Supporting Children who Self-Harm, including Suicidal Ideation Procedure and Practice Guidance
(Fostering & Adoption)

This procedure details the definitions of self-harm and suicidal ideation, the support and training available for foster parents/adopters/staff and the action to take if a child harms themselves or expresses thoughts of suicide.

The term 'child' or 'children' is used to refer to all children under the age of 18 years (16 in Scotland). Where the context specifically relates only to older children, the term 'young person' is used.

The term 'foster parent' is preferred but it is recognised that 'foster carer' is also used in legislation and within the community.

The term *'Adopters'* is used throughout procedures, but depending on the context, it may refer to potential adopters, prospective adopters, or those adopters for whom an adoption order has already been granted.

This procedure forms part of the Polaris Community Quality Management System in line with ISO- 9001:2015 standards and applies to all companies within the Community unless stated otherwise. All group companies are detailed in the current legal structure.

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Contents

What is Self-Harm? **4**

What is Suicidal Ideation? **4**

Self-harm and Suicide **6**

Support for foster/adoptive parents **6**

Immediate actions to be undertaken by the foster/adoptive parent if a child in their care harms themself **7**

Actions to be undertaken by SSW or equivalent **8**

Responding to, recording and reporting incidents of a child disclosing suicidal ideation **9**

Making a referral to Social Care (LA/Trust) is a priority when **9**

Child presenting at hospital **9**

Children who are reluctant to seek medical attention **10**

NICE Guidelines **10**

Review Dates ***10***

Appendix 1 Practice Guidance for Foster/Adoptive Parents **11**

What is Self-Harm?

There has been much debate about appropriate terms to use when considering self-harming behaviour (attempted suicide, deliberate self-harm, self-mutilation etc.). The problem with the term "deliberate self-harm" is that there is an implication of willfulness about it, which may be unhelpful to children if they have little control over their behaviour.

Similarly, the problem with the term "attempted suicide" is that some people take an overdose with little or no suicidal intent. They may plan to swallow pills when someone is in the next room, or when they know someone will come to look for them. Further, it is also important to understand that for some, the idea of suicide, is an 'answer' 'a way out of a particularly difficult time' and not always about actually wanting to die. It is important then to further consider the degree of suicidal intent when children self-harm as this will help to assess risk and clarify motivation.

Self-harm can refer to any behaviour where someone intentionally causes harm to themselves. It can be any behaviour, minor or high-risk, which causes injury or harm.

Staff should be aware that self-harm can take many forms, including the potential use of objects or materials that could present a strangulation or ligature risk. Any concerns regarding environmental safety or items that could be misused must be reported immediately, in line with safeguarding and risk assessment procedures.

Excerpt from the Introduction to the NICE Quality Standard [QS34], 2024

Self-harm refers to any intentional act of self-poisoning or self-injury, regardless of the person's motivation. This may include overdose or physical self-injury. The definition excludes accidental harm, disordered eating, substance misuse, or cultural practices like tattooing or piercing. Self-harm is associated with various mental health conditions, such as personality disorders, depression, bipolar disorder, psychosis, and substance use disorders. People who self-harm are at significantly increased risk of suicide, especially within the year following an incident.

What is Suicidal Ideation?

Suicidal ideation means wanting to take your own life or thinking about suicide. However, there are two kinds of suicidal ideation - Passive and Active:

- Passive suicidal ideation occurs when a person wishes they were dead or that they could die, but do not actually have any plans to commit suicide
- Active suicidal ideation, on the other hand, is not only thinking about it but having the intent to die by suicide, including planning how to do it

A well-regarded approach to understanding how suicidal thoughts develop and how they may escalate into suicidal acts is called the Integrated Motivational-Volitional (IMV) Model.

The IMV model distinguishes **three phases** in the pathway to suicide:

1. **Pre-Motivational Phase**
2. **Motivational Phase**
3. **Volitional Phase**

Each phase involves specific processes and factors that influence whether a person **thinks about suicide** and whether they **act on those thoughts**.

