Outcomes First Group

SELF-HARM & SUICIDALITY POLICY

For Options & Acorn Education & Clinical Teams

Outcomes First Group

SELF-HARM & SUICIDALITY 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 everyone we support. We are committed to effectively managing and reducing the risk of self-harm and suicidality (suicidal behaviours and ideation) by developing understanding of the reasons for the behaviour and implementing good professional practice in our settings.

Self-harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, running in front of cars etc., where the intent is to deliberately cause self-harm.

Suicidality refers to the spectrum of suicide-related thoughts, intentions, and behaviours, including suicidal ideation, planning, attempts, and actions that indicate risk of suicide.

Self-harm and suicidality are both addressed within this policy due to their close association and shared risk factors. While they are distinct behaviours, self-harm is a known risk factor for suicide and may indicate increased vulnerability. All OFG members have a duty to safeguard against self-harm and suicidality. Addressing both within a single policy ensures a consistent, proactive approach to identification, risk management, and safeguarding.

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 student is displaying and therefore the most effective way to respond.

Self-harm is when people deliberately hurt their bodies, with a core intention to cause physical pain or harm to themselves (with or without suicidal intent), whereas self-injurious behaviour is the result of an attempt to self-regulate, express pain/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 – where necessary the clinical team can support in identifying the most appropriate policy to use. As a guide, the self-harm and suicidality policy will usually be followed for students 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 and documents that team members must be familiar with include:

- Self-Harm and Suicidality Guidance (please see Appendix F)
- Ligature Management Policy and related documents including:
- Ligature and Ligature Point Audit Guidance (G25)
- Ligature and Ligature Point Audit Guidance (G25) and Audit Form (CL20)
- Safe use of Hook Ligature Cutters Procedure (SOP10)
- Risk Assessment Templates (Health & Safety)
- Behaviour Policies and Information (Schools and Colleges)
- Use of restrictive intervention and reasonable force policy
- Serious Incident Notification Policy Education
- Group Supervision Policy
- Online Safety & Mobile Devices

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 HOW TO RESPOND TO SELF-HARM & SUICIDALITY

3.1 Be aware of signs that a child might be at risk of harm

See 'Self-Harm and Suicidality Guidance' (Appendix F) for risk factors, triggers and warning signs to be aware of.

3.2 Ensure immediate safety

When an incident relating to self-harm/suicidality occurs, aim to ensure physical safety and act immediately whilst also minimising additional stress or shame.

Team members should establish and act on the following as soon as possible:

- **Severity of injury (if any) and need for medical treatment:**
  Address any immediate physical health needs in line with first aid and emergency procedures. Call 111/999 or other emergency support if required. Use first aid and physical intervention where necessary.
- **Emotional and mental state / level of distress:**
  Consider whether specialist mental health assessment is required. In the event of suicidality, a referral must be made to CAMHS immediately (the referral can be made by education or clinical team and following liaison with parents/carers). Inform OFG's clinical team immediately (within maximum 24 hours - see Appendix A). Where the student is under external mental health services, follow their guidance where available, without delaying immediate safety actions. Headteacher, DSL, Lead Clinician and SENCo to be made aware of any referral made to CAMHS.
- **Immediate safety risk:**
  Increase supervision where needed. Do not leave the student alone if risk is present. Remove harmful items discreetly and respectfully where appropriate.
- **Safeguarding concerns:**
  Report any safeguarding concerns to the Designated Safeguarding Lead at the earliest safe opportunity and follow Safeguarding Policy.
- **Existing safety plan:**
  Where available, this should be referred to and used to inform immediate actions where appropriate.

- **Overdose or intoxication:**
  Any overdose (however small) requires medical advice (A&E or GP). If intoxicated by drugs or alcohol, seek urgent medical assessment and support.

Suicidality requires multi-agency safeguarding-led management in addition to any internal support planning tools – see section 3.9 for further guidance.

3.3 Respond in a trauma-informed and neurodiverse-affirming way

All disclosures, incidents or concerns relating to self-harm or suicidality must be taken seriously and never dismissed.

Responses should be calm, non-judgemental, supportive and measured. Team members should communicate confidence in their ability to support the student, even in distress. Where a student discloses self-harm or suicidality, acknowledge their distress and the courage it has taken to seek help, for example: "I'm really glad you've told me this. I can see you're struggling and I want to help keep you safe."

Provide reassurance, care, and explain limits of confidentiality, including why information may need to be shared to ensure safety. Give the student space to share at their own pace. Staff roles are focused on **active listening and immediate support**, not therapeutic intervention: "I can hear that this feels really overwhelming. I'm here with you and we will get through this together." Clinically trained staff are best placed to provide further therapeutic input. For further guidance regarding how best to engage with students presenting with self-harm and/or suicidality, see 'Self-Harm and Suicidality Guidance' (Appendix F).

Support must be delivered with respect, dignity, and cultural sensitivity. Work collaboratively with the student wherever possible to maintain trust and agency. Where communication is difficult, support alternative methods (non-verbal communication, writing, safe words, emojis). Make reasonable adjustments for disability, neurodiversity, and mental health needs.

