PROTECTING LIFE IN SCHOOLS

iMatter
promoting emotional health and wellbeing

Helping Protect Against Suicide by **Supporting Pupils' Emotional Health and Wellbeing**

Department of Education
www.deni.gov.uk
AN ROINN Oideachais
MÄNNYSTRIE O Lear

CONTENTS

ACKNOWLEDGEMENTS

The following people were involved in the production of this resource

Joe McGinnity (Chair), Education Adviser, Council for Catholic Maintained Schools

Andrew Elliott (Chair), Department of Health, Social Services and Public Safety (DHSSPS)

Gerard Collins (Chair), Principal Officer, DHSSPS

Gayle Manning, Senior Educational Psychologist, Education Authority

Margaret Woods, Mental Health Promotion Manager, BHSCT

Elma Lutton, Principal, Cambridge House Grammar School

Sheila McConnellogue, Educational Psychologist

Cathy Bell, Department of Education

Emer Smyth Senior Specialist Educational Psychologist, Education Authority

Ruth Bell, Acting Adviser, Pupil Personal Development Services, Education Authority

Stephen Dunlop, Educational Psychologist, Education Authority

Joe Henderson, Vice Principal, Lismore Comprehensive School

Cathleen Maguire, Principal Educational Psychologist, Education Authority

Ann Marrion, Senior Educational Psychologist, Education Authority

Annette McGleenan, Vice Principal, St Joseph's Grammar School, Donaghmore

Avril McKay, Vice Principal, Ballyclare High School

Veronica O'Loane, Assistant Principal, St Columbanus College, Bangor

Edith Bell, Director, Familyworks NI

Sinead Magill, Business Manager, NIMACH & CDOP, Public Health Agency

INTRODUCTION

1. The promotion of the emotional wellbeing of pupils has long been a central focus in our schools despite the many competing demands on the time of school staff. The presence of two areas of learning - Personal Development and Mutual Understanding, and Learning for Life and Work – in the statutory curriculum ensures that the emotional wellbeing of pupils is a priority in the classroom.

2. *"Protecting Life in Schools"* seeks to provide further support to schools in this regard and focuses on the many positive, supportive measures that schools can put in place to help safeguard the emotional health and wellbeing of their pupils. It is hoped that this advice will support schools in reducing the incidence of self harm and suicide.

3. This document has been developed in conjunction with the 2014 *"Guide to Managing Critical Incidents in School"* [1], as part of an integrated approach to supporting schools. These will both be especially useful to senior management and pastoral care teams however, it is recommended that **all** staff members should be familiar with them.

4. Research in the area of suicide prevention has indicated that focusing on mental health promotion and developing resilience in the school setting can be more helpful than focusing solely on prevention of suicide.[2] Emotional resilience refers to an individual's ability to adapt to stressful situations or crises.[3] The positive promotion of mental health is therefore the central focus of this document, reflecting this need to be both proactive and preventative.

5. It is accepted that schools and teachers need good quality information to enable them to support pupils' emotional health and wellbeing. This document provides information on what can be done both as part of a whole school approach and through support for individual pupils.

---

1 DE (2014) A *Guide to Managing Critical Incidents in Schools* https://www.deni.gov.uk/publications/guide-managing-critical-incidents-schools

2 Wells, J., Barlow, J. and Stewart-Brown, S. (2003) A systematic review of universal approaches to mental health promotion in schools, Health Education, 103, 4, 197-220

3 Belfast Strategic Partnership – Building Emotional Resilience Strategy consultation document 2014-17

6. It is acknowledged that suicide prevention, within the wider community, involves many strategies including reducing access to the means of attempting suicide. For this reason, the advice within this document should be considered alongside wider school policies, particularly those related to pastoral care and health and safety.

7. In the curriculum,[4] the inclusion of two specific areas of learning on *Personal Development and Mutual Understanding (from Foundation to Key Stage 2) and Learning for Life and Work (at Key Stage 3)* places a statutory requirement on schools to promote emotional wellbeing among their pupils. Schools are already skilled in meeting the pastoral needs of pupils and are highly motivated to help safeguard them. It is hoped that this publication will prove to be a helpful additional resource.

8. Good practice in this area should have a positive impact on many aspects of school life, including:

- School ethos
- Pupil-teacher relationships
- Peer relationships
- Staff wellbeing
- Pupils' life chances
- Parental participation and involvement
- Academic attainment
- Positive behaviour management
- Continuing professional development

4 DE – The Education (Northern Ireland) Order 2006, and the Education (Curriculum Minimum Content) Order (Northern Ireland) 2007 made under it

Key Points

- Pupils' emotional health and wellbeing is already centrally important in school life.
- Statutory Curriculum includes two areas of learning which encompass emotional wellbeing, Personal Development and Mutual Understanding (PDMU) and Learning for Life and Work (LLW).
- It is the responsibility of everyone in school to help maintain this focus.
- Research indicates that the best way to protect life is to promote positive mental health.
- This can be done in school both at the whole-school level and at the level of the individual child.

THE CONTEXT

9. It is widely recognised that mental health consists of two dimensions: (i) mental illness, such as depression, bipolar disorder, personality disorders, dementia and psychotic disorders; and (ii) mental wellbeing, for example life satisfaction, emotional resilience and relationships with others. Good mental health is therefore much more than the absence of mental illness.

10. Evidence shows that 28% of 16 year olds in Northern Ireland have experienced serious personal, emotional, behavioural or mental health problems at some point.[5] Suicide is not inevitable however. This is one of the myths about suicide that the World Health Organisation seeks to expose (see Box 1), primarily because these "myths" present barriers to the effective prevention of suicide.

Box 1: WHO myths and facts about suicide[6]	
Myth	Most suicides happen suddenly without warning.
Fact	The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning. But it is important to understand what the warning signs are and look out for them.
Myth	Someone who is suicidal is determined to die.
Fact	On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.
Myth	Once someone is suicidal, he or she will always remain suicidal.
Fact	Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.
Myth	Only people with mental disorders are suicidal.
Fact	Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.
Myth	Talking about suicide is a bad idea and can be interpreted as encouragement.
Fact	Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

5 The Young Life and Times (YLT) Survey (2013) www.ark.ac.uk/ylt

6 WHO (2014) Preventing Suicide: a global imperative

11. The 'Protect Life - Northern Ireland Suicide Prevention Strategy 2012-2014' [7] promotes a positive view of mental health, aiming to empower individuals in improving their health. This includes:

- An awareness of mental health and wellbeing issues
- An understanding of our emotions and beliefs, and how these can change
- Early recognition of mental ill-health
- Co-ordinated, effective, accessible and timely response mechanisms for those seeking help
- Appropriate follow-up action by statutory and voluntary/community support services

12. The emphasis on promoting mental health in schools is thought to be effective in reducing difficulties among children and young people.[8] Research shows that high levels of mental wellbeing are associated with higher levels of employment, academic achievement and happiness.[9] Specific suicide prevention programmes may also be effective but these should be supported by a mental health promoting culture.[10]

13. These observations are as relevant to the school-age population as they are to older generations and there have been many valuable initiatives introduced in schools with the aim of supporting pupils' mental health and building their resilience.

14. Promoting pupil emotional health and wellbeing, and developing resilience to protect the lives of the children and young people is clearly not just the responsibility of the education sector. While this document focuses largely on how schools can help, it should be understood that schools need to strive to work

7 DHSSPS (2012) 'Protect Life – Northern Ireland Suicide Prevention Strategy 2012-14'

8 Wells, J. Barlow, J & Stewart-Brown, S (2003) A systematic review of universal approaches to mental health promotion in schools, Health Education, 103, 4, 197-220

9 Green, H. McGinnity, A. Meltzer, H. Ford, T. & Goodman, R. (2005) Mental Health of Children and Young People in Great Britain, 2004.

10 Crowley, P. Kilroe, J & Burke, S (2004) Youth Suicide Prevention

in close partnership with the many others who impact upon the lives of children in order to ensure the most positive outcome for each child, including:

- Parents/guardians/ carers and wider family
- The local community
- Colleagues from the voluntary and community sectors, including churches, youth and counselling organisations
- Health and social services (including doctors, psychiatric services, health promotion etc)

15. It is also recognised that many non-educational organisations are engaged in very beneficial work in this area within schools.