The model helps explain how someone might go from feeling overwhelmed to thinking about suicide, and eventually, in some cases, acting on those thoughts. It shows that suicidal behaviour usually doesn't come out of the blue—it often starts with a mix of long-term difficulties (like past trauma or mental health struggles) and triggering events (like a breakup or job loss). When someone feels completely trapped and can't see a way out, suicidal thoughts can develop. Whether those thoughts turn into action depends on other things, like access to help or support, impulsivity, or knowing how to carry it out. The model helps professionals focus support at different stages to keep people safe and help them feel less stuck and alone.

Approximately three quarters of children who die as a result of suicide are male and the most common methods of suicide are asphyxiation, for example by hanging, followed by overdosing.

The Office for National Statistics (ONS) reports that suicide remains one of the leading causes of death among children and teenagers. Recent data show sustained or rising rates following earlier declines, with registered deaths now available up to the end of 2023.

- For children aged 10–17 in England (2011–2023), boys have consistently had higher suicide rates than girls. Males with special educational needs (SEN) remain around 1.5 times more likely to die by suicide than those without (ONS, 2023).
- The Royal College of Paediatrics and Child Health (RCPCH) highlights a continuing resurgence in suicide among males aged 10–14, with increases seen across all genders since 2018.
- Near real-time surveillance data (to late 2024) suggest that suicide rates among young people (10–24) have remained relatively stable in the past year but persistently higher in males.

In the general population, suicide attempts vastly outnumber suicide deaths, with global estimates suggesting around **20–25 attempts for every suicide** (i.e. roughly 1 in 20–25 attempts is fatal) [World Health Organization, 2025; Nock et al., 2008]. Research consistently shows that young people who have experience of being in care or known to child welfare services face a much

higher risk of suicide. A recent meta-analysis found that care-experienced children and young people are more than **three times as likely to attempt suicide** as their peers, with some studies reporting risks closer to four or five times higher [Evans et al., 2017; Evans et al., 2021].

Self-harm and Suicide

Self-harm and suicide are often thought to be the same, or that one inevitably leads to the other. This is not the case. For many people, **self-harm is primarily a coping mechanism** — a way of managing or expressing intense emotional distress. Its function is often to relieve pressure and prevent suicidal behaviour, rather than being an attempt to end life.

However, some individuals who self-harm may also feel suicidal, particularly if they reach a point where they feel unable to cope at all. In these situations, suicidal ideation (thinking about suicide) may develop. In some, but not all cases, suicidal thoughts may progress to a suicide attempt.
It is important to note that **self-harm itself does not directly cause suicidal feelings or behaviours**. Rather, both self-harm and suicidal ideation often stem from the same underlying issues — such as abuse, bullying, financial difficulties, or other significant life stressors.

Support for foster/adoptive parents

All those caring for children who have a history or are considered to be at risk of harming themselves should have completed the 'Introduction to Self-Harm ' and 'Suicide Prevention' training courses. If possible, foster/adoptive parents should complete the training prior to the child coming into their care. If not, within a maximum of 1 week, dependent on the level of risk. This should be agreed at the point of the match being approved. Following completion of these online courses, the Supervising Social Worker (SSW) will have discussed the learning and specific safer caring practices as part of the supervision with foster parents. Adopters, who do not receive regular supervision, will complete the courses independently, but are still expected to apply the safer caring principles in their family setting.

Foster parents/adopters should be aware that the organisation offers in-house anti-ligature training. While this training is not generally required for foster parents or adopters, it can be made available on request if they and the agency feel that, due to high level concerns, it would help them support a child or young person safely. Any requests for this should be discussed with your local Safeguarding Lead before contacting the Learning and Development Team.

Agencies also deliver face-to-face training and can provide bespoke one-to-one training if necessary. In addition, an informative and helpful guide 'Coping with self-harm; A Guide for Parents and Carers' has been developed by researchers at the University of Oxford, is available to download: Coping with Self-Harm: A Guide for Parents and Carers – Highly Commended by the BMA | Oxford Health NHS Foundation Trust

The Agency therapist may in some situations be available for consultation and support as part of the wider multi-agency plan around the child. If deemed necessary, the SSW or equivalent will increase their level of contact with the family.

