



Supporting armed forces children & young people

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1. Background

Forces Children Scotland is committed to the protection of babies, children and young people. Our mission is to improve the interests and wellbeing of children, their families and communities.

Within the spectrum of children and young people from regular, reservist and veteran families, some are particularly vulnerable to risks from a range of actions and behaviours associated with self-harm and suicide. These include those who:

- Threaten to self-harm, including threats of suicide
- Engage in self-mutilation (self-cutting, bloodletting)
- Express suicidal ideation
- Attempt suicide
- Other acts of self-harm

This policy has been informed by:

- The National Child Protection Guidance
- [Scotland’s Self-Harm Strategy and Action Plan 2023-2027](#)
- [Self-Harm Network Scotland](#)

Self-harm - Self-harm is a broad term that can be used to describe a variety of behaviours that lead to physical harm. These include self-cutting or scratching the skin, burning/branding with cigarettes/lighters, scalding, overdose of tablets or other toxins, tying ligatures around the neck, punching oneself or other surfaces, banging limbs/head and hair pulling (Mental Health Foundation, 2006). It may also include risk taking behaviours where the child / young person is careless for their own safety and there is a risk of physical harm. It also includes neglect of physical health for example young people with insulin dependent diabetes who intentionally miss insulin doses, or the restriction of nutritional intake as part of disordered eating. Some forms of self-harm may be considered ‘socially acceptable’ such as tattooing and piercings, however it does not mean that all tattoos or piercings are forms of self-harm; it is about the intention behind them.

Self-harm is not a mental health condition or illness, but a range of behaviours that can be an indicator of poorer mental health and wellbeing or can sometimes occur as a result of mental illness or learning disability. Self-harm usually occurs in response to emotional distress. Self-harm is complex and varies widely from individual to individual. It can serve a variety of functions, including but not limited to:

- Coping with or distracting from distressing emotions or circumstances, including traumatic or adverse experiences
- Regulating emotions or providing release of distressing emotions which have been bottled up
- Comfort or restoring calm by taking care of their injuries. For some people, providing care to oneself following self-harm can be helpful and nurturing (and can be a way to protect against suicide)
- Communicating feelings that are difficult to articulate or have not been listened to
- Gaining control or agency over one's body, feelings or circumstances
- A compulsion or habitual behaviour (self-harm often releases endorphins and dopamine which provide relief and can serve as reinforcement of this behaviour)
- A form of self-punishment, usually linked to feelings of shame, guilt, disgust, self-hatred or low self-esteem
- Cleansing oneself of traumatic or adverse experiences or memories
- A way to feel real, present, alive or escape dissociation/numbness

(Adapted from [Scotland's Self-Harm Strategy and Action Plan 2023-2027](#) and [Self-Harm Network Scotland](#))

Suicide / Suicidal Ideation - The term 'suicide' means an act that is intended to end one's life. Suicidal ideations, often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide (PubMed, 2021).

For some people, the line between a suicide attempt and an act of self-harm is blurred. Some people may not be sure of the outcome they intend, have resigned themselves to 'what will be will be', or their desired outcome may change either over time or even within a single episode.

As a relationship-based organisation, children may take the opportunity to share information about their self-harming and/or suicidal thoughts and behaviours. This may happen in a direct way through verbal disclosure, a questionnaire/assessment tool or there may be physical evidence or apparent injury, which is noted by a member of staff. Forces Children Scotland considers it the duty of all those employed or involved with the organisation to safeguard the wellbeing of all children and young people with whom they come into contact.

Those with lived experience of self-harm ask to be met with compassion and care, in a safe space, without stigma or judgement. When offered support and enabled to make changes for themselves, when they know that support isn't too hard to access and they won't be sent away, then everyone has the same chance to discover a new journey and learn a way forward that works for them. This policy is written with that in mind.

This policy should be read in conjunction with the Safeguarding and Child Protection Policy.

2. Purpose and application of Policy

This policy has been developed to provide information and detail practice requirements regarding the management of children and young people who engage in self-harming behaviours or threats of suicide.

The purpose of this policy is to:

- Provide a framework for self-harm and suicide risk mitigation.
- Provide information about reducing the risks of injury or death and ensuring the safety and wellbeing of those using the service.
- Ensure all staff how to identify and respond to children and young people at risk of self-harm or suicide, and when it is appropriate to break confidentiality and when to refer to mental health services.
- Outline the reporting requirements.
- Reduce the level of uncertainty and stress for staff in working with children and young people who self-harm and express potentially suicidal behaviour.