3.4 Physical Intervention and restraint

Some situations may require physical intervention using approved CPI techniques.
Refer to the Use of restrictive intervention and reasonable force policy.

All physical interventions must be recorded within 24 hours. Once safe, team members must complete reporting via the electronic system.
Clinical teams must be informed and involved in reviewing support plans following incidents.
Post-incident support and debriefing must be provided to both students and staff. For further information see above policy.

3.5 Response to ligatures

Refer to *Health & Safety* Ligature Management Policy and related documents:

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

Where a ligature is applied, it must be removed as quickly as possible. If ligature use is known or repeated, the support plan must be developed with the clinical team and key adults and clearly outline agreed strategies and responses. Contact details and escalation pathways must be clearly available to staff.

It is Mandatory for Options and Acorn education settings to have the following team members trained in 'Ligature':

- Headteacher/Principals (good practice also for Exec Heads)
- Deputy/Assistant Head Teachers
- All Nominated First Aiders

Where there is an individual known to be at high ligature risk, this minimum should be increased to include team members supporting that individual or, where there are further concerns, then the full team on site.

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 support plan can be completed, including agreed strategies for management of any future incidents.

3.6 Approach to Assessing and Meeting Needs

There is clear evidence that **risk assessment tools and scales are not an effective basis** on which to predict future suicidality 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 individual'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. See section 4, 'Seeking Professional Support', for information around how the education team can work with other professionals to complete a 'Self-harm/Suicidality Formulation & Support Plan'. Other strategies to support students are described below.

Following assessment and an agreed support plan, the individual's wellbeing should be monitored, and support reviewed regularly, with staff being alert to changes, escalation or further warning signs.

3.7 Coping strategies to help

A 'Safety Plan' (Appendix C, D & E) should be completed or reviewed with the student to support coping and early intervention (see Appendix A for process). Where possible, this should be completed collaboratively with the student.

Where self-harm is present, the Safety Plan may be used as part of planned support to help identify triggers, warning signs, and safer coping strategies. Where suicidality is present, the Safety Plan must be used only as a supportive structure and must be implemented alongside immediate safeguarding actions, active clinical oversight (OFG clinical team involvement), and escalation to external mental health services where appropriate (e.g. CAMHS or crisis services). It must form part of, and not replace, multi-agency risk formulation and safeguarding processes. The Safety Plan is not a risk assessment tool and must not be used as a standalone intervention in cases of suicidality.

Consideration should be given regarding who will work with the student to complete of this plan: where possible it will be the student's preferred member of team, with support from the pastoral team and/or clinical team where appropriate.

Students should be supported to develop safer coping strategies tailored to function and need, including:

- Writing feelings down or expressive writing
- Helplines or external support contact
- Physical release (e.g. exercise, hitting a pillow)
- Relaxation and grounding techniques
- Self-soothing strategies (e.g. sensory tools, “self-soothe box”)
- Cold stimulation (ice packs/cold water where appropriate)

Ensure that the student is aware of appropriate sources of support, such as:

- OFG’s clinical team
- Local NHS urgent mental health helplines
- Local authority social care service
- Samaritans
- Papyrus Hopeline 247
- Combat Stress helpline
- NHS111
- Childline

3.8 Environment

Environmental risks must be assessed and managed using the least restrictive approach. Where appropriate, items that may be used for self-harm should be removed or secured, while balancing autonomy, dignity, and distress. Students should be involved in safety planning wherever possible.

The ‘Self-Harm/Suicidality Formulation & Support Plan’ should be updated to reflect environmental risk management.

Consideration should be given to dynamic risk (items previously used may be repeated, but substitution risk must also be considered). Returning removed items to the environment can be considered when it is appropriate and following assessment, so that the environment is as least restrictive as possible.

3.9 Additional considerations when suicidality is present

While the core principles of this policy apply to both self-harm and suicidality, the presence of suicidality requires heightened safeguarding and immediate escalation. Where a student expresses suicidal thoughts, intent, planning, or behaviour:

- Immediate safety takes priority at all times, including continuous supervision where risk is present
- The Designated Safeguarding Lead must be informed as soon as possible in line with safeguarding procedures
- The OFG clinical team must be contacted without delay to support risk assessment and ongoing management
- External mental health services (e.g. CAMHS or crisis services) must be involved or contacted immediately (without clinical team involvement where necessary)
- Direct and clear exploration of suicidal thoughts (including intent, plan, means, and timeframe) should be undertaken in a calm, non-judgemental manner where appropriate and with support from the clinical team
- Do not rely on the Safety Plan alone; it must be supplemented by active risk management and external professional involvement
- Decisions must be guided by multi-agency collaboration

All relational and trauma-informed responses outlined in Section 3.3 remain essential; however, they must be delivered alongside immediate safeguarding action. The Safety Plan must not replace clinical risk formulation, safeguarding action, or external mental health assessment.

4.0 SEEKING PROFESSIONAL SUPPORT

For all incidents involving suicidality/self-harm the education team will involve the clinical team to some degree. See Appendix A for the required process.

4.1 School's clinical teams

Schools must notify the clinical team of all self-harm and suicidality incidents immediately to ensure appropriate multidisciplinary support is accessed where needed. See Appendix A for guidance on when and how the clinical team should be involved.

