Self-Harming Policy

Policy Information	
Policy Owner	Executive Headteachers
Issue Version	4
Approving Committee	Education & Safeguarding Committee
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Review Cycle	Annual
Last Review Date	Sept 2025
Next Review Date	Sept 2026

Adoption of the Policy

This Policy has been adopted and reviewed by the Trustees of Transforming Futures Trust

Signed: **Date: 07.10.25**

Chair of the Education and Safeguarding Committee

Version Control Amendments

Version No	Date	Summary of Changes
3	June 2024	General updates taken from NICE Guidance 'Self-Harm: assessment, management and preventing recurrence' September 2022.
4	September 2025	Reviewed, self-harm statistic updated, no further changes

1. Introduction

1.1. It is thought that around 13% of young people may try to hurt themselves on purpose at some point between the ages of 11 and 16, but the actual figure could be much higher.

Girls are thought to be more likely to self-harm than boys, but this could be because boys are more likely to engage in behaviours such as punching a wall, which isn't always recognised as self-harm or doesn't come to the attention of hospitals. The numbers of boys that do self-harm is not as well reported as there is a tendency for self-harm not to be self reported by boys due to the perceived stigma attached. Only a minority of people who have self-harmed present to hospital services, but it remains one of the commonest reasons for hospital attendance.

Self-harm can occur at any age, but there is evidence that the prevalence of self-harm among young people in England is continuing to rise. This increase is being seen in younger age groups as well. A study in 2023 revealed a 22% increase in self-harm hospital admissions for children aged 8 to 17 in a single year.

For some people, self-harm is a one-off episode but repetition is also common, with 20% of people repeating self-harm within a year. People who have self-harmed are at greatly increased risk of suicide.

2. Scope

2.1 This document describes Transforming Futures Trust MAT approach to self-harm. This policy is intended as guidance for all staff including non-teaching staff, executive team and governors/trustees. All educational settings should have policies and procedures for staff to support students who self-harm.

The aims of this policy therefore are to ensure staff know:

- how to identify and recognise self-harm behaviours.
- how to assess the needs of students.
- what do to if they suspect a student is self-harming.
- how to support and signpost the student, peer group, parents/carers if ongoing support is required.

3. Definition of Self-Harm

3.1. The Trust identifies self-harm as any behaviour where the intent is to deliberately cause harm to one's own body, irrespective of the apparent purpose, for example:

- Cutting, scratching, scraping or picking skin.
- Swallowing inedible objects.
- Taking an overdose of prescription or non-prescription drugs.
- Swallowing hazardous materials or substances.
- Burning or scalding.
- Hair-pulling.
- Banging or hitting the head, fists or other parts of the body.
- Scouring or scrubbing the body excessively.
- Chemical harm – e.g. using bleach on the skin, and misuse of aerosol sprays.
- Disordered or restricted eating (this is also a standalone identified mental health condition).
- Deliberate mis-management of identified medical or health needs.

4. Risk Factors

4.1. The following risk factors, particularly in combination, may make a young person particularly vulnerable to self-harm:

Individual Factors:

- Diagnosis of other mental health concerns for example depression / anxiety.
- Poor communication skills.
- Low self-esteem.
- Poor problem-solving skills or coping strategies/ resilience.
- Hopelessness.
- Impulsivity.
- Drug or alcohol abuse.
- Experience of trauma, including neglect or physical, sexual or emotional abuse.

Family Factors:

- Unreasonable expectations.
- Lack of supportive networks (through friends & family).
- Family trauma including depression, self-harm or suicide in the family.

Social Factors:

- Difficulty in making relationships / loneliness.
- Being bullied or rejected by peers.
- Inability to maintain positive relationships and breakdown of friendships.
- Body image, social media and celebrity culture.

5. Warning Signs

5.1. Transforming Futures Trust MAT staff may become aware of warning signs which indicate a student is experiencing difficulties that may lead to thoughts of self-harm or suicide. These warning signs should **always** be taken seriously.

