Outcomes First Group

SELF-HARM POLICY

Children's Education & Care

SELF-HARM POLICY

Contents

Terminology: Please note that the terms “our teams” and ”team member/s” include everyone working with the people in Outcomes First Group’s services in a paid or unpaid capacity, including employees, volunteers, consultants, agency staff and contractors.

1.0 POLICY STATEMENT

Outcomes First Group provides high-quality care and education to create safe, friendly supportive environments and do the best for each individual we support. We are committed to effectively managing and reducing the risk of self-harm by developing understanding of the reasons for the behaviour and implementing good professional practice in our settings.

There is not always a clear distinction between self-harm and self-injury, it can therefore be difficult to identify which type of behaviour the child is displaying and therefore the most effective way to respond.

Self-harm is when people deliberately hurt their bodies, intentionally causing physical pain or harm to themselves, whereas self-injurious behaviour is the result of an attempt to self-regulate, express pain or discomfort or communicate. It is important that all team members are aware of this policy and the Self-Injurious Behaviour Policy.

The appropriate policy should be used in response to the child/young person’s needs with support from the Clinical Team and in discussion with senior leaders. This self-harm policy will usually be followed for children and young people who have Social, Emotional, Mental Health (SEMH) as their primary need, however, some may display self-injurious behaviour (in which case the self-injurious behaviour policy should be followed). The self-injurious behaviour policy will usually be followed for children and young people who

have neurodivergence as their primary need, however, some may display self-harm behaviour (in which case the self-harm policy should be followed).

Other key policies that team members must be familiar with include:

- Ligature Management Policy
- Risk Assessment Templates (Health & Safety)
- Behaviour Policies and Information (Schools)
- Person-centred Behaviour Policy (Children's Homes)
- Restraint Reduction and Terms of Reference Policy
- Notifiable Events Policy - Children's Residential
- Serious Incident Notification Policy Education / Serious Incident Notification Policy Children's Care
- Group Supervision Policy
- Team Member Support – Post Incident

Team members should also be familiar with:

- Embedding Trauma Informed Practice (TIP) in your Service
- Autism Strategy - Ask Accept Develop

2.0 LEGISLATIVE & NATIONAL GUIDANCE FRAMEWORK

Specific legislation, regulation and guidance to be familiar with in relation to this policy are:

- Mental Health Act 1983, Amended 2007
- Human Rights Act 1998, Amended 2005
- Mental Capacity Act 2005
- Mental health and behaviour in schools (publishing.service.gov.uk)

Of particular relevance to this policy is the updated 2024 NICE Guidelines Self-harm: assessment, management and preventing recurrence which state that there is clear evidence that risk assessment tools are not an effective basis on which to predict future suicidal behaviour and incidents of self-harm. For example, in recent NCISH annual reports, 80% of patients who died by suicide were rated as 'low risk', demonstrating that the tools have poor predictive value and should not be used to exclude individuals from care and treatment. **Risk assessment tools should, therefore, not be used as a basis for deciding whether or not to make care and intervention available for an individual.**

3.0 WHAT IS SELF-HARM?

Self-harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of cars etc., where the intent is to deliberately cause self-harm. Some people who self-harm have a strong desire to kill themselves. However, there are other factors which motivate people to self-harm including a desire to escape an unbearable situation or intolerable emotional pain, to reduce tension, to express hostility, to induce guilt or to increase caring from others. Even if the intent to die is not high, self-harming behaviour may express a powerful sense of despair and needs to be taken seriously. Moreover, some people who do not intend to kill themselves may do so, because they do not realise the seriousness of the method they have chosen or because they do not get help in time.

The terms self-harm and self-injury are sometimes used interchangeably; however they are different.

Self-injury is the destruction or alteration of one's body tissue without conscious suicidal intent. This term is used to distinguish these actions from common socially accepted harmful behaviours such as drug use, smoking, excessive alcohol use. Body modification for aesthetic purposes is not included.

Please see the accompanying Self-Injurious Behaviour Policy for further information.

4.0 UNDERSTANDING AND IDENTIFYING SELF-HARM

In considering young people with complex and developmental trauma, the reasons for self-harm fall within two main functions:

Intrapersonal – self-harm may be a coping mechanism and a way of managing strong emotions. This type of self-harm may be hidden from others, e.g., covered cutting on forearms.

