidal ideas

These experiences may combine over time to increase risk, until suicide occurs in a crisis triggered by, for example, the breakdown of a relationship or exam pressures.

Health and social care, and other agencies that work with young people, as well as families and young people themselves, can contribute to suicide prevention through greater awareness of the range of factors that may add to risk and of the "final straw" stresses that can lead to suicide.

Aims of the study

To examine the antecedents of suicide in children and young people aged up to 24.
To determine how frequently suicide is preceded by children and young person-specific factors of public concern (e.g. bullying, abuse, internet and social media use, and educational stressors).
To examine the role of support services.
To make recommendations to strengthen suicide prevention for children and young people.

HOW WE CARRIED OUT THE STUDY

Report coverage

This report covers the second phase of a national investigation into suicide in children and young people. The study has being undertaken in two phases:

1. The first year focused on people aged 10-19 years who died by suicide (includes undetermined deaths) in England. Findings from the first year of data collection were published in May 2016[5].

2. In the second year, data collection has been extended to include a sample of people aged up to 24, in England and Wales.

This report is based on deaths that occurred during a 24 month period (i.e. during the two years of data collection as described above). It describes the antecedents of suicide by people aged under 25 and includes recommendations for services.

Definitions

Suicides are defined as deaths that received a conclusion of suicide or undetermined (open) at coroner's inquest, as is conventional in research and national statistics[10].

Deaths coded with the following International Classification of Diseases, Tenth Revision (ICD-10)[11] codes were included in the study: X60-X84; Y10-Y34 (excluding Y33.9); Y87. This is in line with the Office for National Statistics (ONS) procedures for identifying deaths by suicide. Deaths receiving a narrative verdict at coroner inquest were included in the study if ONS procedures for identifying suicide deaths applied one of these ICD-10 codes.

Further definitions are provided in the appendix (page 26).

Notification of deaths by suicide of children and young people

In this report, findings are presented for England and Wales combined. National suicide data were obtained from ONS for individuals aged between 10 and 24. These deaths occurred between January 2014 and December 2015.

Data sampling

All deaths of people aged 10-19 were included in the sample. A random sample of 20% of deaths of people aged 20-24 was selected from all suicides in this age group in the two year study period (see the appendix, page 26, for further details).

Data sources

In total, there were 922 deaths by suicide in England and Wales in the two year time period. This included 316 deaths of people aged 10-19 and 606 deaths of people aged 20-24, from whom we selected 124 (20%) (Table 2).

These 440 people were the subjects of the main study. Information was received from one or more of the following data sources for 391 (89%).

Table 2: Available data sources

	Number (%)	
	Under 20	20-24
Deaths by suicide in children and young people (notified by ONS)	316	124*
Deaths on which at least 1 report has been obtained	285 (90%)	106 (85%)
Coroner inquest hearings	272 (86%)	103 (83%)
Child death investigations received (under 18s, England only)	74 (52% of deaths in under 18s)	n/a
NCISH data obtained	55 (17%)	16 (13%)
Single source of data received	177 (56%)	85 (69%)

* Note: Based on a 20% sample of all deaths in this age group

1. Coroner inquest hearings (375 cases)

Audio CDs of inquest hearings were requested in all cases. Coroners were sent the name(s) of individuals who died by suicide in their jurisdiction and asked to provide a CD recording of the inquest hearing (or where not available, copy statements or depositions submitted as evidence).

HOW WE CARRIED OUT THE STUDY

2. Child Death Overview Panel (CDOP) child death investigations (under 18 years, England only) (74 cases)

CDOP analysis proformas (Form C) were requested from Local Safeguarding Children's Boards (LSCB) in cases where the CDOP had reviewed the death of an individual by suicide or deliberate self-inflicted harm.

Twenty-eight (19%) LSCBs did not participate, usually due to concerns regarding the release of personal data (n=13) or due to non-response or pending decisions on participation (n=15). There were also LSCBs who had not reviewed, finalised, or provided the Form C to the study at the time of writing.

3. Case Reviews (14 cases)

There is different guidance for carrying out case reviews in England and Wales. However, central to each is that a case review should be carried out when a child (under the age of 18) dies or is seriously injured and abuse or neglect is thought to be involved. Case Reviews were sought from the National Society for the Prevention of Cruelty to Children (NSPCC) national case review repository[12] or from the relevant LSCB.

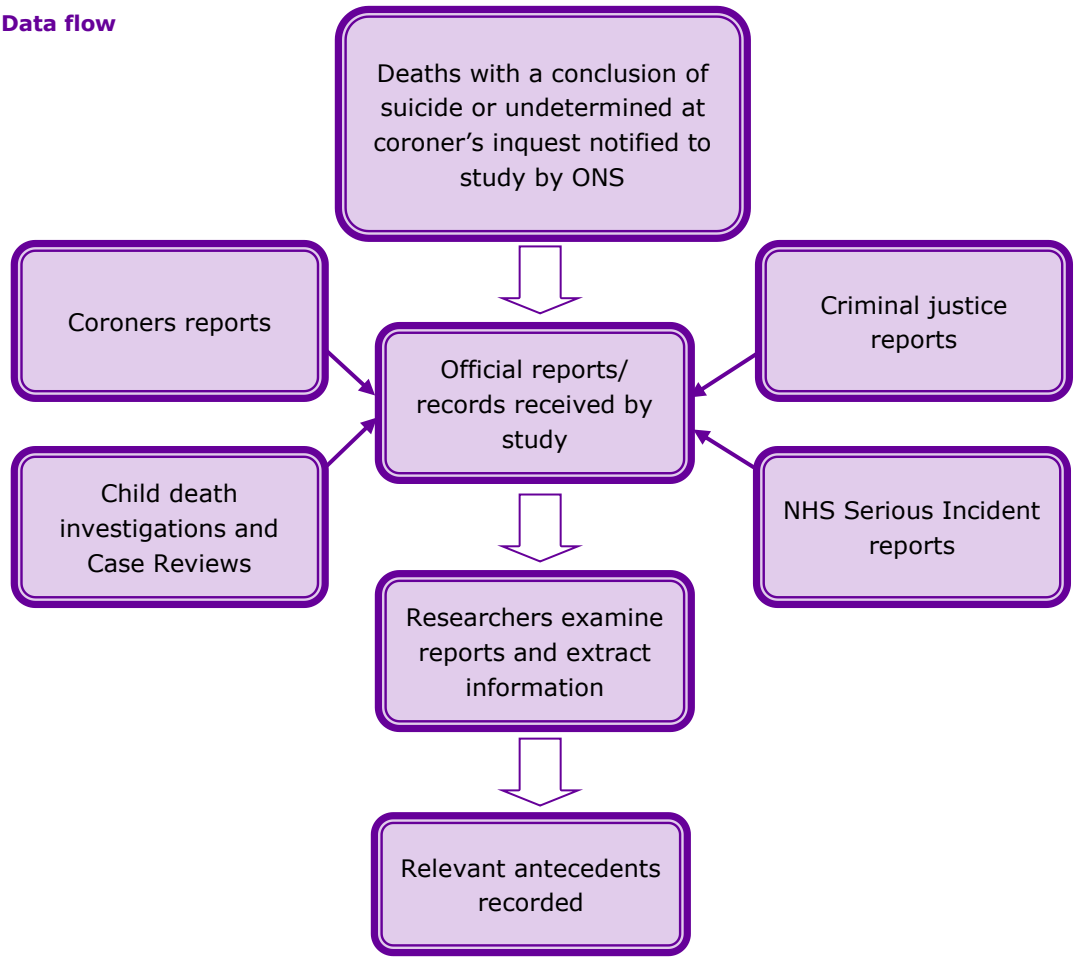
4. Criminal justice system reports (4 cases)

In England and Wales, the Prisons and Probation Ombudsman (PPO) have agreed to notify the study when any new reports meeting the study criteria were published and available to download on their website[13]. The Independent Police Complaints Commission (IPCC) have also agreed to notify the study when any investigations on an apparent suicide of a young person in or after release from custody were conducted.

5. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) data (71 cases)

The NCISH method of data collection is similar across England and Wales. A full description is provided on our website[14] and in our previous national reports.[15,16]

Figure 1: Data flow



HOW WE CARRIED OUT THE STUDY

Briefly:

- patients (i.e. individuals in contact with mental health services within 12 months of suicide) were identified from mental health trust and health board records
- clinical data were obtained for these patients via a detailed questionnaire sent to the consultant psychiatrist responsible for the patient's care.

Seventy-one (16%) individuals were identified as patients from NCISH data. This is lower than the proportion of patient suicides seen in the UK general population as a whole (28%)[4] but higher than we reported in our first year of data collection (12%)[5]. The number of patient suicides is likely to be an under-estimate at this stage and is expected to increase as data collection continues—reflecting the time required to identify and process data on mental health patients who die by suicide.

6. NHS Serious Incident reports (72 cases)

For those individuals who were identified as patients from the NCISH database, the medical director at the NHS Trust or Health Board where the patient was treated was asked to provide a copy of the NHS Serious Incident report. These reports detail the findings from an internal investigation and identify the root causes and recommendations. Not all patient suicides are subject to Serious Incident review. Whether a review is conducted can depend on the timing and level of contact with services, as well as the individual Trusts' own policies on Serious Incident reporting.

Analysis

Information was taken from the sources listed above via a data extraction proforma on to a standardised database for aggregate analysis (Figure 1).

Descriptive figures are presented as numbers and percentages. The denominator in all estimates was the total number of cases on which information was received in each age group (i.e. 285 in the under 20s; 106 in 20-24 year olds) unless otherwise specified. If an item was not recorded in any data source then it was assumed to be absent or not relevant.

Significant differences between age groups and males and females ($p<0.05$) are highlighted in the figures. With this sample size, several differences were of borderline statistical significance. These are shown in the figures as $p<0.1$. Further details on data analysis are provided in the appendix (page 26).

WHAT WE FOUND

Deaths notified in the study period

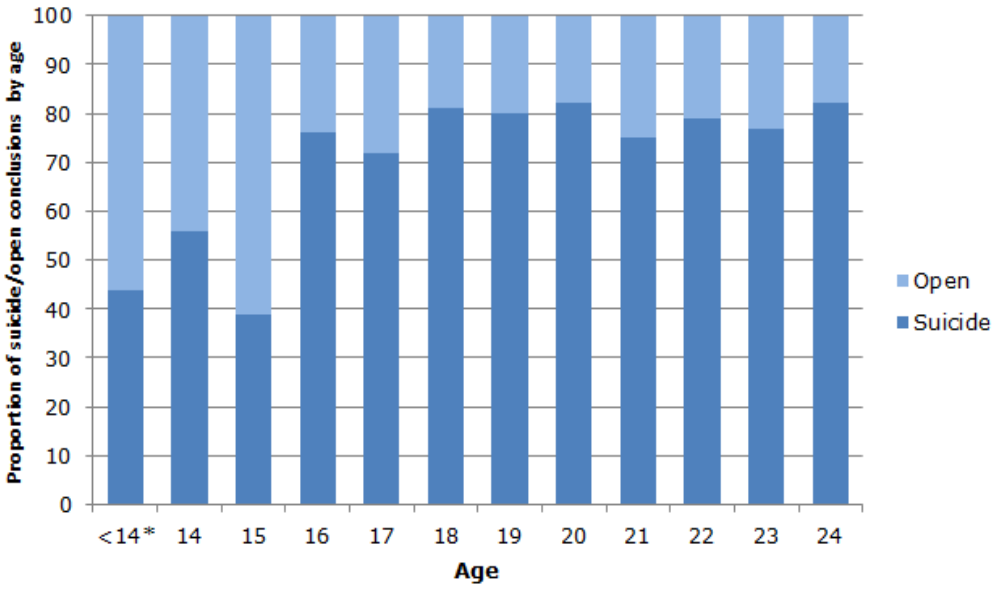
Numbers

We were notified of 922 deaths by suicide in people aged under 25 in the two year study period.

Conclusions

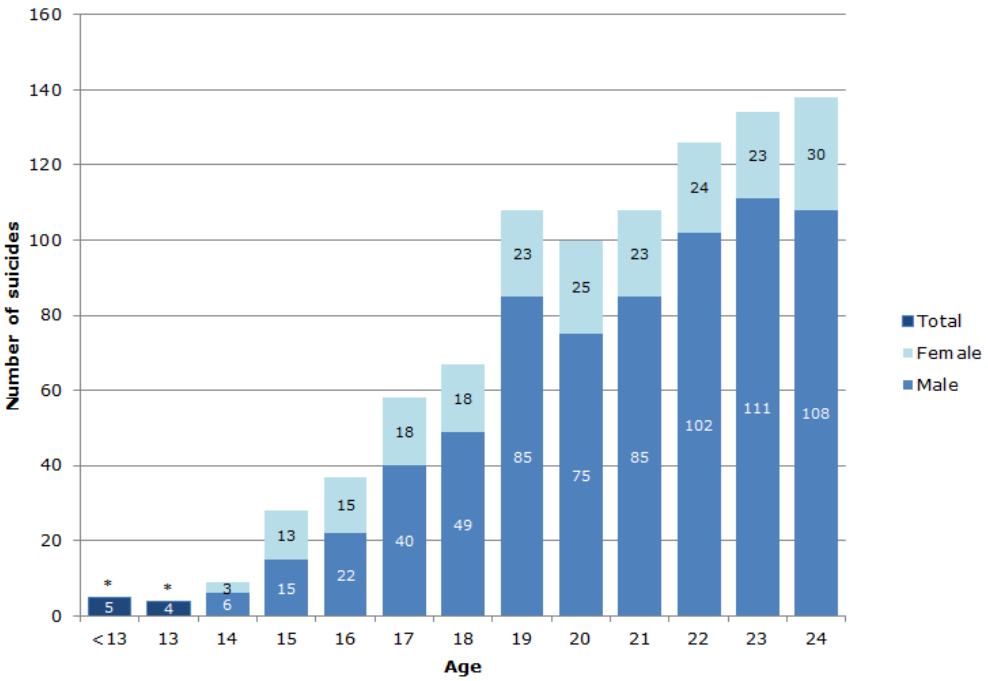
Of the 922 deaths, 708 (77%) received a suicide conclusion at coroner's inquest, and 214 (23%) an undetermined (open) conclusion. The likelihood of receiving an undetermined conclusion was the same in males and females but was higher in those under 16 (Figure 2).

