Bradfields Academy

Self-Injury Policy and Protocol

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Protocol Scope and Aims

This protocol is for all professionals working within Bradfields Academy:

- To support students with the prevention and management of self-injury
- To support staff in responding to incidents involving self-Injury.

The policy and procedure seeks to:

- Support all staff to manage self-injury in a timely way, as it arises
- Improve responses to the presentation, disclosure or suspected signs of self-injury
- Improve the quality of support, advice and guidance, offered by all staff.

Background

Self-Injury is a serious public health issue and is the reason for many admissions to Accident and Emergency Departments every year.

Self – Injury and suicidal threats by a Bradfields' student puts them at risk of significant harm. They should always be taken seriously and responded to without delay. Within Bradfields Academy we will deliver timely, consistent, proportionate and safe responses to presenting self-injury concerns.

Definitions and Context

Self-harm can take many different forms and includes self-injury or self-mutilation. It is the:

> "*act of deliberately causing harm to oneself either by physical injury or self-poisoning* irrespective of the apparent purpose of the act"

It may also be linked to putting oneself in dangerous situations and/or self-neglect.

> "*Self-Injury is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm themselves*".

Self-Injury is a way of coping with difficult or overwhelming situations or emotional states and is not always linked to suicidal thoughts. Some individuals that self-injure may, however, go on to attempt suicide.

The signs of the distress the student may be under can take many forms and can include:

- Cutting behaviours
- Other forms of self-harm, such as burning, scalding, banging, hair pulling
- Self-poisoning including overdoses of tablets or medicines
- Not looking after their needs properly emotionally or physically
- Direct injury such as scratching, cutting, burning, hitting yourself, swallowing or putting things inside
- Staying in an abusive relationship
- Taking risks too easily
- Eating distress (anorexia and bulimia)

- Addiction for example, to alcohol, drugs or sex
- Low self-esteem and expressions of hopelessness.

Identifying Self-Injury

How is self-injury detected?

There are several means through which a member of staff might discover that a student is self-injuring. A student could self-disclose that he or she is self-injuring, a peer might notify a staff member of another student's self-injurious behaviour, or key indicators may be spotted giving arise to concerns.

Signs and symptoms of self-injury are sometimes absent or easy to miss. Arms, hands, and forearms opposite the dominant hand are common areas for injury. Evidence, however, of self-injurious acts can, and does, appear anywhere on the body.

Indicators include:

- Inappropriate dress for season (consistently wearing long sleeves or long trousers in warm weather)
- Constant use of wrist bands/coverings
- Reluctance to participate in events/activities which require less body coverage (such as swimming or PE)
- Frequent bandages, odd/unexplainable paraphernalia (e.g., razor blades or other implements which could be used to cut or pound)
- Heightened signs of depression or anxiety
- Unexplained burns, cuts, scars, or other clusters of similar markings on the skin.

Managing a Suspicion

Self-injury must be treated as a safeguarding concern.

It is not uncommon for individuals who self-injure to offer stories which seem implausible or which may explain one, but not all, physical indicators. For example "It happened while I was playing with my kitten."

If the individual says that he or she is not self-injuring or evades any prompts, do not attempt to force engagement. As with a potential safeguarding disclosure the student may not be ready and all you can do is offer support and reassurance that you are willing to listen if they need to talk to you at a later date. As with a potential disclosure inform the Designated Safeguarding Leads of your suspicions and any conversations had with the student.

Assessing Self-Injury

Who should assess?

Assessment of student needs and next steps will require input from the Designated Safeguarding Leads and the Wider Pastoral Team. Which members of the Wider Pastoral Team will depend on the nature of the injuries and the student involved. For example the medical team will need to be involved if any open wounds are present, and a therapist may be needed in order to enable the student to engage with the medical team.

Unless the student is in obvious emotional crisis, kind and calm attention to assuring that all physical wounds are treated should be the first priority.

All wounds should be treated and covered. This will help to reduce the peer interest.

The wound severity, implements that have been used, location of the injury and observed number of scars from old wounds can all be noted during treatment and discussed with the designated lead and wider pastoral team when triaging next steps.

Asking straightforward medically-focused questions at this stage may also be appropriate if the student is calm and willing to share.

Useful questions in assessing severity and next steps include:

- Where on your body do you typically injure?
- What do you typically use to injure?
- What do you do to care for the wounds?
- Have you ever hurt yourself more severely than intended?
- Have your wounds ever become infected?
- Have you ever seen a doctor because you were worried about a wound?

Any responses to these questions should be noted and passed to the Designated Safeguarding Lead as they will help to assess the way forward in relation to parental contact, and engagement of external services.

As staff are attempting to build a trusting relationship, honesty is important with the student. As with a safeguarding referral, tell them that you will have to pass this on, and who to. Reassure them that they will be kept informed of decisions made. Speak to the Designated Leads or your Line Manager before the student leaves site. It is recognised that this is difficult around transport times and may not always be possible.