Key Points

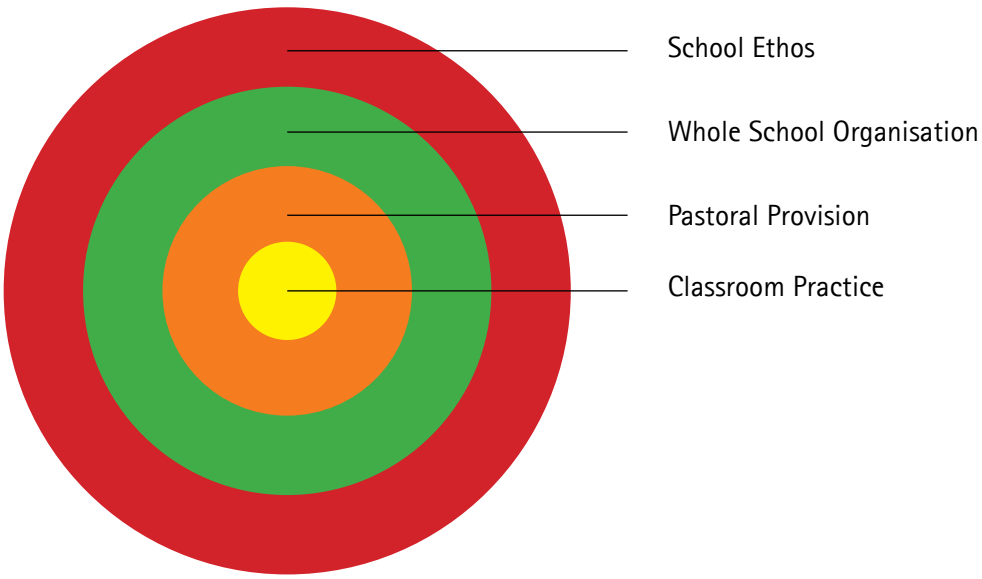
- Everyone has mental health needs.
- Positive mental health underpins all health and wellbeing.
- Mental health is a resource to be protected and promoted.
- Promoting pupil emotional health and wellbeing is a shared responsibility, with individuals, organizations and services working in partnership.

WHAT SCHOOLS CAN DO – THE WHOLE SCHOOL APPROACH

16. Schools have a pastoral responsibility towards their pupils, in particular to safeguard their safety and wellbeing. Within this context, the promotion of pupils' positive mental health to build resilience is a core responsibility. High quality pastoral care practices in schools are very effective ways to support pupil mental health and wellbeing. Schools partner with many external services to help meet the needs of pupils including Education Welfare, Educational Psychology, the Independent Counselling Service for Schools, and various Behaviour and Learning Support Services.

17. Hornby and Atkinson[11] provide a useful model for understanding schools' contributions to pupils' mental health, copied below. They suggest that schools impact on pupils' mental health on a number of levels. This model highlights that the promotion of mental health in schools is a shared responsibility and relates to many aspects of school life.

Hornby & Atkinson Model – Promoting Mental Health in Schools



11 Hornby, G & Atkinson, M (2002) Mental Health Handbooks in Schools

18. It is important for schools to evaluate their practice in relation to each of the four levels outlined in the model:

- The school ethos (which encompasses the values shared by staff and pupils)
- The whole school organisation (which comprises a range of school policies)
- The pastoral care provision
- The classroom practice

19. Schools may also find it beneficial to use an audit tool to evaluate their practice in this area. The Department is formulating a self-assessment audit tool to support schools in this process and this will be circulated once complete.

Characteristics of effective intervention

20. Effective interventions in promoting mental health in schools should:[12]

- Promote mental health rather than focus on the prevention of mental health problems
- Be implemented continuously and be long-term in nature i.e. of more than one year's duration
- Include changes to the school climate rather than brief class-based prevention programmes
- Extend beyond the classroom and provide opportunities for applying the learned skills
- Focus on aspects of the social and physical environment of the school
- Focus on family and community links with the school
- Focus on enhancing generic social competences – coping skills, good peer relationships and self-efficacy
- Involve interactive teaching methodologies – active learning, pupil participation
- Involve the promotion of emotional wellbeing through the curriculum

12 Wells, J. Barlow, J & Stewart-Brown, S (2003) A systematic review of universal approaches to mental health promotion in schools, Health Education, 103, 4, 197-220

Classroom Practice

21. The characteristics of effective intervention, which are listed above, inform classroom practice, including:

Pupil–teacher relationships

Relationship-building underpins all effective teaching and learning. Teachers who are approachable and who have the confidence to provide open channels of communication for children and young people to discuss their emotions can impact significantly on the positive mental health of students.[13] Whilst there is no expectation that teachers should offer counselling support for students, there are fundamental skills from a counselling perspective, particularly active listening skills,[14] which teachers can draw on to promote such relationships.

Peer relationships

22. Fostering co-operative relationships between pupils is important, not solely within the pastoral care context, but also in the context of teaching and learning opportunities across the curriculum. Teachers can support students in the development of their social skills and social competence by offering opportunities for practice and reflection in adult-supported contexts. Part of the statutory requirements within the curriculum, specifically Personal Development and Mutual Understanding and Learning for Life and Work, involve understanding the qualities of relationships, including what a loving, respectful relationship is, and developing strategies for dealing with challenging relationship scenarios.

Positive behaviour management

23. The extent to which predictability, structure and boundaries can ensure emotional security for all students, and therefore contribute to the prevention of mental health difficulties, should not be underestimated. These qualities can be achieved in the learning setting through routines, shared expectations and an understanding of consequences, based on whole-school practice. Students benefit from teachers being consistent and fair in their setting of behaviour limits and enforcement of sanctions.[15]

---

13 Hornby, G & Atkinson, M (2003) A Framework for Promoting Mental Health in School

14 Weare, K (2000) Promoting Mental, Emotional and Social Health

15 Hornby, G & Atkinson, M (2003) A Framework for Promoting Mental Health in School

Inclusive practices

24. A commitment to accommodating individual learning needs informs inclusive practices in the classroom; for example, differentiation should be an integrated component of classroom delivery, ensuring that all pupils feel valued and supported. Efforts should be made to frame students with social, emotional and behavioural difficulties, in particular, as students who 'require support', rather than 'difficult' students.[16] Students will also need support in developing an understanding and appreciation of diversity in the class setting; it is known that a history of victimization leaves children and young people particularly vulnerable to developing mental health difficulties.[17] This understanding of diversity is part of the statutory requirements of the Statutory Curriculum, beginning in Foundation Stage, where, in Personal Development and Mutual Understanding, pupils should understand that everyone is of equal worth and that it is acceptable to be different.

Learning and teaching approaches

25. Facilitative teaching methods can contribute to the positive wellbeing of students as they promote autonomy, also known as internal locus of control, and validate student perspectives. The use of, for example, active learning, pupil participation, peer tutoring and assessment for learning minimizes adult control and encourages students to think for themselves.

Promotion of social and emotional competences through the curriculum

26. The promotion of pupil wellbeing is best served when there is a balance between focus on academic attainment and the promotion of social and emotional competences.[18] Teachers can encourage students to express and understand their feelings in a range of contexts across the curriculum. Opportunities for students to develop coping skills, self-efficacy (an understanding of one's own strengths and limits), self-management, problem-solving skills, self-esteem (valuation of self) and self-belief (confidence of being effective) are ideally integrated into learning and teaching opportunities as part of normal classroom practice.[19]

---

16 Hornby, G & Atkinson, M (2003) A Framework for Promoting Mental Health in School

17 ABA (2015) Focus on: Bullying & Mental Health

18 Hornby, G & Atkinson, M (2002) Mental Health Handbooks in Schools

19 Hill, M. Stafford, A. Seaman, P. Ross, N & Daniel, B (2007) Parenting and Resilience

The Statutory Curriculum

27. Within the curriculum there is a clear recognition of the importance of emotional health and wellbeing with an overall aim '... to empower young people to achieve their potential and to make informed and responsible decisions throughout their lives'. [20] The areas of *Personal Development and Mutual Understanding* (Foundation Stage to Key Stage 2) and *Learning for Life and Work* (Key Stage 3) in particular encompass key elements of the approach taken in this document.