Interpersonal – self-harm is relational and may be referred to as 'attachment seeking' or 'attention needing'. Due to young people not having their underlying needs met consistently in their early development, they may develop other ways to feel seen and heard. This type of self-harm may be on display to others as a form of communication that they are struggling or require help and support.

There can be a mix of the above two functions.

4.1 Risk Factors

The following risk factors, particularly in combination, may make a young person vulnerable to self- harm, although are not limited to:

Individual factors:	Family factors:	Social Factors:
• Past experience e.g. adverse childhood experiences or trauma • Depression/anxiety • Poor communication skills • Low self-esteem • Poor problem-solving skills • Hopelessness • Impulsivity • Substance misuse • Bereavement • Perfectionism • Exam pressure	• Unreasonable expectations • Neglect or abuse (physical, sexual or emotional) • Child being Looked After • Poor parental relationships and arguments • Parental separation and / or loss • Depression, deliberate self-harm or suicide in the family.	• Difficulty in making relationships/loneliness • Persistent bullying or peer rejection • Easy access to drugs, medication or other methods of self-harm. • Copied self-harm behaviour (contagion effect) • Difficult times of year e.g., anniversaries • Criminal behaviour • Accessing, or difficulties within, school

4.2 Triggers

A number of factors may trigger the self-harm incident:

- Family relationship difficulties (the most common trigger for younger adolescents)
- Difficulties with peer relationships e.g., break up of relationship (the most common trigger for older adolescents)
- Bullying/cyberbullying
- Significant trauma e.g., bereavement, abuse
- Child sexual exploitation
- Self-harm behaviour in other students (contagion effect)

- Identification with a peer group which promotes self-harm
- Self-harm portrayed or reported in the media
- Difficult times of the year (e.g., anniversaries)
- Trouble in school or with the police
- Feeling under pressure from families, school and peers to conform/achieve
- Exam pressure
- Times of change (e.g., parental separation/divorce)
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4.3 Warning Signs

There may be a change in the behaviour of the young person that is associated with self-harm or other serious emotional difficulties, these may not be visible. Signs to be aware of may include:

- Changes in eating/sleeping habits
- Increased isolation from friends/family
- Changes in activity and mood, e.g., more aggressive than usual or more withdrawn
- Lowering of academic grades
- Talking about self-harming or suicide
- Frequent injuries (i.e., cuts, bruises, burns) with suspicious explanations
- Wearing trousers and long sleeves in warm weather (to cover injuries)
- Wearing bangles, bracelets and wristbands (to cover injuries)
- Low self-esteem or an increase in negative self-talk
- Difficulty handling emotions or easily overwhelmed
- Extremely sensitive to rejection
- Self-defeating comments and attitude
- Extreme emotional ups and downs (due to the cycle of self-injury).
- Difficulty functioning at school, work or home
- Relationship problems
- Avoiding sports or other activities that would require showing more of one's body.
- The presence of behaviours that often accompany self-injury: eating disorders, drugs/alcohol misuse, excessive risk-taking.
- Discovery of tools used for self-injury (broken disposable razors, lighters, un-bent paper clips)
- Bloodied wads of tissue or toilet paper, blood on clothing
- First aid supplies being used quickly
- Rubbing of arms, especially wrist, through sleeves (cuts often itch while they are healing)
- Withdrawing from activities once enjoyed
- Increased time alone
- Increased time with peers who self-harm

5.0 METHODS OF SELF-HARM

Young people can use a variety of methods to self-harm a

- Cutting
- Taking an overdose of tablets
- Swallowing hazardous materials or substances
- Burning – either physically or chemically
- Over/under medicating e.g., misuse of insulin
- Punching/hitting/bruising
- Hair pulling/skin picking/head banging
- Episodes of alcohol/drug/substance misuse or over/under eating can at times be acts of deliberate self-harm
- Risk-taking behaviours may be acts of deliberate self-harm

Self-harm can be a transient behaviour in young people that is triggered by particular stresses and resolves fairly quickly, or it may be part of a longer-term pattern of behaviour that is associated with more serious emotional/psychiatric difficulty. Where there are a number of underlying risk factors present, the risk of further self-harm is greater. Self-harm always needs to be taken seriously.