Figure 2: Proportion of coroner conclusions, by age



*Note: Ages combined in Figure 2 because of low numbers

Figure 3: Number of suicides, by age and gender



*Note: males and females have been combined in Figure 3 because of low numbers

Age and gender

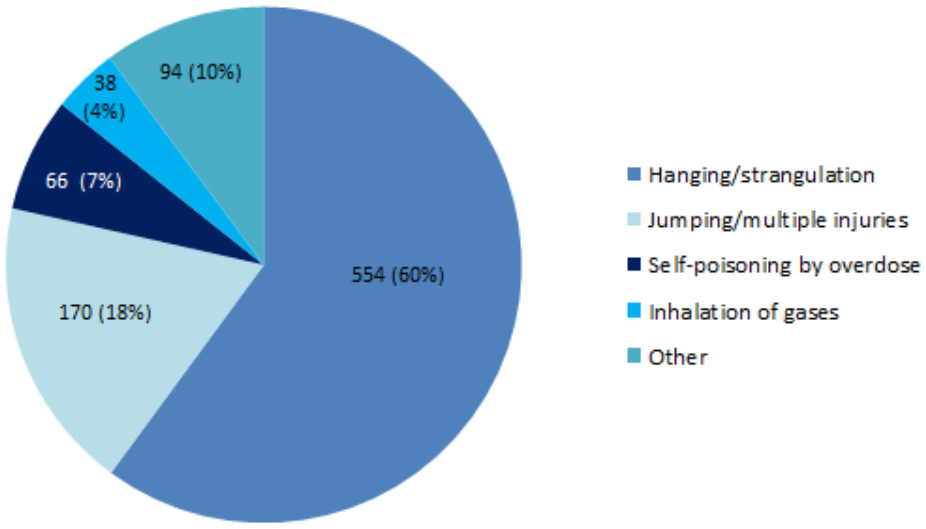
Figure 3 shows the number of suicides by age and gender. The number of suicides increased steadily with age, particularly in the mid to late teens. The number of male suicides was higher than females, especially in the late teens and early 20s, with a male to female ratio of 2.6:1 in those aged 15-19, and 3.7:1 in those aged 20 and over.

There were 316 deaths in people aged under 20 in the two year study period. Of the 606 suicide deaths in people aged 20-24, we included 124 in our sample (see page 5 and page 26 of the appendix).

WHAT WE FOUND

Method of suicide (Figure 4)

Figure 4: Method of suicide

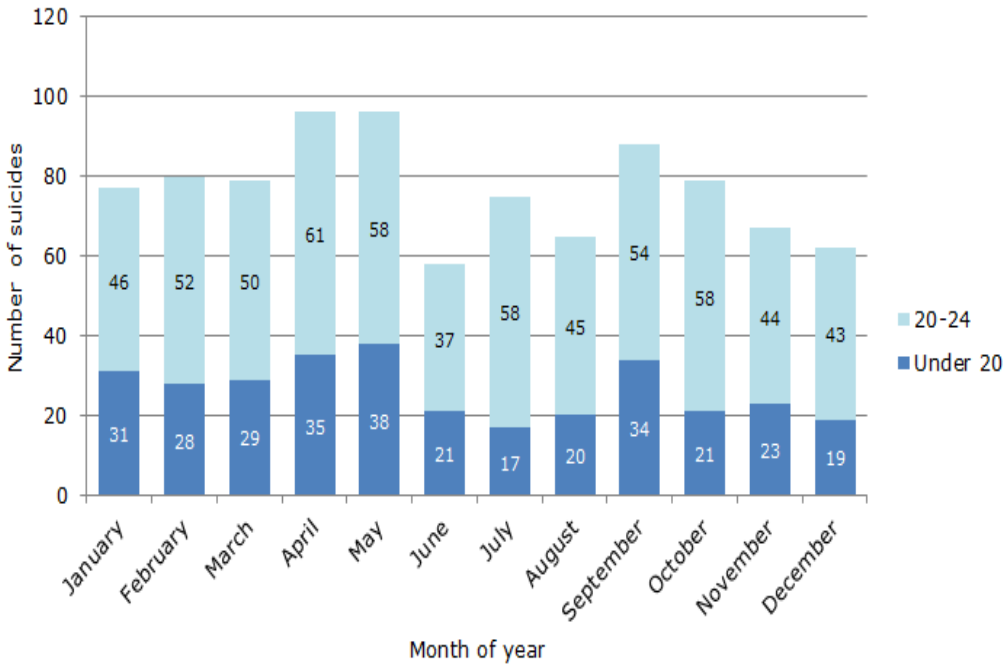


The most common method of suicide was hanging/ strangulation (554, 60%), followed by jumping/multiple injuries, i.e. jumping or lying in front of a train or other vehicle (89, 10%), jumping from a height (56, 6%), or other multiple injuries (25, 3%).

There were 66 (7%) deaths by self-poisoning (overdose). Opiates were the most commonly used substance taken, in 17 deaths; others included barbiturates (n=10), beta blockers (n=9), antidepressants (n=6), and paracetamol or paracetamol/ opiate compounds (n=5).

There were 38 (4%) deaths following gas inhalation. Four-hundred and twenty-two (60%) males died by hanging, similar to the proportion of females (132, 61%). Females died by self-poisoning significantly more often than males (27, 12% v 39, 6%).

Figure 5: Timing of suicides, by month of year



Timing of suicide

Figure 5 shows the number of suicides was higher in the first half of the year. Monthly figures for April (IRR 1.66), May (IRR 1.60), September (IRR 1.52) and February (IRR 1.48) were significantly higher than the baseline (i.e. June, see page 26 for an explanation of IRRs). The lowest numbers were in June and December.

There was a peak in the number of suicides in under 20s in May (IRR 1.75), and in April (IRR 1.65) in 20-24 year olds. The lowest figures for under 20s and 20-24 year olds occurred in July and June, respectively.

WHAT WE FOUND (UNDER 20 YEAR OLDS)

Antecedents of suicide

Of the 922 suicide deaths by young people in the two year study period, we sought to record information on all of the 316 deaths in people aged under 20, and on a 20% sample of all deaths in people aged 20-24 (n=124). In total, we recorded information on 391 (89%) of these 440 children and young people. Two hundred and eight-five (90% of all under 20s) were aged under 20; 106 (85%) were aged 20-24.

The remainder of the findings are based on these 391 individuals (see figures 6-10, tables 3-11). Findings are reported separately for the under 20 and 20-24 year old age groups (see Table 11 in the appendix).

Under 20 year olds

Two hundred and four (72%) were male. Thirty (14%) were from a black or minority ethnic group.

Family environment and relationships

One hundred and twenty-three (43%) lived with two parents (including a step-parent) at the time of death. Sixty-four (22%) lived with a single parent. There was evidence of possible disruption to the family environment by mental illness (45, 16%), physical illness (30, 11%), or substance misuse (30, 11%) in a parent, carer or sibling. Parental domestic violence had been witnessed by 26 (9%). In the 3 months prior to death, 8 (3%) had experienced parental separation or divorce. Sixty-three (22%) were in a relationship at the time of death.

Lesbian, gay, bisexual and transgender (LGBT) young people

Thirteen (5%) were LGBT young people and 4 (1%) were reported to be uncertain about their sexual orientation. Of these 17, 10 (59%) were male. Fifteen (88%) were recorded as experiencing conflict regarding their sexuality e.g. struggling with how they would tell family or friends they were gay or were experiencing internal turmoil regarding their sexuality.

Common antecedents of suicide in LGBT young people are shown in Table 3. Significantly higher proportions of LGBT young people had a history of abuse, were looked after children, and had used the internet in a way that was related to suicide.

Table 3: Antecedents of suicide in LGBT groups aged under 20

	Number (%)
Socially isolated	7 (41%)
Face-to-face bullying	4 (24%)
Abuse (emotional, physical, sexual)	5 (29%)
Looked after child	4 (24%)
Suicide-related internet use	10 (59%)
Previous self-harm	10 (59%)
Suicidal ideas	10 (59%)
Any diagnosis of mental illness	7 (41%)
No service contact	9 (53%)

Abuse

A history of abuse (physical, emotional or sexual) was recorded in 33 (12%). Physical and sexual abuse were the most commonly reported forms of abuse (17, 6% in both cases).

There was a history of child neglect in 14 (5%) cases. In total this gives 38 people with a history of abuse and/or neglect as 9 had experienced both abuse and neglect.

Twenty (7%) had been under a Child Protection Plan or had been subject to a statutory order.

Looked after children

At the time of death, 7 were 'looked after' children (i.e. in care) and a further 19 had previously been looked after children. Of these 26, 5 (19%) were living in a secure children's home or other local authority accommodation. Twelve (46%) were living with a parent(s) (including foster parents, n=3). Fourteen (54%) reported problems with housing or a recent change of accommodation, higher than other under 20s.

WHAT WE FOUND (UNDER 20 YEAR OLDS)

Seventeen (65%) had previously self-harmed—10 (38%) in the 3 months prior to death. Excessive alcohol use was reported in 10 (38%) and illicit drug use in 13 (50%). Fifteen (58%) were reported to have been bereaved—higher than other under 20s—5 by suicide.

Twenty-five (96%) had recent contact (i.e. in the 3 months prior to their death) with at least one agency (Table 4).

Table 4: Contact with services in looked after children aged under 20

	Number (%)
Service contact (at any time)	26 (100%)
Recent service contact	25 (96%)
Mental health services	16 (62%)
Youth justice/police	16 (62%)
Social care/local authority	17 (65%)
Recent contact with multiple agencies*	6 (23%)
Contact with multiple agencies (at any time)	17 (65%)

* Note: see appendix (pages 28-29) for definition

Bereavement

Seventy (25%) were reported to have been bereaved. Twenty (7%) had experienced more than one bereavement. Twenty-six (9%) had lost a parent, 31 (11%) a family member or partner, 22 (8%) a friend or acquaintance. Three (1%) had miscarried. In 44 (63%), the bereavement had occurred in the previous year, 14 (20%) in the 3 months prior to death. In 26 (37%), the bereavement occurred more than 12 months earlier.

Thirty-one (11%) had been bereaved by suicide. Fifteen (5%) had lost a friend or acquaintance to suicide, 10 (4%) a parent, and 5 (2%) a family member or partner. Suicide bereavement occurred within the previous year in 15 (5%), 4 (1%) in the 3 months prior to death. In 15 (5%), the suicide bereavement was more than 12 months earlier.

For many, bereavement added to existing problems (Table 5). A significantly higher proportion of bereaved young people had: experienced disruption to the family environment; a history of abuse or bullying; used the internet in a way that was related to suicide; and had previously self-harmed, expressed suicidal ideas, or used alcohol excessively.

Fifty-seven (81%) of the 70 reported to have been bereaved and 24 (77%) of the 31 bereaved by suicide, had contact with at least one agency—in the majority this was mental health services.

Table 5: Antecedents of suicide in bereaved under 20s

	Number (%)
Family (parent, carer, sibling) history:	
Mental illness	22 (31%)
Physical illness	16 (23%)
Substance misuse	16 (23%)
Witness to domestic violence	13 (19%)
Abuse (emotional, physical, sexual)	17 (24%)
Bullying	23 (33%)
Suicide-related internet use	26 (37%)
Physical health condition	23 (33%)
Excessive alcohol use	26 (37%)
Illicit drug use	24 (34%)
Previous self-harm	50 (71%)
Suicidal ideas (at any time)	49 (70%)
Any diagnosis of mental illness	43 (61%)

Bullying

Fifty-eight (20%) were known to have been a victim of bullying. Forty-eight (17%) were victims of face-to-face bullying and 21 (7%) were victims of online bullying. In 17 (6%) the bullying had occurred in the 3 months prior to death.

WHAT WE FOUND (UNDER 20 YEAR OLDS)

Suicide-related internet use

Seventy-four (26%) had used the internet in a way that was related to suicide. Thirty-seven (13%) searched the internet for information on suicide method and 10 died by a method they were known to have searched on.

Eleven (4%) visited websites that may have encouraged suicide. Twenty-nine (10%) had communicated suicidal ideas or intent online and 21 (7%) had been victims of online bullying—10 in the 3 months prior to death.

Academic pressures

One hundred and forty-five (51%) were in education (school, further or higher education) at the time of death. Sixty-three (43% of those in education) were experiencing academic pressures. In 46 (32% of those in education) these pressures were exam-related, i.e. current or impending exams, or exam results. Of these 46 individuals, 25 (54%) were known to be experiencing exam-related stress. The highest number of deaths in those experiencing academic pressures were in May (9, 14%), April (8, 13%), June (7, 11%) and September (7, 11%).