Primary Curriculum

28. The Personal Development and Learning for Life and Work Areas of Learning focus *'... on encouraging each child to become personally, emotionally, socially effective, to lead healthy, safe and fulfilled lives and to become confident, independent and responsible citizens, making informed and responsible choices and decisions throughout their lives.'* [21]

29. Personal Development and Mutual Understanding has two strands. Personal Understanding and Health and Mutual Understanding in the Local and Wider Community.

    i) Personal Understanding and Health

    By the end of Key Stage 2 pupils should be enabled to explore:

    - *Their self-esteem, self-confidence and how they develop as individuals*
    - *Their management of a range of feelings and emotions and the feelings and emotions of others*
    - *Effective learning strategies*
    - *How to sustain their health, growth and wellbeing and coping safely and efficiently with their environment.'*

20 CCEA (2007) The Northern Ireland Curriculum, Primary p4

21 CCEA (2007) The Northern Ireland Curriculum, Primary p91

ii) Mutual Understanding in the Local and Wider Community

'By the end of Key Stage 2 pupils should be enabled to explore:

- *Initiating, developing and sustaining mutually satisfying relationships*
- *Human rights and social responsibility*
- *Causes of conflict and appropriate responses*
- *Valuing and celebrating cultural difference and diversity*
- *Playing an active and meaningful part in the life of the community and being concerned about the wider environment.'* [22]

Post-Primary Curriculum

30. At Key Stage 3, the Personal Development statutory element within Learning for Life and Work promotes:

- Self-awareness through the provision of opportunities to consider the importance of self confidence and self esteem to physical and emotional/ mental health
- Personal health through recognising and managing factors that may influence physical and emotional/mental health
- Relationships through opportunities to understand the importance of forming and maintaining relationships to physical and emotional/mental health [23]

31. At Key Stage 4 pupils should take increasing responsibility for their own learning and actively demonstrate the skills and capabilities that they will have already acquired throughout the previous key stages in order to deepen and widen their experiences and understanding of the key concepts of Personal Development. One of the aims of the Key Stage 4 Personal Development programme is to provide pupils with opportunities to engage with increasingly complex and challenging issues which are relevant to their daily lives.

22 CCEA (2007) The Northern Ireland Curriculum, Primary, p96

23 CCEA (2007) Personal Development Key Stage 3. Non Statutory Guidance for Personal Development, p1-2

32. Pupils should be enabled to:

- Develop an understanding of how to maximise and sustain their own health and wellbeing
- Reflect on, and respond to, their developing concept of self, including managing emotions and reactions to on-going life experiences
- Recognise, assess and manage risk in a range of real-life contexts
- Develop their understanding of relationships and sexuality and the responsibilities of healthy relationships
- Develop an understanding of the roles and responsibilities of parenting
- Develop further their competence as discerning consumers in preparation for independent living.[24]

33. Among the attitudes and values underpinning the curriculum are the following principles:

- Build learners' Thinking Skills and Personal Capabilities
- Focus on Learning for Life and Work and put this objective at the centre of the curriculum
- Establish 'Connected Learning' where teachers make the connections between different parts of the curriculum more explicit for their pupils

34. The Council for Curriculum, Examinations and Assessment has produced a variety of resources for Key Stages 1-4 to assist teachers in delivering the Personal Development and Mutual Understanding and Learning for Life and Work aspects of the curriculum. *'Protecting Life in Schools'* is a resource which will complement the Council's resources. It will also benefit school staff in helping their pupils to build the resilience required to deal with the many challenges and disappointments they will face in today's world.

35. As our students engage with the components of the curriculum outline above, they should have the opportunity to develop emotional competence and positive mental health. This curriculum should be delivered in a context which respects and values the mental health needs of all the members of the school community.

---

24 CCEA (2007) Personal Development Guidance for Key Stage 4

WHAT SCHOOLS CAN DO – SUPPORTING INDIVIDUALS

36. Through a positive whole school approach pupils are helped to build resilience and increase their positive mental health and wellbeing and therefore be less susceptible to anxiety, depression, self-harm and suicide.

37. However, it is accepted that young people need to develop a range of appropriate "help-seeking behaviours" to support them when coping with specific health needs, normative developmental needs, personal stress or problems. Nonetheless young people and males in particular, can be reluctant to seek help although it is recognised that through the Independent Counselling Service for Schools and other services, seeking help through a variety of sources is becoming more common in schools now. Schools can further assist this through raising awareness of the sources of help available and prominent display and dissemination of posters/leaflets/materials in school.

38. Young people often rely first on friends or try to cope alone before turning to an adult. Adults, including parents/guardians/carers and teachers therefore have an important role to play in encouraging and motivating the young person to overcome resistance to seeking or accepting help. In addition schools/teachers could act as an advocate for a young person in distress by discussing the matter with parents/guardians/carers and relevant school staff and referring them to appropriate services if required.

39. Furthermore, if a help-seeking culture is to be developed and maintained within a school, pupils need to understand that their confidentiality will be respected; they must also be made aware of the potential limits of confidentiality. Young people need to know that anything they disclose which gives rise to concern about their safety or the safety of others will have to be passed on to the Designated Teacher for Child Protection and dealt with appropriately.

40. Research completed by Fortune et al[25] has provided valuable insight into the voice of the child in this area. Adolescents reported that reluctance to seek help can be partially driven by the fear that their needs would not be taken seriously or that they may be dismissed as 'attention-seeking'. Schools/teachers need to be aware that behaviours such as substance abuse, bullying and conduct problems may be signs of a young person's distress. (See section below on Warning Signs of Potential Suicidal Thoughts or Behaviour, paragraphs 62-67).

25 Fortune, S. Sinclair, J. & Hawton, K. (2005) Adolescents' Views on Prevention of Self-Harm, Barriers to Help-Seeking for Self-Harm and How Quality of Life Might be Improved

41. While research suggests that young people are more likely to confide in, or come to the attention of, peers[26] it is important to recognise that young people may lack a supportive group of friends or may have friends who are ill-equipped to support them. Schools therefore do have a key role to play in encouraging social integration and safe-guarding pupils from social isolation.

Key Points

- Young people who most need help may resist it.
- Peers can be very supportive but some young people are socially isolated.
- Young people can be fearful to seek help in case they will not be taken seriously.
- Behaviours such as bullying and conduct problems may be indicators of distress.
- Young people need to understand confidentiality and its limits.

Towards an understanding of self-harming behaviour

42. Schools have found that the emotional distress of young people can sometimes be shown in self-harming behaviours. For this reason teachers need to have an understanding of this behaviour and how young people can be supported.

43. Self-harming behaviour is complex and can occur for a variety of reasons. Self-harm is considered alongside suicide because it is a major risk factor for subsequent suicide. The risk of suicide in the first year after self harm is between 60 to 100 times the risk of suicide in the general population.[27] The *Northern Ireland Lifestyle and Coping Survey* published in 2010 indicates that 10% of 15/16 year olds in Northern Ireland have self harmed at some stage.[28] Suicide is not inevitable however and this is one of the myths about suicide that the World Health Organisation has sought to expose, primarily because these myths present barriers to the effective prevention of suicide. While it may be associated with suicidal behaviour, it can often be significantly different.