We are fully accountable for ensuring appropriate actions are taken by us in order to safeguard any of our service users. This may also include ensuring our partner agencies have taken appropriate actions.

This policy will apply to all children and young people up to the age of 18. For any concerns relating to a young person aged 18 years or above, please refer to our Adult Safeguarding Policy.

Forces Children Scotland takes a children's rights approach to safeguarding and promoting the welfare of every child. A children's rights approach means keeping the best interests of the child and their views in focus when making decisions and working in partnership with them and their families. We will take a careful, evidence-based, person-centred and trauma-informed approach within our actions, which will focus on helping people to find safer ways to manage their distress, over time, and with the right support.

We recognise that:

- The welfare of the child is paramount where their best interests and views do not align.
- All children, regardless of age, disability, gender, race, religion or belief, sexual orientation or identity, have the right to equal protection from all types of harm or abuse.
- Working in partnership with children, young people, their parents, carers and other agencies is essential in promoting young people's welfare.
- Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues.
- All suspicions and incidents of self-harm or suicidal ideation will be taken seriously and responded to swiftly and appropriately.
- It is **everyone's** responsibility to promote and safeguard the welfare of children.

3. Prevalence and Risk Factors

We know that self-harm can affect anyone, from any background, any gender and at any age. The most recent Scottish Health Survey reported that 25% of 16- 24-year-olds and 10% of adults said they had ever self-harmed. Data also suggests self-harm rates are rising. However, the evidence also suggests that with the right care and support most people can and do stop self-harming.

The available evidence, including robust qualitative evidence, also highlights further important aspects of prevalence. For example, self-harm appears to be most prevalent among young women, with girls over 3 times more likely to report self-harm than boys. Marginalised people are also at increased risk, this includes neurodiverse people, LGBT+ people, people who are care experienced, those involved in the justice system, and people experiencing severe and enduring mental illness. In addition, we understand that there can be higher rates of self-harm among people who have experienced childhood adversity or trauma. Furthermore, people who are affected by a range of 'social determinants' for poorer mental health also have a higher prevalence of self-harm. Evidence shows that socioeconomic status can be a factor. For example, people living in the most deprived areas have a higher prevalence of self-harm (17%) compared to those living in the least deprived areas (4%). Additionally, life events particularly those that can lead to stress and worry can increase the risk of self-harm. ([Scotland's Self-Harm Strategy and Action Plan 2023-2027](#)) These actions and behaviours can also be displayed by young children.

Given the level of harm that can result from these actions and behaviours, working with and responding to these behaviours requires specific, intensive and strategic planning and casework. Two major considerations in responding to and managing self-harming behaviours and threats of suicide are harm reduction and duty of care.

Engagement with those with lived experience has shown that the word 'prevention' in relation to self-harm can inhibit people from seeking help, especially if they fear they will be told to immediately stop self-harming. Many people use self-harm as a way to cope. Taking away a means to cope without first offering support to develop other ways to manage can be detrimental. Therefore, a harm reduction approach which helps to minimise the risk of significant injury or infection from self-harm, while still permitting the child or young person to self-harm at the same time as learning alternative coping strategies is the most beneficial approach. Some people may continue self-harming until there is a change in their circumstances.

Duty of care is a legal and ethical obligation for health and social care professionals to ensure the safety and well-being of those they support, acting in their best interests and preventing harm. Duty of care involves actions like reporting neglect, promoting well-being through access to resources, obtaining informed consent, and keeping accurate records, all contributing to a safe and supportive environment for individuals in care.

4. Threats of Self-Harm / Actual Self-Harm or Suicidal Ideation

Threats of self-harm and actual self-harm involve a range of actions, along a continuum, from thoughts about self-harm to a display of self-harming behaviours, to suicide attempts. By definition, self-harm requires not only the self-infliction of injury (to varying degrees of intent), but also importantly, an awareness of motive. The issue of awareness of motive is significant because it is what distinguishes self-harming behaviours from other types of behaviours often associated with and grouped as adolescent risk taking and experimental behaviours.