Sixty-nine (24%) were reported as experiencing problems related to being in education in the 3 months prior to death. In 46 (16%) these were academic pressures. Five died on the day of an exam or the following day.

Students in further or higher education

Sixty (21%) individuals aged 18-19 were students in further or higher education. Of these 60 students, the month with the highest number of deaths was April (11, 18%), followed by May (8, 13%). Twelve (20%) lived in university accommodation. Nineteen (32%) had moved away from their home address to attend college or university. Common antecedents of suicide in students are shown in Table 6 and contact with services in Table 7.

Twenty-two (37%) were experiencing academic pressures—for 9 these pressures were exam-related. Students reported fewer family (8, 13% v 27, 29%), workplace (6, 10% v 32, 35%) or financial problems (5, 8% v 23, 25%) in the 3 months prior to death, compared to other 18-19 year olds (n=92).

Table 6: Antecedents of suicide in students aged 18-19

	Number (%)
Socially isolated	16 (27%)
Suicide-related internet use	10 (17%)
Previous self-harm	25 (42%)
Suicidal ideas at any time	29 (48%)
Suicidal ideas within 1 week of death	12 (20%)
Any diagnosis of mental illness	28 (47%)
Affective disorder (bipolar affective disorder or depression)	13 (22%)
Excessive alcohol use	14 (23%)
Illicit drug use	14 (23%)

Table 7: Contact with services in students aged 18-19

	Number (%)
Service contact (at any time)	33 (55%)
Mental health services	23 (38%)
Youth justice/police	16 (27%)
Social care/local authority	4 (7%)
College/university support services	7 (12%)

Medical history

A physical health condition was recorded in 90 (32%) and in 54 (19%), the condition had lasted for more than 12 months. The most common conditions were respiratory disease (e.g. asthma, n=26, 9%) and dermatological problems (e.g. acne or eczema, n=26, 9%). We have not had access to information on specific treatments for these conditions.

Alcohol and drugs

Alcohol use was reported to be excessive in 64 (22%). Illicit drug use was reported in 98 (34%).

WHAT WE FOUND (UNDER 20 YEAR OLDS)

Toxicological analysis detected alcohol in the blood and/or urine in 57 (25%) cases. Twenty-three (8%) had an alcohol level above the drink driving limit (80 mgs per 100 ml of blood or 107 mgs per 100 ml of urine).

Illicit drugs were detected in 44 (15%) individuals. Prescribed and over the counter drugs were detected outside their therapeutic range in 15 (5%).

Self-harm and suicidal ideas

One hundred and forty-seven (52%) had a history of self-harm. Cutting and self-poisoning (overdose) were the most common methods. Under 20s who self -harmed had high rates of excessive alcohol (33%) and illicit drug use (42%).

One hundred and sixty-three (58%) had expressed thoughts of suicide or hopelessness, e.g. 'I can't do this anymore'. Most often these thoughts were expressed to a health professional (46, 28%) such as a GP or in Accident and Emergency (A&E), friends or peers (36, 22%), their current or former partner (31, 19%) or a family member (30, 18%). Twenty-nine (10%) had communicated suicidal thoughts online.

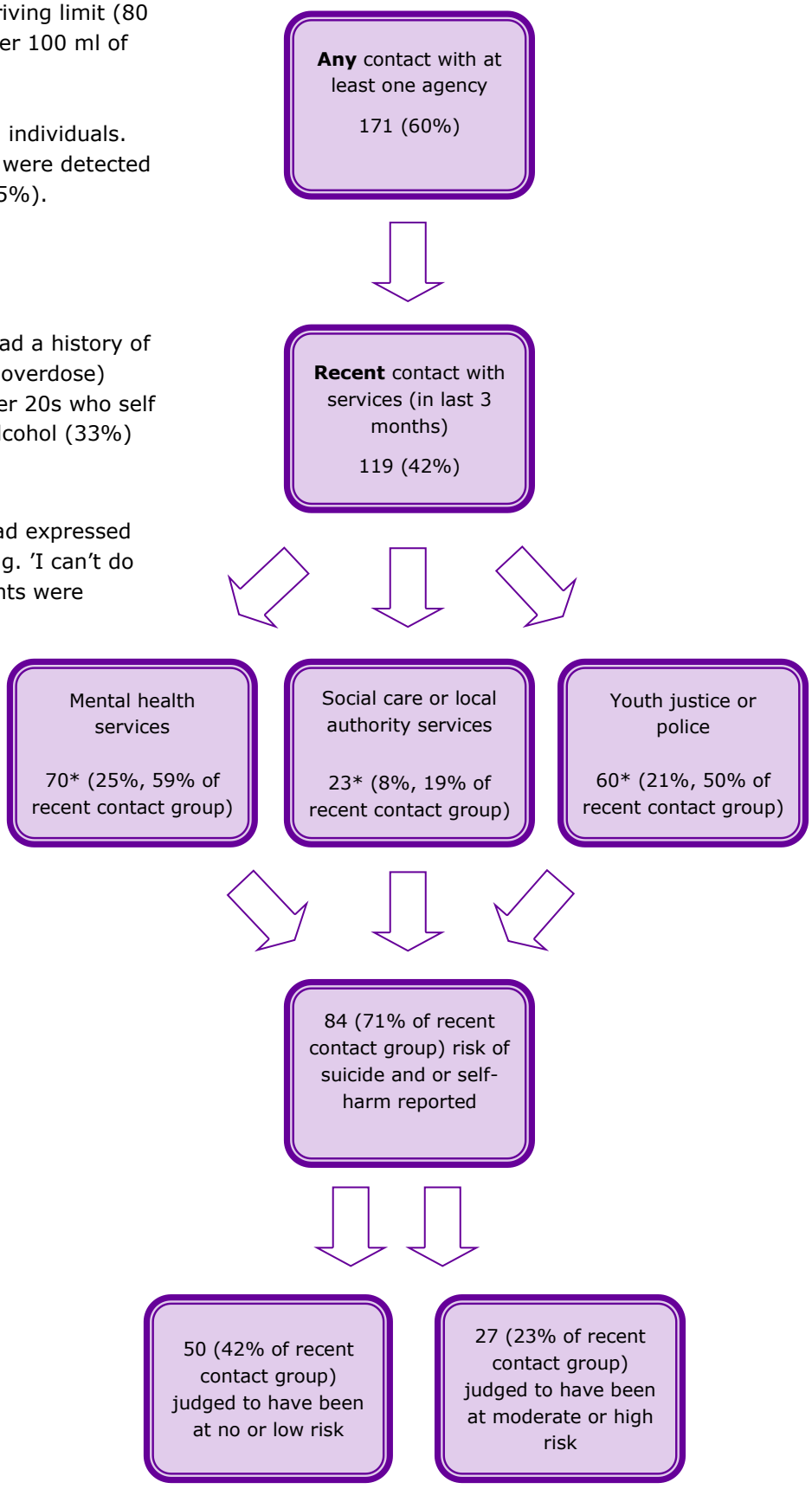
Twenty (7%) had an episode of self -harm in the week prior to death. Medical intervention at A&E was required in 5. Suicidal ideas were reported for 77 (27%) in the week prior to death—38 (14%) on the day of death.

One hundred and two (36%) left a suicide note. Despite this, 14 (14%) received an undetermined conclusion at inquest.

Psychiatric diagnosis

A diagnosis of mental illness was reported in 117 (41%). The most common diagnosis was affective disorder (bipolar or depression; 49, 17%). Forty-seven (16%) were

Figure 6: Contact with services, under 20s



* Note: figures do not tally with the total recent contact group (i.e. 119) as some young people will have recently been seen by more than one agency.

receiving antidepressants These were usually SSRI or SNRI drugs in 41 (14%).

Contact with services

Figure 6 shows the pattern of lifetime and recent contact with front-line services and their recognition of risk. Forty-two percent were in recent contact with any agency, and in 23% of these, risk was viewed as moderate or high—in the others it was unrecorded or seen as low.

Contact with multiple agencies

Thirty-two (11%) had contact with multiple agencies (mental health services *and* social care/ local authority services *and* youth justice/police). In 27 of these, the risk of suicide or self-harm had been considered when last seen by services. Seventeen were judged to be at no or low risk, 8 at moderate or high risk of suicide.

In 6, there was positive evidence of multi-agency working, i.e. good communication between agencies, multi-disciplinary meetings, and attempts at engagement. However, in 20 there was evidence of an absence of multi-agency working, i.e. a lack of information sharing, poor communication and record keeping, delayed or limited multi-agency care plans, or delayed referrals between agencies. In a further 6 cases there was not enough information recorded to make a judgement.

'Out of the blue' deaths

In 3 deaths the young person had had no contact with services, no history of self-harm, no suicidal thoughts, and no contact with a GP or at A&E for mental health problems. Eighty-four (29%) had never expressed suicidal thoughts nor previously self-harmed. In these 84 'out of the blue' deaths there was a general pattern of significantly fewer stresses and early life experiences (e.g. a family history of mental illness, bullying) compared to the under 20s sample as a whole (Table 8). Many (57, 68%) had no known contact with any agencies.

Table 8: Antecedents of suicide in 'out of the blue' deaths, aged under 20

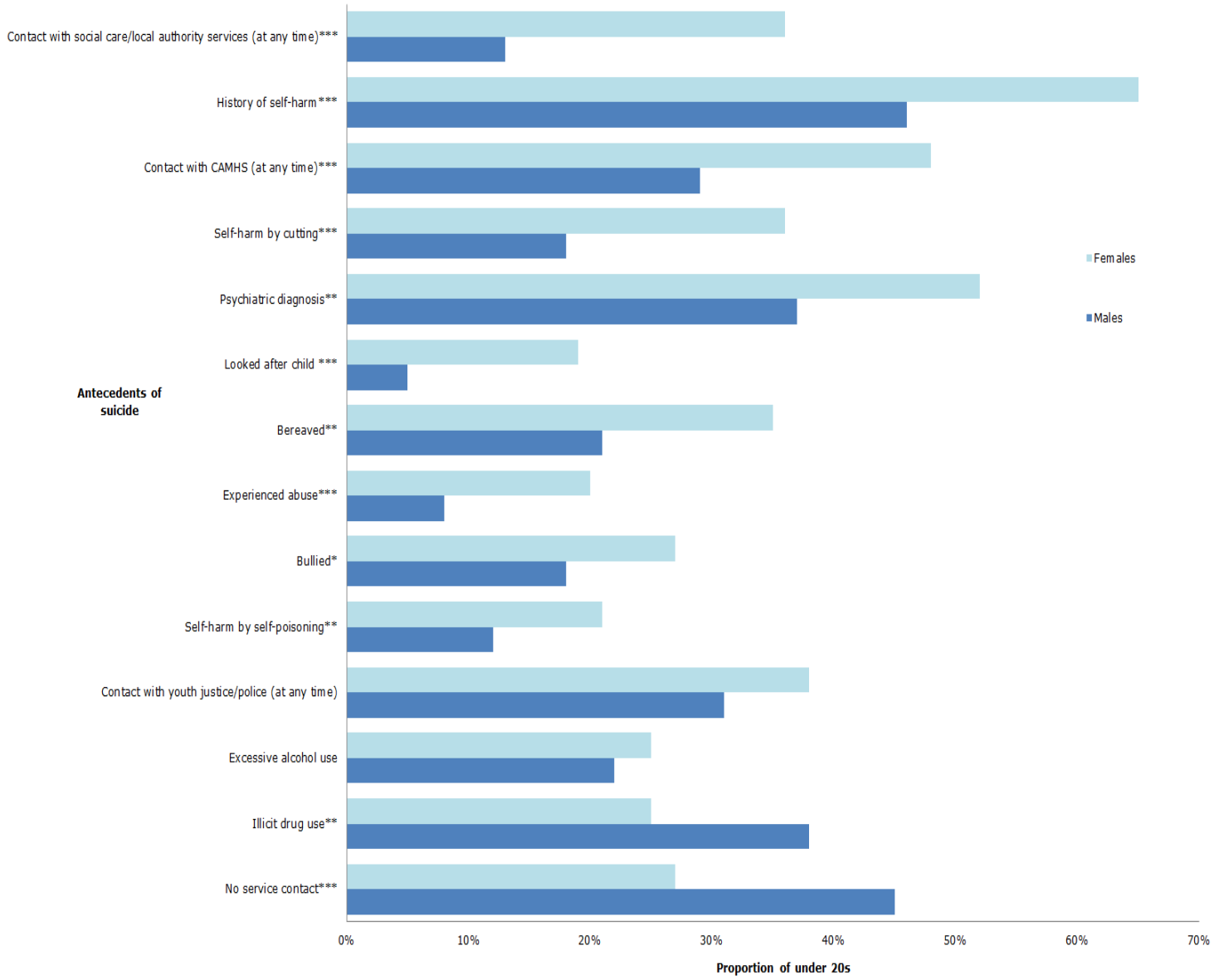
	Number (%)
Family (parent, carer, sibling) history:	
Mental illness	4 (5%)
Physical illness	5 (6%)
Witness to domestic violence	3 (4%)
Bereaved	10 (12%)
Bereaved by suicide	3 (4%)
Bullying	7 (8%)
Suicide-related internet use	10 (12%)
Physical health condition	23 (27%)
Excessive alcohol use	9 (11%)
Illicit drug use	19 (23%)
Any diagnosis of mental illness	17 (20%)

Males and females

Many of the reported antecedents of suicide were more commonly found in females than males (Figure 7). Females more often experienced abuse, bereavement and bullying. They more often had a history of self-harm especially by self-poisoning and cutting. Females were more often known to child and adolescent mental health (CAMHS) and social care or local authority services, and were more often a looked after child. Males, in contrast, more often had a history of illicit drug use and no known contact with agencies.