The clinical team may support in the following ways:

- Collaborative development of a risk formulation using the 'Self-harm/Suicidality Formulation & Support Plan'
- Supporting completion of the 'Understanding Me' document and/or Safety Plan
- Providing consultation and/or reflective practice to team members
- Delivering OFG training (e.g. 'Working Therapeutically with Self-Harm')
- Reviewing school-based risk assessments and support plans
- Supporting communication with students and families/carers
- Providing direct intervention where appropriate using evidence-informed approaches
- Supporting referrals to external agencies

Further assessment may be undertaken by the clinical team where required.

Where suicidality is present, a referral to CAMHS should be made immediately, following liaison with parents/carers. Any professional can make a referral to CAMHS and this can be completed without clinical support where this is not available. Headteacher, DSL, Lead Clinician and SENCo to be made aware. The education and clinical team will work under CAMHS guidance to inform school-based support.

4.2 Self-Harm/Suicidality Formulation & Support Plan

A 'Self-harm/Suicidality Formulation & Support Plan' (see Appendix B and Section 7) should be completed or reviewed with the student and, where appropriate, their family/carers. It is used to support the student within the education setting and should incorporate input from relevant external agencies where involved.

The clinical team will determine their level of involvement in completion of the plan (see Appendix A). In some cases, this will be completed by education staff with clinical guidance.

The formulation aims to understand the student's current presentation, risks, and needs in order to inform support. It should consider historical, current, and future factors alongside strengths and resources.

Key areas to include:

- the student's values, preferences, wishes and what matters to them
- the need for psychological interventions, social care and support
- learning disabilities, neurodevelopmental conditions or mental health difficulties
- reasons for self-harming (appreciating that this may vary from episode to episode)

- social, education and home situations
- any caring responsibilities
- online/social media influences (refer to OFG's policies and guidance where appropriate, including 'Web Filtering Monitoring Policy': Online Safety & Mobile Devices)
- safeguarding concerns
- historic, current and future risk factors
- strengths and protective factors.

The clinical team will support development of the formulation alongside education staff, external agencies (e.g. CAMHS), and the student where appropriate.

Where suicidality is present, the clinical team must support completion of the formulation and support plan and ensure appropriate external referrals are made, working in line with external agency guidance.

4.3 Reoccurring Self-Harm & Suicidality

For students who self-harm/experience suicidality, the aim is to prevent any recurrence. In the event of reoccurring self-harm/suicidality hold a multidisciplinary review (with the student where appropriate) to agree a coordinated plan, involving OFG clinical teams.

This should include:
- Review of existing support and external referrals
- updating the Self-harm/Suicidality Formulation & Support Plan, and Safety Plan with the student
- consideration of further assessment led by the clinical team

4.4 Referral to external agencies

In collaboration with the clinical team and the team around the child, decisions should be made regarding referral to external services (e.g. CAMHS or GP). This should be based on formulation, presenting needs, risk factors, protective factors, and response to previous interventions, rather than risk scoring tools.

Where suicidality is present, a referral to CAMHS should be made immediately, following liaison with parents/carers. Any professional can make a referral to CAMHS and this can be completed without clinical support where this is not available. Headteacher, DSL, Lead Clinician and SENCo to be made aware. The education and clinical team will work under CAMHS guidance to inform school-based support.

5.0 SUPPORTING TEAM MEMBERS AND OTHER CHILDREN

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

Reflective practice sessions (group and/or individual), supervision, debrief meetings and regular team meetings will help team members to deal with what they observe, learn from the incident, and minimise future risk of injury to the individual. The information in the 'Self-Harm and Suicidality Guidance' document (Appendix F) may also be helpful.

Team members should take into account how the student's self-harm/suicidality may affect their close friends and peer groups. Manage peer awareness carefully. Appropriate support should be provided to reduce distress to them, and to reduce contagion risk or social pressure. The setting should contact the clinical team if advice is required around how best to support peers.

Please also see the Wellbeing Policy for team members

6.0 REPORTING AND RECORDING

All incidents involving self-harm, suicidality and self-injurious behaviour must be recorded in line with the Safeguarding Policy and Procedures on the individual's file, on the school's case file management system and, where appropriate, reported under a Serious Incident Notification on Info Exchange. (see policy: Serious Incident Notification Policy - Education). Where there are safeguarding concerns, report to DSL in the first instance.

All incidents involving suicidality or self-harm should be reported to the site's clinical team immediately (within maximum 24 hours - see Appendix A). The SLT in each service should agree how an incident involving self-harm/suicidality should be reported to the clinical team. This should include agreement around which clinical team member to be informed (e.g. Clinical Lead) and method of communication (e.g. via Sleuth notification). 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.

Unless there are safeguarding reasons not to do so, incidents will be reported to the individuals' parents/carers at the earliest opportunity: SLT will decide most appropriate member of staff to report to parents/carers. Incidents may also require reporting to a regulatory body as appropriate.