5.2. Possible warning signs include:

- Changes in self-care / sleeping habits (e.g. student may appear overly tired if not sleeping well).
- Increased isolation from friends or family, becoming socially withdrawn.
- Changes in activity and mood e.g. more aggressive or introverted than usual.
- Lowering of academic achievement.
- Talking or joking about self-harm or suicide.
- Abusing drugs or alcohol.
- Expressing feelings of failure, uselessness or loss of hope.
- Changes in clothing, not taking care of clothing/appearance, wearing loose clothing covering limbs even when it is warm, avoiding PE.
- Weight loss or gain/ changes in eating habits/ excessive visits to bathroom around meal times.
- Fixation of watching/ researching/ discussing related topics, for example, on social media platforms.

6. Staff roles in working with students who self-harm

6.1. Students may choose to confide in a member of staff if they are concerned about their own welfare, or that of a peer. Staff may experience a range of feelings in response to self-harm in a student such as anger, sadness, shock, disbelief, guilt, helplessness, disgust and rejection. However, in order to offer the best possible help to students it is important to try and maintain a supportive, non-judgmental and open attitude – a student who has chosen to discuss their concerns with a member of school staff is showing a considerable amount of courage and trust.

6.2. Students need to be made aware that it is not possible for staff to offer complete confidentiality. **If you consider a student is at serious risk of harming themselves then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a student puts pressure on you to do so.

6.3. Staff observing any of the warning signs or who is aware of a student engaging in or suspected to be at risk of engaging in self-harm should record it as a safeguarding concern on CPOMS or using the relevant school form and pass the concern to the designated safeguarding lead.

6.4 If a child or young person discloses self-harming behaviours to a staff member or they witness self-harm whilst its happening, they should immediately establish:

- The severity of the injury and how urgently medical treatment is needed (if at all). First aid treatment should be provided by a trained first aider or external professional (contact 111 or 999 if felt necessary).
- The student's emotional and mental state, and level of distress.
- Whether there is an immediate concern about the student's safety.
- Whether there are additional safeguarding concerns.
- If immediate additional adult support is required.
- If removing the student from lesson/situation would be beneficial, for example, if their remaining in class is likely to cause further distress to themselves or their peers.

In the case of an acutely distressed student, the immediate safety of the student is paramount, and an adult should remain with the student at all times.

If you witness a pupil self-harming, apply trauma informed de-escalation and regulating techniques as appropriate such as offering alternatives, re-direction or distraction. Ask them to stop or hand you the implement they are using. If they do not, it is best not to try and remove the implement unless there is risk of significant harm to the student. Physical restraint principles should be considered and only applied if there is significant risk of harm to the child, otherwise it is likely to cause additional and unnecessary distress. Seek additional adult support if needed.

6.5. Following any concern, report or observation of self- harming behaviours, the designated safeguarding lead will decide on the appropriate course of action.

This may include:

- Working collaboratively with the student to ensure that their views are taken into account when making future decisions and plans.
- Addressing any immediate ongoing physical health needs.
- Contacting parents / carers.
- Seeking professional advice and support from external professionals e.g. doctor, nurse, EP, counsellor, or social services, through referral to appropriate services for the area in which the student resides.
- Referral to specialist mental health professionals for further assessment and support.
- Ensure the student is aware of sources of immediate support such as local mental health helplines, Samaritans, Childline and so on.
- Development of a support/ care plan, involving the student and their family members/ carers for when they are at school. This should include guidance from other professionals as appropriate and include alternative strategies as well as clarity around staff responses. This may be covered in an Individual Health Care Plan (IHCP) if appropriate.
- Taking into account how the student's self-harm may affect their friends, peer groups, family and other staff and providing appropriate support to reduce distress to the wider cohort. This may involve signposting for further support,

raising general awareness and understanding – for example through PSHE, staff CPD, parental workshops and drop ins, staff debriefs and supervision etc.