WHAT WE FOUND (UNDER 20 YEAR OLDS)

Figure 7: Antecedents of suicide in under 20s, in males and females



*Note: Differences between males and females significant at p<0.01 marked by ***; p<0.05 marked by **. With this sample size, several differences were of borderline statistical significance. Differences between males and females at p<0.1 are therefore marked by *.

Figure 7 shows the largest proportionate difference between females and males at the top and the largest proportionate differences between males and females at the bottom.

WHAT WE FOUND (20-24 YEAR OLDS)

20—24 year olds

Eighty-seven (82%) were male. Eight (13%) were from a black or minority ethnic group. Three were known to be LGBT young people—all were male. Being a looked after child was uncommon in this older age-group.

Family environment and relationships

Fifteen (14%) were living alone at the time of death. Twenty-four (23%) lived with two parents, 17 (16%) lived with a single parent. Evidence of possible disruption to the family environment was less common in this older age-group (see Figure 10 and Table 11). Twenty-seven (25%) were in a relationship at the time of death. Six were victims of domestic violence. Nineteen (18%) had a child or children of their own; 15 of these young parents were male.

Abuse

Eight (8%) had a history of abuse. Emotional abuse was the most commonly reported form of abuse (6, 6%).

Bereavement

Thirty (28%) were reported to have been bereaved—4 had experienced bereavement more than once. Fourteen (47%) had lost a parent, 14 (47%) a family member or partner and 3 (10%) a friend or acquaintance. In 14 (47%) the bereavement had occurred within 1 year; and in 16 (53%) more than 12 months prior to death. Six (6%) had been bereaved by suicide.

Similar to bereaved under 20s, a significantly higher proportion of bereaved young people aged 20-24 had: experienced disruption to the family environment; been abused; previously self-harmed; and used alcohol excessively (Table 9), compared to the sample of 20-24 year olds as a whole.

Of the 30 reported to have been bereaved, 20 (67%) had contact with at least one agency, mainly with mental health services or criminal justice agencies (mostly as perpetrators).

Table 9: Antecedents of suicide in bereaved 20-24 year olds

	Number (%)
Family (parent, carer, sibling) history:	
Mental illness	4 (13%)
Physical illness	5 (17%)
Substance misuse	4 (13%)
Abuse (emotional, physical, sexual)	5 (17%)
Bullying	3 (10%)
Suicide-related internet use	5 (17%)
Physical health condition	9 (30%)
Excessive alcohol use	17 (57%)
Illicit drug use	18 (60%)
Previous self-harm	17 (57%)
Suicidal ideas (at any time)	20 (67%)
Any diagnosis of mental illness	18 (60%)

Bullying

There were 9 (8%) victims of face-to-face bullying. There were no known cases of online bullying.

Suicide-related internet use

Fourteen (13%) had used the internet in a way that was related to suicide. Eight (8%) searched the internet for information on suicide method. Six (6%) had communicated suicidal ideas or intent online. Visiting websites that may have encouraged suicide and online bullying were uncommon.

Students in further or higher education

Fifteen (14%) were in further or higher education at the time of death. Seven (7%) were reported as experiencing problems related to being a student in the 3 months prior to death. In 5 these were academic pressures. Six had moved away from home to attend college or university. Antecedents of suicide in students are shown in Table 10. The number of students aged 20-24 with recent family, workplace, or financial problems were too infrequent to report.

WHAT WE FOUND (20-24 YEAR OLDS)

Table 10: Antecedents of suicide in students aged 20-24

	Number (%)
Previous self-harm	8 (53%)
Suicidal ideas at any time	10 (67%)
Any diagnosis of mental illness	10 (67%)
Affective disorder (bipolar or depression)	4 (27%)
Excessive alcohol use	6 (40%)
Illicit drug use	6 (40%)

Ten (67%) students had been in contact with at least one agency, 9 (60%) with mental health services, and 6 (40%) with criminal justice. Contact with social care or local authority services and college or university support services were too infrequent to report.

Medical history

A physical health condition was recorded in 24 (23%) and in 18 (17%), the condition had lasted for more than 12 months. Respiratory diseases were the most common (7, 7%), but there was a broad range—dermatological, gastro-intestinal (e.g. irritable bowel syndrome), musculoskeletal pain and nervous system (e.g. migraine).

Alcohol and drugs

Forty-four (42%) had a reported history of excessive alcohol use. Illicit drug use was reported in 54 (51%).

Toxicological analysis detected alcohol in the blood and/or urine in 42 (40%) cases. Twenty-nine (27%) had an alcohol level above the drink driving limit.

Illicit drugs were detected in 29 (27%) individuals. Prescribed and over the counter drugs were outside the therapeutic range in 8 (8%).

Employment problems

Forty-two (40%) were employed full-time or completing training. Thirty-two (30%) were unemployed. Thirty-two (30%) reported recent work-related problems, including: being unemployed, problems finding work, or job loss (16, 15%); work pressures (4, 4%); fear of losing job (3, 3%); job dissatisfaction (4, 4%); and sickness (3, 3%).

Financial problems

Twenty-one (20%) had experienced recent financial problems. These included debt (9, 8%) and gambling problems (4, 4%).

Housing instability

Thirteen (12%) reported accommodation problems (i.e. being asked to leave their home), and 17 (16%) had recently changed accommodation. Twenty-three (22%) had relocated to a new area, school, college or university in the last 2 years.

Self-harm and suicidal ideas

Forty-three (41%) had a history of self-harm. Cutting and self-poisoning (overdose) were the most common methods. They had high rates of excessive alcohol (63%) and illicit drug (70%) use.

Fifty-eight (55%) had expressed thoughts of suicide, most often these thoughts were expressed to a health professional (18, 33%) such as a GP or in A&E, their current or former partner (14, 25%), a family member (12, 22%), or friends or peers (9, 16%). Six (11%) had communicated suicidal ideas online. Suicidal ideas were reported for 33 (31%) in the week before death—19 (18%) on the day of death.

A suicide note was left by 35 (33%). Of these, 3 (9%) received an undetermined conclusion at inquest.

Psychiatric diagnosis

Fifty (47%) had a diagnosis of mental illness. The most common diagnosis was affective disorder (22, 21%). Twenty-eight (26%) were receiving antidepressants, and in most cases these were SSRI/SNRI drugs.

WHAT WE FOUND (20-24 YEAR OLDS)

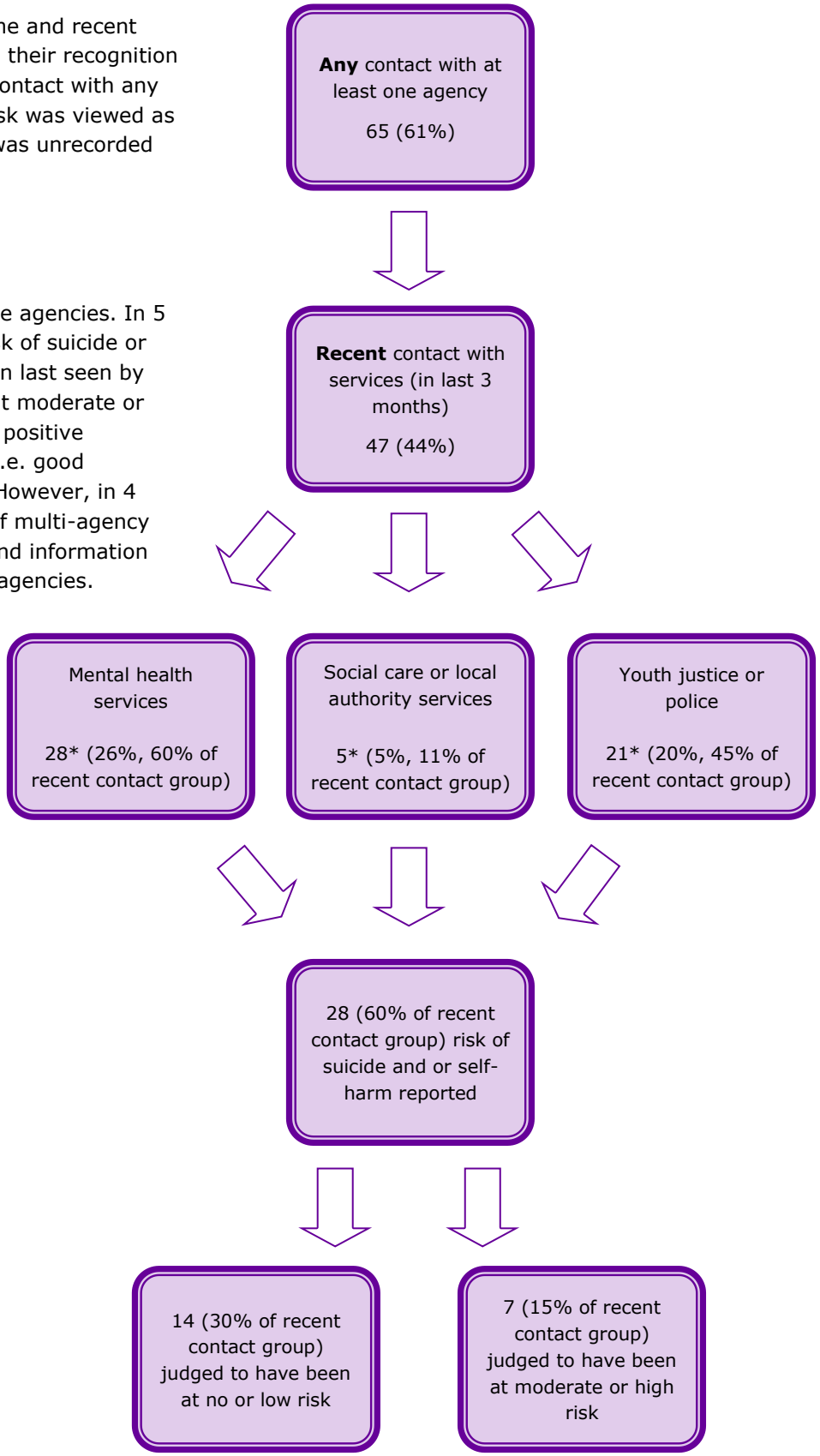
Contact with services

Figure 8 shows the pattern of lifetime and recent contact with front-line agencies and their recognition of risk. Forty-four percent were in contact with any agency but in only 15% of these, risk was viewed as moderate or high—in the others it was unrecorded or seen as low.

Contact with multiple agencies

Eight (8%) had contact with multiple agencies. In 5 of these there was evidence that risk of suicide or self-harm had been considered when last seen by services. Three were judged to be at moderate or high risk of suicide. In 4, there was positive evidence of multi-agency working, i.e. good communication between agencies. However, in 4 there was evidence of an absence of multi-agency working, i.e. poor communication and information sharing, delayed referrals between agencies.

Figure 8: Contact with services, 20-24 year olds



'Out of the blue' deaths

Thirty-seven (35%) 20-24 year olds had never expressed suicidal thoughts nor previously self-harmed.

In these 37 'out of the blue' deaths, fewer had reported bereavement (8, 22%); excessive alcohol (11, 30%) or illicit drug use (11, 30%); diagnoses of physical (4, 11%) or mental ill health (8, 22%); and suicide-related internet use (6, 16%) compared to the sample of 20-24 year olds as a whole. Twenty-six (70%) had no known contact with any agencies.

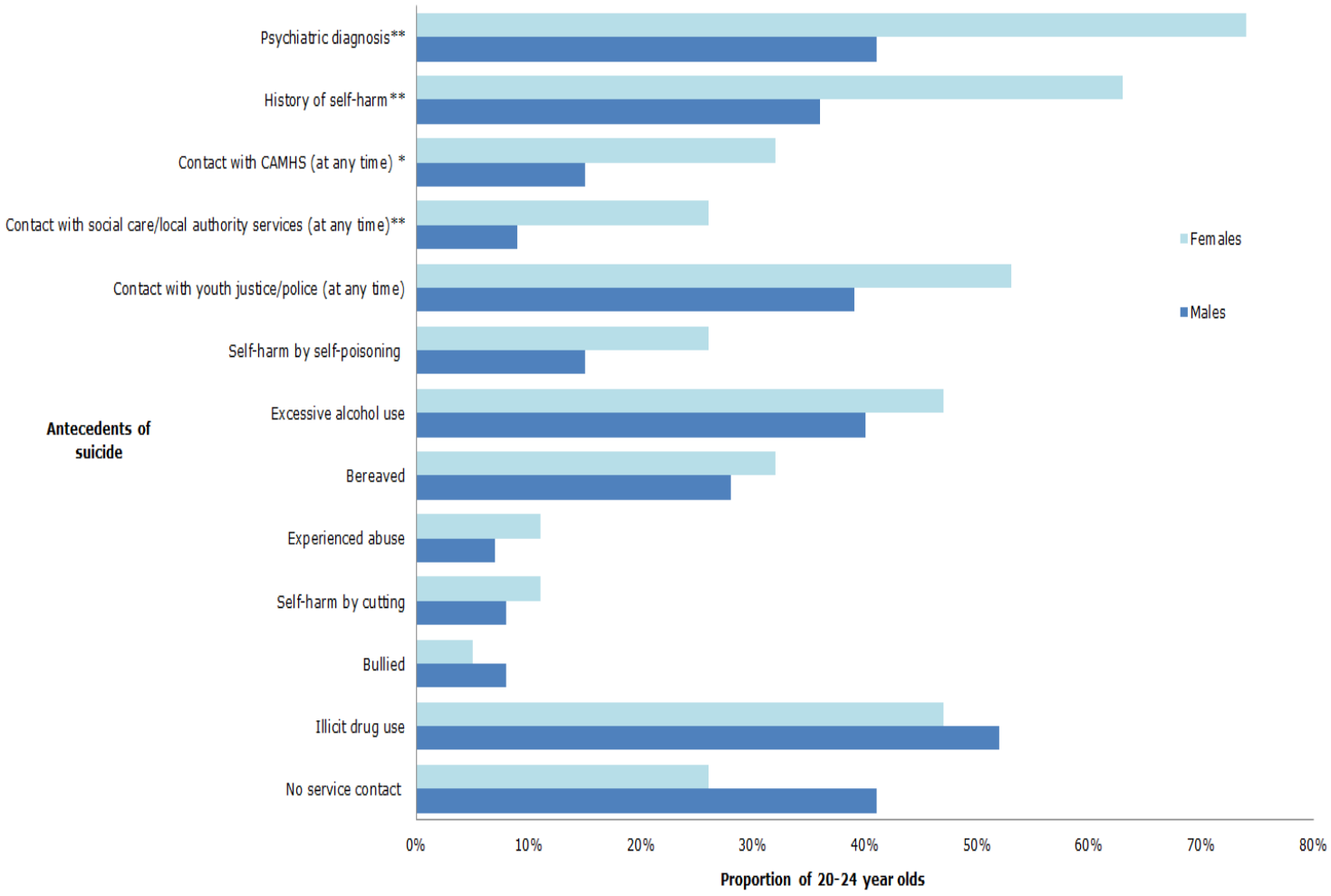
* Note: figures do not tally with the total recent contact group (i.e. 47) as some young people will have recently been seen by more than one agency.