If specialist therapeutic support is provided for the child e.g. CAMHS, the foster/adoptive parents will be able to seek support and guidance from the child's therapist.

Immediate actions to be undertaken by the foster/adoptive parent if a child in their care harms themself

Foster/adoptive parent determines that immediate medical treatment not required	**Foster/adoptive parent determines that immediate medical treatment is required**
Foster/adoptive parent informs their SSW or equivalent (or OOH) and the child's SW (or EDT)	Foster/adoptive parent calls for emergency services or takes the child to the nearest accident and emergency department
Foster/adoptive parent contributes to the professional's immediate assessment of risk	Foster /adoptive parent informs their SSW or equivalent (or OOH) and the child's SW (or EDT)
Usually, the child should be seen by their GP as soon as possible; this will be determined by the professionals involved. This may or may not result in a referral to specialist Child and Adolescent Mental Health Services	Foster/adoptive parent contributes to the professional's immediate assessment of risk
Foster/adoptive parent keeps all professionals updated with the progress and medical guidance / intervention	Medical professionals provide medical treatment and determine whether the child should be admitted to hospital for a therapeutic assessment. It may not be considered to be in the child's best interest to be admitted to hospital. This decision should be taken in consultation with CAMHS practitioner/ CAMHS Crisis Team / equivalent and LA / Trust SW
	Foster /adoptive parent keeps all professionals updated with the progress and medical guidance / intervention
Foster parent records full details of the incident in the child's Charms record'	

Actions to be undertaken by SSW or equivalent

- Complete an immediate assessment of risk
- Provide practical and emotional support to the foster/adoptive parent (and child, if appropriate), providing comfort and reassurance to the child as they navigate their emotional distress
- Record details of the incident on the child's record in Charms:
    - If medical treatment is given and / or specialist support provided at hospital then the incident is notifiable to the Inspectorate (Cymru, England and Scotland). This applies to both Fostering/Adoption (pre-adoption order). External notifications to be made within 24 hours, or the next working day if the event arises over a weekend
    - If this is not the case, the incident is recorded as a monitoring event (refer to Monitoring and Notifiable Event Procedure or equivalent for further details)
- Consider any support needs for the fostering/adoptive family, the child and any other child being cared for e.g. therapist, additional support calls / visits, support worker, CAMHS
- If agreed with the child's SW, visit and speak with the child
- If the immediate assessment of risk determines that other intervention may be required, the SSW or equivalent /child's SW to request that a multi-agency meeting is convened
- Consult with line manager regarding any 'Safety Plan'; line manager will consult with the Responsible Individual, Quality Assurance Team / Fostering Practice Transformation Managers for high-risk cases
- Review the child's ISRAMP (for Fostering) and equivalent for Adoption, agree any new / changes to risk management and harm reduction strategies in consultation with CAMHS, Therapists, foster/adoptive parents, child's SW and child (if appropriate) - any harm reduction strategy should be determined by CAMHS / Therapy services, if they are involved
- If CAMHS / Therapy Services are not involved, consider whether to seek consultation / referral
- In consultation with the line manager, consider whether the incident meets the threshold for reporting to senior managers via the incident portal
- Ensure the incident, strategies and any concerns are fully explored with the foster parent during their supervision
- For Fostering- Ensure that any safer caring strategies and / or safety plans are made known to other adults who may provide care for the child e.g. sleep over foster parents, foster parent support persons, new foster parents
- Ensure that the child's ISRAMP or equivalent is frequently reviewed to ensure it always reflects the current agreed safer caring strategies and / or safety plans
- Ensure that regular multi-agency meetings take place
- Ensure that the Registered Manager/Head of Service has oversight of all serious and significant incidents

Responding to, recording and reporting incidents of a child disclosing suicidal ideation

- All disclosures must be taken seriously and within the context that they are made
- The immediate response should be calm and supportive and consider the need for any urgent interventions, including an urgent referral to GP and CAMHS