26 Health Promotion Agency Design for Living Partnership (2001) Design for Living: Research to support young people's mental health and well-being

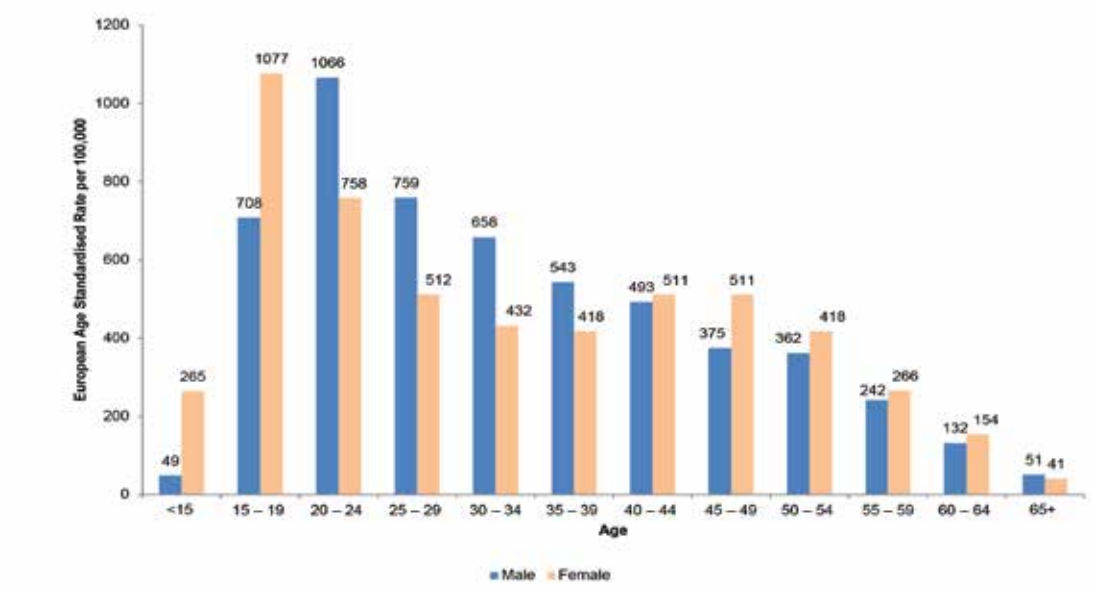
27 Royal College of Psychiatrists (2004) 26. Deliberate self-harm in young people: Factsheet for parents and teachers

28 Northern Ireland Lifestyle and Coping Survey (2010), http://www.dhsspsni.gov.uk/ni-lifestyle-and-coping-survey-2010.pdf

44. Self-harming behaviour is understood to be used as a coping strategy by individuals who are finding the stresses of life very difficult. Sometimes people find that engaging in self-harm distracts them from emotional pain and helps them to carry on with life.[29]

45. The Northern Ireland Registry of Self Harm reports the rate of self-harm by age group. In 2014/15 the highest female rate was observed among 15-19 year olds and the highest male rate occurred among 20-24 year olds.[30]

Figure 7: European Age-Standardised Rate per 100,000 of self-harm in Northern Ireland by age and gender, 2014/15



Source: Northern Ireland Registry of Self-Harm

46. In seeking to support young people who are engaging in self-harm it is important to:

- Listen in a non-judgemental way
- Help them to identify more appropriate coping strategies
- Make further referral for external support
- Treat the self-harm as a safeguarding issue through the designated teacher for child protection

29 Carr, A. (2002) Prevention: What works with Children and Adolescents? A critical review of psychological prevention programmes for children, adolescents and their families

30 Northern Ireland Registry of Self-Harm Annual Report 2013/14

Towards an understanding of suicidal behaviour

47. Suicidal behaviours are complex and there are no simple answers or explanations. Trying to understand the processes involved when a child or young person has thoughts of suicide may help school staff to support those pupils prior to, and at times of, crisis. The education and support of parents is also a very important consideration here.

48. The 2010 Lifestyle and Coping Survey showed that up to one quarter of 16 year olds have experienced serious personal, emotional, or mental health problems and 10% have self harmed.[31] The survey reported that self harming was more frequent amongst girls and boys with sexual orientation concerns had a high risk. The survey also indicated that influencing factors include knowing other people who self harm, the internet and social networking sites. The next DHSSPS Suicide Prevention Strategy will have a focus on self harm and particularly reducing repeat self harm. An e-Safety Strategy for Northern Ireland is also under development and is expected to highlight best practice for young people in relation to social media

49. A psychological model called the 'Cry of Pain' developed by Williams and Pollock offers a way of understanding what might be going on when a person is having suicidal thoughts.[32] Subsequent research by *O'Connor* has further developed the understanding of the thought processes involved.[33] According to this model, suicide does not happen in isolation; rather it is the final step in a series of causally related events. There are likely to be social, psychological and biological factors involved. In the final stage of the model, suicidal behaviour can be viewed as the desire to escape from unbearable pain. This can be a response to something deemed as a *"personal defeat"* after which an individual judges that there is *"no escape"* and *"no rescue"*.

50. Within the model it is acknowledged that certain factors may reduce the likelihood of suicide occurring. There are primarily the 'escape potential' of the individual and the 'rescue factors' within the environment.

---

31 Northern Ireland Lifestyle and Coping Survey 2010, http://dhsspsni.gov.uk/ni-lifestyle-and-coping-survey-2010.pdf

32 Williams, J & Pollock, L (2000) Psychological Aspects of the Suicidal Process in Van Heeringen, K (Ed) Understanding Suicidal Behaviour

33 O'Connor, R (2003) Suicidal Behaviour as a Cry of Pain: Test of a Psychological Model

These can be understood as follows:

(i) Escape Potential

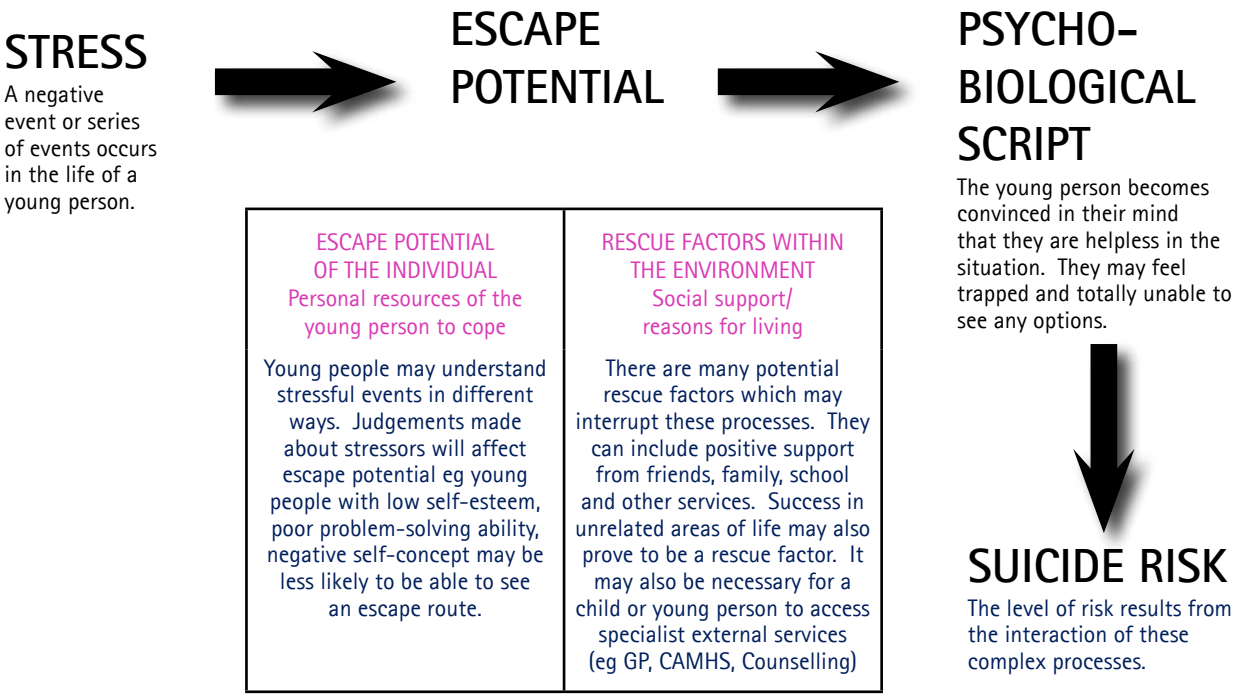
- The personal resources of the young person to cope with stress, rejection and defeat

(ii) Rescue Factors

- The factors within the environment which may prove protective to the young person

51. It is believed that schools are well placed to impact positively on both of these. The diagram below illustrates the Cry of Pain Model. Additional explanatory notes have been added in blue.