7. Further Considerations

7.1. Any meetings or discussions with a student, their parents or their peers regarding self-harm should be recorded as a safeguarding concern and should include:

- Dates and times.
- Concerns raised/ observed.
- Planned actions/ next steps/ follow up.
- Details of anyone else who has been informed.

7.2. This information should be recorded on the child's safeguarding files/ CPOMS.

7.3. It is important to encourage students to let you know if one of their peers is in trouble, upset or showing signs of self-harming.

Friends can worry about betraying confidences so they need to know that self-harm can be very dangerous, and that by seeking help and advice for a friend they are taking responsible action & being a good friend. They should also be aware that their friend will be treated in a caring and supportive manner.

7.4. The peer group of a young person who self-harms may value the opportunity to talk to a member of staff either individually or in a small group. Any member of staff wishing for further advice on this should consult one of the designated safeguarding leads.

7.5. When a young person is self-harming it is important to be vigilant in case close contacts with the individual are also self-harming. Occasionally schools discover that a number of students in the same peer group are harming themselves. This is a phenomenon sometimes called 'contagion'

7.6 Not all students are able to talk about the reasons behind why they are self-harming but are able to talk about the injuries themselves and how they are sustained. This is a form of coping mechanism for some young person. If the student is unable to stop self-harming, they need to understand how to physically look after the wounds it may cause to prevent further physical health implications.

7.7 All staff who support children who do, or who have high likelihood of self-harming, should be offered regular and appropriate training and supervision. Training should also include opportunities to explore staff attitudes, values, beliefs and biases towards self-harm.

8. Students should:

- Ensure all wounds are cared for properly and bandaged appropriately.

- Do not display fresh or open wounds.
- Avoid talking graphically about your injuries to other pupils or describing the methods you use.
- Never encourage anyone to try self-harm themselves.
- When under emotional distress or feeling the urge to self-harm at school, talk to a staff member as soon as possible.
- Try to discuss any additional support you feel you may need while you are going through emotional distress on a 'good day' so that there is a plan already in place when you need it.
- Be aware that staff are there to help you. The more you can talk to them the better able they will be to give you the support and help you need.
- If you are worried that a friend may be self-harming then do talk to a member of staff for support and guidance as we know this can have an impact on their mental health as well as a bystander.
- If you are concerned that a friend may be suicidal, or has mentioned suicide, then alert a member of staff straight away.
- If staff feel there may be a risk of contagion amongst the peer group, then the student may be asked to keep scars and wounds covered to help prevent further students undertaking in self-harm.

9. Parents should

- Understand and support the school's self-harm policy.
- Make sure you are informed and aware regarding self-harm and discuss the subject with your child.
- If your child is self-harming, engage with the school and take an active role in deciding the best course of action for your child.
- Keep the school informed of any incidents outside of school that you feel they should know about.
- Take care of yourself and seek any emotional support you may need in dealing with your child's self-harm. The school can offer support and signposting.

(General updates taken from NICE Guidance 'Self-harm: assessment, management and preventing recurrence', published September 2022).

10. A Tiered Prevention Approach

10.1. The primary reason for engaging in non-suicidal self-injury (NSSI) is emotion regulation. This includes individuals experiencing high levels of depression or anxiety and those who are under-aroused (i.e. feeling numb or disconnected).

NSSI can also be used for social reasons. For example, individuals can use NSSI to isolate themselves or withdraw from social situations, or it can help an individual gain attention from others.

10.2. The concept of NSSI having a social function has led to exploration into understanding social contagion. Social contagion is defined as the presence and spread of behaviour in at least two people in the same social network within a short period of time (Rosen & Walsh, 1989) or statistically significant clusters of people who engage in the same behaviour (Walsh & Rosen, 1985). Social contagion should not be confused with assortative relating, which refers to self-selecting a friend group from peers who engage in similar behaviours and may have similar experiences. Both social contagion and peer selection exist among youth who self-injure (Moyer & Nelson, 2007; Prinstein et al., 2010).