5.1 Use of ligatures

Please also see the *Health & Safety* Ligature Management Policy and related documents including:

- Ligature and Ligature Point Audit Guidance (G25) and Audit Form (CL20)
- Safe use of Hook Ligature Cutters Procedure (SOP10)

Some individuals will use ligatures to inflict injury on themselves. They might be fixed or non-fixed i.e. fixed ligatures are tied to wardrobe rails, shower rails, curtain rails or other secure points. These points do not have to be high as ligatures can be used when kneeling or sitting. It is also possible to self-strangulate manually without the use of a ligature point.

On every occasion when a person ties a ligature, team members must remove the ligature as quickly as possible. The management of people who regularly use ligatures as a method of self-injury needs to be agreed with the clinical team and other key adults. Agreed strategies need to be fully explained in the internal plan and risk assessment. Contact numbers and support services must be identified, and the information should be readily available to team members.

In services where the assessment of the people we support has identified ligature risks, team members (including bank and agency) will receive information and training regarding ligatures and the use of the ligature cutters. Training/refresher training will need to be sought by the service and provided at annual intervals.

If an individual ties a ligature for the first time, following the incident advice must be sought from the clinical team in order that a risk assessment can be completed and strategies for management of any future incidents can be agreed.

5.2 What keeps the self-harm cycle going?

Once self-harm (particularly cutting) is established, it may be difficult to stop. Self-harm can have a number of functions for the young person, and it becomes a way of coping, for example:

- Reduction in tension (safety valve)
- Distraction from problems
- Form of escape
- Outlet for anger and rage
- Opportunity to feel real
- Way of punishing self
- Way of taking control
- To not feel numb
- To relieve emotional pain through physical pain
- Care-eliciting behaviour
- Means of getting identity with a peer group
- Non-verbal communication (e.g., of abusive situation)
- Suicidal act.

When a person inflicts pain upon him or herself, the body responds by producing endorphins, a natural pain-reliever that gives temporary relief or a feeling of peace. The addictive nature of this feeling can make the stopping of self-harm difficult. Young people who self-harm still feel pain, but some say the physical pain is easier to stand than the emotional/mental pain that led to the self- harm initially.

6.0 HOW TO RESPOND TO SELF-HARM

6.1 Child at Risk of Self-Harm

When a young person presents themselves with concerns about self-harm or when we are asked to look into a concern about a child our immediate response needs to be calm and measured. The professional should indicate they feel confident they can be supportive (no matter how anxious they may feel). Initially acknowledge the courage it has taken for the child/young person to seek help and acknowledge the self-harm. At this point it is important to communicate your acceptance of the situation and let them know you care but also to let them know the limits of your confidentiality, explaining the reason why the information needs to be shared in order to keep them safe.

6.2 Child/Young Person has Self-Harmed - Immediate Responses

If you find a child/young person who has self-harmed, try to keep calm, give reassurance and follow the first-aid guidelines. When considering what action and support the child/young person needs, continue to maintain their trust and involve them in decisions. If the child/young person who has self-harmed finds it difficult to vocalise their distress when they are in need of care, support them in trying alternative methods of communication (such as non-verbal language, letters, and using agreed safe words, phrases or emojis). Team members must make appropriate adaptations for any learning disability or physical, mental health or neurodevelopmental condition the child/young person may have.

The team member should establish the following as soon as possible:

- the severity of the injury and how urgently medical treatment is needed
- the person's emotional and mental state, and level of distress
- whether there is immediate concern about the person's safety
- whether there is a safeguarding concern, if there is inform the designated safeguarding lead (DSL)
- whether the person has a self-harm risk assessment
- if there is a need to refer the person to a specialist mental health service for assessment.

In the case of an over-dose of tablets, however small, advice must be obtained from a medical practitioner (accident and emergency department or GP). If the child/young person who has self-harmed is intoxicated by drugs or alcohol, support and advice about medical assessment and treatment is required. When a child/young person who has self-harmed presents to a team member they should:

- treat the child/young person with respect, dignity and compassion, with an awareness of cultural sensitivity.