7.0 DOCUMENT LINKS

OFG's Safety Plan

OFG's Self-Harm & Suicidality Formulation and Support Plan Template

APPENDICES

Appendix A – Process for Options and Acorn Schools to Follow

Self-Harm/Suicidality Incident

Follow policy guidance regarding immediate response:
All team members involved to ensure immediate safety of student and those around the student (using first aid, physical intervention and assessing safety of environment.)
Safeguarding referral made to DSL (where applicable).

For **suicidality**, referral must be made to CAMHS immediately (and without clinical support where necessary)

Complete/review Safety Plan following immediate safeguarding actions and clinical escalation where suicidality is present.

AND

Complete Incident Report (team member/s involved to complete, detailing immediate actions taken, intervention implemented and identifying immediate triggers and contributing factors to incident)

Share incident report with Clinical/Education team as soon as possible
(by team member/s involved in incident: within max. 24 hours of incident)
Where appropriate, and at earliest opportunity, share incident with other key adults (including parents/carers)

Clinical team to review incident report and judge level of clinical input required
(informed by formulation rather than risk rating tools)
Consider: frequency, intensity, method/type, change in student's need and ability to be managed by education team when making judgment. See guidance overleaf *

Clinician to record judgment on Formulation & Support Plan – share with education.

Education team to complete/review Formulation and Support Plan informed by incident report and Safety Plan. Request support from clinical team where necessary.

Education, Clinical team and key adults (e.g. parents/carers) to review / contribute to Formulation and Support Plan via MDT meeting informed by incident report, Safety Plan and clinical knowledge (informed by further assessment where applicable)

Post-incident multi-agency consideration:

- Outside agency(s) input or referral. Where student presents with suicidality, clinical team to support referral to CAMHS/other appropriate outside agency and work under their guidance.
- Clinical training/consultation need
- Staff/student wellbeing (of all impacted).

***Guidance to support Clinical judgement: level of clinical input required**

Clinical team will need to consider the following factors when deciding level of input required:

Suicidality	Where the student is presenting with suicidality, **the clinical team will support education team as part of a multi-disciplinary response and under the guidance of CAMHS** and other appropriate outside agency.
New behaviour:	This is the first time the student has self-harmed in their life and/or whilst being in the service (to the services knowledge).
Frequency:	The student has self-harmed before and/or the student has self-harmed more often than previously/the time between self-harm incidents has decreased. For a student who has self-harmed before, the aim should always be to avoid any further self-harm.
Intensity:	The severity of the self-harm has increased, the student has used further methods of self-harm, and/or required further intervention e.g. medical attention.
Method/Type:	The student has used a different method of self-harm e.g. different tools, different part of body, different category/type of self-harm.
Have the student's needs changed?	e.g. there is a need to address the behaviour in a different way to align with the student's updated preferences and/or the self-harm behaviour needs to reduce further or is re-occurring.

Appendix B – Self-Harm Formulation Support Plan

Self-harm/Suicidality: Formulation and Support Plan

Pupil Name		**Form/year Group**	
Completed by		**Role**	
In Collaboration with		**Role/s**	
Date of completion		**Version no.**	

Consideration should be given following each self-harm/suicidality episode whether this document should be reviewed.
A review should take place, at least, following a change to self-harm/suicidality behaviour.
Whenever reviewed, a new version should be completed and kept on file with previous versions.

As per self-harm/suicidality policy, when there is a presentation of suicidality this document should be completed by a qualified clinician (a psychologist/with oversight from a psychologist), and involvement from outside agencies should always be sought.

This section is to be completed by a member of the clinical team with relevant experience. Clinical judgements should be made resulting from incident Report: (see Appendix A of Self-harm & Suicidality Policy for guidance)		
Date of Incident Report Reviewed:		
Education team to complete/review Formulation & Support Plan - clinical input not deemed necessary for completion (other than on request) **NB. If incident relates to suicidality clinical input necessary (and external referral).** **Comments to support clinical judgment made:**	Yes	No
Signed (clinician's signature, name and job role): **Dated:**		

Self-harm/Suicidality Formulation (Current and Historical Factors leading to Self-harm/suicidality)
Each episode of self-harm/suicidality should be treated in its own right, as the individual's reasons for self-harm/suicidality may vary from episode to episode.

Presenting (what do we see/what is the presenting concern, including any known thoughts, feelings, and behaviours relating to self-harm/suicidality?):

Description of the individual's self-harm/suicidality behaviour

Description of the individual's other presenting difficulties that might relate

Considerations: What happens and how frequently do they occur, including dates if known? Where does it happen? What is their intention at the time of the thoughts/behaviours (e.g. do they plan to harm or end life)? Do they have any specific date, time, location and/or method in mind (describe this)? What support is accessed (including medical where relevant)? What are the individuals' thoughts and feelings about any incidents (regret, sad, plan again)?

Predisposing (what are the factors that make this behaviour more likely/what are the long-term internal or external factors that make the individual more susceptible/vulnerable?):

Considerations: Details of past incidents if additional/different to above. Has the frequency changed over time? Any past significant events e.g. loss, trauma etc? Any learning disability, diagnoses, ACEs, neurodevelopmental conditions or mental health problems that could be associated? What has been their social, peer group, education and home situations? Any caring responsibilities? What is their use of social media/internet and the effects of these on mental health? Any child protection or safeguarding issues?