Diagram 2.....The Cry of Pain Model (Williams and Pollock 2001)



52. The World Health Organisation advises that, whilst not all suicides are preventable, most are.[34] Therefore while it is worthwhile to make efforts to support people and attempt to prevent suicide we must acknowledge the limits of what we can do in this area.

Possible school based strategies

53. It is important to recognise that help seeking and having access to support are seen as protective factors for pupils and having these is associated with lower rates of self harm and suicide. The table below considers the "Cry of Pain" model mentioned earlier in terms of how schools might help at each stage.

Stages in Suicidal Behaviour	Possible School-Based Strategies
Judgement by the individual – how a person views difficult life situations.	Through the curriculum and pastoral care system build resilience: • Build self-esteem and positive self-concept. • Foster the ability to self-reflect and develop problem-solving abilities. • Protect against self-criticism and social perfectionism. • Foster self-reliance and the ability to think and act independently. • Give opportunities for positive interaction with others (e.g. buddy systems/peer support). • Increased pupil involvement in school life and related decision-making
Stressful life event.	Schools can mitigate stressful life events or situations which a young person might perceive as a defeat or a rejection through sensitive handling of, for example: • Academic underachievement/academic failure. • Loss and change. • Bereavement. • Bullying and difficulties in peer relationships. • Suicide of relative, peer, colleague.

34 WHO (2000) Preventing Suicide: A resource for primary health care workers

Stages in Suicidal Behaviour	Possible School-Based Strategies
Evaluating escape potential - social supports as rescue factors.	Schools can ensure that a young person who is at risk of developing low mood, hopelessness or depression is signposted, or referred, to appropriate support or treatment, for example: • Pastoral care within the school. • School-based counselling services. • Medical referral to doctor/Child and Adolescent Mental Health Service (CAMHS). • Specialised support services (bereavement, sexual abuse, difficulties with sexual orientation or family break-up). • Safeguarding services (see section below on safeguarding the pupil, page 27)
Activation of the psychobiological script wherein suicide is perceived as the solution.	• Schools can be on the look-out for warning signs and act appropriately. These are detailed in the section on warning signs (page 25)

Training for teachers

54. Teachers should avail of the relevant and necessary training to equip them with skills to deal with situations involving pupils' suicidal thoughts and behaviour in schools. A combination of training programmes may be best as not all teachers need a high level of skills in suicide intervention. However, all teachers would benefit from suicide awareness training. There are a range of recognised programmes currently in use, examples of these include ASIST, safeTALK and Compassion Fatigue. An overview of these is provided below and additional information is readily available from the Public Health Agency.

(i) ASIST [35]

The Protect Life Strategy specifically mentions ASIST (Applied Suicide Intervention Skills Training) as a means of raising teachers' awareness and skills for dealing

35 ASIST www.livingworks.net

with suicide as a possible issue for young people. ASIST is a two day interactive programme for all caregivers to learn suicide first-aid intervention. This is a highly evaluated programme, designed by Livingworks Education Canada in partnership with Calgary University, Canada. As of October 2015, there were 55 personnel qualified as ASIST trainers in Northern Ireland.

(ii) safeTALK [36]

The "safeTALK" (Suicide Alertness for Everyone) programme is designed to help participants recognise persons with thoughts of suicide and connect them to suicide first-aid resources. The safeTALK awareness-raising programme is considered a good choice for schools as it can be delivered to large numbers at one time and takes less time (around 3.5 hours). This programme should enhance the ability of school staff to recognise individuals at risk and link them to an appropriately-trained person.

It is advisable for schools to have someone in the school trained in ASIST before the safeTALK programme takes place.

(iii) Compassion Fatigue

This was initially developed for the health sector who, working continually with patients who are suffering, in pain or traumatized could suffer compassion fatigue or burnout. It is equally applicable to school staff dealing with the number and variety of issues presenting in schools today. The key here is building resilience amongst staff, educating them to identify the warning signs whilst also ensuring that line management provide a supportive environment. Arguably there is also a need for this to be built into not only continuing professional development but also into initial teacher education and training.

Being alert in school

55. Suicidal behaviour whether fatal or non-fatal is one of the most traumatic occurrences with which a school and its teachers may be faced. It is therefore important that a school's ethos should:

- Have a protective effect on young people and contribute to reducing the likelihood of suicide and self harm

36 SafeTALK www.livingworks.net

- Create a positive environment in which staff can support pupils whom they believe to be at risk and have clear mechanisms for further referral

56. While it is recognised that assessing suicidal risk in young people is not part of the teacher's job they do have a key role to play in protecting pupils and it is important that schools and teachers are aware of:

- Suicide risk factors and protective factors
- Warning signs of suicidal behaviour
- Steps that should be taken when young people seek help
- Support that is available

Suicide risk factors and protective factors

57. The presence of a number of risk factors may increase the vulnerability of a young person to suicidal thoughts and actions. However, protective factors help buffer young people from suicidal thoughts and behaviours. They enhance resilience and can serve to counterbalance risk factors. It is therefore important that schools and teachers readily identify and understand what protective factors are.

Table 1
Risk and Protective Factors (Irish Association of Suicidology 2001)

	RISK FACTORS	PROTECTIVE FACTORS
Characteristics of the individual child	• Low self esteem • Male (suicide) • Increasing age • Poor coping skills • 'Difficult' temperament • Mental distress or illness e.g. anxiety/depression • Alcohol/substance misuse • Stress or worries about school work or peers • History of similar behaviour in the past • Past or current experience of abuse • Feeling isolated • Recent bereavement	• High self-esteem • Female • Higher ability/attainment • Outgoing personality • Good coping skills • Positive school experience • Secure attachment • Resilience • Knowledge of where to seek support

Features of the immediate context	• Access to means of causing self-harm • Being alone • Social exclusion • Alcohol and drugs	• Access to social support • Social inclusion
Family factors	• Family members who self-harm • Family conflict • Parental separation and divorce • Single parent family • Parental illness • Parental drug/alcohol misuse • Sexual/physical abuse • Poverty/low socio-economic status	• One supportive adult relationship • Harmonious family relationships • Low level of material or social hardship • Good role models within family
Peer group	• Arguments with friends • Bullying • Friends who self-harm	• Stable and secure friendship group
School	• Pressure from school to perform well • Assessment • Peer/friendship difficulties • Bullying	• One supportive adult • Inclusive/incorporative ethos • Strong commitment to Personal, Social and Health Education (PSHE) and mental health promotion • Establishment of peer support systems
Wider culture and community	• Minority status • Problems in relation to race, culture or religion • Problems re: sexual orientation or identity • Media: portrayals glamorise deliberate self harm or suicide 'victims' and elicit 'copy-cat' responses by vulnerable children and young people.	• Membership of cultural majority group/social acceptance and social capital • Responsible media coverage and portrayal

58. National Institute of Clinical Excellence guidance[37] is also available in relation to self harm and common mental health disorders. While this is targeted at Health and Social Care staff, the guidance may be a useful reference point for the Education sector.

Clinical guideline on Self-harm: short-term treatment & management (CG16)	Evidence-based clinical guideline for professionals involved in the management of people who self-harm within the first 48 hours of an incident. It recommends that risk assessment tool and scales should not be used to predict future suicide or repetition of self harm, or to determine who should be offered further treatment and who should be discharged. It supports offering integrated and comprehensive psychosocial assessment of needs and risks, taking account of the fact that each person self-harms for individual reasons.
Clinical guideline on Common mental health disorders: Identification and pathways to care (CG123)	Guideline for primary and secondary care clinicians, managers and commissioners. Notes that depression is the most common disorder contributing to suicide. Recommends that people with a common mental health disorder are always asked directly about suicidal ideation and intent. Where there is a risk of self-harm or suicide, assessment should include whether the person has adequate social support and is aware of sources of help. Intervention should include arranging help appropriate to the level of risk. Where the person presents a high risk of suicide, manage the immediate problem first and then refer to specialist services and, where appropriate inform families and carers. Where the suicide risk is considerable & immediate risk, refer them urgently to the emergency services or specialist mental health services.