- work collaboratively with the child/young person to ensure that their views are taken into account when making decisions
- address any immediate physical health needs resulting from the self-harm, in line with locally agreed policies; if necessary, call 111 or 999 or other external medical support. Use First Aid and physical intervention where necessary. Remove potentially harmful items from environment where necessary. Where appropriate inform the clinical team as soon as possible (see Appendix A and B for guidance on when to inform clinical team) and consider whether outside agency mental health support is required urgently
- ensure that the child/young person is aware of sources of support such as clinical team, local NHS urgent mental health helplines, local authority social care services, Samaritans, Combat Stress helpline, NHS111 and Childline, and that people know how to seek help promptly.
- safeguarding issues should be reported to the DSL and the Safeguarding Policy must be followed.
- increase supervision and support if child/young person 's safety is at risk.

6.3 Physical Intervention and restraint

Please also see *Restrictive Physical Intervention Policy.*

Some serious self-harming behaviour may require team members to physically intervene using prescribed physical interventions, such as, CPI, which team members are trained in.

When physical interventions are used, they must be reported, legally within 24 hours of the intervention taking place.

The safety and wellbeing of all those involved is always the highest priority. Once all individuals, including children, young people and team members are safe and calm, a report will be produced by the team members involved.

These will be produced on the electronic recording system used within the setting. The clinical team must be kept informed of the incidents and regularly review the individual's Support Plan.

6.4 Approach to Assessing and Meeting their Needs

There is clear evidence that **risk assessment tools are not an effective basis** on which to predict future suicidal behaviour and incidents of self-harm and should, therefore, **not be used as a basis for deciding whether or not to make care and treatment available for an individual or to predict future self-harm**. The focus of assessment and intervention should be on meeting the person's needs and how to support their immediate and long-term psychological and physical safety rather than formally rating risk using tools, scales or global risk stratification (categorising into low, medium or high risk).

Actions which can meet the person's needs, address their relational context and promote safety to the individual are needed, using personalised approaches and involvement of the individual and family/carers/parents/other sources of support.

6.5 Coping Strategies to Help

A 'safety plan' or 'coping skills' plan (see resources below) can be completed with the young person to help empower them and include them in risk assessment planning when possible. Replacing the cutting or other self-harm with other safer activities can be a positive way of coping with the tension. What works depends on the reasons behind the self-harm. Activities that create emotions which match the emotions intensively can be helpful.

Examples of alternative ways of coping include (please also see appendices):

- Writing a letter expressing feelings, this need not be sent
- Ringing a helpline
- Hitting a pillow or soft object

- Listening to loud music or singing
- Going for a walk/run or other forms of physical exercise
- Using stress-management techniques, such as relaxation
- Using a 'self-sooth box'

Providing factual information on the potential complications of self-harm can be useful for certain people.

It may be helpful to explore with the young person what led to the self-harm – the feelings, thoughts and behaviour involved. This can help the young person make sense of the self-harm and develop alternative ways of coping.

Encourage the young person to talk about what has led him or her to self-harm and remember that listening is a vital part of this process. Support the young person in beginning to take the steps necessary to keep him or her safe and to reduce the self-injury (if he or she wishes to). Offer information about support agencies – see the leaflets appended.

6.6 Review the individual's environment

Assess the safety of the environment, balancing respect for the person's autonomy (appropriate to their age) against the need for restrictions. Use the least restrictive measures. Consider removing items, in accordance with risk, that may be used to self-harm and involve the person who has self-harmed in this decision. For example, removing razor blades, cords, glass, stones where appropriate.
Ensure that the self-harm risk assessment is updated to include risks in the environment. What individuals have used to self-harm in the past is predictive of what they might use in the future, but it is also important to be aware that if these items are removed, other items may be found and used. Removal of these items can be reviewed when it is appropriate so that the environment is as less restrictive as possible, e.g., following assessment.

6.7 Reoccurring Self-Harm

If the child/young person presents with frequent episodes of self-harm, or if intervention has not been effective, carry out a multidisciplinary review with the child/young person (where appropriate) and those involved in their care and support, and others who may need to be involved, to agree a joint plan and approach. This should involve:

- identifying an appropriately trained professional or practitioner to coordinate the child/young person's care and act as a point of contact
- reviewing the existing care and support, and arranging referral to any necessary services
- developing the risk assessment developing a safety plan for future episodes of self-harm, which should be written with and agreed by the child/young person.

The multi-disciplinary team will need to consider whether the self-harm behaviour has changed in frequency, severity or method over time.