Precipitating (what are the immediate internal and external triggers/antecedents that set the self-harm/suicidality behaviours in motion?):

Considerations: What makes self-harm/suicidal thoughts or behaviour more likely or higher risk? In what situations have the thoughts/behaviour/s occurred? What factors are causing the individuals distress? What are the unmet needs? Where does the individual see themselves in the future?

Perpetuating (what current internal and external factors keep this difficulty going? This might include unresolved Predisposing factors):

Considerations: Consider individuals needs/diagnosis/communication/understanding/coping skills and support. What are the potential consequences and/or benefits for the individual? What are adult's responses to the individual's risk? Are the responses of others exacerbating the risk? Individual is closed about self-harm/suicidal thoughts or behaviours?

Protective (internal and external resiliency, strengths and resources which help to maintain an individual's emotional health):

Considerations: What keeps this individual safe? What are the individual's strengths? Current coping strategies? What makes the thoughts/behaviours less likely or less severe? Any actions taken in the past successfully reduced risk? Other services involved? Individuals support network?

Nature of Suicidality Presented (where applicable): to be completed by clinician with relevant experience		
Evidence of Suicidal Ideation (thoughts of engaging in behaviour intended to end one's life)	Yes	No
Evidence of Suicide Plan (formulation of a specific method through which one intends to die)	Yes	No
Evidence of Suicide Attempt (engagement in potentially self-injurious behaviour in which there is at least some intent to die)	Yes	No

Current Presenting Risk (to consider level of concern and immediacy of interventions)

Considerations: Use information gathered in this section to inform Support Plan (below)

What is the severity? (the impact that the risk will have if it occurs)

What is the frequency of the student's behaviour? (ranging from 'one off' to repeated persistently)

What is the student's current mental state? (i.e. levels of distress, impulsivity)

Level of support available to student?

What's the student's level of preoccupation? (ranging from fleeting to persistent and intrusive ideas)

What's the student's level of planning? (ranging from poorly thought-out plans to persistent and comprehensive plans)?

What the student's access to resources required to action the plan?

What are the signs of increasing concern? *(what do we need to look out for? E.g. what they may do or say. Consider previous version/s of this document)*

What events or circumstances are coming up in the future that might impact risk?*(e.g. transitions, losses etc.)*

What is the impact of the student's self-harm/suicidality on others in the school?

Support Plan This is a support plan devised by adults to mitigate and address risk, including 'safety actions' (e.g. monitoring of individual, provision of space to communicate emotions and removable of specific risk objects). Please also see the student's 'My Coping Plan' / 'Safety Plan' for other strategies agreed.		
Specific concerns to Mitigate (record risks in order of priority – use 'Current Presenting Risk' section to inform this):	**Actions Agreed (record actions in order of priority – immediate first):**	**To be completed by – whom and when:**
Detail how the Support Plan has considered mitigating concerns in the environment?		
Detail if and how the student's views have been sought.		
Where the student's views have not been gained, state reasons for this:		
Detail if and how the individual's parents/carers have been consulted (if appropriate).		
Does the individual need further clinical involvement? If so, please provide details.		
Does a referral need to be made to an outside agency? If so, please provide details. NB. In the event of suicidality, involvement from outside agencies is always required.		
What support will be provided to reduce the impact on/support others in the school		

Plan shared with:	**Student**	**Education Team** *(state who)*	**Clinical Team** *(state who)*	**Parent/Carer** *(state who)*	**Other** *(state who)*

Appendix C – Safety Plan (non-widget version)

Safety Plan

A 'safety plan' helps you think about your self-harming and safer ways to cope. Complete this when you are calm to help plan for future moments of distress.

It can also be used in the moment, when you have the urge to self-harm. Try not to immediately act on your emotions: Instead, use this plan.

You can use this either in private or alongside someone. Ask for help at any point.

When am I more likely to self-harm (what are the trigger situations)?

What are the warning signs that I might self-harm (what do I feel, think or do before self-harming)?

What safe/healthy things have I done in the past that helped me cope?

Remember that emotions are like a wave - the feelings will pass eventually. What strategies will I use to 'ride the wave'? *e.g. write down/draw how I am feeling, have a cry, talk to someone, exercise, do a hobby, do a self-care activity (have a bath or do mindful breathing) or distract myself (watch tv, listen to upbeat music)*

What will I tell myself instead of self-harming? *e.g. I am safe, this feeling will pass, I am supported. Try telling yourself 3 positive things about you/your life.*

What advice would I give a close friend who was feeling this way?

Who can I ask for help when it is needed (insert selected phone numbers)?

- Friend or relative:
- Health professional (GP, NHS111, CAMHS):
- Telephone helpline (e.g. Childline, Papyrus Hopeline 247, Samaritans, Combat Stress helpline):
- Other (e.g. school member if in school):

What could others do to help? e.g. keep me company, give me a hug, talk to me or take dangerous items away

What safe place can I go to? e.g. a room, place or area that feels comfortable – this can be in your imagination!

If I have hurt myself

I may need to go to a hospital 'A&E' department. If I can't get there safely, I will call 999.