WHAT WE FOUND (20-24 YEAR OLDS)

Males and females

There were few differences between males and females in the reported antecedents of suicide (Figure 9). Females more often had a history of self-harm, a diagnosis of mental illness and had contact with social care or local authority services. In the 3 months before death, fewer females had relationship problems (4, 21% v 23, 26%). They had more often experienced problems in the workplace (7, 37% v 25, 29%), in accommodation (6, 32% v 21, 24%) or in the family (5, 26% v 18, 21%) in the 3 months before death.

Figure 9: Antecedents of suicide in 20-24 year olds, in males and females



*Note: p<0.05 marked by **; p<0.1 marked by *, see footnote to Figure 7 for explanation of statistical significance.

Figure 9 shows the largest proportionate difference between females and males at the top and the largest proportionate differences between males and females at the bottom.

WHAT WE FOUND (20-24 YEAR OLDS)

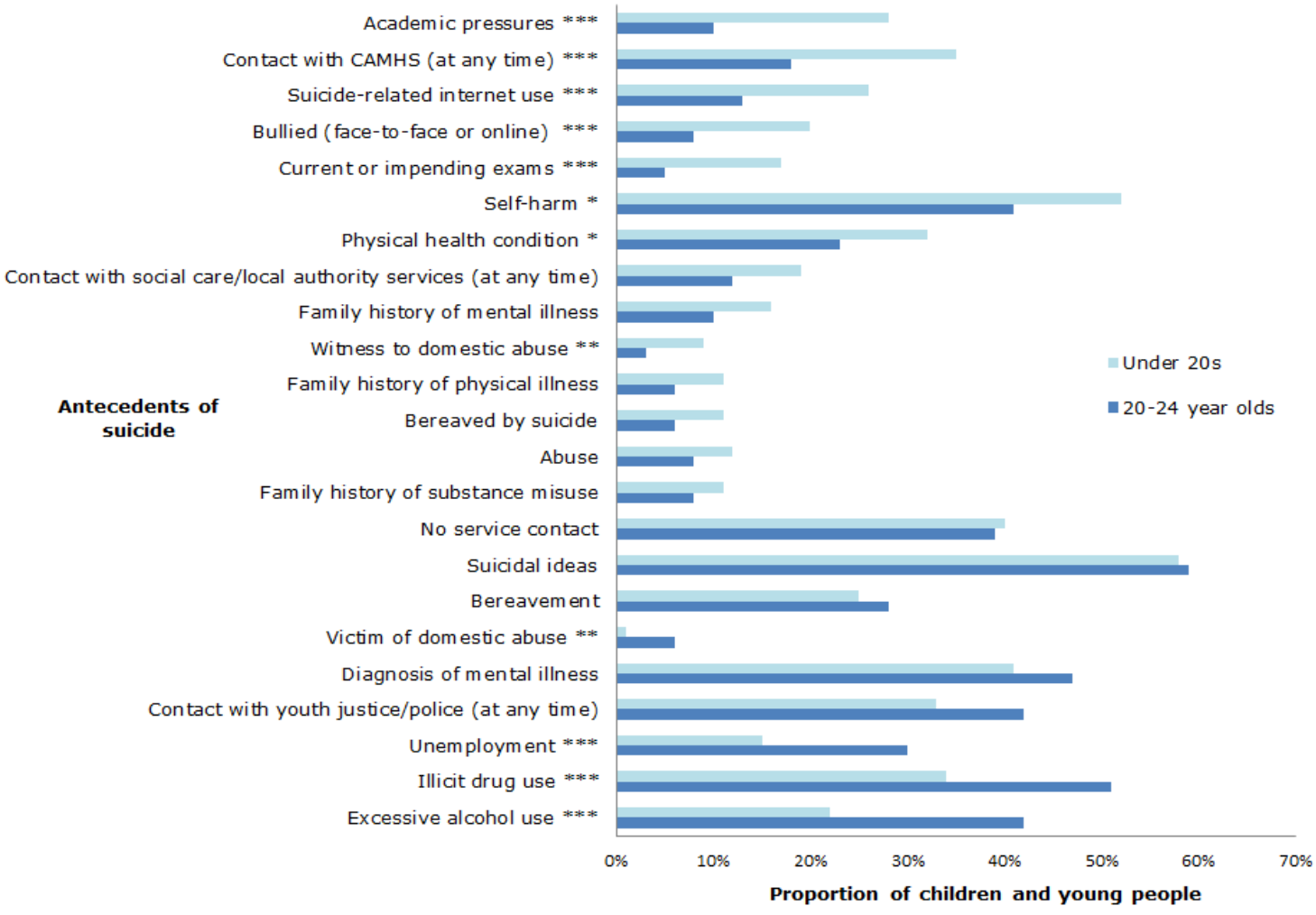
Under 20s compared to 20—24 year olds

Figure 10 and Table 11 show a changing pattern of antecedents between the under 20s and those aged 20-24, although most factors spanned the overall age range. Many antecedents reflected the life experiences of young people at different ages.

Under 20s were more likely to be in education at the time of death with exams and academic pressures more common in this age group. They more commonly had a history of being bullied, while unemployment and housing, financial and workplace problems were more common in the 20-24 year olds.

The younger age group had more often witnessed parental domestic violence whilst the older age group had more often been victims. Suicide-related internet use was a common feature of the under 20s. Excessive alcohol use and illicit drug use were more common in 20-24 year olds.

Figure 10: Antecedents of suicide in under 20s compared to 20-24 year olds



*Note: p<0.01 marked by ***; p<0.05 marked by **; p<0.1 marked by *, see footnote to Figure 7 for explanation of statistical significance.

Figure 10 shows the largest proportionate difference between under 20s and 20-24 year olds at the top and the largest proportionate differences between 20-24 year olds and under 20s at the bottom, with the smallest proportionate differences between the two age groups in the centre.

WHAT THE FINDINGS TELL US ABOUT PREVENTION

We have confirmed the main findings of the first phase of the study which focused on people under 20[5]. We presented these findings as 10 themes that were common to many suicides and that should be the target for prevention. The 10 themes are shown in Figure 11.

Figure 11: Ten common themes in suicide by children and young people

* family factors such as mental illness
* abuse and neglect
* bereavement and experience of suicide
* bullying
* suicide-related internet use
* academic pressures, especially related to exams
* social isolation or withdrawal
* physical health conditions that may have social impact
* alcohol and illicit drugs
* mental ill health, self-harm and suicidal ideas

Many of the stresses that contribute to suicide risk are common in young people, most of whom overcome them without too much difficulty. For a minority, however, the stresses are serious and the risks are real. For this reason, distress in young people should not be dismissed as transient or trivial.

The circumstances that lead to suicide in young people often appear to follow a pattern of cumulative risk, with traumatic experiences in early life, a build up of adversity and high risk behaviours in adolescence and early adulthood, and a "final straw" event (see Figure 12). This event may not seem severe to others, making it hard for professionals and families to recognise suicide risk unless the combination of past and present problems is taken into account. Each component of the model is open to prevention in different ways, for example:

(1) supporting vulnerable young children and their families

(2) promoting mental health in schools to address bullying and online safety

(3) services for self-harm and alcohol and drug misuse in young people

(4) healthy workplace and campus initiatives

(5) crisis services.

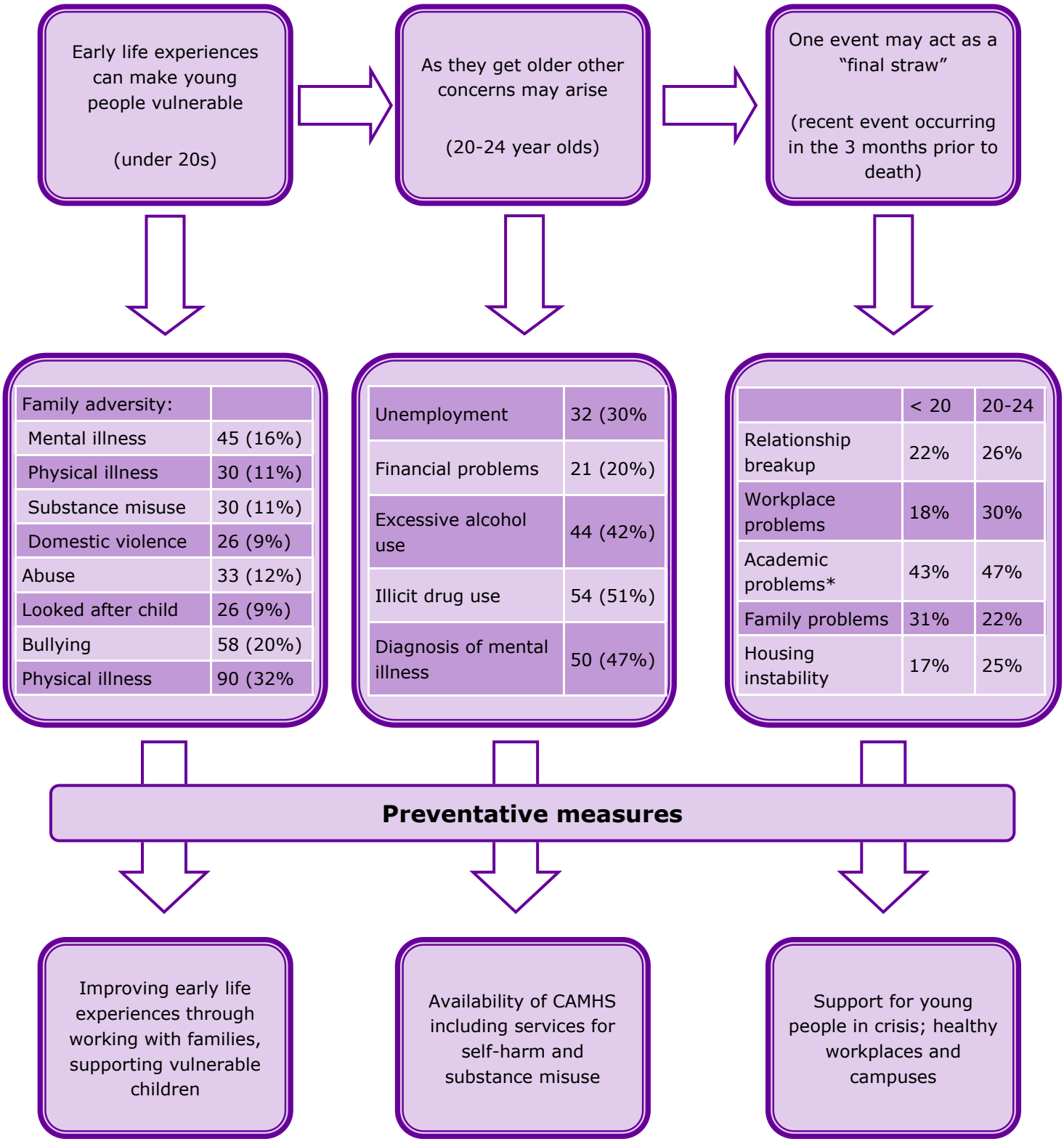
The antecedents of suicide at different ages reflect the changing circumstances of young people's lives but this change is gradual without any clear dividing line at any age. Many services, including mental health, expect young people to move to adult services at 18. The development of youth services with a later and more flexible transition point into adult services, would better reflect the pattern of needs and risk that we have identified.

WHAT THIS STUDY TELLS US

- The study tells us about the stresses that young people may be facing when they take their own lives.
- The findings are based on what was seen as relevant by the people taking part in an official investigation, including the families of the person who died.
- The antecedents of suicide in people under 20 identified in our first report are confirmed in this larger study.
- The study shows us to what extent the antecedents of suicide are similar in young people of different ages.
- The study tells us how often children and young people who died were in contact with services that could have helped them and whether risk was recognised.
- The findings allow us to make recommendations to a range of agencies that work with young people, especially in health, social care and education.