- Foster/adoptive parents (pre-adoption order) must inform their SSW or equivalent and the child's social worker as soon as practicable. If outside of usual working hours, then the Out of Hours Service must be informed.
- Foster parents will record the details in the child's Charms record'
- SSW or equivalent will record the detail as a 'monitoring event' (refer to Monitoring and Notifiable Event Procedure for details) and discuss any concerns with their line manager.
- SSW or equivalent will consider any support needs for the fostering family, the child and any other child being cared for e.g. therapist, additional support calls / visits, support worker
- If agreed with the child's SW, SSW will visit and speak with child
- If the immediate assessment of risk determines that other intervention may be required, the SSW or equivalent /child's SW to arrange a multi-agency meeting

Making a referral to Social Care (LA/Trust) is a priority when

- A child's levels of distress are rising, high or sustained
- The risk or actual self-harm is significant and has caused or is likely to cause severe injury
- The risk of self-harm is increasing or unresponsive to attempts to help
- The level of self-harm incidents increases in frequency and / or severity
- The person requests further help from specialist services
- The levels of distress in those caring for a child are rising, high or sustained despite attempts to help

Child presenting at hospital

Where a child or young person presents at hospital, the healthcare professionals should undertake an assessment and can seek further advice from CAMHS, including in an emergency out of hours.

Guidance from the National Institute of Health and Care Excellence (NICE) should be followed (see hyperlinks below). For example, triage, assessment and treatment should be undertaken by paediatric nurses and doctors trained to work with children who self-harm, ideally in a separate area of the emergency department for children and children.

If hospital admission is appropriate all children under 16 years should be admitted into a

paediatric ward under the overall care of a paediatrician and assessed as soon as is practicable. Alternative homes may be needed in some situations, depending on the child's age, circumstances and physical/mental health, this may include a young person between 16-18 years being on a children's ward subject to their specific needs and choice.

A mental health professional should undertake a preliminary examination and decide what further assessment is required.

In cases of attempted suicide a hospital admission will usually be arranged to enable a psycho-social assessment, which should consider whether or not the child is at risk of significant harm and the need to refer to CAMHS and/or children's social care for assessment. CAMHS should provide a prompt assessment once a referral has been made by a hospital on child who has been admitted following a suicide attempt or serious incident of self-harm.

Children who are reluctant to seek medical attention

- Foster/adoptive parents must encourage children to attend A and E in order to ensure that any necessary medical attention is given and that a CAMHS assessment is triggered
- The response must be in accordance with the risk management strategies within the ISRAMP and/or any other risk management plan
- If a child refuses to do so then this must be immediately discussed with the SSW, LA/Trust SW, CAMHS, Out of Hours, as applicable to resolve the matter and decide a way forward
- If urgent medical care is required, then this must be requested and accessed by the foster/adoptive Parent contacting emergency services if the child refuses to attend.

NICE Guidelines

National Institute for Clinical Excellence (NICE) has produced clinical guidance on treating those who self-harm.
NICE (2004) Self-Harm: the short term physical and psychological management and secondary prevention of self-harm in primary and secondary care.
Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Review Dates

15/12/25 - Reference to Anti -Ligature Training added in Support for foster/adoptive parents section.

Appendix 1 Practice Guidance for Foster/Adoptive Parents

How to Help

It is unhelpful to view children who self-harm as attention seeking or manipulative. It is more helpful to think that the child who has self-harmed is **in need of attention and support.** Trying to understand the underlying emotional distress, the possible reasons for the self-harming behaviour and that this is a communication of inner turmoil is important. The meaning of behaviour varies with each individual, and it is important that those around the child respond in a supportive way as they gain greater understanding of the complex emotions underlying this coping strategy. The Agency takes a combined approach of supporting a child's emotional and mental wellbeing and strategies of harm reduction overseen by a therapist / CAMHS. This view takes account of the need for the individual to find less harmful ways to cope with their feelings while they attempt to live a more positive life. The emphasis is one of managing the self-harm behaviour by encouraging the use of alternative coping strategies by the individual and a consistent, supportive approach from the adults in the network.