Appendix D – Guidance for use of safety plan 'in the moment'

Guidance for use of safety plan 'in the moment'

The safety plan can also be used 'in the moment', when the student has an urge to self-harm.

If an adult is supporting the student 'in the moment', it is essential to consider the student's arousal levels and at what level they are cognitively and emotionally able to engage with the safety plan.

If the student is able to engage fully with their safety plan, use the prompts in green when working through their safety plan to make it applicable to the current situation and to support the student to further regulate and reflect:

1. **When am I more likely to self-harm (what are the trigger situations)?** ***In the moment: Identify with the student what situation has triggered this urge.***
2. **What are the warning signs that I might self-harm (what do I feel, think or do before self-harming)?** ***In the moment: Identify with the student what you are feeling and thinking now.***
3. **What safe/healthy things have I done in the past that helped me cope? AND Remember that emotions are like a wave - the feelings will pass eventually. What strategies will I use to 'ride the wave'?** ***In the moment: Identify with the student which strategy to use now.***
4. **What will I tell myself instead of self-harming?** ***In the moment: Encourage the student to say these things to themself now.***
5. **What advice would I give a close friend who was feeling this way?** ***In the moment: Encourage the student to give themselves the same advice now.***
6. **Who can I ask for help when it is needed (insert selected phone numbers)?** ***In the moment: Ask the student if they need to call or talk to someone else now?***
7. **What could others do to help?** e.g. keep me company, give me a hug, talk to me or take dangerous items away ***In the moment: Offer the student the support that they had identified on the plan.***
8. **What safe place can I go to?** ***In the moment: Offer to support the student to access their safe place now.***

If the student is not regulated enough to be able to work through the safety plan in this way, support the student to access the strategies that they have identified under sections 3-8 (see above) of their safety plan. This may be through verbal support (e.g. reminding of them of the strategies on their plan) and/or visual/practical support (e.g. offering them relevant resources or activities relating to their strategies).

Appendix E – Safety Plan (completed example)

Safety Plan – Completed Example

A 'safety plan' helps you think about your self-harming and safer ways to cope. Complete this when you are calm to help plan for future moments of distress.

It can also be used in the moment, when you have the urge to self-harm. Try not to immediately act on your emotions: Instead, use this plan and follow the green font.

You can use this either in private or alongside someone. Ask for help at any point.

When am I more likely to self-harm (what are the trigger situations)?
When I am tired and after family time 
What are the warning signs that I might self-harm (what do I feel, think or do before self-harming)?
Anxious, stressed and alone 
What safe/healthy things have I done in the past that helped me cope?
Phoning Jo and being honest with her. *Keeping busy.* *Being with other people.* *Writing down my thoughts and feelings – and reminding myself of alternative ways of looking at things.* 
Remember that emotions are like a wave - the feelings will pass eventually. What strategies I will use to 'ride the wave' *e.g. write down/draw how I am feeling, have a cry, talk to someone, exercise, do a hobby, do a self-care activity (have a bath or do mindful breathing) or distract myself (watch tv, listen to upbeat music)*
Focus on my breathing. *Do something else, anything, for at least 20 minutes. Then do something different if it still feels overwhelming.* *If I still have urge to self-harm – I'll call Jo (or others in my plan)* 
What I will tell myself instead of self-harming *e.g. I am safe, this feeling will pass, I am supported. Try telling yourself 3 positive things about you/your life.*
I've got through this before, I can get through this now. These are horrible thoughts, but they are just thoughts, I don't have to act on them. I love Jo and my family and I don't want to hurt them. I am loved.

What advice would I give a close friend who was feeling this way?

You will get through this. You will feel better tomorrow and be grateful you got through it. Just do what helps.

Who can I ask for help when it is needed (insert selected phone numbers)?

- Friend or relative: *Joe or Helen*
- Health professional (GP, NHS111, CAMHS):
- Telephone helpline (e.g. Childline, Papyrus Hopeline 247, Samaritans, Combat Stress helpline):
- Other (e.g. school member if in school): *Miss Smith*

What could others do to help e.g. keep me company, give me a hug, talk to me or take dangerous items away?

Be with me and remind me of what I need to do.

A safe place I can go to e.g. a room, place or area that feels comfortable – this can be in your imagination!

To where my keyworker is, outside or imagining my 'safe place' (on the beach)

If I have hurt myself

I may need to go to a hospital 'A&E' department. If I can't get there safely, I will call 999.

Appendix F - Self-Harm and Suicidality Additional Guidance

Self-Harm and Suicidality Additional Guidance

PURPOSE

The purpose of this guidance is to provide further insight into self-harm and suicidality so that teams can be better informed when supporting students. The guidance should be considered with the individual student in mind and may be particularly useful when completing the Self-Harm/Suicidality Formulation and Support Plan.

WHAT IS SELF-HARM & SUICIDALITY?

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 suicidal intent whilst others do not. There are many 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. As described earlier, self-harm is when people deliberately hurt their bodies, with a core intention to cause physical pain or harm to themselves (with or without suicidal intent), whereas self-injurious behaviour is the result of an attempt to self-regulate, express pain/discomfort or communicate. Self-injurious behaviour 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 and body modification for aesthetic purposes.