WHAT THE FINDINGS TELL US ABOUT PREVENTION

Figure 12: A model of cumulative risk



*Note: this is of the 145 under 20s, and 15 20-24 year olds who were reported to be in education at the time of death

WHAT THE FINDINGS TELL US ABOUT PREVENTION

We have examined a number of groups of young people who have specific risks. In this report we have highlighted:

- young people who are bereaved, especially by suicide, who need bereavement support services to be widely available;
- students in universities and colleges who would benefit from a greater focus on prevention, e.g. staff vigilance for warning signs, as well as access to counselling and primary care;
- looked after children, especially aged under 20, who need stable accommodation on leaving care, and access to mental health care;
- LGBT groups, especially aged under 20, who may have fears over disclosure of their gender identity and may face bullying.

The forthcoming Green Paper on children's mental health is an opportunity to improve prevention and support for these groups.

Internet safety is an important component of suicide prevention in young people, particularly in the under 20s. Further efforts are needed to remove online information about suicide methods and the detail of how they can be used, to increase online vigilance for people who are distressed or being bullied and to teach safe internet use in schools—as recommended for inclusion in personal, social, health and economic (PSHE) education by the Parliamentary Health Committee[17].

The wide range of antecedents that we have found highlights the shared role in suicide prevention among front-line services and agencies, including mental health, social care, youth justice, and education. However, our findings show that a majority of young people who die have not had recent contact with front-line services; when they have, suicide risk has not usually been recognised. Staff in these services need the skills to assess suicide risk as well as the multi-agency collaboration that we have found in too few cases.

Although there are many antecedents of suicide in young people, self-harm is a crucial indicator of risk and should always be taken seriously, even when the physical harm is minor. The development of self-harm services for young people, including young adolescents, in every area of the country is therefore the most important service development for suicide prevention in young people. Services that respond to self-harm should offer psychosocial assessment, prompt access to psychological therapies and services for co-occurring problems such as alcohol or drug misuse, which are linked to risk of subsequent suicide.

WHAT THIS STUDY CAN'T TELL US

- The study can't tell us the exact number of suicides by young people because coroners apply a high standard of evidence for a suicide conclusion and some suicide deaths will have received a different verdict such as accident.
- The design of the study has not allowed us to compare young people who died with others who did not die. We therefore cannot be certain of risk factors and we cannot establish cause and effect.
- The findings are for England and Wales combined because the number of cases from Wales alone is comparatively small. There are no figures specifically for either country in the report.
- These findings are for England and Wales, and may not apply to Northern Ireland and Scotland.
- The study may have under-estimated the true figure for some antecedents, especially in sensitive areas such as abuse or sexuality.
- However, families and investigations may "search for meaning" after a suicide, highlighting factors they see as most relevant. Therefore, figures for some antecedents may have been over-estimated.
- The antecedents are likely to have been relevant to suicide but several are common in young people and cannot be used to predict suicide risk.

APPENDIX

TABLE 11: ANTECEDENTS OF SUICIDE IN UNDER 20S AND 20-24 YEAR OLDS

	Under 20 (n=285)	20-24 (n=106)
Family environment		
Family (parent, carer, sibling) history of:		
Mental illness	45 (16%)	11 (10%)
Physical illness	30 (11%)	6 (6%)
Substance misuse	30 (11%)	8 (8%)
Witness to domestic violence	26 (9%)	3 (3%)
Abuse		
Abuse (emotional, physical, or sexual)	33 (12%)	8 (8%)
Experience of loss		
Bereaved	70 (25%)	30 (28%)
Bereaved by suicide	31 (11%)	6 (6%)
Bullying		
Bullying (any)	58 (20%)	9 (8%)
Social isolation		
Social isolation (i.e. few or no friends)	42 (15%)	12 (11%)
Suicide-related internet use		
Suicide-related internet use overall	74 (26%)	14 (13%)
Search for information on suicide methods	37 (13%)	8 (8%)
Communicated suicidal ideas online	29 (10%)	6 (6%)
Academic pressures*		
Academic pressures overall	63 (43%)	7 (47%)
Current exams, impending exams or exam results at time of death	46 (32%)	3 (20%)
Medical history		
Physical health condition	90 (32%)	24 (23%)
Excessive alcohol use	64 (22%)	44 (42%)
Illicit drug use	98 (34%)	54 (51%)
Self-harm and suicidal ideas		
Previous self-harm	147 (52%)	43 (41%)
Suicidal ideas (at any time)	163 (57%)	58 (55%)
Economic adversity		
Unemployment	44 (15%)	32 (30%)
Workplace problems	50 (18%)	32 (30%)
Financial problems	38 (13%)	21 (20%)
Housing instability	49 (17%)	27 (25%)

*Note: this is of the 145 under 20s and 15 20-24 years olds who were reported to be in education at the time of death

APPENDIX

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APPENDIX

ANALYSIS

As shown in figure 1, information was taken from the data sources (see pages 5 to 7) via a data extraction proforma on to a standardised database for aggregate analysis. Information was collected about demographic factors (sexual orientation, relationship status, living circumstances), education (academic pressures, exam stress), medical history (physical health conditions), psychiatric history (mental disorders, medication), social media and internet use, service contact (with GP, A&E department, mental health services, social care or local authority services, child protection services, youth justice), bullying, abuse, bereavement, and disturbance to the family environment (mental illness, physical ill health, or substance misuse in a parent or carer, domestic violence). Definitions are shown on pages 25 and 26. Findings from England and Wales are presented as aggregate figures.

Antecedents were recorded on the data extraction proforma when they were referred to in any of the data sources as having been present in the young person's life at some time and specifically in the 3 months prior to their death. Reference to an antecedent in an official investigation suggests that it was relevant to the death but not causal.

A random sample of 20% (n=124) of deaths of people aged 20-24 was selected from all suicides in this age group in the two year period—a total of 606 deaths. A 20% sample was chosen to allow a sufficient number of cases to be examined, whilst ensuring there was research capacity to extract and analyse the information. Sampling was based on the proportion of cases from each age group in the total 606 deaths in order to ensure cases were included from each age (20-24). For the two year study period overall data completeness was 89%, i.e. information was received from one or more data sources for 391 of the 440 young people in our sample. We have therefore uplifted the numbers provided in the summary (page 3) based on a complete sample.

The denominator in all estimates was the total number of cases on which at least one report was obtained in each age group (i.e. 285 in the under 20s and 106 in 20-24 year olds), unless otherwise specified. If an item was not recorded in any data source then it was assumed to be absent or not relevant to the case. Pearson's chi square tests or Fisher's exact test (when any subgroup had an expected frequency of less than 5) were used to examine associations between males and females, and between age groups (under 20s and 20-24 year olds). A two-sided p value of less than 0.05 was considered statistically significant. However, with this sample size, there were also several differences that were considered of borderline statistical significance ($p<0.1$).

A Poisson regression model was used to compare the suicide rate by month of the year using the incidence rate ratio (IRR). June was used as the baseline month as it had the lowest incidence of suicide. An IRR greater than 1.0 suggests an increased risk of suicide and 95% confidence intervals were calculated for the precision of the IRRs.

ETHICAL APPROVAL

Approvals were sought and received from the University of Manchester Research Governance and Ethics (12/02/2015); National Research Ethics Service (NRES) Committee North West (13/04/2015); Health Research Authority Confidential Advisory Group (HRA-CAG) (06/05/2015); Public Benefit and Privacy Panel for Health and Social Care (PBPP) (07/10/2016); and Research Management and Governance approvals from individual NHS Trusts and Health Boards.

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The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness would like to acknowledge the assistance it has received in the collection of data for this report. We would like to thank coroners and their staff, Child Death Overview Panels and their respective Local Safeguarding Children's Boards, Medical Directors and Trust/Health Board staff, the Independent Police Complaints Commission and the Prisons and Probation Ombudsman for the provision of data. We would also like to thank Media Services at the University of Manchester for the title page design. We are grateful to our reference group members for offering advice on data items, and our Independent Advisory Group (IAG) members for advice and support in data acquisition. Responsibility for the analysis and interpretation of the data provided from all sources rests with NCISH and not with the original data provider.

APPENDIX

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Gemma Trainor	Royal College of Nursing

APPENDIX

DEFINITIONS

Variable	Definition
Family problems	Recent arguments, reported difficult relationships with family members, and problems affecting the stability of the family environment such as domestic violence, or mental and/or physical illness and substance misuse in a parent, carer, or sibling.
Relationship problems	Recent arguments with a current or ex-partner, being in an on/off relationship, or reported difficulties within the relationship. Relationship breakup was recorded as a separate antecedent.
Had children of their own	Primary carer for their own child or the natural parent of a child they did not have parental responsibility for.
A history of abuse	Physical, sexual and/or emotional abuse.
Looked after children	Children in the care of/being looked after by a local authority.
Social isolation	No or few friends.
Recent social withdrawal	Recently (within 3 months prior to death) demonstrated behaviour such as isolating themselves in their bedroom.
Suicide-related internet use	Suicide-related internet use was recorded as an antecedent if at least one of the following was reported: searching the internet for information on suicide method; visiting website(s) that may have encouraged suicide; communicating suicidal ideas online; or being a victim of online bullying.
Academic pressures	Difficulties with school work, (perceived) failure to meet own, teacher or parental expectations, current exams, impending exams or exam results, other non-exam academic related stresses (i.e. struggling with assignments, unhappy with course), and any other student-related problem.
Physical health conditions	Recorded from medical evidence heard during the coroner's inquest or from other sources of data available, e.g. a child death investigation.
Excessive alcohol use	Alcohol use was recorded as an antecedent in the official reports we used in different ways, e.g. at a level of misuse, persistent heavy drinking, or binge drinking, but with a common theme of excessive use.
Workplace and financial problems, and housing instability	Workplace and financial problems, and housing instability (accommodation problems and/or recent changes to accommodation) were recorded if they had occurred in the 3 months prior to death.

APPENDIX

DEFINITIONS (CONTINUED)

Variable	Definition
Serious recent episode of self-harm	The last episode of self-harm prior to death required medical treatment by either a GP or in hospital. Recorded from medical evidence heard during the coroner's inquest, an NHS Serious Incident report or NCISH data.
Presence of a mental disorder and medication	Recorded from medical evidence heard during the coroner's inquest (i.e. from a GP or consultant psychiatrist), an NHS Serious Incident report, or NCISH data.
Contact with mental health services (previous or current)	Contact with child and adolescent and/or mental health services, including drug and alcohol services.
Contact with social care or local authority services (previous or current)	Contact with child protection services, secure local authority care, or social services or being a previous or current looked after child.
Youth justice or police contact (previous or current)	Contact with a Youth Offending team, with the police either as an offender or a victim of crime, or with the probation service.
Mental health patients	Contact with psychiatric, drug and alcohol, child and adolescent or learning disability services (if they are within mental health services) within 12 months of their death, with their care usually under a consultant psychiatrist.
Multiple contact with services	Contact with each of the following services: child and adolescent or adult mental health services, and social care or local authority services, and youth justice or the police.
'Out of the blue' cases	No contact with any services or agencies, no history of self-harm, no indication of suicidal thoughts or intent, and never seen by a GP or at A&E for mental health problems or for self-harm.

SANDWELL CHILDREN'S SAFEGUARDING PARTNERSHIP

7 Minute Briefing – Working Together 2018; December 2020 Update

Sandwell Children's Safeguarding Partnership

01

In December 2020, **'Working Together to Safeguard Children 2018'** was updated. We've put together this summary, which outlines key changes and details a Government consultation currently being undertaken.

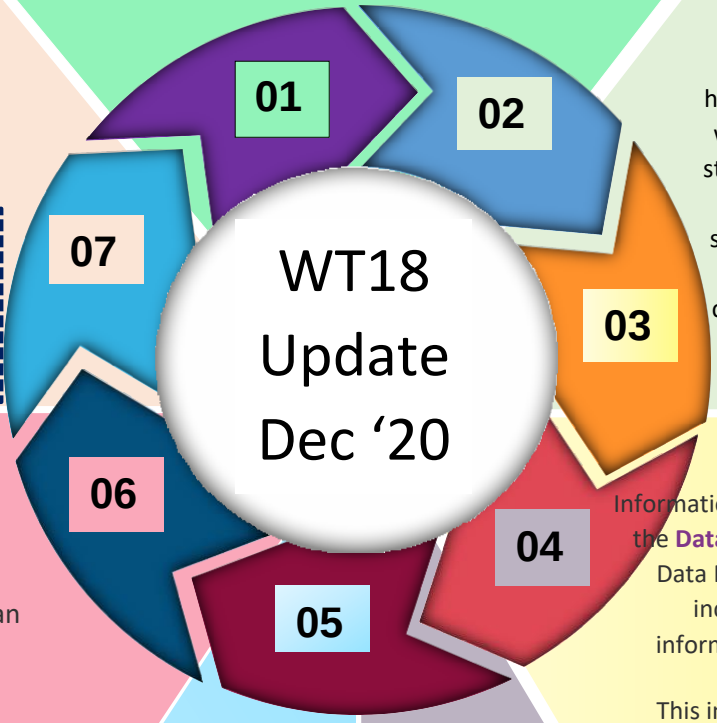
Update to terminology within the document:

Contextual safeguarding was renamed in the guidance as "**assessment of risk outside the home**" (p.25) and teenage relationship abuse has been added as an area of risk, however the primary content of this section has not changed.