Experimental and risk-taking behaviours can frequently become extreme and result in significant levels of harm. It does not equate to every child who engages in extreme risk-taking behaviour intentionally wanting to self-harm. Some displays of behaviours such as self-cutting, self-strangulation or deliberately placing oneself in harm's way, can be relatively easy to define as an act of self-harm. Other types of high-risk activities, which result in harm, may be more difficult to define as either intended acts of self-harm or experimental risk-taking behaviour, for example, substance (mis)use or reckless behaviour.

We will seek to safeguard children and young people who self-harm or have suicidal ideation by:

- ensuring a culture of respecting, listening to and engaging in dialogue with children.
- responding to all allegations and concerns, swiftly and appropriately.
- sharing information about concerns with agencies who need to know when appropriate and involving parents and children appropriately.
- providing effective management for staff through supervision, support and training, including SAFETALK and ASSIST.
- following appropriate whistle blowing procedures and ensuring a culture that enables issues about the protection of children to be addressed.
- appointing a Designated Safeguarding Officer and providing Education, Training and Support to that person.
- monitoring and reviewing the operation of this policy.

It is essential that everyone is aware of their duties concerning this policy and ensure that:

- the safety and wellbeing of the child is promoted.
- the law and statutory guidance concerning child protection and safeguarding is complied with.
- Forces Children Scotland recognises the statutory responsibility of Local Authority Social Work and Police Scotland to ensure the welfare of children, and it is committed to complying with Local Area Child Protection Procedures.
- all staff and volunteers comply with this policy.

Disclosures or concerns arising out of all aspects of our work will be treated the same and are all covered by the policy.

Whistleblowing – If you are concerned of a wrongdoing or that appropriate action has not been taken to deal with a self-harm or suicidal ideation concern, then this is when whistleblowing should take place. This is sometimes referred to as 'making a disclosure' or 'blowing the whistle'. The wrongdoing will typically (although not necessarily) be something you have witnessed at work. Please see Forces Children's Scotland's Whistleblowing Policy for further information.

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5. Assessing Risk Factors and Developing Management Plans

The reasons why children and young people from regular, reservist and veteran families present with self-harming behaviours is under-researched and as such not well understood. The reasons for self-harm are often complex and varied but generally related to a combination of factors which include:

- Past experience of and on-going trauma.
- Significant and continuing stressors in their lives.
- Inadequate or poorly developed emotional or behavioural capabilities.
- Absence of self-care.
- Emerging or diagnosed psychiatric or psychological disorder.
- Lack of appropriate support networks.
- Lack of other coping mechanisms to moderate or address the behaviours.

Self-harm is, in essence, a means of communicating distress, and the task of all professionals is to help the person reveal more about the underlying issues. Identifying the potential likelihood or probability of self-harm requires an assessment of a range of factors indicating risk and need and an assessment of the risk opportunities. This assessment will form the basis of a Safety Plan to mitigate the risks.

Forces Children Scotland believes that every person who self-harms and/or has suicidal thoughts should have a Safety Plan, which gives specific personalised advice on how the individual's risk of self-harm and suicide can be reduced.

The components of a Safety Plan are:

- Identifying the signs that may indicate when an episode of self-harm is more likely (also known as triggers). Further work utilising appropriate assessment tools which assist in gauging and monitoring behavioural patterns, for example, to ascertain when levels of anxiety or stress may be heightened may be helpful.
- Coping strategies to reduce, prevent, or avoid the conditions and times in which the self-harming behaviours may regularly occur, such as planned structured activities at those times, identifying

things to lift or calm mood, things that have helped in the past, ways others can help you and identifying positive distractions.

- Identifying ways to make your situation safer e.g. removal of sharps or medications.
- Reasons for living and/or ideas for getting through tough times.
- Steps for managing potential significant harm, such as a safe place to go to when in crisis or telephoning help-line numbers, 999 or speaking to an identified safe person.
- A plan for when it is necessary to take the child to Accident and Emergency or make a referral to an external agency.

When formulating a Safety Plan consideration should be given to the coordinated and collaborative input of any professionals who may be involved or have expertise to offer.

6. Involvement of Other Agencies and Professionals

Children and young people who display self-harming or suicidal behaviours may already be involved with other services that have expertise to offer in addressing or reducing such behaviours. If a child or young person is not involved with such services, practitioners should consider making referrals or seek consultation with such services as part of the best interests planning.