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

Suicidality refers to the spectrum of suicide-related thoughts, intentions, and behaviours, including suicidal ideation, planning, attempts, and actions that indicate risk of suicide. Nonfatal suicidality can be categorised as follows:

1. ***Suicide ideation*** *- thoughts about death or suicide ranging from passive wishes not to be alive to active thoughts about ending one's life;*
2. ***Suicide intent and plan*** *– thoughts that include a desire or decision to act, and/or consideration of methods, timing, or means; and*
3. ***Suicide behaviours*** *– actions taken, or preparatory acts, with the intent to end one's life, including suicide attempts.*

Suicidal ideation can escalate into suicidal attempts, particularly when combined with risk factors such as distress, hopelessness, substance use or reduced protective supports.

All forms of self-harm and suicidality should be taken seriously as they indicate an increased risk to an individual's safety and wellbeing, thus requiring appropriate safeguarding assessment and response.

UNDERSTANDING & IDENTIFYING SELF-HARM & SUICIDALITY

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

Intrapersonal – behaviours/thoughts may be a coping mechanism and a way of managing, controlling, escaping or ending strong emotions. This type of self-harm/suicidality may be hidden from others, e.g., covered cutting on forearms. Thoughts or behaviours may temporarily reduce distress or create a sense of relief or control.

Interpersonal – behaviours are relational and may be referred to as 'attachment seeking' or 'attention needing'. The behaviour may function to communicate distress**,** seek connection**,** or influence relationships when an individual feels unable to express their needs in other ways. It may arise from fears of abandonment, feelings of being unheard or misunderstood, or a need for care, reassurance, or protection. Due to some children/young people not having their underlying needs met consistently in their early development, they may develop these ways to feel seen and heard.

There can be a mix of the above two functions. Understanding the function of such behaviour helps inform appropriate, compassionate responses focused on reducing distress, strengthening coping strategies, and increasing emotional safety, rather than viewing the behaviour as attention-seeking or manipulative.

Risk Factors

Although not an exhaustive list, the following risk factors, particularly in combination, may make a child/young person vulnerable to self-harm and suicidality (those in bold are more strongly associated with suicidality):

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 • Impulsivity • Substance misuse • Recent triggering events e.g. bereavement • Perfectionism • Exam pressure • Genetics • High levels of agitation • **Persistent hopelessness and/or beliefs that others would be better off without them** • **Previous suicidality** • **Access to means** • **Self-harm itself is an indicator of increased suicide risk**	• 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.	• Social isolation • 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

Triggers

A number of factors may trigger self-harm or suicidality. These include:

- 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
- Exposure to self-harm or suicidal behaviour e.g. in other students (contagion effect), media or online
- Identification with a peer group which promotes self-harm
- Substance use e.g. reducing inhibitions and increasing impulsivity
- 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
- Perceived failure or pressure e.g. exams or facing disciplinary action
- Times of change e.g., parental separation/divorce
- Intense emotional distress e.g., shame, hopelessness, anger or feeling trapped
- Accumulation of stressors (rather than a single event)

Warning Signs

There may be a change in the behaviour of the child/young person that is associated with self-harm or suicidality, although these changes may not be evident. Signs to be aware of may include:

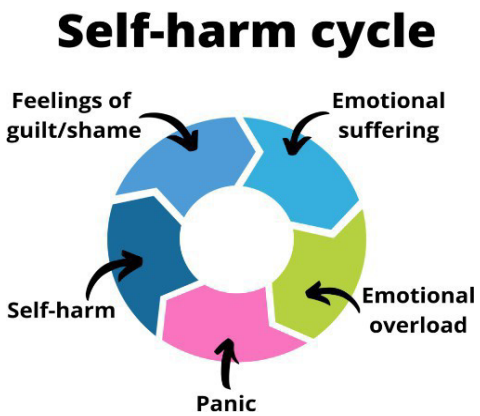
- Changes in eating/sleeping habits
- Increased isolation/withdrawal from friends/family
- Changes in activity e.g., loss of interest in activities or increase in risk taking activities
- Lowering of academic grades
- Communication indicators, such as talking about self-harming or suicide, including on social media
- 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
- Reduced coping e.g. easily overwhelmed or difficulty managing everyday stressors
- Extremely sensitive to rejection
- Self-defeating comments and attitude
- Extreme emotions (e.g. intense sadness, anxiety, anger, shame) or mood changes (due to the cycle of self-injury, including a calmness after distress).
- 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)
- Increased time with peers who self-harm
- Escalation in frequency or severity of self-harm (specific to suicidality)

What keeps the self-harm cycle going?

Once self-harm (particularly cutting) is established, it may be difficult to stop. Self-harm can have several functions for the child/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

Self-harm and suicidal thoughts can temporarily relieve emotional distress by triggering the brain's stress and reward responses. When a person inflicts physical pain, the body releases endorphins—natural pain relievers that can create a brief sense of relief or calm. Although physical pain is still felt, some young people report it feels more manageable than the emotional pain that led to the behaviour. The temporary relief reinforces the cycle, making self-harm increasingly difficult to stop over time.