02

Update to terminology within the document:

The impact of domestic abuse, including controlling or coercive behaviour, has been integrated throughout the revised guidance. Both domestic violence and controlling and coercive control have been added to the definitions within (p.110 & 111). The changes state (p.14) that practitioners need to develop their knowledge and skills in addressing the impact that domestic violence has upon children, both as witnesses and by being forced to collude in this.



07

The Government are consulting on:

*revisions to 'Keeping children safe in education', the statutory guidance that sets out what schools and colleges should do and the legal duties with which they must comply to keep children safe

*revisions to the advice on Sexual Violence and Sexual Harassment between Children in Schools and Colleges

To ensure your views are included click on this link: **Keeping Children Safe in Education: Proposed Revisions 2021**

Deadline: 4 March 2021

03

Addition:

Information has been refined in response to the **Data Protection Act 2018** and General Data Protection Regulation (**GDPR**). This includes guidance about appropriate information sharing of safeguarding and child protection concerns. This includes the explicit statement that data protection legislation does not prevent the sharing of information to keep a child safe and that consent is not required when sharing information for safeguarding and protecting the welfare of a child (p.19).

In making decisions about appropriate information sharing, the guidance recommends using GDPR **lawful bases** for sharing, i.e. **legal obligation** (the exercise of official authority) or **public task** (a task performed in the public interest).

Further information about this is available in the new appendices (Appendix B) and includes a useful myth busting guide to information sharing (p.21).

04

Addition:

Early Help (p.14) "**has a parent/carer in custody"** has been added to the list of children in need of potential early help.

People in Positions of Trust (p.60) **"behaved or may have behaved in a way that indicates they may not be suitable to work with children"** has been added. This was added earlier last year to Keeping Children Safe in Education to capture concerns around transferable risk; for example, where a person who works with children is involved in a domestic abuse incident at home and this may have implications for their suitability to work with children.

05

Mental Health:

The importance of mental health concerns for children has been emphasised throughout the revised document. Mental health has been added to physical health (p.7 & p.14) and the significance of mental health concerns about a child have been linked to abuse, neglect or exploitation.

While aimed at school staff, the advice to refer concerns about a child's mental health to children's services while not making mental health diagnoses (p.18), is relevant to other roles.

Under the referral process "**Where a child or young person is admitted to a mental health facility, practitioners should consider whether a referral to local authority children's social care is necessary"** has been added.

06

Addition:

The Homelessness duty has been added (p.23) in relation to local authorities' duties to intervene at an earlier stage in homelessness and duty to refer.

Safeguarding Partnerships:

In the section on Relevant Agencies, it now says;

"The safeguarding partners should set out in their published arrangements which organisations and agencies they will be working with to safeguard and promote the welfare of children," previously it said "**must set out".**

BLACK COUNTRY CHILD DEATH OVERVIEW PANEL (CDOP)

7 Minute Briefing – Safe Sleeping Practices for Babies

(www.lullabytrust.org.uk)

01 Background

The Black Country CDOP Annual Report 2019-2020 highlights that out of the 24 unexpected deaths that were reported, 10 had elements of unsafe sleeping practices identified.

https://www.dudleyccg.nhs.uk/ccgfunctions/safeguarding

02 Contributing Risks – unsafe sleeping practices, coupled with the following increases risk:

- Co-sleeping (in a bed or sofa)
- Maternal smoking
- Smoking in the home
- Dirty/poor home conditions/overcrowding
- Alcohol/substance misuse
- Bumpers/pillows in the cot
- Parents taking medication which makes them sleepy
- Baby had a low birth weight
- Deprivation/insecure housing.

07 Additional resources

www.lullabytrust.org.uk

www.BasisOnline.org.uk

www.unicef.org.uk/babyfriendly

Birmingham Safeguarding Children Partnership have developed 2 videos about safe sleeping – 'Who's in charge' and they can be accessed here:

https://vimeo.com/502656479

https://vimeo.com/502658053

03 Key Messages

- Put babies on their BACK for every sleep, foot to foot of cot
- On a CLEAR, FLAT SLEEP SURFACE
- Keep them SMOKE FREE day and night

Although sudden infant death syndrome (SIDS) is rare, the Lullaby Trust reports that over 200 babies die every year.

06 Check understanding

Families may be more familiar with different terminology that they have heard, such as 'cot death'.

It is important that you talk about all situations with parents so that they can make informed decisions considering all risk factors that may be present.

Check and check again that parents understand the safe sleep message at EVERY visit.

05 Conversations

Safer sleep must be discussed with all families irrespective of circumstances.

It is crucial that these discussions take place even if at times they are challenging.

<u>Check understanding that</u>:

Families know they should *never* sleep on a sofa or armchair with their baby.

And think about possibly building in support with planning solutions for times when they might do so accidentally (e.g. moses basket next to the sofa, partner takes baby to cot)

04 Bed Sharing

Families should not fall asleep in bed with their baby when:

- **They have recently drunk alcohol**
- **They or their partner smokes**
- **They have taken drugs that may make them sleepy or affect their awareness**
- **Their baby was born prematurely or weighed under 2.5kg or 5½ lbs when they were born**

When drink leaves you dead tired...

who's in charge?

Birmingham Community Healthcare NHS Foundation Trust

Drinking and sleeping with your child can have fatal consequences.

BIRMINGHAM Safeguarding Children PARTNERSHIP

You would never endanger your baby's life on purpose, but you could be putting their safety at risk if you drink while looking after them.

Every year infants are smothered by parents who have been drinking, sometimes with tragic results.

Staying in to drink? Stay in control.

who's in charge?

Ref: 01072 • 09/09/20

7 Minute Briefing

Child to Parent Violence and Abuse

BACKGROUND

Child to parent violence and abuse (CPVA) is the most hidden and stigmatised form of family violence. It is also much misunderstood by agencies and professionals. CPVA is also vastly under reported due to the stigma felt by parents living with an abusive child. Parents and carers often feel guilt and shame when their child is abusive and violent towards them.

1

WHAT IS CHILD TO PARENT VIOLENCE AND ABUSE

There is no current legal definition of CPVA. It is any behaviour used by a child in a family to control, dominate, threaten or coerce a parent or sibling.

It is a recognised as a form of domestic violence and abuse and, depending on the age of the child, may fall under the government's official definition of domestic violence and abuse. Identification of a child involved in CPVA should warrant a referral to children's social care as a safeguarding precaution.

2

WHY IT MATTERS

The impact is extremely severe, debilitating, isolating and often parents and carers do not know how to start to tackle it. Emotional and physical abuse are both part of the picture. Parents often feel ashamed of the situation which can also prevent them from reporting they often see it as *their* failure to control the child.

CPVA can be experienced by mothers, fathers, siblings and carers from daughters and sons, however, studies and statistics show that women and mothers are most at risk. Whilst girls and boys use CPVA, boys are most likely to use physical violence.

It is predominantly mothers, lone parents and those parents facing significant social and family stressors who are most likely to experience abuse from their children.

The majority of cases are in birth families, but there is a higher prevalence in fostered and adopted children since the latter are more likely to have disruptive behaviour problems.

3

WHAT DOES IT INVOLVE

4

Anger is an emotion; violence is about power and control. **Violence is not the same as anger.**

CPVA can include any or all of the following:

Physical violence, including bullying or physical violence to siblings as well as parents. **Emotional, Psychological and Verbal abuse** yelling, screaming, swearing, 'put downs' and humiliation for example.

Financial can include demanding money or things parents cannot afford . Incurring debt that the parent is then responsible for.

RISK FACTORS

5

There are a number of risk factors which make abusive behaviour more likely. There are many reasons why children and young people can become abusive. There may be a combination of issues or no explanation at all.

Witnessing family violence. Trauma, loss and disruption Substance misuse. Mental Health.

Adverse Childhood Experiences (ACE's) are stressful or traumatic events, including abuse and neglect. It is likely that children displaying violent or aggressive behaviours will have an ACE score of at least 4 and in most cases higher.

WHAT IS OUR RESPONSE

6

Richmond Fellowship and Women's Aid are developing an intervention on Child to Parent abuse across Sandwell, Dudley and Walsall, following confirmation of Home Office funding. The referral pathway for this will be opening in 2021. This will be based on the young people using violence and abuse (YUVA) model that will be funded through the Home Office Perpetrator Programme Fund and OPCC match funding.

For more information and/or to make a referral where there is evidence or concerns regarding CPVA please refer as always in the first instance via the MASH team

FURTHER INFORMATION AND READING

7

Thorley and Coates: Let's Talk about child to parent violence 2018

Safeguarding Adult Reviews: Information for individuals

Introduction

When an adult who needs care and support either dies or suffers serious harm and

- Abuse or neglect is thought to have been a factor, and
- Partners could have worked more effectively to protect the adult concerned

then the Care Act 2014 says that the local Safeguarding Adult Board may need to review what has happened. This is called a Safeguarding Adults Review or SAR for short.

These reviews are to see if there are examples of good practice and also whether or not any lessons can be learned about the way organisations worked together to support and protect the person who suffered harm.

The people in charge of the review understand this is likely to be a very difficult time for you, but we want to learn as much as possible about how to do things better in the future.

We would welcome your involvement in the process as much as possible. We believe you should have the opportunity to discuss any concerns you may have and to share your thoughts and opinions.

This leaflet tells you what happens when a SAR is required to be undertaken, and what you should expect.

What are Safeguarding Adult Reviews?

Safeguarding Adult Reviews are one way to improve responses to keep adults who need care and support safe from abuse or neglect and aim to prevent what happened, happening to others.

They will try to ensure that organisations like social services, councils, police and other community-based services understand what happened and identify where responses to the situation could be improved.

From this, we hope to learn all the right lessons including those which impact how they work together. These reviews will not seek to lay blame but to consider what happened and what could have been done differently. They will also recommend actions to improve responses to keep adults with care and support needs safe from abuse or neglect in the future.

Safeguarding Adult Reviews are part of the Care Act 2014 and became law from 1st April 2015. They do not replace but may be in addition to the inquest or any other form of inquiry or review.

How will we undertake the review?

There are different ways in which a SAR can be done, but they involve gathering as much information from as many sources as possible. We can then try to work out exactly what happened, and why. We will consider whether things could or should have been done differently, and ask how things could be done better in the future.

Your involvement in this review

We think you are the best placed to help us understand what happened. Your contribution will be valuable and may help change the way we respond to keeping adults with care and support need safe from abuse or neglect.

We acknowledge this will have been a very difficult time for you and we do not want to add to your distress, but it is important we inform you the review is taking place and to give you an opportunity to be involved.

If you do decide to take part in the review, we will ask you to share your understanding of what happened and why.

You can give your thoughts and views in all or some of the following ways:

- Face-to-face meeting with us,
- Virtual meetings,
- Via a telephone conversation, or
- In writing or via a recording.

What happens to the information you share?

The information you share will help us to build a comprehensive picture of what happened and in turn will help us identify recommendations for change. These recommendations will then be put into an action plan.

Your input will be confidential and you will not be named in the final report.

How long will the review process take?

It is really difficult to say how long a review will take, it very much depends on the amount of information to be gathered and/or people spoken to. You will be given a point of contact who will contact you by your preferred means to keep you updated so that you know how the review is progressing.

What does the review produce?

A report identifying the findings will normally be published on the Sandwell Safeguarding Adult Board's website. The report will be anonymised and will not

contain any identifying details. The findings will also be detailed within Board's annual report.

Next Steps

The decision to take part in this review is entirely yours and if you do not wish to take part your decision will be respected. We will notify you when the review is completed, and the report is available.

If you would like to take part or have any further questions about the review process, please contact the person who has signed the letter attached to this leaflet. They will either answer your questions or direct you to someone who can.

Publication:

The Care Act says that the SAB should consider publishing the review so that others may also learn from the findings. Your views on this will be taken into consideration but it is hoped that you will support any decision to publish the report which will be anonymised, and no real names used.