Talking About Self-Harm

Children who self-harm will usually find it difficult to talk about their actions, either to adults or peers. They may experience different emotions such as shame, fear, self-loathing and disgust. Often, they are more likely to talk with a peer whom they trust because they are worried about the response of adults. This may be more so for children in foster/adoptive care. They may worry about the consequence of disclosing; will they have to move homes, will more questions be asked about their past, who else may be told? They may be frightened of being labelled as mentally ill, suicidal or attention seeking and bad experiences in the past may make it difficult for them to trust people. Disclosures can be challenging for adults to receive and evoke challenging feelings.

It is important for adults supporting children to be able to discuss this and get support from professionals around them to cope so that they are well resourced to offer children and calm and consistent response. Disclosure can initially make the child 's circumstances worse, for example, relationships may become more strained; worry about what will happen next may increase the child 's self-harm; reporting bullying may make things more difficult at school for a short period of time, etc. However, once the initial hurdles are overcome it can also make it possible to draw on support in order to deal with their self-harm – even if the support is informal (from friends and/or family). It is very important not to focus exclusively on the self-harm itself but on the reasons why the child has self-harmed. The fact that the child has been able to disclose shows strength and courage. It is equally important that people hearing a disclosure allows the child to take the discussion at their own pace and direction. One of the things that self-harm offers children is a way to feel in control of something in their lives. Therefore, many fear that by disclosing their self-harm they will lose this control.

This previously secretive act becomes effectively 'public property' and the people around them begin to try to stop their self-harm. Staff and foster/adoptive parents need to ensure that children continue to be involved in all decision-making and are consulted about the services that might be contacted, and about the exact sort of help and information that would support and help them deal with their self-harm. It needs to be made clear who else will be told or involved after they have disclosed private and sensitive information. A lack of control could exacerbate the self-harm by causing further distress. It is also apparent that many children who self-harm are afraid that the only coping strategy (even if maladaptive) that has been keeping them functioning, might be taken away from them.

The response to a disclosure of self-harm is crucially important to supporting the child and promoting their well-being. The reaction a child receives when they disclose their self-harm can have a critical influence on whether they go on to access supportive services. Children who have self-harmed look for responses that are non-judgemental, caring and respectful, acknowledging their pain and distress.

Indicators of suicidal intent (youngminds.org.uk)

- always talking or thinking about death
- deep depression and sadness
- losing interest in daily life
- having increasing trouble sleeping and eating
- feeling helpless or worthless
- self-harming
- feeling angry and that things can't change

Talking about suicide (Papyrus-uk.org)

Lots of people worry that asking and talking about suicide will make suicide more likely to happen – but this isn't the case. Asking a direct question that requires a yes or no answer will ensure that there is no confusion and that the person will understand you are asking them about suicide and nothing else. Potentially, sharing these feelings with someone for the first time may give that young person a huge sense of relief. For many years, people have believed that asking about suicide could put the idea of suicide into someone's head. This is not the case. If someone is thinking of suicide, they're already thinking about suicide. It's not always easy to know if someone is suicidal. After all, we cannot read other people's minds to truly understand how they are feeling in any given moment.

Recent research has indicated that asking a young person if they are experiencing thoughts of suicide can actually reduce the risk of them ending their life. Asking and determining if that person is feeling suicidal gives you the opportunity to explore those feelings further and support them to stay safe. The SSW or equivalent and foster/adoptive parents must seek advice from the Agency therapist and / or CAMHS and agree with the child's social worker who is best placed to speak with the child and how such a conversation should go.

Responding to self-harm incidents

In the short term:

- Remain calm and constructive - do not panic
- Recognise the person as an individual
- Show respect for the person's self-injury behaviour and that you recognise it as a coping mechanism
- Listen to them
- Show genuine concern for an individual's injuries while ensuring verbal and non-verbal communication is congruent. Responses should be consistent, empathetic, and free of judgment. Be aware that words of reassurance paired with visible shock may undermine trust and discourage disclosure
- However, show responsibility for your own feelings so that the person doesn't take the blame for them
- Offer practical help with any injuries and advise about risk reduction, explaining the risks of self-injury
- Try to explore the triggers and develop ways to avoid them
- Encourage the child to talk but don't force them. Children are used to being judged and criticised; show them that you take their problems seriously without doing either
- Reduce the child's feelings of powerlessness by consulting and acting on their views
- Do not let their behaviour or the ways you deal with it make you lose sight of the child themselves - who should always be treated with calmness, care, respect and compassion