The involvement of these services on a consultancy basis or as part of the care team in developing intervention strategies and case management plans is essential to attaining the best outcomes for the child or young person involved. It is essential that other agencies and professionals acknowledge that they have a significant role in assisting to formulate intervention strategies and implementing agreed management plans as part of joint working.

Some partnership agencies such as schools and healthcare professionals may have their own versions of Safety Plans. It's important to share Safety Plans made with the child or young person with these agencies or to adopt their Safety Plan for use with the child or young person whenever possible to avoid the duplication of Safety Plans which might be confusing to them.

7. Identifying Factors Indicating Risks for Potential and Actual Harm

Factors which indicate risk of self-harm or suicide include:

- Previous threats, attempts or acts of self-harm or suicide.
- Preoccupation with or idealisation of self-harm or suicide.
- History of significant mental illness within the family.
- Knowing a friend or family member who has completed suicide.
- Knowing a friend or family member who currently self-harms or has previously self-harmed.



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- Ongoing and presenting psychological or emotional dysfunction, including marked changes in presentation, such as depression, flat affect, mood deterioration (or elevation), hopelessness, high levels of anxiety or unrest, and impulsivity.
- Psychological and psychiatric history.
- Stressors present in a child or young person's life, including current events and occurrences.
- Lack of individual coping strategies and internal mechanisms to deal with distressing or traumatic events.
- Withdrawal, isolation, separation or alienation from networks such as family, peers, social groups and school.
- Excessive involvement in high-risk activities such as reckless actions endangering life, substance use etc.
- At discharge from a Psychiatric inpatient unit service.
- Engagement in online communities that support self-harm and suicidal behaviours.

8. Identifying the Opportunities for Potential and Actual Harm

People who self-harm may feel shame or embarrassment, and staff need to validate their distress and assure them that help is available. Asking about self-harm and suicidal thoughts does not increase the likelihood of suicide, and indeed it is much more likely to lead to a reduction in suicidal risk.

It is helpful to:

- take all self-harm seriously and listen carefully, in a calm and compassionate way
- take a validating and non-judgemental approach about how the person is feeling
- help the person to identify their own coping strategies and support network
- offer information about support services
- ask permission to talk to family members/friends or other services as appropriate
- offer appropriate support to family and friends as necessary
- make a plan for coping with difficult feelings

Try to avoid:

- reacting with strong or negative emotions
- becoming irritated or frustrated
- making assumptions
- using terms such as 'manipulative' or 'attention seeking'
- focussing too much on the self-harm itself, rather than the underlying issues
- forcing the person to talk about their self-harm
- telling the person to stop self-harming
- showing disappointment if the person continues to self-harm

If someone has skin wounds from self-harm, assessment is required to determine the severity of injury and if urgent medical assessment and/or treatment is required. If someone has self-harmed by poisoning or

overdose, attendance at an emergency department is necessary for an evaluation of physical and mental health.

Opportunities for potential and actual harm include:

- Whether there is a plan to self-harm or suicide.
- Where there are means available to carry out self-harm or suicide.
- A significant event or incident occurred with which the child has not coped well with or, in the past has self-harmed as a response to such an event.
- Other factors present which could increase the possibility or desire to follow through with self-harm or suicide, such as access to substances of drugs, involvement with others who self-harm.
- Lack of or reduced contact and monitoring from regular supports.
- Comments indicating an intention to self-harm or suicide.

9. Addressing Risk Factors in a Child's Best Interest

Where it is known that a young person engages in threats of self-harm or actual self-harm, as identified during the referral process or ongoing work with the child or young person, it is essential the safety planning process is put into action. This should be completed in consultation with all professionals and services involved and recorded in the appropriate manner.

Interventions and responses may be required to:

- Ensure the immediate and on-going safety of the child.
- Reduce the harm or prevent it from re-occurring.
- Provide the basis for a management plan which supports and promotes addressing harmful behaviours and the underlying causes.
- Take appropriate decision-making action, such as consult with or report self-harming behaviour to the line manager, or Designated Safeguarding Officer, or other involved professionals who can provide advice and direction.