Your point of contact is:

Name: Charmaine Stephens

Title: Lead Officer Protection & Audit

Organisation: Sandwell Safeguarding Adults Board

Tel:

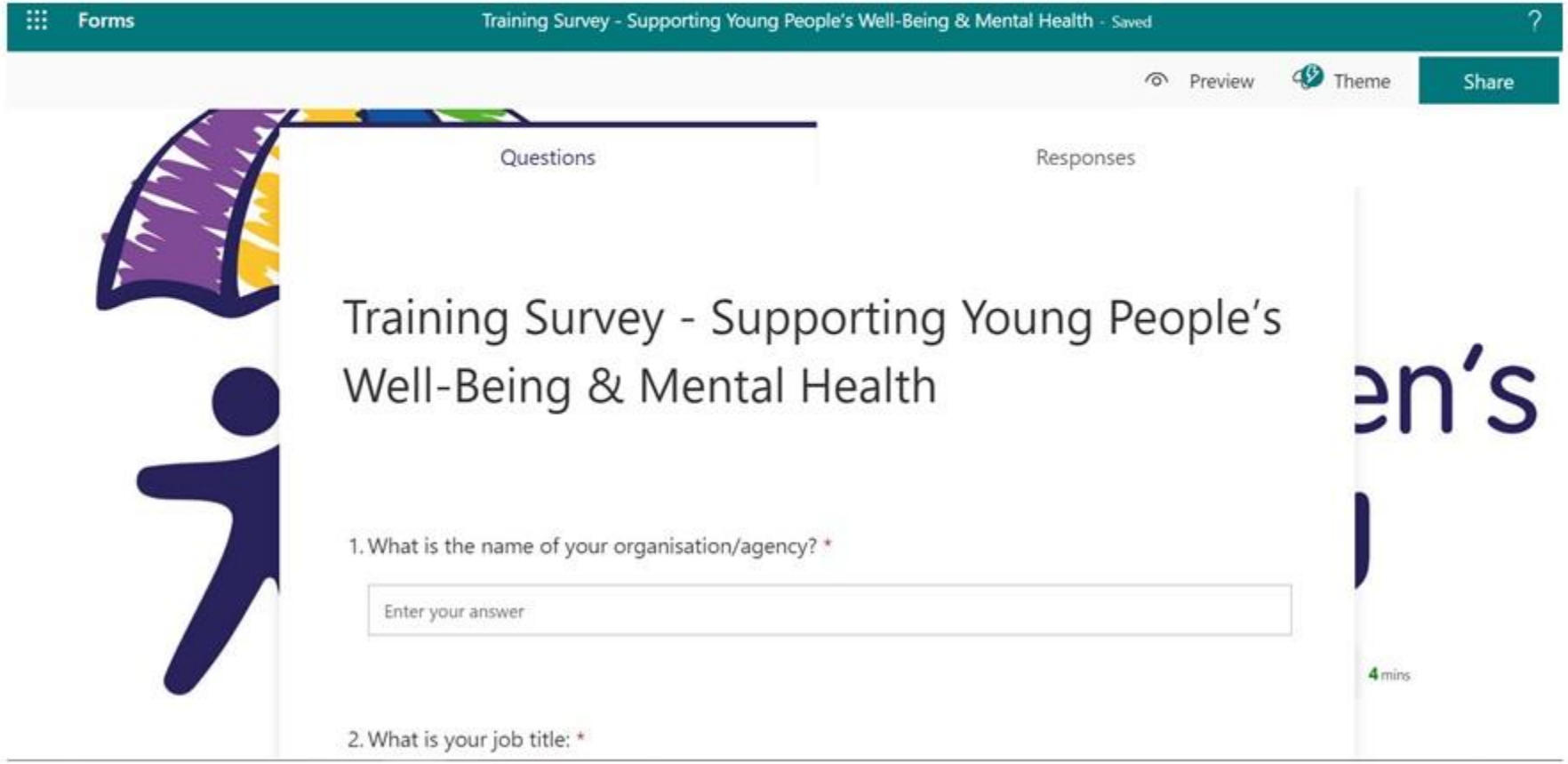
Email: Charmaine_stephens@sandwell.gov.uk

Adapted from Home Office Guidance for Domestic Homicide Reviews, Birmingham Safeguarding Adult Board SAR leaflet, Stoke and Staffordshire Safeguarding Adult Board SAR leaflet and Lancashire Safeguarding Adult Board SAR leaflet

Version: 2
Date of Issue: 01.08.19
Template created by: West Midlands Adult Safeguarding Editorial Group

Training Needs Analysis
Link here:

Supporting Young People's Well-Being & Mental Health



Sandwell Children's Safeguarding Partnership

Be Brave!

An emotion and wellbeing support service

Therapeutic intervention consisting of both 121 and group work.

Our sessions will support you to identify and explore wellbeing though engagement with a diverse range of therapeutic interventions.

To support you to adopt new ways of expressing your emotions, managing your wellbeing in order to empower you, to take control and exercise choice whilst building positive coping mechanisms and longer term resilience.

murray hall community trust

Contact Info

Phone

01902 826 306

Email

CTS@murrayhall.co.uk

murray hall community trust

BUILDING BRAVER MINDS

SUPPORT FOR YOUNG PEOPLE'S EMOTIONAL WELLBEING

For 5 - 18 year olds living in the Sandwell area who are at risk of mental health issues.

The project will offer free emotional and wellbeing support for children and young people through 1-2-1 and group therapeutic intervention.

CONTACT FOR SUPPORT NOW!

www.murrayhall.co.uk

01902 826306

CTS@murrayhall.co.uk

Funded by

NHS Sandwell and West Birmingham Clinical Commissioning Group

murray hall community trust

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Sandwell and West Birmingham
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BUILDING BRAVER MINDS

PUTTING ON A BRAVE FACE?...

WE'RE HERE TO HELP

If you are between age 5 and 18 we can offer you emotional and wellbeing support through 1-2-1 and group activities.

Get in touch today.

CONTACT FOR SUPPORT NOW!

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CTS@murrayhall.co.uk

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NHS Sandwell and West Birmingham Clinical Commissioning Group

Drug Education, Counselling and Confidential Advice (DECCA) Team

DECCA provide the young peoples, aged 18 and under, drug and alcohol service in Sandwell. The remit for the team is multi faceted and fits across all areas of provision for young people's services and is located within Targeted Support Services (TSS), as part of Sandwell Children's Trust (SCT).

Our remit includes:

Universal - Prevention

DECCA deliver harm reduction educational work in mainstream schools, both primary and secondary, face to face to young people.

The team have developed a website, www.ourguideto.co.uk, which contains information on alcohol, drugs and other key issues, for young people, parents/carers but also materials for professionals and workers including teaching programmes. These comprehensive educational programmes, devised through extensive consultation with young people and professionals, and using Department for Education (DfE) recommendations are available for teaching staff to deliver to their pupils. They are age appropriate and meet the needs of the year group they are designed for. The materials have won 2 Children and Young People Now national awards, sponsored by the Children's Workforce Development Council, and have been sold to neighbouring authorities.

The alcohol and drug education programme has been awarded the Feeling Safe Foundation Quality Mark which means that the team have been recognised as delivering Protective Behaviours as part of all the work delivered. The team are proud of this fact as this approach is proven in building resilience with young people; this is essential in the drive to keep them safe and allowing them to make informed decisions about their lives to help keep themselves safe. Staff drug awareness sessions can also be delivered to schools to ensure teachers feel confident and informed on current topics and also the content they need to teach.

DECCA deliver sessions as a sole provider in Key Stage 1 and years 6, 7 and 10, and as part of a multi-agency safeguarding day in year 5. If issues are identified in a school further support is offered and assembly sessions have been created to allow DECCA to input with a higher number of young people as when the need arises. This has been necessary due to the limited number of educational staff available within DECCA.

Schools participation is voluntary but due to the excellent partnership working that has taken place over many years DECCA services are readily accepted by schools and are now bought in by numerous academies, including out of borough.

Targeted - Group work

DECCA deliver group sessions, to young people and adults, in the community who request or need support. This would be a one-off session in most cases, with any additional DECCA offer falling in to one of the following two categories.

Targeted - Proactive Outreach

The team deliver harm reduction education and prevention work, using a structured model, within non-mainstream settings such as Sandwell Community Schools (SCS)/Pupil Referral Units (PRU's), Youth Offending Service (YOS) Looked After Children (LAC) services, special educational needs schools, alternative training providers and any non-mainstream organisations, through direct delivery, as part of a comprehensive Proactive Outreach programme.

Through this approach DECCA access some of the most vulnerable and at-risk young people in the borough, and work with them for a minimum of two sessions, with that number being flexible depending on the young people themselves. They may not be involved with mainstream education and may be classed under official statistics as Not in Education, Employment or training (NEET), but through linking with a wider range of statutory and community partners DECCA are able to engage them. This work enables earlier intervention and referrals are generated, into treatment, from sessions that are run through Outreach. Interventions can then be delivered earlier and thus increase the chances of a successful recovery.

The educational pieces of work that DECCA has produced have been recognised by the Department of Health as models of good practice, in 2007 and 2010, for both Substance Misuse and Alcohol. In 2016 the schemes of work used for Proactive Outreach became accredited through the Feeling Safe Foundation and as such are endorsed by them as following the Protective Behaviours approach to Building Resilience. Project 12 (P12), a programme led on by DECCA, has been recognised by Ofsted in two different inspections, one in a mainstream school and the other for SCS/PRU, as a positive addition to work carried out that leads to the better safeguarding of young people.

Specialist Treatment

The treatment remit is to work with those young people identified as having alcohol and/or drug related issues. The team use a structured psycho-social approach in engaging with identified young people with an emphasis on holistic working.

The strategic children's commissioning unit commissioned an external quality review in 2010. The review found that a standardised treatment/intervention model would further enhance the work that the team was carrying out with young people. No best practice model existed for young people, both nationally or internationally. Due to this DECCA and Commissioner devised an action plan to address this gap. Research was undertaken, and a link made with the University of Birmingham, who had developed a National model of good practice in adult treatment. After significant modifications were done to the various materials, from international and national best practice sources, they were fit for purpose for working with young people. The Sandwell Treatment Effectiveness Model (STEM) has been a major service development and sets DECCA apart from the 'bog standard' treatment service.

With the STEM model, and innovation within the team, successes are now evident in terms of frontline delivery and have been reflected in the external reports received. In conclusion there have been significant service developments and improvements, demonstrated and validated both internally and externally via Public Health England and the National Drug Treatment Monitoring System (NDTMS), from use of STEM since February 2012.

Partnership Working

DECCA is a commissioned service with an outcomes framework and targets. DECCA delivers on targets set for young people's drug education, including alcohol and tobacco, for treatment for young people who are using alcohol and/or drugs or smoking tobacco and in delivery of drug, alcohol and tobacco harm reduction for those most vulnerable. This is facilitated through partnership working as described above.

Based within TSS/SCT DECCA is integrated with services that intervene at the earliest stage. Through strong established links and joint working protocols with services such as CAMHS, Sandwell General Hospital and City Road Hospital, training providers and community groups, DECCA works with young people that are most vulnerable to substance misuse who may not be involved with, or may have significant involvement with, other services.

Through the long-term engagement DECCA have had, with those organisations who work with the hardest to engage, referrals can be progressed to ensure those that require support can access it quickly to prevent further issues arising.

Jon Bull
DECCA Team Manager

Sandwell Children's Trust
DECCA (Drug Education Counselling & Confidential Advice)
6 – 8 Unity Walk
Owen Street
Tipton
DY4 8QL

0121 569 2201
07500 785889
Website: www.ourguideto.co.uk

Sandwell
Metropolitan Borough Council

UPDATED FOR 2020-2021

TRUSTED ADULT TRAINING

Sandwell Educational Psychology Service

SUPPORTING YOUNG PEOPLE'S WELL-BEING & MENTAL HEALTH

Following the success of last year's training, we are offering a new blended learning programme to equip even more members of the children and young people's workforce to support young people's emotional well-being following Covid-19.

This training aims to raise awareness of mental health and well-being as everyone's business, highlight the key skills required to support practice as a Trusted Adult and to provide up to date information on topics pertinent to CYP's mental health. **This course is aimed at all individuals working directly with children or young people; within schools, the voluntary and community sector, Children's Services or within healthcare.**

There is no cost to attend. Please follow the link below and sign up for a date to attend the live webinar. You will be sent an invite to a Microsoft Teams meeting, and a Teams Channel where you can access all of the training materials.

Click here to **SIGN UP** on event brite.

THIS IS A BLENDED LEARNING PROGRAMME. OFFER TO INCLUDE:

- a live 2-hour seminar led by Educational Psychologists
- access to material for independent learning across 9 modules
- access to facilitated online workshops where you can reflect on your learning alongside others and explore topics in greater depth

Inclusion Support
Expertise Experience Excellence

MORE INFORMATION:

Live Seminar: (Duration 2 hours)

- Mental Health is Everyone's Business: exploring mental health in everyday life to understand some of the challenges our children and young people face.
- Approaches to recovery and well-being following Covid-19.
- Introducing key skills to support practice as a Trusted Adult.

Independent Learning Materials:

A variety of recorded webinars will be available to you, covering topics pertinent to children and young people's well-being.

New for 2020/2021:

- Covid-19 Recovery (Well-being for Education Return)
- Identity, Race and Equality

Updated for 2020/2021:

- Relational Wealth and Adverse Childhood Experiences (ACES)
- Staff Well-being During Covid-19
- Exam Stress
- Social Media
- LGBTQ+/Diversity
- Activities for Well-being
- Bereavement and Loss
- The Developing Brain

Embedding Learning:

You will also be invited to access virtual workshops to embed your learning alongside others.

Dates for Wider Workforce Staff:
The training is running during term time, with both morning and afternoon sessions available.

Please note different dates are available for schools, for those supporting children and young people inside of the school environment.

Although there is overlap with last year's training, delegates are still invited to join the updated programme and benefit from accessing the new and updated materials.

If you have any questions regarding this training please contact us at:

Bethany1_Williams@sandwell.gov.uk
Helen_Tyson@sandwell.gov.uk

Sandwell
Metropolitan Borough Council

UPDATED FOR 2020-2021

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Inclusion Support
Expertise Experience Excellence

MORE INFORMATION:

The updated programme includes a focus on returning to education following Covid-19, and incorporates resources provided by the DfE as part of their 'Well-being For Education Return Covid-19' initiative.

Live Seminar: (Duration 2 hours)

- Mental Health is Everyone's Business: exploring mental health in everyday life to understand some of the challenges our children and young people face.
- Approaches to recovery and well-being during the return to education following Covid-19.
- Introducing key skills to support practice as a Trusted Adult.

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Dates for Education Staff:
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NOV 4	NOV 11	NOV 18	NOV 25
DEC 2	DEC 9	DEC 16	JAN 20
FEB 3	FEB 24	MAR 10	MAR 24
APR 21	MAY 5	MAY 19	JUN 9
JUN 23	JUL 7		

Please note that different dates are available, for those supporting children and young people outside of the school environment.

Although there is overlap with last year's training, delegates are still invited to join the updated programme and benefit from accessing the new and updated materials.

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