59. Knowledge of risk factors and protective factors is not always enough to help identify pupils who may be at risk of self harm or suicide. It is also important to be vigilant for possible warning signs. These warning signs are detailed in the section below.

37 National Institute of Clinical Excellence (2011) Self-Harm: Safeguarding Children and Young People, http://pathways.nice.org.uk/pathways/self-harm

Warning signs of potential suicidal thoughts or behaviour

60. At times children and young people will express suicidal thoughts or intentions to adults they trust. Any such expressions should be taken seriously and acted upon, see sections below on Immediate Reactions and Responding to a Distressed Pupil for further advice and guidance.

61. Young people may also express suicidal ideation to their peers rather than to adults. It is important that pupils are encouraged to pass this information to a trusted adult who can take steps to ensure that their friend is kept safe.

62. Sometimes however young people may not express their feelings but those closely involved in their life may be in a position to notice changes in behaviour which can also act as warning signs.

63. It is important to note that the following list is not exhaustive and these symptoms do not necessarily indicate suicide risk. It is, at best, a list of warning signs that may help teachers to identify pupils who may need particular support.

64. Teachers have a key role to play in being able to identify warning signs of potential suicidal thoughts or behaviours.[38] These include:

- Unexpected reduction of academic performance
- Ideas and themes of depression, death and suicide
- Negative changes in mood and marked emotional instability
- Positive changes in mood and calmness
- Significant grief or stress
- Withdrawal from relationships
- Physical symptoms with emotional cause
- Writing about suicide
- Speaking about suicide
- Listening to songs praising suicide

38 Irish Association of Suicidology (2001) Managing Suicide Prevention in Irish Schools: Best Practice Guidelines

- Art work about suicide
- Threats and statements of intent
- Preoccupation with a known suicide
- Life threatening risk taking behaviour
- Break-up of relationships

65. It may also be important to have an awareness of the websites, social media or computer games that young people are engaged with. Some of these have themes and content that may attract vulnerable young people but prove to be detrimental to them.

A pupil at risk – immediate reaction

66. All school staff have a duty of care towards their pupils. The immediate reaction by a member of staff to the alert that a pupil is in distress is crucial to the protection of the pupil. It is therefore important that staff consider in advance how they would react in such a situation. In every such response the two essential elements are

    (i) To respond with empathy and in a non-judgemental way to the child in need; and

    (ii) To follow usual child protection and safeguarding procedures and to make appropriate referrals to ensure the child's safety, because self-harm and expressions of suicidal thoughts are safeguarding issues.

Responding to a distressed pupil

67. When a child or young person is emotionally distressed it can sometimes feel overwhelming to think about what to say or do. Being there to listen and talk can make a difference. As a teacher it is important to:

    - **Listen.** It can be very difficult for a young person to disclose distress so it is essential that he/she is given time and attention. Privacy is also important.

- **Take it seriously.** Disclosures of distress should never be minimised. The young person should be taken seriously but the adult should not express alarm. The young person needs to feel safe and have confidence in adults.
- **Accept the possibility of suicidal thoughts.** These feelings are real and should not be dismissed.
- **Don't promise confidentiality.** Ensure that the young person knows that the information will be handled sensitively but that it must be shared with others to safeguard them.
- **Show a caring attitude.** It is acceptable to express care for the young person and a commitment to their wellbeing.
- **Be open.** If suicidal intent is suspected it is important to ask the young person whether they are thinking of harming themselves and if they have made any plans. This gives the young person permission to be completely honest and, therefore, be able to seek help.
- **Supervise closely.** Keep the child/young person with you until you can deliver them to the care of the Designated Teacher for Child Protection (or appropriate alternative). Sometimes it is more helpful for the teacher to whom the young person expressed their distress to be the one who stays with them while the Designated Teacher makes arrangements to safeguard the child.

Safeguarding the pupil

68. The Designated Teacher for Child Protection (or appropriate alternative) should safeguard the young person by doing the following;

- **Continue to supervise closely.** The pupil should not be left unsupervised at this stage.
- **Contact parents/guardians/carers.** Parents/guardians/carers should be advised of the content of the disclosure, the school's concern and asked to take the child or young person to the GP or Out of Hours Service requesting an **'emergency mental state assessment'** and potential referral to Child and Adolescent Mental Health Services.
- **Safely** ***hand over the young person into the care of parents/guardians/carers.*** Parents should be advised to supervise very closely.

- **If the above is not possible...** If the school cannot safely deliver the child into the care of parents/guardians/carers, or have concerns that appropriate support will not be sought/provided, it is possible for school staff to seek appropriate medical advice acting in *loco parentis*. This would be the exception rather than the rule however.
- **Follow-up.** The Designated Teacher (or other member of staff) should remain in sensitive contact with parents/guardians/carers and plan to support the young person upon return to school. In planning to support the young person the school may wish to seek medical/psychiatric advice in this regard.
- **Support for staff and/or peers.** It is important that individuals who are involved in this type of situation should be carefully supported within the school.
- **Explain to the pupil what will happen next.** Make it clear that someone will stay with them and that you are making every effort to find appropriate help. Explain where they are going, who is going with them and what you are hoping to achieve for them.

See Safeguarding Action Checklist in the next section.

Please note that the above advice has been developed in partnership with the DHSSPS, PHA and school communities.

Available Support

Lifeline - **0808 808 8000**

69. Lifeline is available to all ages and offers immediate help over the phone 24/7 for those who are experiencing distress or despair. All calls are answered by qualified counsellors who are available to listen, help and support an individual's needs in confidence. An individual could be offered an appointment for face-to-face counselling or other therapies in your local area within 7 days. Lifeline can also put an individual in touch with follow-up services to ensure the best possible response meets individual needs. Pupils can phone directly for individual counselling. Lifeline also gives support and guidance to families and carers, concerned friends, professionals, teachers, youth workers, clergy and communities about how to support a young person that may be a risk.

Safeguarding action checklist

The Designated Teacher/ Safeguarding Team may find the following checklist useful in helping to ensure that everything possible has been done to help the pupil.

If there is a disclosure or strong suspicion of suicidal intent, ensure that:

The pupil is listened to and supported in the immediate term (e.g. is with a trusted member of staff). ☐

Designated pastoral care teacher is informed. ☐

Parents/guardians/carers are informed. ☐
How was this done? Provide details below

_____

_____

_____

Parent/guardian/carer comes to the school for the pupil and he/she leaves in their care (parents/guardians/carers are advised to monitor the child closely ☐

Teacher's Name: _____

Time: _____

Date: _____

Parents are advised to take their child to the GP and ask for a mental state assessment and appropriate action. (Concerns around negligence regarding a child's mental health needs should be followed up thorough the normal safeguarding procedures). ☐

School sends a follow-up letter to parents detailing concerns, action taken and advice given. ☐

The designated teacher (or appropriate alternative) staff follows up with Parent/guardian/carer within a short time frame. This should be as soon as possible but must be on the same day the incident has occurred.	☐
Longer-term support is sought for the young person as appropriate.	☐
Teachers' support needs are identified and action taken if appropriate.	☐

CONCLUSION

70. It is hoped that this document will be helpful in validating the good practice already in existence and in providing schools with additional advice on how to support further the children and young people in their care.

71. The aim is neither to heighten the anxiety of school staff around this issue nor to suggest that schools are responsible for every thought and action of all their pupils. Rather it is hoped that this document will help schools staff to better understand the mental health needs of their pupils, to organise schools more effectively to facilitate emotional health and wellbeing and to respond, when necessary, to the needs of vulnerable pupils.

BIBLIOGRAPHY

Anti-Bullying Alliance (2015) Focus on: Bullying and Mental Health, London

ASIST – www.livingworks.net

Carr, A. (2002) Prevention: What Works With Children and Adolescents? A critical review of psychological prevention programmes for children, adolescents and their families.