10.3. Walsh (2006) recommends three strategies for school professionals to minimise risk contagion: reducing communication about NSSI in the school or among peer groups, reducing public exhibit of scars and wounds, and providing short-term psychosocial treatment (short-term counselling and assessment) individually to students.

10.4. <u>A tiered approach to intervention strategies</u>

	Primary Prevention	**Secondary Prevention**	**Tertiary Care**
Tier 1 Level of Support	• Creating school-wide policies and procedures • Providing staff education at all levels • Classroom guidance focusing on emotion regulation and coping skills	• Classroom guidance aimed at discussing self-harm, wounds, and physical care	
Tier 2 Level of Support		• Small group intervention focused on coping skills and emotion regulation • Social network identification	
Tier 3 Level of Support		• Individual student meeting to determine function of NSSI to determine if referral for tertiary care is needed or if brief intervention is sufficient	• Referral of student to extended services • Check in with student

Although attention to policy and warning signs is important, equally important is attention to the driving forces behind NSSI and how to defuse those before they take hold. NSSI is related to emotion dysregulation, negative cognitions, and inadequate coping responses. Therefore, primary prevention efforts in the schools can target these aspects to train individuals at a young age how to identify and regulate emotions and cognitions.

10.5. Classroom guidance could include handouts and discussion of feeling faces worksheets or posters. Another tool is board games that include feeling and affective words and ask students to identify times when they have felt these emotions so they can begin to connect actual experiences to feeling words

10.6. Primary prevention efforts also need to include a step-by-step process for how to cope. Although mental health professionals and school personnel want students to engage in adaptive coping strategies, Trepal, Wester, and Merchant (2015) discovered that, regardless of engagement in NSSI, the more adaptive coping strategies young adults used, the more maladaptive coping strategies they also used. Further, individuals who self-injured reported the greatest number of coping strategies employed. This suggests that individuals who utilise multiple coping methods are potentially not using them effectively but are jumping from one method to another in hopes that one will work. Therefore, primary prevention efforts can be vital because they increase a youth's perception of their ability to effectively manage a stressful event. This process of walking through coping strategies may include breaking down coping step by step. For example, instead of suggesting students take a walk when they experience a high level of anxiety, school counsellors can teach the students how to take a walk mindfully. What do they see? What do they hear? What are they feeling both internally and on the surface of their skin? This breakdown of coping may also entail some guided imagery, such as how they can they imagine some of the intense emotion being pushed out of their pores while they are walking until it reaches a manageable level (Wester & Trepal, 2017). If students are provided with this information and education prior to engaging in NSSI, their appraisal of the situation may be altered when a stressful event occurs because they may have the tools to engage in effective coping strategies. This could then prevent the engagement in NSSI altogether, eliminating the possibility of contagion to others.

10.7. In secondary prevention, school staff would target students who are already engaging in NSSI. Secondary prevention could occur at any of the three tiers of support. Targeted tertiary prevention, which typically occurs in Tier 3, engages with students who chronically or severely self-injure and requires a much more systemic and targeted intervention than most schools can feasibly offer (ASCA, 2012, 2015); however, school personnel still have a role to play in helping identify and refer students who need wrap-around services to address chronic NSSI to appropriate services for the area in which the student resides. Addressing chronic NSSI can also assist in decreasing social contagion in a peer group. Although schools have roles in each of the three levels of prevention, the most strategic and effective use of school resources would be to intervene at the primary and secondary levels of prevention.

10.8. More details of the secondary and tertiary prevention strategies can be found in the source document:

NSSI in the schools: A tiered prevention approach for reducing social contagion by: Kelly L. Wester, Carrie Wachter Morris, and Breton Williams
K_Wester_NSSI_2017.pdf (uncg.edu)