Long term responses:

- Explore current patterns of self-injury behaviour
- Help the child to explore alternatives to self-injury
- Congratulate any progress made, no matter how small, when appropriate
- Do not fall into the trap of seeing the child's self-injury as the sum of their existence
- Support the child to think through the consequences of any self-harm attempts
- Support the child through any therapeutic work
- Reduce social isolation of the child
- The importance of a healthy and well-balanced diet to mental well-being has become increasingly recognised over the past decade. Low self-esteem, moods swings, depression, anxiety and restlessness - which can be related to diet – may be triggering factors for self-harm.
- Offer to find appropriate information for them (be mindful of internet sites, some are more harmful than helpful)
- Encourage the child to access professional help
- Offer to go with them to see a health professional or counselling service

Foster/adoptive parents should remember all the skills and experience they have already acquired and use them by:

- Giving praise to, and valuing, the individual
- Recording carefully to identify patterns/concerns
- Providing opportunities to talk
- Showing in your daily life that there are other ways of coping with the stresses and problems of life
- Talking with children, not at them
- Actively listening
- Keeping the SSW or equivalent and the child's Social Worker informed
- Encourage and create opportunities to talk, doing so at the child's pace and in their time and place
- Think and encourage other ways of communicating and expressing feelings, for example through writing (letters, diary and poetry) or other activities such as art, music or dance. Or provide a punch bag or cushion
- Think about who else they may feel comfortable talking to
- Be sympathetic and understanding to the feelings of shame, guilt and confusion caused to the child by their problems and self-harming behaviour
- Provide practical care and comfort – a favourite meal, a bath

Specific advice following an episode of self-harm or attempted suicide

- In the immediate crisis there are several things to deal with – trying to dissuade the children from self-harming and trying to distract them, getting help, dealing with the emergency services, notifying the relevant people, supporting the child through any medical examination and treatment at hospital. A decision about medical intervention needs to be made early on
- Where a self-harming episode has required hospital treatment, the foster/adoptive parent or the child may subsequently feel that they just want to get home; but before doing so a better move may be for the child to have a thorough psychological assessment by a trained mental health professional (i.e. a CAMHS practitioner). Serious episodes of self-harm, where the child is treated in A&E, may involve waiting for a psychiatric assessment taking place after the physical wound has been treated
- Foster/adoptive parents may be fearful of another attempt at self-harm so an assessment will provide some guidance. for them, and it also shows the child that the problem is being taken seriously.

Afterwards

It is not always easy to cope with the aftermath of a serious incident of self-harm or attempted suicide as it creates additional problems; family life will not feel the same again for a while. However, by using their skills and being patient, it is possible to help for the foster/adoptive parent and their family to help the child to:

- Have a sense of being taken seriously
- Feel supported so as to feel that things will be right again, by getting a sense of perspective and a future
- Feel loved and attached to people who would be hurt by their behaviour

Unfortunately, even everyone's best efforts cannot prevent recurrences of self-harm. It is therefore important to equip those who self-harm with the knowledge that those caring for them will be there for them when they need them and that they can deal with the situation. Foster/adoptive parents may also need to be aware of group dynamics and the possibility that children may copy the behaviour of other children in their home or wider social circle.

Some children appear to reduce, and then finally stop, their self-harm gradually over time, without any formal interventions or prevention strategies from professionals or organisations. This may reflect changes in the child's environment; as the result of moving home, changing schools, finishing examinations, going to university, changing jobs and/or changed financial circumstances, which have the effect of alleviating the underlying problem that caused them to self-harm. This is particularly relevant to the children whose self-harm stems from multiple, interlinked causes. Once one or two of the original factors (such as their family situation, or bullying at school) are removed, they may be in a position where they do not feel they have to use self-harm as a coping strategy (Mental Health Foundation, 2006).