CCEA (2007) The Northern Ireland Curriculum. Primary, Belfast, CCEA

CCEA (2007) Personal Development. Key Stage 3. Non Statutory Guidance for Personal Development, Belfast, CCEA

Collaborative for Academic, Social, and Emotional Learning (2003) Safe and sound: An educational leader's guide to evidence-based social and emotional learning programs, Chicago, CASEL

Crowley, P., Kilroe, J. and Burke, S. (2004) Youth Suicide Prevention. London: HDA

DENI (1991) Suicide among Young People: Managing the Issue in Schools, DENI

Department of Education 2010. Responding to Critical Incidents.

Department of Health (2001) Making it Happen – A Guide to Delivering Mental Health Promotion

DHSSPS (2003) Promoting Mental Health. Strategy and Action Plan 2003-2008. DHSSPS

DHSSPS (2006) Protect Life: A Shared Vision – The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-11, DHSSP

Fortune, S., Sinclair, J. and Hawton, K. (2005) Adolescents' Views on Prevention of Self-Harm, Barriers to Help-Seeking for Self-Harm and How Quality of Life Might Be Improved, Centre for Suicide Research, University of Oxford

Gould, M. (2008, August) Preventing teen suicide: a review of school-based strategies, Paper Presented at the 12th European Symposium on Suicide and Suicidal Behaviour, Glasgow, Scotland

Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) Mental Health of Children and Young People in Great Britain, 2004. Hampshire: Palgrave Macmillan

Hawton, K. and Rodham, K. (2006) By Their Own Hand, London and Philadelphia, Jessica Kingsley Publishers

Health Promotion Agency Design for Living Partnership 2001. Design for Living: Research to support young people's mental health and wellbeing. March 2001

Hill, M. Stafford, A. Seaman, P. Ross, N. & Daniel, B. (2007) Parenting and Resilience. Joseph Rowntree Foundation, York. (www.jrf.org.uk)

Hornby, G. and Atkinson, M. (2003) A Framework for Promoting Mental Health in School, Pastoral Care in Education, 21, 2, 3-9

Hornby, G and Atkinson, M (2002) Mental Health Handbooks for Schools

Hove: Brunner – Routlege

Irish Association of Suicidology (2001) Managing Suicide Prevention in Irish Schools: Best Practice Guidelines (unpublished)

Leenaars, A. (1993) Helping your suicidal child in Lester, D., The Cruelest Death, Philadelphia, Charles Press

Lister-Sharp, D., Chapman, S., Stewart-Brown, A. and Sowden, A. (1999) Health promoting schools and health promotion in schools: two systematic reviews, Health Technology Assessment, 3, 22, 1-207

Mental Health First Aid – http://mhfaengland.org/

Michaud, P. and Fombonne, E. (2005) ABC of Adolescence: Common Mental Health Problems. British Medical Journal. Volume 330

Morris, S. (2005) Responding to Deliberate Self-Harm and Suicidal Thinking in Childhood: the role of the primary school (unpublished)

National Institute of Clinical Excellence, 2011, Self-Harm: Safeguarding Children and Young People, http://pathways.nice.org.uk/pathways/self-harm

NHS Health Advisory Service (1995) Together We Stand: The Commissioning, Role and Management of Child and Adolescent Mental Health Services (NHS Thematic Reviews). London: The Stationery Office

O'Connor, R. (2003) Suicidal Behaviour as a Cry of Pain: Test of a Psychological Model, Archives of Suicide Research, 7, 4, 297-308

Portzky, G. and Van Heeringer, K. (2006) Suicide Prevention in adolescents: a controlled study of the effectiveness of a school-based psycho-educational program, Journal of Child Psychology and Psychiatry, 49, 7, 910-918

Royal College of Psychiatrists (2004) 26. Deliberate self-harm in young people: Factsheet for parents and teachers

Safetalk – www.livingworks.net

Weare, K (2000) Promoting Mental, Emotional and Social Health. London: Routledge

Wells, J., Barlow, J. and Stewart-Brown, S. (2003) A systematic review of universal approaches to mental health promotion in schools, Health Education, 103, 4, 197-220

WHO (World Health Organisation) (2000) Preventing Suicide: A resource for primary heath care workers. Copenhagen: Department of Mental Health. WHO

Williams, J. and Pollock, L. (2000) Psychological Aspects of the Suicidal Process in Van Heeringen, K. (Ed.) Understanding Suicidal Behaviour, Chichester, John Wiley and Sons

1 in 6 people (national service framework 1999) http://www.mentalhealth.org.uk

Appendices

FACTSHEET

Deliberate Self-harm in Young People

This is one in a series of factsheets for parents, teachers and young people entitled *Mental Health and Growing Up*. The aims of these factsheets are to provide practical, up-to-date information about mental health problems (emotional, behavioural and psychiatric disorders) that can affect children and young people. This factsheet looks at the reasons behind why some young people may harm themselves, and offers practical advice about how to cope with this problem.

INTRODUCTION

What is deliberate self-harm?

Deliberate self-harm is a term used when someone injures or harms themselves on purpose. Common examples include 'overdosing' (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, or self-strangulation. It can also include taking illegal drugs and excessive amounts of alcohol. Self-harm is always a sign of something being seriously wrong.

Why do young people harm themselves?

Self-injury is a way of dealing with very difficult feelings that build up inside. People say different things about why they do it:

- Some say that they have been feeling desperate about a problem and don't know where to turn for help. They feel trapped and helpless. Self-injury helps them to feel more in control.
- Some people talk of feelings of anger or tension that get bottled up inside, until they feel like exploding. Self-injury helps to relieve the tension that they feel.
- Feelings of guilt or shame may also become unbearable. Self-harm is way of punishing oneself.
- Some people try to cope with very upsetting experiences, such as trauma or abuse, by convincing themselves that the upsetting event(s) never happened. These people sometimes suffer from feelings of 'numbness'

or 'deadness'. They say that they feel detached from the world and their bodies, and that self-injury is a way of feeling more connected and alive.

Who is at risk?

Self-harm is most commonly triggered by an argument with a parent or close friend. When family life involves a lot of abuse, neglect or rejection, people are more likely to harm themselves. Young people who are depressed, or have an eating disorder, are at greater risk. So are people who take illegal drugs or excessive amounts of alcohol.

Where can I get help?

Anyone who is harming themselves is struggling to cope and needs help. Self-injury is often kept secret – even from friends or family. The person feels so ashamed, guilty or bad that they can't face talking about it. There may be clues, such as refusing to wear short sleeves or to take off clothing for sports.

If you are a parent or teacher, you can help by:

- Recognising signs of distress, and finding some way of talking with the young person about how they are feeling.
- Listening to their worries and problems, and taking them seriously.
- Offering sympathy and understanding.
- Helping with solving problems.
- Staying calm and in control of your feelings.
- Being clear about the risks of self-harm – making sure they know that, with help, it will be possible to stop once the underlying problems have been sorted out.
- Making sure that they get the right kind of help as soon as possible.

It's important to make sure that the young person feels that they have someone they can talk to and get support from when they need it. Otherwise, there is a risk they will harm themselves instead. It's important to ask whether parents and family will be able to give the support that's needed. This may be difficult if there are a lot of problems or arguments at home. As a parent, you may be too upset or angry to be able to give the help that is needed. If so, you should seek advice from your General Practitioner.

Sources of Further Information

- National Self-Harm Network: PO Box 7264, Nottingham NG1 6WJ; email: info@nshn.co.uk
- The Young People and Self Harm information resource website: www.selfharm.org.uk
- Childline provides a free and confidential telephone service for children. Helpline: 0800 1111; www.childline.org.uk
- The Samaritans provide a 24-hour service offering confidential emotional support to anyone who is in crisis. Helpline 08457 90 90 90 (UK), 1850 6092090 (ROI); email jo@samaritans.org; www.samaritans.org.uk
- YoungMinds provides information and advice on child mental health issues. 102-108 Clerkenwell Road, London, EC1M 5SA. Parents' Information Service 0800 0182138; www.youngminds.org.uk
- A CD-ROM designed for 13-17 year olds on mental health which looks at depression and self-harm: *Changing Minds: A Multimedia CD-ROM about Mental Health*. Further details from the Royal College of Psychiatrists: tel. 020 72352351, ext.146; www.rcpsych.ac.uk/usefulresources/publications/books/multimedia.aspx

Or you may like to look at these websites:

www.lifesigns.org.uk

www.nshn.co.uk

www.selfharmalliance.org

- The Mental Health and Growing Up Series contains 36 factsheets on a range of common mental health problems. To order the pack, contact Book Sales at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG; tel.020 7235 2351, ext.146; fax 020 7245 1231; email: booksales@rcpsych.ac.uk , or you can download them from www.rcspych.ac.uk

If you are a teacher, it is important to encourage students to let you know if one of their group is in trouble, upset or shows signs of harming themselves. Friends often worry about betraying a confidence and you may need to explain that self-harm can endanger their lives. For this reason, it should never be kept secret.