METHODS OF SELF-HARM & SUICIDALITY

Methods

Methods of self-harm and suicidal behaviours may include but are not limited to: cutting or injury to the skin, burning or scalding, overdose or poisoning, hanging or suffocation, jumping from height or into traffic, and other deliberate exposure to life-threatening situations. The same method may be used with or without suicidal intent; therefore, all incidents must be treated as high risk and managed in line with safeguarding procedures.

Some actions might not normally be categorised as self-harm but are when the intent is to cause harm or increase risk e.g. misuse of alcohol or substances, deliberate restriction or misuse of food intake, increase in risk-taking behaviours or interfering with wound heading. Avoid making assumptions about intent or behaviour function based on behaviour or method presented.

Self-harm and suicidality can be a transient behaviour in children/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 incidents is greater.

HOW TO RESPOND TO SELF-HARM AND SUICIDALITY

The OFG Self-Harm and Suicidality Policy must be followed at all times. This includes ensuring immediate safety and responding in a trauma-informed, compassionate, and consistent manner. The following are additional responses and strategies. These responses apply to both self-harm and suicidality and reflect a trauma-informed, relational approach. Where suicidality is present, these responses must always be delivered alongside immediate safeguarding action, risk assessment, and escalation procedures as outlined in the policy:

Helpful Responses

- **Be calm, non-judgemental, and practical**
  Use self-regulation strategies to remain calm; a regulated adult supports co-regulation.
  Focus on immediate care and safety.
  Example: "Let's make sure you're okay."
- **Be sensitive and empathic**
  Acknowledge the pupil's experience without judgement.
  Example: "I'm really sorry you're feeling this way. That must be hard."
  This helps reduce shame and supports emotional validation.
- **Recognise the power of listening**
  Feeling heard can reduce distress and isolation. This is important for both self-harm and suicidality but must be combined with appropriate safety and risk management where suicidality is present.
- **Recognise behaviour as communication of need**
  Behaviour is the "tip of the iceberg," reflecting underlying emotional, relational, or environmental factors (e.g. trauma, anxiety, attachment needs). It may function as a way of coping or communicating distress
- **Understand and meet the underlying need**
  Consider:
  - What is the function of the behaviour?
  - What need is not being met?
  - How can this need be met more safely?
- **Allow time and avoid expecting immediate change**
  Change is gradual and requires development of alternative coping strategies. This applies to both self-harm and suicidality; however, suicidality must always be managed alongside immediate safety and ongoing risk management.
- **Use a PACE approach (Playfulness, Acceptance, Curiosity, Empathy)**
  - *Empathy:* "That sounds really overwhelming."
  - *Curiosity:* "I wonder what was going on for you earlier?"
    This supports psychological safety and exploration without blame.
- **Support development of safer coping strategies**
  Help pupils build alternative ways to manage distress, such as:
  - grounding techniques
  - mindfulness or breathing exercises
  - sensory or self-soothing strategies
  - distraction or expression (e.g. drawing, writing)

- **Develop and follow a Safety Plan**
  OFG's Safety Plan can be used to support pupils experiencing self-harm and emotional distress. **Where suicidality is present, any Safety Plan must be used as a supportive tool alongside clear risk management, supervision, and safeguarding escalation procedures. It must be developed with clinical oversight and where appropriate in collaboration with external agencies (e.g. CAMHS or crisis services) and must not be used as a standalone intervention.**

Unhelpful Responses

The following responses can unintentionally increase distress, shame, or risk:

- **Taking personal responsibility for the behaviour**
  Feeling responsible can lead to over-involvement or reactive decision-making. Self-harm/suicidality is complex and multi-determined, and no single adult is responsible for preventing it.
- **Telling off, punishing, or withdrawing attention**
  These responses may reinforce shame and can increase the likelihood of further episodes, particularly where behaviour is linked to unmet emotional needs or attachment difficulties.
- **Showing panic, shock, or disgust**
  Strong emotional reactions can escalate the situation and make the pupil feel unsafe or judged. A calm, regulated adult response supports co-regulation.
- **Making assumptions or interrogating the pupil**
  For example, "Why are you doing this?" can feel blaming. Self-harm/suicidality often serves different functions (e.g. emotional regulation, communication, relief from distress), which should be explored gently over time and with clinical support.
- **Ignoring the behaviour or underlying need**
  The underlying need must always be acknowledged and supported.
  Asking for promises not to harm self
  This can create pressure and guilt and is rarely effective in reducing behaviour.
- **Viewing the pupil as 'bad' or 'mad'**
  This reflects a punitive or pathologising mindset, rather than understanding behaviour as communication of distress.
- **Assuming only 'experts' can respond**
  All staff play a key role in relational safety and early support, even when specialist services are involved.
- **Using stigmatising language (e.g. "self-harmer")**
  Labelling can reinforce identity around the behaviour rather than the person.

ADDITIONAL 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

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

OFG's Safety Plan

OFG's Self-Harm & Suicidality Formulation and Support Plan

OFG's policies and guidance on Online Safety & Mobile Devices

Outcomes
First Group