7.0 SEEKING PROFESSIONAL SUPPORT

For students who have self-harmed, the school will seek the advice of professionals to develop a support plan with the pupil and their family members and carers (as appropriate) for when they are in the education setting. This will include guidance from other agencies involved in the person's care, as appropriate.

Please see appendices detailing the process of seeking professional support.

7.1 School's Clinical Teams

It is important for school to notify the clinical team of self-harm incidents to ensure appropriate multi- disciplined support is accessed where needed. See Appendices for an overview of when and how the clinical service

should be involved.

The clinical team may be involved in the following way:

- providing consultation/training/reflective practice to team members
- work collaboratively with school to develop a support plan for the child/young person
- developing a risk formulation, including a shared understanding of why the child/young person has self-harmed
- reviewing the child/young person's current risk assessment, ensuring that they receive the care they need
- supporting with giving the child/young person and their family members or carers (as appropriate) information about their actions and findings
- providing additional support for the child/young person where appropriate, including developing a collaborative therapeutic relationship with the person and using evidence informed approaches to address self-harm

Further assessment of the self-harm may be required by the clinical team to support the above work.

7.2 Assessment and Risk Formulation

Risk formulation should be a part of any psychosocial assessment completed by the clinical team in collaboration with the education team and the child/young who has self-harmed (where engagement with the child is achieved). This aims to summarise the child/young person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

During the psychosocial assessment, the multi-disciplinary team should explore the functions of self-harm for the child/young person, taking into account:

- their values, wishes and what matters to them
- the need for psychological interventions, social care and support
- any learning disability, neurodevelopmental conditions or mental health problems
- the child/young person 's treatment preferences
- that each child/young person who self-harms does so for their own reasons
- that each episode of self-harm should be treated in its own right, and that the individual's reasons for self-harm may vary from episode to episode
- whether it is appropriate to involve their family and carers
- their social, peer group, education and home situations
- any caring responsibilities
- the use of social media and the internet to connect with others and the effects of these on mental health and wellbeing
- any child protection or safeguarding issues

During the psychosocial assessment, the multi-disciplinary team should explore the following to identify the child/young person's strengths, vulnerabilities and needs:

- historic factors
- changeable and current factors
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors.

Clinicians will seek further support and/or supervision where required around the above, via their clinical supervisor and/or Lead Clinician/Locality Lead.

7.3 Referral to external agencies

In collaboration with the clinical team and the team around the child determine if a referral to other agencies, such as CAMHS, is required. This will require a team decision based on risk formulation (e.g., risk factors present, protective factors, level of impulsivity), effectiveness of intervention to date and what additional therapeutic support the young person might need.

8.0 SUPPORTING TEAM MEMBERS AND OTHER CHILDREN

Please also see the Team Member Support – Post Incident Policy

Observing an incident of self-harm and providing care for that individual is emotionally demanding and can be traumatic and team members may feel distressed as a result. All settings should be supportive environments for team members and ensure they have opportunities to talk about it and reflect on what has happened. The Headteacher/Registered Manager must ensure that team members have regular supervision and are made aware of the confidential counselling service contact details.

Reflective practice sessions, debrief meetings, regular team meetings and individual 'safe space' support sessions will help team members deal with what they observe, learn from the incident, and help to minimise future risk of injury to the individual. The information in the Helpful Resources section will also be helpful.

Team members should take into account how the child/young person's self-harm may affect their close friends and peer groups. Appropriate support should be provided to reduce distress to them as well as the person. The setting should contact the clinical team if advice is required around how best to support peers.

9.0 REPORTING AND RECORDING

All incidents of self-harm and self-injurious behavior must be recorded in the individual's notes, reported in the weekly reports and on the specific functions online system e.g., Access/Sleuth etc.

The SLT and clinical team in each service should collectively agree when and how an incident of self-harm/self-injury should be reported to the clinical team e.g. which named clinician to be informed and how. These decisions can be made at a site-specific level but also can be made in relation to a specific individual depending on their needs. This will help inform the assessment of self-harm.

Incidents may also require reporting to a regulatory body as appropriate.