Specialist Help

If you feel that more professional help is needed, the General Practitioner should be able to tell you what help is available locally, and make a referral to your local child and adolescent mental health service.

The aim is to discover the causes of the problems. It is usual for parents or carers to be involved in treatment. This makes it easier to understand the background to what has happened, and to work out what sore of help is needed.

There are different talking approaches, depending on what is causing the problem. Treatment often involves both individual and family work. Individuals will need help with how to cope with the very difficult feelings that cause self-harm. Families often need help in working out how to make sure that the dangerous behaviour doesn't happen again, and how to give the support that is needed. If depression or anxiety is part of the problem, these will need treating (see Factsheet 34 on depression in children and young people). Occasionally, intensive help may be needed. Sometimes, recovery from very damaging or traumatic experiences happens slowly. Then specialist help is needed over a longer period of time.

References

Carr, A (ed.) (2000) What Works with Children and Adolescents? A Critical Review of Psychological Interventions with Children, Adolescents and their Families. London: Brunner-Routledge.

Rutter, M. & Taylor, E. (eds) (2002) Child and Adolescent Psychiatry (4th edn). London: Blackwell.

Scott, A., Shaw, M. & Joughin, C. (eds) (2001) Finding the Evidence: A Gateway to the Literature in Child and Adolescent Mental Health (2nd edn) London: Gask.

FACTSHEET

Suicide and Attempted Suicide

This is one in a series of factsheets for parents, teachers and young people entitled Mental Health and Growing Up. The aims of these factsheets are to provide practical, up-to-date in formation about mental health problems (emotional, behavioural and psychiatric disorders) that can affect children and young people. This factsheet looks at the reasons behind why people try to kill themselves, and offers advice about what to do to help someone who you feel might be at risk of attempting suicide.

INTRODUCTION

Why do people try to kill themselves?

Nearly everyone has times when they feel sad and lonely. Sometimes, it can feel as if no one really likes us, that we are a failure that we just upset people and that no one would care if we were dead. We may feel angry but unable to say so, or feel hopeless about the future.

It is feelings like these that make some young people try to kill themselves. Often, several upsetting things have happened over a short time and one more upset or rejection is the 'last straw'. An argument with parents is a common example; another is breaking up with a friend, or being in trouble. Teenagers who try to kill themselves are often trying to cope independently with very upset feeling or difficult problems for the first time. They don't know how to solve their problems, or lack the support they need to cope with a big upset. They feel overwhelmed and see no other way out.

Often, the decision to attempt suicide is made quickly without thinking. At the time, many people just want their problems to disappear, and have no idea how to get help. They feel as if the only way out is to kill themselves.

The risk of suicide is higher when a young person:

- Is depressed, or when they have a serious mental illness – if they get the help and treatment they need, the risk can be greatly reduced.
- Is using drugs or alcohol when they are upset.

- Has tried to kill themselves a number of times or has planned for a while about how to die without being saved.
- Has a relative or friend who tried to kill themselves.

Is this just attention-seeking?

No. Attempted suicide should always be taken seriously. The young person needs someone to understand what they have been feeling, although they might find it hard to put into words. They need someone to listen, and who is prepared to help.

Who is most at risk?

- There has been an increase in the suicide rate in young men over recent years.
- Many young people who try to kill themselves have mental health and personality problems.
- Suicide attempts in young people nearly always follow a stressful event – usually relationship problems. However, sometimes the young person will have shown no previous signs of mental health problems.
- Sometimes, the young person has had serious problems (e.g. with the police, their family or school) for a long time. These are the young people who are most at risk of further attempts. Some will already be seeing a counsellor, psychiatrist or social worker. Others have refused normal forms of help, and appear to be trying to run away from their problems.
- Young people who are misusing drugs or alcohol have the highest risk of death by suicide.

How can I help?

- Notice when your child seems upset, withdrawn or irritable.
- Encourage them to talk about their worries. Show them you care by listening, and helping them to find their own solutions to problems.
- Buy blister packs of medicine in small amounts. This helps prevent impulsive suicides after a row or upset. Getting pills out of a blister pack takes longer than swallowing them straight from a bottle. It may be long enough to make someone stop and think about what they are doing.
- Keep medicines locked away.

- Get help if family problems or arguments keep upsetting you and your child.

For parents, it's hard to cope with a child attempting suicide and it's natural to feel angry, frightened or guilty. It may also be hard to take it seriously or know what to do for the best.

Specialist Help

Everyone who has tried to kill themselves, or taken an overdose, needs an urgent assessment by a doctor as soon as possible even if they look OK. The harmful effects can sometimes be delayed. Even small amounts of some medication can be fatal. Poisoning with paracetamol is the most common type of overdose in Britain. Overdosing with paracetamol causes serious liver damage, and each year this leads to many deaths. Even a small number of tablets can be fatal.

All young people who attempt suicide or harm themselves should have a specialist mental health assessment before leaving the hospital. The aim is to discover the causes of the problem. It is usual for parents or carers to be involved in treatment. This makes it easier to understand the background to what has happened, and to work out together whether help is needed.

A lot of young people make another attempt if they do not receive the help they need. Usually, treatment will involve individual or family work for a small number of sessions. A very small number of young people who try to kill themselves really do still want to die. Often, they are suffering from depression or another treatable mental health problem. They may need specialist help over a longer period of time.

Sources of Further Information

- The Samaritans provide a 24-hour service offering confidential emotional support to anyone who is in crisis. Helpline 08457 909090 (UK), 1850 609090 (ROI); email: jo@samaritans.org; www.samaritans.org.uk.
- Young Minds provides information and advice on child mental health issues. 102-108 Clerkenwell Road, London, EC1M 5SA; Parents' Information Services 0800 018 2138; www.youngminds.org.uk.
- A CD-ROM designed for 13-17 year olds on mental health which looks at depression and self-harm: Changing Minds: A Multimedia CD-ROM about Mental Health. Further details form the Royal College of Psychiatrists: tel 020 7235 2351, ext 146; www.rcpsych.ac.uk/usefulresources/publications/books/multimedia.aspx.

Or you may like to look at these websites:

www.lifesigns.org.uk

www.nshn.co.uk

www.selfharmalliance.org

- The Mental Health and Growing Up series contains 36 factsheets on a range of common mental health problems. To order the pack, contact Book Sales at the Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG; tel 020 7235 2351, ext 146; fax 020 7245 1231; email: booksales@rcpsych.ac.uk, or you can download them from www.rcpsych.ac.uk.

References

Carr, A. (ed.) (2000) What works with Children and Adolescents? A Critical Review of Psychological Interventions with Children, Adolescents and their Families. London: Brunner-Routledge.

Rutter, M. & Taylor, E. (eds) (2002) Child and Adolescent Psychiatry (4th Edn). London: Blackwell.

Scott, A., Shaw, M. & Joughin, C. (eds) (2001) Finding the Evidence: A Gateway to the Literature in Child and Adolescent Mental Health (2nd edn). London: Gaskell.

Department of Education
www.deni.gov.uk
AN ROINN Oideachais
MÄNNYSTRIE O Lear

PROTECTING LIFE IN SCHOOLS

Helping Protect Against Suicide
by **Supporting Pupils' Emotional Health and Wellbeing**

iMatter
promoting emotional health and wellbeing