Do not:

- Panic or try quick solutions
- Dismiss what the child or young person says
- Believe that a young person who has threatened to harm themselves in the past will not carry it out in the future
- Disempower the child or young person
- Ignore or dismiss the feelings or behaviour
- See it as attention seeking or manipulative
- Trust appearances, as they may cover up their distress.

Should a suicide assessment be conducted?

Some students who self-injure may also be suicidal, either during the period in which they are injuring or later in their development. Whilst it is uncommon for actively self-injurious students to be suicidal, suicide assessment is warranted –particularly if there is any reason to believe that the student might be actively suicidal.

In this case, suicide assessment should occur immediately and, if suicidality is detected, suicide protocols should be followed from this point forward. Note that while a self-injurious student may not be or have ever been suicidal at the point at which self-injury was detected, the behaviour does serve as a warning sign for some students that suicide may become an option later, especially if the distress underlying self-injury is not adequately addressed.

The current protocol within Bradfields is for an A and E walk in to occur and the suicide risk be reported. This would ensure a Tier 3 Mental health Crisis Team referral would occur immediately.

Once immediate physical safety has been ensured, the Designated Lead or Wider Pastoral Team member would try to ascertain answers to the following questions. These questions need to be asked away from other students.

- How long have they felt like this?
- Are they at risk of harm from others?
- Are they worried about something?
- Ask about the student's health and any other problems such as relationships difficulties?
- Are there abuse and sexual orientation issues?
- What other risk- taking behaviour have they been involved in?
- What have they been doing that helps?
- What are they doing that stops the self-harming behaviour from getting worse?
- What can be done at Bradfields or at home to help them with this?
- How are they feeling generally at the moment?
- What needs to happen for them to feel better?

Risk Assessment

An assessment of risk should be undertaken at the earliest stage by an appropriately trained professional and should consider the student's:

- level of planning and intent
- frequency of thoughts and actions
- signs of depression
- signs of substance misuse
- previous history of self-harm or suicide in the wider family or peer group
- delusional thoughts and behaviours
- feeling overwhelmed and without any control of their situation.

Any assessment of risks should be talked through with the student (if appropriate) and regularly updated as some risks may remain static whilst others may be more dynamic such as sudden changes in circumstances within the family or academy setting.

The level of risk may fluctuate and a point of contact with a backup should be agreed to allow the child or young person to make contact if they need to.

The support needs of students who are aware of the self-injury and the risk of associated self-injury should also be assessed and considered.

If the young person is caring for a child or pregnant family member the welfare of the child or unborn baby should also be considered in the assessment.

Severity of Self-Injury

Research suggests that not all self-injury is equally severe. One study documented 3 self-injury classes:

Superficial

Low lifetime frequency (fewer than 11 episodes of self-injury)

Use forms capable of resulting in largely superficial tissue damage (e.g., scratching or wound interference)

Tend to use relatively few forms of self-injury behaviours

This is the least severe level of lethality, however, people falling in this class might be at an increased risk for suicidal ideation compared to students who do not self-injure.

Battery/light tissue damage

Low lifetime frequency of self-injury (fewer than 11 episodes of self-injury)

Use forms capable of resulting in light tissue damage (e.g., small punctures and bruising)

Tend to use several forms over time (most serious form used results in light tissue damage)

Members of this class are at a higher risk for suicidality, a history of trauma, and disordered eating in comparison to the superficial class and those who do not self-injure.

Chronic/High severity

High lifetime frequency of self-injury (greater than 11 incidents)

Use forms capable of resulting in high tissue damage (e.g., cutting, ingesting caustic substances, bone breaking, etc.)

Tend to use several forms over time (most serious form used results in high tissue damage)

Members of this class are at the highest risk for suicidality, a history of trauma, and disordered eating in comparison to other self-injury classes and non-self-injurers.

Also students within this group are most likely to fulfil the classic "cutter" stereotype e.g. they have self-injury routines, report some degree of perceived dependence on self-injury, report hurting themselves more than intended, and report life interference as a result of their self-injury.

Categories of Risk

In general, students are likely to fall into one of two risk categories:

Low risk students

Students with little history of self-injury, a generally manageable amount of external stress, at least some positive coping skills and some external support are those most likely to be easily managed. Parents may or may not need to be notified in this case depending on the Designated Lead's confidence that self-injury is transient and not severe enough to cause unintended injury. In these cases, it is important to work with the student to come up with strategies for handling stress and for checking in with the Designated Lead, or another on-site trusted adult, during times where they begin to feel like they may be at risk for self-injury or other unhealthy behaviours. Monitoring student behaviour through observation, teacher reports, and periodic check-ins is also warranted for a brief time following a self-injury event.

Higher risk students

Students with more complicated profiles – those who report frequent or long-standing self-injury practices, who use high lethality methods, and/or who are experiencing chronic internal and external stress with few positive supports or coping skills –are likely to require more aggressive intervention and management. Unless there exists a high likelihood that it will pose an additional risk to the student, parental involvement will likely be indicated in these cases. It is important to note that students should be engaged as active participants in each step – even in cases where the next obvious step elicits resistance. Unless the student is in severe crisis and unable to function (in which case parents need to be contacted immediately) the decision to make parental contact should be discussed honestly and respectfully with the student, providing it will not heighten the situation.