10.0. HELPFUL RESOURCES

Understanding and Supporting Young People who Self harm - Acorn Education Helpsheet

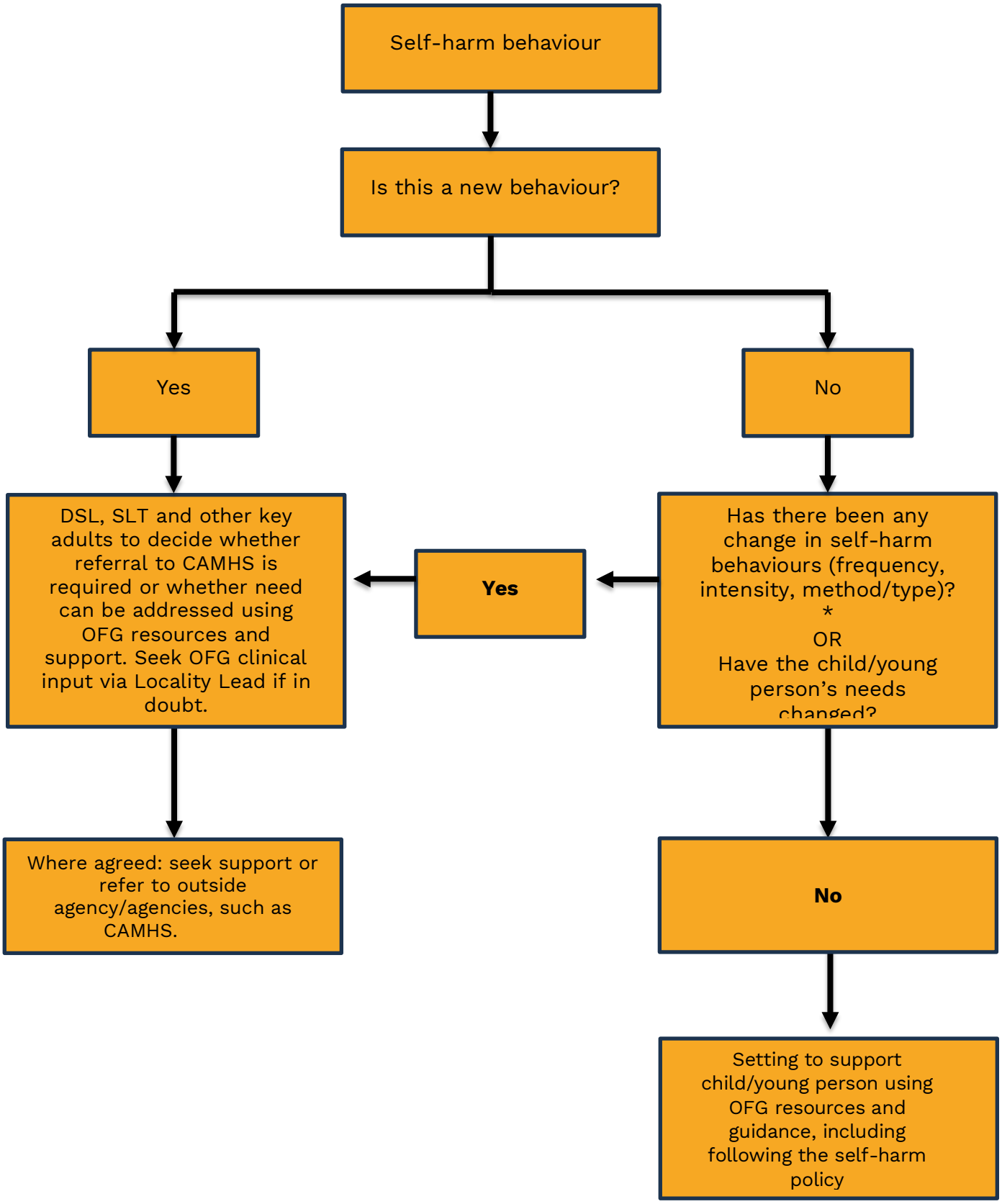
Distractions that can help NAHN list of alternative coping strategies