Chronic or entrenched patterns of self-harming behaviours can be triggered by a specific event but are more likely to be related to psychological functioning. Often this internal component can make it more difficult to predict or map when an episode may occur. Where the self-harming behaviour may be chronic or on-going, there may be reoccurring behaviours or conduct in a child or young person's presentation which signal a self-harming episode is imminent.

Risk management and crisis prevention planning for high-risk children and young people will require review on a frequent basis, sometimes daily or weekly depending on the degree of risk.

10. Responsibilities of Staff

Reducing the risks of self-harm and suicide is a matter of highest priority and should take precedence over all other matters. It is considered as a safeguarding function, which all staff must take personal and collective responsibility for.

When you identify that a young person may be at risk of self-harm or suicide:

- Take immediate action to ensure the safety of the young person.
- Inform the Designated Safeguarding Lead of any concerns and agree actions, including reporting where appropriate.

11. Confidentiality

All staff have a fundamental duty to respect children and young people's rights, including their right to privacy and confidentiality. Children and young people sometimes ask staff not to contact family and friends or partnership agencies. However, in cases with significant suicide risk or physical harm, the right to confidentiality must be balanced against the child's best interests.

Where there are ongoing concerns in relation to a child or young person's self-harming behaviour or suicidal thoughts, staff should seek their consent to share information as early as possible. Consideration should be given to information sharing with the young person's GP or school nurse or supporting them to self-report.

The duty of confidentiality does not prevent staff from listening to the views of family members and friends. They may offer vital insight, leading to a stronger Safety Plan. Good practice includes providing families with non-person-specific information, such as how to gain access to services in a crisis, as well as support services for carers.

12. Reporting and Recording

The following actions need to be taken at a minimum in response to all concerns relating to significant risk of Self-Harm & Suicidal Ideation:

- All staff must discuss the need to break confidentiality with their line manager or the Designated Safeguarding Officer, record their decision about sharing information and the justification for this decision.
- The parent/ carer(s) are contacted, informed of the concern and provided with advice on the day of the disclosure.
- Advice is given to parent/carer(s) about safety planning e.g. GP appointment, taking child to A&E, removing sharp or potentially harmful objects (including medication), providing Shout / Kooth details, monitoring child in the evening / at the weekend.

Accurate and timely recording on the child or young person's files of all incidents related to self-harm is important as this information assists in developing, formulating and reviewing the suicide and self-harm plan for those who engage in self-harm actions or behaviours.

Thresholds

Decisions on the concern's threshold and risk of significant harm should be made in discussion with the Designated Safeguarding Officer.

It is useful to first think of safeguarding as being on a spectrum. At the bottom of this spectrum would be 'Prevention' and at the other end of this spectrum would be 'Child Protection'. When thinking about significant harm, it is important to also include the risks that children pose to themselves. Somewhere in the middle of this spectrum would be 'Early Help'.

When a self-harm or suicidal ideation concern is raised, based on the information available, the level of risk should be determined through assessing the likelihood of occurrence and the severity of harm.

*Risk Rating	Likelihood of Occurrence x Severity of Harm
Likelihood of Occurrence	1 Rare, 2 Unlikely, 3 Moderate, 4 Likely, 5 Almost certain
Severity of injury	1 Minor, 2 Moderate, 3 Significant, 4 Major, 5 Catastrophic

Any assessed risk over a score of 9 should be treated automatically as a safeguarding concern and the Safeguarding and Child Protection Policy followed.

Any assessed risk under 9 should be discussed with the Designated Safeguarding Officer and agreement reached about whether the current measures are sufficient to manage the risk and whether or not parents / carers / school should be informed. For children over the age of 12, the worker will consider the child's wishes as to whether they would like their parent informed and how much additional information beyond the risk of significant harm is provided to them. This is in alignment with UNCRC and children's evolving capacity and right to have a say in the decision affecting them.

There are many circumstances where a child may voice thoughts of self-harm that fall short of a safeguarding concern. Nevertheless, a build-up of concerns over time may in time become serious enough that the child is considered to be a high risk.

Where you have general welfare concerns about a child that are below threshold you should:

- Discuss your concerns with your line manager during regular supervision
- Liaise with other agencies that are working with the child where appropriate and in consultation with the DSO
- Record your actions and note your concern on the chronology of significant events. You should review general welfare concerns periodically, to see whether the build-up of concerns is significant enough to become a safeguarding concern.