Information Sharing and Consent

Professionals involved should work with young people and their families to ensure appropriate support is in place to address both the self-harming and the underlying issues and maintain regular communication with them. This may involve making a referral to other agencies such as their GP, Children's Social Care or the Child and Adolescent Mental Health Services (CAMHS) and a range of other services.

To assess the child or young person's needs and the risks they may be exposed to, information needs to be gathered and analysed. In order to share and access information from the relevant professionals the student's consent may be needed.

Professional judgement must be exercised to determine whether a student in a particular situation is competent to consent or to refuse consent to sharing information.

Consideration should include the student's chronological age, mental and emotional maturity, intelligence, vulnerability and comprehension of the issues. A child at serious risk of self-injury may lack emotional understanding and comprehension and the Gillick Competency/Fraser guidelines should be used.

Informed consent to share information should be sought if the student is competent unless:

- The situation is urgent and there is not time to seek consent
- Seeking consent is likely to cause serious harm to someone or prejudice the prevention or detection of serious crime.

If consent to information sharing is refused, or can/should not be sought, information should still be shared in the following circumstances:

- There is reason to believe that not sharing information is likely to result in serious harm to the student or someone else or is likely to prejudice the prevention or detection of serious crime
- The risk is sufficiently great to outweigh the harm or the prejudice to anyone which may be caused by the sharing
- There is a pressing need to share the information.

Professionals should keep parents informed and involve them in the information sharing decision even if a student is competent or over 16. If, however, a competent student wants to limit the information given to their parents or does not want them to know it at all; the student's wishes should be taken into consideration, unless the conditions for sharing without consent apply.

Where a student is not competent, a parent with parental responsibility should give consent unless the circumstances for sharing without consent apply.

In all cases the decision around information sharing must involve the Designated Safeguarding Lead for the academy.

It is also recommended that the wider pastoral team provide parents with both community and web-based resources for understanding and effectively addressing self-injury. Wherever possible this should be done at a meeting rather than over the phone or email. Another important goal of the meeting is for the team, parents and student to discuss how to create and maintain a supportive, appropriate environment for the student. Helping parents understand the difference between constructive and unhelpful responses to self-injury and related issues will be very important when it is obvious that parent-child dynamics may be contributing to the behaviour.

Finally, the chosen contact point for the team should urge the parents to seek support for their child. This may be counselling within the academy or an outside provider. Alerting parents to the fact that family therapy can be helpful in situations like these may also be appropriate and help to encourage parents/carers to participate in more active engagement in their child's recovery. Having local mental health resources on hand is very helpful and offering to assist in setting up initial appointments can provide an important aid to families in need.

Scheduling a follow-up meeting with parents and the student before leaving the initial meeting should occur. This typically should occur 1-2 weeks and no later than 1 month after the academy detects a significant self-injury incident.

Referral to Local Authority Social Care

The student may be a Child in Need of services (Section 17 of the Children Act 1989) which could take the form of an Early Help assessment or a Common Assessment Framework (CAF) support service.

They may be likely to suffer significant harm, which requires child protection services under Section 47 of the Children Act 1989.

A referral will be made to Local Social Services if the Designated Safeguarding Lead believes that there is a risk of harm to the student. A referral must always be undertaken if any of the following apply:

- The student's actions could have resulted in their death or serious injury and required A&E or hospital admission.
- The intervention and support work with a student is failing to reduce the risk of self-harming behaviour.
- Evidence and risk factors suggest child protection issues may form part of the motivation for self-injury. This includes bullying, and abuse within gangs and child sexual exploitation.

The referral should include information about the back-ground history and family circumstances, the community context and the specific concerns about the current circumstances, if available. The referral must be recorded as any other safeguarding referral would be.

Social Contagion

What is social contagion?

Social contagion refers to the way in which a certain behaviour, such as self-injury, can spread among members of a group. Social contagion is a possibility any time that other students become aware that someone among them is injuring. Research suggests that certain behaviours are susceptible to social contagion both because of their power to communicate as well as the provocative nature of their stigma. Sometimes, behaviours can be unintentionally reinforced by people outside of the group, including adults.

How can we prevent social contagion of self-injury?

To prevent social contagion within the academy, staff must reduce communication around self-injury. If a student is injuring, for example, he or she should be advised not to explicitly talk with other students about engaging in the behaviour. Secondly, staff should help self-injuring students to manage scars and wounds. Visible scars, wounds and cuts should be discouraged.

There must never be a 'shaming' tactic used in order to convince a student to cover their scars or cuts.

To prevent social contagion of self-injury in the academy, students must not be given explicit details about self-injury. This means convening a school-wide assembly on the topic is NOT appropriate. Educating students, however, about signs of distress in themselves and others, as well as teaching the use of positive coping skills, is appropriate. Finally, treatment of self-injury within schools MUST be done on an individual basis. It is not appropriate to treat self-injury in a group therapy setting.

The risk for contagion is increased when high-status or "popular" peers are engaged in self-injury or when self-injury is used as a means for students to feel a sense of cohesiveness or belonging to a particular group.