Mind – Coping with Self-Harm – for 11-18 year olds

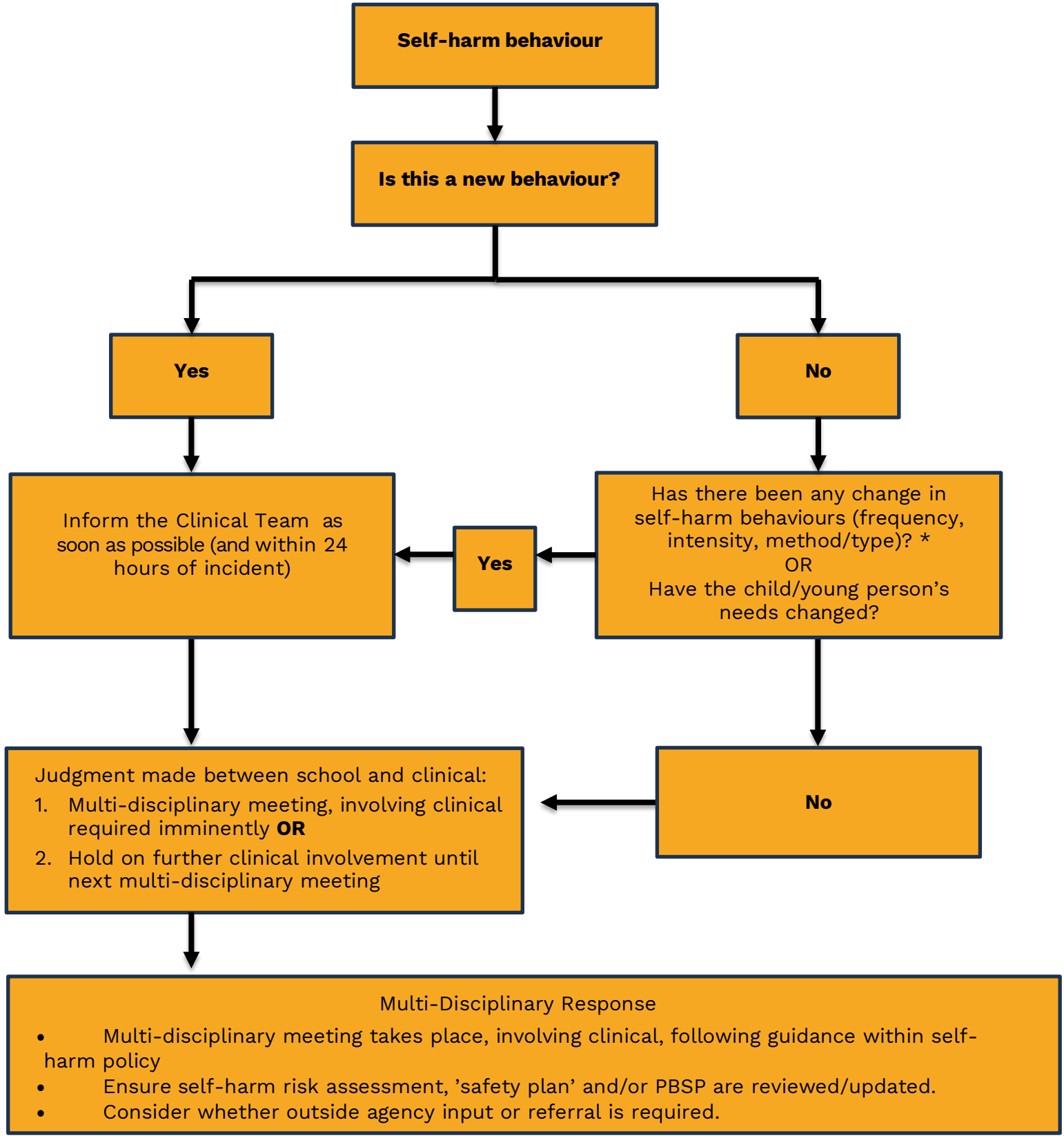
Creating a 'safety plan' | Samaritans – Supporting-someone-with suicidal-thoughts

Young people who self-harm a guide for school staff Royal College of Psychiatrists

APPENDIX A – GUIDANCE FOR SERVICES WITH NO IN-HOUSE CLINICAL TEAM



APPENDIX B – GUIDANCE FOR SERVICES WITH AN IN-HOUSE CLINICAL TEAM



New behaviour:	This is the first time the child/young person has self-harmed in their life and/or it is the first time the they have self-harmed whilst being in the service (to the services knowledge).
Frequency:	The child/young person has self-harmed more often than previously/the time between self-harm incidents has decreased.
Intensity:	The severity of the self-harm has increased, the child/young person has used multiple methods of self-harm, and/or required medical attention.
Method/Type:	The way in which the child/young person self-harms has changed (e.g. cutting, burning, ingesting, etc).

Outcomes
First Group